# Align

## IMPACT MAPPING: INSTRUCTIONS

The Impact Mapping Template will help you connect your project services, products, or resources with the types of changes you would like to create. To complete the template:

1. **Describe *who* you will be working with to create change** in the Who: Partners box. See Partners definition in the [Capture Definitions Table.](#_CAPTURE_DEFINITION_TABLE_1)
2. **Describe *who* you will reach** in the Who: Priority Populations box. See Priority Populations definition in the [Capture Definitions Table.](#_CAPTURE_DEFINITION_TABLE_1)
3. **List out each of your planned project activities** (one activity per row) in the Activities column. These include the activities to produce services, products, or resources you will be creating to promote change through your project.
4. **Identify which types of change you will be achieving per activity** in the Change columns.
5. **For each activity, determine whether it will create a change in Community Engagement, Capacity Building, Policy & Systems Change, SDoH, Health Outcomes and Health Equity, or another category.** See definitions for change categories in the [Capture Definitions Table.](#_CAPTURE_DEFINITION_TABLE_1)
   * Once you have identified which category(ies) an activity will impact, determine what the outcome will be and whether the change will be short-term (ST) or long-term (LT). Type the abbreviation that fits the change into the appropriate column.
     + *Ex: “Increased Awareness of Community Health Needs – ST”*
   * We require that organizations **report on** **at least one Policy and Systems Change outcome and** **one Social Determinant of Health (SDoH) outcome.**
   * If you determined that an activity will have an impact on an SDoH, determine which SDoH domain in particular will be affected. These include Economic Stability (ES), Education Access and Quality (EAQ), Health Care Access and Quality (HCAQ), Neighborhood and Built Environment (NBE), and Social and Community Context (SCC). Type the abbreviation of the SDoH that will be affected in the appropriate column in parentheses.

| **IMPACT MAPPING** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Who: Partners** |  | | **Who: Priority Populations** | | |  | |
| **Activities**  *What activities will we perform to produce services, products, or resources to promote change?* | | **Change**  *What changes will we achieve? Will they be short-term (ST) or long-term (LT)?*  *How will those changes impact a specific SDoH domain?* | | | | | |
| Community Engagement | Capacity Building | Policy & Systems Change | Social Determinants of Health | | Health Outcomes and Health Equity |
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# Align

## PROGRAM MODEL: INSTRUCTIONS

The Program Model Template will help you lay out a roadmap for your project. It will detail who is eligible for your services, products, or resources, their quality and quantity, and what specifically you hope to achieve in the short-term.

To complete the template:

1. **List out each of your planned activities** (one activity per row) in the Activities column. These should be the same activities from your Impact Mapping Template.
2. **Describe the audience for each activity** in the Who column. For direct services, describe who is eligible for these services. For indirect services, describe who you are trying to influence or change. Note: Needs assessments or surveys can be considered indirect services; if you are conducting either method, please indicate who will complete the surveys or whose data you will be using to make changes.
3. **Describe what each activity includes** in the Content column.
4. **Describe the intended quality of each activity** in the Quality column. This could include being culturally responsive, trauma-informed, evidence-based, or other similar descriptors.
5. **Describe the dosage and duration of each activity** in the Quantity column. Share how much of your service you will provide per activity and how long each activity will last.
6. **For each activity, detail your intended outcomes** in the short term. Refer to your intended outcomes in your Impact Mapping Template.

| **PROGRAM MODEL** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Activities**  (From Impact Mapping)  *What activities will you perform to produce services, products, or resources to promote change?* | **Who**  *Who is eligible (direct services) or who are you trying to influence or change (indirect services)?* | **Content**  *What do your services include?* | **Quality[[1]](#footnote-2)**  *What is the intended quality of your outputs?* | **Quantity**  *How much of your service will you provide (dosage) & for how long (duration)?* | **Changes**  (Copy from your Impact Mapping Outcomes)  *What will your activity achieve in the short-term?* |
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# Capture

## PRIORITY METRICS

In the Capture phase, we will be helping you collect a set of metrics, including ***priority* metrics** that are core for any organization evaluating an intervention. You can view the 10-priority metrics in the [Appendix below](#_PRIORITY_METRICS_BY).

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| **What are “priority metrics”?**   * Foundation of your evaluation work * Allow CDPHE and ResultsLab to make cross-cutting comparisons across grantees * Intended to capture the essential features of most interventions * Will evolve over time as ResultsLab gains deeper insights into grantees’ measurement processes |

The priority metrics will be the foundation for your own evaluation work – and they also allow CDPHE & ResultsLab to make cross-cutting comparisons across grantees. These metrics were developed after a thorough review of all grantees’ applications and Align evaluation plan templates. They’re intended to capture the essential features of all or most interventions. These metrics, particularly the ones related to outcomes, will evolve and be refined as CDPHE & ResultsLab gain deeper insights into how you plan to measure and assess your impact.

The priority metrics are just the starting point of your evaluation. We invite you to collect additional information that’s tailored to your unique evaluation questions and data needs.

The following section will provide an overview of these priority metrics. We’ve also included a data collection method recommendations table that you can use to collect priority and other metrics.

The CDPHE & ResultsLab tool development process is iterative – we’ll be adapting to make sure that our tools and learnings are helping to further CDPHE’s goals as well as your organization’s evaluation needs!

# Capture

## MEASUREMENT PLAN: INSTRUCTIONS

The Measurement Plan template will help you link Evaluation Questions to evidence and data collection methods. To complete the template:

1. **In the Grantee Metric column, describe what data your organization will collect to answer the CDPHE evaluation question and fulfill the CDPHE priority metric.** Reflect on what evidence you would need to collect to answer the question and what your organization has the capacity to collect during your project. See the [Capture Definitions table](#_CAPTURE_DEFINITION_TABLE) in the Appendix below to view examples of metrics for the Who, Implementation, and Outcomes categories.
2. **In the Data Collection Methods column, describe the data collection method(s) you will use to collect information.** Consult the [Selecting Methods to Collect Your Data section](#_SELECTING_METHODS_TO) in the Appendix below to generate ideas about which evaluation methods may be right for your project. These methods will also need to be submitted as a screenshot or document as a supplement to your template submission.
3. **In the Tool Name & New Versus Existing column, share the name of the data collection tool you will be using to collect information and whether it is a new tool that will need to be created or a tool your organization currently uses.** For data collection tools that will be used to collect information on CDPHE priority metrics, you will need to submit an image or an exact copy of the tool in RedCap when you upload your next quarterly report.
4. **OPTIONAL: Repeat this process for your own organization’s evaluation questions.** Your organization may have additional evaluation questions that are not already captured by the CDPHE priority metrics. You have the option of adding your own evaluation questions and describing your custom metrics, data collection methods, and tools for collecting data in the table below.

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| **MEASUREMENT PLAN** | | | | |
| **Evaluation Questions** | **Metrics**  *What data will you collect to demonstrate change?* | | **Data Collection Methods**  *What method will you use to gather information to count as evidence?* | **Tool Name & New Versus Existing**  *Is this a tool that you would need to create, or does it already exist? You will include your tools (images or exact copy) in your RedCap submission.* |
| **CDPHE Evaluation Questions** | **CDPHE Priority Metric** | **Grantee Metric** |
| **Who:** Who did you reach/serve? Who did you partner with? | | | | |
| What priority populations did HDCGP reach/serve? | # of CDPHE priority populations directly served/reached by your project, categorized by CDPHE priority population groups, tracked over time |  |  |  |
| # of CDPHE priority populations indirectly reached (estimate) |  |  |  |
| Who are the grantees partnering with? | # of individuals partnering with your project, by partners categories, tracked over time |  |  |  |
| **Implementation**: What and how many services, products, or resources have we developed? | | | | |
| How are these partnerships contributing to achieving outcomes? & What did HDCGP grantees do to promote change? | Type of activities performed, tracked over time |  |  |  |
| # and type of outputs produced by your project by type of activity, tracked over time |  |  |  |
| **Outcomes*:*** What changes did we achieve? What did we learn? | | | | |
| What policy and system changes related to SDoH, health equity, and outcomes have grantees achieved? | # and type of Policy and Systems changes intended by activity, tracked over time |  |  |  |
| # and type of Policy and Systems changes achieved, tracked over time |  |  |  |
| What improvements in SDoH, health equity, and health outcomes have grantees achieved? | Type and extent of documented SDoH improvements by HP 2023 Domains, tracked over time |  |  |  |
| Type and extent of documented improvements in Health Outcomes |  |  |  |
| Type and extent of documented improvements in Health Equity |  |  |  |

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| **Repeat this Measurement Plan for your Organization’s Evaluation Questions.** Using your own evaluation questions, think about which metrics you would want to collect, how you would collect them, and whether the tool exists or needs to be developed. | | | | |
| **Grantee Evaluation Questions** |  | **Grantee Metric** | **Data Collection Tools/Instruments** | **Tool Name and New Versus Existing** |
| **Who:** Whose lives will you change? Who did you reach/serve? | | | | |
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| **Implementation**: What and how many services, products, or resources have we developed? | | | | |
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| **Outcomes*:*** What changes did we achieve? What did we learn? | | | | |
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**Appendix**

## PRIORITY METRICS BY CATEGORY AND HDCGP’S EVALUATION QUESTIONS

The table below lists the **10-priority metrics** for grantees. Each priority metric is tied to an overarching evaluation question that CDPHE has about the HDCGP program. By answering these questions and collecting data in line with these priority metrics, CDPHE will be able to share HDCGP’s impact with different audiences. Note: Not all of the metrics will be relevant for each project, grantees should identify metrics closest aligned to their respective projects.

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| --- | --- | --- |
| **Priority Metrics Category** | **Priority Metrics** | **HDCGP Evaluation Questions** |
| **Priority Populations** | * # of CDPHE priority populations directly served/reached by CDPHE priority population categories, tracked over time * # of CDPHE priority populations indirectly reached (estimate) | What priority populations did HDCGP reach/serve? |
| **Partners** | * # of individuals partnering with your project, by partners categories, tracked over time | Who did the grantees partner with? |
| **Activities** | * Type of activities performed, tracked over time | How did these partnerships contribute to achieving outcomes? What did HDCGP grantees do to promote change? |
| **Outputs** | * # and type of outputs produced by your project by type of activity, tracked over time |
| **Policy and Systems Changes (Outcomes)** | * # and type of Policy and Systems changes intended by activity, tracked over time * # and type of Policy and Systems changes achieved, tracked over time | What policy and system changes related to SDoH, health equity, and outcomes did grantees achieve? |
| **Social Determinants of Health (Outcomes)** | * Type and extent of documented SDoH improvements by HP 2023 Domains, tracked over time | What improvements in SDoH, health equity, and health outcomes did grantees achieve? |
| **Health Outcomes/Health Equity (Outcomes)** | * Type and extent of documented improvements in Health Outcomes * Type and extent of documented improvements in Health Equity |

## SELECTING METHODS TO COLLECT YOUR DATA

There are a variety of methods available that will help you collect data. ResultsLab is in the process of building data collection method(s) and question examples that you can use and adapt to measure priority metrics in your own context. You can also review the Source Bank to identify additional methods and indicators to evaluate your project.

As you are selecting a method, consider: *Which method is in alignment with the way your project hopes to bring about change? What method does my organization have capacity for? What method do I find most interesting?*

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| --- | --- | --- | --- |
| **Priority Metrics Category** | **Priority Metrics** | **Suggested Methods (tools)** | **Other Methods**  ***Possible, but challenging or may not produce high-quality data*** |
| **Priority Populations** | * # of CDPHE priority populations directly served/reached by CDPHE priority population categories over time * # of CDPHE priority populations indirectly reached (estimate) over time | * Administrative data collection (Enrollment Forms) |  |
| **Partners** | * # of individuals partnering with your project, by partners categories | * Administrative or Event-based data collection (Partner Forms or Event Logs) |  |
| **Activities** | * Type of activities performed | * Administrative data collection (Attendance registers, Event logs, Service delivery tracking form) | * Field visits |
| **Outputs** | * # and type of outputs produced by your project by type of activity |
| **Policy and Systems Changes (Outcomes)** | * # and type of Policy and Systems changes intended by activity * # and type of Policy and Systems changes achieved | * Surveys * Focus groups * Interviews * Secondary data analysis | * Digital Analytics (Website/social media analytics) * Geospatial Analysis (Service availability/coverage mapping) * Social media tracking * Network mapping * Observation |
| **Social Determinants of Health Outcomes** | * Type and extent of documented SDoH improvements by HP 2023 Domains | * Surveys * Focus groups * Interviews * Secondary data analysis | * Observation |
| **Health/Health Equity Outcomes** | * Type and extent of documented improvements in Health Outcomes * Type and extent of documented improvements in Health Equity | * Secondary data analysis * Surveys (Ex: Retrospective Assessments) * Focus groups * Administrative data Collection | * Observation |

## CAPTURE DEFINITION TABLE

| **Category** | **Priority Metrics** | **Definitions** | **Key Categories and Examples** |
| --- | --- | --- | --- |
| **Priority Populations** | * # of CDPHE priority populations directly served/reached by your project, categorized by CDPHE priority population groups, tracked over time * # of CDPHE priority populations indirectly reached (estimate) | **CDPHE Priority Populations**  ***Directly Served or Engaged***: Individuals who participate in or receive services provided through the grantee's intervention.  ***Indirectly Reached:*** Individuals who may benefit from systemic or programmatic improvements achieved by the grantee, even if they do not directly participate in or receive services from the intervention. | **Key Priority Populations:**  LGBTQIA+, aging population, having disabilities, low socioeconomic status, racialized minorities, rural dwellers  **Population Engagement Examples:**   * Total # of individuals served over time * - % of low socioeconomic status individuals directly served over time |
| **Partners** | * # of individuals partnering with your project, by partners categories, tracked over time | **Partners**  Organizations, groups, or individuals that collaborate with grantees to achieve shared goals. Partners may contribute resources, expertise, networks, or support. The nature of partnerships can range from formal agreements to informal collaborations, depending on the scope and purpose of the relationship. | **Key Partners:**  Academic organizations, community members and leaders, governmental organizations, non-profit organizations, private organizations, decision and policy makers, providers  **Partners Engagement Examples:**   * Total # of partners engaged over time * # of Policy Makers engaged over time |
| **Activities** | * Type of activities performed, tracked over time | **Activities**  These are the core activities performed within your project. See examples in the next column. | **Activities Examples:**  Needs assessments; evaluations; stakeholder mobilization; capacity building; informing and raising awareness campaign; facilitating networking opportunities; delivering training and professional development; designing and developing new programs; strategic planning; providing operational support; etc. |
| **Outputs** | * # and type of outputs produced by your project by type of activity, tracked over time | **Outputs**  Outputs are the immediate, tangible products, services, or deliverables that result from the intervention’s activities. Outputs may include the number of workshops held, people trained, resources distributed, and services provided. See examples of activities and their outputs in the next column | **Activity to Output Examples:**   |  |  | | --- | --- | | *Activity* | *Output* | | Needs Assessment | Revised Strategic Plan | | Informing and raising awareness campaign | 11 meetings, 15 media posts, 4 radio appearances | |
| **Policy and Systems Changes (Outcomes)** | * # and type of Policy and Systems (PS) changes intended by activity, tracked over time | What are Policy and Systems Changes? Assessing Policy and Systems Changes requires analyzing specific pathways in or between organizations and the institutional structures that affect those pathways’ functions.  **Systems Elements:**   * ***Pathways:*** Organizational and inter-organizational arrangements set up to deliver programs and services. * ***Institutional structures:*** The institutional context in which pathways function. This includes policies, laws, and regulations; funding flows and resource allocations; culture, norms, standard operating procedures; and knowledge bases.   **System Change**  Shifting the conditions— including structures, practices, policies, resource flows, power dynamics, and mindsets—that produce societal problems and hold them in place. | **Key Types of Intended Policy and Systems Changes:**  **Increased pathway capacity:** A set of programs and services that shows improvements in:   1. ***Scale:*** Additional program slots and better access so that the supply of program slots is able to meet the need of the focal population(s) 2. ***Quality:*** The ability of programs and services in the system to meet quality standards, and the adequacy of tailoring for the purpose of meeting participant/client needs) 3. ***Comprehensiveness:*** The extent to which there is the right mix of programs to meet the diverse needs of potential participants/clients)   **Improved pathway connections:** A set of programs and services that shows increases in:   1. ***Linkage between steps:*** Clients can successfully move from one step to another 2. ***Alignment of pathway step outcomes:*** All steps build on one another and/or have complementary purposes 3. ***Cross-system coordination:*** Linkage and alignment with complementary systems   **More conducive institutional structures:** Changes to institutional structures that create new sets of incentives, constraints, and opportunities, which – in turn – allow and encourage actors to build more effective pathways.  **Activity to Policy and Systems Change Examples:**   |  |  | | --- | --- | | *Activity* | *Output* | | Needs assessment and strategic planning | New/improvements in programs (*increase pathway capacity in comprehensiveness*) | | Community engagement, stakeholder mobilization, internal capacity building | Creation of community advisory board (*more conducive institutional structures*) | |
| * # and type of PS changes achieved, tracked over time | **Achievement of Policy and Systems Change**  The goal of policy and systems changes is to introduce structural transformations in pathways and/or institutional frameworks. However, early signs of progress can be assessed by observing **relational changes, transformative shifts, and/or advancements in the stage of system change.** | **Key Results of Policy and Systems Changes:**  **Levels of System Change:**   * Structural (changes in policies, resources, services delivered), * Relational (connections and power dynamics), * Transformative (Mental Models)   **Stages of System Change:**   * Development * Placement on the Agenda * Adoption & Implementation * Maintenance & Update   **Example of Level of System Change:**   * Increase % of staff/community members that support *x* proposed change after their participation in *x* training/meetings (transformative change) |
| **Social Determinants of Health Outcomes** | * Type and extent of documented Social Determinants of Health (SDoH) improvements by Healthy People 2023 (HP 2023) Domains, tracked over time | **Social Determinants of Health Improvements May Include:**   * Improvements in individual, family, and community behaviors and connections * Improvements in individual, family, and community living conditions * Improvements in access, quality, comprehensiveness, or equity of medical services * Improvements in access, quality, comprehensiveness, or equity of non-medical services   Grantees are encouraged to develop specific metrics to track improvements in SDoH, aligning with the HP 2030 objectives for each of the five SDoH domains. | **Key Categories:**  **Healthy People 2030 Social Determinants of Health Domains***:*   * Economic Stability (ES) * Education Access and Quality (EAQ) * Health Care Access and Quality (HCAQ) * Neighborhood and Built Environment (NBE) * Social and Community Context (SCC)   **Types (and Examples) of Social Determinant of Health Outcomes:**   * ***Individuals, families or communities' behaviors*:** Increased physical activity (Neighborhood and Built Environment), strengthened community connections (Social and Community Context) * ***Individuals, families or communities' living conditions:*** Increased household income, stable employment, access to affordable and quality housing or education, enhanced food security (Economic Stability) * ***Medical services:*** Increased healthcare coverage, enhanced access, improved quality of care (Health Care Access and Quality) * ***Non-Medical services:*** Better coordination between teachers and counselors, equity in academic outcomes, culturally competent and linguistically appropriate education (Education Access and Quality) |
| **Health/Health Equity Outcomes** | * Type and extent of documented improvements in Health Outcomes * Type and extent of documented improvements in Health Equity | **Health Outcomes**  Health outcomesrefer to measurable changes in the health status of individuals or populations, resulting from policy and systems changes and social determinants of health improvements. These outcomes capture the effectiveness of strategies aimed at improving health and well-being and can be categorized into dimensions, such as mortality, morbidity, quality of life, and disease prevalence.  **Health Equity**  Health equity involves reducing and ultimately eliminating unfair and avoidable disparities in health outcomes across different population groups. It ensures that everyone has a fair and just opportunity to achieve their highest level of health, regardless of factors such as race, ethnicity, income, gender, geographic location.  **Important Health Outcome/Equity Considerations**   * Changes at the community/population level should be reported under health outcomes. * Grantees should be prepared to identify secondary data sources for measuring these health outcomes. | **Health Outcome Key Categories:**  Using primary or secondary data, grantees may report health improvements in areas such as: mental health, substance use, pregnancy and childbirth, cancer, cardiovascular diseases, pulmonary diseases, or other chronic diseases.  **Health Outcomes Examples:**  Health outcomes indicators may include:   * Disease-specific survival rates * Mortality rates * Morbidity rates * Reduced complications * Quality-Adjusted Life Years (QALYs) * Disability-Adjusted Life Years (DALYs) * Infant mortality rates * Preterm births * Maternal mortality and complications * Rates of depression * Anxiety * Substance use disorders * Prevalence or incidence in infectious diseases   **Health Equity Outcome Examples:**   * Decreased infant mortality disparities among racial or socioeconomic groups * Reductions in prevalence of chronic conditions like diabetes or hypertension across demographic groups |

1. This could include being culturally responsive, trauma-informed, evidence-based, etc. [↑](#footnote-ref-2)