# Developing Community Health Improvement Plan Metrics

OREGON HEALTH AUTHORITY

## Overview

This document provides guidance to CCOs about developing Community Health Improvement Plan (CHP) priority metrics. These are quantifiable measures used to track and assess the health of communities.

## Requirements

Per the current CCO Contract, CHPs must "identify metrics or indicators used to monitor progress towards the identified CHP health priority goals." In the recently released CCO CHP self-assessment checklist, the following evaluation criteria was updated for this requirement: "Metrics/indicators include baseline data and targets used to monitor progress towards identified CHP priority goals".

## Identifying CHP Indicators

To monitor the impact of CHPs, "indicators" must be identified to establish a baseline and to measure progress. An example of an indicator is the "percentage of tobacco users among Oregon adults." In selecting indicators, there are certain characteristics to keep in mind:

- Effective indicators are relevant; they show you something about the system that you need to know.
- Effective indicators are analyzed by subgroup (e.g., race/ethnicity, gender, sexual orientation, disability, geography, income, etc.) to illustrate disparities
- Effective indicators are easy to understand, even by people who are not experts.
- Effective indicators are reliable; you can trust the information that the indicator is providing.
- Effective indicators are based on accessible data; the information is available or can be gathered while there is still time to act.

The OHA Public Health Division recently updated the resource, "Data Sources for Health Assessments and Health Improvement Plans." This document lists potential data sources to aid in developing indicators for CHPs.

## KEY TERMS

**Baseline data:** Initial measurement of an indicator, prior to the start of interventions.

**Goals:** What is expected to be achieved in the long-term.

**Health status:** The current state of a given population as described by quantitative data (e.g., morbidity, mortality, access to health care).

**Indicator:** A measure or data that describe community conditions currently and over time (e.g., poverty rate, homelessness rate).

**Objectives:** The process steps to meet the goals and how the CHP partners plan to achieve them.

**Outcomes:** The desired effect on the community, what the measure of success will be.

**Target:** End goal or aim of interventions.

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## Developing SMARTIE CHP Goals

While SMART or SMARTIE Goals are not required for CCO CHPs, they are a recommend best practice. The concept of SMART goals has been expanded to include the concepts of inclusiveness and equity. This helps incorporate the voices of those most impacted by inequities. SMARTIE goals are defined as:

| | | |
|---|---|---|
| **Specific** | Reflects an important aspect of what your organization seeks to accomplish. | What goal are you trying to realize? |
| **Measurable** | Includes standards by which reasonable people can agree on whether the goal has been met. | How much? How often? How many? |
| **Achievable** | Is challenging enough that achievement would mean significant progress. | Will we be able to accomplish this? |
| **Relevant** | Is related to achieving the overall goal. | Is it relevant to the priority issue and the vision? |
| **Timebound** | Includes a clear deadline. | When will it happen? What is a realistic timeframe? |
| **Inclusive** | Brings traditionally marginalized people into decision-making and processes in a meaningful way. | How will you include underrepresented voices? |
| **Equitable** | Seeks to address systematic injustice, inequity, or oppression. | How does it seek to address injustice, inequity, or oppression? |

Table adapted from the MAPP 2.0 User's Handbook, p. 159.

Using the guidance provided above and on page one, here's an example of a CHP metric that includes baseline data, an indicator, SMARTIE goal, and target:

| CHP Priority Area | Indicator | Baseline | Goal | Target |
|---|---|---|---|---|
| Housing & houselessness | Number of unsheltered individuals in Coos County, as measured through a point-in-time count. | 457 | By 12/31/29, reduce the number of unsheltered individuals in Coos County by 50% through engaging houseless advocates and individuals to address the social determinants of health. | 228 |

Note: While the data listed in the table is up to date, the goals and targets were developed by OHA as an example and are not part of a CCO's CHP.

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It is recommended that CCOs work with their CHP partners to identify more than one indicator for each CHP priority area. Identifying multiple indicators can help to confirm trends and whether interventions have been successful over time. It is also important to note the availability of data for each indicator. For example, is data collected every five years or annually?

The table below provides an example of how multiple indicators could be used to track progress throughout a five-year CHP

| CHP Priority Area | Indicator | Goal | Baseline Data | First Year Data (2025) | Second Year Data (2026) | Third Year Data (2027) | Fourth Year Data (2028) | Target (2029) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Housing & houselessness | Number of unsheltered individuals in Coos County, as measured through a point-in-time count. | By 12/31/29, reduce the number of unsheltered individuals in Coos County by 50% through engaging houseless advocates and individuals to address the social determinants of health. | 457 (2024) | | | | | 228 |
| Housing & houselessness | Number of available shelter beds in Coos County, as measured by Oregon Housing and Community Services. | By 12/31/29, double the number of available shelter beds in Coos County through engaging housing service providers, housing advocates and county leaders. | 23 (2023) | | | | | 46 |
| Housing & houselessness | Student homelessness rate per 1,000 students enrolled in Coos County, as measured by Oregon Housing and Community Services. | By 12/31/29, reduce the student homelessness rate in Coos County by 50% through engaging local school districts and families affected by student houselessness. | 73.58 (2023) | | | | | 36.79 |

## Additional Resources

# Developing Community Health Improvement Plan Metrics

**1. SMARTIE Goals webinar recording**

In 2022, the Transformation Center hosted a SMARTIE Goals webinar that was led by the organization Insight for Action. Topics covered in the webinar include (with timestamp notes):

- Crafting goal statements: 6:45
- SMART vs. SMARTIE goals: 20:50
- Examples of SMARTIE goals: 31:40
- Presentation from Columbia Pacific CCO about experiences designing SMARTIE goals for the Columbia Pacific CCO Regional Health Improvement Plan: 37:55

**2. OHA Transformation Center CHA/CHP guidance and training webpage.**

**3. Most recent CCO CHPs and CHP progress reports.**

**4. Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 Handbook.**

**Additional questions?**

Please contact Staci DeLeon-Davis, Tom Cogswell, or transformation.center@odhsoha.oregon.gov.