• Service coordination • Service integration • Access • Information systems • Cost • Access	with medical home; % participants accessing needed community resources/activities) -Enhanced service coordination (e.g. referral systems, between primary and specialty care) -Systems that decrease wait time for specialty services (e.g. behavioral health, emergency care) -Increased service integration (e.g. mental health and primary care) -Increased workforce capacity (e.g. training, consultation) -New/enhanced programs that fill gaps in services, reduce duplication -Enrollment and retention in new programs -# participants receiving chronic condition self management -Increased community-based outreach, supports and services -Improved transitions from one level of care to another (e.g. securing necessary home-based services on d/c) -# slots opened by providers to uninsured -Increase system capacity for utilization review -Create and maintain system for cross-agency case reviews to address client needs -Reduced no-show rates among uninsured -Increased use of evidence-based practices with uninsured -Develop process for instituting components of Pt. Centered Medical Home model -MIS improvements (e.g. to support care management) -Development of coordinated, cross agency system for collecting relevant information on health care utilization and outcomes (e.g. shared measurement system)
Individual outcomes	-Improved patient management of medications -Participant perception of self-management skills -Increased patient/caregiver satisfaction -Decreased patient isolation/increased community integration (e.g. attendance at community events over time, acceptance of home visits, phone contact, whether patient or caregiver initiate contact); improved perception of opportunities to stay engaged in meaningful activities at home/in community -% of participants engaged in chronic condition self-management -Improved health status and functional capacity (e.g. depression, self-perceptions of wellness/health over time)
Long-term outcomes	-Reduction in inappropriate ER visits -Decreased risk of hospitalization due to falls and other in-home hazards -Decrease in preventable hospital stays -Reduced (or delayed) nursing home placements after a hospital stay -Decreased spending for dually eligible MaineCare/Medicare on nursing homes -Decreased annual health care costs -Improved health status (specific to program interventions and target population)

	-Community members express satisfaction with level of involvement -Leadership development offered to community members
Community Capacity Building	-Training (e.g. advocacy, facilitation, collective impact, network weaving) is conducted and is responsive to partner and community needs -Training reaches key partners and community members -Community members learn to collect information, help interpret findings, use data for planning
Develop shared vision and goals	-Criteria set for identifying population, geography, health issue, intervention -Consensus reached on health issue and/or intervention -Health issue reflects the needs/concerns of community -Communities develop a plan with a common agenda that aligns programs and services to comprehensively address selected health issue (-Community develops viable and sustainable plan (TiP) -Communities define clear objectives related to selected intervention -Goals reflect individual and caregiver experience (including perception of opportunities to stay engaged in meaningful activities at home and in community) (TiP) -Plan prioritizes community-identified issues -Leadership of partner organizations aligned at all levels to support plan
Information Gathering and Measurement	-Assesses baseline community health status; community readiness -Uses secondary data to amplify/confirm qualitative data and inform strategy -Results are made available/accessible to partners and community -Explores pre-existing models/programs/systems in designing project -Conducts system-wide study of patient and system level data capacity -Implements evaluation and uses findings for project improvement
Network Development and Impact	-Network action -New partners and sectors engaged in the work -New collaborations result in action/outcomes that advance goals -Partners critical to achieving goals remain engaged -Increased trust and connections among small/emerging organizations and with mainstream organizations -Effective leadership -Network develops work plan with participation of partners -Responsiveness to emerging policy/program issues -Health focus incorporated into other sectors -Network action results in system changes -Increased community participation in systems change
System-level Outcomes • Service delivery	-Increased service capacity -Increased access to care (e.g. Increased #/proportion uninsured enrolled in plan/program; increased #/% uninsured

Assessment Matrix: Achieving Better Health in Communities (DRAFT 1 September 2014)

- This matrix is a preliminary framework for the evaluation of Achieving Better Health in Communities. It is based on grantee proposals, 6-month progress reports, interviews, and implementation RFP.
- This is a comprehensive list of possible indicators, but not all indicators pertain to all 3 initiatives. Once grantees are further along toward planning and implementation, we will refine this list as we learn more about which indicators pertain to your goals, and which ones we can collect across grantees.
- The final evaluation framework will include methods and data sources and who will collect data (local evaluation team or external evaluator team)
- The analytic domains roughly follow the three phases of the initiative: pre-planning; planning; and implementation. Some of the indicators may map to more than one phase; for example, network and partnership formation may occur in pre-planning and planning grants.

Analytic Domains	Indicators
Network/partnership/ collaborative formation[1]	-Sectors identified as important to goal achievement represented -Participation level is consistent or appropriate given project phase & skills/role -Members have appropriate level of decision-making authority to advance project goals -Efforts are made to distribute leadership, identify emerging leaders, conduct leadership development -Membership includes community members -Community members meaningfully engaged in decision making process -Members oriented to purpose, process, and goals to enable meaningful participation -Members value participation -Members feel that collaborative is contributing to positive change -Culture is considered in designing strategies -Collaborative emphasizes collective learning
Engage members of marginalized population	-Data gathered in ways that are culturally sensitive -Community members participate in data collection activities (e.g. interviews, conversations, focus groups, etc) -Community members assist in design of data collection tools, data collection, analysis, reporting, interpreting results -Community members actively engaged in developing action plan

[1] The network indicators listed in this row are examples of the types of indicators that are associated with network effectiveness. The evaluation plan will include indicators from survey submitted by grantees to MeHAF.