FROM STRATEGY TO MEASUREMENT: WHY ALIGNMENT MATTERS IN COMMUNITY HEALTH

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"Survey the path for your feet, and all your ways will be sure." (Proverbs 4:26)

At healthcare executive meetings, leaders routinely review infection rates, readmissions, net patient service revenue and case mix index. Some are routine operational measures; others function as key performance indicators (KPIs), a term healthcare adopted from the business world.

KPIs help translate strategy into measurable goals and connect our Gospel commitments, mission, vision and values to day-to-day work. Business-derived models such as SMART goals, leading versus lagging indicators, along with healthcare quality frameworks such as Total Quality Control and Donabedian's structure-process-outcome model, can help organize that work. Yet many of these models assume significant control over inputs and processes, making them easier to apply in manufacturing and some healthcare operations than in community health.[1]

Similar to manufacturing or other service industries, healthcare does have inputs, processes and outputs. However, quality and processes in the majority of industries are fundamentally different from improving health across people with varied diagnoses, social circumstances, access barriers and comorbidities. Biology, behavior, environment, economics and policy shape outputs in ways healthcare organizations cannot fully control, making these models challenging, particularly in community health.

Because community health focuses on factors that shape individual and community well-being, many of which lie outside healthcare delivery, it creates a central dilemma for executives, boards, the public and policymakers: How should community health or community impact be measured, and what does success look like?

Effective measurement in community health should separate what health systems control, what they influence and what broader community outcomes they support through strategy, partnerships and disciplined execution.

Though it is morally powerful to say healthcare should solve issues such as food insecurity, housing or gun violence, these are not common operational tasks suited to traditional quality improvement; they are "wicked" problems shaped over generations by policy, economics, geography and social conditions. No single program, organization or industry can solve them alone. That reality does not absolve healthcare organizations of responsibility; it defines the boundaries of their impact.[2]

Community health, therefore, needs metrics that distinguish healthcare delivery from broader health outcomes while keeping them aligned. Quality management principles remain useful, but they must be adapted to a community health paradigm, making measurement frameworks complementary rather than competing.

BUILDING MEANINGFUL MEASURES

A practical measurement approach should answer three questions: What is within the organization's control? What outcomes are influenced but not owned? And how do program outputs connect to long-term community health goals identified

through strategy and other foundational documents, such as the community health needs assessment (CHNA) and linked to the community health improvement plan (often known as CHIP or implementation strategy)?

Logic models are planning tools well-suited for community health, articulating what a program does and what it hopes to accomplish using "if–then" logic.[3] This model provides a practical way to answer questions about accountability, influence and impact by connecting program design, implementation and outcomes without overstating what the organization owns and linking program activity to longer-horizon outcomes. Like Donabedian, it distinguishes inputs (structure), activities (process) and outputs (outcomes), but it also adds short-, intermediate- and long-term outcomes, and importantly, assumptions and contextual factors.

The inputs, process and outputs sections of the logic model lend themselves to tools such as SMART goals to measure KPIs within their span of control. While the outputs contribute to broader outcomes, healthcare organizations should avoid claiming ownership of those results driven more by context than by their own programs.

For example, a community health KPI should not be "eliminating food insecurity in the community," which is a strategic aspiration. Instead, it should focus on a feasible operational measure, such as the number of patients screened for food insecurity and verified as connected with a food bank. That KPI reflects the inputs required to build a screening program and train staff, the activity of screening patients, and the output of connecting patients with food insecurities to resources. It measures how well the organization performs the work it can control and improve.

PRIORITIZING WHAT HEALTH SYSTEMS CAN INFLUENCE

Once leaders distinguish control from influence, the next question is what to prioritize. An impact-versus-feasibility exercise helps translate mission, vision, values and strategy into practical and motivating KPIs.

Impact is the why: the scale of positive change and value a project could create. Feasibility is the how: the capability, effort and time required to accomplish it.

High-impact, high-feasibility work is low-hanging fruit that can quickly improve efficiency and effectiveness. High-impact, low-feasibility work represents strategic initiatives that require time and resources but offer substantial benefits. Low-impact, high-feasibility programs may be tempting because they are easy to start, but they offer limited payoffs. Low-impact, low-feasibility work should generally be avoided because it requires significant investment with little return, and programs with low impact, in general, should not become KPIs because of their limitations toward reaching strategic outcomes. Plotting options on a 2x2 impact-feasibility matrix makes these distinctions easier to see and discuss.[4]

Because no organization can address all social determinants of health at once, the CHNA helps teams narrow their focus to shared priorities through the CHIP. Those priorities can anchor the logic model, guiding inputs and processes that produce outputs in support of CHNA/CHIP-aligned outcomes.

MEASURING WHAT WE CAN INFLUENCE

This same distinction between aspiration, influence and control is important in community benefit reporting. Politicians, think tanks and media often focus on the value of nonprofit healthcare using IRS community benefit reporting. However, this is a blunt tool for showing community value. The same KPI discipline should apply here, with measurement focusing on what the organization can intentionally influence.

Uncompensated care, charity care and unreimbursed Medicaid are important. Yet, healthcare systems have limited influence over these categories, mostly through financial assistance policies and location of services. Healthcare systems do not control Medicaid eligibility, insurance markets, coverage affordability or employment-based insurance, all of which are significant policy factors that drive these categories.

By contrast, community benefit activities and community-building investments create stronger opportunities for an intentional community health strategy. A community benefit program itself has inputs, processes and outputs that can be defined in a logic model to track larger outcomes, such as the number of programs or the amount of dollars.

Healthcare should not claim sole responsibility for societal conditions it did not create and cannot solve alone, but it should be accountable for the work it can lead, the partnerships it can strengthen, and the arguments it can help shape.

WHAT DOES SUCCESS LOOK LIKE?

The practical challenge, then, is turning measurement discipline into governance discipline. For the C-suite, success should mean disciplined alignment with, rather than ownership of, community-level outcomes. The question is not whether one organization can solve a generational social problem alone, but whether its strategy, investments, partnerships and KPIs align with the role it can credibly play. A strong community health KPI shows that the organization is doing the right work, at the right level of influence, and consistently enough to learn and improve.

ALIGNMENT: THE MEASURE OF DISCIPLINE

Community health sits at the intersection of healthcare delivery, social care, policy, economics and community infrastructure. Its challenges are complex and resistant to simple intervention. That complexity should not lead to vague measurement or inflated claims; it should lead to greater discipline.

The central task is alignment: strategy with community needs, activity with organizational roles, investment with spheres of influence, and KPIs with levels of organizational control. Healthcare should not claim sole responsibility for societal conditions it did not create and cannot solve alone, but it should be accountable for the work it can lead, the partnerships it can strengthen, and the arguments it can help shape.

In community health, success is not measured by aspiration alone. The real test is whether the work is aligned, measurable and accountable.

By considering the path to better community health and establishing the conditions that lead to impact, healthcare can play its role in building a community where everyone has a fair and just opportunity to live a healthy life and flourish.

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NOTES

1. SMART goals relate to specific, measurable, achievable, relevant and time-bound goals. Total Quality Control is a management system that aims to integrate quality improvement into every aspect of an organization. Also of interest may be: Avedis Donabedian, "Evaluating the Quality of Medical Care," *Milbank Quarterly* 83, no. 4 (2005): 691-729, originally published in *Milbank Memorial Fund Quarterly* 44, no. 3, pt. 2 (1966): 166-203, https://doi.org/10.1111/j.1468-0009.2005.00397.x.
2. Horst W. J. Rittel and Melvin M. Webber, "Dilemmas in a General Theory of Planning," *Policy Sciences* 4, no. 2 (1973): 155-69, https://doi.org/10.1007/BF01405730.
3. "Evaluation Guide: Developing and Using a Logic Model," U.S. Centers for Disease Control and Prevention, https://www.cdc.gov/library/media/pdfs/2024/10/logic_model.pdf.
4. Victoria Thompson and Tucker O'Donnell, "Using the Feasibility and Impact Matrix for Policy Prioritization," NACCHO, October 17, 2025, https://www.naccho.org/blog/articles/using-the-feasibility-and-impact-matrix-for-policy-prioritization.

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