

Results-Based Accountability

A framework used for
Community Development work
at United Way Fox Cities



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What will we cover today?

Overview

Population Accountability

Performance Accountability

How they fit together

Turn the Curve Exercise

Resources & Wrap-up

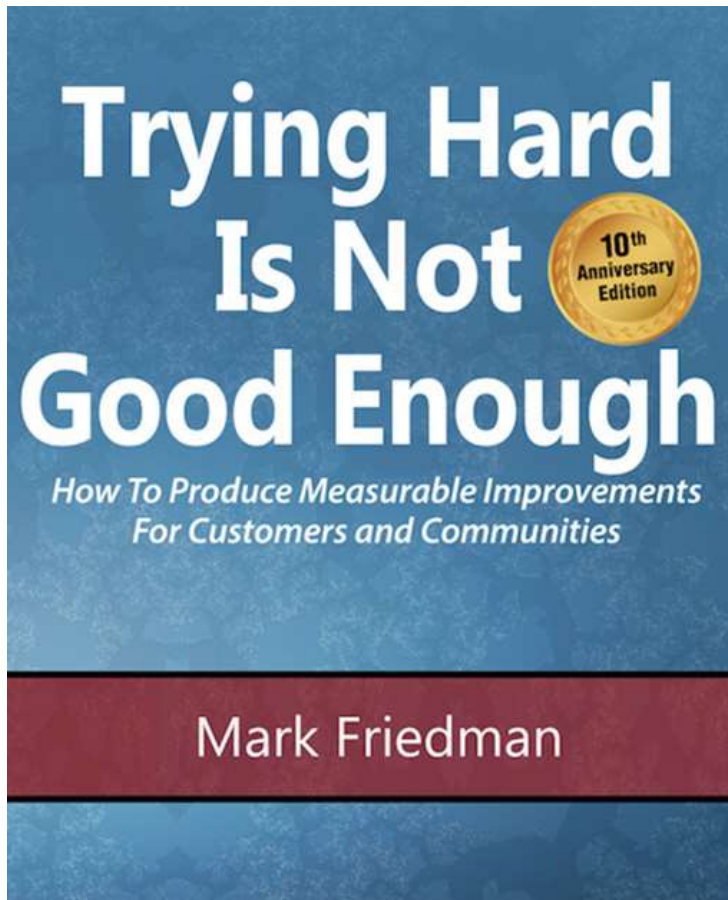


**Thank you for
joining us!**



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Why RBA?



- International movement (RBA/OBA)
- Nearly 50 other United Ways
- Starts with the end in mind
- Link programs' performance to population-level community results

Why RBA?

- Population Accountability vs. Program Accountability
- Use data to inform decisions, process improvement and “Turning the Curve”
- United Way Fox Cities has been on an RBA journey
 - Strategic Plan to set community-level Goals
 - RBA Task Force and pilot
 - Training with Mark Friedman





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Characteristics of a good framework

Simple

Common sense

Plain language

Minimum paper

Useful

RBA fits all of these characteristics!

UWFC is adopting the RBA framework and adapting our work accordingly.



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The RBA framework

Population Accountability

about the well-being of

WHOLE POPULATIONS

For Cities – Counties – States – Nations

Performance Accountability

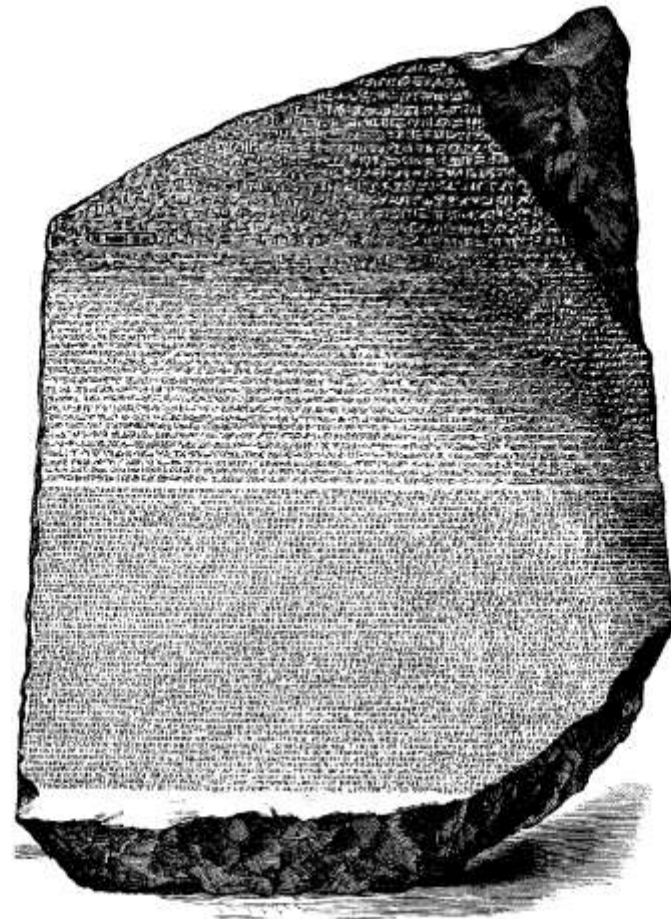
about the well-being of

CLIENT POPULATIONS

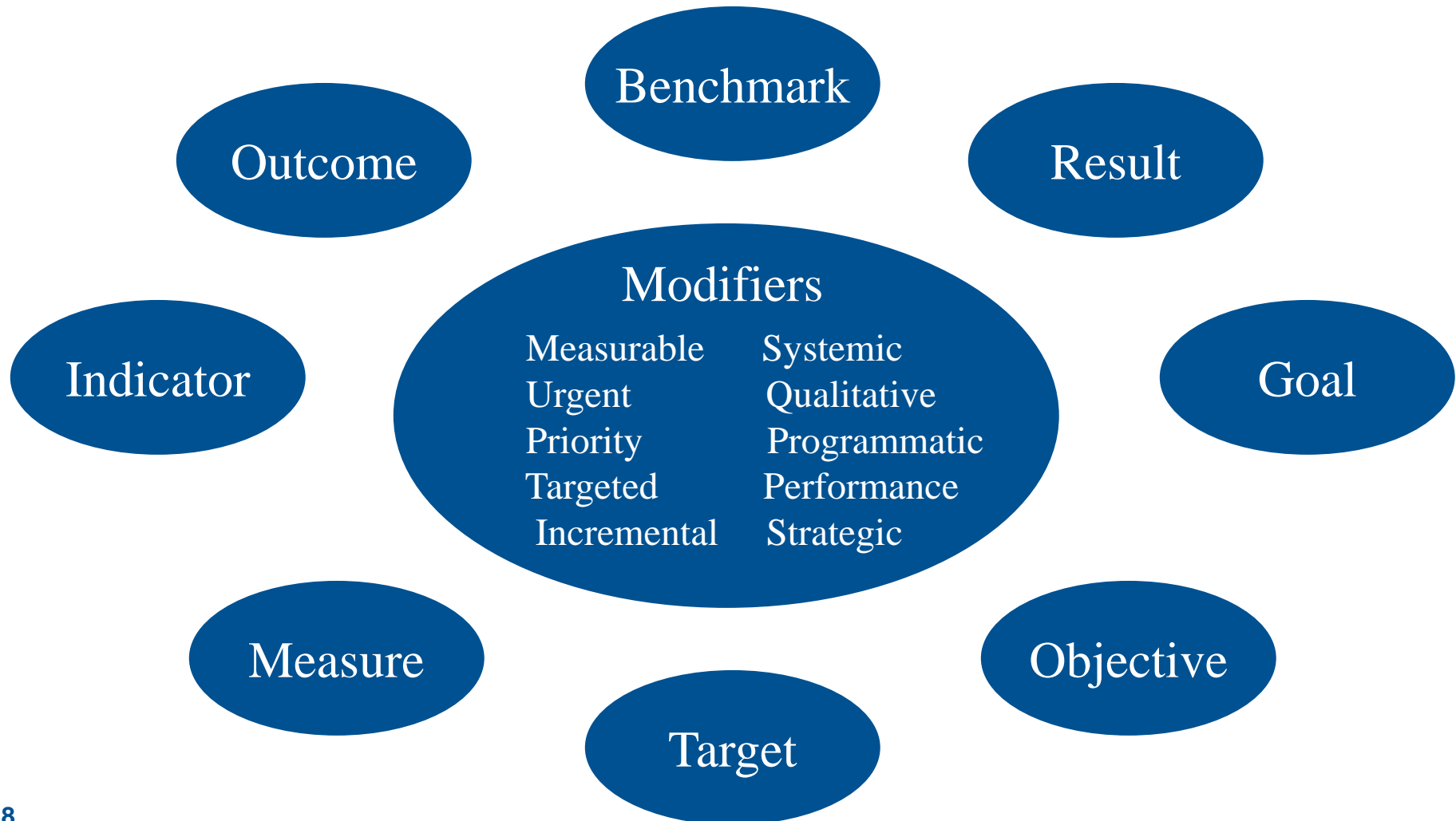
For Programs – Agencies – Service Systems

Tenets of RBA

- Common language
- Common sense
- Common ground



The language trap





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Definitions

Population

QUALITY OF LIFE GOAL

A condition of well-being for children, adults, and/or families.

Safe communities

POPULATION INDICATOR

A measure which helps quantify the achievement of a goal.

Crime rate

Performance

PERFORMANCE MEASURE

A measure of how well a program or service system is working.

Three types: 1. How much did we do?

2. How well did we do it?

3. Is anyone better off? = Customer Results

POP QUIZ!



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1. Safe Community
2. Crime Rate
3. Average Police Department response time
4. An educated workforce
5. Adult literacy rate
6. People have living wage jobs and income
7. % of people with living wage jobs and income
8. % of participants who get living wage jobs

Population Accountability

For whole populations in a
specified geographic area

United Way Fox Cities' Goals



Individuals and families are financially stable



Children and youth are on track to reach their full potential

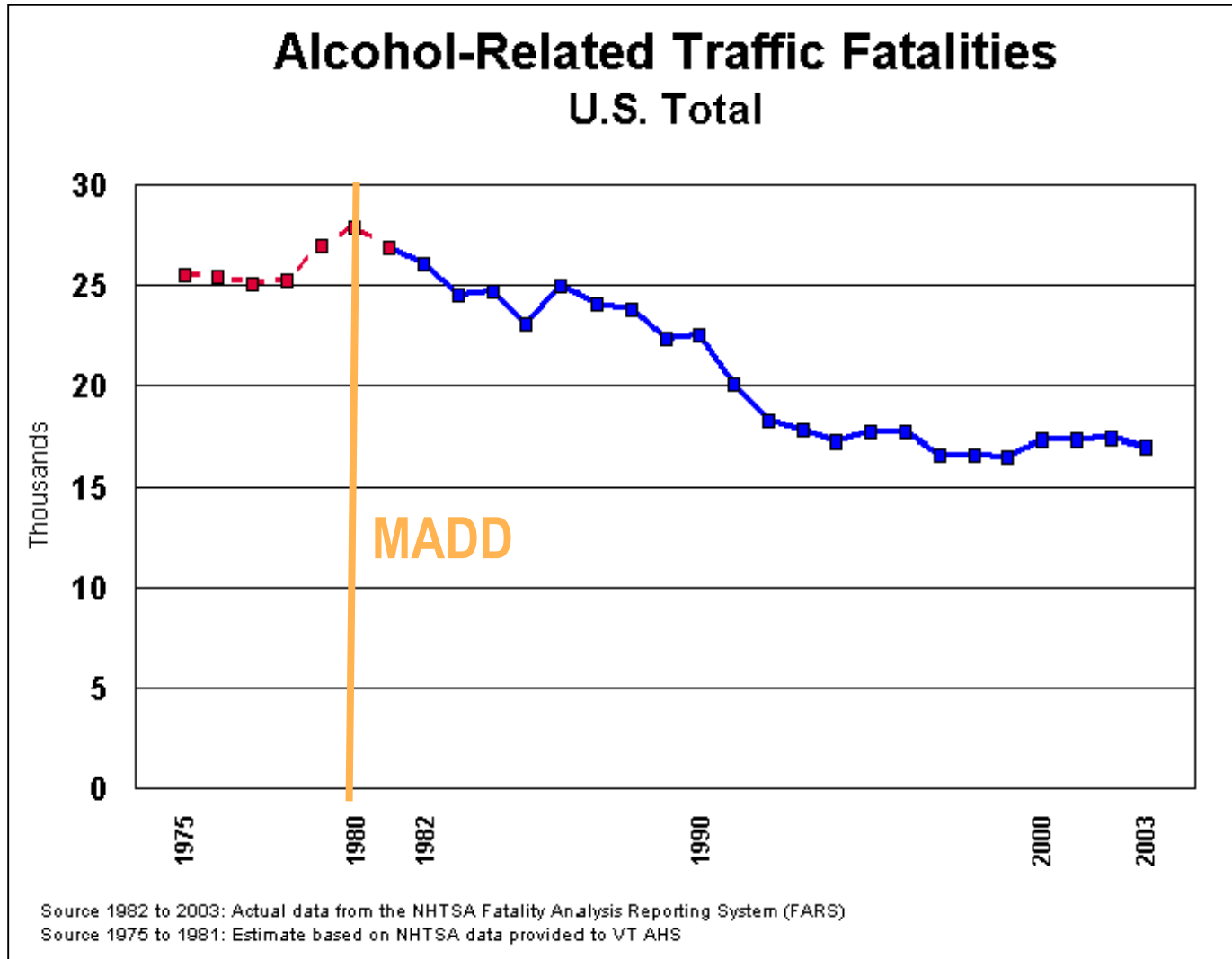


Children, youth and adults are healthy



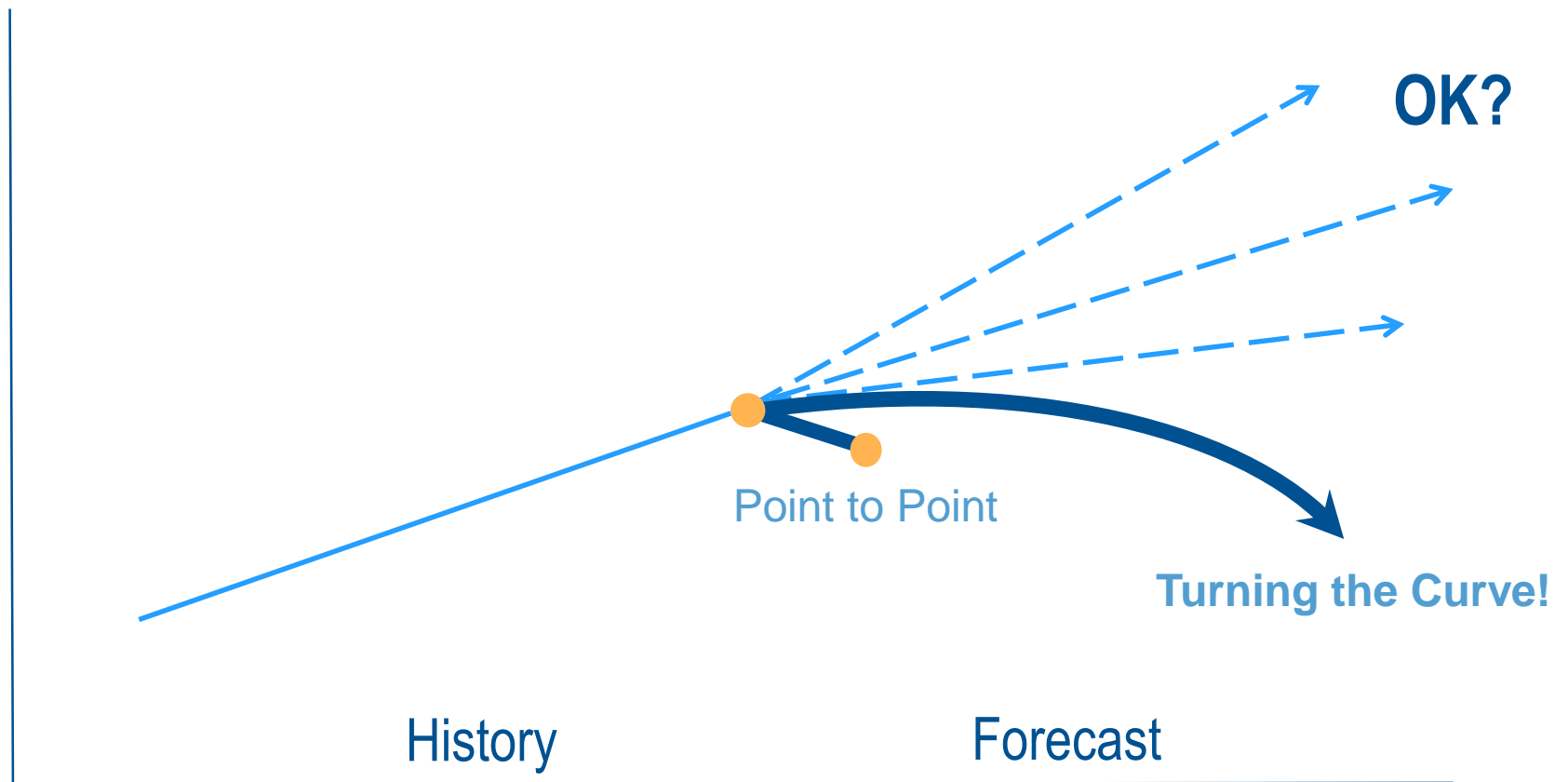
Children are free of abuse and neglect

Population Accountability in action: Mothers Against Drunk Driving

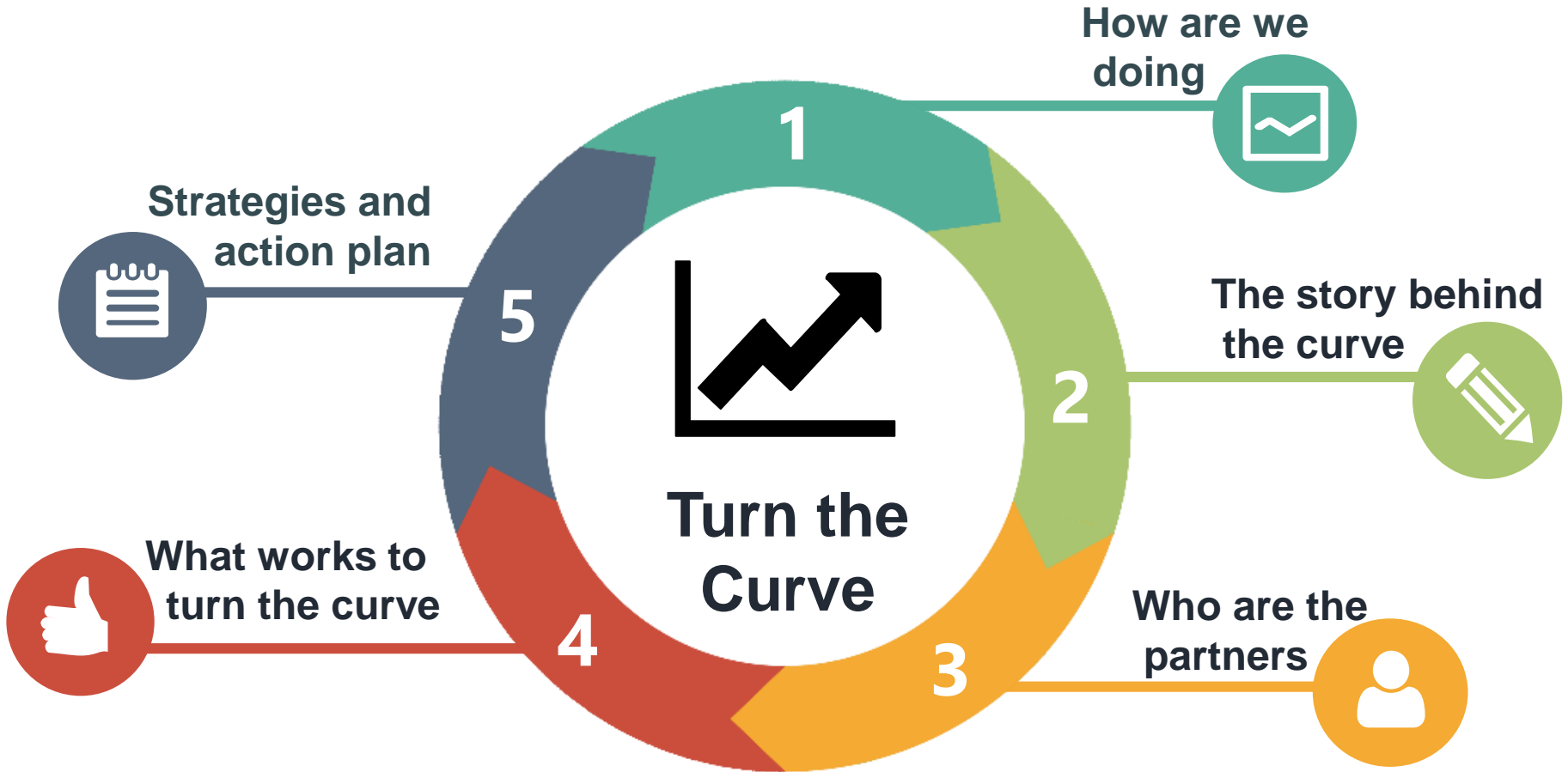


Population Indicator Baseline

Baselines have two parts: history and forecast



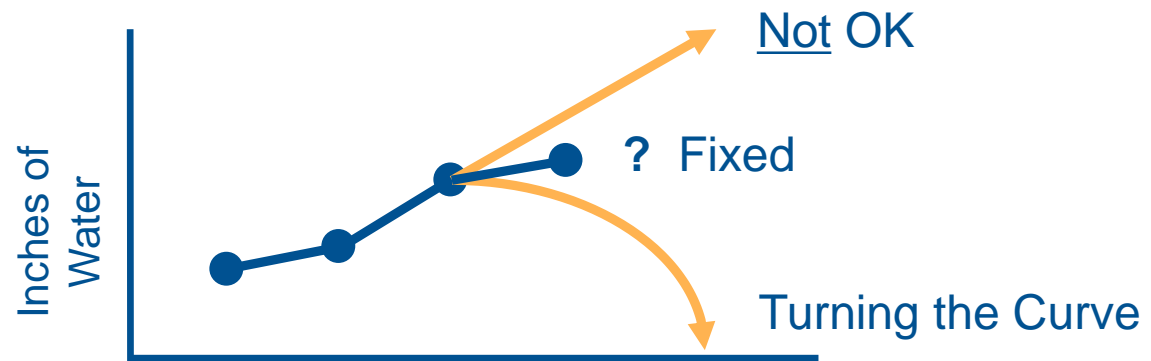
Turn the Curve thinking



The “Leaking Roof”

Experience:

Measure:



Story behind the baseline (causes):

Partners:

What Works:

Action Plan:

Time for a short break...



... or, “How Not to Create a Baseline”

Performance Accountability

For programs, agencies, and
service systems



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The RBA framework

Population Accountability
about the well-being of
WHOLE POPULATIONS

For Communities – Cities – Counties – States – Nations

Performance Accountability
about the well-being of
CLIENT POPULATIONS

For Programs – Agencies – and Service Systems

Performance Measures

	Quantity	Quality
Input Effort	How much did we do?	How well did we do it?
Output Effect	Is anyone better off?	



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Education Performance Measures

	Quantity	Quality
Effort	Number of students	Student to teacher ratio
Effect	Number of high school graduates	Percent of high school graduates

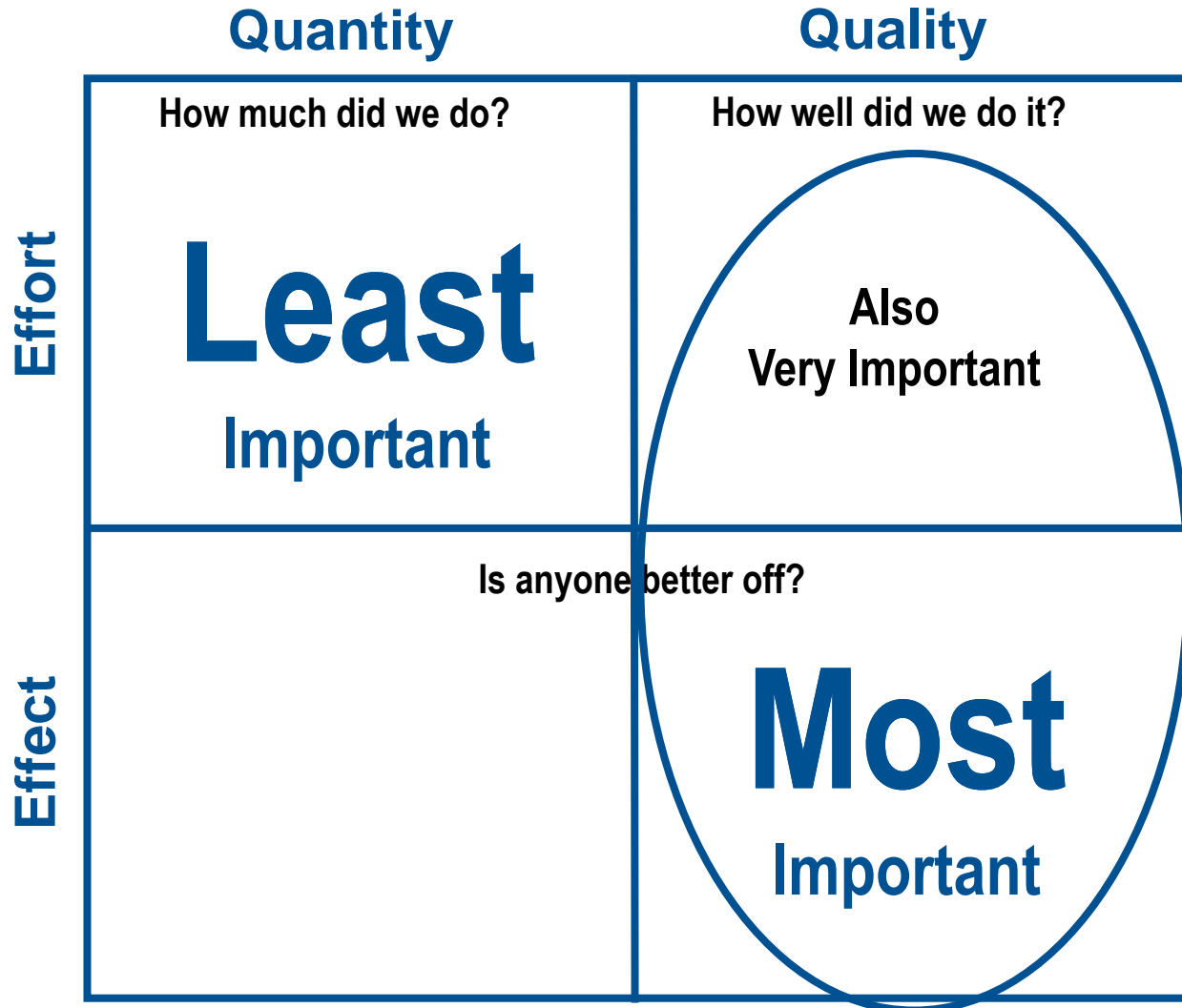


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Education Performance Measures

	Quantity	Quality
Effort	Number of students	Student to teacher ratio
Effect	Number of 9th graders who graduate on time and enter college or employment after graduation	Percent of 9th graders who graduate on time and enter college or employment after graduation

Not all Performance Measures are created equal



Not all Performance Measures are created equal

	Quantity	Quality
Effort	<p>How much did we do?</p> <p>Most Control</p>	<p>How well did we do it?</p>
Effect	<p>Is anyone better off?</p> <p>Least Control</p>	

POP QUIZ!



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- # of people served
- % participants who got jobs
- staff turnover rate
- # participants who got jobs
- % of children reading at grade level
- cost per unit of service
- # applications processed
- % patients who fully recover



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Purpose of performance measures

1. The **first purpose** of performance measurement is to **improve performance**.
2. **Avoid** the “performance measurement equals punishment” **trap**.
 - Create a healthy organizational environment.
 - Start small.

Grid



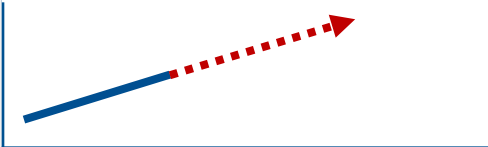

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How much did we do?	How well did we do it?
<p><u>Customers</u> # of customers served # of customers by subcategories</p> <p><u>Activities</u> # activities (by type of activity) # of people receiving each type of activity</p>	<p><u>Customers</u> % of customers served by subcategories</p> <p><u>Activities</u> % of people completing an activity % of timely activities % of activities meeting standards</p> <p><u>Other Measures</u> % staff trained Staff turnover ratios Customer satisfaction</p>
Is anyone better off?	
<p># with improved skills/knowledge # with improved attitude/opinion # with improved behavior # with improved circumstances</p>	<p>% with improved skills/knowledge % with improved attitude/opinion % with improved behavior % with improved circumstances</p>

Dashboard



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<p>1. Baseline with history and forecast</p>	<p>Performance Measure Baseline and Forecast</p> 
<p>2. Story behind the baseline</p>	<p>What are the causes and forces at work? What information or research is needed?</p>
<p>3. Who are our partners</p>	<p>Partners:</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____
<p>4. What works to turn the curve</p>	<p>Three best ideas including no cost / low cost ideas:</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ <p style="text-align: right;">No cost / low cost Off the wall idea</p>
<p>5. New results</p>	<p>Updated Performance Measure Graph</p> 

Grid

Partnership Community Health Center



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RESULTS BASED ACCOUNTABILITY – PROGRAM MEASURES

How much did we do? (Quantity)	How well did we do it? (Quality)
<p><u>Customers</u></p> <ul style="list-style-type: none"> • 10073 community residents accessed at least one visit to PCHC dental programming • 117 students from Appleton Area School District-Wilson, West, Central and Kaleidoscope accessed care through Smiling programming • 502 dentures provided • 843 enrolled into health insurance during Open Enrollment 2017 • 645 patients accessed the farmers market through RX for Healthy Living • 443 patients received RX assistance • 1584 new patients were enrolled in Badger Care receiving advocacy services <p><u>Activities (monthly/annually)</u></p> <ul style="list-style-type: none"> • 5 sessions with AASD students was completed monthly • 3 "Healthy Hours" conducted on dental care • 10 advocacy activities including call in, visits and staff advocacy events with local partners and state/federal officials • 40 Saturday hours were open for new and existing patients to meet the demand for services 	<p><u>Customers</u></p> <ul style="list-style-type: none"> • 19.85% increase in patients from measured years in 2014-2016 • 50% of patients experiencing homelessness were referred to dental appointments • 100% total extractions received dentures • 86% patients completed treatment plans • 72% of patients had health insurance coverage throughout the year • 100% of new patients seeking care were scheduled for appointments • 36% average no show rate through practice for new patient. <p><u>Activities</u></p> <ul style="list-style-type: none"> • 100% patients needed specialty care were referred to Tri-County Dental or Dental Associates. • 86% of patients were assessed for health insurance coverage • 100% of uninsured patients needed RX were referred to Patient Assistance Program or Community RX program <p><u>Measures</u></p> <ul style="list-style-type: none"> • 98/100 (98%) of patients responded that they would recommend PCHC to others • 92/100 (92%) stated that they were satisfied with their care • 312 patients signed onto advocacy letters stating the value of their care • 3 staff members (100%) attended trauma informed care symposium • 3 trauma informed care activities implemented
Is anyone better off?	
<ul style="list-style-type: none"> • 477 6-9 year olds had sealants placed • 7238 adults received tobacco education and referred to cessation • 74 pregnant patients were referred to prenatal dental care • 741 new patient appointments were filled through pilot • 1 new HIV patient had dental care 	<ul style="list-style-type: none"> • 39% 6-9 had sealants placed • 100% adults received tobacco education and referred to cessation • 76% pregnant patients were referred to prenatal dental care • 92% with asthma were seen to establish an asthma action plan and RX therapy • 100% of new HIV patients were linked to specialty care

Dashboard Partnership Community Health Center



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PROGRAM PERFORMANCE DASHBOARD											
1. Baseline with history and forecast	<table border="1"> <caption>Dental Quarterly No Show Rate</caption> <thead> <tr> <th>Quarter</th> <th>No Show Rate</th> </tr> </thead> <tbody> <tr> <td>2017 Q1</td> <td>17.33%</td> </tr> <tr> <td>2017 Q2</td> <td>15.30%</td> </tr> <tr> <td>2017 Q3</td> <td>15.98%</td> </tr> <tr> <td>2017 Q4</td> <td>15.22%</td> </tr> </tbody> </table>	Quarter	No Show Rate	2017 Q1	17.33%	2017 Q2	15.30%	2017 Q3	15.98%	2017 Q4	15.22%
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2017 Q4	15.22%										
2. Story behind the baseline	<p>What are the causes and forces at work?</p> <ul style="list-style-type: none"> Dental care is not a priority for many patients. Fear and shame play a significant role in patient behavior. Trauma, stress, pain, and anxiety also impact patient access and willingness to attend scheduled visits even if there is significant dental need. PCHC has struggled with patient no-shows and late cancellations since the inception of our clinic. Patient barriers to care are well documented and include transportation, fear of high cost, avoidance of medical conditions, early childhood trauma and the complexity of the lives of patients living at or below the poverty level PCHC added new providers to our team and began to attract many new patients who had been outside of oral health care. Many new patients were scheduled but faced barriers to care. <p>What information or research is needed?</p> <ul style="list-style-type: none"> Dentrix electronic health record/scheduling data Patient surveys and treatment plan completion data Provider team input 										
3. What works to turn the curve?	<p>Three best ideas including no cost / low cost ideas:</p> <ol style="list-style-type: none"> 24 hour confirmation phone call that includes patient engagement and daily community partner emails on open appointments regarding open appointments Team approach to outreach and education to patients about the importance of their care Phone and scheduling messaging that embrace a comprehensive message of the importance of care. 										

4. Who are our partners?	<p>Partners:</p> <ol style="list-style-type: none"> The PATIENT and family is the most important partner for success Internal team members at all levels: Dental schedulers, Outreach/Enrollment, Dental providers Network of Community Partners, including schools and CBOs 										
5. New results	<table border="1"> <caption>2017 to Present Quarterly Dental No Show Rate</caption> <thead> <tr> <th>Quarter</th> <th>% No Show Rate</th> </tr> </thead> <tbody> <tr> <td>2017 Q1</td> <td>17.33%</td> </tr> <tr> <td>2017 Q2</td> <td>15.30%</td> </tr> <tr> <td>2017 Q3</td> <td>15.98%</td> </tr> <tr> <td>2017 Q4</td> <td>15.22%</td> </tr> </tbody> </table>	Quarter	% No Show Rate	2017 Q1	17.33%	2017 Q2	15.30%	2017 Q3	15.98%	2017 Q4	15.22%
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6. New results narrative	<ul style="list-style-type: none"> The best way to care for a patient is to connect them with coverage and care and provide them with the most appropriate and comprehensive information prior to their visit Data shows the initial impact of the new requirement to confirm appointment 24 hours ahead. When the appointment is not confirmed it is immediately opened up for the next patient seeking care. We have seen a significant increase in access and compliance. PCHC started proactive patient education around our model of care that focused on engagement and patient education Health access education is now provided in English, Spanish and Hmong. Aggressive messaging to patients occurred throughout the year to new and existing patients to establish care, utilize the sliding fee scale and connect oral care to total health. In Q3, PCHC saw a slight increase in no show but the trend is continuing to decrease. Starting in Feb 2018, PCHC team will be conducting a quality improvement project focused on improving the no-show rate in collaboration with our Outreach and Enrollment team. All patients will continue to receive phone calls, texts and as appropriate education prior to the appointment about how to use the sliding fee scale and understand their health insurance benefit. Transportation needs are assessed and patients in need will be linked to resources. 										



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Recap of RBA Reporting

☀ Quality of Life Goals:

- Population indicators showing the curves we want to turn
UWFC will track the Indicators related to our Goals

☀ Programs:

- Performance measures

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

You will report this using the Grid

- Performance improvement

Positive actions taken in the interest of turning the curve on a Performance Measure and any related accomplishments

You will report this using the Dashboard

- Success stories that show how individuals are better off

You will provide one story each year

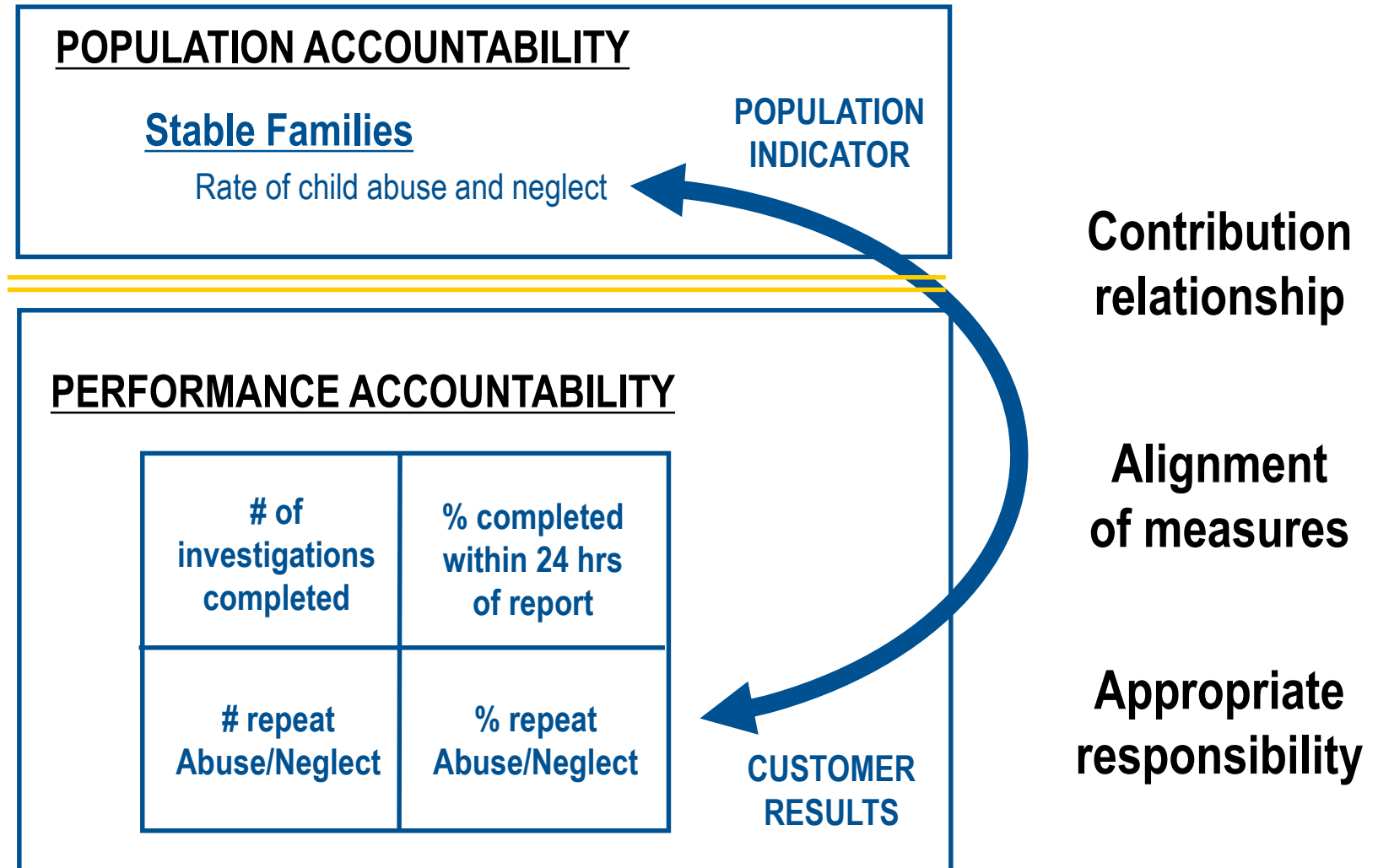
How Population and Performance Fit Together

How program outcomes can create change in the community

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Linking Performance to Population





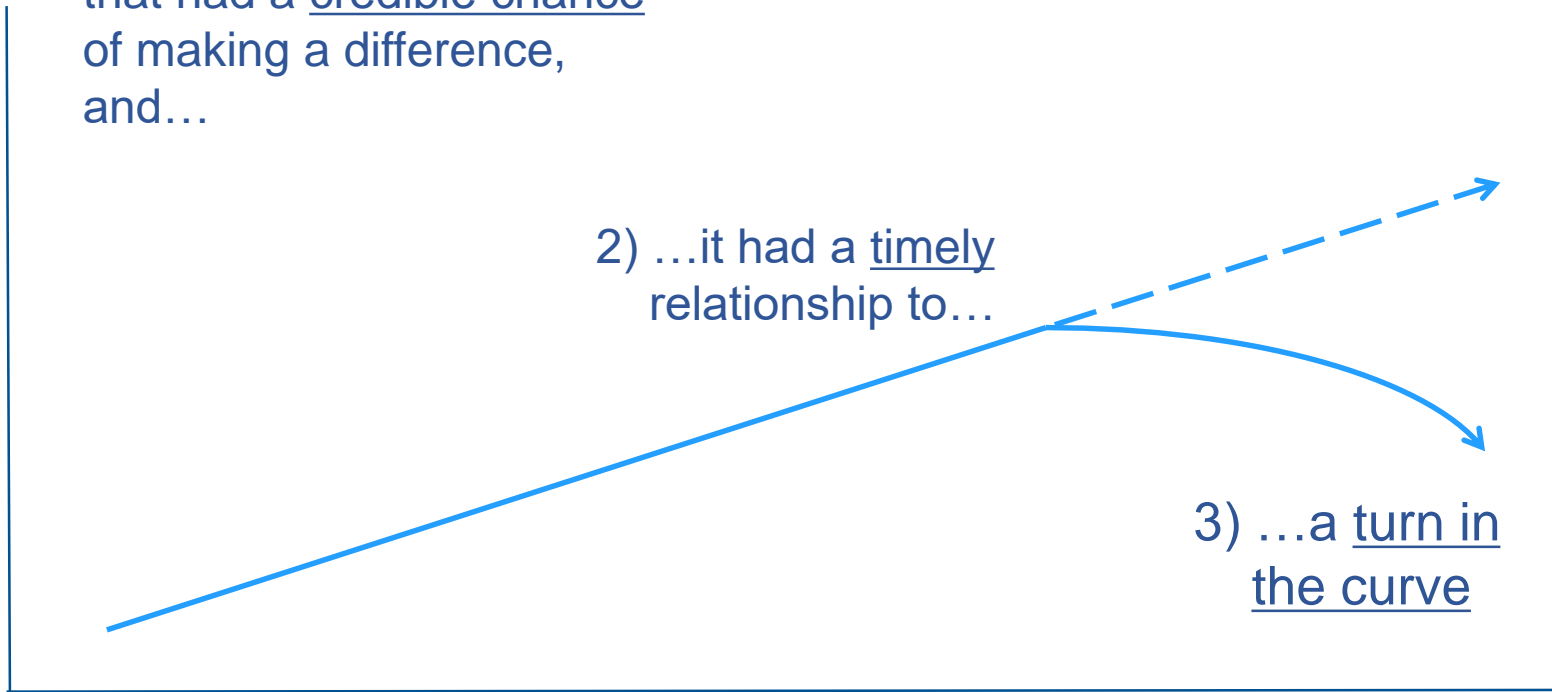
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Contribution to Turning the Curve

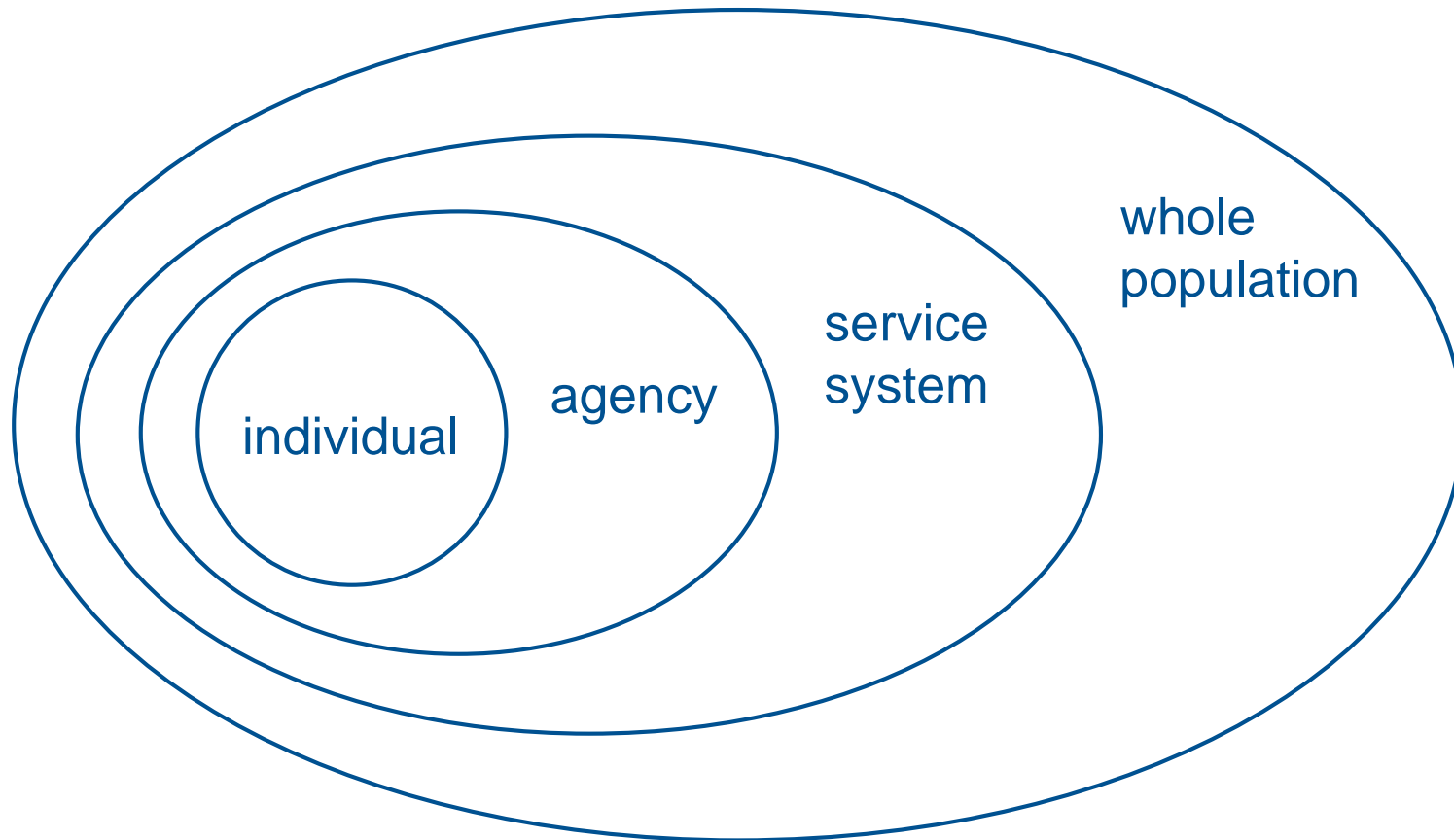
1) We tried a bunch of stuff that had a credible chance of making a difference, and...

2) ...it had a timely relationship to...

3) ...a turn in the curve



Levels of influence



Levels of influence



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Time for a short break...



“What if we don’t change at all ...
and something magical just happens?”

... or, “How Not
to Turn the Curve”

Turn the Curve Exercise

Continuous improvement of
performance measures

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Turn the Curve – Program Performance

5 min: Starting Points

- timekeeper and reporter
- identify a performance measure to work on

5 min: Performance measure baseline

- discuss what this performance measure tells us
- forecast – OK or not OK?

10 min: Story behind the baseline

- causes/forces at work
- information & research agenda part 1 - causes

10 min: Partners

- who can help us improve
- formal and informal partners

10 min: What works? (What would it take?)

- no-cost / low-cost ideas
- information & research agenda part 2 – what works

5 min: Report: select three best ideas to share out

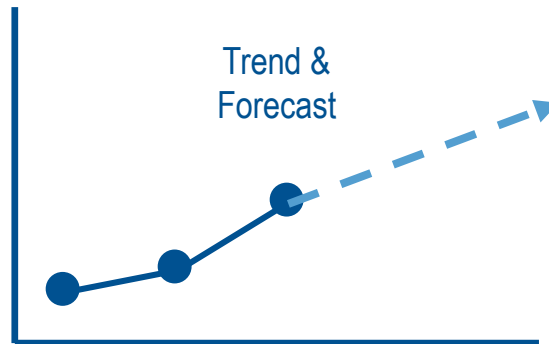
Two pointers to action

The diagram shows a box on the right labeled "Two pointers to action". Three arrows point towards this box from the left: one from "causes/forces at work", one from "who can help us improve", and one from "What works? (What would it take?)". A line also connects the bottom of the box to the "What works?" section.

ONE PAGE Turn the Curve Report: Performance

Program: Mental Health Counseling

Performance Measure
Baseline



Story behind the baseline

----- (List as many as needed)

Partners

----- (List as many as needed)

What Works – Three Best Ideas

1. -----

2. -----

3. ----- No-cost / low-cost

4. ----- **Off the Wall**

Use this format to report on your flip chart paper

Next steps

1. Check out our website

- www.unitedwayfoxcities.org/our-work/rba

2. Check out other resources:

- resultsaccountability.com
- raguide.org

3. Check out a book:

- Trying Hard Is Not Good Enough
- Turning Curves

4. Reach out for additional support:

- Coaching sessions



Thank you!

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