SAN DIEGO ACCOUNTABLE
COMMUNITY FOR HEALTH

USING RESULTS-BASED ACCOUNTABILITY™ TO CREATE AND MEASURE A PORTFOLIO OF INTERVENTIONS

Guidance for Accountable Communities for Health

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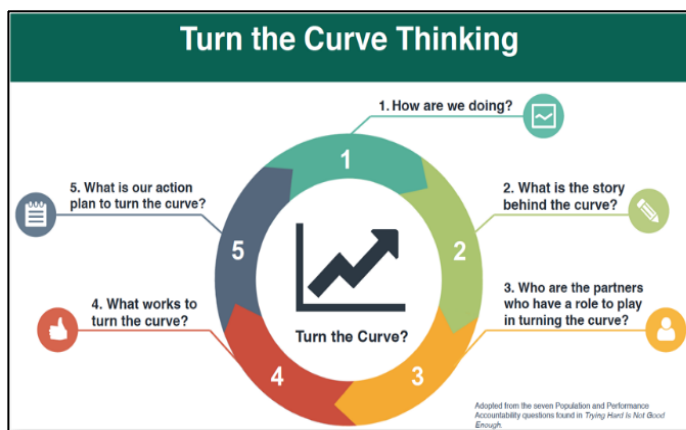
Introduction

What is Results-Based Accountability™?

Results-Based Accountability™ (RBA) is a disciplined way of thinking and taking action that can be used to improve the quality of life in communities, cities, counties, states, and nations, as well as to improve the performance of programs. RBA is an approach to measurement that puts the focus on the ends and works backward to the means using simple, plain language.



Source: Clear Impact

RBA concepts have been around for over 15 years and have been used in the U.S. and internationally by county, state, and national governments as well as community-based organizations. RBA offers clear, sequential steps in its "Turn the Curve" approach (see figure). The first steps are for stakeholders to define a goal, review population data trends for the topic of interest, and understand the many reasons the trend is moving in the wrong direction (story behind the curve). The next steps are to identify the partners who have a role to play in impacting the issue, review best and promising practices, and create a multi-stakeholder action plan that will reverse negative data trends and improve wellbeing in the area of focus. RBA keeps evaluation simple (how much did we do, how well did we do it, and is anyone better off?) and makes it easy to update strategies when circumstances change. The process may be revisited and updated when new conditions are present (e.g., COVID-19).

Using RBA to Create a Portfolio of Interventions

Accountable Communities for Health (ACHs) are community-based partnerships formed across multiple sectors that develop a shared vision and take action to improve the health and wellbeing of a community. Involvement of the community and a focus on equity are components that make this model unique. One essential element of an ACH is a portfolio of interventions (POI), a diverse network of interventions that address both more immediate physical and behavioral health needs, as well as those that require longer-term commitment, such as addressing health-related social needs and equity. The POI is based on the idea that in any given community, there are organizations addressing the same problem or targeting similar goals, but this often happens in silos without sufficient coordination to significantly improve population health. To strengthen impact, the POI offers a strategy to more intentionally and strategically link and align activities and address gaps across organizations and sectors. Prior to embarking on POI development, the ACH must have the conditions in place to support this type of collective impact, such as a common agenda, backbone support, shared measurement systems,

mutually reinforcing activities, and continuous communication. (See Resources for *Collective Impact Readiness Assessment*.)

This document is designed to assist ACHs to use the RBA process as a framework for developing, implementing, and refining a POI that reflects community needs and priorities and incorporates a methodology for measuring impact at the population and program levels. The steps and recommendations included in this toolkit are based, to a large degree, on the experience of the San Diego Accountable Community for Health (SDACH).

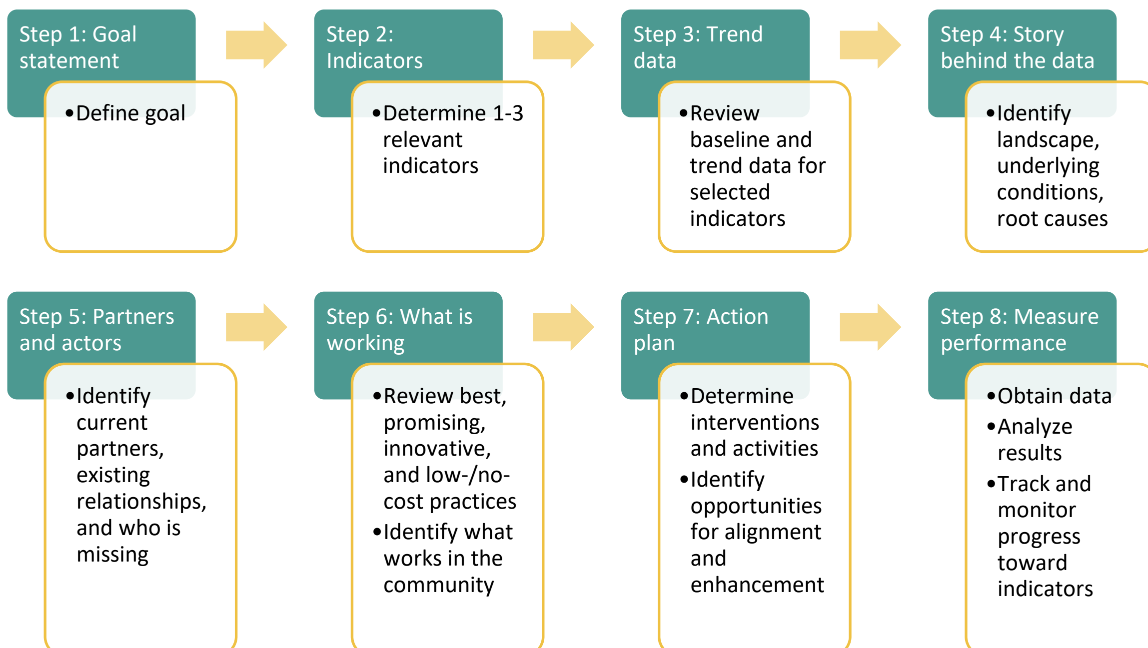
RBA to POI Process

Initial Steps

The first step in the process is to convene the ACH partners and stakeholders who will work together to develop the POI using the RBA model. Partners should be engaged and ready to undertake this work in a collaborative and cooperative manner over an adequate period of time. Developing a POI may take weeks or months, depending on factors such as the frequency of meetings, the availability of population-level data, existing programs and partnerships, and the degree to which partners are engaged. As with most collaborative efforts, in-person meetings may be more conducive to building partnerships and teamwork; however, with skillful facilitation, the process can be very successful in virtual meeting settings.

To start, a basic overview of RBA terminology and steps will provide partners with foundational knowledge and an understanding of the entire process. (See Resources for a Glossary of RBA Terms.)

The following steps are tailored for ACHs to develop a POI using the RBA process and expand upon the earlier steps identified for turn-the-curve thinking in a variety of other settings.



1. Determine Goal Statement

The first step for ACH leadership is to facilitate the team through the process of defining a goal statement (also known as a result statement) for your POI. The goal statement should reflect the quality-of-life conditions desired for your community. The goal statement should be broad and contain three key elements: a population, a geographic area, and a condition of wellbeing.

Examples of **populations** (and subpopulations, if relevant) include:

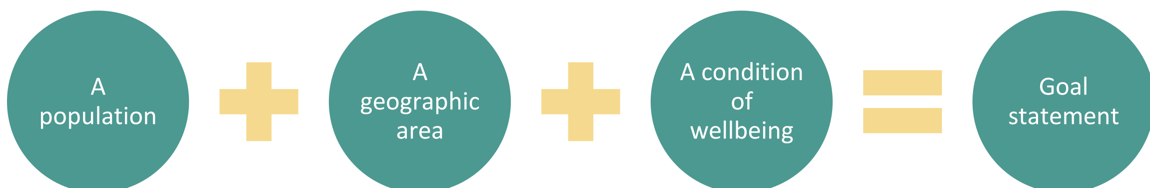
- All residents
- All adults with diabetes
- All seniors
- All children
- All individuals without health insurance

Examples of **geographic areas** include:

- A county
- A city
- A region
- A neighborhood
- A school or school district catchment area

Examples of **conditions of wellbeing** include:

- Nutrition security
- Community safety
- School readiness
- Economic security
- Clean environment



Use simple language when creating your goal statement and avoid referencing data, percentages, or specific improvements. Examples of **goal statements** include:

- All children in Northern Heights School District enter school ready to learn
- All people in West Sacramento are economically secure
- All residents of East San Jose are safe
- All people in North San Diego County eat sufficient quantities of nutritious foods

2. Identify Indicators

Once the goal statement has been established, the team will work together to determine how to best measure progress toward the desired goal. The team will select one to three indicators of progress based on population-level data relevant to the goal statement. Indicators should be understandable by a broad range of audiences and say something important about the goal. Importantly, the indicator

should be based on data that is available and updated on a timely basis. (See Resources for Identifying Indicators Worksheet.)

Indicators should be selected that best meet the following criteria:

- Communication Power—Does the performance measure communicate to a broad range of audiences?
- Proxy Power—Does the performance measure say something of central importance about the program? Does it have "data herd" power, meaning when this measure improves, are other measures most likely to improve as well?
- Data Power—Is quality data available on a timely basis?

Examples of indicators related to goal statements include:

- Goal statement: All children in Northern Heights School District enter school ready to learn
  Indicator: Percent of children entering kindergarten who are ready to learn based on kindergarten readiness assessment
- Goal statement: All people in West Sacramento are economically secure
  Indicators: Employment rate; percent of youth not in education, employment, or training
- Goal statement: All residents of East San Jose are safe
  Indicator: Crime rates
- Goal statement: All people in North San Diego County eat sufficient quantities of nutritious foods
  Indicators: Percent of adults below 200% of the federal poverty level who have experienced food insecurity in the past year; percent of children who eat five or more servings of fruits and vegetables daily

3. Review Trend Data

Team members will next review the data related to selected indicators. Obtaining population-level data can be challenging, as data sources for some conditions of wellbeing may be limited. (See Resources for Population Health Data Sources.) Questions for consideration include:

- What publicly available population-level data sources can you access for your focus area?
  - Select the data that matches your geographic region of focus. National or state-level data may be easy to access, but won't tell the story of more localized focus areas, such as a counties, Zip codes or census tracts.
- How reliable is the data?
  - Be sure the data is from a credible source, is recent (e.g., within the past one to two years, if possible), and is accessible by team members.
  - Get to know epidemiologists or others from your local public health department who may have easy access to health data.
- Can the data be disaggregated by the lenses of health equity?
  - Disaggregating data by race/ethnicity, age, geographic location, income level, and other factors helps to expose trends that otherwise may be hidden. This approach can be used to establish the scope of the problem, uncover gaps, and help identify impacted populations.

Once data sources have been identified, team members will review the data over time to determine if the "curve," or trend, is going in the right or wrong direction and help identify areas for improvement.

4. Determine the Story Behind the Data

Too often, data is presented without recognition of the community conditions that influence data trends. Further, population-level data often lags behind current trends and circumstances that may have a significant impact on health and wellbeing, such as the impact of COVID-19. The team will examine and discuss the landscape, underlying conditions, root causes, and political and/or institutional environments that have influenced each indicator and affected data trends. This information will be useful in determining approaches that can help to "turn the curve," or change data trends in the future.

When discussing the story behind the data, focus on root causes of the selected condition of wellbeing. Explore both positive and negative effects, current as well as anticipated impacts, and both internal and external influences. Focus on the causes and resist the urge to jump to solutions, which some will try to do. (See Resources for Story Behind the Data Worksheet.)

5. Identify Which Partners Play a Role

Thinking broadly about the goal and indicators, the next step is to identify who has a role to play in turning the curve. The discussion of the story behind the curve and root causes will help the team to recognize both traditional and nontraditional partners who are currently making an impact, as well as those who could contribute in the future. Possible partners may include, but are not limited to:

- Funders
- Local government agencies
- School districts
- Universities
- Community-based organizations
- Hospitals
- Advocacy groups
- Public health
- Law enforcement
- Youth leaders
- Community leaders
- Patient groups
- Businesses

Think about which partners address the selected indicators in the identified geographic region. Explore the relationships between and among these partners and look for opportunities to make new connections, break down silos, and understand racial inequities. The team may identify partners who are already working on the issue, as well as those who may have a role to play or could offer diverse perspectives, but aren't yet engaged. (See Resources for *Asset-Based Community Development*.)

6. Determine What is Working

An exploration of best and promising practices related to the selected condition of wellbeing will set the stage for developing an action plan. Several government sources describe evidence-based practices, such as Healthy People 2030, The Community Guide, the U.S. Preventive Services Task Force database,

and peer-reviewed publications. A literature review is an additional way to reveal the evidence base for various interventions. (See Resources for Evidence-Based Resources.) Interventions that have had success locally but have not been formally studied, as well as those that have strong evidence but have not yet been implemented, should be considered. The team will also consider the feasibility of implementing various interventions with particular attention to cost and necessary resources.

7. Develop Action Plan

Next, the team will begin the process of identifying interventions and related action steps to address the selected goal. It is helpful at this stage to summarize and review results of the previous steps with attention to:

- Goal statement and indicators
- Root causes and community conditions
- Current and potential partners
- Best, promising, innovative, and feasible interventions

(See Resources for Summary Example.)

Although discussion may initially focus on brand new interventions, the team should be encouraged to explore interventions that support, expand, or enhance current interventions with a focus on reaching new populations and/or addressing gaps in service. This approach leverages the strength of ACHs as multi-sector collaboratives to create new partnerships and break down silos. Considerations and discussion questions include:

- What kinds of expertise, experience, and resources do partners have to contribute?
- Where is the passion, motivation, and interest in the community?
- Where is there alignment between current organizational focus areas and the identified goal statement?
- Who has existing staff to engage in identified interventions?
- Which partners could offer support for low- or no-cost interventions?

The above factors will inform discussion of possible interventions. Each root cause identified in the story behind the data may point to a specific strategy or action. Criteria for interventions and related discussion questions include:

- Leverage—how much impact will the proposed intervention make on results, indicators, and turning the curve?
- Specificity—is the intervention specific enough to be implemented and can it be measured?
- Feasibility—is the intervention affordable and is there an identified individual or organization to take a leadership role?
- Values—is the intervention consistent with personal and community values?
- Equity—will the intervention address a gap in service or reach priority populations or geographic areas that have been underserved?
- Influence—will the intervention support, expand, or enhance current efforts?

(See Resources for Intervention Selection Worksheet.)

Interventions and actions may be updated when:

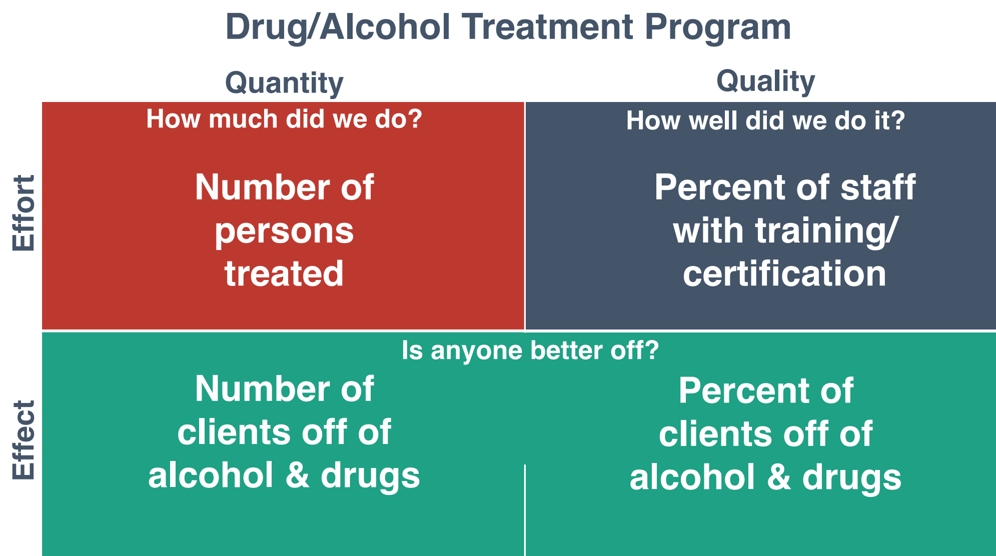
- New partners come onto the scene
- New or innovative ideas emerge about what works
- New information becomes available about how to turn the curve
- New staffing or funding becomes available
- Community conditions change

Once interventions have been selected, the team will determine specific action steps necessary for implementation of each intervention. Considerations include a realistic timeline, identification of lead and additional partners, necessary outreach, communications, and measurement (see below). Together, the identified interventions and related action steps will make up the action plan.

8. Measure Performance

Performance measures are measures of how well a program or agency is working. They focus on the quantity and quality, as well as effort and effect, resulting in three performance measures: How much did we do? How well did we do it? Is anyone better off?

The figure below provides examples of performance measures for a drug/alcohol treatment program. The red box, "how much did we do," usually tracks the number of individuals served. "How well did we do it," measures the quality of an organization's services, in this case the percent of staff with a certain training or certification. This measure could also reflect client satisfaction with the training, staff satisfaction, or staff retention. "Is anyone better off," focuses on client changes, which in this case is the number of clients abstaining from alcohol and drugs. Other examples could be the number and percent of high school graduates, children entering kindergarten ready to learn, or patients with hypertension who have their blood pressure under control. It could also be measured through a pre/post-test of knowledge, attitudes. or behaviors to demonstrate improvements.



Performance measures related to equity, diversity and inclusion could include the percent of members of the leadership team who self-identify as people of color, women, LGBTQ, or disabled; percent of staff who believe they are treated fairly and with respect in the workplace; or percent of staff who feel their workplace is committed to creating a diverse and inclusive environment. Whenever possible, performance measures should be disaggregated by race/ethnicity or region to better understand

disparities. More information about how to use the RBA model to measure diversity, equity and inclusion can be found in the Clear Impact publication entitled, *"Diversity, Equity and Inclusion Made Measurable: Suggestions for Getting Started with DEI Measures Within Individual Organizations,"* (November 2021).

The RBA model suggests selecting only three to five performance measures that communicate most effectively how well a program is doing. If several measures are under consideration, your team can select the final measures based on the same criteria as those used to select indicators; specifically communication power (communicates to a broad audience), proxy power (says something of central importance), and data power (is available on a timely basis).

While an agency focuses on improving the health of its own client base, it cannot be held accountable for improving the health of an entire community. This type of change can only happen with many organizations working together to make changes over a longer period of time. In the RBA model, this contrast is referred to as performance accountability vs. population accountability.

An ACH is ideally positioned to work with programs and agencies to identify and track performance measures related to the desired result. Clear Impact offers an RBA scorecard product that tracks each of the steps in the turn-the-curve model, including progress on performance measures. Other software programs can also be used to track progress on performance measures, such as Tableaux, Infogram, Microsoft Excel, or others. Tracking performance measures over time supports organizations in staying focused on their desired result and provides a methodology for communicating improvements to a larger audience.

Conclusion

Developing a POI within a multi-stakeholder collaborative can be a challenging proposition for many reasons. Health and wellness challenges are complex and seemingly unsolvable. Every stakeholder at the table is advocating for their own client population's needs. Historic inequities mean certain problems are deeply rooted in communities of color. Poverty is an underlying cause of many conditions, but groups are powerless to solve it. Some partnerships can spend months or years trying to develop an action plan and see little progress, resulting in frustration for everyone involved. Stakeholders may leave the table if they don't see quantifiable results.

The RBA model can help an ACHs narrow their focus so they can create a POI with concrete action plans and measurable results that are supported by a core group of partners. The process starts by using data to understand where the greatest need is. It then works backward to figure out how to reverse negative data trends by understanding the story behind the data, getting the right partners to the table, understanding what works to turn the curve, and creating an action plan. The cycle can be revisited and updated as needed. RBA also provides a framework for measuring and tracking success to demonstrate to a broad audience (e.g., partners,

Strategies for Success

- Look to reliable partners for intervention leadership
- Provide adequate staff support
- Engage community leaders and those with lived experience
- Focus on potential benefits to partners to enhance engagement
- Start with low-hanging fruit to achieve initial wins
- Be flexible and responsive to changing conditions
- Embrace the emergence of new ideas, partnerships, political will, etc.

agencies, funders, policymakers) that things are improving. The model gives groups permission to narrow their focus, rather than trying to solve all problems in a community, or even all aspects of a particular health issue. Multiple portfolios can be developed targeting different conditions or neighborhoods if necessary. Using this model, ACHs can understand and communicate the most pressing problems in their communities and convene stakeholders to create and measure an effective POI, giving ACHs a roadmap for moving forward and making a difference.

Resources

Collective Impact Readiness Assessment

Glossary of RBA Terms

Identifying Indicators Worksheet

Population Health Data Sources

Story Behind the Data Worksheet

Asset-Based Community Development

Evidence-Based Resources

Summary Example

Intervention Selection Worksheet