



# Developing a State Health Improvement Plan: Guidance and Resources

A Companion Document to ASTHO's  
State Health Assessment Guidance and Resources

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## How to Use This Guide

This guidance document includes seven modules and describes the process for developing a state health improvement plan (SHIP):

- I. Identifying and Engaging Stakeholders in Planning and Implementation.
- II. Engaging in Visioning and Systems Thinking.
- III. Leveraging Data Inputs.
- IV. Establishing Priorities and Identifying Issues through Priority Setting.
- V. Communicating about SHIP Priorities.
- VI. Developing Objectives, Strategies, and Measures.
- VII. Implementing and Monitoring the SHIP.

Each module includes:

- A preview of content and key components.
- SHIP process steps, including information about the relevant Public Health Accreditation Board (PHAB) standards, measures, and guidance.
- Ideas for structuring the planning process and preparing for implementation and monitoring.
- Important considerations and helpful tips to use throughout the process.
- Key terms and acronyms.
- Specific examples and lessons learned from states.
- Sample tools and links to additional resources.

The State Health Assessment (SHA) is the foundation for developing a SHIP. Therefore, this guide is a companion guide to ASTHO's *State Health Assessment Guidance and Resources*, which is available online at <http://www.astho.org/Programs/Accreditation-and-Performance/ASTHO-Publishes-State-Health-Assessment-Guidance-and-Resources/>, and replaces the previous SHIP Guidance and Resources document released in 2011. We recommend reading through this entire guide before embarking on the planning process. Similar to the SHA process, the improvement planning process also contains a set of interconnected planning and stakeholder engagement activities rather than a set of completely linear steps. The guidance provided in Module 1, "Identifying and Engaging System Stakeholders," will be relevant throughout the SHIP process and is critical for successful implementation.



## Introduction

This guide is intended to be a resource for state health departments who are developing a SHIP. ASTHO has seen increased interest in the state health assessment and state health improvement planning process due to the development of PHAB accreditation, and the creation of grant initiatives, such as CDC's National Public Health Improvement Initiative. This guide includes information and tips based on state health departments' experiences developing and implementing SHIPs.

ASTHO produced this guide to be applicable to both state health departments seeking public health accreditation through PHAB and those developing a SHIP but are not seeking accreditation. The information provided in this guide is intended to be consistent with PHAB requirements and documentation guidance and includes references to PHAB requirements and documentation guidance. **ASTHO does not guarantee that states who follow the guidance in this document will meet PHAB requirements.**

## State Health Assessment (SHA), State Health Improvement Plan (SHIP) and National Public Health Accreditation Board (PHAB) Accreditation

The SHA and SHIP, along with the health department's organizational strategic plan, are prerequisites for state health departments that pursue PHAB Accreditation. For state health departments seeking accreditation, information about relevant PHAB requirements is highlighted throughout this guide in pink boxes like the one below. *PHAB Standards and Measures Version 1.5* is available online at [http://www.phaboard.org/wp-content/uploads/PHABSM\\_WEB\\_LR1.pdf](http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf).

### PHAB Standards and Measures

**PHAB Standard 5.2** – Conduct a comprehensive planning process resulting in a tribal/state/community health improvement plan.

**Measure 5.2.1 S** – A process to develop a state health improvement plan.

**Measure 5.2.2 S** – State health improvement plan adopted as a result of the health improvement planning process.

**Measure 5.2.3 A** – Elements and strategies of the health improvement plan implemented in partnership with others.

**Measure 5.2.4 A** – Monitor and revise, as needed, the strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners.

*(PHAB Standards and Measures Version 1.5, pages 129-143)*

PHAB describes the state health improvement process as follows:

*The state health department's SHIP addresses the needs of all citizens in the state.*

*The SHIP is a long-term, systematic plan to address issues identified in the SHA. The purpose of the SHIP is to describe how the health department and the community it serves will work together to improve the health of the population of the jurisdiction that the health department serves.*

*The community, stakeholders, and partners can use a solid SHIP to set priorities, direct the use of resources, and develop and implement projects, programs, and policies.*

*The plan is more comprehensive than the roles and responsibilities of the health department alone, and the plan's development must include participation of a broad set of community stakeholders and partners. The planning and implementation process is community-driven. The plan reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors.*

*(PHAB Standards and Measures Version 1.5, page 129)*

## Principles to Guide the State Health Improvement Plan

In 2013, Sara Rosenbaum of George Washington University's School of Public Health and Health Services, in collaboration with CDC, published *Principles to Consider for the Implementation of a Community Health Needs Assessment Process*. Through a review of public health literature and resources from professional organizations, she was able to identify common principles for a community health assessment and community health improvement. Although this list of principles was developed for nonprofit hospitals conducting community health needs assessments, the principles highlight foundational elements that are relevant for all community health improvement processes, including the SHIP.

Below is a summary of insights from *Principles to Consider for the Implementation of a Community Health Needs Assessment Process*, Sara Rosenbaum, June 2013:

- **Multi-sector collaborations that support shared ownership of all phases of community health improvement, including assessment, planning, investment, implementation, and evaluation.**  
Findings from the literature point to shared ownership during all phases as particularly important for maximizing collective impact. Successful multi-sector collaborations have a coordinating entity, often referred to as the “backbone,” that helps to facilitate shared commitment, shared measurement, continuous communication, and mutually reinforcing plans of action.
- **Proactive, broad, and diverse community engagement to improve results.**  
The literature suggests that it is essential to facilitate community engagement at each phase of the community health improvement process. It is particularly important to structure the assessment and planning process and resulting interventions so that stakeholders have a shared sense of ownership. Some important stakeholders to engage include civic and faith-based organizations, community hospitals, community-based healthcare providers, health consumers, businesses, private insurers and health plans, and education and social service agencies.
- **A hospital's definition of community that encompasses a significant enough area to allow for population-wide interventions and measurable results, and includes a targeted focus to address disparities among subpopulations.**  
Note: This principle is specific for hospitals conducting a community health needs assessment (CHNA); however, the underlying principle of targeted efforts to address disparities is an important principle for the SHIP.
- **Maximum transparency to improve community engagement and accountability.**  
The literature reveals a number of benefits that can result from maximum transparency throughout the collaborative community health improvement process, including more community buy-in and trust in the process and resultant investments and actions, better decisionmaking based on identified needs and the evidence base, shared responsibility for outcomes, and enhanced evaluation of the effectiveness of investments and interventions.

- **Use of evidence-based interventions and encouragement of innovative practices with thorough evaluation.**  
Findings from the literature point to the effectiveness of evidence-based interventions in community health improvement. At the same time, innovative or promising practices are important for furthering community health.
- **Evaluation to inform a continuous improvement process.**  
Evaluation of collaborative and innovative efforts in cities, regions, and states is critically important for continuing to build a strong evidence base for community interventions and continuous improvement of local efforts to improve community health.
- **Use of the highest quality data pooled from and shared among diverse public and private sources.**  
The literature suggests that a key factor for success in collaborative assessment and planning efforts is the development of agreements for sharing data. Shared data is key for building a strong evidence base and for monitoring and evaluating community health improvement interventions. Agreements related to data sharing must ensure appropriate privacy and security safeguards.

## Process Steps and Products for the SHIP

In many states the process for conducting SHAs and creating SHIPs are linked and system stakeholders are engaged in one continuous process that includes both.

The full SHA and SHIP process includes the steps listed below. The steps covered in this guide are indicated with a check mark (✓). For all items not checked, see ASTHO's SHA guidance at <http://www.astho.org/Programs/Accreditation-and-Performance/ASTHO-Publishes-State-Health-Assessment-Guidance-and-Resources/>.

- Identify and engage stakeholders in planning and implementation.
- Engage in visioning and systems thinking.
- Collect or analyze data.
  - Health status.
  - Environmental scan and asset mapping.
  - Themes and strengths.
  - Forces of change.
  - Strengths, weaknesses, opportunities, and threats (SWOT).
  - System capacity.
- Summarize and present findings from the assessment.
- Communicate and vet priorities.
- Establish priorities and identify issues through priority setting.
- Develop objectives, strategies, and measures.

- Develop and implement workplan.
- Monitor, evaluate, and update SHIP.

The development of a SHIP will result in the following deliverables or products, as described in this guide:

- Partnership, coalition, or committee engaged to lead the process.
- Plan for communicating priorities to stakeholders.
- Set of priority issues.
- Implementation plans for each priority issue.

# MODULE 1

## Identifying and Engaging Stakeholders in Planning and Implementation

### Module Overview

The [\*State Health Assessment Guidance and Resources\*](#) (Module 1, pages 9-31) provides detailed guidance on convening a multi-sector partnership to conduct SHAs. States may choose to use this group to conduct their SHIP process, consider ways to complement or supplement SHA partnerships, or convene a different group. PHAB guidance suggests that an existing “broad, comprehensive partnership” that is convened by or in which the state health department participates may be used to complete the SHA and SHIP process.

This module will help states understand how to:

- Assess their readiness to convene a SHIP partnership that reflects the public health system.
- Structure the planning group to be effective planners.
- Foster leadership.
- Engage new partners in innovative ways.
- Provide tools for implementing effective meetings.

### Key Content and Components

- ◆ Assessing readiness.
- ◆ Understanding the state public health system context.
- ◆ Structuring collaborative planning, SHIP partnership, and workgroups.
- ◆ Leadership.
- ◆ Engaging new partners.
- ◆ Meeting methods and tools.



## Related PHAB Guidance

### PHAB Standards and Measures

#### PHAB Measure 5.2.1 S – A process to develop a state health improvement plan

Required documentation 1.a:

**1. State health improvement planning process that included:**

*Guidance: The state health department must document the collaborative state health improvement planning process. The process may be a national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described. National models include, for example, State Health Improvement Plan (SHIP) Guidance and Resources, Mobilizing for Action through Planning and Partnerships (MAPP) (developed for local health departments but can be used in state health departments), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) and the University of Kansas Community Toolbox. Examples of tools or resources that can be adapted or used include Community Indicators process project, Asset Based Community Development model, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020.*

**a. Broad participation of community partners**

*Guidance: Participation by a wide range of community partners representing various sectors of the community. Partners are organizations that work with the state health department on health issues and could include other governmental agencies, statewide not-for-profit groups, statewide associations, veterinarian organizations, and others, including organizations that are not health-specific, for example, education advocates, businesses, recreation organizations, faith-based organizations, etc. Members of this group may or may not be the same as members of the community health assessment partnership. Documentation could be, for example, participant lists, attendance rosters, minutes, or membership lists of work groups or subcommittees.*

**NOTE: Bullets b-d for 5.2.1 S are on page 30, and bullet e for 5.2.1 is on page 39.**

*(PHAB Standards and Measures Version 1.5, pages 130-131)*

While PHAB standards and measures related to SHIP are found in Domain 5, Measure 4.1.1 A (see Appendix A) calls for the state health department’s “establishment, engagement, and active participation in a comprehensive community health partnership or coalition.” PHAB’s guidance for a partnership or coalition indicates that it can be the coalition or partnership convened for the purposes of a SHA and SHIP:

*“The state health department must document a current, ongoing comprehensive community partnership or coalition in which it is an active member. The purpose of the partnership or coalition must be to improve the health of the community, and therefore, must be engaged in various issues and initiatives. A comprehensive community partnership, in this context, is a partnership that is not topic or issue specific. It is a community partnership that addresses a wide range of community health issues. The comprehensive partnership or coalition may be organized into several committees or task forces to address specific issues, for example, teenage pregnancy, social determinants of health, health equity or increased opportunities for physical activities. This partnership or coalition may be the same group that developed the community health assessment and community health improvement plan. This partnership or coalition may work on various issues addressed in the Standards and Measure, such as access to care (Domain 7).”*

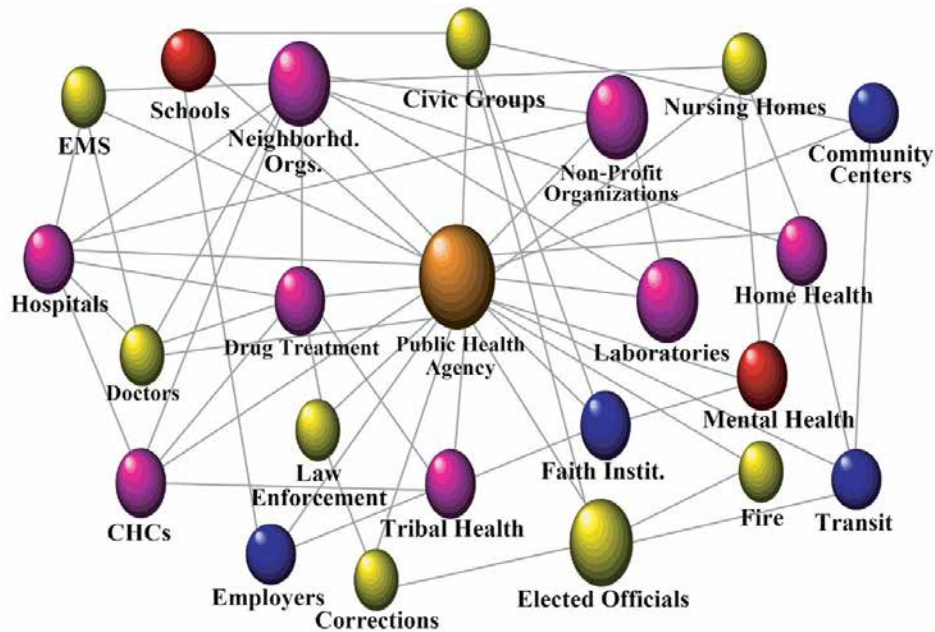
If this coalition or partnership guides the development and implementation of the SHIP, it is important to keep in mind some of the other documentation requirements for 4.1.1 A, such as “provide a list of the participating partner organizations for the partnership(s) or coalition(s)” and documentation of “a change in the community, a change in policy, or a new or revised program that was implemented through the work of the partnership(s) or coalition(s)” (PHAB Standards and Measures Version 1.5, pages 116-118).

## Assessing Readiness and Understanding the State Public Health System Context

CDC has defined a public health system as “public and private entities and sectors which contribute to public health services within a community.” These may include civic groups, nonprofit organizations, employers, schools, and others as indicated in Figure 1.1 below. More detailed information on defining the public health system and classification of health departments is included in the [State Health Assessment Guidance and Resources](#) on pages 10-13. As described above, “the health department must document a current, ongoing comprehensive community partnership or coalition in which it is an active member. The purpose of the partnership or coalition must be to improve the health of the community and, therefore, must be engaged in various issues and initiatives.” For example, Oklahoma’s State Health Improvement Plan includes partnerships with “committed individuals representing business, labor, legislature, healthcare providers, tribes, academia, nonprofit organizations, state and local government organizations, professional affiliations, and parents.” The state public health system is not static, so the SHIP partnership should look for opportunities to strengthen networks and accrue new partners over time.



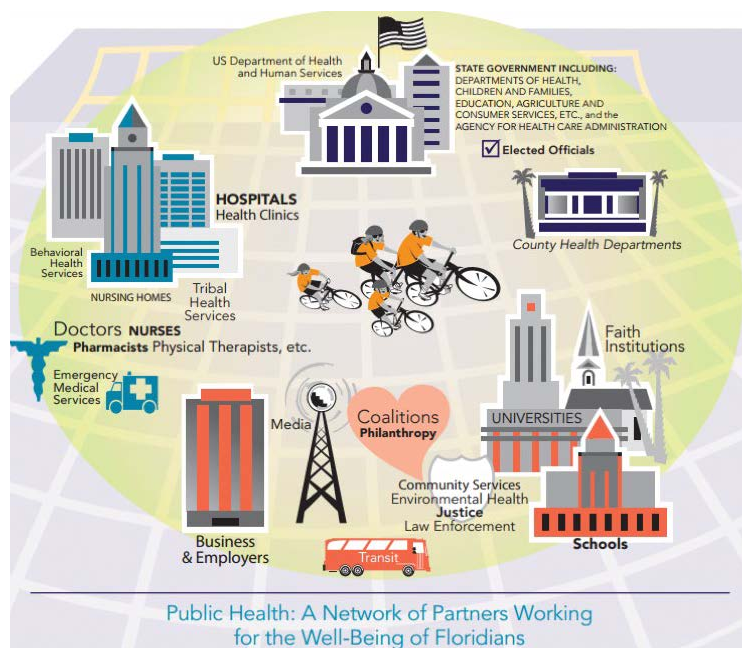
**FIGURE 1.1 PUBLIC HEALTH SYSTEM**



Source: CDC. "The Public Health System and the 10 Essential Public Health Services."

The state health department should consider developing a tailored diagram of the public health system that will resonate with a range of stakeholders involved with the SHIP process. Figure 1.2 shows an example from Florida.

**FIGURE 1.2. DIAGRAM OF FLORIDA'S PUBLIC HEALTH SYSTEM**





Assessing readiness is a critical step to ensure success of the planning and implementation process, and should be done early on to inform design of the process and timeline. A readiness assessment tool can be helpful to guide the SHIP steering committee in determining whether the requisite elements are in place to move forward. Figure 1.3 is an example of readiness assessments.

**FIGURE 1.3 READINESS ASSESSMENT CHECKLIST**

CRITICAL ELEMENTS (MUST HAVE)	0	1	2	3	4
	0=NOT AT ALL → 4=COMPLETELY				
Process has strong sponsors					
Process has effective champions					
Support outweighs opposition					
Key resources are budgeted					
Core participants are willing and available					
There is general agreement on purpose and outcomes					
There is general agreement on how to proceed					
Scope of the planning effort is reasonable					
Staff and technical support have been identified					
<b>DESIRED ELEMENTS (NICE TO HAVE)</b>					
Purpose and benefits are well-understood					
Participants understand health improvement planning					
All needed resources are in place					
Outside technical assistance has been lined up					
Participation and organizational structure is clear					
Roles and responsibilities are clear					
A planning process has been specified					
Time frame has been specified in a workplan					

Source: Adapted from John M. Bryson and Farnum K. Alston. 2005. *Creating and Implementing Your Strategic Plan: A Workbook for Public and Nonprofit Organizations*. San Francisco: Jossey Bass.



### **IMPORTANT CONSIDERATIONS: Laws, Regulations, Policies, and Trends (at the state and federal level)**

Each state should have a thorough understanding of the relevant state-level laws, regulations, and policies that will affect SHIP planning and implementation. It is also very important to share that information with SHIP partnership stakeholders.

Affordable Care Act (ACA) implementation has a number of important implications for the SHIP. CDC's health system transformation web page (<http://www.cdc.gov/stltpublichealth/Program/transformation/>) is a good resource for keeping up to date on emerging issues and opportunities related to health system transformation.

State health department representatives we spoke to mentioned four key topics related to ACA implementation that will affect the SHIP moving forward:

- Non-profit hospitals are now required to conduct community health needs assessments (CHNAs) and many states are working to engage hospitals to align their CHNA planning and implementation efforts with the SHIP. Hospitals are also increasingly engaging directly in community prevention and population health initiatives because of changes in reimbursement as a result of ACA. See page 17 of this guide for additional tips about how to engage healthcare partners in the SHIP.
- Many states have already expanded Medicaid and others are considering whether to do so in the future. State health departments we spoke to identified this as a key part of access to care discussions and having important implications for all prevention efforts.
- Through the Center for Medicare and Medicaid Services (CMS), states that are involved with State Innovation Models Initiatives are now required to develop a "Population Health Plan." A number of states we spoke to are in the process of determining how to ensure that the SHIP and the Population Health Plan are coordinated efforts.
- State health departments and their public health system partners are poised to be important experts on population health and community health, and the SHIP planning and implementation process provides an opportunity to develop strong, collaborative efforts for population health. IOM's 2012 report on primary care and public health found: "Ensuring that members of society are healthy and reaching their full potential requires the prevention of disease and injury; the promotion of health and well-being; the assurance of conditions in which people can be healthy; and the provision of timely, effective and coordinated health care. A wide array of actors across the United States—including those in both primary care and public health—contribute to one or more of these elements, but their work is often carried out in relative isolation. Achieving substantial and lasting improvements in population health will require a concerted effort from all of these entities, aligned with a common goal. The integration of primary care and public health could enhance the capacity of both sectors to carry out their respective missions and link with other stakeholders to catalyze a collaborative, intersectoral movement toward improved population health." See Appendix C for IOM's Principles for Successful Integration of Primary Care and Public Health.

## Structuring the Collaborative Planning Process and SHIP Partnership

This section discusses suggestions for stakeholder engagement throughout the SHIP process.

States can take a number of approaches when designing the structures to support the SHIP process. Typically, this includes a formal partnership structure to ensure the development and implementation of the process, with workgroups for each priority, as well as a measurement or evaluation workgroup to lead the creation, measuring, and monitoring of action plans for each priority.

### SHIP Partnership

Individuals representing stakeholders (i.e. policymakers, local health departments, other state governmental departments, foundations and funders, and statewide organizations representing local health departments, education, transportation, hospitals, and other healthcare providers, etc.) typically form some sort of defined structure or SHIP partnership to fully develop, implement, and evaluate improvement plans.

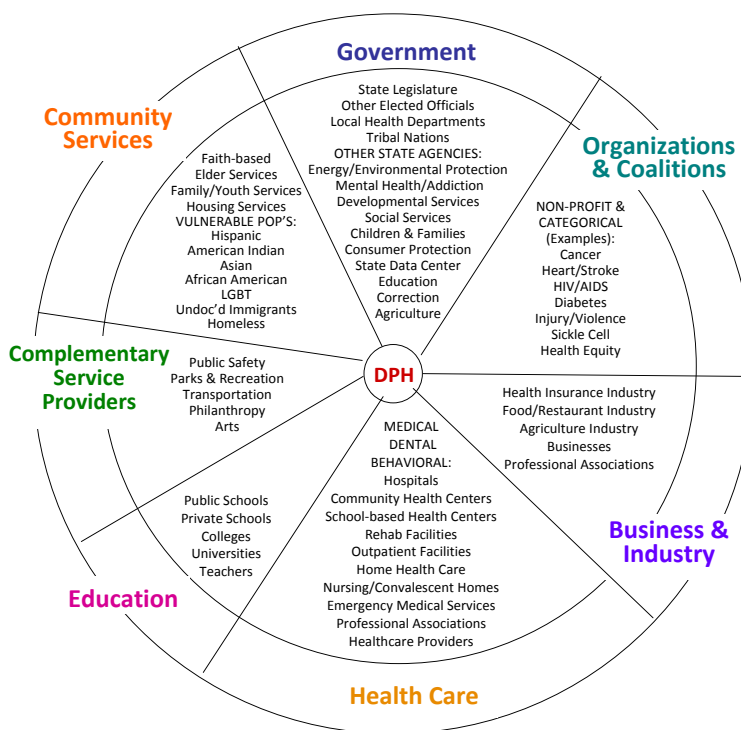
To help ensure comprehensive implementation, states should give consideration to the types of strategies and sphere of influence stakeholders have, including their reach across the social ecological model (see Figure 6.1 on page 57). This reach includes ensuring a continuum of activities that address health across the lifespan and the diversity of the state's population. For more information on the Social Ecological Model, refer to Module 6 on page 55.

### Opportunities for Stakeholder Engagement

Stakeholder engagement can be done in a variety of ways based on the structure of the SHIP process. The SHIP steering committee can provide oversight on the engagement process by using workgroups, subcommittees, key informant interviews, asset mapping, and system self-assessment on different content areas. PHAB Measure 4.1.1 A (described on page 58 of this document) provides detailed information on parameters and characteristics for partnerships and coalitions.

The SHIP process should engage a diverse range of stakeholders to ensure cross-sector buy in and collaboration. When identifying stakeholders to engage, the SHIP executive committee should look broadly across the public health system, as depicted in Figure 1.1 on page 14. Using a stakeholder wheel, like the one created by the Connecticut Department of Public Health (shown in Figure 1.4 on page 18), can help the executive committee consider the range of potential sectors and stakeholders in public health and look beyond traditional partners and existing relationships to increase the breadth of perspectives represented in the process.

**FIGURE 1.4 SECTOR AND STAKEHOLDER WHEEL**



Source: Connecticut Department of Public Health

As with the SHA process, special consideration for vulnerable populations is paramount, so the SHIP executive committee should take special care to identify and engage stakeholders to assure the SHIP addresses social, economic, and environmental determinants of health. Stakeholders can be engaged in a variety of ways depending on their expertise, skills, and resources, including informing the prioritization process, identifying and engaging community groups when seeking public input, serving on priority workgroups, and monitoring and evaluating the SHIP. Stakeholders with expertise in vulnerable populations should be engaged to inform the prioritization process ensuring that disadvantaged community members are represented. These stakeholders can also be helpful in engaging hard-to-reach populations in gathering community input. In addition, after priorities are selected, stakeholders with special expertise in each priority should be invited to serve on workgroups. For example, if healthy child development is selected as a priority area, it would be important to engage partners from education, early childhood, and youth development sectors. Stakeholders with quantitative analysis or evaluation expertise can be engaged to participate in designing a measurement plan and monitoring implementation of the SHIP.

After identifying different sectors from which stakeholders can be recruited, teams can use a matrix (Figure 1.5) to determine the capacity of each stakeholder. This matrix can be used to collect contact information, various areas of expertise, and identify and track methods of involvement. When determining how best to engage stakeholders, it is important to understand partners' motivations for participating in the SHIP process and the resources they can offer to ensure an appropriate level of engagement and commitment.

**FIGURE 1.5 STAKEHOLDER MATRIX**

STAKEHOLDER INFORMATION			ROLE					
Organization	Contact Person	Area of Expertise/Sector	SHIP Partnership	Measurement/Evaluation Workgroup	Priority 1 Workgroup F = Facilitator; M = Member	Priority 2 Workgroup F = Facilitator; M = Member	Priority 3 Workgroup F = Facilitator; M = Member	Priority 4 Workgroup F = Facilitator; M = Member

Source: Adapted from Connecticut Department of Public Health and Health Resources in Action, Inc.

While not all stakeholders need to be involved at the same levels of the SHIP process, engaging a wide breadth of stakeholders in planning and decisionmaking will allow for a broader range of perspectives and will achieve a more balanced voice and more equitable representation of diverse interests and values.

### Action Planning and Implementation Workgroups

The partnership should develop workgroups for each priority issue and have engagement with diverse stakeholders and partner organizations. Module 4 provides information on selecting priority issues from data compiled in the SHA. As described in Module 6, each workgroup will focus on specific tasks and objectives related to the priority issue. The formation of workgroups is an opportunity to engage new partners that may not have time to participate in the entire SHIP process, but have expertise or existing work experience related to a specific topic area and are committed to alignment of implementation activities. These workgroups help draft objectives and identify strategies and potential measures, and will work with the organizations and groups they represent to implement the action plans (as described in Modules 6 and 7).

### Measurement or Evaluation Workgroup

In addition to the priority issue workgroups, the health department and the SHIP leadership may find it helpful to form a measurement or evaluation workgroup that reports to the partnership or state health department. This group is responsible for drafting or finalizing the objectives, strategies, and measures, and providing technical expertise for measurement and monitoring. This team of data and evaluation experts can provide vital support to the workgroups and to the overall partnership for development of SMART objectives and realistic measurement plans and strategies that are likely to produce the desired outcomes.

## Engaging New Partners in Implementation

In addition to the action planning stage described above, implementation efforts offer additional opportunities to engage new partners. In many cases, new partners are essential for the implementation of plans. Without new partners who have a shared commitment and responsibility for improving population health, the plan might never be fully implemented. The state health department, or any single agency or organization, cannot do it all on their own and needs partners to share in implementation. See pages 38-39 for tools to identify new assets and partners that can be engaged in action planning and implementation.

### **FIGURE 1.6 STAKEHOLDER ENGAGEMENT — CONSIDERATIONS FOR SUCCESSFULLY ADVANCING HEALTHY EQUITY**

*Adapted from: NACCHO. (2014). Mobilizing and Organizing Partners to Achieve Health Equity.*

To identify, communicate, and develop strategies to achieve health equity, the SHIP partnership must mobilize and organize the right people. The Mobilizing for Action through Planning and Partnerships (MAPP) Health Equity Supplement from NACCHO suggests including the following types of stakeholders in the health improvement planning process:

- Population groups that are affected by health disparities due to racism, gender inequity, socioeconomic status, and other structural inequities.
- Individuals with decisionmaking ability and the knowledge and power to influence policies, investments, and laws that have caused (or can prevent) health inequity.
- Individuals with expertise in data analysis and measurement of social, economic, and health inequity indicators.
- Groups that can communicate the causes of health inequities in a way that inspires people to work on achieving health equity.
- Facilitators that can create an environment which leads to productive discussions about health inequities and possible solutions or collaborative action.

As states engage new partners for action planning and implementation, they should consider other initiatives or planning activities that are underway and relevant to the SHIP priorities and seek opportunities to align efforts. For instance:

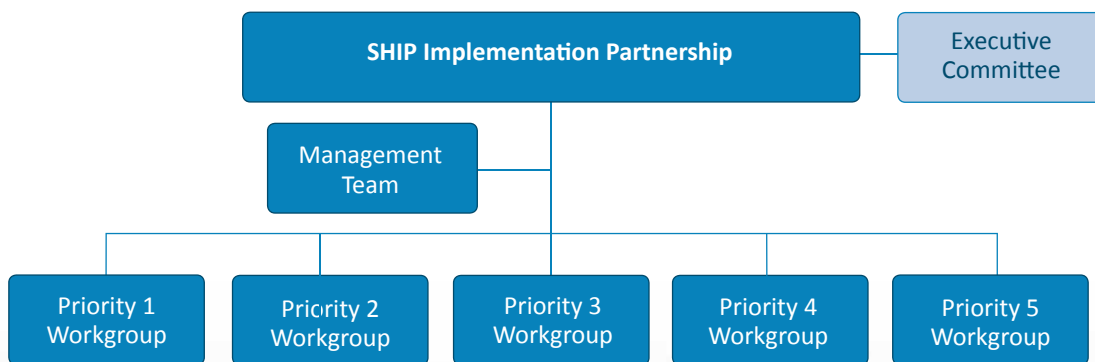
- Many states have activities underway that seek to integrate public health and primary care.
- State education systems may have a strong school health component.
- Transportation and land-use sectors regularly create regional and state-level long range plans that can impact health.
- State economic development plans may have goals and initiatives that are relevant to the SHIP.

## Sample Structure

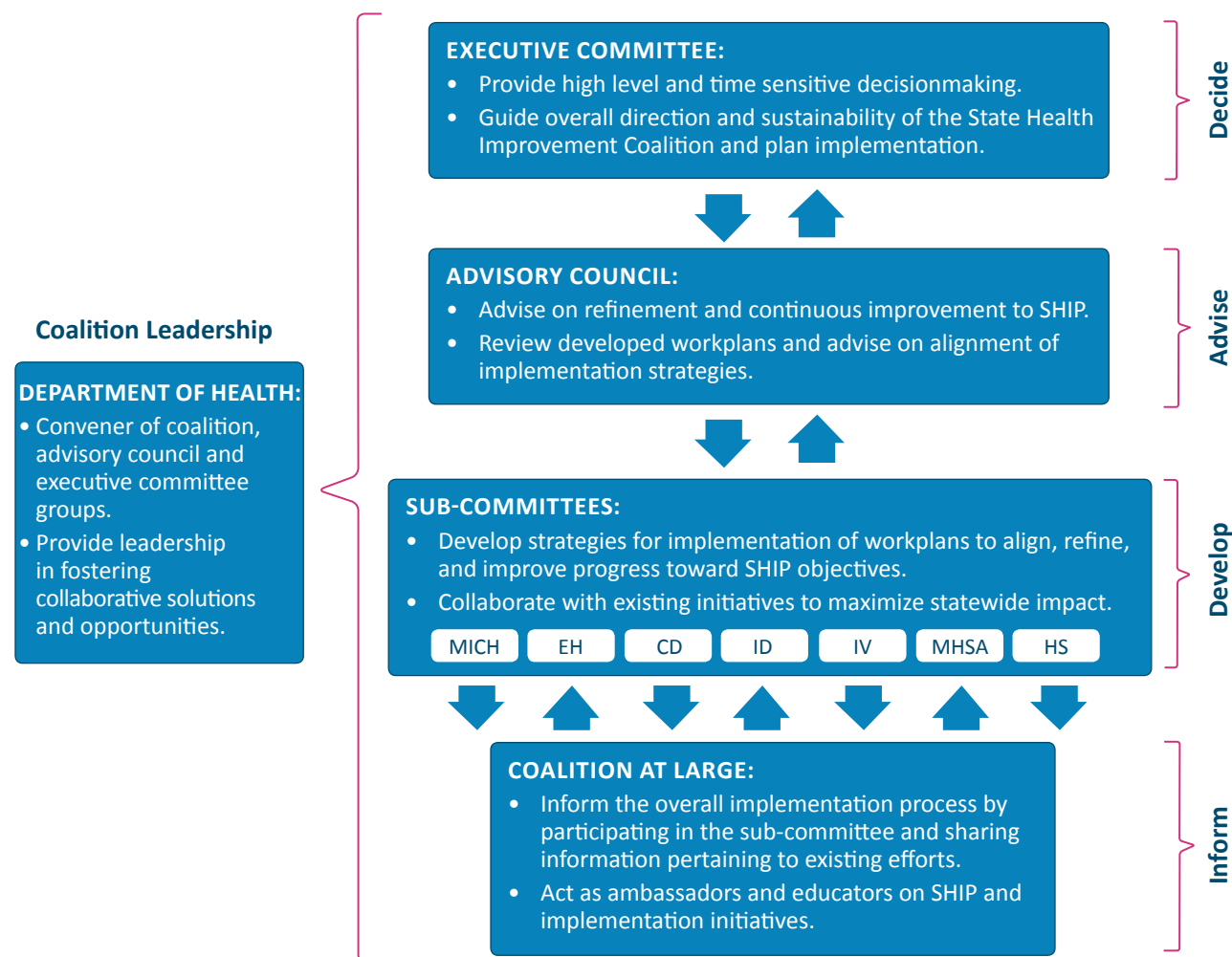
A sample structure to support development, implementation, and continued monitoring of a state health improvement plan might look something like Figure 1.7, with the number of workgroups varying based on the number of priority issues. Figure 1.8 shows an example of Connecticut’s partnership structure.

Staff support is also necessary for providing administrative and logistical help during the SHIP process, such as planning, convening, and documenting workgroup meetings. Typically, at least one staff person is assigned to each workgroup for this type of support. If it is not feasible to assign a staff member, it will be important to solicit support for these roles from other key partner organizations with the same degree of investment.

**FIGURE 1.7 SAMPLE STRUCTURE**



**FIGURE 1.8 SAMPLE ORGANIZATIONAL STRUCTURE — CONNECTICUT SHIP IMPLEMENTATION COALITION**



### Group Functionality

The governance structure of the state health department and existing relationships with stakeholders and partners will inform group functionality and the development of an appropriate SHIP partnership structure. Regardless of the final structure, it is important for the SHIP partnership to include representatives from a variety of sectors, allowing for diverse perspectives and resources throughout the process. Other factors to consider when developing the governance structure are the strengths of each of the members, including skills, expertise, and represented populations. PHAB measure 4.1.1 A provides basic guidance for the development and formation of partnerships.

Other considerations when developing a structure for group functionality include the need to work collaboratively and with partners, even though it may be time-consuming and could present various challenges. Collaborating on strategies, such as communication plans, and meeting structure, and establishing foundational principles to support collaborative group work is important to achieve success. This can be done by developing mission, vision, and value statements as described on page 20 of the [State Health Assessment Guidance and Resources](#).



## Rules of Engagement

Rules of engagement are norms or agreements developed to guide the functioning of a group. These rules are developed collectively, but the state health department must ensure that they are functional and meet the needs of all partner types. Figure 1.9, adapted from the ASTHO SHA guide, includes sample questions to consider when developing rules of engagement.

### FIGURE 1.9 QUESTIONS TO CONSIDER WHEN DEVELOPING RULES OF ENGAGEMENT

- Is there one organization or division designated as the meeting logistics lead for development of the SHIP? (This could be internal or external to the health department.)
- What responsibilities do members of the group have?
- What is the required or expected level of attendance?
- What are the consequences if someone does not meet the responsibilities?
- Who is responsible for arranging meetings?
- What meeting locations are most accessible and comfortable for group members? What are neutral meeting locations?
- How is the agenda set?
- Who will take notes at the meeting?
- How will meeting logistics, minutes, and activities be communicated to the group?
- Who facilitates meetings? (Include substitutes in case the lead facilitator is absent.)
- How will decisions be made?
- Who will make the final decision?
- What are our group norms? What are the expectations of behavior toward other group members?
- How do new partners become involved in the group?

The Connecticut Department of Public Health (CTDPH) recommends reading the book *Terms of Engagement* by Richard Axelrod. CTDPH found the four basic principles outlined in the book—Widen the Circle of Involvement, Connect People to One Another, Create Communities of Action, and Promote Fairness—offer a strong foundation for their staff readiness to lead the SHIP process and provide useful framework for collaboration.

When engaging SHIP partnership and workgroup members, one of the most important considerations is determining and formalizing the levels of commitment to SHIP implementation. The SHIP partnership and its workgroups should clearly define roles and expectations. As described on page 24 of the [State Health Assessment Guidance and Resources](#), adopting formal agreements such as charters, bylaws, or memoranda of understanding can be very helpful in defining roles and delegating responsibilities, ultimately supporting a more successful implementation of the plan. Examples of a charter from Washington State’s Public Health Improvement Partnership and bylaws from Illinois’ State Health Improvement Plan Planning Team are included in Appendix D1 and D2.

## Leadership

States have developed a variety of approaches for the leadership and governance of their SHIP process. In Illinois, the SHIP Implementation Coordination Council is co-chaired by the governor's office in order to facilitate and foster engagement and participation by other state agencies (such as environment, human services, and transportation). Many states select local health departments, in addition to multi-sectoral stakeholders, to serve as members of their SHIP steering committee and workgroups. Washington State is an example of a decentralized state that has made substantial efforts to integrate local health jurisdictions as leaders within the partnership to oversee the SHIP process. As a result, public health leaders at the state and local level are invested in the implementation and outcomes of the plan. For more information, read the case study for Washington State in Module 3 on page 34. In Illinois, the state has a legislatively-mandated Implementation Coordination Council (ICC) that oversees a number of charges, including the SHIP. Illinois' SHIP ICCs established an ad hoc committee to oversee the SHIP, which allows for broader stakeholder participation in leading the SHIP development. For more information, see the Illinois' case study in Module 7 on page 79.



### **IMPORTANT CONSIDERATIONS: Alignment with State Health Department's Performance Management Model**

A performance management system includes the setting of performance standards, measuring of progress, and reporting of results, and the application of quality improvement activities when improvement is needed. Performance standards are developed, monitored, and reported as they are related to important administrative functions, programs, and services provided by or through the health department; these could include the health department's strategic plan and state health improvement plan activities.

Therefore, a set of performance standards, related to the state health department's work associated with SHIP development, implementation, monitoring, and evaluation, should be developed and incorporated into the performance management system. The standards should include a baseline, targets, and measurement plans, and be monitored and reported on a regular basis. When results are not achieving defined standards, formal quality improvement tools and processes should be applied to improve results.

According to the PHAB Acronyms and Glossary of Terms, Version 1.5, "a fully functioning performance management system that is completely integrated into health department daily practice at all levels includes:

1. Setting organizational objectives across all levels of the department.
2. Identifying indicators to measure progress toward achieving objectives on a regular basis.
3. Identifying responsibility for monitoring progress and reporting.
4. Identifying areas where achieving objectives requires focused quality improvement processes."

ASTHO has developed a position statement on performance management in public health that references the importance of performance management for a more efficient, effective, and accountable public health system. The full position statement can be located at: <http://www.astho.org/Policy-and-Position-Statements/Position-Statement-on-Performance-Management/?terms=performance+management>.

## Meeting Methods and Tools

Effective meetings are key to ensure forward momentum and sustained engagement throughout the SHIP process. Planning and facilitation skills are critical for good meetings. Module 1 of the [State Health Assessment Guidance and Resources](#) covers a range of tips and tools for facilitating successful meetings. Some of the topics covered include meeting design, partnership communication strategies, effective and neutral facilitation, meeting evaluation to inform improvements for future meetings, and documenting meetings and process.

### FIGURE 1.10 RESOURCES AND LINKS – PARTNERSHIP

- IOM. (2012). An Integrated Framework for Assessing the Value of Community-Based Prevention. [http://www.nap.edu/download.php?record\\_id=13487#](http://www.nap.edu/download.php?record_id=13487#)
- IOM. (2012). For the Public's Health: Investing in a Healthier Future. [http://www.nap.edu/download.php?record\\_id=13268#](http://www.nap.edu/download.php?record_id=13268#)
- IOM. (2013). Toward Quality Measures for Population Health and the Leading Health Indicators. [http://www.nap.edu/download.php?record\\_id=18339](http://www.nap.edu/download.php?record_id=18339)
- Kania, J. and Kramer, M. (2011). Collective Impact. [http://www.ssireview.org/articles/entry/collective\\_impact](http://www.ssireview.org/articles/entry/collective_impact)
- Kania, J., Hanleybrown, F., and Juster, J. (2014). Essential Mindset Shifts for Collective Impact. [http://www.ssireview.org/articles/entry/essential\\_mindset\\_shifts\\_for\\_collective\\_impact](http://www.ssireview.org/articles/entry/essential_mindset_shifts_for_collective_impact)
- Irby, M. and Boyle, Page (2014). Aligning Collective Impact Initiatives. [http://www.ssireview.org/articles/entry/aligning\\_collective\\_impact\\_initiatives](http://www.ssireview.org/articles/entry/aligning_collective_impact_initiatives)
- IOM. (2012). Primary Care and Public Health: Exploring Integration to Improve Population Health. [http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2012/Primary-Care-and-Public-Health/Primary%20Care%20and%20Public%20Health\\_Revised%20RB\\_FINAL.pdf](http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2012/Primary-Care-and-Public-Health/Primary%20Care%20and%20Public%20Health_Revised%20RB_FINAL.pdf)
- MAPP. (2014). Health Equity Supplement. <http://www.naccho.org/topics/infrastructure/mapp/framework/mapppubs.cfm>
- Axelrod, Richard. (2010). Terms of Engagement, 2nd Edition.
- Baker, et al. (1994). Health Reform and the Health of the Public Forging Community Health Partnerships.
- Health Research and Educational Trust. (2012) Managing Population Health: The Role of the Hospital. [http://www.hpoe.org/Reports-HPOE/managing\\_population\\_health.pdf](http://www.hpoe.org/Reports-HPOE/managing_population_health.pdf)
- Himmelman, A.T. (2002). Collaboration for a Change: Definitions, Decision-Making models, Roles, and Collaborative Process Guide. <https://depts.washington.edu/ccph/pdf/files/4achange.pdf>
- Klaus, T.W. (March, 2012). Building Effective Collaborative Partnerships. [Presentation] [https://www.hhs.gov/ash/oah/sites/default/files/ash/oah/oah-initiatives/ta/experience\\_expertise\\_klaus.pdf](https://www.hhs.gov/ash/oah/sites/default/files/ash/oah/oah-initiatives/ta/experience_expertise_klaus.pdf)
- County Health Rankings Action Center <http://www.countyhealthrankings.org/roadmaps/action-center/work-together>

## MODULE 2

# Engaging in Visioning and Systems Thinking

## Module Overview

The first step to producing a SHIP is to develop the mission, vision, and values to guide the SHIP partnership and give a shared sense of purpose. This step may have already been completed during the SHA process (as described in the [State Health Assessment Guidance and Resources](#) on pages 20-23), but depending on the time that elapsed between then and developing a SHIP, the partnership may wish to review and refine these statements to guide efforts.

This module touches on mission, vision, and values and provides guidance, resources and examples of how to include concepts of health equity in the vision and values, as well as how to incorporate systems thinking and a collective impact framework.

### Key Content and Components

- ◆ Mission, vision, and values.
- ◆ Health equity in vision and values.
- ◆ Systems thinking and collective impact.

## Mission, Vision, and Values Statements

If a shared vision was not created during the SHA process, time should be taken to develop one as the partnership kicks off the SHIP process. As described in the *State Health Assessment Guidance and Resources*, a shared sense of purpose among the partners involved in the SHA and SHIP processes helps create a strong foundation for collective work. Through work on the mission, vision, and values, the partnership will collectively define the SHIP's purpose and detail the charge of the project team, committees, and workgroups. If new stakeholders are added while moving from the development of SHA and into SHIP, it may make sense to add to or review the mission, vision and values. After reviewing all of the SHA data, the group should have a more thorough understanding of the current state of health, which might clarify and enhance the facilitation of a meaningful vision that is reflective of both the current state and the desired state.

See the [State Health Assessment Guidance and Resources](#) (pages 20-23) for a more detailed description and examples related to developing mission, vision, and values.

## Health Equity in Vision and Values

Given the importance of addressing and improving the health of vulnerable populations, highlighting a focus on health equity in the vision and values may provide important guidance to the SHIP process. NACCHO recently released a supplement to the MAPP handbook, *Mobilizing and Organizing Partners to Achieve Health Equity*, which includes some useful tips on practical ways for a partnership to consider health equity in the process of developing a vision (see Figure 2.1 and Figure 2.2).

## FIGURE 2.1 RESOURCES AND LINKS – PARTNERSHIP

Source: NACCHO. (2014). *Mobilizing and Organizing Partners to Achieve Health Equity*.

Questions to ask participants who are creating vision statements that aim to achieve health equity:

- What does an equitable community look like to you?
- What would be different in our community if all people had circumstances in which they could live healthy and flourishing lives?
- What would institutions (e.g., health departments, schools, prisons, hospitals, corporations) do differently if they contributed to a more equitable community?
- What would our community look like if all people and groups were equally represented in positions of power and decisionmaking?
- In five years, if our community successfully worked towards achieving health equity, what would we have accomplished?
- If our community were nationally recognized as an equitable place to live, what would people say?

Questions to generate value statements that ensure health equity is in the collaborative process:

- What must be in place to ensure that our SHIP process is equitable, transparent, accessible, and inclusive, particularly of those affected by inequity?
- What values must we uphold to ensure equitable participation?
- How do we ensure we do not inadvertently create, contribute to, or support decisions, policies, investments, rules, and laws that contribute to health inequities?
- How do we ensure that the community drives and owns the process?
- How do we ensure that we can share power with those affected by inequity?

## FIGURE 2.2 HEALTHY MINNESOTA PARTNERSHIP VISION AND VALUES

***All people in Minnesota enjoy healthy lives and healthy communities.***

### ***We Value... Connection***

We are committed to strategies and actions that reflect and encourage connectedness across the many parts of our community. Our collaboration, cooperation, and partnerships reflect our shared responsibility for ensuring health equity and creating healthy communities.

### ***We Value... Voice***

People know what they need to be healthy, and we need to listen. Every part of every community has an equal claim to having their voices heard and considered in new conversations about health.

### ***We Value... Difference***

We are all members of many communities, with great diversity of experience, perspectives, and strengths. Those differences make us stronger together than we would be alone.

## Collective Impact

The term collective impact was first introduced in 2011 by John Kania and Mark Kramer in the *Stanford Social Innovation Review*. Collective impact is frequently referenced in public health as an important framework for increasing the impact that can be achieved through collaborative work. Collective impact involves diverse stakeholders working across sectors who take a systematic approach to develop solutions to problems, build and leverage collaborative relationships, and work toward shared objectives across organizations. Successful collective impact initiatives work to build upon and enhance traditional approaches to collaboration and coalition building through structured process, committed staff, defined infrastructure, mutual mission and values, a shared agenda, methods of outcome measurement, consistent communication, and support and reinforcement of activities between all members involved (Edmondson & Hecht, 2014). The original collective impact framework focused on five conditions as shown in Figure 2.3.

### FIGURE 2.3 COLLECTIVE IMPACT – KEY CONCEPTS

Conditions for Collective Success:

- **Common agenda.**  
All partners share a vision for change that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions.
- **Shared measurement systems and approaches to evaluating progress.**  
All partners agree upon and track common metrics, allowing for more alignment across organizations, accountability, and shared learning from each other's successes and failures. In many of the most successful examples of collective impact, the partners use web-based systems to report and aggregate data for common metrics.
- **Mutually reinforcing activities.**  
Within successful collective impact initiatives, all organizations are not required to work on every strategy; rather, each partner organization excels in specific activities that are coordinated with other partners. A collaboratively developed strategic plan, like SHIP, is the foundation and roadmap for successfully carrying out mutually reinforcing activities.
- **Continuous, consistent, and open communication.**  
All partners must engage in frequent communication to ensure that there is trust in the partnership.
- **“Backbone” support organization(s) to convene and coordinate, including dedicated staff.**  
Ongoing support by dedicated staff is critical to guiding strategy, aligning actions, and mobilizing resources for collective impact.

Reference: Kania, J and Kramer, J. (2011). “Collective Impact.” *Stanford Social Innovation Review*.

Many public health issues are adaptive problems, as opposed to technical problems, meaning they are complex and no single agency or organization has the resources or authority to make the necessary changes to solve the problem. Effective solutions to adaptive problems require stakeholders to work together and change their organizational behaviors in order to create solutions. Groups that have worked to apply collective impact across the country have identified a number of additional factors that contribute to success, as shown in Figure 2.4.

## FIGURE 2.4 COLLECTIVE IMPACT – SUCCESS FACTORS

Additional factors that facilitate success:

- Coordinated assessment and planning.
- Build a culture of continuous improvement.
- Collective impact process should emphasize evidence-based decisionmaking and strengthen relationships.
- Shared leadership and clear responsibility and accountability for individual partners.
- Ability to be innovative in leveraging investments and weaving together different funding streams.
- Coordinated approaches to changes in policy (regulatory, legislative, and institutional).
- Involvement of partners and community leaders with expertise in community organizing.
- A broad coalition that can have influence from both the top-down and the bottom-up.
- Embracing “the paradox of combining *intentionality* (that comes with the development of a common agenda) and *emergence* (that unfolds through collective seeing, learning and doing).”
- Sharing credit is as important as taking credit.

### References:

Kania & Kramer. (2013). *Embracing Emergence: How Collective Impact Addresses Complexity*.

Kania, Hanleybrown, & Splansky Juster. (2014). *Essential Mindset Shifts for Collective Impact*.

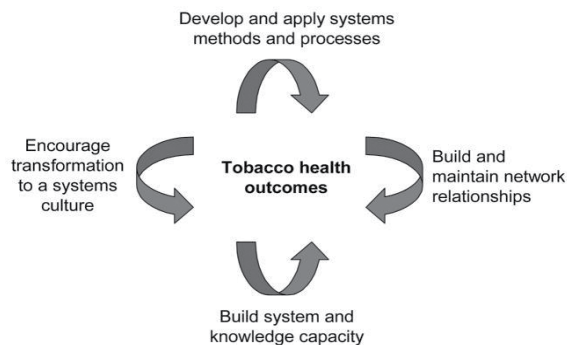
Trust for America’s Health. (2014). *Twin Pillars of Transformation: Delivery System Redesign and Paying for Prevention*.

Sprong & Stillman. Health Resources in Action. (2014). *Building Healthy Communities by Leveraging Multi-Sector Investments: New Opportunities to Improve the Health and Vitality of Communities*.

Illinois Public Health Institute. (2014). *Community Development and Health in the Chicago Metro Region—Key Ideas and Opportunities for Action and Engagement*.

A useful concept for collective impact and adaptive problem-solving approaches is “systems thinking.” Figure 2.5 shows a high level systems thinking framework for addressing public health issues. This model shows four inter-related components that are essential for taking a systems approach to addressing complex public health issues. More resources for systems thinking and adaptive problem solving can be found in the important consideration box on page 30.

## FIGURE 2.5 INTEGRATIVE SYSTEMS THINKING FRAMEWORK FOR COMPLEX SYSTEMS IN PUBLIC HEALTH



Source: Leischow et al, 2008





## **IMPORTANT CONSIDERATION: Visioning and Systems Thinking throughout the SHIP Process**

### **Systems Thinking in Public Health**

Institute of Medicine. (2012). *An Integrated Framework for Assessing the Value of Community-Based Prevention*. Washington, DC: The National Academies Press. [www.ncbi.nlm.nih.gov/books/NBK206926/](http://www.ncbi.nlm.nih.gov/books/NBK206926/)

Georgia Health Policy Center and National Network of Public Health Institutes. (2014). Leading through Health System Change Planning Tool. <http://www.acaplanningtool.com/home>

Learning for Action. Latham, N. *A Practical Guide to Evaluating Systems Change in a Human Services System Context*. 2014. [http://www.evaluationinnovation.org/sites/default/files/Systems%20Change%20Evaluation%20Toolkit\\_FINAL.pdf](http://www.evaluationinnovation.org/sites/default/files/Systems%20Change%20Evaluation%20Toolkit_FINAL.pdf)

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Sterman, J. (2006). Learning from Evidence in a Complex World. *American Journal of Public Health* 96(3), 505-514. <http://jsterman.scripts.mit.edu/docs/Sterman-2006-LearningFromEvidence.pdf>

ASTHO. (2014). Collaborative Partnerships and Practices for Accreditation Preparation. <http://www.astho.org/Accreditation-and-Performance/Accreditation-Collaborative-Partnerships/White-Paper/Home/>

### **Collective Impact**

Collective Impact Forum, an initiative of FSG and the Aspen Institute Forum for Community Solutions <http://www.collectiveimpactforum.org/>

FSG Knowledge Exchange <https://clearimpact.com/fsg-collective-impact-resources/>

Stanford Social Innovation Review [http://www.ssireview.org/articles/entry/collective\\_impact](http://www.ssireview.org/articles/entry/collective_impact)  
[http://www.ssireview.org/supplement/collective\\_insights\\_on\\_collective\\_impact](http://www.ssireview.org/supplement/collective_insights_on_collective_impact)  
[http://www.ssireview.org/articles/entry/the\\_dawn\\_of\\_system\\_leadership](http://www.ssireview.org/articles/entry/the_dawn_of_system_leadership)



# MODULE 3

## Leveraging Data Inputs

### Module Overview

During the SHA process, the state health department and partnership developed key findings from the assessments and data collection and analysis. The SHA data and key findings should be the core used to develop the SHIP. However, depending on the time lapse between the development of SHA and the SHIP, or because other important data sources are of interest, states may wish to update or add to the data used to support the SHIP decisionmaking. In this module, guidance is provided for using SHA data, and other sources of data, to support the selection of SHIP priorities and detailed goals, objectives, strategies, and measures. Approaches and examples for using data to support alignment between the SHIP and local, national, and other state efforts are also provided in this module.

#### Key Content and Components

- ◆ State health assessment report(s).
- ◆ Other uses of data in the SHIP process.
- ◆ Community-level and regional-level assessments and plans.
- ◆ Existing monitoring, surveillance, and evaluation data.
- ◆ Statewide summaries for specific issues.
- ◆ National rankings and dashboards.
- ◆ Inventory of assets and resources.
- ◆ Identifying disparities.

## Related PHAB Guidance

### PHAB Standards and Measures

#### PHAB Measure 5.2.1 S – A process to develop a state health improvement plan

Required documentation 1.b – 1.d:

**1. State health improvement planning process that included:**

**b. Information from community health assessments**

*Guidance: Data and information from the community health assessment provided to participants in the state health improvement planning process to use in their deliberations. This may include a list of data sets or evidence that participants used for the community health assessment.*

**c. Issues and themes identified by stakeholders in the community**

*Guidance: Evidence that community and stakeholder discussions were held and that they identified issues and themes. The list of issues identified by the community and stakeholders must be provided as documentation.*

**d. Identification of assets and resources**

*Guidance: Community assets and resources could be anything that the state could utilize to improve the health of the community. Community assets and resources could include, for example, skills of residents, the power of state associations (e.g., service associations, professional associations) and institutions (e.g., faith based organizations, foundations,, institutions of higher learning), as well as other community factors for example, parks, social capital, community resilience, a strong business community, etc. Community assets and resources can be documented in a list, chart, narrative description, etc.*

**NOTE: Bullet a for 5.2.1 S is on page 34 and bullet e for 5.2.1 is on page 39.**

*(PHAB Standards and Measures Version 1.5, page 131)*

There are a number of data inputs that the state health department and SHIP partnership can leverage for the planning process, including:

- SHA report(s) – health status data, stakeholder-identified issues and themes, and systems assessments such as National Public Health Performance Standards assessments.
- Community-level and regional-level data and assessments.
- Existing monitoring, surveillance, and evaluation data (include from previous SHIPs, if applicable).
- Statewide data summaries for specific issues.
- National rankings and dashboards.
- Inventory of assets and resources.
- Data analysis to identify populations experiencing the greatest health disparities.

These data inputs will be used throughout the SHIP planning and implementation processes. If a state has followed the information outlined in ASTHO's [State Health Assessment Guidance and Resources](#), their findings from the SHA reports will have data and information needed for the prioritization process. However, states may also wish to conduct an environmental scan of available data at the beginning of the SHIP process to provide a sense of what data will be available for action planning and implementation, for instance, providing additional baseline data to create measurable objectives and targets. This environmental scan will also help identify gaps where further work is needed to find and compile data, or where new systems need to be put in place for data surveillance, collection, or analysis. Further, information from the environmental scan, particularly key findings and identified priorities for other state, regional and local plans, helps to identify opportunities for alignment.

## State Health Assessment Report(s) – Health Status Data, Stakeholder-Identified Issues and Themes, and System Assessments

SHAs produce most of the data needed for developing the SHIP. Pages 56-57 and page 74 of the [State Health Assessment Guidance and Resources](#), State Health Assessment Guidance and Resources provide a description of the findings that should be developed through the SHA process, and pages 75-86 provide more information about how to summarize and present these findings. SHAs will include **health status indicators covering a range of secondary data and primary data from community surveys, focus groups, and other qualitative data collection methods**. The SHA may also include a SWOT analysis, forces of change assessment, public health system capacity assessment, or inventory of assets and resources. The process may have also yielded findings from the assessments including issues, themes, and identification of an increase or decrease in significant health problems that were identified by the SHA steering committee, or statewide and community stakeholders through the SHA engagement process.

The state health department should work with the SHIP partnership to determine if other data inputs are needed, and what they are. States will vary on results in terms of the comprehensiveness of the SHA findings. Also, if there is a lag between the completion of the SHA and SHIP, some SHA data will need to be updated.

## Other Uses of Data in the SHIP Process

### 1. Community-Level and Regional-Level Assessments and Plans

Healthy People 2020 Objective PHI 15-4 is to “increase the proportion of local jurisdictions that have linked health improvement plans to their state plan.” Many states report that community and regional-level assessments and plans are very valuable inputs for SHAs, and if not included, they should be in the SHIP process. In order to maximize alignment between statewide priorities and initiatives and local and regional efforts, there must be continuous communication and collaboration related to community health data. Many states review local health department priorities and strategies as part of their SHA, or during the SHIP process, to identify key community concerns to address in the SHIP. In addition, other local and state stakeholders, such as nonprofit hospitals, United Ways, regional planning agencies, and other state agencies, also produce assessments and plans that might be helpful in the SHIP process. If such plans seem relevant to the SHIP priorities (see Module 4) they can help in the action planning stage to identify common existing strategies and efforts that the SHIP can leverage for greater impact.

#### **Case Study: Washington State – Aligning the SHIP with Local Community Health Improvement Efforts**

In order to better align state and local efforts, the Washington State Department of Health (WASDPH) has taken a systematic approach to compiling and tracking community health assessment and improvement planning efforts across the state. Washington state has a decentralized public health system, which includes the state department of health and 35 local health jurisdictions. Additionally, the state has had a legislatively mandated public health services improvement plan in place since the early 1990s, as well as a pool of Local Capacity Development Funds (on the order of \$225,000 per year). The law includes a provision for “consultation with local health departments and districts, the state board of health, the health services commission, area Indian health service, and other state agencies, health services providers, and citizens concerned about public health,” however, it does not include any specific requirements related to the level of collaboration or alignment that must occur beyond consultation.

The state department of health and local health jurisdictions in Washington decided to take a planned approach to long-term collaboration and alignment and have instituted systems and processes to support efforts. Importantly, Washington’s [Public Health Improvement Partnership](#) is co-chaired by the state department of health and a local health official. Several representatives from the state’s association of local public health officials serve on the partnership along with representatives from individual local public health agencies and local boards of health. The Public Health Improvement Partnership has had a longstanding interest in aligning local and statewide planning efforts, but as more nonprofit hospitals conducted community assessments per requirements in the ACA the partnership saw a particular need to be more systematic about keeping track of local community health assessment efforts. WASDPH created a web page linking to local community health assessments across the state, as shown in Figure 3.1. The partnership works with these local organizations across the state to gather input and share the priorities from the SHIP and the [agenda for change action plan](#) to move toward greater alignment and collaboration between local and statewide health improvement efforts.

**FIGURE 3.1 WASHINGTON STATE – MATRIX AND LINKS TO COMMUNITY HEALTH ASSESSMENTS PLANS**

Available at: <http://www.doh.wa.gov/Portals/1/Documents/1200/assess.pdf>

Update 04-28-14

		CHA	CHIP	SP	CHNA	CHA/CHIP Sites
1	Adams			<a href="#">2013</a>		
2	Asotin					
3	Benton-Franklin	<a href="#">ongoing</a>	<a href="#">2013-2017</a>		<a href="#">County Collaborative 2012</a>	<a href="#">assess data</a> <a href="#">CHIP process</a>
4	Chelan-Douglas			<a href="#">2013</a>	<a href="#">Central Washington Hospital 2013</a>	
5	Clallam	<a href="#">2012</a>				
6	Clark	<a href="#">2010</a>	<a href="#">2012</a>	X	<a href="#">St. John Medical Center 2013</a> <a href="#">Legacy Health 2013</a>	<a href="#">assess data</a>
7	Columbia	<a href="#">2009</a>	<a href="#">2011-2014</a>			
8	Cowlitz	<a href="#">2010</a>	X	<a href="#">2010</a>	<a href="#">St. John Medical Center 2013</a>	
9	Garfield	<a href="#">2012</a>		<a href="#">2011</a>		
10	Grant	X				
11	Grays Harbor	<a href="#">2013</a>	X	<a href="#">2010-2013</a>	<a href="#">Grays Harbor Community Hospital 2013</a>	<a href="#">assess data</a>
12	Island	<a href="#">2012</a>	<a href="#">2012</a>			
13	Jefferson	X				
14	Kitsap	<a href="#">2012</a>	<a href="#">2012</a>	<a href="#">2011-2021</a>		<a href="#">CHIP process</a>
15	Kittitas	<a href="#">2012</a>	<a href="#">2013-2017</a>	<a href="#">2011-2014</a>		<a href="#">assess data</a>
16	Klickitat	<a href="#">2012</a>	X		<a href="#">WPHD/DOH 2012</a>	
17	Lewis	X		<a href="#">2011-2015</a>		
18	Lincoln	<a href="#">2012</a>				
19	Mason	X	X	<a href="#">2008-2013</a>		
20	NE Tri			<a href="#">2012-2016</a>	<a href="#">Providence Health and Services 2013</a> <a href="#">Providence Health and Services 2013</a>	
21	Okanogan			X		
22	Pacific			<a href="#">2013-2015</a>		
23	Public Health Seattle-King County	X	X		<a href="#">Seattle Children's Hospital 2012</a> <a href="#">Group Health 2013-2015</a> <a href="#">Highline Medical Center 2013</a> <a href="#">NW Hospital and Medical Center 2013</a> <a href="#">Overlake Hospital Medical Center 2011</a> <a href="#">Seattle Cancer Care Alliance 2012-2015</a> <a href="#">St. Francis Hospital 2013</a> <a href="#">Swedish Ballard 2013</a> <a href="#">Swedish Health Services 2013</a> <a href="#">Swedish First Hill and Cherry Hill 2013</a> <a href="#">Swedish Issaquah 2013</a> <a href="#">Virginia Mason 2013-2015</a> <a href="#">Auburn Medical Center 2013</a>	
24	San Juan			<a href="#">2012-2014</a>		
25	Skagit		X			
26	Skamania	<a href="#">2012</a>				
27	Snohomish	<a href="#">2013</a>			<a href="#">Providence Health and Services 2013</a> <a href="#">Swedish Edmonds 2013</a>	
28	Spokane	2009	<a href="#">2011</a>	2009	<a href="#">St. Luke's Rehabilitation Institute 2013</a> <a href="#">Providence Health and Services 2013</a> <a href="#">Mary Bridge Children's Hospital 2013</a>	
29	Tacoma-Pierce	<a href="#">2013</a>	X	<a href="#">2011-2015</a>	<a href="#">Tacoma General Hospital 2013</a> <a href="#">Franciscan Health System 2013</a> <a href="#">Allenmore Hospital 2013</a> <a href="#">St. Anthony Hospital 2013</a> <a href="#">St. Clare Hospital 2013</a> <a href="#">St. Joseph Hospital 2013</a>	<a href="#">assess data</a>
30	Thurston	X				<a href="#">assess data</a>
31	Wahkiakum	<a href="#">2012</a>		<a href="#">2012</a>		
32	Walla Walla	<a href="#">2011</a>	<a href="#">2011-2013</a>	<a href="#">2011</a>	<a href="#">Providence Health and Services 2011</a> <a href="#">Walla Walla General Hospital 2013</a>	<a href="#">assess data</a>
33	Whatcom	<a href="#">2013</a>	<a href="#">2012-2016</a>	<a href="#">2010-2014</a>	<a href="#">St. John Medical Center 2013</a>	
34	Whitman	2009	X	<a href="#">2013</a>		
35	Yakima			<a href="#">2013-2016</a>		
	<b>Total completed</b>	<b>20 / 57%</b>	<b>9 / 26%</b>	<b>19 / 54%</b>	<b>13 / 37%</b>	<b>NA</b>
	<b>Total in-process</b>	<b>6 / 17%</b>	<b>8 / 3%</b>	<b>2 / 6%</b>		<b>NA</b>

Many states are developing processes for tracking and compiling local data for State Health Improvement Planning. See Module 7, page 80, in this document for more information about the systems that the New York State Department of Health is putting into place to monitor local implementation efforts related to the statewide SHIP priorities.

## **2. Existing Monitoring, Surveillance, and Evaluation Data**

If a state already has an existing SHIP, data or results from the monitoring and evaluation of strategy implementation, and progress toward objectives, will be very important inputs for the SHIP prioritization and planning process; the inputs will provide baseline data to set achievable objectives for improving health and determining effective strategies. If a state has not completed a formal state health improvement planning process in the past, it will likely have evaluation data from existing initiatives and programs that will be useful for the planning process. The state health department and SHIP partners should take inventory of available surveillance and evaluation data across organizations. It may be that detailed evaluation data is not needed during the SHIP prioritization process. However, once priority issues are selected, the evaluation and surveillance data will be very useful for action planning, implementation, and monitoring.

## **3. Statewide Data Summaries for Specific Issues**

PHAB Measure 1.4.2 S requires the production of “statewide summaries or fact sheets to support health improvement planning processes at the state level.” These summaries or fact sheets “condense the state’s public health data,” and Measure 1.4.2 S states that “data summaries are not the same as a community health assessment.” The complete documentation requirements for PHAB Measure 1.4.2 S are available in Appendix E. Data summaries are intended to inform and support partners’ health improvement efforts at the state level. As such, the state health department and partners can determine the specific purpose, content, and dissemination of the data summaries to meet their needs throughout the SHIP planning and implementation process. The data may be useful for increasing understanding of specific health issues, supporting the selection of strategies by the SHIP partnership, and engaging stakeholders throughout the implementation process. Data summaries can be focused on specific diseases or conditions (i.e., cancer or obesity), health behaviors, or sets of issues or social conditions (i.e., adolescent health or inequitable opportunities in employment or education).

## **4. National Rankings and Dashboards**

In addition to looking at local and regional data within the state, the state health department and SHIP partners should also reference comparative national data and peer-to-peer comparisons with other states. Such comparisons may already have been used in the SHA, but they have continued utility in the SHIP planning process for developing objectives and targets and ongoing monitoring of implementation results. Sources for comparative data are included in Figure 3.2.

CDC published [Prevention Status Reports](#) to provide state-by-state information about the status of public health policies and practices related to 10 public health issues: excessive alcohol use, food safety, healthcare-associated infections, heart disease and stroke, HIV, motor vehicle injuries, prescription drug overdose, teen pregnancy, tobacco use, and nutrition, physical activity, and obesity.

The reports describe the public health problem using public health data, identify potential solutions drawn from research and expert recommendations, and include the status of those solutions for

each state and the District of Columbia. The reports are designed to be useful at various points in the SHIP process. CDC recommends using the Prevention Status Reports to:

- Identify public health policy and practice priorities across a range of public health topics (or within a specific topic of interest).
- Inform existing state priorities, initiatives, programs, and strategies (e.g., state health improvement plans, coalition action plans, performance improvement plans, and strategic plans).
- Highlight health problems and improvement opportunities.
- Promote use of evidence-based and expert-recommended public health policies and practices.

### **FIGURE 3.2 SAMPLE SOURCES FOR COMPARATIVE DATA**

#### **CDC**

- Behavioral Risk Factor Surveillance System (BRFSS) <http://www.cdc.gov/brfss/>
- Youth Risk Behavior Surveillance System (YRBSS) <http://www.cdc.gov/HealthyYouth/yrbs/>
- CDC WONDER <http://wonder.cdc.gov/>
- Healthy People 2020 and Data2020 <http://www.healthypeople.gov/2020/default.aspx>
- National Center for Health Statistics <http://www.cdc.gov/nchs/>
- Prevention Status Reports <http://www.cdc.gov/psr/>

#### **Health Resources and Services Administration (HRSA)**

- HRSA Health Data Center & Reporting <https://bphc.hrsa.gov/datareporting/>
- Data Resource Center for Child and Adolescent Health <http://www.childhealthdata.org/>

#### **U.S. Department of Health and Human Services**

- Health Indicators Warehouse <https://www.healthdata.gov/dataset/health-indicators-warehouse>

#### **U.S. Department of Labor**

- Bureau of Labor Statistics Data Tools Page <http://www.bls.gov/data/>
- OSHA's Statistics and Data Page <https://www.osha.gov/oshstats/>

#### **U.S. Environmental Protection Agency (EPA)**

- EPA Data Finder <http://www.epa.gov/datafinder/>

#### **Federal Bureau of Investigation**

- Violent Crime <https://www.fbi.gov/investigate/violent-crime>

#### **U.S. Census and American Communities Survey**

- American Fact Finder <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

#### **Annie E. Casey Foundation KIDS COUNT Data Center** <http://datacenter.kidscount.org/>

#### **America's Health Rankings** <http://www.americashealthrankings.org/>

#### **County Health Rankings and Roadmaps** <http://www.countyhealthrankings.org/>



## 5. Inventory of Assets and Resources

Asset mapping can be another helpful tool for moving from the assessment and planning stages to action. The SHIP partnership can use asset maps developed during the SHA process or create them, if desired. Through the development of supportive, reciprocal relationships between community residents, organizations, and institutions, the SHIP partnership can leverage existing resources and capacities to improve health. States can apply principles of asset based community development in the SHIP process by structuring strategies and interventions that build on the capacities and assets that already exist, rather than solely focusing on what is missing or problematic. Figure 3.4 shows a worksheet that can be used by the SHIP partnership and its workgroups to inventory assets supporting action planning and implementation.

The [State Health Assessment Guidance and Resources](#) (pages 13-15 and 67-69) provides information on inventorying and mapping assets as part of state-level assessment and planning. PHAB's Glossary of Terms (p.5) provides a broad framework for conceptualizing assets based on the community development model, which includes three levels of assets to be considered. The first is the gifts, skills and capacities of the individuals living in the community. The second level of assets includes citizen associations through which local people come together to pursue common goals. The third level of assets is those institutions present in community, such as local government, hospitals, education, and human service agencies. Figure 3.3 outlines core components of asset mapping.

### FIGURE 3.3 CORE COMPONENTS OF ASSET MAPPING

- 1. Define the scope of the asset map.** It is unlikely that a state health department would need an asset map covering all assets in the state. The amount of data would be overwhelming. Decide what topic(s) the asset map is needed for and create an asset map specific to that need.
- 2. Define the community.** Similar to the health assessment, the boundaries of an asset map must be clear. It could be a neighborhood, county, region, the whole state, or another form of community.
- 3. Identify assets I: Initial scan.** Information on assets can be found in a variety of ways. A good place to start is to collect information from internet searches or other public databases. Another important source of information can be media reports. (Note: another common method for asset mapping at a local level is surveying a community. While this method may be better suited for asset mapping at the local level, it could be useful in some situations on the state level.)
- 4. Identify assets II: Snowball.** Following initial information gathering, it is useful to take a snowball approach by contacting assets that have already been identified and asking for referrals to other assets.
- 5. Assess the strengths and weaknesses of assets.** In assessing assets, it is important to remember the purpose of the asset map and use that to guide the examinations. One fundamental question to ask at this stage is, "do the assets meet the needs of the community?" It is likely that additional questions will arise related to the specific purpose of a given asset map.
- 6. Identify the gaps.** What unmet needs are left? What assets would meet this need?

**Comprehensive asset assessment:** For a more advanced understanding of community assets, map the relationships between assets and leadership capacities and cultures. A comprehensive assessment examines the interrelatedness of the assets present in a community.



As described in the [State Health Assessment Guidance and Resources](#), the District of Columbia Department of Health (DCDOH) collected existing assessments and plans throughout the area as a way of getting input and feedback from a broader range of community residents and stakeholders. Through this process, the DCDOH was able to capitalize on what was learned from recently conducted stakeholder engagement activities, including important information on assets and resources.

**FIGURE 3.4 WORKSHEET: IDENTIFY EXISTING ASSETS TO ADDRESS THIS ISSUE**

What assets, resources, or efforts exist to address this issue? (List one per row.)	Organization, person, or group?	Is this group already working with us?	If not, should they be working with us?	Who can we contact with this group?

Source: Michigan Public Health Institute and Kansas Health Institute

### Identifying Populations Experiencing the Greatest Health Disparities

Per the guidance in the [State Health Assessment Guidance and Resources](#), the State Health Status Assessment will produce data and information about health disparities related to health outcomes, risk factors, and determinants, and that data will be of critical importance for prioritizing and selecting SHIP priority issues (see Module 4 for more discussion of prioritization). As the SHA data is being presented to stakeholders and the public, the SHIP Partnership can gather additional input and information related to disparities and priority populations. Figure 3.5 lists some questions to consider for identifying priority populations that were adapted from a worksheet developed by the Missouri Department of Health and Senior Services. ASTHO has compiled reports produced by states that share data, maps, and strategies related to health disparities and health equity on its website: <http://www.astho.org/Programs/Health-Equity/Health-Equity-Reports-by-State-and-Territory/>.

**FIGURE 3.5 QUESTIONS TO CONSIDER – PRIORITY POPULATIONS**

Adapted from Missouri Department of Health and Senior Services, <http://health.mo.gov/data/InterventionMICA/AssessmentPrioritization.html>

1. Looking at key health and strategic issues that have come out of SHA and SHIP, what disparities related to demographic factors were found? (e.g., age, gender, income, educational attainment, race, ethnicity, etc.)
2. What geographic disparities were identified?
3. What are the priority population(s) you would like to impact through your strategies?
4. Who are subgroups of the priority population(s), if any?
5. What is approximate number of people comprising the priority populations and any of its subgroups?
6. What are the shared social and cultural characteristics of the priority populations?
7. What stakeholders can be engaged to increase engagement and impact for the priority populations?
8. Other considerations for working with the priority populations?

# MODULE 4

## Establishing Priorities and Identifying Issues through Priority Setting

### Module Overview

Prioritizing the strategic issues into a manageable number is important for focusing efforts and allocating resources to produce impact and outcomes. This module provides guidance, resources, and tips for designing and managing collaborative multi-stakeholder prioritization processes.

### Key Content and Components

- ◆ Overview of prioritization process.
- ◆ Prioritization criteria.
- ◆ Nominal group technique.
- ◆ Prioritization matrix.
- ◆ Hanlon method.
- ◆ Strategy grid.
- ◆ Key tips for facilitating successful prioritization processes.

### Related PHAB Guidance

#### PHAB Standards and Measures

##### PHAB Measure 5.2.1 S – A process to develop a state health improvement plan.

Required documentation 1.e:

##### 1. State health improvement planning process that included:

*Guidance: The state health department must document the collaborative state health improvement planning process. The process may be a national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described. National models include, for example, State Health Improvement Plan (SHIP) Guidance and Resources, Mobilizing for Action through Planning and Partnerships (MAPP) (developed for local health departments but can be used in state health departments), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) and the University of Kansas Community Toolbox. Examples of tools or resources that can be adapted or used include Community Indicators process project, Asset Based Community Development model, National Public Health Performance Standards Program (NPHSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020.*

##### e. A process to set health priorities.

*Guidance: A description of the process used by participants to develop a set of priority state health issues.*

**NOTE: 5.2.1 S bullet a is on page 9 of this guide and bullets b-d are on page 32**

*(PHAB Standards and Measures Version 1.5, pages 131-132)*

## Overview of Prioritization Process

Narrowing down or prioritizing the strategic issues to a manageable number is important for focusing efforts and allocating resources to produce impact and outcomes. In addition, it is also important to the process of identifying and selecting strategies and conducting data analysis and tracking. Prioritization criteria methods and decision-making tools can help ensure that the prioritization is successful. The SHIP prioritization process will follow seven basic steps:

1. Identify cross-cutting health and strategic issues: review key findings, assets, and resources from the SHA. Identify strategic issues, focusing on those that are cross-cutting and emerge in more than one assessment. NACCHO defines strategic issues in its MAPP framework as “those fundamental policy choices or critical challenges that must be addressed for a community to achieve its vision.”
2. Design a prioritization process that will work well for the SHIP Partnership or any other stakeholders involved. (Prioritization processes are described on pages 42-50.)
3. Determine process facilitation needs and secure a facilitator for the process.
4. Review the vision and values for the SHIP process and discuss how they inform the prioritization criteria and process.
5. Identify prioritization criteria.
6. Conduct a prioritization process using the selected criteria.
7. Be open to an iterative prioritization process. Review priorities that emerge to consider:
  - a. Are vision and values reflected?
  - b. Were any of the prioritization criteria more difficult to consider in the process? Is there anything more that should be done to ensure those criteria are considered?
  - c. Are there other internal or external stakeholders that should weigh in before we finalize the priorities?
  - d. What can be done at a systems level? Are there other system issues that should be considered?

Each state’s SHIP Partnership will likely take a unique approach to prioritizing its issues. There are a number of useful prioritization processes and decision-making tools that groups can utilize and the guidance below provides some detail on commonly used methods and tools.

During the SHA process, the state health department, SHA Partnership, and stakeholders may have developed findings and a high-level subset of health issues from the SHA results, using criteria similar to those below. In this stage of the SHIP process, the SHIP Partnership should be working from those findings, and any other information or data that is subsequently developed, to determine the SHIP priorities. In particular, it is important to review the SHA findings and other data and identify cross-cutting issues, themes, or areas of concern. Because they emerge from multiple types of assessments, cross-cutting issues are likely the most strategic issues to address; once these are identified, utilizing a prioritization process will help the Partnership narrow and focus on the plan’s priorities. Alternatively, the SHIP Partnership may take findings from the SHA and other data review and apply the prioritization processes below to determine what the priority issues for the SHIP. See the [State Health Assessment Guidance and Resources](#) (pages 56-58, 74, 76) for guidance on how to develop key findings from the SHAs.

## Prioritization Criteria

One key foundational step for any prioritization process is developing prioritization criteria or prioritization considerations. Figure 4.1 shares a range of criteria that are used by health departments and their partners during the prioritization process. The broad categories represent common types of criteria and each column includes specific ways of defining the criteria that the project team might consider. The [State Health Assessment Guidance and Resources](#) uses a similar set of criteria for developing findings from the Health Status Assessment (pages 56-58). During the SHIP process, applying these criteria to the subset of issues developed from the SHA findings or the identified cross-cutting strategic issues can help narrow the list of priorities for inclusion in the SHIP.

**FIGURE 4.1 EXAMPLES OF CRITERIA AND CONSIDERATIONS FOR PRIORITIZATION PROCESSES**

*Adapted from the Los Angeles County Department of Public Health and New Hampshire Division of Public Health Services*

Magnitude of Public Health Issue (Category A)	Disproportionate Effects (Category B)	Importance of Public Health Issue (Category C)	Effectiveness of Potential Interventions (Category D)	Feasibility (Category E)
<ul style="list-style-type: none"> <li>Severe health consequences (may be measured by mortality rate, premature death, disability, quality adjusted life years).</li> <li>Percent of population at risk.</li> <li>Large measure of individuals affected (may be measured by prevalence, incidence or other measure of impact).</li> <li>Economic and social cost on the population.</li> <li>Problem is cross-cutting to multiple issues.</li> <li>Problem affects health across the life span.</li> </ul>	<ul style="list-style-type: none"> <li>Magnitude of measured disparity between various groups.</li> <li>Specific vulnerable population(s) are disproportionately affected.</li> </ul>	<ul style="list-style-type: none"> <li>A health inequity exists for the issue.</li> <li>Alignment with national, state, and local objectives.</li> <li>Public health has a clearly established role.</li> <li>Extent of public concern.</li> <li>Level of support from community members and other stakeholders.</li> <li>Work on this issue is mandated by statute or other authority.</li> <li>Legal or ethical concerns.</li> <li>Linkage to an environmental concern, including safety.</li> </ul>	<ul style="list-style-type: none"> <li>Evidence-based interventions and successful application.</li> <li>Co-benefits – additional rationale for a given intervention.</li> <li>Preventability of issue or condition.</li> <li>Extent to which interventions will mitigate root causes.</li> <li>Opportunity to increase health or social equity.</li> </ul>	<ul style="list-style-type: none"> <li>Cost-effectiveness.</li> <li>Size of the gap between existing resources and need.</li> <li>Resources needed are available.</li> <li>Timeliness of implementation and expected benefits.</li> <li>Ease of implementation.</li> <li>Within the control of engaged stakeholders to implement.</li> <li>Likelihood of maintaining effort.</li> <li>Culturally appropriate and acceptable to community members.</li> </ul>

The SHIP executive committee should select and provide clearly defined criteria to stakeholders during the prioritization process. Figure 4.2 shows an example of a handout with definitions for criteria; these types of handouts are useful to distribute to all stakeholders so everyone is on the same page while decisions are made to narrow down and prioritize key issues from SHA findings. If possible, the SHIP Partnership should also be engaged in reflecting on and contributing to the criteria that will be used for prioritization.

**FIGURE 4.2 PRIORITIZATION CRITERIA WORKSHEET**

 **PRIORITIZATION CONSIDERATIONS**

*Use this worksheet to list potential health problems or priority issues and thoughts based on level of priority. Indicate (H) for high, (M) for medium, and (L) for low with the following considerations:*

- **Size of problem:** Number of people per 1,000, 10,000, or 100,000.
- **Seriousness of problem:** Impact on individual, family, and community levels.
- **Feasibility:** Cost, internal resources and potential external resources, and time commitment.
- **Disparities:** One or more population is disproportionately affected, particularly the low income and most vulnerable members of the community.
- **Available expertise:** Can we make an important contribution?
- **Importance to the community:** Evidence that it is important to diverse community stakeholders.

**Important notes:**

- The health and strategic issues column should be pre-populated with findings or strategic issues from the SHA or group discussion of key prioritization issues.
- Leave a couple blank rows to allow participants the option to add a new idea.
- The prioritization considerations columns can be edited to include considerations and criteria selected for the process.

Health and Strategic Issues	Prioritization Considerations						Comments, questions, or additional thoughts
	Size of the problem	Seriousness of not addressing	Feasibility, cost, time, resources	Disparities	Available expertise	Importance to the community	
	(H,M,L)	(H,M,L)	(H,M,L)	(H,M,L)	(H,M,L)	(H,M,L)	

**NOTE: Be cautious about overemphasizing “size of the problem,” because that may mask issues that affect smaller numbers but reflect troubling and persistent disparities and inequities.**

**Based on the responses above, list the top five issues:**

- 1.
- 2.
- 3.
- 4.
- 5.

*Source: Illinois Public Health Institute*

## Nominal Group Technique

The nominal group technique is a very popular method that helps groups make decisions and ensures that all meeting participants have the opportunity to provide input into the process. This technique can also help if there are vocal members that dominate the discussion and decisionmaking process.

Nominal group technique involves:

- **Discussing and developing a list of potential health and strategic issues to prioritize.** Using data and key findings from the SHA, participants identify, share, and discuss cross-cutting themes, emerging issues, health disparities, and potential strategic issues that need to be addressed to improve the health of the state. This step in the process ensures that everyone has the chance to contribute to any forthcoming issues that they see emerging from the assessment data. This discussion results in a fairly lengthy list of health and potential strategic issues for the SHIP that must be prioritized to be more actionable and realistic. A facilitator should record each idea on a whiteboard or flip-chart paper.
- **First round of discussion.** After a list of issues has been developed, the first round of discussion takes place allowing people to ask clarifying questions about various issues. During this discussion, some issues may be combined or reworded for clarity. In the SHIP process, it is very common that similar issues are combined during the discussion.
- **Reflection on the issues, in consideration of the criteria.** It is very important to allocate time for individuals to reflect on the issues considering the criteria that has been provided. Figure 4.3.A includes a sample criteria matrix that could be used by participants to develop an understanding of how important each issue is to them by rating each issue under consideration.
- **Initial round of voting.** Once the full list of health issues and consideration of the criteria is established, an initial round of votes is cast based on the criteria. Each participant receives a specific number of votes, normally between 3-5, which can be cast in any manner they see fit. A participant can choose to cast all three votes on one or spread them across multiple issues.
- **Second round of discussion.** After tallying votes, participants discuss results and reduce the list according to the number of votes and consensus of the group discussion. After reducing the list, another round of combining items might be appropriate, depending on the discussion.
- **Final round of voting.** In the final round of voting, participants are usually given just one vote in an attempt to further narrow the list. The process will be different in each situation depending on the number of items the group is trying to reach. Additional rounds of voting or discussion can be utilized depending on the specific situation.

The nominal group technique is often used when a group wants to generate ideas and then narrow them to a more concise set. A skilled facilitator, supplies for recording and voting, and clear understanding of the ground rules for the process are critical for success with the nominal group technique. For in-depth information on the step-by-step process, advantages and disadvantages, and how to prepare and conduct this type of technique, see the resources and links in Figure 4.9 on page 50.

## Prioritization Matrix

A prioritization matrix is a simple way to quantify priority scores for health problems while considering a number of criteria. Figures 4.3.A and 4.3.B outline how to use a prioritization matrix.

**FIGURE 4.3A EXAMPLE PRIORITIZATION MATRIX**

	Criterion 1 (Rating × Weight)	Criterion 2 (Rating × Weight)	Criterion 3 (Rating × Weight)	Priority Score (Add the scores)
Health Problem A	$2 \times 0.5 = 1$	$1 \times .25 = .25$	$3 \times .25 = .75$	2
Health Problem B	$3 \times 0.5 = 1.5$	$2 \times .25 = 0.5$	$2 \times .25 = 0.5$	2.5
Health Problem C	$1 \times 0.5 = 0.5$	$1 \times .25 = .25$	$1 \times .25 = .25$	1

### FIGURE 4.3B STEPS FOR USING A PRIORITIZATION MATRIX

*Adapted from NACCHO, First Things First: Prioritizing Health Problems.*

**Create a matrix**—list all prominent health problems down the y-axis and all the criteria across the x-axis so that each row is represented by a health issue and each column is represented by a criterion. Next, include an additional column to track the priority score.

**Rate criteria**—after rating each health issue against the criterion, fill in the cells of the matrix. An example of a rating scale with higher numbers indicating items that meet criteria is provided below:

4 = High priority

3 = Moderate priority

2 = Low priority

1 = Not priority

**Weigh criteria**—assign weights to each criterion by level of importance. For example, if Criterion 1 is twice as important as Criterion 2 and 3, then the weight of Criterion 1 could be (0.5) while the weight of Criterion 2 and 3 could be (.25). Then multiply the rating by the weighted criterion in each cell.

**Calculate scores**—calculate scores for each health problem by adding the scores across the row. Then assign a ranking scale to each health problem with the highest priority score being 1 and the lowest priority score being 4.



**FIGURE 4.4 SAMPLE PRIORITIZATION MATRIX, EXCERPT FROM NEW HAMPSHIRE**

Proposed Issue	Criteria						Total score
	Severe health consequences (3)	Large number of people affected (2)	Disproportionate effects among subgroups (2)	Problem results in economic and social cost (1)	Problem has life-span effect (3)	Feasibility (1)	
Healthy mothers and babies							
Obesity and diabetes							
Heart disease and stroke							

## Hanlon Method

The Hanlon method, also known as the basic priority rating system, is a frequently used approach for prioritizing health issues, often in combination with other methods.

The Hanlon method uses three criteria – magnitude, seriousness, and effectiveness of intervention – in a simple equation that adds the rating for magnitude (A) to the rating for seriousness (B) and then multiplies that sum by the intervention’s effectiveness (C) to arrive at a final rating.

Traditional Hanlon equation:  $(A + B) \times C = \text{rating}$

The criteria can also be weighted if the group considers one criteria to be more important.

For example, more heavily weighting the seriousness component (B) could yield the following equation:  $(A + 2B) \times C = \text{rating}$ .

## Strategy Grid

The strategy grid is a tool to prioritize two important criteria selected by the group. Since this tool only focuses on two criteria, it is not recommended to use it as the final way to prioritize issues; however, it can be helpful in narrowing in on key issues, in combination with the nominal group technique or the prioritization matrix. This tool can also help prioritize strategies or activities to address an issue, especially if using the criteria cost/impact or cost/feasibility. Figures 4.5 and 4.6 outline how to use a strategy grid.

**FIGURE 4.5 STEPS FOR USING A STRATEGY GRID**

*Adapted from NACCHO Guide to Prioritization Techniques.*

1. Select criteria—choose two broad criteria that are most important to group members. Some examples are ‘importance/urgency,’ ‘cost/impact,’ ‘need/feasibility,’ or ‘priority/performance.’
2. Create a grid—set up a grid with four quadrants and label each axis with a broad criteria. Create arrows to indicate the direction of ‘high’ and ‘low’ as shown below.
3. Label quadrants—based on the axes, label each quadrant as ‘high priority/high performance,’ ‘high priority/low performance,’ ‘low priority/high performance,’ ‘low priority/low performance,’ or ‘high cost/high impact,’ ‘high cost/low impact,’ ‘low cost/high impact,’ ‘low cost/low impact’ etc.
4. Categorize and prioritize—write health issues being prioritized in the appropriate quadrants. The examples below are for ‘priority/performance’ and ‘need/feasibility.’
  - Quadrant 1: High Priority/Low Performance; High Need/Low Feasibility—These are important priority areas that require increased attention.
  - Quadrant 2: High Priority/High Performance; High Need/High Feasibility—These are the highest priority areas and should be given resources to improve.
  - Quadrant 3: Low Priority/High Performance; Low Need/High Feasibility—These have low priority and resources may need to be reallocated to higher priority areas.
  - Quadrant 4: Low Priority/Low Performance; Low Need/Low Feasibility—These are the lowest priority areas and may need little or no attention.

**FIGURE 4.6 EXAMPLE STRATEGY GRIDS, ADAPTED FROM NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS (NPHS) USER GUIDE**

<b>Perceived Priority</b>	<b>High</b> ↑	<b>I</b> High Priority Low Performance	<b>II</b> High Priority High Performance
	↓ <b>Low</b>	<b>IV</b> Low Priority Low Performance	<b>III</b> Low Priority High Performance
		<b>Low</b>	<b>High</b>
<b>Current Level of Performance</b>			

<b>Perceived Need</b>	<b>High</b> ↑	<b>I</b> High Need Low feasibility	<b>II</b> High Need High feasibility
	↓ <b>Low</b>	<b>IV</b> Low Need Low feasibility	<b>III</b> Low Need High feasibility
		<b>Low</b>	<b>High</b>
<b>Potential feasibility</b>			

## Key Tips for Facilitating Successful Prioritization Processes

Facilitators who conduct the prioritization process should have a good understanding of the group, its needs, and the data and information that will be prioritized. Facilitating requires careful planning, skillful execution and flexibility, and clear steps to move forward. Figure 4.7 includes general meeting facilitation activities adapted from Ingrid Bens' *Facilitation at a Glance* for pre-facilitation, facilitation, and post-facilitation. Figure 4.8 includes tips from NACCHO on building health equity into facilitation processes.

**FIGURE 4.7 FACILITATOR TIPS**

### Pre-Facilitation Activities

<p><b>Assessment and Design</b></p>	<ul style="list-style-type: none"> <li>• Gather information about the group and its intended purpose and needs.</li> <li>• Summarize and verify for accuracy with the leader and key members.</li> <li>• Draft meeting objectives, process design, and annotated agenda.</li> <li>• Identify what the group may need to review or do prior to the meeting to maximize meeting efficiency and effectiveness.</li> </ul>
<p><b>Feedback and Refinement</b></p>	<ul style="list-style-type: none"> <li>• Solicit member feedback on facilitation plan, including objectives and pre-meeting work.</li> <li>• Listen for and identify any gaps in what members and leadership want and need.</li> <li>• Develop final objectives, participant assignments, and process design, and clarify any changes in the annotated agenda.</li> </ul>
<p><b>Final Preparation</b></p>	<ul style="list-style-type: none"> <li>• At a minimum, preparation time should be equivalent to the length of the facilitation session. Complex sessions may require even more preparation time.</li> <li>• Clarify all roles and responsibilities for activities prior to, during, and after the meeting.</li> <li>• Check suitability of the meeting location.</li> <li>• Provide leadership with feedback on logistics, member communication, etc.</li> <li>• Identify all materials and supplies needed.</li> <li>• Develop and prepare all materials and handouts.</li> <li>• Distribute and include a due date on any participant assignments; the due date may occur prior to the meeting or during the meeting.</li> <li>• Schedule and send meeting and assignment reminders.</li> </ul>

**FIGURE 4.7 FACILITATOR TIPS—CONTINUED**

**Facilitation Activities**

<p><b>Beginning</b></p>	<ul style="list-style-type: none"> <li>• Room set-up is critical. Ensure seating fits group needs and post any necessary materials or visuals.</li> <li>• Greet members and engage with them as much as possible, this helps encourage future participation. It is important to develop personal connections and build relationships.</li> <li>• Conduct introductions and share the roles, objectives, agenda, and process, asking for comments or questions. Facilitate the setting of ground rules or communicate established ground rules. Solicit updates and actions since previous meetings as needed. Introduce the first (and any subsequent) processes clearly using written and verbal instructions, when possible.</li> </ul>
<p><b>During</b></p>	<ul style="list-style-type: none"> <li>• Ensure that all members participate. Manage conflict, intervene as needed, and help group members adhere to the ground rules. Keep a positive tone and maintain a high energy level for the group. Ensure someone is keeping track of the discussion. Move through the agenda, discussion, and process.</li> <li>• Remember the 3 P's of process checking: check <b>pace</b>, keep track of the <b>process</b>, and take the group <b>pulse</b>.</li> <li>• Periodically summarize any ideas that have been developed and reflect them back to the group.</li> </ul>
<p><b>Ending</b></p>	<ul style="list-style-type: none"> <li>• Ensure objectives were met, decisions were made, and action steps and commitments for member ownership are in place (with names and dates).</li> <li>• Summarize objectives, decisions, and action items.</li> <li>• Conduct a written evaluation of the session and solicit verbal feedback.</li> <li>• Ensure all recorded notes (flipcharts) are delivered to the person transcribing.</li> <li>• Determine follow-up date, time, and actions.</li> <li>• Thank participants and leadership, and make sure key leaders understand the group's goals and celebrate any accomplishments.</li> </ul>

**Post- Facilitation Activities**

<p><b>Assessment and Design</b></p>	<ul style="list-style-type: none"> <li>• Always follow-up no matter how formal or informal the session. After some time has passed, check in to find out if the session helped with the group's progress and effectiveness.</li> <li>• Share results of evaluations and solicit additional feedback as appropriate.</li> <li>• Ensure follow up activity assignments are clear and distributed. It is recommended that clear roles and accountability are established in advance so that the group can successfully implement follow-up actions in the defined time period following the meeting.</li> <li>• Some sessions may require a follow-up meeting to discuss progress, further evaluate effectiveness, and plan next steps.</li> </ul>
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Source: Adapted from *Facilitation at a Glance, 2nd edition, 2008, Ingrid Bens and GOAL/QPC.*

#### **FIGURE 4.8 FACILITATOR TIPS – BUILDING HEALTH EQUITY INTO THE PROCESS**

*Source: NACCHO. (2014). Mobilizing and Organizing Partners to Achieve Health Equity.*

- Communicate a health equity approach to community health improvement.
- Establish rules that ensure a safe place for discussion.
- Reflectively listen and create a space for participants to contemplate emotional or controversial ideas and use participant reflection to bring the group to a new level of awareness of the root causes of health inequity.
- Identify any tensions in the room and use any discomfort to uncover new information.
- Assess power dynamics in the room and structure conversation to prevent it from stifling participation from those with less power.
- Design a process that encourages those who are not comfortable discussing difficult topics publicly to contribute to the discussion.
- Uncover contradictory or competing perceptions of health equity and develop a common understanding among participants.
- Focus conversations on equality as opposed to remediating health problems with more programs and activities.

#### **FIGURE 4.9 RESOURCES AND LINKS – PRIORITIZATION**

*Source: NACCHO. (2014). Mobilizing and Organizing Partners to Achieve Health Equity.*

- University of Wisconsin Extension – Nominal Group Technique  
<http://www.uwex.edu/ces/pdande/resources/pdf/Tipsheet3.pdf>
- CDC Evaluation Brief: Gaining Consensus Among Stakeholders Through the Nominal Group Technique  
[www.cdc.gov/healthyyouth/evaluation/pdf/brief7.pdf](http://www.cdc.gov/healthyyouth/evaluation/pdf/brief7.pdf)
- Minnesota Department of Health – QI Toolbox  
<http://www.health.state.mn.us/divs/opi/qi/toolbox/>
- NACCHO Guide to Prioritization Techniques  
<http://www.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples-2.pdf>

# MODULE 5

## Communicating SHIP Priorities

### Module Overview

As discussed in the [State Health Assessment Guidance and Resources](#) (Module 4, pages 75-86), the state health department should communicate about SHA and SHIP in ways that speak to a range of audiences, particularly those who have an interest in community health throughout the state. Specifically, the SHA and SHIP should be presented in a manner that is useful to (a) public health professionals working at state, local, and tribal health departments, (b) public health system partners across a range of sectors from education, transportation, economic development, etc., and (c) the general public. The *State Health Assessment Guidance and Resources* includes detailed information and tips from states about how to engage the public in the SHA and SHIP using many tactics, including electronic community feedback, focus groups, community forums, town halls, listening sessions, presentations, webinars, and social media. This module presents tips and strategies from states who have taken strategic approaches to communicating with diverse stakeholders throughout SHIP planning and implementation.

### Key Content and Components

- ◆ Successful strategies for communicating about the SHIP.
- ◆ Listening sessions and public hearings.
- ◆ Newsletters.
- ◆ Social media.
- ◆ Changing the conversation and narrative about how to improve health.

### Related PHAB Guidance

PHAB provides specific guidance about communicating and seeking input on SHA findings. Measure 1.1.2 S, Guidance 2, states that the health department must provide “opportunity for the state population at large to review drafts and contribute to the community health assessment. The health department must document that the preliminary findings of the state level community health assessment were distributed to the population at large and that their input was sought.” Additionally, Measure 1.1.3 A, Guidance 2, states: “the health department must document how it communicates the community health assessment findings to the public.” PHAB does not provide specific guidance to states on communicating to the public about priority state health issues or SHIP.

### Successful Strategies for Communicating the SHIP


#### Listening Sessions and Public Hearings

As described on page 80 of [State Health Assessment Guidance and Resources](#), the Oklahoma State Department of Health (OSDH) took a very robust approach to soliciting resident feedback to their SHA by carrying out a series of listening sessions across the state to hear directly from Oklahomans about their most important health issues.

The Illinois Department of Public Health and SHIP Partnership, by state law, are required to hold at least three public hearings on the draft SHIP. The state holds hearings in the northern, central, and southern regions of the state, and some members of the SHIP team attend each hearing. The SHIP team reviews a summary report of themes, issues, and concerns from the hearings and makes additions and adjustments to the SHIP based on public input.

CTDPH held eight community forums across the state seeking public input on SHA findings and data. CTDPH also conducted one online meeting in Spanish to allow for additional participation from across the state. Following the release, CTDPH conducted interactive webinars for each priority area with advisory council and workgroup stakeholders.

**FIGURE 5.1 TEMPLATE FOR SHIP PUBLIC HEARING MEETING NOTICE**



**SHA**  
STATE HEALTH AGENCY LOGO

**MEETING NOTICE**

**STATE HEALTH IMPROVEMENT PLAN PUBLIC HEARING**

The State Board of Health is gathering input and reaction to the draft 2015 State Health Improvement Plan. Input is needed from the many sectors of the public health system including businesses, healthcare providers, local public health departments, community groups, universities, and state agencies. The draft plan for public review and comment can be found at {insert URL}.

Hearing Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
Location: \_\_\_\_\_

If you wish to attend, you must bring a government-issued photo ID and comply with all security measures at the location.

If you wish to provide oral testimony at the hearing, you may sign-in onsite beginning at {insert time}. Oral testimony will be strictly limited to 3 minutes. Please bring two copies of your testimony to submit at the hearing.

Those who wish to submit only written testimony can do so in one of three ways:

1. Electronically: {insert instructions}
2. By mail: {insert instructions}
3. In-person: {insert instructions}

The deadline for submitting written testimony is {insert date/time}.

Please contact {insert name of agency} at {insert phone number} if you have any other questions concerning the hearing or visit the State Health Improvement Plan web site at: {insert URL}.



## Newsletters

As shown in Figure 5.2, the Washington State Public Health Improvement Partnership publishes a quarterly newsletter that shares overall SHIP updates, progress, and activity related to the SHIP priorities.

**FIGURE 5.2 WASHINGTON STATE PUBLIC HEALTH IMPROVEMENT PARTNERSHIP NEWSLETTER**



### 2012 PHIP Report

In 2010, the Public Health Improvement Plan recommended system transformation to better respond to economic uncertainties and changing population health. To address these recommendations, the Public Health Improvement Partnership created the Agenda for Change workgroup, which developed an action plan to transform governmental public health in Washington State. In late 2012, the Partnership adopted the Agenda for Change action plan as its 2012 Public Health Improvement Plan.

The Partnership will continue its mission of building a culture of accountability and quality improvement; measuring and improving public health services, and strengthening the public health system to address the demands of a changing environment in our state.



The 2012 Public Health Improvement Plan outlines work accomplished in the past two years. It also charts a roadmap for the next two years:

1. Focus on strategic priorities
2. Develop foundational public health services
3. Transform business practices



#### IN THIS ISSUE

- 2012 PHIP Report
- New Partnership Structure
  - ▶ Strategic Priorities
  - ▶ Foundational Public Health Services
  - ▶ Transform Business Practices

The partnership welcomes new members to bring fresh perspective to all of its workgroups. The experience will provide exposure to a rich learning environment where you can engage in system wide thinking and opportunities to forge new collaborations and advance public health practice in Washington.

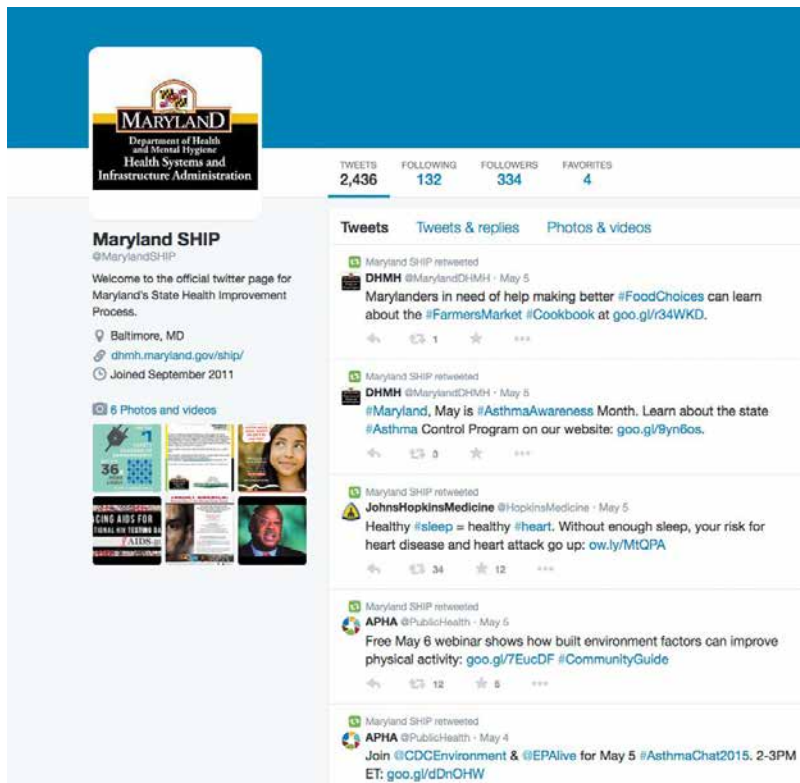
#### CONTACT

360.236.4085  
pkip@doh.wa.gov  
[www.doh.wa.gov/pkip](http://www.doh.wa.gov/pkip)

## Social Media

The Maryland Department of Health and Mental Hygiene has an active social media presence for its SHIP. As shown in Figure 5.3, the Maryland SHIP has a Twitter account that provides timely information and updates related to SHIP priorities.

FIGURE 5.3 MARYLAND SHIP TWITTER ACCOUNT



# MODULE 6

## Developing Objectives, Strategies, and Measures

### Module Overview

Once the priorities have been determined, the next step is to define the desired outcomes through measurable objectives, identify evidence-based strategies and a framework for implementing, and measuring the shared work of partners who are committed to SHIP implementation. Including time-framed measurable objectives in the SHIP provides a foundation for a SHIP implementation workplan and helps states track progress on the objectives for each priority over time.

To begin this work, the state department of health and the SHIP Partnership need to decide on an appropriate structure to support development of the objectives, strategies, and detailed implementation plans, and carry out the subsequent implementation plans. In this module, guidance is provided for determining stakeholder involvement and structure, including sample structures from states. Tools and guidance for developing objectives, identifying and matching strategies, and developing measures are also included. The module concludes with models and tools to prepare for and develop a more detailed implementation and measurement workplan.

#### Key Content and Components

- ◆ Developing stakeholder structures.
- ◆ Developing objectives.
- ◆ Aligning the SHIP with local, state, and national plans.
- ◆ Identifying strategies.
- ◆ Developing measurable outcomes and indicators of health improvement.
- ◆ Using logic models and other tools for action planning.

### Peer Lessons Learned

The Illinois Public Health Institute interviewed state health department representatives on ASTHO's SHIP Advisory Committee and found several thematic lessons learned.

- **Create a realistic timeline.** The process for developing, refining, and adopting plans that include goals, measurable objectives, strategies, and activities is very time-consuming. This work cannot be rushed and almost always takes longer than anticipated. Adjust the timeline based on the assumption that planning will take longer than originally proposed.
- **Create and facilitate effective meetings.** Make sure the first meeting, as well as those that follow, allows for discussion in a structured manner so that it is productive. Stakeholders are more inclined to talk about programs, activities, and strategies rather than developing measurable objectives. Work with stakeholders and guide them through a process that will produce the desired plan components. Evaluate meeting effectiveness to determine what is working and what can be improved for maximum effectiveness.
- **Engage subject matter experts as soon as priorities are selected.** Subject matter experts for each of the priority issues are essential to this work.
- **Stakeholder engagement is ongoing.** Continuously engage stakeholders throughout the process. Be open to working with diverse stakeholders and developing new partnerships. Opportunities for stakeholder engagement are outlined in Module 1 on page 17.

- **Begin the process with a scan of existing plans and efforts.** Identify measurable objectives and define strategies by looking at existing strategic plans within the state and at the federal level.
- **Work to maintain stakeholder involvement.** Participation in planning meetings tends to trail off after the first couple of gatherings. To keep stakeholders engaged, be creative and ensure that they have something of value to take back to their organizations or populations they serve. Develop relationships and practice personal outreach.
- **Allocate staff time to support this work.** Planning and hosting meetings, managing logistics, recruiting and conducting outreach, facilitating, and documenting meeting process and progress requires a lot of work. Anticipate staffing needs to support this work and allocate workers accordingly.
- **Take time to identify improvement opportunities.** All of ASTHO's advisory members reported things they would do differently on their next round and many shared plans for improving upon the existing SHIP. Debrief with stakeholders and peers periodically to identify strengths and improvement opportunities. Document lessons learned and implement immediate improvements, as applicable.

## Related PHAB Guidance

### PHAB Guidance

**PHAB Measure 5.2.2 S, Documentation 1 Guidance: The state health department must provide a state health improvement plan that includes all of the following:**

Required documentation 1.a – 1.d:

- a. The desired measurable outcomes or indicators of health improvement effort and priorities for action, from the perspective of the population of the state. The plan must include statewide health priorities, measurable objectives, improvement strategies, and activities with time-framed targets that were determined in the planning process. In establishing priorities, the plan must include consideration of addressing social determinants of health, causes of higher health risks and poorer health outcomes of specific populations and health inequities. Measurable and time-framed targets may be contained in another document, such as an annual work plan. If this is the case, the companion document must be provided with the state health improvement plan for this measure. Strategies may be evidence-based, practice-based, or promising practices or may be innovative to meet the needs of the population. National state-of-the-art guidance (for example, the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020 should be referenced, as appropriate.
- b. Policy changes needed to accomplish the identified health objectives must be included in the plan. Policy changes must include those that are adopted to alleviate the identified causes of health inequity. Policy changes may address the social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, and zoning, for example.
- c. Designation of individuals and organizations that have accepted responsibility for implementing strategies outlined in the state health improvement plan. This may include assignments to staff or agreements between planning participants, stakeholders, other governmental agencies, or other statewide organizations. For this measure, agreements do not need to be formal, such as an MOA/MOU.
- d. States must demonstrate that they considered both tribal and local health department health improvement priorities. Consideration of national priority alignment could include the National Prevention Strategy and Healthy People 2020.

*(PHAB Standards and Measures Version 1.5, pages 136-137)*

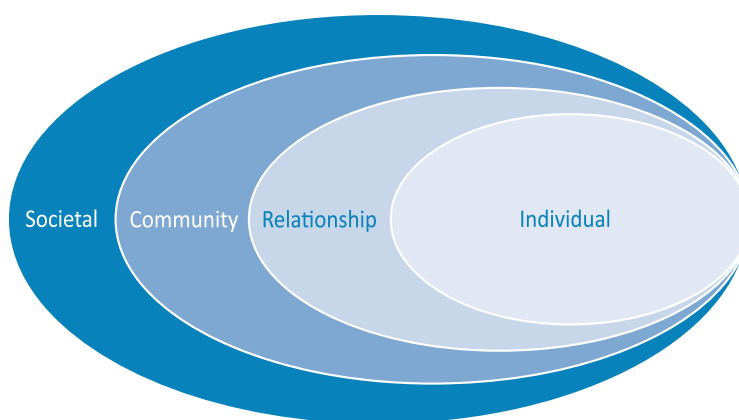
## Developing a Structure for Drafting Objectives, Strategies, and Measures

State health departments must engage partners for collaboration on SHIP implementation in order to improve the health of all populations within the state. As described previously in Module 1, partners should include a variety of stakeholders with a diverse geographic and population reach and have the ability to implement strategies and activities across the social ecological model continuum (see Figure 6.1).

The social ecological model includes a continuum of activities that address multiple levels across the lifespan and the diversity of the state's population. The continuum of the model includes:

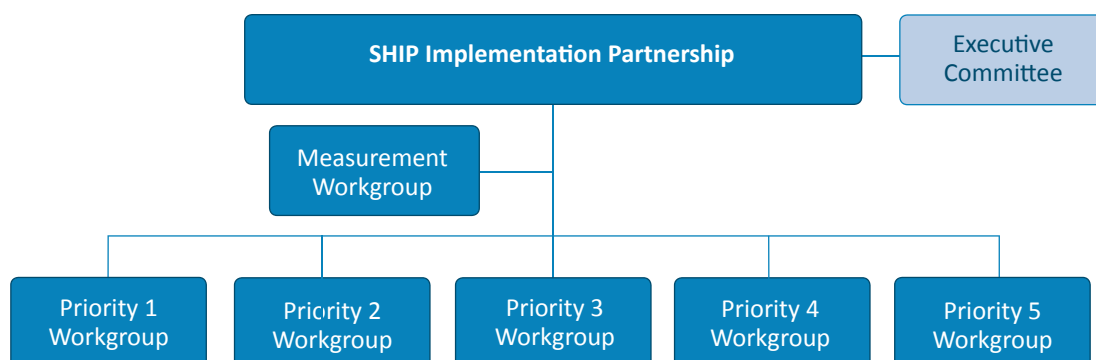
- **Societal:** Those who work to create state and local policy, laws, and regulations and who engage in advocacy and the use of media to influence social norms and values related to the priority health issues.
- **Community:** Those who work at the community level to impact local culture, access to healthcare, and other health resources related to housing, education, employment, transportation, food systems, parks and recreation, education, and the natural and built environment.
- **Relationship:** Those who work to impact families, peer groups, and other social networks including worksite wellness, schools, faith groups, and other social vehicles.
- **Individual:** Those who work directly with individuals to increase knowledge, promote positive behaviors, and create favorable attitudes toward healthy lifestyles and choices.

**FIGURE 6.1 SOCIAL ECOLOGICAL MODEL**



Stakeholders who are engaged in the improvement planning and implementation process may be organized into a variety of different structures. These structures often include a multi-sectoral SHIP partnership consisting of oversight and guidance, data and evaluation expertise and workgroups for each of the priority issues. Similar to Figure 1.7 in Module 1, the structure in Figure 6.2 includes more specific activities and roles.

**FIGURE 6.2 SAMPLE STRUCTURE**



**FIGURE 6.3 PHAB MEASURE 4.1.1 A**

**PHAB Measure 4.1.1 A – Establishment, engagement and active participation in a comprehensive community health partnership or coalition**

Required documentation 1:

**1. Collaborative partnerships with others to address public health issues.**

*Guidance: The state health department must document a current, ongoing comprehensive community partnership or coalition in which it is an active member. The purpose of the partnership or coalition must be to improve the health of the community, and therefore, must be engaged in various issues and initiatives. A comprehensive community partnership, in this context, is a partnership that is not topic or issue specific. It is a community partnership that addresses a wide range of community health issues. The comprehensive partnership or coalition may be organized into several committees or task forces to address specific issues, for example, teenage pregnancy, social determinants of health, health equity or increased opportunities for physical activities. This partnership or coalition may be the same group that developed the community health assessment and community health improvement plan. This partnership or coalition may work on various issues addressed in the Standards and Measure, such as access to care (Domain 7).*

*For full text, see **Appendix A** of this guide or PHAB Standards and Measures Version 1.5, pages 116-118.*

### SHIP Partnership

PHAB provides guidance on expectations regarding state health department collaborative partnerships that can help guide the development of the SHIP partnership. As mentioned in Module 1, the guidance for required documentation 1 of PHAB Measure 4.1.1 A specifically describes a partnership that may be similar to the SHIP partnership (See Figure 6.3). The partnership should include representatives from organizations who are able to impact strategies to improve population health.



## Priority Workgroups

The partnership and state health department should identify stakeholders who have content expertise and the capacity to address priorities through a variety of different strategies including policy systems and environmental change. Workgroups are charged to develop and adopt implementation plans that are aligned with other plans, including separate workgroups and state plans, as discussed in Module 1. Following the adoption of plans, workgroup members' organizations, including state health department representatives, are expected to manage plans through implementation, measurement, and reporting; each workgroup reports to the partnership. For these workgroups to be successful at creating shared plans, an experienced facilitator is often needed to actively engage the members in sharing ideas, opportunities, challenges, and expertise while developing a plan and facilitating support through consensus and commitment. If he or she has the appropriate skillset, the workgroup chair may serve as the facilitator. States that have conducted SHIP processes highly recommend appointing or selecting co-chairs or co-leaders for the workgroups to ensure consistent leadership, particularly if one of the chairs cannot participate or fulfill their role. Staff support is needed to maintain consistent communication among the team and partnership, manage all logistics and meeting requirements, and document the collective efforts of the workgroup.

## Measurement or Evaluation Workgroup

Forming a group of individuals with expertise in data analysis, measurement, and evaluation can help support the priority workgroups and minimize the need for partnership members in the technical aspect of the improvement planning. This workgroup can help guide the work of the priority workgroups as they develop implementation and measurement plans. Specifically, this workgroup can refine draft plans and ensure they are measurable and likely to succeed if implemented. This workgroup is also in a position to see the draft plans and help support alignment across plans.

## Constructing the Plan

Each priority should have its own detailed implementation and measurement plan and include goals, objectives, strategies, interventions, and actions, in addition, the plan should highlight available resources and individual responsibilities. Logic models can be a useful tool to develop these plans and ensure the theory behind the selection of strategies and interventions is likely to produce the intended short, intermediate, and long-term outcome objectives. However, a detailed workplan, such as a Gantt chart, may also be needed to support implementation efforts, specifically with activity timelines and measurement.

One of the first steps in developing a plan may include discussion and decisions on some important exploratory questions. The full partnership may take on this task to help lay the groundwork for the development of measurable objectives and strategies, which is usually completed by a single workgroup or workgroups for each priority area.

- **What efforts are already in place to address each priority?** This includes continued identification of current initiatives being implemented, and determining which are working or making progress and which are ineffective and why.
- **What do we hope to accomplish in five years for each priority?** Consider the overall desired identification of high level long-term goal(s) for each priority.
- **How will we know if we are successful?** Discuss how progress and success can be measured.
- **How is this priority aligned with other state and national priorities?** Determine linkages and alignment with other strategic plans and initiatives, as well as national priorities such as [CDC Winnable Battles](#), [Healthy People 2020](#), and the [National Prevention Strategy](#).



- **What opportunities exist that can be leveraged to address this priority?** Discuss and identify potential opportunities that may support the implementation of collective efforts to impact a priority.
- **What barriers or potential threats may impact our ability to positively implement this priority?** Discuss and identify potential challenges and threats that could affect collective efforts to impact a priority.
- **How can partners contribute to achieving the long-term goal(s)?** Discuss types of resources, strategies, and activities each partner is best suited for and if they are willing to commit these toward implementation.
- **Who should be engaged to address each priority issue?** Identify individuals and organizations needed to be engaged on workgroups. Discuss which partners, organizations, individuals, and other entities are potential workgroup members to develop and implement plans.

Working with the partnership to answer these questions for the identified priorities lays the groundwork for developing objectives, strategies, and measures and ultimately solid implementation plans. Some of the components for implementation plans are described in Module 7 on page 73 from the PHAB Standard 5.2.2 S (Version 1.5), required documentation and guidance for 1a-d and include “desired measurable outcomes or indicators of health improvement and priorities for action, policy changes needed to accomplish health objectives, individuals and organizations that have accepted responsibility for implementing strategies and consideration of Tribal, local, and national priorities.”

There are a couple of common approaches for developing objectives and strategies:

### **Starting with Goal Development:**

Starting with goal development, while the end or overall desired result is in your mind, is often recommended because the focus is on the outcomes or changes that need to occur in order to improve health. Goals are outlined on page 63. Once the desired end results are clearly defined, additional necessary changes or outcomes can be defined to achieve the long-term goals. In addition, strategies can be selected that will help create the changes. Defining the desired outcome first helps to ensure that the focus stays here, as opposed to the selection of the most familiar strategies that may or may not achieve the outcome.

1. For each priority issue, define what long-range change or goal will be needed to achieve the overall vision of the improvement plan. This approach is often referred to as outcome-based planning, or beginning with the end in mind. What are the desired end results related to the priority issue?
2. Once a goal is clearly articulated, identify the incremental changes or outcomes needed to accomplish that goal. Outcomes may be specified as short-term (6 months-2 years), intermediate (1-3 years) and long-term (4-5 years or more). In a logic model framework, outcomes may be defined by establishing the long-term goal(s) and asking the question: What changes need to occur to achieve this goal? When those changes or outcomes are defined, continue to ask this question to identify the long-term, intermediate and short-term outcomes.
3. For each outcome, develop a measurable objective statement that includes a specific measurement of desired change and direction of the change (e.g., 5% increase), target audience, and timeline for achievement. The results of measurable objectives are the outcomes defined in the previous step.

4. Next, identify the mechanisms, or strategies, to achieve this change. What overall approaches to achieving the goal and objectives can be deployed based on best practices, available resources, and likelihood for creating impact? Strategy may be a collection of activities and tactics linked together to produce planned results. Multiple strategies may be needed to achieve an objective.

### **Starting with Strategy:**

1. In some cases, stakeholders or state health department representatives have ideas about particular strategies to deploy as a result of best practice research, funding requirements, or new initiatives that align with the vision. Strategies are defined on page 63. While not the most desirable approach, some planning processes start by defining the strategy prior to the goal(s) and objectives. When strategy is defined, planners consider desired scale, resources needed, capacity of stakeholder organizations, and other important considerations.
2. Once the strategy is clearly articulated, ask “what change can the strategy be expected to create?” It is important to use best practice research to answer this question and guide the formation of goal(s). The expected changes may be the short-term and intermediate outcomes. Long-term changes are often a result of achieving a combination of short and intermediate outcomes and inform the goal or desired end-state.
3. For each outcome, develop a measurable objective statement as described in step 3 of the previous approach.
4. Once measurable objective statements have been developed, it may become evident that the strategy is not enough to achieve the stated goal, in which case, 1) change the goal to reflect what can be addressed through the strategy-driven outcomes, or 2) develop additional outcomes that will need other strategies to be achieved.

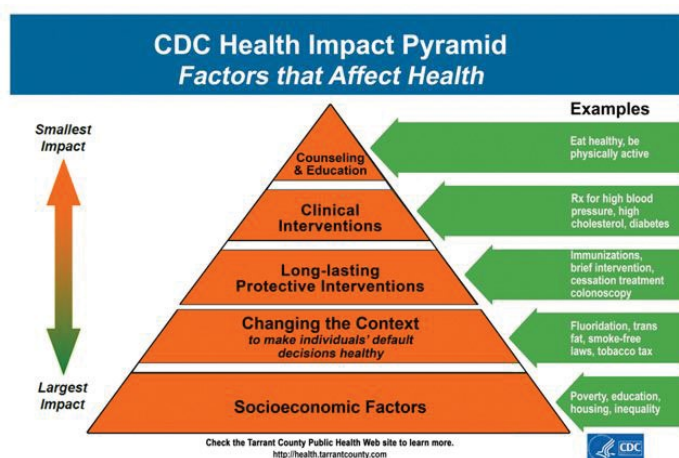
Often planning includes both approaches listed above, and requires staff and stakeholders to work from a starting point that makes the most sense for them. Planning leaders should keep in mind that this is an iterative rather than a linear process that moves among the goals, strategies, and objectives in order to fully refine the plan. For instance, as objectives are developed, there may be a need to revise the goal; and as strategies are identified, it may become clear that they cannot fully assure the objective, and the objective may need to be adjusted.

Throughout this process, it is important to consider available resources and cultural appropriateness when making decisions.

### **Understanding What Impacts Health**

Another important consideration, prior to defining goals, objectives, and strategies, is understanding what has the greatest impact on health; select outcomes and strategies that will have the largest impact. As shown in CDC’s Health Impact Pyramid in Figure 6.4, socioeconomic factors such as poverty, education, and housing inequality have the greatest impact on health, followed by the need to change environments to make healthy choices the default or easy choice. This includes things such as fluoridation in water, limiting or removing trans-fat from foods, tobacco taxes, or smoke-free laws. The next rung of factors includes long-lasting protective interventions such as immunizations, early detection testing for some diseases, smoking cessation treatment, and other long-lasting protective interventions. Following that are clinical interventions, such as prescriptions for high blood pressure, high cholesterol, and diabetes, and finally counseling and education, which have the smallest impact on health. Explore and plan for a combination of approaches across this spectrum with an emphasis on policy, systems, and environmental change to achieve the greatest impact as well as on socioeconomic factors that must be addressed to reduce health disparities.

**FIGURE 6.4 HEALTH IMPACT PYRAMID**



Source: Frieden, T. (2010). *A Framework for Public Health Action: The Health Impact Pyramid*. *American Journal of Public Health*.

**FIGURE 6.5 RESOURCES AND LINKS FOR POLICY, SYSTEMS, AND ENVIRONMENTAL CHANGE**

What Works for Health – policies and programs that can improve health

<http://www.countyhealthrankings.org/policies>

CDC's Healthy Community Design Initiative

<http://www.cdc.gov/healthyplaces/>

Healthy Planning Coalitions – tools and resources

<https://www.planning.org/nationalcenters/health/psecoalitions/resources.htm>

Minnesota Department of Health

<http://www.health.state.mn.us/healthreform/ship/techassistance/pse02222012.pdf>

NACCHO Issue Brief

[http://www.naccho.org/topics/HPDP/mcah/upload/issuebrief\\_pse\\_webfinal.pdf](http://www.naccho.org/topics/HPDP/mcah/upload/issuebrief_pse_webfinal.pdf)

Cook County Department of Public Health factsheet on policy, systems, and environmental change

<http://www.cookcountypublichealth.org/files/CPW/PSE%20Change.pdf>

## Developing Objectives, Strategies, and Measures

There are many tools that can be utilized to support the development of objectives, strategies, and measures. Some of the tools explored in this section include root cause analysis, tree diagrams, and logic models. Many SHIP advisory committee members reported that stakeholders experienced differences in the use of terminology, therefore, it is critical to determine a common set of definitions for key terms and continually reinforce the agreed upon definitions to assist with implementation planning across multiple stakeholders and workgroups.

For this guide, the following definitions are provided and may be adapted to fit the language most common or comfortable for the partnership.

## Goals

Goals are broad statements of what the partnership hopes to accomplish related to the priority and may include the approach or “by or through” phrase (adapted from The County Health Rankings and Roadmaps, Action Plan Worksheet). Goals are general statements expressing a program’s aspirations or intended effect on one or more health problems, often stated without time limits. (*Turnock, B.J. Public Health: What It Is and How It Works. 4<sup>th</sup> ed. Sudbury, MA: Jones and Bartlett; 2009.*)

A goal is generally stated as follows: The goal is to (effect, e.g. improve, decrease, etc.) the (problem/need/opportunity) of (target population) by/through (x mechanism).

## Objectives

Objectives are targets for achievement through interventions. They are time limited and measurable in all cases, and use various levels for an intervention, including outcome, impact, and process objectives. (*Turnock, B.J. Public Health: What It Is and How It Works. 4<sup>th</sup> ed. Sudbury, MA: Jones and Bartlett; 2009.*) The County Health Rankings and Roadmaps states that objectives can be “expressed in terms of changes in behavior, norms, knowledge, attitudes, capacities, and conditions. One or multiple objectives may be needed for each goal.”

A SMART objective is generally stated as follows: (measure and direction of change) in (what behavior, attitude, etc.) by (whom) by (when).

## Outcomes

Planners often use the terms outcome and objectives interchangeably. For the purpose of this guide, objectives are the specific measurable statements regarding the changes that need to occur to achieve the vision of the plan, and outcomes are the defined changes resulting from objectives. Therefore, outcomes are the specified knowledge, behavior change, or the change in a risk factor, community norm, health status, etc.

## Strategies

Strategies define how the objectives will be reached and specify the type of activities that must be planned, by whom and for whom. (Healthy People 2020).

## Activities, Interventions, and Tactics

To deploy the strategies and achieve the objectives, a planned set of activities, interventions, and tactics must be implemented. These may include conducting workshops and meetings, delivering services, developing products, curriculum, and tools, forming partnerships, advocacy efforts, working with the media, etc.

## Measures

Measures identify a quantifiable change resulting from the intervention that will demonstrate progress toward the objective. Measures may be specific to process, outcome, or impact objectives.

Figure 6.6 is a visual adapted from Kansas Health Institute’s Community Health Improvement (CHIP) Collaborative Handbook and shows how the components fit together in a plan.

**FIGURE 6.6 PLAN COMPONENTS**



### Develop Plans Based on SHA Data

As stakeholders convene to begin plan development and create goals, objectives, strategies, and implementation plans, it is important to remind planners to utilize data from SHA that supported the selection of priorities so that decisions about objectives and strategies are also made based on data. Distributing an overview of the data related to each priority is a good place to start; this data will also need to be summarized in a brief description for the SHIP document. The Healthy Maine 2020 plan includes excellent summary documents for each priority; the documents are available online at <http://www.maine.gov/dhhs/mecdc/healthy-maine/index.shtml>. Ideally, priority descriptions should include the following information, in a clear and succinct manner:

- Base of information to understand why the priority was selected.
- Importance of the priority health need.
- A summary of the data and information.
- Population groups, especially those disproportionately affected.
- Specific social and economic conditions causing disparities.
- Relationship to Healthy People 2020 objectives.

In addition to the data points, any other information gathered on existing efforts can be a helpful starting point. This could include information such as progress on the topic since the last plan or SHIP, information regarding what is working and what is not working, and objectives from other plans that are related to the SHIP priorities.

## SMART Objectives

Since objectives serve as the desirable end-products, or goals of the plan, it is important to make them measurable. The most common approach to developing objectives is to make them SMART. SMART objectives are specific, measurable, achievable, relevant, and time-oriented. While SMART objectives are frequently referred to in requests for proposals, guides, and other planning initiatives, developing them takes practice and usually requires a few rounds of refinement. For this reason, it may be useful to engage the partnership or the priority workgroups to help brainstorm and initially identify or develop objectives. Once complete, you could then submit the draft to a smaller group of experts, such as a measurement workgroup (as referenced on page 58) or subject matter experts, to refine and create a final draft of SMART objectives for the partnership or priority workgroups to approve. It is also a good idea to start with existing measurable objectives from existing strategic plans at the local, state, and federal level.

### FIGURE 6.7 DEFINING SMART OBJECTIVES

**Specific** – specify what is to be achieved, by how much (target).

**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.

**Relevant** – align objectives with the vision, strategy, and role of partners who will implement.

**Time-oriented** – establish a timeframe for achieving the objective.

Figure 6.8 shows a simple template that may be useful for writing objectives.

### FIGURE 6.8 GUIDANCE FOR WRITING SMART OBJECTIVES

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

Example: 30 percent increase in the percentage of schools with healthy vending policies implemented by June 2016.

In order to finalize objectives you must define a target and baseline. Target and baseline are defined as:

**Target:** Desired end point; amount of change reflected by a number or percentage.

**Baseline:** Current rate or number in relation to the defined objective.

One of the most challenging aspects of developing SMART objectives is setting targets. Defining an achievable and realistic target is not an exact science but should be done thoughtfully through consideration of baseline data, desired level of improvement, and time and resources available for improvement. The Healthy People 2020 toolkit offers the following guidance, adapted from Healthy Maryland 2000:

1. Relate the measure to an important national or state priority.
2. Measure a result that can be achieved in five years or less.
3. Ensure that the result is meaningful to a wide audience of partners.
4. Define the strategy that will be used to reach a result.

5. Define the accountable entities.
6. Draft measures that meet statistical requirements for validity and reliability, and have an existing source of data.

**FIGURE 6.9 EXAMPLE OF SMART OBJECTIVE WITH TARGET AND BASELINE**

<b>Goal</b>	Protect all Oklahomans from exposure to secondhand smoke.
<b>Objective 1</b>	Increase the proportion of multi-unit housing facilities [from 1% (baseline) to 25% (target)] with voluntary smoke-free policies by June 2014.

## Strategies

According to PHAB 5.2.2.1a, “strategies may be evidence-based, practice-based, or promising practices, or may be innovative to meet the needs of the population. National state-of-the-art guidance (for example, the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020) should be referenced, as appropriate.”

Since stakeholders will be expected to support and implement the strategies, engagement from them in identifying and developing strategies is crucial. Develop workgroups with subject matter experts and those who have the opportunity and scope to address priority issues to increase the likelihood that plans will be implemented. To get a sense of the work already being done, the workgroups will identify existing initiatives and assets as related to the priority area in the state. (The worksheet in Figure 3.4 on page 39 can be used for this purpose.)

Potential strategies to achieve the smoke-free policy objective in Figure 6.9 might be to:

- Promote adoption of voluntary smoke-free policies in public housing.
- Promote adoption of voluntary smoke-free policies in private multi-unit residences.

Tactics and activities might include:

- Providing technical assistance and resources to local tobacco control coalitions and advocates.
- Working with local tobacco control coalitions and advocates to engage and educate housing authority officials, landlords, and tenants.
- Developing a partnership between public health and the statewide housing authority.
- Conducting a statewide media campaign on the benefits of smoke-free multi-unit housing.
- Sharing sample smoke-free policies that can be adopted by local public housing authorities and landlords with local tobacco control coalitions.
- Providing information on the financial savings in cleaning, renovation costs, and other incentives for landlords who adopt smoke-free policies.
- Organizing non-smokers to communicate with landlords on the desire to reduce smoking in multi-unit housing.



## FIGURE 6.10 RESOURCES AND LINKS FOR OBJECTIVES AND STRATEGIES

The following resources can be used to identify objectives and effective strategies to ultimately align with national priority areas:

- The Community Guide: <http://www.thecommunityguide.org/>
- What Works For Health (County Health Rankings): <http://www.countyhealthrankings.org/roadmaps/what-works-for-health>
- Healthy People 2020: <https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources>
- HHS Action Plan to Reduce Racial and Ethnic Disparities: <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285>
- National Prevention Strategy: [www.surgeongeneral.gov/priorities/prevention/strategy/index.html](http://www.surgeongeneral.gov/priorities/prevention/strategy/index.html)
- CDC's Winnable Battles: <http://www.cdc.gov/winnablebattles/>
- Robert Wood Johnson Foundation Community Health Advisor: <http://www.community-healthadvisor.org/>
- Cancer Control PLANET: <http://cancercontrolplanet.cancer.gov/>
- SAMHSA's National Registry of Evidence-Based Programs and Practices: <http://www.nrepp.samhsa.gov/>
- Office of Juvenile Justice and Delinquency Prevention: <http://www.ojjdp.gov/mpg>
- Center for Training and Research Translation (Center TRT): <http://www.centertrt.org/>
- Partnership for Prevention, Action Guides to Improve Community Health: <http://www.prevent.org/Action-Guides/The-Community-Health-Promotion-Handbook.aspx>
- Guide to Clinical Preventive Services: <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/>
- Cochrane Public Health Group: <http://ph.cochrane.org/>
- Centre for Reviews and Dissemination: <http://www.york.ac.uk/inst/crd/>
- Campbell Collaboration: <http://www.campbellcollaboration.org/>

*In addition to the resources above, CDC is currently developing, [The CHI Navigator Tool](#) to help non-profit hospitals identify community health improvement resources. This tool will serve as a one-stop shop for finding best practices.*



## Tools for Developing SMART Objectives and Strategies

### Logic Models

A logic model can be used to help define and communicate alignment of strategies, objectives, and goals. While some people shy away from logic models because they fear its complexity, logic models can actually provide a process and structure to demonstrate this work in a fairly simple manner.

Consider the following guidance for using logic models:

1. The visual depiction of a logic model shows the pathways to achieving goals or long-term objectives through short and intermediate outcomes. The pathways to the short and intermediate outcomes are articulated through strategies and activities.
2. The iterative process of creating a logic model provides an opportunity to define resources required for activities, including people and money, among other necessary resources.
3. Logic models help planners articulate the rationale and resources needed to implement strategies by forcing a disciplined consideration of inputs or what is needed to fully carry out the plan.
4. Logic models are a useful planning and evaluation tool, and they also serve as an important communication tool. Keep the logic model fairly clean and simple, using arrows to show directions and relationships, to avoid intimidating or confusing the audience. Use a clear and concise narrative summary to define and communicate any assumptions, connections among strategies, objectives, and goals, and any other intricacies not clear in the visual.

### What Does a Logic Model Look Like?

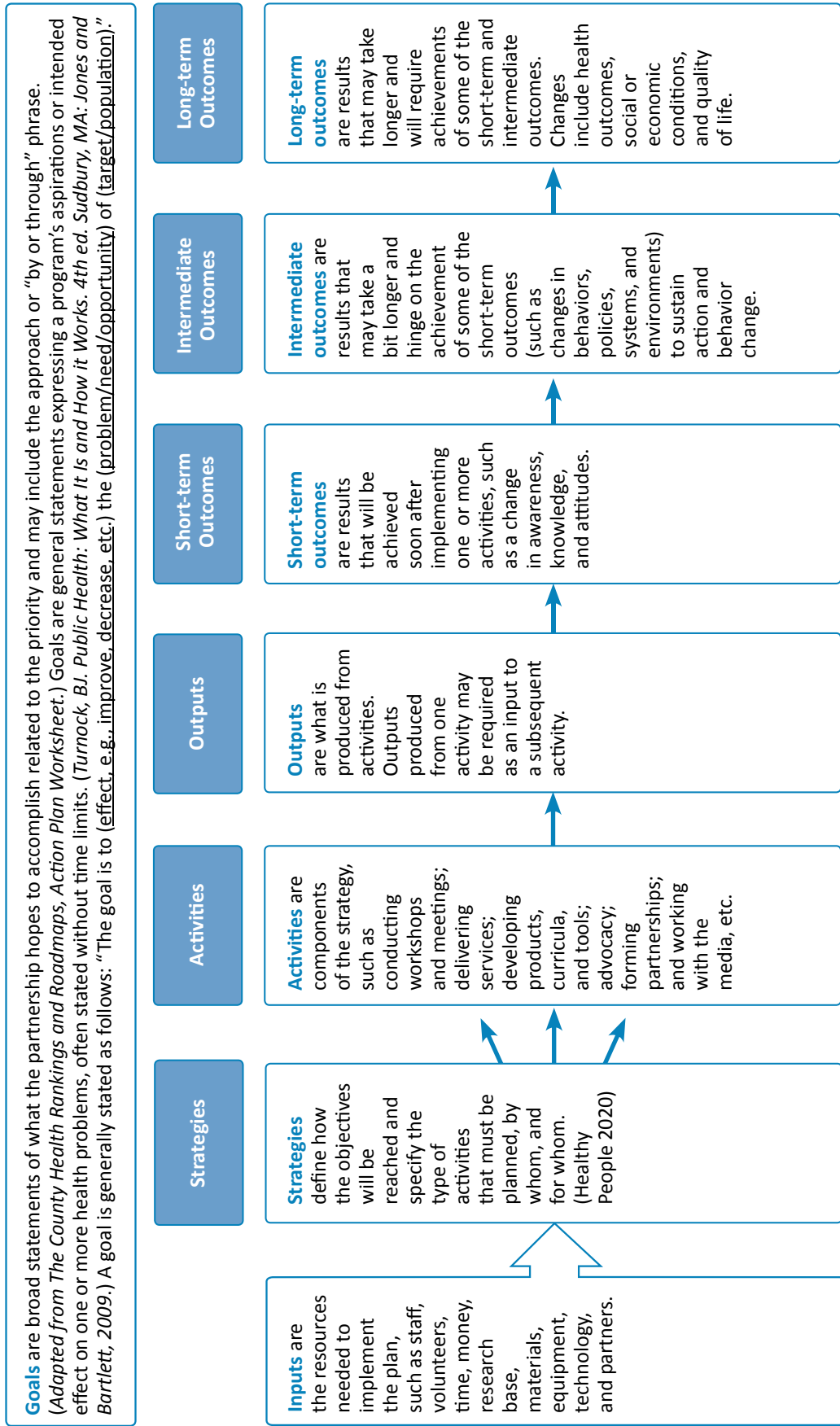
Logic models are usually displayed visually, but the form of the “picture” varies. Logic models typically have two common visual displays, they are either in a series of columns, or a “flow chart” depicting boxes and arrows. Either of these visual displays will work for clarifying the relationship among strategies, objectives, and goals, but a flow chart format makes it easier to visualize the relationships among plan components as “pathways.” To see a sample logic model, refer to the template in Figure 6.12.

#### FIGURE 6.11 RESOURCES AND LINKS FOR LOGIC MODELS

There are a number of excellent resources for developing logic models.

- The University of Wisconsin’s Cooperative Extension Program Development and Evaluation Unit has a webpage with templates, sample logic models, and an online self-study module. Resources can be found here: <http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html>.
- CDC has a logic model library that can be found here: [http://libguides.library.cdc.gov/logic\\_model](http://libguides.library.cdc.gov/logic_model).
- The W.K. Kellogg Foundation Logic Model Development Guide is available online at <https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide>.
- The Tearless Logic Model (from the Global Journal of Community Psychology Practice) takes the traditional logic model approach and translates it into a less daunting process that breaks the logic model process down into a series of manageable, jargon-free questions. A description of the Tearless Logic Model process can be found here: <http://www.gjcpp.org/en/tool.php?issue=7&tool=9>.

**FIGURE 6.12 LOGIC MODEL TEMPLATE**



**Objectives** are specific, measurable statements regarding the changes that need to occur to improve health. **Outcomes** are the defined changes resulting from objectives.

Logic model formats and the terms employed vary widely among experts. In general, key logic model terms include:

- **Inputs:** The resources needed to implement the plan, such as staff, volunteers, time, money, research base, materials, equipment, technology, and partners.
- **Activities:** These are components of the strategy, such as conducting workshops and meetings, delivering services, developing products, curriculum, and tools, advocacy, forming partnerships, and working with the media, etc.
- **Outputs:** These are what is produced from activities. Outputs produced from one activity may be required as an input to a subsequent activity.
- **Outcomes:** The “so what” of the plan. If activities are implemented as intended, who or what will change? Outcomes are often depicted as short, medium, or long-term:
  - **Short-term:** Results that will be achieved soon after implementation of one or more activities, such as a change in awareness, knowledge, or attitudes.
  - **Intermediate:** Results that may take a bit longer and hinge on the achievement of some short-term outcomes, such as changes in behaviors, policies, systems, and environments to sustain action and behavior change.
  - **Long-term:** Results that may take longer and will require achievement of some of the short-term and intermediate outcomes; changes include health outcomes, social or economic conditions, and quality of life.

Arrows are used in logic models to show the direction and linkage of each component to demonstrate the logic and pathways.

## Constructing a Logic Model

To begin developing a logic model, you can either start with your strategies and activities, or with the objectives and their outcomes and goals. Starting with one of these components, work through each section of the logic model. Think of a logic model as telling a story since it is a visual depiction of the plan. Beyond the visual display, another benefit is “checking” the thinking, theory, and logical connections between the available resources to dedicate to the effort (inputs), strategies and activities to implement the plan, results of the activities and strategies (outputs), and impact or change created by the implementation of the collection of strategies and action. Further, the lines or arrows connecting the short-term, intermediate, and long-term outcomes communicate the importance of early success, and to ultimately achieve a goal, building on that success to create the next level of change.

## Theory of Change

Theory of change is a methodology, like logic models, for analysis of complex public health issues and helps to understand the relationships among actions and results. Theory of change involves identifying the type of strategies used to accomplish a goal or objective. It is similar to a logic model, but it is less detailed and articulates the pathway(s) to reach the desired long-term outcome.

### FIGURE 6.13 STEPS TO DEVELOP A THEORY OF CHANGE

1. Identify a long-term [outcome].
2. Conduct “backwards mapping” to identify the preconditions [e.g. short and intermediate outcomes] necessary to achieve that goal.
3. Identify the interventions that your initiative will perform to create these preconditions.
4. Develop indicators for each precondition that will be used to assess the performance of the interventions.
5. Write a narrative that can be used to summarize the various moving parts in your theory.

*Adapted by the Harvard Family Research Project from [www.theoryofchange.org](http://www.theoryofchange.org)*

Stakeholders can utilize theory of change in the planning process to establish a common understanding of the problems or priority issues and determine what is needed to ensure the outcome will be achieved. A theory of change will likely require multiple strategies to achieve the intended change, working through short and intermediate outcomes to achieve the sought after long-term outcome. The theory of change methodology creates a cause and effect framework — showing that if a particular strategy or set of strategies is carried out, then a particular result will occur.

### Using Root Cause Analysis to Develop Objectives and Outcomes

In order to make an impact and set ambitious yet achievable targets for objectives, the SHIP partnership may want the plan to focus, to the extent possible, on risk factors or root causes of the identified health priorities to determine desired outcomes, as shown in the Health Impact Pyramid in Figure 6.4 on page 61. Focusing on root causes may mean addressing policy, systems, and environmental drivers of health. For instance, obesity is a health problem with risk factors that include poor nutrition and sedentary lifestyles. The root cause of these risk factors, for various populations, may be due to lack of access to affordable and healthy foods, extensive marketing efforts promoting unhealthy foods, or limited access to safe places to be physically active.

Tools that explore root causes can help the partnership dig deeper into priority issues and determine underlying causes to create a plan that will have greater impact on the issue. Appendix J includes descriptions of a variety of root cause analysis tools.

### Laying the Groundwork for a Workplan

For each priority, a workplan or detailed implementation and measurement plan should be developed and include the components defined in Module 7 beginning on page 73: goals, objectives, strategies, and interventions and actions, as well as available resources and individuals responsible for the action plans.



**IMPORTANT CONSIDERATION: Aligning with Local, Tribal, and National Objectives, Strategies, Measures (5.2.2 S 1.d.)**

In order to align with local, tribal, and national objectives, strategies, and measures, there are several important considerations. The SHIP must address social determinants of health and health inequities, and the causes of health risks and outcomes within specific populations. These factors contribute to health disparities which cause a decrease in health status experienced by disadvantaged populations due to differences in economic, educational, social or environmental factors. In order to achieve long-term improvement, social and economic conditions that influence equity must also be considered, such as education, housing, transportation, access to healthy food, employment, safety, and community empowerment. States must also demonstrate that they considered including the needs of local health departments and tribal health departments in their development of priorities.

# MODULE 7

## Implementing and Monitoring SHIP

### Module Overview

After states have developed goals, objectives, strategies and activities, and tactics, the next step is to create a more detailed action plan and organize partners for implementing the identified action steps. The SHIP implementation process is more formative than the processes for developing a SHIP, with few comprehensive examples of implementation activities. As a result, this module provides an overview of the process for developing an action plan and covers various considerations for action planning and implementation from PHAB and other resources. Additionally, this module includes case studies and examples from states on various components of implementation, including policy and framework development, coordination with other initiatives, and alignment and monitoring.

### Key Content and Components

- ◆ Dissemination of the SHIP.
- ◆ Developing and implementing action plans and workplans.
- ◆ Tips for success: implementing, monitoring, and updating the SHIP.

### Related PHAB Guidance

#### PHAB Guidance

**PHAB Measure 5.2.2 S, Documentation 1 Guidance: The state health department must provide a state health improvement plan that includes all of the following:**

- a. The desired measurable outcomes or indicators of health improvement effort and priorities for action, from the perspective of the population of the state. The plan must include statewide health priorities, measurable objectives, improvement strategies, and activities with time-framed targets that were determined in the planning process. In establishing priorities, the plan must include consideration of addressing social determinants of health, causes of higher health risks and poorer health outcomes of specific populations and health inequities. Measurable and time-framed targets may be contained in another document, such as an annual work plan. If this is the case, the companion document must be provided with the state health improvement plan for this measure. Strategies may be evidence-based, practice-based, or promising practices or may be innovative to meet the needs of the population. National state-of-the-art guidance (for example, the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020) should be referenced, as appropriate.
- b. Policy changes needed to accomplish the identified health objectives must be included in the plan. Policy changes must include those that are adopted to alleviate the identified causes of health inequity. Policy changes may address the social and economic conditions that influence health equity, including housing, transportation, education, job availability, neighborhood safety, and zoning, for example.
- c. Designation of individuals and organizations that have accepted responsibility for implementing strategies outlined in the state health improvement plan. This may include assignments to staff or agreements between planning participants, stakeholders, other governmental agencies, or other statewide organizations. For this measure, agreements do not need to be formal, such as an MOA/MOU.
- d. States must demonstrate that they considered both tribal and local health department health improvement priorities. Consideration of national priority alignment could include the National Prevention Strategy and Healthy People 2020.

*(PHAB Standards and Measures Version 1.5, pages 136-137)*

## PHAB Guidance

### PHAB Measure 5.2.3 A, Documentation 1 and 2 Guidance:

**The health department must provide a tracking process of actions taken toward the implementation of the community health improvement plan.** The tracking process must specify the strategies being used, the responsible partners involved, and the status of the effort or results of the actions taken. Documentation could be, for example, a narrative, table, spreadsheet, or a combination. This may look like a work plan that includes the status of the implementation of the work plan.

The health department must document areas of the plan that were implemented by the health department and/or its partners. Examples must identify a specific achievement and describe how it was accomplished.

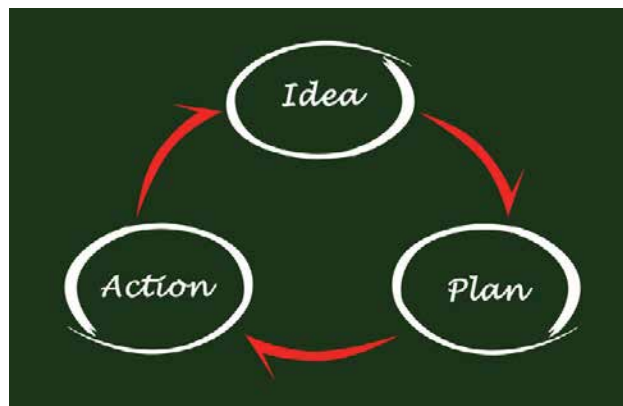
### PHAB Measure 5.2.4 A, Documentation 1 and 2 Guidance:

**The health department must provide an annual report on the progress made in implementing strategies in the community health improvement plan.** The report will consider the feasibility and the effectiveness of the strategies and/or changing priorities, resources, or community assets. If the plan was adopted within the year, a report of a previous plan may be provided or detailed plans for assessment and reporting may be submitted.

**The health department must document that the health improvement plan has been reviewed and revised as necessary based on the required report.** The revisions may be in the improvement strategies, planned activities, timeframes, targets, or assigned responsibilities listed in the plan. Revisions may be based on, for example, achieved activities, implemented strategies, changing health status indicators, newly developing or identified health issues, and changing level of resources. If the plan was adopted less than a year before it was uploaded to PHAB, the health department may provide (1) revisions of an earlier plan or (2) detailed plans for a revision process..

## Developing and Implementing Action Plans and Workplans

The transition from planning to action is often challenging. To help with this transition, use the priority workgroups to develop a clear workplan, or action plan, for each priority. The workplan should outline specific activities, accountabilities and timelines. As described below, some states have also developed overarching frameworks and action steps that provide guidance on how to monitor the SHIP. Figure 7.1 provides an example of how to construct an implementation or action plan using the Oklahoma second-hand smoke example from Module 6. Note that the information in this plan is illustrative and it was not part of the SHIP that was developed by the Oklahoma State Department of Health.





**FIGURE 7.1 SAMPLE ACTION PLAN FORMAT**

<b>PRIORITY: Tobacco</b> <b>GOAL: Reduce Second-Hand Smoke Exposure</b>				
<b>Outcome Objective 1:</b> Increase the proportion of multi-unit housing facilities [from 1% (baseline) to 25% (target)] with voluntary smoke-free policies by June 2014. <b>Strategy:</b> Promote adoption of voluntary smoke free policies in public housing.				
Activities/Tactics	Person/Group Responsible	Timeline	Process Indicators*	Outcome Indicator*
Provide training and resources to local tobacco control coalitions and advocates to engage and educate housing authority officials and tenants.	ODOH; Oklahoma Lung Association; local tobacco control organizations.	July 2010–June 2011	1. Curriculum developed. 2. Informational resources for housing authorities on financial benefits of smoke-free policies provided to local advocates. 3. Informational resources for public housing tenants on benefits of eliminating second-hand smoke provided to local advocates. 4. 100 local advocates trained to engage with housing authority officials.	1. 100 local advocates demonstrate increased knowledge of how to promote smoke-free policies to local housing authorities. 2. 50 local advocates meet with local housing authorities to promote smoke-free policies. 3. 10 local housing authorities adopt smoke-free policies.
*Process Indicator: A process indicator is the measure or documentation of the program or service provided. While there are many potential process indicators, it is important to make decisions regarding which information is most important to monitor in order to understand whether or not the program or intervention is on track to achieve the outcome. *Outcome Indicator: The measures of change at certain milestones to lead to the overall target.				

*Adapted from NACCHO's Developing a Local Health Department Strategic Plan: A How-To Guide.*

Washington State drafted the Public Health Improvement Plan Agenda for Change Action Plan in 2012, which clearly reflects the strong partnership between the state and local health departments on the Public Health Improvement Plan, and includes focused attention on local health jurisdictions working with local partners on achieving the objectives of the plan. More current practice suggests that states may want to include accountabilities or other stakeholders and sectors that are part of the SHIP Partnership.

**FIGURE 7.2 WASHINGTON PHIP AGENDA FOR CHANGE ACTION PLAN**

**Internal Working *DRAFT* PHIP Agenda for Change Action Plan | 6-15-12**

**3. Increase the number of communities that encourage adults to make healthy choices for themselves and their families.**

Strategies	The State Department of Health will ...	Local Health Jurisdictions will ...
<p>a) Provide affordable, healthy food and beverages in worksite, institution, community, and neighborhood settings.</p>	<ol style="list-style-type: none"> <li>1. Provide access to current statewide data on fruit and vegetable intake and the availability of affordable healthy food and beverages.</li> <li>2. Provide training and technical assistance on evidence-based policies and programs that increase the availability of healthy food and beverages and improve nutrition.</li> <li>3. Work with state agencies and partners to develop and adopt healthy food and beverage procurement guidelines (that include guidelines about availability of sweetened beverages).</li> <li>4. Promote one site of recommended healthy food and beverage procurement guidelines for all state agencies.</li> </ol>	<ol style="list-style-type: none"> <li>1. Identify communities with limited access to healthy food and beverages.</li> <li>2. Work with partners to identify, implement, and evaluate policy, system, and environmental changes that can increase access to affordable, healthy food and beverages.</li> <li>3. Work with local board of health to influence adoption of healthy food and beverage procurement policies that align with state guidelines.</li> </ol>

The SHIP Partnership should keep in mind the following components when developing and implementing action plans and workplans:

- Working collaboratively to develop a workplan that multiple partners will implement (PHAB Measure 5.2.3 A).
- Designating organizations and individuals that are responsible for implementing SHIP strategies (PHAB Measure 5.2.2 S, Guidance 1.c.).
- Utilizing an implementation committee and workgroups.
- Identifying implementation strategies that will be led by the health department (PHAB Measure 5.2.3 A, Guidance 2.).
- Linking to the health department strategic plan (PHAB Measure 5.3.2 A, Guidance 1.g.).
- Developing financing strategies for implementation, including seeking out or allocating resources for implementation.
- Continuing to develop strong partnerships and encouraging alignment of organizational mission, goals, and initiatives with SHIP.
- Leading policy and systems approaches to addressing the priority strategic issues.
- Tracking progress and impact, including an annual report on progress and revisions or updates to SHIP (PHAB Measures 5.2.3 A and 5.2.4 A).

## Case Studies and Success Stories for Implementing, Monitoring, and Updating SHIP

The initiatives and approaches highlighted in this section demonstrate some of the emerging and innovative implementation work that state health departments and SHIP partnerships are engaging in across the country. ASTHO looks forward to continued collaboration with states to identify emerging best practices that can be shared with peers, especially as more states develop a body of knowledge and experience related to SHIP implementation.

### **Minnesota: Intentionally building a policy focus into the Healthy Minnesota 2020 process**

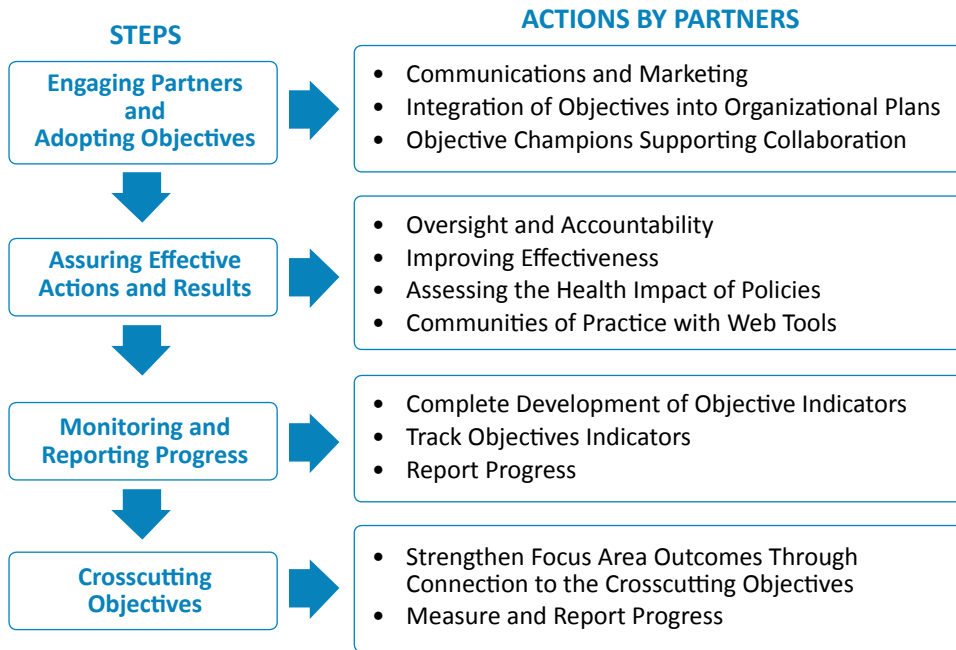
Minnesota’s policy focus for Healthy Minnesota 2020 began with the state health assessment (SHA). This process and documentation, under the direction of the Healthy Minnesota Partnership, took “the opportunity for health” as a framing narrative. The Partnership continued in this vein by creating a Healthy Minnesota 2020 plan that emphasizes the interrelatedness of the factors that create health. The Partnership also emphasized that these factors, such as educational attainment and economic opportunity, are the product of policy decisions.

To implement Healthy Minnesota 2020, the Partnership is intentionally trying to change the nature of the public conversation about health — which means changing the *policy* conversation. The Partnership’s implementation of Healthy Minnesota 2020 uses “health in all policies” as its most effective strategy for creating conditions allowing all people the opportunity to be healthy. Each year, the Partnership chooses a policy initiative and brings a “health lens” to that policy to increase understanding and opportunities for people in Minnesota to be healthy, with particular attention paid to how structural racism has posed restrictions. For example, in 2014 the Partnership provided a health perspective to the minimum wage legislative debate by emphasizing the relationship between income and health.

### **Wisconsin: Collaborative development and use of a framework for implementation**

Through collaboration with a broad set of stakeholders and partners, the Wisconsin Department of Health Services developed an overall framework to guide SHIP implementation, making it easier for state and local level partners to know *how* they can engage. The framework focuses on engagement, effectiveness, monitoring and tracking, and the establishment of crosscutting objectives that connect the SHIP’s focus areas.

**FIGURE 7.3 IMPLEMENTATION FRAMEWORK FOR HEALTHIEST WISCONSIN 2020**



RAISE  
AWARENESS



## Illinois: Developing coordinated approaches

By law, Illinois convenes a SHIP Implementation Coordination Council (ICC), to coordinate SHIP activities, which include:

- Serving as a forum for collaborative action.
- Coordinating existing and new initiatives.
- Developing detailed implementation steps.
- Implementing specific projects.
- Identifying public and private funding sources.
- Promoting public awareness of the SHIP.
- Advocating for implementation of the SHIP.
- Reporting to the Governor and General Assembly annually on the status of the SHIP.

SHIP ICC membership includes several state agencies with health, human services, and public health responsibilities, as well as local health departments and individuals with expertise or who represent constituencies engaged in public health issues.

In late 2014, as part of the charge to coordinate initiatives and raise awareness for implementation of the SHIP, the Illinois Department of Public Health (IDPH), Illinois Governor's Office of Health Innovation and Transformation (GOHIT), and SHIP ICC worked together to sponsor eight health transformation summits around the state. This innovative approach sought to initiate more deliberate connections among SHIP efforts and health system transformations that are being driven by ACA and state innovation model efforts described on page 16.

### The goals for the health transformation summits were to:

1. Raise awareness of critical statewide initiatives to foster collaborative health transformation, which included the following:
  - SHIP and related priority area metrics.
  - Alliance for Health – State Innovation Model planning grant (Center for Medicare and Medicaid Innovation).
  - GOHIT.
  - We Choose Health (Illinois' Community Transformation Grant program).
  - Proposed regional health improvement collaboratives (a component of the state's Medicaid 1115 Waiver application).
2. Convene groups of multi-sectoral stakeholders around the state to discuss local priorities for health improvement and provide feedback about how state government can support their local and regional work.
3. Serve as a starting point for a statewide assessment and development process that IDPH will undertake in 2015, gathering input as a step in the development of the next SHIP, due in 2016.

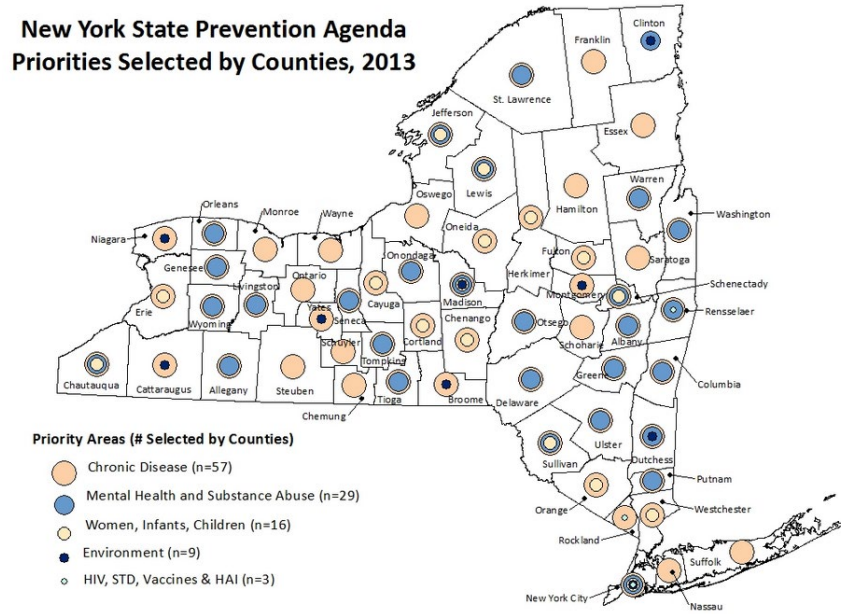
## Florida and New York State: Tracking State and Local Alignment Around Priority Issues

Several states provide regularly-updated online tracking of alignment between state and local priorities for SHIPs and CHIPs; Figures 7.4 and 7.5 show examples from Florida and New York state. Florida and New York state both developed matrices for tracking alignment between state and local priorities. New York state has also developed a map to show the geographic distribution of local jurisdictions that have priorities aligned with SHIP.

**FIGURE 7.4 TRACKING STATE AND LOCAL ALIGNMENT OF PRIORITY ISSUES – FLORIDA**

State Health Improvement Plan and Community Health Improvement Plans Alignment		Statewide Total	Alachua	Baker	Bay	Bradford	Brevard	Broward	Calhoun	Charlotte	Citrus
Chronic Disease Prevention	Overweight and Obesity	47	1	1	1	1	1	1	1	1	
	Smoking and Tobacco Use	27	1				1			1	
	Diabetes	20	1	1	1		1				1
	Heart Disease and Stroke	10	1	1			1				1
	Cancer/Cancer Screenings	8	1	1			1	1			
	Asthma	0									
	CLRD	2		1							1
	High Blood Pressure	6		1							
<b>Total</b>	<b>120</b>	<b>5</b>	<b>6</b>	<b>2</b>	<b>1</b>	<b>5</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>3</b>	
Access to Care	Maternal and Child Health/Infant Mortality	24	1				1	1		1	
	Teen Pregnancy	14				1					
	Oral Health	16	1				1			1	
	Poverty	10							1		
	Mental Health	13									
	Access to Healthcare	54	1	1	1	1	1	1		1	1
	<b>Total</b>	<b>131</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>1</b>

**FIGURE 7.5 TRACKING STATE AND LOCAL ALIGNMENT OF PRIORITY ISSUES – NEW YORK STATE**





Organization Submitting CHA/CHIP or CSP: Rest of NYS (Rev 05/28/2014)		Prevention Agenda Priorities						Website for Report	Implementing Partner Organizations, In Addition to LHDs and Hospitals, Identified in Plan												
HOSPITAL	LHD	Prevent Chronic Disease	Promote a Healthy and Safe Environment	Promote Healthy Women, Infants and Children	Promote Mental Health and Prevent Substance Abuse	Prevent HIV/STDs, Vaccine-Preventable Diseases and Healthcare-Associated Infections			Community Health Centers	Health Plans	Business	Philanthropy	College/University	School	Faith-Based	Housing	Mental/Behavioral Agencies/Organizations	Transportation	School Services	Media	
	Albany County Dept. of Health	X				X															X
Albany Medical Center		X				X									X						
<b>St. Peter's Health Partners:</b> St. Peter's Hospital		X				X									X						
<b>St. Peter's Health Partners:</b> Albany Memorial Hospital		X				X									X						
	Allegheny County Dept. of Health	X				X															X
Cuba Memorial Hospital		X				X															X
Jones Memorial Hospital		X				X															X
	Broome County Health Dept.	X	X																		X
Our Lady of Lourdes Memorial Hospital		X	X																		X
<b>United Health Services:</b> Binghamton General and CS Wilson Hospital		X		X																	X
	Cattaraugus County Health Dept.	X	X																		X
Olean General Hospital		X	X																		X
	Cayuga County Health Dept.	X		X																	X
Auburn Memorial Hospital			X																		X
	Chautauqua County Health Dept.	X		X	X																X
Westfield Memorial Hospital		X		X																	X
Women's Christian Association Hospital		X		X	X																X
	Chemung County Health Dept.	X																			X
<b>Arnot Health:</b> Arnot Ogden Medical Center and St. Joseph's Hospital		X																			X

## Maryland: Monitoring and Evaluating State and Local Progress

PHAB Measures 5.2.3 A and 5.2.4 A require tracking and reporting on SHIP progress. Several states have developed report cards or dashboards to monitor the health priorities in the SHIP. Some aspects of the monitoring mechanism include identifying metrics for SHIP priorities, showing status and trends using arrows and often red (poor), yellow (static), and green (positive progress) to help viewers understand the status at a glance. Maryland's online SHIP tracker not only covers most of these aspects, but also tracks progress on SHIP indicators at the county level (see Figure 7.6).

**FIGURE 7.6 MARYLAND SHIP 2014 TRACKER**



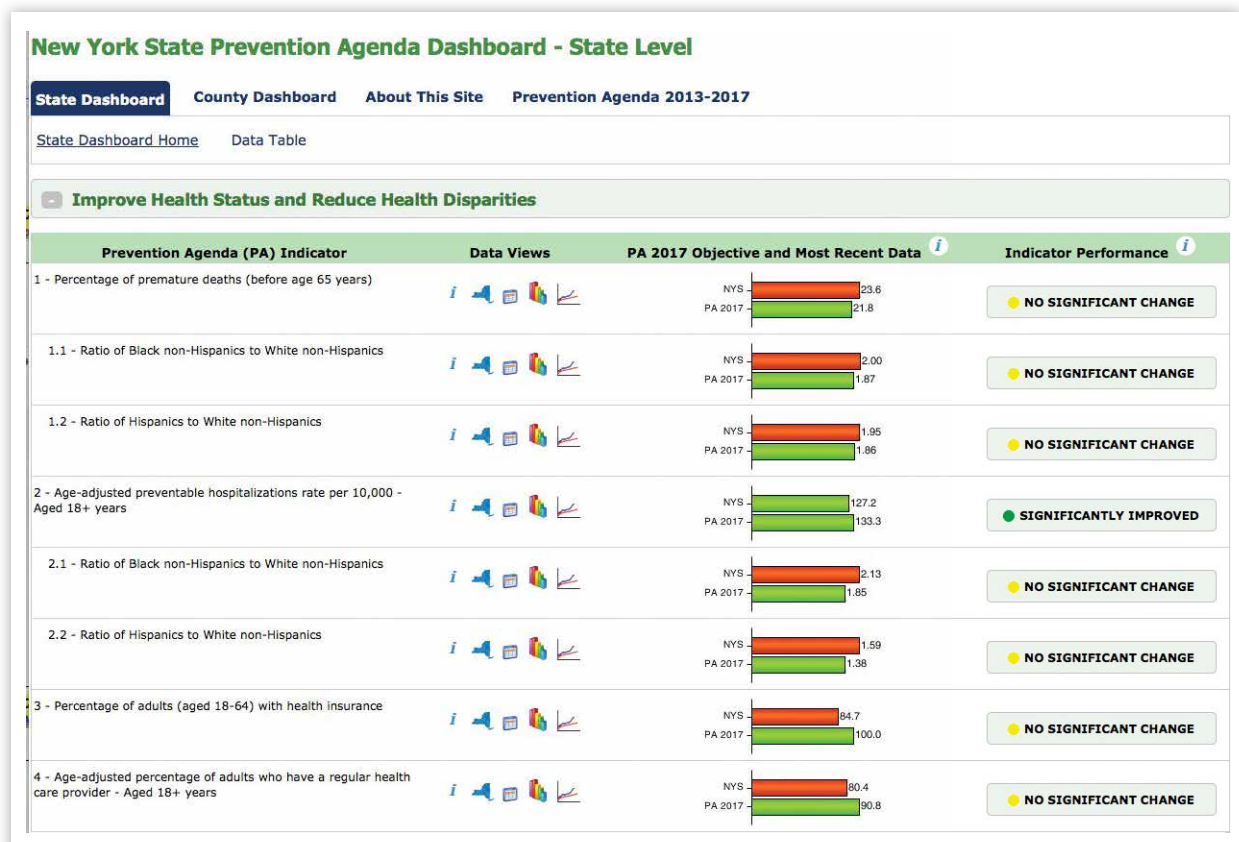
Connecticut's [Healthy Connecticut 2020 Performance Dashboard](#) tracks hundreds of health indicators related to its SHIP priorities (See Figure 7.7).

**FIGURE 7.7 HEALTHY CONNECTICUT 2020 PERFORMANCE DASHBOARD**



Finally, the New York Prevention Agenda Dashboard includes a number of similar features, including both state and county level data, progress toward targets, annual progress, and the option to view data in various formats including maps, bar graphs, trend lines, and table views.

**FIGURE 7.8 NEW YORK PREVENTION AGENDA DASHBOARD**



## Conclusion

Building on public health systems research, identifying best practices from public health and other fields, and using the experience from states that have already conducted a SHIP, this guide is designed to assist states in launching an initial SHIP, or improving the next one. ASTHO hopes that this guide has offered insights, resources, strategies, and tools that are practical and useful in the SHIP process.

This guide presents approaches to develop a SHIP by applying key principles of a SHA, including:

- Multi-sector collaborative processes that support shared ownership of all phases of state health improvement.
- Proactive, broad, and diverse community engagement to improve results.
- Maximum transparency to improve community engagement and accountability.
- Use of the highest quality data pooled from and shared among diverse public and private sources.

Applying these principles to produce a multi-faceted plan that identifies strategic priorities, sets SMART objectives, and promotes collaborative action and monitoring will set the stage for states to implement strategies and actions that promote health equity, effect policy change, and improve the overall health and well-being of their residents.

By aligning this guide with PHAB standards, measures, and guidance, ASTHO hopes that it will be useful for states planning to seek accreditation. Nonetheless, this guide should be useful to any state wishing to develop a plan for improving the health of its residents through programs, alignment, and policy development, even if it doesn't intend to pursue accreditation in the near future. As more states undertake SHIP production, ASTHO will support continuous learning and quality improvement, hoping to build on this guide for the long term.

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## APPENDIX A: PHAB MEASURE 4.1.1 A

### PHAB Standards and Measures

**PHAB Measure 4.1.1 A** – Establishment, engagement and active participation in a comprehensive community health partnership or coalition.

Required documentation 1:

**1. Collaborative partnerships with others to address public health issues.**

Guidance: The state health department must document a current, ongoing comprehensive community partnership or coalition in which it is an active member. The purpose of the partnership or coalition must be to improve the health of the community, and therefore, must be engaged in various issues and initiatives. A comprehensive community partnership, in this context, is a partnership that is not topic or issue specific. It is a community partnership that addresses a wide range of community health issues. The comprehensive partnership or coalition may be organized into several committees or task forces to address specific issues, for example, teenage pregnancy, social determinants of health, health equity or increased opportunities for physical activities. This partnership or coalition may be the same group that developed the community health assessment and community health improvement plan. This partnership or coalition may work on various issues addressed in the Standards and Measure, such as access to care (Domain 7).

Alternatively, the health department must document their involvement in several current ongoing partnerships or coalitions that address specific public health issues. In this case, each collaboration must address a particular public health issue or population. Examples of collaborative partnerships include: an anti-tobacco coalition, a maternal and child health coalition, an HIV/AIDS coalition, a childhood injury prevention partnership, child labor coalition, immigrant worker/community coalition, newborn screening advisory group, integrated chronic disease prevention coalition, and a partnership to decrease childhood obesity. Partnerships addressing issues that impact on health, for example, housing, transportation, or parks and recreation are acceptable...These partnerships and coalitions, whether a broad multi-issue partnership or a group of single issue partnerships or coalitions, may address an already established program area; newly identified issues; issues identified by the health assessment; strategies or actions included in a health improvement plan; a potential public health threat or hazard; populations with particular health needs; and/or goals of the health department, community, region or state. They may address broad public health issues, for example health equity or access to community resources. The partnerships or coalitions may also address issues that impact health, for example, smart growth and the built environment, education and training, employment rates or transportation.

These partnerships or coalitions may be convened by the health department, by another organization, or by community members. The health department must actively participate. Examples must be from current, active partnerships and not partnerships that have completed their tasks and disbanded. Partnerships must include representation of the community impacted.

Documentation could be a summary or report of the partnership(s) or coalition(s), indicating on-going activities; meeting minutes and agendas; progress reports; evaluations; etc.



## PHAB Standards and Measures

**PHAB Measure 4.1.1 A** – Establishment, engagement and active participation in a comprehensive community health partnership or coalition.

These partnerships or coalitions may be convened by the health department, by another organization, or by community members. The health department must actively participate. Examples must be from current, active partnerships and not partnerships that have completed their tasks and disbanded. Partnerships must include representation of the community impacted.

Documentation could be a summary or report of the partnership(s) or coalition(s), indicating ongoing activities; meetings minutes and agendas; progress reports; evaluations, etc.

Required documentation 2:

### **2. Partner organizations or representation**

Guidance: The health department must provide a list of the participating partner organizations for the partnership(s) or coalition(s) referenced above. Organizational and representational membership must be listed; individuals' names are not required. For example, names of: the hospitals; school systems; and specific businesses, social service organizations, not-for-profit organizations, faith institutions, private citizen groups, or particular population groups. The membership must be broad and include various sectors of the community. Community members must be included.

Required documentation 3:

### **3. The health department must document a change in the community, a change in policy, or a new or revised program that was implemented through the work of the partnership(s) or coalition(s) identified in Required Documentation 1, above.**

Guidance: Examples could be an increase in the number and types of locations where tobacco use is not permitted, an increase in the number of miles of bike paths, a local zoning change, the removal of soda vending machines from public schools, an increase in the frequency of restaurant inspections, an increase in the number of community police stations, policies that address social determinants of health, etc.

*(PHAB Standards and Measures Version 1.5, pages 117-119)*



**APPENDIX B: STAKEHOLDER MATRIX**

STAKEHOLDER INFORMATION			ROLE					
Organization	Contact Person	Area of Expertise/Sector	SHIP Partnership	Measurement/Evaluation Workgroup	Priority 1 Workgroup F = Facilitator; M = Member	Priority 2 Workgroup F = Facilitator; M = Member	Priority 3 Workgroup F = Facilitator; M = Member	Priority 4 Workgroup F = Facilitator; M = Member

*Adapted from Connecticut Department of Public Health*

## APPENDIX C: IOM'S PRINCIPLES FOR SUCCESSFUL INTEGRATION OF PRIMARY CARE AND PUBLIC HEALTH

### Principles for Successful Integration of Primary Care and Public Health

The Institute of Medicine (IOM) Committee on Integrating Primary Care and Public Health reviewed integration examples to identify common themes and lessons learned resulting in a set of principles for successful integration of primary care and public health:

- A shared goal of population health improvement;
- Community engagement in defining and addressing population health needs;
- Aligned leadership that
  - bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity,
  - clarifies roles and ensures accountability,
  - develops and supports appropriate incentives, and
  - has the capacity to manage change;
- Sustainability, key to which is the establishment of a shared infrastructure and building for enduring value and impact, and
- The sharing and collaborative use of data and analysis.

*Source: IOM. (2012). Primary Care and Public Health: Exploring Integration to Improve Population Health, pages 5-6.*

The IOM committee found each of these principles to be important for integration, yet acknowledged that starting with any of the principles is more important than waiting until all principles are in practice. The principles are a good fit for community health assessment and improvement as population health improvement goals are collaboratively defined and based on shared data and critical analysis; community engagement is built in throughout assessment, planning and implementation to ensure understanding of community needs and to build a strong infrastructure of partners working collaboratively to improve population health by implementing a shared plan; and leadership promotes alignment to ensure comprehensive set of strategies across multiple organizations and geographical locations are in concert with one another to improve population health outcomes for priority issues.

## APPENDIX D1: STATE OF ILLINOIS SHIP PLANNING TEAM BYLAWS

### STATE OF ILLINOIS State Health Improvement Plan Planning Team BYLAWS

#### ARTICLE I

##### Membership:

Section 1-1. The members of the State Health Improvement Plan Planning Team (the “SHIP Team”) are appointed by the Director of the Illinois Department of Public Health (the “Department”), in accordance with Section 5-565 (a-10) of the Administrative Civil Code (P.A. 93-0975).

Section 1-2. Members shall serve until the submission of the SHIP Team’s final report to the General Assembly. Vacancies in membership shall be filled by the Director of the Department.

Section 1-3. The Director of the Department or his or her designee shall chair the SHIP Team.

Section 1-4. Absent SHIP Team members may be represented by surrogates, who may participate in SHIP Team meetings but are not entitled to vote.

#### ARTICLE II

##### Meetings:

Section 2-1. Regular meetings shall be scheduled by the SHIP Team. It shall be the responsibility of the Department to give notices of the location, date and time of said regular meetings to each member of the SHIP Team at least ten (10) days prior to each of the said meetings.

Section 2-2. Special meetings may be called by the Chair or by request of 12 members of the SHIP Team, in accordance with the Open Meetings Act. It shall be the responsibility of the Department to give notices of the location, date and time of said regular meetings to each member of the SHIP Team at least ten (10) days prior to each of the said meetings.

Section 2-3. A meeting may be rescheduled by the Chair.

Section 2-4. All SHIP Team meetings shall be open to the public unless a meeting or portion thereof qualifies for a closed session in accordance with the Open Meetings Act. Minutes of SHIP Team meetings shall be kept in accordance with the Open Meetings Act.

Section 2-5. The Chair shall prepare an Agenda of business scheduled for deliberation prior to each meeting. The approval of Minutes from the previous meeting shall be included on each Agenda. The Agenda shall be distributed to the members of the SHIP Team at least five days prior to a scheduled meeting.

### **ARTICLE III**

#### **SHIP Team Officers:**

Section 3-1. The Director of the Department shall select a Co-Chair from among the SHIP Team members. The Chair and Co-Chair shall have the duties and responsibilities described in these Bylaws.

Section 3-2. If the Chair's membership on the SHIP Team is vacated for any reason, or the Chair resigns from that office, the Co-Chair shall serve in place of the Chair until the designation of a new Chair by the Director of the Department.

### **ARTICLE IV**

#### **Conducting Business:**

Section 4-1. All business shall be conducted in a manner consistent with the intent of Robert's Rules of Order.

Section 4-2. It is the intent of the SHIP Team to reach consensus on decisions brought to it for action. In the event that goal cannot be attained, each SHIP Team member shall have one vote on a contested motion. A contested motion shall be passed by a majority vote of the members present, except as otherwise provided in these bylaws. A member is present to conduct business if attending a meeting in person, or by audio or video conference, if such audio or video conferencing is available. Physical presence at the SHIP Team meetings, however, is strongly encouraged and is preferred by the SHIP Team.

Section 4-3. The Chair shall preside at all SHIP Team meetings. In the Chair's absence, the Co-Chair shall preside over that meeting and assume the Chair's duties related to that meeting. In the absence of both the Chair and Co-Chair, the SHIP Team shall appoint a presiding officer for that meeting, by majority vote.

Section 4-4. The presiding officer shall be responsible for conducting the meeting in accordance with the Bylaws and the Agenda, and may recognize non-member attendees who wish to comment during the meeting. The duration of public comments shall be at the presiding officer's discretion.

## ARTICLE V

### Committees:

Section 5-1. The SHIP Team may form standing committees or ad hoc committees.

Section 5-2. SHIP Team members will be asked to express their committee preferences for consideration. The Chair shall appoint the membership of the committees, taking into consideration the expressed preferences. The Chair of each committee shall be appointed by the Chair of the SHIP Team. Each committee may elect a Vice-Chair. Persons who are not members of the SHIP Team may serve as adjunct, non-voting members of a Committee, appointed by the Committee Chair. The Committee Chair shall be available to report on committee activities.

Section 5-3. Each committee Chair shall promptly notify, through SHIP Team staff, all SHIP Team members and the Department of all dates, times and locations for all regularly scheduled, rescheduled or special meetings of the committee.

Section 5-4. All committee meetings shall be open to the public unless a meeting or portion thereof qualifies for a closed session in accordance with the Open Meetings Act. Minutes of committee meetings shall be kept in accordance with the Open Meetings Act.

Section 5-5. All committee business shall be conducted in a manner consistent with the intent of Robert's Rules of Order.

Section 5-6. Each committee member shall have one vote on a contested motion. Contested motions shall be passed by a majority vote of the members present. A member is present to conduct business if attending a meeting in person, or by audio or video conference, if audio or video conferencing is available.

## ARTICLE VI

### Bylaws:

Section 6-1. Adoption or amendment of these Bylaws requires a two-thirds vote of the SHIP Team members present and voting. Amendments shall be proposed at a meeting of the SHIP Team and voted upon during the next subsequent meeting.

## APPENDIX D2: WASHINGTON PUBLIC HEALTH IMPROVEMENT PARTNERSHIP

<http://www.astho.org/programs/accreditation-and-performance/Washington-Public-Health-Improvement-Partnership-Charter/>

## APPENDIX E: PHAB MEASURE 1.4.2 S

### PHAB Standards and Measures

**PHAB Measure 1.4.2 S** – Statewide summaries or fact sheets of data to support health improvement planning processes at the state level.

Required documentation 1:

#### 1. State health data summaries or fact sheets

Guidance: The state health department must provide summaries or fact sheets that condense the state's public health data. Data summaries may address a combination of public health issues or may focus on a particular health issue regarding the population served. Statewide health data summaries are not the same as a community health assessment. A data summary can take several forms. It can be an overview, summary, or synopsis of a particular health issue, such as cancer or obesity. Or it can address a set of issues, such as health equity or the health issues of the state's adolescents. It may also focus on select key indicators of the health of the state, such as health behaviors like tobacco use or healthful eating. Health data summaries produced by national or federal sources are insufficient documentation of the measure, unless the state health department demonstrates how the data summary was supplemented with additional data collected and analyzed by the state health department. Documentation could be, for example, a summary, fact sheet, brief, overview, a single document of comprehensive data, or a dynamic website with comprehensive state data that is updated as data are available (e.g., web-based dashboard).

Required documentation 2:

#### 2. Distribution of summaries of state data to public health system partners, community groups and key stakeholders.

Guidance: The state health department must document the distribution of summaries of health data to public health system partners, community groups, tribal health departments, local health departments, elected officials, or key stakeholders, such as governing entities or community advisory groups. This may include partners, including community-based organizations, civic groups, and any others who receive services, help in the delivery of services, or support public health services. Documentation could be, for example, a mailing list, email list-serve, posting on the website, press releases, meeting minutes documenting distribution of the profile, presentations, inserts or flyers, or a website of data that is updated as data are available.

*(PHAB Standards and Measures Version 1.5, pages 52-53)*

**APPENDIX F: IDENTIFY EXISTING ASSETS WORKSHEET**

What assets, resources, or efforts exist to address this issue? (List one per row)	Organization, person, or group	Is this group already working with us?	If not working with us should they be?	Who can we contact with this group?

Source: Missouri Department of Health and Senior Services



## APPENDIX G: PRIORITIZATION CRITERIA WORKSHEET

### Prioritization Considerations

Use this worksheet to list potential health problems or priority issues and thoughts on the level of priority.

Indicate (H) for high, (M) for medium, and (L) for low with the following considerations:

- **Size of the problem:** Number of people per 1,000, 10,000, or 100,000.
- **Seriousness of the problem:** Impact on individual, family and community levels.
- **Feasibility:** Cost, internal resources and potential external resources, time commitment.
- **Disparities:** One or more populations are disproportionately affected, particularly the low income and most vulnerable members of the community.
- **Available expertise:** Can we make an important contribution?
- **Important to the community:** Evidence that it is important to diverse community stakeholders.

#### Important notes:

The “Health and Strategic Issues” column should be pre-populated with findings or strategic issues from the SHA and/or group discussion of key issues that are being prioritized. Leave a couple blank rows to allow participants the option to add a new idea.

The “prioritization considerations” columns can be edited to include the considerations/criteria selected for the process.

Health and strategic issues	PRIORITIZATION CONSIDERATIONS						Comments, questions or additional thoughts
	Size of the problem (H, M, L)	Seriousness of not addressing (H, M, L)	Feasibility, cost, time, resources (H, M, L)	Disparities (H, M, L)	Available expertise (H, M, L)	Importance to the community (H, M, L)	

Note: be cautious about overemphasizing “size of the problem,” because that may mask issues that affect smaller numbers but reflect troubling and persistent disparities and inequities.

Based on the responses above, list the top five issues:

- 1.
- 2.
- 3.
- 4.
- 5.

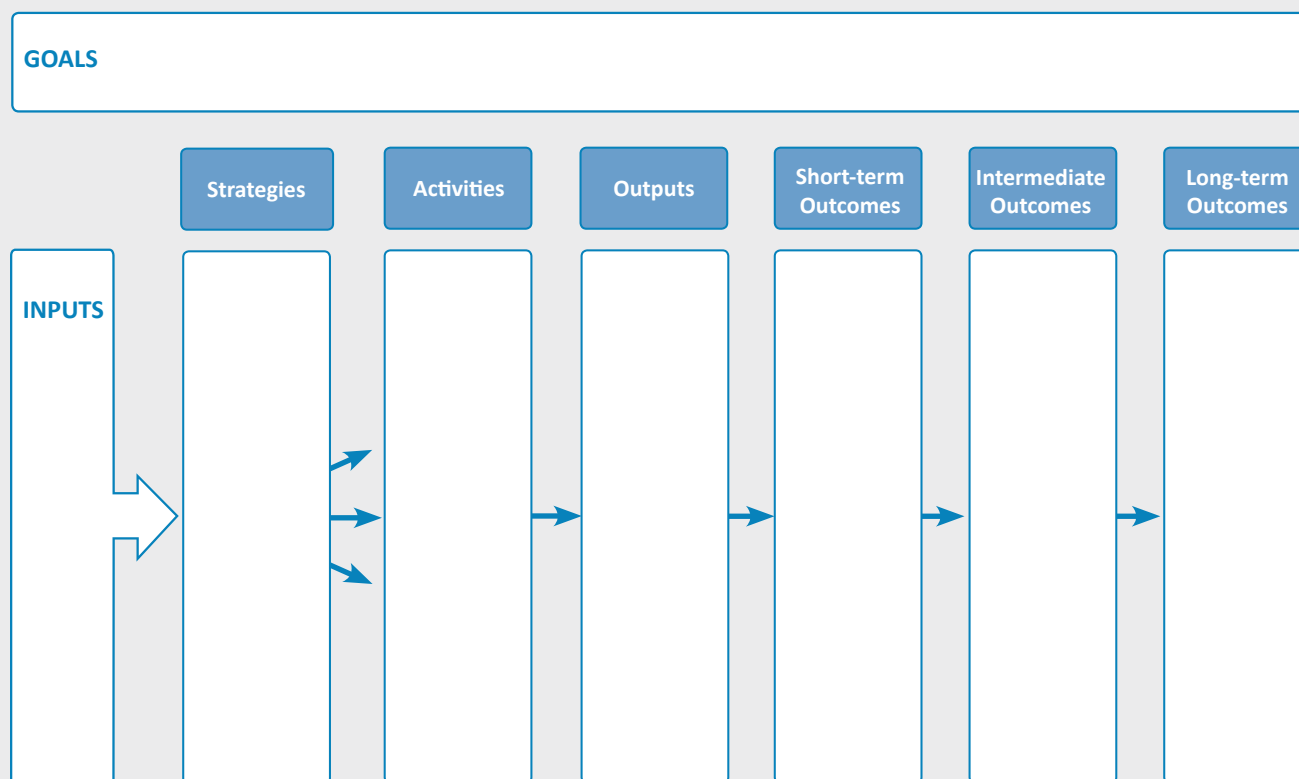
Source: Illinois Public Health Institute

**APPENDIX H: SAMPLE PRIORITIZATION MATRIX**

Proposed issue	CRITERIA						Total score
	Severe health consequences (3)	Large number of people affected (2)	Disproportionate effects among subgroups (2)	Problem results in economic and social cost (1)	Problem has life-span effect (3)	Feasibility (1)	

*Adapted from New Hampshire Department of Health and Human Services*

## APPENDIX I: LOGIC MODEL TEMPLATE



## APPENDIX J: ROOT CAUSE ANALYSIS TOOLS

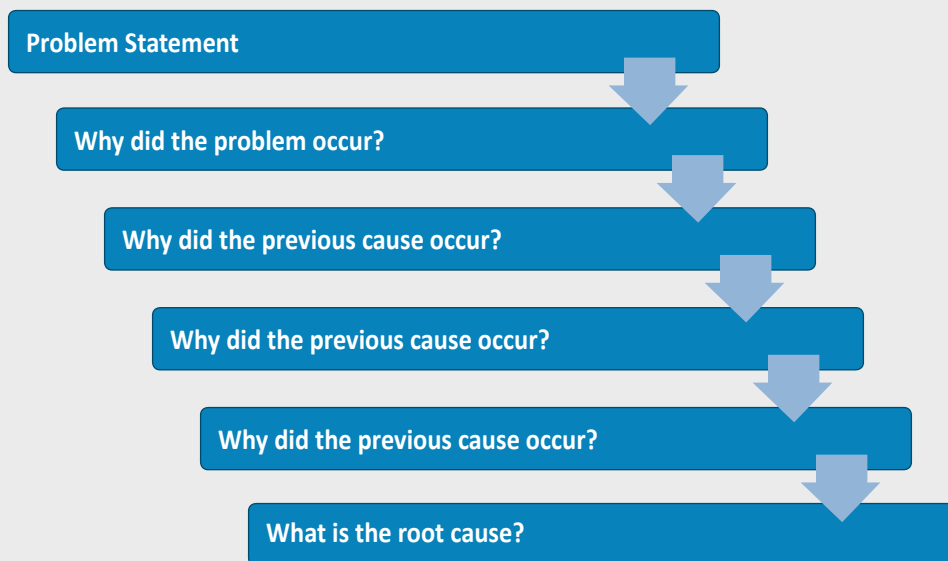
### The 5 Whys

To find the underlying reasons for a problem, it is important to consider causes that are not immediately apparent and find hidden relationships between different root causes. These can be determined through use of the “5 Whys” tool. This method is used to repeatedly ask probing questions about an issue until a root cause is identified and can be directly addressed. When facilitating this activity in a group setting:

- Write the problem as defined through the assessment and the workgroup on a summary poster for the entire group.
- Then, ask participants to brainstorm possible causes for the problem.
- The next step is to identify a few top causes.
- For each identified top cause, ask why the cause occurs.
- When this cycle is repeated about 5 times for each, it should help identify root causes.

Figure 6.11 provides a template for the flow of asking the “5 Whys.” Once the entire group can reach consensus on which causes can be addressed, those become the focus for developing objectives and strategies. When using this tool, be sure to involve diverse stakeholders in answering the question of “why?” because the responses may vary depending on the perspective. Also, different levels of expertise are needed, especially to get at issues of inequities – often the root “why?” is a policy issue that calls for a policy response, not a typical “intervention” or public health program.

## FIVE WHYS ANALYSIS TEMPLATE



### Tree Diagram and Population Health Driver Diagram

According to the American Society for Quality, a tree diagram is used to break down categories into finer and finer levels of detail. Developing a tree diagram helps move thinking step by step from generalities to specifics. It is called a tree diagram because it starts with one item that branches into two or more, each of which branches into two or more, and so on. It looks like a tree with trunk and multiple branches. (<http://asq.org/learn-about-quality/new-management-planning-tools/overview/tree-diagram.html>)

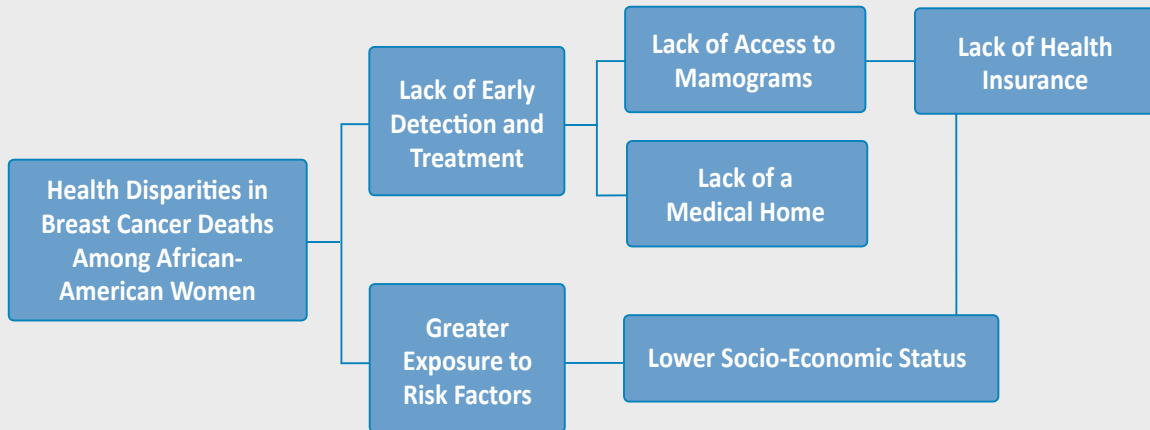
The Public Health Foundation (PHF) has developed a related tool, the Population Health Driver Diagram that helps workgroups to explore a priority issue and its underlying causes by identifying the “cause and effect” relationships. Groups identify and agree on primary and secondary drivers for the priority. Knowing secondary drivers is useful for workgroups when they get to the point of identifying short and intermediate outcomes and specific interventions designed to impact the secondary drivers. Further guidance is provided including construction steps and a sample on PHF’s website. (<http://www.phf.org/resources-tools/Documents/PH%20Driver%20Diagram%20Paper,%20Final.pdf>)

To create a cause and effect tree diagram, identify the specific priority issue and use the “5 Whys” process, that is, ask, “Why is this happening?”

- Write down the answers. Then look at the answers, and ask again, “Why is this happening?”
- Continue to repeat this process until the group identifies the underlying root causes, that is, when the group can no longer identify a “why” for the answer it has arrived at.
- Then, if possible, define your objectives to describe a SMART change in the root cause.
- Construct short-, intermediate- and long-term outcomes by working backward along the pathway of causes.

If the process has effectively identified the cause and effect relationships, then strategies and activities can be developed to address the short-term outcome.

## FIVE WHYS ANALYSIS TEMPLATE



## Health Problem Analysis Tool

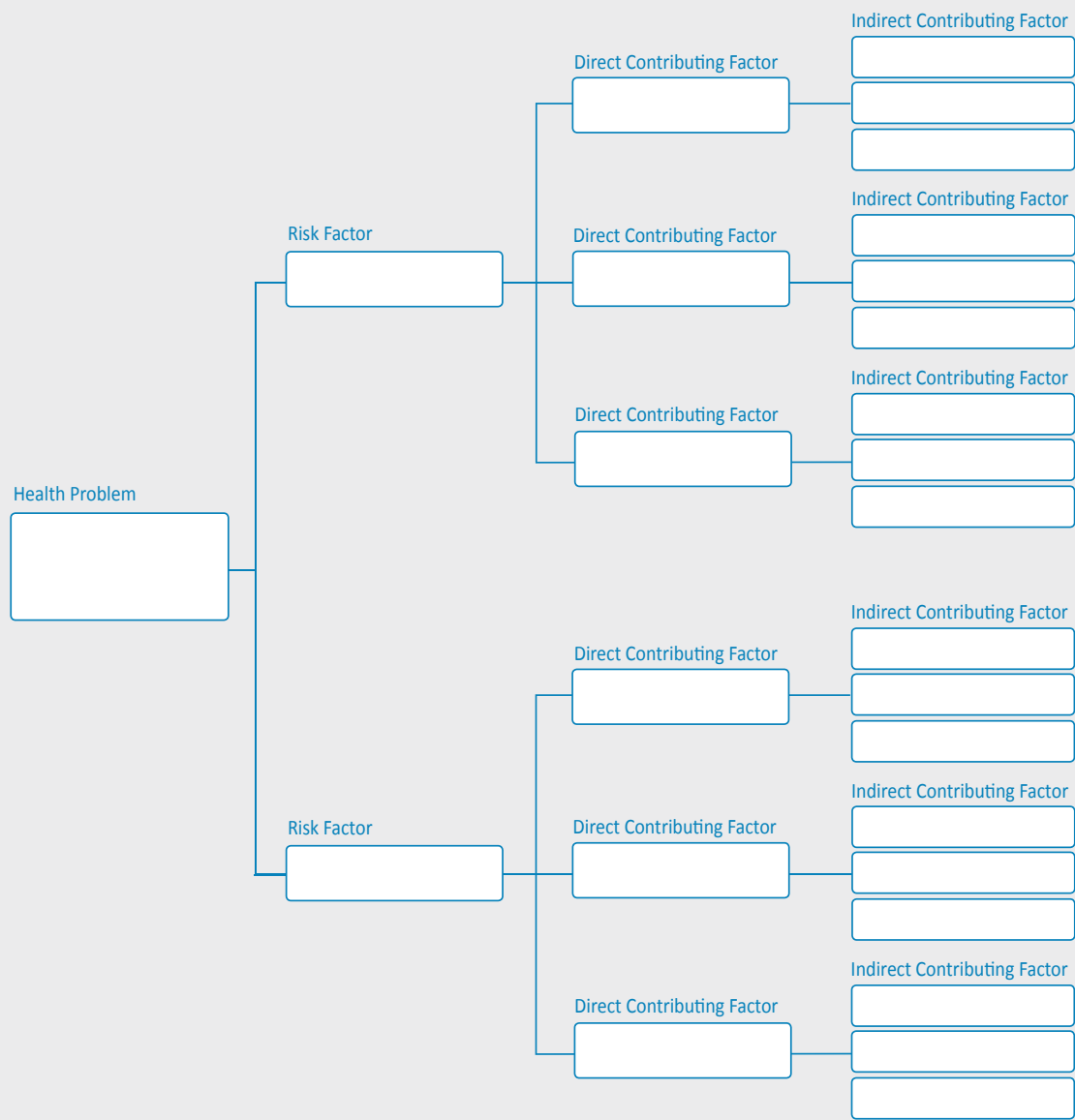
In Illinois, the state health department encourages the use of a similar tool, the Health Problem Analysis Tool. This tool is best suited for health problems as opposed to systems issues as it relies on an understanding of risk factors, direct contributing factors, and indirect contributing factors. The terms are defined below:

**Risk Factor** – Scientifically established factor (determinant) that relates directly to the level of a health problem. A health problem may have any number of risk factors identified.

**Direct Contributing Factor** – Scientifically established factors that directly affect the level of a risk factor.

**Indirect Contributing Factors** – Community-specific factors that directly affect the level of the direct contributing factors. These factors can vary greatly from community to community.

# HEALTH PROBLEM ANALYSIS TOOL



Adapted from: National Association of County and City Health Officials (1991). APEX-PH Workbook

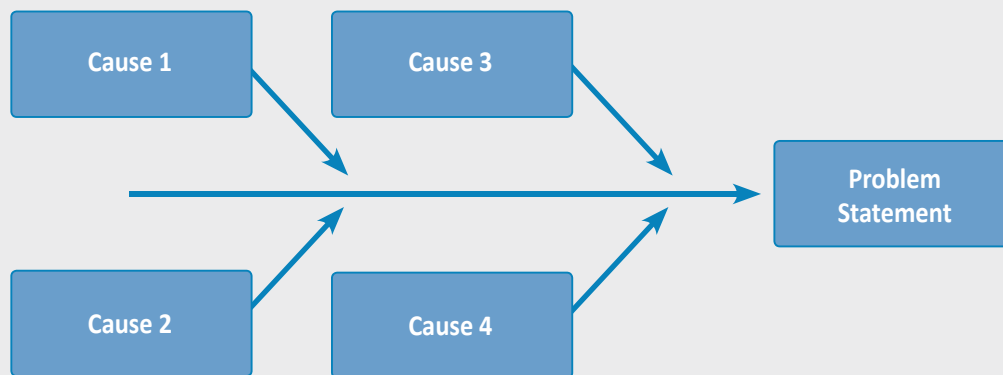
## Fishbone Diagram

Another useful tool that is similar to the tree diagram and health problem analysis is a fishbone diagram, which is another cause and effect diagram.

### Steps for Constructing a Fishbone Diagram

1. Draw an arrow leading to a box that contains a statement of the problem.
2. Draw smaller arrows (bones) leading to the center line, and label these arrows with major causal categories.
3. For each cause, identify deeper, root causes. The 5 Whys tool is helpful to identify deeper root causes.

### FISHBONE DIAGRAM TEMPLATE



*Adapted from Michigan Public Health Institute*



**APPENDIX K: SAMPLE ACTION PLAN FORMAT**

<b>Priority:</b>				
<b>Goal:</b>				
<b>Outcome Objective:</b>				
<b>Activities/Tactics</b>	<b>Person/Group Responsible</b>	<b>Timeline</b>	<b>Process Indicators*</b>	<b>Outcome Indicators**</b>

\*Process Indicator: A process indicator is the measure or documentation of the program or service provided. While there are many potential process indicators, it is important to make decisions regarding which information is most important to monitor in order to understand whether or not the program or intervention is on track to achieve the outcome.

\*\*Outcome Indicator: The measures of change at certain milestones to lead to the overall target.

*Adapted from NACCHO's Developing a Local Health Department Strategic Plan: A How-To Guide*







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