GDAHC +

A Learning Guide to Social Impact Assessment for Community Health

SIX STEPS TO MEASURE OUTCOMES AND DEMONSTRATE SUCCESS

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The Community Health Peer Learning (CHP) Program aims to advance progress toward population health improvements through the expanded capture, sharing, and use of electronic health data from diverse sectors. Engaging ten Participant Communities and five Subject Matter Expert (SME) communities in a peer learning collaborative, the CHP Program builds community capacity and supports the identification of data solutions, acceleration of local progress, and dissemination of best practices and lessons learned.

This learning guide is part of a series developed by CHP SME communities - highlighting their practical experiences, noting key lessons, and sharing insights relevant to those working as part of local initiatives to improve population health. The guides are intended to inform the ongoing work of CHP Participant Communities, as well other projects supported through a rapidly growing number of place-based health improvement initiatives. While individual guides address specific topics, such as community-wide information exchange capacity building, at their core, they also tell a story of how data infrastructure development, enabled through purposeful collaboration, can help drive better care, smarter spending, and healthier communities. We hope you find these stories to be engaging, practical, and useful!

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Table of Contents

Introduction

Social Impact is "the effect of an activity on the social fabric of the community and [the] wellbeing of individuals and families"[i] in that community. A Social Impact Assessment (SIA) sets expectations and measures the changes—for better or worse—of specific social activities and/or interventions on the community and the people who live, work, play and pray there.

Measuring the social impact of community-level health work is a valuable and meaningful practice. It helps validate the effort; demonstrate improvements; connect the community and get their buy-in; prove a positive return on investment; build opportunities to spread the work; and secure funding for ongoing efforts, among myriad other reasons. Most importantly, measuring the social impact of community-level health work helps ensure that the desired social improvements take place.

This guide focuses on community health-improvement interventions. For this type of work, the SIA process preferably will include multi-sector partners; engage the community; adopt a population health lens; consider the Social Determinants of Health (SDoH); promote elimination of health disparities; identify and use specific actions that will improve the current health status of individuals and the community; and leverage demographic health data (electronically to the extent possible).

Intended Users and Uses

In response to the emergent (and increasingly urgent) need to conduct SIAs for community health initiatives, this learning guide provides direction to the following organization and project types:

1. Organizations with missions designed to address health-related concern(s) that limit positive economic and social momentum in a community.

2. Projects led by community health organizations.

3. Community health-improvement projects that are the result of collaborative community efforts and that may (or may not) be organized by a backbone organization.

This guide was written to assist with SIA for projects focused on community health; therefore, the discussion in this document assumes that the impact to be assessed is improvement in both individual and population

health outcomes. Thus, this guide is not relevant to the assessment of social impact from broad-scale economic development projects, even though such projects may have intended or unintended health consequences. Collective impact—a structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change[ii]—is encouraged of those using this guide. The guide may serve as a framework to assess other types of social impact as adapted by the user, and provides context that may support "health-in-all-policies" evaluations. Incorporated in this document are examples of community experiences in conducting an impact analysis for quality, cost, health information technology (IT), and population health-related work.

Purpose and Framework of the Guide

In recent years, SIA has proved an increasingly important tool for demonstrating the social value of community health initiatives, facilitating engagement of benefactors and investors, and promoting adoption and support by community members. Moreover, the work typically conducted through community health initiatives is different from the work measured by the related Environmental Impact Assessment (EIA) and Return on Investment (ROI) methodologies. SIA—an assessment tool originally focused on gauging the successes of public service projects—offers an appropriate means of determining the social value of community health work.

The realization and acceptance that social conditions influence both the health of individuals and populations at large have increased the prominence of SIA as a tool used to predict and monitor the social impact of community health-improvement interventions. Moreover, the shift in philanthropic focus by the Robert Wood Johnson Foundation (RWJF) to a "Culture of Health" and the concentration by the RWJF, private funders and the federal government on the SDoH have elevated the importance of SIA.

Yet, anecdotal evidence suggests that many past community health-improvement projects have not followed plans and protocols that would lend the interventions to useful SIAs. Further, most of the related published studies and research focus on calculating social impact for organizations and projects with broad, sweeping social agendas or assisting philanthropic foundations with assessing the performance of their grantees. To help community health organizations develop a planning framework and to analyze the value of their work, this document provides **a high-level systematic framework for planning community-level work and a coordinated process for conducting the correlated social impact assessment**.

The guide assumes the reader has a rudimentary understanding of SIA as well as basic planning experience; nonetheless, a comprehensive bibliography, a glossary, and reference materials—with background information on SIA, including the history of SIA—are included at the end of this guide. Pages 27 and 28 provide a comprehensive example of a project with social impact.

Social Impact Analysis for Community Health Improvement Initiatives in Six Steps

The six-step process map depicted in Infographic 1 is a recommended approach to conducting a SIA. An ideation phase that vets the project comes before activation of the six process steps. The ideation phase includes definition of the purpose, mission and vision and consideration of the overarching, iterative Plan, Do, Check, Act (PDCA) tool that is useful in guiding and governing the entire methodology.

In some ways, SIA is similar to the business planning process used by for-profit and non-profit businesses alike, except SIA focuses on social impact versus the financial bottom line (i.e., profit) and outcomes instead of outputs (e.g., number of widgets produced). The SIA is an upfront activity and is integral to all aspects of the project planning, program management, implementation, measurement and review processes.

Prelude

Ideation: Purpose, Mission and Vision	
Key Activities	• Identify and Understand the Need • Frame the Vision • Define the Purpose and Mission • Incorporate the Plan, Do, Check, Act (PDCA) Methodology

Understanding the Need(s) and Framing the Vision

The desire to improve health and health outcomes for individuals and communities drives community-level health-improvement work. The desired improvement may represent a vision of improved living conditions; access to healthier foods and walking trails; increased access to clinical services; higher quality and less expensive clinical care; or healthier, more educat-

ed, and economically advantaged individuals in the targeted community, among other examples. Beyond a direct intent to improve population health or influence the SDoH, a community health-improvement project may strive to achieve some aspect of the Health Care Triple Aim, which in turn would influence social conditions through improved health; increased access to health care; and lower costs.

Comparing the future desired state to the current state, in which conditions presumably do not promote optimal health and economic conditions, is useful in formulating a needs assessment; that is, what "needs" to be addressed or solved to move to the desired future state.

Define the Purpose and Mission

A clear and well-focused mission statement will serve to guide all major decisions that are made to support a community health organization or a community health-improvement initiative—especially decisions about which new programs and projects to undertake, which to avoid, and which to exit.[iii]

To formulate and focus the intervention, first understand and embrace the purpose—the reason or the **why** this project should be undertaken. Then determine the mission—**what** the project will do and **how** the work will be done. Finally, state the vision—**where** things will be in the future (note: as a desired state, the vision may not be attainable, but there should be movement toward the vision with each step along the project trajectory).

Realization of the mission or purpose is the desired social impact. Potential social impact(s) may include improved health behaviors, more family time, increased productivity and higher earnings, and other outcomes that result from improvements in the social fabric that are possible when people are healthier. "Impact is what matters: what are the strategic goals that align with your purpose and what are the measureable results of achieving the vision."[iv] For community-level health-improvement work, the purpose, mission, vision and impact may look like this:

Example 1: Purpose, Mission, Vision and Impact

Purpose: The Why	The Mission: The What and How	The Vision: The Where	The Impact(s)
We want to help people avoid diabetes and its complications so that they may lead happier, healthier and more productive lives.	To eliminate diabetes from the world, we will hold Diabetes Prevention Programs (DPP) to help the people who live in zip code ##### avoid diabetes by eating nutritious foods and exercising more.	Short-term: to prevent new diabetes diagnoses in zip code #####. Long term: a world without diabetes.	• The number of individuals who participate in a DPP. • An increase in healthy food consumption. • A reduction in the number of newly diagnosed diabetics.

The Importance of Plan, Do, Check, Act (PDCA)

Managing the processes of achieving social impact and measuring outcomes will benefit from embracing

PDCA. PDCA is both a valuable tool during the measurement and monitoring step and a methodology that facilitates and augments the overall SIA process. PDCA is a useful tool during the project ideation process and through implementation, monitoring and reporting.

Adoption of an inquisitive culture that seeks operational efficiency will promote the regular and mandatory use of PDCA in all processes and practices. PDCA helps verify that the process is performing as expected. Further, it uses ongoing troubleshooting to create a cycle for continuous improvement and learning when a process breakdown or improvement opportunity arises and course correction is critical. With PDCA:

- changes are implemented on a small versus a grand scale;
- checks are put in place to analyze results and determine if the change was successful;
- if successful, changes are implemented on a wider scale; and
- if changes are not successful, then the check step (analysis) starts over.

The PDCA practice is applicable for all processes and is useful as a tool to help improve internal operations and to monitor and assess initiatives and programs. The universality of a PDCA practice focuses on process breakdowns, makes improvements in small identifiable increments where the

cause and effect can be isolated, and minimizes finger pointing. This approach works well when dealing with multi-stakeholder initiatives comprised of individuals and organizations that may have competing interests. Performance metrics are valuable components of PDCA and are integral elements of the "Check" phase of the process.

Example 2 below considers the effect of a warning system integrated by the Henry Ford Health System into its Electronic Medical Record System (Epic) in an effort to minimize the delivery of low-value health care services as determined through the Choosing Wisely program. This warning system is a type of PDCA in that it offers timely guidance to medical providers so that they may respond quickly with changes to medical treatment plans.

Example 2: Epic, Choosing Wisely and Performance Metrics—The PDCA Use of Electronic Medical Records

In 2011, the American Board of Internal Medicine Foundation (ABIMF) created Choosing Wisely, a program focused on "reducing waste in the health care system and avoiding risks associated with unnecessary treatment. [Choosing Wisely] calls upon medical specialty societies and other organizations to identify tests or procedures commonly used in their field whose necessity should be questioned and discussed with patients."[v]

In 2015, the Henry Ford Health System (HFHS), a comprehensive, integrated health system headquartered in Detroit, Michigan, began a pilot to embed Choosing Wisely recommendations into its Epic (EMR) workflows. This pilot, conducted in collaboration with Stanson Health, consisted of turning on seven Choosing Wisely Best Practice Alerts (BPA) that affect outpatient and inpatient orders. These BPAs pop up when a provider attempts to order a test, medication or procedure as classified "low value" according to Choosing Wisely, offering the ordering physician a reminder to reconsider the action. Analytic tools measured the impact of Choosing Wisely on clinical decision-making and workflow disruption. Upon successful completion of the pilot in 2016, the HFHS added more than 70 additional BPAs to its Epic workflow. HFHS performance measures show significant reductions in the delivery of low-value care (see the Vitamin D example below).

Example 2a: Guiding the Use of Vitamin D Testing through HFHS's Epic System

By integrating Choosing Wisely into Epic's workflows, HFHS has experienced great success in reducing the delivery of low-value care. Appropriate use of Vitamin D testing is of keen interest to Henry Ford. Vitamin D testing offers two opportunities for improvement: 1) reduction of low-value (inappropriate) Vitamin D tests; and 2) the use of appropriate Vitamin D tests when appropriate. Through use of BPAs in Epic, HFHS has seen a 35 percent reduction in low-value tests and an increase of 30 percent in appropriate tests. **These screen shots show how BPAs appear in Epic:**

When a provider orders low-value Vitamin D testing, the message "Don't perform population based screening for 25-OH-Vitamin D deficiency" appears.
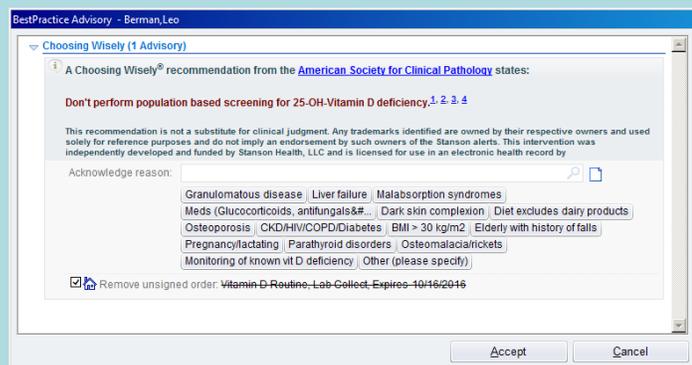
A dynamic link to the American Society for Clinical Pathology takes the ordering provider to this page:
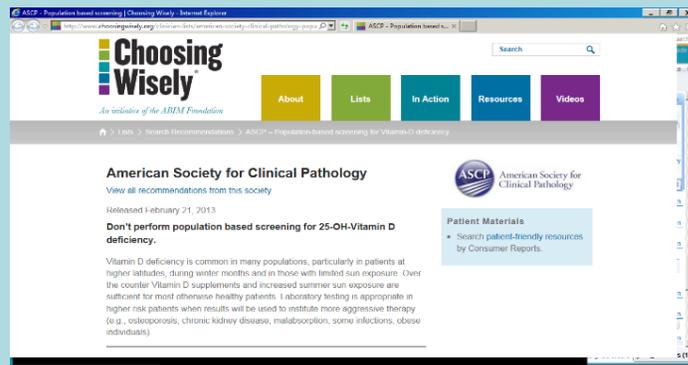
Hovering over the words "Vitamin D Deficiency" will provide a pop-up definition.
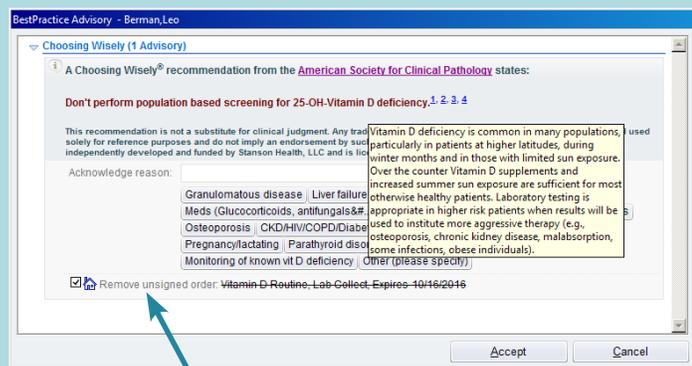
HFHS further promotes Choosing Wisely throughout the organization with employee screen savers.

Note: "Remove the Unsigned Order" is the pre-selected default. If the provider selects one of the "Acknowledge Reasons" options, the system automatically deletes the defaulted section "Remove the Unsigned Order," while tracking these actions.

Preparing to Tackle SIA

Understanding the community's social and economic conditions is an important precursor to development of a viable intervention that meets the needs of the community and correlates those needs to health outcomes. A mission is adopted once the intervention is determined to be feasible and of value to the community. Then it is time to move to the formal Step 1: Situation Analysis (Framing the Metrics).

The Greater Detroit Area Health Council (GDAHC), a Regional Healthcare Improvement Collaborative, follows the SIA process shown in Infographic 1. This approach has been developed and refined over years and incorporates tenets learned from manufacturing, logistics, and business environments. GDAHC embraces PDCA as an integral step on every project and employs this tool in all of its business practices.
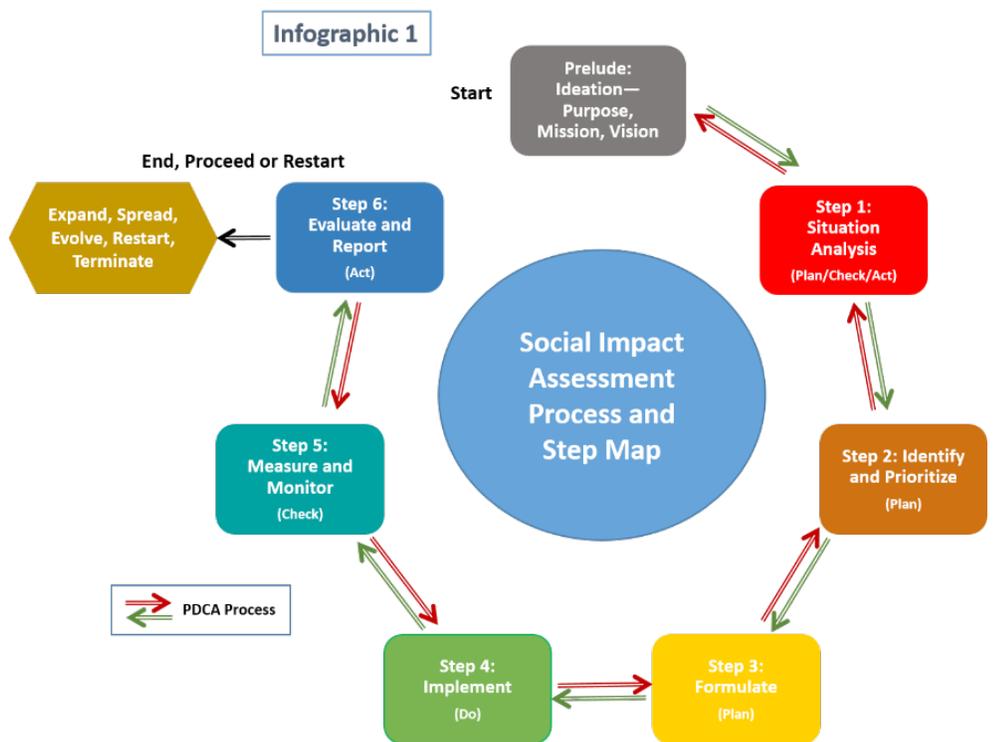
Once a need (purpose) is identified and an idea and plan to fix that need are solidified, GDAHC prepares to act. A first step is to define a mission for the project, keeping in mind that the work to be undertaken must align with the organization's overarching vision and mission. GDAHC views its vision as a beacon calling the organization and its work to this desired future state: "Healthy people. Healthy economy."

Step 1

Situation Analysis and Priority Setting	
Key Activities	• Conduct a Situation Analysis • Consider use of a Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis • Capacity Planning: Resource and Pro-Forma Financial Models • Establish Priorities (Frame the Metrics)

The key activities undertaken in Step 1 will set the tone for the rest of the SIA and establish the potential success of the intervention.

Conduct a Situation Analysis[1]

According to the World Health Organization (WHO), a situation analysis is an assessment of the current health situation and is fundamental to designing and updating national policies, strategies and plans."[vi] While the WHO's frame of reference is broader than the work typically undertaken by a community health-improvement project, undertaking a situation analysis is still an important step in framing an intervention.

Borrowing further from the WHO, a community health-improvement initiative should assess the current health situation in terms of the "epidemiology, demography and health status of the population … and … encompass the full range of current and potential future health issues and their determinants"[vii] as related to the planned intervention. It may be easier to measure some aspects of the "situation" than other characteristics. For example, it should be possible to count the number of people who use the emergency department (ED) for non-life-threatening medical conditions or premature births. In contrast, determining the impact that a lack of transportation or limited access to utilities has on health outcomes may be more difficult to ascertain.

Consider and include the SDoH in the SIA to the extent that these factors influence the current situation and the degree the intervention will change the social fabric. Academic circles and global health markets have long known that the social environment plays an important role in health outcomes; yet, acceptance of this theory in the U.S. medical community is a recent phenomenon. This shift in philosophy accedes that clinical interventions have less influence on health outcomes than social factors, and is one driver behind the increased interest in SIA. The work measuring and grading social and health conditions across the U.S. undertaken by the RWJF and the University of Wisconsin and the resulting County Health Rankings are prime examples of how the social environment influences health and health outcomes.[viii] The reader should become familiar with this important work

[1]See pages 42 – 43 in the Glossary for more information on Situational Assessment and SWOT.

and look for ways to leverage the results to understand and select areas of opportunity in the community.

Consider a SWOT Analysis

Strategic analysis is [generally defined as] the use of various tools to prepare business strategies by evaluating the opportunities and challenges faced by the company as it moves forward. Typically, strategic analysis involves a review of internal strengths and weaknesses as well as factors in the external environmental that could affect business.[ix] Creating a Strengths, Weaknesses, Opportunities and Threats (SWOT) matrix during the situation analysis will help ensure that project work aligns with both internal and external momentum and challenges.

Capacity Planning: Develop Resource and Pro-Forma Financial Models

There are three primary considerations to capacity planning: 1) determination of the **requirements** of the project/program; 2) assessment of **current capacity** including resources and constraints; and 3) analysis of **future projections** over the short, mid and long-terms.[x] Other considerations include the continual evaluation of needed capacity to ensure that appropriate resources are available throughout the project cycle and assessment of the project's financial wherewithal. A pro-forma budget will predict financial needs and help secure adequate levels of funding. Tracking of actual expenditures throughout the process will ensure funding levels continue to meet the needs of the intervention. Community partners and stakeholders will expect accurate financial reports.

Priority Setting (Framing the Metrics)[2]

Important activities in Step 1 include the definition and development of the metrics for measuring the success of the project. When developing metrics to measure success in community-level work, one needs to be careful to distinguish among the four metrics that will gauge the success of the initiative: 1) inputs (items controlled by the project team); 2) outputs (stepping-stones to achieving social impact); 3) processes (ways to monitor, evaluate and improve operational performance[xi]); 4) outcomes (i.e., social changes). These metrics will help assure that the community-level health-improvement work is targeted, doable, measurable and achievable.[xii]

The first three metrics (inputs, outputs, and process), shown below in Example 3, are similar in definition and measurement to metrics used to track performance towards achievement of goals in general. **Outcomes, which**

[2]See page 37 in the Reference Materials for more information on Framing Metrics and pages 40 – 43 in the Glossary for related definitions.

measure the long-lasting impact and changes in social conditions, differentiate SIA from other types of evaluation and create the rationale for undertaking community-level work.

Keep in mind that the processes to collect data and conduct the appropriate analytical work during the measurement and monitoring and evaluation and reporting steps will rely on both quantitative and qualitative techniques. It is wise to consider at this stage the challenges that may arise in gathering various types of data needed to measure and evaluate outcomes and success.

Example 3: (This example builds on the purpose, mission, vision and impact from Example 1 on page 8):

Inputs	Outputs	Process	Outcomes
# of Diabetes Prevention Program (DPP) classes held	# of people who enrolled in the classes # of people who attend the classes regularly # of people who avoid a diabetes diagnosis	# of classes held # of people expected to attend the classes—used to determine if "teaching" capacity was met	• Fewer people diagnosed with diabetes
# of healthy cooking classes hosted	# of people attending the classes	# of people expected to attend the classes—used to determine if "teaching" capacity was met	• Increased consumption of fruits and vegetables • Lower incidences of diabetes in the community

Step 2	Define Opportunities for Intervention and Identify Stakeholders	
	Key Activities	• Conduct a Gap Analysis (Needs Assessment) • Identify Stakeholdersorities (Frame the Metrics)

Conduct a Gap Analysis

A gap analysis is an operational tool most often used to identify internal performance deficiencies. However, it is also valuable when assessing short-term goals to evaluate gaps in actual performance and the desired performance, and may help explain why a project or organization is not performing to its potential. In the SIA context, "gap refers to the space between 'where we are' (present state) and 'where we want to be' (target state)."[xiii] Defining the gap is not a simple exercise: it may take a lot of time to accurately as-

sess both the current state and the desired future state, as well as to clearly identify the steps, resources, plans, etc. that are needed to close any gaps.[xiv] Exhibit 1 below is a template for completing a gap analysis.

Further, community-level projects may need to deal with multiple gaps as they integrate the needs of competing constituents and competing goals, such as a collaboration goal; a multi-sector data sharing goal; or a community health goal. Under such circumstances, conduct a separate gap analysis and track the progress for each goal. When multiple goals influence the overall project, identify these potential disruptors as "Barriers to Completion" and then monitor them for resolution. At any point in the process, where one goal impedes completion of another goal or the project in its entirety, this must be brought to the immediate attention of the team.

Under the Affordable Care Act, not-for-profit hospitals must complete a Community Health Needs Assessment (CHNA) once every three years in order to maintain their tax exempt status. The CHNA is an example of a gap analysis as it looks at unmet health needs in the hospitals' service areas and expects the hospitals to implement programs to close those gaps. Example 4 depicts how the CHNA is an example of a gap analysis.

Exhibit 1: Sample Gap Analysis Template

Process Evaluated:								
Completed By:						Date of Analysis:		
Best Practice or Target	Current State or Baseline	Gap Between Best Practice and Current State	Action/ Resources Needed to Close Gap	Interaction with or Relevance to Other Goals	Barriers to Completion	Steps to be Taken	Person/ Organization Responsible	Expected Completion Date
←―――――――――― (Fill in the blanks on the lines below) ――――――――――→								

Example 4: Community Health Needs Assessments as a Form of Gap Analysis

The Example	The Community Health Needs Assessment (CHNA) required of nonprofit hospitals under the Affordable Care Act (ACA) is a great example of a Gap Analysis.
The CHNA as a Gap Analysis Tool	Using a CHNA, a hospital evaluates the current health status of the population that it serves and then identifies areas of greatest opportunity (need) to improve health. Often the CHNA will list three to five areas of utmost concern regarding population health and then identify and implement ways to improve health in those areas.
Value and Applicability to SIA	Actions taken in response with a CHNA should have a social impact and hospitals should aim to employ SIA throughout their planning and implementation processes. Leveraging the PDCA philosophy to ensure identification of potential deviations promptly and instigation of prompt corrective actions will ensure achievement of positive improvements in health outcomes relative to the identified needs.

Identify Stakeholders[3]

Collaborative efforts need to engage a range of stakeholders extending from the members of the collaborative to its community partners and the beneficiaries of its work. The ability to collaborate effectively is essential in community-level projects as it is difficult to make progress solving a community need without engaging all affected stakeholders. Engaging community partners may require extra work and thoughtful outreach because the myriad stakeholders represent a range of frequently competing interests and many community members may not recognize their role on the project.

Exhibit 2: Ways to Identify Stakeholders[xv]

Review the project charter to identify sponsors, influential players, etc.
Review contracts to identity stakeholders who are engaged through a contractual relationship, such as suppliers, local agents, client contacts, etc.
Review any stakeholder registers and governmental contacts
Interview highly influential stakeholders on a one-on-one basis to get their recommendations
Conduct brainstorming sessions with the project team and other experts
Conduct due diligence to determine who cares about the goal of the project or initiative
Conduct due diligence to determine who can support efforts to catalyze change and share progress/results
Understand who will be impacted and what the project means to them

Regardless of any challenges, **stakeholder identification (and subsequent engagement) is one of the most important processes in community-level benefit work**. "If stakeholders are not satisfied, then your project will not be completed successfully. Therefore, you must identify the stakeholders at the beginning of the project and [include and] manage them throughout the project's life cycle."[xvi] The need to keep looking for appropriate project stakeholders will continue throughout the project life cycle. It is difficult to overestimate the influence of those with power and interest, so monitor these factors closely as they will change over time.[xvii]

Step 3

Formulate	
Key Activities	• Organize the Project Collaboratively with Team Members • Develop and Define Objectives and Deliverables • Define Roles and Responsibilities

[3]See page 33 in the Reference Materials for more information on the stakeholder identification.

Organize the Project Collaboratively with Team Members[4]

Collaboration is the coming together to fix problems that need community-level partnerships, where local, seemingly disparate organizations and leaders recognize that they can do more together by leveraging their resources and harnessing their collective ingenuity and creativity. Regional Health Improvement Collaboratives (RHICs) work in the community-level health-improvement space and establish their direction through consensus among their partners and members.[5]

The use of collective impact—a means to facilitate agreement on the project and its mission, objectives and deliverables—is highly recommended in the formulate phase and, indeed, would be very helpful in crystalizing partnerships and common thinking as the project is being ideated and defined. Collective impact is challenging because this process expects and needs the stakeholders to commit to working together and to suspend the competitive nature of their "home" organizations as well as all hidden agendas in order to support the public, community good, though these are not reasons to shy away from such work.

Develop and Define Objectives and Deliverables

Understanding and documenting the connection between an organization's or a project's objectives and its deliverables will help the team understand how to best deliver the desired social impact. Objectives and deliverables help lay the path to success. Keep in mind that full awareness and acceptance of all partners and collaborators is preferred to complete these activities.

Objectives define desired and expected benefits, outcomes or performance improvements that will measure success. "Establishing objectives for an entity or project is an activity that takes place during the planning process to determine what the project is supposed to accomplish when ended. Without a clear and comprehensible definition of objectives it is impossible to plan for the end result."[xviii]

Definition of objectives drives measurement criteria; it is difficult to reach the desired goals without determining the expected benefits and outcomes and without measuring movement towards the end game. Phasing goals and objectives over a phased time horizon facilitates achievement by making the goals less daunting. This helps create momentum and encourages the team to build on successes instead of trying to reach the finish line in one fell swoop.

[4]*The Network for Regional Healthcare Improvement created this graphic.*

[5]*Please refer to the Reference Materials for more information on RHICs and the Network for Regional Healthcare Improvement.*

Deliverables are "outputs" or "products." Deliverables are not objectives— they are items produced only to enable achievement of the objectives. "Deliverables are the tangible things that the project will produce to enable the objectives to be achieved."[xix] Tangible, real outputs will ensure achievement of the proposed benefits.[xx] Deliverables often have a level of quality or specification associated with them, factors used to assess performance. Deliverables are not outcomes but they may have outcomes associated with them, such as increased efficiency, cost savings, increased revenue, or value for the customer.[xxi]

Exhibit 3: Sample Template for Documenting Objectives and Deliverables[xxii]

Objectives	Deliverables
(Expected benefits, outcomes, improvements)	(Tangible outputs or products that will enable us to achieve the objectives)
Objectives are listed in this column	Listed in this column are deliverables. Note that there may not be a 1-1 correspondence of one objective to one deliverable–for example, one deliverable may address several objectives

Define Roles and Responsibilities

An organization or project team will struggle to achieve its desired outcomes without clearly defined roles and responsibilities for team players, stakeholders and other constituents. It is important to know the leaders and who is responsible for what functions. Without this clarity, activities may flounder, finger pointing may occur, and no one will be held accountable. That is no way to be successful. When developing roles and responsibilities, it is reasonable to assess the skills and strengths of each team member and to be cognizant always of the political aspects of assigning title and responsibilities; this may save headaches along the project continuum.

Implement[6]	
Key Activities	• Develop the Project Plan • Manage the Project

Step 4

The project is approved, the metrics, objectives and deliverables are determined, the stakeholders are at the table, the roles and responsibilities are assigned, and the types of data needed to measure success are agreed upon—now it's time to act. In the implementation step, it is time to get to work! First things first: the project plan is crucial to implementation. Moreover, management of the plan is required once the plan is developed.

[6]*Implementation steps are not described as they are unique to each organization or project.*

Project Management (PM)

PM has proven to be the most effective method of delivering products within cost, time and resource constraints. The primary challenge of PM is to achieve all of the project goals within the given constraints of scope, time, quality and budget. The secondary—and more ambitious—challenge is to optimize the allocation of necessary inputs and integrate them to meet pre-defined objectives.

Exhibit 5: Steps Involved in Project Management[xxiii]

- Define project goals;
- Outline the steps needed to achieve those goals;
- Identify the resources required to accomplish those steps;
- Determine the budget and time required for each of the steps, as well as the project as a whole;
- Oversee the actual implementation and execution of the work; and
- Deliver the finished outcome.

The entire team is responsible for the result, but it is advisable to assign someone responsibility for overall management of the project. John A. Ariyo, Manager of Community Initiatives for the city of Hamilton, Ontario, suggests the project managers working on community-levels projects use the terms "community" and "engagement" together in order to form a bond with their audience and create a perception that the project manager is a "people person."[xxiv]

Step 5

Measure and Monitor	
Key Activities	• Measure • Monitor • Revisit PDCA

"Monitoring and measurement of performance is the longest phase in the performance management [and SIA] cycles. During this phase, the manager/evaluator is supposed to keep an eye on the performance related to the set targets and constantly monitor it in order to be able to keep it on the right track…the purpose of this phase is not only to measure and evaluate the end results but to control the overall performance throughout the whole period between target setting and evaluation. This gives the true meaning to the performance management system for it is a system for management and not just for evaluation of the performance."[xxv]

Measurement[7]

Measurement is not the same as metrics. Metrics—the basepoint and target—are a response to the goals (and objectives) of the organization or project. Measurement, on the other hand, tracks progress and is the basis for letting project teams know that they are moving forward towards achievement of the predefined objectives. Measurement requires that the team determine which data and information are important, how to document, capture, and record those data throughout the process, and how to track and report progress. Although gathering data does not take place until Step 6, the measurement methodologies to support subsequent quantitative and qualitative analysis (see pages 22 – 24) should be determined in Step 5.

If a project has more than one goal (the desired end state), then objectives should be established for each goal and the measure of success for each objective should be defined and tracked separately. Data will form the basis for the selected performance measurements. Graphs or other tracking mechanisms are good ways to summarize the data and performance. Please note that as digitization of patient data continues to increase, the use of electronic medical records (EMRs) will grow, likely exponentially, as a source of data for measurement purposes (see Example 5 below).

Example 5: Measurement Using EMRs

As part of the Chronic Disease Coordinating Networks grant through the Centers for Disease Control and Prevention (CDC) and the Michigan Department of Health and Human Services GDAHC, Henry Ford Health System, Macomb County (Michigan) and the American Medical Association partnered on an Epic pilot to build a clinical prediabetes program for Epic's prediabetes registry. The tenets of SIA and PDCA helped recognize a gap in the ability to efficiently identify prediabetes patients, refer them to a Diabetes Prevention Program (DPP) and follow up (or provide a feedback loop). Therefore, the Epic pilot developed workflows, alerts and a customized referral order. The pilot focused on ease of use, clinician satisfaction and effectiveness of both decision support and the feedback mechanism. Further, development of an evaluation tool with metrics helped measure utilization of the system. Implemented in January 2017, the pilot has been an important tool to get prediabetes patients into DPP.

Only outcomes provide a true measure of success for social impact. Yet, as performance measurement begins, it may be valuable to track both outputs and outcomes, keeping in mind that the outcomes are most important and most challenging to identify. One should also focus on measuring the outcomes that the entity or project are able to influence. Trying to measure global outcomes outside the scope or control of the project may create stress and predispose the project efforts for failure.

[7]*More information on the differences between inputs, outputs and outcomes is available in the Reference Materials on page 32.*

The analytic work that goes into SIA for community health projects should include questions of how to measure and attribute successes for multi-partner work; how to access appropriate cost, use, clinical, outcome, and other associated data for analysis; and how to provide a coherent value message to different stakeholder groups around success, among other issues. Answers to these questions and guidance on how to address the challenges associated with collaborative efforts are important because many—including insiders, outsiders, investors, and others who are impacted—are asking for the value proposition—that which the SIA should be able to demonstrate.

Example 6: Measures/Data Sources Used in a DPP Implemented in Macomb County, Michigan

Measure	Data Source
Equity: Increase in number of patients in priority population with hypertension diagnosis recorded on their EMR and with pre-diabetes recorded on their EMR.	Data collected from providers • Benchmark • Prevalence
Equity: Number of people in priority populations from the census tract(s) with access to the retailers offering healthy food options.	Publicly available US Census Data
Equity: Use of walking resources by DPP participants whose zip code is within a census tract that is representative of priority population.	Survey of DPP participants: • Zip code information • Activities in which respondents participated
Sustainability: Extent to which documentation on EMRs is supporting provider goals for diagnosing and managing pre-diabetes.	Survey of providers
Sustainability: Perceived benefits to pharmacies of providing these services.	Survey of pharmacies
Sustainability: Sales revenue from healthy food options.	Data about retailer revenue
Sustainability: Perceptions of municipal leaders about the impact of improved physical activity resources on economic development, quality of life, safety and health in their community.	Survey of municipal leaders

Monitoring[xxvi]

The purpose of monitoring is to improve efficiency and effectiveness by tracking actual performance.

Performance monitoring is the systematic gathering and analysis of information in parallel with the accomplishment of the task or job. This means that someone has the task to gather information as the work is underway and make the necessary analysis from which a clear picture on the actual performance is determined in order to facilitate any necessary decisions. Both the goals and the aligned metrics are needed to monitor performance. Tools and methods must be identified and appropriate and sufficient resources must be in place and available in order to effectively monitor performance.

Plan, Do, Check, Act (PDCA) Revisited

At this point in the process, PDCA is a tool to evaluate successes and steps in managing the process. Keep in mind that PDCA is a universal tool used to augment the overall project management process and, as previously noted, the planning aspects of PDCA are viable and useful during project ideation. Example 7 below presents an example of an effective use of PDCA to make process improvements.

Example 7: PDCA—Reducing Emergency Room Visits

In an effort to reduce unnecessary visits to the emergency department (ED), a physician organization in Detroit set about educating patients on appropriate use of the ED. The reductions noted were not significant until the PDCA methodology helped identify a process breakdown. Recognizing that "if this is an emergency, please call 911" was the first thing patients heard when calling a physician's office after hours, it was determined that a change in the message was warranted. By spotting a process breakdown and implementing a simple change in the message, inappropriate ED use was reduced from 49 visits per 1,000 patients to seven visits per 1,000 patients.

Step 6

Evaluate and Report	
Key Activities	• Perform the "Final" Impact Analysis • Gather Data and Ask Questions • Conduct Quantitative Analysis • Conduct Qualitative Analysis • Message and Disseminate

The project plan is in place and things are moving along (preferably smoothly). The project manager has things under control and the team is getting along famously. So, what is next? It is time to assess the impact and value of the work being done and determine if expected outcomes will be (or are being) achieved. Taking early steps to begin assessment of the social impact is important. If things are not moving in a forward direction and the process

is not working well, the team needs to take a step backward and conduct a PDCA to determine where, why and how things are breaking down.

It is important to frame impact analysis tools and their planned usages early in the SIA process, with the understanding that they may evolve over time as the project matures. Creating a unique set of impact analysis tools can be quite costly and makes it difficult for funders and other evaluators to compare one project or organization to the performance of similar projects and entities. Therefore, to the extent feasible and practical, consider the use of existing analytic tools, such as those shown in Exhibit 4 below. Unless a project is unique, there is no need to "reinvent the wheel."

Exhibit 4—Impact Analysis Tools and Tenets[8]

Tools	Tenets and Uses
Comparator Groups	Used to measure relative performance
Common Metrics	Standard definitions and process measurements
Other "Like" Initiatives	Projects to be aware of, learn from and build on their momentum
Benchmarks	"Best in Class" to be used for comparing work
Timeframe	Future point when outcomes will be measured and project completed
Savings	Improvements (monetary or positive outcomes)
Extrapolation/ Scaling	Expanding interventions to larger populations/different geographies

Gather Data and Ask Questions[9]

Data are required to measure success and prove the value of the initiative. Based on the project's objectives and deliverables, the team must determine the appropriate data characteristics such as who, what, when, where, and how much, as well as how said data will be collected. The data collected must represent a "currency" that is meaningful. While frequently cash, the "currency" reported may equate to lives, changes in health status (e.g., lower blood pressure, lower HbA1c scores for diabetics, etc.), iterations, cycles, and many other examples.

Data collection may be both quantitative and qualitative. No one method of data gathering is superior in all situations. Most efforts will require both quantitative and qualitative data. Determining which data are necessary is a critical step before one can establish a baseline and understand results.

[8]Please see pages 34 – 35 in the Reference Materials for expanded detail on Impact Analysis Tenets and Tools.

[9]Please see page 36 in the Reference Materials for general considerations to be explored before undertaking the data collection process and for more info on data gathering, collection and use.

Thoughtful, careful planning will prevent wasting time collecting data that are never used.

Conduct Quantitative Analysis

Quantitative analysis may seem easier and more straightforward than qualitative analysis as it deals with data that are in the form of numbers. That is not always a correct assumption, however, as qualitative judgment must be used to interpret the numbers. In order to interpret numbers as reported, one must have an understanding of the assumptions that underlie them. Consider the following when developing a quantitative framework:

- Use metrics from the project;

- Research periodicals and journals for comparative data;

- When doing comparisons, use a common language—that is, use the same definitions;

- Identify and include cost and non-cost metrics;

- Calculate actual project savings as well as the costs that are avoided;

- Extrapolate the savings to determine the potential impact from program spread; and

- Vet the process and final product with a peer or expert review.[xxvii]

Conduct Qualitative Analysis

Qualitative data are anecdotal and generally not gathered in a numerical format, therefore, they are often referred to as soft data. Qualitative data may refer to feelings, perceptions or experiences, often not based in fact. Methods to capture qualitative data include interviews, surveys, feedback forums, consultations, and diaries, among others. Listening to peoples' stories is a great way to gather qualitative data.

Outcomes are the true measures of success for most nonprofits and community-level collaborations but data related to outcomes are frequently difficult to obtain and understand.[xxviii] Outcomes may not lend themselves to quantitative analysis, such as those defined by performance metrics, and rather may be determined only through long-term qualitative analytics. Qualitative data are relevant for understanding the social value of the project as these data help contextualize the quantitative findings.

The qualitative data selected to assess a community health-improvement endeavor may attempt to measure esoteric variables such as project impact on people; social inclusion; level of beneficiary participation in the project design and implementation stages; project impact on the social and living

conditions and/or economy; and project-specific mechanisms needed to mitigate potential adverse effects. Social impact attempts to measure long-term improvements in community-level work, improvements frequently not measured quantitatively. So, one should become very familiar with the ways to frame and measure qualitative results.

Message and Disseminate[10]

Most people intrinsically know that communication is important. Indeed, a lack of communication frequently sits at the top of employee satisfaction surveys. Sometimes communication concerns surface even in companies that send out regular communications because the frequency of communication is not the same as the effectiveness of the communication.

When communicating about projects and related successes, it is essential to know to whom the messages will go and what kinds of messages are most relevant for the intended recipients. It is also important to have a basic expectation on how the messages will resonate with the desired audiences; some may prefer paper reports while others may prefer social media. Generally, a thoughtful mix of communication channels will be useful in order to reach a variety of constituents with an array of communication preferences.

The importance and need to develop comprehensive communication strategies with tactics aimed at each area of focus addressed by the project as well as each type of audience cannot be understated. Consider hiring a consultant with communications expertise if a communication specialist is not part of the project team.

Next Steps

Once the intervention is completed, it is time to determine next steps. Potential next steps include extrapolation and spread of a successful initiative; recalibration of a project that shows potential (hopefully this was determined and addressed through the PDCA process); and termination of the project.

Scale (Extrapolate and Spread)

To increase their impact, many nonprofits seek to "scale up" by expanding their interventions to reach larger populations. This scaling process most commonly involves implementing the intervention at new sites or expanding the capacity of existing sites to serve a larger number of participants. So why go to scale? Primarily to spread the impact of the intervention. Scaling can also be a practical approach: Rather than starting from scratch, it often makes more sense to take a model that works well in one community and try

[10]*Please see the Reference Materials on page 39 for more information on developing effective communications.*

it out in another. Interventions that go to scale may also benefit from being part of a larger network that shares resources and operating procedures. A larger network may allow an intervention to produce bigger outcomes at a faster pace than each individual site could do on its own. Further, demonstrating impact on a larger scale can help create greater visibility and provide an advantage in attracting additional support for the intervention.[xxix]

Recalibrate (Adjust or Start Over)

Data are required to measure success and prove the value of the initiative. Based on the project's objectives and deliverables, the team must determine the appropriate data characteristics such as who, what, when, where, and how much, as well as how said data will be collected. The data collected must represent a "currency" that is meaningful. While frequently cash, the "currency" reported may equate to lives, changes in health status (e.g., lower blood pressure, lower HbA1c scores for diabetics, etc.), iterations, cycles, and many other examples.

Terminate

For myriad reasons some interventions do not reach their expected potential. Rather than waste limited resources, sometimes it is best to terminate the project and pursue another opportunity.

Closing Thoughts

This learning guide has provided a framework to ensure achievement of the organization/project's mission and project goals. Community-level work is hard, it takes time, and it requires a level of altruism and allegiance to improving the environment and conditions under which many people live. It is most certainly not for the faint of heart. Planning, managing and following through on commitments will help assure success in all endeavors. Nurture success with project members who:

- Are devoted to advancing community interests
- Are prepared to adjust to the realities of projects and politics
- Foster transparency
- Support the project team
- Network and nurture relationships and partnerships
- Ensure all monitoring and reporting systems are robust and auditable
- Have fun
- Make a difference

A Successful Example—The GDAHC Hypertension Intervention Program (HIP)

As part of the Robert Wood Johnson Foundation (RWJF) Aligning Forces for Quality (AF4Q) grant, GDAHC created and hosted a cross-sector, community-level **R**ace, **E**thnicity **a**nd **L**anguage (REaL) Committee focused on improving population health by identifying and resolving health disparities. The REaL Committee was renamed the Health Equity Research Group (HERG) in 2016 and is directly responsible for a number of exciting and innovative programs that are improving population health and reducing health inequities. With SIA, programs are identified through the strategic prioritization of objectives.

The Hypertension Intervention Program (HIP) is a REaL initiative that was successful in reducing hypertension among the African American population in Detroit. This effort has provided input to new GDAHC projects. For example, GDAHC is a subrecipient of a Centers for Disease Control and Prevention grant on Chronic Disease Coordinating Networks and is using lessons learned from the HIP to develop programs to address hypertension in Macomb County.

HIP was based on a program conducted at the University of Alabama at Birmingham, Finding Answers: Disparities Research for Change program, which evaluated innovative interventions to reduce racial and ethnic disparities in health care. The overarching HIP goal was to improve the quality of care for African Americans with hypertension and the program objective was to decrease blood pressure rates for participants by 10 percent during the nine-month trial. (Total time was two years, including planning and wrap-up.)

The following high level hypotheses and program measurement and evaluation parameters guided HIP:

- Evaluation of the usefulness of a culturally sensitive, storytelling intervention on blood pressure control and medication adherence in a trial of 300 African American patients;
- Evaluation of the usefulness of a peer-to-peer model (supplemented by additional professional clinical information on blood pressure control) to improve high-blood pressure management (note: this was an important aspect of the HIP Program because it bridged the clinical elements of health with the "people" side, thereby incorporating and integrating the non-medical aspects of health toward positive results).

GDAHC recruited cross-sector partners who would bring depth and diversity of thought to the project while also accruing benefits for their organizations. The partners involved in HIP were involved early in the process and include Wayne State University's School of Medicine; Health Centers Detroit (FQHC); Detroit Medical Center; Mercy Primary Care Clinic (free clinic); Henry Ford Health System's Institute of Multicultural Health; Molina Health; Beaumont Health; Voices of Detroit Initiative; and MPRO.

As the convener and project lead, GDAHC was responsible for project management, scheduling meetings, documenting decisions, and keeping the project on track. The HIP team met on a regular basis, more frequently at the beginning as the project was structured and actions plans implemented. As part of an approved Institutional Review Board study, the HIP team was required to identify, document and follow standard protocols for interactions with project participants and the collection and analyses of data. Researchers were engaged in data collection and used quantitative methodologies to analyze the data. Every team member participated in all aspects of project development, implementation, and measurement.

Monitoring of program participants took place on a regular basis with blood pressures checked at baseline and in three-month intervals. GDAHC followed up with participants throughout the project. Updates to outreach protocols and communications took place on an ongoing basis to ensure patient engagement. The study objective of a 10 percent decrease in average blood pressure was achieved. Results analyzing final blood pressure readings (n-127) showed:

- A drop in average systolic blood pressure rate of 15.90 mmHg (148.63 mmHg at baseline to 132.73 mmHg), representing a 10.7 percent reduction; and
- A drop in average diastolic blood pressure rate of 9.92 mmHg (98.2 mmHg at baseline to 88.28 mmHg), representing a 10.1 percent reduction.

A Successful Example—The GDAHC Hypertension Intervention Program (HIP) (Cont'd)

Anecdotal evidence based on interviews, follow-up visits, and subsequent monitoring of blood pressure for the study participants show that the project hypothesis and evaluation parameters were successful:

- Culturally sensitive, storytelling was useful in blood pressure control and medication adherence;
- Peer-to-peer mentoring is an effective protocol when used in conjunction with regular medical care to reduce blood pressure (note: this was a critical piece of HIP because it bridged clinical elements of health / "people" side, integrating the non-medical aspects of health toward positive results).

Based on these positive results, it is assumed that this study improved the quality of care for African American patients with hypertension, but there is no empirical evidence to support this assumption. Therefore, GDAHC and project partners from Wayne State University initiated a follow-up project to research the long-term effects of the original intervention in achieving the social impact. This new study follows the same planning protocols as the original HIP program. The new project has engaged most of the original HIP participants to assess how they now manage their health and interact with the health care delivery system. The project structure helps assess the social impact of the original work.

Regional Healthcare Improvement Collaboratives – A Case Study

Many communities across the country recognize that regional healthcare improvement collaboratives—or RHICs—are an ideal mechanism for developing coordinated, multi-stakeholder solutions for their healthcare cost and quality problems. No one can fix the healthcare system alone—it requires change from providers, purchasers, and communities. Through this unique collaboration, these stakeholders are able to tackle compelling health challenges together.

By definition, RHICs are independent, non-profit organizations comprised of multiple stakeholders who come together to improve health and healthcare. To be a RHIC, four key stakeholders need to be at the table and actively involved in organizational government and health system improvement: 1) healthcare provides; 2) healthcare payers; 3) healthcare purchasers; and 4) healthcare consumers. RHICs do not provide healthcare or pay for healthcare. They convene those who do—and the people and the communities they service—to identify ways to catalyze change for better outcomes and lower costs.

There are over 40 RHICs in the U.S. All of the leading Collaboratives are members of the Network for Regional Healthcare Improvement, providing programs to support improved healthcare for over 35 percent of the U.S. population. These Collaboratives have demonstrated a unique ability to work with providers and other community stakeholders to measure and improve quality and reduce costs in their respective states and regions. Yet, despite their uniqueness, common goals and a shared understanding of what ails U.S. healthcare and how to fix it bind each Collaborative together.[xxx]
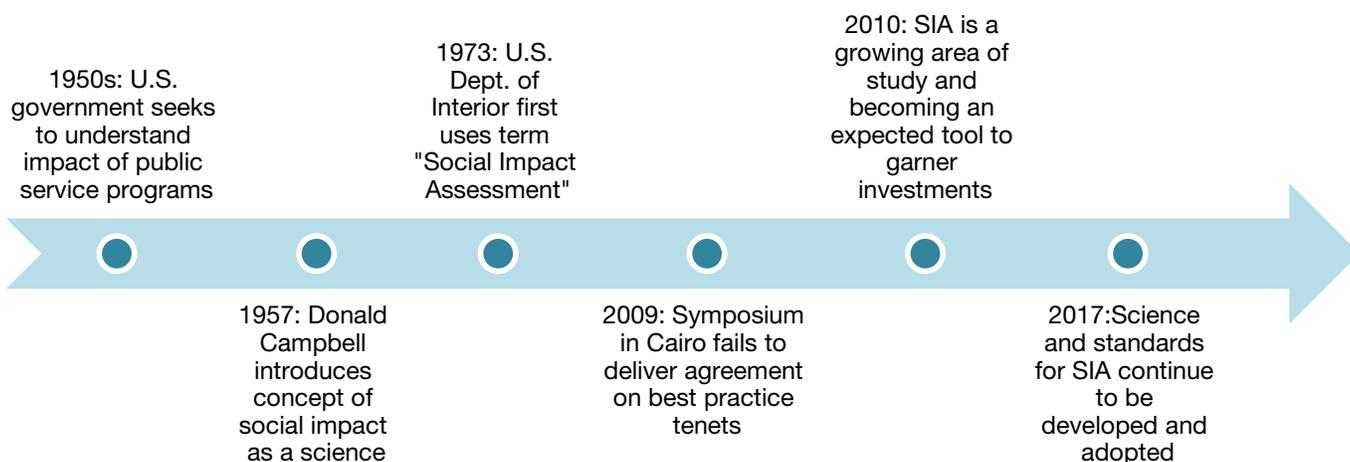
Reference Materials
History of Social Impact Assessment (SIA)

"Social impact assessment has its roots in government measures designed to understand the impact of public service programs"[xxxi] and was ideated as far back as the 1950s, although "the term 'social impact assessment' was first used by the Department of the Interior in 1973 while preparing an Environmental Impact Statement."[xxxii] SIA was ideated as an adjunct to the EIA tool that had been used at that time for many years, and continues to be used widely today. However, as a tool to measure the impact of public service programs, SIA is distinctly different from EIA and has been evolving over the years into the requisite methodology for measuring the impact of the various types of programs and interventions that ultimately cause social change.

According to Geoff Mulgan, as reported in the Stanford Social Innovation Review: "Over the last few decades, many people have attempted to measure what is sometimes called social, public, or civic value—that is, the value that nongovernmental organizations (NGOs), social enterprises, social ventures, and social programs create. The demand for these metrics has come from all sectors: Foundations want to direct their grants to the most effective programs; public officials, policymakers, and government budget offices have to account for their spending decisions; investors want hard data analogous to measures of profit; and nonprofits need to demonstrate an impact to funders, partners, and beneficiaries. Metrics to meet these needs have proliferated over the last 40 years, resulting in hundreds of competing methods for calculating social value."[xxxiii]

Mulgan further reports in "Measuring Social Value" that funders, nonprofit executives, and policymakers are very enthusiastic about measuring social value.[xxxiv] He also notes, "despite the enthusiasm for metrics, few people actually use them to guide decisions," largely because decision makers conflate three very different roles: accounting to external stakeholders, managing internal operations, and assessing societal impact.[xxxv]

Further complicating SIA is the desire to assign or attribute social impact across an array of activities and players (organizations and/or individuals) engaged in the work. It may be possible to define the overarching impact of large, multi-stakeholder initiatives. However, breaking that impact down to the activity or by participant may be so challenging that the effort to do so does not warrant the investment, which is one of the reasons this document focuses on and provides guidance to organizations and projects operating in the community health arena with more clearly defined and specific missions and goals.

1950s: U.S. government seeks to understand impact of public service programs

1973: U.S. Dept. of Interior first uses term "Social Impact Assessment"

2010: SIA is a growing area of study and becoming an expected tool to garner investments

1957: Donald Campbell introduces concept of social impact as a science

2009: Symposium in Cairo fails to deliver agreement on best practice tenets

2017: Science and standards for SIA continue to be developed and adopted

Additional Rationale for SIA

McKinsey & Company offers the following compelling reasons for undertaking SIA work:

- Social change unites funders, social investors, nonprofits, and social enterprises. To achieve social change, the social sector must identify what approaches work — and why.

- The goal of SIA is to drive improvements that increase the value of programs to the people they serve. SIA helps organizations to plan better, implement more effectively, and successfully bring initiatives to scale. Assessment also facilitates accountability, supports stakeholder communication, and helps guide the allocation of scarce resources.

- There is a great deal of debate on how to measure social impact, due in large part to the difficult nature of assessing social change. It takes money. It takes time. It takes imagination and creativity.

- In spite of these challenges, social impact assessment is not only necessary but also critical. The social sector's commitment is to serve its constituents and while their lives cannot be measured in outputs and outcomes, they are ultimately the reason we should assess our work.[xxxvi]

Interestingly, as the concept of SIA becomes more robust, organizations and entities are discovering that a change in performance measurement is warranted as the way the way performance has been measured in the past focuses on outputs and thereby does not provide a path to measuring outcomes or social value. Outputs are results. Outcomes are improvements.

A Primer in Performance Metrics

Metrics refer to a wide variety of tools used to evaluate the performance of employees, products, projects, programs, services, and customer satisfac-

tion, to name a few. In order to establish a metric, an organization or project team first needs to find a critical process, find outputs that correspond to the amount or type of work, and then set goals for those outputs.[xxxvii]

One way to measure project health is to break down and keep track of measurements according to seven criteria: resources, cost, time, scope, quality, safety, and actions. Regardless of how these criteria are chosen or measured, it is common that any metric or set of metrics links to an overarching strategy, and is chosen in order to measure the performance of the overall strategy of that organization or project against a 'critical success factor'.[xxxviii]

To be effective, compare performance metrics to established benchmarks or business objectives. This provides appropriate context for the values used in the metric and allows business users to better act on the information they are viewing. Context allows metrics to make an impact.[xxxix]

Developing performance metrics usually follows a process of:[xl]

1. Establishing critical processes/customer requirements;
2. Identifying specific, quantifiable outputs of work; and
3. Establishing targets against which results may be scored.

Performance metrics keep organizations and teams on target and are helpful in keeping both internal and external stakeholders up-to-date in terms of how the organization or project is performing. Use of a dashboard that communicates performance against the selected metrics is a valuable tool to publicize and report results and performance on a regular basis.

A good metric is characteristically: **M**easurable, **E**asy, **T**imely, **R**epeatable, **I**nsightful, and **C**ontrollable.[xli] When formulating metrics for an organization, collaborative, or project, one should keep in mind the age-old adages: "that what gets measured gets done," and "you cannot improve that which you cannot measure."

When defining metrics to measure the successes of the organization or project, one should start with a baseline measure that would represent the starting point or current state (this is the point from which changes that result from project actions may be measured; such changes may be positive or negative). The next step is to identify the target or desired ideal state. When setting a target, one should ask herself or himself (and of course team members and collaborators) what is a reachable, doable goal; why is that target important; and what does it mean or represent for the success of the project. It is equally important to be certain that everyone fully understands the process used to identify targets.

Inputs, Outputs and Outcomes

Consider these definitions when deciding how to measure the entity or project's success, keeping in mind that only "outcomes" is the true measure that will ultimately link to the objectives and improve conditions in the community being served:

- Inputs describe how much in the way of resources (both financial and non-financial, such as volunteer time, materials, equipment, etc.) was used to conduct an activity. This is important to know in order to ensure effective and efficient use of resources.

- Outputs measure the activities conducted by the organization or under the project scope, such as the number of classes held, the number of students enrolled or graduated, the number of concerts performed and number of concertgoers attending, the number of members enrolled, and the like. The problem with this type of data is that, while they show the quantity of program services provided, they do not indicate whether any real benefits resulted. Did the students learn anything? What was the quality of the concerts? How well were the members served? Deliverables are important and are useful in determining if the corresponding services or products have been provided. **Outputs are deliverables and should not be used to measure attainment of objectives**.

- Outcomes measure how much better off clients, stakeholders, project beneficiaries, or society as a whole, are a result of the organization's activities. For example, by how much has the teenage pregnancy rate in a community been reduced through the efforts of a charity whose mission includes educating children about the undesirable results of getting pregnant at a young age?[xlii]

Gap Analysis

A gap analysis is an operational tool most often used to identify internal performance deficiencies. A gap analysis tool is also useful to evaluate the success of an organization in achieving its mission statement, especially for an organization with a narrow, precise mission. Further, a gap analysis is useful when measuring specific activities and projects. In the instance where an organization has broken down its mission into a number of small events, gap analysis is helpful in assessing the progress and actions needed to close the gap between the current and desired future states of each smaller project. A gap analysis would be less effective in measuring grand, sweeping mission statements.

Stakeholder Identification

Project managers should carefully distinguish between engaging stakeholders and engaging the community.[xliii] Engaging community stakeholders may require a broader approach as well as broader considerations to be successful. Stakeholders still have their role; but community engagement will extend far beyond the scope of traditional stakeholders and will be important in long-term adoption and sustainability of the work.

Potential Brainstorming Questions to Identify Stakeholders[xliv]	
• Who is directly involved in the project? • Who is indirectly involved in the project? • Whom does the project affect? • Whom does the project's outcome affect? • Who are the winners and losers from the project's success? • Who wants to complete the project successfully and who does not? • Who are the project's community beneficiaries?	• Who are the suppliers? • Who has the authority to make the project succeed? • Who can make the project fail? • Who are the users of the results of the project? • Who are the competitors? • Who are the collaborators? • Which stakeholders have already been identified? • Does the project or outcome affect a local community?

Project Managers

"Project managers can employ various methods and approaches to run projects, generally selecting the best approach based on the nature of the project, organizational needs and culture, the skills of those working on the projects, and other factors. As part of a strong project management plan, project managers implement controls to assess performance and progress against the established schedule as well as the budget and objectives that are part of the project management plan, which is often referred to as the project scope."[xlv]

As explained under the section "Metrics," in the nonprofit and community development worlds, there is no common, easily understood measure of success. Therefore, the project manager and project team (or entity management) must define what success looks like and how to measure and report the project's successes.

Tips for Project Management at the Community Level[xlvi] (offered by John Ariyo)	
Tip	**Rationale**
Focus on old school tools	Gain trust with use of a proven, formal process, such as Critical Chain Project Management (CCPM) and Critical Path Method (CPM) for overall project management, and tools such as Gantt Charts and PERT Charts to monitor overall project trajectory
Determine project guiding principles	Allow stakeholders and partners to have access to project information and to participate in various activities
Do your homework	Research, understand, and focus on key, related community issues
Go beyond the usual suspects	Engage members of the community where they are
Learn from your community	Find those already doing great things in your community and learn from them—be a great listener
Don't reinvent, collaborate	Build on what works instead of wasting time and resources to create something new; collaboration offers a means to be efficient and effective while minimizing the strain on limited resources
Communicate, communicate, communicate	There is no such thing as too much communication
Don't forget your team	The needs of your project team are real and should not be overlooked in efforts to engage the community and other stakeholders
Be clear on your engagement limitations	Be upfront about project limitations—don't promise that which cannot be done
Report back, please	Let stakeholders and community partners and members know how and when their feedback will be used and what the end product looks like; don't go out to the community only when you want something—respect and thank those who work with you

Impact Analysis Tenets and Tools Identified and Explained
Comparator Groups—a group of companies that are selected according to size, sector, geographic spread, or other criteria, and used to measure relative performance or to benchmark a company against.[xlvii]
Common Metrics—common metrics have standard definitions and measurement processes, often related to core activities; creating consistent performance measures and allowing comparison of one entity or project to another. As a given activity or process may be measured in different ways depending on the type of data that are collected and how the data are characterized, common metrics rely on established data, and allow comparative perspectives and benchmarked results across other similar entities, projects, and initiatives. Common metrics that are familiar in nomenclature help highlight results that are meaningful to a variety of stakeholders. Accordingly, it is important to insist on effective, enforceable and meaningful metrics.
Other "Like" Initiatives—as part of due diligence, become aware of similar or like initiatives taking place locally or across the country. Understand what may be learned from these initiatives, how to leverage lessons learned, and how to build on momentum. Also, these initiatives will provide intelligence into developing metrics, measuring inputs and outputs, and guiding the use of limited resources.

Impact Analysis Tenets and Tools Identified and Explained (Cont'd)

Benchmarks—know what benchmarks exist and how they may be used to evaluate the performance of your entity, collaboration, or project. Learn from those benchmarks and incorporate best practices into your work. Benchmarks provide examples of how peer entities or related projects are approaching similar issues:

   a) a point of reference (best-in-class) from which measurements and comparisons may be made;
   b) something that serves as a standard by which others may be measured or judged;
   c) a standardized problem or test that serves as a basis for evaluation or comparison (computer system performance)[xlviii]

Timeframe—a time horizon, or planning horizon, is a fixed point of time in the future when certain processes will be evaluated or assumed to end. A timeframe is the estimated length of time for a plan, program, or project to complete, an endeavor to succeed, an investment to yield returns, an obligation to become due, a right to mature, etc. Select a reasonable timeframe for the project in order to realize progress on the mission or the project's end. If a funder gives a timeframe, make certain to assess accurately what may be accomplished in that period. Focus on a statistically valid sample size and time. The planning horizon has two key dimensions: time and cost. There are three types of planning horizons, each of which is relative to the base year with different levels of detail:

• Strategic Horizon or Strategic Plan (Years 1-30)
• Tactical Horizon or Tactical Plan (Years 1-10)
• Operational Horizon or Operating Plan (Year 1)[xlix]

Gaining agreement on a common time horizon for action is particularly important in community-level work, as each participant will have very different time horizon habits. Leveraging the strength of a collaborative will garner great benefit and ensure that no partner or the overall project is disadvantaged.

Savings—most community-level work exists to generate savings of some type, which may or may not be monetary in nature. When most people think of savings, they think in terms of lower costs, but savings from a community-wide initiative may generate savings of a different kind. Outcomes may generate financial savings that are not necessarily clear or easily attributed to the framing organization, collaborative, or project.

In the early planning stages, seek agreement on the things to be measured and to quantify those measurements. Quantify the savings in the "currency" that is most important to the stakeholders. That currency may be expressed in terms of dollars (e.g., dollars invested; dollars saved; lower total cost of care; lower health care premiums; among many others). Conversely, the team may decide that the "currency" is something less tangible, such as lives saved; number of people reached; visits to a primary care provider; and, of course, many other results that are tracked in terms other than standard financial metrics and that should ultimately result in financial savings (difficult to define and attribute to the intervention).

Extrapolation/Scaling[11]

Following are six steps that determine and ensure that community-level work will successfully scale:
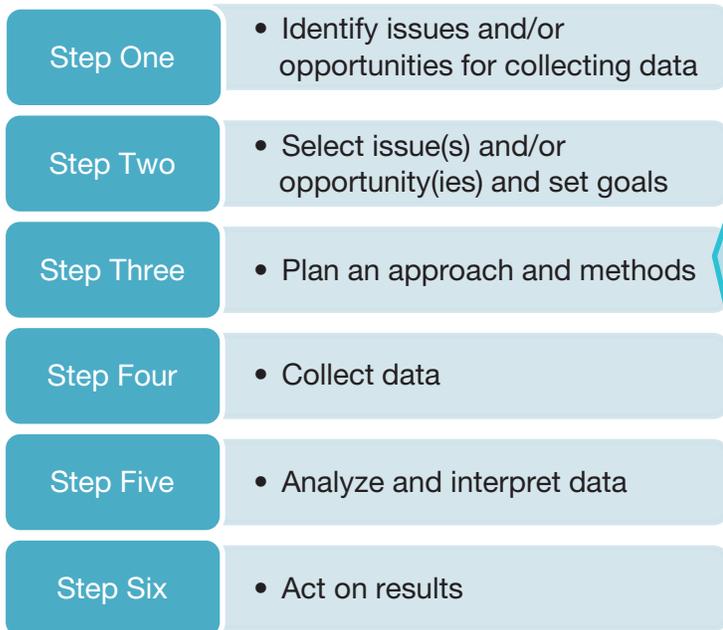
   1. Determine whether the intervention is ready to go to scale;
   2. Select the best approach to bring the intervention to scale;
   3. Select sites that are best suited to the intervention;
   4. Develop the capacity and infrastructure to manage multiple sites;
   5. Evaluate the scaling process; and
   6. Share promising practices and lessons about scale with other nonprofits.

Data Gathering, Collection and Use

Some general considerations to undertake before the data collection process:[l]

- Availability: Are the data currently available? If not, are the data easily collectible?

- Accuracy: Do the data contain biases? Are the data verifiable and auditable?

- Timeliness: Are the data timely enough to evaluate performance? What is the frequency for data collection and reporting?

- Cost: What is the cost of collecting the data? Are there sufficient resources available for data collection?

Per the Ontario Human Rights Commission, the following are six steps for collecting data:[li]

Step One	• Identify issues and/or opportunities for collecting data
Step Two	• Select issue(s) and/or opportunity(ies) and set goals
Step Three	• Plan an approach and methods
Step Four	• Collect data
Step Five	• Analyze and interpret data
Step Six	• Act on results

- About whom are the data collected?
- To whom will the group or interest be compared?
- From what locations or geographical areas will the data be gathered?
- What categories will be used to identify the group of interest and comparator group?
- How should data be collected?
  - o Qualitative Data
  - o Quantitative Data
- What sources of data should be used to collect information?
  - o Pre-existing or official data
  - o Survey data
  - o Interviews and focus group
  - o Observed data
- How long (scope) will the data be collected?

Please reference the following resources for more information on gathering, collecting and using data:

- Performance Measurement Team Department of Management and Budget. Fairfax County Manual for Data Collection and Performance Measurement." 2007. Available at: http://www.fairfaxcounty.gov/dmb/performance_measurement/data_collection_manual.pdf.

- Ontario Human Rights Commission. "What is involved in collecting data—six steps to success." Available at http://www.ohrc.on.ca/en/count-me-collecting-human-rights-based-data/6-what-involved-collecting-data-%E2%80%93-six-steps-success.

Quantitative Data: Strengths and Weaknesses[lii]

Potential strengths of quantitative data:

- Perceived to be more credible and reliable than qualitative data because of the use of numbers, and thereby considered an objective source of data.

- Excels at summarizing, organizing and comparing large amounts of information, and drawing general conclusions about a research topic of interest.

- Can help measure progress and success.

- Good at identifying trends and determining the magnitude of a research topic of interest.

Potential weaknesses of quantitative data:

- Focusing on numbers and rankings alone can overly simplify or lead to an inaccurate understanding of complex situations and realities, unless provided in a broader context.

- The accuracy of quantitative data can be influenced by manipulation and bias of the researcher, among other factors, unless checked by the researcher's professionalism and the use of accepted data collection research methods

Quantitative Framework

Factors to consider and things to do when developing a quantitative framework:

- Use metrics from the project: don't complicate measurement by introducing data from other sources that most likely are not relevant to the project;

- Research periodicals and journals for comparative data: be certain to cite all sources for vetting purposes;

- When doing comparisons, use a common language—that is, use the same definitions;

- Identify and include cost and non-cost metrics (quality of life, readmissions avoided, etc.) as appropriate;

- Calculate actual project savings as well as the costs that are avoided (cost avoidance can be a volatile topic as some will argue that there is limited or no value in cost avoidance because it's difficult to prove those costs would have been incurred in the future);

- Extrapolate the savings to determine the potential impact from program spread—this can be done building on a sample population from the project and projecting the effects on a larger population, region or territory, say from a neighborhood to a city, county or state;

- Vet the process and final product with a peer or expert review—an unbiased approval will elevate the acceptability of the project work.

Qualitative Data: Strengths and Weaknesses[liii]

Potential strengths of qualitative data:

- Excels at "telling the story" from the participant's viewpoint (it helps participants feel like they have been heard).

- Can help others better understand the issue or problem by providing the rich descriptive detail that explains the human context of numerical results.

Potential weaknesses of qualitative data:

- Perceived that the accuracy of qualitative data can be influenced by false, subjective or manipulated testimonies. Good qualitative data, checked by a professional researcher and gathered using accepted data collection research methods, can address the impact of such factors.

- Depending on the nature and size of the project, as well as the sophistication of the methods and analysis used, can take a significant amount of time, be very labor-intensive, and yield results that may not be general enough for policy-making and decision-making purposes."

Communication Tenets and Guidelines

Basic matters incorporated in communication, messaging, and dissemination of information are:

- Know the message(s).

- Develop a messaging format that is simple, clear, and precise (even when the information does not lend itself to simplicity). Make certain the story is compelling.

- Understand the target audience(s)—who would find the message of interest or meaningful? What type of messaging does this audience respond to or prefer?

- Select a meaningful cadence to the communications—appropriate communication needs to take place on a regular basis all through the project lifecycle. Preserve stakeholders and the community engagement by keeping them in the loop; stakeholders should not be surprised with the news that is reported. Individuals appreciate and welcome personal feedback and thank-you notes.

- Establish the best frequency for communicating news about the project and communicate at regular intervals throughout the project lifecycle. For impact, use an unscheduled time to get across big, breaking news. Keep in mind that communication specialists report that people need to receive messages multiple times and in multiple formats before they can internalize that message. So, yes, use standard communication formats and intervals but augment those with other interesting and provocative ways of messaging.

- Monitor successes in messaging and disseminating information; lever lessons learned and build on successes in order to improve the value and impact of future communications.

- Use innovative communication channels, PSAs, and social media to enhance messaging.

- Coordinate messages with readily available websites and tools; e.g. the Centers for Disease Control website: (http://www.thecommunityguide.org/healthconnumication/index.html).

- Brand the communications through templates that carry logos, colors, and themes that people will associate with the project and its key messages.

Glossary

Backbone organization – a separate organization dedicated to coordinating the various dimensions and collaborators involved in a community or multi-stakeholder initiative.[liv]

Collective impact – a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change.[lv]

Culture of Health –broadly defined as one in which good health and well-being flourish across geographic, demographic, and social sectors; fostering healthy equitable communities guides public and private decision making; and everyone has the opportunity to make choices that lead to healthy lifestyles.[lvi]

Environmental Impact Assessment (EIA) –the process to measure the anticipated effects on the environment of a proposed development or project. If the likely effects are unacceptable, design measures or other relevant mitigation measures may reduce or avoid those effects.[lvii]

Health Care Triple Aim –the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. Note that the Triple Aim is a single aim with three dimensions.[lviii]

Health in All Policies – In the context of the 8th WHO Global Conference on Health Promotion, it has been defined as "an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity." Founded on health-related rights and obligations, this approach emphasizes the consequences of public policies on health determinants and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making.[lix]

Gap analysis – a technique used to assess the differences between the current and desired performance levels of a project as well as to determine how to meet those requirements. Gap refers to the space between "where we are" (the present state) and "where we want to be" (the target state).

Inputs – the resources and data used to influence an output.[lx]

Metrics – a wide variety of tools used to evaluate the performance of employees, products, projects, programs, services, and customer satisfaction, to name a few. In order to establish a metric, an organization or project team first needs to find a critical process and outputs that correspond to the amount or type of work, and then set goals for those outputs.[lxi] Metrics keep organizations and teams on target and are helpful in keeping both internal and external stakeholders up-to-date in terms of how the organization or project is performing. Performance metrics measure an organization or project's activities and performance.[lxii] Output metrics measure deliverables and/or results. Outcome metrics measure impact. Use of a dashboard that communicates performance against the selected metrics is a valuable tool to publicize and report results and performance on a regular basis.

Mission – a statement used to communicate the purpose of an organization.

Objectives – serve as a basic tool to underlay all planning and strategic activities as well as to quantify a level of performance.[lxiii] Hence, objectives must define desired benefits, outcomes or performance improvements expected from the project. A good objective should be **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime-bound and it must not describe what you plan to do, how you plan to do it, or what you plan to produce. Often, objectives are expressed in the form: "To [improve/ increase/enhance/etc.] something, by [x amount], by [dd/mm/yy date]."[lxiv]

Outputs –short-term results, deliverables or products; in community-level work, an output might report the number of people who attended an event or received information on how to improve their health.

Outcomes – are the real reason for undertaking community-level work. Outcomes measure the long-lasting impact and changes in the community that are the result of the work undertaken.

Population Health – "the health outcomes of a group of individuals, including the distribution of such outcomes within the group;" an approach that aims to improve the health of an entire human population.[lxv]

Purpose – the reason something exists.

Project – an undertaking with specific start and end parameters designed to produce a defined outcome. A project is different from ongoing processes, such as a governance program or an asset management program.

Project Management (PM) – the discipline of using established principles, procedures and policies to manage a project from conception through completion.[lxvi] Included in PM is "the initiating, planning, executing, controlling, and closing the work of a team to achieve specific goals and meet specific success criteria."

Qualitative analysis methods – describe a specific context, event, people or relationship in a broad contextual way, by trying to understand the underlying reasons for behavior, thoughts and feelings. Common qualitative research methods include observation, one-on-one interviews, focus groups and intensive case studies.

Qualitative data – are in the form of words, but may also include any information that is not numerical in form, such as photographs, videos and sound recordings.

Quantitative analysis – examination of measurable and verifiable data such as earning, revenue, wages, market share, etc.[lxvii] Analysis of a situation or event, especially a financial market, by means of complex mathematical and statistical modeling.[lxviii]

Quantitative data – can be quantified and verified, and is amenable to statistical manipulation. Quantitative data defines.[lxix] Information about quantities; that is, information that can be measured and written down with numbers.[lxx]

Responsibilities — the specific tasks or duties that members complete as a function of their roles. They are the specific activities or obligations for which they are held accountable when they assume—or are assigned to—a role on a project or team.[lxxi]

Return on Investment – A performance measure used to evaluate the efficiency of an investment.[lxxii]

Roles — the positions team members assume or the parts that they play in a particular operation or process. Examples of roles may include project manager; team lead; facilitator; program analyst, etc.

Situation analysis – "an assessment of the current health situation and is fundamental to designing and updating national policies, strategies and plans. A strong situation analysis is not just a collection of facts describing the epidemiology, demography and health status of the population. Instead, it should be comprehensive, encompassing the full range of current and potential future health issues and their determinants. It should also assess the

current situation as compared to the expectations and needs of the country. Such a situation analysis can then serve as the basis for setting priorities to be addressed in the policy, strategy or plan through the process of a broad, inclusive policy dialogue."[lxxiii]

Strengths, Weaknesses, Opportunities and Threats (SWOT) – is an acronym for strengths, weaknesses, opportunities, and threats and is a structured planning method that evaluates those four elements of an organization, project or business venture.[lxxiv]

Social fabric – the composite demographics of a defined area, which consists of its ethnic composition, wealth, education level, employment rate and regional values.[lxxv]

Social Impact Assessment – "the processes of analyzing, monitoring and managing the intended and unintended social consequences, both positive and negative, of planned interventions (policies, programs, plans, projects) and any social changes invoked by those interventions. Its primary purpose is to bring about a more sustainable and equitable biophysical and human environment."[lxxvi]

Stakeholder – an individual, group, or organization who may affect, be affected by or perceive itself to be affected by a decision, activity, or outcome of a project. Put more simply, you can say that if someone has any kind of interest in your project, or has any kind of interest in your project, they are your project's stakeholder.

Strategic analysis – "[generally defined as] the use of various tools to prepare business strategies by evaluating the opportunities and challenges faced by the company as it moves forward. Typically, strategic analysis involves a review of internal strengths and weaknesses as well as factors in the external environmental that could affect business."[lxxvii]

Vision –outlines what a company wants to be in the future. However, when dealing with non-profit organizations and community-level work, it is reasonable that the vision describes the desired future state of the community (or beneficiary of the work) rather than perpetuation of the organization or project team leading the work.

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Appendix

Founded in 1944, the Greater Detroit Area Health Council (GDAHC) is a nationally recognized Regional Health Improvement Collaborative (RHIC), a member and governing participant of the Network for Regional Health Improvement (NRHI), and a Robert Wood Johnson Foundation (RWJF) Aligning Forces for Quality (AF4Q) grantee. GDAHC has a long, successful history of promoting and leading multi-sector, multi-stakeholder community collaboration focused on improving health outcomes, improving the health care delivery system, increasing patient access, and managing the cost of care.

GDAHC is a member organization and its members include those who get care, give care and pay for care; that is, health systems, health plans, employers, labor unions, providers, universities and other learning institutes, safety-net clinics, faith-based organizations, social services organizations, mental and behavioral health organizations and providers, community service organizations, consumers, government, and others. A complete list of members is available is www.gdahc.org.

Coordination and collaboration are the hallmarks of GDAHC's longevity and represent the services most desired by GDAHC's members. GDAHC's members stay at the table because of the relationships they are able to build and nurture across the community and the collective impact they are able to advance as part of the GDAHC collaborative. GDAHC's members report consistently that GDAHC's value proposition is its ability to convene disparate stakeholders, and coordinate and manage projects across these stakeholders in order to drive positive community health outcomes.

GDAHC directs the Southeast Michigan Regional Area Health Education Center (AHEC)—a HRSA program—in coordination with Wayne State University. AHEC works to improve access to primary care for all Michigan residents, many of whom live in areas that have too few health professionals. Through recruitment and retention initiatives, as well as special clinical education programs, AHEC seeks to expose disadvantaged students to health care opportunities, expand the number of underrepresented minorities in the health professions, and encourage students and health professionals to work in areas that need greater access to primary care providers.

GDAHC'S purpose is "to improve the health and economic wellbeing of individuals, organizations and communities."

GDAHC's mission is "to innovate and transform health and care by leveraging the strength of collaboration." GDAHC is fully committed to better health

for all and recognizes that the integration of social determinants with clinical care is necessary to achieve better health.

GDAHC's vision is "Healthy people. Health economy."

GDAHC operates as a 501c3 in Southeast Michigan (SEMI), has 12 employees and an annual budget of $1.5 million.

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