

Health & Wellness

Performance Measurement Framework

September 2009

ISSUE AREA

Response

AREA GOAL

Prevention

AREA GOAL

Access

AREA GOAL

Outcomes

Outcomes

Outcomes

A Guide to Navigating the Outcomes Framework

- Impact Area: An overall goal within Issue Area.
- Outcomes: Intermediate changes necessary to achieve success toward an Impact Area Goal.
- Indicators: How goals are measured

HEALTH & WELLNESS

Response

Meet safety and essential needs

Prevention

Reduce risk of chronic disease

Access

**Connect underserved
communities with health services**

HEALTH & WELLNESS

Response

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Reduce risk of chronic disease

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Connect underserved communities and populations with health services

Outcomes

Resolve immediate crisis

Achieve and maintain stability

Create safe environments

Outcomes

Increase physical activity

Improve healthy eating habits

Improve overall health environment

Outcomes

Overcome or eliminate access barriers

Connect and receive necessary care

Improve integration of health services

HEALTH & WELLNESS

Response

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Connect underserved communities and populations with health services

Outcomes	Indicators
Resolve immediate crisis	# people meeting balanced food need
	# people provided with emergency housing or financial assistance
	# people made safe from abuse
Achieve and maintain stability	# people receiving ongoing support services
Create safe environments	Criteria: Engage in community initiatives

Outcomes	Indicators
Increase physical activity	# of increased adults getting recommended physical activity
	# of increased youth getting recommended physical activity
	#of people decreasing Body Mass Index (BMI)
Improve healthy eating habits	# of adults increasing recommended fruit & veg intake
	# of youth increasing recommended fruit& veg intake
Improve overall health environment	Criteria: Engage in community initiatives

Outcomes	Indicators
Overcome or eliminate access barriers	# of people decreasing barriers to care
	# people acquiring health insurance
Connect to and receive necessary care	# people with a usual source of care
	# people connected to primary care provider
	# people utilizing coordinated care
Improve integration of health services	#people using integrated services
	Criteria: Engage in community initiatives

Response: Meet safety and essential needs

Outcome: Resolve Immediate Crisis

Indicator	Definitions	Notes
# of people meeting balanced food need	<p>“meeting balanced food need” means that people should have access at all times to adequate, nutritious diets to lead a healthy active life.</p> <p>(source: USDA nutrition guidelines, childstats.gov)</p>	<p><i>Measurement:</i></p> <p>1) Keep track of total # of participants provided with food assistance during funding period.</p> <p>1a) Identify # of participants provided with <i>at least one day of</i> balanced food need during funding period.</p>
# of people provided with emergency housing or financial assistance	<p>“emergency housing” can mean shelter services or temporary/ interim housing placement</p> <p>“financial assistance” includes financial assistance to remain housed or prevent eviction/utility shutoff, or similar types of <i>emergency</i> financial assistance.</p>	<p><i>Measurement:</i></p> <p>1) Keep track of total number of participants provided with emergency housing during funding period (# people & # nights)</p> <p>2) Keep track of total number of participants provided with emergency financial assistance during funding period (# people, type of assistance, and \$ amount).</p>
# of people made safe from abuse	<p>“Made safe” can mean any of:</p> <ul style="list-style-type: none"> • Providing a safe home or shelter away from abuse • Other assistance required to live without abuse or violence. such as developing a safety plan, or access to an advocate or social worker 	<p><i>Measurement:</i></p> <p>1) Total number of people placed in a safe home or shelter.</p> <p>2) total number of participants assisted in developing a safety plan or/and connected to an advocate or social worker</p>

Response: Meet safety and essential needs

Outcome: Achieve & maintain stability

Indicator	Definitions	Notes
# of people receiving ongoing support services	“receive ongoing services” means clients undergo an intake process that identifies which resources might be required. It means further that program ensures client utilizes said resources.	<i>Measurement:</i> 1) Intake assessment of participant needs. 2) Interim and/or post-tests to determine if participant is addressing identified needs.

Outcome: Create safe environments

Criteria	Indicators
Engaged in Community Initiatives	Programs will define their own indicators to measure innovations in one or more or more of the following areas: <ul style="list-style-type: none"> •identifying & filling gaps in services •increasing system capacity •changing public policy •developing effective new practices •increasing awareness of issues •changes in community conditions

Prevention: Reduce risk of chronic disease

Outcome: Increase physical activity

Indicator	Definition	Notes
# of increased adults getting recommended physical activity	<p><i>“Adults” are individuals aged 19+</i></p> <p><i>“Recommended physical activity” (adapted from CDC) is defined as: # of adults aged ≥ 18 years who report moderate physical activity for ≥ 30 minutes ≥ 5 times/week or who report vigorous physical activity for ≥ 20 minutes ≥ 3 times/week.</i></p>	<p><i>Good way to measure: pre-test and several post tests throughout program year. Track increases in physical activity, as well as participants reaching & maintaining recommended levels throughout the year.</i></p>
# of increased youth getting recommended physical activity	<p><i>“Youth” are individuals aged 0-18.</i></p> <p><i>“Recommended physical activity” (adapted from CDC) is defined as: # of school aged children and youth who report doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey.</i></p>	<p><i>Good way to measure: pre-test and several post tests throughout program year. Track increases in physical activity, as well as participants reaching & maintaining recommended levels throughout the year.</i></p>
# of people decreasing their Body Mass Index (BMI)	<p><i>“BMI” is a formula that uses both weight and height to estimate body fat. Adults & Youth/Children (age 2-18) should be measured using different CDC calculators. (See impact plan working definition.)</i></p>	<p><i>Pre- and post-test of # of participants in underweight, normal, overweight, and obese ranges</i></p> <p><i>Pre- and post-test of BMI & count of those that decreased BMI</i></p>

Prevention: Reduce risk of chronic disease

Outcome: Improve healthy eating habits

Indicator	Definition	Notes
# adults increasing recommended fruit & veg intake	<i>“Adults” are individuals aged 19+ Recommended fruit & vegetable intake (adapted from CDC): “# adults >=18 years old who report eating fruits and vegetables >= 5 times/day during the previous 7 days.”</i>	<i>Good way to measure: pre-test and several post tests throughout program year. Track increases in fruit & veg intake, as well as participants reaching & maintaining recommended levels throughout the year.</i>
# youth increasing recommended fruit & veg intake	<i>“Youth” are individuals aged 0-18. Recommended fruit & vegetable intake (adapted from CDC): “# school-aged children and youth who report eating fruits and vegetables >= 5 times/day during the previous 7 days.”</i>	<i>Good way to measure: pre-test and several post tests throughout program year. Track increases in fruit & veg intake, as well as participants reaching & maintaining recommended levels throughout the year.</i>
# of people decreasing their Body Mass Index (BMI)	“BMI” is a formula that uses both weight and height to estimate body fat. Adults & Youth/Children (age 2-18) should be measured using different CDC calculators. (See impact plan working definition.)	Pre- and post-test of # of participants in underweight, normal, overweight, and obese ranges Pre- and post-test of BMI & count of those that decreased BMI

Prevention: Reduce risk of chronic disease

Outcome: Improve overall health environment

Criteria	Indicators
Engaged in Community Initiatives	<p>Programs will define their own indicators to measure innovations in one or more or more of the following areas:</p> <ul style="list-style-type: none">• identifying & filling gaps in services• increasing system capacity• changing public policy• developing effective new practices• increasing awareness of issues• changes in community conditions

Access: Connect underserved communities and populations with health services

Outcome: Overcome or eliminate barriers to access

Indicator	Definition	Notes
# people decreasing barriers to care	<p>“Barriers to care” are those financial, structural, and personal barriers that may limit an individual’s access to quality care:</p> <ul style="list-style-type: none"> • Ability to pay for care (with or without health insurance) • Ability to get to a health facility • Ability to get to an appropriate health professional • Ability to communicate (linguistic differences) • Ability to communicate (cultural differences, including issues relating to race, ethnicity, gender, sexuality, religion) • Other as needed 	<p><i>Measurement:</i></p> <ol style="list-style-type: none"> 1) Intake assessment of individual’s self-reported mental, physical, and social health needs. 2) Intake assessment of barriers to address those health needs, followed by specialized work to overcome each barrier. 3) Interim and/or post-tests to report on progress toward addressing barriers and meeting identified health needs.
# people acquiring adequate health insurance	<p>“adequate health insurance” means the individual is fully able to afford care opportunities.</p>	<p><i>Pre-test of insurance status:</i></p> <ul style="list-style-type: none"> # uninsured # underinsured # adequately insured <p><i>Post-test to establish changes:</i></p> <ul style="list-style-type: none"> # acquiring any health insurance # acquiring adequate health insurance

Access: Connect underserved communities and populations with health services

Outcome: Connect and receive necessary care

Indicator	Definitions	Notes
# people with a usual source of care	“usual source of care” is defined as a particular doctor’s office, clinic, health center, or other place where a person usually goes if he or she is sick or needs advice about personal health matters.	Emergency rooms do not count in this definition of “usual source of care.” Measurement: Pre- and post- reporting to show change.
# people connected to a primary care provider (PCP)	“connected to” means that a person has PCP on record. “primary care provider” is a health care service provider chosen by an individual to serve as his/her health-care professional and capable of handling and coordinating a variety of health-related problems, keeping a medical history and records on the individual, and of referring the person to specialists, as needed.	Measurement: Pre- and post- reporting to show change.
# people utilizing coordinated care	“coordinated care” refers to health-related opportunities provided by a person’s PCP. “utilizing” means that the person actually uses the care of the PCP <u>at least one time per year.</u>	Measurement: Follow-up with participant to collect.

Access: Connect underserved communities and populations with health services

Outcome: Connect and receive necessary care

Indicator	Definitions	Notes
<p># people using integrated services</p>	<p>“Integrated services” improve coordination and the delivery of health services to maximize resources, improve care, increase participant satisfaction, while ensuring the cost-effectiveness of programming.</p> <p>“Integrated services” is achieved when clients receive/use services in <i>two or more</i> of the following categories:</p> <p>Physical health services: diagnostic, therapeutic, and preventive services provided to ensure physical health. They may include primary care, dental, long-term care, specialty health services, etc.</p> <p>Mental health services: diagnostic, therapeutic, and preventive services provided to promote mental health. These services may include psychiatric care, counseling, substance abuse services, etc.</p> <p>Social health services: supportive services that ensure well-being, adjustment, and social functioning, which can include case management, respite, social supports, crisis services, etc.</p>	<p><i>Measurement:</i></p> <ol style="list-style-type: none"> 1) Intake assessment of individual’s self-reported mental, physical, and social health needs. 2) Intake assessment of types of health services received/used at program entry. 3) Interim assessments of types of health services received/used to show change.

Access: Connect underserved communities and populations with health services

Outcome: Improve integration of health services

Criteria	Indicators
Engaged in Community Initiatives	Programs will define their own indicators to measure innovations in one or more or more of the following areas: <ul style="list-style-type: none">• identifying & filling gaps in services• increasing system capacity• changing public policy• developing effective new practices• increasing awareness of issues• changes in community conditions