San Diego Accountable Community for Health Stakeholder Meeting – January 29, 2019

MEETING SUMMARY

Accountable Communities for Health

On January 29, 2019, *Be There San Diego* convened the San Diego Accountable Community for Health (SD ACH) Stakeholders to review the progress made so far and to look ahead at the SD ACH goals for 2019, where the work will include meaningful progress with equity at the center.

Kitty Bailey, Executive Director, *Be There San Diego*, opened the meeting by welcoming Stakeholders and each attendee introduced themselves. Kitty thanked Stakeholders for their continued commitment and outlined the purpose of the meeting – to provide an overview of SD ACH progress and goals for 2019, to provide an update on our data framework and our approach to capacity building and training based on Stakeholder input, and to get feedback from Stakeholders on building a foundation of equity in our SD ACH work.

Reviewing Progress and Looking Ahead to 2019

Kitty began her remarks by reviewing the shared Mission, Vision, and Values of the SD ACH:

- **Mission:** To create a "wellness system" that ensures individuals, families, and communities in San Diego have access to all they need to create a lifetime of health and wellness
- **Vision:** Health, wellness and equity for all of our communities, regardless of zip code
- **Values:** Equity, Inclusivity, Neutrality, and Accountability

Kitty reaffirmed the first aim of the SD ACH which focuses on **achieving ideal cardiovascular health across the lifespan** for all communities in San Diego by addressing the root causes of disease. Kitty reviewed the cardiovascular protective factors including the concept of "wellbeing" and the important concepts of access and equity at the core of our work. The group reviewed the governance structure of the SD ACH and Kitty encouraged those in attendance who do not currently sit on any of the workgroups to visit or join a workgroup to participate in the development and foundational work of the SD ACH.

Next, Kitty shared a timeline and process which illustrates the three phases of the SD ACH work towards ideal cardiovascular health across the lifespan. **Phase 1: Aligning and Connecting** took place during 2017 and early 2018 and focused on convening Stakeholders, building the relationships necessary to foster collaborative work, and aligning shared goals. **Phase 2: Learning and Designing,** occurred during summer 2018 and included outreach to partners across different sectors to collect information to form robust portfolios of interventions and to identify new partnership and linkage opportunities. **Phase 3: Creating and Scaling**, is where the SD ACH work is currently, includes building robust portfolios, tracking our progress through data, ensuring equity is at the center of the work, and seeking investments for the Wellness Fund.

Kitty provided an update on the three Portfolios that are under development:

- **Southeastern San Diego Portfolio of Interventions (SESD POI)**: Southeastern San Diego was the original priority community for the SD ACH. In 2017, SD ACH conducted a survey to identify existing community-based services. In 2018, workshops were held in the region to gather partners to discuss the data collected and determine ways to align existing efforts to create greater impact. These workshops identified three priorities for the SESD POI including organizational bartering, data collection, and a directory of agencies.

- **North County Portfolio of Interventions Pilot**: The subcommittee working on the North County pilot has chosen the North Inland Region as the priority geographic area and has selected "nutrition" as the first priority protective factor of focus. The subcommittee is currently focusing on identifying North County partners who are addressing nutrition. Live Well San Diego's Community Leadership Team in North County has agreed to include the pilot in the Community Enrichment Plan for the region.

- **Neighborhood Networks**: *Be There San Diego* is working to create a network of solutions to improve individual and population health by connecting at-risk individuals with proven community resources. The Neighborhood Networks concept aims to achieve a return on investment by using a coordinated community-based approach to address the social determinants of health, which drive 80% of health outcomes.

After Kitty provided a description of the Neighborhood Networks concept, **Marvin Gordon, MD, SD ACH Stakeholder and the Regional Medical Director for Health Net of California**, succinctly summarized the information:

> ***"Community resources are assets. Those assets have value. That value can be measured through metrics and outcomes. This is part of a system that addresses both wellness and healthcare."***

Following the update on progress, Kitty presented the **SD ACH goals for 2019**:

- Strengthen our Governance
- Build our Portfolios
- Ensure equity at our core
- Establish strong data approaches
- Create sustainability
- Effectively communicate our work
- Add evaluation to our work

Building our SD ACH Data Framework: Population and Program Measures

Christy Rosenberg, Director of Programs, *Be There San Diego* and Alaina Dall, BTSD Consultant, revisited the cardiovascular protective factors and framed the discussion around using data to monitor progress toward ideal cardiovascular health. They shared the Priority Population Health Outcomes and goal to reduce heart attack and stroke-related hospitalizations, emergency department visits and deaths by 20% by 2030. This will be achieved through a 20% improvement in the priority indicators related to each protective factor. They summarized the priority and secondary Population Health Indicators for each protective factor as identified by the Data and Metrics Workgroup through a comprehensive research, review and selection process based on publicly available data specific to San Diego county.

> ***Priority Population Health Outcomes: To reduce heart attack and stroke-related hospitalizations, emergency department visits, and deaths by 20% by 2030***

To clarify how the 20% reduction was selected, Christy reviewed the extensive efforts by the Data and Metrics Workgroup to research models and to align SD ACH goals with the research base from the American Heart Association to achieve ideal cardiovascular health across the lifespan. Christy invited all Stakeholders to attend a Data and Metrics Workgroup meeting to learn more about the process of determining outcomes and indicators.

Alaina and Christy debuted the new SD ACH Data Dashboard for attendees. The dashboard is an online, interactive tool that is currently under development and will be available on the SD ACH website in the near future.

The dashboard includes baseline and trend data for each of the Population Health Indicators broken down by age group including Adults, Adolescents, and Children and by protective factor. The dashboard currently includes publicly available data. The next phase of dashboard development will include program outcomes from community partners. The dashboard will serve as a tool to help ensure that the work of the SD ACH is accountable and transparent to the community.

Christy and Alaina introduced the Results Based Accountability model as a way to align population health and program data. The model was created in 2005 and has since proven to be successful nationally by using data-driven decision making to solve complex social problems. The model starts with the end goal and works backwards to determine the "means" of achieving that goal, which calls on various sectors to become engaged. The framework allows for whole population health and program performance to be acknowledged as separate but connected operations. Alaina presented an improvement pathway example, showing the end goal and the detailed means working from program outcomes in multiple domains to population outcomes at the county level. The pathway allows for individual programs to see where they are contributing to the overall goals and it presents opportunities for mutual enforcement.

Building Our Capacity: Training Opportunities for SD ACH Partners

Cheryl Moder, BTSD Consultant, shared the feedback received through the community survey conducted over the summer of 2018, which indicated a collective desire for capacity building opportunities pertaining to data collection and reporting. Similarly, Cheryl shared feedback gathered during the last SD ACH Stakeholder meeting, specifying the type of technical assistance capacity building requested which included training on program evaluation, data collection, data-driven improvements, pursuing funding opportunities, and seeking community input on data.

Cheryl announced that as a response to this feedback, a **four-part training series** focused on data will be offered to partners. The series will focus on data collection, evaluation methods, and Results-Based Accountability. Additionally, a series of "**Best Practice Academy**" webinars will be offered multiple times a year to highlight best practices and innovative efforts of SD ACH partners and other experts.

Building a Foundation of Equity in Our SD ACH Work

Kathryn Shade, Community & Resident Engagement Workgroup (CREW) Chair, reintroduced the work of CREW to the Stakeholders by sharing the group's newly revised Purpose Statement:

The purpose of the Community & Resident Engagement Workgroup (CREW) is to ensure the resident and community voice is integrated as an essential component of the ACH and is embedded in the program, policy, and practice of all workgroups, consistent with the core values of the ACH.

Kathryn explained that CREW is committed to lifting the voice of residents and the community and is working towards the greater SD ACH commitment to equity which strives to provide all communities with fair opportunities to attain their full potential. Kathryn encouraged attendees to consider various questions when thinking about how to incorporate equity into our work:

- *How do we ensure our work is consistent with ACH core values?*
- *How do we develop a structure / process for institutionalizing the consideration of equity in program, policy and practice across all workgroups?*
- *How do we adopt an "Equity Lens" in our ACH work?*
- *How do we create safe, trusting spaces to engage one another in these conversations?*
- *Where do we start?*

Kathryn followed these questions by sharing CREW's 2019 goal to help ensure that the SD ACH work is grounded in equity: *Develop, implement and share a best practice tool to guide all of the ACH work built on the core values of accountability, equity, inclusivity, and neutrality that encompasses social and racial justice.*

To achieve this goal, Kathryn shared that CREW is working on developing a tool for all ACH workgroups to use to help ensure their work is consistent with ACH core values and that an equity lens is applied to all ACH work. To illustrate potential tools, Kathryn shared examples of existing equity tools and described the different formats. As for next steps, CREW will incorporate feedback from Stakeholders and SD ACH workgroups through March and will share a draft equity tool with the Stewardship Group in April. The goal is for the equity tool to be finalized in May and implemented in June.

Vital Stakeholder Input on Equity

Following Kathryn's update, Stakeholders were asked to think about the following questions. In small groups, Stakeholders shared their perspectives and then reported out to the full group. Below is a summary of the discussion.

- *What does equity look like in our ACH work?*
- *What will the evidence be that we are successfully applying an equity lens to our ACH work? How will we know if we are being equitable?*
- *Do you know of additional equity tools or best practices to share to inform our ACH work?*

What does equity look like in our ACH work?

- Consider all regions of the county
- Include insured and uninsured populations
- Allocate funds to those who need it (identified through data)
- Diversity training for all workgroups
- Capacity building/health literacy training for the community
- Integrate equity in program, policy, and practice
- Meet people where they are so everyone can end in the same place
- Identify gaps in the data and get missing data from other sources
- Distribute resources based on need
- Create a courageous, brave spaces for fearless conversations
- Not putting a band aid on something that is broken
- Adequate resources in areas where they are lacking

What will the evidence be that we are successfully applying an equity lens to our ACH work? How will we know if we are being equitable?

- Wellbeing data will be our indicator
- Collect and analyze population health data
- Satisfaction survey between community and SD ACH workgroups
- Analyzing the percent of the Wellness Fund going to system level work versus program level work (we want to change the system, not put a band aid on it)
- Create and utilize an equity dashboard

Do you know of additional equity tools or best practices to share to inform our ACH work?

- Kaiser Family Foundation literature on embedding equity into work
- Centers for Disease Control and Prevention equity tool
- Create an equity dashboard for accountability
- Improve awareness of results and barriers
- Spread news equitably through channels such as newsletters and social media
- Incorporate trauma and resilience tools