# MOBILIZING FOR ACTION THROUGH PLANNING & PARTNERSHIPS

## MAPP 2.0

## USER'S HANDBOOK

NACCHO℠
National Association of County & City Health Officials

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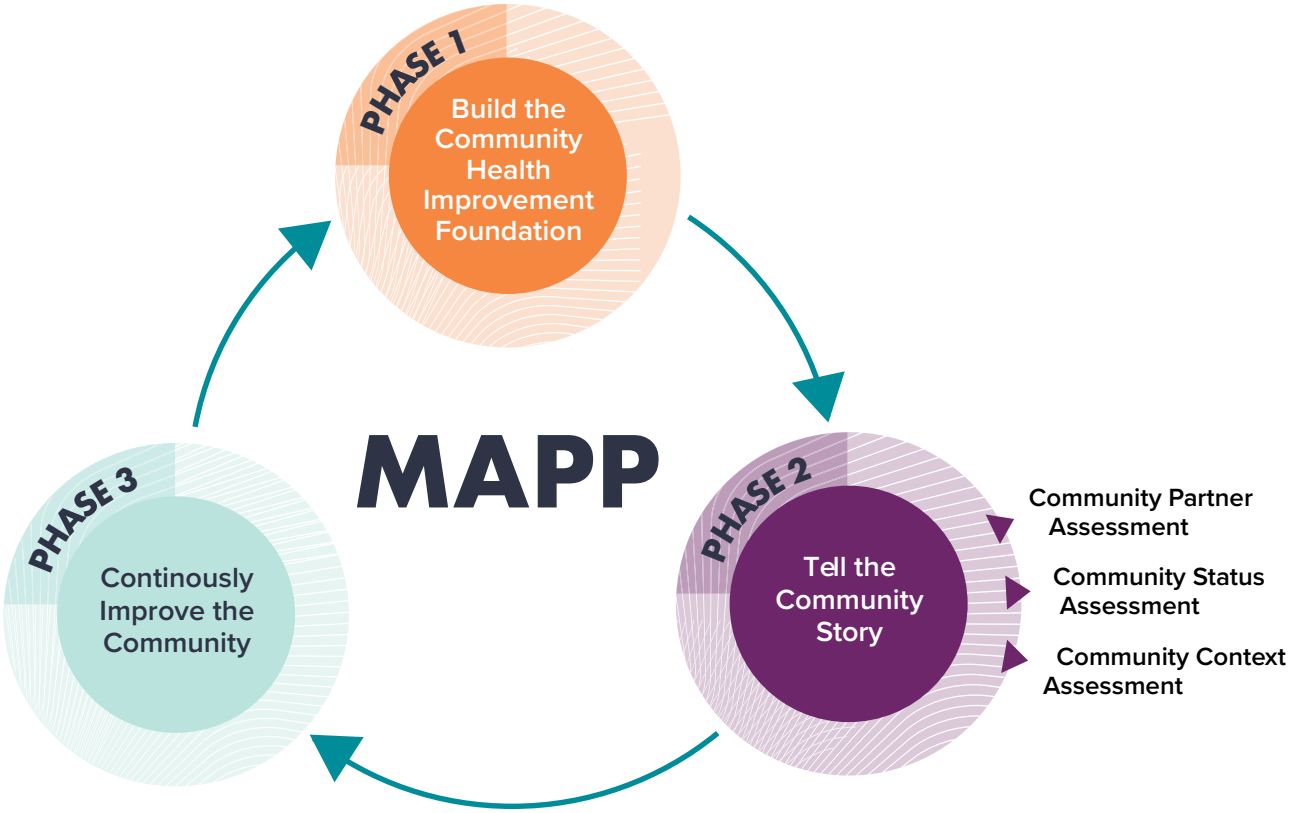

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The National Association of County and City Health Officials (NACCHO) represents the nation's nearly 3,000 local health departments. These city, county, metropolitan, district, and Tribal departments work every day to protect and promote health and well-being for all people in their communities. For more information about NACCHO, please visit **www.naccho.org**.

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# ACRONYMS

**ADT** = Assessment Design Team

**CCA** = Community Context Assessment

**CDC** = Centers for Disease Control and Prevention

**CH[N]A** = Community Health [Needs] Assessment

**CHI** = Community Health Improvement

**CHIP** = Community Health Improvement Plan

**CPA** = Community Partner Assessment

**CSA** = Community Status Assessment

**HRSA** = Health Resources and Services Administration

**LHD** = Local Health Department

**LPHS** = Local Public Health System

**LPHSA** = Local Public Health Systems Assessment

**MAPP** = Mobilizing for Action through Planning and Partnerships

**NACCHO** = National Association of County and City Health Officials

**PHAB** = Public Health Accreditation Board

**SDOH** = Social Determinants of Health

# WELCOME

**Thank you** for reading the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 Handbook. Communities can use this handbook to complete a community-driven, multi-sector process to improve community health and achieve health equity. We hope you will find it useful to help your community achieve its unique vision for a healthy future.

MAPP provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action. It emphasizes the vital role of broad stakeholders and community engagement, the need for policy, systems, and environmental change, and alignment of community resources toward shared goals. The process results in a community health [needs] assessment (CH[N]A) and a community health improvement plan (CHIP).

We encourage you to connect with your colleagues in public health across the United States who have experience in community health improvement (CHI) or are working on it for the first time. Join the MAPP Network (**virtualcommunities.naccho.org/mappnetwork**) to find more MAPP resources and forums to ask questions and share tools and stories with other MAPP practitioners. The National Association of County and City Health Officials (NACCHO) is also available to support your CHI work.

# INTRODUCTION TO MAPP 2.0

MAPP 2.0 is the updated framework for CHI developed by NACCHO. The goal of MAPP is to achieve health equity by identifying urgent health issues in a community and aligning community resources. **Health equity** is the assurance of the conditions for best health for all people.[1] MAPP involves developing a community-wide vision for health, involving organizations across sectors, assessing both community needs and strengths, and assigning resources to the underlying drivers of inequity.

> ***Note:*** *Throughout this handbook, words in* **bold** *are important terms that the Glossary defines. The Glossary is at the end of the handbook.*

CHI is a strategic process for assessing community health needs, prioritizing them, and identifying resources to address them. MAPP outlines this process with step-by-step guidance, examples of what success could look like, opportunities to adapt the guidance, and more resources.

MAPP is generally facilitated by one or more organizations that complete the process with the guidance, input, and participation of many people and organizations who work, learn, live, and play in the community. It brings together many different stakeholders, sectors, and populations to identify shared priorities for improving community health and to act together for change. Although local health departments (LHDs) are often the face of CHI, MAPP positions them to convene the process, allowing the work and outcomes to remain "community-owned." This handbook gives decision-making power for MAPP to the community, with support, coordination, and encouragement from the LHD.

MAPP is an opportunity to strategically work toward a community-owned vision through collective action. Your community is probably already engaged in activities that highlight community assets and needs and efforts to improve community health. The MAPP framework organizes and aligns these activities under one umbrella.

You can apply MAPP in countless ways and can adapt this handbook to your available skills, expertise, time, and resources. MAPP will look different in every community. Communities that have extensive partnership, assessment, and planning experience might complete phases at the same time or more quickly. Communities with little assessment and planning experience may decide to try a portion of MAPP before committing to the entire process. However you decide to do MAPP, the community's wishes and needs should drive the process.

[1] Jones, C. (2014). Systems of power, axes of inequity: Parallels, intersections, braiding the strands. *Medical Care*, 52(10, Suppl. 3), S71–S75. Retrieved from www.tfah.org/wp-content/uploads/2020/08/Jones_SystemsofPower.pdf

Although MAPP is adaptable, a community doing MAPP can expect the following:

- A three-phase process that takes about two years to complete, before applying the CHIP
- Activities that unite the community, including community members, organizations from the local public health system (LPHS), community organizers, community power-building organizations, and other regional groups
- A process that begins in a linear fashion but promotes continuous understanding of the community's needs and how to address them over time
- A collaborative approach to identifying the community's needs and strengths and how to address them

The whole MAPP cycle takes time, effort, and dedication. Although completing a cycle takes three to five years, you don't need to start from the beginning at every cycle. Refer to the Phases and Steps of MAPP table for a recommended timeline by which to revisit certain steps or update certain data after a MAPP cycle is complete.

These recommendations for updating data align with requirements for LHD accreditation and non-profit hospital CH[N]A requirements. They are also based on recommendations from the field about which elements to revisit more or less frequently (e.g., workgroup membership, vision development).

*Use this graphic, or create your own, to share the steps of the MAPP 2.0 process with your community.*

# Phases and Steps of MAPP

| STEP | DESCRIPTION | Suggested Frequency to Revisit or Update | | |
|---|---|---|---|---|
| | | *Annual/ Ongoing* | *3 years* | *5 years* |
| **Phase I: Build the Community Health Improvement Foundation**<br>This phase unites many partner organizations and people to plan for MAPP. | | **Estimated Timeline: 9 months** | | |
| 1. Do a Stakeholder and Power Analysis | Identify people and groups who have an effect on MAPP, and whom MAPP will affect, and analyze those impacts. | X | | |
| 2. Establish or Revisit CHI Leadership Structures | Develop a diverse core group and steering committee of community members and partner organizations to direct the process. | X | | |
| 3. Engage and Orient the Steering Committee | Onboard the steering committee to MAPP to establish baseline understanding of foundational concepts for CHI, health equity, and community engagement. | X | | |
| 4. Establish Administrative Structures for MAPP | Decide who will provide administrative support for MAPP and how to formalize partnerships and organizational commitments to MAPP. | | | X |
| 5. Develop the Community Vision | Collectively define "the community" and a vision for a healthy future. | | | X |
| 6. Do the Starting Point Assessment | Reflect on the past cycle, identify resources available for the current cycle, and create goals for the current cycle. | | | X |
| 7. Identify CHI Infrastructure Priorities and Develop Workgroups | Establish two to four workgroups to strengthen CHI infrastructure during the current CHI cycle. | X | | |
| 8. Develop the Workplan and Budget | Outline milestones and goals for MAPP. | | | X |
| **Phase II: Tell the Community Story**<br>This phase includes preparation, application, and analysis of the three assessments. | | **Estimated Timeline: 9 months** | | |
| 1. Form the Assessment Design Team | Recruit a team that represents the community to coordinate the design, application, and interpretation of the assessments. | X | | |
| 2. Design the Assessment Process | Design the process for the assessments, specifically thinking about the order in which the assessments will be done. | X | | |
| 3. Do the Three Assessments | Do the Community Partner Assessment (CPA), Community Status Assessment (CSA), and Community Context Assessment (CCA) to understand the status of health in your community. | | X | |

| | | | | |
|---|---|---|---|---|
| 4. Triangulate Data, Identify Themes, and Develop Issue Statements | Develop a thorough understanding of the community through data triangulation, identifying cross-cutting themes that will be used to develop issue statements that reflect the issues faced by the community. | | X | |
| 5. Develop Issue Profiles through Root Cause Analysis | Discuss the findings and develop "issue profiles" of the issues identified in the previous step, including descriptions/contributors of the problem, priority community indicators that tie together "upstream and downstream" metrics, and assets to address the issues. | | X | |
| 6. Share CH[N]A Findings | Use the data across the three assessments and issue profiles to develop and share CH[NA findings with the community. | | X | |
| **Phase III: Continuously Improve the Community**<br>This phase centers on developing the CHIP by prioritizing issues and applying and evaluating strategies by community partners. | | **Estimated Timeline: 6 months** | | |
| 1. Prioritize Issues for the CHIP | Using findings from the three assessments in Phase II and the issue profiles, identify three to five priority issues for the CHIP. | | | X |
| 2. Do a Power Analysis of Each Issue | Do a power analysis to assess how each priority issue is influenced by people and institutions, including the factors that caused or led to the issue. | X | | |
| 3. Set Up Priority Issue Subcommittees | For each priority issue, create a subcommittee to develop the action plan and assign the implementation process for selected strategies. | X | | |
| 4. Create Community Partner Profiles | Distribute and analyze "partner profile" worksheets for each partner selected to be on the priority issue subcommittee to further understand their values, mission, available resources, and programmatic efforts related to the priority issue. | X | | |
| 5. Develop Shared Goals and Long-Term Measures | Develop broad goal statements for each priority issue and identify how to measure progress. | | | X |
| 6. Select CHIP Strategies | Using selected goals, identify strategies along the health equity action spectrum to achieve the desired outcome. | X | | |
| 7. Develop Continuous Quality Improvement Action Planning Cycles | Develop an action plan including objectives, measures, timelines, and a plan-do-study-act cycle that details the needed milestones and responsibilities of the MAPP team and subcommittee members. | X | | |
| 8. Monitor and Evaluate the CHIP | Plan ongoing monitoring of CHIP priorities through data collection and activity performance to observe measurable progress on goals and strategies over time. | X | | |

# History and Evolution of MAPP

MAPP is one of the most widely used and reputable CHI frameworks in the field. NACCHO created it in 2001 in response to a national charge to shift from traditional program and organizational strategic planning to a community-owned, systems approach that considers the complex and evolving challenges faced uniquely by public health.[2] Over the years, NACCHO, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA) have updated MAPP to align with national strategies. These updates include developing guidance on the changing CHI requirements across sectors, integrating CDC's Local Public Health System Assessment (LPHSA), elevating MAPP as a foundation for health equity, and reinforcing national initiatives and frameworks such as the 10 Essential Public Health Services, the Foundational Public Health Services, Public Health 3.0, Public Health Accreditation, and Healthy People.

The first national evaluation of MAPP ended in 2019. It revealed that MAPP is an effective framework for leading CHI processes, including starting cross-sector partnerships, gathering community views, meeting accreditation requirements, and raising awareness of health equity. However, it provided foundational evidence for the need to further embed health equity and community engagement in MAPP, revise the framework to be more adaptable and responsive to community needs, facilitate sustained partner engagement, and offer advanced training and guidance on this complex work.

To address these recommendations, NACCHO led a MAPP evolution process through an exploration of field needs, promising practices, and expert guidance. NACCHO organized a 23-member, multidisciplinary MAPP Evolution Steering Committee, which guided the process; facilitated focus groups and key informant interviews with diverse public health and healthcare practitioners and experts in health equity and CHI practice; and did an environmental scan of the literature and field strategies to inform the MAPP revisions.

With public health evolving to take a more active role in fighting health inequities, this MAPP redesign is perfectly timed to coincide with the evolution of other national initiatives like the 10 Essential Public Health Services, Public Health Accreditation Board (PHAB) Standards and Measures Version 2.0, and Healthy People 2030, which are all shifting to focus on health equity.

MAPP

# *History of MAPP*
# TIMELINE

**1969**

501(c) community benefit standard established

**1988**

Institute of Medicine report, "The Future of Public Health" - Public health in disarray

**1991–1995**

APEXPH* is created, a public health planning framework

**2001**

MAPP is developed

**2002–2003**

Revisions to LPHSA built into MAPP

**2010**

Affordable Care Act establishes community health assessment requirements

**2011**

Public Health Accreditation Board launched

**2017**

Public Health 3.0

**2019**

National MAPP evaluation

**2020**

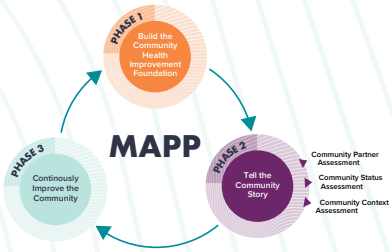
10 EPHS*** updated

**2023**

FPHS** updated

**2023**

MAPP 2.0 is launched




**APEXPH: Assessment Protocol for Excellence in Public Health*
***FPHS: Foundational Public Health Services*
****10 Essential Public Health Services*

# MAPP's Goal: To Achieve Health Equity

**The goal of MAPP is to achieve health equity.** Health equity is the assurance of the conditions for optimal health for all people.[3] Optimal health means physical, mental, social, cultural, and spiritual well-being, beyond the lack of disease or infirmity. This level of health is essential for people to reach their full capacity and participate in society.

Much of the work of public health is to ensure that the conditions in which people live, learn, work, play, and worship allow them to achieve optimal health. These conditions are called the **social determinants of health (SDOH)**. Despite public health's efforts, many people and communities do not have the opportunity to achieve health.

These differences in opportunity contribute to **health inequities**. Health inequities are "preventable differences in the distribution of disease and death that are systematic, patterned, unjust, and associated with imbalances in power and systems of oppression."[4] The SDOH are a useful framework for addressing the outcomes of health inequities, but true health equity cannot be achieved through focusing on those outcomes. To eliminate health inequities, communities must address the underlying systems of power, privilege, and oppression that drive them.

The **root causes of health inequity** lay the foundation for, and persist as part of, a continued legacy of injustice and inequity. They were initiated through the theft and colonization of Indigenous land and the exploitation of enslaved African people through chattel slavery to build America. Laws, policies, and norms that were designed to maintain these systems compose our institutions today. They provide the platform for social exclusion, marginalization, systemic violence, domination, powerlessness, and the denial of cultural expression across all types of social identities in addition to race (e.g., gender, sexual orientation, class, immigration status, education level).

### *What is the Role of Local Public Health?*

Agencies such as LHDs and hospitals, which are often charged with leading a process like MAPP, have had a historical role in helping, or harming, community trust and interactions.

As you shift to transferring power over the process and outcomes to the community, consider asking, "How have our leading agencies and organizations excluded community members from this work? What can we do to build trust and have this process be community-driven?"

[3] Jones, C. (2014). Systems of power, axes of inequity: Parallels, intersections, braiding the strands. Medical Care, 52(10, Suppl. 3), S71–S75. Retrieved from www.tfah.org/wp-content/uploads/2020/08/Jones_SystemsofPower.pdf

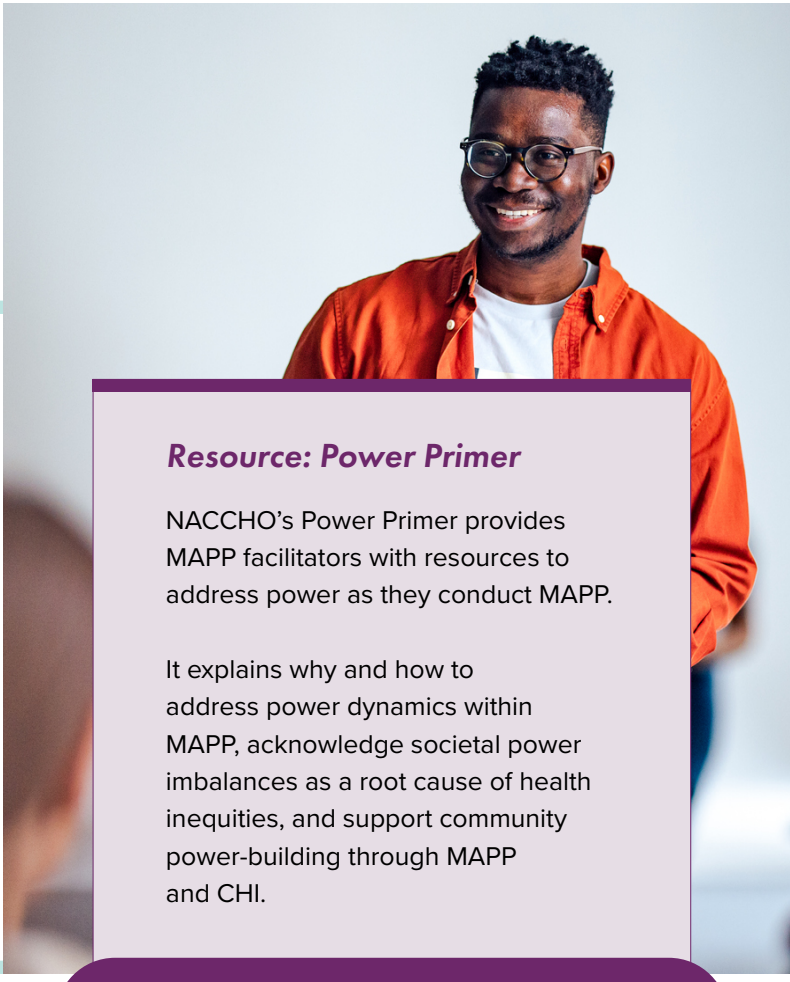
[4] Whitehead, M. (1992). The concepts and principles of equity and health. Int J Health Serv, 22(3):429-45. doi: 10.2190/986L-LHQ6-2VTE-YRRN

These systems result in an inequitable concentration of power, wealth, and resources with select, privileged groups, leaving others with scarcity and harm. Power imbalances impact who is included or excluded from making decisions that impact people's opportunity for health. For example, power over funding decisions is often concentrated with organizational leaders or elected officials. This allows politics to drive decisions and excludes people who will be impacted, such as frontline workers and community members, from funding decisions.

The way these systems maintain inequity is unique to each community's history and dynamics, but social injustice, power, and oppression are common across all. They will continue to create inequities if we do not examine and break down these structures and build new ones rooted in equity, community power, and community-identified strengths and assets.

Health equity is both an outcome to work toward and a process to get there by involving the community in decisions that impact them. Every community is unique, and its characteristics might impact the ability or readiness to engage in health equity work. Such characteristics include size, demographics, and setting; resources; history and strength of community partnerships; influence of those partnerships on setting agendas and priorities; comfort discussing health equity-related topics; and standards and requirements of priority (e.g., accreditation, non-profit hospital community benefit). MAPP provides tools to begin the work.

> *Where do we start? It seems to me that so often we think of this work as linear. We're socialized to think this way: 'Start here, do this, then next, do this.'* ***It's not linear work and it really doesn't matter where we start, as long as we do start."***
>
> **— DR. RENEE CANADY**



### *Resource: Power Primer*

NACCHO's Power Primer provides MAPP facilitators with resources to address power as they conduct MAPP.

It explains why and how to address power dynamics within MAPP, acknowledge societal power imbalances as a root cause of health inequities, and support community power-building through MAPP and CHI.

**DOWNLOAD THE POWER PRIMER**
**at naccho.org/mapp**

*Note: To learn more, read MAPP's* ***Health Equity Action Spectrum*** *in Phase I, Appendix J, outlining the relationships between these factors and how they influence health outcomes.*

## MAPP Theory of Change

The MAPP Theory of Change describes how MAPP helps communities achieve health equity. It is grounded in the context of what led to health inequities, what opportunities exist to address it, and important assumptions about the work.

| CONTEXT | ASSUMPTIONS |
|---|---|
| • Addressing social justice is within the history and scope of work of public health.<br>• The perpetuation of white supremacy culture and domination has created historic and current injustices leading to inequities.<br>• MAPP is influenced by the same structures and systems and by individual community context.<br>• Funding can expand opportunities to advance equity or constrain it when driven by politics or power dynamics and not community need. | • Health equity means creating conditions for **optimal health**—physical, emotional, cultural well-being, not only the absence of disease or infirmity.<br>• To advance health equity, we must do the following:<br>  o Address the power imbalances rooted in white supremacy<br>  o Recognize and identify how white supremacy has created historic and current injustices, which lead to inequities<br>  o Break down these structures and create new ones rooted in equity, community power, and community strengths and assets |

## MAPP Components to Achieve Equity

MAPP uses the following Practices and Foundational Principles to advance health equity:

### *Practices*

| PRACTICE | DESCRIPTION |
|---|---|
| **Centers the Goal to Achieve Health Equity** | MAPP centers health equity as both the process and the ultimate outcome of the process. MAPP alone cannot advance health equity but is a critical tool positioning communities to collectively work toward this vision. |
| **Start Where You Are** | MAPP is adaptable to a community's resources, skills, expertise, experience, and individual goals. It can be tailored to any community's starting point. Through iterative MAPP cycles, a community can reach its vision. |
| **Build Whole Community Partnerships** | MAPP emphasizes the critical role of partnerships in advancing health equity; it cannot be done by one organization alone. The success of MAPP depends on the community's ability to bring community members impacted by inequities, agencies, and organizations together to collaboratively guide MAPP. This requires fostering inclusion, developing deep and trusting relationships, and building community power and ownership of the MAPP process. |
| **Tell the Community Story** | MAPP fosters a shared exploration of whom inequities are adversely impacting, the origins of those inequities, and the community strengths and assets to address them through the three assessments, which value community voice as equally important to quantitative data. The community's voice is central to the assessments in the collection, application, and presentation of the community's story. |
| **Mobilize Community Action** | MAPP uses the power of partnerships built through the MAPP process to develop and apply strategies. |
| **Transform Systems** | MAPP advances equity through transforming the systems that maintain inequities. This includes addressing imbalances in power by forming alliances with community members to build community power, addressing the root causes of inequity, and working toward community-owned solutions. |

## *Foundational Principles*

The MAPP Foundational Principles were developed with the MAPP Evolution Steering Committee and field input to express the guiding values for the MAPP redesign. They outline a vision for CHI that aligns with the MAPP Theory of Change, as a community-led process to improve population health. Each component of MAPP was designed with these foundational principles in mind, to ensure it helps advance health equity through a community-driven process.

| FOUNDATIONAL PRINCIPLE | DESCRIPTION |
|---|---|
| **Equity** | Encourages shared exploration of the social injustices, including white supremacy, structural racism, class oppression, and gender oppression, that create and maintain inequities. Mobilizes community action to address these injustices through transformative change to the structures and systems that maintain inequities and creates the opportunity for all to achieve optimal health. |
| **Flexible** | Meets the real-time, evolving, and unique needs of diverse MAPP communities, organizations, and sectors through an adaptable framework. |
| **Continuous** | Maintains continuous learning and improvement through iterative community assessment, planning, action, and evaluation cycles. |
| **Community Power** | Builds community power to ensure those most impacted by the inequities and actions addressed through CHI are those that guide the process, make important decisions, and help drive action. |
| **Inclusion** | Fosters belonging and prevents "othering" by identifying and removing barriers to community participation and ensuring all stakeholders and community members, regardless of background or experience, can contribute to MAPP. |
| **Trusted Relationships** | Builds connection and trust by honoring the knowledge, expertise, and voice of community members and stakeholders. |
| **Data and Community Informed Action** | Identifies priorities, strategies, and action plans that are driven by the community's voice and grounded in community need as identified through timely qualitative and quantitative data. |
| **Strategic Collaboration and Alignment** | Creates a community-wide strategy that appropriately aligns the missions, goals, resources, and reach of cross-sectoral partners to improve community health and address inequities. |
| **Full Spectrum Actions** | Encourages community improvement through approaches ranging from provision of direct services to policy, systems, and environmental change and community power-building for supportive communities that enable health and well-being for all. |

# Who is Involved in MAPP?

To collaboratively pursue health equity, MAPP relies on a wide range of people, groups, and organizations representing and servicing community needs.

MAPP engages the entire **local public health system** (LPHS), which includes any organization or entity that contributes to the health or well-being of the community.[5] Members of the LPHS will highlight strengths and gaps in the system, opportunities for alignment, data collection and sharing, and participation in applying the CHIP.

To foster **community ownership**, MAPP involves community members in every step. Community members can take on roles with decision-making power and offer input on MAPP, even if they do not serve on a formal team or committee. Their roles and responsibilities can change over time depending on their interests, skills, and resources.

MAPP emphasizes the importance of engaging community **power-building organizations** (sometimes called grassroots or community organizers, or base-building groups). These groups represent the needs and shared vision of their community and can help advocate for change outside of government.[6]

Therefore, MAPP provides the opportunity to engage a wide range of community members, groups, agencies, and organizations such as the following:

- Local community power-building organizations
- Local government (e.g., city council, agencies for health, housing, and transportation)
- Private and non-profit community organizations
- Healthcare institutions and service providers (e.g., hospitals, community health centers, Federally Qualified Health Centers, clinics, laboratories)
- Faith-based organizations
- Schools and colleges
- Foundations and philanthropists
- Unions and other groups representing workers' needs

Many organizations can be sponsors who commit resources and give legitimacy to MAPP by demonstrating public support and endorsing the effort. Having the support of elected officials (county or city council) and those who informally influence public opinion (local media, community leaders) is helpful.

[5] Centers for Disease Control and Prevention. National public health performance standards. Retrieved April 11, 2023, from www.cdc.gov/publichealthgateway/nphps/

[6] Lead Local. Lead local glossary. Retrieved March 29, 2023, from www.lead-local.org/glossary

## Adaptability

MAPP is adaptable to your community. Your community may change which steps of MAPP you do, and how you do them, based on your resources (funding, staff time), experience, extent of partnerships, readiness to explore health equity, and more. Every community has unique goals and a unique vision to work toward in MAPP. Use your available resources and community's unique vision for a healthy future to determine how you alter MAPP to your needs.

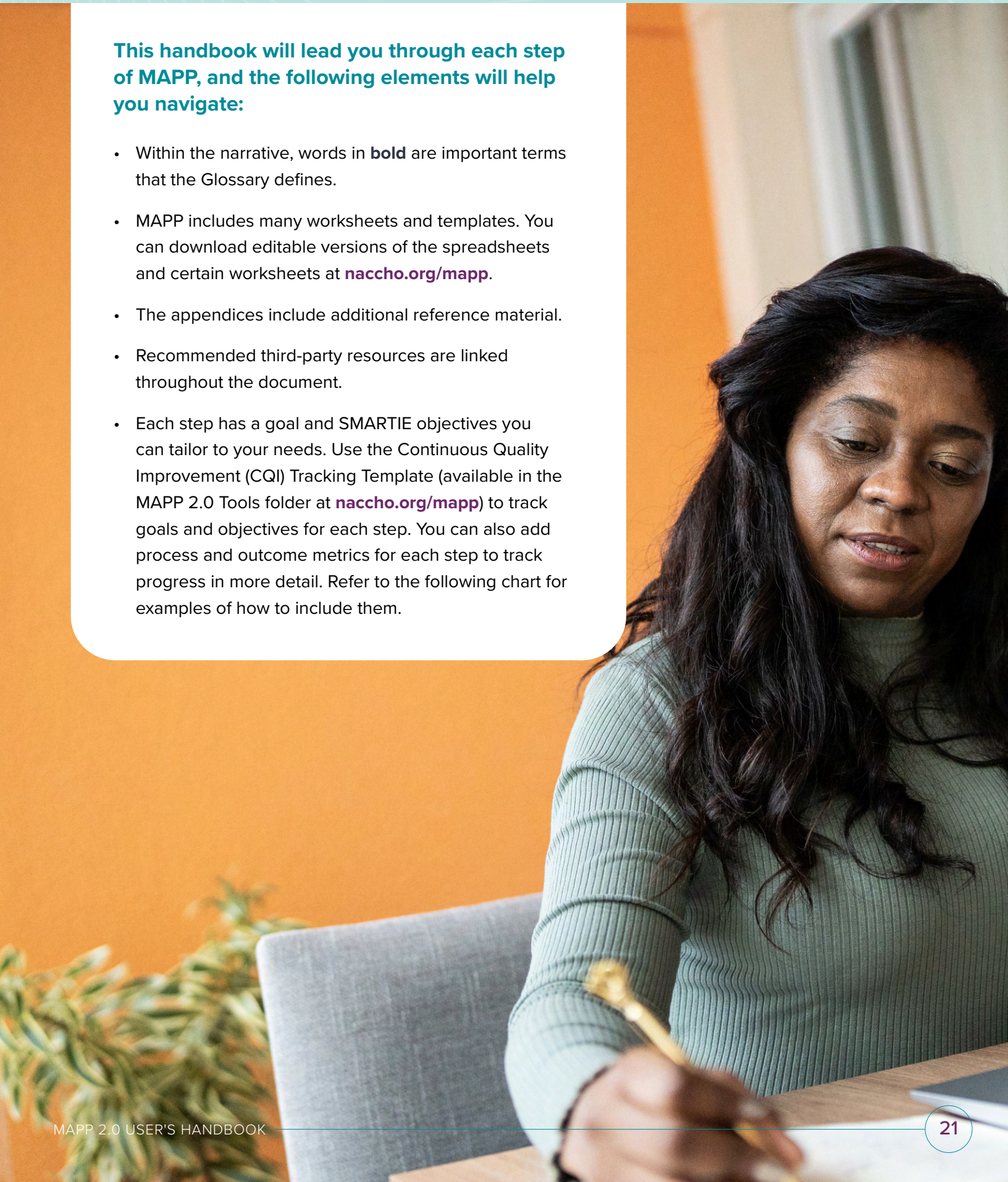
If your community does not have funding to support all the activities in MAPP, try to understand how this work could become part of other funded projects that stakeholders are leading in the community. Brainstorm projects and activities that align with the steps of MAPP to highlight opportunities to streamline the work. For example:

- *Are other coalitions or organizations recruiting partners to improve community health?*
- *Could agencies with funded staff support data collection and analysis?*
- *Could other organizations who are assessing and addressing community health priorities support the CH[N]A or CHIP?*
- *Are other organizations or groups discussing health equity with the community?*

# How to Use This Handbook

## This handbook will lead you through each step of MAPP, and the following elements will help you navigate:

- Within the narrative, words in **bold** are important terms that the Glossary defines.
- MAPP includes many worksheets and templates. You can download editable versions of the spreadsheets and certain worksheets at **naccho.org/mapp**.
- The appendices include additional reference material.
- Recommended third-party resources are linked throughout the document.
- Each step has a goal and SMARTIE objectives you can tailor to your needs. Use the Continuous Quality Improvement (CQI) Tracking Template (available in the MAPP 2.0 Tools folder at **naccho.org/mapp**) to track goals and objectives for each step. You can also add process and outcome metrics for each step to track progress in more detail. Refer to the following chart for examples of how to include them.

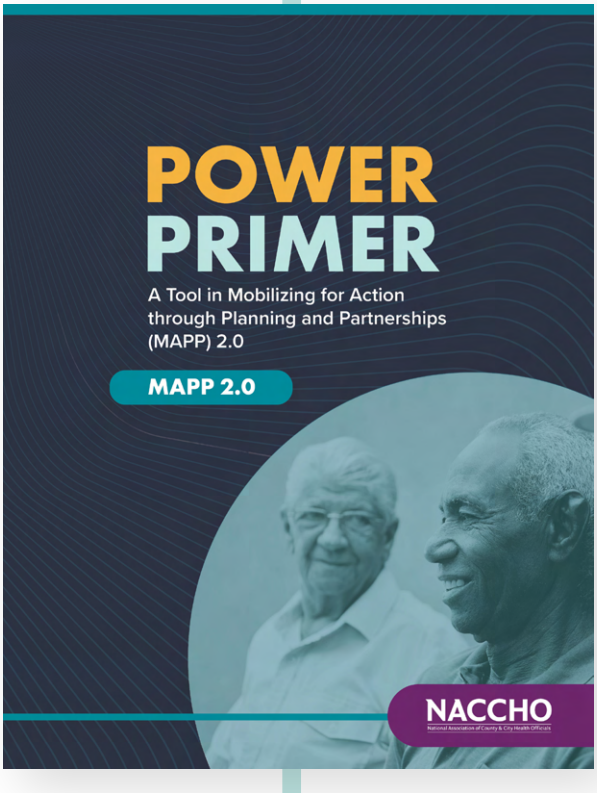


| GOAL | SMARTIE OBJECTIVES | PROCESS METRICS | OUTCOME METRICS |
|---|---|---|---|
| Create long-range outcome statements that broadly define the direction of the phase and desired outcomes. | Short to intermediate outcome statements describing what will be achieved in progress toward the goal. SMARTIE objectives are specific, measurable, achievable, realistic, timebound, inclusive of impacted populations, and promote equity. | Measures of whether the planned activities to achieve the objectives have been applied as intended. | Measures of whether the expected outcomes of the activities have been achieved (to determine if you have met your objective). |
| **Phase I, Step 2: Establish or Revisit CHI Leadership Structures** | | | |
| Establish a diverse core group and steering committee of community members and partner organizations to direct the process. | By XX date, confirm #XX people for the core group, inclusive of community members and local organizations.<br>By XX date, confirm #XX people for the steering committee. | # of sectors outside of healthcare invited to participate on the core group or steering committee<br># of organizations invited to have a representative on the steering committee | #XX members of the steering committee confirmed |
| **Phase II, Step 5: Develop Issue Profiles through Root Cause Analysis** | | | |
| Develop issue profiles of the issues identified using a root cause analysis. | By XX date, develop XX issue profiles for each issue developed in the previous step using a root cause analysis that includes descriptors/ contributors of the problem, priority community indicators, and potential solutions to address the issues. | # of fishbone diagrams completed<br># of "5 Why" worksheets completed | # of issue profiles developed<br># of priority community indicators identified |
| **Phase III, Step 4: Create Community Partner Profiles** | | | |
| Review and analyze community partner profiles for each partner selected to be on the priority issue subcommittee. | By XX date, XX partners complete a community partner profile to further align them with priority issues based on their ability to impact the issue. | # of partners asked to complete a community partner profile | # of community partner profiles completed |

# Helpful Resource: Power Primer

The MAPP Power Primer helps communities explore how power impacts health equity in their community and how to address power imbalances for a more equitable process. The Power Primer is for staff at LHDs and other organizations that facilitate MAPP (or CHI generally) and who:

- Are familiar with concepts and terms and have experience working in health equity, racial justice, and meaningful community engagement
- Want to better understand and practice naming and addressing power within their organizations and CHI processes
- Want to address power imbalances and dynamics in their MAPP process, change material conditions for communities, and win policy campaigns
- Are willing to take risks and offer each other grace as they face challenges and make mistakes together




The Power Primer is not an introduction to health equity. Rather, it explores the concepts of power and community power-building, which are closely connected to advancing health equity.

The MAPP Handbook also notes which power practices from the Power Primer apply at each step of MAPP.

To access the Power Primer, visit **naccho.org/mapp**.

# Getting Started: Is MAPP Right for You?

The first step is to decide whether MAPP is the right framework for your community. You will do a Starting Point Assessment in Phase I, but for now consider the following questions and characteristics of MAPP to determine if MAPP is a good fit.

| CHARACTERISTICS OF MAPP | MORE QUESTIONS FOR CONSIDERATION |
|---|---|
| **Is health equity part of our vision?** | |
| The goal of MAPP is to achieve health equity. This handbook will help your community examine what inequities exist, determine what drives them, and dedicate resources to advance health equity. | • Do our values align with those of MAPP?<br>• Are we ready to talk about equity?<br>• Are we willing to let go of old priorities? |
| **Are we interested in partnering with organizations across sectors?** | |
| MAPP involves the LPHS of organizations, agencies, and groups across sectors. It includes groups that may not be familiar with local public health. Part of your role will be to help all partners see their place in achieving the community's vision. | • How extensive are our networks with organizations across sectors?<br>• Do our partner organizations have the capacity to engage in MAPP?<br>• Could we join any community initiatives already occurring? |
| **Are we committed to authentic community engagement?** | |
| The community should be engaged in every phase of MAPP. Community members can take leadership roles and provide guidance and feedback. Prioritizing this will require resources (to the extent possible) to help community members participate (stipends, vouchers, childcare, meals, etc.) | • What is our relationship, and our partners' relationship, with the community?<br>• Are we ready to give decision-making authority to the community?<br>• Can we prioritize community engagement and dedicate resources to support it? |
| **Can we dedicate the necessary time?** | |
| A MAPP cycle can take up to two years, before applying the CHIP. This requires significant energy, investment from partners, clear vision, and project management. After completing one cycle, parts of MAPP can be updated rather than redone completely. | • What is our collective capacity to complete a MAPP cycle?<br>• What might prevent us from completing a MAPP cycle?<br>• What resources can we use? |

If your answer to many of these questions is "No," you might use these questions to guide conversations about what is needed to prepare for a successful MAPP cycle.

If your answer to many of these questions is "Yes," then MAPP is the right framework. Keep reading to begin *Phase I: Build the Community Health Improvement Foundation*.

# PHASE I: BUILD THE COMMUNITY HEALTH IMPROVEMENT FOUNDATION

## Introduction

*Phase I: Build the Community Health Improvement Foundation* includes activities that build commitment and ownership among a wide variety of participants to set the stage for the rest of MAPP. This phase includes guidance for building relationships with community members and organizations so the people involved in MAPP represent the entire community.

In this phase, community members will develop a shared vision for the community and its health. Additionally, you will build strategic relationships with partners, prepare for the CH[N]A, and create a steering committee and workgroups to advance MAPP. This phase is foundational to the rest of MAPP and requires time, energy, and creativity.

Use the MAPP Workplan Template, MAPP Budget Template, and Budget Guidance to plan your MAPP process. You'll refine the process throughout Phase I, which includes guidance for assessing and aligning resources, and throughout MAPP.

### GOALS:

- Involve community members who represent populations experiencing inequities to guide and participate in MAPP planning
- Build strategic relationships with new and existing partners to engage throughout MAPP
- Establish the MAPP Core Group and Steering Committee that represent the community
- Develop a shared understanding of MAPP and the community's vision for the future
- Evaluate what resources are available and needed to achieve MAPP's goals effectively
- Create workgroups to build the infrastructure for CHI

## OUTCOME METRICS:

- # of new and existing community organization partners re/engaged with MAPP
- # of community organizations represented on the steering committee
- % of steering committee members from communities experiencing inequities
- # of workgroups established for CHI infrastructure priorities

## STEPS:

1. Do a Stakeholder and Power Analysis
2. Establish or Revisit CHI Leadership Structures
3. Engage and Orient the Steering Committee
4. Establish Administrative Structures for MAPP
5. Develop the Community Vision
6. Do the Starting Point Assessment
7. Identify CHI Infrastructure Priorities and Develop Workgroups
8. Develop the Workplan and Budget

### After completing Phase I, you will have answered the following questions:

- Whom should we include in MAPP?
- What will be the leadership and administrative structure of MAPP?
- How do we define our community?
- What is the community's vision for the future?
- What is our mission and what are our values?
- What resources are available and needed for MAPP?
- What are our goals for this MAPP cycle?
- How will our community proceed through MAPP?



# Definitions

Before starting Phase I, review the following types of groups to get an idea of the different ways people can become formally involved in MAPP:

- **Core Group:** Two to three people lay the groundwork for MAPP by devoting initial resources such as staff time or funding. They regularly support and lead MAPP to ensure it moves forward. This is likely the group of people involved in MAPP from the beginning.
- **Steering Committee:** A broad group of 10 to 12 stakeholders directs MAPP. The stakeholders represent the community's populations and organizations. The steering committee includes people with resources, community members, and critical public health sectors.
- **CHI Infrastructure Workgroups:** Three to four groups lead strategic projects to improve MAPP. They are established at the end of Phase I, and their focus areas are based on the results of the Starting Point Assessment. Topics might shift after Phase II.

Additionally, review these glossary terms, which will be used in Phase I: **stakeholder, health equity, root causes of health inequity, social determinants of health**

# Step 1: Do a Stakeholder and Power Analysis



| | |
|---|---|
| **GOALS** | • Do a Stakeholder and Power Analysis to understand the characteristics of all that have a "stake" in MAPP and CHI efforts.<br>• Assess how best to use stakeholder characteristics to identify and build relationships. |
| **SMARTIE Objective** | By XX date, identify #XX stakeholders to add to the Stakeholder Analysis Table. |
| **Supplemental Tools/Resources** | • Stakeholder Brainstorm Toolkit (Appendix B)<br>• Tips for Planning Meetings (Appendix C)<br>• Stakeholder Analysis Table (in MAPP 2.0 Tools folder) |

## Introduction

MAPP is a process for collective action among many stakeholders, who assist in the process and inform it. As you dive into MAPP, you must first consider all the people involved in and impacted by the CHI process. The Stakeholder and Power Analysis is a dynamic process to identify and assess the power, interest, influence, and importance of people, organizations, and institutions that can impact MAPP or be impacted by it.

Many people are involved in MAPP who can influence the process through their power, resources, lived experiences, and relationships. For example, they might have relationships with communities experiencing inequities or provide historical community context. **Stakeholders** are all persons, agencies, and organizations with an investment or stake in the health of the community and the LPHS. They include people and organizations that receive or deliver services that promote the public's health and well-being. Throughout this analysis, think broadly about potential stakeholders and consider all who have an interest or stake in improving community health.

The Stakeholder and Power Analysis will help you understand who has the power to make decisions, or advance or stop efforts, in order to engage them effectively. Knowing your stakeholders better positions you to manage, engage, and turn them into advocates and supporters of MAPP in your community. Furthermore, appropriately engaging stakeholders can help build relationships, create sustainable change, and increase the success of MAPP.

Additionally, this analysis will also provide the foundation for looking at the systems of power, privilege, and oppression that impact your community. You will consider the role of the community and the powers that impact it. Keep in mind how your community interacts with the CHI efforts and how you can challenge system norms in MAPP.

To assess and build these relationships, the Stakeholder and Power Analysis involves the following steps:

1. **Brainstorm** potential stakeholders to engage in MAPP. Through a visual brainstorming process, you will identify and create an initial list of people, partners, organizations, coalitions, and other groups.
2. **Gather** all known stakeholder information into a Stakeholder Analysis Table to further analyze their connections to MAPP. Refer to this table throughout the process to assist with the various activities, assessments, and resources needed.
3. **Consult** with stakeholders by holding short interviews to understand more about them and other stakeholders. Use interviews to fill in the chart and to add stakeholders to the list.
4. **Analyze** your Stakeholder Analysis Table. Through a series of analyses, you should gain a full picture of your stakeholders, how they can contribute to MAPP, and how best to engage them.
5. **Interpret Results Collectively.** Look at the results of your analyses as a whole and reflect on how best to start engaging stakeholders.

## Instructions

### 1. BRAINSTORM STAKEHOLDERS

#### *Compile existing information*

Start by adding existing information about the agencies, organizations, and people who were involved in previous CHI cycles or community health activities to a Stakeholder Analysis Brainstorm List, such as the one below, whether you plan to engage them or not. This list is a starting point for you to consider who has and has not been represented, and you can expand it as needed.

| Stakeholder Name | Section/Community Represented | Comments/Notes |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## *Collectively brainstorm*

Now, extend beyond your known network and consider all stakeholders you might want to engage. Remember, stakeholders are not always partners; they are people with a stake in MAPP and the community. Consider, "What people or groups of people are likely to be affected by MAPP?" and "Who might influence MAPP or the community it serves?" Think broadly and build out the list thoroughly.

To identify, communicate, and develop strategies to achieve health equity and promote MAPP, the team must mobilize, organize, and engage community members. Anyone who works, learns, lives, and plays in your community might have a role in MAPP because they have expertise about what works well in their community, what issues affect their ability to live a healthy life, and what resources improve health. Include community groups and populations impacted by inequities in your list.

Consider this diverse range of stakeholders throughout the brainstorm:

- Population groups that are affected by health inequities due to racism, gender inequity, socioeconomic status, and other structural inequities
- People interested in improving community health, who contribute to improving community health, and who are informed about those efforts (e.g., elected officials, health inspectors, housing advocates, environmentalists)
- People and organizations with decision-making authority over MAPP
- People with the knowledge and power to influence policies, investments, and laws that contribute to (or can address) health inequity
- People and organizations with expertise in data analysis and measurement of social, economic, and health inequity indicators
- Groups that can communicate the causes of health inequities in a way that inspires people to work on achieving health equity
- Organizations that involve community members and uplift their voices and identities
- Facilitators who can create an environment that leads to productive discussions about health inequities and possible solutions or collaboration

Additionally, consider these guiding questions as you brainstorm:

- Who is responsible for making decisions that might affect MAPP?
- Are there policies or programs emerging or in existence that will benefit from or be affected by this work? If so, who needs to be informed?
- Which organizations or coalitions represent and uplift our local community?
- Which people are likely to be affected by the outputs of this work? Who, although not directly affected, may be interested in the results of this work?
- Who has been involved in similar projects in the past?
- Which groups or people might provide relevant information, data, equipment, or resources?
- Who is likely to have a negative view of MAPP?
- Which stakeholders are essential to involve? Who is it preferable to involve? Who needs to be consulted? Who needs to be informed?
- Which parties are likely to be the most influential?
- Who will be critical to the MAPP planning, assessments, and implementation?
- What organizations have community members in decision-making roles (e.g., boards, coalitions), who can help us model the same principle?

Additionally, use the Stakeholder Brainstorm Toolkit, which includes diagrams and classifications that can reveal stakeholders your team might not have considered.

There is no limit on how many stakeholders to include on this list; however, keep it manageable.

## *Narrow down the list (optional)*

If you have a large list of stakeholders after your brainstorm, prioritize a shorter list of stakeholders to analyze in more detail based on your goals for MAPP and your team's capacity.

Consider the following to select your short list of stakeholders for analysis:

- Stakeholders who have the greatest stake in MAPP. For example:
    - What groups and communities will be impacted by MAPP and therefore should be involved? Who represents their needs or works with them?
    - Who can offer the most critical resources?
    - Who will help expand the reach of this CHI process to more community members?
- Priority areas from the most recent CHI cycle and the communities influenced by them. For example:
    - Organizations that work closely with community members affected by those priority areas
    - Government officials and organizations related to local policies or laws that are relevant to your past or current MAPP cycle

Create a new list with these selected stakeholders. You will transfer this list later to the Stakeholder Analysis Table.

## 2. GATHER STAKEHOLDER INFORMATION

### *Create and fill out the stakeholder analysis table*

The Stakeholder Analysis Table provides a uniform way to document information about stakeholders. It allows you to find and compare stakeholders at a glance and is referenced throughout MAPP, especially when there is an opportunity to invite more people to participate.

First, make your own Stakeholder Analysis Table. This is the information captured in the Stakeholder Analysis Table template. You can add categories to this list, but the categories below will be used in future analysis, so do not remove any.

| CATEGORY | DESCRIPTION |
|---|---|
| **Organization** | Name of organization or person, including contact information |
| **Knowledge of Community Health Improvement (CHI) Efforts** | The stakeholder's estimated level of knowledge about CHI or MAPP. This will help you identify stakeholders that have CHI expertise and those who may need more information or guidance before fully engaging in MAPP. Scored from 1 to 3. |
| **Knowledge of Community Needs** | The stakeholder's level of knowledge about specific community needs. Add notes about their expertise. *Scored from 1 to 3.* |
| **Interest** | The stakeholder's interest in the local MAPP process or advantages and disadvantages that MAPP may bring to them or their organization. This will help you better understand their position and address their concerns. |
| **Alliances** | To whom is the stakeholder loyal or accountable? Alliances are important to MAPP and can assist with data sharing, resources, communication efforts, and more. These alliances can also encourage nontraditional stakeholders to get involved and can create an ecosystem of care that promotes community health. |
| **Resources and Skills** | The resources and skills—human, financial, technological, political, analytical, etc.—available to the stakeholder and his or her ability to mobilize them |
| **Power** | The ability of the stakeholder to affect the implementation of MAPP based on his or her resources that are critical to MAPP, leadership or organizing abilities, influence over local organizations and communities, or relationships with others in power. *Scored from 1 to 3.* |

Transfer your selected stakeholders from the Stakeholder Analysis Brainstorm List to the Stakeholder Analysis Table and fill in information for each. Fill out the chart as thoroughly as possible now so you can reference it later. You can clarify any missing information in the interviews that follow.

For more information and instructions on how to develop and fill out the Stakeholder Analysis Table, refer to the examples and scoring mechanism on the template.

## 3. CONSULT WITH STAKEHOLDERS

### *Identify gaps in knowledge*

Your team probably does not know every stakeholder on the Stakeholder Analysis Table or have expertise in every field related to the community's health. Now, you will interview individual stakeholders to understand their stake in more detail.

To help you identify whom to interview, consider the following:

- What important information is missing from the table?
- What information do you wish you had gathered about your stakeholders and partners during your last CHI cycle?
- What skills, expertise, or resources would have been helpful to have?
- Which columns have more information than others?
- What information do you hope to compare across stakeholders?

If your table is mostly filled out, focus on expanding your stakeholder list. Consider the following:

- What kinds of organizations were not considered, and who can help identify them?
- Which stakeholders or partners understand MAPP or CHI enough to recommend more stakeholders?

Document the extra information you would like to gather and brainstorm about who can provide it.

## Choose two to three priority people to interview

Now that you have identified the information to gather, your team will plan for and hold two to three interviews to fill in the gaps. The interviews should expand upon the information in your table and reveal other stakeholders. You can hold more interviews based on your team's time and capacity.

To focus your interviews, think about any information missing from the Stakeholder Analysis Table that would help you to understand the network of people around MAPP. Consider those who interact with the community, systems, and policies (e.g., hospital systems, local business, community organizations). To be thorough, you could interview a few different kinds of stakeholders:

| PEOPLE TO INTERVIEW | EXAMPLES |
|---|---|
| 1. A person who has strong relationships with the stakeholders and who can help you identify the following about all or most of them:<br>• Skills, resources, knowledge, and power of stakeholders<br>• Other stakeholders to interview | • People with influence in the community and strong, diverse alliances<br>• People with much knowledge of CHI, community needs, and stakeholders<br>• Community health strategists<br>• Executive staff at public health organizations<br>• Local hospital program/management staff<br>• People who work directly with the community |
| 2. A stakeholder you don't know much about but you know is important for MAPP. This interview is directly focused on *that person's organization alone*. | • LPHS organizations outside of health/healthcare (community organizers, businesses, faith-based organizations, etc.) |
| 3. A stakeholder who is working to advance health equity and who can provide information about community needs and other stakeholders and identify other important people to add to the table. | • Knows about CHI or community needs<br>• Has power to influence community engagement or public opinion or organize community members around a cause<br>• Can advise on transferring power to community members and uplifting community voice |

## Prepare for interviews

Now that you have identified people and organizations of interest, plan your interviews with each selected stakeholder to gather the desired information and build new relationships.

- Send a personal invitation with the following:
    - An introduction to yourself, your organization, your goals for MAPP, and the Stakeholder and Power Analysis
    - A genuine reason for why you are requesting an interview and why their input is valuable
    - Clear information about how the information you gather will be used (e.g., to help you figure out whom else to invite to participate in MAPP)
    - An explanation that interviews will be recorded or you will take notes with their permission
- Select a space that is comfortable for the person—a central location in your community (e.g., coffee shop, community center) or near the person's workplace—or schedule a virtual meeting.
- Schedule enough time to have a thorough discussion without being too long (e.g., 30–60 minutes).

## *Develop and use your interview protocol*

- Include an informative introduction about the goals for MAPP and the interview and how the information will be used.
- The questions you select for your interview protocol depend on the stakeholder and information you want to gather. You might do the following:
    - Ask people to react to the priorities and players in past CHI cycles or to the current identified stakeholders.
        - Do you have any impressions on this list of stakeholders? (Reference the brainstorm list.)
        - Which stakeholders from this list have you worked with before?
        - How would these priorities resonate with the people you work with?
    - Allow interviewees to add their own ideas of whom to involve and what they know about them.
        - Whom else would you add to this list to help identify or address community needs?
        - What other community health coalitions, partnerships, or initiatives in the community should we be aware of?
    - Use "if...then" scenarios to determine interviewees' knowledge of their experience with CHI efforts and the stakeholders involved.
        - If your organization is planning a CHI process, then whom would you invite to participate as a partner?
        - If your organization wanted to shift community power, then what organizations would you engage?
    - Ask organizations about their work and impact on the community (do your own research first).
        - What are your current priorities at your organization?
        - How has your organization been involved in CHI efforts in the past?
        - Would you be interested in participating in this MAPP process?
- Close by thanking the person for their time. Ask if they would like to stay in touch or up to date on MAPP. Ask if they have any questions. Explain how they can get involved and reaffirm the value you think they would bring to the work.

After each interview, add the new information to the Stakeholder Analysis Table. Consider the following and note the answers in the table:

- Which stakeholders were mentioned often by those interviewed?
- What were their impressions of other stakeholders or their organizations?
- Were there helpful suggestions for implementation or information on how stakeholders might be impacted by MAPP?

## 4. ANALYZE STAKEHOLDERS AND PREPARE FOR THEIR ENGAGEMENT

At a glance, your Stakeholder Analysis Table might be overwhelming. With more insight, your team will be able to strategically manage and engage these stakeholders. You will do the following analyses of your stakeholders to determine their potential roles in MAPP and add more information to your Stakeholder Analysis Table:

- **Primary, Secondary, and Key Stakeholders:** Categorize stakeholders based on their impact on MAPP, the effect MAPP will have on them, and their general interest in MAPP.
- **Alliance Analysis:** Assess stakeholders' alliances to promote more collective action and expand your network.
- **Knowledge Analysis:** Explore stakeholders' knowledge of MAPP, the CHI process, and community needs.
- **Power Analysis and Mapping:** Classify stakeholders according to their power over MAPP and their interest in it, highlight decision-makers with power to impact the community both positively and negatively, and determine the focus of your engagement plan.

After completing your analysis, you will be able to answer the following questions:

- Which stakeholders understand community needs, and what is the best way to engage them?
- Which stakeholders have the most power over the success of MAPP, and how can we increase their interest in MAPP?
- Who has an interest in MAPP's success that we could involve or encourage to spread the word about MAPP?
- Who might stand in the way of MAPP's success?
- What other partnerships and alliances will expand our network of partners and resources?

### *Primary, secondary, and key stakeholders*

On the Stakeholder Analysis Table, critically look at your stakeholders' characteristics and organize them into the following categories. This simple categorization helps you easily organize and reference your Stakeholder Analysis Table.

**PRIMARY STAKEHOLDERS**

- Directly affected (positively or negatively) by MAPP
- Benefit from MAPP outcomes
- Might include a specific population, residents of a designated geographic area, people at risk for poor health outcomes, people in a particular institution or program (e.g., students at school, welfare recipients)

**SECONDARY STAKEHOLDERS**

- Indirectly affected (positively or negatively) by MAPP
- Directly involved with or responsible for beneficiaries of MAPP outcomes (e.g., family members, friends, doctors, social workers, human service organizations, community volunteers)
- Jobs or lives might be affected indirectly by the efforts (e.g., police, emergency room personnel, property owners, contractors, employers)

**KEY STAKEHOLDERS**

- Have an influence on MAPP (e.g., agency leadership, government officials, policymakers, state and federal agencies, influential community members, media)
- Have an interest in the outcome of MAPP, even if they will not be impacted by or involved in it (e.g., businesses, advocates, community activists, academia, researchers, funders, and the community at large)

## *Alliance analysis*

The alliance analysis helps you understand the network of organizations in the community and identify stakeholders of interest. Look at your Stakeholder Analysis Table and consider the following:

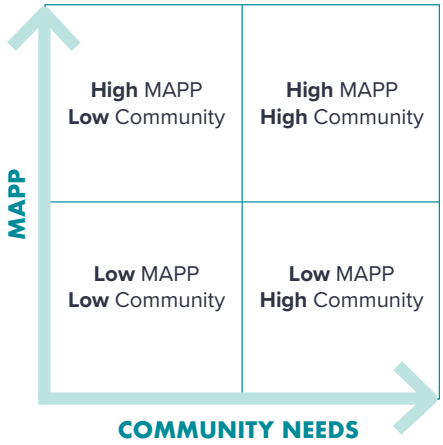
- What alliances exist, formally or informally, between stakeholders?
- What alliances potentially support or threaten MAPP?
- Which stakeholders can be a bridge between your team and other organizations and groups?
- How might these relationships impact MAPP?

Reference the jellybean diagram from the Stakeholder Brainstorm Toolkit for a reminder of different sectors to consider. Note these alliances on your Stakeholder Analysis Table. Using this information, your team can form an idea of how to combine and maximize resources across organizations or develop specific strategies in the CHIP based on relationships between organizations. Additionally, you can use these relationships to encourage collective action.

## *Knowledge analysis*

The Stakeholder Analysis Table includes your estimated score of each stakeholder's knowledge of MAPP and community needs. Although two stakeholders might have similar roles or serve the same or overlapping communities, they might not have the same knowledge of these two things.

Using the information from the Stakeholder Analysis Table, map each stakeholder onto a grid like the one here.




### Interpreting the Results

This information will help you decide whom to engage in MAPP, when to engage them, and how to tailor communication to them. Note the suggested engagement methods in bold. Add notes to your Stakeholder Analysis Table based on these conclusions.

| KNOWLEDGE OF MAPP/CHI | | |
|---|---|---|
| | **High MAPP/Low Community**<br>People who know a lot about MAPP or CHI but not community needs<br>**Leverage their skills and interest to assist with MAPP and get others involved. Do not prioritize their opinion on community needs over that of people with more expertise.** | **High MAPP/High Community**<br>People who know about the CHI process and community needs<br>**Prioritize continuing their engagement. These stakeholders are ready to contribute meaningfully right away. Ask if they can identify anyone else to involve.** |
| | **Low MAPP/Low Community**<br>People who are not aware of MAPP or community needs and strengths to improve equity<br>**Do not prioritize their engagement but consider if they have resources to offer.** | **Low MAPP/High Community**<br>People who know about community needs and strengths but not CHI as a resource. Includes those experiencing inequities.<br>**Prioritize getting to know them and sharing how MAPP can help address needs.** |
| | **KNOWLEDGE OF COMMUNITY NEEDS** | |

## *Power analysis and mapping*

Power is dynamic and relational, and one person's power changes depending on the context they are in. Power imbalances are reproduced through political, social, and economic systems designed to concentrate power among some and exclude others. A foundational principle in MAPP is building community power, which means uplifting community voices and building community power to ensure those most impacted by inequities and the CHI process guide the process, make important decisions, and drive action.

In this analysis, "power" is considered the ability of a person or organization to influence the success of MAPP. Specifically, it is the ability to control the processes of setting agendas, distributing resources, making decisions, and determining who is included or excluded from these processes.[7] For a deeper exploration of power, and how to transfer power over MAPP to community members, refer to the Power Primer.

Understanding the power of stakeholders will help you know whether to engage them in MAPP early, as allies, or if you will need to work around them in the future to do MAPP activities (like the assessments or CHIP). The power analysis is a working session with various tools that will help you determine who has that power. It will also provide the groundwork for your team to consider the systems of oppression that impact your community.

Here are the assumptions and goals[8] guiding the power analysis:

### Assumptions of the Power Analysis:

- Power relationships are unequal, resulting in systemic problems and conditions that affect community health.
- Systemic root causes create community health inequities, and power is being exercised through them. We must develop strategies that address these realities.
- Understanding stakeholder power and how it is exercised is necessary for achieving long-term progressive social change.

### Goals of the Power Analysis:

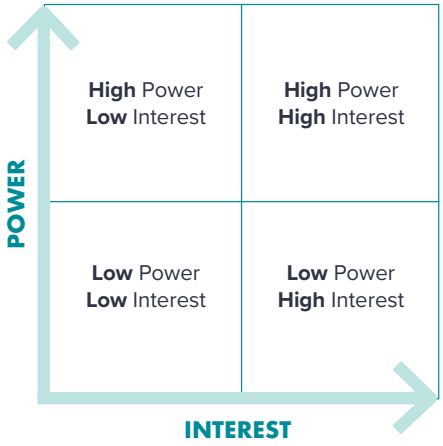
- Produce a picture of current power relations for a given set of stakeholders that interact with the community and MAPP
- Develop a shared understanding and language of what power is and how it can influence decision-makers and change power relations
- Identify the most promising stakeholders with whom to focus efforts to organize and build relationships that will advance MAPP
- Develop effective strategies to transfer power and encourage community ownership through MAPP to build power and win social change

The analysis includes two activities:

- **Power and Interest Mapping:** This activity will organize stakeholders into four categories based on their power over the MAPP process and interest in its success.
- **Decision-Makers and Targets:** This activity will highlight the decision-makers with power to impact the community both positively and negatively and targets of the social action; these groups will be the focus of your engagement plan.

[7] VeneKlasen, L., & Miller, V. (2002). *A new weave of power, people & politics: The action guide for advocacy and citizen participation.* Oklahoma City: World Neighbors.

[8] Ward, C., & Thompson, A. (2007, November). *Power analysis* -- trainer-training.* Retrieved March 29, 2023, from www.ctbh.org/documents/Power_Analysis_Trainer_Training.pdf. Northeast Action Training. (Adapted from)




## POWER ANALYSIS ACTIVITY 1: POWER AND INTEREST MAPPING

**Purpose:** Classify stakeholders according to their power to advance or block efforts in MAPP and interest in the outcomes of MAPP.

**Power and Interest Mapping Descriptions and Examples**

| AREA OF ANALYSIS | EXAMPLES |
|---|---|
| *Power* over MAPP refers to a person's or organization's influence over the implementation of MAPP, including CHIP strategies. Consider the following:<br>• Which stakeholders make decisions that directly impact the community?<br>• Who makes decisions that directly impact MAPP?<br>• Who else in the community can influence this group of decision-makers? | • Leadership responsible for allocating core funding and resources or who give legitimacy to MAPP<br>• Community members, groups, or organizations who influence public opinion and can encourage or deter people from becoming involved<br>• Existing coalitions who do similar work in the community and who could become involved in MAPP or resist joining<br>• Leadership of community organizations likely to help with the assessments or implement CHIP strategies<br>• Local foundations with funding for MAPP<br>• Members of local government who advocate for or against discussing and addressing inequities |
| *Interest* in MAPP refers to a person's or organization's likely interest in MAPP due to the positive or negative effects it could have on them. Even if they are not aware of MAPP, they could be categorized into "High Interest" if MAPP will significantly impact them.<br>Consider the following:<br>• What are the advantages and disadvantages of MAPP to them?<br>• Why might they be interested in getting involved in MAPP?<br>• Do they want MAPP to be successful? | • Community organizations interested in working more closely with MAPP, local public health, or in receiving funding now or in the future<br>• Community members who could have access to new services as a result of MAPP<br>• Local public health leadership interested in seeing the success of a MAPP process<br>• Staff responsible for meeting requirements through CHI (e.g., LHD accreditation or non-profit hospital tax-exempt status through community benefit) |

Review one stakeholder at a time and classify each according to power over MAPP and interest in it. Use a piece of paper to map your list of stakeholders on a power/interest grid like the one on the previous page. If your list of stakeholders is large, consider mapping only the key stakeholders that you determined were important to engage based on their knowledge, alliances, or interview answers. Add the information about their power and interest to the Stakeholder Analysis Table.

**Interpreting the Results:** The position you assign to a stakeholder on the grid can assist you in the management step and the activities throughout MAPP. Stakeholder management is the process by which you identify key stakeholders and gain their support. In MAPP, it is also about transferring power and uplifting community voices.

Use the following table of classifications and considerations to understand how to engage stakeholders.[9] Remember, you might still need to engage stakeholders with low power and low interest in unique ways.

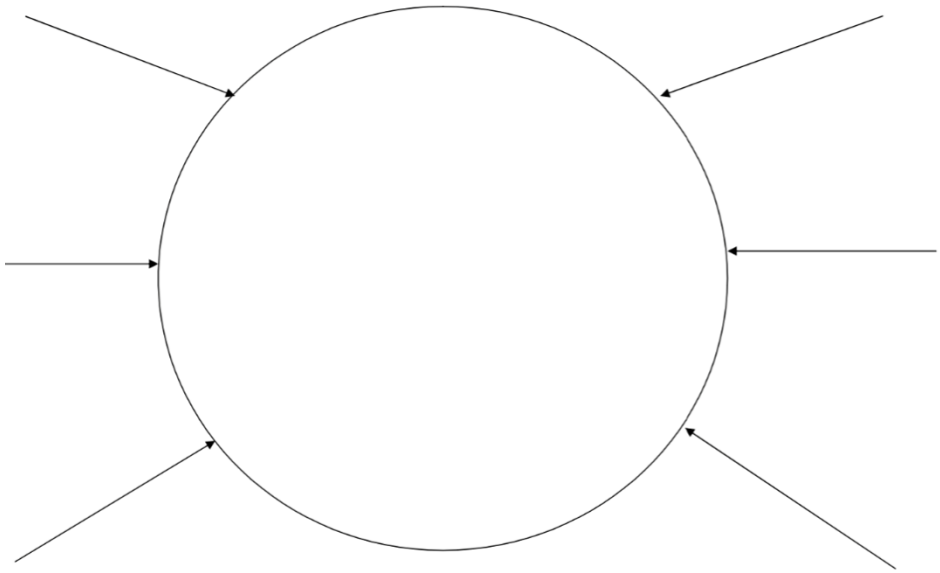
| POWER | | |
|---|---|---|
| | **High Power/Low Interest (Latent)**<br>People who are usually unaffected by MAPP but could be extremely helpful if they became involved<br>• Keep them informed and connect periodically without overwhelming them<br>• Identify opportunities to use their resources<br>• Offer opportunities for their input<br>*Consider the following:*<br>• Could the work benefit from their influence?<br>• How do we increase their interest and commitment?<br>• How can we use their resources despite their low interest? | **High Power/High Interest (Influencers)**<br>People who are invested in the outcomes of MAPP and can help or harm its success<br>• Cultivate or monitor these relationships<br>• If their interest aligns, provide meaningful roles (not tasks) they will enjoy<br>• If their interest does not align, avoid conflict or have meaningful conversation to find alignment in your values<br>*Consider the following:*<br>• Is their influence beneficial or harmful?<br>• How are they already influencing the work?<br>• How can we encourage them to use their power in a positive way? |
| | **Low Power/Low Interest (Apathetic)**<br>People who do not require management<br>• Don't overwhelm them with communication but keep them informed (e.g., through newsletters)<br>• Occasionally revisit if they should participate in MAPP if their power or interest changes<br>*Consider the following:*<br>• Should we start involving them in the work?<br>• If we determine MAPP will impact them, how can we promote the benefits of MAPP to them to increase their investment? | **Low Power/High Interest (Defenders)**<br>People who are invested in the outcomes of MAPP but do not have power to influence<br>• If their interests align (achieving equity), invite them to participate and increase their influence in MAPP<br>• If their interest somehow conflicts with MAPP, ensure no major issues arise<br>*Consider the following:*<br>• What has their role been to date?<br>• What are their views?<br>• How can we grow their power in the process? |
| | **INTEREST IN MAPP** | |

[9] Kent County Essential Needs Task Force. Equity toolkit: Tool 3, power matrix. Retrieved March 29, 2023, from http://entfkent.org/about/equity-resources/tool-3-power-matrix/

# POWER ANALYSIS ACTIVITY 2: EXPLORING POWER—DECISION-MAKERS AND TARGETS

**Purpose:** You have already considered who has an influence on MAPP and who will be affected by it. Exploring that power through more mapping can help identify the specific systems with that power to affect MAPP.

In this activity, you will identify (1) who is in the community; (2) which decision-makers impact them, both positively and negatively; and (3) which decision-makers you will target for engagement.



## Instructions:

1. Diagram the community. What makes up the whole community? Write all the specific parts of your community inside the circle (e.g., schools, local businesses and organizations, hospitals, police departments). Rely on your Stakeholder Analysis Table to fill in the circle.
2. Which elements of the community contribute to CHI efforts? Look at the drawing of the community and highlight or circle the different entities that influence these efforts.
3. Larger systems will also affect your community. Identify the larger systems that directly influence the community's health/CHI efforts and place them on the arrowed lines around the circle.
4. What is the relationship between those services within your community and the larger systems? List those relationships below the diagram to refer to later (e.g., tobacco advertisements placed in local stores are controlled by the local system of media).
5. Now that you have identified the systems, think about the relationship between those systems. How do they affect each other? Indicate this on the diagram by drawing an arrow connecting the systems. For example, if tobacco companies sponsor events in the community, draw an arrow showing the relationship between the tobacco industry and the system (media) that controls the advertisements through sponsorships.

**Interpreting the Results:** Use the information above to summarize who has power in your community, the nature of their power, and your target stakeholders for engagement.

| **WHO HAS THE POWER?**<br>Who has the power in your community? | **WHAT IS THAT POWER?**<br>What kind of power do they hold? What resources do they control? | **POTENTIAL TARGET**<br>Of those who have power, identify potential targets who are necessary to build relationships with to achieve the desired outcome. Be specific (organizations, people, etc.). |
|---|---|---|
| | | |
| | | |
| | | |

Consider the following:

- How can you best engage your identified targets throughout MAPP?
- How can you use the diverse power of your stakeholders?
- How can you engage organizations or people that work within that system?
- How can you influence this group or person?

## 5. INTERPRET RESULTS COLLECTIVELY

At this point, you have two lists: general list of all stakeholders and Stakeholder Analysis Table outlining who your stakeholders are, their investment in the process, and their power. Both lists are important. One helps you frame your efforts, and the other helps your team in active engagement. Additionally, the lists help your group understand the power and systems in their community.

Remember, the Stakeholder and Power Analysis is useful only if you actually use the information gathered. Stakeholders are not only those involved in the MAPP Core Group, Steering Committee, subcommittees, and workgroups but also those with a stake in MAPP and the community. Although not all stakeholders will take part in MAPP, you should understand how they impact MAPP and how your efforts will impact them.

Now that you have completed your Stakeholder Analysis Table, consider the following:

- Who is of highest priority to engage in MAPP?
- Whom do we need to engage quickly?
- Who will require more strategic planning to engage effectively?

Stakeholder engagement will begin now, and continue throughout MAPP, starting with development of leadership structures in Step 2.

### POWER PRACTICES FROM THE POWER PRIMER

**4. Build—Cultivate Relationships with Communities and Partners**

# Step 2: Establish or Revisit CHI Leadership Structures

**GOAL**

Establish a diverse core group and steering committee of community members and partner organizations to direct the process.

**SMARTIE Objectives**

- By XX date, confirm #XX people for the core group.
- By XX date, confirm #XX people for the steering committee.

## Introduction

Use the information in your Stakeholder Analysis Table to help identify members of the core group and steering committee, and people and organizations to engage in the future.

## What are the Opportunities to Participate in MAPP?

MAPP is led by two formal committees. The **core group** (two to three people) does most day-to-day work and dedicates the most time, and the **steering committee** (10 to 20 people) provides direction and community input and focuses everyone on the vision.

Additionally, each phase has one group that oversees the core activities of that phase:

- In Phase I, **CHI infrastructure workgroups** are set up to support foundational resources for MAPP (such as partnership development or funding).
- In Phase II, the **assessment design team (ADT)** leads the implementation of the three assessments. The ADT might dissolve after this phase.
- In Phase III, **priority issue subcommittees** oversee the implementation of each priority in the CHIP.

Refer to the following table for a summary of the MAPP implementation groups and their work. Send personal invitations to steering committee members now because their participation will begin right away. Personalize your invitations with details about why their participation is valued and how MAPP might benefit their work.

### *Examples of How People can Get Involved in Multiple Phases of MAPP*

**Derrick,** the executive director at a Federally Qualified Health Center, is on the steering committee and joins an issue profile group focused on improving access to care in Phase III.

**Carmela,** an epidemiologist at the LHD, is on the core group and data workgroup. She joins the ADT in Phase II.

**Tomás,** a resident in the county, participates in the vision development. He joins the ADT to develop a plan to recruit the focus group and helps prioritize issues for the CHIP.

Once the steering committee has been organized, ask for recommendations on other people to invite to make the committee more representative of the community. You can invite members of the remaining MAPP implementation groups to join general MAPP activities in Phase I and inform them of new opportunities as they arise.

**POWER PRACTICES FROM THE POWER PRIMER**

**4. Build—Cultivate Relationships with Communities and Partners**

*MAPP Implementation Groups*

| Group and Size | Description | Activities and Time Commitment | Recommended Expertise and Skills |
|---|---|---|---|
| **Community Members and Organizations** | Community members and organizations are invited to participate and provide input throughout MAPP and stay informed about the status. | • Does the vision activity<br>• Shares assessment results<br>• Prioritizes issues | Invite the community widely to participate. Prioritize creating opportunities for communities experiencing inequities to contribute by working with trusted partners. |
| **Convened in Phase I** | | | |
| **Core Group**<br>2–3 people | Lays the groundwork for MAPP by devoting initial resources such as staff time or funding. Regularly supports and leads the MAPP process to ensure it moves forward. | • Maintains communication across partners and facilitates meetings<br>• Gathers steering committee feedback<br>• Builds partners' commitment<br>• Manages daily activities | • Project management (setting timelines, communications, delegating tasks)<br>• Facilitation |
| **Steering Committee**<br>10–20 people | Gives the MAPP process direction. Represents community's populations and organizations. Includes people with resources, community members, and people from the LPHS. | • Provides input and feedback on major steps of MAPP<br>• Meets regularly (e.g., monthly) | • Represents LPHS and community<br>• Community needs and strengths<br>• Positive relationships with community members |
| **CHI Infrastructure Workgroups**<br>2–4 groups,<br>4–6 people each | Leads strategic projects to improve MAPP, based on the results of the Starting Point Assessment. Topics might shift after Phase II. | • Develops and does activities to improve MAPP<br>• Presents updates and facilitates discussion at planning meetings<br>• Meets regularly (e.g., monthly) | • Partnership development<br>• Local funders, funding opportunities<br>• Community engagement<br>• Data sharing, infrastructure |
| **Convened in Phase II** | | | |
| **Assessment Design Team**<br>3–6 people | Leads the design, implementation, and analysis of the three assessments. | • Does assessment process<br>• Leads data triangulation<br>• Facilitates root cause analysis<br>• Shares assessment findings | • Data collection and analysis<br>• Qualitative and quantitative data<br>• Data visualization/presentation<br>• Facilitation<br>• Community engagement |
| **Convened in Phase III** | | | |
| **Priority Issue Subcommittees**<br>4–6 committees,<br>3–6 people each | Assigned to specific priority areas of the CHIP that align with their expertise. | • Leads implementation of CHIP strategies<br>• Meets regularly | • Ongoing monitoring and evaluation<br>• Continuous quality improvement<br>• Data collection and reporting<br>• Connections with local public health organizations doing activities |

# Step 3: Engage and Orient the Steering Committee

| | |
|---|---|
| **GOAL** | Onboard the steering committee to MAPP to establish baseline understanding of foundational concepts for CHI, health equity, and community engagement. |
| **SMARTIE Objectives** | • By XX date, host #XX orientation meetings with all members of the core group and steering committee.<br>• By XX date, establish the mission statement and guiding values for the core group and steering committee. |
| **Supplemental Tools/Resources** | • Tips for Planning Meetings (Appendix C)<br>• Fact Sheet: Steering Committee Involvement in MAPP (Appendix D)<br>• Example Orientation Meeting Agenda and Facilitation Guide (Appendix E)<br>• Health Equity Education Resources (Appendix F) |

## Introduction

Now that you have invited people to join the steering committee and core group, you will onboard them to MAPP. Everyone should get to know each other and develop a common understanding of how to use MAPP to achieve health equity. The steering committee will also define "the community" and develop a mission statement and guiding values.

### *Prepare to Collaborate*

Throughout orientation, communicate that MAPP is an adaptable collaboration. Try to avoid positioning your team as the only lead of the process. You can help steering committee members build relationships and own the process by providing space for them to connect and suggest ways to adapt the process.

The agenda and activities of your orientation will be specific to your community. The nature of your partnerships, experience with MAPP, knowledge of concepts related to health equity, and existence of other initiatives or coalitions will all influence what information you choose to include. You might host a one-day event or a series of short meetings. Reference Tips for Planning Meetings to make sure meetings are accessible to everyone. Following are some suggested outcomes of the orientation activities.

No matter how you facilitate the orientation activities, participants should be able to do the following afterward:

- Explain the purpose of a CHI process
- Name the basic steps of MAPP
- Define "health equity" and describe how MAPP activities work toward equity
- Explain why MAPP brings together organizations across sectors
- Explain why authentic community engagement is important to MAPP
- Describe the roles of the core group and steering committee to facilitate MAPP
- Collectively define what "the community" means to them
- Name the mission statement and guiding values of the steering committee and other MAPP leadership

# Onboarding to MAPP

Orientation meetings should be interactive and generate excitement for the activities ahead. The following resources can help you structure your meeting(s) and achieve your objectives. Select a facilitator to guide conversation about how MAPP can help achieve health equity and why it requires participation of partners across the community.

For example, you might host two orientation meetings with the following agendas. The Example Orientation Meeting Agenda and Facilitation Guide provides detailed guidance for both meetings.

| ORIENTATION MEETING 1 | ORIENTATION MEETING 2 |
|---|---|
| **Goal:** Steering committee members are prepared, knowledgeable, and energized to engage in MAPP to achieve health equity. | **Goal:** The core group and steering committee can envision where they are headed in MAPP and feel connected to one another as members. |
| **Agenda**<br>• Welcome and Overview<br>• Introductions<br>• Overview of MAPP<br>• *Break*<br>• Overview of Health Equity as the Goal of MAPP<br>• Questions and Reflections<br>• Closing and Next Steps | **Agenda**<br>• Welcome and Overview<br>• Re-introductions<br>• Define "The Community" Activity<br>• Mission Statement Development<br>• Values Statement Development<br>• Closing and Next Steps |
| **Resources**<br>• Example Orientation Facilitation Notes (Meeting 1)<br>• Steering Committee Member Participation in MAPP Fact Sheet<br>• Health Equity Resources Guide | **Resources**<br>• Example Orientation Facilitation Notes (Meeting 2)<br>o Facilitation guidance for defining "the community"<br>o Facilitation guidance for developing mission and values statements |

# Defining the Community and Developing Mission and Value Statements

The second part of onboarding is to define what "the community" means to the steering committee and develop a mission statement and guiding values.

## *Define "The Community"*

How often do you hear the term "the community"? What is a community? What defines your community? Who is part of "the community" that MAPP is designed to serve? Facilitate a discussion with the steering committee to develop an initial definition of "the community," which will be refined in the upcoming community visioning event.

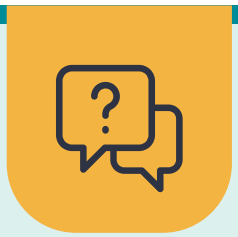
**Define the community discussion questions**

- How do you define community?
- Who is in our community?
- How might we define "the community" for our MAPP process?

## *Mission and Values Statements*

### MISSION STATEMENT:

A mission statement briefly describes the purpose of the collaborative's work and what members will do to fulfill that purpose. It answers the question, "What is our purpose, and how will we achieve it?"



#### *Dive Deeper with "Why" Questions*

Use "Why" questions to get to the deeper purpose of the work. For example:

- ***Why does this group leading MAPP exist?*** To improve community health.
- ***Why do we need this group to improve community health?*** Everyone needs to come together to do this work.
- ***Why is that important?*** Some groups have poorer health outcomes than others, and their voices need to be heard.
- ***New answer to "Why does this group exist?":*** This group exists to include the voices of all groups within the community, especially those experiencing health inequities, to improve population health.

### VALUES STATEMENT:

Values statements describe the core values of the MAPP collaborative's culture and work with the community. They answer the question, "What will we need to stay committed to in this work?"

A mission statement is crucial because it helps distinguish the collective work of MAPP from the work steering committee members are already doing. Values statements outline what is important to the steering committee as members work on MAPP together.

These statements, and the community vision (developed in Step 5), will help the steering committee and partners remember the purpose of the work. Although the actual work of MAPP may change over time, its purpose will not.

The steering committee can get creative and tap into their beliefs about the purpose of the work and their role in it. Develop one mission statement and three to seven values statements. Use three to five of each of the following types of example questions to guide your discussion. Review Example Orientation Meeting Agenda and Facilitation Guide (Meeting 2) for detailed instructions.

### Example purpose questions for the mission statement

- Why does this group leading MAPP exist?
- What is the value of MAPP and our work to the community?
- Why is this work of MAPP important? Why should people care?
- What would institutions (e.g., LHDs, schools, prisons, hospitals, corporations) do differently if they contributed to a more equitable community?

Additionally, participants should define *how* the group will achieve that purpose.

### Example "how" questions for the mission

- Whom does the work of MAPP serve?
- What do we do as participants of this MAPP work?
- What is the benefit of our work?

### Example values statement questions

- What do we need to do to work together effectively to achieve our mission?
- What type of working environment is necessary for our partnership to achieve its mission?
- What ground rules should we set to ensure we are all working effectively to achieve our mission?
- What must be in place to ensure our MAPP process centers on the needs of those affected by inequities?
- What values must we uphold to ensure equitable participation?
- How do we ensure we do not unintentionally create, contribute, or support decisions, policies, investments, rules, and laws that contribute to health inequities?
- How do we ensure the community drives and owns the process?
- How do we ensure we can share power with those affected by inequity?

Next, identify behaviors that demonstrate, and don't demonstrate, the core values.

### Example questions to identify behaviors for the values

- What would it look like to demonstrate this value in our MAPP work?
- What kinds of behaviors would signal that we were not committed to this value?

Celebrate the development of the mission and values statements by sharing them on social media, your website, and any shared materials of the committee. Remind the committee of the mission statement often, perhaps by opening each meeting by reciting the mission and values statements.

### *Examples of Values Statements*

- "Inclusiveness: We respect all people and create opportunities for diverse people and perspectives to be involved."
- "Flexibility: We remain open to changing our process to best understand and respond to the needs of all populations within our community."
- "Education: We continuously create opportunities to learn more about the needs of our community and how they can be addressed, and prioritize the expertise that people bring from their daily life."

**POWER PRACTICES FROM THE POWER PRIMER**

1. **Process—Unpack Personal and Organizational Power and Privilege**
2. **Form—Build a Container for Your Work Together**
5. **Share—Practice Power-Sharing with Partners and Community Internally and Externally**

# Step 4: Establish Administrative Structures for MAPP



| | |
|---|---|
| **GOAL** | Decide on an administrative structure to support the core group's and steering committee's community health work. |
| **SMARTIE Objective** | By XX date, MAPP partners operate with shared understanding of their roles, duties, and commitments as outlined in a formal agreement. |

## Introduction

Now that the steering committee and core group have been established and onboarded, consider how this coalition of partners and the MAPP work will be supported and administratively managed.

The purpose of this step is to establish the following:

- Who will provide administrative support or "backbone" for MAPP
- To what extent this coalition of partners will be formalized

The best options for these decisions are the ones that work for your community's unique situation.

## Considerations

### *Administration for MAPP*

You will need to determine how to manage the administrative tasks of MAPP. These follow many of the roles of a "backbone" organization from the Collective Impact model and include the following:[10,11]

- Managing funding that's dedicated to support MAPP or tracking total funding dedicated to support MAPP
- Facilitating communication among partners
- Aligning partners to the shared vision and mission
- Establishing methods for shared measurement
- Supporting community engagement and ownership of the process
- Contributing resources

One organization or agency might take on these roles to increase accountability of partners and advance the work. These roles will also be supported by the CHI infrastructure workgroups, established later in Phase I.

[10] Collective Impact Forum. *Backbone starter guide: A summary of major resources about the backbone from FSG and the Collective Impact Forum.* Retrieved March 29, 2023, from https://collectiveimpactforum.org/wp-content/uploads/2021/12/Backbone-Starter-Guide.pdf

[11] Mongeon, M., Levi, J., & Heinrich, J. (2017). *Elements of accountable communities for health: A review of the literature.* NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. Retrieved March 29, 2023, from https://nam.edu/elements-of-accountable-communities-for-health-a-review-of-the-literature/

Following are a few options for who could provide the administrative backbone:

- **Steering committee shares roles of the backbone:** In this structure, the steering committee operates as one entity sharing roles of a backbone organization. Here are some considerations of this method:
    - The partners involved on the steering committee have more accountability.
    - One organization is less likely to be considered the "lead" or given most of the work.
    - There is greater opportunity to democratize decision-making with this shared leadership.
    - If formal policies are not in place for the partnership, there could be a lack of accountability to the partnership.

- **One organization acts as the backbone:** In this structure, one organization that is represented on the steering committee operates as the backbone. Here are some considerations of this method:
    - The organization should have the capacity to manage the administration and funding of the MAPP work.
    - The coalition should not give most of the daily work of MAPP to the backbone organization.
    - The organization should be familiar with developing cross-sector partnerships and have skills in convening partners, managing timelines and workplans, managing funding streams, and leading advocacy for more funding and resources.
    - The organization might be an LHD, hospital, or other entity.
    - The mission and vision of the organization should align with that of MAPP so they can better pursue funding opportunities to support MAPP.
    - This role may have a large administrative burden.

## *Formalizing Partnerships through Written Agreements*

MAPP unites many people and stakeholders who do not typically work together. Although they might be excited about the work and establishing a shared mission and vision, they should also establish how the process will be managed and how partners will remain accountable to their duties. Written agreements, bylaws, or policies establish shared understanding of exactly how each partner will contribute to MAPP. Without such formal agreements, organizations might drop out or be confused about what is expected of them, which can cause the group to lose momentum. Here are several ways to formalize a partnership:

### 501(c)(3) non-profit status

There are benefits to establishing the entity providing backbone support as a 501(c)(3) tax-exempt non-profit organization, including having access to more funding opportunities than a government agency has. This entity might be one of the following:

- **A new 501(c)(3) organization established by the steering committee:** In this approach, the steering committee members would be the board of directors operating the new organization. The benefit of this approach is that the steering committee members' participation is solidified in bylaws and financial ties. However, formalizing in this way can have significant start-up costs.

- **An existing 501(c)(3) organization operating as the backbone:** This option would come with the considerations for shared ownership of and alignment with the work stated earlier but opens more funding opportunities and does not require the steering committee to take on start-up costs.

The considerations of formalizing a partnership as a 501(c)(3) for community health work are explored in more detail in **NACCHO's 501(c)(3) Decision Guide for Local Health Departments in Community Health Coalitions.**

## Memoranda of understanding

Alternatively, you may decide to formalize partnerships within the coalition by developing memoranda of understanding (MOUs). An MOU outlines a shared agreement between two or more parties. It includes the broad concepts of mutual understanding, shared goals for all parties, and any shared plans that have been established.

An MOU could be as simple as a signed, one-page agreement establishing that certain parties have agreed to work on MAPP together, or it could be a multi-section document outlining all agreements of the partnership. Here are some considerations of an MOU:

- It clearly outlines the responsibilities of each partner.
- Partners could refer to a detailed MOU in the future to increase accountability.
- It provides greater opportunity for individual organizations to provide tailored input into what they could offer and details of their commitment.
- It leaves room to be creative in how the coalition is governed.
- Although MOUs promote accountability, they are not legally binding.
- MOUs should be established with input from an organization's leadership so the partnership does not fail if individual staff leave.
- Partners may be put off from participating if MOUs are too rigid or outline work that is too burdensome.

# Step 5: Develop the Community Vision



| | |
|---|---|
| **GOAL** | The core group, steering committee, community members, and representatives of the broad LPHS collectively define the community and a vision for a healthy future. |
| **SMARTIE Objectives** | • By XX date, the core group and steering committee facilitate a community event to develop an aspirational community vision.<br>• By XX date, the core group and steering committee design mission and values statements to guide MAPP. |
| **Supplemental Tools/Resources** | • Tips for Planning Meetings (Appendix C)<br>• Example Visioning Event Agenda and Facilitation Guide (Appendix G) |

## Introduction[12]

What are you really working toward in MAPP? What would health equity look and feel like in your community?

The purpose of this step is to facilitate a launch or "visioning" event for MAPP in which the community defines (1) what "the community" means to them; and (2) their long-term, aspirational vision for the community. This vision answers the question, "Where do we want to be in the future?" It will guide the rest of the process because all MAPP activities are geared toward achieving the community's vision.

Here are the goals of this visioning process:

- Define "the community"
- Develop an aspirational vision for the community
- Build relationships among the individuals and groups involved in and affected by MAPP
- Increase community awareness of, enthusiasm for, and engagement in MAPP

## Instructions

Ask the steering committee what would make a successful visioning event. The visioning event should engage the community widely so it is truly community designed and owned. Include activities in which all participants can write their ideas (or share through something creative), rather than only facilitating discussion. Detailed facilitation guidance is available in the Example Visioning Event Agenda and Facilitation Guide.

Here is an example agenda for a half-day visioning event:

- Welcome and Introduction
- Define "The Community" Activity
- Vision Statement Brainstorm
- Vision Statement Development
- Celebration
- Closing

These activities are designed to open participants' imaginations. Try to keep the energy alive and positive. Have a plan but remain open to changing the activities if energy is low or the activity is not resonating with the group.

[12] Art of Transformational Consulting. Visioning toolkit. Retrieved March 29, 2023, from https://atctools.org/toolkit_tool/visioning-toolkit/#more-1696. (Adapted from)

**Next, create a plan with the following details:**

- **Activities:** You can include other activities that tap into many different skill sets—group discussion, paired interviews, journaling, art, etc. You can also divide the process in other ways:
  - **One meeting or multiple:** Multiple meetings give time for the discussions to "sink in" but require a greater time commitment and may result in less participation.
  - **Virtual/in-person:** An in-person event creates tangible, positive energy and connections, while virtual events might increase participation.
  - **Community interviews:** Community partners can ask their constituents some visioning questions and share their input with the steering committee to include in the event.
- **Date and time:** Pick a time that is feasible for most people to attend, such as after work hours or on the weekend.
- **Location:** Select a venue with plenty of space for all participants to sit at tables in small groups and in a central location with parking and public transportation, as applicable.
- **Participants:** Use your steering committee and partner networks to invite the community to the event. Use multiple invitation methods (e.g., online, mail, social media, flyers).
- **Roles:**
  - **Facilitator:** Select an energizing, neutral facilitator who can skillfully lead a large group through creative activities. For a directory of national facilitators, visit https://atctools.org/atc-directory/.
  - **Recorder(s):** Task at least one person to take notes during the event. Take pictures of completed activities.
  - **Room support:** Assign members of the steering committee to greet guests at the door, answer questions, distribute materials, and provide feedback during/after the meeting.
  - **Materials:** Include items such as flip charts, sticky notes, sticky walls, pens, markers, worksheets, and any technology needs.
  - **Refreshments:** If possible, provide snacks and refreshments during the meeting or a meal if the meeting will last longer than a few hours.
- **Participation support:** Refer to Tips for Planning Meetings for considerations of how to make meetings more accessible for participants.

Finally, proudly share the new vision statement with your partners and stakeholders. They are great tools to use in recruiting partners and in announcing progress because they are efficient and use the community's own words. The vision statement should not change throughout MAPP and should be revisited about every five years to ensure it still resonates with the community.

**POWER PRACTICES FROM THE POWER PRIMER**

4. **Build—Cultivate Relationships with Communities and Partners**
5. **Share—Practice Power-Sharing with Communities and Partners Internally and Externally**

# Step 6: Do the Starting Point Assessment

**GOAL**

The core group and steering committee reflect on the past cycle, identify resources available for the current cycle, and create goals for the current cycle.

**SMARTIE Objectives**

- By XX date, the core group and steering committee complete all reflection/metric tracking sections of the instrument.
- By XX date, the core group and steering committee review the suggested strategies and identify goals and metrics for the next cycle within the instrument.

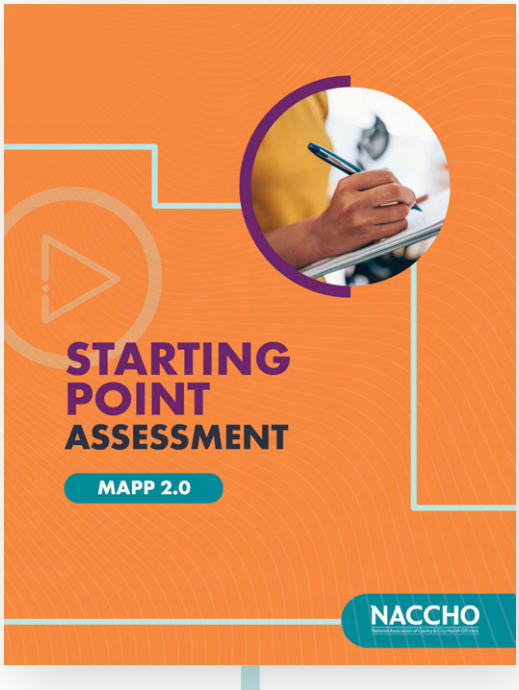
## Introduction

Now, the core group and steering committee will do the Starting Point Assessment.

The Starting Point Assessment will help your community identify goals for this MAPP cycle and resources still needed to achieve those goals. The Starting Point Assessment will help you decide how to structure your CHI process based on your experience in CHI, available resources, and goals for the cycle.

After completing the Starting Point Assessment, you will have identified the following:

- Goals for improvement in this MAPP cycle
- Current resources to support MAPP (funding, partnerships, skills and capacities of personnel, and other resources)




**POWER PRACTICES FROM THE POWER PRIMER**

7. **Evolve—Reflect on Process, Outcomes, Accountability, and Sustainability**

# Step 7: Identify CHI Infrastructure Priorities and Develop Workgroups

| | |
|---|---|
| **GOAL** | Develop two to four workgroups to strengthen CHI infrastructure during the current CHI cycle. |
| **SMARTIE Objectives** | • By XX date, the core group and steering committee review results of the Starting Point Assessment and select two to four focus areas to strengthen CHI infrastructure during the current cycle.<br>• By XX date, confirm #XX steering committee members for each workgroup priority.<br>• By XX date, each workgroup will have completed its initial meeting and workgroup charter. |
| **Supplemental Tools/Resources** | • Workgroup Charter Example (Appendix H)<br>• Workgroup Suggested Tiered Strategies (Appendix I)<br>• Workgroup Charter Template<br>• CQI Tracking Template (in MAPP 2.0 Tools folder) |

## Introduction

In this step, the steering committee identifies two to four focus areas to improve the CHI infrastructure from the Starting Point Assessment and establishes workgroups. The workgroups will work on the focus areas throughout the CHI cycle. Workgroup members include people from the core group, steering committee, and others with skills and knowledge related to the focus areas.

## Instructions

### *Select CHI Infrastructure Focus Areas*

With the steering committee, revisit the findings from the Starting Point Assessment and use these questions to identify the top two to four CHI infrastructure focus areas that the collaborative will work on throughout the CHI cycle:

- In which focus areas do we have the *most* capacity?
- In which focus areas do we have the *least* capacity?
- Which focus areas are the *most critical* to helping us facilitate a community-led, strategic process to achieve health equity?
- Given our staff and resources, how many focus areas could we feasibly make progress on in this CHI cycle?

### Examples of Focus Areas

- **Funding:** Connecting with local funders and philanthropy or applying to national opportunities for CHI funding
- **Community engagement:** Assessing how the MAPP team can better engage the community and creating actionable goals to increase community ownership of MAPP
- **Partnerships:** Seeking opportunities to expand the network of partnerships, especially to those outside the "traditional" health sector
- **Data collection:** Developing the infrastructure and processes to continually update the CH[N]A findings and share them with the community
- **Communications:** Identifying reliable ways to communicate to the public; designing and sharing the CH[N]A and CHIP; writing materials in a way that all community members can understand; connecting with local organizations to increase reach
- **Health equity:** Discussing and adopting a shared understanding of the principles of health equity to drive the MAPP process

Some focus areas align directly with the Starting Point Assessment domains, while others are subsets or combinations of topic areas covered in the assessment.

## *Establish Workgroup Membership and Roles*

Develop one workgroup for each focus area (e.g., a community engagement workgroup, a funding workgroup) with four to six members per workgroup. Members can be from the core group and steering committee and others identified in the Stakeholder Analysis Table.

Workgroup members do the following activities:

- Identify goals and objectives for the focus area and steps to achieve them
- Find opportunities throughout MAPP to make progress on the focus area
- Track progress on the focus area during MAPP
- Regularly update the steering committee about what is needed to achieve the goals
- Meet regularly, in addition to the core group/steering committee meetings

Also identify a chairperson for each workgroup to do the following:

- Set workgroup meeting agendas with input from members
- Ensure workgroup members are accountable for their tasks
- Keep the workgroup on track with the timelines for objectives and goals
- Update the core group and steering committee about the workgroup's progress

Other potential workgroup roles might include the following:

- **Administration:** Notetaking, email correspondence, and scheduling meetings
- **Facilitation:** Leading meeting discussions and conversations with external partners
- **Continuous quality improvement:** Guiding the workgroup to reflect periodically on its work together and progress toward the goals to identify areas for improvement

## *Develop Goals, Objectives, and Process Measures*

Each workgroup should narrow down the list of goals for its workgroup and develop objectives and process metrics for each using the following instructions.

### Select workgroup goals

Reference the data from the Starting Point Assessment related to the workgroup focus area and discuss the following:

- What is our status on this focus area?
- What is going well?
- What is not going well?
- What goals for this focus area written in the Starting Point Assessment are the most critical to address?
- What other goals would we add to this list?

Then, develop two to three goals for the workgroup. Goals are long-range outcome statements that broadly define the direction of the program. The statements should reflect the desired outcomes of achieving the CHI infrastructure priorities.

***Example:*** *Convene a cross-sectoral group of organizational and community partners to participate in this CHI cycle and future CHI cycles.*

### Select two to three strategies to achieve the goals

Review the sections of the Workgroup Suggested Tiered Strategies related to your topic area and goal(s). Select and document two to three strategies, or develop your own, to help reach your goal.

### Establish objectives and process measures

Consider what is needed to make progress:

- What is needed to achieve this goal?
- What resources do we need?
- Whom do we need to involve?

Establish two to four objectives for each goal. Objectives are short- to intermediate-range outcome statements that are concrete and tied to achievement of goals. The statements should describe what will be achieved in your progress toward accomplishing the goal statement. Use the SMARTIE approach, in which objectives are specific, measurable, achievable, realistic, timebound, inclusive, and equitable.

***Example:*** *By July 10, the steering committee will include representatives from at least five different sectors of the LPHS.*

Then, establish three to six process measures for each goal. Process measures help to evaluate whether the planned activities to achieve the objectives have been accomplished. These should articulate how you will know your collaborative is moving in the right direction to achieving the goals.

***Example:*** *# of different sectors invited to participate on the steering committee*

## Develop a Workgroup Charter

The workgroup charter establishes and documents how the team will meet its established goals. Fill in the Workgroup Charter Template with the following information:

- **Workgroup Name:** Give your workgroup a name that matches its purpose (e.g., Community Engagers or Communications Workgroup).
- **Charter Version/Date:** Document the current date when the charter is being written.
- **Subject:** Describe your workgroup's focus area.
- **Problem/Opportunity Statement:** Describe why this workgroup was set up and the impact of its progress. Reference relevant data from the Starting Point Assessment.
- **Chairperson:** Write in the chairperson's name.
- **Team Members, Areas of Expertise, and Role:** Outline team members, their affiliations, areas of expertise related to the workgroup, and role (e.g., administration, facilitation).
- **Action Plan:**
    - **Scope:** Identify the workgroup's focus area in relation to this MAPP cycle.
    - **Considerations:** What challenges might you encounter in achieving these goals, or what issues should you think about now?
    - **Available Resources:** What resources are available to help achieve the goals?
    - **Key Stakeholders:** What individuals/ organizations might be impacted by the work of this workgroup? How will you communicate with them regularly?
- **Goals and Objectives:** Outline the goals, objectives, and process metrics established earlier. What overarching outcomes will the workgroup achieve to improve the CHI infrastructure? What are the key milestones to achieve those goals? How will they do that? By when? How will you know you are making progress?
- **Communications Plan:** When will the workgroup meet, and where? How will members communicate with each other between meetings?
- **Tracking Progress:** Who will track progress toward the objectives and how? How often will workgroup members report on individual progress? Who will report to the core group and steering committee about progress?
- **Accountability Mechanisms:** How will you establish accountability of members to their tasks? How frequently are they expected to report progress? How will the project be managed, and what is each member's responsibility to contribute to that system?

Each workgroup should complete the following Workgroup Charter Template and can reference the Workgroup Charter Example in the Phase I Appendices. After completing the charter, add your goals, objectives, and metrics to the CQI Tracking Template and major dates to the workplan.

# *Workgroup Charter Template*

| | |
|---|---|
| **Workgroup Name:** | |
| **Charter Version/Date:** | |
| **Subject:** | |
| **Problem/Opportunity Statement:** | |
| **Chairperson:** | |
| **Team Members, Areas of Expertise, and Roles** | |
| **Name, Organization/Affiliation** | **Areas of Expertise to This Workgroup and Roles** |
| | |
| | |
| | |
| **Action Plan** | |
| **Scope:** | |
| **Considerations:** | |
| **Available Resources:** | |
| **Other Resources Required:** | |
| **Key Stakeholders:** | |

| Goals and Objectives | | |
|---|---|---|
| **Goals** | **Objectives** | **Process Metrics** |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Communications Plan** | | |
| Regular meeting time and location: | | |
| Preferred method of communication: | | |
| **Tracking Progress** | | |
| Tracking: | | |
| Reporting: | | |
| **Accountability Mechanisms:** | | |
| | | |

## POWER PRACTICES FROM THE POWER PRIMER

1. **Process—Unpack Personal and Organizational Power and Privilege**
2. **Form—Build a Container for Your Work Together**

# Step 8: Develop the Workplan and Budget

| | |
|---|---|
| **GOAL** | Develop a workplan and budget to outline milestones and goals for MAPP. |
| **SMARTIE Objectives** | • By XX date, the core group and steering committee will develop an initial workplan outlining main milestones and goals for MAPP.<br>• By XX date, the core group and steering committee will develop an initial budget to accompany the workplan. |
| **Supplemental Tools/Resources** | • MAPP Workplan Template (in MAPP 2.0 Tools folder)<br>• MAPP Budget Template (in MAPP 2.0 Tools folder) |

The guidance in this step will help you design your CHI process in a way that is adaptable to your resource needs and that advances your selected focus areas.

## *Develop a MAPP Workplan*

Use the MAPP Workplan Template to plan for Phases II and III of MAPP.

Include the following steps and activities of MAPP in your workplan to get started:

- Phase II: Tell the Community Story
  - Form the assessment design team
  - Do the three assessments
  - Analyze the data
  - Share CH[N]A findings
- Phase III: Continuously Improve the Community
  - Select strategic issues
  - Assign partner responsibilities
  - Write the CHIP
  - Apply the CHIP
  - Monitor CHIP progress in achieving identified goals

In addition to including these steps, the workgroups should add their assignments for working on the CHI infrastructure priorities to the MAPP workplan.

The workplan can be a dynamic document you update during steering committee meetings. You will refine the workplan as you move through the process. For example, after you convene the ADT in the beginning of Phase II, the ADT can decide how and when to do assessments and update the workplan with that information. Additionally, the remaining phases of MAPP will include guidance that you can adapt to the current experience, resources, and goals of each community.

The MAPP Workplan Template will help you develop your workplan.

# *MAPP Workplan Template*

**Download an editable version from the MAPP 2.0 Tools folder at naccho.org/mapp**

| Phase III: Continuously Improve the Community | | | | | | |
|---|---|---|---|---|---|---|
| **Activity** (*Written Description*) | **Lead Person** (*Name*) | **Support** (*Team[s]/Person[s]*) | **Start Date** (*Date*) | **End Date** (*Date*) | **Status** (*Dropdown*) | **Status Description** (*Written Description*) |
| **Step 1: Prioritize Issues for the CHIP** | | | | | | |
| Review the issue profiles and determine whom to | | | | | | |
| Determine criteria for prioritization | | | | | | |
| Review potential prioritization methods and determine which to use | | | | | | |
| Prioritize issues using the chosen method(s) | | | | | | |
| Validate the prioritized issues with the MAPP Core Group, Steering Committee, and/or community | | | | | | |
| Share the prioritized issues with the community | | | | | | |
| **Step 2: Do a Power Analysis of Each Issue** | | | | | | |
| Do a Landscape Analysis to identify the people, communities, agencies, and organizations who could positively or negatively impact the success of MAPP | | | | | | |
| Do a Power Analysis for each issue identifying how power and influence impact the issue and which key partners, stakeholders, and opponents should be mapped to the issue | | | | | | |
| **Step 3: Set Up Priority Issue Subcommittees** | | | | | | |
| Brainstorm people to include on each priority issue subcommittee | | | | | | |
| Identify and invite 3-6 people to involve in each priority issue subcommittee | | | | | | |
| Select a chairperson (or two) for each subcommittee | | | | | | |
| **Step 4: Create Community Partner Profiles** | | | | | | |
| Review the Community Partner Profiles with all priority issue subcommittee partner members | | | | | | |
| Have each subcommittee partner member complete the Community Partner Profile | | | | | | |
| Analyze the completed Community Partner Profiles and note how each partner aligns with the priority issue and how best to engage them on the issue | | | | | | |
| **Step 5: Develop Shared Goals and Long-Term Measures** | | | | | | |
| Plan the process for developing shared goals and long-term measures | | | | | | |
| Apply the process for developing shared goals and measure using the Goal Development Worksheet | | | | | | |
| Draft the shared goals and long-term measures | | | | | | |
| Finalize the shared goals and long-term measures with the priority issue subcommittee, MAPP Core Group, MAPP Steering Committee, and/or community | | | | | | |
| **Step 6: Select CHIP Strategies** | | | | | | |
| Brainstorm strategies | | | | | | |
| Prioritize strategies | | | | | | |
| Select and adopt strategies with the priority issue subcommittee, MAPP Core Group, MAPP Steering Committee, and/or community | | | | | | |
| **Step 7: Develop Continuous Quality Improvement Action Planning Cycles** | | | | | | |
| Prepare for implementation by establishing accountability with the priority issue subcommittee | | | | | | |
| Develop SMARTIE objectives for each priority issue goal and strategy | | | | | | |
| Develop a logic model for each goal to establish how implementation and outcomes will be tracked | | | | | | |
| Develop action plans for each objective aimed at achieving the outcome objectives and addressing the selected strategies | | | | | | |
| Review action plans looking for opportunities to coordinate and combine resources for maximum efficiency and effectiveness | | | | | | |
| Draft the CHIP | | | | | | |
| Finalize and share the CHIP | | | | | | |
| Implement and monitor the progress of the action plans | | | | | | |
| **Step 8: Monitor and Evaluate the CHIP** | | | | | | |
| Prepare for evaluation by engaging stakeholders and describing the activities to be evaluated | | | | | | |
| Develop an evaluation plan and process to assess the impact of strategies and adjust as needed | | | | | | |
| Share the results of the evaluation with others | | | | | | |
| **Continuous Quality Improvement: Reflection on Phase III** | | | | | | |
| Evaluate the effectiveness of Phase III using this workplan document and phase objectives | | | | | | |

## Develop a MAPP Budget

Use the MAPP Budget Template to document all costs for your entire CHI process. Your budget should include the following estimated costs:

- **Personnel:** Staff who will be paid within your organization to work on MAPP
- **Contractual costs:** People or organizations hired to contribute to specific parts of MAPP, such as facilitators, designers, and data analysts.
- **Equipment and supplies:** Meeting facilitation (e.g., flip charts, markers, printing costs), technology, mailing, etc.
- **Other costs:** Meeting space rentals, stipends or incentives for community engagement, food, transportation, etc.

## MAPP Budget Template

**Download an editable version from the MAPP 2.0 Tools folder at naccho.org/mapp**

| Personnel | | | | | | |
|---|---|---|---|---|---|---|
| **Staff Member** | **Scope of Work** | | **Salary** | **FTE** | **Total Cost** | **Funding Source** |
| *Health Planner* | | | *$55,000* | *0.50* | *$27,500* | *Local Health Department (in-kind)* |
| *Epidemiologist* | | | *$65,000* | *0.50* | *$32,500* | *Local Health Department (in-kind)* |
| | | | | | $0 | |
| | | | | | $0 | |
| | | | | | $0 | |
| **Total Personnel** | | | | | **$60,000** | |
| | | | **Fringe*** | ***30%*** | **$18,000** | |
| **Total Personnel + Fringe** | | | | | **$78,000** | |

| Contractual Costs | | | | | | |
|---|---|---|---|---|---|---|
| **Contractor** | **Service Scope** | **Service Unit** | **Unit Cost** | **Total Units** | **Total Cost** | **Funding Source** |
| *Jane Smith* | *Facilitate Visioning Sessions* | *Hour* | *$100* | *5* | *$500* | *United Way* |
| *ABC Media* | *Design CH[N]A Report* | *Flat Rate* | *$2,000* | *1* | *$2,000* | *City/County Health Department Budget* |
| | | | | | $0 | |
| | | | | | $0 | |
| | | | | | $0 | |
| | | | | | $0 | |
| **Total Contractual Costs** | | | | | **$2,500** | |

| Equipment and Supplies | | | | | | |
|---|---|---|---|---|---|---|
| **Expense Item** | **Description** | **Service Unit** | **Unit Cost** | **Total Units** | **Total Cost** | **Funding Source** |
| *Computer* | *For staff member usage* | *Item* | *$1,200* | *2* | *$2,400* | *City/County Health Department Budget* |
| | | | | | $0 | |
| | | | | | $0 | |
| | | | | | $0 | |
| | | | | | $0 | |
| **Total Equipment and Supplies** | | | | | **$2,400** | |

| Other Costs | | | | | | |
|---|---|---|---|---|---|---|
| **Expense Item** | **Description** | **Service Unit** | **Unit Cost** | **Total Units** | **Total Cost** | **Funding Source** |
| *Large Meeting Hall* | *For 6 community meetings* | *Meetings* | *$200* | *6* | *$1,200* | *City/County Donation (in-kind)* |
| | | | | | $0 | |
| | | | | | $0 | |
| | | | | | $0 | |
| | | | | | $0 | |
| **Total Other Costs** | | | | | **$1,200** | |

| **Total MAPP Costs** | **$84,100** |
|---|---|

**Adjust fringe to your organization's rate.*

**POWER PRACTICES FROM THE POWER PRIMER**

**6. Strategize and Act—Implement, Amplify, and Invest in Community-Identified Priorities and Solutions**

# Continuous Quality Improvement: Reflection on Phase I

**Congratulations!** You have completed *Phase I: Build the Community Health Improvement Foundation.*
Take some time to collectively reflect on the following:

- What went well?
- What did not go well?
- What goals were achieved?
- What goals were you not able to achieve?
- What would you like to change as you move into the next phase?

# PHASE I

# APPENDICES

A. Budget Guidance
B. Stakeholder Brainstorm Toolkit
C. Tips for Planning Meetings
D. Fact Sheet: Steering Committee Involvement in MAPP
E. Example Orientation Meeting Agenda and Facilitation Guide
F. Health Equity Education Resources
G. Example Visioning Event Agenda and Facilitation Guide
H. Workgroup Charter Example
I. Workgroup Suggested Tiered Strategies
J. Health Equity Action Spectrum

# A. Budget Guidance



A good way to begin creating a budget for your community health improvement (CHI) process using Mobilizing for Action through Planning and Partnerships (MAPP) is to ask, "What is it going to take to carry out the planning process?" While the answer to this question will vary depending on the unique characteristics and circumstances of the community, common costs within each budget category outlined in the MAPP Budget Template are shown here, along with questions for consideration.

Add anticipated costs to the MAPP Budget Template as you go through this guidance. Be sure to identify in-kind resources to fully document the actual costs of the project and recognize the commitments being made by the participating agencies. Continue to revise your budget as you move through MAPP and set processes for all key activities, including the three assessments in Phase II.

## *Personnel*

The efforts of the MAPP core group, steering committee, workgroup members, assessment design team, and other community participants must be supported by identified project staff. Staff will be needed to obtain requested documents and other information, provide support (e.g., organize meetings, take notes, or follow up), and organize the participants' work. The first step in completing the personnel budget is to identify staff that are available or needed to support the process. Here are some questions to consider:

- Will you need to hire a full-time planner to staff the process?
- Will you need other new full- or part-time staff, such as an administrative assistant or an epidemiologist?
- Which staff from participating organizations will support the planning effort?

Include in the budget only those people who will support the process, not those who will be participating exclusively as steering committee, workgroup, or assessment design team members.

After identifying staff needs, indicate the full-time salary for each position and the proportion of staff time to be assigned to MAPP. Then, working with the core group and other key participants, identify the source(s) of funding available or needed for each position. Identifying the source(s) of funding for each line item in your budget will help you determine any other funding sources such as grants that your community may want to apply for.

## *Contractual Costs*

Contractual costs may be either consultant agreements or contracts with other organizations to carry out specific components of the effort (such as a community survey or data analysis). Here are some questions to consider:

- Are there necessary activities for which the project staff lack either the time or skill to perform? Could a consultant or another agency do these?

- Is a consultant needed for a single task (such as data collection or facilitation) or to manage and document the entire process? (This will depend, in part, on the availability of existing staff to provide in-kind support).
- Will the consultant be paid by the hour, by project component, or on a flat-fee basis? Agreeing on a figure based on project component or the total project may reduce the risk of having to pay a consultant for accruing more hours than anticipated.
- Can or should certain partners do a part of the project?
- Should facilitation services be brought into the process?

## *Equipment and Supplies*

You may need equipment such as computers to create interim reports and the final document. Supplies for meetings may include flip charts, markers, binders for participant materials, and name badges. Determine if any organizations providing personnel to support the CHI process already have in-kind resources in this category.

## *Other Costs*

You will likely have other costs such as the following throughout MAPP. Identify whether these costs will be supported through in-kind contributions or if they will require new sources of funding.

- You will need meeting space throughout the process. Some activities will require large meeting rooms (i.e., community meetings). If participating agencies lack sufficient meeting space for larger meetings, you might need to rent space. To determine space costs, estimate the number of meetings to be held and the length of each meeting.
- You might need funds to reimburse some participants for travel to and from the planning meetings, including parking, public transportation, or mileage expenses.
- Other items may include books for staff to better research and understand a key issue and refreshments for committee meetings.
- Copying, printing, and postage costs are often underestimated. Consider these for meeting notices and materials, interim and draft reports, and reproduction of the final plan.

## The Local Public Health System "Jellybean" Diagram

This "jellybean" diagram shows many players in the local public health system. You can create your own stakeholder diagram on paper, or use online diagramming software, to show connections among partners in Mobilizing for Action through Planning and Partnerships (MAPP) 2.0. In the future, you might use those relationships to conduct MAPP. When using this tool, remember that community members are the central focus of MAPP. You might put them in the center of the diagram, as in the example below. Consider their interconnectedness within the diagram as you build it.

## Identify Stakeholders Based on Assets

*Adapted from the American Hospital Association Community Health Improvement Asset Classification*[1]

Think about the different types of assets in your community that would contribute to the success of MAPP. Assets might include human, physical, political, and existing intervention resources. Review the categories below to brainstorm potential stakeholders through the asset classifications:

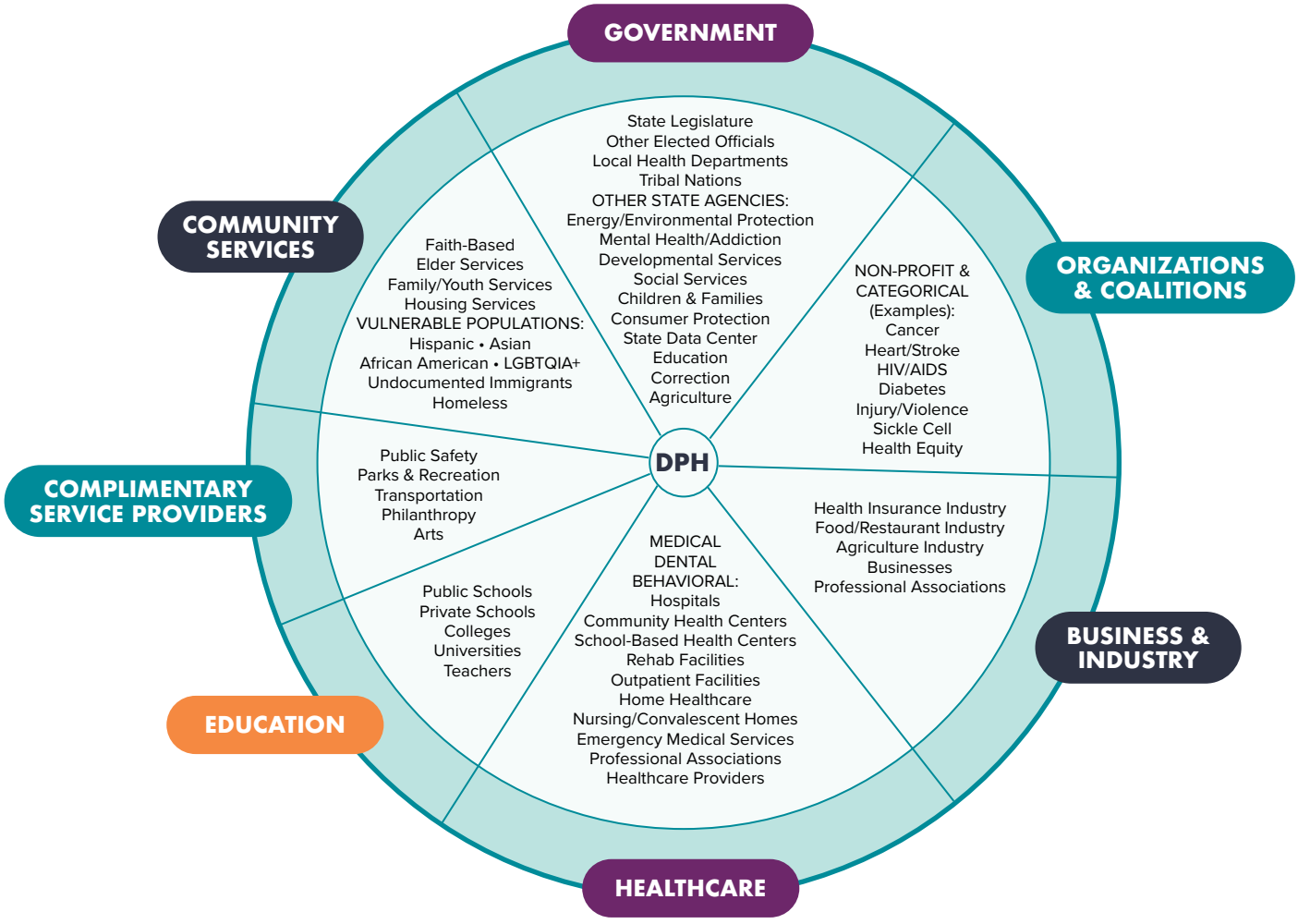
- **Human resources:** Who is already involved in MAPP, or ready to be involved? This might include staff within the local public health system who work on community health improvement; partnering community organizations' staff, board of directors, or community members; and their individual expertise, talent, training, and skills.

[1] www.healthycommunities.org/resources/toolkit/files/step2-identify-engage-stakeholders

- **Physical resources:** What physical resources are available to contribute to MAPP (e.g., public spaces, meeting rooms), and who can provide access to them?
- **Informational resources:** What are the formal and informal networks of communication and formal or informal associations of people in the community?
- **Political resources:** What are the constituencies of elected officials and public and private institutions that are advocating for resources and policy changes related to MAPP?
- **Existing intervention resources:** What existing community initiatives could be combined or aligned with MAPP?

## Stakeholder Wheel

This stakeholder wheel, adapted from the Connecticut Department of Public Health, shows the range of potential sectors and non-traditional stakeholders that can be involved in the public health system. You could create a table for each sector and sub-category and fill in local community organizations, coalitions, and people for each.



# C. Tips for Planning Meetings



Use the following recommendations to help plan Mobilizing for Action through Planning and Partnerships (MAPP) meetings and check out **Conducting Effective Meetings**[1] from the Community Tool Box for more guidance.

## *Scheduling the meeting:*

- **Schedule smart:** Find a time that works best for everyone by asking directly or using a scheduling poll (e.g., Doodle, Calendly). Participants will have various work and personal schedules, so evenings or weekends may not work for everyone. Limit meetings to no more than two hours.
- **Schedule and promote the meeting far in advance:** Give your invitees enough time to plan to attend the meeting. They might need to change their schedule or coordinate transportation or childcare.
- **Make meetings accessible:** Travel to the attendees, rather than asking them to travel to you. Use a neutral, central meeting space that is easily accessible to public transportation and for people with disabilities. Rotating meeting locations can accommodate members from all over the region. Select a room that will fit the number of participants.

## *Promoting the meeting:*

- **Encourage everyone's participation:** Explain in your promotions that community members' input is the most important aspect of this activity.
- **Advertise the meeting widely:** Use the network of steering committee members, workgroup members, and organizational partners to help promote the meeting and ask for recommendations on ways to advertise. Use multiple methods including the Internet (emails to organizations, social media posts, your website), flyers, signs, mailers, etc.

## *Hosting the meeting:*

- **Assist with transportation:** Provide transportation, transportation stipends, parking vouchers, mileage reimbursement, etc. for all who travel to the meeting.
- **Provide childcare:** Provide childcare (facilitated by a trained childcare professional) on site for any parents or guardians attending with small children.
- **Serve food and drink:** Provide a meal, snacks, or refreshments to build community, stimulate creative thinking, and show appreciation for your guests.
- **Be yourself:** Encourage informality by asking everyone to use their name and **pronouns**[2] in their introductions and on their name tags and not to lead with their job title or organizational affiliation.
- **Keep it fun:** Build in "informal" time before and after the meeting for participants to socialize and get to know each other.

[1] https://ctb.ku.edu/en/table-of-contents/leadership/group-facilitation/main
[2] https://pronouns.org/

# D. Fact Sheet: Steering Committee Involvement in MAPP



This fact sheet provides examples of how the steering committee is involved in each phase of Mobilizing for Action through Planning and Partnerships (MAPP). You may edit the information in this fact sheet and use it for recruiting the steering committee.

| Step | How Steering Committee Members Participate |
|---|---|
| **Phase I: Build the Community Health Improvement Foundation** | |
| The steering committee is convened and onboarded to the MAPP process. Members complete activities and assessments to decide on the work they will guide in this MAPP cycle. They help engage other community members in the work and help connect the MAPP collaborative with various resources. | • Attend orientation activities and trainings to become familiar with MAPP<br>• Plan the activities to develop a community-wide vision for our future<br>• Assess how we can improve our work from previous community health improvement cycles<br>• Develop workgroups to increase efficiency and effectiveness of the process<br>• Create a workplan to guide the process |
| **Phase II: Tell the Community Story** | |
| The MAPP collaborative prepares and does three community health assessments. The assessment design team, which might include steering committee members, does much of this work. This phase will require much effort to continually engage the community. Populations experiencing inequities will be prioritized to participate in the development, implementation of, and completion of assessments. | • Develop an assessment design team to lead the process<br>• Provide feedback on the assessment design team's plans for the assessments<br>• Assist the assessment design team with strategies to reach more community members to plan, implement, and participate in the assessments<br>• Facilitate an activity to share the data with the community |
| **Phase III: Continuously Improve the Community** | |
| MAPP brings the community together to interpret the results of the assessments. Key issues are prioritized to be included in the community health improvement plan. Organizational partners align themselves with the priorities and discuss what actions they will take to address them, as teams. | • Facilitate activities with the community to prioritize issues for the community health improvement plan<br>• Help identify other organizational partners and community members that align with the priority areas<br>• Align with priority areas that match work and expertise<br>• Work as teams with other partners to identify strategies to target the priority areas<br>• Develop a plan to stay connected throughout implementation of the community health improvement plan |

# E. Example Orientation Meeting Agenda and Facilitation Guide

This facilitation guide outlines an orientation meeting that would be appropriate for a community starting Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 for the first time. You may choose to adapt this agenda, or create an entirely new one, based on your community's experience with MAPP, history of taking collective action in the community, and knowledge of community health improvement (CHI).

**EXAMPLE ORIENTATION MEETING #1:**

## Orientation for Steering Committee Members

*Goal:* Steering committee members are prepared, knowledgeable, and energized to engage in MAPP to achieve health equity.

*Objectives:* By the end of this meeting, attendees will be able to do the following:

- Explain the purpose of a CHI process
- Name the basic steps of MAPP
- Define "health equity" and describe how MAPP activities work toward equity
- Explain why MAPP brings together organizations across sectors
- Explain why authentic community engagement is important to MAPP
- Describe the roles of the core group and steering committee to facilitate MAPP
- Collectively define what "the community" means to them
- Name the mission statement and guiding values of the steering committee and other MAPP leadership

*Agenda:*

- Welcome and Overview
- Introductions
- Overview of MAPP
- Overview of Health Equity as the Goal of MAPP
- Questions and Reflections
- Closing and Next Steps

# *Agenda with Notes for Facilitation*

| TOPIC AND GOAL | NOTES |
|---|---|
| **Welcome and Overview**<br><br>Welcome attendees to the orientation and set the stage for what you will be reviewing together. | • Welcome attendees to the orientation and thank them for attending.<br>• Review agenda.<br>• Introduce the session: *The purpose of this session is to create a common understanding of the MAPP process. MAPP is a framework to collaboratively improve community health, and we will review the steps today. MAPP is an adaptable process, and we will define what it can look like in our community.*<br>• Review objectives:<br>  ○ Get to know everyone in the room.<br>  ○ Explain the purpose of community health improvement.<br>  ○ Describe the phases and steps of MAPP.<br>  ○ Explain key concepts that guide the MAPP framework.<br>  ○ Name the roles of the core group and steering committee.<br>• Note there will be a Part 2. |
| **Introductions**<br><br>Allow steering committee members to get to know one another. | • Facilitate steering committee member introductions:<br>  ○ Their name, organization, and role<br>  ○ One thing they enjoy about the community or how they feel their work is related to improving community health<br><br>*Note: If you have a large group (11+), facilitate this in pairs or small groups.* |
| **Overview of MAPP**<br><br>Review the basic concepts of MAPP to outline what the process might look like. | • Provide foundational information about MAPP and your community's established process for community health improvement (if applicable) including:<br>  ○ How you define community health improvement<br>  ○ Overview of the MAPP framework and steps<br>  ○ Roles of steering committee, core group, partners, and community members in MAPP |
| **Health Equity Overview**<br><br>Introduce core concepts around health equity. | • Provide foundational information about how a MAPP process can be used to achieve health equity. This conversation will be structured differently in every community, but it may be helpful to review:<br>  ○ How you define health equity<br>  ○ Distinguishing between the root causes of health inequity and social determinants of health<br>  ○ Examples of how your community has addressed either root causes or social determinants of health in the past<br>  ○ Why community engagement is critical to meeting the community's needs and advancing health equity<br><br>*Note: Reference the Health Equity Education Resources in the Phase I Appendices of the MAPP Handbook for resources to assist with this section.* |
| **Questions and Reflections** | • Facilitate a reflective discussion:<br>  ○ *What stands out from our conversations today?*<br>  ○ *What excites you about this work?*<br>  ○ *What hesitancies do you have about this work?*<br>  ○ *What might be some opportunities to adapt this process to fit our community?*<br>  ○ *What should we do next?* |
| **Closing and Next Steps** | • Thank attendees for their participation.<br>  ○ *In our next meeting, we will define what "the community" means to us. We will also develop a mission statement and values statements to guide our work together.* |

**EXAMPLE ORIENTATION MEETING #2:**

## Define the Community and Identify Mission and Values

*Goal:* The core group and steering committee can envision where they are headed in MAPP and feel connected to one another as members.

- Collectively define what "the community" means to them
- Name the mission statement and guiding values of the steering committee

### *Agenda:*

- Welcome and Overview
- Re-introductions
- Define "The Community" Activity
- Mission Statement Development
- Values Statements Development
- Closing and Next Steps

### *Agenda with Notes for Facilitation*

*Include more breaks as needed.*

| TOPIC AND GOAL | NOTES |
|---|---|
| **Welcome, Introductions, and Overview**<br><br>10 minutes | • Welcome attendees to the session and thank them for attending.<br>• Facilitate introductions: *Name, organization, role, and your organization's mission*<br>• *What is sticking with you from the last meeting?*<br>• Introduce the session: *The purpose of this session is to define what "the community" means to us and to develop mission and values statements.*<br>• Review agenda.<br>• Review objectives:<br>  ○ Collectively define what "the community" means to them.<br>  ○ Name the mission statement and guiding values of the steering committee. |
| **Define "The Community"**<br><br>*Introduction*<br>5 minutes | • *In all our work, we probably hear the phrase "the community" often. MAPP is about improving community health and achieving health equity for the community. But to do that, we need to know whom we're talking about.* |
| **Define "The Community"**<br><br>*Activity Instructions*<br>25 minutes | • Working in groups of three to five people, members respond to the following questions, write their individual/collective thoughts on sticky notes, and add them to their group's flip chart page.<br>  ○ How do you define community?<br>  ○ Who is in our community? |

| TOPIC AND GOAL | NOTES |
|---|---|
| **Define "The Community"**<br><br>*Debrief*<br>20 minutes | • Facilitate sharing out from each table to the larger group. Ask the group to note any common themes.<br>• Ask the following questions to help narrow down to one definition. Have one person take notes at the front of the room.<br>  o How might we define "the community" for our MAPP process?<br>  o What is clear about our definition of the community?<br>  o What is unclear about our definition of the community?<br>  o What might be our working definition of the community?<br>  o How will this definition help us in our work? |
| ***Break*** | |
| **Mission Statement Development**<br><br>*Introduction*<br>5 minutes | • *At the beginning of this meeting, everyone shared their best understanding of their organization's mission statement. What is the benefit to having a mission statement? How would a mission statement help us collaborate on MAPP?*<br>• Define a **mission statement:** A brief description of the purpose of the collaborative's work and what members will do to fulfill that purpose. Answers the question, "What is our purpose, and how will we achieve it?" |
| **Mission Statement Development**<br><br>*Activity Instructions*<br>45 minutes | • *We will go through a similar activity as we did to define "the community." Which of the following questions should we use to guide our discussion? Let's pick three:*<br>  o Why does this group leading MAPP exist?<br>  o What is the value of MAPP and our work to the community?<br>  o Why is this work of MAPP important? Why should people care?<br>  o What would institutions (e.g., local health departments, schools, prisons, hospitals, corporations) do differently if they contributed to a more equitable community?<br>• In new small groups, members use the same process as above to respond to the selected questions.<br>• Facilitate large-group sharing of their responses. Ask what common themes they see.<br>• *Before we write the mission statement, we will need to define "how" we will achieve this purpose we've started to outline.*<br>• In the same small groups, members respond to these three questions:<br>  o Whom does the work of MAPP serve?<br>  o What do we do as participants of this MAPP work?<br>  o What is the benefit of our work? |
| **Mission Statement Development**<br><br>*Debrief*<br>20 minutes | • Facilitate discussion to bring all ideas together into a one- to two-sentence mission statement:<br>  o From what everyone has shared, what do you think might be the purpose of our work together?<br>  o What is important to know about how we achieve that purpose together?<br><br>*Note: Avoid using meeting time to "wordsmith." Once the group has agreed on the key concepts, have a small group of people work on the mission statement outside of the meeting and share it with the group.*<br><br>• Celebrate the development of your mission statement. |
| ***Break*** | |

| TOPIC AND GOAL | NOTES |
|---|---|
| **Values Statements Development**<br><br>*Introduction*<br>5 minutes | • Develop three to seven values statements that define the core values of the steering committee and other partners in MAPP. Values statements describe how you will work together and with the wider community to achieve the mission.<br>• Define a **values statement:** A statement describing the core values of the MAPP collaborative's culture and work with the community. It answers the question, "What will we need to stay committed to in this work?" |
| **Values Statements Development**<br><br>*Activity Instructions*<br>45 minutes | • *We will go through the same type of small-group activity one more time, using three to five of these questions:*<br>  o What do we need to work together effectively to achieve our mission?<br>  o What type of working environment is necessary for our partnership to achieve its mission?<br>  o What are some ground rules we want to set to ensure we are all working effectively to achieve our mission?<br>  o What must be in place to ensure our MAPP process is centered on the needs of those affected by inequities?<br>  o What values must we uphold to ensure equitable participation?<br>  o How do we ensure we do not inadvertently create, contribute, or support decisions, policies, investments, rules, and laws that contribute to health inequities?<br>  o How do we ensure the community drives and owns the process?<br>  o How do we ensure we can share power with those affected by inequity?<br>• In new small groups, have members use the same process as above to respond to the selected questions.<br>• Next, identify behaviors that demonstrate, and don't demonstrate, the core values, using these two questions:<br>  o What would it look like to demonstrate this value in our MAPP work?<br>  o What kinds of behaviors would signal we were not committed to this value? |
| **Values Statement Development**<br><br>*Debrief*<br>20 minutes | • Facilitate discussion to bring all ideas together into three to seven values statements.<br><br>*Note: Use voting or prioritization to narrow down the core values. Without too much wordsmithing, define each top value to make sure everyone has a shared understanding. Avoid combining multiple values into one statement. Prioritize the top few the group can remember.*<br><br>• Celebrate the development of your values statements. |
| **Questions and Reflections**<br><br>15 minutes | • Facilitate a reflective discussion, which can also help you plan for the community visioning event:<br>  o What stands out to you from our conversations?<br>  o When did you feel motivated during these activities?<br>  o When did you feel unsure during these activities?<br>  o What have we learned about our potential work together?<br>  o How can we keep our mission and value statements alive? |
| **Closing**<br><br>5 minutes | • Thank attendees for participating.<br>• Revisit MAPP workplan or next steps to formalize the steering committee. |

# F. Health Equity Education Resources

## Introduction

### *Purpose of This Resource*

The goal of Mobilizing for Action through Planning and Partnerships (MAPP) is to achieve health equity. To reach that goal, the people and organizations involved in MAPP need a shared understanding of what health equity is and what it looks like to assess and address it effectively. This document includes concepts that will be important for partners involved in MAPP to understand, suggested educational resources for each concept, and suggested tools to support health equity education and practice.

### *How to Use This Resource*

Every community is unique given its shared understanding of health equity and readiness to discuss and address it. Consider this document a launchpad to begin or continue your journey of understanding and addressing health equity.

## Concepts and Resources

There is a lot to explore around what health equity means and how to achieve it. Following are seven concepts that the steering committee and key partners should understand as you progress through MAPP. This partial list will help you build foundational knowledge.

### CONCEPTS FOR FOUNDATIONAL KNOWLEDGE OF HEALTH EQUITY

- The goal of MAPP is to achieve health equity. Health equity is the assurance of conditions to achieve optimal health.
- Health inequities are differences in outcomes that are unjust, unfair, and actionable.
- Health outcomes are driven, in part, by the conditions in which people live. Part of public health's role is to improve these conditions to ensure people can achieve optimal health.
- Differences in the quality of the social determinants of health (like the conditions in which people live and work) are driven by unequal distribution of power and resources. We must address these root causes of inequity to see sustainable change in health inequities.
- Community members and populations experiencing inequities must be included at each step of the MAPP process to meet their needs.
- Addressing health inequities requires gathering sufficient and effective data to understand them.
- To improve population health and advance health equity, we must address both the social determinants of health and the factors that drive their unequal distribution.

The following table includes resources to help you develop a shared understanding of the concepts and how they apply to MAPP. For example:

- Ask partners to complete an anonymous survey ranking their familiarity with and understanding of each concept to identify which concepts to start with.
- Share the resource list with the steering committee and ask each member to review at least one article and share takeaways at a meeting.
- Open some steering committee meetings with a discussion of the concepts.

| RESOURCE CITATION AND LINK | DESCRIPTION |
|---|---|
| **Concept:** The goal of MAPP is to achieve health equity. Health equity is the assurance of conditions to achieve optimal health.[1] | |
| Braveman, P., Arkin, E., Orleans, T., Proctor, D., and Plough, A. (2017). *What is health equity? And what difference does a definition make?* Princeton, NJ: Robert Wood Johnson Foundation. Retrieved March 30, 2023, from www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html | This report includes a definition of health equity, key steps toward health equity, principles to guide efforts toward health equity, common terms, examples of advancing health equity, and other resources. |
| **Concept:** Health inequities are differences in outcomes that are unjust, unfair, and actionable. | |
| Braveman, P. (2014, Jan-Feb). What are health disparities and health equity? We need to be clear. *Public Health Rep, 129*(Suppl 2), 5–8. Retrieved March 30, 2023, from www.ncbi.nlm.nih.gov/pmc/articles/PMC3863701/ | This article proposes definitions to distinguish "health disparities" from "health equity." |
| Klein, R., & Huang, D. (n.d.). *Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative.* Centers for Disease Control and Prevention. Retrieved March 30, 2023, from www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf | This PowerPoint presentation was developed for the Healthy People 2020 initiative to distinguish disparities, inequities, and inequalities, with examples. |
| **Concept:** Health outcomes are driven, in part, by the conditions in which people live. Part of public health's role is to improve these conditions to ensure people can achieve optimal health. | |
| Healthy People 2030. Social determinants of health. Retrieved March 30, 2023, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health | The Healthy People 2030 framework outlines five domains of the social determinants of health. Each is defined and includes objectives to improve health and reduce health disparities. |
| **Concept:** Differences in the quality of the social determinants of health (like the conditions in which people live and work) are driven by unequal distribution of power and resources. We must address these root causes of inequity to see sustainable change in health inequities. | |
| County Health Rankings & Roadmaps. Understand and identify root causes of inequities. Retrieved March 30, 2023, from www.countyhealthrankings.org/take-action-to-improve-health/learning-guides/understand-and-identify-root-causes-of-inequities#/1/0 | This guide "focuses on understanding how inequities in communities impact health." It includes information about root causes, why it is important to address them, and how you can identify them in your community. |

[1] Jones, C. (2014). Systems of power, axes of inequity: Parallels, intersections, braiding the strands. *Medical Care, 52*(10, Suppl. 3), S71–S75. Retrieved from www.tfah.org/wp-content/uploads/2020/08/Jones_SystemsofPower.pdf

| RESOURCE CITATION AND LINK | DESCRIPTION |
|---|---|
| **Concept:** Differences in the quality of the social determinants of health (like the conditions in which people live and work) are driven by unequal distribution of power and resources. We must address these root causes of inequity to see sustainable change in health inequities. (cont'd) | |
| National Academy of Sciences. Exploring the root causes of health inequity. Retrieved March 30, 2023, from https://nap.nationalacademies.org/resource/24624/RootCausesofHealthInequity/ | This resource, as well as the full "Pathways to Health Equity" report from NASEM (2017), outlines the importance of addressing health inequities to improve population health. It describes the interplay between and provides definitions of health behaviors, social determinants of health, and root causes of inequity. Chapter 3 focuses on the root causes of inequity. |
| National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu, A., Negussie, Y., Geller, A., et al., editors. (2017, Jan. 11). *Communities in action: Pathways to health equity.* Washington, DC: National Academies Press (US). Retrieved March 30, 2023, from www.ncbi.nlm.nih.gov/books/NBK425845/ | |
| Bailey, Z.D., Feldman, J.M., & Basset, M.T. (2021). How structural racism works—racist policies as a root cause of US racial health inequities. *N Engl J Med, 2021*(384), 768–773. Retrieved March 30, 2023, from www.nejm.org/doi/full/10.1056/NEJMms2025396 | This article describes structural racism and the importance of acknowledging that racism is "produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government, and embedded in the economic system as well as in cultural and societal norms." It provides examples and outlines the role of institutions to dismantle structural racism. |
| **Concept:** Community members and populations experiencing inequities must be included at each step of the MAPP process to meet their needs. | |
| González, R. (2020). *The spectrum of community engagement to ownership.* Facilitating Power. Retrieved March 30, 2023, from http://bit.ly/3KmJYNW | This spectrum is referred to throughout MAPP to describe the different levels at which community members are given decision-making power in a process like MAPP. The complete resource describes the importance of sharing power and how to use it as an assessment, policy development, campaign development, or evaluation tool. |
| Sathasivam, D., Everette, T.D., & Siegel, K. (2023). *Transformational community engagement to advance health equity.* Robert Wood Johnson Foundation. Retrieved March 30, 2023, from www.rwjf.org/en/insights/our-research/2023/01/transformational-community-engagement-to-advance-health-equity.html | This report provides an overview of why community engagement is important to achieve equity. It outlines different levels of power sharing and provides strategies and tactics to work toward transformational community engagement. |
| **Concept:** Addressing health inequities requires gathering sufficient and effective data to understand them. | |
| Penman-Aguilar, A., Talih, M., Huang, D., Moonesinghe, R., Bouye, K., & Beckles, G. (2016, Jan-Feb). Measurement of health disparities, health inequities, and social determinants of health to support the advancement of health equity. *J Public Health Manag Pract., 22*(Suppl 1), S33–S42. Retrieved March 30, 2023, from www.ncbi.nlm.nih.gov/pmc/articles/PMC5845853/ | This technical article describes five practices to advance health equity nationally by measuring health disparities, health inequities, and social determinants of health. The five practices might be included in a local level health assessment. |

| RESOURCE CITATION AND LINK | DESCRIPTION |
|---|---|
| **Concept:** To improve population health and advance health equity, we must address both the social determinants of health and the factors that drive their unequal distribution. | |
| County Health Rankings & Roadmaps. Develop strategies to promote health and equity. Retrieved March 30, 2023, from www.countyhealthrankings.org/take-action-to-improve-health/learning-guides/develop-strategies-to-promote-health-and-equity#/1/0 | This guide "focuses on identifying strategies to promote health and equity, so that a fair and just opportunity for good health can be a reality for everyone in your community." It includes a description of community-driven solutions, the influence of policy on root causes, effective strategies to promote equity, and how to begin. |
| powell, j.a., Menendian, S., & Ake, W. (2019). *Targeted universalism policy & practice.* Othering & Belonging Institute at UC Berkeley. Retrieved March 30, 2023, from https://belonging.berkeley.edu/sites/default/files/2022-12/Targeted%20Universalism%20Primer.pdf | This is a primer on the concept of "targeted universalism." In this framework, a society sets universal goals and pursues them with targeted processes to specific groups. This provides a framework to understand what strategies and actions are needed to achieve equity. |

## Other Resources and Repositories

The following courses and resource repositories offer information and practices to help you measure, understand, and address health equity, as well as facilitate effective conversations about the topics. Use the following tools and resources to advance your understanding of and work toward health equity. For example:

- Select a training course(s) to complete as a group as you conduct MAPP.
- Collectively identify two to three learning areas or practices you would like to pursue in this MAPP cycle.
- Review at least one resource repository in detail and select two to three practices you would like to include in this MAPP cycle.

| TOOL, TYPE, AND SOURCE | DESCRIPTION |
|---|---|
| **Roots of Health Inequity**<br>*Online course*<br><br>National Association of County and City Health Officials (NACCHO), supported by the National Institutes of Health<br>**http://rootsofhealthinequity.org** | This online learning collaborative offers a starting place for those who want to address systemic differences in health and wellness that are actionable, unfair, and unjust. It includes case studies, readings, and presentations and is designed to be completed as a group. |
| **Power Primer: A Tool in Mobilizing for Action through Planning and Partnerships (MAPP) 2.0**<br>*Educational resource and practical toolkit*<br><br>NACCHO<br>Download from **www.naccho.org/mapp** | The Power Primer is a resource for communities to explore how power impacts health equity in their community and how they can address power imbalances to lead a more equitable process. It is designed for use with MAPP. |
| **Health Equity and Social Justice Resources**<br>*Resource repository*<br><br>NACCHO<br>**www.naccho.org/programs/public-health-infrastructure/health-equity#resources** | NACCHO's Health Equity and Social Justice program advances the capacity of local health departments to confront the root causes of inequities in the distribution of disease and illness through public health practice and their organizational structure. This website includes trainings, resources, and recommended readings. |

| TOOL, TYPE, AND SOURCE | DESCRIPTION |
|---|---|
| **Health Equity Guide**<br>*Repository and toolkit*<br><br>Human Impact Partners<br>**https://healthequityguide.org** | This guide outlines strategic practices that health departments can use to advance health equity from creating internal organizational change to addressing inequities in the community. It includes a database of toolkits, articles, websites, templates, guides, and other resources to advance the practices. |
| **Health Equity Resource Library**<br>*Resource repository*<br><br>Center for Public Health Practice, Minnesota Department of Health<br>**www.health.state.mn.us/communities/practice/resources/equitylibrary/** | This library includes tools, templates, and resources to build public health departments' health equity capacity. It includes information to support discussions about health equity, data collection, and policy development. |
| **Health Equity Strategy Bank**<br>*Repository*<br><br>NACCHO<br>**www.virtualcommunities.naccho.org/mappnetwork/home** | This online repository offers strategies that local jurisdictions implementing MAPP have used to address equity. Health departments can submit their own strategies or find ideas of evidence-based practices for their community health improvement plan. |

# G. Example Visioning Event Agenda and Facilitation Guide



*Goal:* Community members envision and describe an aspirational future for a healthy community, which will guide the rest of the MAPP process.

*Agenda:*

- Welcome and Introductions
- Define "The Community"
- Vision Statement Brainstorm
- Vision Statement Development
- Celebration
- Closing



## *Agenda with Notes for Facilitation*

| GOAL | NOTES, QUESTIONS, AND ACTIVITIES |
|---|---|
| **Welcome and Introduction (15 minutes)**<br><br>Welcome participants with enthusiasm to the MAPP Visioning Event. | **Set-up:** Music, refreshments, colorful materials, decorations, and greeters make an inviting space.<br><br>**Instruct:** Describe what MAPP is and why developing a shared vision for the community is important. Outline the agenda.<br><br>**Activity:** Do a short, easy icebreaker at tables or with the full group (e.g., ask, What do you like to do for fun? What was your first concert?) |
| **Define "The Community" (45 minutes)**<br><br>Collectively define "the community," which will be the focus of this collaborative MAPP process. | **Set-up:** Each table has a flip chart titled, "Our community includes…"<br><br>**Instruct:** The goal of MAPP is to achieve health equity in the community. Whom do we mean when we say "the community"? Who exactly is in that group?<br><br>**Activity:** At each table, participants respond to these questions. Take notes on sticky notes and add to a flip chart.<br>• How do you define the community?<br>• Who is in our community?<br><br>**Debrief:** Each table shares one to two key takeaways. Take notes on a flip chart at the front of the room.<br><br>*Note: Affinity diagrams are useful tools to narrow down a large set of items into key themes (refer to **this guidance**).*[1] |
| ***Break (15 minutes)*** | |

[1] https://balancedscorecard.org/wp-content/uploads/pdfs/affinity.pdf

| GOAL | NOTES, QUESTIONS, AND ACTIVITIES |
|---|---|
| **Vision Statement Brainstorm (30 minutes)**<br><br>Envision an aspirational future for the community. Participants brainstorm, "Where do we want to be in the future?" This is where the collective dreaming begins. | **Set-up:** Each table has a flip chart titled, "Our vision for a healthy community is..."<br><br>**Instruct:** It is easier to work toward a goal when it is well-defined. What is our vision for a healthy community? Dream big about what it would look like for our community to truly thrive. Visualize without considering time, resources, or funding. Include details of what it would feel like to live in that future state.<br><br>**Activity:** Each table responds to three to five of the following questions (or add your own). Everyone should respond to the same questions.<br>• What does an equitable and healthy community mean to you?<br>• What are important characteristics of a healthy community for all who work, learn, live, and play here?<br>• In your ideal community, what would you hear, see, taste, touch, and smell?<br>• In five years, if our community successfully worked toward achieving health equity, what would we have accomplished?<br>• What would be different in our community if all people had circumstances in which they could live healthy and flourishing lives?<br>• What would our community look like if all people and groups were equally represented in positions of power and decision-making?<br><br>***Optional activity:*** Newspaper Article: It's the year 20XX, and a national newspaper is writing a feature article on your community and how it has become an ideal, equitable place to live. What do you hope they will write? What types of things will residents say when interviewed about their life in the community? What kinds of images would they show? What does a healthy community look like? |
| ***Break (15 minutes)*** | |
| **Vision Statement Brainstorm (30 minutes)**<br><br>Develop a two- to three-sentence vision statement based on the group brainstorm that answers the question, "Where do we want to be in the future?" | **Set-up:** Hang the visioning flip charts on the walls around the room.<br><br>**Instruct:** Ask participants to do a "gallery walk" of the visions on the flip chart. Then, facilitate a conversation:<br>• *What stands out to you from our visioning brainstorm?*<br>• *What themes are common across the groups?*<br>• *What themes feel critical to include in our vision statement?*<br><br>Take notes on their responses and help the group form a two- to three-sentence vision statement. You might be able to complete your statement in the meeting, or a sub-group of three to five people can "wordsmith" after the meeting.<br><br>When you have reached a comfortable stopping point (and not gone over time), facilitate a closing discussion:<br>• *What resonates with you from today?*<br>• *What excites you about our community's future?*<br>• *What opportunities are there to work toward our vision?*<br>• *How would you like to stay involved in working toward this vision through MAPP?* |
| **Celebration (15 minutes)**<br><br>Celebrate this achievement and everyone's participation. | Close with a celebratory activity like writing the vision statement on a large sheet of paper and having everyone sign it or take a photo together holding the vision statement. |
| **Closing (15 minutes)**<br><br>Close the session and garner interest in continued engagement. | Thank participants for joining the session. Provide information about how they can stay involved in MAPP to help see this vision become a reality. |

# H. Workgroup Charter Example



| | |
|---|---|
| **Workgroup Name:** Partnership Building Workgroup | |
| **Charter Version/Date:** 1.0/April 10, 2024 | |
| **Subject:** Partnership building | |
| **Problem/Opportunity Statement:** In this MAPP cycle, Blue County has made it a priority to build more partnerships with organizations outside of health and healthcare. This workgroup will help identify organizations, make initial connections, and develop a relationship for current or future partnership. They will also share progress on the MAPP process with these organizations. In the last cycle, Blue County collaborated with 8 partners. This workgroup will help increase that to 12 organizations. | |
| **Chairperson:** Jane Smith | |
| **Team Members, Areas of Expertise, and Roles** | |
| **Name, Organization/Affiliation** | **Areas of Expertise to This Workgroup and Roles** |
| Jane Smith, Blue County Health Department | Worked on last 2 MAPP cycles; regularly builds partnerships for community health work |
| Anita Brown, Blue County Cares | Executive director of a social services organization that connects clients to services with organizations across the county; has lots of connections with other social and health services organizations |
| Jeremiah Jones, Action in Blue County | Has been organizing within the county for 10 years; can help bridge connections to other organizations representing residents' needs outside of health/social services |
| **Action Plan** | |
| **Scope:**<br>• This workgroup will identify organizations, contact them to gauge their interest, and host one-hour introductory meetings with each.<br>• After the introductory meetings, the workgroup establishes the best fit for the organization within the MAPP process (e.g., suggest how they could become involved; add them to a list of partner contacts who are kept up to date).<br>• After making this determination, contact with the new partner organizations will be managed by the appropriate MAPP teams (e.g., assessment design team, steering committee). The workgroup will not be solely responsible for the ongoing communication with the organization. | |
| **Considerations:**<br>• Many organizations have noted they are too busy with their own priorities to get involved in MAPP this cycle, which may prevent their participation.<br>• Workgroup members each work within health or healthcare. This might extend the time it takes to identify organizations. | |

**Available Resources:**

- Workgroup member time to identify and contact organizations
- Meeting space for meet-and-greets
- Handouts to share MAPP information with potential partners

**Other Resources Required:**

- Funding to facilitate travel of our team/partner organizations for initial meetings

**Key Stakeholders:**

- Steering committee: They are developing the larger list of partners for MAPP; we can update them about our progress during monthly meetings and establish a process to let them know when a new organization is confirmed. They can also help us refine how a particular organization could become more involved.
- Existing partner organizations: We will tell our list of committed partners when a new partner is added so they can begin to collaborate quickly.

**Goals and Objectives**

| Goals | Objectives | Process Metrics |
|---|---|---|
| Develop multi-sector, diverse partnerships for this and future MAPP cycles that represent the diversity of the community and provide needed resources for MAPP. | By June 22, 2024, develop a list of at least 10 other local organizations outside of public health and healthcare. | # of organizations considered for involvement<br># of sectors outside of health/ healthcare explored |
| | By July 9, 2024, send an introductory email or call each organization on the list. | # of organizations from the list contacted |
| | By July 23, 2024, meet with each organization to discuss their potential involvement in MAPP. | # of organizations from the list who replied to initial email/call<br># of meetings scheduled with organizations<br># of follow-ups to meetings received |

**Communications Plan**

| | |
|---|---|
| Regular meeting time and location: | • Second Wednesday of the month, 1:00 PM EST, virtually<br>• 30-minutes after each steering committee meeting (in person) |
| Preferred method of communication: | • Email to entire workgroup |

**Tracking Progress**

| | |
|---|---|
| Tracking: | • Copy CQI Tracking Sheet to use for this workgroup.<br>• Revisit at the end of each meeting. Tim refines updates and adds to the tracker. |
| Reporting: | • Discuss items to report each month during the virtual meeting.<br>• Jane emails the core group and steering committee and announces updates at in-person meetings. |

**Accountability Mechanisms:**

- Questions can be asked by email, but updates will be given during one of the twice-monthly meetings.
- Each member should report monthly on the following:
  - Progress on their assignments
  - Challenges
  - Questions

# I. Workgroup Suggested Tiered Strategies



The following suggested strategies will help you plan how to address the priorities identified in the Starting Point Assessment for Mobilizing for Action through Planning and Partnerships (MAPP). The strategies are organized into three tiers of Good, Better, and Best practices and are divided into subcategories aligning with what was assessed in the Starting Point Assessment.

| COMMUNITY ENGAGEMENT | | |
|---|---|---|
| **GOOD** | **BETTER** | **BEST** |
| **Decision-making power of community members over community health improvement (CHI)** | | |
| Reserve spaces on the steering committee for representatives of community power-building organizations<br><br>Community Engagement Spectrum Level: Involve | Reserve spaces on the steering committee for community members representing populations negatively impacted by inequities<br><br>Community Engagement Spectrum Level: Collaborate | Steering committee primarily comprises community power-building organizations, community members, and community-based organizations<br><br>Community Engagement Spectrum Level: Defer To |
| **Outreach to engage community members in MAPP** | | |
| Invite community organizers and community power-building organizations to share about their work and to discuss opportunities to collaborate | Use connections with community organizations to invite participation of communities experiencing inequities | Include community champions in leadership roles who can make connections to communities experiencing inequities |
| **Gathering community input** | | |
| Participate in a local public event to gather community input on the MAPP process | Develop and apply a method to gather broad community feedback at the beginning and end of each MAPP phase | Standardize a process to continuously gather, interpret, and incorporate community feedback on MAPP |
| **Paying community members for their time** | | |
| Provide a stipend to community members who participate in steering committee meetings | Provide a stipend to community members for participating on the steering committee and for any additional MAPP work they complete | Provide community members who work on MAPP a stipend/ hourly pay in proportion to what full-time staff of your organization are paid for the same amount of time |
| **Sharing updates with the community** | | |
| Share the community health [needs] assessment (CH[N]A) and improvement plan (CHIP) widely through multiple media methods (online, print, mail) | Provide a quarterly newsletter about your MAPP progress | Continuously update a public website with the MAPP process timeline and milestones achieved to date |

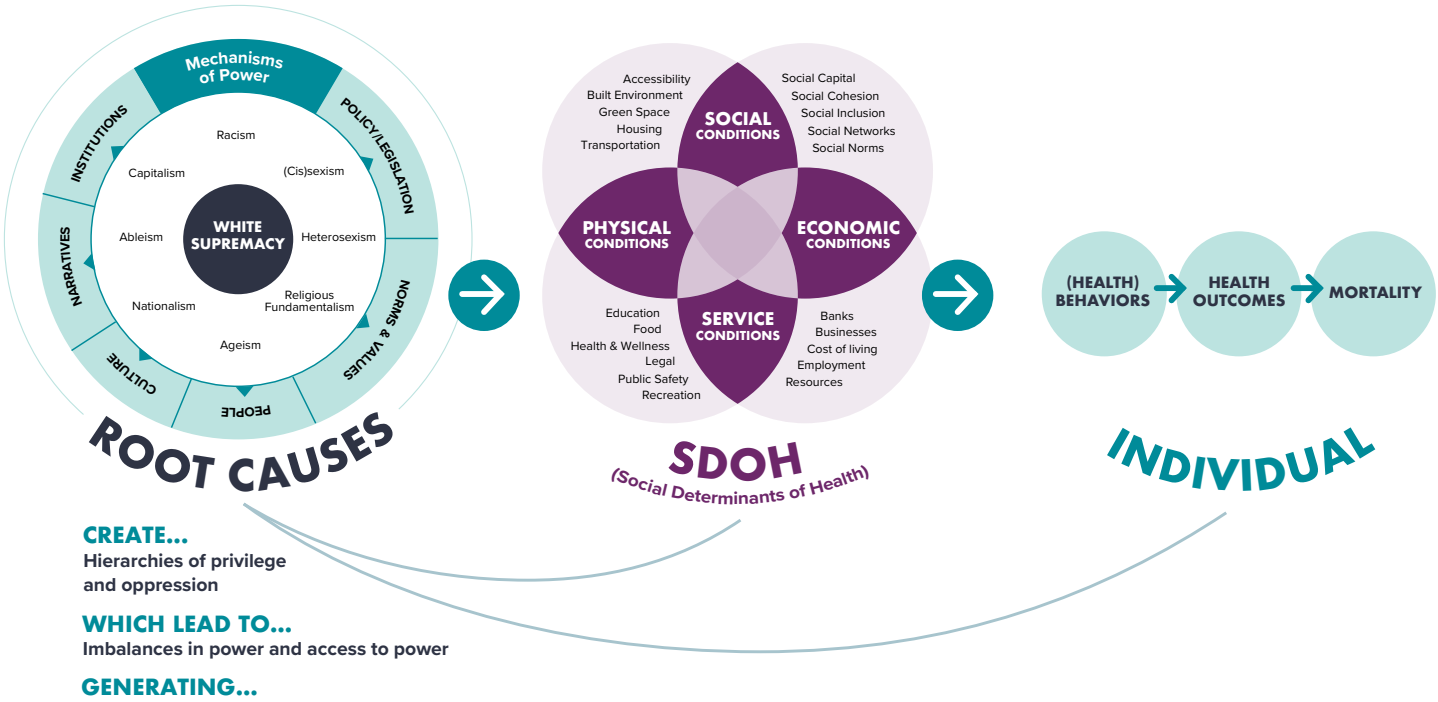
| PARTNERSHIPS | | |
|---|---|---|
| **GOOD** | **BETTER** | **BEST** |
| **Diversity of organizations involved in MAPP** | | |
| • Engage at least one organization within each sector related to community health and equity<br>• Learn about the work of local community organizers and request a conversation to learn more about their work | • Engage organizations that represent each level of the health equity spectrum<br>• Identify ways to align CHI work with the goals of local community organizers and invite these organizations to a conversation about collaboration | • Talk with organizations whose work addresses root causes of health inequity about how their participation in CHI can help address root causes |
| **Partnership strength** | | |
| • Invite partner organizations to share their hopes for the partnership and what is needed to increase their engagement | • Invite conversation at each steering committee and partner meeting about how partners' work aligns with the goals of the coalition | • Explore options to formally structure partnerships into a coalition (e.g., memoranda of understanding, developing a mission specifically for the coalition)<br>• Identify opportunities to align goals across partner organizations' strategic planning efforts |
| **Partner engagement across MAPP** | | |
| • Identify how partner organizations can be involved in each step of MAPP | • Adopt a rotating schedule in which a different partner organization leads or hosts each MAPP meeting | • Set expectations within CHI for responsibility to be divided among partner organizations and not one or two "lead" organizations<br>• Identify areas of MAPP that can be transferred to be the responsibility of partner organizations |
| **DATA AND ASSESSMENTS IMPROVEMENT STRATEGIES** | | |
| **GOOD** | **BETTER** | **BEST** |
| **Data sharing and data access** | | |
| • Develop data-sharing agreements to represent at least 50% of involved sectors<br>• Include secondary data sources that can be disaggregated by race and ethnicity | • Develop data-sharing agreements to represent at least 70% of involved sectors<br>• Include at least one secondary data source that can be disaggregated by at least three subgroups (e.g., gender, race, ethnicity, age) | • Develop data-sharing agreements to represent at least 90% of involved sectors<br>• Include at least two secondary data sources that can be disaggregated by at least three subgroups (e.g., gender, race, ethnicity, age) |

| **Quantitative assessment** | | |
|---|---|---|
| *Indicators* | | |
| • Include indicators within each level of the health equity spectrum (systems of power, privilege, and oppression, social determinants of health, and health behaviors and outcomes) | • Include at least two indicators at the "systems of power, privilege, and oppression" category of the assessments | • Indicators are spread across root causes, social determinants of health, and health outcomes and behaviors |
| *Survey methods* | | |
| • Use survey questions from valid and reliable tools (e.g., Behavioral Risk Factor Surveillance System)<br>• Use convenience or "snowball" sampling for data collection (e.g., invite people you know to participate) | • Use cluster or stratified sampling for data collection (e.g., randomly select and invite participants from organizations, schools, or other groups who share experiences)<br>• Compare results to national/state/Tribal/regional/county level trends | • Use random sampling for data collection (e.g., randomly select and invite participants from all the people who live within certain ZIP codes, communities, or Tribes) |
| *Observation methods* | | |
| • Develop a brief form to complete when observing, watching, or listening to the topic of interest<br>• Train one team member to use the form<br>• Identify one to two locations where observations can be recorded | • Develop a brief form in collaboration with community members to complete when observing, watching, or listening to the topic of interest<br>• Train two to three team members to use the form<br>• Identify three to five locations where observations can be recorded and later compared<br>• Consider other ways to record observations (e.g., photos, video) | • Train four to eight team members to use the form<br>• Identify six to 10 locations where observations can be recorded and later compared<br>• Use other ways to record observations through pictures, videos, etc.<br>• Recruit community members/partners to complete and submit the form. Collect basic demographic information to account for location of observations and other contextual details. Consider paying or offering incentives for participating community members. |
| *Secondary methods* | | |
| • Use summary tables with data from secondary data source to find data specific to the indicators in your quantitative assessment<br>• Filter data by geography to find the lowest level of data available on your community<br>• Filter data by year to explore trends over time<br>• Document source and develop a table to share results | • Download raw data from publicly available data source<br>• Clean data and narrow to specific indicators in your quantitative assessment by geography and years<br>• Run descriptive statistics for key indicators (e.g., prevalence, count, incidence)<br>• Document source and develop data-visualization products to share results (e.g., infographic) | • Use interactive **mapping techniques** to visualize place-based inequities and examine potential solutions to address inequities |

| | | |
|---|---|---|
| **Qualitative assessment** | | |
| *Populations represented* | | |
| • At least 80% of populations experiencing inequities are represented in qualitative data | • At least 90% of populations experiencing inequities are represented in qualitative data | • 100% of populations experiencing inequities are represented in qualitative data |
| **Systems/partners assessment** | | |
| • Invite partner organizations who participated in the last MAPP cycle to complete the survey<br>• At least 50% of partner organizations who completed the survey attend at least one collaborative meeting | • Use network of current partners to identify one to two new organization(s) to participate in the partners' assessment<br>• At least 70% of partner organizations who completed the survey attend at least one collaborative meeting | • Use network of current partners to identify three to five new organizations to participate in the partners assessment<br>• At least 90% of partner organizations who completed the survey attend at least one collaborative meeting |
| **Sharing results of the CH[N]A with the community** | | |
| • Have the CH[N]A available both in print and on a website that's easy to find | • Use data visualization or GIS mapping tools to display the data | • Use an online dashboard system that is updated regularly and can be modified to show data related to various demographics |
| **CHIP DEVELOPMENT AND IMPLEMENTATION** | | |
| **GOOD** | **BETTER** | **BEST** |
| **CHIP priorities across health equity spectrum** | | |
| • Include priorities at each level of the health equity spectrum | • Majority of priority areas are focused on social determinants of health or root causes | • Limit priority areas that are dedicated to health behaviors/ outcomes to no more than 20% of your CHIP |
| **Monitoring and evaluating the CHIP** | | |
| • Develop a system and expectations for gathering data on CHIP progress<br>• The organization facilitating the CHIP collects data from partners twice a year | • Partner organizations report their own data quarterly to the organization facilitating the CHIP<br>• Progress on CHIP priorities is updated twice a year | • Progress on CHIP priorities is updated at least quarterly<br>• Partner organizations report their own data directly into the CHIP monitoring system |
| **Reporting progress** | | |
| • Develop a system and expectations for reporting progress on the CHIP to the community (e.g., annual report)<br>• Have the CHIP available both in print and on a website that's easy to find | • Report progress on the CHIP at least annually | • Use data visualization or GIS mapping tools to display updated CHIP priority data<br>• Report progress on the CHIP twice a year |

| LEADERSHIP SUPPORT TO ADDRESS HEALTH EQUITY | | |
|---|---|---|
| **GOOD** | **BETTER** | **BEST** |
| **Further develop the support of the leading organizations in CHI** | | |
| • Ensure these figures are involved within MAPP and are aware of how they can contribute to its success | • Communicate the focus to advance health equity through CHI within mission, vision, and values statements | • Develop a strategic plan outlining the organization's goals to advance equity internally and externally |
| **Engage those who are potentially supportive of health equity work** | | |
| • Identify the priorities of these people and groups and areas for potential alignment<br>• Identify potential resources these parties could bring to MAPP | • Develop strategic communications to talk about the goal to achieve health equity through CHI with these people and groups | • Facilitate a discussion with the organizations or people to find alignment in activities and identify resources they can dedicate to CHI |
| **Prevent those who are vocally unsupportive from derailing efforts and lessen the potential loss of resources** | | |
| • Identify the impact their lack of support will have on MAPP<br>• If their lack of support will have an impact, identify priorities of these people and groups and seek to find alignment in values, efforts, and desired outcomes | • If their lack of support will have an impact, facilitate a conversation with them to gain clarity about what they hope to see from the MAPP process or the outcome they want | • If their lack of support will have an impact, identify ways to involve them without derailing the community's goals<br>• If their lack of support will not have a major impact, aim to understand their view and use that understanding to strengthen your messaging |

# J. Health Equity Action Spectrum




| | ROOT CAUSES (STRUCTURAL) | ROOT CAUSES (INSTITUTIONAL) | SDOH | INDIVIDUAL |
|---|---|---|---|---|
| **WHAT?** | This level specifies actions that address the underlying structural – social, political and economic – systems that lead to hierarchies of privilege and oppression, imbalances in power and resultant social injustices throughout society. | This level specifies actions that address an organization or institution's culture, practices, policies and processes that lead to health inequities at the community and individual levels. | This level specifies actions taken within a community to address that community's conditions and resources that impact community member's ability to optimize health. | This level specifies actions that address different populations' access to, and quality of, care to alleviate risk of/and health outcomes at the individual level. |
| **IMPACT?** | **Shifts social ideologies, norms, beliefs, values and culture** | **Shifts POWER from institutions to comunities.** | **Increases access to care and resources (reactive); builds whole, healthful, and sustained infrastructure (preventive) in a community** | **Increases access to care (reactive), information and resources (preventive)** |
| **Example Strategies** | | | | |
| | Aligning with social movements<br>Building narrative power<br>Defering to community leadership<br>Rectifying historical injustices<br>Subverting harmful dominant narratives | Accountability metrics<br>Building power with communities<br>Centering leadership of directly impacted<br>Cross-sector coalition building<br>Health and Racial Equity Impact Assessments (HEIAs and REIAs)<br>Equity reviews to revise inequitable policies, practices, or programs<br>Recruitment of, training of, and pathways to employment for community members | Advocating for policy change at the local/community level<br>Community advisory boards<br>Data-sharing agreements<br>Incorporating community voice | Compensating community members for their expertise<br>Culturally relevant care<br>Language justice<br>Non-stigmatizing language<br>Targeted outreach<br>Trauma-informed care |

# PHASE II:
# TELL THE COMMUNITY STORY

## Introduction

*Phase II: Tell the Community Story* emphasizes the need for a complete, accurate, and timely understanding of community health and well-being across all sub-populations within the community. This phase guides communities through a CH[N]A done through an array of views, ranging from health outcomes to root causes of those outcomes.

### GOALS:

- Engage the community in developing a comprehensive and timely CH[N]A
- Identify the top population health priorities and health inequities in the community, including their root causes

### OUTCOME METRICS:

- # of sub-populations that were given power to shape the CH[N]A
- # of community members that understand the importance and effects of the CH[N]A

### STEPS:

1. Form the Assessment Design Team
2. Design the Assessment Process
3. Do the Three Assessments
4. Triangulate Data, Identify Themes, and Develop Issue Statements
5. Develop Issue Profiles through Root Cause Analysis
6. Share CH[N]A Findings

# Definitions

When beginning the CH[N]A using MAPP, revisit the definitions for the following Glossary terms: **health inequity, SDOH, root causes of health inequity**, and **optimal health**. These definitions remind us that communities are full of health inequities.

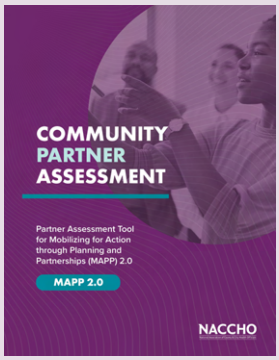
MAPP uses the CH[N]A to uncover not only what inequities exist but also why they exist. Phase II uncovers health inequities through the collection and analysis of quantitative and qualitative data on root causes of health inequities and their influence on data related to the SDOH, risk behaviors, and health outcomes.

Merely assessing health status through health indicators, such as chronic disease rates, paints an incomplete picture that prevents strategic action to address the root causes. Collecting data from different levels of indicators, ranging from clinical care all the way upstream to root causes of health inequities (systems of power, privilege, and oppression), allows communities to paint a full picture of existing inequities and understand how to address these inequities to create optimal health for all types of populations within their communities.

## The Three Assessments

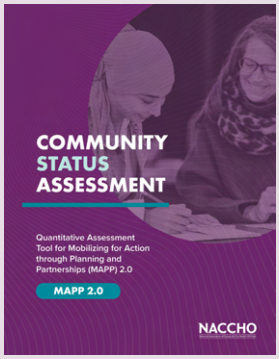
Three assessments, described on the following page, are an essential component of Phase II because they achieve the following:

- Help communities collect data and information from several perspectives including qualitative and quantitative sources
- Advance the community's understanding of health inequities
- Examine indicators ranging from downstream health outcomes and health behaviors, SDOH, and systems of power, privilege, and oppression
- Draw on the capacity of a broad range of sectors and partners to achieve health equity
- Provide rich views and strengths-based data from people with lived experience
- Guide communities through a deep analysis of historical, systemic, and structural information that reveals the root causes of inequity



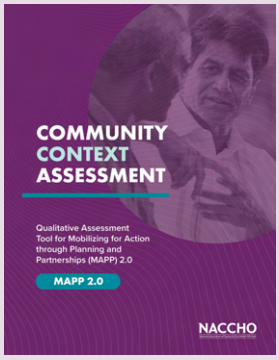

## COMMUNITY PARTNER ASSESSMENT (CPA)

Replacing the LPHSA from MAPP 1.0, this assessment provides a structure for all community partners to look critically at their (1) individual systems, processes, and capacities; and (2) collective capacity as a network of community partners to address health inequities. Use the CPA to identify current and future actions to address health inequity at individual, systemic, and structural levels.




## COMMUNITY STATUS ASSESSMENT (CSA)

This assessment collects quantitative data on the status of your community such as demographics, health status, and health inequities. The CSA helps a community move "upstream" and identify inequities beyond health behaviors and outcomes, including their association with SDOH and systems of power, privilege, and oppression. This foundational community-driven assessment will reveal both data gaps and issues and inequities that need to be further explored through other assessments.




## COMMUNITY CONTEXT ASSESSMENT (CCA)

This assessment is a qualitative tool to assess and collect data through three domains: community strengths and assets, built environment, and forces of change. It collects the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems. The CCA centers on people and communities with lived experiences and lived expertise. It focuses on the views, insights, values, cultures, and priorities of those experiencing inequities firsthand. Communities may tailor the domains based on their own context.

You may do the three assessments in any order that makes sense for your community. This phase of MAPP aligns the three assessments to paint the picture of health within the community.

*Step 2: Design the Assessment Process* gives guidance on how to determine the most effective way to do these assessments in your community.

# Step 1: Form the Assessment Design Team

| | |
|---|---|
| **GOAL** | Recruit a team representative of the community and responsible for coordinating the design, implementation, and interpretation of the assessments. |
| **SMARTIE Objective** | By XX date, develop an ADT, which includes at least eight people with data expertise and resources, who represent sub-populations identified in the previous CH[N]A to experience the greatest inequities. |
| **Supplemental Tools/Resources** | • Building Your Assessment Design Team Worksheet<br>• Assessment Design Team Charter Template |

Aligning the three assessments and ensuring information from all three is used collectively to paint the picture of health within the community is essential to completing this phase. Having one ADT that can participate in all aspects of Phase II, particularly the three assessments, ensures communities can easily find connections throughout the spectrum of indicators (from downstream to upstream) and use these connections to describe the extent of the health issues in their communities.

Select a chairperson (or two) for the ADT to guide the team and keep work on track with the activities outlined in the larger MAPP workplan. At least one chairperson should be a member of the lead organization for the CHI process who has extensive knowledge and expertise in data collection, analysis, synthesis, and communication (e.g., LHD director of planning and evaluation). Having another chairperson that represents a community partner (e.g., steering committee member or lead staff from a steering committee organization) will also ensure that the community has ownership of and representation in this process from the beginning.

When forming the ADT, recruit eight to 10 diverse members who bring the following expertise and resources to the process:

- Data collection (e.g., survey administration and focus group facilitation)
- Collecting quality of life data
- Access to data and data systems and the ability to share data
- Data analysis and interpretation
- Communicating data
- Data literacy and working with others to become data literate
- Understanding health equity and SDOH needs
- Understanding forces of change and associated opportunities and threats (e.g., migration in and out of a community, growing disillusionment with government, hospital closure, natural disaster, and the passage of new legislation)
- Understanding community context (e.g., community history, demographics, culture, languages, norms, and lived experiences)
- Knowledge of health inequities across geographic areas
- Identifying and pooling resources (e.g., funding, space, and staff)
- Process improvement
- Fostering community engagement and participation
- Experience with design thinking

Specific areas of expertise are recommended for doing each of the three assessments. The assessment guidance documents explain this in more detail.

Although certain expertise would be very useful in different steps of Phase II (e.g., experts in communicating data should be heavily involved in Steps 4 through 6, and those with access to data and data systems should be heavily involved in Steps 2 and 3), you should engage all members of the ADT throughout all of Phase II. ADT members should include members of the steering committee, staff from steering committee and core group organizations, partners, stakeholders, and community members.

To understand how to engage team members with different areas of expertise, use the Building Your Assessment Design Team table to brainstorm potential members of your ADT, their areas of expertise, and their role in each step of Phase II. At this time, revisit the activities you completed in *Phase I, Step 2: Establish or Revisit CHI Leadership Structures* to identify people and organizations for MAPP involvement. Review the organizations or people you assigned to the ADT and consider them as you continue to build this team and refine roles of team members.

Use the following designations to note the role ADT members should have in each step:

- **Lead Role** *(Heavy Effort)*: Directs the team during this step of the phase. The lead, who can work with a co-lead, will work with the ADT chairperson(s) to create activities that will help reach the objectives for the step, assign team members to activities, determine how the team will report progress, and schedule and prepare meetings to complete the step.
- **Key Role** *(Moderate Effort):* Manages select activities determined by the ADT chairperson(s) and lead for the step and guides other team members in their area of expertise to assist in completing activities. Team members with a key role for a step should attend all ADT meetings while the step is in progress.
- **Supporting Role** *(Minimal Effort):* Assists team members with key roles in doing activities related to the step and may attend ADT meetings less frequently while the step is in progress.

Someone who takes a lead role in one step might take a key or supporting role in another to divide the work and align people's expertise with the task.

## BUILDING YOUR ASSESSMENT DESIGN TEAM WORKSHEET

**Chairperson(s):**

| Member | Area(s) of Expertise | **STEP 2:** Design the Assessment Process | **STEP 3:** Do the Three Assessments: CPA | **STEP 3:** Do the Three Assessments: CSA | **STEP 3:** Do the Three Assessments: CCA | **STEP 4:** Triangulate Data, Identify Themes, and Develop Issue Statements | **STEP 5:** Develop Issue Profiles through Root Cause Analysis | **STEP 6:** Share CH[N]A Findings |
|---|---|---|---|---|---|---|---|---|
| *e.g., Jane Doe* | *Data analysis and interpretation* | *Key Role* | *Supporting Role* | *Key Role* | *Key Role* | *Lead Role* | *Lead Role* | *Key Role* |
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Once you have formed the ADT, orient members to MAPP and concepts of health equity and community engagement. Refer to the Health Equity Education Resources from *Phase I, Step 3: Engage and Orient the Steering Committee* and tailor these presentations to your ADT. ADT members who are not on the steering committee must also become familiar with these concepts to ensure Phase II aligns with the MAPP Theory of Change and Foundational Principles.

Use the first meeting with the ADT to review these presentations and develop an Assessment Design Team Charter that outlines the team's scope of work, roles and responsibilities, and expectations. Revisit the ADT members and their roles at the beginning of each remaining step of this phase so you can evaluate if you need to add others to the team to provide any missing skills. Reviewing the team structure and each person's role on the team at each step ensures progress remains consistent. Including expectations in your charter can help the ADT successfully do Phase II.

All types of communities with various resources, partners, data literacy levels, and data skills sets are encouraged to use MAPP. Here are some potential challenges and opportunities you might encounter when developing and working with the ADT.[13]

- **Varying Levels of Data Literacy:** ADT members may not all have the same level of understanding or use the same language for data, analysis, and outcomes. Being able to read, write, and communicate data in context is essential for this phase of MAPP. Take time to ensure everyone has a similar level of understanding during your first meeting. Develop shared language and goals for how you will discuss the assessments to ensure the team works collectively to strengthen its data literacy.
- **Alignment of Different Levels of Data and Analytics Skills:** While all ADT members will focus on all aspects of Phase II, their data and analytics skills are likely to match certain steps better than others. Understand the skills of each member, how their skills will be most useful, and how to pair members to complement skill sets. The Building Your Assessment Design Team Worksheet can help you map this.

**POWER PRACTICES FROM THE POWER PRIMER**

1. **Process—Unpack Personal and Organizational Power and Privilege**
2. **Form—Build a Container for Your Work Together**
5. **Share—Practice Power-Sharing with Partners and Community Internally and Externally**

[13] Goasduff, L. (2020). *Avoid 5 pitfalls when building data and analytics teams.* Gartner. Retrieved March 29, 2023, from www.gartner.com/smarterwithgartner/avoid-5-pitfalls-when-building-data-and-analytics-teams/

# *Assessment Design Team Charter Template*

The goal of a team charter is to define and document your team's objectives, resources, and constraints.[14] Creating a team charter will help you to learn about team members and put structure or boundaries around the group process. To build the best team possible and avoid potential conflicts that can hinder productivity, you should establish guidelines about how you will work together.[15] Use this template to develop a charter for the ADT.

**Chairperson(s):** Name the person(s) who will guide the team and keep work on track with the activities outlined in the larger MAPP workplan. At least one chairperson should be a member of the lead organization for the CHI process who has extensive knowledge and expertise in data collection, analysis, synthesis, and communication (e.g., LHD director of planning and evaluation). Having another chairperson that represents a community partner (e.g., steering committee member or lead staff from a steering committee organization) will also ensure that the community has ownership of and representation in this process from the beginning.

**Members, Roles, and Responsibilities:** Refer to your completed Building Your Assessment Design Team Worksheet and include names, roles, and responsibilities here.

| Name | Roles and Responsibilities |
|---|---|
| e.g., Jane Doe | Lead for data triangulation, identifying top issues, and developing issue profiles through root cause analysis. Will play a key role in designing the assessment process and doing the CSA and CCA. Will support doing the CPA. |
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**Team Purpose:** The ADT ensures that the process for doing the assessments and interpreting the data from them to create issue statements and develop a comprehensive CH[N]A is cohesive. The ADT ensures this work contributes to achieving the community vision and practices the community values to make sure the process centers on community.

**Vision:** Include the vision developed in Phase I.

**Guiding Values:** Include the values developed in Phase I and any other principles or norms that define how this team will work together during the project.

**Scope of Work:** The ADT does Phase II, which includes the following activities:

- Designing the process your community will use for the three assessments
- Doing the three assessments and analyzing and interpreting the data from them
- Identifying crosscutting themes from the three assessments and developing a full understanding of the community through data triangulation
- Interpreting findings and crosscutting themes to develop issue statements that reflect the issues faced by the community
- Developing issue profiles of the identified issues by using root cause analysis methods
- Developing and sharing findings through a CH[N]A

Note any other activities required of the ADT and the timeframe in which the team expects to complete this work.

**Governance:** Include information on communication, decision-making, conflict resolution, and commitments.[16] Think through the following:

- How will the team communicate, including frequency and methods (e.g., email, social media, team meetings)?
- What is the maximum expected response time?
- How will decisions be made?
- How will you stay on track?
- How will you resolve differences?
- How will you handle different levels of participation and commitment?
- What process will you follow if someone does not live up to his or her responsibilities?
- What are the consequences for poor performance?

**Meeting Schedule:** Include the general timing of meetings (e.g., two-hour meetings quarterly, one-hour monthly meetings, or one-hour meetings every second and fourth Tuesday of the month).

**Milestones and Key Dates:** Review your MAPP workplan and note any milestones and key dates the ADT is working toward or needs to be aware of.

[14] Center for Creative Leadership. What's a team charter, and how can it keep your team on track? Retrieved March 29, 2023, from www.ccl.org/articles/leading-effectively-articles/what-is-this-team-for-and-why-am-i-here

[15] TemplateLAB. 49 useful team charter templates (& examples). Retrieved March 29, 2023, from https://templatelab.com/team-charter-templates/#google_vignette

[16] TemplateLAB. 49 useful team charter templates (& examples). Retrieved April 11, 2023, from https://templatelab.com/team-charter-templates/#google_vignette

| GOAL | Design the overall process your community will use for the three assessments. |
|---|---|
| **SMARTIE Objectives** | • By XX date, determine XX opportunities for using current resources to support the assessments.<br>• By XX date, develop a workplan for completing the assessments in your community. |
| **Supplemental Tools/Resources** | • How Data Answer the Guiding Questions Worksheet<br>• MAPP Workplan Template (in MAPP 2.0 Tools folder)<br>• MAPP Budget Template (in MAPP 2.0 Tools folder) |

Base the overarching process your community will use for the three assessments on your community's guiding questions for the CH[N]A and results from your Starting Point Assessment. The guiding questions will help your community understand what "big picture" information to collect for your CH[N]A. The Starting Point Assessment will highlight available data sources including data access and sharing capabilities, indicators measured in previous CH[N]As, and resources needed to collect data. In this step, you will determine how to use current resources for the assessments and decide on an order for completing the assessments.

## Step 2.1: Adopt Guiding Questions for Your Community's CH[N]A

The guiding questions your community selects for your CH[N]A will inform the assessments. You will answer these guiding questions once the data from all three assessments have been triangulated to highlight key themes, which are overarching public health topics, and uncover the "big picture" of health in your community. Following are examples of guiding questions you may use for your assessment.

- What aspects of the community vision from *Phase I: Build the Community Health Improvement Foundation*, if any, has our community achieved?
- What does health equity look like in our community?
- How equitable are the health outcomes in our community?
- What are the sub-populations within our community that have higher health risks or poorer health outcomes?
- What structural and social factors contribute to higher health risks or poorer health outcomes of certain populations within our community?
- What protective structural and social factors (including assets, strengths, and resources) in our community support the health and wellness of community members and bring us closer to our vision of health?
- How are various types of community stakeholders impacting health inequities in the community or contributing to the health and wellness of community members?

The ADT should refine or add to these guiding questions based on any other requirements or considerations your community may have for the CH[N]A.

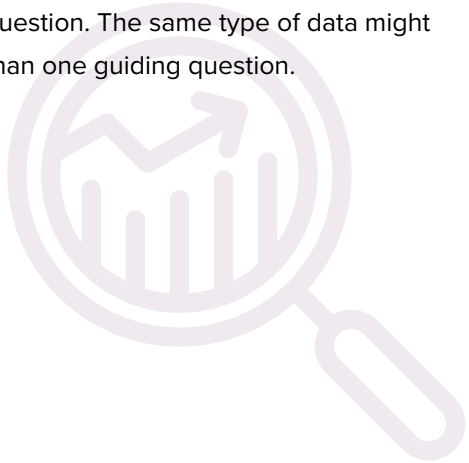
*Note: The previous questions were developed based on the PHAB Standards and Measures Version 2022—Standard 1.1, which outlines how Tribal, local, and state health departments can participate in or lead a collaborative process resulting in a comprehensive CH[N]A.*[17]

## Step 2.2: Understand How Data Answer the Guiding Questions

Once you have guiding questions, use the following template to think about what types of data are needed to answer these questions, how data will be collected, and what resources your community can use to help collect data. Use the following descriptions to help you complete the table:

- **Guiding Question:** Include any of the previous questions or questions you have tailored for your community that will meet the requirements and considerations that your community has for the CH[N]A.
- **Data Answering the Question:** Think about the types of data that will answer the guiding question. These can include quantitative data on health outcomes, qualitative data on current housing conditions from residents in a certain neighborhood, information on community-based organization activities that promote health and wellness, etc.
- **Collecting the Data:** Think about how you will collect the data to answer the guiding question. Collection methods can include reviewing secondary data sources, a community survey in certain neighborhoods, interviews with community-based partners, etc.
- **Resources and Activities to Use:** Think about the current resources available to your core group, steering committee, ADT, and other workgroups that can assist in collecting the data and recent or pending activities in which the data can be collected. You can use information from your Starting Point Assessment to assist in completing this column. Try to be specific about the timing in which these resources will be available and when these activities will occur. Examples include the following:
    - The largest health system in the community will release survey data on chronic disease outcomes in May 20XX.
    - Partner X will host community meetings in June 20XX.
    - The annual partners' meeting will be held in February 20XX.

Add more rows to this table depending on the number of guiding questions you have and the amount of data you might need to collect to answer each guiding question. The same type of data might answer more than one guiding question.



[17] Public Health Accreditation Board. (2022). *Standards & measures for initial accreditation: Version 2022.* Retrieved March 29, 2023, from https://phaboard.org/wp-content/uploads/Standards-Measures-Initial-Accreditation-Versiozn-2022.pdf

## HOW DATA ANSWER THE GUIDING QUESTIONS WORKSHEET

**Guiding Question:**

| What data will help answer this guiding question? | How do we collect the data? | What current resources or activities can we use to help collect the data? |
|---|---|---|
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**Guiding Question:**

| What data will help answer this guiding question? | How do we collect the data? | What current resources or activities can we use to help collect the data? |
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**Guiding Question:**

| What data will help answer this guiding question? | How do we collect the data? | What current resources or activities can we use to help collect the data? |
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## Step 2.3: Refine Your Workplan

Now that you better understand what type of data answers the guiding questions, how to collect the data, and the current resources you can use to collect the data, you can begin to refine your workplan.

As was mentioned previously, you may do the assessments in any order. Based on the previous worksheet, think about the following when determining the order of the assessments:

- **Upcoming activities you can use to help collect the data you need:** Communities organizing listening sessions or focus groups with residents might want to consider also collecting CCA data during these data-collection activities. Asking community members about community strengths and assets, the built environment, and forces of change could be an opportunity to connect various focus areas back to the CHI process.
- **Data you may have already collected that can support the completion of an assessment:** Communities with a lot of existing quantitative health data might want to do the CSA first to quickly complete one of the three assessments and excite people about moving forward.
- **ADT and other stakeholders and partners that will be involved in the assessments and how you have engaged them up to this point:** Communities without strong partnerships might consider doing the CPA first to introduce systems-thinking and build relationships with those outlined in the stakeholder analysis.

If you are still not sure which assessment to do first, or in what order to do them all, begin with the CPA because select components of this assessment align with information collected from stakeholders and partners in Phase I. You can then follow up with the CSA to reveal data gaps, issues, and inequities to further explore in the CCA.

Once you have decided on an order for the assessments, review your timeframe for doing them that you determined in *Phase I, Step 8: Develop the Workplan and Budget*. Use this timeframe as a foundation for revising your workplan and budget with the MAPP Workplan Template and MAPP Budget Template. Continue to use these documents to outline your core activities (including data-collection methods), activity leads, timelines, and resources needed for the remaining steps of Phase II. You will continue to refine these documents as you work through the three assessments and the rest of Phase II.

# Step 3: Do the Three Assessments

**GOAL**

Do the CPA, CSA, and CCA to understand the status of health in your community.

**SMARTIE Objectives**

- By XX date, do the full CPA to understand MAPP partners' individual systems, processes, and capacities, and the collective capacity as a network of community partners, to address health inequities.
- By XX date, do the full CSA to collect quantitative data on demographics, health status, and health inequities.
- By XX date, do the full CCA to collect qualitative data on the insights, expertise, and views of people and communities affected by social systems to understand the community's strengths, assets, and culture.

Now that you have refined your workplan to include details about how you will do the three assessments, you are ready to begin your CH[N]A. As you do the assessments, keep in mind how the data from the three assessments will come together to inform key themes and issues in *Phase II, Step 4: Triangulate Data, Identify Themes, and Develop Issue Statements.* Review Figure 1 representing the data-triangulation process on page 109 to understand how data from the three assessments will be organized during triangulation.

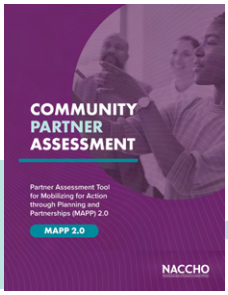
When collecting data, think about where the data fit along the **health equity action spectrum**. Do they represent **root causes of health inequities, SDOH, health behaviors, or health outcomes**? How do the data from each assessment relate to and influence the other two assessments? Continue to ask these questions as you do the three assessments.

*Note: Refer to pages 110–112 for descriptions of systems of power, privilege, and oppression, SDOH, health behaviors, and health outcomes.*

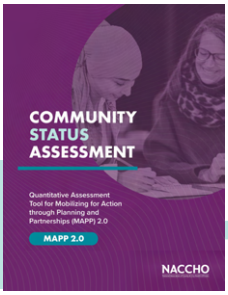
**POWER PRACTICES FROM THE POWER PRIMER**

3. **Study—Learn about Your Communities' Histories**
4. **Build—Cultivate Relationships with Communities and Partners**

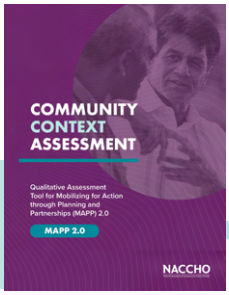
CPA




CSA




CCA



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|---|---|
| **GOALS** | • Identify crosscutting themes and develop a full understanding of the community through data triangulation.<br>• Collectively interpret findings and crosscutting themes to develop issue statements that reflect the issues faced by the community. |
| **SMARTIE Objectives** | • By XX date, identify crosscutting themes that are supported by data from all three assessments.<br>• By XX date, engage XX community members, particularly those experiencing health inequities, in the data triangulation.<br>• By XX date, develop issue statements that reflect issues faced by the community from the identified themes and interpretation of the assessment findings.<br>• By XX date, engage XX community members, particularly those experiencing health inequities, in the process used to develop issue statements. |
| **Supplemental Tools/Resources** | • Helpful Hints for Presenting Data (Appendix A)<br>• Developing Cross-Cutting Themes Worksheet<br>• MAPP Workplan Template (in MAPP 2.0 Tools folder)<br>• MAPP Budget Template (in MAPP 2.0 Tools folder) |

## Step 4.1: Determine How to Engage Stakeholders, Partners, and Community Members in Data Triangulation, Identifying Themes, and Developing Issue Statements

Develop a plan for how to involve stakeholders, partners, and community members in data triangulation, identifying cross-cutting themes, and developing issue statements. Themes are overarching public health topics that are represented in two to four words. Examples include community perceptions of health, structural racism, safe and affordable housing, community connectedness, chronic disease, physical activity, and birth outcomes and infant mortality. The ADT should work with the steering committee to answer the following questions:

- How will we ensure stakeholders, partners, and community members can fully understand the collective results from the three assessments?
- How will we facilitate a process to help stakeholders, partners, and community members identify cross-cutting themes and develop issue statements that are informed by all three assessments?
- How will we ensure everyone is aware of our themes and issue statements?

Based on your responses to these questions, review your ADT structure, adding and shifting members and roles as needed. You should also update your workplan and budget using the MAPP Workplan Template and MAPP Budget Template to account for any data-presentation needs (e.g., summarizing data for newsletters or reports or presenting data at a community event).

# Step 4.2: Prepare Collective Results from Assessments for the Community

MAPP will generate a lot of data. Determine the best way to prepare the results from the three assessments so community members, stakeholders, and partners can prepare for and participate in data triangulation. At this time, you should have summaries from each of the three assessments, and you may even have presented the data to the community. Whether the community will see the data for the first time or see the collective data from all three assessments, ensure the data can be easily understood so community members can participate in recategorizing the data for data triangulation. Presenting data clearly and concisely helps emphasize the important findings and results of your CH[N]A.

You can and should present data in various ways, such as the following:

- Written updates of the process (e.g., newsletters, reports, and summaries of findings)
- Presentations to the community and media
- Maintaining an open, public process

Helpful Hints for Presenting Data in the Phase II Appendix describes these formats.

When presenting the data to the community, be sure the data answer the guiding questions from the three assessments:

## *CPA Guiding Questions*

- What capacities, skills, and strengths does each organization involved in MAPP bring that could contribute to improving community health and advancing the MAPP goals?
- Who is involved in MAPP? Who else needs to be involved?

## *CSA Guiding Questions*

- What does the status of the community look like, including key health, socioeconomic, environmental, and quality-of-life outcomes?
- What populations are experiencing inequities across health, socioeconomic, environmental, and quality-of-life outcomes?
- How do systems influence outcomes?

## *CCA Guiding Questions*

### Community strengths and assets

- What strengths and assets do community members have?
- How do these community strengths and assets contribute to community health?
- Which strengths and assets can be used and strengthened to address health inequities?

## *CCA Guiding Questions (cont'd)*

### Built environment

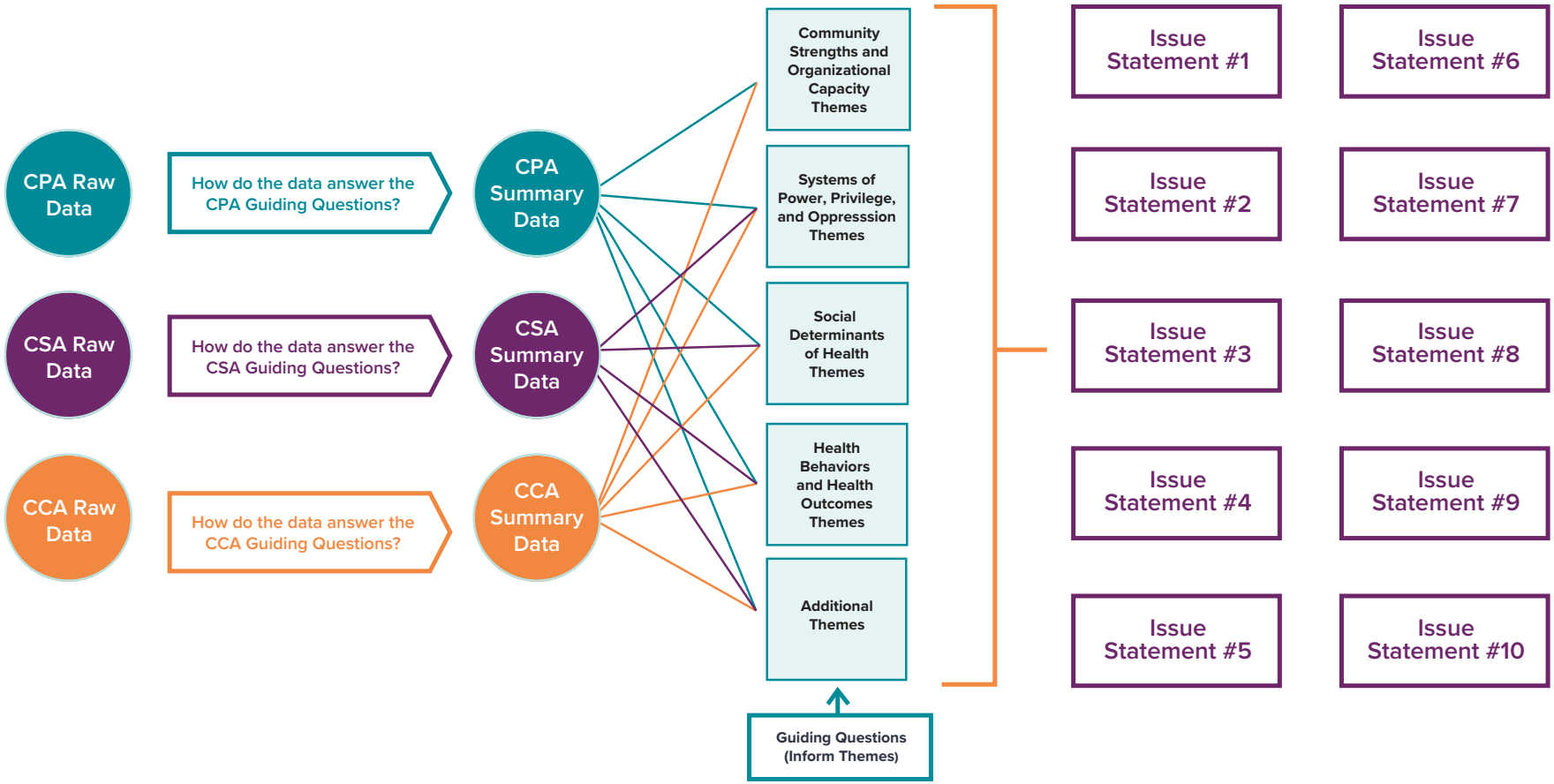
- What physical assets and resources exist in the built environment of the community?
- How do these resources differ across neighborhoods, particularly in those experiencing the greatest health inequities?
- How do community members view and interact with their built environment?
- How do these interactions impact community members' health?
- What aspects of the built environment in communities impact health inequities?
- How can those aspects be improved or addressed to improve community health?

### Forces of change

- What is occurring or might occur that affects the health of the community or the LPHS? (These can be both things in the community and things in the larger societal and economic context.)
- Which communities are disproportionately impacted by these forces of change? How and why are they disproportionately impacted?
- How does historical and structural context (e.g., broken treaties, exclusionary policies, dehumanizing practices, or history of resistance and community organizing) shape the forces of change today, and who benefits from current conditions?
- How have climate change and COVID-19 changed conditions in the community?
- What have health departments done to help?

The last step of this phase will provide more guidance on communicating how the data summaries relate to each other and the overarching guiding questions for your CH[N]A that you adopted in *Phase II, Step 2.1: Adopt Guiding Questions for Your Community's CH[N]A*. For now, communicate to partners, stakeholders, and community members the data from each assessment summary and how the data will be used for data triangulation. You can use Figure 1 to review the data-triangulation process with the community after presenting the data.

**FIGURE 1.** *Data-Triangulation Process*



# Step 4.3: Organize Summary Data from the Assessments into Cross-Cutting Themes

Once you have presented and reviewed the data with partners, stakeholders, and the community, and they are familiar with the data-triangulation process, you will organize the data summaries from the three assessments for data triangulation.

For this step, organize the data under themes that fall into the following categories:

- Systems of Power, Privilege, and Oppression Themes
- SDOH Themes
- Health Behaviors and Health Outcomes Themes
- Community Strengths and Organizational Capacity Themes

Remember, themes should capture broad topics and should be no more than two to four words. This allows your community to develop innovative, strategic activities during the final phase of MAPP—*Phase III: Continuously Improve the Community*, as opposed to activities that rely on the current state, are familiar, or are easy. When identifying themes that fit into the first three categories listed, think through the **health equity action spectrum** (refer to Phase I, Appendix J). It shows the links between root causes and health outcomes, showcasing the SDOH as a key mediator of this connection between root causes and health outcomes. More information on these categories and examples of themes you may identify based on the data from the CPA, CSA, and CCA are listed below.

## *Systems of Power, Privilege, and Oppression*[18,19,20]

Systems of power, privilege, and oppression represent the root causes, or structural drivers, of inequity. There are various frameworks for understanding power. Refer to the Power Primer to review different frameworks and understand how they make power more visible and how they can be used to achieve systems change. One framework to highlight from the Primer Power is “power over” vs. “power with”:

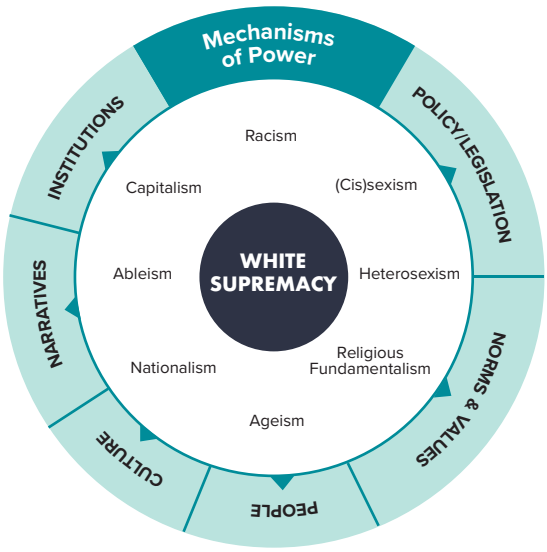
In society, “power over” plays out all the time. A select few groups have enormous capacity to shape laws, shrink government services, control the narrative, and repress legislation, policies, and protests that threaten their hold on political and economic power. Using a “power over” mindset in our work, even unintentionally, will perpetuate inequities rather than address them.

In a “power with” framework, we accept that power is actually infinite. The more we share power, the more it expands. Shifting to this mindset helps us conceive of how to share power with community members and organizers. When we share power, we create space for centering the voices of those most impacted by health inequities and shift the power imbalances that caused the inequities in the first place.

[18] National Association of County and City Health Officials. (2023). *Power Primer: A tool in mobilizing for action through planning and partnerships (MAPP) 2.0*

[19] Palmer, G., Ferńandez, J., Lee, G., Masud, H., Hilson, S., Tang, C., et al. Oppression and power. In Rebus Community, *Introduction to community psychology*. Retrieved March 29, 2023, from https://press.rebus.community/introductiontocommunitypsychology/chapter/oppression-and-power/

[20] Power & privilege definitions. Retrieved March 29, 2023, from www.vanderbilt.edu/oacs/wp-content/uploads/sites/140/Understanding-Privilege-and-Oppression-Handout.doc




Privilege operates on personal, interpersonal, cultural, and institutional levels and gives advantages, favors, and benefits to members of dominant groups at the expense of members of target groups. In the United States, privilege is granted to members of one or more of these social identity groups: White people; able-bodied people; heterosexuals; males; Christians; middle or owning class people; middle-aged people; English-speaking people.

Oppression embodies the combination of prejudice and institutional power, which creates a system that discriminates against some groups (often called "target groups") and benefits other groups, including those groups mentioned earlier who experience privilege (often called "dominant groups"). Examples of these systems are racism, sexism, heterosexism, ableism, classism, ageism, and antisemitism. These systems enable dominant groups to exert control over target groups by limiting their rights, freedom, and access to basic resources such as healthcare, education, employment, and housing.

Themes related this category may include the following: community perceptions of health, community representation, structural racism, discrimination, or gentrification. Data contributing to these themes could include data related to the policy and power analysis of partners from the CPA, voter registration and residential segregation data from the CSA, and data related to the experiences of racism, oppression, and discrimination and community safety/social connectedness from the CCA.

## *SDOH*[21]

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH

SDOH can be grouped into the following five domains from Healthy People 2030:

1. **Economic Stability**
2. **Education Access and Quality**
3. **Healthcare Access and Quality**
4. **Neighborhood and Built Environment**
5. **Social and Community Context**

These five domains may also appear as themes from your data, or you could be even more specific about which SDOH themes you highlight. Examples of themes include safe and affordable housing, access to mental health services, food security/food access, employment, community connectedness, transportation, and community engagement and inclusion. Data contributing to these themes could include data related to partners' workforce and SDOH focus areas from the CPA, air quality and unemployment data from the CSA, and data related to digital infrastructure and food and nutrition from the CCA.

[21] Healthy People 2030. Social determinants of health. Retrieved March 29, 2023, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

## *Health Behaviors and Health Outcomes*[22]

**Health behaviors** are actions people take that affect their health. They include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as smoking, excessive alcohol intake, and risky sexual behavior.

**Health outcomes** represent how healthy a community is right now. They reflect the physical and mental well-being of residents within a community through measures representing length and quality of life.

Themes that fall into this category include the following: healthy eating, substance use, sexual health, birth outcomes and infant mortality, childhood obesity, chronic diseases, physical inactivity, tobacco use, and behavioral health. Data contributing to these themes could include infant mortality rate and physical inactivity from the CSA and data related to substance use and mental health from the CCA.

In addition to these three categories, data from portions of your CPA and CCA related to community strengths, resources, and capacity, and how these elements are supported in the CHI process by partners, stakeholders, and community members, may also fit into the Community Strengths and Organizational Capacity category. Data contributing to this theme could include information from the CPA on how partner organizations' capacity and activities align with the 10 Essential Public Health Services and data from the CCA on community organizing and resiliency.

Your community might identify other themes from the data that don't fit into any of the previous categories. For example, the data might highlight a theme on equity or enhancing community trust. Include these in an "Other Themes" section during data triangulation.

When approaching this exercise with stakeholders, partners, and community members, orient them to the **health equity action spectrum** and the categories that have been influenced by this spectrum. This orientation should include the following:

- An overview of the health equity action spectrum, specifically discussing how root causes influence the SDOH, which influence health behaviors and health outcomes, and a discussion of public health practices that have historically addressed these causes of inequities. You may also want to highlight the **Bay Area Regional Health Inequities Initiative (BARHII)** Framework to discuss current and emerging public health practice.
- Definitions of the three categories and examples that relate specifically to your community
- A discussion of the type of data that could fit into the three categories and one or two examples using the data that your community has collected within the three assessments

[22] County Health Rankings & Roadmaps. County health rankings model. Retrieved March 29, 2023, from www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

Refer to the Health Equity Education Resources from *Phase I, Step 3: Engage and Orient the Steering Committee* as you develop this orientation.

Facilitating this activity can be challenging because people will have to reconcile personal interests with overarching community interests. In addition, conflicting interests and different views can create tension, especially when bringing together your ADT, steering committee, partners, stakeholders, and community members. Consider designing a facilitated conversation to review the data that includes the guiding questions from *Phase II, Step 2.1: Adopt Guiding Questions for Your Community's CH[N]A*. These guiding questions should inform your themes. The Developing Cross-Cutting Themes Worksheet on the next few pages can assist in setting up your activity for brainstorming themes. If possible, use a "sticky wall" to appeal to visual learning styles when doing this activity. A sticky wall is a large sheet of nylon sprayed with adhesive, allowing sheets of paper to stick to it. You can move and reorganize those sheets during a facilitated discussion.

*Image Source: Aurora Consulting | www.auroraconsult.com/the-sticky-wall/*

## *Developing Cross-Cutting Themes Worksheet*

Cross-cutting themes can fall into the categories discussed earlier or other categories identified by your community. This worksheet can help you brainstorm cross-cutting themes as you look across the data summaries for the three MAPP assessments. You may add more rows based on the number of themes you develop for each category.

| **SYSTEMS OF POWER, PRIVILEGE, AND OPPRESSION THEMES**<br>*What themes did you see among the data summaries from the CPA, CSA, and CCA that relate to systems of power, privilege, and oppression? What data points inform these themes?* | |
|---|---|
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |

| **SOCIAL DETERMINANTS OF HEALTH THEMES**<br>*What themes did you see among the data summaries from the CPA, CSA, and CCA that relate to the SDOH? What data points inform these themes?* | |
|---|---|
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |

| **HEALTH BEHAVIORS AND HEALTH OUTCOMES THEMES**<br>*What themes did you see among the data summaries from the CPA, CSA, and CCA that relate to health behaviors and health outcomes? What data points inform these themes?* | |
|---|---|
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |

| COMMUNITY STRENGTHS AND ORGANIZATIONAL CAPACITY THEMES<br>*What themes did you see among the data summaries from the CPA and CCA that relate to what partners, stakeholders, and community members can offer to support the CHI process? What data points inform these themes?* | |
|---|---|
| **Theme:** | |
| **CPA Data** | |
| **CCA Data** | |
| **Theme:** | |
| **CPA Data** | |
| **CCA Data** | |

| OTHER THEMES<br>*What themes did you see among the data summaries from the CPA, CSA, and CCA that don't fit into the other categories? What data points inform these themes?* | |
|---|---|
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |
| **Theme:** | |
| **CPA Data** | |
| **CSA Data** | |
| **CCA Data** | |

## Step 4.4: Develop Issue Statements[23,24]

After identifying cross-cutting themes, you are ready to create issue statements. Most communities identify themes, or issue topics, and issue statements (collectively known as "issues") that they can reasonably address in a five-year period. Communities will ultimately focus on three to five final issues, which will become the foundation for a CHIP to take action to improve health in the community. The final phase of MAPP—*Phase III: Continuously Improve the Community*—involves prioritizing the issues and narrowing them into strategic, actionable steps.

An issue statement is a one- to two-sentence statement that identifies and summarizes why and how the issue occurs, how serious it is, and its outcomes and impacts. Issue statements should answer the following questions:

- WHO is affected?
- HOW big is the issue?
- WHAT contributes to the issue?
- WHEN and WHERE is the issue most likely to occur?

Your ADT should work with the steering committee, partners, stakeholders, and community members to draft issue statements for each cross-cutting theme with data from the assessments that support your themes. Go through the questions above for each theme that you have identified, using supporting data to answer questions, then use the responses to draft your issue statement. The following example will assist you in completing this step.

### *Example Issue Statement Development from Theme and Assessment Summary Data*

Here is an example of a theme related to the SDOH that you may have identified from your assessment summaries and data from the assessments that support the theme.

| SOCIAL DETERMINANTS OF HEALTH THEMES | |
|---|---|
| **Theme: Food Security and Food Access** | |
| **CPA Data** | Food banks located in neighborhood Y have very close partnerships with the neighborhood groups and churches in this neighborhood to set up weekly food pantries but have been unable to sustain partnerships in neighborhoods X and Z. |
| **CSA Data** | 75% of residents in neighborhoods X, Y, and Z have limited access to grocery stores with fresh fruits and vegetables. 90% of the African American residents in AA City also live in these neighborhoods. |
| **CCA Data** | In all focus groups that were conducted in neighborhoods X, Y, and Z, residents noted that the few grocery stores or places to buy groceries in or near their neighborhood have low-quality fruits and vegetables that are grossly overpriced. |

[23] Writing a problem statement: Instruction. Retrieved March 29, 2023, from www.hqontario.ca/portals/0/documents/qi/qi-problem-statement-instruction-sheet-en.pdf

[24] Centers for Disease Control and Prevention. Problem identification. Retrieved March 29, 2023, from www.cdc.gov/policy/polaris/policyprocess/problem-identification/

Your answers to the issue statement questions may include the following:

- **WHO is affected?** African American residents in AA City.
- **HOW big is the issue?** 75% of residents have limited access to grocery stores with fresh fruits and vegetables.
- **WHAT contributes to the issue?** In addition to the limited number of grocery stores, the groceries available to the residents are low-quality and grossly overpriced.
- **WHEN and WHERE is the issue most likely to occur?** This issue is occurring in X, Y, and Z neighborhoods in AA City.

You can then use your responses to the questions and any other relevant data to draft your issue statement:

> *African American residents in AA City, who mostly reside in neighborhoods X, Y, and Z have limited access to fresh, affordable, and high-quality food because 75% of residents in these neighborhoods have limited access to quality grocery stores and there are limited resources to bring more affordable, fresh foods into these neighborhoods.*

When developing statements, you may want to refine your themes to create more descriptive issue topics that accurately summarize your statement. For example, after crafting the issue statement above, your topic may stay the same as your original theme—Food Security and Food Access—or you may refine it to Access to Healthy Food.

In the next step of this phase, you will begin to explore these issue statements through a root cause analysis and develop issue profiles.

# Step 5: Develop Issue Profiles through Root Cause Analysis

| | |
|---|---|
| **GOAL** | Develop issue profiles of the topics identified in the previous step using a root cause analysis. |
| **SMARTIE Objectives** | By XX date, develop XX issue profiles for each issue developed in the previous step using a root cause analysis that includes descriptors/contributors of the problem, priority community indicators, and potential solutions to address the issues. |
| **Supplemental Tools/Resources** | • Helpful Hints for Presenting Data (Appendix A)<br>• Fishbone Diagram Template<br>• 5 Whys Worksheet |

Once the issues, including the topics and their corresponding statements, have been identified and developed by the community, the ADT should meet to discuss the topics and develop issue profiles for each, engaging members of the core group, steering committee, and partners as needed. These issue profiles are important because they connect the current status of the community's health and well-being to potential strategies. These strategies will address the inequities highlighted within the CH[N]A and help move the community toward its vision for community health and well-being that it determined in Phase I. Issue profiles will be used in the following ways:

- In the community's full CH[N]A report to highlight key aspects revealed by the data
- When prioritizing which issues the CHIP will focus on
- When creating community partner profiles for the chosen priority issues in Phase III

Issues profiles for your topics will include the following:

- Description of the issue, which includes contributors to the problem highlighted within the issue
- A set of priority community indicators tying together upstream and downstream metrics
- Potential solutions, including community and partner/stakeholder assets, to address the topic

Doing a root cause analysis of each issue will help you to develop these components. Many methods exist for doing a root cause analysis. Two useful methods to look at issues related to the community's health and well-being are the fishbone diagram and 5 Whys.

# Fishbone Diagram

A fishbone diagram, also known as a cause-and-effect diagram, helps explore all potential root causes of a particular issue or problem. This helpful tool visually represents the causes of a problem or phenomenon, factors that have a high/low impact on those problems/phenomena, and how to resolve a situation.[25]

Figure 2 provides an example of a fishbone diagram. The issue statement is written in the box at the "head" of the fish. The rest of the fishbone then consists of one line drawn across the page, attached to the issue statement, and several lines, or "bones," coming out vertically from the main line. These bones are labeled with different categories.[26,27] The categories you choose are up to you, but you may want to include categories that fall under the following themes:

**POLICIES:**

Identify policies at the organizational, local, state, or federal levels that may contribute to the issue.

**PEOPLE:**

Identify any human causes of the issue, which may point to views that community members have regarding the issue or health behaviors that people engage in related to the issue.[28]

**ENVIRONMENT:**

Identify environmental conditions that impact the issue, including the physical environment, which is where people live, learn, work, and play. People interact with their physical environment through the air they breathe, water they drink, houses they live in, and the transportation they access to travel to work and school.[29]

[25] SixSigma. (2017). *What is ishikawa (fishbone diagram)?* Retrieved March 29, 2023, from www.6sigma.us/etc/what-is-ishikawa-fishbone-diagram/

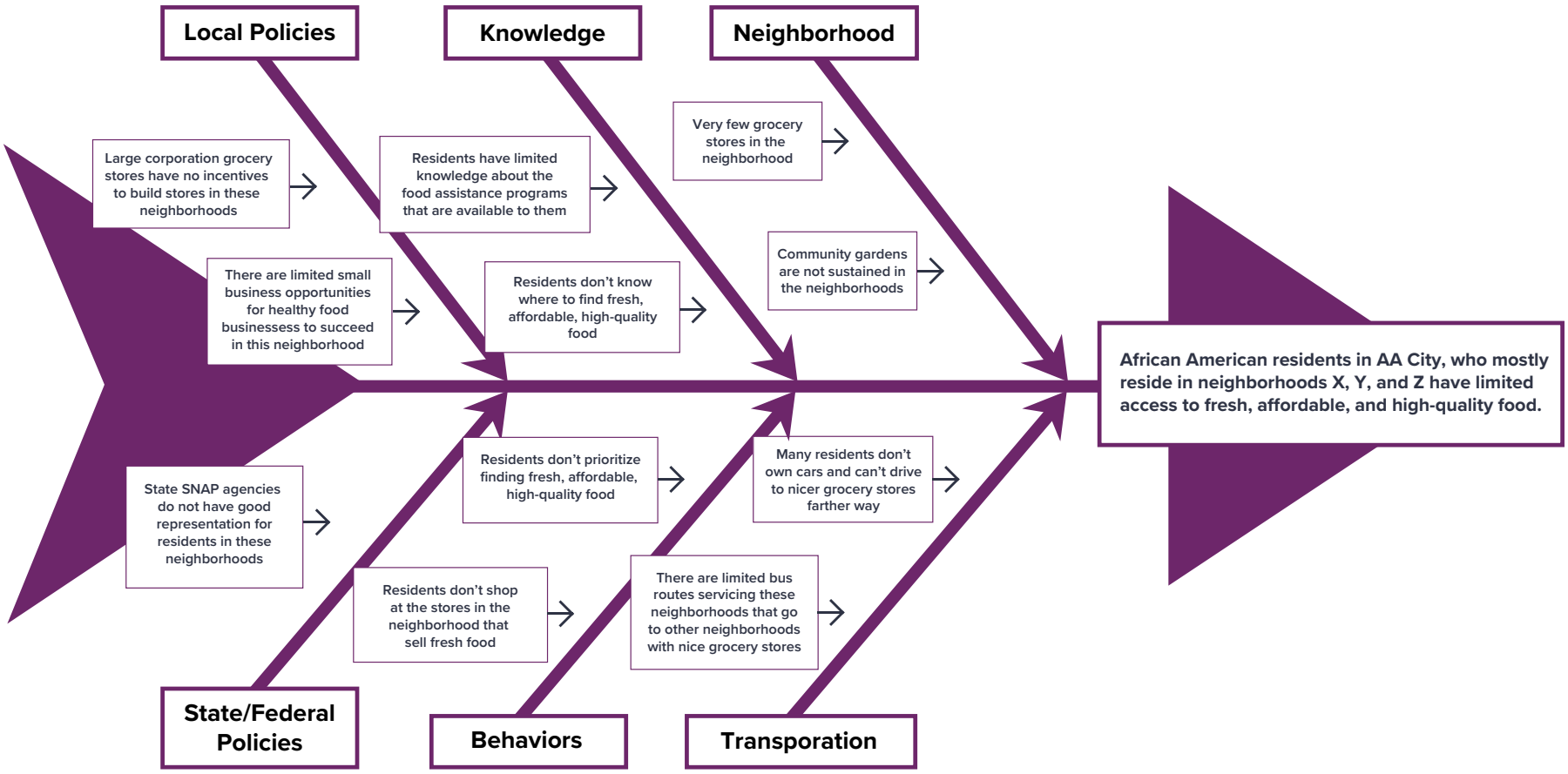
[26] Simon, K. (2010). *The cause and effect (a.k.a. fishbone) diagram.* ISIXSIGMA. Retrieved March 29, 2023, from www.isixsigma.com/tools-templates/cause-effect/cause-and-effect-aka-fishbone-diagram/

[27] City of Fort Collins: FC LEAN. *Fishbone diagram*. Retrieved March 29, 2023, from www.fcgov.com/lean/files/fishbone-reference-guide.pdf

[28] County Health Rankings & Roadmaps. Health behaviors. Retrieved March 29, 2023, from www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors

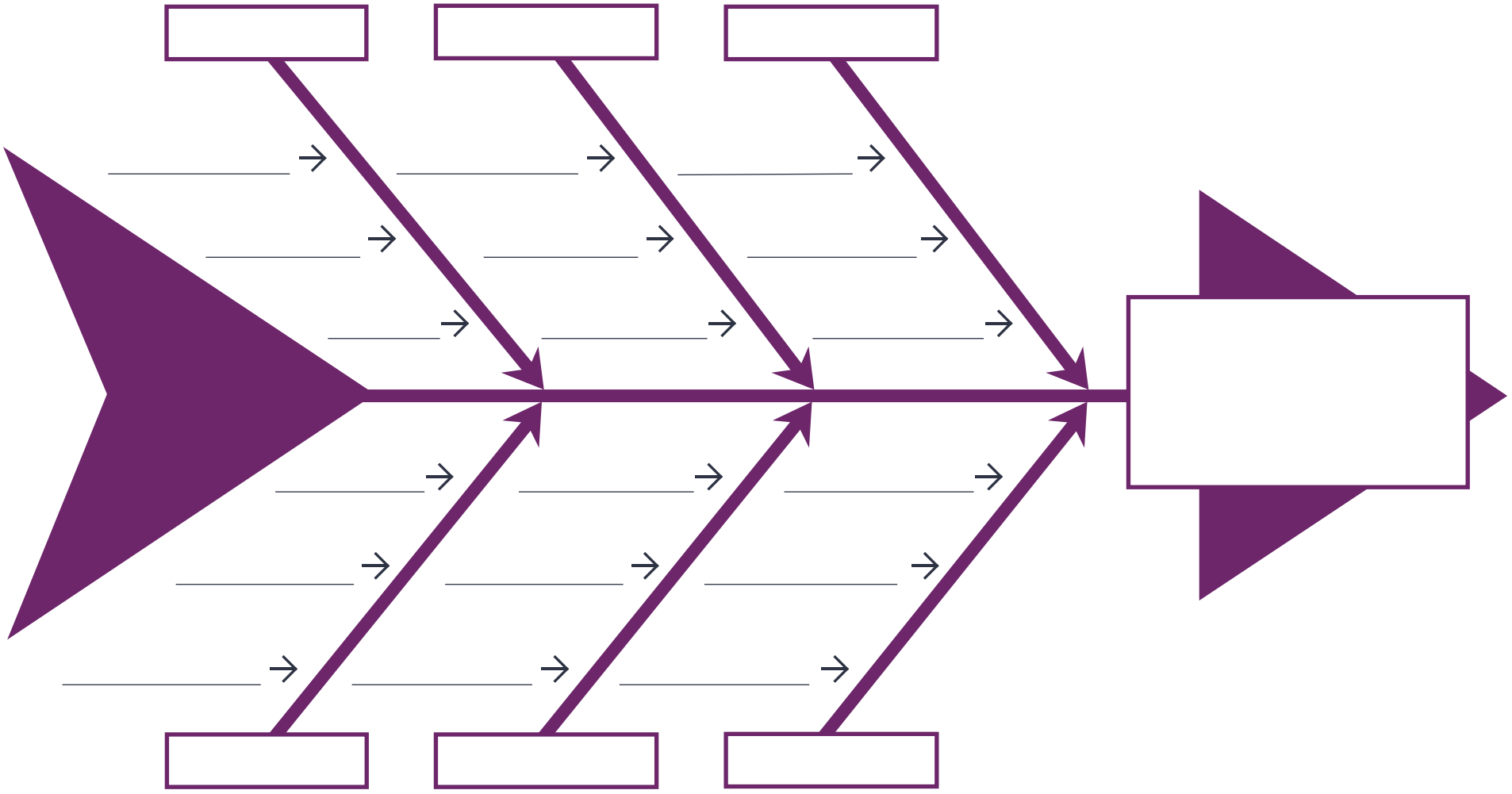
[29] County Health Rankings & Roadmaps. Physical environment. Retrieved March 29, 2023, from www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment

**FIGURE 2.** *Fishbone Diagram*



# *Fishbone Diagram Template*

Use this template to make a fishbone diagram for each issue statement. Write your issue statement in the box at the "head" of the fish. Put your categories in the boxes at the end of the "bones" and put causes in the branches of the six main "bones." Review the earlier example to assist you.



Communities are encouraged to use the fishbone diagram in combination with the 5 Whys to do a root cause analysis of their issue statements. Once you identify the many potential causes of the top issue by using a fishbone diagram, use the 5 Whys to closely examine each one to ensure you identify the root cause(s). This will help you explore the upstream causes related to systems of power, privilege, and oppression, including ideologies such as classism, racism, ableism, ageism, xenophobia, fat phobia, and white supremacy.

## The 5 Whys

The 5 Whys is an activity used to systematically identify the root causes of a specific problem and the relationships between these root causes. It is a systematic way to solve problems and to consider cause-and-effect relationships, making it a strong companion of the fishbone (cause-and-effect) diagram activity. This activity can be especially useful when the real cause of the problem is unclear, and complex techniques or statistical analyses are not available or useful. It helps you identify the root cause of a problem, which if eliminated, would prevent a problem from reoccurring. Although it identifies causes of the problem, it should not be used to place blame on a person or organization.

To do this activity, participants identify an issue, then ask "Why?" at least five times to get to the root cause. This process helps you get beyond the surface of a problem and peel away the layers of symptoms to identify the root causes of a problem or condition. Sometimes, you may need to ask "Why?" more than five times to get to the root cause of the issue. The questioning can stop once the group agrees it has identified the root cause. During this exercise, your responses to "Why?" should be grounded in data and observation from your assessments. Refer back to data from all three assessments and make sure the data support your answers.

Also remember that root causes represent structural determinants that influence health. These include mechanisms that generate stratification and social class divisions in society and that define individual socioeconomic position within hierarchies of power, prestige, and access to resources[30] (e.g., institutions, social norms and values, culture, policies and legislation, narratives). Also think about how these are further influenced by the ideologies that were mentioned above.

**Here's how to do the 5 Whys:**

1. Write down the issue statement. Ensure that the issue statement is the current condition. This helps the group formalize the problem and ensures people agree on and focus on the same problem. Use data to describe the issue when possible (e.g., Happy County's teen pregnancy rates rose 15% from 2021 to 2022).
2. Ask why the problem identified in the issue statement is occurring. Review your assessment data to determine the answer and write this answer below the problem.
3. Ask why the problem is occurring again, review the data, and write that answer down.
4. Repeat the second and third steps until the group agrees the problem's root cause has been identified.

[30] World Health Organization. (2010). *A conceptual framework for action on the social determinants of health.* Retrieved April 11, 2023, from www.who.int/publications/i/item/9789241500852

Use the 5 Whys Worksheet on the following page to do this activity on the issue statements that you developed in the previous step. The following example will help you fill out the worksheet. It follows the issue statement example that we developed in the previous step and we used to create our example fishbone diagram above. You may note that the answers listed here begin to connect some causes outlined in the fishbone diagram and reveal the root causes.

**EXAMPLE OF 5 WHYS**

**Issue Statement:** *75% of residents in neighborhoods X, Y, and Z in AA City, who are mostly African American, have limited access to quality grocery stores with fresh fruits and vegetables.*

| | Answer | Assessment(s) Supporting Answer |
|---|---|---|
| **Why is the above problem happening?** | There is a limited number of quality grocery stores with fresh fruits and vegetables located in these neighborhoods. | CSA, CCA |
| **Why is the above problem happening?** | Grocery store corporations and small businesses with quality fresh foods do not receive tax incentives to set up stores in these neighborhoods. | CSA, CPA |
| **Why is the above problem happening?** | AA City does not have any policies that promote investment in these neighborhoods. | CCA |
| **Why is the above problem happening?** | AA City does not promote investments in neighborhoods in the city that have consistently low rates of home ownership and high rates of poverty, which applies to neighborhoods X, Y, and Z. | CSA, CCA |
| **Why is the above problem happening?** | Neighborhoods X, Y, and Z have mostly attracted minority, low-income renters due to their affordability compared to other neighborhoods in the city. | CCA |

The example above is a great opportunity to go beyond asking “Why?” five times to get to why these neighborhoods have historically been home to minority, low-income residents. This might be linked back to historical events in your city or county (including the migration of jobs and mass departure of residents) or historical policies such as redlining that have been revealed in the Forces of Change domain within the CCA. Remember, keep asking “Why?” until you get to the root cause.

# *5 Whys Worksheet*

Use this worksheet to complete the 5 Whys. If needed, add entries to ask the question a few more times until the group agrees that the root cause of the problem or issue has been identified. Once the group agrees on the root cause of the problem, the team can decide what action to take to address the root cause. Complete a worksheet for each key problem your community is facing.

| **PROBLEM OR ISSUE:** | | |
|---|---|---|
| | **Answer** | **Assessment(s) Supporting Answer** |
| **Why is the above problem happening?** | | |
| **Why is the above problem happening?** | | |
| **Why is the above problem happening?** | | |
| **Why is the above problem happening?** | | |
| **Why is the above problem happening?** | | |
| **Why is the above problem happening?** | | |
| **ROOT CAUSE:** | | |

## Issue Profiles

Once you have done root cause analyses of identified issues, you can create issue profiles for each. Use these to orient the steering committee, partners, stakeholders, and community members to the issues that were identified and developed in *Phase II, Step 4: Triangulate Data, Identify Themes, and Develop Issue Statements.* They also connect the issues to the data collected through the assessments.

Issue profiles should be easy for the community to understand. They should be visually attractive, include simple graphics and charts, and use colors and images. It may help to work with your communications team, use PowerPoint, or explore free design tools such as Canva to make the profiles attractive and easy to understand. Helpful Hints for Presenting Data in the Phase II Appendix has ideas on how to structure the issue profiles. Descriptions of each part of the issue profile, and tips on how to craft these, are listed here.

- **Issue Topic:** This is the original theme, or refined theme, developed in *Phase II, Step 4: Triangulate Data, Identify Themes, and Develop Issue Statements.* Remember, this should be an overarching public health topic that is represented in two to four words. Examples include community perceptions of health, structural racism, safe and affordable housing, community connectedness, chronic disease, physical activity, and birth outcomes and infant mortality.
- **Issue Statement:** This is the issue statement developed in *Phase II, Step 4.4: Develop Issue Statements*. Remember, an issue statement is a one- to two-sentence statement that identifies and summarizes why and how the issue occurs, how serious it is, and its outcomes and impacts.
- **Description of the Issue:** Your description should answer the question, "Why is this issue important in our community?" and highlight contributors to the issue that were identified through the root cause analysis (fishbone diagram and 5 Whys). This is an opportunity to talk about how root causes, or structural determinants, and SDOH uniquely influence this issue in your community.
- **Priority Community Indicators:** Review the table created for your issue topic (theme) in *Phase II, Step 4.3: Organize Summary Data from the Assessments into Cross-Cutting Themes* and review the data from the CPA, CSA, and CCA that you included to support the topic. What indicators from these assessments were highlighted? How are these indicators represented in your root cause analysis? How do these indicators, and related indicators from other highlighted topics, tie together upstream and downstream metrics?

Continuing with an earlier example—Access to Healthy Food from AA City—you may have noted the following indicators, and their metrics, that supported this topic or other related issues from the root cause analysis:

| INDICATOR | METRIC |
|---|---|
| Nutrition | Fruit/vegetable consumption |
| Food Security | Percent of households experiencing food insecurity |
| Food Environment Index | Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best) |
| Residential Segregation — Non-White/White | Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents |

In this section of the issue profile, highlight both quantitative and qualitative data related to the indicators and metrics that align with your issue. Think about the summary data and theme highlighted from your CCA and CPA that align with the identified indicators and metrics:

| INDICATOR | METRIC | CCA/CPA SUMMARY DATA AND THEMES |
|---|---|---|
| Nutrition | Fruit/vegetable consumption | Many community members discussed how they don't know how to prepare vegetables, so they don't eat them often. |
| Food Security | Percent of households experiencing food insecurity | Many community members mentioned having to limit the amount and type of food they buy because of financial constraints. |
| Food Environment Index | Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best) | There are few healthy food options located in these neighborhoods. |
| Residential Segregation—Non-White/White | Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents | Neighborhood still suffers from the closing of the nearby sports arena, which removed businesses, jobs, and residents from the area 10 years prior. |

Refer back to the **health equity action spectrum** to understand where these metrics fall on the spectrum. Think of the core categories you organized your themes under in *Phase II, Step 4.3: Organize Summary Data from the Assessments into Cross-Cutting Themes:*

- Systems of Power, Privilege, and Oppression
- SDOH
- Health Behaviors and Health Outcomes

You may even add another column to the table to note where these metrics and themes fall on the spectrum (refer to following example).

| CATEGORY | INDICATOR | METRIC | CCA/CPA SUMMARY DATA AND THEMES |
|---|---|---|---|
| Health Status and Health Behaviors | Nutrition | Fruit/vegetable consumption | Many community members discussed how they don't know how to prepare vegetables, so they don't eat them often. |
| SDOH | Food Security | Percent of households experiencing food insecurity | Many community members mentioned having to limit the amount and type of food they buy because of financial constraints. |
| SDOH | Food Environment Index | Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best) | There are few healthy food options located in these neighborhoods. |
| Systemic (Systems of Power and Oppression) | Residential Segregation—Non-White/White | Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents | Neighborhood still suffers from the closing of the nearby sports arena, which removed businesses, jobs, and residents from the area 10 years prior. |

Review your root cause analysis to see how these upstream and downstream metrics and themes are tied together.

- **Potential Solutions:** Refer to your priority community indicators, the upstream and downstream metrics that impact the issue, and how these metrics are influenced by each other. Identify upstream and downstream efforts that could impact these upstream and downstream metrics and adequately address the issue. Review the **BARHII Framework** for examples of what type of solutions impact various parts of the spectrum. Include solutions that highlight community and partner/stakeholder assets that were identified in the CPA.

Once you have developed issue profiles for each issue, you are ready to share your community's assessment findings.

# Step 6: Share CH[N]A Findings

| | |
|---|---|
| **GOAL** | Share the findings from the CH[N]A. |
| **SMARTIE Objectives** | By XX date, develop XX methods for sharing findings from the CH[N]A to increase availability and accessibility of the data. |

In the final step of *Phase II: Tell the Community Story*, you will use the data from the three assessments and issue profiles to develop and share the CH[N]A findings, determining the best ways to bring the data to life and capture the full story of the community and the health and well-being of its residents.

This step is also an opportunity to review the assessment requirements for the different requiring bodies (e.g., PHAB, IRS, and HRSA). Requirements for these agencies usually include a written report of CH[N]A findings. You can use the sample outline[31] below to help craft your CH[N]A written report, which includes descriptions of requirements from PHAB,[32] IRS,[33] and HRSA.[34] Adjust the outline below in terms of the types of sections that are included in your report, their order, and their content based on the specific findings from your CH[N]A and the type of information you would like to present to your community.

## CH[N]A Sample Report Outline

- **Acknowledgments:** Highlight partners, stakeholders, and collaborators who contributed to the CH[N]A and authors of the report.
- **Table of Contents:** Identify the sections of the report and corresponding page numbers.
- **Executive Summary:** Summarize what readers can expect to find in the report. Include highlights such as the purpose, methods, major findings and emerging themes, and next steps and recommendations.
- **Introduction/Overview:** Introduce the purpose and goals of the CH[N]A and the process used for the CH[N]A. You may mention the use of the MAPP framework and other frameworks your community used in this process (e.g., **County Health Rankings Model** and the **Healthy People 2030 Framework**). Also include the mission, vision, and values developed in *Phase I, Step 5: Define the Community and Develop the CHI Mission, Vision, and Values* and the proposed timeline for your CHI process.

[31] Head Start: ECLKC. Prepare the community assessment report. Retrieved March 29, 2023, from https://eclkc.ohs.acf.hhs.gov/program-planning/community-assessment-foundation-program-planning-head-start/prepare-community-assessment-report

[32] Public Health Accreditation Board. (2022). *Standards & measures for initial accreditation: Version 2022*. Retrieved March 29, 2023, from https://phaboard.org/wp-content/uploads/Standards-Measures-Initial-Accreditation-Version-2022.pdf

[33] IRS. Community health needs assessment for charitable hospital organizations - section 501(r)(3). Retrieved March 29, 2023, from www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

[34] Health Center Solutions. HRSA needs assessment. Retrieved March 29, 2023, from https://healthcentersolutions.com/hrsa-needs-assessment/

- **Methodology:** Include information on the different primary and secondary data sources you used for the CH[N]A (both qualitative and quantitative data sources) and other information regarding the methods for the CH[N]A. Describe how the community engaged in, and provided input to, the process. Also include ways in which the process and methods for the CH[N]A were rooted in the foundational principles of MAPP, specifically equity.

- **Community Profile:** Include a definition and description of your community or jurisdiction, map(s) of your community or jurisdiction, and demographics of the population. These demographics may include gender, race, age, socioeconomic factors, income, disabilities, mobility (travel time to work or to healthcare), educational attainment, home ownership, employment status, immigration status, and sexual orientation. This section may also provide historical context of your community that connects to the demographics and health issues that will be highlighted throughout the report.

- **Health Issues:** Describe the health issues identified through the assessments related to health outcomes (life expectancy, infant mortality, leading causes of death, etc.) and health behaviors (substance use, sexual activity, healthy eating, physical activity, smoking, etc.). You may choose to group these health outcomes and behaviors into categories that align with the health behavior and health outcome themes that you developed in *Phase II, Step 4.3: Organize Summary Data from the Assessments for the Community*. Be sure to address the existence and extent of health disparities between and among specific populations in the community or areas in the community; you must identify populations with an inequitable share of poorer health outcomes.[35]

- **Factors Contributing to Health:** Discuss factors that contribute to the health outcomes and behaviors described in the previous section. This should include findings related to the following SDOH categories as defined by Healthy People 2030:[36]

    - Economic Stability
    - Education Access and Quality
    - Healthcare Access and Quality
    - Neighborhood and Built Environment
    - Social and Community Context

  This should also include factors related to systems of power, privilege, and oppression (structural racism, gentrification, lack of representation, discrimination, etc.). Again, refer to the themes developed in *Phase II, Step 4.3: Organize Summary Data from the Assessments for the Community*. Highlight health disparities, high health-risk populations, and community factors that contribute to higher health risks and poorer health outcomes of specific populations.

[35] County Health Rankings & Roadmaps. County health rankings model. Retrieved March 29, 2023, from www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

[36] Healthy People 2030. Social determinants of health. Retrieved March 29, 2023, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

- **Community Assets and Resources:** Highlight community assets and resources identified in the CCA that address the health issues and factors contributing to health outlined in the previous section. These assets and resources should include sectors outside of health/healthcare, specifically those that align with the factors contributing to health.
- **Conclusions and Recommendations:** Include your topics and issue statements that were identified and developed in *Phase II, Step 4.4: Develop Issue Statements* and key information from each corresponding issue profile.
- **Next Steps:** Describe how the CH[N]A findings and conclusions will be used moving forward, highlighting key steps from *Phase III: Continuously Improve the Community.*
- **Appendices:** Includes surveys, interview questions, presentations, supplemental data, and other documents, including issue profiles and summary reports from the CPA, CSA, and CCA.

In addition to sharing a written report, consider sharing methods and platforms that can be updated annually and easily understood by the community. These can include an online data dashboard, online summary report, community presentation, or interactive website.

Sharing and presenting the results through various methods can also make the data more accessible to more audiences. It is important to share the findings with people who were directly involved in the CHI process, such as the steering committee and workgroup members, and people who may not have participated in the process, such as the community at large and other stakeholders identified through the stakeholder analysis. Presenting the findings from your CH[N]A will ensure the community remains involved in the CHI process, particularly for the development and implementation of the CHIP. In this step, you may want to bring in your communications team to ensure the communications methods appeal to all audiences.

**Congratulations!** You have reached the end of *Phase II: Tell the Community Story.*

Moving from assessment to planning is a huge milestone in the CHI process. Celebrate with all involved. Use the momentum gained through completing this phase to move into *Phase III: Continuously Improve the Community.*

# Continuous Quality Improvement: Reflection on Phase II

After wrapping up this phase, ask the following questions of the ADT, core group, and steering committee:

- What went well?
- What did not go well?
- What goals did you achieve/not achieve?
- What would you like to change as you move to the next phase?
- What was the result of your process metrics? Outcome metrics?

# PHASE II

# APPENDIX

# A. Helpful Hints for Presenting Data

MAPP will generate a lot of data that the community needs to understand. Presenting data clearly and concisely helps emphasize the important findings and results of your CH[N]A. You can and should present data in various ways such as the following:

- Written updates of the process (e.g., newsletters, reports, and summaries of findings)
- Presentations to the community and media
- Maintaining an open, public process

## *Written Reports:*

- Use an attractive, colorful layout.
- Update the community and media throughout the process. Consider launching a newsletter or publishing information in a report.
- Highlight only the important facts or findings. Don't waste space on details.
- Use clear, simple charts. The easier they are to understand, the better.
- Summarize major findings in as many places as possible.
- Write in a clear, simple style that readers without a public health background can understand.
- Acknowledge community views of public health. If there is a specific area of interest, address it.
- Know your audience. Carefully select interesting visual aids and language that participants can understand.
- Check the accuracy of all data and information presented. Incorrect data can affect the perceived credibility of the presenter and of the entire process.

## *Oral Presentations:*

- Keep presentations brief—less than 30 minutes per issue.
- Invite special interest groups and representatives from all community organizations.
- Cover only the highlights. What is unusual, either in number or by trend?
- What finding may be of particular concern to the community?
- Use visual aids that highlight only important information. Clear, simple charts get the point across better than numbers.
- Stimulate interaction. Encourage discussion about areas of specific interest.
- Be organized. Provide information that may interest participants.
- Use plain language. Scientific or statistical jargon may be unnecessary and confusing.
- Keep it simple. Be clear and concise.
- Summarize. Spend the last two minutes reviewing the major findings so participants don't get lost among all the facts.
- Give participants summary handouts and fact sheets.
- Check equipment in advance to ensure it works properly and have back-ups in case of failure.
- Use maps of geographic areas to show what the information means to different communities or neighborhoods.

# PHASE III: CONTINUOUSLY IMPROVE THE COMMUNITY

## Introduction

*Phase III: Continuously Improve the Community* is the final phase of MAPP. This phase involves developing a CHIP, which is a three- to five-year, systematic effort to address public health issues based on the results of the CH[N]A from Phases I and II. This plan is used in collaboration with community partners to set priorities, coordinate actions, and target resources. It will also further define the vision established in Phase I.

Phase III uses methods of CQI and rapid cycle improvement to promote a data-driven action plan that addresses priority issues. It looks at where the community is, where it wants to go, and how it will get there. With an emphasis on addressing priorities targeting root causes of inequity and SDOH, Phase III encourages communities to take transformational approaches that use strategic partnerships for sustainable impact.

### GOALS:

- Identify strategic priorities for the CHIP across the health equity action spectrum that meet community needs
- Strategically align partner organizations to priority issues by developing priority issue subcommittees
- Develop shared measures to track CHIP activities across partners
- Develop an action plan to achieve the community vision and MAPP goals effectively
- Do CQI on strategies as they are carried out

### STEPS:

1. Prioritize Issues for the CHIP
2. Do a Power Analysis of Each Issue
3. Set Up Priority Issue Subcommittees
4. Create Community Partner Profiles
5. Develop Shared Goals and Long-Term Measures
6. Select CHIP Strategies
7. Develop Continuous Quality Improvement Action Planning Cycles
8. Monitor and Evaluate the CHIP

# Step 1: Prioritize Issues for the CHIP

| | |
|---|---|
| **GOAL** | Using the findings from the three assessments in Phase II and the issue profiles, collectively identify three to five priority issues for the CHIP. |
| **SMARTIE Objective** | By XX date, determine XX priority issues to address in the CHIP. |

At the end of Phase II, the community developed a set of strategic issues based on CH[N]A findings. **Strategic issues** are fundamental policy choices or critical challenges that must be addressed for a community to achieve its vision. They are key issues that affect multiple aspects of healthy living in your community.

The next step is to prioritize the strategic issues. Prioritization allows the community to narrow down the issues to a manageable number so it can target resources, use existing efforts, and develop achievable goals and strategies to address community needs. This process ensures that the CHIP addresses the most critical needs of the community. Prioritized issues will be continuously monitored through shared community indicators and will be revised or carried over to future CHI cycles to evaluate long-term impact.

## Step 1.1: Review Issue Profiles and Determine Whom to Involve

Ensure that all involved (core group, steering committee, ADT, workgroups, and other community members) understand the goals and process of prioritization. Once all are oriented to the process, review and reflect on the issue profiles from Phase II.

The group responsible for prioritization is at the discretion of the MAPP Core Group and Steering Committee. This group should represent the community and the LPHS. Consider equitable ways to involve people and organizations that come from and work with communities impacted by inequities to amplify the voices of those most affected. Based on the topics of the issues, consider other partners, stakeholders, and community members to include in the prioritization process, including those most impacted by the decisions to follow and whose voices need to be represented. Orient those added to the group, as appropriate.

## Step 1.2: Determine Criteria for Prioritization

The group will use a set of criteria to select priority issues. These criteria should be relevant to the community and agreed upon by the group. Although all findings from the assessments are important, the CHIP will focus on a few prioritized issues over the next three to five years. Determining these criteria will help the team select priority issues without bias or impact of any one stakeholder group's preference.

The criteria provide a standard for everyone to follow, to focus the conversations, and to encourage consensus. You can revisit your vision, mission, and value statements to help you select criteria. Choose at least five criteria for the prioritization process.

Here are some commonly used criteria:[37]

- Relevance of the issue to community members
- Magnitude/severity of the issue
- Urgency to solve the issue
- Impact of the issue on communities impacted by inequities
- Availability and feasibility of solutions and strategies to address the issue
- Trending health concerns (e.g., COVID-19, mental health, obesity, and access to healthcare)
- Availability of resources (time, funding, staffing, equipment) to address the issue
- Opportunity to apply upstream strategies to address the issue
- Social, political, historical, and cultural context of the issue

## Step 1.3: Determine Prioritization Method(s)

The prioritization process can be done in many ways. There is no right or wrong method, and each has benefits. You may choose one method or multiple. For example, you may use a multi-voting technique to engage community members broadly and the nominal group technique with the steering committee to narrow down to the main three to five issues to be used in your CHIP.

Below are different processes you can use to prioritize your issues. This list includes processes that require various levels of input and engagement from participants. Review the guide for direction on which technique best fits the needs of your work, step-by-step instructions, and examples.

| PROCESS | DESCRIPTION |
|---|---|
| **Multi-Voting** | Multi-voting is typically used when a long list of health problems or issues must be narrowed down to a top few. This process is appealing because it allows a health problem that may not be a top priority of any person, but is favored by all, to rise to the top. In contrast, a straight voting technique would mask the popularity of this type of health problem and make reaching consensus harder. |
| **Prioritization Matrix** | A prioritization matrix is a common tool for prioritization and is ideal when health problems are considered against many criteria or when an agency is restricted to focusing on only one priority health issue. Although decision matrices are more complex than alternative methods, they provide a visual method for prioritizing and account for criteria with varying degrees of importance. |
| **Strategy Grid** | Strategy grids facilitate agencies in refocusing efforts by shifting emphasis toward addressing problems that will produce the greatest results. This tool is particularly useful when agencies are limited in capacity and want to focus on areas that provide the greatest return on effort. This tool may help shift from brainstorming with many options to a focused plan of action. |
| **Nominal Group Technique** | The nominal group technique is useful in the early phases of prioritization when there is a need to generate many ideas in a short time and when input from multiple people must be considered. This technique can be used to brainstorm ideas and create a broad list of possibilities. A great advantage of this technique is a democratic process allowing for equal say among all participants, regardless of their position in MAPP or the community. |
| **Hanlon Method** | The Hanlon Method for prioritizing health issues is a well-respected technique that objectively considers explicitly defined criteria and feasibility factors. Though complex, the Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values. |

*Note: Find more descriptions and instructions for each method in NACCHO's Guide to Prioritization Techniques*[38]

Prioritized issues should resonate with both community members and those in the LPHS. As you prioritize issues, center equity by involving community members, especially those from communities affected by inequities. Be intentional about where you host this process. Meet people where they are, including health fairs, community events, and public spaces, or by hosting focus groups. Such events also provide great opportunities to use the multi-voting technique. Additionally, engage partners who have relationships with the community.

## Step 1.4: Validate Priorities

Prioritized issues have significant impacts for the community and the LPHS. The core group and steering committee should agree on the chosen priority issues. Remember to reference the MAPP vision and values.

## Step 1.5: Share Results

Share the three to five priority issues with everyone who participated in MAPP and with the community at large. Create opportunities for people to learn more about the process and to get involved in future MAPP activities. At this stage, you are well on your way to developing the CHIP.

**POWER PRACTICES FROM THE POWER PRIMER**

**3. Study—Learn about Your Communities' Histories**

[37] National Association of County and City Health Officials. (n.d.). *QI project prioritization and selection process.* Retrieved April 11, 2023, from www.naccho.org/uploads/downloadable-resources/QI-Project-Prioritization-and-Selection-Process.pdf

[38] National Association of County and City Health Officials. (n.d.). *Guide to prioritization techniques.* Retrieved April 12, 2023, from www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

# Step 2: Do a Power Analysis of Each Issue

| | |
|---|---|
| **GOAL** | Do a power analysis of each priority issue to assess how the issues are influenced by people and institutions, including the factors that cause or lead to the issue. |
| **SMARTIE Objectives** | • By XX date, do a power analysis of XX issues to assess the systems, organizations, and people who have an impact on each priority issue.<br>• By XX date, do a landscape analysis of XX issues. |
| **Supplemental Tool/Resource** | Potential Partners and Opponents Table |

Now that you have chosen the priority issues, you will do a power analysis[39] of each priority issue. This involves identifying the systems, organizations, and individuals that can either positively or negatively impact progress on the issue. Based on this information, the appropriate potential partner can be identified for each priority subcommittee to develop interventions to address the issues.

The goals of the power analysis are to do the following:

- Assess the systems, organizations, and people who have an impact on the priority issue
- Identify whom the issue affects the most and where there is opportunity to build their influence
- Identify factors and people perpetuating the problems

This power analysis involves the following steps:

- Identify potential partners and opponents of addressing the priority issue
- Determine who is aligned to the issue and who has power to influence it
- Consider how to engage each partner and manage opponents

## Instructions

### 1. INVITE PARTICIPANTS

Invite five to eight people to analyze each priority issue. The group might include members of the core group, steering committee, and ADT, as well as partners and stakeholders who are aligned on and understand the priority issues. These people should represent various sectors and have expertise and connections to potential stakeholders of the priority issue. Each analysis takes about two to four hours, although times will vary depending on the issue.

[39] The power analysis was developed by Human Impact Partners (HIP) and is adapted and used here with permission. For more information about HIP resources and tools, visit https://humanimpact.org.

## 2. GATHER INFORMATION

Review the data that informed how you chose the priority issue. Revisit the issue profiles, 5 Whys activity, fishbone diagram, Stakeholder Analysis Table, and any other foundational information to orient the group.

## 3. IDENTIFY PARTNERS, OPPONENTS, AND RELEVANT POWER

This step will help you identify the people, communities, agencies, and organizations who could positively or negatively impact the success of the priority issue. In your brainstorm of groups and individuals, consider government entities, local politicians, racial justice organizations, housing organizations, school districts, and more, depending on the focus of your priority issue. Consider the following:

- **POWER:** Who has power over the issue?
    - What factors influence this issue (e.g., resources, services, and social determinants related to how the issue impacts the community)?
    - Who can influence the issue or the factors that affect it?
    - Who is responsible for implementing the change we seek, and who holds them accountable?
- **PARTNERS:** Who is aligned with the issue?
    - What values, expectations, or shared understandings underlie the issue?
    - Whom does this issue most impact?
    - Who would agree with us on the need to improve the status of this issue?
    - Which organizations or people are already working on this issue?
    - Which organizations or people could provide relevant data, resources, or other support?
- **OPPONENTS:** Who is not aligned with this issue?
    - What are the opposing arguments to making the change we seek?
    - Who would be impacted negatively if we made the change we seek?
    - Who would disagree with us on the need to improve the status of this issue?
    - Which organizations or people work against making progress on this issue?
    - Which organizations or people have the greatest ability to derail our efforts?

Check your assumptions with a broader group and community members for consensus and validation.

## 4. COMPLETE THE PARTNERS AND OPPONENTS TABLE

Create a table using the template below and record the following information about each person or organization you identified:[40]

- **Stakeholder name/organization**
- **Impact:** How are they impacted by this issue? What do they do to influence this issue?
- **Relevant Power(s):** What type of power do they have related to this issue?
- **Accountability:** To whom do they report, and to whom are they otherwise accountable? Who determines their budget?
- **Influenced by:** Whom are they ultimately influenced by?
- **Alignment:** Is their work aligned with this issue? Are they supportive of it, or against it?

[40] Human Impact Partners. Landscape analysis: Activity #1. Retrieved March 29, 2023, from https://docs.google.com/document/d/1Mk5gL_bhjaSbdO9J7N9QjnOCAdS1hvh0hgE8wAKqzJ0/edit. (Adapted from)

## *Potential Partners and Opponents Table*[41]

| **PRIORITY ISSUE:** | | | | | |
|---|---|---|---|---|---|
| **Stakeholder**<br>Name or Organization | **Impact**<br>How are they influenced by the issue? What impact could they have? | **Relevant Power(s)**<br>What type of power do they have related to this issue? | **Accountability**<br>To whom are they accountable? | **Influenced by**<br>Whom are they ultimately influenced by? | **Alignment**<br>Are they supportive or against making progress on this issue? |
| | | | | | |
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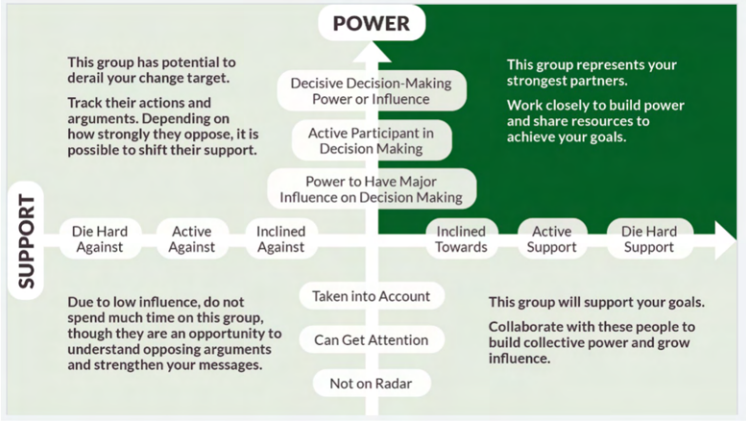
[41] Human Impact Partners. Landscape analysis: Activity #1. Retrieved March 29, 2023, from https://docs.google.com/document/d/1Mk5gL_bhjaSbdO9J7N9QjnOCAdS1hvh0hgE8wAKqzJ0/edit. (Adapted from)

## 5. DO POWER MAPPING[42]

In this activity, you will categorize the stakeholders you identified based on their power and influence over the issue and their support of it. You will use this information to engage those who support addressing the issue and those who could have a positive impact. They will help you identify and implement effective strategies to address the issue. Create one power map for each priority issue. Place individual stakeholders onto the map according to their power over the issue and their support for addressing the priority issue.




## 6. DETERMINE HOW TO ENGAGE STAKEHOLDERS

Facilitate a conversation about who needs to be involved or engaged from the map to make progress on the priority issues using the questions below:

- Who is of highest priority for us to engage around this issue?
- Who might derail our efforts?
- Who could support strategies targeting health outcomes, SDOH, or systems of power, privilege, and oppression?
- Whom can we engage more so they have greater power over how we address this issue?

Here are suggestions of how to engage stakeholders within the quadrants of the power map:

- **High Power/High Support**
  - Include on priority issue subcommittee.
  - Consult them about how they can support addressing this issue.
  - Consider who is of highest priority in this group for you to engage.
- **Low Power/High Support**
  - Identify how stakeholders in this group who are impacted by the issue can have more decision-making power over activities.
  - Include these stakeholders in brainstorming meetings to identify strategies.
  - Keep up-to-date on progress related to the issue.
  - Consider how it would feel to share power among these people to fix imbalances and how to shift power to make the work more equitable.
- **High Power/Low Support**
  - Stay informed about the work these people are doing that might negatively impact progress on your priority issue.
  - Aim to understand their values or what they feel is important to address instead.
  - Consider common ground you could find with these stakeholders, how to excite them about MAPP, and how to increase their engagement.
- **Low Power/Low Support**
  - Increase their support of the issue through public communications about your work.
  - Be mindful of how an increase in their power could negatively impact your work.

[42] Human Impact Partners. Power mapping activity. Retrieved March 29, 2023, from https://jamboard.google.com/d/1nSNsZ1Tdc3TqiF_RhzIsKNhlkPpa2BqDSu84k_V2D9Y/viewer?f=2

# Step 3: Set Up Priority Issue Subcommittees

| | |
|---|---|
| **GOAL** | For each priority issue, recruit a group of community members, partners, and stakeholders to (1) develop goals, strategies, and objectives for the priority issue; (2) develop the action plan; and (3) assign the implementation process for selected strategies. |
| **SMARTIE Objective** | By XX date, develop a subcommittee for each priority issue that includes at least XX partners and XX community members from populations greatest impacted by the priority issue. |
| **Supplemental Tool/Resource** | Priority Issue Subcommittee Brainstorm Table |

The CHIP requires expertise, time, and commitment to be successful. Although all partners, stakeholders, and community members involved in MAPP so far have a shared commitment to improving the health of their community, certain people will participate on subcommittees to address the priority issues. Each priority issue subcommittee has three to six people who direct the CHIP by identifying shared goals, long-term measures, and strategies. They also develop CQI action plans for the issues. These subcommittees meet regularly and manage the ongoing tasks related to the strategies. Setting up subcommittees also helps to establish accountability early in the process.

Revisit the stakeholder analysis, past subcommittees, CPA, and the power analysis to help determine who should be on each subcommittee. Consider including the following:

- Those most affected by the priority issue
- Organizations and systems that perpetuate the issue or need
- Those who directly and indirectly address the issue
- Those charged with carrying out activities, interventions, and actions related to the issue
- Organizations and institutions that serve or otherwise interact with those groups

Consider people with technical skills such as the following:

- Project management and communication
- Access to data and data systems, and the ability to share data
- Understanding health equity and SDOH needs
- Identifying and pooling resources (e.g., funding, space, and staff)
- CQI
- Monitoring and evaluation

Once each subcommittee has been developed, it should select a chairperson (or two). The chair guides the team, keeps work on track, facilitates meetings, and regularly updates the core group and steering committee. The chair must have good project management, facilitation, and presentation skills and be able to do activities such as the following:

- Plan meetings and schedule conference calls
- Prepare and distribute agendas and meeting minutes
- Distribute materials such as information from the core group and steering committee
- Lead the development of SMARTIE goals, strategies, and the action plan
- Monitor progress on strategy implementation
- Hold individual committee members accountable

You could also consider having two subcommittee chairs. One would be from the core group, manage logistical tasks, and keep everyone on track; the other would be a subject matter expert on the priority issue.

Using the Priority Issue Subcommittee Brainstorm Table, consider people who need to be included on these subcommittees. Revisit the stakeholder analysis, past subcommittees, CPA, and the power analysis to inform the table. Once the table is done, facilitate a discussion about whom to include with the core group and steering committee. Share the results with all involved in the process and the community at large.

**POWER PRACTICES FROM THE POWER PRIMER**

1. **Process—Unpack Personal and Organizational Power and Privilege**
2. **Form—Build a Container for Your Work Together**
5. **Share—Practice Power-Sharing with Partners and Community Internally and Externally**

## *Priority Issue Subcommittee Brainstorm Table*

| Priority Issue | Potential Subcommittee Member(s) (Person or organization) | Alignment (Organizational mission, interventions, programming, research, etc.) | Notes |
|---|---|---|---|
| **Priority Issue #1** | | | |
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| | | | |
| | | | |
| | | | |
| **Priority Issue #2** | | | |
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| **Priority Issue #3** | | | |
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# Step 4: Create Community Partner Profiles

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|---|---|
| **GOAL** | Review and analyze community partner profiles for each partner selected for the priority issue subcommittee to further understand their values, mission, resources, and programmatic efforts related to the priority issue. |
| **SMARTIE Objective** | By XX date, XX partners complete a community partner profile to align them with priority issues based on their ability to impact the issue. |
| **Supplemental Tool/Resource** | Community Partner Profile |

Achieving health equity requires strategic collaboration and alignment across multiple sectors to systemically undo historical injustices, tackle inequities, and provide everyone with the opportunity to live healthy, fulfilling, and productive lives. Partnerships are critical to implementation of the CHIP, and the priority issue subcommittees should include partners who are strategically aligned with the priority issues.

Distribute the Community Partner Profile worksheet to everyone on the priority issue subcommittees to complete. The purpose of the profile is to help you engage partners effectively by understanding how their organization's work aligns with the priority issue. The profile collects the following information:

- Organizational mission, goals, and values
- Available assets and resources to assist with the action plan
- Access to and knowledge of appropriate data and metrics
- Alignment of current interventions, programs, and activities
- Engagement and involvement with priority sub-populations experiencing inequities related to the priority issue

The core group should fill out its mission, vision, and values statement from the visioning event in Phase I in to the first table. The community partner should fill out the second table to identify alignment between their organization's work and the CHIP priority issue that their organization is positioned to address.

# *Community Partner Profile*

**To be filled out by the MAPP Core Group**

| | |
|---|---|
| **MISSION STATEMENT** | |
| **VISION STATEMENT** | |
| **VALUES STATEMENT** | |
| **PRIORITY ISSUE** | |

**To be filled out by the Community Partner**

| |
|---|
| **Organization Name:** |
| **Primary Contact & Email:** |
| **Sector:** *(e.g., public health, healthcare, social services, housing, transportation, business)* |
| **Describe the community/ies your organization serves** |
| |
| **Organization mission statement** |
| |
| **Organization values** |
| |

**CHIP Priority Issue:** _____

*List the programs, services, or interventions related to the priority issue, the goals and objectives of those efforts, and the metrics used to track outcomes (impact) and process (implementation).*

| Describe your current programs, services, or interventions related to the priority issue | Associated Goals and Objectives | Outcome Metrics | Process Metrics |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Organizational Resources**

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

- ☐ Funding to support community engagement (e.g., stipends, gift cards)
- ☐ Food for community meetings
- ☐ Childcare for community meetings
- ☐ Policy/advocacy skills
- ☐ Media connections
- ☐ Social media capacities
- ☐ Physical space to hold meetings
- ☐ Technology to support virtual meetings
- ☐ Coordination with Tribal government
- ☐ Staff time to support community engagement and involvement
- ☐ Staff time to support interpretation and translation
- ☐ Lending interpretation equipment for use during meetings
- ☐ Staff time to support relationship-building between MAPP staff and other organizations (e.g., introductions to government agencies or organizers)
- ☐ Staff time to participate in MAPP meetings and activities
- ☐ Staff time to help plan MAPP meetings and activities
- ☐ Staff time to help facilitate MAPP meetings and activities
- ☐ Staff time to help implement strategies
- ☐ Staff time to transcribe meeting notes/recordings

**Other, please specify:**

**What are your initial thoughts about goals or strategies that may be developed around this priority issue?**

Each priority issue subcommittee should review the completed profiles together and use the information to identify opportunities to align organizational work to support the strategic issue or determine what resources can be shared to support the strategic issue.

**POWER PRACTICES FROM THE POWER PRIMER**

4. **Build—Cultivate Relationships with Communities and Partners**

# Step 5: Develop Shared Goals and Long-Term Measures

| | |
|---|---|
| **GOAL** | Each priority issue subcommittee develops broad goal statements for each issue and identifies how to measure progress. |
| **SMARTIE Objectives** | • By XX date, identify XX goals for each priority issue based on assessment data and subcommittee member expertise.<br>• By XX date, identify XX long-term measures for each goal. |
| **Supplemental Tool/Resource** | Goal Development Worksheet |

During this step, subcommittees will form goals and identify long-term measures for their priority issue. Goals are broad, long-term outcomes that set the direction for addressing priority issues. Long-term measures are evidence-based, quantifiable ways to know a goal has been achieved. Together, the goal and long-term measures answer the question of what will be achieved by addressing this priority issue and how you will know the strategy was successful.

When developing goals and long-term measures, use assessment data and the issue profiles to inform the decision and to test assumptions about potential options. Additionally, reflect on the strengths of the community and LPHS to ensure the goals and measures are realistic and achievable.

This step will answer the following questions:

- What transformational goals would achieve the community's vision?
- How do goals align with the mission and value statements?
- What long-term desired outcomes are associated with the priority issues?
- What long-term measures are associated with the goals?

Each subcommittee develops goals and identifies long-term measures for its priority issue. Collaborating on the goals and long-term measures with partners has the following benefits:

- Ensures goals tie back to the community vision from Phase I
- Effectively aligns partners to priority issues
- Identifies any challenges that might impact progress toward achieving the goals
- Empowers partners to address priority issues through activities they had a role in planning

## Step 5.1: Plan the Process

The meeting to establish goals and long-term measures can be done in several ways, including a one-day retreat with multiple stakeholders, a series of meetings, or a virtual workshop.

To plan for the meeting, follow these steps:

- Choose a facilitator to lead the conversation (e.g., member of the steering committee or core group, workgroup chair, or outside consultant).
- Choose attendees (e.g., priority issue subcommittee, stakeholders, community members).
- Set a date.
- Pick a platform or venue (e.g., one-day retreat, series of meetings, virtual workshop).

- Design a clear process that attendees will use to identify and agree upon goals, using the tools below.
- Provide each attendee with relevant data and information about each priority issue (e.g., the issue profile from Phase II).
- Create an agenda with the following items:
  - Purpose of the meeting
  - Brainstorm of goals
  - Consideration of strengths, weaknesses, opportunities, and threats (SWOT)
  - Discussion of community partner profiles
  - Next steps for developing strategies
- After the meeting, send notes, the results of the meeting, and any follow-up information about next steps.

## Step 5.2: Develop Goals and Identify Shared Measures

Goals are broad, long-term aims (about three to five years) that define the desired result associated with the priority issue. A strong goal statement is concise, does not use jargon, is specific, easy to understand, and direct. It should not reference any specific programs or services.[43]

### *Targeted Universalism and Transformational Approaches*

To achieve health equity through MAPP, the CHIP should go beyond the work community partners are already doing. Many efforts of the CHIP are **transactional approaches**, in that they address specific issues and do not change the way the LPHS works as a whole. They lessen the impact of root causes of health inequity but do not address them directly. **Transformational approaches** fundamentally change the way the LPHS operates.

MAPP is also based in the theory of **targeted universalism**, or "setting universal goals and using targeted processes to achieve those goals."[44] Following this principle, you should customize the CHIP to the needs of communities experiencing inequities. Additionally, consider what fundamentally must change in the community to achieve health equity and what barriers may impact those efforts.[45]

Progress toward the CHIP's goals can be tracked by shared long-term measures. Shared measures are a set of indicators that all partners agree to pursue in their work related to the goal. Shared measures focus on the combined impact the community organizations are making on the priority issue rather than the work of one organization. The **Community Tool Box resource on collective impact** includes more background information about developing shared measures.

Use the following Goal Development Worksheet to brainstorm and develop goals and shared measures for each strategic issue in the priority issue subcommittees. Once completed, share the goals with the MAPP Core Group, Steering Committee, and other subcommittees. Remember, goals are more likely to be achieved when they are clearly defined, written down, told to others, and repeated often.

**POWER PRACTICES FROM THE POWER PRIMER**

**3. Study—Learn about Your Communities' Histories**

[43] Minnesota Department of Health. Objectives and goals: Writing meaningful goals and SMART objectives. Retrieved April 11, 2023, from www.health.state.mn.us/communities/practice/resources/phqitoolbox/objectives.html

[44] powell, j.a., Menendian, S., & Ake, W. (2019). *Targeted universalism policy & practice*. Othering & Belonging Institute at UC Berkeley. Retrieved March 30, 2023, from https://belonging.berkeley.edu/targeted-universalism

[45] Othering & Belonging Institute. Transactional versus transformative change. Retrieved April 18, 2023, from https://belonging.berkeley.edu/transactional-versus-transformative-change

# *Goal Development Worksheet*

## GOAL BRAINSTORM

*Repeat this worksheet for all priority issues.*

**Orienting Information**

*Provide the following information to orient the group on the mission, vision, and value statements.*

| | |
|---|---|
| **PRIORITY ISSUE** | |
| **MISSION STATEMENT** | |
| **VISION STATEMENT** | |
| **VALUES STATEMENT** | |

**Brainstorm**

*Collectively think through and discuss the following questions to form your goal(s):*

**Reflecting on the orienting information and issue profile, what outcomes do we hope to achieve related to the priority issue?**

*For example: People with historically low food access can access nutritious produce easily; everyone has transportation to care; residents are aware of the mental health services located in the county and regionally.*

**What national- or state-level goals relate to this priority issue?**

*Reference resources like County Health Rankings, Healthy People, or your state's health plan.*

**Based on your review of the vision and priority issue, what are some potential goals for this priority issue?**

**What are the current barriers to achieving these potential goals?**

*Consider barriers in the following categories: community, policy/legal, technical, financial, other.*

**What measurements can we use to track progress on the priority issue?**

**What resources are available to address the issue, if any?**

**How can the goal include the voices and priorities of historically marginalized people?**

**How might potential goals have unintentionally different impact along lines of race, gender, class, ability, access, or power? How can the goal lessen this?**[46]

**Develop Goal(s)**

*Combine the information from the brainstorm to form a clear goal statement. You may develop more than one goal to address the priority issue.*

[46] Massachusetts Department of Elementary and Secondary Education. *Creating SMARTIE goals.* Educator Evaluation Implementation Resources 2021-2022. Retrieved April 17, 2023, from www.doe.mass.edu/edeval/implementation/smartie-goals.docx

# Step 6: Select CHIP Strategies

**GOAL**

Based on the priority issue goals, identify strategies that will achieve the desired outcome.

**SMARTIE Objectives**

- By XX date, select XX strategies for each goal.
- By XX date, do XX analysis on XX strategies to determine if they can be successfully applied.

Strategies are activities people perform to reach the goal. Strategies are informed by the goal, assessment data, issue profiles, and vision. A goal may have several potential strategies, or one strategy may apply to multiple goals. You should work toward generating several strategies that reflect the range of choices the community may select to achieve its vision. When developing strategies, also think about past patterns of actions, new realizations, and previous strategies that worked or didn't work.

To address root causes of inequity, try to focus strategies on the systems and policies that contribute to health. Additionally, identify any community-driven solutions. As you identify and develop strategies, think about what institutions or organizations could apply the policy or practice. Prioritize actions that will uplift the community and provide measurable progress.

As you develop these strategies, also consider the following:

- Trying to address equity without taking on policy change can enable health disparities. Use effective strategies to address root causes of health inequities.
- Choosing evidence-informed strategies that have been shown to work and are good for a community will increase the possibility of success.
- Understand the unique factors and dynamics that make up a community (culture, history, environments, locations, resources, assets, and challenges) to ensure the strategy resonates with people.
- To have the greatest impact and success, engage a broad group of stakeholders including community members and decision-makers.
- For greater sustainability, select strategies that align with the focus areas and resources of partners in the subcommittee, using the community partner profile.

Strategies for the CHIP may take the form of one or more of the following:

- **Rapid Cycle Improvement:** Your community might have strategies that are still being applied from the last CHI cycle, or from partner organizations. One option is to gradually change this intervention to improve it and ensure it meets the goal using successive Plan-Do-Study-Act cycles:[47]
    - **PLAN:** Create a plan for the intervention you will apply.
        - Draft an aim statement for what your intervention will accomplish and how you will track success.
        - Create a plan of what will be implemented, by whom, and by when.

[47] Minnesota Department of Health. PDSA: Plan-do-study-act. Retrieved March 29, 2023, from www.health.state.mn.us/communities/practice/resources/phqitoolbox/pdsa.html

- **DO:** Apply your action plan and gather data about implementation and the immediate and short-term outcomes.
- **STUDY:** Reflect on the data you have gathered to determine whether the intervention was implemented as intended and whether it was successful.
- **ACT:** Determine how to change the intervention to make it more effective.

- **New Evidence-Based Strategy:** You might need to adopt a new strategy if the current work does not help accomplish your goals. Rather than creating an entirely new strategy, reference reputable sources to adopt an evidence-based practice that has been shown to be effective at addressing the priority issue. Reference resources like the **National Institutes of Health's Evidence-Based Practices, Programs, and Resources.**
- **New Intervention:** An existing strategy may not meet the needs of the community and address the goal. In this case, you could develop a new intervention. For each strategy that is not evidence-based, you should perform an impact assessment or racial equity impact assessment (REIA). This assessment will help you understand the impact of the strategy on different groups and how a proposed action or decision will likely affect different racial and ethnic groups. REIAs can help to minimize unanticipated adverse consequences of chosen strategies. They can help prevent institutional racism and identify new options to improve long-standing inequities. Do the impact assessment before enacting new strategies. Using the **Center for Racial Justice Innovation's Racial Equity Impact Assessment**, discuss the questions to anticipate, assess, and prevent potential adverse consequences of proposed strategies on different marginalized and disadvantaged groups.

# Step 6.1: Brainstorm Strategies

Before starting the brainstorm, ensure everyone is aware of the criteria you will use to choose the final strategies. Selection criteria[48] might include the following:

- **Community Readiness:** Will community stakeholders support this strategy?
- **Impact:** What is the likelihood the strategy will work?
    - *Is the strategy tailored to the specific community it is intended to address?*
- **Policy Impact:** Does the strategy address policies or practices that affect inequities?
    - *Does the strategy target policy and environment to better address the root causes of inequity?*
- **Cost-Benefit:** Could any results, either anticipated or unintended, outweigh the potential positive outcomes of the strategy?
- **Influence:** Can community stakeholders carry out the strategy?
- **Opportunity:** Are there other strategies to use or build on?
- **Resources:** Can the community access the resources needed for the strategy?
    - *How well does this align with the existing work and focus of partners on this subcommittee?*

[48] County Health Rankings & Roadmaps. Choosing your strategy. Retrieved April 17, 2023, from www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/choosing-your-strategy

## *Strategy Brainstorm*

For each goal, answer the following questions to brainstorm about effective strategies:

- What past action(s) worked?
- What past action(s) did not work?
- What new realizations or approaches may support a strategy?
- What are the strengths of the community and partners around the priority issue?
- What threats need to be addressed?
- What implementation details accompany each strategy?

In addition to this brainstorm, you can use the Health Equity Strategy Bank on the MAPP Network to find ideas about what to include in the CHIP. This tool offers strategies to address health inequities organized according to their impact along a spectrum from root causes to SDOH to the individual level. This spectrum is based, in part, on the BARHII Framework. In addition, you can reference evidence-based practices such as NACCHO's Model Practices Database, The Community Guide, National Prevention Strategy, and Healthy People 2030.

# Step 6.2: Prioritize Strategies

Now, prioritize your list of brainstormed strategies. Revisit the strategy criteria to help select which strategy is most feasible and has the greatest impact. Then, look at each strategy individually. Consider what is needed for implementation and what impact the strategy will have on the community, including resources, funding, return on investment, feasibility, community support, effectiveness, and potential negative consequences.

Then, brainstorm barriers to implementation for each potential strategy. Barriers include limited resources, little to no community support, legal or policy obstacles, and technological difficulties. Barriers do not necessarily eliminate a strategy option, but the group must address the barrier to pursue the strategy.

To prioritize the strategies, you can use the same prioritization techniques used for prioritizing the issues. You can also test the feasibility, impact, and fit of the strategies using the following analyses:

| | |
|---|---|
| **SWOT Analysis** | A Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis identifies the strengths and weaknesses of the potential strategy (S-W), and broader opportunities and threats (O-T). It develops a fuller awareness of the strategies, which helps with both prioritization of strategies and strategic planning thereafter. |
| **SOAR Analysis** | Strengths, Opportunities, Aspirations, and Results (SOAR) is a strategic planning approach that focuses on strengths and seeks to understand the entire system by including the voices of relevant stakeholders. SOAR conversations center on what an organization is doing right, what skills could be enhanced, and what compels stakeholders.[49] |
| **NOISE Analysis** | Needs, Opportunities, Improvements, Strengths, and Expectations (NOISE) is a strategic planning tool and useful alternative to SWOT and SOAR. This analysis allows decision-makers to analyze the current state of an issue and to create a strategic improvement plan that focuses on what they do not have rather than what they need to do. It uses solution-focused language that helps teams build on their knowledge and goals and overcome identified obstacles. |
| **PEARL Test** | Propriety, Economics, Acceptability, Resources, and Legality (PEARL) is a list of five questions that determine whether a strategy should be adopted or not. If the answer to any question is no, a strategy should be revised or eliminated. Remaining strategies that pass the PEARL test should be prioritized based on a list of criteria. |
| **CHIM** | Community Health Improvement Matrix (CHIM) is a tool for addressing the SDOH through CHI planning. Its worksheet helps people think through how upstream they are working and helps identify potential interventions, strategies, and partners that are more upstream. It is a matrix of prevention levels and intervention levels. |
| **SCORE** | Strengths, Challenges, Options, Responses, and Effectiveness (SCORE) is another alternative to the SWOT analysis that gives a bit more depth for strategic assessment. One aim of a SCORE analysis is measurable results. SCORE also assesses both before and after action, supporting continuous improvement. |

**POWER PRACTICES FROM THE POWER PRIMER**

**6. Strategize and Act—Implement, Amplify, and Invest in Community-Identified Priorities and Solutions**

[49] Stavros, J., & Hinrichs, G. (2009). *The thin book of SOAR: Building strengths-based strategy.*

# Step 7: Develop Continuous Quality Improvement Action Planning Cycles

| | |
|---|---|
| **GOAL** | Develop an action plan including objectives, measures, timelines, and a plan-do-study-act cycle that details the needed milestones and responsibilities of the MAPP teams and subcommittee members to achieve the community vision. |
| **SMARTIE Objectives** | • By XX date, develop XX objectives for XX strategies to achieve the goals selected.<br>• By XX date, create an XX action plan(s) that details the needed resources, expertise, timeline, and measures to address the goal(s) created for the priority issue. |
| **Supplemental Tools/Resources** | • SMARTIE Objectives Worksheet<br>• 90–180 Day Implementation Worksheet |

Action planning is an approach, rather than a specific method, which helps people focus ideas and decide what steps are needed to achieve a goal over a period of time.[50] This planning cycle results in objectives and an action plan that details how to apply strategies to achieve the priority issue goal.

Action planning will follow a plan-do-study-act cycle to monitor progress toward the goal of each strategy and allow you to correct course as needed:

- PLAN the strategy to implement and an evaluation plan to track impact.
- DO (i.e., apply or implement) the strategies of your CHIP, tracking data to understand impact.
- STUDY the results of the evaluation data.
- ACT by changing the strategy implementation as needed for better outcomes toward the goal.

The PLAN stage of action planning has the following steps:

- Develop realistic and measurable SMARTIE objectives for each strategy.
- Develop a logic model to establish how implementation and outcomes will be tracked.
- Develop action plans to achieve the outcome objectives and address the selected strategies.
- Develop an evaluation plan and process to assess the impact of strategies and adjust as needed.

[50] Involve. Action planning. Retrieved April 11, 2023, from https://involve.org.uk/resources/methods/action-planning

# Step 7.1: Develop SMARTIE Objectives

Objectives are specific sub-steps or milestones that lead to the successful completion of a goal.[51] Objectives can be developed in many ways, but the SMARTIE method[52] helps make them clear and intentional. Objectives for strategies in the CHIP need to be specific, measurable, achievable, relevant, timebound, inclusive, and equitable. By setting SMARTIE objectives, the priority issue subcommittee can communicate better about the desired outcome, track progress, and establish accountability.

| | | |
|---|---|---|
| **Specific** | Reflects an important aspect of what your organization seeks to accomplish (programmatic or capacity-building priorities) | What goal are you trying to realize? |
| **Measurable** | Includes standards by which reasonable people can agree on whether the goal has been met (by numbers or defined qualities) | How much? How often? How many? |
| **Achievable** | Is challenging enough that achievement would mean significant progress—a "stretch" for the organization | Will we be able to accomplish this? |
| **Relevant** | Is related to achieving the overall goal | Is it relevant to the priority issue and the vision? |
| **Timebound** | Includes a clear deadline | When will it happen? What is a realistic timeframe? |
| **Inclusive** | Brings traditionally marginalized people—particularly those most impacted—into processes, activities, and decision/policymaking in a meaningful way | How will you include underrepresented voices and share power? |
| **Equitable** | Seeks to address systemic injustice, inequity, or oppression | How does it seek to address systemic injustices, inequality, or oppression?[53] |

[51] SAMHSA Native Connections. (n.d.) *Setting goals and developing specific, measurable, achievable, relevant, and time-bound objectives*. Retrieved April 11, 2023, from www.samhsa.gov/sites/default/files/nc-smart-goals-fact-sheet.pdf

[52] The Management Center. SMARTIE goals worksheet. Retrieved March 29, 2023, from www.managementcenter.org/resources/smartie-goals-worksheet/

[53] Minnesota Department of Health. (2019). *Monitoring and revising the community health improvement plan: Process guide and worksheet.* Retrieved March 29, 2023, from www.health.state.mn.us/communities/practice/assessplan/lph/docs/chip-monitor-revise-guide.docx

Much like the goal-setting process, first establish the forum and process for drafting and selecting SMARTIE objectives. As a group, brainstorm objectives that are directly associated with the achievement of the strategy. If there are alternative ideas for objectives, apply the prioritization methods to strategically select which objectives are most feasible and impactful. Measurable objectives should be:

- Valid and reliable
- Focused on outcomes
- Informed by data
- Directly related to the priority issue, goal(s), and strategy
- Able to link performance to the expected improvement
- Responsive to changes in expected results

Here are some more tips for writing SMARTIE objectives:

- Provide quantitative baselines for each objective that leads to an increase, decrease, or maintenance over time.
- Referencing a logic model makes developing SMARTIE objectives easy. Rephrase outcomes in the logic model into SMARTIE objectives.

### EXAMPLE OF A SMARTIE OBJECTIVE

**Goal #1:** Improve awareness of the mental health services located in the county and regionally

**Strategy:** Promote availability of existing provider mental health trainings online and in-person

**Objective 1A:** By September 2025, provide six Mental Health First Aid trainings to increase the ability of clinical providers to recognize mental health issues, decrease stigma, and improve awareness of where to refer those in need for assistance

After choosing SMARTIE objectives, the subcommittee should bring recommendations to the MAPP Core Group and Steering Committee for discussion. Once all objectives are agreed upon, celebrate and share with the community at large.

# *SMARTIE Objectives Worksheet*

Complete the following worksheet to write SMARTIE objectives for each goal.

| **PRIORITY ISSUE:** | | | |
|---|---|---|---|
| **Goal:** What broad, long-term outcome do we want to achieve? | **Goal 1:** | | |
| **SMARTIE Objectives** | **Objective 1.1** | **Objective 1.2** | **Objective 1.3** |
| **Specific:** Who? (target population and persons doing the activity) and What? (action/activity) | | | |
| **Measurable:** How will we quantify success? | | | |
| **Achievable:** Is this feasible given resources and constraints? | | | |
| **Relevant:** Will this help make significant progress toward the goal/strategic priority? | | | |
| **Timebound:** By when will this objective be met? | | | |
| **Inclusion:** How will we include underrepresented voices and share power? | | | |
| **Equitable:** How does it seek to address systemic injustices, inequality, or oppression? | | | |
| **Objective Statement:** Use the information brainstormed above to draft SMARTIE objective statements. | **Objective 1.1:** | **Objective 1.2:** | **Objective 1.3:** |

# Step 7.2: Develop a Logic Model for Each Goal

Developing a logic model can help you can identify all the pieces of your intervention and what you can track to understand if your intervention is having a positive effect. A logic model is a visual display of process metrics (how an intervention is implemented) and outcome metrics (short-, intermediate-, and long-term). Building a logic model will help the priority issue subcommittee understand whether the strategies are being implemented as intended and whether they are effective.

A logic model includes the following parts (adapted from **NACCHO's strategic planning guide** and **Measuring What Matters in Public Health**):

| LOGIC MODEL PART | EXAMPLE |
|---|---|
| **Goal:** The overarching goal related to the priority issue | Residents have opportunities to participate in health-promoting activities to lower their risk of chronic disease. |
| **Process Metrics** | |
| **Activities:** The distinct actions to apply the strategies (e.g., developing products, delivering services, developing infrastructure) | Train community-based organizations (CBOs) on the importance of physical activity to lower risk of chronic disease. |
| **Outputs:** The direct results of an activity. Described in terms of size and scope of the services and products delivered or produced by the program. | Number of one-hour trainings provided to CBOs |
| **Outcome Metrics** | |
| **Short-term outcomes:** The immediate impact of the activities (e.g., change in awareness, knowledge, skills, or attitude) | CBO staff knowledge of physical activity resources in the community<br>***Indicator:*** *% change in knowledge from training pre/post-test* |
| **Intermediate outcomes:** Changes that occur after a series of activities (1–3 years)<br>***Indicators:*** Information that will be collected to track intermediate outcomes | Community member use of physical activity resources in community<br>***Indicator:*** *Enrollment in local gyms and recreation centers* |
| **Long-term outcomes:** Occur only after short-term and intermediate outcomes are achieved. Organizational, environmental, or system-level changes.<br>***Indicators:*** Information that will be collected to track long-term outcomes. This information may come from CH[N]A data. | Rate of heart disease in the community<br>***Indicator:*** *Cardiovascular disease mortality rate per 100,000* |

You can use Worksheet 3 of **Measuring What Matters in Public Health** to develop a logic model for each goal of your priority issue.

## Step 7.3: Develop an Evaluation Plan to Track Implementation and Impact

You will additionally need to determine how you will evaluate your strategy by tracking the short-, intermediate-, and long-term outcomes of your activities, as well as targets for each indicator, based on what you outlined in your objectives. Develop the evaluation plan now so you can include it in your action plan. The community partners who apply the strategies from the CHIP should also monitor progress and recommend revisions.

For any indicators you are tracking, make an evaluation plan that includes the following:

- What are our sources of data for each indicator?
- Who will track each indicator (short-, intermediate-, and long-term)?
- Where will the progress on the indicators be tracked?
- How often will indicators be updated?
- What are our baseline and target measures for each indicator?
- How frequently will we assess progress on the indicators to decide if we need to adjust our implementation?

You can track evaluation roles through a central document or spreadsheet that includes space for tracking implementation activities, short-, intermediate-, and long-term outcomes (with dates when updates are due), and notes if changes to the intervention are made based on the data. Partners will likely need to track their own implementation activities and report outcome data in the central document. The CQI Tracking Template includes an example of a CHIP tracking worksheet. Add all of these details to your action plan, as described in the next step.

## Step 7.4: Develop the Action Plan

An action plan translates objectives into specific activities that MAPP participants will carry out. An effective action plan is a detailed outline of tasks and assignments. Action plans may be organization-specific or call for collective action from several organizations within the priority issue subcommittee. This plan also establishes how progress will be measured, evaluated, and adjusted.

The action plan should include the following:

- Specific activities
- Names of implementers
- Timeframes
- Needed resources
- Evaluation duties

The first step in developing the action plan is to assign accountability. Collective action requires that people be committed to the process, vision, and goals. By always providing clear guidance on roles, responsibilities, and expectations, you help people know how they are going to be accountable. Check in periodically with people assigned to tasks to see what challenges they are facing and how to overcome those challenges. Once you have identified accountability for each objective, participating organizations should identify how they can incorporate the goals, strategies, and objectives into their organizational plans.

The second step is to develop the workplan using the 90–180 Day Implementation Worksheet. You may add to or copy this worksheet as needed.

Once the action plan(s) is developed, the priority issue subcommittee should review it with the MAPP Core Group and Steering Committee. If possible, organize a large meeting to present and discuss all the goals, objectives, and action plans. During this meeting, identify common or duplicative activities and seek ways to combine or coordinate the use of limited community resources.

# *90–180 Day Implementation Worksheet*

| **Strategic Priority Area:** *List the name of the priority issue that this work is addressing.* | **Goal Statement:** *Write a goal statement explaining the strategic advantage of moving in this direction. How will this work move us toward our vision?* |
|---|---|

| **Accomplishment:** *List the specific desired accomplishment in past tense, as if it had already happened—for example, created an inventory of existing resources.* | **Start Date:**<br>**End Date:** |
|---|---|

| **Implementation Steps (How):** | **When:** | **Who:** |
|---|---|---|
| *List the steps to complete the accomplishment. Start each step with a verb that captures the action. Make it as concrete as possible.* | *Identify the completion date of each step.* | *Identify who will complete the step.* |
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **5.** | | |
| **6.** | | |

| **Team Members:** *List the names of all the team members.* | **Collaborators/Partners:** *Potential collaborators who can contribute resources or assist with implementation* | **Special Considerations:** *List any special considerations such as:*<br>• *Resources needed*<br>• *Seasonal time considerations*<br>• *Staff/people time required* |
|---|---|---|

**Performance Measures**
*How will we know we are making a difference?*

| Short-Term Indicators | Source | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| **Long-Term Indicators** | **Source** | **Frequency** |
| | | |
| | | |
| | | |
| | | |

*Note: This worksheet was adapted from the Institute of Cultural Affairs in the USA with permission. It is one element of the Technology of Participation (ToP) facilitation methodology. For more information about ToP resources and training opportunities, visit* ***www.ica-usa.org.***

## Step 7.5: Write the CHIP

A CHIP describes your community's MAPP process and summarizes priority issues, goals, strategies, and activities. A CHIP is a long-term, systematic effort to address public health problems on the bases of the results of CH[N]A activities and the CHI process. This plan is used by health and other governmental education and human services agencies, in collaboration with community partners, to set priorities and coordinate and target resources. The CHIP is community-owned. This is not a plan for just one agency but represents the whole LPHS.

You can present a CHIP as follows:

1. Executive Summary
2. Description of the Process
    a. Overview of MAPP
    b. People and organizations involved
    c. Community vision statement
    d. Assessments done
    e. Description of how priority issues, goals, strategies, and objectives were selected and prioritized
3. Strategic Issues, Goals, Strategies, Objectives, and Activities
    a. Description of each priority issue
    b. Assessment data related to each priority issue
    c. Goals, strategies, objectives, and activities related to each priority issue
    d. Timeline(s) for achieving the objectives and activities
    e. Performance measures and indicators of progress for each activity
    f. People and organizations responsible for implementing activities
4. Summary

**POWER PRACTICES FROM THE POWER PRIMER**

**6. Strategize and Act—Implement, Amplify, and Invest in Community-Identified Priorities and Solutions**

# Step 8: Monitor and Evaluate the CHIP

| | |
|---|---|
| **GOAL** | Apply the CHIP with ongoing evaluation to monitor performance and adjust where needed. |
| **SMARTIE Objectives** | • By XX date, develop a monitoring system for XX objectives to track progress over time.<br>• Revisit monitoring system every XX (cycle) to ensure activities are on track and all are accountable to the action plan. |

Now, you are ready to DO (i.e., implement or apply) the CHIP according to your action and evaluation plan and monitor its impact. You probably won't see impacts on the priority issues and goals in the short-term, but ongoing monitoring of the implementation of the strategies and short-term outcomes is important. By monitoring and revising the CHIP strategies as they are implemented, you can ensure they are being applied as intended for the best possible outcome. With that data, you can adjust and improve the plan for greater impact.

An effective monitoring and revision process includes the following:[54]

- Involving all who are responsible for implementing the CHIP, such as the priority issue subcommittees
- Clear roles and responsibilities of the partners in the process (e.g., what data they should collect, when they should collect data, and how they should share data)
- Regular meetings to review and revise the CHIP
- Scheduled and ongoing data review, information-sharing, and discussion of progress toward the goals of the CHIP

Implement your evaluation plan by collecting data about both the process and outcome of the interventions. Both are important to evaluate because they help you determine why an intervention was successful, or not, and help you use resources more efficiently.

- Process metrics evaluate *how* the intervention activities are implemented. They answer the question, *Is the strategy implemented as it was intended?*
- Outcome metrics evaluate the short-, intermediate-, and long-term outcomes of the intervention. Some outcomes may take time and may not be measurable for months, or even years.

STUDY the results of your intervention to determine whether it was effective and what contributed to that success. Look at the data based on your predetermined schedule and consider the following:

- Is the intervention being implemented as intended, based on our process metrics?
- How could we increase our efficiency?
- How could we better serve populations experiencing inequities related to this priority issue?
- Are we seeing the intended impact on the short-term outcomes?

[54] Minnesota Department of Health. (2019). *Monitoring and revising the community health improvement plan: Process guide and worksheet.* Retrieved March 29, 2023, from www.health.state.mn.us/communities/practice/assessplan/lph/docs/chip-monitor-revise-guide.docx

ACT on those results by deciding to *adapt, adopt, or abandon* any element of the intervention. Make only those changes to the intervention that are backed up by data or evidence-based strategies.

- *Adapt* part of the intervention by changing it slightly to be more effective or efficient.
- If you tried something new and it was effective, adopt it as an official part of the intervention.
- *Abandon* any new practices that worsened results or were ineffective.

If you decide to try something new, make small, incremental changes to your intervention to ensure any changes in outcomes were due to the change you made. Test a change on a small scale by implementing it with a distinct subgroup for a short period of time (which you could determine by disaggregating the data by subpopulations). Improving outcomes in the short term by making small changes to your implementation will ultimately improve outcomes in the intermediate and long term.

Then, the Plan-Do-Study-Act cycle begins again by making changes to your intervention and updating your data-collection plan, as needed.

You can monitor the impact of your CHIP in several ways, depending on the capacity and resources available. No matter what method you choose, all partners need to contribute to updating data on the suite of metrics identified in the action plan. With the potential for cross-cutting goals, strategies, and activities, subcommittee chairs and the core group should communicate to ensure activities are ongoing and barriers are being addressed.

### *Track Process Metrics and Short-Term Outcomes*

Monitoring the impact of an intervention on short-term outcomes allows you to make changes sooner.

Tracking process metrics highlights the connection between how the intervention was delivered and what the outcome was so you can change your implementation methods based on data.

Sharing the results of the CHIP with community members regularly is critical so they know whether the time and resources invested into the process were effective. As your resources allow, consider developing an online data dashboard to report on the CHIP, which could include interactive reports, mapping features, and visualizations. If resources do not allow for a data dashboard, even a regularly updated webpage or document with updates on implementation will do.

You should fully evaluate or summarize the CHIP every three to five years to determine whether the strategies are meeting the goals.

**POWER PRACTICES FROM THE POWER PRIMER**

**7. Evolve—Reflect on Process, Outcomes, Accountability, and Sustainability**

# Continuous Quality Improvement: Reflection on Phase III

After wrapping up this phase, ask the following questions of the ADT, core group, and steering committee:

- What went well?
- What did not go well?
- What goals did you achieve/not achieve?
- What was the result of your process metrics? Outcome metrics?

## Additionally, reflect on this MAPP process as a whole:

Revisit your goals from the Starting Point Assessment

- On which goals did you make significant progress?
- What do you think contributed to this success?
- On which goals did you not make significant progress?
- What would you do differently in the future to achieve this goal?
- How might you change your goals for a future MAPP cycle?
- What goals will you continue to track throughout CHIP implementation?

Overall, among all three phases, what went particularly well?

Overall, what were the most difficult parts of MAPP?

What new insights have you gained?

What will you change to improve future MAPP cycles?

Note your reflections and include them in your future Starting Point Assessment processes when you begin a new MAPP cycle.

# Conclusion

**Congratulations on completing MAPP for community health improvement!** Remember, you do not need to completely restart the process every three to five years. Instead, build on the partnerships and momentum from this cycle while updating key data to ensure the work is having a positive impact toward achieving health equity.

This community-wide, collaborative work is critical to developing healthy, equitable communities. The whole process is not easy, but we hope the tools provided in this handbook have supported you on the journey. As you continue this work, reach out for resources and people to support you and your community. Join and add your questions to the MAPP Virtual Community (**virtualcommunities.naccho.org/mapp**) or contact NACCHO staff at **mapp@naccho.org**.

# GLOSSARY

This glossary provides definitions for terms of art in Mobilizing for Action through Planning and Partnerships (MAPP) 2.0.

**aggregate data**
Data about multiple populations or groups of people, or from multiple sources, that are combined so you cannot make conclusions about one group (e.g., by age, race, ethnicity, or geographic residence). Data are typically aggregated for public reports or to reveal information that is observable only when the groups are considered together.[1]

**assessment design team (ADT)**
A MAPP sub-team with relevant expertise and resources that participates in all aspects of MAPP Phase II, particularly the three assessments

**asset mapping**
A community asset or resource is anything that improves the quality of community life (e.g., abilities of community members, physical structure or place, a business, associations, institutions, or organizations). Asset mapping is the process of plotting these resources onto a geographical map of the community.

**built environment**
The human-made surroundings that influence overall community health, including the individual behaviors that drive health. The built environment includes many types of physical elements, such as homes, sidewalks, and public transportation.[2]

**codebook**
A list of themes to categorize and analyze qualitative data that is either developed before gathering data or built as qualitative data are gathered[3]

**coding**
The process of making connections between qualitative data that are gathered (e.g., quotes, transcripts, notes) and the themes in the codebook

**community champion**
A public official, community leader, concerned citizen, health or human service worker, or volunteer who works hard and well to start or support an initiative or intervention, to bring a program or idea to reality, or to otherwise improve the quality of life of a particular group or of the community as a whole[4]

**community engagement**
The involvement of people who will be affected by MAPP in the process to ensure their needs and desires drive the work. Strong community engagement involves interpersonal trust, communication, and collaboration.[5,6]

**community experiencing inequities**
Communities that have higher rates of disease and death because of unjust causes, like oppression and imbalances in power. They should be involved in their local MAPP process to ensure it meets their needs.

**community health [needs] assessment (CH[N]A)**
An evaluation of a community's health needs and issues at the state, Tribal, local, or territorial level based on systematic, comprehensive data collection and analysis. Non-profit hospitals develop "community health needs assessments."[7]

**community health improvement (CHI)**
A long-term (three- to five-year), community-wide strategic planning process to improve a community's health outcomes. It engages community members and organizations that contribute to public health in a comprehensive assessment, identification of priority issues, development of action steps to address issues, and implementation and evaluation of those steps.

**community health improvement plan (CHIP)**
A strategy that a community develops to describe how it will work together to address the public health problems highlighted in the community health [needs] assessment. It is typically updated every three to five years.[8]

**community organizing**
A diverse set of strategies and methods to support community members to be in relationship with one another; invest in each other's leadership; share a common identity shaped by similar experiences and an understanding of the root causes of their conditions; and use their collective analysis to create solutions and strategize to achieve them. This may also be referred to as "base-building."[9]

**community ownership**
Community members contribute to decisions about how the MAPP activities are carried out, and the MAPP process belongs to the community as a whole, not to one agency or organization.

**community power**
The ability of communities most impacted by systematic inequities to develop, sustain, and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity[10,11]

**community power-building**
A set of strategies used by communities most impacted by structural inequity to increase their community power (refer to **community power**)[12]

**community power-building organization (CPBO)**
An organization that engages "residents of communities most impacted by structural oppression in setting an agenda toward changing systems to create and sustain healthy communities— and build their leadership, skills, and expertise to achieve and oversee that agenda"[13]

**core group**
Two to three people who devote initial time and resources to the MAPP process and keep it moving forward

**data triangulation**
The process of bringing together the information from the three MAPP assessments to interpret the community's key issues and assets

**demographic data**
Measures of total population and percent of total population by age group, gender, race and ethnicity, where these populations and sub-populations are located, and the rate of change in population density over time, due to births, deaths, and migration patterns

**disaggregate data**
Numerical or non-numerical information collected from multiple sources, or on multiple measures, variables, or individuals that has been combined and broken down into smaller units. Data are often disaggregated to make comparisons between different groups.[14]

**enabling resource**
A resource offered to community members to support their engagement in MAPP, such as direct payment, or supports like childcare, transportation, snacks/meals, and translation/interpretation

**evaluation**
A systematic way to improve and account for public health actions by involving procedures that are useful, feasible, ethical, and accurate

**focus group**
A qualitative data method in which a small group of participants (about eight to 10 people) responds to a set number of questions

**forces of change**
Trends, factors, and events currently or historically at play in the community that impact community health and well-being

**ground truthing**
The process of sharing qualitative data findings with participants to make sure the interpretations of what they shared are correct, before the data are published

**health behavior**
An action people take that affects their health positively (e.g., exercise) or increases their risk for disease (e.g., smoking)[15]

**health disparity**
The difference in health outcomes or access to healthcare across populations, which results from socioeconomic, biological, and psychological factors and the behavior of individuals. This term does not account for the unequal structuring of life chances.

**health equity**
When everyone has a fair and just opportunity to achieve optimal health (refer to **optimal health**)[16]

**health equity action spectrum**
A model designed by NACCHO for the MAPP 2.0 framework to describe the links among the root causes of health inequity, social determinants of health, and individual-level health outcomes. This spectrum then supports identification of action public health practitioners can take along the spectrum to advance health equity.

**health inequity**
The difference in the distribution of disease and death that is preventable, systematic, patterned, unjust, and associated with imbalances in power and systems of oppression[17]

**health outcome**
The physical and mental well-being of residents in a community. It is measured by how long they live and their quality of life (feeling healthy, comfortable, and able to enjoy life events).[18,19]

**health status**
The current state of a given population as described by various quantitative data (e.g., morbidity, mortality, access to healthcare)[20]

**indicator**
A measure or data that describe community conditions currently and over time (e.g., poverty rate, homelessness rate, number of food stamp recipients, life expectancy at birth, heart disease mortality rate). It helps answer how we are doing regarding the community conditions we care about.

**intersectionality**
The idea that any person can identify with multiple social categories at once (e.g., related to race, ethnicity, gender, sexual orientation, socioeconomic status) and that each category has a different influence on the person's level of power and privilege in the world[21]

**local public health system (LPHS)**
All the people and organizations who deliver the essential public health services in a community, including assessing the population's health, developing policies to support health, and ensuring people in the community can be healthy. It includes a wide variety of agencies (federal, state, and local), laboratories and hospitals, as well as non-governmental public and private agencies, voluntary organizations, and people.[22]

**oppression**
The historically and socially rooted disadvantage and injustice that keep power with a dominant group and systematically put down other groups[23]

**optimal health**
A state of complete physical, mental, and social well-being and not only the absence of disease or illness[24]

**partner**
A person, group, or organization engaged in the MAPP process at any step

**partnership**
A relationship between two or more people or organizations. Different partnerships can vary in how much the partners collaborate and share resources.

**power**
The ability to control the processes of setting agendas, distributing resources, making decisions, and determining who is included in and excluded from these processes[25,26]

**primary data**
Data collected directly, for example through surveys, listening sessions, interviews, or observations[27]

**privilege**
The unearned social power that all people within a dominant group have based on formal and informal institutions of society. People who have privilege may not notice it, but they benefit from it consistently.[28]

**priority issue subcommittee**
A committee established in Phase III of MAPP who develops and leads implementation for strategies to address priority issues within the community health improvement plan

**qualitative data**
Information that is summarized without numbers and typically in textual or narrative format (e.g., focus group notes, open-ended interview or questionnaire responses, and observation notes)[29]

**quantitative data**
Data expressing a certain quantity, amount, or range. Usually there are measurements associated with the data.[30]

**root causes of health inequity**
The underlying political, social, and economic systems that create imbalances in power and resources to perpetuate inequities. They determine whether people have access to the opportunities and resources they need to thrive.[31]

**secondary data**
Data that have already been collected by another group or for another purpose[32]

**social determinants of health (SDOH)**
The conditions of the environments where people are born, live, learn, work, play, worship, and age that affect their health and well-being[33]

**social justice**
Fairness in society defined by at least three related health-promoting principles: (1) social and economic equality, which refers to creating a structure of equality in society's basic institutions; (2) political equality, which includes the ability to participate fully in a democracy, and to avoid a disproportionate advantage or disadvantage in influencing public decisions; and (3) an affirmation of cultural heritage and freedom to express cultural identity[34]

**stakeholder**
A person, group, or organization that has a personal or professional interest in, or impact on, the MAPP process

**steering committee**
A MAPP sub-team of 10–20 people who can support the community health improvement process, including those with resources, local funders and philanthropists, community members, and others from the local public health system

**strategic issue**
Fundamental policy choices or critical challenges that must be addressed for a community to achieve its vision

**systems of power, privilege, and oppression indicator**
Indicators that represent the policies, practices, and programs of institutions that contribute to adverse outcomes and conditions for communities

**targeted universalism**
The process of setting shared goals for the entire community and providing groups with what they need to reach them[35]

**transactional approach**
An activity related to a public health problem that addresses specific issues (like food insecurity or poverty) but does not change how the local public health system operates overall[36,37,38]

**transformational approach**
An activity related to a public health problem that permanently changes the way the local public health system operates and therefore has an impact on multiple issues over time. These activities shift the underlying values and political will of the people and organizations in the local public health system[39,40,41]

**workgroup**
A MAPP sub-team tasked with improving a specific community health improvement infrastructure priority over the course of MAPP

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