Institute for Healthcare Improvement

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Poverty Reduction in North East Wisconsin
March 11, 2017

I. Intent:

The purpose of this report is to provide a history and summary of observations and recommendations from the poverty reduction work in North East Wisconsin.

II. Background:

Summary of Prior History of work that IHI has done related to this work

IHI has been working with communities for many years. Our work has included communities in developed countries and low and middle-income countries. In projects like the Triple Aim (improving health, experience of care and per capita cost), health care organizations played a significant role as community partners. In other work we have done, health care has played less of a role.

At the conclusion 7 years of work with organizations and communities on the Triple Aim in 2014, we wanted to work more closely with a few selected communities. The IHI board supported this work and committed resources to the partnerships. Our goal was to help the communities accelerate work they were already considering. We felt this would continue to help us build upon existing knowledge and understanding of work in communities.

In the article, Pursuing the Triple Aim: The First 7 Years published in the Milbank Quarterly in 2015, we summarized our observations and illustrated with case examples a set of principles for working on the Triple Aim. This framework can be applied to many community problems and we used it as part of our work in Wisconsin.

1. Identifying and/or Creating Leadership and Governance Structures for your effort
   A. Choose a relevant Population for improved health, care and lowered cost.
   B. Articulate a Purpose that will hold your stakeholders together.
   C. Coordinate with multiple Stakeholders.

2. Create a portfolio of work
   A. Identify a population segment on which to focus.
   B. Conduct a needs and assets assessment.

C. Develop a portfolio (group) of projects and investments (resources, policy, and communication/activism) that will yield results.
D. Develop a plan for delivery of services at scale for any projects in your portfolio.

3. Developing a Learning System for Population Management
A. Use population-level measures.
B. Develop an explicit theory or rationale for system changes.
C. Learn by iterative testing (e.g., Plan-Do-Study-Act [PDSA] cycles, sequential testing of changes, Shewhart time series charts).
D. Use informative cases to "act with the individual; learn for the population."
E. Learn during scale up (5X) 5,25,125, 625, etc.
F. Select leaders to manage and oversee the learning system.

Some other relevant background to this work comes from the IHI innovation series June 30th 2016.

"In the Pursuing Triple Aim article we described assessing the population's needs and assets, using that knowledge to create a portfolio of projects, redesigning services to meet the population's needs, and delivering those services to those who needed them.

One of the biggest assets of any community is the many community-based organizations (CBO) that exist in the community. Based on our past work with communities, we have a set of thoughts regarding them that are pertinent to this work:

1. Communities have an abundant number of community-based organizations (CBOs) tackling a wide variety of social issues with little to no coordination between them often resulting in duplication of efforts.

2.True co-production with those with lived experience isn't happening well in communities. CBOs often still frame the issues and theories of change through the eyes of the practitioner or funder.

3.The CBOs generally have limited knowledge of the total needs of the community, i.e. how many people could use their service. And they may not have thought through how to reach scale, i.e., the total number who could use this service. Grant funding may lead to this problem because CBOs receive grants to provide services for a specific number of individuals and not for all who could use that service.

4. There is no mechanism in the CBOs to identify those at highest risk for significant social/ economic problems.

5.CBOs often measure activity and not outcomes.

6. CBOs generally have limited quality improvement skills. Their focus is on implementing programs and not learning their way to an implementation.

7. The community coalition will need to add value to the work of the CBOs. That may come in the form of quality improvement training and support, coordination among CBOs, new financial resources and supporting the data needs of the various portfolio activities.

One other observation that deals with subpopulations is that, often as a portfolio of work is put together for a community, those with lived experience do not inform it. For example, when working on ending veteran homelessness, consider involving some homeless veterans in the design of the work."

As we began to explore partnership with the team in Wisconsin, we informed them that we did not have content expertise in poverty. We did have expertise in working with a community and using quality improvement to tackle various problems, but we hoped that they would bring knowledge of poverty to help the work. As it turned out, at the beginning, the knowledge about reducing poverty was provided by the community based organizations in NE WI. . It was an experiment to start the work without a person with a high level of content expertise. As a team, we have learned together about working on poverty. Also Tim Smeeding, the former Director of the Institute for Research on Poverty of the University of Wisconsin provided some guidance.

<u>Brief comments on poverty work in the US</u>

Three resources that were helpful to this work were Ruby Payne's book, Bridges Out of Poverty and the work of the Federal Reserve Bank of San Francisco, Investing in What Works for America's Communities and What Counts: Harnessing Data for America's Communities.

In the book What Works, they share history and examples from the last 100 years of community development with a special emphasis on poverty alleviation. The book starts by describing a top down approach of urban renewal and public housing and ends with a new approach that is:

"1. Entrepreneurial in nature and fundamentally cross-sectorial, engaging more partners than are currently involved in community development;
2. Data-driven and capable of sense-and-respond adjustments; and

3. Composed of both people- and place-based interventions."

In the book they site successful examples like the South Bronx and Harlem Children's Zone in New York City and Purpose Built Communities in Atlanta. All of these are examples with a focus on place- and people-based strategy.

Elizabeth A. Duke, Governor, Board of Governors of the Federal Reserve System wrote "At one time, policy discussions revolved around whether community development was about people or places. I would argue that the debate is over and both sides won. Successful community development is based on attention to both the physical infrastructure, whether housing or commercial spaces, and the health and welfare of the residents therein. Safe and affordable housing will always be an important concern for lower-income Americans, but the recent recession and resulting damage to communities across the country make it clear that communities are more than physical structures. Sustainable communities—those that can weather economic downturns—not only provide decent housing, but also have the resources to support individuals and families and to create a dynamic business environment." This is a good summary statement that encourages a comprehensive approach to the work on poverty.
In the book What Works, they described a new approach in which a governance structure they called the Quarterback would help organize an array of resources including: health, education/job training, community development and the data infrastructure to coordinate their activities for low-income communities.

"The quarterback must choose strategies from both sides, including:

human capital/people: early childhood interventions, schools, health, recreation, workforce development (including connecting people to good quality jobs); and

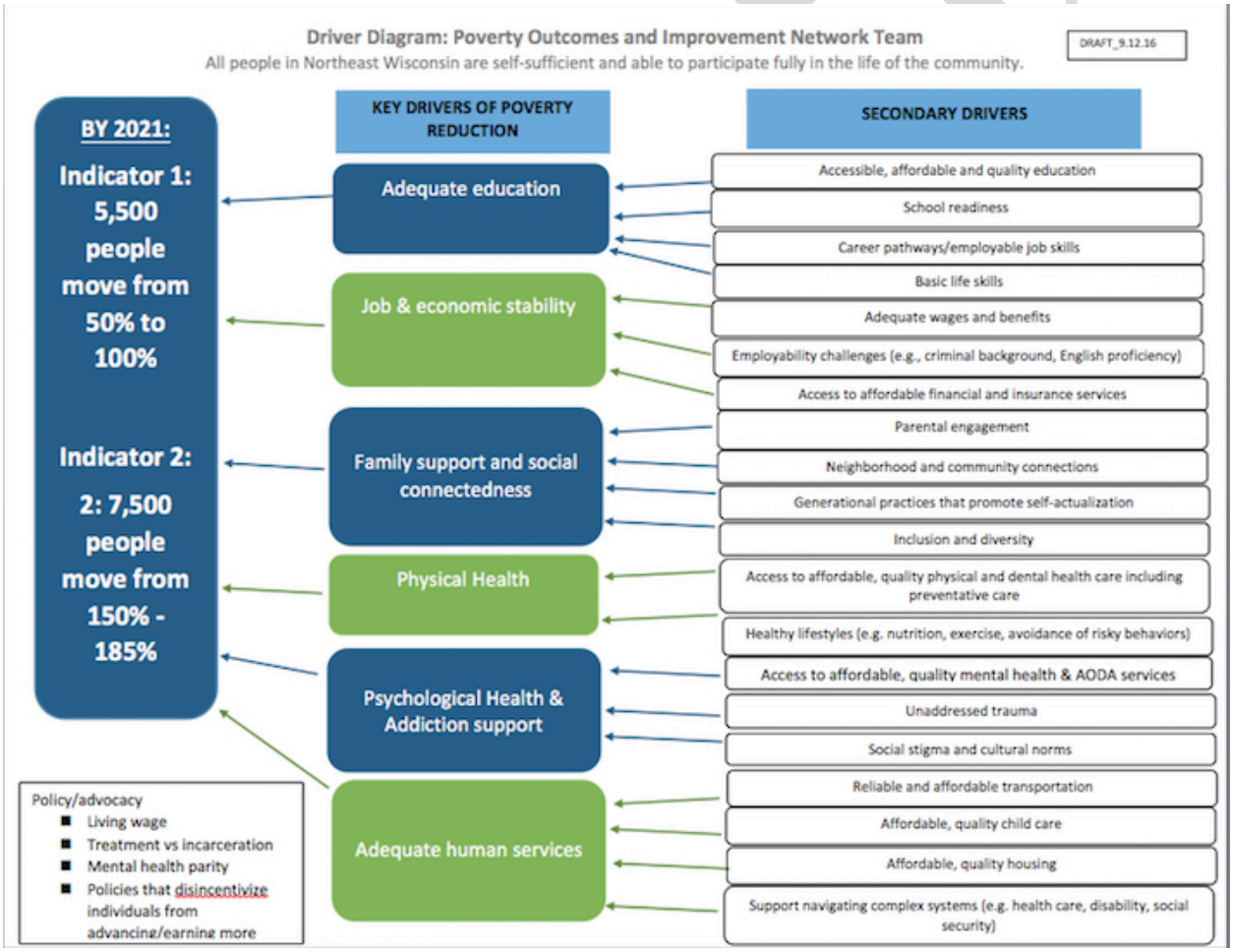
physical capital/place: affordable housing improvements, community facilities, well-lit and safe community spaces, transportation, health clinics, parks, grocery stores and other essential businesses, and anchor institutions (e.g., hospitals, universities) that may play a special role in creating good- paying local jobs."

III. Description of Work to Date:

The work began in the summer of 2015 when IHI and the Basic Needs Giving Partnership (BNGP) agreed to partner together on the goal of reducing poverty in North Eastern Wisconsin. The BNGP was made up of a set of community foundations and philanthropic organizations representing three different communities: Green Bay, Appleton/Fox Valley and Oshkosh. An important early decision was that they would attempt to do this work as one region and not three separate communities.

Their first major action was in July of 2015 when they held a stakeholder meeting with representative organizations from across the region. The main output from this meeting was a set of possible aims for the work and a diagram that highlighted a set of key primary and secondary drivers, which are illustrated in figure 1.

Figure 1 Driver Diagram for the Poverty Outcome and Improvement Network Draft September 12, 2016



The aims listed in this diagram are still under discussion. The drivers have been used to support the work. At the end of this meeting IHI suggested that the BNGP leadership group enhance their governance structure to support this work more broadly.

During the fall of 2015 and into part of the winter, the three communities recruited organizations into a new regional learning collaborative: Poverty Outcome and Improvement Network (POINT). This collaborative network was planned to last for 18 months. During this time there would be 6 two-day learning session meetings along with group coaching calls each month.

At IHI we attempt to support content theory along with execution/implementation theory in any project that we support. The driver diagram represented our content theory and the execution theory was to help organizations implement quality improvement projects through a collaborative structure that would help alleviate poverty. We wanted to help them coordinate services for individuals they served and implement strategies to be able to identify the most vulnerable in their population.

At the first meeting/learning session in February of 2016, we had nearly 100 organizations and over 400 participants. At the 2nd, 3rd and 4th learning session meetings, we had around 200 people and 60 unique organizations. Most of the organizations were from social services, health and dental care and mental health along with funder organizations.

The main focus for year one was for organizations to identify and work on an improvement project within their own organization to assist then to increase their quality improvement capability. The selection of the project was informed by the POINT driver diagram. Each organization developed an aim/goal, measures and ideas they wanted to test. The organizations were taught improvement skills such as using plan, do study act (PDSA) cycles of learning and run charts. They were then coached to use these improvement skills. To make the work manageable, the organizations were broken up into 6 affinity groups: Physical and Dental Health, Supportive Services for Families and Youth, Increasing Economic Self Sufficiency, Housing Services, Psychological Health and Addictions Support, and Community Supports, Connections, and Coordination. These groups met once a month over WebExwith the IHI team. In addition, over twenty local skilled volunteer improvement coaches were provided by local businesses to support the teams. A secondary focus was to encourage teams to work on the coordination of services for individuals.

Parallel to this work there was an initiative to develop a set of indicators to measure activity at the regional level in each area of the key drivers. They have been collected monthly. The hope for this work was to get a real time indication of activity that might lead to a reduction of poverty. See Appendix A for the initial indicators. The indicators are part of an overall

measurement strategy for the poverty reduction initiative in NE WI that includes measures at three levels.

1. Overall outcome: Discussion has been around 100% Federal Poverty Level (FPL) and 200% FPL. Both might be included even if the initial focus might be on 200% first since different interventions might be needed for the two groups. The WI Poverty Measure which includes benefits received and earnings might also be considered since Tim Smeeding stressed the importance of support programs to reduce poverty. It is important that data are available over time for the outcome measures selected. Gathering such data should be the first step. Developing a goal (how much, by when) could follow.

2. Intermediate outcomes (more related to drivers): Tim Smeeding stressed that health and education drive poverty. Data on teen pregnancies, Low birth weight babies, high school graduation rates, and ready for kindergarten are often available from existing state and federal databases. More specific Intermediate outcomes could be selected based on which areas the region might focus on going forward.

3. Indicators: The objective of the collection of data on indicators connected to the NE WI drivers of poverty was to have data focused on the population of individuals living in poverty that organizations could "count" each month relatively easily. See Appendix A. Data on indicators are not normally available from state and federal databases. The counts give some indication of the number of people affected in a positive way month to month during the timeframe of POINT or beyond. It is a mix of process and outcome measures

The initial BGNP leadership governance evolved from the summer of 2015 to now to become the Regional Council on Poverty. More members were added, governing rules were adopted and a chairman and vice chairs were chosen.

As this work moves into its second year of activity, we continue to encourage the teams to work on their projects using the quality improvement tools and meeting with their community quality improvement coaches. In addition, IHI and the local representatives will support them on a series of action group topics that we hope will lead to further action through collaboration and coordination at the regional level.

Quality Improvement Advancement:
This action group would include discussion of QI methods and sharing on ongoing projects started at LS1 for current teams still wanting help, new teams, or new team members.

Improving Coordination of Services:
The focus of this action group would be on coordinating multiple referrals for an individual toward a specific outcome such as self-sufficiency.

Implementing a Coordinated Entry System:
The focus of this action group would be on implementing a coordinated entry system for housing services.

Improving Referrals:
Teams could incorporate testing to improve referrals into their present projects or start a new project.

Building Life Skills:
This action group would focus on areas such as financial, emotional and acquired skills (Reading, writing, computing), and language.

Relationship Building:
This action group would focus on areas such as mentoring and friends, family and back-up support.

Matching individuals with available jobs:
This action group would not be about job creation or wages (business initiative) but might focus on increasing skills of individuals or using current skills to match with available jobs.

IV. Observations from our work in North East Wisconsin

1.Many of the community-based organizations have seen the value of quality improvement tools on their projects. Some of the organizations saw enough value that they are applying it broadly to their own organization in areas beyond their chosen project.

2. The business community has supported the POINT by providing local quality improvement coaches to support the community-based organizations with their quality improvement projects. At the time of this writing we have 20+ coaches.

3. We saw individual CBO's consolidate with other teams to form a larger group to tackle an important issue. One example is approximately 12 organizations coming together to work on trauma informed care.

4. IHI encouraged the selection of a set of indicators to watch over time that would be important to poverty reduction. Significant time was spent initially deciding on a set of indicators. We hoped that CBOs that were part of the point could report, but also that others who were not part of the POINT could also report. It would be advantageous to have more CBOs reporting data on the indicators.

5.The governance group has steadily matured over time and is evolving to think through its future roles and long-term strategy. They have not chosen a specific aim. However, we still have the general aim to decrease poverty.

6. Improvement in poverty was not expected in the initial stages of the initiative t so, at this point in time, there has been no measurable improvement in poverty.

7. Neither IHI nor the regional council had an overall content expert on poverty supporting this project for any appreciable amount of time. The team in Wisconsin and IHI worked together to gain more knowledge about poverty.

8. There is recognition that a community-based approach is needed to tackle some specific problems or issues. In the Fox Valley, the housing organizations are consolidating their approach on a coordinated entry system for housing. In Oshkosh, they have developed a system called the hub for coordinating referrals on a community basis.

V. Recommendations

1. Consideration should be given to work at a community level on 3 or 4 strategic projects that can be taken to scale. To facilitate the development of a portfolio, a set of guiding principles that shape behavior in the region could be developed. Guiding principles will reflect theories about what changes are necessary (e.g. No wrong door to access all services needed; People living in poverty should receive all the benefits for which they are eligible; Remove penalties so it always pays to work (Paul Ryan)A community has to think as a system; etc.) As you develop this portfolio you will need to think about how you can financially support the work.

2. The present work has focused on the development of people primarily working through the CBOs. There is a need to understand other work going on in housing, transportation, or other community and economic development in the region that has an impact on poverty. Place based interventions should consider the impact on individuals who can make the choice to leave.

3. There is good momentum in the POINT on which to build. Quality improvement should be used as the basis for achieving success for the projects in the regional portfolio of work.

4. A bigger role for the business community is needed. The action group on matching individuals to available jobs is focused on enhancing partnerships between CBOs and businesses to prepare and hire people in poverty. There are a number of businesses presently connected to POINT through the local QI coaches or on the boards of CBOs. To gather their further input and support, more businesses should be considered for the regional council.

5. You also might consider partnership with local government officials. There are numerous opportunities. For example, Green Bay has a mayor and Brown County has a County Board; Appleton has a City Manager and Outagamie County has a Board of Supervisors; Oshkosh has a City Manager and Winnebago County has a County Board. Representatives from local government should be considered for the regional council.

6. The regional council needs to develop a data/measurement strategy. During the past year we have attempted to collect a set of indicators, Appendix A, with mixed success. Moving forward, a decision should be made about the overall measurement strategy including outcome measures, intermediate outcome measures and which indicators should be gathered over time and how to support that work. The measurement strategy needs to be an integral part of a learning system to ascertain whether interventions in the region are making an impact on poverty. The learning system should include study of individuals living or having lived in poverty to ascertain how policies and interventions affect their lives.

VIII: Appendices:

Appendix A
Adequate Education
# of low-income Individuals completing workforce training this month
# of individuals participating in GED classes this month
# of low-income individuals receiving support to overcome barriers this month in order to participate in post-secondary education or certificate programs
# of high school students participating in programs this month because they are at-risk for not graduating on time.

# of children who are newly identified this month as not developmentally on track to enter kindergarten

Job & Economic Stability
# of individuals who start employment this month with a salary > $25,000/year
# of clients your organization serves who have passed the probationary period for their employment this month
# of individuals newly reporting predatory loans this month
# of new applicants this month for energy assistance
# of individuals receiving financial literacy services this month

Family Support & Social Connectedness
# of individuals who received congregate (meal site) or home-delivered meals this month
# of youth from low-income families with support from a positive adult role model this month
# of low-income individuals participating in parenting education or support group this month
# of individuals using respite or caregiver support services this month

Physical Health
# of emergency room visits for non-emergency care this month
# of low-income individuals starting to practice a new healthy behavior this month

Psychological Health and Addiction Support
# of individuals not following their mental health treatment plan this month
# of drug or alcohol-related hospitalizations or overdoses this month
# of individuals this month reporting "more than 3 poor mental health days in past 30 days"
# of individuals newly receiving treatment or support this month for adverse childhood experiences

Adequate Human Services
# of low-income individuals making positive, incremental movement toward self-sufficiency
# of low-income individuals who have experienced transportation as a barrier to their self-sufficiency or basic needs this month
# of families receiving subsidized child care this month
# of individuals paying more than 31% of their monthly income for housing this month