Health Promotion and Health Communication Framework Guide

Adopted June 2023

Nebraska Division of Public Health

The World Health Organization (WHO) defines health promotion as (WHO 1986): "Health promotion is the process of enabling people to increase control over and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy lifestyles to well-being."

In public health practice, health promotion planning, and strategy development necessitates consideration of the social determinants of health. This includes, but is not limited to, social and community influences and location, gender and culture, socioeconomic and environmental conditions, and lifestyle and behavioral factors. Addressing the fundamental determinants of health ensures activities to promote health are focused on equity of access to services, programs, and equity of outcomes.

The Social Ecological Model of Health Promotion, adapted from UNICEF (2014)[6]

The Social-Ecological Model. This model reflects the multifaceted relationship between individual, relationship, community, and societal factors. The overlapping rings demonstrate how factors at one level influence factors at another level. The model also suggests that it is necessary to act across multiple levels of the model at the same time. This approach is more likely to sustain prevention efforts over time and achieve population-level impact.

Health Promotion Framework Guide Purpose

The purpose of this Health Promotion Planning Framework is to act as an overarching "how to" guide across the Division of Public Health DPH). This is an overarching framework the DPH follows in the development or improvement of health promotion/health communication activities across the division to ensure that staff have considered the critical factors in project design. It is not specific to any one program or topic but is used across the department. It meets public health accreditation measures and ensures a standardized, strategic approach for developing and implementing health promotion/health communication activities.

The framework is divided into three parts, each part containing a series of steps. The Documentation Template will guide staff through the parts and of aligning health promotion work with this framework. The hyperlinks in the template correspond with each part providing the rationale and resources supporting the processes of health promotion, education, and communication.

After the parts and steps framework is the Health Promotion Spectrum, which helps staff ensure activities/programming are meeting "baseline" standards. The intent of the spectrum is for DPH staff to

strive for ideal programming and maximize outcomes while also recognizing ideal in all of the spectrum's areas will not always be achievable but moving up in some areas is possible.

Documentation Template

Part I: Assess

Step 1. What is the issue and how was it determined that it was a priority?

1a. Who are the key populations at highest risk and how were they determined?

Step 2. Is the work in compliance with the ADA, Title VI and CLAS requirements?

2a. What are the determinants of health and health equity factors the activity is addressing?

Step 3. How did staff/the program collaborate with partners?

Part II: Plan

Step 4. How did staff/the program engage the community?

4a. In planning for dissemination, answer the following:

- What's the ultimate aim of this work?
- Who did staff/the program partner with?
- If applicable, who is the program's key population contractor?
- Who is the focus population?
- What are the main messages of this activity?
- How is the activity being disseminated?
- Where will the activity be disseminated or targeted?
- What concerns or reactions may the larger community have with the activity and/or its messaging? How are those concerns/reactions being addressed? Are those being taken into consideration when before the activity launches.

Step 5. What is your evidence base for this activity and where is it documented?

Part III: Implement

Step 6. How does the activity's metrics and indicators that align with a theory of change?

Step 7. How is activity implementation being monitored and what adjustments have you made as a result?

7a. How is the activity being evaluated?

Part 1: Assess

Step 1: Determine that an issue is a priority and identify key populations at highest need

Identifying the populations at highest risk or with the greatest need ensures work is being done to reduce health disparities. Identifying disparities based on health outcomes and/or risk can occur at the same time as determining if an issue is a priority.

- Use data to determine if an issue is a priority. While programs may have access to specific data sources, the following are reliable sources of data used throughout the agency:
  - Disease registries addressing conditions such as communicable disease, cancer, and birth defects.
  - Healthcare data such as hospitalization and emergency room visits.
  - National surveys with state data such as the National Children's Health Survey.
  - Vital records such as birth and death data.
  - Data has often been analyzed and compiled into readily accessible reports and online tools:
    - Atlas is a web-based data visualization platform for delivering Nebraska Public Health data: https://dhhs.ne.gov/Pages/Nebraska-Public-Health-Atlas.aspx
    - County health rankings: https://www.countyhealthrankings.org/explore-health-rankings/nebraska?year=2023
    - CDC Places provides model-based, population-level analysis and community estimates of health measures: https://www.cdc.gov/places/index.html

Step 2: Health Equity Considerations

Ensure that the root causes of health are appropriately included and that the access, inclusion, and belonging factors for specific populations are considered (e.g., geographical location, veterans, race, ethnicity, gender, sexual orientation, minority populations, literacy level, those who live in poverty, and people with disabilities).

- Target multiple determinants of health with the selected intervention.
- Develop objectives for the intervention which specifically address the relationship between a population's health status and determinants of health.
- Understand reinforcing or inhibiting factors for a population's health which can stem from determinants and health inequities. These factors can impact the success of a health promotion or education activity. Consider the following:
  - Knowledge, attitudes, beliefs, values or confidence can facilitate or hinder motivation toward change.
  - Trust can be either a reinforcing or inhibiting factor depending on the community's trust level with the agency. Determining factors for trust include:
    - Historical relationship with DPH and/or other agencies trying to achieve a similar outcome.
    - Historical trauma or oppression experienced by that population.

BARRIERS/SUPPORTS:

a. Government policies and procedures

b. Corporate interests

c. Political interests

d. Targeting intervention appropriately

e. Interactions between individuals and their communities/community partners

f. Support systems in the community

    - Previous partnerships and the associated outcomes.
    - Ability for input and participation in decision making.
    - Reaching agreement about sharing raw data for analysis and sharing results with opportunity for input prior to publication or submission.
  - The degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others is important when designing an intervention. Determine health literacy/reading levels
    - https://readabilityformulas.com/free-readability-formula-tests.php
    - https://readabilityformulas.com/articles/how-to-use-smog-readability-formulas-on-health-literacy-materials.php
  - Culturally and Linguistically Appropriate Services standards (CLAS) (Appendix B) help agencies and organizations provide services that are responsive to their customers' language and culture. CLAS Standards help ensure quality services, creates credibility with communities and promotes health equity.

Step 3: Health Impact

Ensure that barriers and supports are addressed, and that the program will be maximally impactful. This involves considering social determinants, policies, and the build environment of your community.

- Get feedback activity from the key population through Focus Groups and Community Meetings to identify if community members anticipate any possible barriers or supports.
- Collaborate with community organizations that work in the community, to see if they have insight on barriers or supports.
- Perform an environmental scan of the resources in the community
- Analyze disparities data to identify possible problems or challenges with implementation in the community.
- Conduct a SWOT (Strengths and Weakness of the organization and Threat and Opportunities in the external environment) analysis. SWOT Tool: https://www.mindtools.com/amtbj63/swot-analysis

Part 2: Plan

Step 4: Collaboration

Collaborating with internal and external partners is essential. Partners serve as the bridge to the population activities aim to reach. It is important to be transparent and communicative, and to approach partners with cultural humility. Have a plan to identify partners and communicate the process.

- Hold, or participate in, community meetings and discuss the data. Get feedback from the community and use that in program development and implementation. This can include asset

mapping. Reach out to community partners and get their opinion on the program. Engage them as much as possible in program development (and implementation).

- Be aware of history, power and power structures. Partners can help with understanding the social, political and local issues that are of importance or concern in a community.
- Ensure that the people involved in program development and implementation include those the program will be affecting.
- Develop a feedback loop so that those engaged in planning are also involved in implementation and know how their feedback informed the process.
- Health Equity Resources/tools: https://humanimpact.org/products-resources/issue-area/?filter=iss1-145
- CDC's "Preferred Terms for Select Population Groups & Communities": https://www.cdc.gov/healthcommunication/Preferred_Terms.html
- Communications Tool: Plain Language for Public Health: https://publichealthcollaborative.org/resources/plain-language-for-public-health/

Step 5: Engagement

Involvement of the target population should be one of the first key activities when planning a program. Without knowing what a community wants, needs, or is ready for, the opportunity to best serve them may be missed. There are many strategies to involve the community in program planning. The important thing is that it been done. Keep in mind, certain cultural values may need to be accommodated to ensure participation and commitment.

- Early on get input about needs, priorities and what was learned during the assessment steps. There are several ways to do this, including advisory committees/boards, focus groups, information sessions, key informant interviews, open houses or surveys.
- Test products, messages and strategies with the target community. This ensures that what is produced will be understood and meaningful and get the intended results. Some forms of testing include intercept interviews, focus groups, questionnaires at community events or surveys.
- Disseminate intentionally and strategically. Be prepared to communicate the following to to increase awareness about the program, test for sensitivities and determine if additional steps are needed:
  - What's the ultimate aim of this work?
  - Who did staff partner with?
  - Who is the focus population?
  - What are the main messages of this activity?
  - How is the activity being disseminated?
  - Where will the activity be targets or disseminated?
  - What concerns or reactions may the larger community have with the activity and/or its messaging? How are those concerns/reactions being addressed? Are those being taken into consideration when before the activity launches?

Step 6: Identify or develop interventions using evidence-informed and/or evidence-based practice

When identifying, evaluating and prioritizing health promotion and education interventions, first review the scientific literature to determine which interventions have been shown to be effective, then customize the evidence-based or promising practice to be appropriate for the community.

A model for evidence-informed decision making in public health

- Evidence-informed decision making is the process of distilling and disseminating the best available evidence from research, context and experience, and using that evidence to inform and improve public health practice and policy. Evidence-informed decision making in public health considers the valuable evidence from a variety of sources:
    - Community health issues and local context
    - Existing public health resources
    - Community and political climate
    - The best available research findings
  - Utilize free and trusted online resources to gain knowledge and develop hands-on evidence-informed decision-making skills https://www.nccmt.ca/learning-centre?lang=en
- Evidence-based practice guidelines and systematic reviews provide the highest quality of evidence. Evidence-based practice guidelines are an exhaustive summary of the literature around a specific topic, while systematic reviews are a synthesis of individual studies. A meta-analysis is one type of systematic review that aggregates studies and estimates an effect. The following are a few examples of some reputable resources:
  - Access the scientific literature using the DPH Public Health Digital Library https://nphco.tdnetdiscover.com/
  - Agency for Healthcare Research and Quality - This site offers links to evidence-based practice reports and reviews as well as clinical practice guidelines.
  - Cochrane Library - This online library is a collection of evidence-based medicine databases.
  - Guide to Community Preventive Services - This guide is developed by an independent, non-federal task force appointed by the Director of the CDC. The task force reviews and evaluates evidence-based materials on the effectiveness and cost-effectiveness of community preventive health services.
  - Morbidity and Mortality Weekly Report - From the CDC, this website includes disease trends and continuing education opportunities and links to state health departments and public health organizations.
- Narrative reviews and individual studies are also good sources of evidence. Narrative reviews (e.g., book chapters, reports, proceedings from scientific meetings) are less systematic and more subjective than practice guidelines and systematic review. When evaluating individual studies, the most weight should be given to those studies with the strongest study design. Randomized control trials have the strongest study design and produce the highest quality of evidence followed by cohort studies, case-control studies, and cross-sectional studies. These can also be

accessed through the DPH Public Health Digital Library for staff, found here: https://dhhsemployees/sites/PH/DigitalLibrary/Pages/Home.aspx

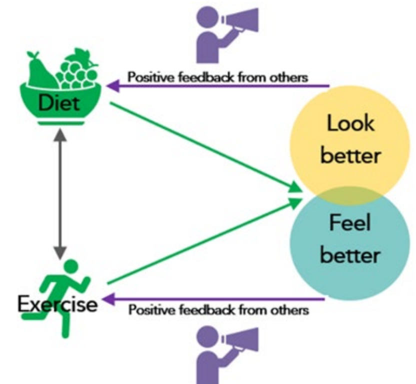
Part 3: Implement

Step 7: Align goals/objectives with Appropriate Metrics/Indicators

A Theory of Change and a Logic Model are in many ways very similar. Both methods map out the needed resources , the main activities that will occur, what the program will deliver as well as the intended end results to be achieved (outcomes and impact). Where they differ is that primarily a Theory of Change works to explain why a change will occur as opposed to simply what will occur. As a result, a Theory of Change is often more complex and needs to account for the context of the intervention, as well as the influence of factors outside of the intervention. Which method is appropriate will depend on the importance of the intervention, the complexity of the scenario, when it's being developed and the time, resources and the skills available. A logic model is often created after the program has been developed, working from resources through activities to the end result. A Theory of Change is best created before an intervention starts, mapping backward with the end result in mind to identify the most appropriate intervention.

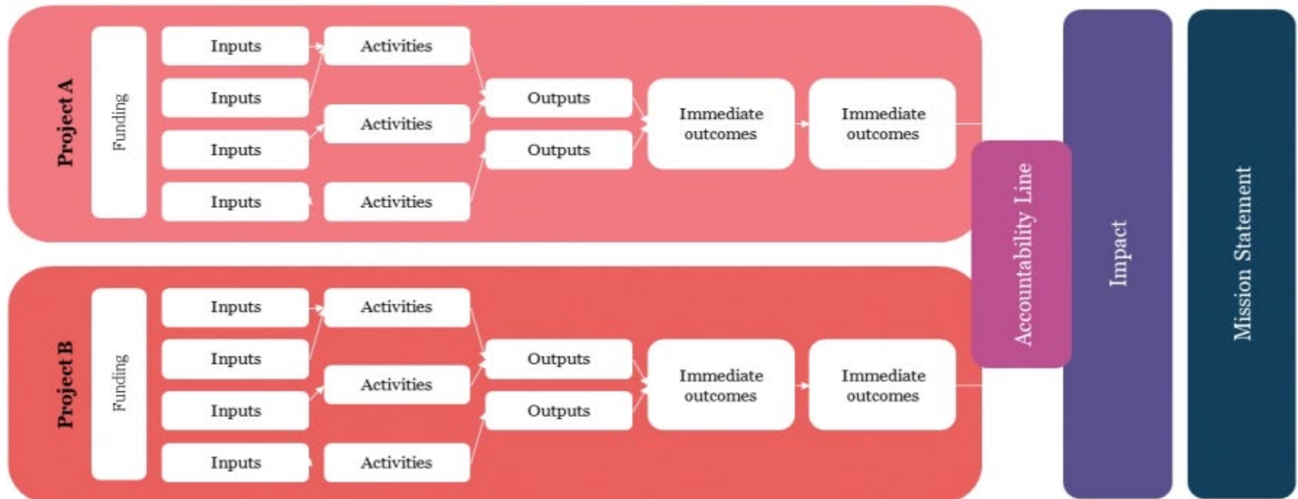
- **Theory of Change**

Documenting the theory of change involves detailing how a program or initiative is expected to produce desired outcomes and impact. It outlines the causal relationships between inputs, activities, outputs, outcomes, and impact. Theory of change documentation strengthens strategies and maximizes results by charting out the work ahead, what success looks like and how to get there. Unlike a logic model, theory of change documentation links outcomes and activities to explain HOW and WHY the desired change is expected to come about.



Adapted from: Patton, M. Q. (2008). *Utilization-Focused Evaluation, 4th Edition*. Sage.

- Downloadable templates to assist in developing a theory of change can be found here: https://assets.aecf.org/m/resourcedoc/aecf-theoryofchange-templates-2022.pdf



- **Logic Model**

Documenting the logic model involves summarizing the key components of a program in a way that others can understand at a glance A logic model is a table or diagram that shows HOW your program or initiative will work to fulfill an identified need. In developing a logic model, one may start from the outcomes and work backward, or start from inputs and activities and work forward. However, before starting, a clear and comprehensive understanding of the specific problem situation that is being addressed must be established

- Logic model toolkit: https://www2.ed.gov/about/offices/list/oese/oss/technicalassistance/easnaemlogicmodeltoolkit12016.pdf
- CDC Logic Model Checklist: https://www.cdc.gov/evaluation/steps/step2/Step-2-Checklist-Final.pdf
- Other resources:
  - https://www.cdc.gov/dhdsp/docs/logic_model.pdf
  - https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/logic-model-development/main

Logic Model Template Example

Inputs	Activities	Enablers	Intermediate Outcomes	Impacts

- **Theory of Change vs Logic Model - which one should be used?** Some considerations to think about are:
  - **Time and Resource:** A Theory of Change, due to its additional complexity, often requires more time and resource to get it established.
  - **Type of the intervention:** A Theory of Change is designed to capture the complexities of relationships. If there a lot of factors to creating the change you would like to see, a Theory of Change might be more appropriate. A more straightforward intervention might lend itself to a Logic Model.
  - **Stage of development:** A Theory of Change works best when it is developed before the intervention has been put in place and is used to identify and shape the intervention and activities. A Logic Model, on the other hand, isn't used to identify the types of interventions to implement or to help your team understand why a change will occur. Logic Models are better when you have already designed your intervention to act as a roadmap for depicting the relationship between program activities and its intended effects.
  - **Scale of the intervention:** A Theory of Change helps generate and capture a depth of understanding which isn't present in a logic model. It is, therefore, well worth the time to develop one for interventions or programs which are of greater magnitude to your area. For small projects which aren't expected to last long, a Logic Model can be preferable because you likely will not be using as much time or resources.

Step 8: Monitor and Evaluate

Monitoring and evaluation are necessary to determine successes, identify weakness and areas of opportunity, develop new strategies, re-maneuver and adapt programming. While this is step 8 in the plan, a best practice is to determine how the intervention will be evaluated before beginning the actual work. A strong monitoring and evaluation process to support reporting on the success of the initiative/activity is essential to partners and funders. Monitoring should include assessing for consistency in implementation while also providing opportunities for modifications. Evaluation determines whether an intervention is effective, sustainable and worthwhile.

DPH uses performance management structures to guide Division work – Clear Impact Results Based Accountability, the DPH Strategic Plan, and the DPH State Health Improvement Plan. Aligning with public health accreditation measures of these systems can strengthen the initiative and provide opportunities for input and exposure to the issue and increase the agency's success in meeting the measure.

- Use a continuous quality improvement process to monitor your implementation and make adjustments as needed.
- Review the most current DPH PMQI plan: https://dhhsemployees/sites/ph/Pages/Home.aspx
- Evaluate the activity for impact. There are three main types of evaluation:
    - Process evaluation - Did the program do what it said would be done? Were the objectives meet?
    - Impact evaluation – Were any short-term changes achieved as a result of the activity? These are often changes in knowledge, attitudes and behaviors. Changes in inhibiting or reinforcing factors can also be documented.
    - Outcome evaluation – Was there a change in longer-term health outcomes? They are sometimes the hardest to quantify. It takes a long time to see changes in health outcomes, yet outcomes are the strongest measure of success.
- Performance Management alignment for the activity:
    - Review the DPH Clear Impact Results Based Accountability performance measures. Program work contributes to long-term outcome measures in this system.
    - Review the most current DPH strategic plan. https://dhhsemployees/sites/ph/Pages/Home.aspx The Strategic Plan contains the Division's best thinking about strategies that will support the division's vision and the department's mission. Measures in this plan impact the division's outcome measures and are generally shorter-term and more internally focused.
    - Review the most current State Health Improvement Plan (SHIP). https://dhhsemployees/sites/ph/Pages/Home.aspx The SHIP contains actionable strategies and activities that support the infrastructure and equity of Nebraska's public health system, as well as the health status of Nebraskans. Measures in this plan impact the public health system and are generally shorter-term and more externally focused.

Health Promotion Spectrum

Adding this Health Promotion Spectrum to DPH's health promotion/health communication framework is a way to try to categorize activities and reflect on if the activity/initiative is being designed to have the greatest possible impact while taking into account limited resources. The following spectrum provides guidance on how to identify where a program falls on it baseline, developing, or ideal. It is meant to facilitate discussion when a DPH program area is goal setting and think about where their intervention is going to sit on the spectrum then use the "Moving Along the Health Promotion Spectrum" questions to move a program towards ideal.

It is suggested this guide be used in the following manner:

1. Use the Health Promotion Spectrum to ensure the program is/will be somewhere on the spectrum.
2. Use the "Moving Along the Health Promotion Spectrum" tool's prompt questions to assist with action planning for moving the program up the spectrum to ensure the most comprehensive and effective program possible.
3. Document action plans to move programming up the spectrum and reevaluate the program periodically. A Health Promotion Spectrum Checklist can be found in Appendix B.

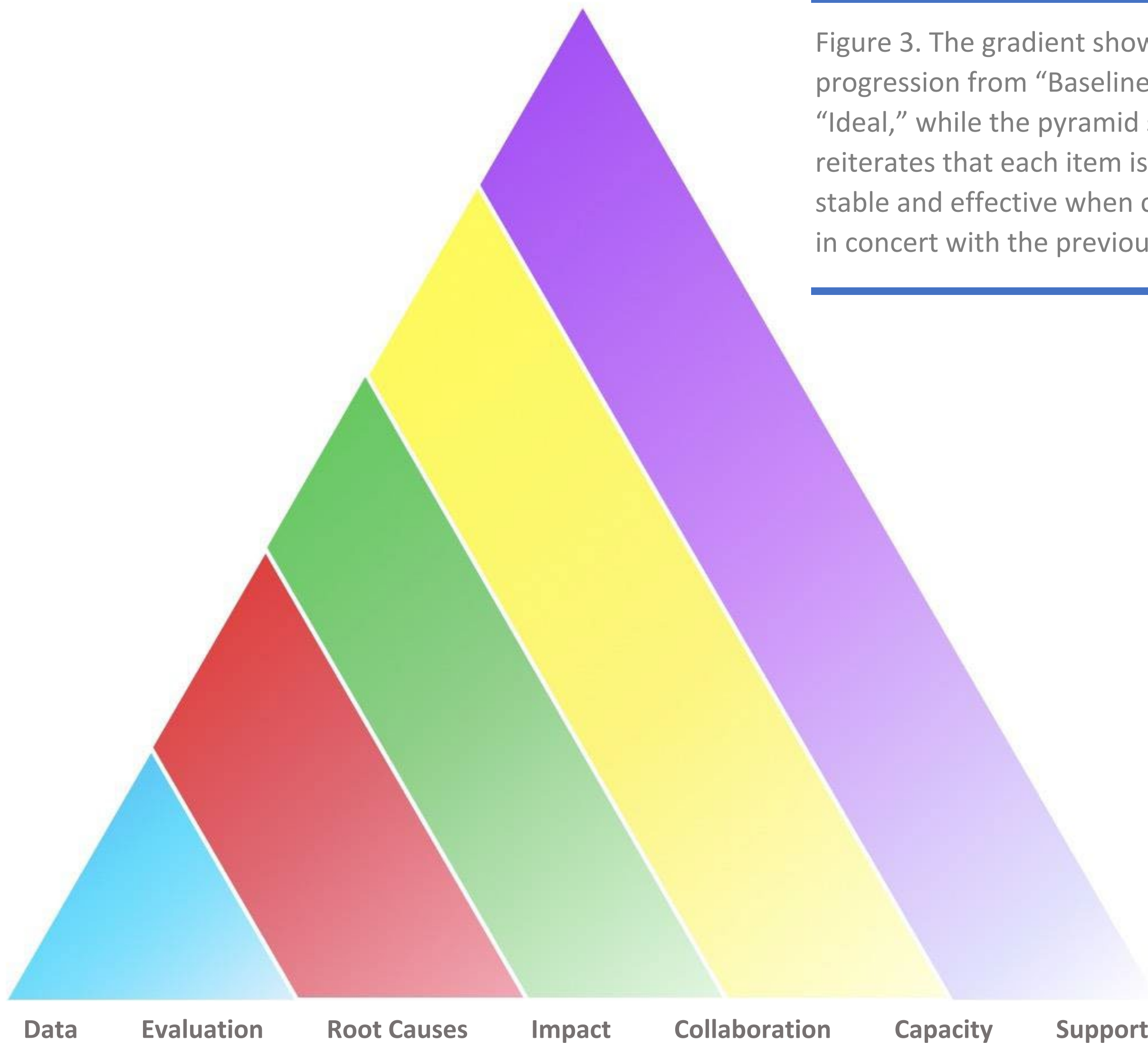


Figure 3. The gradient shows a progression from “Baseline” to “Ideal,” while the pyramid structure reiterates that each item is more stable and effective when considered in concert with the previous.

Figure 3

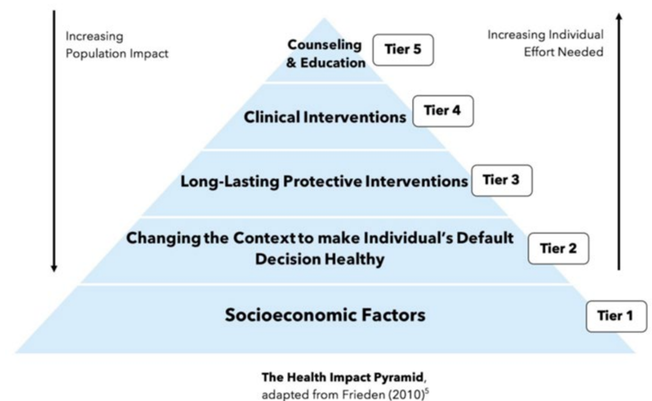
Baseline

- Data collection is occurring according to grant, performance management, quality improvement, or other guidelines
- Data are reviewed monthly or quarterly for major discrepancies
- The program has not developed a theory of change or logic model to measure performance
- Program is evidence-informed versus evidence-based
- Access, belonging, and inclusion questions have been raised, but no specific response has been added to the program
- Health Impact Pyramid, as part of the program, is not explicitly considered
- Capacity for implementation is not explicitly considered
- Barriers are occasionally considered and mitigated
- Supports are occasionally used

- Community is notified occasionally of plans
- Community is engaged insofar as the program affects them
- Staff are involved in implementation, but not in selection or decisions about development
- Staff of other offices and bureaus are not engaged
- DPH does not publish papers or make presentations in this program area
- DPH is not part of program-related community organization task forces, and other such meetings
- The mission, vision, and values of DPH are used to inform program development and quality improvement but action plans for quality improvement and/or to address developing policy are not explicitly considered

Better

- Data collection is occurring beyond the mandated guidelines
- Data are analyzed by program staff, or by epidemiology
- A theory of change or logic model have been developed for the program but is not fully realized in performance measurement
- Programs is both evidence-based and evidence-informed
- Access, belonging, and inclusion considerations inform program development in a general sense
- Health Impact Pyramid is considered, and program is in Tiers 3-5
- Capacity for implementation is considered, but does not inform program selection
- Barriers are regularly considered and fewer than half are mitigated
- Supports are regularly considered and fewer than half are used
- Community is brought up to speed and engaged often
- Community provides feedback
- Staff are involved in discussions about selection, development, and implementation
- Staff of other offices or bureaus are aware of activities and surface level collaborations are explored
- Action plans for quality improvement to address developing policy, removing barriers, and providing resources exist but are not fully fleshed out or immediately useable
- DPH is actively seeks out forums in which to lead, but might not be viewed as a necessary content expert or leader
- DPH occasionally publishes a paper or makes a presentation in this program area



The Health Impact Pyramid, adapted from Frieden (2010)[5]

Ideal

- Data collection is occurring in addition to mandated guidelines, in a specific and thoughtful way to improve program implementation, quality of services, and community understanding of success

- Data is being evaluated by a professional evaluator, in a formalized, scientific way; if possible, community participatory research practices are used
- There is fully realized theory of change that guides program evaluation
- Program is evidence-based
- Access, belonging, and inclusion explicitly considered and is used to create programs
- Health Impact Pyramid is considered, and program is in Tiers 1-2
- Capacity for implementation is considered and informs program selection
- Barriers are regularly considered, and more than half are mitigated
- Supports are regularly considered, and more than half are used
- Community drives program selection, development, and implementation
- Community feedback is used to change the program
- Staff feel their voices are heard and respected
- Creative collaborations with other offices or bureaus are actively explored
- Specific action plans for quality improvement have been made to address developing policy, removing barriers, and providing resources, and can be put into place as more funding becomes available
- DPH is actively sought out as a leader in discussions regarding public health in Nebraska
- DPH publishes articles and/or makes presentations to professional groups in this program area

Moving Along the Health Promotion Spectrum

The following prompt questions are meant to help facilitate thinking on how to move a program along the spectrum.

Data collection

- What type of evidence and best practices is the program using?
- What data are being used to determine who is served, in which communities?
- Are there similar programs in other states, or has this been pursued in Nebraska before?
- Has the program developed process and outcome measures?
- Does the program have clear and appropriate data collection procedures and resources?

Evaluation

- How often does the program review the data that being collected?
- Are the data collected being analyzed for trends and efficacy of implementation, either by program staff or by epidemiology?
- Does the program have an external evaluator looking at program success?
- Is evaluation occurring in a way that is useful to the program, and to programs that are trying to replicate the initiative, e.g., in other states?

Evidence Base

- How are staff finding evidence-based/evidence-informed programs, and what percentage of activities are evidence-based v. evidence-informed?

Root Causes of Health

- What root causes (a.k.a., social and structural determinants of health) are important in the community in which the activity is being implemented?
- What root causes were considered and how did they affect program development?
- Are the staff working with other DPH areas to address a common root cause of health?
- What root causes will the activity target next?
- How does the activity further access, inclusion, and belonging?
- How does the activity work to decrease inequities in health?
- What communities of people does the activity benefit?
- What communities of people does the activity burden?
- Does this activity benefit the people it is meant to benefit, without placing an undue burden on other people?

Health Impact Pyramid

- Which pyramid tier does the activity fall into?
- Is the activity thinking about how to move toward Tiers 1-2?
- Is the activity making the healthy choice, the easy choice?
- Is the activity minimizing individual effort on the part of community members?

Capacity for implementation

- Does the DPH area have sufficient capacity (funding, resources, staff) to implement the program with current resources? With resources dedicated for the next 5 years?
- Does the community have willingness, engagement, and support of the consumers/customers/residents?
- Does the activity maximize resources within the capacity of the department and the community?

Barriers and supports

- What barriers and supports exist?
- Have staff tried to mitigate barriers and/or use supports for the activity?

Appendix A: CLAS Standards

NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES STANDARDS

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Appendix B: Health Promotion Spectrum Checklist

	Baseline		Better		Ideal
	Data collection is occurring according to grant, performance management, quality improvement, or other guidelines		Data collection is occurring beyond the mandated guidelines		Data collection is occurring in addition to mandated guidelines, in a specific and thoughtful way to improve program implementation, quality of services, and community understanding of success
	Data are reviewed monthly or quarterly for major discrepancies		Data are analyzed by program staff, or by epidemiology		Data is being evaluated by a professional evaluator, in a formalized, scientific way; if possible, community participatory research practices are used
	The program has not developed a theory of change or logic model to measure performance		A theory of change or logic model have been developed for the program but is not fully realized in performance measurement		There is fully realized theory of change that guides program evaluation
	Program is evidence-informed versus evidence-based		Programs is both evidence-based and evidence-informed		Program is evidence-based
	Access, belonging, and inclusion questions have been raised, but no specific response has been added to the program		Access, belonging, and inclusion considerations inform program development in a general sense		Access, belonging, and inclusion explicitly considered and is used to create programs
	Health Impact Pyramid, as part of the program, is not explicitly considered		Health Impact Pyramid is considered, and program is in Tiers 3-5		Health Impact Pyramid is considered, and program is in Tiers 1-2
	Capacity for implementation is not explicitly considered		Capacity for implementation is considered, but does not inform program selection		Capacity for implementation is considered and informs program selection
	Barriers are occasionally considered and mitigated		Barriers are regularly considered and fewer than half are mitigated		Barriers are regularly considered, and more than half are mitigated
	Supports are occasionally used		Supports are regularly considered and fewer than half are used		Supports are regularly considered, and more than half are used
	Community is notified occasionally of plans		Community is brought up to speed and engaged often		Community drives program selection, development, and implementation

	Community is engaged insofar as the program affects them		Community provides feedback		Community feedback is used to change the program
	Staff are involved in implementation, but not in selection or decisions about development		Staff are involved in discussions about selection, development, and implementation		Staff feel their voices are heard and respected
	Staff of other offices and bureaus are not engaged		Staff of other offices or bureaus are aware of activities and surface level collaborations are explored		Creative collaborations with other offices or bureaus are actively explored
	DPH is not part of program-related community organization task forces, and other such meetings		Action plans for quality improvement to address developing policy, removing barriers, and providing resources exist but are not fully fleshed out or immediately useable		Specific action plans for quality improvement have been made to address developing policy, removing barriers, and providing resources, and can be put into place as more funding becomes available
	The mission, vision, and values of DPH are used to inform program development and quality improvement but action plans for quality improvement and/or to address developing policy are not explicitly considered		DPH is actively seeks out forums in which to lead, but might not be viewed as a necessary content expert or leader		DPH is actively sought out as a leader in discussions regarding public health in Nebraska
	DPH does not publish papers or make presentations in this program area		DPH occasionally publishes a paper or makes a presentation in this program area		DPH publishes articles and/or makes presentations to professional groups in this program area

Acknowledgements

This document was created using and/or modifying from sections of:

Washington State Department of Health 2018 Guide for Health Promotion and Health Education Activities

Chicago Department of Public Health 2018 Healthy Chicago 2.0 Health Promotion Program Framework