Strategic Collaboration and Alignment Tool

Background and Problem Description

It is well documented that a person's zip code is a superior predictor of health than genetic code. The World Health Organization defines the social determinants of health (SDOH) as, "*the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels*." [1] Health equity is defined as the assurance of health for all people and health inequities are differences in health status that are systematic, patterned, unfair, unjust, and *actionable*.[2] However, this action cannot rest on one individual, organization, or even sector.

Addressing the SDOH to achieve health equity requires strategic collaboration and alignment across multiple sectors to systematically undo historical injustices, tackle inequities, and provide everyone with the opportunity to live healthy, fulfilling, and productive lives. An individual's access to an affordable home, healthy food, safe neighborhoods, quality education, clean air, or livable wages all contribute to overall health and well-being. This holistic approach requires the coming together of all government agencies, social services, health care, businesses, faith-based organizations, and community members, to name just a few. Community health improvement (CHI) processes are primed to facilitate this work through ongoing collaboration, community health assessments (CHAs), community trust building, and implementation of a community health improvement plan (CHIP). The Public Health Accreditation (PHAB), the Internal Revenue Service (IRS), and the Heath Resources and Services Administration (HRSA) require health departments, non-profit hospitals, and health centers, respectively, to conduct community health improvement processes. As of 2016, 78% of health departments conducted a community health assessment (CHA) and 67% developed a CHIP. However, among these health departments, only 53% developed performance measures to monitor implementation of the plan and only 31% measured progress against Healthy People goals.[3] A recent study of CHI processes revealed that the field frequently requested additional guidance around collaborative implementation and evaluation of a CHIP across community partners.[4]

Despite ongoing efforts to engage partners, CHIP implementation typically falls on a select few organizations. Too often, the metric of success is how many partners attend a meeting, complete a survey, or express interest along the path of CHI. If partners do happen to jointly implement a CHIP, insufficient efforts are made to identify common community indicators and shared performance metrics to monitor progress and impact of CHIP implementation. Organizations are adept at internal performance improvement processes including strategic planning, performance measurement, and quality improvement, however, these efforts are rarely linked to the broader CHI effort. Every community must think more strategically about how their overarching mission, reach, and available resources fit into CHIP implementation. Partners must ask themselves, two questions: 1) *What role do I play in creating a healthy and vibrant community?* and 2) *How will I know I am making an impact?* No one organization can do this alone.

This tool provides a series of steps to carefully think about how a cross-sectoral approach may be taken to act on and measure a community's most complex problems through a CHI process. The tool offers guidance on using CHA data to gain a full understanding of the problem, identifying the most relevant partners to address the SDOH influencing the problem, conducting an inventory of how partners are currently addressing the problem, developing individual and shared roles in the CHIP, and identifying a shared measurement strategy to link organizational level metrics to community-wide indicators, such as Healthy People.

Instructions

This tool includes a series of worksheets intended to facilitate strategic collaboration and alignment of community partners to coalesce around common goals and shared metrics for successful CHIP implementation. Note that this process should be completed after community partners have been primed on foundational concepts such as health equity and the SDOH and after the collaborative selection of the CHIP priorities. This process should be completed for each CHIP priority.

1. **Describe the Current Situation**: The CHI coordinating organization(s) and/or those most familiar with the community health assessment (CHA) should summarize the data to describe the current situation surrounding the CHIP priority, including inequities. This worksheet should provide community partners with a snapshot of why the CHIP priority was selected.

2. **Describe the Current Context**: The CHI coordinating organization(s) should describe specific systems across the SDOH that influence the problem related to the CHIP priority. For example, the "Neighborhood/Built Environment" SDOH may be influencing a CHIP priority of obesity if certain sub-populations do not have access to grocery stores. The community partners best positioned to address each SDOH related to the CHIP priority should also be identified. Please note that partners should have been introduced to the SDOH prior to this process.

3. **Complete Community Partner Profiles**: Each community partner positioned to impact the CHIP priority should complete an organizational profile describing how it's mission, reach, existing work, and resources may align with the CHIP priority. The CHI coordinating organization(s) should send the completed "Current Situation" and "Current Context" worksheets as reference for completing the profiles. Community partners must complete these profiles prior to attending a collaborative action planning workshop for identifying CHIP goals, strategies, objectives, and metrics. Some partners may complete more than one profile if their organization impacts multiple CHIP priorities.

4. **Identify Shared Methods and Measures:** Community partners should be group by their CHIP priorities to collaboratively develop shared CHIP goals, strategies, objectives, and measures. During an in-person or virtual workshop, each organization will use their profiles completed in the previous step to inform their contribution to CHIP implementation. Partners should bring their profiles to this workshop.

CHIP Priority: What is the Current Situation?

This section describes the CHIP priority, should be completed by the organization(s) coordinating the community health improvement process, and shared with community partners.

1. CHIP Priority Area:
2. Problem Description: *Fill the table below with CHA data to describe why the CHIP priority was selected.*

Briefly describe why this CHIP priority was selected using data from the community health assessment (CHA)	
Community/Healthy People Indicators: *Include data on community indicators (health status and SDOH) related to this CHIP priority describing the magnitude of the problem*	Existing inequities: *Include data dissaggregated by subgroups such as race, gender, sexual orientation, socioeconomic status to highlight inequities in health status and determinats*
Lived experience: *Include qualitative data on the lived experience of those experiencing inequities. This data describe community perceptions and considered in combination with quantiative data.*	**Community Strengths/Assets**: *List the identified strengths and assets that emerged through the CHA process that may be leveraged to address this CHIP priority*

CHIP priority: What is the Context?

Social Determinants of Health: *Use the table below to brainstorm how the SDOH are influencing the problem and identify community partners that may play a role in improving each SDOH.*

Describe specific systems across the social determinants of health that influence the problem related to the CHIP priority described above.		Which community partners play a role in addessing this SDOH?
	Economic Stability	
	Education	
	Health and Health Care	
	Neighborhood and Built Environment	
	Social and Community Context	

Community Partner Profile

Each community partner identified above should complete the following worksheet to identify how their organization's mission, goals, reach, and resources aligns with the specific CHIP priority area. These worksheets should be returned to the CHI coordination organization(s).

Organization Overview

- Sector:
- Organization Name:
- Organization Mission:
- Describe the community served by your organization:

Organizational Alignment with CHIP

Complete the table below to identify the alignment between your organization's mission and the CHIP priority area that your organization is positioned to address.

CHIP Priority: List the Community/Healthy People Indicators most relevant to your organization's mission:			
Describe the current programs, services, or interventions	Associated Goals and Objectives	Outcome Metrics	Process Metrics

**Add or delete rows based on number of programs, services, or interventions that related to the CHIP priority area.*

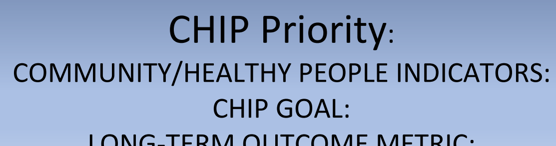
Organizational Resources

Successful CHIP implementation involves a community to pool available resources. Indicate which of the following resources your organization may provide to assist with achieving this CHIP priority.

☐ Funding ☐ Expertise ☐ Relationships ☐ Meeting space ☐ Data access	Other, please specify:

Strategic Collaboration and Alignment: Shared Methods and Measures

Community partners best positioned to impact a CHIP priority area collaboratively identify shared CHIP goals, strategies, and outcome metrics along with organization specific actions and process metrics. One worksheet should be completed per CHIP goal. One CHIP priority may have multiple goals. Each partner should reference their Community Partner Profile Worksheet to inform their role in this discussion.



CHIP Priority:

COMMUNITY/HEALTHY PEOPLE INDICATORS:

CHIP GOAL:

LONG-TERM OUTCOME METRIC:

Strategies:

Shared SMART Objectives (short-term outcomes):

1.
2.
3.

PARTNER 1:

Key Actions:

Process Metrics:

PARTNER 2:

Key Actions:

Process Metrics:

PARTNER 3:

Key Actions:

Process Metrics:

PARTNER 4:

Key Actions:

Process Metrics:

variety of tools and processes may be used to conduct a community CHA; the essential ingredients are community engagement and collaborative participation.

Community Health Improvement Plan - A community health improvement plan (CHIP) is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health.

Community Health Indicator - – A quantitative expression of population level health status rather than the individual level. Indicators tell you something about overall health in the community for which no single organization should be held accountable. Also referred to as a population indicator.

Goals - Long-range outcome statements that are broad enough to guide the organization's programs, administrative, financial and governance functions.

Health Equity - the assurance of health for all people and health inequities are differences in health status that are systematic, patterned, unfair, unjust, and *actionable*

Objectives - Short to intermediate outcome statements that are specifically tied to the goal. Objectives are clear, measurable and communicate how a goal will be achieved. Objectives may be referred to as outcome objectives. Outcome - Specific changes in knowledge, attitudes, behaviors, skills, status, or level of functioning expected to result from specific program activities. Outcomes are expressed as different levels of results a program seeks to achieve.

Performance Measure – A quantitative expression of how much, how well, and at what level programs, services, and products are provided to customers within a given period. In other words, performance measures, quantify activities and processes of a program.

Social Determinants of Health - the conditions in the social, physical, and economic environment in which people are born, live, work, and age

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[1] World Health Organization. Who.int. https://www.who.int/social_determinants/en/ Accessed: July 17, 2020.
[2] Margaret Whitehead. "The Concepts and Principles of Health and Equity." Intl Jl of Health Services 3 (1992): 429. [paraphrased]
[3] National Association of County and City Health Officials. 2016 National Profile of Local Health Departments. http://nacchoprofilestudy.org/wp-content/uploads/2017/10/ProfileReport_Aug2017_final.pdf Accessed: July 17, 2020.
[4] University of Illinois at Chicago. National Evaluation of Mobilizing for Action through Planning and Partnerships. 2019. Unpublished.