An Integration Guide to Collective Action
Developed by the Greater Upper Valley Integrated Services Team

PURPOSE

GUVIST is a learning network, holding space virtually for willing partners to learn about our process, regional examples of integration, the Collective Impact Model and a common language for this work. GUVIST is also an integration incubator and a technical assistance entity for the region, developing ideas and facilitating them into action. More information about GUVIST's purpose and active work can be found on our **website**.

This Integration Guide developed by GUVIST is a resource for organizations and communities who wish to intentionally build integrated service delivery networks, a collaborative process that sets networks up for successful and long term change. The guide is drawn from many sources, including integration work in **Ten Steps for Improving Blood Pressure Control in New Hampshire**,[1] development of the Early Childhood Service Delivery Integration (ECSDI) network, early GUVIST analyses, and the **Collective Impact Model**.

Each chapter defines terminology, includes a longer narrative about the "why" and "how," overviews key steps, and links to tools and resources. Each application of the process will differ in its goals and therefore some elements will be more important than others. Although the steps appear to be linear, the steps can be undertaken in any order or even skipped. Please use this as a guide, not as a sequential checklist. As a learning collaborative, GUVIST's process is iterative and will be improved upon through lessons learned with each network. The guide will be revised as we learn together.

If you are looking for assistance implementing quality improvement changes through collective action, you are encouraged to contact GUVIST's Integration Catalyst at **GUVISTCatalyst@gmail.com**.

Written by: Cara Baskin
Reviewed and Approved by: GUVIST Executive Council
Date Last Revision: 1/6/25

EXECUTIVE SUMMARY

1. Integration Incubation

Steps Overview:

Complete Proposal for Change form
Review, develop and refine proposal

Tools:

Proposal for Change form
Review Criteria

2. Service Delivery Network Development

Steps Overview:

Identify and incorporate key players and atypical partners into network
Map current landscape and clarify goals
Consolidate & make meaning of available data
Initial Collaboration Evaluation
Develop and center around Integration Aim
Document Theory of Change

Tools:

Project Charter
Initial Collaboration Evaluation
Theory of Change
Integration Aim Statement
Fishbone Diagram
Flowchart
5 Whys

3. Implementation Coordination

Steps Overview:

Create Logic Model
Create Community Engagement Plan
Determine strategies to address Integration Aim
Define Measures of Success
Coordinate Mutually Reinforcing Activities
Identify and pursue funding needs

Tools:

Logic Model
Community Engagement Plan
Data Collection and Shared Measurement Plan
Project Storyboard

4. Sustainability and Evaluation

Steps Overview:

Collect data
Plan for handoff from backbone
Finalize a Project Report
Network Collaboration Evaluation

Tools:

Project Report
Network Collaboration Evaluation

See Appendix for Tools

Sources

1. INTEGRATION INCUBATION

Process and terminology

What is Integration? GUVIST promotes service integration believing that it will improve the experience of people who receive services from multiple organizations by helping service providers operate interdependently by design. Integration of leadership, decision-making, operations, and responsibility between partners can be defined in the following ways:

Leadership: Developing sustainable relationships opens communication between organizations and builds trust and leadership support for long-term commitment to achieve both short and long-term goals.

Decision-making: Though partners remain autonomous, they commit to identifying overlaps and gaps between missions, uncovering duplication and fragmentation. Problem solving these inefficiencies is achieved through shared decisions to create a common agenda, mutually reinforce activities, assess, pool and leverage available funds, share data tracking and measurement, and include those with lived experience.

Operations: Integration of operations means that organizations function interdependently by design. This requires challenging assumptions about how the system currently operates, and community members' experience with the system, and identifying infrastructure and processes that intentionally disrupt the status quo. Over time this creates the desirability of working together in a new way, which opens doors for further innovation.

Responsibility: The integration of leadership, decision-making and operations culminate in a shared accountability for the wellbeing of our community and the system of care. Partners that work towards integration are responsible for not only their own service recipients, but intentionally bridging services between their organizations and community/informal networks, which increases access to services, and the ability to do so with dignity.

How to Start? A **Proposal for Change** provides a format for users to articulate a problem and opportunity for how integration could improve service delivery. Filling it out with other health or social service organizations you aim to work with is a collaborative effort that gets the ball rolling. While GUVIST has an Executive Council to help those who submit the proposal further develop their ideas, your organization's leadership might help you consider scope and feasibility using criteria such as our **Review Criteria**.

2. SERVICE DELIVERY NETWORK DEVELOPMENT

Process and terminology

Network development can be described in four stages: Form, Storm, Norm, and Transform. "In [the forming] stage of collaboration, success often hinges on the level of shared clarity around purpose, structures, strategies, leadership, and key tasks."[2] There are two goals at this stage: develop the network and reach clarity around a common agenda.

What is a Network? Networks are defined by the interdependence of the people and organizations in them, enduring relationships which are mutually maintained, governance ("participant governed") and structure.[3] These categories set a network apart from a hierarchy or a market.

Within that, there are several types of networks. Service delivery networks differ from information sharing, knowledge sharing and resource exchange networks by their organizations' upstream focus on service delivery. This focus intends to effectively change how services are delivered and how organizations work together to improve the downstream experience for community members. Commitment between organizations is high, there is shared decision making, responsibility and trust, and the goal is to change outcomes through solving operational or policy problems together.[3] See Appendix A for the **Level of Organization Integration Rubric**.

How do you form a Network? Integrated Service Delivery Networks are made up of a backbone, those providing Community Voice and partner organizations.

Backbones are a pillar of Collective Impact. On a large scale, that might be an organization that manages coordination and financial support. The backbone ensures open and continuous communication, coordinates scheduling, facilitates conversation, and keeps track of goals and process. This includes convening partner organizations, leading them through the pillars of Collective Impact, and providing tools to guide those conversations. Community Voice is expanded upon in the next section.

In the Form stage of network development, the goal is to create a bounded network. Without boundaries, such as purpose, geography, or partners, pre-existing models of service delivery will continue. The network will not be an exhaustive list of people who could be involved, but an intentional formalization of loose networks that occur naturally with the addition of partners that should be involved.

To identify partner organizations, name who is already doing work around the issue (who may or may not already know about the proposal) and others who are adjacent to the issue or should be involved. Be respectful of people or organizations who are not interested. Based on the goal, consider what service level to include at the outset. This could be direct service providers, administration, middle management, leadership, funders or community leaders. Changes in personnel should not affect sustainability. Consider which roles at an organization can do the work, not individual people. Who meets in the network may change throughout the process based on the goal and current decision making needs. Consider inviting atypical partners who might be outside your sector but can amplify impact (i.e. going outside typical clinical partners to invite landlords into lead poisoning prevention).

Early conversations with potential partners should introduce the concept of integration, set ground rules around frequency of meetings, preference around virtual or in person, and clarity around the problem and opportunities. A **Project Charter** can help solicit commitment (see Appendix B for example). Partners should know why they are included, their role and decision-making power, the network's goals, and their level of commitment to participating. Have leadership from partner organizations sign off on the Charter to ensure clarity around the work.

What is a Common Agenda? "A vision for change shared by all participants that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions."[4]

The Proposal for Change is the first draft of your vision for change and early conversations in the network help partners understand the problem together. The joint approach will ultimately be your mutually reinforcing activities (see Implementation Coordination). To create it, you need the right people at the table to reflect on the current state. Mapping the current landscape will help clarify the problem for the network. Use a **Flowchart** (see Appendix C) to depict how community members flow through the system (from the provider or community member's perspective) and envision an ideal experience for both the system and community members. A **Fishbone Diagram** (see Appendix D) might help your network name the roots of the problem where change could start. It is a cause and effect diagram that is usually organized by root causes of an outcome in terms of environment, supplies, culture, people, process, etc. The **5 Whys** exercise (see Appendix E) similarly guides users to question why the effect is happening, repeatedly, until you find a root cause. Where are gaps, barriers and capacity to improve?

Data is important in four ways. First, to quantify the problem. Consolidate and make meaning of available data to better understand the need, uncover inequitable care or outcomes, and decide on your target population. The goal is to move from looking at data, to understanding the information, and sharing the same knowledge base, which can be followed by action. Partners might come to the table with quantitative or qualitative data on their Proposal for Change form.

Data should be viewed with an equity lens. "Equity is fairness and justice achieved through systematically assessing disparities in opportunities, outcomes, and representation and redressing [those] disparities through targeted actions."[5] An equity lens asks what disparities exist among different groups, taking into account historical and current institutional sources of inequality. It takes intentional steps to build the power of the people most affected by inequities in order to narrow gaps while improving overall outcomes. Bringing an equity lens to data collecting or analysis means thinking carefully about how it will be disaggregated to reveal disparities by geography, race/ethnicity, income level, gender, disability, language, age or other characteristics. Consideration should be given to data that might skew or hide the reality for certain populations. If data is missing for a subgroup, consider why; perhaps that population does not access services for a reason. Those answers might reveal who is benefitting from the system and who is not.

Early organizational analyses (Organizational Network Analysis, Social Support Network Analysis Project and Family Level Network Analysis) of GUVIST defined the core elements of integrated service delivery networks (inquire for more information). The development, structure and functionality of these networks are what prime them to be effective.

In order to set yourself up for success with your goals, take the time to intentionally create networks with those elements. An **Initial Collaboration Evaluation**[6] may be used to measure what elements a network possesses at the beginning of an integration project (and where lies room for growth). A second evaluation near the end of the work allows measurement of growth. The **Dimensions of Success** are Relationships, Process and Results,[7] and are the other three ways data is relevant and important. Shared measurement later on will tell you about results and impact. In the meantime, a collaboration evaluation provides data on process (Does the network have the characteristics of a service delivery network; How are decisions made?) and relationships (Does the network have the commitment level of an integrated network?). Integration thrives on these two dimensions to achieve results.

The result of conversations in this phase with the accompanying tools should lead to an understanding of who is doing what and where, and areas for improvement. Use the current landscape, data, and identified opportunities to develop a **Theory of Change** (see Appendix G). This tool holds the problem, desired results, community needs and assets, influential factors, steps needed to bring change, measurable short and long term effects, as well as assumptions about each. It is similar to a logic model but more explanatory than descriptive.

From this work comes an **Integration Aim** statement to center around your goals and the pillars of work to achieve them.

The backbone ensures continuous communication within the network, but also outside the network. This may mean informing organizations through regular meetings, other roundtables, websites, and keeping lists of partners, aim statements and products updated. Partners are encouraged to keep their home organizations updated on successes, challenges and progress as well.

Network partners should check in with their leadership before moving to the next phase of the process.

3. IMPLEMENTATION COORDINATION

Process and terminology

Throughout these phases, the backbone summarizes network progress in a **Project Storyboard**. Consider this a narrative of how the network advances its Proposal and Project Charter, adding process, successes and challenges.

Community Voice is a key element of the Service Delivery Network. Seeking out and incorporating the lived experience of people receiving services in the region helps combat assumptions, helps include feedback, concerns and input are incorporated into strategies, and ensures changes are wanted, appropriate and representative of the needs and desires of the community.

"Community" can be defined in many ways. As one example, GUVIST aims to serve all ages and populations in its region; the community includes parents, caregivers, patients in clinical settings, youth, people with disabilities, elderly, etc. Services could mean mental health, transportation, clinical services, programs/services for disabilities, legal/municipal services, housing, food security, programs/services for early childhood/elderly, substance use, education, state programming, and social connection.

Community Engagement is "the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their wellbeing."[8] Community engagement strategies can provide qualitative data that give context to hard data and better represent the target population. To build a **Community Engagement Plan**, consider using the Collective Impact Forum's **Community Engagement Toolkit**[9] (see Appendix F). Solicit and incorporate community voice.

A few items to keep in mind:

Know your "why." Have your network articulate why community engagement is important to the project. What are you trying to learn and how will it contribute to your results? What can the community member(s) contribute and what role will they play on your team? How will they benefit from participation? Also be aware if these efforts are already happening in any of your organizations. Consider asking local family advisory boards.

Choose your strategy on the **Engagement Spectrum** (see Appendix F). Do you intend to inform, consult, involve, collaborate with or empower community members as part of your network's decision-making process? How much decision-making power will you share? How will you communicate? Shed the idea that community members need your help, and instead see them as members of your network. What assets do they bring to the table? While your network might bring *content* expertise about service delivery, community members' unique experiences or relationships bring *context* expertise.

Build your table equitably. Note how the network does or does not represent the target population (intended beneficiary) in terms of geography, demographics, and experience with the issue at hand. Test your assumptions about the target population. Avoid tokenism; one individual cannot speak on behalf of an entire group (see Appendix H).

Meet people where they are. Bring them up to speed with relevant and digestible information, orienting them to the group's purpose without industry jargon. Encourage participation, judgment free. Listen, go slow and build trust. Moving too quickly will default to a top down approach.

Remove barriers to participation. Consider transportation, internet connection, time involved, the stigma of a meeting place, childcare, work hours and appropriate compensation. Be clear about your intentions and limitations so as not to create more distrust in the system. Close the loop. You'll want to follow up with community members to show what work you've done.

Examples of engagement methods: facilitated conversation/deliberate dialogue, peer support, interviews, surveys, panel/focus group or storytelling. This could be in person or virtual, with community champions, patients or staff with lived experience.

After defining the problem, areas of opportunity, root causes and desired changes, come to consensus on strategies to address your Integration Aim. This is the crux of the work and where commitment of network members will be tested. **Mutually Reinforcing Activities** are the "Engagement of a diverse set of stakeholders, typically across sectors, coordinating a set of differentiated activities through a mutually reinforcing plan of action."[10] What actions will each organization in the network take to fulfill the joint approach of your common agenda, with the mindset of "What can my organization contribute?" rather than "What can I get out of this work?" Remember, integration is not meant to add work to your job, but instead adapt *how* you work to be more effective and efficient. You might consider changes to job descriptions, coordinating programming, streamlining communication between agencies, education, new workflows, sharing or scaling best practices, staffing, IT changes, shared software, policy change, shared funding, access to or shared use of data.

This series of conversations encompasses the Storm and Norm stages of network development.[2] The important pieces of Storming are clear and consistent communication and information sharing, rules for managing consensus and conflict, clear goals and activities to get there. It is a critical time for shared decision making. Your network might also develop facilitative leadership beyond the backbone, which is important to sustainability of change. In the Norm stage, the network actively implements its strategies. The network will need to delegate roles, acknowledge successes and setbacks, and use data to inform decision making and changes. Keep leadership informed and involved.

Make an implementation plan using a **Logic Model** (see Appendix I), documenting the inputs and activities that will lead to the intended short and long term results and lasting impact. Remember to include your efforts to address health equity. Set a timeline for your activities, perhaps in phases, to maintain engagement and momentum.

Consider using the **Wheel of Engagement**[11] (see Appendix J) to be clear about levels of commitment and how network members plan to participate. For each strategy, do members intend to be core to development and functioning, involved, supportive or merely interested in updates?

What about Funding? Some strategies might require financial resources. Money might be necessary for the cost of new personnel, a shared website, tools or software that are shared, costs of co-planning an event, co-location, cost of training or building a community of practice. Money might also be necessary to stipend community engagement to pay for people's time, transportation or other needs. You might consider pooling funds from each organization in the network. Perhaps there are larger financial needs and the network applies for a grant together. Research, choose and pursue shared funding sources as needed. This step requires deep organizational trust and commitment, as well as a fiscal sponsor. Be sure to keep leadership involved and communication open.

The network will need to specify **Measures of Success** that will let you know if your intervention is making a difference. Make a plan for what data to collect, how it will be collected and shared, and who will collect and respond to it. See Appendix K for **Data Collection Plan**.

Shared Measurement is a pillar of Collective Impact that means "Identifying common metrics for tracking progress toward a common agenda across organizations, and providing scalable platforms to share data, discuss learnings, and improve strategy and action."[12] Multiple organizations must agree to measure the same things in the same way or collect agreed-upon measures that help determine if your intervention/mutually reinforcing activity is making a difference. Shared measures should be: a valid/reliable measure of the goal, understandable to all stakeholders, produced by a trusted source, comparable across agencies/regions, affordable to gather and report, available consistently over time, and changeable by local action.

Shared responsibility is a core element of integration. How well are we doing in reaching our integration aim? If all members in the network commit to collecting data on their efforts and reflecting on changes made or lack thereof, they are accepting responsibility as a unit. Results are one dimension of success, in addition to process and relationships, and all three should be taken into consideration when evaluating the impact of an integrated network.

The backbone will ensure products are updated as progress is made, and partners are encouraged to keep their home organizations updated on successes, challenges and progress as well.

Network partners should check in with their leadership before moving to the next phase of the process.

4. SUSTAINABILITY AND EVALUATION

Process and terminology

By definition, integration is not a one time end goal, but an ongoing action. The network is not intended to adjourn, but to thrive beyond facilitation by the backbone. Preparation is needed to ensure sustained action and continued impact. In this phase, the network should collect data to monitor performance, complete a final evaluation and plan for handoff from the backbone.

The final stage of network development is Transform/Adjourn.[2] In this stage, the network will decide, based on its actions and results so far, whether or not it is accomplishing its intended impact or if it needs to pivot, scale or replicate its activities (transform).[2] Partners should consult with the backbone for continuation of facilitation beyond the original scope, as new goals might require reconfiguring the network. Otherwise, the network can discuss sustainability of current activities.

Four sustainability factors that make integration viable are people, process, impact, and resources.[13] Not every element of your work will need to be sustained. Some factors will be more important than others for you. Defining what elements need to be in place for the change to be sustained is a conversation specific to your network and its goals.

- *People factors* encompass the partners in your network and their relationships, along with community voice, making sure the change is wanted and needed. Are partners willing to sustain changes to how they work, regardless of personnel changes? Have you closed the loop with community members or made a plan to reengage/reassess the need?
- *Process factors* are about the change being made and how the work gets done. Are roles and activities clear? Is leadership informed and supportive? Will partners continue to openly and consistently communicate to maintain relationships? Have partners taken on leadership roles within the network in lieu of backbone facilitation?
- *Impact factors* are inclusive of data collection/shared measurement to track long term change and build your compelling case for the continued need to work in this new way. Are your partners willing to keep collecting data and reflect periodically together?
- *Resource factors* include not only financial resources, but adequate human resources. What ongoing cost is needed to maintain the change? Successful and sustainable collaborations are ones where everyone in the network has a role to play; responsibility and commitment is shared.

The plan for handoff can be assessed by scoring the **Network Sustainability Plan**. The plan includes all the key steps outlined in this Integration Guide with a simple scoring system, for consistency. With a minimum score of 70%, achieved by working through most of the steps, the network is expected to have reached its goals of integration and primed itself for sustainability. The process of moving through these steps is the action that builds trust, commitment and change among partners.

The backbone should facilitate a second **Network Collaboration Evaluation** after implementing mutually reinforcing activities. The results will show how the network changed over time, providing information on what elements might have influence over success and how the backbone can improve the integration process for future networks. Partners might schedule a 6 month check in with the backbone and polish their Storyboard into a **Project Report**, so all can learn from successes and challenges, and include baseline data, need, aim, activities, partners, funding and outcomes.

APPENDIX

Appendix A. Levels of Organization Integration Rubric[2]

Table 1. Levels of Organizational Integration Rubric

Level of Integration	Purpose	Strategies and Tasks	Leadership and Decision Making	Interprofessional Communication
Independent (none) 0	None identified	Shared strategies and tasks do not exist	No shared leadership or decision-making structures	Nonexistent or very infrequent and unplanned
Network	Create a web of communication	Loose or no shared structures	Nonhierarchical	Very little interprofessional conflict
1	Identify and create a base of support To explore interests	Flexible, roles not defined Few clear tasks	Flexible	Communication among members is planned, but infrequent
Cooperating	Work together to ensure tasks are done	Member links are advisory in nature	Nonhierarchical, decisions tend to be low stakes	Some degree of personal commitment and investment
2	Leverage or raise money	Few structures and shared tasks	Facilitative leaders, often voluntary	Minimal interprofessional conflict
		Distinct organizational missions	Several people form a "go-to" hub	Communication among members is clear, but largely informal
Partnering	Share resources to address common issues	Strategies and tasks are developed and maintained	Central leadership group identified	Some interprofessional conflict
3	Organizations remain autonomous but support something new	Tasks are delegated	Partners share equally in the decision-making process	Communication system and formal information channels developed
	To reach mutual goals together	Documented overlaps in organizational mission	Decision-making mechanisms are in place	Evidence of problem solving and productivity
Unifying	Extract money from existing organizations and merge resources to create something new	Formal structure to support strategies and tasks	Strong, visible leadership	High degree of commitment and investment
4	Commitment for a long period of time to achieve short- and long-term outcomes	Specific short- and long-term strategies and tasks identified A shared organizational mission	Committee and subcommittees formed Roles and responsibilities clear and designated	Possibility of interprofessional conflict is high Communication is clear, frequent and prioritized

Appendix B. Sample Project Charter

Clinical-Community Integration for Cardiovascular Disease

Opportunity: The VT Department of Health and GUVIST are managing a CDC grant to advance health equity for individuals at risk of cardiovascular disease by focused strategies that are mindful of the social drivers of health. This is a funded opportunity to build capacity and mitigate clinical needs by addressing social needs. The grant offers a total of $65,000 in year one and $50,000 in the following three years across two implementation sites which could cover costs of personnel, IT functionality, a referral platform or self-measured blood pressure monitoring in public spaces, among other supports the implementation sites need to deliver this care. System wide transformation across multiple agencies can be achieved by implementing or expanding strategies in your organization.

Goals: Streamline SDOH screening with focused referrals for social needs, to reduce CVD risk for populations with hypertension and/or high cholesterol. Collect data to measure impact of addressing social needs on CVD risk. Share a model that can be scaled or replicated in other populations or settings.

Process: Elements of a project could include:

- Identifying population with CVD risk
- Developing, standardizing or expanding tracking and monitoring of social needs
- Building and expanding network of community partners to address social needs
- Monitoring referrals to and utilization of appropriate and consistent social services
- Building or maximizing team based care (i.e. community health workers, care coordinators, community nurses) to mitigate social service barriers

Project Scope: Patients in primary care panels with hypertension (>/= 140/90 mmHg) and/or high cholesterol (LDL >110 mg/dL).

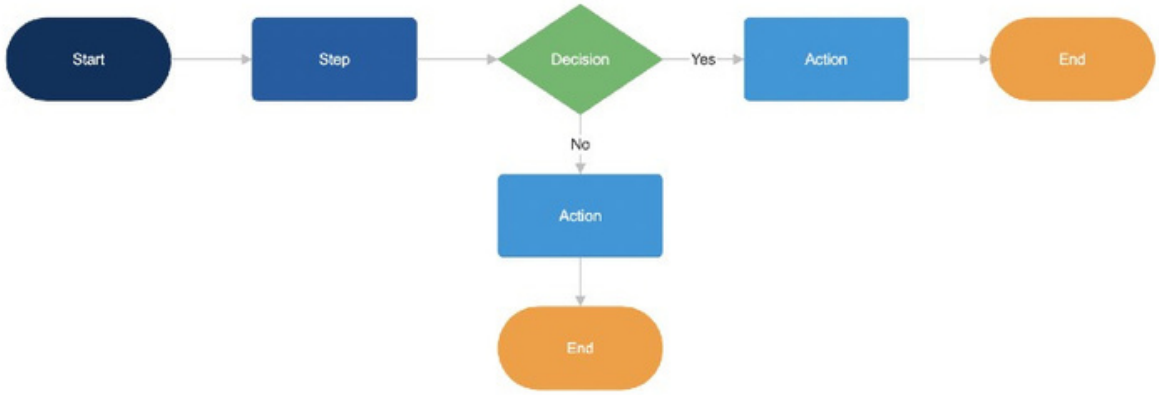
Potential Measures:

- Hypertension control
- Hyperlipidemia control
- Cardiac events
- Closed referrals to community partners

Partners:

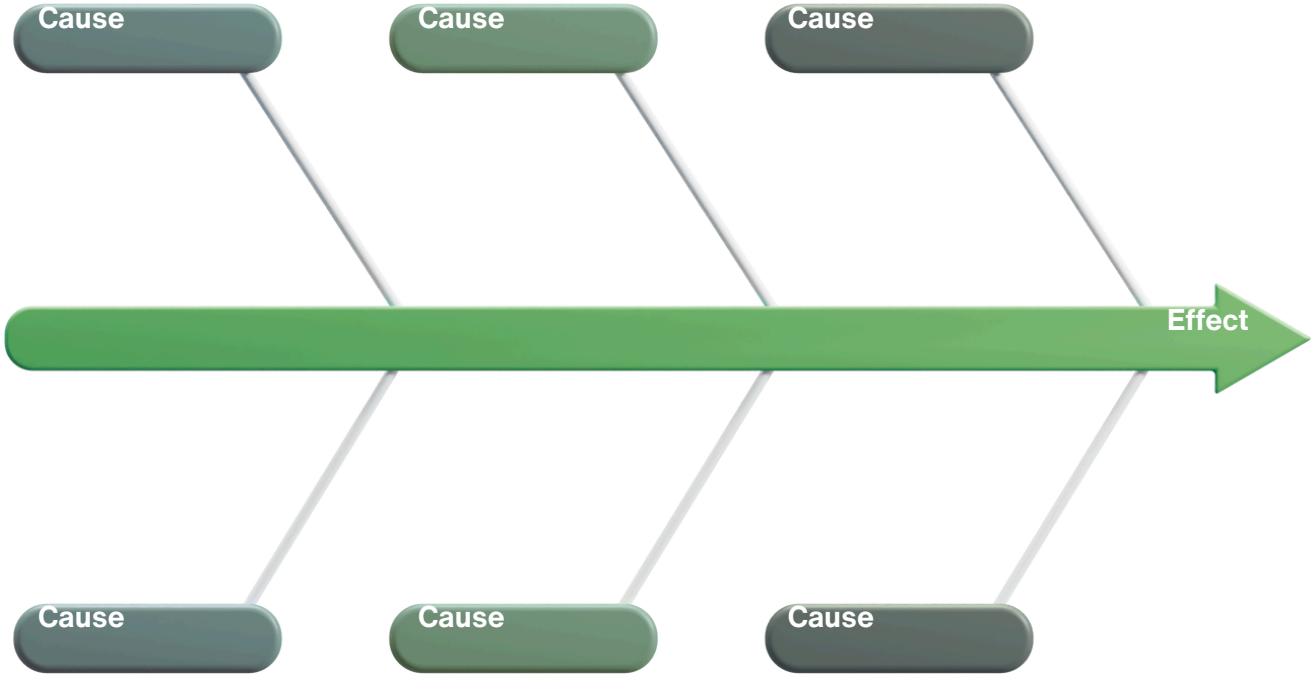
Grant Reporting & Network Development	Nicole Hamlet, VDH Rudy Fedrizzi, VDH Cara Baskin, GUVIST
Implementation Sites:	Little Rivers Health Care Good Neighbor Health Clinic
Fiscal Sponsor:	Public Health Council of the Upper Valley
Community Partners	Willing Hands, VT Food Bank, Hannaford, NHS

Appendix C. Flowchart



Appendix D. Fishbone Diagram

Common categories of root causes are environment, supplies, culture, people, process. List specific factors under each category. This diagram can be used in conjunction with the 5 Whys Exercise.



Appendix E. 5 Whys Exercise[14]

Template: 5 Whys

EVENT. What happened? Define the problem as an *event*:

PATTERN. What's been happening? Define the problem as a *pattern* by selecting a poor performance factor:

STRUCTURE. Why is it happening? What are the tangible and intangible structures determining the results we see?

1. Why is that?
2. Why is that?
3. Why is that?
4. Why is that?
5.

ACTION. What are the implications for action? What can you do to change the results?

Appendix F. Community Engagement Spectrum

from the **Community Engagement Toolkit**[9]

The Collective Impact Forum adapted this from the International Association for Public Participation (IAP2) www.iap2.org

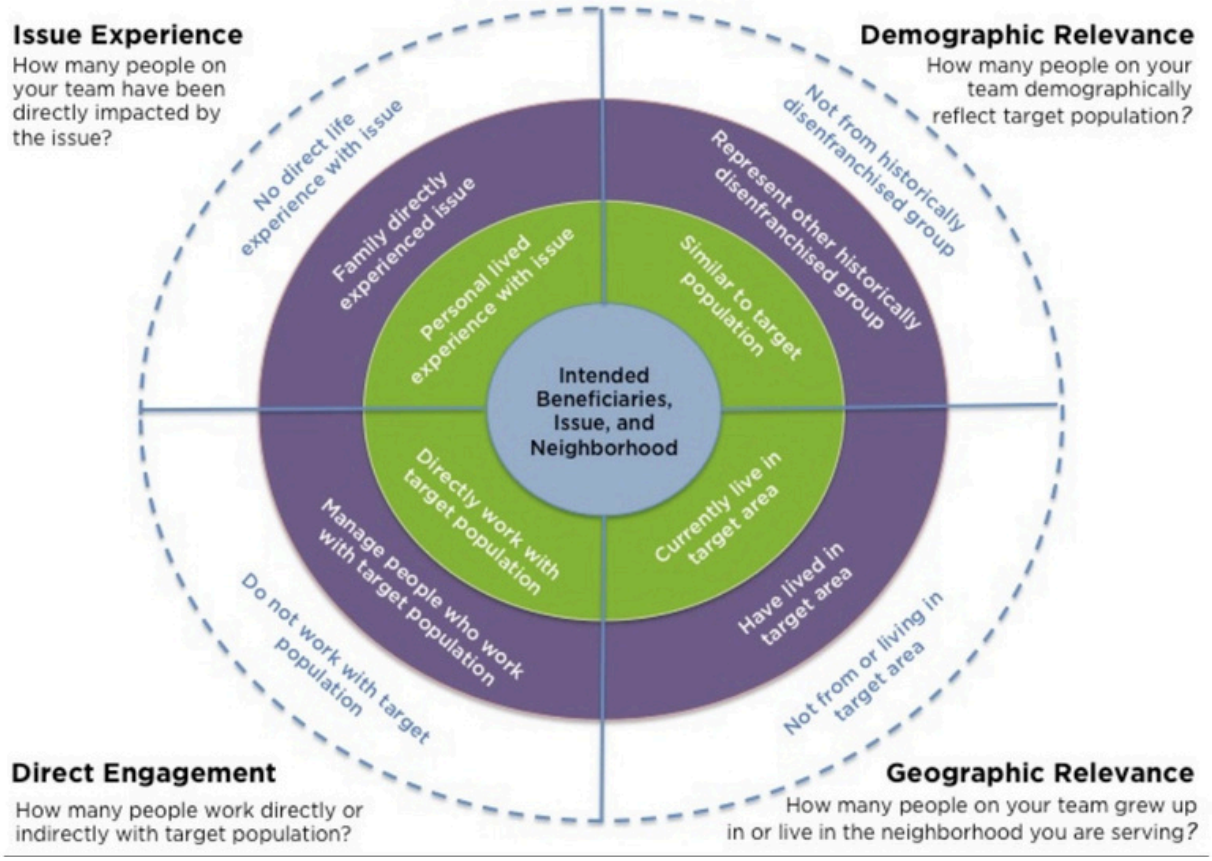
Increasing Impact on Decision-Making and Implementation

INFORMING	CONSULTING	INVOLVING	COLLABORATING	EMPOWERING
Providing balanced and objective information about new programs or services, and about the reasons for choosing them	Inviting feedback on alternatives, analyses, and decisions related to new programs or services	Working with community members to ensure that their aspirations and concerns are considered at every stage of planning and decision-making. We also engage their assets as partners to implement solutions.	Enabling community members to participate in every aspect of planning and decision-making for new programs or services. Community members actively produce outcomes.	Giving community members sole decision-making authority over new programs or services, and lead work to implement solutions. Professionals only serve in consultative and supportive roles
We will keep you informed	We will keep you informed, listen to your input and feedback, and let you know your ideas and concerns have influenced decisions	We will ensure your input and feedback is directly reflected in alternatives, and let you know how your involvement influenced decisions. We will engage you as partners to implement solutions.	We will co-create and co-produce solutions with you. You will be true partners in making and implementing decisions for the community, your advice and recommendations will be incorporated as much as possible.	We will support your decisions and work to implement solutions.
Fact sheets, newsletters, websites, open houses	Surveys, focus groups, community meetings and forums	Community organizing, leadership development, workshops	Advisory boards, seats on governing boards, engaging and funding as partners	Support full governance, leadership, and partnership

Appendix G. Theory of Change

Discussion Topic	**Assumptions** (principles, beliefs and ideas)
1. Problem/Issue including Key Audience: Who is most affected by this issue?	
2. Desired Results: Long-term expectations for change. Target of interventions: Who/What will change? Who benefits?	
3. Community Needs & Assets: Can provide baseline indicators	
4. Influential Factors: i.e. Protective and risk factors, barriers and supports, existing policy environment that could influence change	
5. Action-oriented Steps Needed to Bring Change:	
6. Measurable Effects of Work (Short-term):	
7. Wider Benefits of Work (Medium-term):	

Appendix H. Building Equity into our Tables[9]



Appendix I1. Logic Model Template

Planned Work			*Results*		
Needs	**Inputs**	**Activities**	**Immediate Outputs**	**Long-Term Outcomes**	**Impacts**
What change does the system need? i.e. Improved coordination between health and human services	Resources needed to implement activities	What each organization in the network will do	Tangible deliverables resulting from activities	Changes in people or conditions because of activities and outputs	Longer term outcomes- high level change to system

Appendix I2. Sample Logic Model for Lead Poisoning Prevention Network

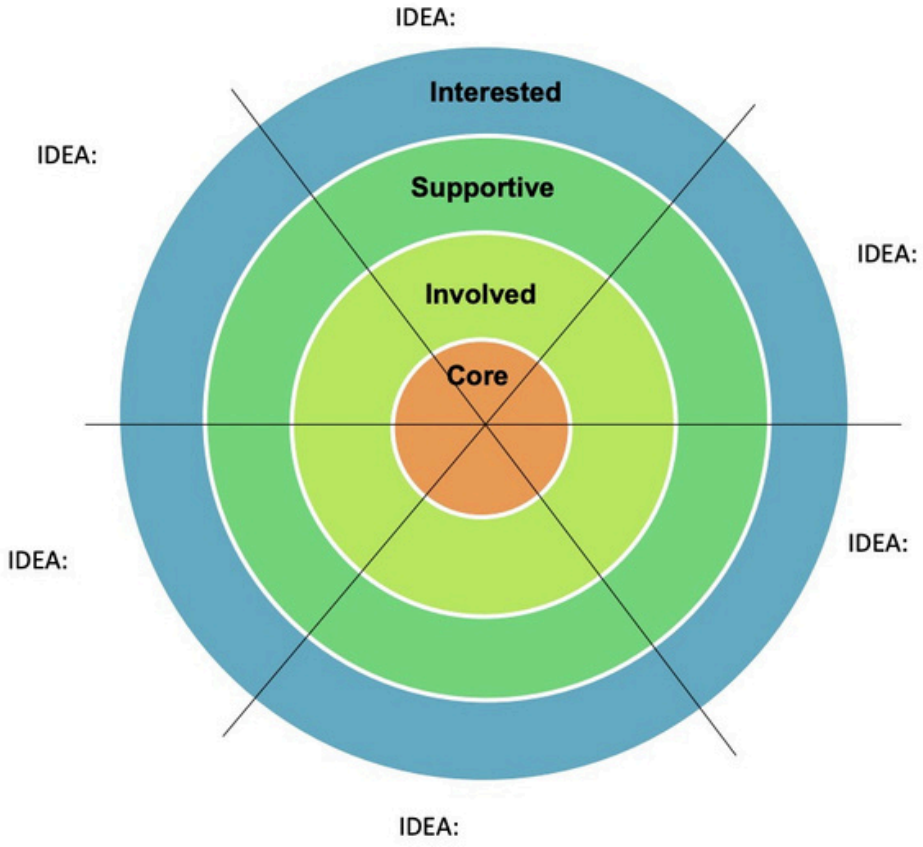
Planned Work			*Results*		
Needs	**Inputs**	**Activities**	**Immediate Outputs**	**Long-Term Outcomes**	**Impacts**
Informed parents	Parent education handout	Locate VDH parent interviews with known barriers Propose intern project Support intern in creating handout/personalize by town Other methods of storytelling? Implement in bistate clinics and share widely elsewhere (i.e. listserv, Parent Child Center, daycare, Vital Communities, ECEA)	Handout that is persuasive with local data, informed by known barriers and concerns with lead testing	Parents making informed decisions	Improved testing rates
Accurate registry	Streamlined communication between lab and Healthy Homes	Reach out to practices to confirm workflow/expectations	Clarity around roles	Accurate registry	Ability to make data informed quality improvements in future
Better alignment with state requirements	Provider education EMR flags/hardstops Incentives	Grand rounds Meeting individually with clinics Recognition of exceptional test rates Suggest lead testing as NCQA measure/meet with Blueprint managers Recommend workflows, EMR best practices, suggestions to reduce coagulation Suggest adding lead to work plan of nurses who round clinics for immunizations Recommend catch up testing in VT Clarity around monitoring positives and misalignment between state law and lab cutoffs for recommending followup	Provider awareness; built in best practices	Willingness and ability to improve rates	Improved testing rates
Consistent reflection on data	Identify benchmark Identify who in each clinic can access data	Request overdue rates at DH and use as proxy Identify immunization rates Delegate roles and check ins for ongoing reflection of clinic data	Setting realistic goal for NH/VT Providing opportunity to check in	Ability to quickly respond to worsening rates in future	Maintain lead testing as a priority
Improved access to tests	POC tests	Identify funding for lead tests at WIC and other clinics	Ability to procure tests	Lower barriers to testing	Improved testing rates
Alignment between VT and NH practices	Relationship building	Convene VT Healthy Homes, VCHIP and NH DHHS	Open line of communication across border	Sharing of best practices	Alignment and optimized practices bistate
Equitable action	Data Capacity to manage positives	Access/interpret data on high risk populations (i.e. Medicaid, low income housing) Identify resources needed to manage positives Identify leaders who can educate/influence Partner with towns; influence policy; inform through legislation	Equity lens on who is most affected	Ability to intervene	Equity in exposure, testing, support for positives
Fewer positives	Known sources of exposure	Identify sources of exposure from [Healthy Homes? DHHS?] Ensure sources communicated to providers, parents, towns	Growing list of sources of exposure	Ability to mitigate future exposures by sharing information	Prevention of lead exposure

Appendix J. Wheel of Engagement [11]

EXERCISE WORKSHEET

Plot your ideal level of participation on the Wheel:

- **Core** – Interested in being actively involved in the functioning and development of the idea.
- **Involved** – want to be frequently consulted and given opportunities to provide in-depth feedback. (i.e. attending topic specific/community specific/age specific discussions or workshops)
- **Supportive** – want to provide some form of support and input (i.e. attending future community forums, answering surveys and providing input online).
- **Interested** – want to be kept informed of the progress of the initiative, but not be directly involved in the work (i.e. newsletter, informed about opportunities to participate in events)



Appendix K. Data Collection Plan

Suggested steps:

1. Define your goals. What is the problem? What am I trying to improve? What data describes the problem/ improvement opportunity? What are your global goals? S.M.A.R.T. goals?

2. Determine what data will inform your improvement work. What data will you collect that will let you know if your intervention is making a difference? Will you use qualitative or quantitative data?

3. How will you collect and analyze your data?

- Where will you get the data?
- Who is responsible for gathering the data?
- When and where will you collect data?
- How will you ensure everyone is collecting data the same way?

Data definitions:

- Conceptual definition: Describes what you are trying to measure
- Operational definition: Defines how data is collected to operationalize the conceptual definition
    - Includes what something is and how to measure it
    - Removes ambiguity so that all people involved have the same understanding of the characteristic or feature in question

Sample Data Collection table, adapted from UWHealth:

S.M.A.R.T. Aim Statement (Specific, Measurable, Achievable, Relevant, and Time-bound)									
What question are you answering?	**What is being measured?**	**Metric definition**	**Goal (with units)**	**How will data be collected?**	**How will data be validated?**	**Who will collect it?**	**Start Date:**	**End Date:**	**How will data be shared?**
							Pre:	**Pre:**	
							Post:	**Post:**	

Sources

1. Fedrizzi R, Persson K (Eds.). 2014. Ten Steps for Improving Blood Pressure Control in New Hampshire. https://scholars.unh.edu/cgi/viewcontent.cgi?article=1028&context=ihpp
2. Woodland R, Hutton M, Evaluating Organizational Collaborations: Suggested Entry Points and Strategies. American Journal of Evaluation. 2012. DOI: 10.1177/1098214012440028.
3. Mazur B, Woodland R. 2022. GUVIST Network Analysis Project Wrap-Up. [Powerpoint slides].https://drive.google.com/file/d/1Qk2911bEC2I8rxauwu4YC0Ed6q587YKI/view?usp=sharing
4. Collective Impact Forum. 2015. Getting Started with Collective Impact Collaborating to Create a Common Agenda. Collective Impact Forum. https://www.fsg.org/wp-content/uploads/2021/08/Collaborating-to-Create-a-Common-Agenda-11-03-2015-Handout_0.pdf
5. Kania J, Williams J, Schmitz P, Brady S, Kramer M, Juster JS. 2021. Centering Equity in Collective Impact. Stanford Social Innovation Review, 20(1), 38–45. https://doi.org/10.48558/RN5M-CA77.
6. Attell BK, Kingery K, Adimu T, Butts J, Howard P, Saha S, Minyard K. Development and Validation of a Measure to Assess Readiness to Advance Health and Equity: The Assessment for Advancing Community Transformation (AACT). Eval Health Prof. 2023 Dec;46(4):309-319. doi: 10.1177/01632787221139244.
7. Ogden C. 2016. Social Change Networks: Keep Telling the Evolving Story. Interaction Institute for Social Change. https://interactioninstitute.org/change-networks-keep-telling-the-evolving-story/.
8. Principles of Community Engagement - Second Edition. 2024. Agency for Toxic Substances and Disease Registry. https://www.atsdr.cdc.gov/community-engagement/php/executive-summary/?CDC_AAref_Val=https://www.atsdr.cdc.gov/communityengagement/pce_execsummary.html
9. Schmitz P. 2017. Community Engagement Toolkit. https://collectiveimpactforum.org/wp-content/uploads/2021/12/Community-Engagement-Toolkit.pdf
10. Brady S, Juster JS. 2016. Collective Impact Principles of Practice: Putting Collective Impact into Action. Collective Impact Forum. https://collectiveimpactforum.org/blog/collective-impact-principles-of-practice-putting-collective-impact-into-action/
11. Tamarack Institute. 2017. Stakeholder Engagement Tool. Tamarack Institute. https://www.tamarackcommunity.ca/interactive-tools/stakeholder-engagement-wheel
12. FSG. 2011. Collective Impact: Implementing Shared Measurement. FSG. [Powerpoint slides]. https://collectiveimpactforum.org/wp-content/uploads/2021/12/collective_impact_shared_measurement_webinar_0.pdf.
13. Tamarack Institute. 2022. Sustainability Self-Assessment. Tamarack Institute. https://www.tamarackcommunity.ca/hubfs/Sustainability-Self-Assessment-Tool-EN-Fillable.pdf?hsLang=en-us
14. IHI. 2019. 5 Whys: Finding the Root Cause. Institute for Healthcare Improvement. https://www.ihi.org/resources/tools/5-whys-finding-root-cause#downloads