TACHI Learning Session – Portfolio of Interventions

August 25, 2022

Agenda

- Portfolio of Interventions (POI) Intro
- POI Example: San Diego Accountable Community for Health
- Breakout session #1 (within your ACH team)
  - Starting to define your POI
- Breakout session #2 (across ACH teams)
  - POI feedback and discussion

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Objectives

1. Understand **what a Portfolio of Interventions is** and why your ACH needs one
2. Know **where to start** in defining your POI
3. Begin **defining a POI** for your ACH

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What is a Portfolio of Interventions?

When you hear the phrase “Portfolio of Interventions” what comes to mind?

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What is a Portfolio of Interventions? A definition

A Portfolio of Interventions is a set of mutually-reinforcing activities selected by cross-sector partners, focused on improving non-medical factors that influence health, and aligned to achieve community health and health equity goals.

- Mutually-reinforcing, aligned activities complement and enhance the actions of others.
- A POI builds from the partners' existing activities, which partners develop into a "portfolio" by doing business differently to achieve shared outcomes.
- A mature portfolio addresses non-medical factors impacting health (*including* upstream determinants of health) across timelines and domains (from clinical to environment/systems).
- A POI demonstrates the ACH's value proposition to the community and key stakeholders.

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What is a Portfolio of Interventions? Domains

- policy & systems
- environment
- clinical-community linkages
- community programs/social services
- clinical

Source: "Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health, " Health Affairs Blog, January 16, 2019. DOI: 10.1377/hblog20190115.234942

What is a Portfolio of Interventions? Example

Vision: All children of Sesame County will live, play, and learn in environments that support their optimal health

Quantitative and qualitative data pointed to asthma as a major health issue among children in Sesame County

POI Goal: Reduce asthma and the negative impacts of asthma on children in Sesame County

Objective 1: Decrease asthma-related Emergency Department (ED) visits and racial and ethnic disparities in asthma-related ED visits by children in Sesame County

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What is a Portfolio of Interventions? Example (early stage)

Objective: Decrease asthma-related Emergency Department (ED) visits and racial and ethnic disparities in asthma-related ED visits by children in Sesame County

Clinical

Addition of a patient educator to provide **asthma self-management education** in 3 pediatric clinics of partner FQHC

Clinical-Community Linkages

Effective **process to connect** FQHC partner's patients to community-based asthma-related home visiting programs

Community Programs and Human/Social Services

Community-based asthma-related **home visiting programs** providing home asthma trigger identification and connections to home remediation services

No-cost **remediation services** to reduce asthma triggers in the home

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What is a Portfolio of Interventions? Example #2 (more advanced stage)

Objective: Decrease asthma-related Emergency Department (ED) visits and racial and ethnic disparities in asthma-related ED visits by children in Sesame County

Clinical

Asthma self-management education in all pediatric and family medicine clinics of partner FQHCs

Clinical-Community Linkages

Effective, **patient-centered linkages** between hospitals, pediatric providers, and community-based asthma-related home visiting programs

Community Programs

No-cost **home remediation services** to reduce asthma triggers in the home

Community-based asthma-related **home visiting programs** providing education, home asthma trigger identification, and connections to home remediation services

Policy & Environment

Local Housing Authority interior design **policies** to eliminate asthma triggers (e.g., no carpeting)

Legal and other interventions with **commercial landlords** to conduct **property-wide remediation** for asthma triggers

Organizing to **relocate a recycling plant**, which bring trucks and pests into community

SYSTEMS

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Portfolio of Interventions: Where to start?

Articulate the goal and measurable objectives

Identify existing interventions/activities

Work towards alignment across existing interventions

Identify gaps and opportunities to expand work across domains

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Creating Alignment & Mutual Reinforcement

What can be done with *existing resources* that will lead to *greater progress* towards your shared goal and objectives?

¿Examples from your work?

¿What gets in the way of alignment?

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Creating alignment and mutual-reinforcement: A (real) example

- Two youth-serving organizations that offer mentoring: one school-based and community-based
- Organizations collaborated to create a new mentoring program where pairs start off meeting in schools, then transition to community
- New program led to more administrative work, confusion, conflicts due to different organizational goals
- Alignment: School-based pairs that wanted to meet in the community were offered to join the community-based mentoring program; community-based pairs that wanted to meet at school were offered the school-based option

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Creating Alignment & Mutual Reinforcement

- ✓ Look for ways to simplify things from participants' perspectives
- ✓ Look for ways to help your partners fulfill their institutional goals

- X Avoid creating something new
- X Minimize creating extra work, particularly for front line staff

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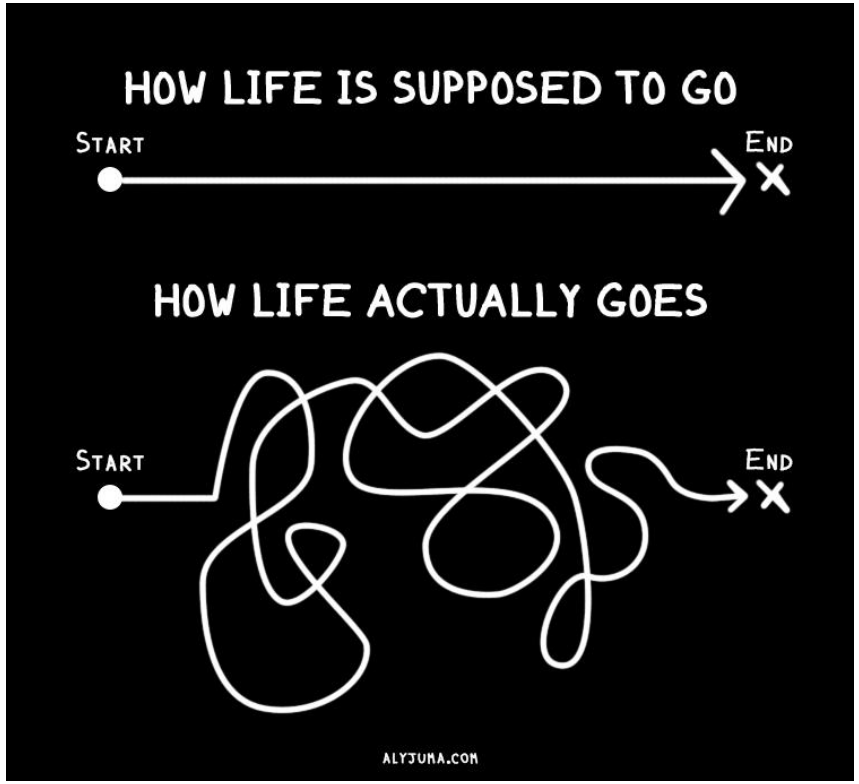
Portfolio of Interventions:

San Diego's Journey

Remember

- This is a journey, not a destination!
- On the journey we learn to…
  - ✓ Think in ‘systems’ instead of programs
  - ✓ Build relationships across partners
  - ✓ Work together in new ways
- May sound linear but it was not



Timeline

Accountable Communities for Health

Sept 2016: Grant awarded

2017-2019: Deep work to develop the following "infrastructure" components

- Partners
- Governance structure
- Overarching framework
- Data priorities

2019-2020: POI development

Cardiovascular Protective Factors

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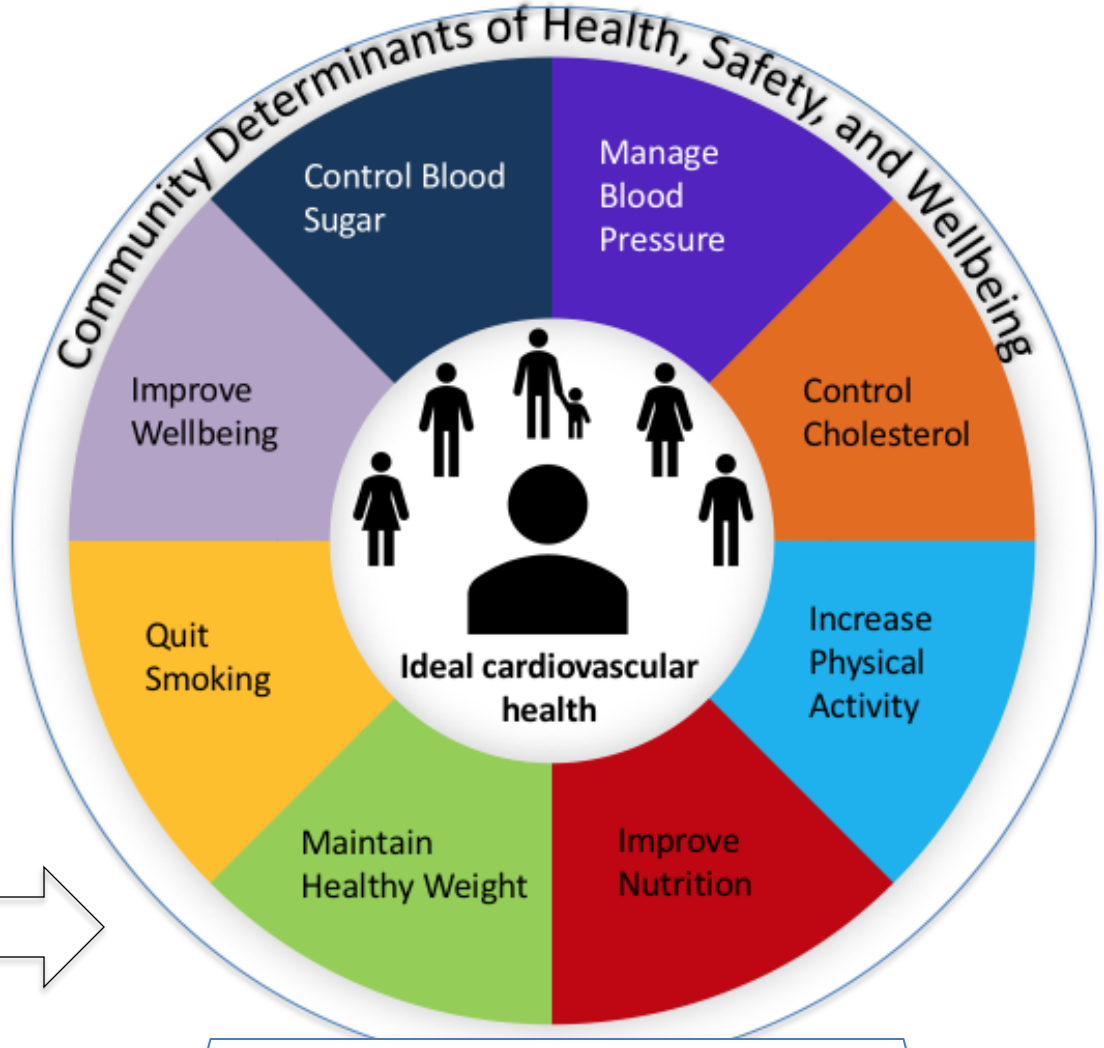
Community



EQUITY and ACCESS

North Inland Region
Portfolio of Interventions Pilot

Initiated Process: January 2019
Completed Process: Oct 2020

North Inland Region POI

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- Region selected by SD ACH Collective Action Workgroup
- Convened subcommittee in early 2019
- Multiple sectors represented
  - Healthcare
  - Nutrition assistance organizations
  - Health and Human Services Agency (includes Public Health Dept)
  - 2-1-1 San Diego
  - Nonprofit organizations

North County POI Process

Accountable Communities for Health

What are our goals and indicators?

- Define goal
- Determine 3-5 relevant nutrition indicators

How are we doing?

- Review baseline and trend data for the selected nutrition indicators
- Determine what will happen if we do nothing

What is the story behind the curve?

- Identify North Inland landscape, underlying conditions, root causes, political and/or institutional environments

Which partners play a role?

- Review identified partners
- Identify existing relationships between/among partners
- Determine who else needs to be at the table

What is working?

- Review best, promising, innovative, and low-/no-cost practices
- Identify what is working in the community

What is our action plan?

- Identify and bring partners together
- Identify opportunities for alignment, enhancing strengths, and/or addressing gaps

Performance Accountability

Obtain program data from identified interventions

- How much did we do?
- How well did we do it?
- Is anyone better off?

Analyze results

Track and monitor progress

Assess progress toward indicators

Based on the Results-Based Accountability Model https://clearimpact.com/results-based-accountability/

Overall Goal and POI Goal

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Overall Goal: Lifelong cardiovascular health

POI Goal: All people in North Inland Region eat sufficient quantities of nutritious foods.

Data Point: 1

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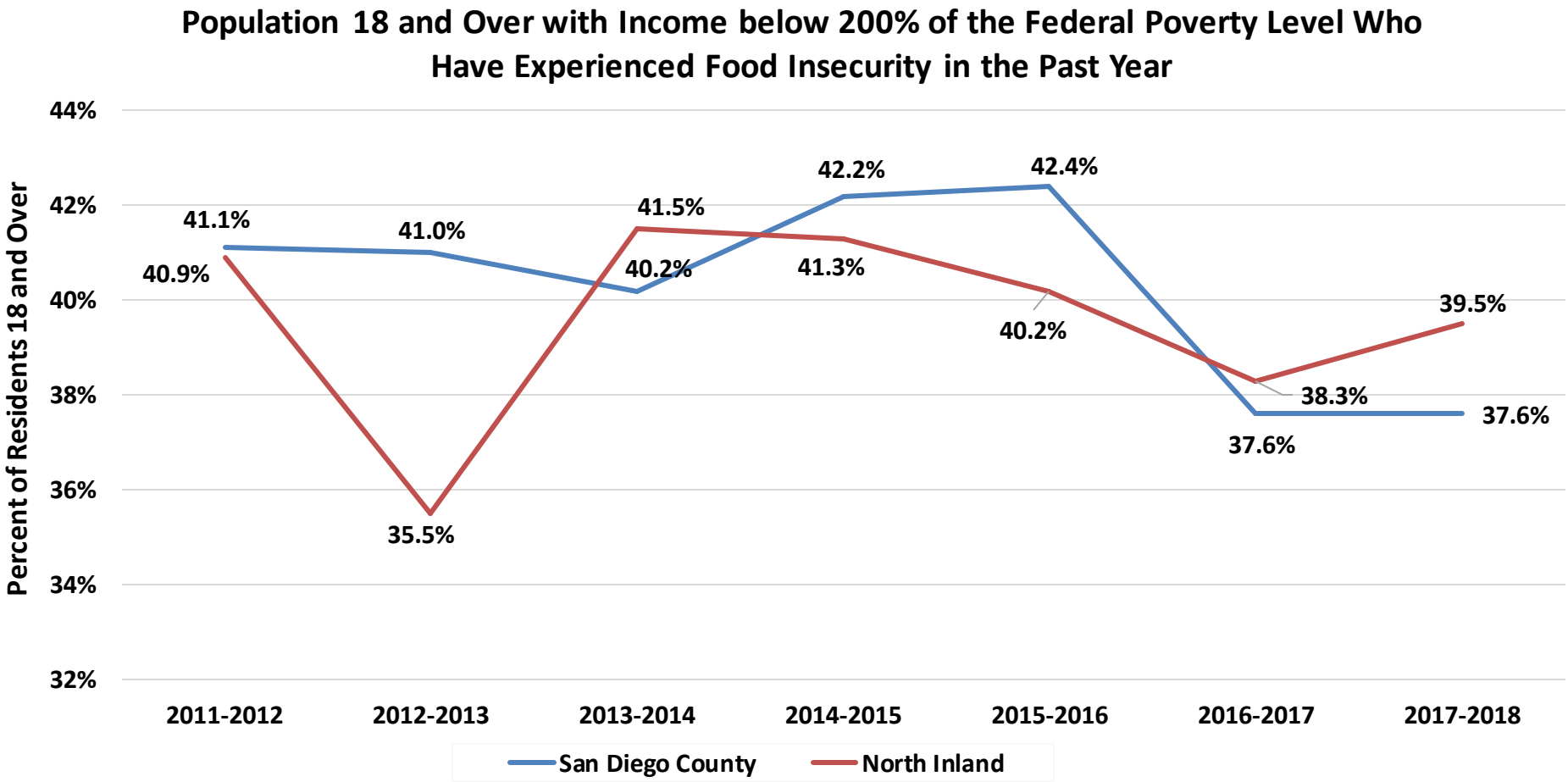

Respondents were asked various questions related to food security; questions asked of residents < 200% of the Federal Poverty Level.
Source: 2011-2018 California Health Interview Survey.
Prepared by County of San Diego, Health & Human Services Agency, Public Health Services, Community Health Statistics Unit, 5/2020.

Data Point 2

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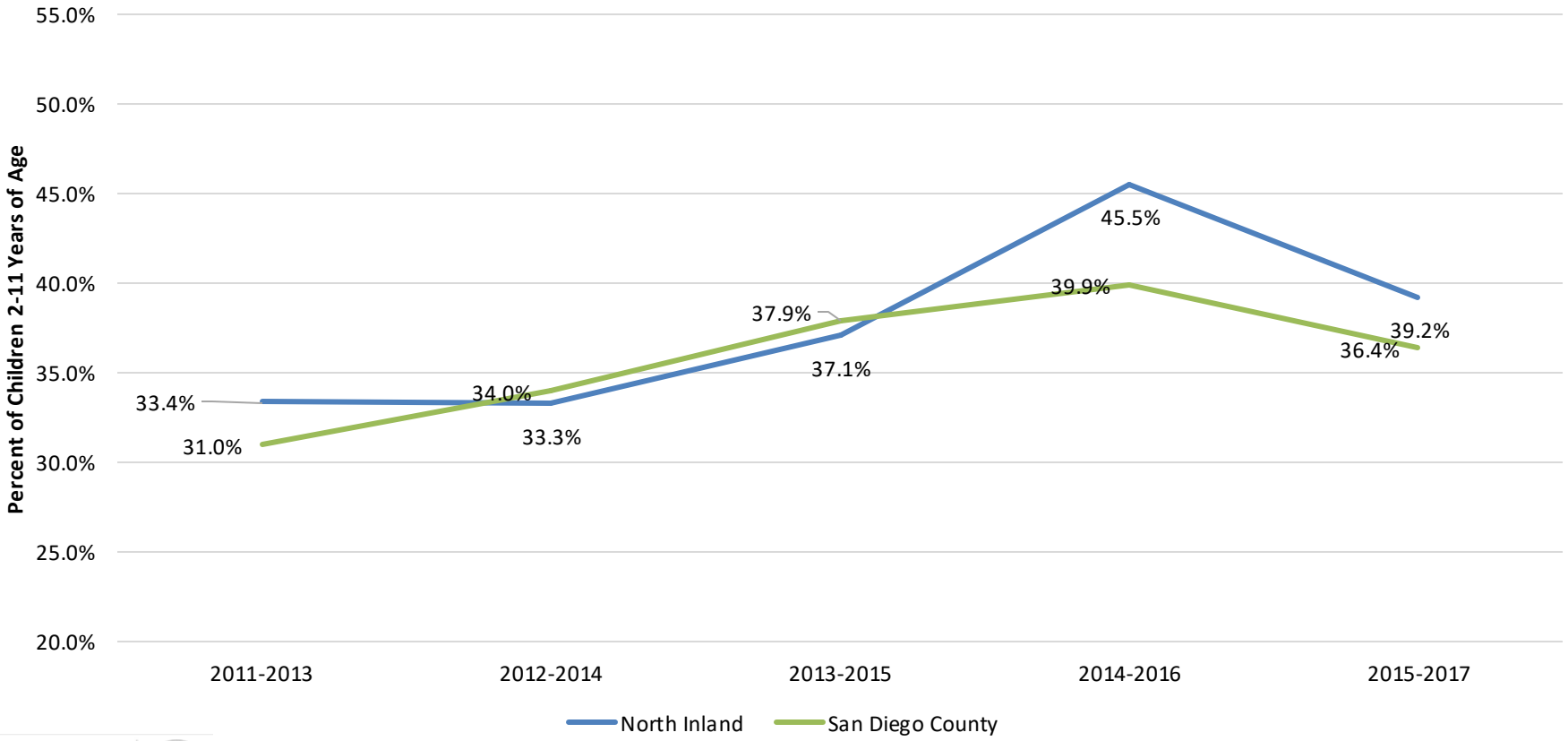
Percent of Children Ages 2-11 Who Eat 5 or More Servings of Fruits and Vegetables Daily (as reported by parents)



COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY PUBLIC HEALTH SERVICES

Source: 2011-2017 California Health Interview Survey

Prepared by County of San Diego, Health & Human Services Agency, Public Health Services, Community Health Statistics Unit, 8/2019.

Story Behind the Curve – Barriers

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- Current political climate
- Perceived higher cost of nutritious foods
- "Food deserts" due to built environment and/or transportation issues
- Less time to prepare nutritious meals
- Less food access and funding in rural areas
- High cost of housing and other basic needs
- Highly affected populations: rural residents, migrant farm workers, those living on reservations

Story Behind the Curve – Assets

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- Expanded San Diego Food Bank
- Hospitals and clinics conducting nutrition security assessments
- 2-1-1 and CIE conducting SDoH screenings
- Indian Health Council provides resources and has access to federal funds
- Largest city's mayor is supportive of nutrition security efforts

Which Partners Play a Role

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- Over 50 programs identified that serve North Inland region with nutrition services that address selected indicators
- Criteria for POI inclusion:
  - Open to working with others toward shared goal and indicators
  - Open to partnering with others to enhance opportunities for program improvement
  - History of working well with others
  - Willing and able to make time commitment
  - Willing to share aggregate program data

Which Partners Play a Role

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- Programs were categorized to determine balance across ACH domains and health equity lenses
- Subcommittee members serve as leads for all strategies and objectives
- One organization has been identified that could possibly serve as a “mini backbone” to carry work forward

What is Working

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- Conducted literature review to determine evidence-based, promising, and innovative nutrition practices
  - School-Based Interventions
  - Farmers Market Utilization
  - Community Redesign & Policy
  - Nutrition Education & Resources
- Explored ways for interventions to employ equitable, effective methods

Strategies & Objectives

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Strategy:

- Increase the number of organizations serving children ages 2-5 that conduct **standardized nutrition security screenings** and make appropriate referrals

  Objective:

  - Train North Inland home visiting programs and early care and education providers to implement two-question validated nutrition security measurement tool and refer to nutrition assistance resources, as needed
  - Lead: Nancy Roy, community advocate (formerly with Palomar Health)

Strategies & Objectives

Accountable Communities for Health

Strategy:

- Increase the number of schools that implement practices that **increase access to and consumption of nutritious foods**

  Objective 1:

  - Create a learning collaborative for North Inland region school district nutrition services directors
  - Lead: Candy Gibson, North County Food Policy Council

  Objective 2:

  - Conduct advocacy for school district nutrition policies and resources
  - Lead: TBD

Strategies & Objectives

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Strategy:

- **Increase participation in distribution of fresh foods** by food pantries and congregate meal programs

  Objective 1:

  - Increase North Inland region participation in San Diego Food Bank's Feeding Everyone with Equity and Dignity (FEED) program
  - Lead: Shelly Parks, San Diego Food Bank

  Objective 2:

  - Increase food distribution to seniors with limited transportation
  - Lead: TBD

Strategies & Objectives

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Strategy:

- Increase **trauma-informed nutrition** policies and programs

  Objective 1:

  – Conduct Trauma-informed Nutrition Learning Collaborative

  – Lead: Adrienne Markworth, Leah's Pantry

  Objective 2:

  – Improve trauma-informed nutrition activities

  – Lead: TBD

  Objective 3:

  – Increase adoption of Trauma-informed Code of Conduct

  – Lead: TBD

North Inland Nutrition Portfolio of Interventions

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Cardiovascular Protective Factor – Nutrition		
SD ACH Domains		**North Inland Nutrition Interventions (Examples)**
	Clinical	Nutrition security screenings and referrals in clinical settings Nutrition education (individual and classes) in clinical settings
	Community	Nutrition security screenings and referrals in home visiting programs Nutrition services directors learning collaborative Participation in FEED program Trauma-Informed nutrition learning collaborative Food distribution to seniors
	Clinical-Community Linkages	Neighborhood Networks—CHWs address nutrition security needs for high-risk health plan members 2-1-1
	Policy, Systems or Environmental	School district wellness policies that address nutrition LCAP funding for nutrition programs and services

Note: This table presents examples of components of a portfolio of interventions that, when balanced by the lenses of health equity and implemented in alignment, can lead to greater impact on ensuring that all residents of North Inland region eat sufficient quantities of nutritious foods..

Outcome Data

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Objective 1.1: Train North Inland home visiting programs to implement two-question validated nutrition security measurement tool and refer to nutrition assistance resources, as needed

	Quantity	Quality
Effort	**How much did we do?** Number of organizations (or individuals) trained on using validated nutrition screening tool	**How well did we do it?** % of organizations (or individuals) that implement screening tool with all of their new families
Effect	**Is anyone better off?** • # of clients who received a nutrition screening • # of clients referred to nutrition resources	**Is anyone better off?** • % of clients who received a nutrition screening • % of clients referred to nutrition resources

Data source(s): First 5, others

Timing of baseline data collection: TBD

Reporting Frequency: TBD

Next steps:

Lead partner: Nancy Roy

ACH is bigger than the POI

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2020 Initiatives

Neighborhood Networks

Building countywide partnerships with new financial arrangements managed by the ACH to meet individual social needs for better health

Revenues to be used to support ACH backbone and Wellness Fund

Collective Action Framework

Linking No. County partners to align resources for better nutrition access using the Results Based Accountability model and creating a framework to replicate in other communities

Stakeholder Learning Community

Creating ongoing opportunities for learning, dialogue, and community-clinical linkages on emerging community health and equity priorities

Thank you!

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