# Planning for and Selecting High-Impact Interventions to Improve Community Health

## A Guide to Applying Logic Models to Community Health Interventions

Communities Transforming

*To make healthy living easier*

National Center for Chronic Disease Prevention and Health Promotion
Division of Community Health

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### Contributing Writers

Nicole Lezin, Cole Communications Inc.
Robin Soler, CDC
Michael Orta, ICF International

### Advisors and Reviewers

Nicole Flowers, CDC
Cindy Getty, CDC
Sherry Maxy, CDC
Emily Hite, ICF International
Drew Bradlyn, ICF International

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# Contents

# Introduction

As communities seek ways to become healthier places, they face an array of choices on how to intervene—choices that can seem daunting. Which interventions are possible? Which are likely to have the greatest impact and make a real and lasting difference by reaching more people with the greatest intensity?

This guide is intended for community health planning coalitions, agencies, and health departments working together to improve community health—particularly, but not exclusively, those funded by the Centers for Disease Control and Preventions (CDC). It is designed to guide coalitions and groups involved in planning community health improvement efforts toward high-impact interventions. Specifically, this guide will help coalitions or other planning groups

- **Identify** high-impact interventions.
- Take concrete steps to ensure the interventions selected are **evidence-based**.
- Apply the "**Twin Approach**" (which couples population-wide interventions with more targeted interventions to advance health equity) in the design, selection, and implementation of interventions.
- Use **logic models** to select and develop the most effective interventions for a particular community, either on their own or within a broader strategic planning effort.

## About This Guide

This guide is organized into three main sections, and uses logic models as a key planning tool. Logic models offer a systematic way to identify, assess, choose, and implement high-impact interventions. They are components of a broader strategic planning process and help guide decisions.

The first section of the guide describes each step in a logic model, including suggestions within the steps on how to use evidence-based interventions, address health equity and reduce health disparities, and use the Twin Approach. The second section provides activities and examples for creating a community-specific and intervention-specific logic model. The third section briefly reviews how a logic model can contribute to a broader community health improvement effort or strategic planning process. It highlights the overlap and connections across intervention selection using a logic model approach, overall strategic planning, and the Community Health Improvement (CHI) Digital Journey.

Throughout this guide, we provide links to CDC and other resources, built-in activities to help you put concepts to immediate use, and examples of communities that have put these ideas into practice. Look for these icons to identify elements of this guide:


**Key Points**


**Links and Resources**


**Activities**


**Community Examples**


**At-a-Glance Section Summaries**

The table of contents is hyperlinked, allowing you to click to each section quickly. Also, the following textbox highlights key decision points in this document, with clickable links to the related pages.

**CHECKLIST OF KEY DECISION POINTS**

- ☑ Review CDC's Community Health Improvement (CHI) Digital Journey (page 3).
- ☑ Define high-impact interventions (page 3).
- ☑ Convene your stakeholders (page 4).
- ☑ Plan your interventions using a logic model framework (page 6).
  - ✓ Determine the ultimate health impact and long-term outcomes (page 8).
  - ✓ Identify policy, system, and environmental improvements (page 10).
  - ✓ Consult the evidence base for specific high-impact interventions (page 11).
  - ✓ Select primary and supportive interventions (page 13).
  - ✓ Consider feasibility (page 13).
  - ✓ Address health equity through the Twin Approach (page 13).
- ☑ Create your logic model for high-impact interventions (page 18).

## A Context for Choosing High-Impact Interventions: The Community Health Improvement Digital Journey

The task of choosing community health interventions should take place within a broader strategic planning process. CDC's CHI Digital Journey is a defined, yet flexible series of planning and action steps that lead to a community health improvement plan. The CHI Digital Journey is a decision support tool that includes steps for building strong coalitions, defining your community, conducting a Community Health Needs Assessment (CHNA), implementing interventions, and evaluating efforts. This guide supports intervention selection, which is a distinct step in the CHI Digital Journey.

CDC's CHI Digital Journey and this guide incorporate key recommendations from the University of Kansas Work Group for Community Health and Development, including engagement of community members, collection of high-quality data through a CHNA, and use of evidence-based strategies.[1] Yet, like any strategic planning process, the CHI Digital Journey can take many forms and paths. It is adaptable to each community. Your context for choosing high-impact interventions will be determined by the outcomes of earlier steps in the CHI Journey and will be unique for your community.

## Defining High-Impact Interventions

Because high-impact interventions are the focus of this guide, some basic definitions may be helpful to distinguish these from other types of interventions.

"High impact" is the product of two intervention factors: (1) the extent to which the intervention **reaches** a moderate, large, or substantial proportion of the population and (2) its **intensity**.


The **reach** of an intervention simply refers to how many people it touches or what proportion of a population is affected by the policy, system, or environmental (PSE) improvement. Some interventions are designed to reach an entire community. For example, smoke-free policies in all outdoor places will reduce exposure to tobacco smoke for all people regardless of personal characteristics. Some interventions are designed for a very specific population subgroup. Baby-friendly hospital initiatives are designed to reach pregnant woman who were not intending to breastfeed.

**Intensity** refers to the strength or effect the intervention may have in terms of its ability to change behaviors known to affect chronic disease outcomes (such as smoking). Greater

[1] Fawcett S, Holt C, Schultz J. *Some Recommended Practice Areas for Community Health Improvement*. Lawrence, KS: Work Group for Community Health and Development, University of Kansas; 2011.

frequency and longer duration of exposure to an intervention result in greater intensity. The expected effect of an intervention, to the extent the evidence describes it, is another clue as to how intense an intervention may be. Is the intervention designed to influence health outcomes directly, or is it a few steps removed? For example, improving the healthy food offerings available in restaurants, vending machines, and cafeterias, is more direct—and **intense—**than posters or other reminders to eat healthier.

Consider the difference in both reach and intensity between a single employer's smoke-free workplace policy and a comprehensive smoke-free air policy—one which prohibits smoking in all workplaces, restaurants, and bars in a jurisdiction. A smoke-free policy in one workplace offers a relatively limited **reach** of tobacco control messaging and behavior change prompts. Only people who work for or visit that employer are exposed to the intervention.

On the other hand, a comprehensive smoke-free air policy protects larger numbers of people from involuntary exposure to secondhand smoke because it reaches everyone who enters all workplaces, restaurants, or bars. The greater frequency and duration of exposure to a comprehensive smoke-free air policy make it more **intense** than a smoke-free intervention limited to one employer's workplace.

## Convening Your Stakeholders

Whose input do you need to select the best interventions for your community? Do your coalition members represent multiple sectors and populations experiencing health disparities? Although building a strong coalition is an earlier step in the CHI Digital Journey, now is a good time to ensure the right people or sectors are engaged in the process. Too often, groups engaged in community health improvement planning lack partners from other sectors or members who represent those experiencing health inequities. Use the activity on the following page to consider whether you have the right people at the decision table.

## COALITION CHECK: ARE THE RIGHT PEOPLE AT THE TABLE?

1. Where are we now?
    - How do our current partnerships or coalitions reflect the populations experiencing inequities in our community?
    - Are the skills and motivations of our partners and stakeholders aligned with our community needs (based on the results of an assessment) or the requirements or goals of the resources available?

2. How can we build diverse and inclusive partnerships or coalitions?
    - What partners are we missing in our partnerships or coalitions that should be included?
    - What partners do we need to engage to address the major social determinants of health impacting our community (e.g., housing, transportation, education, urban planning, business)?
    - What are the common priorities of potential partners that can serve as levers for collaboration?

3. How can we engage new partners in a meaningful way?
    - What process can we develop and implement to regularly assess our partnerships or coalitions to see who else should be invited to help advance our goals of achieving health equity?
    - What can we do differently to improve or enhance our partnerships or coalitions?
    - What potential issues concern our partners? What issues can be anticipated?
    - How can we ensure that all partners meaningfully participate and influence decision making?

Adapted from: Centers for Disease Control and Prevention. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013.

# Planning for High-Impact Interventions: Walking Through Your Logic Model

## At-a-Glance: What's in This Section?

This section

- Reviews some **basic planning steps** that help with selecting interventions.
- Walks through **steps** in the logic model that are useful for selecting high-impact interventions.

## Logic Models: What They Are and Why They Are Important

As the name suggests, **logic** models are supposed to be **logical**—revealing the assumptions and rationale for a choice of activities. Mostly linear, they are a visual portrayal of an "if, then" proposition:

> **If** we input various resources to undertake A, B, and C activities and get these outputs in the near future, **then** we have a greater likelihood of achieving Y and Z outcomes within a few years and ultimately achieving our long-term outcomes to have this type of impact within X timeframe.

By showing the underlying logic that connects inputs, activities, outputs, outcomes, and impact, logic models can make a compelling case for a selected set of interventions—and for the up-front investment in launching them. Logic models can help your group select high-impact interventions by ensuring there are clear connections between the activities you plan to implement and the outcomes you hope to achieve. The more specific information you include, the stronger your logic model will be.


A well-developed logic model should make sense when read in either direction—from inputs and activities to impact ("If we do *this*, then we can expect to achieve *that*.") or in reverse, from impact to activities and inputs ("To have *this type of impact*, we need to implement *these activities* and have *these resources* in place first.").

Take tobacco use as an example. In multiunit housing, secondhand smoke seeps through windows, floors, and ventilation systems, affecting everyone (smokers and nonsmokers alike), but particularly the developing lungs of children and frail lungs of older people living in the building. Because many low-income families live in rented apartments instead of single-family homes, secondhand smoke in multiunit housing can contribute to health disparities among an especially vulnerable population.

A CHNA reveals high levels of disease that may be related to or exacerbated by exposure to tobacco smoke. An environmental and policy scan reveals that other communities have had success with persuading housing authorities and landlords to designate multiunit housing as smoke-free living spaces. The evidence base supports this intervention as potentially having a high impact because it can reach large numbers of people (everyone living in these units) with a high degree of intensity, if enforced.

In this example, **inputs** could include the data collection process that revealed a high disease rate in this subgroup of residents, the coalition's environmental and policy scan, and the search for evidence-based interventions.[2] The **activity**—as recommended by an evidence-based compendium of tobacco control interventions—is obtaining designation of multiunit housing facilities as smoke-free. One important **output** of that activity is to have these policies not just on paper, but actually enforced across many housing units.

If those activities and outputs are implemented, what happens next? One **short-term outcome** is that residents of those buildings are less likely to be exposed to secondhand smoke. As a result, an **intermediate outcome** might be a reduction in conditions associated with tobacco smoke exposure, such as asthma-related symptoms and respiratory tract infections like pneumonia and bronchitis. As a bonus, the smoke-free policy gives smokers living in those buildings an additional—and powerful—motivation to quit.

Over time, these cumulative and widespread reductions in tobacco smoke exposure and smoking will eventually lead to **long-term outcomes** of reduced rates of tobacco-related illnesses, such as lung cancer and heart disease. Finally, as more and more people have access to smoke-free environments, these reductions in tobacco-related illnesses will become substantial. Change can occur one housing unit at a time, but eventually impact an entire community—and an entire community's chronic disease rates. That is the ultimate goal—to **impact** chronic disease rates at the community or jurisdiction level.

The following steps include basic logic model components—inputs, project activities, outputs, short-term outcomes, intermediate outcomes, long-term health outcomes, and impact—to show how these can be used to organize and drive the selection process for

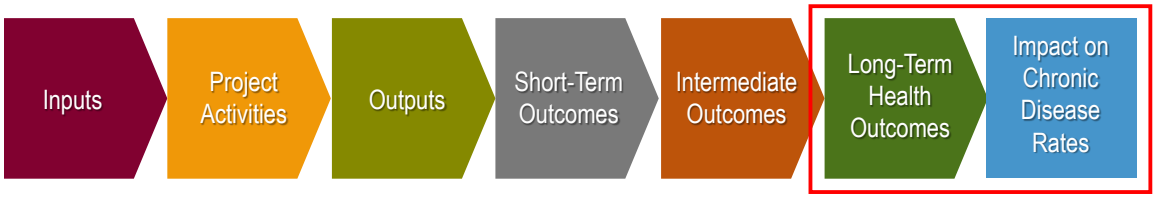
[2] Schoenmarklin S. *Secondhand Smoke Seepage into Multi-Unit Affordable Housing*. Saint Paul, MN: Tobacco Control Legal Consortium; 2010.

high-impact interventions. A red box indicates the specific logic model components relevant to the steps and activities.

## Impact: Starting with the End in Mind

As noted earlier, well-developed logic models should make sense whether they are read from left to right or from right to left (starting with ultimate impact and working back to specific activities and inputs). Because this guide is designed to lead to the selection of interventions that will have a measureable impact on chronic disease rates at the community or jurisdiction level ("high-impact interventions"), we will begin with the end in mind—at the impact side of the logic model.

### Identify the Ultimate Community Health Impact You Plan to Achieve




To achieve high-impact health outcomes, you first need accurate information on both the broader population and vulnerable subgroup populations. A CHNA is a tool for understanding community needs and assets. By systematically collecting information on communities and the populations within them (including vulnerable populations), CHNAs can be extremely useful as your coalition considers where and how it can have an impact in the community.

Using the CHNA results (or other similar census or other data about community health needs), discuss what the data reveal (or confirm). Consider which areas of the community have the greatest need, who is most affected by chronic disease, and where your coalition believes it could have the greatest impact.

### RESOURCES FOR IMPLEMENTING THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

- Community Health Navigator Resources, CDC.
- Community Health Needs Assessment Toolkit, Community Commons.
- Principles of Community Engagement (2nd edition), National Institutes of Health.
- Community Health Improvement Resources, Missouri Department of Health and Senior Services.
- State Health Improvement Plan (SHIP) Guidance, Association of State and Territorial Health Officials (ASTHO).
- Mobilizing for Action through Planning and Partnerships (MAPP), National Association of City and County Health Officials (NACCHO).
- Video: Primary Care + Public Health in the Community, Institute of Medicine of the National Academies.

Use the following activity to discuss and identify the health **impact** and **long-term outcomes** your coalition or group wishes to achieve. These are initial discussion questions. You will want to return to questions of need and impact throughout the planning process.

### IDENTIFYING COMMUNITY HEALTH IMPACT: DISCUSSION QUESTIONS

With your CHNA or other data in hand and your coalition members assembled, consider these questions. Options include asking individuals to reflect on the questions and then share their answers, dividing into small groups to discuss and then compare ideas, or setting up flip charts around the room and having individuals or teams rotate from one "station" to the next to consider and add to the ideas of others.

- What do the data show us?
- What are the areas of greatest need in our community?
- Who are the people in greatest need?
- What are the areas of greatest potential impact?
- What outcomes do we need to improve and for how many people?
- What have we learned from the data about the people who have the highest disease rates?

## Identify Policy, System, and Environmental Improvements to Reduce Rates of Chronic Disease


What chronic disease outcomes in the community need to be improved? How many people could be affected? Who is experiencing the highest rates of disease? The answers to these questions, building on the CHNA data from the first step, will help refine your planning group's sense of where it can and should have the greatest impact.

A scan of existing PSE factors can help pinpoint opportunities for improvement. Use the following activity to discuss and identify PSE factors.

### SCANNING FOR POLICY, SYSTEM, AND ENVIRONMENTAL FACTORS: DISCUSSION QUESTIONS

What are the policy, system, and environmental factors that could be improved to reduce rates of chronic disease in your community? For example,

- What is the extent of smoking ordinances? Do they cover multiunit housing complexes?
- What physical activity and nutrition guidelines are in place in your community's schools?
- Do all community residents have equal access to healthy foods?
- Do all community residents have equal access to community services for chronic disease prevention, risk reduction, and disease management?
- Are outdoor areas and play environments safe?

Knowing which PSE factors influence rates of chronic disease will help you identify the intermediate- and short-term outcomes and outputs for your logic model. The following community example lists a sample of outputs and outcomes from a strategic plan that resulted, in part, from an environmental and policy scan.

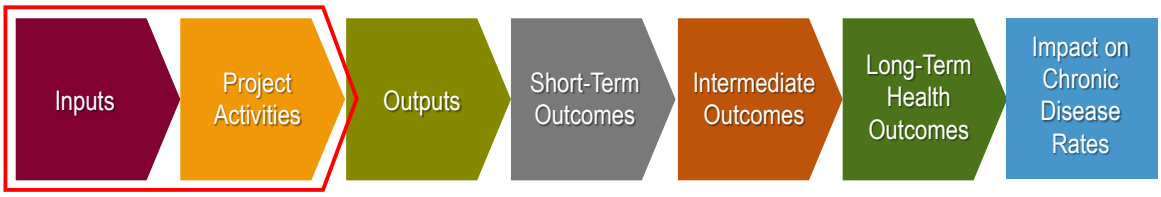
### OUTPUTS AND OUTCOMES IN A STRATEGIC PLAN

The Los Angeles County Department of Public Health's strategic plan for 2013-2017 relied, in part, on a scan of internal and external policy issues as a way to choose strategic priorities. The following are specific policies that support active living, healthy eating, and tobacco-free living:

- Increase the number of local jurisdictions that implement transit-oriented districts and other land use planning policies that promote walkable, bikeable, and safe communities and the use of mass transit, while avoiding displacement of affordable housing.
- Increase engagement with cities, public institutions, businesses, and community organizations to increase access to and demand for healthy food and beverage options and reduce access to and demand for less-healthy options.
- Develop strategies to increase participation in the Supplemental Nutrition Assistance Program (SNAP) and increase healthy food and beverage purchases among SNAP participants, including incentives for purchasing fresh produce.
- Work with health care organizations to adopt and implement a standard protocol for tobacco use screening and referral to cessation services.
- Increase the capacity of community agencies to improve preconception health through the use of web-based platforms.

For a full copy of the strategic plan, go to the County of Los Angeles Department of Public Health: Strategic Plan 2013-2017.

## Chart Your Path: Identifying High-Impact Interventions to Achieve Your Goal




Your coalition has already taken into account the related PSE factors and the impact you hope to achieve. As your group deliberates an array of possible interventions, it must also consider evidence-based approaches, supportive interventions, feasibility, and actions needed to advance health equity.

## Consult the Evidence Base

CHNA data, decisions about the impact to be achieved, and the results of environmental and policy scans can point the way ahead. Once these are in hand, it is time to consult the scientific literature. By doing so, you can identify specific strategies and interventions

supported by the evidence, meaning they have been evaluated, found to be effective, and recommended by experts.

Community health resources are too scarce to waste on interventions that do not work—or do not work well in a particular setting or with a specific population. Fortunately, the evidence base for interventions to address chronic disease risk factors—tobacco use, unhealthy diets, and lack of physical activity—is growing steadily. The evidence base grows as good-quality studies evaluate interventions to determine whether they work, how, and under which specific conditions. **Evidence** is derived from evaluating an intervention. A recommendation based on evidence means it works—but how well, for whom, and under what conditions needs to be understood before you include it in your plan.

**Evidence** is derived from evaluating an intervention. A recommendation based on evidence means it works—but how well, for whom, and under what conditions needs to be understood before you include it in your plan. Evidence and recommendations do not guarantee high impact.

Groups such as the Task Force on Community Preventive Services, the Institute of Medicine, CDC's Office on Smoking and Health, and CDC's Division of Nutrition, Physical Activity, and Obesity have already sifted through multiple research studies to identify what works and under what conditions.

**RESOURCES FOR EVIDENCE-BASED INTERVENTIONS**

- CDC's Division of Nutrition, Physical Activity, and Obesity.
- CDC's *The Guide to Community Preventive Services*.
- CDC's Office on Smoking and Health.
- County Health Rankings and Roadmaps: What Works for Health.
- Institute of Medicine of the National Academies.
- Kansas University's Community Tool Box.

Beyond identifying strategies and interventions that match the community's needs and the coalition's goals to reduce chronic disease rates, consider whether the evidence supports implementing the intervention in a community like yours, with similar demographics and other characteristics. Remember that evidence alone is not enough; it must be paired with **reach** and **intensity** to have high impact.

With a set of possible interventions and the evidence base as a filter, your coalition can reconvene to discuss the results of this step and narrow the list of potential interventions and strategies to select those most likely to have high impact.

## Primary and Supportive Interventions

Consider ways that interventions might be combined to have more impact than any single intervention alone.

**Primary interventions** more directly affect risk factors or behaviors. They have the greatest potential reach and impact for the desired outcomes. For example, corner store conversions are a primary intervention in which convenience stores receive equipment and training to make healthier foods more accessible and attractive to customers.

**Supportive interventions** are those that may not have high impact on their own, but can enhance the reach, effectiveness, or knowledge about a primary intervention. Health education, training, transportation, and promotional signs may not achieve lasting impact on their own, but can support or "boost" other interventions that are more powerful and direct, such as corner store conversions.

Decide which primary interventions, on their own or combined with supportive interventions, are most likely to reach a moderate or large proportion of the population with enough intensity to change the health behaviors known to affect chronic disease outcomes. Interventions that support each other are more likely to have high impact.

## Feasibility

As your coalition reviews possible high-impact interventions, remember that one size does not necessarily fit all. To customize and refine lists of possible high-impact interventions, consider the **feasibility** of each, given the resources you have available. Consider whether each intervention will be **acceptable** to community members and decision makers and culturally **appropriate** for target populations. The activity on page 17 offers more questions to consider when identifying interventions that offer the greatest chances of having a high impact.

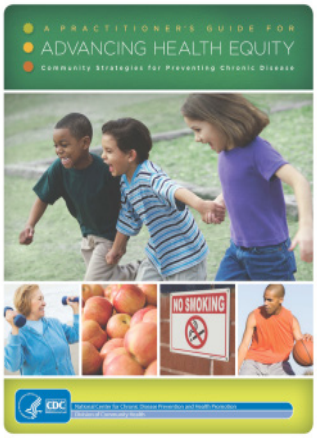
## Addressing Health Equity and Health Disparities

Many conditions—including chronic diseases—reflect disparities in health status across populations. As your coalition identifies high-impact interventions, consider whether and how those interventions will address health disparities and advance health equity. Reducing disparities involves reducing the gap in disease rates or risk factors for population subgroups. Advancing health equity means increasing everyone's opportunity to achieve optimal health regardless of gender, age, sexual identity, race, ethnicity, or other characteristics. For more information about health disparities and health equity, see *A Practitioner's Guide for Advancing Health Equity*.

### A PRACTITIONER'S GUIDE FOR ADVANCING HEALTH EQUITY: COMMUNITY STRATEGIES FOR PREVENTING CHRONIC DISEASE

This publication (available here) from CDC's Division of Community Health helps practitioners address disparities in chronic disease health outcomes so that health equity—the attainment of the highest level of health for all people—can be achieved. It is filled with lessons learned from local, state, and tribal organizations.

This publication also offers many examples and suggestions for how practitioners can integrate the concept of health equity into building organizational capacity, engaging the community, developing partnerships, identifying health inequities, and evaluating their efforts.




## The Twin Approach

Historically, public health has funneled resources in one of two directions: toward an **entire population** to achieve population-wide impact or toward a **specific population** to reduce disparities. In theory, a population-wide intervention should help everyone become healthier. In practice, this does not always occur. Some populations will become healthier, which is desirable. But what if some population groups benefit more than others, and the disparities between them actually widen?

### THE TWIN APPROACH

The Twin Approach is composed of the following elements:

Population-wide or general interventions with health equity in mind. (The focus is on implementing high-impact interventions within the general population.)

**and**

Targeted and culturally tailored interventions designed to address subpopulations with the highest disease rates. (The focus is on implementing tailored interventions *at the same time* within vulnerable or priority populations.)

Consider this example: During the 2006-07 and 2010-11 school years, obesity prevalence among New York students in kindergarten through 8th grade decreased by 5.5% overall. However, this decrease masks notable differences across racial and ethnic groups that might make us see this success story in a different light. Specifically, obesity prevalence decreased by 12.5% for white children, 7.6% for Asians/Pacific Islanders, 3.4% for

Hispanics, and only 1.9% for African Americans. Overall prevalence declined, but disparities increased.[3]

**THE TWIN APPROACH: POPULATION-WIDE AND TAILORED APPROACHES WORKING TOGETHER**

In multiunit housing like apartment buildings, secondhand smoke finds its way into units where people don't smoke—and into the bedrooms and lungs of young children. Over 40% of all public housing residents are children, and smoking rates are higher among adults with lower incomes.

A population-wide intervention to protect people from secondhand smoke exposure might help reduce smoking rates overall, but if it did not work as well among residents of public housing, these families might face about the same levels of exposure as before—and the gap between their exposure (and future disease patterns) and those of their more affluent neighbors might increase.

To prevent this unintended consequence, we can promote the population-wide intervention as before, but also provide culturally appropriate, tailored support focused on smokers who live in public housing to bolster their success rates in quitting.

The Twin Approach applies both population-wide and tailored interventions. In the previous example, the population-wide intervention is designed to protect the general population from secondhand smoke exposure, while the culturally appropriate, tailored intervention reaches a subpopulation at higher risk of exposure. Tailored interventions play a critical role in the Twin Approach to help address disparities.

Instead of choosing between two approaches, nest one within the other and combine them. This approach is called the Twin Approach because we continue to pursue population-wide interventions, while coupling them with targeted interventions tailored to meet the needs of a specific population subgroup. The targeted intervention is related to the population-wide intervention and helps guard against inadvertently increasing disparities. Use the following activity to help your coalition consider whether the Twin Approach is being applied in your interventions.

[3] Day SE, Konty KJ, Leventer-Roberts M, Nonas C, Harris TG. Severe obesity among children in New York City public elementary and middle schools, school years 2006-07 through 2010-11. *Prev Chronic Dis.* 2014;11:130439.

## ARE WE APPLYING THE TWIN APPROACH?

### Population-Wide or General Population

- Has the general population been identified?
- How are you integrating health equity into intervention selection, design, and implementation? Have potential unintended consequences been considered?

### Vulnerable or Priority Population

- Has the vulnerable or priority population within the general population been identified?
- Do barriers exist that might make selected interventions less effective for vulnerable or priority populations? If so, can tailored interventions be implemented that reduce the negative effect of those barriers?
- Do supportive interventions contain activities tailored to the unique characteristics of the vulnerable or priority population?

If the responses to the previous questions are all "Yes," then you are applying the Twin Approach. If some questions are unclear or the answers are "No," consider these questions:

### General Population

- What process can our coalition set up to fully understand health inequities?
- What are the diverse needs we need to consider when designing or selecting strategies that will have the greatest population-wide or general population impact?
- Are our organization's interventions supporting a health equity approach?
- Are our organization's interventions inhibiting a health equity approach?
- What are the key variables our organization should use to track the influence of our efforts for the population-wide or general population?

### Vulnerable or Priority Population

- What type of information does our organization or coalition need to ensure full understanding of health inequities in the community?
- What tools and resources can our organization or coalition use to identify and understand health inequities?
- What should our organization or coalition consider when selecting strategies that will have the greatest impact on populations experiencing health inequities?
- What are the diverse needs of the vulnerable or priority population?
- How can our organization verify that selected strategies align with the needs of populations experiencing health inequities?

Taking into consideration all the concepts described in the previous activity—from the PSE factors discovered in the policy and environment scan to determinations of feasibility and the application of the Twin Approach—reconvene your coalition to select interventions. The following activity will help your coalition complete this step.

## SELECTING HIGH-IMPACT INTERVENTIONS

For each potential high-impact intervention your coalition or planning group is considering, track your findings with a work sheet like this one, and then compare the results for multiple interventions. Individuals or small work groups could take on the task of completing the work sheet for particular interventions, which could then be discussed with the larger group.

### POTENTIAL INTERVENTION

Brief Description: _____

Source: _____

- ❑ This intervention has a high potential impact on chronic disease risk factors
  - Reach—reaches many or most in population or subpopulation
  - Intensity—strong, direct, and effective
- ❑ This intervention enhances or improves policy, system, or environmental (PSE) factors
  - Which ones? How?
  - How can we boost the effectiveness of the PSE improvement in our community?
- ❑ The evidence base supports this intervention for our community or population
  - Which studies or recommendations?
  - In which population (e.g., age, gender, race or ethnicity, language) and setting?
  - Do you have a compelling reason to believe that the intervention will work for your community given population characteristics and community context?
- ❑ This intervention is feasible, useful, and appropriate
  - How do we know or why do we believe this?
- ❑ This intervention incorporates the Twin Approach to address health equity or disparities in both general and vulnerable or priority populations
  - Is there literature to help us understand if the targeted (supporting) intervention will work with our priority population? See questions on page 16.

### INTERVENTION COMPARISON GRID

In each category, rate the intervention as Low, Medium, High, or Need More Info to see if any interventions stand out.

| Interventions | Potential High Impact | | Addresses PSE Factors | Evidence Base Supports | Feasible, Useful, Appropriate | Twin Approach |
|---|---|---|---|---|---|---|
| | Reach | Intensity | | | | |
| Intervention A | | | | | | |
| Intervention B | | | | | | |
| Intervention C | | | | | | |

# Creating a Community-Specific Logic Model for High-Impact Interventions

## At-a-Glance: What's in This Section?

This section provides activity templates with examples for your coalition or planning group to use to select and refine your high-impact interventions.

## Overview

Now that your coalition has considered a variety of potential high-impact interventions, it's time to translate your results into a logic model. Once again, start with the end in mind, treating each component as a piece of a larger puzzle. Note that some pieces will be more distinct and complete than others. For example, a lack of information highlights a knowledge gap or resource gap that needs to be addressed for you to move forward.

Visit the links in the following box for information on how to build logic models.

**LOGIC MODEL RESOURCES**

- Evaluation Guide: Developing and Using a Logic Model, CDC Division for Heart Disease and Stroke Prevention.
- Logic Model Development Guide, W.K. Kellogg Foundation.
- Advocacy Progress Planner (Logic Model Builder), Aspen Institute.

## Activity: Creating a Logic Model for High-Impact Interventions

The rest of this section is intended to be completed as a group activity, ideally with flip charts, a large wall, or a whiteboard, where each piece of the puzzle can be shared, discussed, and moved or edited as needed. For each part, discuss the answers to the questions and capture your decisions. Examples are provided for each component. You could also use these examples as a practice round, before your group tackles its own interventions and logic model.

It might help to create a large logic model on a white board or flip chart. As you answer the questions in this section, place your answers in the appropriate boxes on the logic model. Consider how the boxes link. Does the information for each box align? For example, does the evidence available support the long-term outcomes you want to improve? Does your logic model begin to split by disease area or behavior change needs?

Are there gaps in the logic—places where the information simply is not available? Step back and assess your logic model, and consider carefully what else needs to be known or done before you leap into action.

Remember: logic models are written on flip chart paper, whiteboards, or computer screens—not in stone. Feel free to revisit and revise them, as needed, and as you learn more about your interventions and their impact.

## Impact

- What long-term **impact** do we hope to achieve?
- What impact does the **funding source** require? (This answer may drive or influence your decisions.)

**IMPACT WE HOPE TO ACHIEVE:**

_____

_____

(Examples: Reduce chronic disease rates for X population by Y%, decrease disparities in access to preventive services or fresh fruits and vegetables)

## Long-Term Outcomes

- What **long-term outcomes** do we need to change in order to have this impact? By how much? For how many people? For whom?
- What health outcome is having the biggest negative effect on our community?

**LONG-TERM OUTCOMES:**

_____

_____

(Examples: Decreased rates of overweight or obesity, tobacco use prevalence, uncontrolled high blood pressure and high cholesterol)

## Intermediate Outcomes

- What are some behaviors that would need to change to lead to the intermediate outcomes?

**INTERMEDIATE OUTCOMES:**

_____

_____

(Examples: Increased consumption of healthy foods, compliance with tobacco-free policies, consumption of healthy beverages, tobacco cessation)

## Short-Term Outcomes

- What are some short-term changes (e.g., access, availability, knowledge, attitudes) that would lead to those behavior changes?
- What strategies are known (from the evidence base) to affect health behaviors or health risks? How many people can we reach?

**SHORT-TERM OUTCOMES:**

_____

_____

(Examples: Increased access and availability to healthy foods; decreased exposure to secondhand smoke; increased access to and availability of healthy beverages; changes in knowledge, attitudes, or awareness)

## Outputs

- What policy, system, and environmental improvements are required?

**OUTPUTS:**

_____

_____

(Examples: Number of new farmers markets, number of multiunit housing complexes with voluntary smoke-free policies, number of schools with modified procurement policies, number of people who viewed a public health education initiative)

## Activities

- What intervention or combination of interventions will likely have the highest impact (reach × intensity) on our community?
- Do these interventions impact members of our target populations equally?
- Are there other interventions we should be implementing at the same time? Are there interventions already occurring in our community that we should join?
- What is the extent of public support for the proposed strategy?

**ACTIVITIES:**

_____

_____

(Examples: Establish farmers markets, implement voluntary smoke-free multiunit housing policies, modify school procurement policies, implement a public health education initiative)

## Inputs

- What resources do we have available to launch these activities?
- What other resources do we have and need?
- What additional funding is available?
- Are there special circumstances we should consider?
- Are others in the community working on supportive or competing strategies?

These inputs can include funding (which is important), as well as data (e.g., from CHNAs or other assessments); policy and environmental scan results; and information about community engagement, research and evaluation partners, connections among stakeholders, goodwill and support, influence, investments of time and energy, and creativity.

**INPUTS:**

_____

_____

(Examples: staff, community capacity, partners, other resources and funding)

# The Broader Community Action Context

The steps described previously are specifically designed to build consensus about the highest-impact interventions to improve community health, although they overlap with traditional strategic planning for any organization. For example, when a coalition's members gather to discuss the type of impact they want to achieve, their conversation is likely to sound similar to vision and mission discussions that are cornerstones of strategic planning for any endeavor. Likewise, policy and environmental scans may seem similar to "SWOT" analyses—assessments of an organization's strengths, weaknesses, opportunities, and threats. However, instead of an organization or division within a larger agency, the unit of analysis here is an entire community, including its most vulnerable populations experiencing the highest chronic disease rates.

As the following table illustrates, the logic model and high-impact intervention steps described in this guide fit within the context of CDC's CHI Digital Journey, which is based on the Robert Wood Johnson Action Cycle, especially as it relates to health equity, nurturing strong coalitions, defining community and exploring community needs, setting priorities, and selecting interventions.

| High-Impact Intervention Planning Steps | Logic Model Components | Sections of the CHI Digital Journey |
|---|---|---|
| Convene coalition to discuss CHNA results and agree on ultimate community health impact | Impact on Chronic Disease Rates (as a result of the activities and subsequent outcomes, chronic disease rates fall for target population and community) | Choose Effective Policies and Programs<br>Act on What's Important<br>Evaluate Actions |
| | Long-Term Health Outcomes (e.g., sustained or more widespread changes in behavior that reduce the prevalence of risk factors for chronic disease) | |
| Identify policy, system, and environmental factors | Intermediate Outcomes (e.g., initial behavior changes stemming from the changes achieved as short-term outcomes) | |
| | Short-Term Outcomes (e.g., changes in access, availability, knowledge, and attitudes among a large segment of the population) | |
| | Outputs (e.g., policy, system, and environmental improvements) | |
| Consult the evidence base and reconvene the coalition to discuss the evidence base and its implications<br>Select specific strategies that lead to outcomes and are high impact<br>Monitor, review, and revise as needed | Project Activities (e.g., work to change or sustain a policy, system, or environment that affects chronic disease) | Define Community<br>Assess Needs and Resources<br>Focus on What's Important |
| | Inputs (what the coalition or planning group brings to the table in terms of talents, creativity, energy, funding, collaborative networks or partners, influence, and collective impact) | |

Like any planning process, this one warrants periodic updates to monitor progress and disparities, assess whether any adjustments should be made, and whether community health needs have shifted. Your coalition must also stay informed about the rapidly evolving evidence base to see whether new interventions might be relevant to the community's needs.

## Conclusion

The health problems and disparities in our communities did not arise overnight, nor will they be overcome quickly. Yet in communities across the country, steady progress is being made. We can accelerate this progress even more by focusing on reach and intensity, using CHNAs to gain consensus about problems and potential solutions, deploying evidence-based interventions that also deliver high impact, and using logic models to show how current activities connect to our aspirations for healthier people and places.

In both strategic planning and the CHI Digital Journey, the next steps address the implementation, monitoring, and evaluation of the selected strategies or interventions. The evidence base and guidance supporting these interventions include tool kits and other resources to guide implementation and evaluation. As part of the planning process, you should consider benchmarks for implementation and evaluation, depending on the interventions selected.

No community can afford to scatter or waste resources on interventions that may be well-meaning, yet ultimately ineffective. With these tools, we can all do a better job of choosing the interventions that have the greatest potential to yield high-impact outcomes and reduce the disparities that have no place in a healthy, thriving society.

# Additional Resources

In addition to the tools listed throughout this guide, the following webinars, fact sheets, guides, and other materials may also be helpful.

## CDC's Community Health Online Resource Center

A searchable database of practice-based resources to help implement community-level changes to prevent disease and promote healthy living. Resources include webinars, model policies, tool kits, guides, fact sheets, and other practical materials, all organized and searchable by content area.

## National Association of City and County Health Officials: Chronic Disease Prevention Toolkit

Publications, tools, and resources related to chronic disease prevention, obesity, nutrition, diabetes, heart disease, cancer and tobacco issues, geared to local (county and city) health departments and their partners.

## Community Commons

An interactive mapping, networking, and learning site for the broad-based healthy, sustainable, and livable communities' movement. Maps, data, affinity groups, connections to peers, articles, and many other resources.

## Kansas University Community Tool Box

Tool kits on topics such as creating and maintaining partnerships, assessing community needs, developing frameworks and interventions, developing strategic and action plans, increasing participation, enhancing cultural competence, writing grant applications, implementing social marketing efforts, and sustaining your work or initiative.

## Prevention Institute

Research reports, frameworks, tool kits, training services, technical assistance, and other resources that promote primary prevention at local, state, and national levels.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**Corporate Headquarters**
9300 Lee Highway
Fairfax, Virginia 22031
Phone: (703) 934-3000
Fax: (703) 934-3740

**Atlanta Office**
3 Corporate Square NE, Suite 370
Atlanta, Georgia 30329
Phone: (404) 321-3211
Fax: (404) 321-3688

**www.icfi.com**