Mobilizing for Action through Planning and Partnerships (MAPP)

user's handbook

NACCHO
National Association of County & City Health Officials

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WELCOME

Thank you for reading the MAPP Handbook. This Handbook is a resource, among others, that can be used by MAPP communities to move through the process of organizing partners, collecting comprehensive data, and implementing an action plan. This Handbook is intended for leaders who are facilitating the MAPP process in their **community**. Handbook tips and worksheets can guide you through the MAPP philosophy and provide ideas for engaging **local public health system** partners and **community members** in a successful process.

This Handbook is meant to be used. The worksheets provided can be completed within the Handbook itself or replicated for use as separate documents. In addition, the Handbook includes spaces where brainstorming can be documented.

No one does this work alone. For additional support connect with MAPP Navigators on the MAPP Social Network (**http://mappnetwork.naccho.org**) or reach out to NACCHO staff. Joining the MAPP Network can orient you to the process and connect you to seasoned MAPP users. MAPP Navigators and their contact information are listed on the MAPP Network and can provide guidance. Experienced MAPP Navigators provide MAPP Users and communities with access to resources and improve MAPP processes by providing encouragement, direction, and wisdom.

For the full list of resources, please visit the MAPP website (**www.naccho.org/mapp**). Online you will find more details about the process and additional stories from the field.

Throughout the Handbook you will see words in **bold**, which are terms of art used in the MAPP process. These terms are further defined in the glossary on page 130.

INTRODUCTION

The definition of **health** encompasses a broad range of conditions, not just health in terms of healthcare. Improving health is deliberate to ensure the conditions for a dynamic state of complete physical, mental, spiritual, and social well-being. MAPP is a community-wide strategic planning process for improving public health. This framework helps communities prioritize **public health** issues, identify resources for addressing them, and take action to improve conditions that support healthy living. MAPP is generally led by one or more organizations and is completed with the input and participation of many organizations and individuals who work, learn, live, and play in the community.

This MAPP Roadmap (Figure 1) illustrates the six phases of the MAPP process.

1. In Phase One, **Organize for Success/Partnership Development**, community members and agencies form a partnership and learn about the MAPP process.
2. During Phase Two, **Visioning**, those who work, learn, live, and play in the MAPP community create a common understanding of what it would like to achieve. In the MAPP Roadmap below, the vision is "A Healthier Community." The community decides the vision, which is the focus of the MAPP process.
3. During Phase Three, **Four MAPP Assessments**, qualitative and quantitative data are gathered to provide a comprehensive picture of health in the community.
4. In Phase Four, **Identify Strategic Issues**, the data are analyzed to uncover the underlying themes that need to be addressed in order for a community to achieve its vision.
5. In Phase Five, **Formulate Goals and Strategies**, the community identifies goals it wants to achieve and strategies it wants to implement related to strategic issues.
6. During Phase Six, **Action Cycle**, the community implements and evaluates action plans to meet goals, address strategic issues, and achieve the community's vision.

FIGURE 1. The MAPP Roadmap

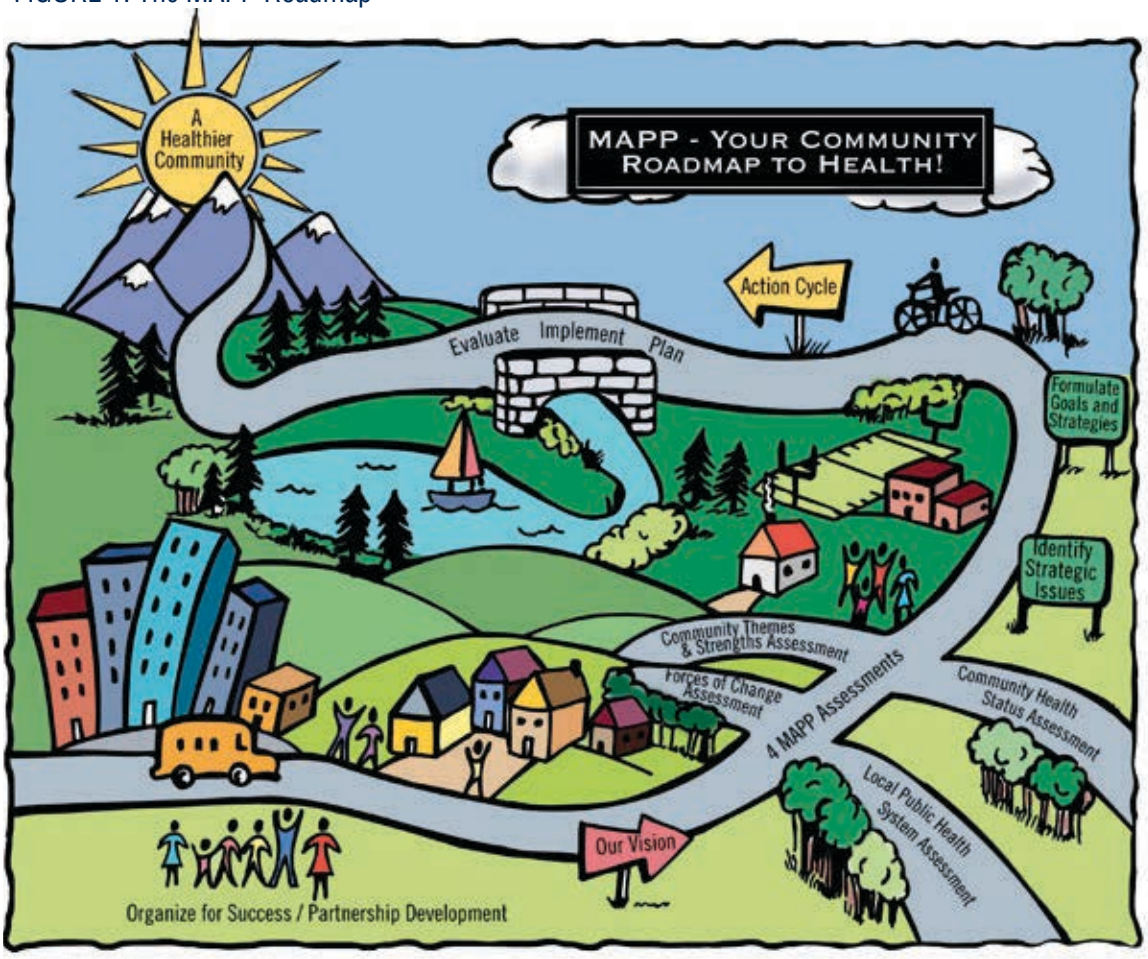


FIGURE 2. MAPP Academic Model

Use the MAPP model that resonates with your community; some people prefer a linear depiction, whereas others feel inspired by the MAPP Roadmap.

Show movement through the process. Clark County, Kentucky, adds footprints to the MAPP Roadmap as the MAPP process moves forward.

The steps in the MAPP process are similar to other strategic planning and assessment models (see Figure 2). What makes MAPP unique is that it is a community-owned process that involves broad representation of the local public health system and uses qualitative and quantitative data from four assessments to inform the development, implementation, and **evaluation** of strategic **community health improvement plans**.

Remind the community of the process; hang up the MAPP Roadmap at meetings.

MAPP is described as a framework because previous and current work in a community can be integrated into the process. For communities that have extensive partnership, assessment, and planning experience, some phases can occur concurrently or more quickly. Communities with little assessment and planning experience may decide to try a portion of the process before committing to the entire process.

History of MAPP

MAPP was developed to respond to the need to improve public health practice. In 1988, the Institute of Medicine (IOM) published the report *The Future of the Public's Health in the 21st Century,* which asserted that the public health system was in disarray. The report was the impetus for creating several types of assessments, standards, and improvement processes. In 1991, NACCHO, with support from the CDC, developed the **Assessment Protocol for Excellence in Public Health** (APEX PH) to help local health departments assess community health status and establish the leadership role of the health department in the community. APEX PH was continuously updated and revised through the 1990s. In 1997, the IOM published another report titled *Improving Health in the Community: A Role for Performance Monitoring*, which emphasized the importance of active community involvement in public health performance monitoring and detailed what a community health improvement plan should contain. During this time, public health practitioners were also requesting a process that was driven and owned by the community. In response, APEX PH evolved into MAPP. NACCHO, with support from the CDC, developed MAPP with substantive input from the field and careful attention to research and literature. MAPP was developed to provide structured guidance that would result in an effective strategic planning process that would be relevant to public health agencies and the communities they serve.

INTRODUCTION

MAPP is an iterative, flexible framework that can be tailored by communities to fit their needs. Even though MAPP is flexible, maintaining the integrity of the process involves these nine critical elements:

- Creating **strategic plans**;
- Encouraging systems thinking;
- Enlisting community ownership and **stakeholder** investment;
- Sharing responsibility and working toward a collective vision;
- Using comprehensive data to inform the process (data include information on **health status**, **quality of life**, assets, external forces, and how the local public health system functions);
- Building on previous experience (not necessarily MAPP experience; may include partnerships, other assessments, etc.);
- Encouraging partnerships;
- Involving the local public health system; and
- Celebrating successes.

Make the MAPP materials resonate with your community. The Lincoln County, Oregon, MAPP team modified the MAPP Roadmap to reflect the geography of the community. The ocean was added and the mountains were removed.

If a local health department is seeking **accreditation** through the Public Health Accreditation Board's voluntary program, MAPP provides the foundation and framework for users to fulfill several accreditation measures. Users need to ensure that consideration is given to specific requirements outlined in the accreditation Standards and Measures. More information can be found on Public Health Accreditation Board's Web site at **www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/**

PHASE ONE: Organize for Success/ Partnership Development

Completing Phase One answers the following questions:

1. **Who should be included in the MAPP process?**
2. **Is the community ready to conduct a MAPP process?**
3. **What are the resource needs for implementing a MAPP process?**
4. **How will the community proceed through the MAPP process?**

The **facilitating MAPP organization** is building a commitment among partners, engaging and educating participants, designing a process that uses participants' time wisely, setting a tone of openness and sustained commitment, and planning to implement a successful MAPP process. The **MAPP Core Group** lays the groundwork to make the MAPP process more manageable.

Think broadly about participants! Include members of the community and the local public health system. Community involvement and feedback is critical to the success of the MAPP process. The local public health system includes the organizations that ensure healthy living conditions in a community and includes the agencies and organizations in a community that provide the **10 Essential Public Health Services** (Figure 3). While the MAPP Core Group may initiate and coordinate collaborative work, the vision defining the collaborative effort is driven by the participation, experiences, and goals of community members and the local public health system partners. The approach to engage community members should be guided by social awareness but may hinge on community context, setting, and priorities.

The Boston, Massachusetts MAPP process defines community at the neighborhood level and values the unique assets in each Boston neighborhood.

The Thomas Jefferson Health District in Charlottesville, Virginia, defines community at the county level and values the unique assets in each of the six distinct localities (one city, five counties in its jurisdiction).

FIGURE 3. 10 Essential Public Health Services

The **10 Essential Public Health Services** (**www.cdc.gov/NPHPS/essentialservices.html**) describe the public health activities that should be undertaken in all communities. The Essential Public Health Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

The Essential Public Health Services are the following:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable.
8. Assure competent public and personal healthcare workforce.
9. Evaluate **effectiveness**, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Brainstorm all the different agencies, organizations, and individuals who deliver one or more Essential Public Health Services. Many entities will not identify themselves as public health professionals. For instance, a sheriff will probably not self-identify as a member of the local public health system; however she provides Essential Service 1 by collecting traffic safety data, which she then uses to solve community health problems.

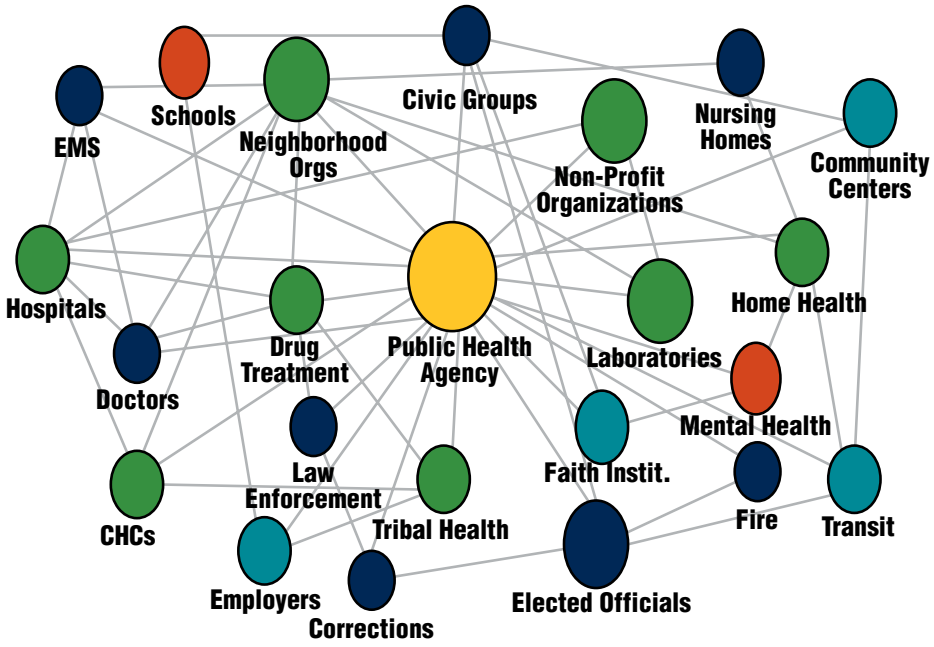
Brainstorm different options for defining community. Should there be one MAPP process for multiple counties? Does defining community at the neighborhood level better serve the process? However the geographic parameters are defined (e.g., neighborhood level or multiple counties), ensure community members from all of the regions are represented.

Figure 4 depicts a "jelly bean diagram" of how different providers of the Essential Public Health Services may engage with each other. This network of providers represents a local public health system. Many communities start their MAPP processes by creating their own jelly bean diagram to show how their partners relate to each other and the ways they would like partners to work together in the future.

MAPP processes should also include **community members**—anyone who works, learns, lives, and plays in your community. Community members have expertise about what works well in their community, what issues affect their ability to live healthy lives, and resources in the community that they can use to improve health. Community members also provide useful information about the feasibility of strategies and can be key players in implementing action plans.

Addressing the **social determinants of health inequity** through a MAPP process requires engaging individuals who have knowledge about social, economic, institutional, and other contextual factors that affect health directly or indirectly in a community. Many of these individuals do not identify themselves as public health professionals. Community members have profound insight into what supports and undermines healthy living. Additionally, representatives from the housing authority, transportation department, advocacy groups, and universities may have information that is useful to incorporate into the MAPP process.

FIGURE 4. How Essential Public Health Services Engage One Another

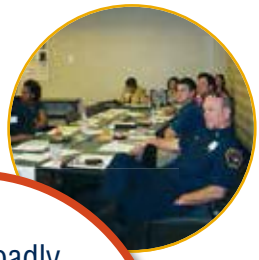


Create your own jelly bean diagram using PARTNER Tool (**www.PARTNERtool.net**).

Phase One involves the following activities:

- Developing community coalitions;
- Planning public health partnership activities;
- Planning a community strategic planning process; and
- Engaging community members around improving public health.

Before starting Phase One, identify partnerships or coalitions that currently exist in your community that could inform or could be integrated into a MAPP process. Then brainstorm ways the existing partnerships and coalitions could be more inclusive of the local public health system, more strategic, and more community-driven. The brainstorm will inform how to complete Phase One.



Think broadly about who to engage. Participants from different sectors can provide various resources and expertise.

Organizing for Success/Partnership Development occurs throughout the process. The partnership should frequently ask the question "who is missing from the process?"

What partnerships or coalitions exist in the community? **Brainstorm below:**	How can these partnerships and coalitions be more inclusive of the local public health system, more strategic, and more community-driven? How can existing coalitions be enhanced to align with the MAPP process?

Step One: Determine the Need

Identify a group of individuals who are interested in facilitating or supporting a MAPP process. Have them answer the following questions and discuss whether the answers are compelling enough to move forward with the process.

- Why should we complete a MAPP process?

- What critical issues do we hope to address?

- Who is driving the process?

- What do we want to get out of the MAPP process?

What barriers might get in your way?	How will you address barriers?

Step Two: Identify and Organize Participants

There are three ways that individuals can participate in a MAPP process:

- MAPP Core Group;
- **MAPP Steering Committee**;
- Participant in one or more of the six phases of the process.

The MAPP Core Group includes the two to three people who regularly support and lead the MAPP process and ensure that it moves forward.

The MAPP Steering Committee is the 10- to 20-person group that gives the MAPP process direction. The Steering Committee may serve in a similar function as a board of directors and should be representative of the local public health system.

Individuals can participate in one or more phases of the process even though they do not serve on the Core Group or Steering Committee. The roles and responsibilities of individuals can change throughout the process depending on their individual interests, and the skills and resources they bring to the process. In making invitations to participate in the Core Group, Steering Committee, or other aspects of the MAPP Process, it may to helpful to create a spreadsheet that includes the following columns:

- Contact name;
- E-mail;
- Phone;
- Organization, if any;
- Organizational Mission;
- Individual's Expertise;
- Resources/assets;
- Long-term availability/interest;
- Essential Public Health Service;
- Person who will extend invitation to contact; and
- Roles and responsibilities (e.g., Core Group member, Steering Committee member, Assessment **Sub-committee** member, Facilitator, Public Relations, Evaluator, Sponsor).

For each identified participant, it is important to craft a tailored communication that aligns their individual and organizational interests with the MAPP process. A generic e-mail is not as effective as personalized communication that details the following:

- How the MAPP process aligns with an organization's mission.
- How the individual or organization will benefit from the MAPP process.
- What the individual or organization can contribute to the MAPP process.

In addition to creating messages tailored to prospective participants, it is also important to identify the best person and method for delivering the communication.

Identify **key sponsors** of the MAPP process. Sponsors should give legitimacy to the effort by demonstrating public support and endorsing the initiative. Sponsors will support the process by committing resources.

Logic models help articulate how a MAPP process should result in systems or health improvement and provide a framework for process and outcome evaluations.

WORKSHEET: Circles of Involvement

Developing Key Relationships for Implementation

The following is a useful method for brainstorming all of the partners in your MAPP process. The Circles of Involvement exercise is one way of determining how to increase the level of engagement among people in the community who can successfully support, influence, and leverage the desired MAPP process and outcomes. It was developed by the Institute of Cultural Affairs and is one element of the Technology of Participation (ToP)® facilitation methodology, and is used here with permission. For more information about Technology of Participation (ToP)® resources and/or training opportunities, visit **www.ica-usa.org**.

Step One: Community Partner Brainstorm

TIME: 20 minutes

FORMAT: Small group exercise (seven to eight participants seated at round tables)

MATERIALS:

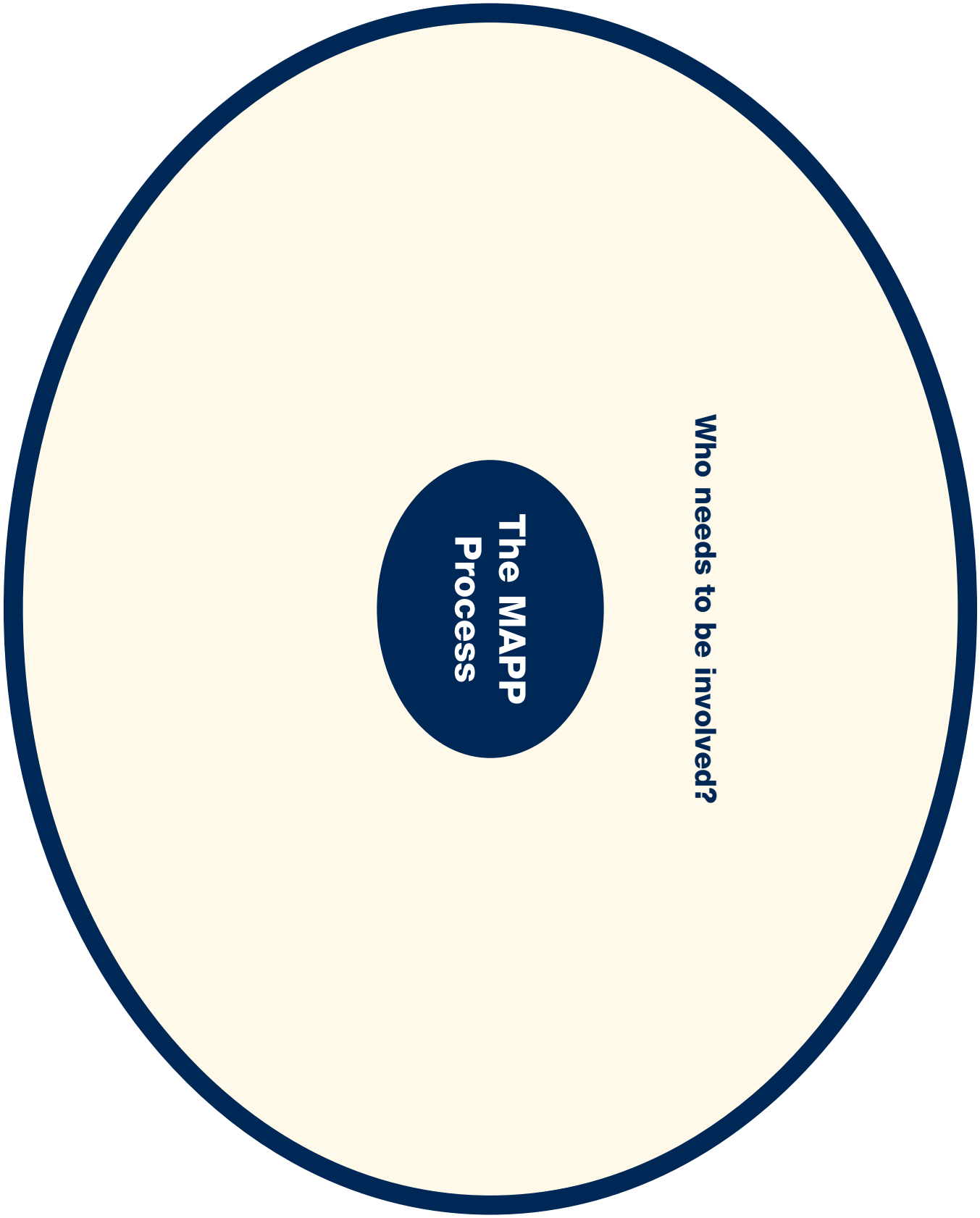
- Markers
- Jelly bean diagram
- 10 Essential Services of Public Health
- Circles of Involvement: Developing Key Relationships for Implementation worksheet

DIRECTIONS:

- The purpose of this exercise is to think broadly about the local public health system.
- Review the 10 Essential Services of Public Health and the Jelly bean diagram.
- Think about which organizations and individuals deliver essential public health services. Also, remember to think about groups and individuals who receive essential public health services.
- Identify the different individuals and groups that comprise this community's local public health system and identify how they are interconnected.
- Write the individuals and groups on the worksheet: *Circles of Involvement: Developing Key Relationships for Implementation*.

WORKSHEET: Circles of Involvement

Developing Key Relationships for Implementation



Adapted from "Creating a Framework of Support and Involvement" originally created by The Canadian Institute of Cultural Affairs.

Step Two: Circles of Involvement Review

TIME:

5 minutes

FORMAT:

Large group (20–30 participants)

MATERIALS:

Description of circles

DIRECTIONS:

- Let participants know that this is a ToP-created resource.
- Have volunteers read aloud to the entire group the five paragraphs describing the different circles of involvement.
- As volunteers read descriptions of the different circles of involvement, encourage participants to underline key words.

Circles of Involvement

Developing Key Relationships for Implementation

Circle—MAPP Core Group

On one hand, this is the group that does most of the day-by-day work. On the other hand, this is also the group that plots, plans, facilitates, and orchestrates the authentic participation of people in all the circles who finally make the MAPP process happen. They were almost certainly around the initial tables when the desire to mobilize the community planning effort began. They think through how to move through the various MAPP phases; decide who needs to be involved; call the meetings; prepare the materials, processes, and reports; and make the calls, in person and by phone, to enlist the support of others. These are people who have real passion for the whole process, who see themselves as responsible for monitoring and coordinating its various components, and who can pretty much always be counted on to step forward when needed.

Circle of Engagement (MAPP Steering Committee)

These are people committed to the MAPP process who can be called on to help with specific tasks at particular times. They don't see themselves as the prime movers of the process but are willing to assume their fair share of responsibility for aspects of it. They may need to be reminded of decisions they've made to shoulder parts of the process and are generally responsive to requests from the Core Group members to work with them on certain tasks. This circle includes people who may or may not have been involved in the initial community mobilization or process design. It also includes people who can become increasingly engaged in MAPP's rollout and leadership and so can gradually move into the Core Group.

Circle of Champions

Champions are people who typically hold positions of leadership in the community and are, or need to be, committed to the MAPP process' success. They may or may not be very involved in the daily activities of its implementation. They are the authorizers of the effort, MAPP advocates, the ones whose blessings can clear away some of the "underbrush" or roadblocks. They are the cheerleaders who can strategically appear to affirm the work that has been done, recognize the people who have made it happen, and ensure that the whole community knows that the endeavor has top-level support. They know how to open doors, make connections, and say a word in the right places. They need to be kept informed of what's happening (big picture) and where to plug in strategically without having to be involved in the minute details. They often appreciate making their contribution where it will do the most good and then stepping back until the next time.

Circle of Information and Awareness

These are people who usually aren't very close to the MAPP process or its implementation, but need to be kept in the loop as things unfold. They are able, because of their positions and roles, to lend support to the effort or to raise questions about the MAPP process and slow it down. They may be other community members or people who weren't involved in developing the MAPP process, but are affected in some way by it. They will hear things about the process and its work from other sources and will draw conclusions based on what they hear. Sometimes these people have responsibility for or access to communications media that reach a wide audience. They need to be honored by occasional visits and reports that allow them to see the value in what is happening and to have their questions about it answered honestly. Sometimes, people in this circle can move into the Circle of Engagement—or even Champions.

Circle of Possibility

Long shots and wild cards also have a role to play. These are people one wouldn't immediately think of as being related to the MAPP process (imagine that!), but who just might find areas of common cause with it. Maybe they weren't even around when MAPP started. They could turn out to be a MAPP partner, be able to provide helpful resources, or give it a boost in some way. Coming up with these names is an exercise in creative brainstorming that expands a group's thinking about who it needs to keep in mind and look for. It can produce a wealth of surprising opportunities. These are relationships with people and groups that need to be explored, without assuming that they will necessarily turn out to be supportive. When they do turn out to be supportive, however, it can be a great gift.

3 Step Three: Circles of Involvement Placement

TIME:

20–25 minutes

FORMAT:

Small group exercise (seven to eight participants seated at round tables)

MATERIALS:

Circles of Involvement: Developing Key Relationships for Implementation and description of circles worksheet

DIRECTIONS:

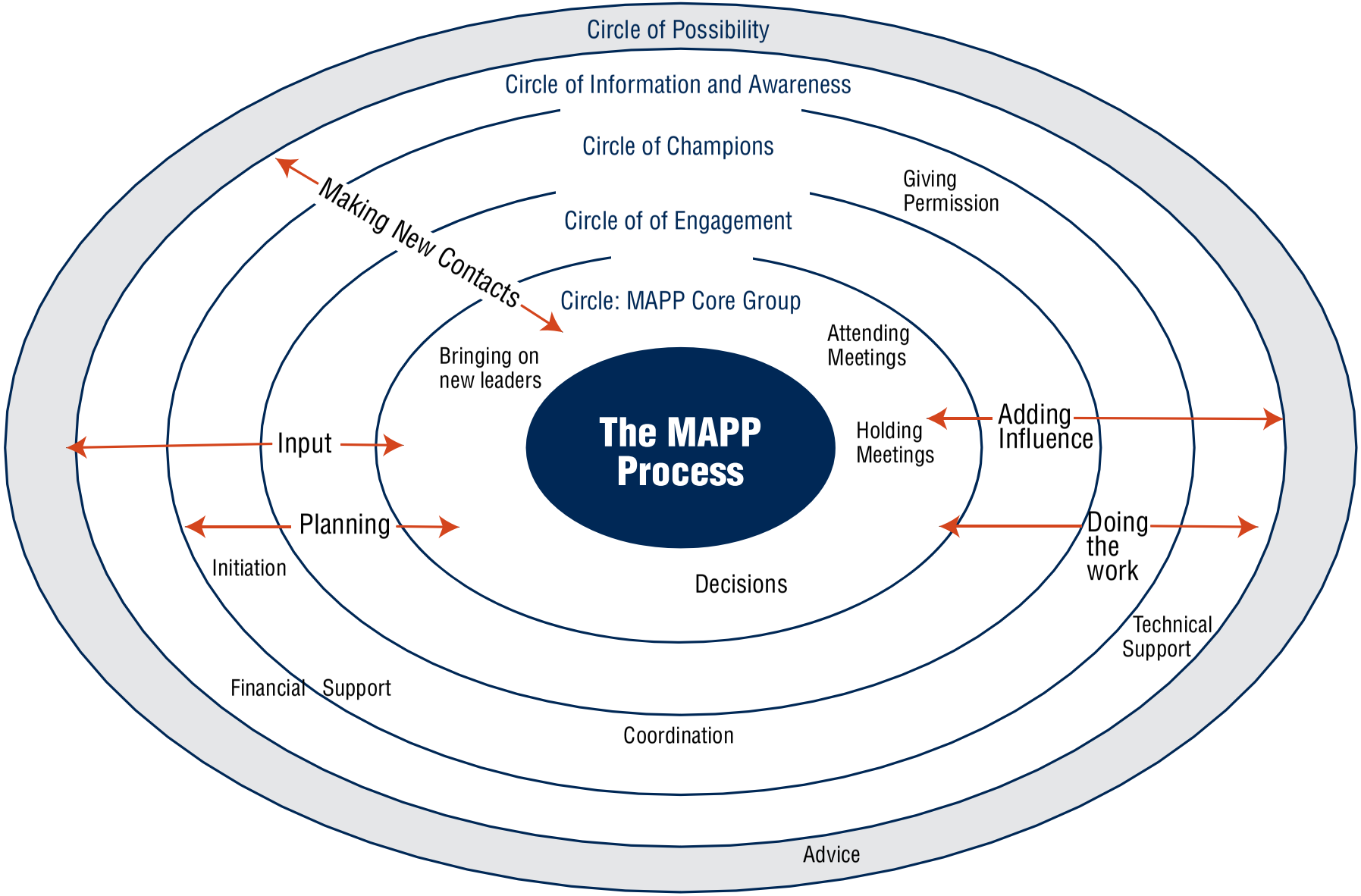
Place each entity brainstormed in Step One of the exercise in the corresponding circle of involvement on the worksheet: Circles of Involvement: Developing Key Relationships for Implementation.

NOTE: An entity could fall into more than one circle of involvement.

WORKSHEET:

Circles of Involvement

Developing Key Relationships for Implementation



Adapted from "Creating a Framework of Support and Involvement" originally created by The Canadian Institute of Cultural Affairs.

Step Three: Design the Planning Process

Engaging local public health system partners and community members from the beginning and throughout all phases of the process will help ensure that a sufficient workforce exists to implement action plans. If local public health system partners and community members do not see the MAPP process as a collaborative, community-owned process, they will rely on the lead organization(s) to implement action plans and to be accountable for this work.

Refer to the Bay Area Regional Health Inequities Initiative (BARHII) Self-Assessment Toolkit for ideas on how to effectively engage community members. (**www.barhii.org/resources/toolkit.html**)

When designing the MAPP process, think about the following questions:

- What will the process entail?
- How long will it take?
- What will the results be and how will we know when we are finished?
- Who will perform each task?

The following is a useful method for setting partner expectations. Use this visual and interactive activity at the beginning of the MAPP process to designate tasks to partners and develop a plan for action.

Using a **Sticky Wall™**, large Post-it® notes, or flip charts, list the six MAPP phases in columns across the top with all of the steps for each phase listed below the phase name. In place of a Sticky Wall, substitute butcher or flip chart paper. Each phase's steps will become tasks assigned to different partners to complete. At this point, it is better not to attach specific times or deadlines to tasks. The goal is to mobilize partners to volunteer for tasks that speak to their strengths, capacities, and interests.

Create the MAPP timeline with local public health system partner input to ensure the timeline captures events or other factors that may influence the timeline's feasibility and to improve partner ownership of the process.

- Give each partner a different color Post-it note pad and have them write their name and organization on them. Then, have the partners approach the Sticky Wall and begin to select tasks they will help complete and indicate their desired level of involvement (i.e., lead or support partner) by sticking their Post-it on specific tasks.
- Provide partners with time to approach all the tasks in which they may be interested.
- Begin to work through the columns and ask for volunteers to participate in any tasks that have not already been chosen.

Developing a timeline for completing a task can directly follow this activity or it can be done at a second meeting. After the meeting, collect the information in the worksheet on page 22 and send it to all the partners to foster accountability and transparency in the process.

Create a timeline that works for the community. To design the timeline, consider:

1. Are there partner deadlines that should inform the MAPP process?
2. When are annual community events?
3. What will be completed by year one?
4. What political events may influence the timeline (e.g., elections, legislature calendar, statewide public health policy implementation)?

Sample Planning Wall

WORKSHEET: Design the Planning Process

	Key Elements of the Phase	Lead Partners	Support Partners	Completion Date	Celebrate: Milestone and Method	Quality Improvement or Evaluation Method
Phase One: Organize for Success/ Partnership Development						
Phase Two: Visioning						
Phase Three: Four MAPP Assessments						
Phase Four: Identify Strategic Issues						
Phase Five: Formulate Goals and Strategies						
Phase Six: Action Cycle						

WORKSHEET: Develop the Timeline

The time it takes to enter the action cycle depends on how much experience the community has and the methods the community decides to use in the process. It is important to create a timeline that details when each phase will be completed to maintain momentum. It is also important to be flexible to changing contexts and partnership dynamics.

The following is a useful table for completing the MAPP Timeline. This is an appropriate activity for the MAPP Steering Committee to ensure that the expectations of local public health system partners and community members will be met. This is an overall timeline for the process and is based on 18 months. Tailor the timeline to meet the expectations of community members and local public health system partners. It may be appropriate for MAPP communities to create a more detailed timeline like a Gantt chart.

Tasks by Phase						
MONTH	**Phase One:** Organize for Success/Partnership Development	**Phase Two:** Visioning	**Phase Three:** Four MAPP Assessments	**Phase Four:** Identify Strategic Issues	**Phase Five:** Formulate Goals and Strategies	**Phase Six:** Action Cycle
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						

Step Four: Assess Resource Needs

Assessing resource needs and planning a budget can help determine which activities will have direct costs associated with them. Also, this will allow the MAPP partners to plan how to meet the funding needs.

When assessing resource needs, consider the following:

- Staff time;
- Data collection and information gathering;
- Meeting space, meals, and refreshments;
- Travel by partners, community members, staff, or consultants;
- Report production and printing;
- Consultant costs; and
- Educational and training materials.

While the MAPP process may be enhanced by grant funding, many communities begin MAPP without direct funding. The following is a useful worksheet to develop a budget and strategize potential sources of financial support. Identify in-kind services that may meet the budget needs. It is also a good idea to develop alternative plans if funding becomes unavailable. Above all, do not be discouraged by a limited budget.

In some instances, resource needs may include capacity building, leadership development, and coaching for community members. Where there is a knowledge or skills gap, this will be crucial in supporting community members' authentic participation in decision-making processes.

WORKSHEET: Develop the Budget

Resource Need	Description of Cost	Estimated Cost	Potential Source	Potential In Kind	Alternative
PERSONNEL					
Example	50% of a full-time employee to coordinate MAPP	$20,000 annually	Grant: three-year grant	The local health department supports 50% of full-time employee to coordinate MAPP	Share coordination role among three agencies
CONTRACTUAL COSTS					
Example	Hire professional facilitator to lead National Public Health Performance Standards Local Assessment	$3,000 for contract	Local hospital	United Way has professional facilitator	Trade facilitators with neighboring county who is also doing MAPP
SUPPLIES					
Example	Flip charts	$100 (2 packs at $50 each)	Chamber of Commerce	Local community college	All partner agencies host at least one meeting and provide all supplies for the meeting
Telephone					
Information Technology					
Postage and Shipping					
Printing					
Travel					
Conference Registration					
Meeting Space					
Other Costs					

Step Five: Conduct Readiness Assessment

Convene the MAPP Core Group and come to consensus on the following statements listed in the readiness assessment below. Ideally, all of the critical elements will be in place before proceeding.

Critical Elements	Yes	No
Process has strong sponsors	☐	☑
Process has effective champions	☐	☑
Process has leadership support	☐	☑
Support for process outweighs opposition	☐	☑
Key resources are budgeted	☐	☑
Core Group participants are willing and available	☐	☑
There is general agreement on process purpose and outcomes	☐	☑
There is general agreement on how to proceed	☐	☑
Scope of the planning effort is reasonable	☐	☑
General time frame of the planning effort is reasonable	☐	☑
Sufficient staff and technical support have been identified	☐	☑
Majority of relevant partners are engaged	☐	☑

Desired Elements	Yes	No
What each partner will contribute to the process is known	☐	☑
Sufficient staff and technical support is available and committed	☐	☑
Purpose and outcomes of planning process are clearly defined and understood	☐	☑
Individual and collective goals of planning process are well-understood	☐	☑
Participants understand principles of strategic planning	☐	☑
All needed resources are available	☐	☑
Outside **technical assistance** is available, as needed	☐	☑
Process organizational structure and participation is clear and agreed upon	☐	☑
Roles and responsibilities are clear and agreed upon	☐	☑
Work plan with realistic timeframe is available and agreed upon	☐	☑
All relevant partners are fully engaged	☐	☑
Core Group members are aware of other assessment and planning efforts underway in community, past efforts, and partners involved in current and past efforts	☐	☑
Philosophy about community health and strategic planning is generally shared among most partners	☐	☑
Plan to monitor and evaluate the planning process is in place	☐	☑

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

Step Six: Determine How the Process Will Be Managed

Matrix of Organized Participation and Roles within Organize for Success/Partnership Development

In the step, determine the roles and responsibilities for the process and plan for the first meeting of the MAPP Steering Committee. Consider the types of attributes each participant brings to the process. On page 29 is a matrix that depicts the type of participation recommended for MAPP Phase One. This table is included in the introduction to each phase.

The following terms are used:

MAPP Core Group—includes the two to three people who regularly support and lead the MAPP process and ensure that it moves forward. These individuals are usually from the agencies leading the MAPP process. They are responsible for organizing the process and this group often includes the primary individual(s) that provide staff support to the Steering Committee.

MAPP Steering Committee—is the 10- to 20-person group that gives the MAPP process direction. The Steering Committee may serve a similar function as a board of directors and should be representative of the entire local public health system. They provide guidance throughout the entire process.

Sub-committees—for several phases of MAPP, especially the four MAPP Assessments, it is recommended that sub-committees be designated to oversee the work. The sub-committee should include representation from the MAPP Steering Committee. Other individuals from outside the Steering Committee may also be recruited for their specific expertise, skills, or knowledge. Generally, sub-committees are composed of five to eight individuals. However, some phases (such as the MAPP Assessments) may warrant more members.

Community—broad community participation is vital to a successful MAPP process. Although community members should be recruited to participate on the MAPP Steering Committee, activities for each MAPP phase should include specific consideration of ways to gain broader community member participation. This will ensure that the community's input is a driving factor throughout the MAPP process and that the community ultimately feels ownership of the final results and actions.

Phase One: Organize for Success/Partnership Development			
MAPP Core Group	MAPP Steering Committee	Sub-committees	Community
• Initiate and launch the process; get it "off the ground." • Organize and plan the process. • Identify needed and available resources. • Conduct readiness assessment. • Recruit Steering Committee members. • Propose sub-committee membership for upcoming MAPP phases (Four MAPP Assessments, etc.).	• Convene and begin meeting during this phase. • Provide input into who else should be recruited for Steering Committee membership. • Approve plan for MAPP process (as developed and proposed by Core Group). • Identify resources to meet needs. • Provide input on, and ultimately approve, sub-committee membership for upcoming MAPP phases.	• None recommended in this phase.	• Recruit some community members to participate in the Steering Committee. • Ensure broader community is aware of the new MAPP process.

What attributes are important for the Steering Committee in your community?

The goal of the first meeting is to orient the Steering Committee to the MAPP framework. The following list of tasks will assist you in planning and conducting your first MAPP Steering Committee meeting:

- Write agenda;
- Identify pre-meeting assignments for the Steering Committee;
- Write meeting objectives and share with the MAPP Steering Committee;
- Order food and beverages (providing food and beverages may increase participation);
- Reserve meeting space;
- Create a room set-up conducive to team building;
- Develop meeting evaluation;
- Secure meeting facilitator;
- Secure meeting note taker;
- Invite participants;
- Hold meeting;
- Evaluate how well your meeting met its objectives; and
- Follow-up on post-meeting action items and assignments.

Consider creating an application process for Steering Committee participation. An application process helps ensure that members understand expectations and are genuinely interested in participating.

Consider participating in the learning community, *The Roots of Health Inequity*, (rootsofhealthinequity.org) as a MAPP Steering Committee. This can serve as a platform for discussing the root causes of poor health in your community.

Consider implementing Steering Committee term limits. Term limits would allow for new ideas, new assets, and new energy to periodically stimulate the process.

Consider the size of the MAPP Steering Committee. Groups with fewer than 10 members may not adequately represent the community and local public health system and may not have enough personnel to fully support the MAPP process. MAPP Steering Committees with greater than 20 members may be more difficult to manage and may have challenges in reaching consensus and moving forward.

Step Seven: Conduct Process Evaluation for Phase One

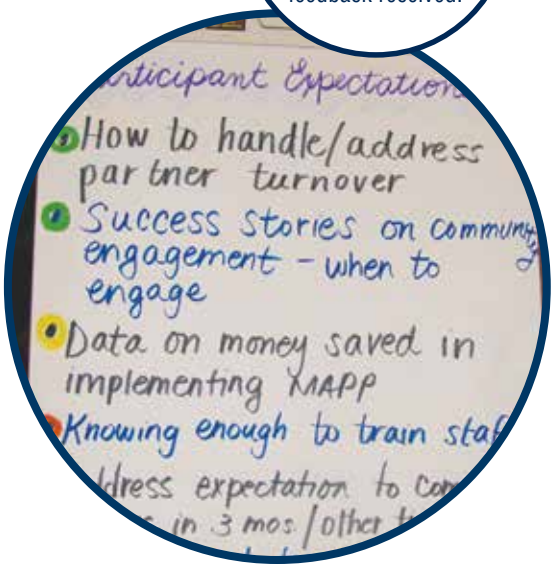
Process evaluation will measure progress and identify reasons for celebration throughout the MAPP journey. This also encourages continuously improving the implementation of your MAPP framework. The MAPP Core Group should determine how often to conduct the evaluation (e.g., quarterly), who will participate (e.g., community members), and in what format the evaluation will be completed (e.g., facilitated conversation). See the table on page 32 for an example process evaluation worksheet.

The following questions may be useful for conducting a process evaluation of Phase One. The MAPP Core Group can ask Steering Committee members the following:

1. Did we ensure that the appropriate participants were included?
2. Did we educate participants on the activities that will be undertaken, their responsibilities, how long it will take, and the results that are expected?
3. Did we structure a planning process that engages participants as active partners?
4. Did we structure a planning process that uses participants' time well?
5. Did we structure a planning process that builds commitment?
6. Did we set a tone of openness and sustained commitment among participants?
7. Did we structure a planning process that results in a realistic plan?

In Clark County, Kentucky, the MAPP coordinator periodically asks the following at the end of meetings: What is going well in this process? What would you like to change about our meetings?

Capture responses to process evaluation questions and make changes to the process to address the feedback received.



If they answer no, ask these questions:

1. Who else needs to be included?
2. What about the process do we need to improve?
3. What about the process remains unclear?

WORKSHEET: Process Improvement

Once the Phase One has been completed, conduct a process evaluation to ensure continuous improvement. The following is a useful method for reviewing the quality of the MAPP implementation and to identify areas for ongoing improvement. This worksheet can assist in creating the process evaluation plan.

PHASE ONE: Organize for Success/Partnership Development	
How will we celebrate success?	
How will we communicate success to our community?	
How will we evaluate our process?	
What are the lessons learned?	
How will we apply these lessons to improve our process?	

NOTES

NOTES

PHASE TWO: Visioning

Completing Phase Two answers the following questions:

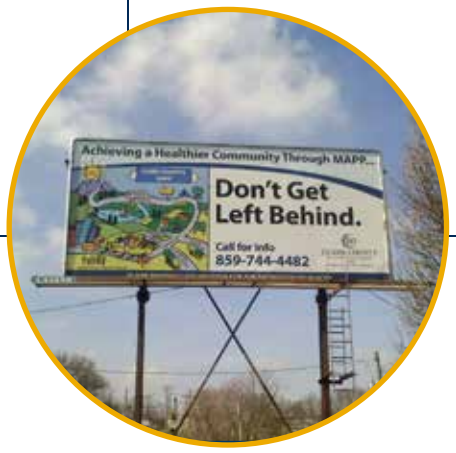
1. **Where do we, as a community, see ourselves in three to five years?**
2. **What values will support us through the MAPP process?**

During this phase, the community members and local public health system partners are collaboratively determining a focus, purpose, and direction for the MAPP process that results in a shared vision and corresponding value statements.

Matrix of Organized Participation and Roles within Visioning

Below is a matrix that depicts the type of participation recommended for MAPP Phase Two.

Phase Two: Visioning			
MAPP Core Group	MAPP Steering Committee	Sub-committees	Community
• Plan visioning sessions. • Identify and secure session facilitator(s) and engage with them in preparing for visioning session(s). • Summarize the results of the visioning session(s). • Draft vision statement and values.	• Oversee and participate in the Visioning phase. • Develop a plan for gaining broad community participation and identify community representatives to participate in visioning session(s).	• None recommended; however, a MAPP community may designate a sub-committee to conduct the activities in this phase identified for the Core Group.	• Broad community participation is essential. • Ensure the community receives announcements and updates through a broad spectrum of community mechanisms (media, word of mouth, etc.). • Promote Visioning session(s) broadly to encourage community participation.



Step One: Identify Other Visioning Efforts

Identify existing community visions that could inform or could be integrated into a MAPP process. Then discuss whether the existing visions, if applicable, represent the diverse views of community members and the local public health system. Your brainstorm may help determine if you can use an existing vision or update an existing vision. In either case, it is important for your partnership to embrace all the vision elements. See the table on page 37 to brainstorm existing vision statements in the community.

If the partnership decides to develop a new community vision, ask the Core Group, Steering Committee, and other partners to describe their experiences with visioning processes that worked well and visioning processes that were less successful. Reflect on the partnerships' experience and use this input to design the MAPP visioning process.

What community visions, if any, already exist? **Brainstorm below:**	Do the existing community visions represent broadly the views of community members and the local public health system?

Step Two: Design the Visioning Process and Select a Facilitator

There are several ways to develop vision and value statements. Most communities design an interactive brainstorming session that involves broad representation from the community and local public health system. Brainstorming is focused on identifying where the community wants to be in the future. Here are some questions you can use to structure a brainstorming session to develop vision and value statements.

Collect information at events and meetings already occurring in your community.

VISION QUESTIONS

- What does a healthy community mean to you?
- What are important characteristics of a healthy community for all who work, learn, live, and play here?
- In your ideal community, what would you hear, see, taste, touch, and smell?
- Five years from now, what would we want the local newspaper to say about the health of our community?

VALUE QUESTIONS

- What needs to be in place for us to work together effectively to achieve our vision?
- What type of working environment is necessary for our partnership to achieve its vision?
- What are some ground rules we want to set to ensure we are all working effectively to achieve our vision?

Step Two: Design the Visioning Process and Select a Facilitator continued

Ask the Steering Committee what types of methods might work best for brainstorming answers to the questions on the previous page. Consider the following methods:

- Facilitated small group discussion;
- Facilitated large group discussion;
- Quiet reflection and individual brainstorming;
- Community survey;
- "Man on the street" interviews; and
- Affinity diagrams.

Phase Two is an opportunity to widely involve community members and local public health system partners. Some MAPP communities engage children in the process by asking for visual depictions of a healthy community. Whichever method is chosen, ensure an inclusive meeting format.

Many communities use multiple methods.

If you conduct visioning in a group setting, use a meeting facilitator who is perceived as neutral and fair.

Do not wordsmith with a large group of people; focus on collecting ideas and appoint a small group or individual to complete the wordsmithing.

Consider collecting Community Themes and Strengths Assessment data (see page 62) during the Visioning Phase as well.

Step Three: Conduct the Visioning Process

Determine and provide the following information about your visioning process:

- Date/Time of the Event(s);
- Participants;
- Location;
- Facilitator(s);
- Recorder(s);
- Other Support Staff;
- Materials; and
- Other Details.

The Visioning phase provides an opportunity to increase community awareness, enthusiasm, and engagement in the MAPP process. Provide a brief overview of the MAPP process before engaging in visioning activities. After the visioning activities, share next steps so people know what they need to do to move toward their vision. Ask people to sign up for MAPP assessment sub-committees or other activities that support your process.

TIP SHEET: Large Brainstorming Visioning Event

The following is a useful method for structuring a community visioning process. A similar approach can be used with a committee visioning process. The process details the development of a shared vision and common values.

Preparations

Select a meeting facility that can readily accommodate 40–100 persons. Set up the room with participants seated in a circle. This encourages participation by all people attending.

Send clearly worded and timely invitations to avoid confusion. Take care to ensure that the session time and location support broad attendance. Carefully consider the venue and schedule and how it will accommodate participants with differing schedules or lifestyles (e.g., those who work nights, parents with small children, those who rely on public transportation). Ensure the location is accessible both in geographic location and for persons with physical disabilities. Additionally, childcare may need to be provided.

Key individuals to support the visioning process include the following:

- A facilitator who can effectively manage the large group process in a neutral way.
- One or two note-takers to record the discussion. Recording is a task that should not be assigned or undertaken lightly. The recorder(s) should be skillful at organizing and synthesizing material and should strive to capture the exact wording—to the extent possible—used by participants.
- One or two observers to provide feedback to the facilitator. You may also want to designate some individuals to act as observers. These individuals can assure everything is on track and can provide suggestions to the facilitator throughout the meeting(s) if needed.

Welcome/Introduction

Set the tone of the visioning session by greeting participants when they arrive, arranging for clear signage, and offering refreshments. Helping people feel comfortable upon arrival and communicating to participants the importance of their presence can go a long way toward building trust and commitment.

Have the facilitator or a MAPP Steering Committee representative open the meeting by explaining what MAPP is and why a visioning process is important. Be sure to emphasize that the goal is to create a shared vision for the community and not a vision for any one organization.

Building Rapport/Icebreaker

After the introduction, dedicate a small amount of time to building rapport among the participants. Give everyone in the room a chance to introduce themselves to the full group. Consider having participants engage in icebreaker exercises; these can help to ease tension in the room and get everyone comfortable. Icebreaker activities might include the following:

- As people introduce themselves, ask them to state their expectation for the meeting. They can also be asked to state a fun fact about themselves to help familiarize themselves with one another.
- Because all of the participants may not know each other well, divide participants into groups of two to four to "chat" for 10 minutes, then return to the larger group to introduce each other.

Be creative with the ice breakers. Clark County, Kentucky asked the question "what was your first music concert?" for its icebreaker.

Vision Brainstorming and Development

Once participants are comfortable with the meeting purpose and with each other, the dialogue should move toward discussing a vision for the community. Questions should be formulated beforehand to drive this discussion. Useful visioning questions might include the following:

- What does a healthy community mean to you?
- What are important characteristics of a healthy community for all who work, learn, live, and play here?
- How do you envision the local public health system in the next five years?

Responses to these questions should focus on broad concepts, not details. Responses can be collected through brainstorming activities or by having participants write their ideas down and then share them. The session can be organized to gather information through small group processes or the questions can be addressed by the group as a whole. The approached used may depend on the number of participants in the session.

TIP SHEET: Large Brainstorming Visioning Event

Possible approaches for brainstorming include the following:

- Ask each person to write down what they believe about healthy communities. Then ask participants to pair up, share their thoughts, and develop a joint list. Participants should clarify each other's ideas and discuss any conflicting information. Then each pair can join another pair and repeat the process. The process is repeated until the entire group is back together.
- Ask each participant to write down their ideas. Then go around the room and post all ideas on a flip chart (this can be shortened by limiting the number of ideas offered). After all ideas are shared, the group discusses and organizes them.
- Distribute Post-it notes and ask participants to write down their ideas—one idea per Post-it. Then have participants affix their ideas to a wall. A small group then moves the ideas around until common ideas are grouped together. List and discuss the common ideas.

Values Brainstorming and Development

Once many ideas have been gathered and there is consensus about the concepts contained in a community vision, the group can proceed to identifying common values (this may be done in the second part of the first session or during a second session). It is strongly recommended that the actual drafting of the vision statement be done by a small task force or staff group rather than the large group of participants.

The values brainstorming process should be similar to the visioning process and can use the same brainstorming techniques. Questions to elicit thoughts on common values include the following:

- Taking into consideration the shared vision that has been developed, what are the key behaviors that will be required of the local public health system partners, the community, and others in the next five to ten years to achieve the vision?
- What type of working environment or climate is necessary to support MAPP community members and local public health system partners in performing the above behaviors and in achieving the vision?

Closing the Session/Check-out

At the end of each session, have the facilitator ensure that everyone is comfortable with the session's results. Give participants a chance to make final comments or express concerns about the process or results. This helps to ensure that participants leave the session feeling positive about the progress accomplished and it may also improve future group processes. Close the meeting with a discussion of next steps. Discuss the need for and timing of future meetings. Make sure everyone understands the next steps and how follow-up will occur.

Session Follow-up

After the visioning session, a small group should compile the results and draft statements for the shared vision and common values. The draft statements should be presented to the visioning group participants through a follow-up session or through other mechanisms. Participants should be given a chance to make minor adjustments.

Once everyone is satisfied with the vision and values, work with the MAPP Steering Committee to adopt each one. Keep the statements alive through the remainder of the MAPP process by adding them to all MAPP materials, such as brochures, leaflets, and reports. References to vision and values statements should be made at the beginning of each MAPP Steering Committee meeting.

Step Four: Formulate the Vision Statement and Common Values

There are multiple ways to express your community vision. Visions can be a phrase, a short paragraph, a diagram, or a story. Ask your partners and community members what type of format resonates with them.

Determine and provide answers to the following questions to complete this phase:

What is your Community Vision?

Use "community member" instead of resident to be more inclusive in your vision statement.

What value statements will guide your process?

The Knox County, Tennessee, process wrote their vision by asking each Steering Committee member for ONE word. Three members created a vision statement that included the "ONE word" from each Steering Committee member.

Step Five: Keep the Vision and Values Statements Alive

Use the table below to brainstorm how to keep the vision and values statements alive.

How can we make our community aware of our vision and value statements on an ongoing basis?	
How can we use our vision and value statements in communications with the public?	
When and where is it helpful to read our vision and value statements aloud?	
Where can we display our vision and value statements?	

Step Six: Celebrate Success

Brainstorm ways you can celebrate the success of conducting Phase Two: Visioning.

Brainstorm below:

Step Seven: Conduct Process Evaluation for Phase Two

Ask the community members, "did we guide the community through a collaborative process that resulted in a shared vision and values?"

If participants answer no, ask these questions:

- Why wasn't the process collaborative?

- Why isn't the vision and values shared?

- What could have been improved?

- What will be done in subsequent phases to ensure better collaboration?

WORKSHEET: Process Improvement

Once the vision has been created, conduct a process evaluation to ensure continuous improvement. The following is a useful method for reviewing the quality of the MAPP implementation and to identify areas for ongoing improvement. This worksheet can assist in creating the process evaluation plan.

PHASE TWO: Visioning	
How will we celebrate success?	
How will we communicate success to our community?	
How will we evaluate our process?	
What are the lessons learned?	
How will we apply these lessons to improve our process?	

NOTES

PHASE THREE: Four MAPP Assessments

At the end of Phase Three, the MAPP community will have an understanding of the four assessments used in the MAPP process, which provide a comprehensive picture of health and what is happening related to health in a community.

These are the four assessments:

- **The Community Health Status Assessment (CHSA) provides quantitative information on community health conditions.**
- **The Community Themes and Strengths Assessment (CTSA) identifies assets in the community and issues that are important to community members.**
- **The Local Public Health System Assessment (LPHSA) measures how well different local public health system partners work together to deliver the Essential Public Health Services.**
- **The Forces of Change (FoC) Assessment identifies forces that may affect a community and opportunities and threats associated with those forces.**

The four assessments do not have to be completed in a particular order. Communities that do not have strong local public health system partnerships might consider conducting the LPHSA first to introduce systems-thinking and build relationships. Communities that have a lot of existing quantitative health data might want to consider conducting the CHSA first to quickly complete one of the four assessments and get people excited about moving forward in the process. Communities that organize a community visioning event might want to consider also collecting CTSA data during the event. Asking community members about themes and strengths could be a brainstorming activity that then leads them to think about a long-term vision for their community. Communities that have multiple leaders concerned about external forces like changes in legislation, demographics, and the economy might want to conduct the FoC Assessment first to get community leaders excited about the MAPP process.

A community health assessment is one of the three prerequisites for Public Health Accreditation Board applications. Collecting qualitative and quantitative data during MAPP's Phase Three may contribute to the community health assessment prerequisite, which requires the collection and use of both primary and **secondary data.**

Internal Revenue Service (IRS) Requirements for Non-Profit Hospitals: Community Benefit

Under the authority of the Patient Protection and Affordable Care Act of 2010, the IRS requires that non-profit hospitals complete a comprehensive **community health needs assessment** and implementation strategy every three years to maintain non-profit status. The assessment and planning process must include public health expertise in completing the community health needs assessment and an implementation strategy is required to adhere to the law. Including a broad set of local public health system partners in assessment efforts can help such hospitals meet these requirements, as it can contribute valuable data to a comprehensive community health needs assessment and provide a forum for health departments to contribute to the hospitals' related efforts. When creating the MAPP timeline, work with your partners to ensure they can meet their individual assessment requirements. For more information visit www.naccho.org/topics/infrastructure/mapp/chahealthreform.cfm.

Involve community members and local public health system partners in designing, implementing, and analyzing each assessment because they know what kinds of methods will elicit community participation in the assessment process. They also can help administer surveys, facilitate focus groups, promote assessment activities, identify and pool resources, offer staff support, and provide meeting space. Analyzing and interpreting data require understanding the community context; community members and local public health system partners provide this important insight.

Many MAPP communities utilize four sub-committees to complete the four MAPP assessments. The four assessment sub-committees may not have the same participants. Ensure communication between sub-committee members to avoid duplicating work and to support an efficient data collection process.

Matrix of Organized Participation and Roles within the Four MAPP Assessments

Below is a matrix that depicts the type of participation recommended for MAPP Phase Three.

Phase Three: Four MAPP Assessments				
	MAPP Core Group	MAPP Steering Committee	Sub-committees	Community
	See details below for each assessment.	See details below for each assessment.	See details below for each assessment.	See details below for each assessment.
Community Health Status Assessment	• Support Steering Committee and sub-committee activities. • Assist with data collection and analysis, community health profile development, and broad presentation and distribution of assessment results to community. • Ensure connectivity between methods and promotion of all MAPP assessments.	• Oversee sub-committee activities. • Identify data sources for sub-committee. • Select locally appropriate **indicators**. • Provide input into Community Health Profile development.	• Sub-committee, with expertise in data, should oversee the CHSA. • Engage community members to participate in CHSA planning and completion. • Collect and analyze data. • Develop Community Health Profile. • Present and distribute assessment results to community.	• Present and distribute the Community Health Profile throughout the community. • Involve community in the CHSA sub-committee; additional community participants may be recruited if desired.
Community Themes and Strengths Assessment	• Support Steering Committee and sub-committee activities.	• Oversee sub-committee activities.	• Form sub-committee with expertise in community engagement, knowledge of community, and in data collection and analysis, oversee the CTSA.	• *Broad community participation is essential.* • Promote broad community participation in all assessment activities.

Phase Three: Four MAPP Assessments				
	MAPP Core Group	MAPP Steering Committee	Sub-committees	Community
	See details below for each assessment.	See details below for each assessment.	See details below for each assessment.	See details below for each assessment.
Community Themes and Strengths Assessment *continued*	• Ensure connectivity between methods and promotion of all MAPP assessments.	• Provide recommendations for gaining broad community participation in assessment. • Participate in activities as needed.	• Engage community members to participate in CTSA planning and implementation and to provide feedback in CTSA. • Prepare for CTSA activities and ensure effective implementation. • Oversee implementation of activities. • Compile results.	• Ensure the community receives announcements and updates through a broad spectrum of community mechanisms (media, word of mouth, etc.). • Ensure participation of community members representing the diversity of the community, including those disproportionately affected by poor health outcomes or community conditions.
Local Public Health System Assessment	• Support Steering Committee and sub-committee activities. • Ensure connectivity between methods and promotion of all MAPP assessments.	• Oversee sub-committee activities. • Assist in ensuring broad LPHSA participation in LPHSA. • Participate in Essential Services Orientation session. • Respond to performance measures instrument. • Discuss results and identify challenges and opportunities.	• Convene a sub-committee, if preferred, to oversee LPHSA. • Engage community members to participate in LPHSA planning and implementation. • Prepare for LPHSA activities and ensure effective implementation. • Ensure facilitation and recording of all LPHSA sessions.	• Engage community members in the LPHSA sub-committee; additional community participants can be recruited if desired.
Forces of Change Assessment	• Prepare for and plan brainstorming session(s). • Identify and secure session facilitator(s) and engage with them in preparing for visioning session(s). • Summarize and compile the assessment results. • Ensure connectivity between methods and promotion of all MAPP assessments.	• Entire committee should participate in brainstorming session(s) to identify influential forces. • Identify opportunities and threats for each force.	• None recommended; however, some Steering Committees may want to designate a FoC sub-committee to conduct the responsibilities identified for the Core Group.	• *Broad community participation is essential.* • Engage community members in the FoC sub-committee; additional community participants may be recruited if desired.

Community Health Status Assessment

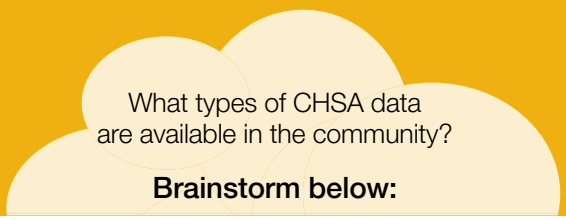
Conducting the Community Health Status Assessment (CHSA), answers the following questions:

- **How healthy is the community?**
- **What does the health status of the community look like?**

The CHSA collects quantitative information on health status, quality of life, and risk factors.

Before starting this assessment, the MAPP Steering Committee members brainstorm existing sources of CHSA data. Many local public health system partners collect health status data. Then critically think about the data the local public health system partners are willing to share. Determine if the data represent the status of the entire community and are inclusive of the entire local public health system. Discuss whether the data have been used strategically to inform improvements. The discussion should inform how you design this assessment.

Community Health Status Assessment continued



Do existing community health status data reflect all the segments of the community and various public health system sectors? What segments of the community or local public health system are missing? Have the data been used strategically?

Community Health Status Assessment continued

Step One: Create a Sub-committee

The sub-committee should include members who:

- Have access to data;
- Can analyze data;
- Can create a system for managing data; or
- Have an interest in data.

Consider local public health system partners (e.g., Hospital representatives, university epidemiologists) who may have data collection and analysis expertise

Brainstorm sub-committee members and what strengths they offer:

Community Health Status Assessment continued

Step Two: Create a List of Indicators

Sub-committee members will brainstorm and select **indicators** that are important to the community. During the indicator brainstorm, the sub-committee members should reference the community's vision and the interests of the individuals and organizations involved in the process. Begin the conversation by reviewing the 12 categories of data in the table below and deciding which ones are the most important. Then the sub-committee can talk about specific indicators of interest in each category. Think broadly about health and quality of life, beyond traditional types of health indicators.

12 Categories of Data

1. **Demographic Characteristics;**
2. **Socioeconomic Characteristics;**
3. **Social Determinants of Health Inequity;**
4. **Health Resource Availability;**
5. **Quality of Life;**
6. **Behavioral Risk Factors;**
7. **Environmental Health Indicators;**
8. **Social and Mental Health;**
9. **Maternal and Child Health;**
10. **Death, Illness, and Injury;**
11. **Infectious Disease;** and
12. **Sentinel Events.**

Prioritize the indicators. The Austin/Travis County, Texas, MAPP process created an indicator criteria matrix to narrow the list of indicators.

Check out the core and extended indicator lists in the MAPP Clearinghouse **(www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/phase3CHSA.cfm).**

In considering **health equity** refer to Resources for Social Determinants of Health Indicators **www.naccho.org/topics/infrastructure/CHAIP/upload/Final-Resources-on-Social-Determinants-of-Health-112811.pdf**

Community Health Status Assessment continued

Step Three: Collect Data for Community Selected Indicators

Data that have been collected in the past, collected by other parties, or result from combining data, or information from existing sources are considered secondary data. All communities have some form of secondary community health status data. Sub-committee members should take inventory of data that are already available related to the indicators brainstormed in the previous step. They should consult with the local health department, state health department, hospitals, community health centers, United Ways, schools, law enforcement, and other organizations that collect health data to see what is already available.

Example of sources of health status data include:

- State databases;
- U.S. Census Bureau American Community Survey www.census.gov/acs/www/;
- County Health Rankings www.countyhealthrankings.org;
- Community Commons' Community Health Needs Assessment toolkit http://assessment.communitycommons.org/CHNA;
- Health Information Warehouse http://healthindicators.gov; and
- Healthy People 2020 www.healthypeople.gov.

Collect new data (i.e., conduct **primary data collection**) only if it is necessary and your community has the resources. Data collection does not have to be perfect. However, it is important to note the limitations of existing data and ways data collection can be improved in the future.

Community Health Status Assessment continued

Step Four: Organize and Analyze Data

At a minimum, analyze data by socioeconomic status, mortality rates, gender, age, race, ethnicity, geographic area, and other common population subgroups. Show trends over time and compare results with that of peer communities, state averages and targets, and national targets such as *Healthy People 2020* objectives.

Mapping is a technique to analyze data visually. This may require software and requires knowledge in quantitative data analysis.

Community Health Status Assessment continued

Step Five: Compile and Disseminate Results

The results can be presented as a written report, slide presentation, or online resource. The results should be shared with community members and local public health system partners. When disseminating results, provide information on how community members and public health system partners can learn more about the MAPP process and provide feedback on what they learned through this assessment.

Community Health Status Assessment continued

Step Six: Create a System to Monitor Indicators over Time

MAPP is an iterative process and after a few years, community health status data will become out of date. Creating a system that is easily updated will allow the community to track changes over time. Even though the community will not complete a MAPP process every year, updating CHSA data may occur more frequently. This will help sustain your community's MAPP process and support the next iteration.

A sustainable monitoring system requires clear definition of roles, including leadership, coordination, and communication. One organization can take the lead, but other organizations should contribute to monitoring the data system.

Sub-committee should make decisions related to:

- Frequency of data collection;
- Quality of data;
- Comparison to peer, state, or national data;
- Need to modify or add indicators;
- Methods for maintaining data systems;
- Sophistication of technology used (systems can range from low tech to high tech with price variations); and
- Communication mechanisms that will support continuous use of the data system.

Community Health Status Assessment continued

Step Seven: Create a List of Challenges and Opportunities

Before moving to Phase Four, Identify Strategic Issues, the sub-committee should put together a summary of challenges and opportunities related to health status based on the findings of the CHSA. The summary is a more manageable list of issues that will be compared to the results from the other three assessments.

In creating a list of challenges and opportunities, partners should examine the CHSA results in light of the following questions:

- Does this health problem affect large numbers of people, have serious consequences, show evidence of wide inequity between groups or increasing trends, and is it susceptible to proven interventions?

- Does the issue have broad implications over the long term for potential health improvements?

- By addressing this issue, is there potential for a major breakthrough in approaching community health improvement?

- Is this issue one that has been persistent, nagging, and seemingly unsolvable?

- Does this issue identify a particular strength that can be replicated throughout the community?

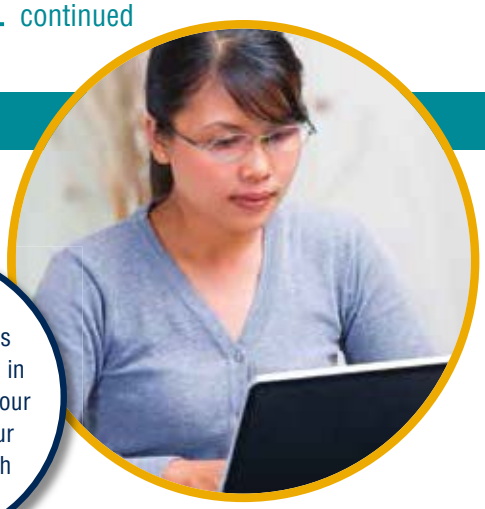
- Is ongoing monitoring of this issue possible?

Ideally, the final list will include 10–15 community health status issues that will be more closely examined in Phase Four: Identify Strategic Issues.

Community Health Status Assessment continued

Step Eight: Share Results with Community

Share the results from the assessment with the community and with participants from the assessment. Results can be distributed at meetings, online, or through traditional or social media. When sharing results from the assessment, provide information about how people can learn more about the MAPP process and provide feedback on the assessment results.



Results from the MAPP assessments can either be shared in one summary of all four assessments or four summaries for each assessment.

Community Themes and Strengths Assessment

Conducting the Community Themes and Strengths Assessment (CTSA), answers the following questions:

- **What is important to the community?**
- **How is quality of life perceived in the community?**
- **What assets does the community have that can be used to improve community health?**

The CTSA identifies community thoughts, experiences, opinions, and concerns.

Before starting this assessment, brainstorm existing sources of community themes and strengths data. Many local public health system partners collect quality of life data. Critically think about the qualitative data you have and determine if the data represent the views of different segments of the community, especially those disproportionately affected by poor health outcomes or community conditions. Discuss whether the data have been used strategically to inform improvements. The discussion should inform how you design this assessment.

Step One: Create a Sub-committee

Members of the CTSA sub-committee should have an interest or expertise in collecting quality of life data. Sub-committee members should also be able to identify effective ways to encourage the community-at-large and specific target populations to participate in the assessment.

Community Themes and Strengths Assessment continued

What types of community themes and strengths data are available in the community? **Brainstorm below:**	Do existing community themes and strengths data reflect all segments of the community? Have the data been used strategically?

Community Themes and Strengths Assessment continued

Step Two: Choose Method(s) for Collecting Data

Three levels of information gathering should occur during the CTSA:

1. Open discussion to elicit community concerns, opinions, and comments in an unstructured way;
2. Surveys or discussions to identify perceptions of quality of life; and
3. Asset mapping to identify the capacity of individuals, civic associations, and local institutions.

The chart below suggests some methods for collecting new data. Ask community members which methodologies will elicit honest participation.

Resources
To learn more about asset mapping, visit the Asset-Based Community Development Institute website: www.abcdinstitute.org

Methods of Collecting Data

APPROACH	DESCRIPTION	ADVANTAGE	DISADVANTAGE/ BARRIERS	OTHER CONSIDERATIONS
Community Meetings	• Broad, inclusive community meeting (60–100 people)—often called a "town hall" meeting. Open discussion among a large group of participants. Can be conducted multiple times in larger communities.	• Can reach a large number of people. • Helps to publicize the process as well as get community input.	• Requires a great deal of promotion to get broad community involvement. • Some individuals/groups may dominate the discussion or "pack" the meeting.	• Requires a strong facilitator. • Discussions can be incorporated into the agendas of already-existing town meetings.
Community Dialogues	• Smaller (20–35 people) gatherings where all/many sectors of the community are represented. May be conducted with multiple groups.	• Useful for exploring complex issues in greater depth. • Useful for engaging affected sectors of the community.	• Some individuals or groups may dominate the discussion. • Group atmosphere may hinder honest opinions.	• Requires a strong facilitator.
Focus Groups	• Small group of participants (generally 8–10) that responds to a set number of questions. Useful for providing specific direction and/ or reactions to concepts from targeted groups (i.e., identified sub-populations).	• Participants react to ideas together and can build off of each other's comments. • Quick way to hear various thoughts and statements. • Shared experience, therefore, can be enjoyable.	• Some individuals may dominate the discussion. • Group atmosphere may hinder honest opinions. • Only a small number of people can realistically participate.	• Requires a strong facilitator. • Requires at least one recorder.

Community Themes and Strengths Assessment continued

Methods of Collecting Data				
APPROACH	**DESCRIPTION**	**ADVANTAGE**	**DISADVANTAGE/ BARRIERS**	**OTHER CONSIDERATIONS**
Walking or Windshield Surveys	• Conducted by driving or walking around the community and taking notes of aspects of the community that can be observed. Helps to identify assets (i.e., a small pond where children swim that offers a recreation site) or unrecognized issues (i.e., potholes).	• Requires only a small number of people to conduct the survey. • Can bring new awareness of **community assets** or issues.	• Requires an open mind to identify previously unrecognized assets/ issues.	• Fairly easy to conduct, but should not be the only mechanism used for information gathering. Good supplement to other mechanisms.
Photovoice	• Small group of people (8–10) walks through the community taking pictures of things that strike them. A collective presentation or book is produced with text describing issues and opportunities. The text is provided by the participants and is indicative of their voice.	• Particularly attractive to youth. • Builds teamwork within group. • Presentations engage larger group. • A picture is worth a thousand words.	• Requires open mind to identify assets and issues. • Some important assets can't be photographed.	• Easily done but takes strong mentoring if youth are involved. Good supplement to other mechanisms. • Requires a camera and capacity to process film or view video footage.
Individual Discussions/ Interviews	• Individual discussions—through informal conversations or formal interviews—can gather in-depth feedback from representative community members. The interviews are 1-1. Can be done with key community leaders or community members representing specific sub-populations.	• Builds awareness of MAPP process. • Gathers in-depth input and feedback in an open setting. • Easy to implement	• Only a small number of people can realistically participate. • May put undue emphasis on interviewees' issues of interest.	• Fairly easy to conduct, but should not be the only mechanism used for information-gathering. Good supplement to other mechanisms.
Surveys	• Can include written, telephone, or in-person surveys. A traditional approach to gathering community input	• Useful for reaching large numbers of people. • Focuses on investigating issues raised in other areas of the process or can gather open-ended responses.	• Not interactive. • No in-depth feedback on issues. • May not elicit thoughts on a subject of importance if not included in survey. • Respondent bias—hard-to-reach populations often don't respond.	• Should not be the only information-gathering mechanism. Good to supplement with one or more of the interactive approaches

Community Themes and Strengths Assessment continued

When selecting methods for this assessment, identify the following resource needs:

- Consultants;
- Survey instrument development and dissemination;
- Focus group associated costs (e.g., refreshments, facilitator);
- Meeting space;
- Travel costs; and
- Staff time.

Gather information at already established events in the community such as meetings, agricultural fairs, farmers markets, holiday festivities, and fundraisers.

Ask representatives from the community to review surveys or questions that you will use to ensure the questions will make sense to participants, particularly those with different cultures, languages, and frames of reference.

Community Themes and Strengths Assessment continued

Step Three: Gather Data

Select methods to collect information from individuals who represent the diversity in the community. Most communities use multiple methods in different settings to ensure broad representation. This assessment may be useful in gathering data about sub-populations within the community (e.g., homeless population).

Solicit the help of students, staff members at local organizations, volunteers, retirees, and individuals who have a special connection with segments of the community.

Community Themes and Strengths Assessment continued

Step Four: Review and Summarize Data

Have sub-committee members and other volunteers read through the data collected through this assessment to identify major issues, perceptions, and assets. Summarize major themes and strengths in a one- to two-page document.

Step Five: Share Results with Community

Share the results from the assessment with the community and with participants from the assessment. Results can be distributed at meetings, online, or through traditional or social media. When sharing results from the assessment, provide information about how people can learn more about the MAPP process and provide feedback on the assessment results.

Local Public Health System Assessment

Conducting the Local Public Health System Assessment (LPHSA), answers the following questions:

- **What are the activities, competencies, and capacities of the local public health system?**
- **How are the 10 Essential Public Health Services being provided to the community?**

The LPHSA is completed using the **National Public Health Performance Standards** (**NPHPS**) Local Instrument. The LPHSA measures how well the local public health system delivers the 10 Essential Public Health Services.

Essential service providers and recipients convene to complete the NPHPS Local Instrument. The NPHPS instrument describes what the local public health system would look like if all the organizations, groups, and individuals in the community worked together to ensure that essential services were delivered optimally. The descriptions of what should occur in the community serve as model standards (optimal, not minimal standards) of local public health system performance. Community representatives and local public health system partners participate in facilitated discussions to determine how well their local public health system achieves model standards. The NPHPS Local Instrument is divided into chapters to correspond with each of the10 Essential Public Health Services. Each chapter has a series of model standards and questions that are used to guide a facilitated discussion. Answers to the questions serve as measures of local public health system performance.

The 10 Essential Public Health Services

(www.cdc.gov/NPHPS/essentialservices.html)

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable.
8. Assure competent public and personal healthcare workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Local Public Health System Assessment continued

Step One: Create a Sub-committee

The sub-committee should include members who:

- Represent diverse segments of the local public health system;
- Can identify organizations that provide Essential Public Health Services in the local community; and
- Can identify individuals who represent the interests of recipients (i.e., community members) of Essential Public Health Services.

Local Public Health System Assessment continued

Step Two: Plan the Assessment Process

Review the NPHPS Local Instrument Implementation Guide (www.naccho.org/performancestandards), which provides an overview of the process, information on the critical steps, a timeline, implementation tips and the NPHPS Local Instrument. Brainstorm community members and local public health system partners to invite.

Brainstorm potential invitees below:

See the "Circles of Involvement" worksheet on pages 14–19.

Local Public Health System Assessment continued

Step Three: Conduct the Assessment

Consult the NPHPS Local Assessment Implementation Guide (www.naccho.org/performancestandards), which provides step-by-step instructions for conducting the NPHPS Local Assessment Instrument. Review the NPHPS Local Assessment Facilitator Guide (www.naccho.org/performancestandards) for detailed descriptions to facilitate the NPHPS Local Assessment.

Step Four: Review Results and Identify Challenges and Opportunities

Through facilitated discussion, categorize assessment results on Essential Public Health Service performance into one of the following groups:

- Success, maintain effort;
- Success, cut back resources;
- Challenge, requires increased activity; and
- Challenge, requires increase coordination.

Supplement responses with comments captured by recorders during instrument completion. Additional detailed guidance is available in the NPHPS Implementation Guide.

Step Five: Share Results with Community

Share the results from the assessment with the community and assessment participants. Results can be distributed at meetings, online, or through traditional or social media. When sharing results from the assessment, provide information about how people can learn more about the MAPP process and provide feedback on the assessment results.

Forces of Change Assessment

Conducting the Forces of Change (FoC) Assessment answers the following questions:

- **What is occurring or might occur that affects the health of the community or the local public health system?**
- **What specific threats or opportunities are generated by these occurrences?**

The FoC Assessment identifies all the forces and associated opportunities and threats that can affect, either now or in the future, the community and local public health system. Forces can be trends, factors, or events.

- Trends are patterns over time, such as migration in and out of a community or growing disillusionment with government.
- Factors are discrete elements, such as community's large ethnic population, an urban setting, or the jurisdiction's proximity to a major waterway.
- Events are one-time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation.

Forces of Change Assessment continued

What existing work in the community is similar to the FoC Assessment? **Brainstorm below:**	How can existing work be more inclusive of the local public health system, more strategic, and more community-driven?

Forces of Change Assessment continued

Step One: Create a Sub-committee

Identify individuals who have knowledge about forces and associated opportunities and threats. Elected officials, agency directors, business leaders, grassroots organizations, long-standing residents, and other community leaders have the information needed to complete this assessment.

Step Two: Complete the FoC Assessment Worksheet

Completing the FoC Assessment involves brainstorming different forces and identifying opportunities and threats associated with each force. The worksheet on the following pages can be used to guide the process. Ask sub-committee members what method they would like to use to complete the assessment. Some communities have completed the assessment using facilitated conversation, small group discussions, informal lunch meetings, and e-mail exchanges. The sub-committee must also decide who else besides sub-committee members should be involved in the assessment.

WORKSHEET: Forces of Change Brainstorming

The following two-page worksheet is designed for MAPP Committee members to use in preparing for the Forces of Change brainstorming session. This worksheet may also be used to conduct the assessment.

What are Forces of Change?

Forces are a broad all-encompassing category that includes trends, events, and factors.

- **Trends are patterns over time**, such as migration in and out of a community or a growing disillusionment with government.
- **Factors are discrete elements**, such as a community's large ethnic population, an urban setting, or a jurisdiction's proximity to a major waterway.
- **Events are one-time occurrences**, such as a hospital closure, a natural disaster, or the passage of new legislation.

What Kind of Areas or Categories Are Included?

Be sure to consider any and all types of forces, including:

- social;
- economic;
- political;
- technological;
- environmental;
- scientific;
- legal; and
- ethical.

How to Identify Forces of Change

Think about forces of change—outside of your control—that affect the local public health system or community.

1. What has occurred recently that may affect our local public health system or community?
2. What may occur in the future?
3. Are there any trends occurring that will have an impact? Describe the trends.
4. What forces are occurring locally? Regionally? Nationally? Globally?
5. What characteristics of our jurisdiction or state may pose an opportunity or threat?
6. What may occur or has occurred that may pose a barrier to achieving the shared vision?

Also, consider whether or not forces identified were unearthed in previous discussions.

1. Was the MAPP process spurred by a specific event such as changes in funding or new trends in public health service delivery?
2. Did discussions during the Local Public Health System Assessment reveal changes in organizational activities that were the result of external trends?
3. Did brainstorming discussions during the Visioning Phase or Community Themes and Strengths Assessment touch upon changes and trends occurring in the community?

WORKSHEET: Forces of Change Brainstorming

Using the information from the previous page, list all brainstormed forces, including factors, events, and trends. Continue onto another page if needed.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

WORKSHEET: Forces of Change—Threats and Opportunities

List the major categories identified on page 77 ("Forces"). Then, for each category, identify the threats and opportunities for the public health system or community created by each. Continue onto another page if needed.

Forces (Trend, Events, Factors)	Threats Posed	Opportunities Created

Forces of Change Assessment continued

Step Three: Summarize Key Findings

Summarize the most prominent findings in a two- or three-page written summary.

Step Four: Share Results with Community

Share the results from the assessment with the community and with participants from the assessment. Results can be distributed at meetings, online, or through traditional or social media. When sharing results from the assessment, provide information about how people can learn more about the MAPP process and provide feedback on the assessment results.

Completion of Phase Three: Four MAPP Assessments

Phase Three: Celebrate Success

At the conclusion of Phase Three, brainstorm ways you can celebrate the success of completing the Four MAPP Assessments.

Brainstorm below:

WORKSHEET: Process Improvement

Once the Four MAPP Assessments have been conducted, conduct a process evaluation to ensure continuous improvement. The following is a useful method for reviewing the quality of MAPP implementation and to identify areas for ongoing improvement. This worksheet can assist in creating the process evaluation plan.

PHASE THREE: The Four MAPP Assessments	
How will we celebrate success?	
How will we communicate success to our community?	
How will we evaluate our process?	
What are the lessons learned?	
How will we apply these lessons to improve our process?	

NOTES

PHASE FOUR: Identify Strategic Issues

Completing Phase Four answers the following questions:

1. What issues are critical to the success of the local public health system?
2. What fundamental policy choices or critical challenges must be addressed in order for the community to achieve its vision?

Strategic issues are fundamental policy choices or critical challenges that must be addressed in order for a community to achieve its vision. During this phase, data from the four MAPP assessments are reviewed and synthesized.

The Four MAPP Assessments Flowchart (Figure 5) on page 84 emphasizes that data from any one assessment should inform the interpretation of data from the other assessments, and no one assessment should bias the process. Summarizing the results from each assessment in terms of major challenges and opportunities can help to identify underlying themes in the data.

If the questions below are difficult to answer, revisit the previous MAPP phase, **Four MAPP Assessments**, and collect the necessary data.

- **The Community Health Status Assessment answered:**

  What health conditions exist in the community?

- **The Community Themes and Strengths Assessment answered:**

  Why do health conditions exist?
  What assets are available in the community?
  What is the quality of life in the community?

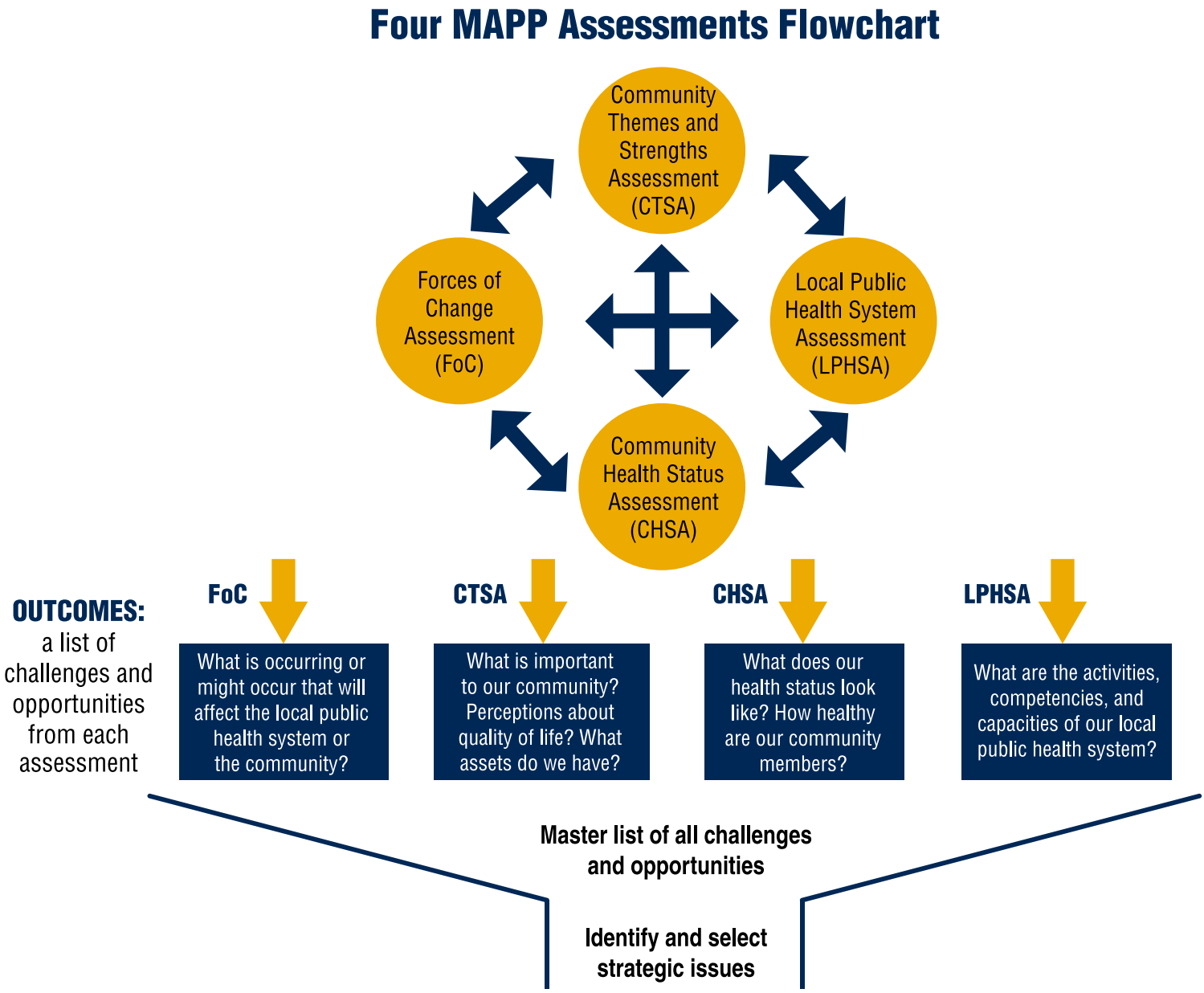
- **The Local Public Health System Assessment answered:**

  What system weaknesses must be improved?
  What system strengths can be used?
  What short-term or long-term system performance opportunities are there?

- **The Forces of Change Assessment answered:**

  What forces affect how to take action?

FIGURE 5. Four MAPP Assessments Flowchart



When approaching this phase, think about the story that is unfolding from the four assessments. Based on the data, what are some of the major issues that seem to affect multiple aspects of healthy living in your community? What types of relationships, policies, community conditions, and decisions affect people's ability to live healthy?

After identifying underlying themes that affect the community, rephrase themes as strategic issues. Strategic issues are written as questions that need to be answered in order for a community to achieve its vision. When developing strategic issues, it is important to ensure all four assessments inform the question the community wants to answer. Strategic issues are supposed to be broad, which allows for the development of innovative, strategic activities as opposed to relying on the status quo, familiar, or easy activities. Broad strategic issues can help align the overall community's strategic plan with the missions and interests of individual local public health system partners. Most communities identify more strategic issues than they can reasonably address in a five-year period and will ultimately focus on three to five strategic issues. The final list of strategic issues is the foundation for a **community health improvement plan** to take action to improve health in the community. The latter phases of the MAPP process involve narrowing strategic issues into strategic actionable steps.

Strategic issues are not health conditions. Health conditions, like diabetes prevention or substance abuse, are described in the CHSA. Strategic issues represent underlying challenges that need to be addressed, which would lead to improvement in health conditions. Strategic issues should impact more than one health condition. For instance, the Knox County, Tennessee, strategic issue, "How can we position health as a consideration in community policy and planning decisions?" can positively affect the status of several health conditions in the community.

Matrix of Organized Participation and Roles within Identifying Strategic Issues

Below is a matrix that depicts the type of participation recommended for MAPP Phase Four.

Phase Four: Identify Strategic Issues			
MAPP Core Group	MAPP Steering Committee	Sub-committees	Community
• Compile and summarize results from four MAPP Assessments. • Plan process to identify strategic issues. • Provide staff support at meeting(s) in which strategic issues are identified. • Summarize the results of the meeting(s).	• Approve general process for identifying strategic issues. • Participate (entire committee) in meeting(s) at which strategic issues are identified and analyzed.	• Charge small groups with specific tasks related to identifying strategic issues, if preferred.	• Engage community through the Steering Committee.

Step One: Determine the Method for Completing this Phase

Convene the Steering Committee and work together to answer the following questions:

- How will we present data from all Four MAPP Assessments to our local public health system partners and community members? (This may have already occurred in Phase Three.)

- How will we ensure our local public health system partners and community members can fully comprehend results from the four assessments?

- How will we facilitate a process to help our local public health system partners and community members identify strategic issues that are informed by all four assessments?

- How will we prioritize our strategic issues?

- How will we ensure everyone is aware of our strategic issues?

Step Two: Present Summary of All Four Assessments

For the CHSA, present the data related to the top 10–15 indicators that were most important to your community members and local public health system partners. Present differences in health status based on categories such as age, race, ethnicity, geographic area, and compare to state and national **benchmarks**, such as Healthy People 2020 national objectives. If your community has a lot of indicators, organize your indicators by topic and select one indicator that best represents that category. Encourage people to look at the full CHSA results for more information. Present a summary of opportunities and challenges that emerged from CHSA data.

Work with community members to identify the best way to share data in a relevant way. Ask community members what methods would be most effective in getting people to identify strategic issues.

For the CTSA data, provide a summary of the following:

1. Key themes related to quality of life;

2. Issues that are important to community members;

3. Community assets; and

4. A summary of opportunities and challenges identified by community members.

For the LPHSA, provide information about the Essential Public Health Services that the local public health system delivers well and the Essential Public Health Services that the system could do a better job providing to the community. Provide information about areas for local public health system improvement and a summary of opportunities and challenges.

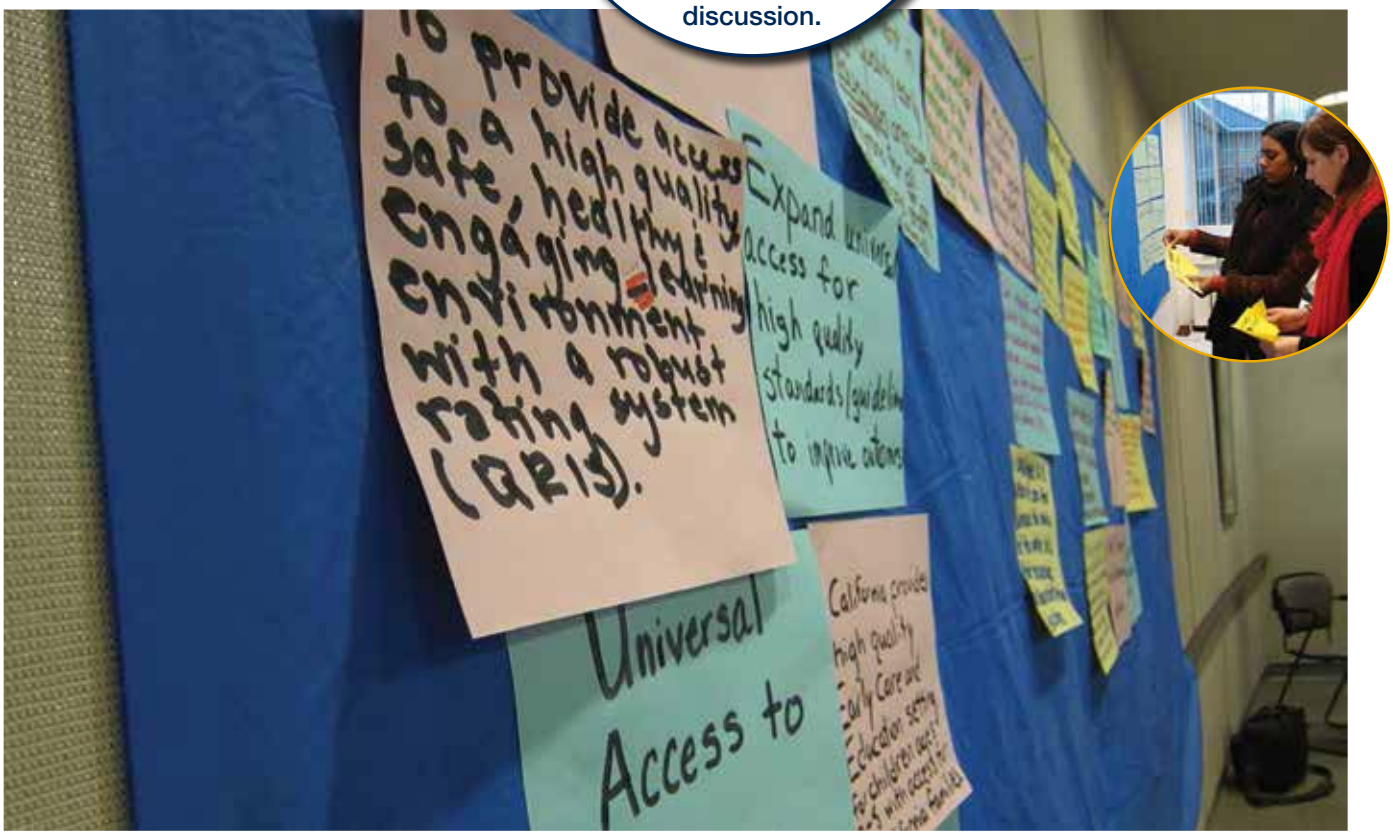
For the FoC Assessment, provide a summary of the forces that are or will affect the community and the opportunities and threats associated with each force.

Step Three: Brainstorm Potential Strategic Issues

Brainstorm themes that emerge from the four assessments and list the specific data points that inform each theme. For instance, CHSA data related to **chronic disease**, LPHSA data on workforce development, and FoC data on economic development may suggest a need for better sustainable community design. Brainstorm without prioritizing. Prioritizing will occur later in the process. This worksheet can assist in brainstorming themes.

Facilitating this phase can be challenging because individuals will have to reconcile personal interests with overarching community interests. In addition, conflicting interests and different perspectives can create tension in the process. Consider designing a facilitated conversation to review the data. Use the Objective, Reflective, Interpretive, Decisional (ORID) method. Learn more from *The Art of Focused Conversation.*

If possible, use a **Sticky Wall** to appeal to visual learning styles. A Sticky Wall is a large sheet of nylon that is sprayed with adhesive allowing paper to stick to it. Sheets can be moved around and reorganized during a facilitated discussion.



What themes did you see among three or more of the assessments? What data points informed these themes?	
THEME:	
CTSA Data	
CHSA Data	
LPHSA Data	
FoC Data	
THEME:	
CTSA Data	
CHSA Data	
LPHSA Data	
FoC Data	
THEME:	
CTSA Data	
CHSA Data	
LPHSA Data	
FoC Data	
THEME:	
CTSA Data	
CHSA Data	
LPHSA Data	
FoC Data	
THEME:	
CTSA Data	
CHSA Data	
LPHSA Data	
FoC Data	

WORKSHEET: Determine Root Causes of Health Issues: Using the 5 Whys

Consider using this worksheet to identify strategic issues that represent the root causes of poor health or community conditions.

What Are the 5 Whys?

The 5 Whys are one way to systematically identify root causes to solve a specific problem. It may also help you determine how different root causes of an issue are related to one another. It should focus on the whys and not be used to identify who or to place blame on a person or organization. It is a systematic way to solve problems and to consider cause-effect relationships.

When Should We Use the 5 Whys?

It should be used when a group is working to solve a problem. It is especially useful as part of a process to solve complex problems where the real cause of the problem is unclear. It should be used to identify the root cause of a problem, which if eliminated, would prevent a problem from reoccurring. The 5 Whys are most useful when complex techniques or statistical analysis are not available or useful.

How Do the 5 Whys Work?

The 5 Whys are a set of questions that help get beyond the surface of a problem and peel away the layers of symptoms in order to identify the root causes of a problem or condition. This is done by asking the question "why?" five times in order to get to the root cause. Sometimes fewer questions identify the root cause and sometimes you may need to ask the question more than five times. The questioning can stop once the group working together on the issue agrees that it's identified the root cause of a problem.

Here's how it works:

1. Write down the specific issue. Ensure that the issue is the current condition. This helps the group formalize the problem and ensure that they 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 percent from 2011 to 2012).
2. Ask why the problem is occurring. Write the answer below the problem.
3. If the answer provided does not identify the root cause of the problem that you wrote in the first step, ask why the problem is occurring again and write that answer down.
4. Complete the second and third steps until the group agrees that the problem's root cause is identified.

The 5 Whys can be used on their own or along with a fishbone diagram. A fishbone diagram helps explore all potential root causes of a particular issue or problem. Once you identify the many potential causes or issues by using a fishbone diagram, then you can use the 5 Whys to closely examine each one to ensure you identify the root cause(s). For more information on fishbone diagrams, visit: www.isixsigma.com/tools-templates/cause-effect/cause-and-effect-aka-fishbone-diagram/.

Example of 5 Whys

PROBLEM OR ISSUE:

The rate of primary care doctors in Happy City who accept Medicaid has decreased over the past five years.

1. **Why is this problem happening?**
   Providers are frustrated with high rates of appointment no-shows in Medicaid patient population.
2. **Why is the problem stated in #1 happening?**
   Patients do not always have reliable transportation to medical appointments.
3. **Why is the problem stated in #2 happening?**
   Providers are located in areas of the city far from where the majority of Medicaid patients live.
4. **Why is the problem stated in #3 happening?**
   Providers are concerned about safety of their patients and their staff by locating practices in particular areas.
5. **Why is the problem stated in #4 happening?**
   Rates of crime are high in areas of the city with high proportion of Medicaid patients.

WORKSHEET: Determine Root Causes of Health Issues: Using the 5 Whys

5 Whys Worksheet

Use the worksheet below and on the next page to guide you in completing 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 is identified.

Once the group agrees that the root cause of the problem has been identified, the team can move forward in deciding what action to take to act upon the root cause. Add additional entries to the worksheet to allow you to do this for each key problem you're facing.

PROBLEM OR ISSUE: _____

1. **Why is this problem happening?** _____
2. **Why is the problem stated in #1 happening?** _____
3. **Why is the problem stated in #2 happening?** _____
4. **Why is the problem stated in #3 happening?** _____
5. **Why is the problem stated in #4 happening?** _____

PROBLEM OR ISSUE: _____

1. **Why is this problem happening?** _____
2. **Why is the problem stated in #1 happening?** _____
3. **Why is the problem stated in #2 happening?** _____
4. **Why is the problem stated in #3 happening?** _____
5. **Why is the problem stated in #4 happening?** _____

WORKSHEET: Determine Root Causes of Health Issues: Using the 5 Whys

PROBLEM OR ISSUE: _____

1. **Why is this problem happening?** _____

2. **Why is the problem stated in #1 happening?** _____

3. **Why is the problem stated in #2 happening?** _____

4. **Why is the problem stated in #3 happening?** _____

5. **Why is the problem stated in #4 happening?** _____

PROBLEM OR ISSUE: _____

1. **Why is this problem happening?** _____

2. **Why is the problem stated in #1 happening?** _____

3. **Why is the problem stated in #2 happening?** _____

4. **Why is the problem stated in #3 happening?** _____

5. **Why is the problem stated in #4 happening?** _____

Step Four: Synthesize and Prioritize Strategic Issues

Strategic issues have significant consequences for the community and the local public health system. Determining the consequences of *not* addressing an issue will help the community members determine if the issue will be a priority strategic issue.

To determine whether an issue is strategic, ask partners and community members the following questions:

Everyone gives their 2¢. Three Rivers District Health Department in Kentucky gave everyone two pennies to vote on the top strategic issues. Once each person had designated their top two priorities, they were done.

1. Is the issue related to our community's vision?
2. Will the issue affect our entire community?
3. Is the issue something that will affect us now and in the future?
4. Will the issue require us to change the way we function?
5. Is the solution to this issue not obvious?
6. In order to address the issue, do we need leadership support?
7. Are there long-term consequences of us not addressing this issue?
8. Does the issue require the involvement of more than one organization?
9. Does the issue create tensions in the community?

The more times you answer ***yes*** to the questions above the more strategic the issue is.

Step Four: Synthesize and Prioritize Strategic Issues continued

There is no one way to prioritize strategic issues. Community members and local public health system partners should identify the criteria and process to prioritize strategic issues. Reference the **Tip Sheet: Prioritizing Issues in a Community Health Improvement Process*** for ideas on methods for prioritization and see the next page for a description of one potential prioritization technique. Identify three to five strategic issues. More than five strategic issues may be difficult to manage.

Remember to ensure that the strategic issues resonate with the community members and local public health system partners. Some MAPP communities use targeted focus groups to obtain feedback regarding the chosen strategic issues. Referencing the MAPP vision statement may be useful to ensure that the strategic issues align with the MAPP process.

Identify three to five strategic issues. More than five strategic issues may be difficult to manage.

*www.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf

WORKSHEET: Nominal Group Technique

The following is a useful method for prioritizing strategic issues. This can be used with the MAPP Steering Committee. To begin prioritizing strategic issues, use the Nominal Group Technique.

1. **Generate strategic issues based on the data.**

2. **Write the strategic issues on a flip chart, ask for clarifying questions.**

3. **Each participant ranks the order of the strategic issues.**

   EXAMPLE:

   Strategic issue A: 3

   Strategic issue B: 2

   Strategic issue C: 4

   Strategic issue D: 1

   "4" is the most important ranking and "1" is the least important.

4. **Combine the rankings of all participants.** Add the totals for each strategic issue. The strategic issue with the highest total is the top priority. The strategic issue with the next highest total is the second priority and so on.

   EXAMPLE:

	Participant 1	Participant 2	Participant 3		TOTAL
Strategic issue A	3	4	4	=	11
Strategic issue B	2	1	2	=	5
Strategic issue C	4	3	3	=	10
Strategic issue D	1	2	1	=	4

Adapted from Michael Brassard, Diane Ritter, Francine Oddo and Janet MacCausland. 2007. *The Public Health Memory Jogger II*. Salem, NH: GOAL/QPC.

A skillful facilitator can address tensions and can help create a common understanding among participants. The following scenarios will describe tensions that might occur during this phase and ways to create a productive opportunity for discussion.

SCENARIO 1: Jane says there is no public transportation available to the health department, which you know isn't true.

- **Recommended response:** Jane, thank you for sharing your frustration with transportation. Tell me more so I can better understand the issue. This is important information that will inform our process to improve our community. Let's write this information down. By the way, there are some options that may be helpful such as…

  [If existing services do address Jane's need] I'm sorry you were unaware of these services. It sounds like we need to do a better job of letting people know about them. How do you think we should advertise them?
- **Unproductive response:** Jane, we have transportation services; you just didn't know about them.

SCENARIO 2: Mike believes sexually transmitted infection (STI) rates are high because prevention services are of poor quality.

- **Recommended response:** Mike, I understand you think services to prevent STIs should be improved. Tell me more. In what ways do you think services could be improved? This is important information that will inform our process to improve our community. Let's write this information down.
- **Unproductive response:** Mike, your experience was an exception. STI prevention services are actually the best in the country.

SCENARIO 3: The way Betty interprets the data seems illogical.

- **Recommended response:** Betty, help me understand. Do you have experiences or stories related to the data? This is important information that will inform our process to improve our community. Let's write this information down.
- **Unproductive response:** Betty, the data do not support your idea, and our epidemiologist agrees with my interpretation.

SCENARIO 4: Steven challenges the validity of the data and how the data were collected.

- **Recommended response:** Steven, I agree there are limitations with the data. What concerns you in particular? Help me understand your concerns. This is important information we should consider in deciding what these data mean for our community. Let's write this information down.
- **Unproductive response:** We did our best collecting the data. There is no such thing as perfect data. We have to work with what we have.

Step Five: Disseminate Results

Share the three to five strategic issues with everyone who participated in the MAPP process and the community at large. When disseminating results, create an opportunity for people new to the process to learn more and get involved in the action cycle.

Step Six: Conduct Process Evaluation for Phase Four

The following questions may be useful for conducting process evaluation of Phase Four. The MAPP Core Group can ask participants who helped identify the strategic issues the following:

1. Did we effectively analyze and synthesize the data from all four MAPP assessments?

2. Did we use an effective process to identify the fundamental policy choices or critical challenges that must be addressed in order for our community to achieve its vision?

3. Did we ensure partners collectively identified and felt ownership of strategic issues?

4. Did we ensure strategic issues were not biased by any one agency's agenda?

5. Did we ensure our strategic issues resonate with the community?

WORKSHEET: Process Improvement

Once the strategic issues have been identified, conduct a process evaluation to ensure continuous improvement. The following is a useful method for reviewing the quality of the MAPP implementation and to identify areas for ongoing improvement. This worksheet can assist in creating the process evaluation plan.

PHASE FOUR: Identify Strategic Issues	
How will we celebrate success?	
How will we communicate success to our community?	
How will we evaluate our process?	
What are the lessons learned?	
How will we apply these lessons to improve our process?	

Step Seven: Celebrate

Moving from assessment into planning is a milestone in the MAPP process. Celebrate with everyone who has been involved. Use the momentum to move quickly into goal setting, strategy development, and the action cycle.

How will you celebrate the success of identifying strategic issues?

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PHASE FIVE: Formulate Goals and Strategies

Completing Phase Five answers the following questions:

1. What are the long-term results associated with the identified strategic issues?
2. What strategies can the community take to reach the goals?

During this phase, the community and local public health system partners form goal statements related to each strategic issue and identify strategies for achieving each goal. It's important to use assessment data to inform goal setting and to test assumptions about potential strategies.

Matrix of Organized Participation and Roles within Formulate Goals and Strategies

Below is a matrix that depicts the type of participation recommended for MAPP Phase Five.

Phase Five: Formulate Goals and Strategies			
MAPP Core Group	MAPP Steering Committee	Sub-committees	Community
• Prepare information to assist in developing strategies and goals. • Plan process to formulate goals and strategies, including identifying and supporting sub-committee(s) if needed. • Plan and staff the meeting(s) where goals and strategies are formulated. • Summarize the meeting(s) results. • Draft the planning report to guide next steps.	• Participate (entire committee) in meeting(s) at which strategies and goals are selected and confirmed. • Oversee development of the planning report and adopt the plan. • Ensure community member review and buy-in of strategic issues.	• May be formed to discuss each strategic issue in-depth and identify the goals, strategies, and barriers.	• Obtain community input into feasible and effective strategies. • Obtain broad community buy-in of strategies and goals in some manner.

Step One: Determine How Goals and Strategies Will Be Developed

- What is the forum and duration? (e.g., one-day retreat, series of meetings?)

- Who will be involved?

- Who will facilitate?

- What process will be used for identifying and agreeing upon goals and strategies?

Step Two: Develop Goals

Reference the vision statement in this phase to ensure the goals and vision align.

This worksheet can be completed for each strategic issue.

- What is the strategic issue?

Develop at least one goal that will help answer this strategic issue.

WORKSHEET: Brainstorming

DIRECTIONS: Use this worksheet to brainstorm the current situation for each of the chosen strategic issues. This information will help you move forward in thinking about the goals and strategies to develop around each issue for Phase Five of MAPP. Think broadly about each issue when you are completing the worksheet. Add additional tables as needed.

STRATEGIC ISSUE #1:	
What current work is focused on the issue, if any?	
What resources are currently available to address the issue, if any?	
Who in the community would support work on this issue? What is their level of support?	
What potential barriers are there to addressing this issue? Consider barriers in the following categories: community, policy/legal, technical, financial, other.	
What are your initial thoughts about goals or strategies that may be developed around this strategic issue?	

Brainstorming

STRATEGIC ISSUE #2:	
What current work is focused on the issue, if any?	
What resources are currently available to address the issue, if any?	
Who in the community would support work on this issue? What is their level of support?	
What potential barriers are there to addressing this issue? Consider barriers in the following categories: community, policy/legal, technical, financial, other.	
What are your initial thoughts about goals or strategies that may be developed around this strategic issue?	

Step Three: Generate Various Strategies

Consider the unique information provided by the data from the Four Assessments that helped inform the strategic issue; develop one strategy that will help reach this goal.

Brainstorm the following questions:

- What past action has worked?
- What past action has not worked?
- What new realizations may support a strategy?
- What are the strengths of the community around the strategic issue?
- What are the opportunities of the community?
- What threats will need to be addressed?

Step Four: Brainstorm Potential Barriers to Implementation

Identifying potential barriers can increase the success of strategy implementation. Develop strategies that take into account the barriers. Information about barriers may also be used in the action cycle when creating more detailed plans.

Step Five: Draft Strategy Implementation Details

- What specific strategies need to take place?

- What is a reasonable timeline?

- Which organizations and individuals should be involved?

- What resources are required and where will they come from?

Step Six: Strategy Selection and Adoption

- Based on your review of the vision and strategic issues, what are the apparent goals?
- What broad alternatives might members of the local public health system pursue?
- What are the potential barriers to realizing these alternatives?
- What implementation details accompany each strategy alternative?

Goals	Strategies	Barriers	Implementation

WORKSHEET: PEARL Test

Use the **PEARL** test to systematically select strategies for adoption.

PEARL stands for:

- **Propriety:** Is the strategy consistent with the essential services and public health principles?
- **Economics:** Is the strategy financially feasible? Does it make economic sense to apply this strategy?
- **Acceptability:** Will the stakeholders and the community accept the strategy?
- **Resources:** Is funding likely to be available to apply this strategy? Are organizations able to offer personnel time and expertise or space needed to implement this strategy?
- **Legality:** Do current laws allow the strategy to be implemented?

If the answer to any of these five questions is no, a strategy should probably be revised or eliminated.

Remaining strategies that pass the **PEARL** test should be prioritized based on additional criteria such as:

POTENTIAL STRATEGY:

	YES	NO
Is the strategy consistent with the essential services and public health principles?	✔	
Is the strategy financially feasible?	✔	
Does it make economic sense to apply this strategy?	✔	
Will the stakeholders and the community accept the strategy?	✔	
Is funding likely to be available to apply this strategy?	✔	
Are organizations able to offer personnel time and expertise or space needed to implement this strategy?	✔	
Do current laws allow the strategy to be implemented?	✔	
What is the potential impact on the strategic goal?	✔	
What is the cost of this strategy in terms of dollars, people, and time?	✔	
Is it likely that the strategy can be successfully implemented?	✔	

Step Seven: Conduct Process Evaluation

- Did we use an effective process for formulating our goals and strategies?

- Did we ensure our goals and strategies reflect what the community collectively wants to achieve?

- Did we effectively formulate goals and strategies so that we can develop practical work plans?

WORKSHEET: Process Improvement

Once the goals and strategies have been formulated, conduct a process evaluation to ensure continuous improvement. The following is a useful method for reviewing the quality of the MAPP implementation and to identify areas for ongoing improvement. This worksheet can assist in creating the process evaluation plan.

PHASE FIVE: Formulate Goals and Strategies	
How will we celebrate success?	
How will we communicate success to our community?	
How will we evaluate our process?	
What are the lessons learned?	
How will we apply these lessons to improve our process?	

Step Eight: Celebrate and Share the Plan

How will you celebrate the successful creation of your goals and strategies?

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PHASE SIX: Action Cycle

At the end of Phase Six, you will have answered the following questions:

1. **What will be done to realize the community's vision?**
2. **Who will do it?**
3. **How will it be done?**
4. **How will we know we have made improvements?**
5. **How can we continually improve?**

The Action Cycle involves three activities: planning, implementation, and evaluation. The Action Cycle looks similar to continuous **quality improvement** cycles in that information about how well you are achieving your goals should inform improvements in your planning and implementation. In this phase, you will use goals and strategies identified in the previous phase to develop a community health improvement plan comprised of multiple practical work plans. Your community will implement the work plans, evaluate how well they are meeting goals and objectives, and implement revised work plans as part of an iterative process.

Action planning and implementation in the MAPP process is very similar to the planning many people conduct on a daily basis. However, in the MAPP process, you are orchestrating activities among different individuals and organizations. Transparency, effective communication, trust, and leadership are critical in ensuring that the community successfully implements its strategic plan. The commitment and engagement you have cultivated and the evaluations and improvements you have made throughout the process are strong foundations for collective action. Successful MAPP processes ensure all people involved know what actions are being taken by whom and how those actions relate to the ultimate vision.

Most committees create Action Teams to address one strategic issue or one goal. The Action Teams develop measurable objectives and identify activities related to their assigned topic. Action Teams can use the implementation worksheet on the next page to identify who will do what by when. The implementation worksheet also shows how actions are related to strategic issues and how the community will know whether the activities meet objectives.

Be sure to compose your Action Teams of individuals who have and have not participated in the process. When you engage new participants, it is important to orient them to the MAPP process.

Matrix of Organized Participation and Roles within the Action Cycle

Below is a matrix that depicts the type of participation recommended for MAPP Phase Six.

Phase Six: Action Cycle			
MAPP Core Group	MAPP Steering Committee	Sub-committees	Community
• Provide support to assure process sustains itself and action occurs. • Recruit additional participants for plan implementation and evaluation as needed. • Support sub-committees and Steering Committee as needed.	• Oversee action planning, implementation, and evaluation across all strategies. • Oversee recruitment of additional participants to assist in plan implementation and evaluation as needed. • Secure and/or assist in ensuring resources needed for implementation and evaluation are available.	• Form sub-committee(s) or small groups to oversee implementation and evaluation. • Form small groups to oversee action plans for each strategy and report back to Steering Committee as requested.	• Ensure community is aware of action and progress. • Engage community members in implementation to increase likelihood of success.

Step One: Organize for Action

Before starting the Action Cycle, ask your Steering Committee to answer the following questions:

- Are the right people included?

- Who is missing?

- What Action Teams should be convened?

- What is the structure for facilitating accountability?

Step Two: Develop Objectives

Each Action Team should be associated with either a strategic issue, goal, or strategy. Action Team members should work together to specific, measureable, achievable, realistic, and time specific (SMART) objectives.

Tips for Writing SMART Outcome Objectives:

- Objectives should be written in SMART (specific, measurable, achievable, realistic, and time specific) format.
- Quantitative baselines should be provided for each objective that leads to an increase, decrease, or maintenance over time.
- Referencing a logic model makes developing SMART objectives easy. Rephrase outcomes in the logic model into SMART objectives.

Logic models can help communicate the relationship between activities and desired outcomes. Logic models can also provide structure for evaluation.

Step Three: Establish Accountability for Achieving Objectives

Establishing accountability does not mean that one individual or organization has power over other individuals and can use that power to demand that things get done. In the MAPP process, you want to create an understanding among your partners and community members that in order to achieve your collective goals and vision, you need to work together. Collective action requires that people are committed to the process, the vision, and goals. Building commitment starts at the beginning of the process with proper engagement. If the process was truly collaborative from the beginning, people will more likely be committed and accountable to implementing plans. By always providing clear guidance on roles, responsibilities, and expectations, you help people know how they are going to be accountable. It is also important to check-in periodically with people assigned with tasks to see what challenges they are facing and what can be done to overcome those challenges.

Step Four: Develop Work Plans

Keep in mind the questions you answered in the preceding steps as you go through the worksheet on the following page to develop the work plan. The worksheet can be added to and replicated as needed when creating work plans.

The "90-180 Day Implementation Worksheet" has been developed by the Institute of Cultural Affairs and is one element of the Technology of Participation (ToP)® facilitation methodology. It is included with permission of ICA in the USA. For more information about Technology of Participation (ToP)® resources and/or training opportunities, visit **www.ica-usa.org**.

Non-profit hospitals can use information from the MAPP process to meet Internal Revenue Service Community Health Needs Assessment requirements.

Consider using business planning techniques to develop a revenue generating project.

The MAPP process can be instrumental in helping local health departments prepare for public health accreditation, as it will yield a community health assessment and community health improvement plan that can be completed in a manner consistent with Public Health Accreditation Board requirements.

WORKSHEET: 90–180 Day Implementation

90–180 Day Implementation Worksheet			
Strategic Issue: List the name of the strategic issue that this work is addressing.	**Why:** Write a brief sentence explaining the strategic advantage of moving in this direction. How will this work affect the strategic issue?		
Objective (What): List the specific desired accomplishment in past tense, as if it had already happened—for example, created an inventory of existing resources.		**Start Date:** **End Date:**	
Implementation Steps (How):	**When:**	**Who:**	
List the steps to complete this accomplishment.	Identify the completion date of each step.	Identify who will complete the step.	
Start each step with a verb that captures the action. Make it as concrete as possible.			
1.			
2.			
3.			
Team Members: List the names of all the team members.	**Collaborators or Partners:**	**Evaluation Measures:**	**Special Considerations:**
	Build a list of potential collaborators who should be involved because they can help this effort or because they need to be engaged for the overall success of the MAPP plan.	Write down two or three "measures" you will use to evaluate the degree of success that you have accomplished at the end of the 90 or 180 days.	List any special considerations such as: • Resources needed; • Seasonal time considerations; • Staff/ people time required; and/or • Others.

WORKSHEET: 90–180 Day Implementation

Implementation Worksheet			
Strategic Issue:	**Why:**		
Objective (What):		**Start Date:** **End Date:**	
Implementation Steps (How):	**When:**	**Who:**	
1.			
2.			
3.			
4.			
5.			
6.			
Team Members:	**Collaborators or Partners:**	**Evaluation Measures:**	**Special Considerations:**

Step Five: Review Action Plans for Opportunities to Coordinate

The Steering Committee should review implementation worksheets from the different Action Teams to determine if there are opportunities to streamline efforts. Feedback from the Steering Committee should inform revisions to implementation plans.

Step Six: Take Action

Action Teams should use the implementation worksheet to guide action. As your community implements its plans, it is important to monitor progress and collect data to ensure actions are achieving measurable objectives and community goals. The MAPP process up to this point prepares communities to take action. During Phase Six communities implement the work that ideally improves local public health.

Consider purchasing project management software to help coordinate activities among different people and organizations.

Consider using a Balanced Scorecard to monitor progress over time. Visit: www.rtmteam.net.

WORKSHEET: Writing a Community Health Improvement Plan

A community health improvement plan includes a description of your community's MAPP process and a summary of the strategic issues, goals, strategies, and activities. A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A community health improvement plan is a community-owned plan. This is not a plan for just one agency, but is representative of the local public health system.

To read example community health improvement plans, visit http://mappnetwork.naccho.org/page/cha-chip-examples.

A community health improvement plan is one of the three prerequisites for Public Health Accreditation Board applications. MAPP can assist local health departments in fulfilling the community health improvement plan prerequisite.

Community health improvement plans can be presented in the following manner:

1. **Executive Summary**

2. **Description of the Process**

   a. Overview of MAPP;
   b. Individuals and organizations involved;
   c. Community vision statement;
   d. How four assessments were conducted;
   e. How strategic issues, goals, strategies, and objectives were selected and prioritized.

3. **Strategic Issues, Goals, Strategies, Objectives, and Activities**

   a. Description of each strategic issue;
   b. Assessment data related to each strategic issue;
   c. Goals, strategies, objectives, and activities related to each strategic issue;
   d. Timeline for achieving the objectives and activities;
   e. Performance measures and indicators of progress for each activity;
   f. Individuals and organizations responsible for implementing activities.

4. **Summary**

Step Seven: Evaluation

At least every 12 months, evaluate how well your community is achieving its measurable objectives and goals. During Phase Six, it is important to conduct an outcome evaluation, which is different from the ongoing process evaluation conducted during the earlier phases. Use information from your evaluation to revise objectives or activities. Most communities complete cycles of plan, implement, and evaluate about every two to three years.

In addition to measuring how well your actions are meeting your goals and objectives, it is also important to evaluate how well the Action Cycle is going. Use the following process evaluation questions to check in with your partners and community members. Use the information to implement process improvements.

- Did we effectively use assessment data to inform action cycle planning?
- Did we identify objectives related to each strategy and goal?
- Did we use an effective division of labor and organizational structure?
- Did we ensure system partners have ownership of action cycle activities?
- Did we ensure energy and progress was sustained throughout the action cycle?
- Did we effectively use evaluation results to improve action cycle activities?
- What worked well in this iteration of the process?
- What will you do differently next MAPP iteration?

WORKSHEET: Process Improvement

Once the Action Cycle has begun, conduct a process evaluation to ensure continuous improvement. The following is a useful method for reviewing the quality of the MAPP implementation and to identify areas for ongoing improvement. This worksheet can assist in creating the process evaluation plan.

PHASE SIX: Action Cycle	
How will we celebrate success?	
How will we communicate success to our community?	
How will we evaluate our process?	
What are the lessons learned?	
How will we apply these lessons to improve our process?	

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CONCLUSION

Conducting collaborative community health improvement processes like MAPP is important and challenging work. MAPP is not meant to be completed quickly and easily. Every community that has used the process has learned as it went along and has identified ways it could improve implementation in the future. Don't worry about implementing the perfect process. Do your best with what you have and capture lessons for future iterations. As you work on the process with your community, remember you're not alone. There are plenty of resources and people who can support you. Visit the MAPP website (www.naccho.org/mapp) often and join the MAPP Network at www.mappnetwork.org. Also, feel free to contact NACCHO staff anytime at mapp@naccho.org.

GLOSSARY

10 Essential Public Health Services

The 10 Essential Public Health Services, developed by representatives from federal agencies and national organizations, describe what public health seeks to accomplish and how it will carry out its basic responsibilities. The list of 10 services defines the practice of public health. These services include:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Access/Access to Care

This is the extent to which a public health service is readily available to the community's individuals in need, including the capacity of the agency to provide service in a way that honors the social and cultural characteristics of the community. It also focuses on agency efforts to reduce barriers to service utilization. "Access to care" refers to access in a medical setting.

Accreditation

For public health departments, accreditation is defined as:

1. The development and acceptance of a set of national public health department accreditation standards;
2. The development and acceptance of a standardized process to measure health department performance against those standards;
3. The periodic issuance of recognition for health departments that meet a specified set of national accreditation standards; and
4. The periodic review, refining, and updating of the national public health department accreditation standards and the process for measuring and awarding accreditation recognition.

Action Cycle

During Phase Six, Action Cycle, the community implements and evaluates action plans to meet goals, address strategic issues, and achieve the community's vision.

Assessment Protocol for Excellence in Public Health (APEXPH)

This is an assessment and planning tool developed by NACCHO for use by local health departments and other organizations. The APEXPH workbook includes three parts: an organizational capacity assessment of the local health department; a community health assessment process; and a discussion of implementation, evaluation, and monitoring issues. MAPP was developed from APEXPH.

Behavioral Risk Factors

Risk factors in this category include behaviors that are believed to cause, or to be contributing factors to most accidents, injuries, disease, and death during youth and adolescence as well as significant morbidity and mortality in later life.

The Behavioral Risk Factor Surveillance System includes the indicators tobacco use, illegal drug use, binge drinking, nutrition, obesity, exercise, sedentary lifestyle, seatbelt use, child safety seat use, bicycle helmet use, condom use, pap smear screening, and mammography screening.

Benchmarks

These are points of reference or a standard against which measurements can be compared. In the context of indicators and public health, a benchmark is an accurate data point, which is used as a reference for future comparisons, similar to a baseline.

Centers for Disease Control and Prevention (CDC)

The CDC is one of the major operating components of the Department of Health and Human Services. The CDC's mission is collaborating to create the expertise, information, and tools that people and communities need to protect their health—through health promotion, prevention of disease, injury and disability, and preparedness for new health threats.

Chronic Diseases

These are diseases of long duration, generally slow progression, and can be multi-symptomatic. Examples include heart disease, stroke, cancer, arthritis, chronic respiratory diseases, and diabetes.

Community
Broad community participation is vital to a successful MAPP process. Community members should be recruited to participate on the MAPP Steering Committee. Activities for each MAPP phase should include specific consideration of ways to gain broader community member participation. This will ensure that the community's input is a driving factor.

Community Assets
Contributions made by individuals, citizen associations, and local institutions that individually or collectively build the community's capacity to assure the health, well-being, and quality of life for the community and all its members.

Community Health Assessment (CHA)
A community health assessment is a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community. An ideal assessment includes information on risk factors, quality of life, mortality, morbidity, community assets, forces of change, social determinants of health and health inequity, and information on how well the public health system provides essential services. Community health assessment data inform community decision-making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans.

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

Community Health Needs Assessment (CHNA)
Provisions of the Patient Protection and Affordable Care Act require each non-profit hospital facility in the United States to conduct a CHNA and adopt an implementation strategy to meet identified community health needs. In conducting the CHNA, non-profit hospitals are required to take into account input from persons who represent the broad interests of the community served, including those with special knowledge of or expertise in public health.

Community Member
This is anyone who works, learns, lives, and plays in the MAPP community.

Death, Illness, and Injury
Health status in a community is measured in terms of mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease). Mortality may be represented by crude rates or age-adjusted rates; by degree of premature death (Years of Productive Life Lost); and by cause (disease—cancer and non-cancer or injury—intentional, unintentional). Morbidity may be represented by age-adjusted incidence of cancer and chronic disease. This is a category recommended for collection in the Community Health Profile.

Demographic Characteristics
Demographic characteristics of a jurisdiction include measures of total population as well as 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.

Effectiveness
This is the degree to which an intervention achieves a desired outcome in practice.

Environmental Health Indicators
The physical environment directly impacts health and quality of life. Clean air, water, and safely prepared food are essential to physical health. Exposure to environmental substances, such as lead or hazardous waste, increases risk for preventable disease. Unintentional home, workplace, or recreational injuries affect all age groups and may result in premature disability or mortality. This is a category recommended for collection in the Community Health Profile.

Evaluation
This is a systematic way to improve and account for public health actions by involving procedures that are useful, feasible, ethical, and accurate.

Facilitating MAPP Organization
This is the organization(s) that is leading the MAPP efforts.

Formulate Goals and Strategies
In Phase Five, Formulate Goals and Strategies, the community identifies goals it wants to achieve and strategies it wants to implement related to strategic issues.

Four MAPP Assessments
During Phase Three, Four MAPP Assessments, qualitative and quantitative data are gathered to provide a comprehensive picture of health in the community.

Health
This is a dynamic state of complete physical, mental, spiritual, and social wellbeing and not merely the absence of disease or infirmity.

Health Disparity
Health disparities are differences in health outcomes or access to health care across populations, which result from socioeconomic, biological, and psychological factors as well as the behavior of individuals. This term does not account for the unequal structuring of life chances.

Health Equity
Health equity is the realization by *all* people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally, and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups, particularly for those who have experienced historical or contemporary injustices or socioeconomic disadvantage.

Health Inequity
Health inequities are differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.

Health Resource Availability
Factors associated with health system capacity, which may include both the number of licensed and credentialed health personnel and the physical capacity of health facilities. In addition, the health resources category includes measures of access, utilization, and cost and quality of health care and prevention services. Service delivery patterns and roles of public and private sectors as payers and/or providers may also be relevant. This is a category recommended for collection in the Community Health Profile.

Health Risk
This is a condition of humans that can be represented in terms of measurable health status or quality-of-life indicators.

Health Status
This is the current state of a given population using various indices, including morbidity, mortality, and available health resources.

Identify Strategic Issues
In Phase Four, Identify Strategic Issues, the data are analyzed to uncover the underlying themes that need to be addressed in order for a community to achieve its vision.

Incidence
This is the measure of the frequency with which new cases of illness, injury, or other health condition occur among a population during a specified period.

Indicator
This is a measure of health status or health outcome such as the number of people who contract a respiratory disease or the number of people who die from a particular chronic disease. Measures/data that describe community conditions (e.g., poverty rate, homelessness rate, number of food stamp recipients, life expectancy at birth, heart disease mortality rate) currently and over time. Helps to answer the question: How are we doing regarding the community conditions we care about?

Infectious Disease
A disease caused by the entrance into the body of a living organism (e.g., Bacteria, protozoans, fungi, or viruses). An infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person.

Injury
Any damage to the body due to acute exposure to amounts of thermal, mechanical (kinetic or potential), electrical, or chemical energy that exceed the individual's tolerance for such energy, or to the absence of such essentials as heat or oxygen. This includes intentional injuries (e.g., homicide, suicide) as well as unintentional injuries, regardless of where they occur, the activity that was taking place when the injurious event happened, or the object that was involved in the energy transfer.

Key Sponsors
These are the persons or groups that benefit from, or regularly interact with, the organizations, programs, or services of the public health system.

Local Public Health System
This is the collection of public, private and voluntary entities, as well as individuals and informal associations, that contribute to the public's health within a jurisdiction.

MAPP Core Group
This includes the two to three people who regularly support and lead the MAPP process and ensure that it moves forward.

MAPP Steering Committee
This is the 10–20 person group that gives the MAPP process direction. The Steering Committee may serve in a similar function as a board of directors and should be representative of the local public health system.

Maternal and Child Health
This is a set of programs and policies focusing on birth data and outcomes as well as mortality data for infants and children. Because maternal care is correlated with birth outcomes, measures of maternal access to, or utilization of, care is included. One of the most significant areas for monitoring and comparison relates to the health of a vulnerable population: infants and children. Births to teen mothers are a critical indicator of increased risk for both mother and child. This is a category recommended for collection in the Community Health Profile.

Mobilizing for Action through Planning and Partnerships (MAPP)
This is a community-wide strategic planning process for improving public health.

National Association of County and City Health Officials (NACCHO)
NACCHO's members are the approximate 2,700 local health departments across the United States. NACCHO's vision is health, equity, and security for all people in their communities through public health policies and services. NACCHO's mission is to be a leader, partner, catalyst, and voice for local health departments in order to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives.

National Public Health Performance Standards (NPHPS)
The NPHPS is designed to measure public health practices at the state and local levels. Three NPHPS instruments exist to measure local, state, and government provision of the 10 Essential Public Health Services, respectively. The local instrument, referred to as the local public health system assessment in Mobilizing for Action through Planning and Partnerships (MAPP), evaluates the capacity of local public health systems to deliver the 10 Essential Public Health Services. The NPHPS Local Instrument is the instrument used to complete the Local Public Health System Assessment in MAPP.

Organize for Success/Partnership Development
In Phase One, Organize for Success/Partnership Development, community members and agencies form a partnership and learn about the MAPP process.

Prevalence
This is the number or proportion of cases or events or attributes among a given population.

Primary Data Collection
Primary data are data observed or collected from original sources, ranging from more scientifically rigorous approaches such as randomized controlled trials to less rigorous approaches such as case studies.

Public Health
This is the science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of the social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health.

Quality Improvement
This is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes that achieve equity and improve the health of the community.

Quality of Life
While some dimensions of quality of life can be quantified using indicators that research has shown to be related to determinants of health and community wellbeing, other valid dimensions of quality of life include the perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life. This is a category recommended for collection in the Community Health Profile.

Secondary Data
These are data that have been collected in the past, collected by other parties, or result from combining data or information from existing sources.

Sentinel Events
These are cases of unnecessary disease, disability, or untimely death that could be avoided if appropriate and timely preventive services or medical care were provided. These include vaccine-preventable illness, avoidable hospitalizations (those patients admitted to the hospital in advanced stages of disease which potentially could have been detected or treated earlier), late stage cancer diagnosis, and unexpected syndromes or infections. Sentinel events may alert the community to health system problems such as inadequate vaccine coverage or lack of primary care and/or screening. This is a category recommended for collection in the Community Health Profile.

Social and Mental Health
This data category represents social and mental factors and conditions, which directly or indirectly influence overall health status and individual and community quality of life. This is a category recommended for collection in the Community Health Profile.

Social Determinants of Health (SDH) Inequity
This is the complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, and health services; structural and societal factors that are responsible for most health inequities. SDH are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices.

Socioeconomic Characteristics
Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education, and employment, and the proportion of the population represented by various levels of these variables. This is a category recommended for collection in the Community Health Profile.

Stakeholders
All persons, agencies, and organizations with an investment or "stake" in the health of the community and the local public health system. This broad definition includes persons and organizations that benefit from and/or participate in the delivery of services that promote the public's health and overall wellbeing.

Sticky Wall™
A Sticky Wall™ is a large sheet of nylon that is sprayed with adhesive that allows paper to stick to it.

Strategic Plan
This is a plan resulting from a deliberate decision-making process that defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward.

Sub-committee
For several phases of MAPP, especially the Four MAPP Assessments, it is recommended that sub-committees be designated to oversee the work. The sub-committee should include representation from the MAPP Steering Committee. Other individuals from outside the Steering Committee may also be recruited for their specific expertise, skills, or knowledge. Generally, sub-committees are composed of five to eight individuals. However, some phases (such as the MAPP Assessments) may warrant more members.

Technical Assistance
An array of support, including advice, recommendations, information, demonstrations, and materials, provided to assist the workforce or organizations in improving public health services.

Visioning
During Phase Two, Visioning, those who work, learn, live, and play in the MAPP community create a common understanding of what it would like to achieve. The community decides the vision, which is the focus of the MAPP process.

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Health Equity

Mobilizing and Organizing Partners to Achieve Health Equity

"Health equity is the realization by all people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally, and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups."

—Adewale Troutman in ***Health Equity, Human Rights and Social Justice: Social Determinants as the Direction for Global Health***

Achieving health equity requires collaboration, coordination, and collective action. The Mobilizing for Action through Planning and Partnerships (MAPP) process can help communities develop a culture of continuous collaborative health improvement that can guide them through this process. This supplement provides tools and resources for communities that seek to frame their MAPP process around health equity.

Addressing health inequities can be an ever-evolving, unpredictable process. Often, no right or wrong answer exists for how to achieve health equity. Communities may find themselves at different stages of readiness to tackle the complex questions and issues that underlie the root causes of health inequities.

Each MAPP community should consider its own expectations, goals, and vision as it undertakes health equity work and use the provided tools as appropriate. NACCHO staff and the MAPP Network (**http://mappnetwork.naccho.org**) are available as resources for MAPP and invite your thoughts and suggestions as you work in your communities on this process.

Health Equity

How to Use this Supplement

All stages of the MAPP process can be conducted with a health equity frame. Accordingly, the pages in this supplement are meant to be integrated into your MAPP Handbook. The page numbers below show where each health equity page can be inserted into your book. For example, "Getting Started, page 6a," can be inserted behind page 6 of your existing book.

Introduction	• Getting Started (page 6a) • Selecting a Facilitator (page 6b)
Phase 1	• Revisit Your Circle of Involvement (page 18a)
Phase 2	• Creating a Vision for Health Equity (page 38a)
Phase 3	• Community Health Status Assessment: Measuring Health Inequity (pages 56a-56b) • Reflecting on Health Disparities and Health Inequity Data (page 68a) • Local Public Health System Assessment: System Contributions to Assuring Health Equity (pages 72a-72d) • Forces of Change Assessment: Identify Forces that Affect Health Equity (page 76a)
Phase 4	• Identifying Strategic Health Equity Issues (page 88a) • Identifying Root Causes of Health Inequity (page 92a)
Phase 5	• Developing Health Equity Strategic Issues, Goals, and Strategies (page 104a)
Phase 6	• An Action Cycle for Achieving Health Equity (page 118a)
Health Equity References	• Page 136a

Health Equity

Health Equity in MAPP

Achieving health equity involves identifying, preventing, and reversing the effects of patterned decisions, policies, investments, rules, and laws that have caused social and economic inequities that affect people's abilities to live healthy lives.

Using a Health Equity Frame

The way people interpret and organize information influences the way they define a problem and how they devise strategies to solve it. As people work on protecting and preserving the public's health, they may not realize that they are influenced by certain values, assumptions, and perspectives. Frames define the following:

- Legitimate and trustworthy sources of knowledge;
- Which research questions people pursue or ignore (e.g., do we study the poor, or do we study which policies produce poverty?);
- The attribution of responsibility for health or illness (To individuals? Or systems?);
- Appropriate targets for policy; and
- How and where to use resources.

Questions are never neutral. Rather, people apply frames that influence the questions they ask. Questions are posed within specific social, political, historical, and cultural contexts. Questions are often driven by institutional agendas, values, and priorities that may or may not address community members' needs and wants.

"Health equity is the realization by all people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups, particularly those who have experienced historical or contemporary injustices or socioeconomic disadvantage."

—Adewale Troutman in *Health Equity, Human Rights and Social Justice: Social Determinants as the Direction for Global Health*

Health inequities are "differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill."

—Margaret Whitehead in *The Concepts and Principles of Equity and Health*

Selecting a Facilitator

Communities can use facilitators throughout the Mobilizing for Action through Planning and Partnerships (MAPP) process to help guide group discussions. Discussions that identify sources of health inequity can be difficult to facilitate. People may feel uncomfortable discussing racism, classism, and gender inequity. Some people might feel personally attacked or responsible, while others might deny inequities exist. People might feel the problem is outside their control or too much to tackle. They may find it easier to maintain and not challenge the status quo.

A skilled facilitator brings attention to emotions, contradictions, and discomfort that often arise when discussing the root causes of health inequity and uses the tensions to identify systemic, structural, and institutional changes that can result in health equity. When selecting a facilitator, consider someone who can skillfully do the following:

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

Resources for Understanding Health Equity

The following resources may help communities as they seek to achieve health equity. These tools can help individuals and groups develop a common framework for understanding health equity and facilitate meaningful dialogue about the root causes of health inequity.

Assessing Readiness for Addressing Health Inequities

Community partners can use the Organizational Self-Assessment for Addressing Health Inequities Toolkit developed by the Bay Area Regional Health Inequities Initiative (http://barhii.org/resources/toolkit.html) to determine if they are ready to address health inequities. The toolkit helps organizations identify the skills, practices, and infrastructure needed to achieve health equity.

Roots of Health Inequity Web-Based Course

Communities can use the Roots of Health Inequity Web-Based Course (http://www.rootsofhealthinequity.org/) to educate public health leaders. The course includes interactive content, case studies, questions for reflection and group discussion. MAPP participants can use the course to develop a common framework for understanding health equity.

Unnatural Causes Dialogue

Many communities have screened the Unnatural Causes documentary series (http://www.unnaturalcauses.org/) and facilitated community dialogues to increase awareness and better understand the root causes of health inequity in their communities. California Newsreel, the organization that produced the documentary series, provides a discussion guide on its website to help people digest, reflect, and apply the knowledge that is gained from viewing the documentary series.

The Raising of America

The makers of Unnatural Causes will release The Raising of America in fall 2014. This documentary series will encourage viewers to facilitate dialogue about improving early child health and development to create a healthier, more prosperous, and more equitable nation. The series' website (http://www.raisingofamerica.org/) provides tools to promote community engagement and discussion.

Circles of Involvement

Developing Key Relationships for Implementation

Health Equity

Revisit Your Circle of Involvement

To identify, communicate, and develop strategies to achieve health equity, you need to mobilize and organize the right people. Reference the individuals, groups, and organizations you have included in your Circle of Involvement worksheet.

Ask members of the MAPP Core Group whether your Circle of Involvement includes the following:

- Population groups that are affected by decisions, policies, investments, rules, and laws that have compromised their abilities to live healthy lives. These groups include people who are the subject of racism, gender inequity, and class exploitation;
- People who have knowledge about the structure of power and patterns of decisions, policies, investments, rules, and laws that have caused health inequity;
- Groups that can influence processes that can combat, reverse, and prevent decisions, policies, investments, rules, and laws that have caused health inequity;
- People who know how to measure social, economic, and health inequities;
- Groups that can communicate the causes of health inequities in a way that inspires people to work on achieving health equity; and
- People who can facilitate productive discussions about health inequities that result in strategies and collaborative action.

Engage individuals and groups that are committed to achieving social justice and health equity, have power and influence in the community, and can be allies in an equitable partnership. Examples of groups that could have representation in your Circle of Involvement include the following:

- Civil rights organizations;
- Labor organizations;
- Organizations representing minority groups, including religious minorities, immigrant populations, and English as a foreign language groups;
- Housing authorities and service providers for the homeless;
- Community development organizations;
- Community organizing groups;
- Women's rights organizations;
- Gay, lesbian, bisexual, transgender organizations;
- Child advocacy groups;
- Developmental and physical disability rights organizations;
- Mental health advocacy organizations; and
- Organizations dedicated to transparency, accountability, representation, participation, and inclusiveness in democracy.

Creating a Vision for Health Equity

MAPP Communities can create vision statements that aim to achieve health equity. When planning a visioning event, consider asking participants the following visioning questions:

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

Also consider asking the following questions to generate **value** statements that will guide your collaborative process:

- What must be in place to ensure our MAPP process is equitable, transparent, accessible, and inclusive, particularly of those affected by inequity?
- What values must we uphold to ensure equitable participation?
- How do we ensure we do not inadvertently create, contribute, 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 to those affected by inequity?

Brainwriting is a technique that can help foster participation among all members in a group. After providing a prompt, ask each person to reflect and write his or her ideas on a sheet of paper without talking. After a limited amount of time, have people pass their papers to another person. Each person will then review the previous person's ideas and add to their thoughts. Repeat the process several times.

In Ingham County, Michigan, the health department convened staff dialogues to ask questions like, "If Ingham County were to address racism in a meaningful way, internally or externally, what would it look like?"

Community Health Status Assessment: Measuring Health Inequity

Several approaches exist for exploring and documenting areas of health inequity as part of the Community Health Status Assessment. All three of the following strategies should be used to identify patterns of health inequity in a community.

1. Cross-Tabulations that Measure Health Disparities

Health disparities are differences in health status. The term "health disparities" is not the same as "health equity." "Health disparities" describes simply differences in health outcomes among groups and does not describe the reasons why differences in health status exist. Still, information about health disparities can provide insight on health inequities depending on how the data are analyzed and discussed.

Cross-tabulations can be used to identify differences in health status among different groups. For instance, you can collect data on cardiovascular disease prevalence. You can also collect data on race and gender. You can then use cross-tabulations to see if there are differences in the prevalence of cardiovascular disease based on race and gender.

	White		Black		Hispanic/Latino		Asian-Pacific Islander		Native Indian/ Alaska Native	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Prevalence of diabetes in the county										
Infant mortality rate										
Prevalence of youth violence										

	Unemployed		Employed, part-time		Employed, full-time	
	Male	Female	Male	Female	Male	Female
Prevalence of heart disease						

Examples of data that should be collected and used in cross-tabulations to identify health disparities include the following:

- Income;
- Race;
- Ethnicity;
- Immigration status;
- Gender;
- Sexual identity;
- Education;
- Age;
- Employment status; and
- Homeownership and housing status.

These categories represent segments of your population that may experience different health outcomes. Comparing the health status of subgroups to those with the worst, the best, or the average or median health status can give you insight into groups affected by inequity. You can also compare subgroup health status with targets such as Healthy People 2020 objectives.

Community Health Status Assessment: Measuring Health Inequity continued

2. Indicators of Inequity

In addition to measuring health disparities, you should include measures of social and economic inequity. As with health outcomes, many indicators of socioeconomic status can be stratified by demographic category to show how different groups are affected by inequity.

	White		Black		Hispanic/Latino		Asian-Pacific Islander		Native Indian/ Alaska Native	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
High school graduation rate										
Percent living in poverty										

Example indicators of inequity that can be included in a Community Health Status Assessment include the following:

- Median household income;
- Percent of people living in poverty;
- Median value of owner-occupied homes;
- Percent of households below poverty;
- Percent of children under 18 in poverty;
- Unemployment;
- Percent of people without car ownership;
- Percent of renters;
- Civic engagement[1];
- High school graduation rate;
- Income inequality[2];
- Wealth inequality;
- Segregation[3];
- Bank loans by race, income, gender, and neighborhood;
- Political participation by race, income, and gender;
- Allocation of city or county budget by neighborhood;
- Level of housing inspections by neighborhood;
- Home foreclosure rates by neighborhood; and
- Disinvestments in community (e.g., outsourcing jobs to other countries).

Visit the Connecticut Association of Directors of Health's Health Equity Index (https://www.sdoh.org/) for examples of maps and health equity data. Hear the association discuss how it developed and used the Health Equity Index through NACCHO University's eLearning module, "Health Equity, Data Collection, and Analysis," available at http://www.naccho.org/university.cfm.

Alameda County analyzed data by neighborhood and found that in 2003, nearly 41% of African Americans and 26% of Latinos resided in higher-poverty neighborhoods, compared to 4% of Whites.

3. Geographic Mapping to Uncover Patterns on Health Inequity

Communities can use geographic mapping of data on health disparities and inequity to uncover patterns of health inequity. Geographic mapping provides pictures of where people are most affected by poor health status and areas where people experience relative good health. To map health status, you will need to have geographic data indicators such as zip code, census tract, or county residence. You can map health status by where people live. You can also overlay different measures of health status, race, ethnicity, age, income, immigration status, gender, and education to see patterns of inequity. Creating maps that show changes over time provides information on how inequities accumulate and concentrate over time.

[1] Examples of measures of civic engagement can be found at http://www.civicyouth.org/tools-for-practice/survey-measures-of-civic-engagement/

[2] Examples of measures of income inequality can be found in De Maio, F. (2007). Income inequality measures. *Journal of Epidemiology and Community Health*, 61(10):849–852.

[3] Examples of measures of segregation can be found at https://www.census.gov/hhes/www/housing/housing_patterns/pdf/app_b.pdf

Reflecting on Health Disparities and Health Inequity Data

The Community Themes and Strengths Assessment can be used to collect information about how community members experience the effects of health inequities. You can design this assessment to investigate what in your community currently and historically has contributed to health inequities identified in the Community Health Status Assessment. You can use the following questions to engage your community members in a conversation about the root causes of health inequities. Be sure to include individuals affected by inequity in your conversations.

1. What patterns do you see in the health inequity data?
2. Think about the groups that experience relatively good health and those that experience poor health. Why do you think there is a difference?
3. If you have identified individual behavioral reasons for differences in health status among different groups, what are some reasons why it is easier for some to make healthy choices than others?
4. What assets exist in our community? Where are these assets located, and who has access to them? How do these assets support health?
5. Who is in charge at local agencies, retail stores, healthcare providers, schools, and other institutions in our community? How do these institutions support or inhibit health?
6. What conditions (excluding individual behavior) in a community support some groups' abilities to experience better health than others? What conditions in a community inhibit some groups' abilities to experience good health? Who makes decisions that influence these conditions? What motivates the decisions they make that results in differences in health status? Where does power to make these decisions come from?
7. What public and corporate policies support healthy living? What policies inhibit healthy living? Which groups are affected by these policies? Who has the power to make and implement those policies? What motivates them to develop policies that favor some over others?

Measure the Effects of Discrimination on Health

Consider using **Experiences of Discrimination** survey questions in your Community Health Themes and Strengths Assessment. This survey is a reliable and valid instrument for measuring the experiences of discrimination. The results can be used to understand the extent to which your community experiences discrimination. When analyzed together with Community Health Status Assessment data, your community can get a picture of how discrimination is associated with poor health outcomes.

Conditions that Support Health Equity

The Connecticut Association of Directors of Health has identified nine social determinant domains. The following domains can be used to structure a Community Themes and Strengths Assessment that focuses on health inequity.

1. Economic security and financial resources;
2. Livelihood security and employment opportunity;
3. School readiness and educational attainment;
4. Environmental quality;
5. Availability and utilization of quality medical care;
6. Adequate, affordable, and safe housing;
7. Community safety and security;
8. Civic involvement; and
9. Transportation.

Local Public Health System Assessment continued

Health Equity

System Contributions to Assuring Health Equity

When completing the Local Public Health System (LPHS) Assessment using the National Public Health Performance Standards (NPHPS) Instrument, your group can reframe questions about essential service delivery to identify how well the LPHS acknowledges and addresses health inequities. The following questions provide examples of how the instrument can be revised to focus on health equity.

Essential Public Health Service 1: Monitoring Health Status

At what level does the LPHS…

- Conduct a community health assessment that includes indicators intended to monitor differences in health and wellness across populations, according to race, ethnicity, age, income, immigration status, sexual identify, education, gender, and neighborhood?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Monitor social and economic conditions that affect health in the community, as well as institutional practices and policies that generate those conditions?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 2: Diagnosing and Investigating Health Problems

At what level does the LPHS…

- Operate or participate in surveillance systems designed to monitor health inequities and identify the social determinants of health inequities specific to the jurisdiction and across several of its communities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Collect reportable disease information from community health professionals about health inequities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Have the necessary resources to collect information about specific health inequities and investigate the social determinants of health inequities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 3: Inform, Educate, and Empower People about Health Issues

At what level does the LPHS…

- Provide the general public, policymakers, and public and private stakeholders with information about health inequities and the impact of government and private sector decision-making on historically marginalized communities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide information about community health status (e.g., heart disease rates, cancer rates, and environmental risks) and community health needs in the context of health equity and social justice?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Plan and conduct health promotion and education campaigns that are appropriate to culture, age, language, gender, socioeconomic status, race/ethnicity, and sexual orientation?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Plan campaigns that identify the structural determinants of health inequities and the social determinants of health inequities (rather than focusing solely on individuals' health behaviors and decision-making)?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 4: Mobilizing Community Partnerships to Identify and Solve Health Problems

At what level does the LPHS…

- Have a process for identifying and engaging key constituents and participants that recognizes and supports differences among groups?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide institutional means for community-based organizations and individual community members to participate fully in decision-making?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide community members with access to community health data?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 5: Developing Policies and Plans that Support Individual Community Health Efforts

At what level does the LPHS…

- Ensure that community-based organizations and individual community members have a substantive role in deciding what policies, procedures, rules, and practices govern community heath efforts?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

At what level does the LPHS…

- Identify local public health issues that have a disproportionate impact on historically marginalized communities (that are not adequately addressed through existing laws, regulations, and ordinances)?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

System Contributions to Assuring Health Equity

Essential Public Health Service 7: Link People to Needed Personal Health Services

At what level does the LPHS…

- Identify any populations that may experience barriers to personal health services based on factors such as on age, education level, income, language barriers, race or ethnicity, disability, mental illness, access to insurance, sexual orientation and gender identity, and additional identities outlined in Model Standard 7.1?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Identify the means through which historical social injustices specific to the jurisdiction (e.g., the inequitable distribution health services and transportation resources) may influence access to personal health services?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Work to influence laws, policies, and practices that maintain inequitable distributions of resources that may influence access to personal health services?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 8: Assure a Competent and Personal Health Care Workforce

At what level does the LPHS…

- Conduct assessments related to developing staff capacity and improving organizational functioning to support health equity initiatives?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Identify staff perspectives on the facilitators and barriers to addressing health equity initiatives?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Include staff members that are often excluded from planning and organizational decision-making processes in workforce assessments?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Recruit and train staff members from multidisciplinary backgrounds that are committed to achieving health equity?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Recruit and train staff members that reflect the communities they serve?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Local Public Health System Assessment continued

System Contributions to Assuring Health Equity

Essential Public Health Service 9: Evaluate the Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

At what level does the LPHS…

- Identify community organizations or entities that contribute to the delivery of the Essential Public Health Services to historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Monitor the delivery of the Essential Public Health Services to ensure that they are equitably distributed?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

Essential Public Health Service 10: Research for New Insights and Innovative Solutions to Health Problems

At what level does the LPHS…

- Encourage staff, research organizations, and community members to explore the root causes of health inequity, including solutions based on research identifying the health impact of structural racism, gender and class inequity, social exclusion, and power differentials?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Share information and strategize with other organizations invested in eliminating health inequity?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Use Health Equity Impact Assessments to analyze the potential impact of local policies, practices, and policy changes on historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Facilitate substantive community participation in the development and implementation of research about the relationships between structural social injustices and health status?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

Forces of Change Brainstorming

Forces of Change Assessment: Identify Forces that Affect Health Equity

Questions to Identify Forces

Powerful organized interests develop structures and support policies and practices that can either contribute to health equity or cause health inequities. The following questions can be answered during the Forces of Change Assessment to identify these forces, opportunities, and threats.

- What patterns of decisions, policies, investments, rules, and laws affect the health of our community?
- Who benefits from these decisions, policies, investments, rules, and laws?
- Whom do these decisions, policies, investments, rules, and laws harm?
- Who or what institutions have the power to create, enforce, implement, and change these decisions, policies, investments, rules, and laws?
- What interests support or oppose actions that contribute to health inequity?
- What opportunities exist to influence decisions, policies, investments, rules, and laws to benefit all groups?
- What forces now and in the future can reinforce health inequity in our community? How can we mitigate or prevent these forces?
- What forces now and in the future can reinforce health equity in our community? How can we take advantage of these forces?

When posing these questions, be sure to include people that are affected by health inequity.

Identifying Strategic Issues to Address Health Equity

As you develop strategic issues, remember that questions are never neutral. Rather, people apply frames that influence the questions they ask. They are posed within specific social, political, historical, and cultural contexts. Questions are often driven by institutional agendas, values, and priorities that may or may not address community members' needs and wants.

The following table contrasts conventional and health equity questions that can be used to understand public health problems and identify potential solutions. When analyzing data from the MAPP Assessments to identify strategic issues, use a health equity frame to ask your community these questions.

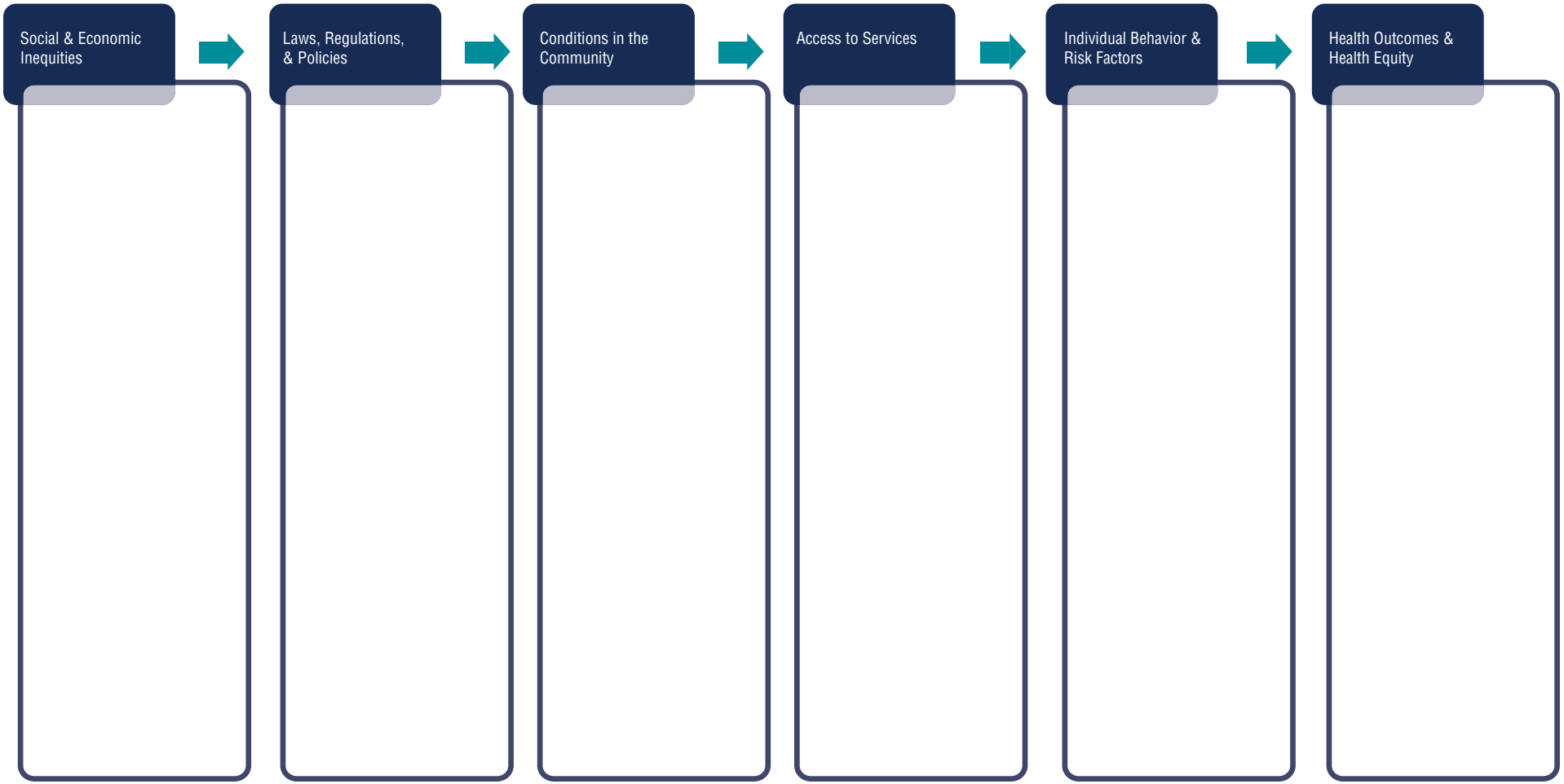
CONVENTIONAL APPROACH	HEALTH EQUITY APPROACH
Why are people unhealthy in our community?	What social conditions and economic policies make some people more likely to be unhealthy?
Why can't vulnerable populations access services?	What institutional policies and practices prevent people from accessing services?
What types of services and resources do we need to improve health?	What fundamental policy changes do we need?
How do we reduce disparities in health outcomes?	How do we eliminate the social injustices that produce inequities in health outcomes?
What programs and services do we need to address health disparities?	What kind of collective action and structural social changes do we need to tackle health inequities?
What unhealthy behaviors should we discourage among vulnerable populations?	What interests and power structures affect people's health and wellness?
Which government officials, expert researchers, or media personalities best understand the issue?	Which community members and grassroots organizations can best define the issue?
Which public officials and research institutions will decide on appropriate courses of action?	How can we work within our communities to define and prioritize public health concerns?
How can we make people more responsible for their own health?	How can we create social responsibility and public accountability to protect the public good?

Identifying Root Causes of Health Inequity

Ask community members to review data from the four MAPP Assessments. Ask them to map the data to show what they learned about relationships among the following:

- Health outcomes and health equity (from Community Health Status Assessment);
- Individual behavior and risk factors (from Community Health Status Assessment);
- Access to services (from Local Public Health System Assessment);
- Conditions in the community (from Community Themes and Strengths Assessment);
- Law, regulations, and policies (from Local Public Health System Assessment and Community Themes and Strengths Assessment); and
- Social and economic inequities (from Community Health Status Assessment and Community Themes Assessment).

Ask your community members to share how social and economic inequities affect how laws, regulations, and policies decisions are made and how those decisions shape the conditions in the community that affect how people can access services, engage in healthy living, and maximize their health outcomes.



Developing Health Equity Strategic Issues, Goals, and Strategies

Given what group members share, ask them what fundamentally has to change in the community to achieve health equity. Fundamental change may be in the form of the following:

- Policies, laws, and decision-making processes;
- Redistribution of power in decision-making;
- Reallocation of resources;
- Transparency in decision-making processes that support social and economic equity;
- Mobilizing, engaging, and sharing power and resources with those affected by inequity; and
- Accountability in decision-making.

Use information from the discussion to develop strategic issues, goals, and strategies.

Example of a Health Equity Strategic Issue, Goal, and Strategy

Strategic Issue:
How can the public health community address shortened life spans and inferior quality of life for communities of color and poor communities?

Goal:
Prevent land use policies that expose neighborhoods and community members to environmental hazards, displacement, and sprawl.

Strategy:
Forge relationships with social movements rooted in developed coalitions and provide technical assistance that fuels advocacy.

In the rural community of Mound Bayou, Mississippi, the Delta Health Center helped establish a bank branch where local black community members were hired as tellers and supervisors. As a result, racial discrimination in mortgage lending decreased.

An Action Cycle for Achieving Health Equity

When identifying actions for achieving health equity, remember to use a health equity frame and the data about health inequities collected in the MAPP Assessment phase. The table below contrasts remedial actions that do not address root causes of inequity with actions that investigate, reverse, or prevent the causes of health inequity.

Remedial Actions	Health Equity Actions
Track health outcomes by county	Track the accumulation of health-harming conditions and decision processes that produce those conditions
Treat or repair people's health and life conditions	Tackle negative life conditions with the goal of permanent social change to prevent reproduction of conditions
Support subsidies for low-income housing	Oppose discriminatory housing practices and gentrification that causes displacement
Regulate permissible levels of toxic chemicals	Limit the production of toxic chemicals and disproportionate burden on communities of color
Provide inhalers and clinical services to those communities with high asthma rates	Prevent the predominant location of polluting sites in communities of color and communities with low income levels

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Health Equity

Mobilizing and Organizing Partners to Achieve Health Equity

"Health equity is the realization by all people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally, and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups."

—Adewale Troutman in ***Health Equity, Human Rights and Social Justice: Social Determinants as the Direction for Global Health***

Achieving health equity requires collaboration, coordination, and collective action. The Mobilizing for Action through Planning and Partnerships (MAPP) process can help communities develop a culture of continuous collaborative health improvement that can guide them through this process. This supplement provides tools and resources for communities that seek to frame their MAPP process around health equity.

Addressing health inequities can be an ever-evolving, unpredictable process. Often, no right or wrong answer exists for how to achieve health equity. Communities may find themselves at different stages of readiness to tackle the complex questions and issues that underlie the root causes of health inequities.

Each MAPP community should consider its own expectations, goals, and vision as it undertakes health equity work and use the provided tools as appropriate. NACCHO staff and the MAPP Network (**http://mappnetwork.naccho.org**) are available as resources for MAPP and invite your thoughts and suggestions as you work in your communities on this process.

Health Equity

How to Use this Supplement

All stages of the MAPP process can be conducted with a health equity frame. Accordingly, the pages in this supplement are meant to be integrated into your MAPP Handbook. The page numbers below show where each health equity page can be inserted into your book. For example, "Getting Started, page 6a," can be inserted behind page 6 of your existing book.

Introduction	• Getting Started (page 6a) • Selecting a Facilitator (page 6b)
Phase 1	• Revisit Your Circle of Involvement (page 18a)
Phase 2	• Creating a Vision for Health Equity (page 38a)
Phase 3	• Community Health Status Assessment: Measuring Health Inequity (pages 56a-56b) • Reflecting on Health Disparities and Health Inequity Data (page 68a) • Local Public Health System Assessment: System Contributions to Assuring Health Equity (pages 72a-72d) • Forces of Change Assessment: Identify Forces that Affect Health Equity (page 76a)
Phase 4	• Identifying Strategic Health Equity Issues (page 88a) • Identifying Root Causes of Health Inequity (page 92a)
Phase 5	• Developing Health Equity Strategic Issues, Goals, and Strategies (page 104a)
Phase 6	• An Action Cycle for Achieving Health Equity (page 118a)
Health Equity References	• Page 136a

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Health Equity

Health Equity in MAPP

Achieving health equity involves identifying, preventing, and reversing the effects of patterned decisions, policies, investments, rules, and laws that have caused social and economic inequities that affect people's abilities to live healthy lives.

Using a Health Equity Frame

The way people interpret and organize information influences the way they define a problem and how they devise strategies to solve it. As people work on protecting and preserving the public's health, they may not realize that they are influenced by certain values, assumptions, and perspectives. Frames define the following:

- Legitimate and trustworthy sources of knowledge;
- Which research questions people pursue or ignore (e.g., do we study the poor, or do we study which policies produce poverty?);
- The attribution of responsibility for health or illness (To individuals? Or systems?);
- Appropriate targets for policy; and
- How and where to use resources.

Questions are never neutral. Rather, people apply frames that influence the questions they ask. Questions are posed within specific social, political, historical, and cultural contexts. Questions are often driven by institutional agendas, values, and priorities that may or may not address community members' needs and wants.

"Health equity is the realization by all people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups, particularly those who have experienced historical or contemporary injustices or socioeconomic disadvantage."

—Adewale Troutman in *Health Equity, Human Rights and Social Justice: Social Determinants as the Direction for Global Health*

Health inequities are "differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill."

—Margaret Whitehead in *The Concepts and Principles of Equity and Health*

Selecting a Facilitator

Communities can use facilitators throughout the Mobilizing for Action through Planning and Partnerships (MAPP) process to help guide group discussions. Discussions that identify sources of health inequity can be difficult to facilitate. People may feel uncomfortable discussing racism, classism, and gender inequity. Some people might feel personally attacked or responsible, while others might deny inequities exist. People might feel the problem is outside their control or too much to tackle. They may find it easier to maintain and not challenge the status quo.

A skilled facilitator brings attention to emotions, contradictions, and discomfort that often arise when discussing the root causes of health inequity and uses the tensions to identify systemic, structural, and institutional changes that can result in health equity. When selecting a facilitator, consider someone who can skillfully do the following:

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

Resources for Understanding Health Equity

The following resources may help communities as they seek to achieve health equity. These tools can help individuals and groups develop a common framework for understanding health equity and facilitate meaningful dialogue about the root causes of health inequity.

Assessing Readiness for Addressing Health Inequities

Community partners can use the Organizational Self-Assessment for Addressing Health Inequities Toolkit developed by the Bay Area Regional Health Inequities Initiative (http://barhii.org/resources/toolkit.html) to determine if they are ready to address health inequities. The toolkit helps organizations identify the skills, practices, and infrastructure needed to achieve health equity.

Roots of Health Inequity Web-Based Course

Communities can use the Roots of Health Inequity Web-Based Course (http://www.rootsofhealthinequity.org/) to educate public health leaders. The course includes interactive content, case studies, questions for reflection and group discussion. MAPP participants can use the course to develop a common framework for understanding health equity.

Unnatural Causes Dialogue

Many communities have screened the Unnatural Causes documentary series (http://www.unnaturalcauses.org/) and facilitated community dialogues to increase awareness and better understand the root causes of health inequity in their communities. California Newsreel, the organization that produced the documentary series, provides a discussion guide on its website to help people digest, reflect, and apply the knowledge that is gained from viewing the documentary series.

The Raising of America

The makers of Unnatural Causes will release The Raising of America in fall 2014. This documentary series will encourage viewers to facilitate dialogue about improving early child health and development to create a healthier, more prosperous, and more equitable nation. The series' website (http://www.raisingofamerica.org/) provides tools to promote community engagement and discussion.

Circles of Involvement

Developing Key Relationships for Implementation

Health Equity

Revisit Your Circle of Involvement

To identify, communicate, and develop strategies to achieve health equity, you need to mobilize and organize the right people. Reference the individuals, groups, and organizations you have included in your Circle of Involvement worksheet.

Ask members of the MAPP Core Group whether your Circle of Involvement includes the following:

- Population groups that are affected by decisions, policies, investments, rules, and laws that have compromised their abilities to live healthy lives. These groups include people who are the subject of racism, gender inequity, and class exploitation;
- People who have knowledge about the structure of power and patterns of decisions, policies, investments, rules, and laws that have caused health inequity;
- Groups that can influence processes that can combat, reverse, and prevent decisions, policies, investments, rules, and laws that have caused health inequity;
- People who know how to measure social, economic, and health inequities;
- Groups that can communicate the causes of health inequities in a way that inspires people to work on achieving health equity; and
- People who can facilitate productive discussions about health inequities that result in strategies and collaborative action.

Engage individuals and groups that are committed to achieving social justice and health equity, have power and influence in the community, and can be allies in an equitable partnership. Examples of groups that could have representation in your Circle of Involvement include the following:

- Civil rights organizations;
- Labor organizations;
- Organizations representing minority groups, including religious minorities, immigrant populations, and English as a foreign language groups;
- Housing authorities and service providers for the homeless;
- Community development organizations;
- Community organizing groups;
- Women's rights organizations;
- Gay, lesbian, bisexual, transgender organizations;
- Child advocacy groups;
- Developmental and physical disability rights organizations;
- Mental health advocacy organizations; and
- Organizations dedicated to transparency, accountability, representation, participation, and inclusiveness in democracy.

Creating a Vision for Health Equity

MAPP Communities can create vision statements that aim to achieve health equity. When planning a visioning event, consider asking participants the following visioning questions:

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

Also consider asking the following questions to generate **value** statements that will guide your collaborative process:

- What must be in place to ensure our MAPP process is equitable, transparent, accessible, and inclusive, particularly of those affected by inequity?
- What values must we uphold to ensure equitable participation?
- How do we ensure we do not inadvertently create, contribute, 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 to those affected by inequity?

Brainwriting is a technique that can help foster participation among all members in a group. After providing a prompt, ask each person to reflect and write his or her ideas on a sheet of paper without talking. After a limited amount of time, have people pass their papers to another person. Each person will then review the previous person's ideas and add to their thoughts. Repeat the process several times.

In Ingham County, Michigan, the health department convened staff dialogues to ask questions like, "If Ingham County were to address racism in a meaningful way, internally or externally, what would it look like?"

Community Health Status Assessment: Measuring Health Inequity

Several approaches exist for exploring and documenting areas of health inequity as part of the Community Health Status Assessment. All three of the following strategies should be used to identify patterns of health inequity in a community.

1. Cross-Tabulations that Measure Health Disparities

Health disparities are differences in health status. The term "health disparities" is not the same as "health equity." "Health disparities" describes simply differences in health outcomes among groups and does not describe the reasons why differences in health status exist. Still, information about health disparities can provide insight on health inequities depending on how the data are analyzed and discussed.

Cross-tabulations can be used to identify differences in health status among different groups. For instance, you can collect data on cardiovascular disease prevalence. You can also collect data on race and gender. You can then use cross-tabulations to see if there are differences in the prevalence of cardiovascular disease based on race and gender.

	White		Black		Hispanic/Latino		Asian-Pacific Islander		Native Indian/ Alaska Native	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Prevalence of diabetes in the county										
Infant mortality rate										
Prevalence of youth violence										

	Unemployed		Employed, part-time		Employed, full-time	
	Male	Female	Male	Female	Male	Female
Prevalence of heart disease						

Examples of data that should be collected and used in cross-tabulations to identify health disparities include the following:

- Income;
- Race;
- Ethnicity;
- Immigration status;
- Gender;
- Sexual identity;
- Education;
- Age;
- Employment status; and
- Homeownership and housing status.

These categories represent segments of your population that may experience different health outcomes. Comparing the health status of subgroups to those with the worst, the best, or the average or median health status can give you insight into groups affected by inequity. You can also compare subgroup health status with targets such as Healthy People 2020 objectives.

Community Health Status Assessment: Measuring Health Inequity continued

2. Indicators of Inequity

In addition to measuring health disparities, you should include measures of social and economic inequity. As with health outcomes, many indicators of socioeconomic status can be stratified by demographic category to show how different groups are affected by inequity.

	White		Black		Hispanic/Latino		Asian-Pacific Islander		Native Indian/ Alaska Native	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
High school graduation rate										
Percent living in poverty										

Example indicators of inequity that can be included in a Community Health Status Assessment include the following:

- Median household income;
- Percent of people living in poverty;
- Median value of owner-occupied homes;
- Percent of households below poverty;
- Percent of children under 18 in poverty;
- Unemployment;
- Percent of people without car ownership;
- Percent of renters;
- Civic engagement[1];
- High school graduation rate;
- Income inequality[2];
- Wealth inequality;
- Segregation[3];
- Bank loans by race, income, gender, and neighborhood;
- Political participation by race, income, and gender;
- Allocation of city or county budget by neighborhood;
- Level of housing inspections by neighborhood;
- Home foreclosure rates by neighborhood; and
- Disinvestments in community (e.g., outsourcing jobs to other countries).

Visit the Connecticut Association of Directors of Health's Health Equity Index (https://www.sdoh.org/) for examples of maps and health equity data. Hear the association discuss how it developed and used the Health Equity Index through NACCHO University's eLearning module, "Health Equity, Data Collection, and Analysis," available at http://www.naccho.org/university.cfm.

Alameda County analyzed data by neighborhood and found that in 2003, nearly 41% of African Americans and 26% of Latinos resided in higher-poverty neighborhoods, compared to 4% of Whites.

3. Geographic Mapping to Uncover Patterns on Health Inequity

Communities can use geographic mapping of data on health disparities and inequity to uncover patterns of health inequity. Geographic mapping provides pictures of where people are most affected by poor health status and areas where people experience relative good health. To map health status, you will need to have geographic data indicators such as zip code, census tract, or county residence. You can map health status by where people live. You can also overlay different measures of health status, race, ethnicity, age, income, immigration status, gender, and education to see patterns of inequity. Creating maps that show changes over time provides information on how inequities accumulate and concentrate over time.

[1] Examples of measures of civic engagement can be found at http://www.civicyouth.org/tools-for-practice/survey-measures-of-civic-engagement/

[2] Examples of measures of income inequality can be found in De Maio, F. (2007). Income inequality measures. *Journal of Epidemiology and Community Health*, 61(10):849–852.

[3] Examples of measures of segregation can be found at https://www.census.gov/hhes/www/housing/housing_patterns/pdf/app_b.pdf

Reflecting on Health Disparities and Health Inequity Data

The Community Themes and Strengths Assessment can be used to collect information about how community members experience the effects of health inequities. You can design this assessment to investigate what in your community currently and historically has contributed to health inequities identified in the Community Health Status Assessment. You can use the following questions to engage your community members in a conversation about the root causes of health inequities. Be sure to include individuals affected by inequity in your conversations.

1. What patterns do you see in the health inequity data?
2. Think about the groups that experience relatively good health and those that experience poor health. Why do you think there is a difference?
3. If you have identified individual behavioral reasons for differences in health status among different groups, what are some reasons why it is easier for some to make healthy choices than others?
4. What assets exist in our community? Where are these assets located, and who has access to them? How do these assets support health?
5. Who is in charge at local agencies, retail stores, healthcare providers, schools, and other institutions in our community? How do these institutions support or inhibit health?
6. What conditions (excluding individual behavior) in a community support some groups' abilities to experience better health than others? What conditions in a community inhibit some groups' abilities to experience good health? Who makes decisions that influence these conditions? What motivates the decisions they make that results in differences in health status? Where does power to make these decisions come from?
7. What public and corporate policies support healthy living? What policies inhibit healthy living? Which groups are affected by these policies? Who has the power to make and implement those policies? What motivates them to develop policies that favor some over others?

Measure the Effects of Discrimination on Health

Consider using **Experiences of Discrimination** survey questions in your Community Health Themes and Strengths Assessment. This survey is a reliable and valid instrument for measuring the experiences of discrimination. The results can be used to understand the extent to which your community experiences discrimination. When analyzed together with Community Health Status Assessment data, your community can get a picture of how discrimination is associated with poor health outcomes.

Conditions that Support Health Equity

The Connecticut Association of Directors of Health has identified nine social determinant domains. The following domains can be used to structure a Community Themes and Strengths Assessment that focuses on health inequity.

1. Economic security and financial resources;
2. Livelihood security and employment opportunity;
3. School readiness and educational attainment;
4. Environmental quality;
5. Availability and utilization of quality medical care;
6. Adequate, affordable, and safe housing;
7. Community safety and security;
8. Civic involvement; and
9. Transportation.

Local Public Health System Assessment continued

Health Equity

System Contributions to Assuring Health Equity

When completing the Local Public Health System (LPHS) Assessment using the National Public Health Performance Standards (NPHPS) Instrument, your group can reframe questions about essential service delivery to identify how well the LPHS acknowledges and addresses health inequities. The following questions provide examples of how the instrument can be revised to focus on health equity.

Essential Public Health Service 1: Monitoring Health Status

At what level does the LPHS…

- Conduct a community health assessment that includes indicators intended to monitor differences in health and wellness across populations, according to race, ethnicity, age, income, immigration status, sexual identify, education, gender, and neighborhood?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Monitor social and economic conditions that affect health in the community, as well as institutional practices and policies that generate those conditions?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 2: Diagnosing and Investigating Health Problems

At what level does the LPHS…

- Operate or participate in surveillance systems designed to monitor health inequities and identify the social determinants of health inequities specific to the jurisdiction and across several of its communities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Collect reportable disease information from community health professionals about health inequities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Have the necessary resources to collect information about specific health inequities and investigate the social determinants of health inequities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 3: Inform, Educate, and Empower People about Health Issues

At what level does the LPHS…

- Provide the general public, policymakers, and public and private stakeholders with information about health inequities and the impact of government and private sector decision-making on historically marginalized communities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide information about community health status (e.g., heart disease rates, cancer rates, and environmental risks) and community health needs in the context of health equity and social justice?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Plan and conduct health promotion and education campaigns that are appropriate to culture, age, language, gender, socioeconomic status, race/ethnicity, and sexual orientation?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Plan campaigns that identify the structural determinants of health inequities and the social determinants of health inequities (rather than focusing solely on individuals' health behaviors and decision-making)?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 4: Mobilizing Community Partnerships to Identify and Solve Health Problems

At what level does the LPHS…

- Have a process for identifying and engaging key constituents and participants that recognizes and supports differences among groups?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide institutional means for community-based organizations and individual community members to participate fully in decision-making?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide community members with access to community health data?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 5: Developing Policies and Plans that Support Individual Community Health Efforts

At what level does the LPHS…

- Ensure that community-based organizations and individual community members have a substantive role in deciding what policies, procedures, rules, and practices govern community heath efforts?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

At what level does the LPHS…

- Identify local public health issues that have a disproportionate impact on historically marginalized communities (that are not adequately addressed through existing laws, regulations, and ordinances)?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

System Contributions to Assuring Health Equity

Essential Public Health Service 7: Link People to Needed Personal Health Services

At what level does the LPHS…

- Identify any populations that may experience barriers to personal health services based on factors such as on age, education level, income, language barriers, race or ethnicity, disability, mental illness, access to insurance, sexual orientation and gender identity, and additional identities outlined in Model Standard 7.1?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Identify the means through which historical social injustices specific to the jurisdiction (e.g., the inequitable distribution health services and transportation resources) may influence access to personal health services?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Work to influence laws, policies, and practices that maintain inequitable distributions of resources that may influence access to personal health services?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 8: Assure a Competent and Personal Health Care Workforce

At what level does the LPHS…

- Conduct assessments related to developing staff capacity and improving organizational functioning to support health equity initiatives?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Identify staff perspectives on the facilitators and barriers to addressing health equity initiatives?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Include staff members that are often excluded from planning and organizational decision-making processes in workforce assessments?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Recruit and train staff members from multidisciplinary backgrounds that are committed to achieving health equity?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Recruit and train staff members that reflect the communities they serve?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Local Public Health System Assessment continued

System Contributions to Assuring Health Equity

Essential Public Health Service 9: Evaluate the Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

At what level does the LPHS…

- Identify community organizations or entities that contribute to the delivery of the Essential Public Health Services to historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Monitor the delivery of the Essential Public Health Services to ensure that they are equitably distributed?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

Essential Public Health Service 10: Research for New Insights and Innovative Solutions to Health Problems

At what level does the LPHS…

- Encourage staff, research organizations, and community members to explore the root causes of health inequity, including solutions based on research identifying the health impact of structural racism, gender and class inequity, social exclusion, and power differentials?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Share information and strategize with other organizations invested in eliminating health inequity?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Use Health Equity Impact Assessments to analyze the potential impact of local policies, practices, and policy changes on historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Facilitate substantive community participation in the development and implementation of research about the relationships between structural social injustices and health status?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

Forces of Change Brainstorming

Forces of Change Assessment: Identify Forces that Affect Health Equity

Questions to Identify Forces

Powerful organized interests develop structures and support policies and practices that can either contribute to health equity or cause health inequities. The following questions can be answered during the Forces of Change Assessment to identify these forces, opportunities, and threats.

- What patterns of decisions, policies, investments, rules, and laws affect the health of our community?
- Who benefits from these decisions, policies, investments, rules, and laws?
- Whom do these decisions, policies, investments, rules, and laws harm?
- Who or what institutions have the power to create, enforce, implement, and change these decisions, policies, investments, rules, and laws?
- What interests support or oppose actions that contribute to health inequity?
- What opportunities exist to influence decisions, policies, investments, rules, and laws to benefit all groups?
- What forces now and in the future can reinforce health inequity in our community? How can we mitigate or prevent these forces?
- What forces now and in the future can reinforce health equity in our community? How can we take advantage of these forces?

When posing these questions, be sure to include people that are affected by health inequity.

Identifying Strategic Issues to Address Health Equity

As you develop strategic issues, remember that questions are never neutral. Rather, people apply frames that influence the questions they ask. They are posed within specific social, political, historical, and cultural contexts. Questions are often driven by institutional agendas, values, and priorities that may or may not address community members' needs and wants.

The following table contrasts conventional and health equity questions that can be used to understand public health problems and identify potential solutions. When analyzing data from the MAPP Assessments to identify strategic issues, use a health equity frame to ask your community these questions.

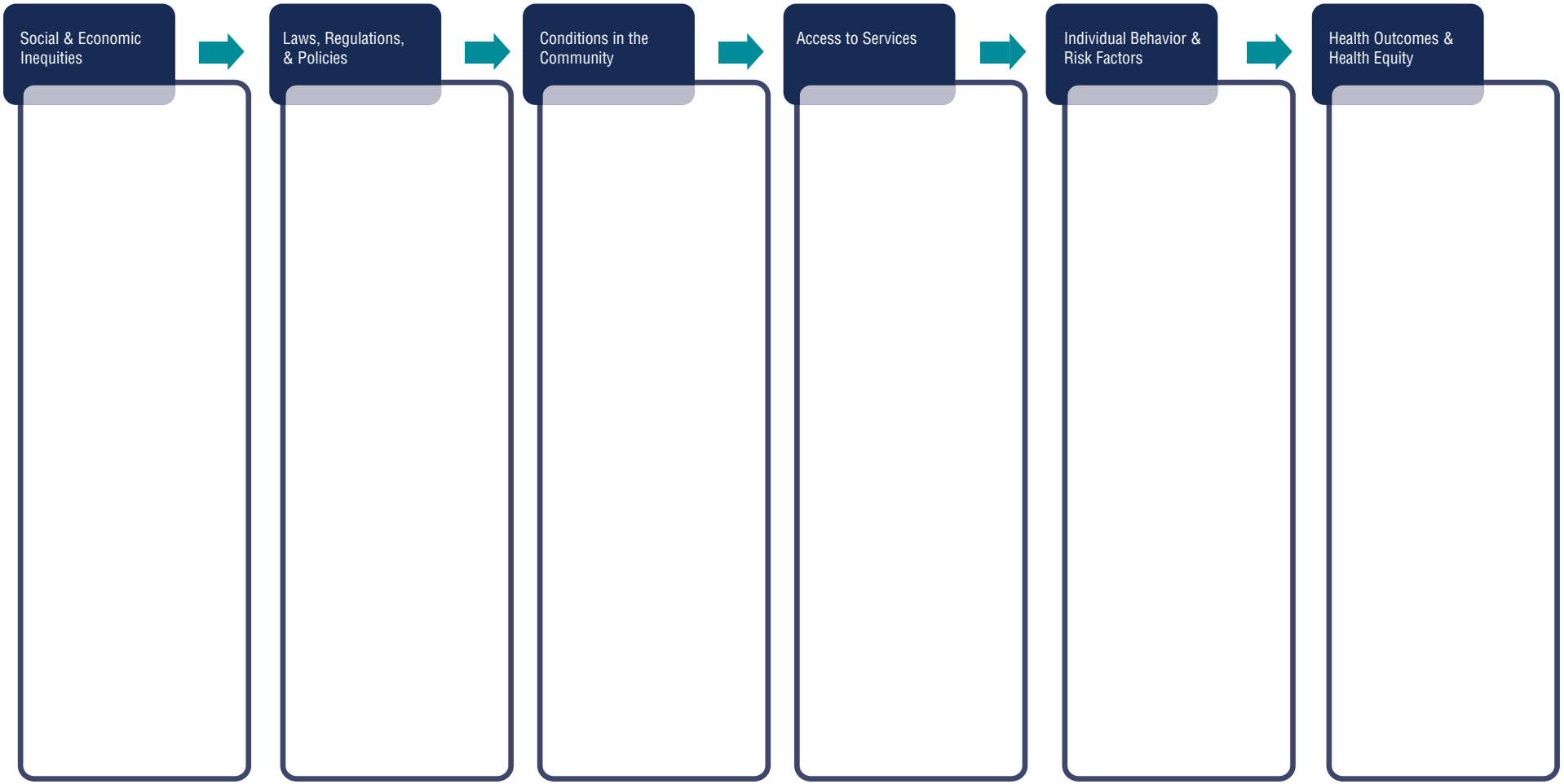
CONVENTIONAL APPROACH	HEALTH EQUITY APPROACH
Why are people unhealthy in our community?	What social conditions and economic policies make some people more likely to be unhealthy?
Why can't vulnerable populations access services?	What institutional policies and practices prevent people from accessing services?
What types of services and resources do we need to improve health?	What fundamental policy changes do we need?
How do we reduce disparities in health outcomes?	How do we eliminate the social injustices that produce inequities in health outcomes?
What programs and services do we need to address health disparities?	What kind of collective action and structural social changes do we need to tackle health inequities?
What unhealthy behaviors should we discourage among vulnerable populations?	What interests and power structures affect people's health and wellness?
Which government officials, expert researchers, or media personalities best understand the issue?	Which community members and grassroots organizations can best define the issue?
Which public officials and research institutions will decide on appropriate courses of action?	How can we work within our communities to define and prioritize public health concerns?
How can we make people more responsible for their own health?	How can we create social responsibility and public accountability to protect the public good?

Identifying Root Causes of Health Inequity

Ask community members to review data from the four MAPP Assessments. Ask them to map the data to show what they learned about relationships among the following:

- Health outcomes and health equity (from Community Health Status Assessment);
- Individual behavior and risk factors (from Community Health Status Assessment);
- Access to services (from Local Public Health System Assessment);
- Conditions in the community (from Community Themes and Strengths Assessment);
- Law, regulations, and policies (from Local Public Health System Assessment and Community Themes and Strengths Assessment); and
- Social and economic inequities (from Community Health Status Assessment and Community Themes Assessment).

Ask your community members to share how social and economic inequities affect how laws, regulations, and policies decisions are made and how those decisions shape the conditions in the community that affect how people can access services, engage in healthy living, and maximize their health outcomes.



Developing Health Equity Strategic Issues, Goals, and Strategies

Given what group members share, ask them what fundamentally has to change in the community to achieve health equity. Fundamental change may be in the form of the following:

- Policies, laws, and decision-making processes;
- Redistribution of power in decision-making;
- Reallocation of resources;
- Transparency in decision-making processes that support social and economic equity;
- Mobilizing, engaging, and sharing power and resources with those affected by inequity; and
- Accountability in decision-making.

Use information from the discussion to develop strategic issues, goals, and strategies.

Example of a Health Equity Strategic Issue, Goal, and Strategy

Strategic Issue:
How can the public health community address shortened life spans and inferior quality of life for communities of color and poor communities?

Goal:
Prevent land use policies that expose neighborhoods and community members to environmental hazards, displacement, and sprawl.

Strategy:
Forge relationships with social movements rooted in developed coalitions and provide technical assistance that fuels advocacy.

In the rural community of Mound Bayou, Mississippi, the Delta Health Center helped establish a bank branch where local black community members were hired as tellers and supervisors. As a result, racial discrimination in mortgage lending decreased.

An Action Cycle for Achieving Health Equity

When identifying actions for achieving health equity, remember to use a health equity frame and the data about health inequities collected in the MAPP Assessment phase. The table below contrasts remedial actions that do not address root causes of inequity with actions that investigate, reverse, or prevent the causes of health inequity.

Remedial Actions	Health Equity Actions
Track health outcomes by county	Track the accumulation of health-harming conditions and decision processes that produce those conditions
Treat or repair people's health and life conditions	Tackle negative life conditions with the goal of permanent social change to prevent reproduction of conditions
Support subsidies for low-income housing	Oppose discriminatory housing practices and gentrification that causes displacement
Regulate permissible levels of toxic chemicals	Limit the production of toxic chemicals and disproportionate burden on communities of color
Provide inhalers and clinical services to those communities with high asthma rates	Prevent the predominant location of polluting sites in communities of color and communities with low income levels

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