The Joyful Complexity of Measuring Social Determinants of Health

NC IOM Accountable Care Communities Task Force
June 29, 2018 11am

EMMA OLSON, LMSW, MPH

INTERIM DIRECTOR OF PARTNERSHIPS AND EVALUATION

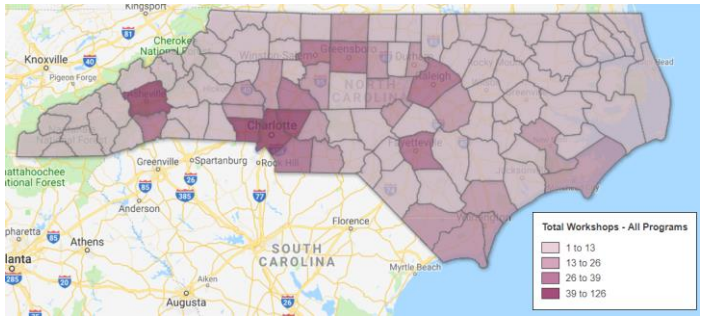
EOLSON1@UNCA.EDU ~ (828)258-7715

Presentation Agenda

- Introduction
- Complexity of terms and blending models
- Introduce Results-based Accountability™ framework and key terms
- Share our approaches: partners, processes and measures
- Identify lessons learned and recommendations
- Facilitate discussion about additional measures and what resonates

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results™

NC Center for Health and Wellness at UNC Asheville



Heat Map of NCCHW Initiatives Impact across NC

Mission

Develop equitable opportunities that lead to healthy North Carolina Communities.

What We Do

NCCHW works to impact policy, build capacity and ignite community initiatives by working through a web of cross-sector relationships organized around building healthier places throughout the state.

How We Work

Culture of Results is a training and technical assistance program that supports state-wide initiatives, as well as local public health departments, hospitals, clinics, universities and community providers to measure impact and improve results. Culture of Results team members engage partner organizations in learning and using a framework known as Results-based Accountability (RBA) and its evidence-based, common sense tools to plan and evaluate their projects and services.

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results™

Accountable Care Communities – Why Measure?

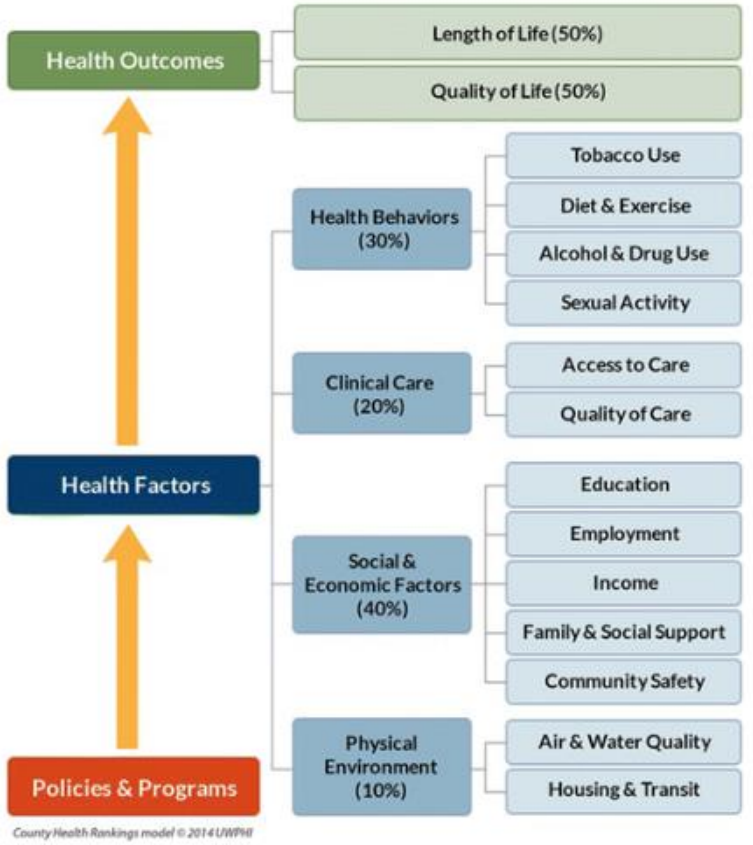
Accountable Care Communities (ACCs) are an emerging promising model for addressing the social, behavioral, and economic factors that impact health outcomes and health care cost (social determinants of health).

ACCs across the country have begun to address: • Food security • Housing • Transportation • Employment • Education • Child Care • Caregiving • Poverty • Health Equity

"ACCs have the ability to inventory existing and needed community resources, proactively target individuals within the community and guide them towards needed resources, and allow and facilitate navigation across community and health system services."

"Each of these functions is dependent upon the ability to share identified and de-identified data that improves coordination and efficiency of service delivery, provides an understanding of the community's social and health needs, and allows all participants to evaluate their impact on health utilization and population-based outcomes."

(Plescia and Dulin, Accountable Care Communities: Moving from Health Care Delivery Systems to Systems of Health, 2017)



N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

The Complexity of Social Determinants of Health and Categories

Social determinants of health are **conditions in the environments** in which people are born, live, learn, work, play, worship, and age **that affect a wide range of health, functioning, and quality-of-life outcomes and risks.** (Healthy People 2020 Definition)

Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

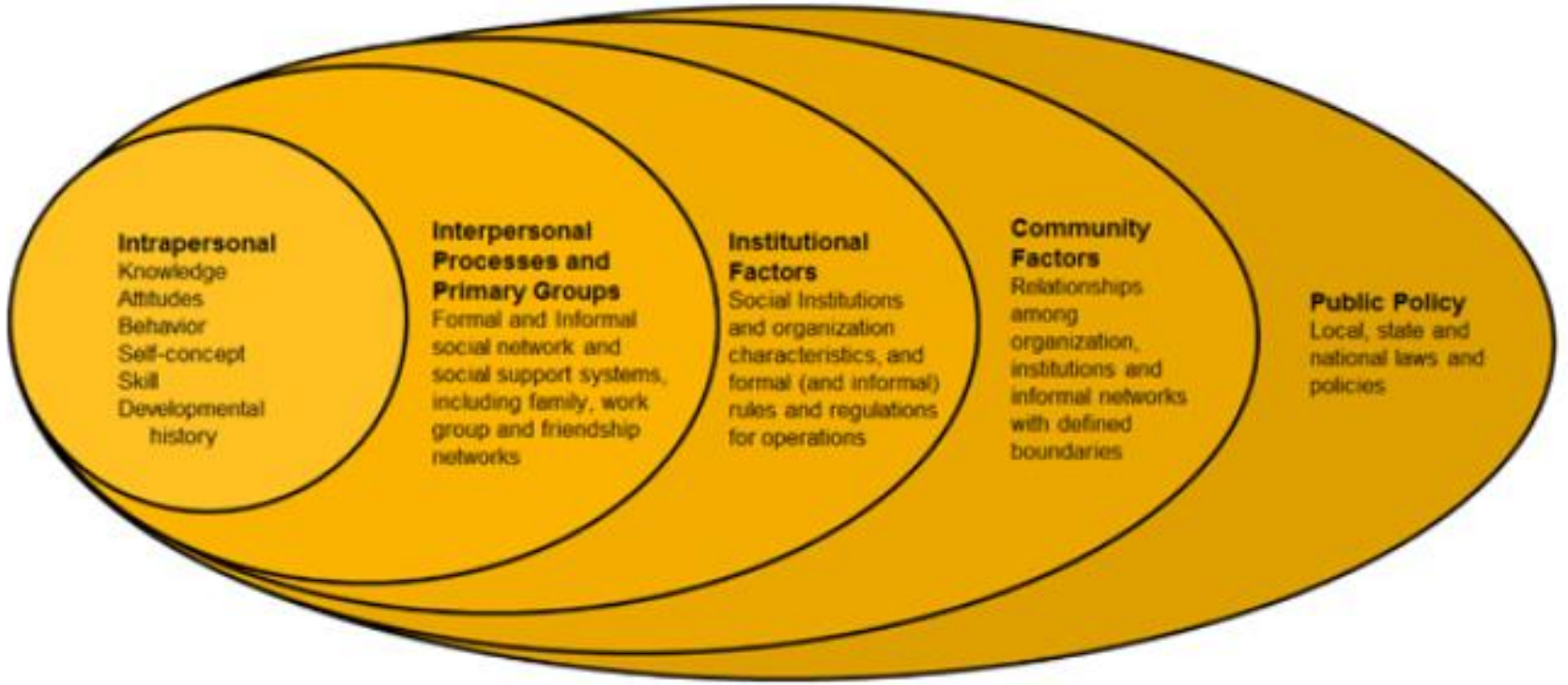
SDOH are **often sorted into categories**, such as neighborhood and built environment, health and health care (accessibility and quality), economic stability, educational opportunities and social and community context.

Partnerships showcased today developed various categories for capturing complex SDOH influences.

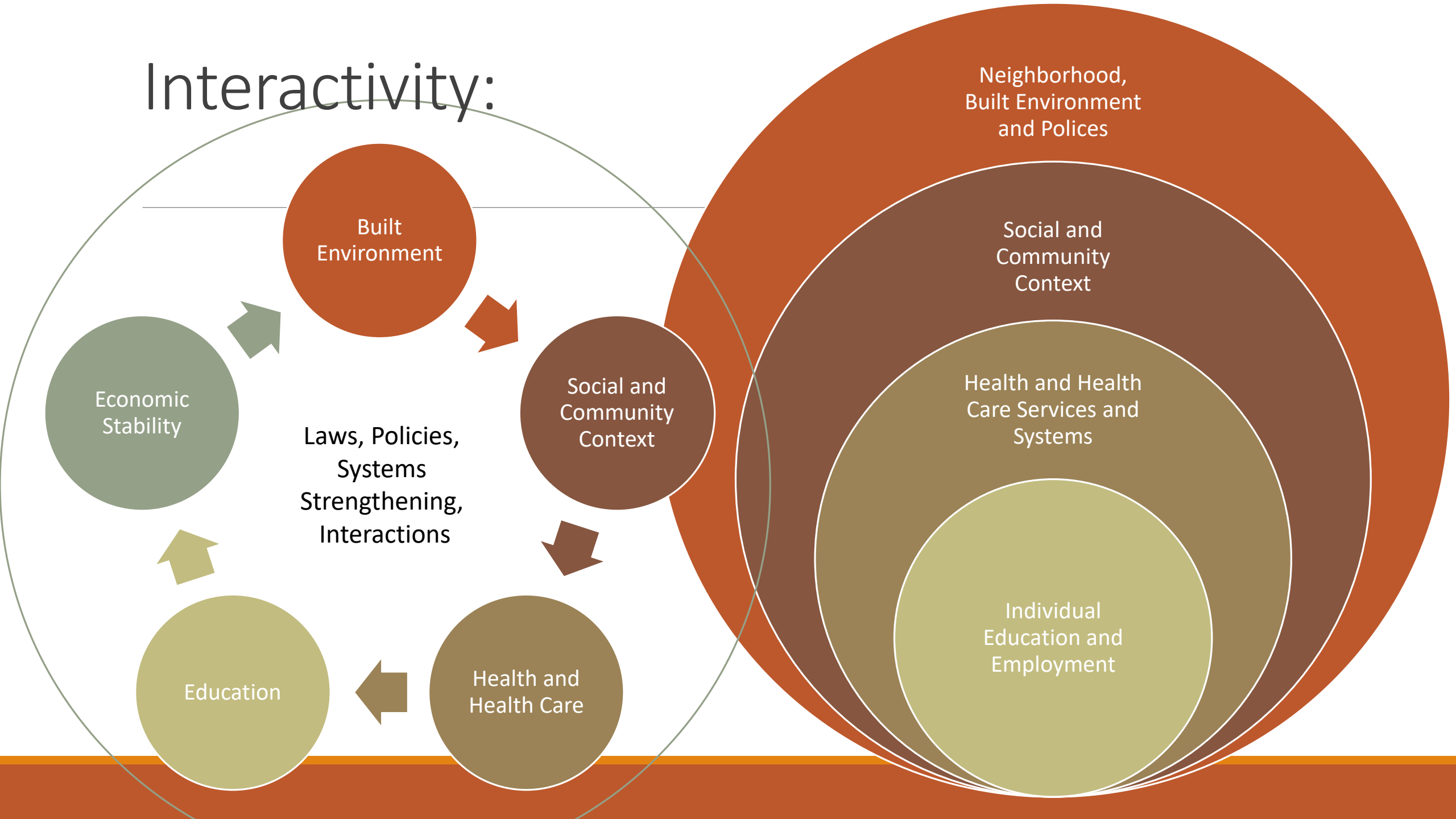
N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

SDOH Act on Many Levels: Social-Ecological Model of Influences

Social determinants are **conditions for health and the interactions between people and each other, institutions, environments and policies.**



Interactivity:



Examples of Social and Physical Determinants

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Residential segregation
- Language/Literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- Built environment, such as buildings, sidewalks, bike lanes, and roads
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements (e.g., good lighting, trees, and benches)
- Culture

Results-based Accountability™- Finding Focus!

Basic principles:

- **Common ground**— start with the result (end) and work backwards to the strategies (means)
- **Common language** – inclusivity and transparency (see handout)
- **Common sense**— free tools and exercises that can be used again and again

RBA is a process (seven steps of thinking) to get product(s)

Clear Impact Scorecard as a platform to share results, data (community indicators and performance measures, and stories behind them) about strategies

Recognized by the Center for Disease Control (CDC), the National Institute of Health (NIH), the NC Department of Health and Human Services, foundations, hospital systems, and others governmental agencies as an effective practice for evaluation and planning

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results™

Distinction Between Types:

Population Accountability

About the well-being of
WHOLE POPULATIONS

- States
- Counties/Cities
- Subgroup within an area

Ex: All residents in North Carolina

Pregnant mothers in Morrisville

Performance Accountability

About the well-being of
CUSTOMERS (People Served/Changed)

- Organization
- Program
- Projects

Ex: All customers served by an Accountable Care Community's strategies

RBA Framework

The ENDS

POPULATION ACCOUNTABILITY

RESULT: Community conditions of health and well-being

COMMUNITY INDICATOR: (CI)
Community-wide measures to reflect progress towards achieving results

Through

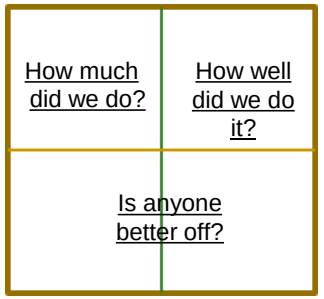
PERFORMANCE ACCOUNTABILITY: STRATEGY

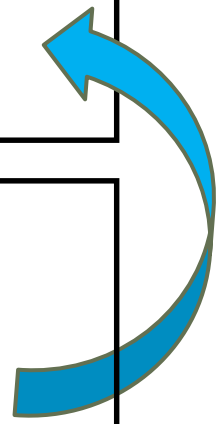
CUSTOMER RESULTS: Changes from strategies/programs

The MEANS

PERFORMANCE MEASURES: (PM)

Measures of strategy or program impact:





RBA Framework: ACC Example

The ENDS

POPULATION ACCOUNTABILITY

RESULT: Healthy, safe, thriving and supported communities across North Carolina

COMMUNITY INDICATOR: % of North Carolinians Making Living Wages

Through

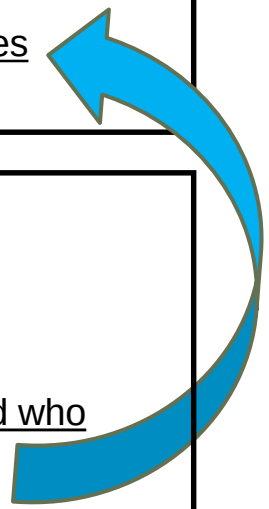
PERFORMANCE ACCOUNTABILITY: STRATEGIES

CUSTOMER RESULTS: Economically secure families

PERFORMANCE MEASURES:

The MEANS

# of community resources inventoried (how much), % of people in need who are referred to community programs (how well), % who increase their household income through participation (better off)



Examples of Partners, Processes and Measures

1. **Community Food Strategies- Regional Community Indicators**: Multi-year work to train partners in RBA, developing and prioritizing community indicators which were aggregated, then beginning to "turn the curve" through key strategies

2. **WNC Healthy Impact- Regional Priority Scorecard for SDOH**: Support the network in creating regional community health assessment priorities (3) including SDOH, and community indicators infused with RBA processes

3. **Futures Group- Crosswalk of Asheville and Buncombe County Strategic Plans**: Multidisciplinary research team reviewed strategic plans for overarching themes and sample measures

4. **Mobilizing Action for Resilient Communities:** Trainings for "tipping grant" recipients rolled up into overarching measures and connected to community indicators

5. **Mothering Asheville Steering Committee:** RBA exercise to create the vision for grant proposal and prioritize measures; ongoing evaluation support for alignment across measures and with key strategies

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

REGIONAL VISIONING DATA

A visioning exercise based on the Results Based Accountability (RBA) framework was conducted at six regional food network gatherings across North Carolina in 2016.

COMMUNITY FOOD STRATEGIES

RESULT:

A thriving, sustainable community-based food system across all of North Carolina.

EXPERIENCE:

The wordcloud to the right shows phrases that define the experience if the result were true.

TOP INDICATORS BY REGION:

Common indicators identified in three regions are in blue.

CHARLOTTE:

- # of school, community, home gardens
- # of farmland acres in production
- **% farmers making a livable wage**
- # of restaurants sourcing local foods
- **Distance from resident homes to purchase local, healthy food**
- # of GAP certified farmers
- Average age of farmers

NORTHEAST:

- # of supply chain connections
- # of economic opportunities in food & farming for people of color and/or low-income individuals
- # of viable small farms
- **% of population with chronic disease related to diet or food production**
- **$ of local food sales**
- # of minority farm owners or principle operators
- # of acres in small-scale production

SOUTHEAST:

- **% of population with a livable wage**
- **% of food secure families**
- % of population with a healthy weight
- **$ of local food sales**
- Amount of direct sales by local farmers

TRIAD:

- % of farmers markets that accept SNAP, EBT, WIC, senior vouchers
- **Distance low-income residents are to grocery store**
- % of local institutions sourcing local foods
- Happiness Index
- **% of population that is food secure**
- **% of population with diabetes or hypertension**
- # of favorable policies supporting local foods

TRIANGLE:

- % of food budget spent on local products
- **Distance to healthy food outlets**
- **% of population that is food secure**
- Water quality indicators
- Profits from local farms
- # of schools teaching agriculture curriculum
- Happiness index

WESTERN:

- **% of population with a livable wage**
- **% of food secure families**
- **% of population with chronic disease**
- # of farmland acres in (food) production
- **$ of local food sales**
- # of pounds of food diverted from landfills
- % of community satisfied with leadership and their ability to be heard
- $ of SNAP vouchers at farmers markets

www.communityfoodstrategies.org

COMMUNITY FOOD STRATEGIES

Empower local food councils with knowledge and organizational capacity to positively impact their community's local food and farm economy.

Process: Convenings with food councils and partners across the state to understand **regional priorities for food systems change indicators**

Sample Community Indicators:

- % of producers/population with a livable wage
- % of food secure families
- Distance (low-income) residents to healthy food outlets

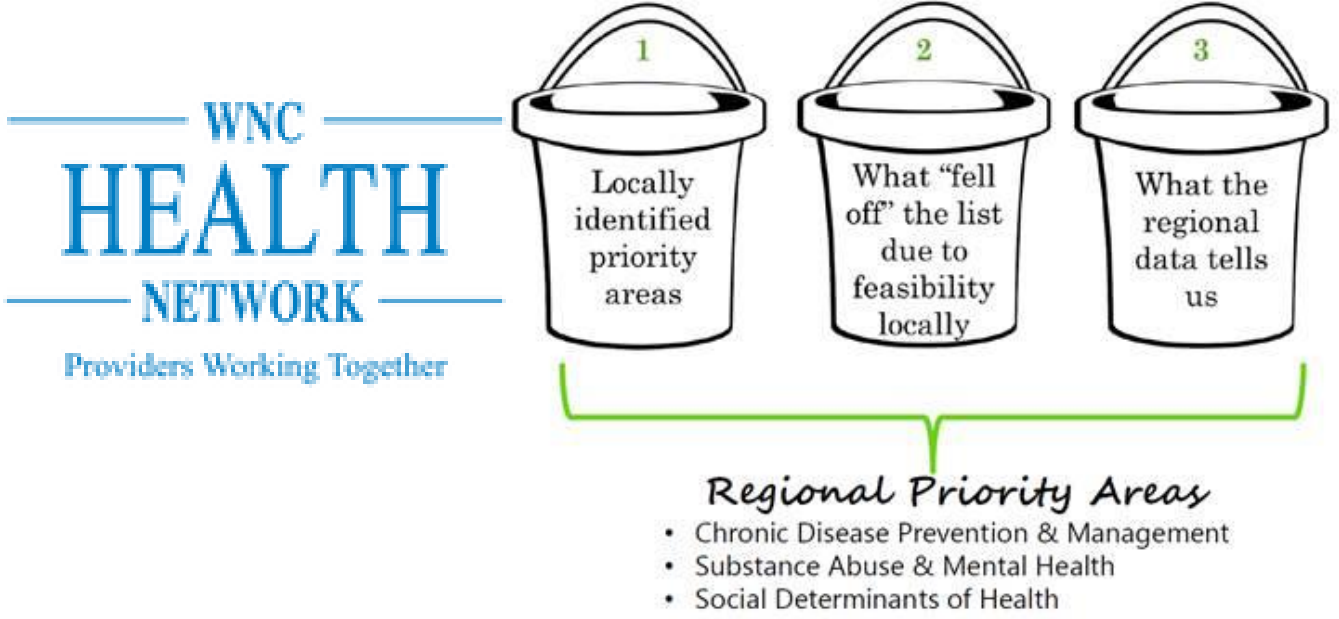
WNC HEALTHY IMPACT INITIATIVE

Partnership and coordinated process (16 counties' hospitals + public health agencies) to assess health needs, develop collaborative plans, take coordinated action, and evaluate progress and impact.

Process: Data collection for Community Health Assessments (CHA) and Community Health Improvement Processes (CHIP) across WNC. **Social Determinants Regional Priority Scorecard (draft) developed to address regional priority at a local level** by: Connecting to regional partners, evidence-based interventions, local news & research and funding opportunities; Displaying shared topics of interest for peer support, alignment, and learning; Identifying shared performance measures & regional comparison data

Sample Community Indicators: (See Scorecard)

Sample Strategies and Resources: Adverse Childhood Experiences Collaboratives, Clinical/Community Connections, Early Childhood Education, Food Security, Housing, SDOH Equity



12 Indicators of Social Determinants of Health	Time Period	Actual Value	Current Trend	Baseline % Change
SDOH Individuals with < High School Education (arithmetic mean)	2015	30.5	↘ 5	-5% ↘
SDOH Households with Limited/No English	2015	21,096	→ 0	0% →
SDOH Single-Parent Households	2015	23,135	→ 0	0% →
SDOH Low Access to Food Sources	2012	10,474	→ 0	0% →
SDOH Households Living in Rental Housing	2015	95,205	↗ 5	11% ↗
SDOH Households Paying >30% of Income on Rent	2015	95,205	↗ 5	11% ↗
SDOH Households with No Transportation	–	–	–	–
SDOH Crowded Households (>1 person/room)	–	–	–	–
SDOH Median Household Income	2015	39,219	↘ 1	4% ↗
SDOH Individuals Living Below Federal Poverty Line	2015	301,617	↗ 5	11% ↗
SDOH Unemployed Individuals (arithmetic mean)	2016	5	↘ 1	0% →
SDOH Uninsured Individuals	2015	83,849	↘ 3	-27% ↘

Overarching Themes

Six Overarching Themes in All Reports- Connected to Diversified Economy and Increased Equity

#1 EMPLOYMENT CREATION

#2 TRAINING and SUPPORT (FOR Increased and Equitable INCOME GENERATION)

-including education to some extent

#3 BUILT ENVIRONMENT: AFFORDABLE, QUALITY HOUSING & REAL ESTATE INFRASTRUCTURE

#4 TRANSPORTATION

#5 LAND USE PLANNING AND ENVIRONMENTAL SUSTAINABILITY

#6 HEALTHCARE

Three Themes Connected to Other Focus Areas (Aligned with Futures Report; not present across all reports)

#7 SHARED VISION

#8 EXPAND LEADERSHIP

#9 COMMUNITY ENGAGEMENT/COOPERATION

Local Strategic Plans Reviewed:

Living Asheville: Comprehensive Plan for Our Future – May 2017

Buncombe County Sustainability Plan Update – March 2017

AVL 5X5 VISION 2020 – Dec 2015

Gro WNC Regional Plan for 2040 – May 2013

FUTURES GROUP: ASHEVILLE/BUNCOMBE COUNTY STRATEGIC PLAN CROSSWALK

Forum for discussing and catalyzing actions that will advantage AVL/BC five years out and beyond.

Process: **Multi-disciplinary team reviewed local strategic plans and synthesized priority areas and themes. Found six overarching themes** and presented sample strategies and performance measures for each as well as other findings

Sample CIs and PMs:

Employment Creation:

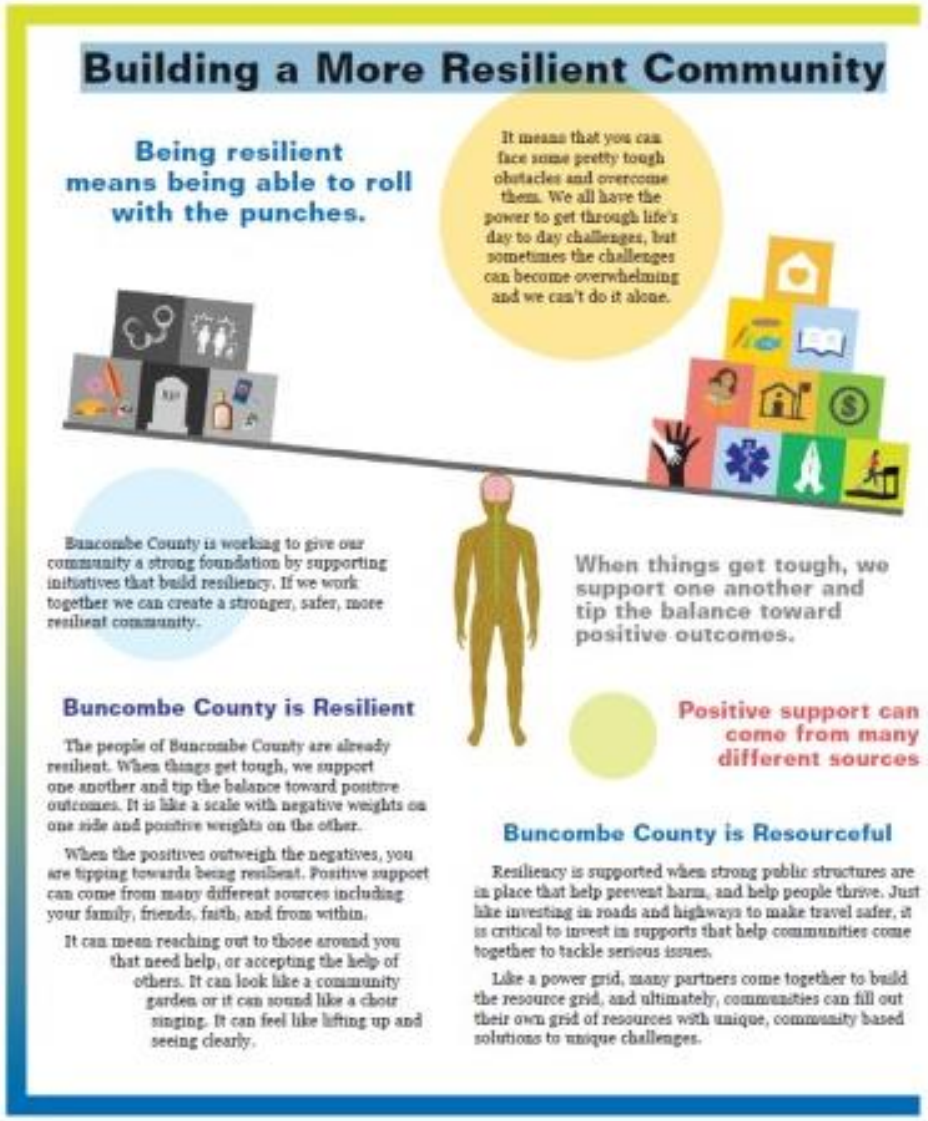
- % employment rates in disadvantaged communities (CI)
- # of new jobs with earnings above $50k announced through the Chamber of Commerce (PM)

Training and Support:

- # of children enrolled in four- and five-star rated child care centers (PM)
- # of participants in financial education classes through OnTrack Financial (PM)

Community Engagement:

- # of citizens applying for Buncombe County boards (CI)



FUNDED BY HEALTH FEDERATION OF PHILADELPHIA AND THE ROBERT WOOD JOHNSON FOUNDATION

MOBILIZING ACTION FOR RESILIENT COMMUNITIES (MARC)

Creating a trauma-informed workforce and bolstering community awareness of the impact of trauma and resources to prevent and heal. Tipping Point Grants 'stack' positive factors and 'off-load' negative factors.

Process: RBA trainings for staff and **"tipping point" grant recipients to identify performance measures, aggregate and "roll up" measures and connect to community indicators for CHIP, trauma and resilience**

Sample Community Indicators and Areas:(some race/ethnicity comparisons) Poverty measures, "Meal Gap" (budget shortfall for food), ACE scores, health measures, access measures (to food, health care), poisoning deaths, CPS/maltreatment reports, early intervention services enrollment, unemployment rates, incarceration rates, graduation rates, premature deaths

Sample Performance Measures:
# of community partners/agencies engaged
# of resources created
 # key types of development evaluation activities conducted by staff
$ invested (through grant) AND by community (comparison)
# of changes made- community partners/providers who increased resiliency, coping skills, knowledge and improved behaviors

MOTHERING ASHEVILLE

Advocate for institutional policies that address structural racism, implicit bias, access to care, and social determinants of health to promote increased access to preventive services in community-based settings (for Black women).

Process: RBA exercise to co-create **vision for implementation grant proposal**, prioritize community indicators and performance measures. **Scorecard to review regularly, track progress and revisit connections to strategy areas**

Sample Community Indicators: (race/ethnicity comparisons) Disparities in IMRs, poverty rates, high school graduation rates, single parent households

Sample Performance Measures connected to each Strategy Area:

- Increase Community Capacity and Sustainability: # of community leaders trained in facilitative leadership, breastfeeding, doula services, safe sleep, or preconception/interconception related- community advocacy
- Support a Clinical Shift to Community-Centered Health: % of African- American pregnant women served by MA doulas who attend prenatal care within the first trimester, attend the postpartum visit, and deliver full term
- Impact Community and Environmental Policy Change: $s of funding for Community Health Workers and reimbursement for Doulas for pregnant and postpartum African-American women in Buncombe County
- Expand Strategic Communications: # of earned media (web and print publications, broadcast) mentions of the disparity in infant mortality among African Americans and the efforts by CCHH in Buncombe County in local and statewide media

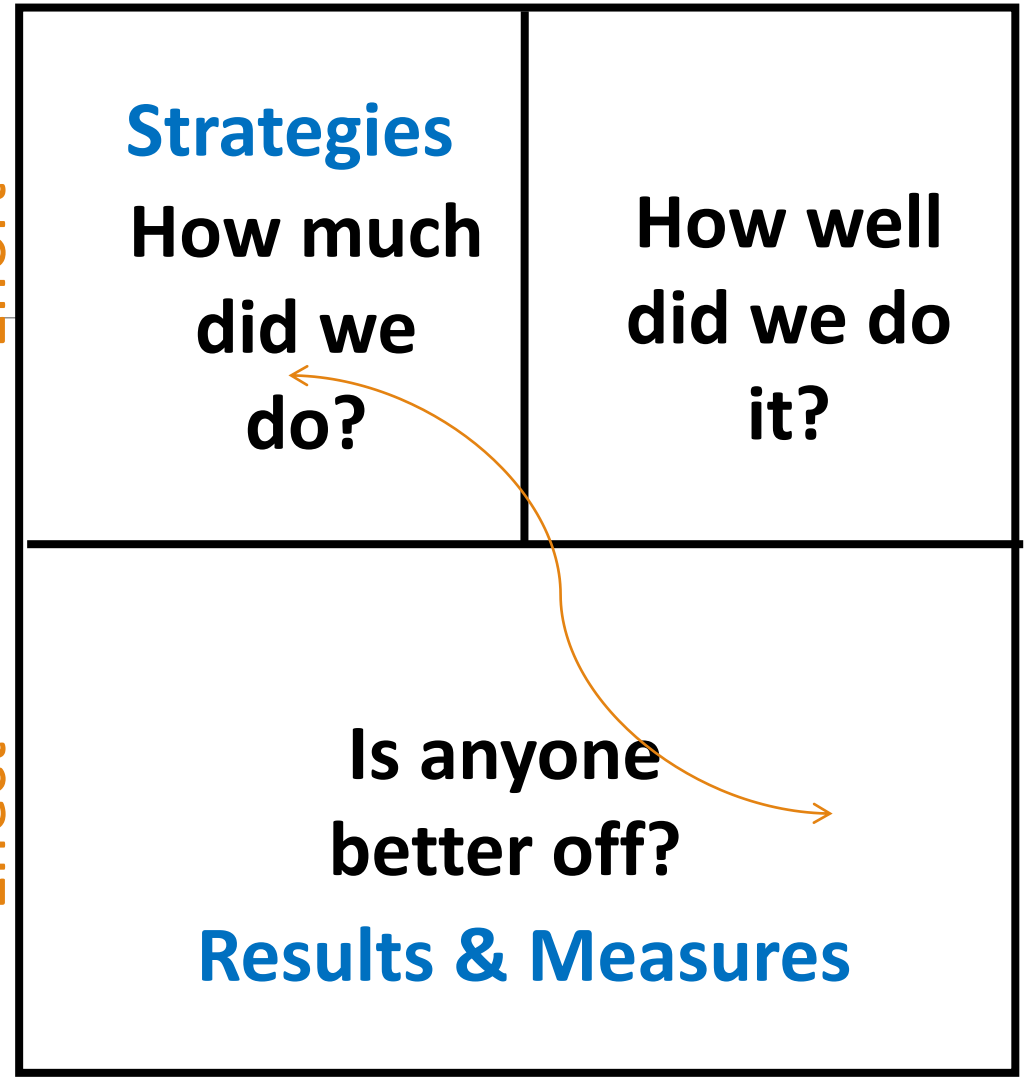
Lessons Learned and Recommendations

1. CONNECT RESULTS AND MEASURES TO STRATEGIES: BOTH DIRECTIONS WORK
2. CONSIDER ALIGNMENT AND ROLLING UP
3. MAKE COMPARISONS TO UNDERSTAND NEEDS AND TAKE AN EQUITY APPROACH
4. PROMOTE DATA-DRIVEN DECISION MAKING
5. PRIORITIZE MEASURES TO STREAMLINE THE COMPLEXITY

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

1. CONNECT RESULTS AND MEASURES TO STRATEGIES: BOTH DIRECTIONS WORK

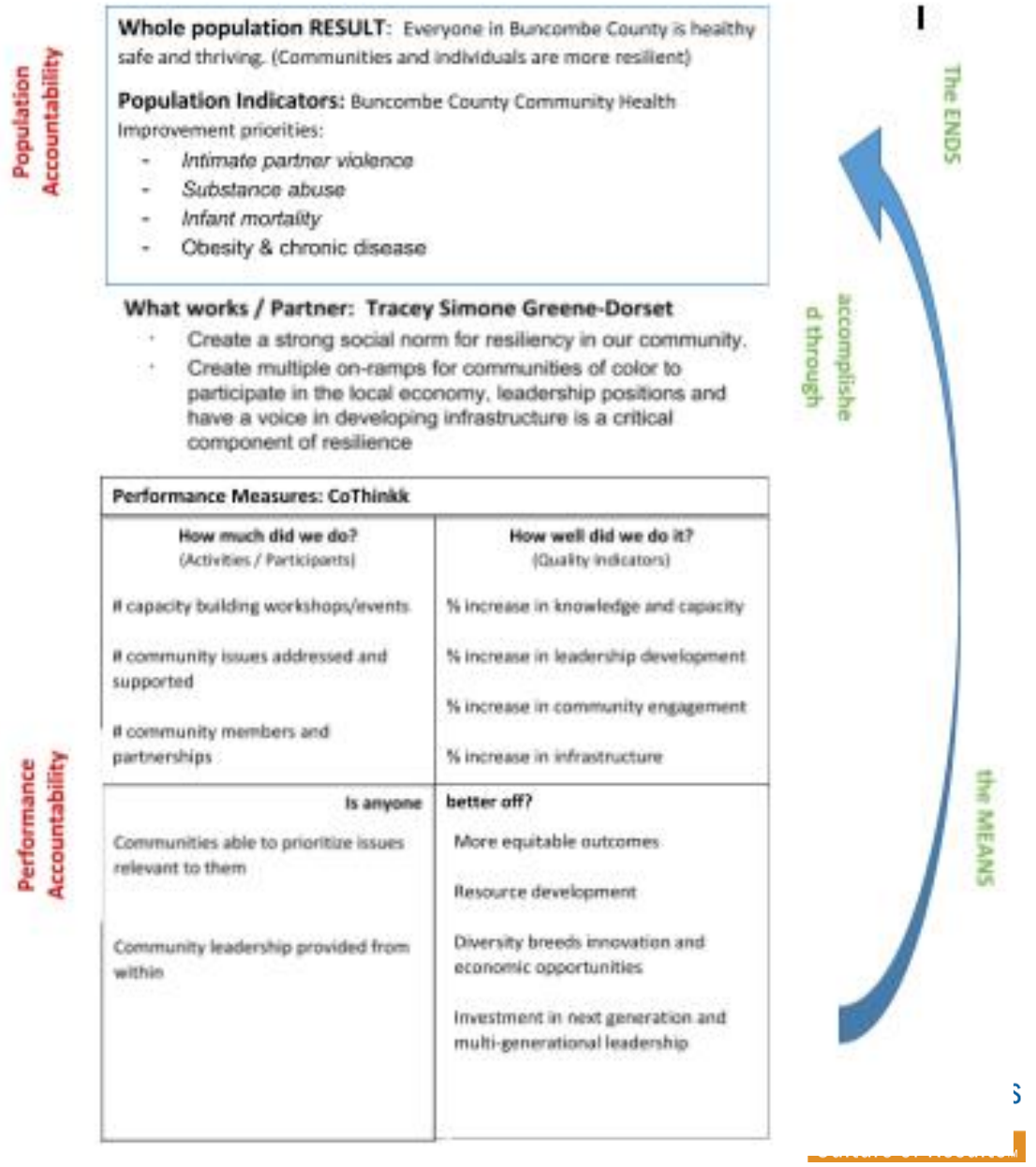
- Start with the result and how you would measure "better off" for our communities overall (community indicators) or the people served (performance measures), then work backwards to strategies
- OR Start with strategies (what you do or plan to) and then connect to performance measures and indicators
  - This enables you to ask are we doing things right?



N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

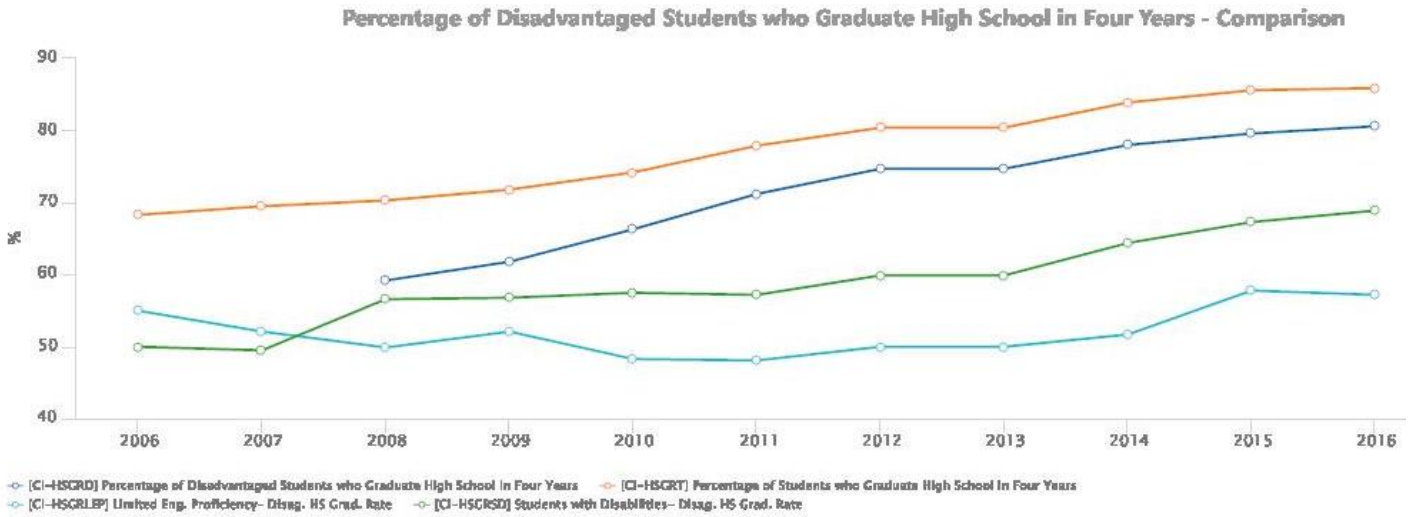
2. CONSIDER ALIGNMENT AND ROLLING UP

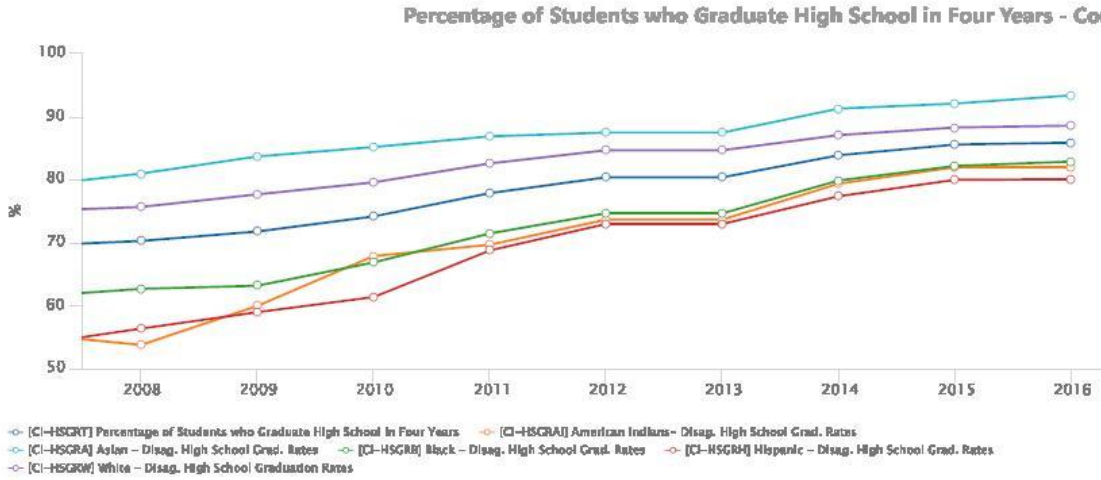
- Between YOUR performance measures (across projects or departments and rolling up to various levels of your agency)
- Between your performance measures and community indicators
- With partners measures



5. MAKE COMPARISONS TO UNDERSTAND NEEDS AND TAKE AN EQUITY APPROACH

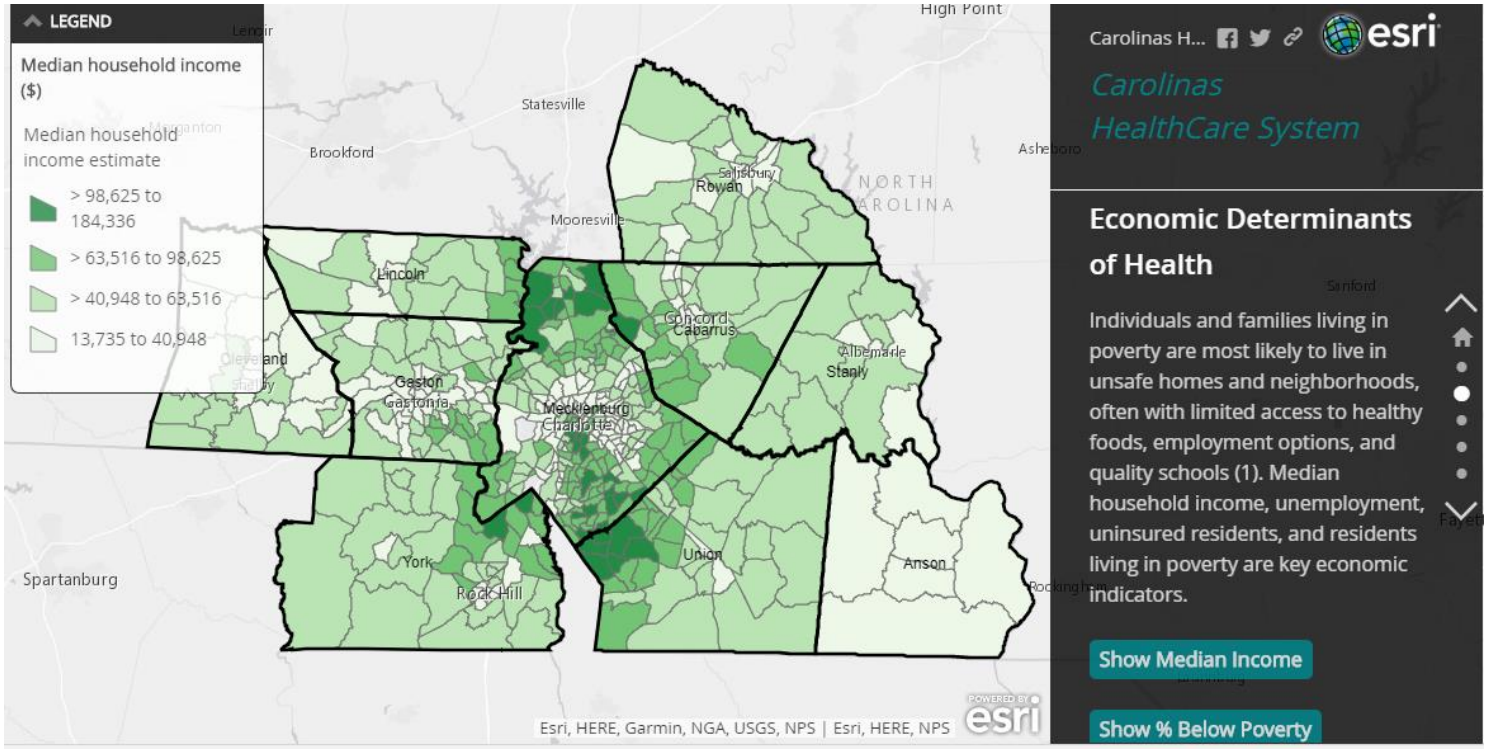
- Stratify/disaggregate data and compare to take an equity approach and get a full(er) picture





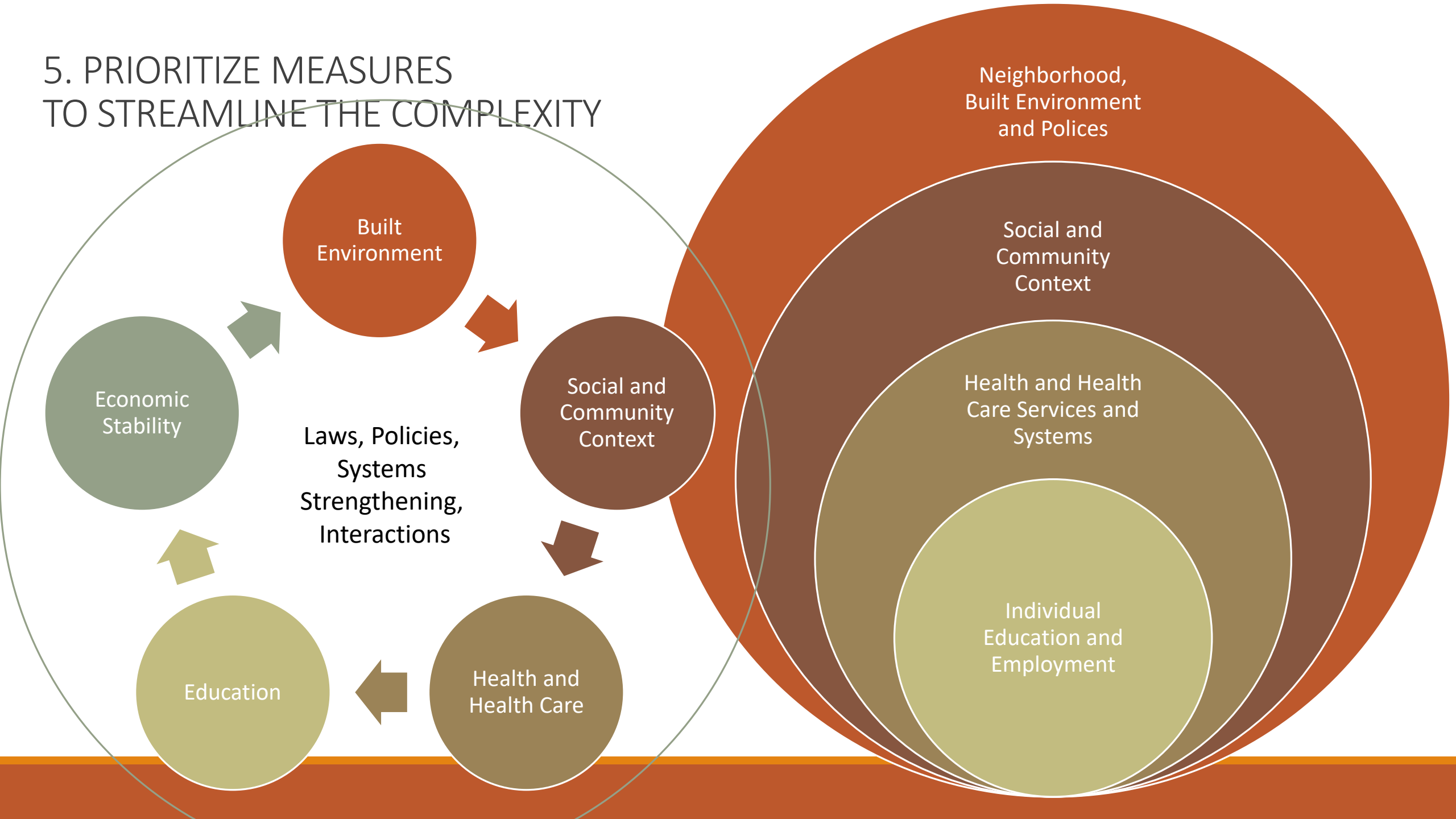
4. PROMOTE DATA-DRIVEN DECISION MAKING

- Review data regularly to determine needs, find gaps in services offered, allocate resources
- Look at connections between performance measures and community indicators to ask:
  - Are we doing the right things?



NC Institute for Public Health SDOH Map

5. PRIORITIZE MEASURES TO STREAMLINE THE COMPLEXITY



Prioritizing Measures: RBA Filters

- Data Power

We have the data or it's easy to get. Reliable. Valid. If we don't have the data but it feels important, we add the measure to our Data Development Agenda.

- Communication Power

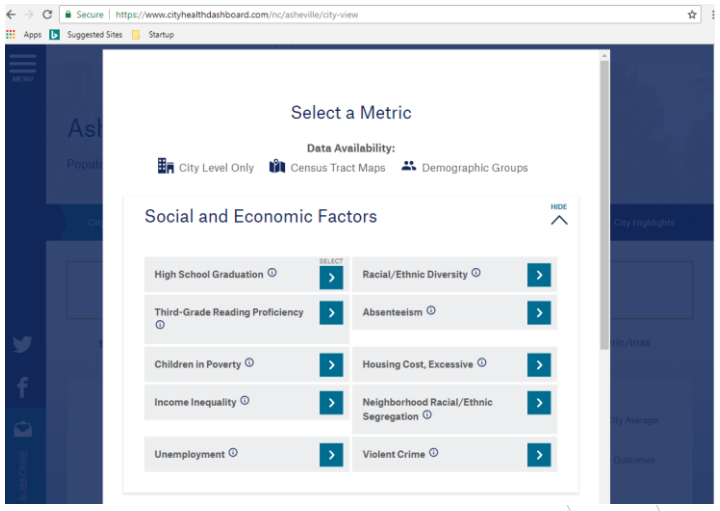
The data can be understood by the intended audience. You may have different measures for different audiences (funders, general public, staff).

- Connective/Proxy Power

The information feels important. It is connected to the work you do and to other important measures of performance or population wellbeing.

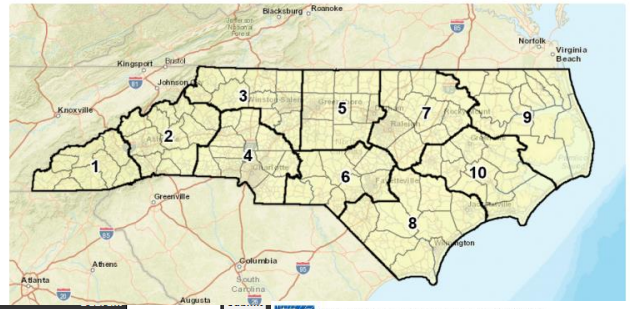
N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

Sample Community Indicator Sources and Measures



Community Well-Being	**Poverty** % of individuals living in poverty (100% Federal Poverty Level)	13.5%	15.40%	2016
	Housing Cost Burden % of households spending 30% or more of household income on housing costs	32.2%	31.6%	2012-2016
	Unemployment Unemployment rate	3.8	5.1	2016
	High-Quality Child Care % of kids in 4/5 star child care	69.0%	73%	2016-2017
	Food Insecurity % of population that is food insecure	13.9%	16.5%	2015
	Low Access to a Grocery Store % of population with low access to a grocery store	21.6%	N/A	2015
	Transportation % of households without access to a vehicle	5.6%	6.3%	2016
	Violent Crime Violent crime rate per 100,000 population	282.6	374.9	2016
	Life expectancy Life expectancy (years) at birth - avg.	78.9	78	2014-2016
	Racial Disparity in Life Expectancy Life expectancy (years) at birth	White : Black 79.3 : 73.4	White : Black 78.8 : 75.8	2014-2016

DHHS Releases Interactive Map Showing Social Determinants of Health Indicators Across North Carolina



NCIOM

Events | News | Blog | Directions | Search

ABOUT US | OUR WORK | NC HEALTH DATA AND RESOURCES | PUBLICATION

NORTH CAROLINA COUNTY HEALTH PROFILES

NC COUNTY HEALTH DATA

This interactive county map aggregates key health data for North Carolina's one hundred counties. The map can be filtered to show a statewide comparison for four health topics: uninsured adults, poverty, infant mortality, and heart disease.

Select a topic

- Uninsured Adults
- Poverty
- Infant Mortality
- Heart Disease

DHHS Home | A-Z Site Map | Divisions | About Us | Contacts

NCDHHS

North Carolina State Center for Health Statistics

NCPH North Carolina Public Health

BRANCHES AND PROGRAMS | STATISTICS AND REPORTS | INTERACTIVE HEALTH DATA

SCHS Home
About Us
Contacts

Quick Links
Recently Added Publications
Mailing List for Publications
Vital Facts: A Typical Day in North Carolina

Related Sites
Vital Records
Other Sites

DHHS > DPH > SCHS

N.C. State Center for Health Statistics

The North Carolina State Center for Health Statistics is responsible for data collection, health-related research, production of reports and maintenance of a comprehensive collection of health statistics. We provide high quality health information for better informed decisions and effective health policies. Our goal is to improve the health of all North Carolinians and their communities.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Jobs at N.C. DHHS | Terms of Use | Accessibility | Contact the Webmaster

Updated: June 15, 2018

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

SEARCH

CDC A-Z INDEX

Social Determinants of Health: Know What Affects Health

Social Determinants of Health (SDOH)
Sources for Data on SDOH
CDC Research on SDOH
Tools for Putting SDOH into Action
CDC Programs Addressing SDOH
Policy Resources to Support SDOH
Frequently Asked Questions
Archived Spotlight Resources

Social Determinants of Health (SDOH)

Sources for Data on Social Determinants of Health

SOURCES FOR DATA ON SOCIAL DETERMINANTS OF HEALTH

Data can be a catalyst for improving community health and well-being. Understanding data on social determinants of health, such as income, educational level, and employment, can help focus efforts to improve community health. The following tools are supported by CDC resources; some tools include references to data sources outside of CDC.

Prioritizing Measures: RBA Filters

- Data Power

We have the data or it's easy to get. Reliable. Valid. If we don't have the data but it feels important, we add the measure to our Data Development Agenda

- Communication Power

The data can be understood by the intended audience. You may have different measures for different audiences (funders, general public, staff).

- Connective/Proxy Power

The information feels important. It is connected to the work you do and to other important measures of performance or population wellbeing.

Prioritizing Measures for SDOH

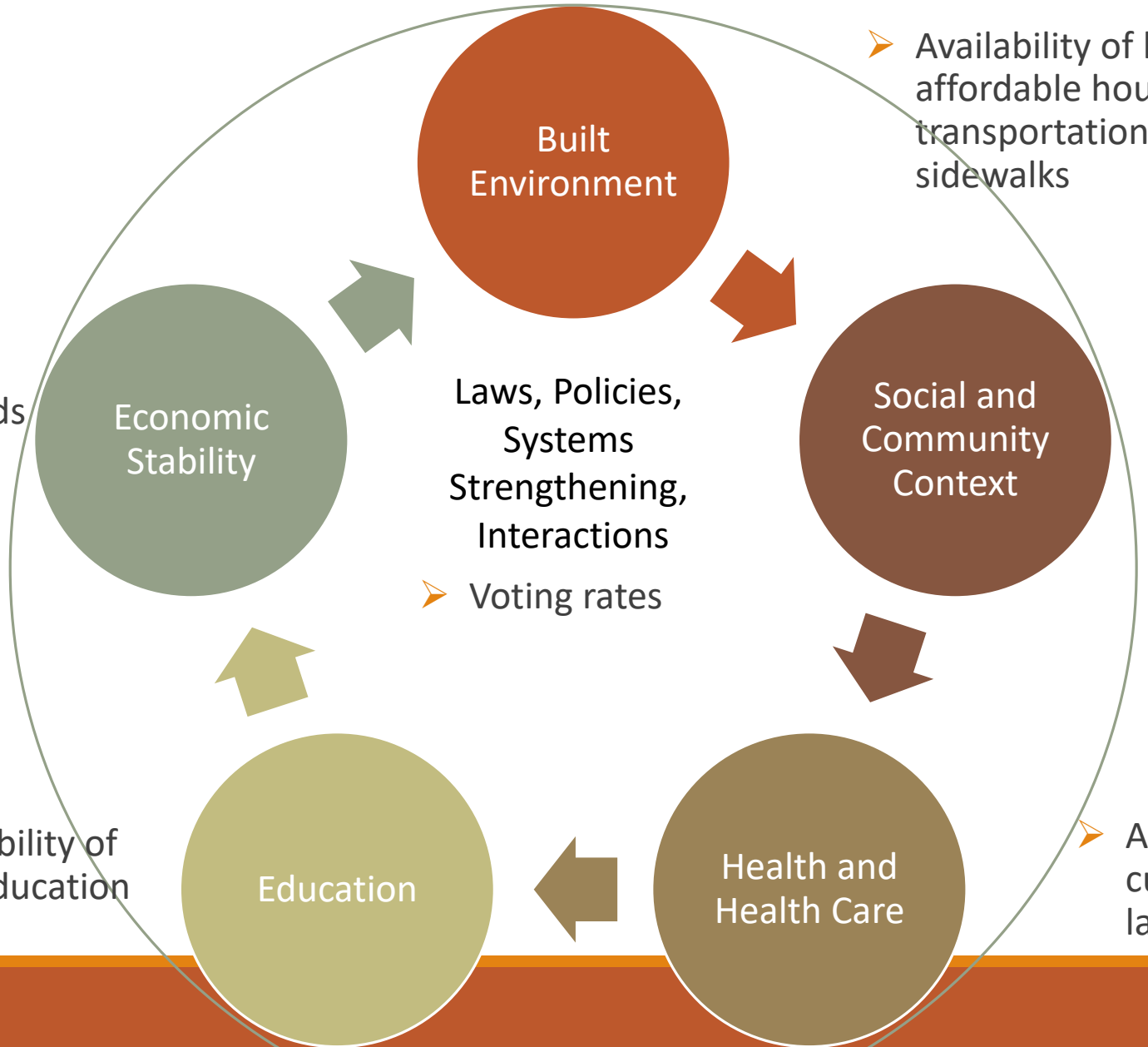
- **Connective/Proxy Power**

The information feels important. It is connected to the work you do and to other important measures of performance or population wellbeing.

- *Think about the intersections between SDOH areas (example safe housing, transportation, child care)*
- *Look at people in environments (rent burdened households, living wages)*
- *Consider large, long term ROI (early education, 3rd grade math/reading levels as indications of future success)*
- *Equity approaches*

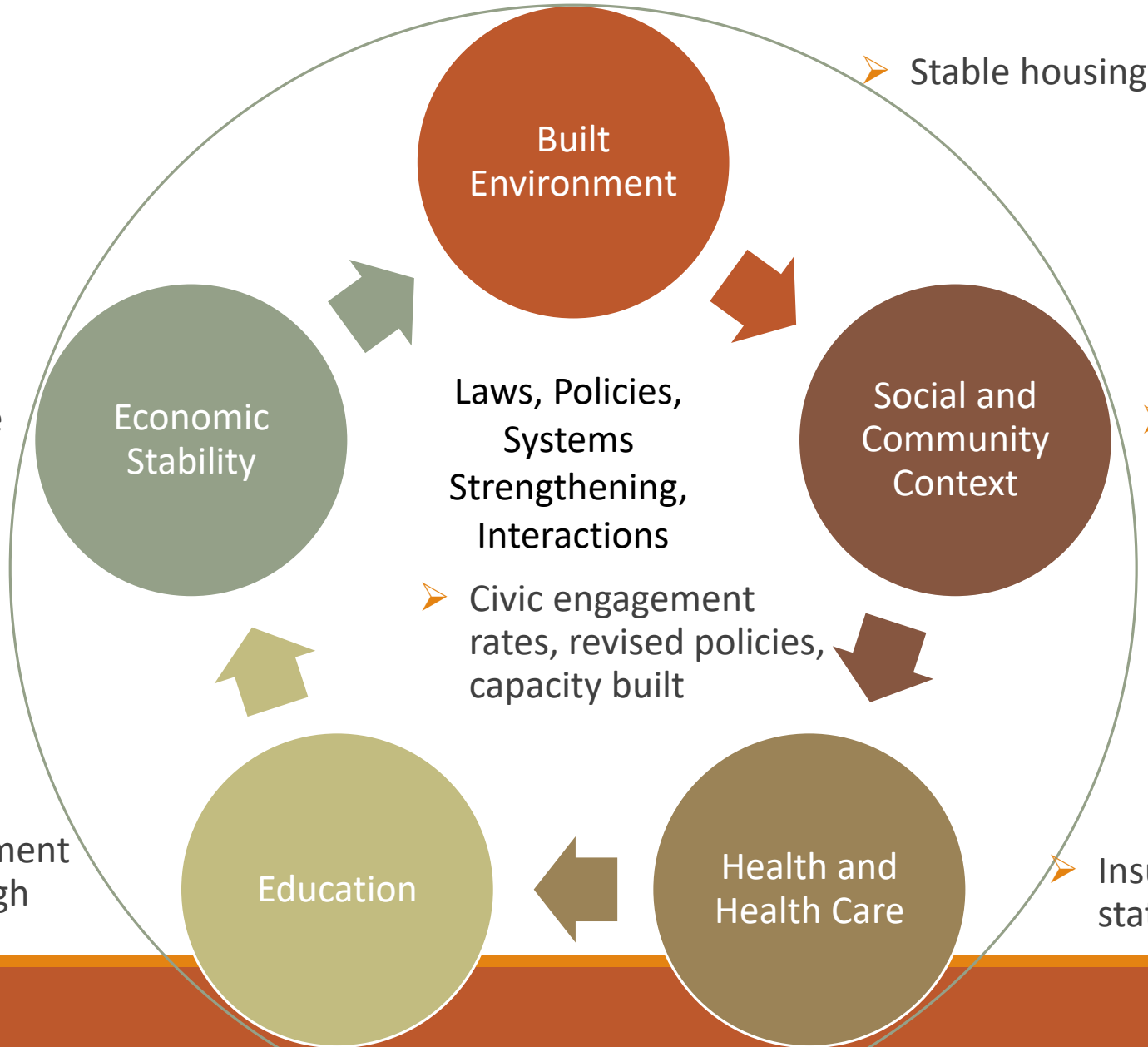
N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

Example Headline Community Indicators for SDOH



- Availability of healthy food, affordable housing, transportation, green spaces, sidewalks
- Safety and resiliency measures (trust), resource grids/ vulnerability measures
- Accessibility of health care, cultural competency and languages of workforce
- Quality and availability of Early Childhood Education programs
- Living wage rates, poverty rates, rent-burdened households

Headline Performance Measures for SDOH-Changes in:



- Stable housing
- Level of social support
- Insurance, self-rated health status
- Proficiency and educational attainment @ 3rd grade and high school
- Household income
- Civic engagement rates, revised policies, capacity built

Thank you for all you do to contribute!

Word cloud of the results for the initiatives described today

Discussion

Any questions? Comments?

What are other measures people are using?

Did any of the measures you heard about today seem particularly important for the recommendations this group will be providing?

Did any of the lessons learned resonate?

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

HANDOUTS: The Joyful Complexity of Measuring Social Determinants of Health

NC IOM Accountable Care Communities Task Force
June 29, 2018 11am

EMMA OLSON, LMSW, MPH

INTERIM DIRECTOR OF PARTNERSHIPS AND EVALUATION

EOLSON1@UNCA.EDU ~ (828)258-7715

RBA Terms and Definitions

Population Accountability

Result

- A condition of well-being for children, adults, families or communities (whole populations)

Community Indicator

- A measure which helps quantify the achievement of a result

Strategy

- A coherent collection of actions (programs, initiatives, systems, and services) that has a reasoned chance of improving results

Performance Measures

- A measure of how well a program, agency, service system or strategy is working:
  - How much did we do? How well did we do it? Is anyone better off?

Performance Accountability

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

RBA Terms and Definitions- ACC Example

Population Accountability

Result

- Healthy, safe, thriving and supported communities across North Carolina

Community Indicator

- % of North Carolinians Making Living Wages

Strategies

- ACCs will inventory existing and needed community resources, target individuals in need, refer to needed resources, and facilitate navigation across community and health system services.

Performance Measures

- # of community resources inventoried (how much), % of people in need who are referred to workforce development programs (how well), % who increase their household income through participation (better off)

Performance Accountability

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

Examples of Partners, Processes and Measures

1. **Community Food Strategies- Regional Community Indicators**: Multi-year work to train partners in RBA, developing and prioritizing community indicators which were aggregated, then beginning to "turn the curve" through key strategies

2. **WNC Healthy Impact- Regional Priority Scorecard for SDOH**: Support the network in creating regional community health assessment priorities (3) including SDOH, and community indicators infused with RBA processes

3. **UNCA Community Engagement Council:** Led RBA exercises for faculty and staff across departments to identify results, workgroup on community indicator "buckets" and sample indicators connected to required performance measures

4. **Futures Group- Crosswalk of Asheville and Buncombe County Strategic Plans**: Multidisciplinary research team reviewed strategic plans for common themes and community indicators

5. **Mobilizing Action for Resilient Communities:** Trainings for "tipping grant" recipients rolled up into overarching measures and connected to community indicators

6. **Mothering Asheville Steering Committee:** RBA exercise to create the vision for grant proposal and prioritizing community indicators and performance measures as connected to strategies

N.C. Center for Health & Wellness at UNC Asheville
Culture of Results℠

REGIONAL VISIONING DATA

A visioning exercise based on the Results Based Accountability (RBA) framework was conducted at six regional food network gatherings across North Carolina in 2016.

COMMUNITY FOOD STRATEGIES

RESULT:

A thriving, sustainable community-based food system across all of North Carolina.

EXPERIENCE:

The wordcloud to the right shows phrases that define the experience if the result were true.

TOP INDICATORS BY REGION:

Common indicators identified in three regions are in blue.

CHARLOTTE:

- # of school, community, home gardens
- # of farmland acres in production
- **% farmers making a livable wage**
- # of restaurants sourcing local foods
- **Distance from resident homes to purchase local, healthy food**
- # of GAP certified farmers
- Average age of farmers

NORTHEAST:

- # of supply chain connections
- # of economic opportunities in food & farming for people of color and/or low-income individuals
- # of viable small farms
- **% of population with chronic disease related to diet or food production**
- **$ of local food sales**
- # of minority farm owners or principle operators
- # of acres in small-scale production

SOUTHEAST:

- **% of population with a livable wage**
- **% of food secure families**
- % of population with a healthy weight
- **$ of local food sales**
- Amount of direct sales by local farmers

TRIAD:

- % of farmers markets that accept SNAP, EBT, WIC, senior vouchers
- **Distance low-income residents are to grocery store**
- % of local institutions sourcing local foods
- Happiness Index
- **% of population that is food secure**
- **% of population with diabetes or hypertension**
- # of favorable policies supporting local foods

TRIANGLE:

- % of food budget spent on local products
- **Distance to healthy food outlets**
- **% of population that is food secure**
- Water quality indicators
- Profits from local farms
- # of schools teaching agriculture curriculum
- Happiness index

WESTERN:

- **% of population with a livable wage**
- **% of food secure families**
- **% of population with chronic disease**
- # of farmland acres in (food) production
- **$ of local food sales**
- # of pounds of food diverted from landfills
- % of community satisfied with leadership and their ability to be heard
- $ of SNAP vouchers at farmers markets

www.communityfoodstrategies.org

COMMUNITY FOOD STRATEGIES

Empower local food councils with knowledge and organizational capacity to positively impact their community's local food and farm economy.

Process: Convenings with food councils and partners across the state to understand **regional priorities for food systems change indicators**

Sample Community Indicators:

- % of producers/population with a livable wage
- % of food secure families
- Distance (low-income) residents to healthy food outlets

WNC HEALTHY IMPACT INITIATIVE

Partnership and coordinated process (16 counties' hospitals + public health agencies) to assess health needs, develop collaborative plans, take coordinated action, and evaluate progress and impact.

Process: Data collection for Community Health Assessments (CHA) and Community Health Improvement Processes (CHIP) across WNC. **Social Determinants Regional Priority Scorecard (draft) developed to address regional priority at a local level** by: Connecting to regional partners, evidence-based interventions, local news & research and funding opportunities; Displaying shared topics of interest for peer support, alignment, and learning; Identifying shared Performance Measures & regional comparison data

Sample Community Indicators: (See Scorecard)

Sample Strategies and Resources: Adverse Childhood Experiences Collaboratives, Clinical/Community Connections, Early Childhood Education, Food Security, Housing, SDOH Equity

WNC HEALTH NETWORK
Providers Working Together

Regional Priority Areas

- Chronic Disease Prevention & Management
- Substance Abuse & Mental Health
- Social Determinants of Health

12 Indicators of Social Determinants of Health	Time Period	Actual Value	Current Trend	Baseline % Change
SDOH Individuals with < High School Education (arithmetic mean)	2015	30.5	↘ 5	-5% ↘
SDOH Households with Limited/No English	2015	21,096	→ 0	0% →
SDOH Single-Parent Households	2015	23,135	→ 0	0% →
SDOH Low Access to Food Sources	2012	10,474	→ 0	0% →
SDOH Households Living in Rental Housing	2015	95,205	↗ 5	11% ↗
SDOH Households Paying >30% of Income on Rent	2015	95,205	↗ 5	11% ↗
SDOH Households with No Transportation	–	–	–	–
SDOH Crowded Households (>1 person/room)	–	–	–	–
SDOH Median Household Income	2015	39,219	↘ 1	4% ↗
SDOH Individuals Living Below Federal Poverty Line	2015	301,617	↗ 5	11% ↗
SDOH Unemployed Individuals (arithmetic mean)	2016	5	↘ 1	0% →
SDOH Uninsured Individuals	2015	83,849	↘ 3	-27% ↘

RESULTS: 1) OUR COMMUNITY IS EDUCATED, HEALTHY, SAFE, THRIVING, RESILIENT AND IN HARMONY WITH THE NATURAL ENVIRONMENT.

2) ALL PEOPLE HAVE ACCESS TO THE EDUCATIONAL RESOURCES NECESSARY FOR MEANINGFUL EMPLOYMENT AND TO HELP THEM MAKE INFORMED DECISIONS ABOUT THEIR LIVES AND THE COMMUNITY.

UNCA COMMUNITY ENGAGEMENT COUNCIL

Strengthen UNCA impact through civic and cultural engagement, sustained partnerships and focus on economic vibrancy.

Process: RBA Whole Distance Exercise for population results; Subgroup looks at community indicator areas to match results and researches available data, looks at alignment with other indicators (UNC, City and National) and required performance measure reports

Sample Community Indicators and Areas:
1) **Educational Attainment**: *%* NC students completing high school in four years (comparisons by race/ethnicity and among "disadvantaged groups"); 2) **Economic Self-Sufficiency**: Median Household Income; % of rent burdened households; 3) **Health Status**: % of NC adults who report good, very good, excellent health; % of NC adults who couldn't access needed care 4) **Environment Accessibility and Sustainability**: Transportation Indicators (BC CHIP Pedestrian/Bus Counts); Greenspaces/Experiencing Outdoors Indicator (Kids in Parks Counts); 5) **Civic Leadership and Community Participation**: Voting rates

Sample Performance Measures: https://results.unca.edu/strategic-plan
Economic Impact Analysis: $450 million contributed to the community

Overarching Themes

Six Overarching Themes in All Reports- Connected to Diversified Economy and Increased Equity

#1 EMPLOYMENT CREATION

#2 TRAINING and SUPPORT (FOR Increased and Equitable INCOME GENERATION)
-including education to some extent

#3 BUILT ENVIRONMENT: AFFORDABLE, QUALITY HOUSING & REAL ESTATE INFRASTRUCTURE

#4 TRANSPORTATION

#5 LAND USE PLANNING AND ENVIRONMENTAL SUSTAINABILITY

#6 HEALTHCARE

Three Themes Connected to Other Focus Areas (Aligned with Futures Report; not present across all reports)

#7 SHARED VISION

#8 EXPAND LEADERSHIP

#9 COMMUNITY ENGAGEMENT/COOPERATION

Local Strategic Plans Reviewed:

Living Asheville: Comprehensive Plan for Our Future – May 2017

Buncombe County Sustainability Plan Update – March 2017

AVL 5X5 VISION 2020 – Dec 2015

Gro WNC Regional Plan for 2040 – May 2013

FUTURES GROUP: ASHEVILLE/BUNCOMBE COUNTY STRATEGIC PLAN CROSSWALK

Forum for discussing and catalyzing actions that will advantage AVL/BC five years out and beyond.

Process: **Multi-disciplinary team reviewed local strategic plans and synthesized priority areas and themes.** Found six overarching themes and presented sample strategies and performance measures for each as well as other findings.

Sample CIs and PMs

Employment Creation:

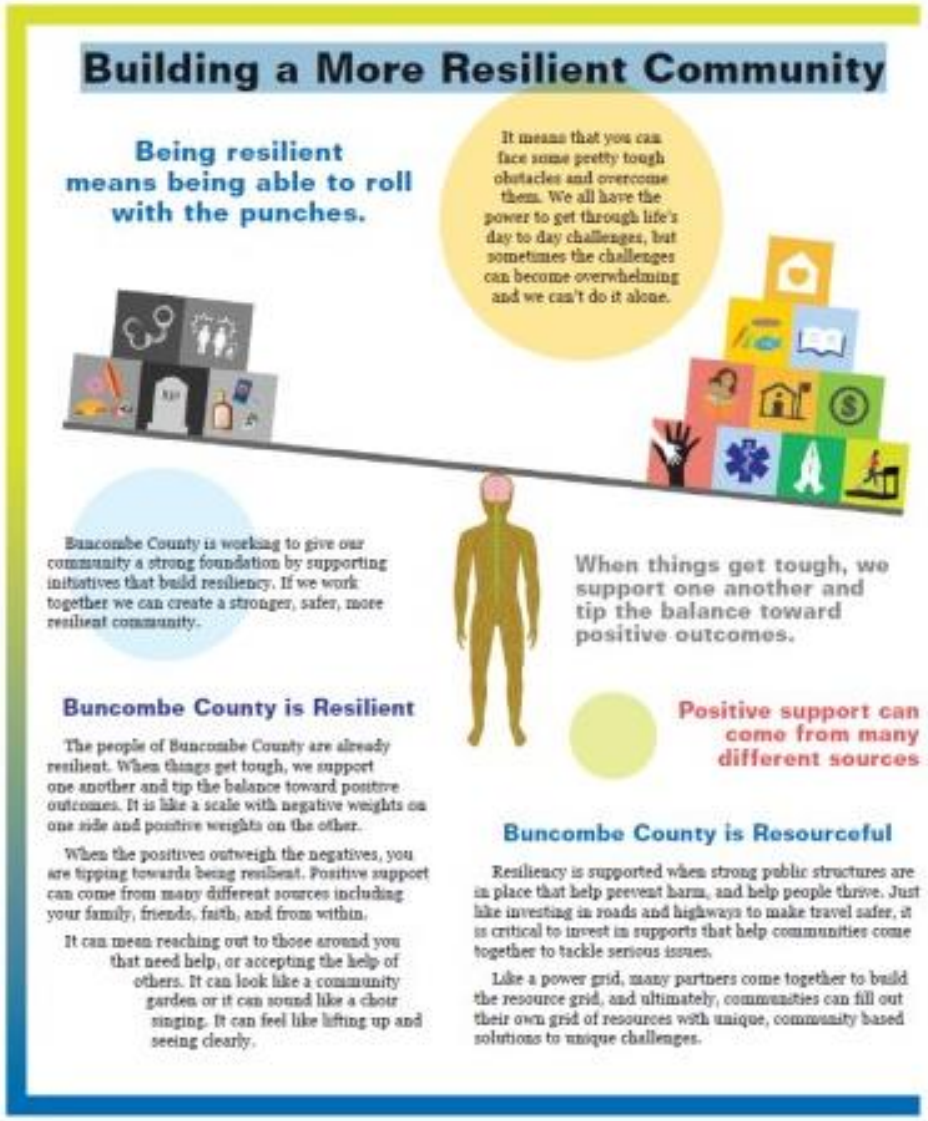
- % employment rates in disadvantaged communities (CI)
- # of new jobs with earnings above $50k announced through the Chamber of Commerce (PM)

Training and Support:

- # of children enrolled in four- and five-star rated child care centers (PM)
- # of participants in financial education classes through OnTrack Financial (PM)

Community Engagement:

- # of citizens applying for Buncombe County boards (CI)



FUNDED BY HEALTH FEDERATION OF PHILADELPHIA AND THE ROBERT WOOD JOHNSON FOUNDATION

MOBILIZING ACTION FOR RESILIENT COMMUNITIES (MARC)

Creating a trauma-informed workforce and bolstering community awareness of the impact of trauma and resources to prevent and heal. Tipping Point Grants 'stack' positive factors and 'off-load' negative factors.

Process: RBA trainings for staff and **"tipping point" grant recipients to identify performance measures, aggregate and "roll up" measures and connect to community indicators for CHIP, trauma and resilience**

Sample Community Indicators and Areas:(some race/ethnicity comparisons) Poverty measures, "Meal Gap" (budget shortfall for food), ACE scores, health measures, access measures (to food, health care), poisoning deaths, CPS/maltreatment reports, early intervention services enrollment, unemployment rates, incarceration rates, graduation rates, premature deaths

Sample Performance Measures:
# of community partners/agencies engaged
# of resources created
# key types of development evaluation activities conducted by staff
$ invested (through grant) AND by community (comparison)
% of changes made- community partners/providers who increased resiliency, coping skills, knowledge and improved behaviors

MOTHERING ASHEVILLE

Advocate for institutional policies that address structural racism, implicit bias, access to care, and social determinants of health to promote increased access to preventive services in community-based settings (for Black women).

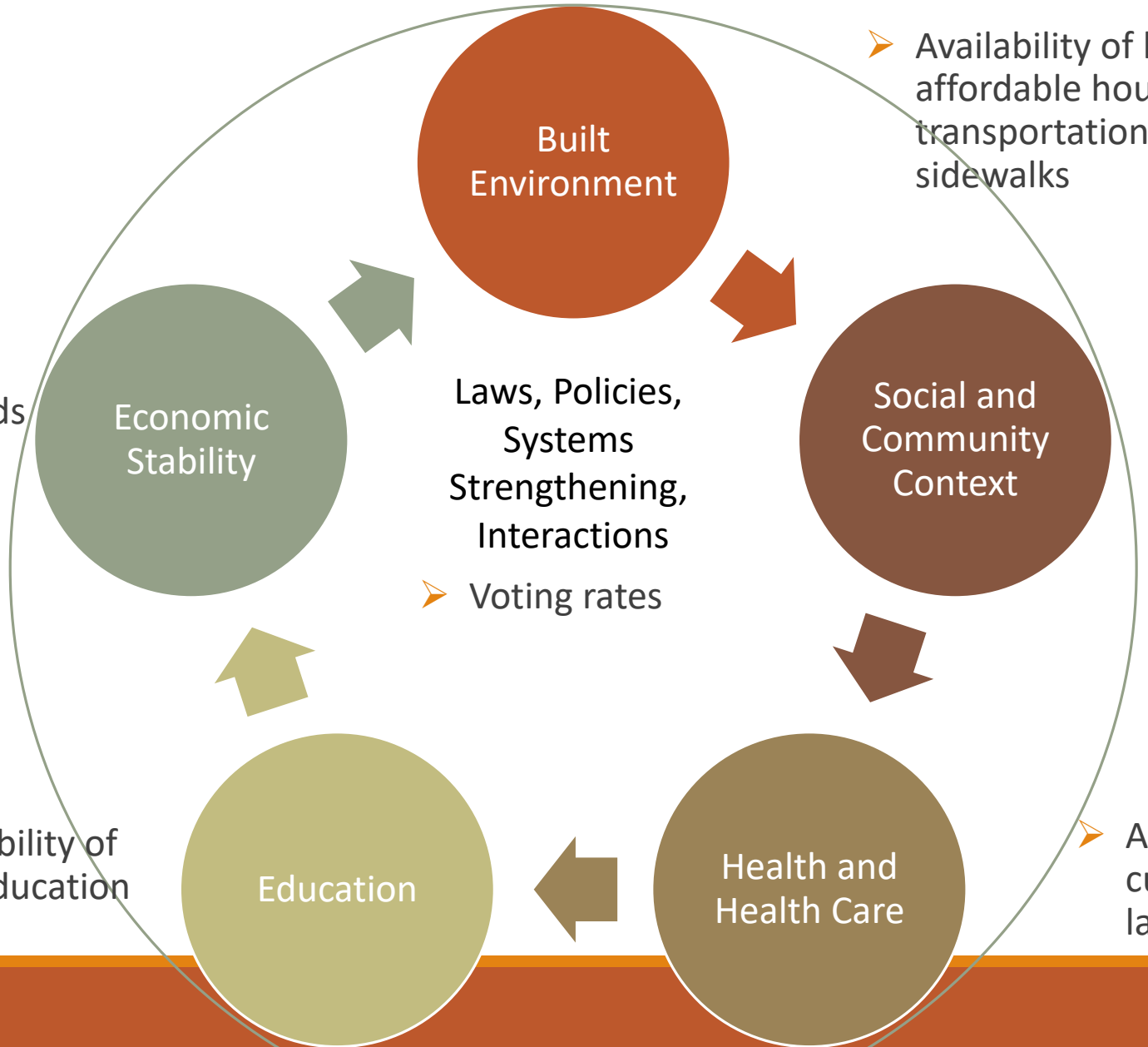
Process: RBA exercise to co-create **vision for implementation grant proposal**, prioritize community indicators and performance measures. **Scorecard to review regularly, track progress and revisit connections to strategy areas.**

Sample Community Indicators: (race/ethnicity comparisons) Disparities in IMRs, poverty rates, high school graduation rates, single parent households

Sample Performance Measures connected to each Strategy Area:

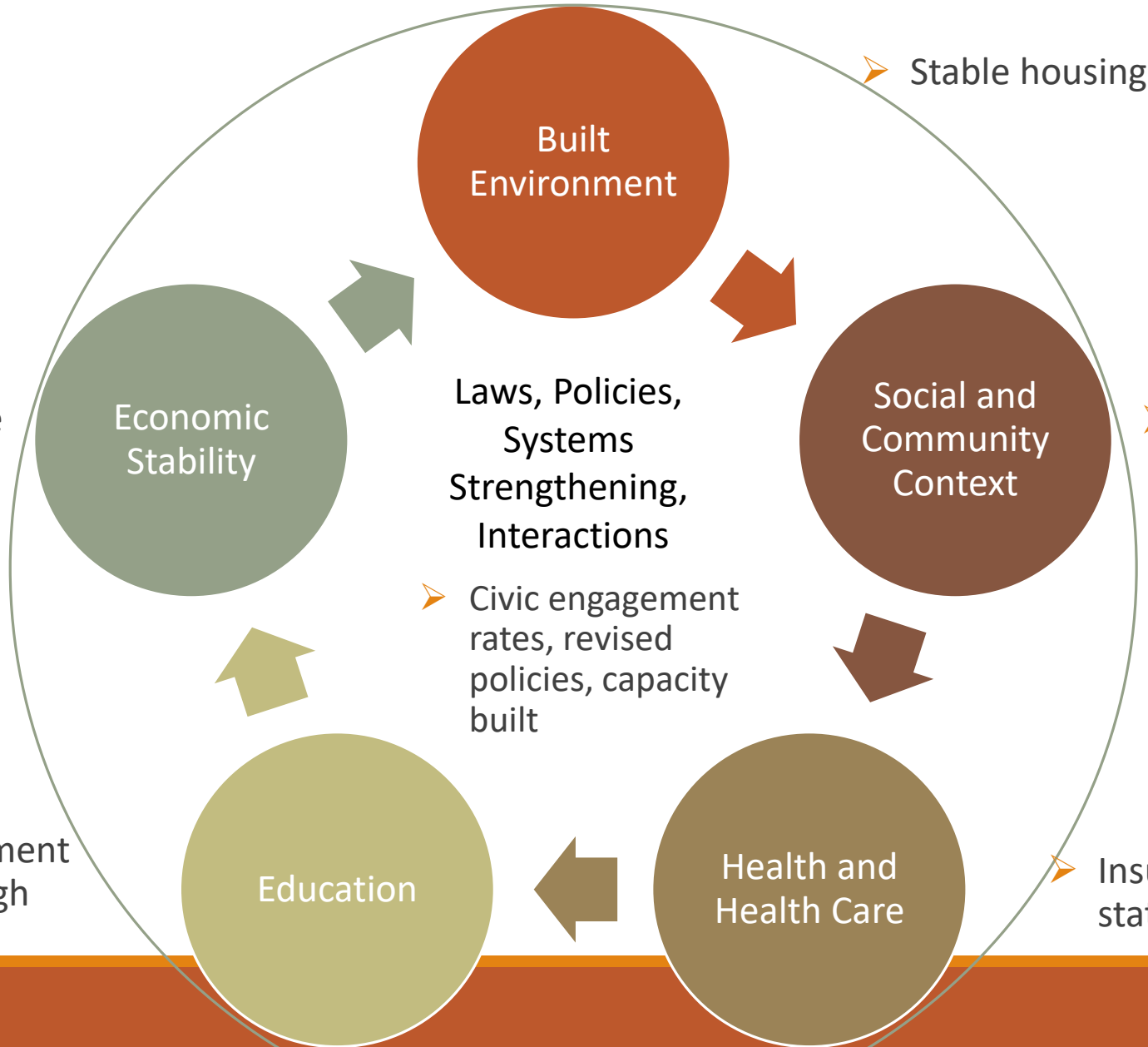
- Increase Community Capacity and Sustainability: # of community leaders trained in facilitative leadership, breastfeeding, doula services, safe sleep, or preconception/interconception related- community advocacy
- Support a Clinical Shift to Community-Centered Health: % of African- American pregnant women served by MA doulas who attend prenatal care within the first trimester, attend the postpartum visit, and deliver full term
- Impact Community and Environmental Policy Change: $s of funding for Community Health Workers and reimbursement for Doulas for pregnant and postpartum African-American women in Buncombe County
- Expand Strategic Communications: # of earned media (web and print publications, broadcast) mentions of the disparity in infant mortality among African Americans and the efforts by CCHH in Buncombe County in local and statewide media

Example Headline Community Indicators for SDOH



- Availability of healthy food, affordable housing, transportation, green spaces, sidewalks
- Safety and resiliency measures (trust), resource grids/ vulnerability measures
- Accessibility of health care, cultural competency and languages of workforce
- Quality and availability of Early Childhood Education programs
- Living wage rates, poverty rates, rent-burdened households

Headline Performance Measures for SDOH-Changes in:



- Stable housing
- Level of social support
- Insurance, self-rated health status
- Proficiency and educational attainment @ 3rd grade and high school
- Household income
- Civic engagement rates, revised policies, capacity built