WAKE COUNTY

POPULATION HEALTH TASK FORCE

REPORT · 2018

WAKE COUNTY
NORTH CAROLINA

INTRODUCTION

Wake County is poised to be a national leader in population health. By taking a broader view of community health and looking beyond medical care to such social determinants as housing, transportation, education, employment, social support, culture and the physical environment, we can begin to focus the county's extraordinary assets towards creating a healthier environment to improve the health and wellbeing of all our residents.

In 2017, the Wake County Board of Commissioners appointed the Population Health Task Force to clarify this vision. With the enthusiastic support of the county's health care providers, service agencies, and partner organizations, the Task Force has created a blueprint for placing population health at the center of our shared efforts.

While we recommend some strategic investments, our work focused primarily on using Wake County's excellent community resources to achieve well-defined goals around population health. Through closer coordination and a smarter approach using data, we plan to improve the health outcomes across all populations. When talking about "health" – in the context of this report – we intend a broad focus on physical, mental, and social wellbeing recognizing that health is not merely the absence of disease or infirmity.

By making population health the guiding framework for Wake County's service to residents, we have the opportunity to create a national model for improving health outcomes and creating a thriving community for all. Our region is already a hub for some of the most exciting developments in healthcare, data analytics, and civic engagement anywhere in the country, and we plan to leverage and utilize these assets within our strategies to improve outcomes.

This work was made possible by the leadership and participation of all Task Force members, community representatives and Wake County staff. We are grateful for the time and insight of so many of our community leaders, and we look forward to the work ahead.

It's time to build on our past successes to protect our most vulnerable, promote equitable access to health and wellbeing of our residents, and advance the quality of life for all.

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ACKNOWLEDGEMENTS

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In addition to the 25 appointed members, the success of the Population Health Task Force was made possible by the contributions of more than 100 community members representing government, education, community leaders, nonprofits, the business community, medical and public health professionals, and other invited guests.

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EXECUTIVE SUMMARY

In 2017, the Wake County Board of Commissioners appointed the Population Health Task Force to study the county's overall approach to the health and wellbeing of our residents and make recommendations for improvement.

The Task Force considered a wealth of data, research, community feedback, and national best practices.
Our findings suggest policy changes and investments the Board of Commissioners might consider that can produce measurable improvements in the county's population health. As a concept of health, "population health" is defined as 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group'.[1] It is an approach that considers both health outcomes and the determinants of those outcomes. Our goal is to employ a broad definition of "health" which is a state of complete physical, mental, and social wellbeing – not merely the absence of disease or infirmity.

Studies show that only 20 percent of health outcomes are achieved through the provision of medical care – the rest is a combination of a person's genetics, healthy behaviors, social and economic factors and the physical environment. This broad definition of "health" cannot be achieved solely by the provision of affordable, accessible, and quality healthcare. It can only be achieved by aligning medical care with "social determinants of health" to make prevention and wellness activities the easy choice and improve health throughout all stages of life.

These recommendations build on the excellent work that has already made Wake County the healthiest county in the state and are based on the belief that every Wake County resident, regardless of background or neighborhood, should have equal opportunity to live a healthy and abundant life. There is also an urgent need to address income disparities in Wake County. In 2016, more than 100,000 Wake County residents lived at or below the federal poverty level, which is estimated to be $24,300 of household income for a family of four. To provide more insight into the scale of poverty in Wake County, more than 70 of the 100 counties in North Carolina had a total population of "less" than 100,000 residents. Poverty's impact must not be overlooked as we strive to improve health outcomes.

Overarching goals of the Population Health Task Force:

1. **Broaden the definition of "health" to guide policy and budgetary decisions**
   Recognize that health is achieved by aligning access to medical services with other "social determinants" such as social and economic factors, the physical environment and healthy behaviors, and that a wide variety of county programs and services affect population health and have a direct impact on the health of residents including affordable housing, education and income, transportation and social services.

2. **Align existing efforts and departments within Wake County with a "Health in All Policies" approach to improve health**
   By recognizing the broader health implications of almost every county action, we can begin to incorporate health considerations into decision-making processes across departments, sectors and policy areas to ensure that decision-makers are informed about the health, equity, and sustainability impact of various policy options to maximize population health.

3. **Focus on outcomes over activities**
   Defining desirable and measurable health outcomes will allow Wake County, county agencies and partners to make smarter investments, prioritize resources and improve collaboration. The Community Health Needs Assessment should be resourced as a continuous process and utilized as one of the tools to connect specific actions to carefully define measures of success, allowing Wake County to benchmark specific health measures.

[1] https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.93.3.380

4. **Distinguish and address the needs of the general population, vulnerable residents, and frequent users of health and social services by implementing the recommendations of the Task Force work groups**
   Population health is a broad framework for addressing community needs. The Task Force suggested three strategies to approaching population health in Wake County:
   a. A broad, countywide initiative for all county residents with focused prevention strategies
   b. Targeted efforts for selected vulnerable populations identified through data-driven and community engagement process with better coordination among agencies and partners serving vulnerable populations
   c. Intense "case management" for high risk individuals who are frequent users of health and social services with better coordination among the agencies and partners serving frequent users

5. **Recognize population health as a key component of Wake County's competitiveness**
   Population health is an intrinsically worthy goal, but it is also a competitive advantage as Wake County continues to grow and attract new residents and employers - broadly investing in measurable improvements in health will reap rewards not only for our residents but will bring new investments in people, talent, and capital.

Summary of Recommendations

The Population Health Task Force consisted of three distinct working groups - the Healthy Wake Work Group, the Vulnerable Populations Work Group, and the Familiar Faces Work Group. Each work group provided more detailed recommendations which are incorporated into three overarching recommendations. (Appendix I)

1. ***Sustain and expand the scope of the Community Health Needs Assessment (CHNA) and increase the focus on implementation.***
2. ***Ensure the alignment of population health initiatives and resources with cross-county efforts, statewide efforts, and appropriate data metrics.***
3. ***Designate a public/private partnership Implementation Team to operationalize, coordinate, and evaluate population health initiatives.***

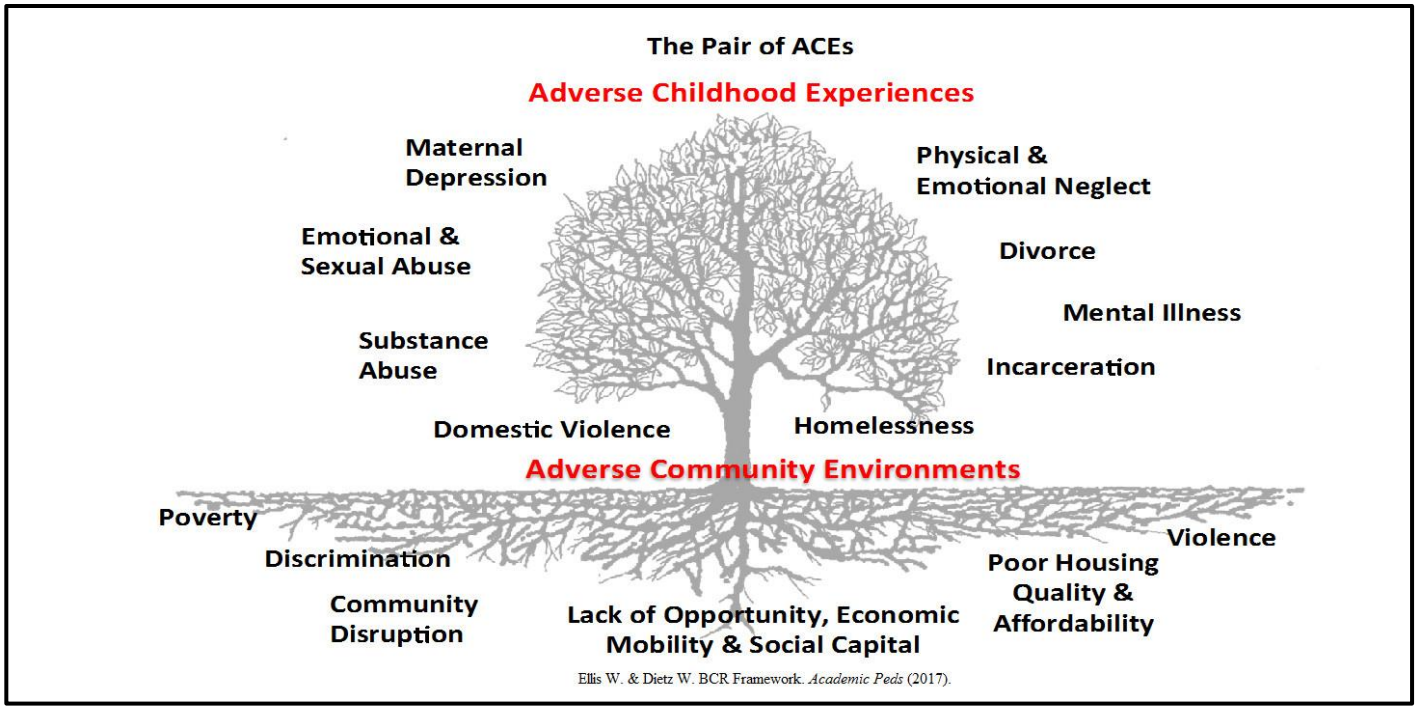
Healthy Wake Work Group Recommendations

The Healthy Wake Work Group focused on recommendations addressing all Wake County residents and supporting overall health and wellbeing.

1. Designate and adequately fund public /private partnership to coordinate health-related efforts in Wake County. The partnership – which must begin work immediately – must be nimble while remaining focused on a strong mission. It must be broadly representative and financially secure, and it will be tasked with implementing the policy recommendations of this report and providing an annual update of the county's progress. (Appendix ll)

2. Address the wellness and healthcare needs of Wake County by broadening the scope of and increasing participation in the 2019 Community Health Needs Assessment. The CHNA should be resourced and empowered to connect actions and interventions to outcomes.

3. "Make the healthy choice the easy choice" by creating and enriching healthy physical and educational environments by 2030.



Vulnerable Populations Work Group Recommendations

Vulnerable populations are those at higher risk for poor health as a result of social, economic, political, and environmental factors (as listed above), as well as limitations caused by illness, disability, or aging. The underlying assumption of this work group is that every person, irrespective of their background or geographic location, should have a fair and just opportunity for the best possible health and wellbeing and that adverse childhood experiences are directly correlated with poverty.

1. Develop a community grant fund to support population health initiatives. Encourage all businesses, philanthropic organizations, and other donors to support the fund by investing fiscal or human capital in communities identified as most vulnerable by use of a data driven methodology. The grant funding should address the HOPE (Health Opportunity and Equity) continuum of indicators for health outcomes, socioeconomic factors, social environments, physical environments, and access to health care. (Appendix lll) The grant funding should also address Community Health Needs Assessment priorities in vulnerable communities.

2. Create safe and humane environments and remove barriers to healthy food, affordable transportation, and housing.

3. Reduce over-criminalization that removes children from schools and parents from homes, decrease incidence of Adverse Childhood Experiences (ACEs), reduce incarceration, and support employment.

4. Encourage early childhood brain development and enjoy a more creative, healthy, well-educated, and economically-engaged population.

5. Expand the Wake County-administered Social and Economic Vitality Model working in Southeast Raleigh and the Eastern Region to vulnerable communities identified in the Western, Northern, and Southern areas of the County to address disparities in health and social outcomes countywide. Measures of success in the short term may include more students trained, more students receiving universal breakfast in the classroom, an increase in summer food initiatives, diversion training, and more children in high quality pre-K programs. Long term measures of success may include lower adverse community and childhood experiences for those living in vulnerable communities.

Familiar Faces Work Group Recommendations

"Familiar faces" describes a relatively small group of residents who access multiple health services in Wake County such as hospitals, homeless shelters, mental health service providers, emergency medical services (EMS), and detention services.

Familiar faces have persistent and unaddressed physical, mental and behavioral health challenges that result in acute, high-cost interventions. The county currently lacks intense coordinated information-sharing and support that familiar faces need in order to achieve better outcomes. Addressing the healthcare and social needs of familiar faces requires collaboration and innovation. Leaving these needs unaddressed hurts quality of life and increases overall costs of care, diverting resources away from more proactive population health efforts.

1. Develop an ongoing Wake County Familiar Faces Work Group and utilize business agreements/collaboration with local hospitals, jail system, EMS, Alliance and other community providers to share and link pertinent data. Develop advanced analytics to identify residents at highest risk.

2. Align a public/private partner to issue a Request for Proposal and identify a lead organization who could coordinate existing organizations and/ or manage a central database capable of using data analytics to identify persons in need of services.

3. Pilot the use of a standardized Social Determinants of Health screening assessment and design a uniform enrollment process to connect people to appropriate resources.

4. Develop community protocols to coordinate the existing case management programs in the community. Consider piloting new interventions with a subset of the population. Provide training and support, and engage workforce currently working directly with familiar faces.

5. Develop a return on investment model to demonstrate cost savings and develop a case for scale and sustainable support to meet the needs of this population.

Key Findings

Wake County is a leader in health. The Task Force recommendations build on past successes, encourage recognition of the health effects of county policy, and support alignment of work focused on a broader understanding of what produces health.

Wake County is learning from others. The Task Force recommendations build on lessons learned from others while recognizing Wake County's unique needs. Those lessons will be enhanced by using data to better understand and measure our needs, combined with state-of-the-art analytics that allow us to identify populations with the greatest needs and greatest opportunities for savings that can be reinvested for further gains.

Wake County is resetting the agenda. The Task Force recognizes the statutory responsibility of our Wake County Human Services Department and Board to link people to needed personal health care services and ensure the provision of health care when otherwise unavailable, as well as to evaluate effectiveness, accessibility, and quality of personal and population-based health services. In addition to the work of the department and Board, county commissioners and community partners, the Task Force recommends the creation of a comprehensive Wake County blueprint for addressing the policy, coordination, and service gaps necessary to improve the health of our county and to support alignment of all health-related work.

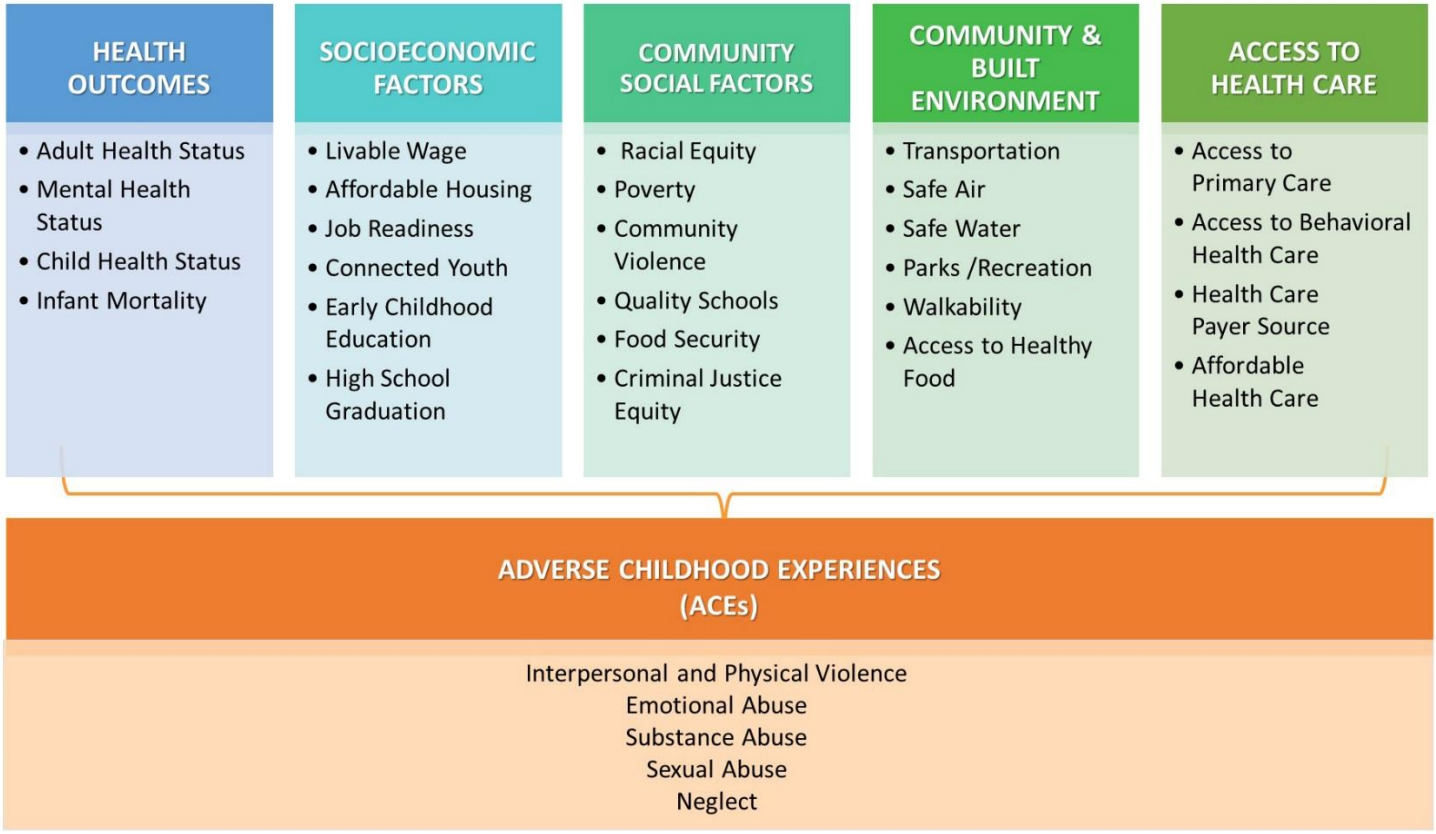
Wake County can make measurable improvement in health for all residents. The Task Force recommends that Wake County define specific health measures that align with benchmarks at the local, state, and national level and work toward definitive improvement objectives in population health by 2030.

No community in the country is better-positioned to tackle these crucial challenges. Wake County's unique combination of resources, civic goodwill, and openness to change create the perfect environment for demonstrating how population health can guide major improvements in overall wellbeing.

We have this opportunity thanks to the dedication and farsighted generosity of so many who came before.
We're grateful for the chance to build on their work and help assure a thriving future for all Wake County residents.

BACKGROUND

Population health is a comprehensive approach to analyzing what makes people healthy. Traditional metrics like individual health care and quality of health services are important, but population health encourages a broader examination of social and environmental factors. The World Health Organization defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." This more expansive view of health allows policymakers a more complete picture of community resources and needs.



Wake County is already doing well on health outcomes, consistently ranking first among North Carolina counties. We are fortunate to have world-class medical, public health, environmental, and social service providers in the region, and county officials are making steady investments in vulnerable communities, education, housing, transportation, behavioral health, food security, and other areas that influence population health.

There is still work to be done. Wake County's Community Health Needs Assessments continue to find disparities in health and social outcomes, service gaps and barriers to access, especially for our most vulnerable neighbors. There is also a need for better coordination and alignment between different services and programs within the county.

The Wake County Board of Commissioners appointed this Task Force to review the efforts already underway and recommend improvements. The Population Health Task Force was established to:

- Examine how communities across the country are approaching population health.
- Develop comprehensive recommendations to address health disparities; encourage healthier communities; influence the county's architecture, streetscapes, parks, and zoning to promote healthier environments; and make the healthy choice the easy choice for all residents, so that healthier outcomes become the default.
- Recommend outreach strategies that can engage the widest array of stakeholders in promoting health-conscious policies and choices for residents.

Wake County is consistently ranked as the healthiest county in North Carolina, a finding echoed in the 2018 County Health Rankings Report from the Robert Wood Johnson Foundation[2]. Of the state's 100 counties, we ranked first for healthy behaviors, second for both longevity and quality of life, third for social and economic factors, and fourth for clinical care. But Wake County was ranked 77th in physical environment, a category that includes housing, air and water quality, and the built environment. Despite the superior overall rankings, our county also suffers from significant disparities in health. There is an urgency to address these disparities: 93,252 people in Wake County have income of less than $24,000 per year. This population in Wake County is larger than the entire population of 70 other North Carolina counties.

While recognizing our successes thus far, we can and must do better. That will mean (1) reducing health disparities, and (2) improving health outcomes by focusing resources on high-impact areas.

Our high overall health ranking masks significant disparities within the county. We have vulnerable and underserved populations whose health outcomes are remarkably poor compared to the general population. It is important that we seek solutions for these high-need populations that might otherwise remain hidden in data averages.

Wake County should join the national shift from "volume to value." That is, instead of measuring the number of services we provide, we should define clear metrics for the *outcomes* we hope to achieve. We must also recognize that the factors defining good health are much broader than the volume of medical care provided. Understanding how medical care is evolving and how other factors contribute to positive health is crucial in reconsidering resource allocation. As we learn more about what works, we can re-allocate resources to those efforts with a greater return on investment, including the evidence-based practices addressing Adverse Childhood Experiences (ACEs) and building resilience.

Wake County is home to world-class human services, health systems and medical professionals. We have a strong base of community organizations and individuals who care deeply about meeting the needs of our most vulnerable citizens. We are investing in many programs and services - including transportation, affordable housing, behavioral health care, education and more - that improve the health of our residents. Wake County also has a robust history of engaging communities in addressing our health and social concerns.

Carefully considered investment and improved coordination will not only improve the health and wellbeing of all our residents but will also enhance our community competitiveness.

Population Health Defined

Population health is an approach that considers both health outcomes and the determinants of those outcomes. In the American Journal of Public Health, researchers David Kindig and Greg Stoddart[3] offered definitions for the term *population health:*

> ...*[P]opulation health as a concept of health* [is] defined as 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group.' These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, disabled persons, or prisoners.

Kindig and Stoddart also identified critical components of population health and emphasized the intersections of those components:

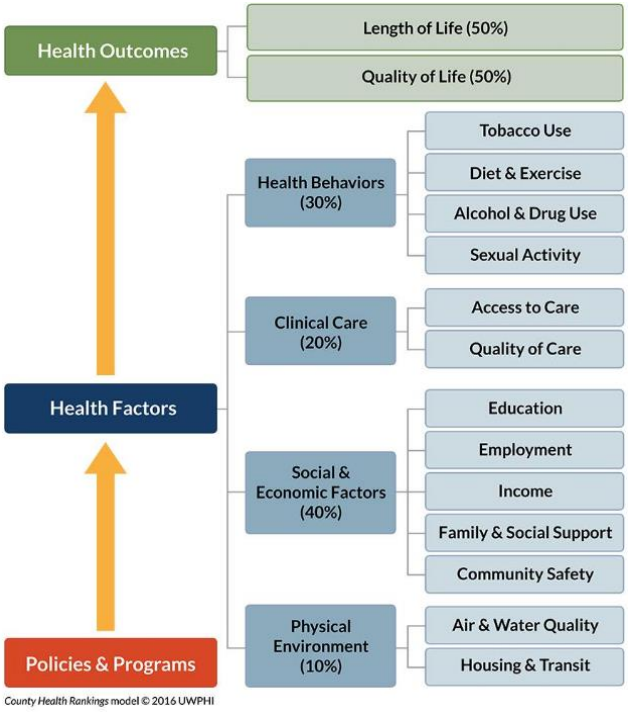
> …[A] hallmark of *the field of population health* is significant attention to the multiple determinants of such health outcomes, however measured. These determinants include medical care, public health interventions, aspects of the social environment (income, education, employment, social support, culture) and of the physical

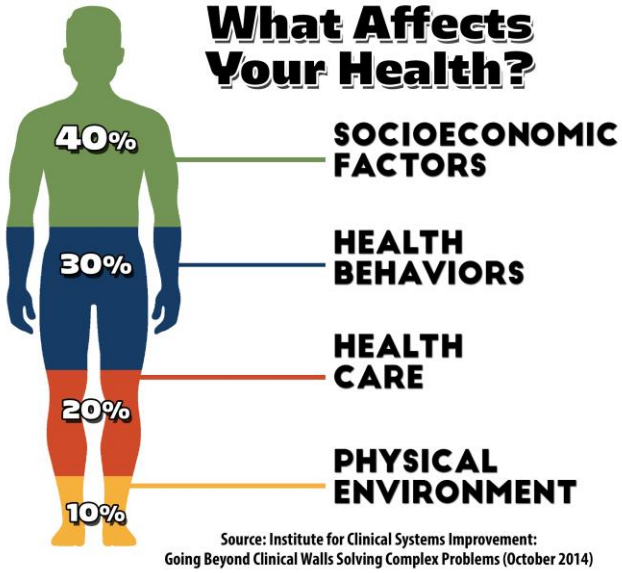
[2] http://www.countyhealthrankings.org/app/north-carolina/2018/rankings/wake/county/outcomes/overall/snapshot
[3] https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.93.3.380

environment (urban design, clean air and water), genetics, and individual behavior. We note with caution that such a list of categories can lead to a view that they operate independently; population health research is fundamentally concerned about the interactions between them, and we prefer to refer to "patterns" of determinants.

Aligning with these definitions, the Robert Wood Johnson Foundation offers a solid population health framework through its *Healthy Communities* projects. Their annual County Health Rankings & Roadmaps uses a range of health factors to determine the relative overall health of communities. The four categories of health factors include:

1. Health Behaviors (30%): tobacco use, diet and exercise, alcohol and drug use, sexual activity
2. *Clinical Care (20%):* access to care, quality of care
3. *Social and Economic Factors (40%):* education, employment, income, family and social support, community safety
4. *Physical Environment (10%):* air and water quality, housing and transit





RWJF's population health framework emphasizes that health outcomes are produced by a *combination* of the health behaviors of an individual, the clinical care they receive, the social and economic factors they face, and the physical environment in which they live. Importantly, clinical care - what many often think of as "healthcare"- only accounts for twenty percent of what produces good health. The other, more weighted, aspects of supporting positive health outcomes are often referred to as "social determinants of health." Population health improvement programs are most effective when they address all of these factors.

Formation of the Task Force

The Wake County Board of Commissioners solicited and received nominees to serve on the Population Health Task Force. Chaired by Wake County Commissioner Sig Hutchinson and co-chaired by Dr. Stuart Levin, the Task Force included 25 members with a broad representation of health care providers, social services providers, and community leaders.

The Task Force organized into three work groups: Healthy Wake, Vulnerable Populations, and Familiar Faces. Each work group provided more detailed recommendations which are incorporated into three overarching recommendations. (Appendix I)

Healthy Wake – This group considered the needs of Wake County as a whole, focusing on the importance of healthy behaviors for all residents. They examined factors that shape health for both communities and individuals, including race, ethnicity, housing, income, public education, and environmental infrastructure. The suggested health strategies from this work group include prevention and convenience, which align with the Task Force's charge to make the healthy choice the easy choice.

Vulnerable Populations – This title refers to groups of people who are at risk for poor health outcomes. People in this category have socioeconomic factors associated with long-term poor health outcomes. They may have chronic health conditions or be at risk for acute medical problems. This work group considered long-term strategies to improve negative socioeconomic conditions. They prioritized strategies for children and youth, low-income residents, adults with no high school diploma, and residents who are unemployed.

Familiar Faces – "Familiar faces" refers to people who are the most frequent users of emergency and medical, social, law enforcement, and other services, often due to being in vulnerable populations, as well as having chronic health and behavioral conditions and other risk factors. Health interventions for these groups account for a disproportionate share of the community's investment. The root causes of their health concerns need to be addressed for Wake County to improve population health and address disparities in health outcomes.

In 2017, Wake County commissioned a study to better understand how familiar faces interact with the county's services for homeless populations, emergency medical care, and jail systems. The goal of this work group is to reduce the number of acute crises by improving case management and ongoing services. In addition to creating better health outcomes for familiar faces, reducing the number of people in this high-cost population will conserve resources that can be reinvested in the community.

For the greatest impact, population health efforts should create a stronger base of prevention, a healthy environment to live in, and a culture that "makes the healthy choice the easy choice."

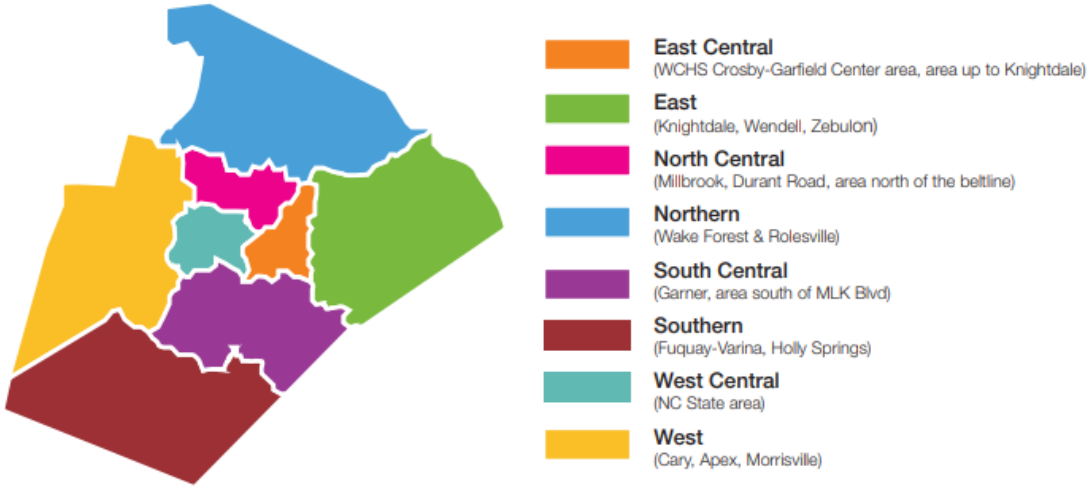
POPULATION HEALTH CONTEXT & MODELS

The Task Force considered the context of health initiatives in the state of North Carolina and looked to models of what others are doing to improve population health.

Community Health Needs Assessment

As the Population Health Task Force and its work groups identified priorities, it became clear that there was significant overlap with priorities identified through the 2016 and 2013 Community Health Needs Assessment (CHNA) processes. Required by state law for local health departments and by federal law for nonprofit hospitals, the CHNA forms the county's foundational approach to understanding and influencing the factors that affect population health.

Every three years, the Wake County Human Services Public Health Division conducts a formal community-wide CHNA[4] with substantial research of primary and secondary data, as well as involvement of multiple community stakeholders including public health agencies, hospitals, private practitioners, and community leaders. The most recent Community Health Needs Assessment in 2016[5] identified four priority areas: 1) Health Insurance Coverage, 2) Transportation, 3) Access to Health Services, 4) Mental Health and Substance Abuse. In addition to these, the 2016 CHNA identified several other health priorities and mapped them across eight County Service Zones.



Need Category	East Central	East	North Central	Northern	South Central	Southern	West Central	West
Health Insurance Coverage	2	3	1	2	3	4	2	1
Mental Health & Substance Abuse	4	2	3		1	1	3	2
Employment	3	1	4	1		4		
Transportation		4		3	4	2		3
Income and Poverty	1		2		2		1	
Housing & Homelessness								4
Oral Health						3		
Health Professionals				4				

[4] http://www.wakegov.com/humanservices/data/Pages/default.aspx
[5] http://www.wakegov.com/humanservices/data/Pages/default.aspx

The CHNA for 2019 to 2021 has already begun:

Phase 1 Establish a Community Health Assessment Team and Conduct an Assessment
Phase 2 Define Priorities and Develop an Action Plan
Phase 3 County and Stakeholders Implement / Work the Plan
Phase 4 Ongoing Process of Evaluation
Phase 5 Re-engage for the Next Community Health Needs Assessment

In the interim years between CHNAs, Wake County Human Services publishes a "State of the County Health Report." This report provides updates on key health indicators and status updates on actions related to CHNA priorities. All three county hospitals, Advance Community Health, and other partners also use the CHNA to develop their community health plans. The partners continue to communicate and try to connect efforts around the identified community priorities. The Task Force commends Wake County Human Services, our hospitals and community partners who continue to align their collective impact in addressing identified community needs.

North Carolina Medicaid

The North Carolina General Assembly recently enacted legislation to transform the Medicaid program from its current fee-for-service payment model to a managed care model. Once implemented in 2019, Medicaid will no longer pay doctors, hospitals, and other health care providers for the services they provide to Medicaid recipients. Instead, Medicaid will pay private health insurers a fixed amount per recipient, and the insurer will both manage the care of the recipient and pay the providers for the services provided.

Tasked to implement the new Medicaid system, the NC Department of Health and Human Services (NCDHHS) is working to include requirements for these health insurers to focus not only on traditional medical services but also on the social determinants of health such as housing, transportation, food security, and personal safety.

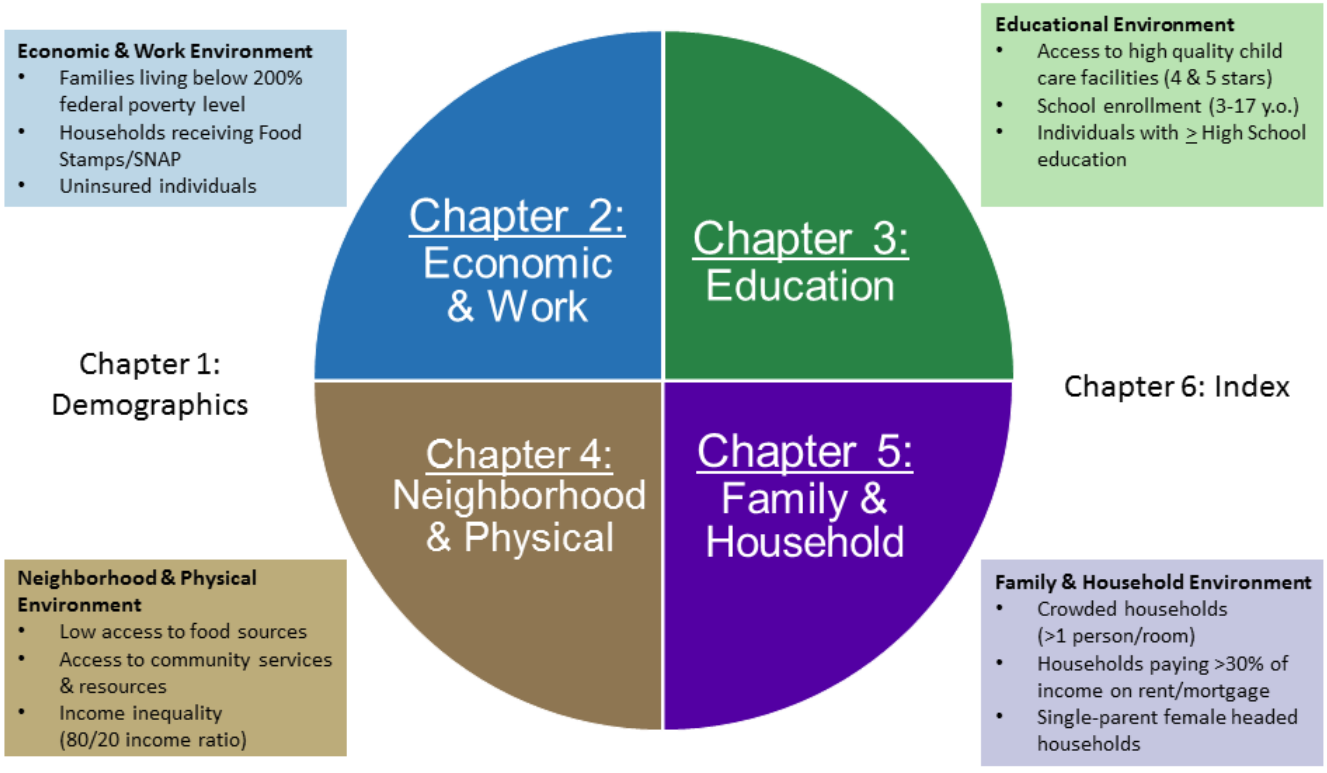
NCDHHS is also working to develop statewide technology that will improve communication and coordination between traditional health care providers and community-based social service organizations. As Wake County further refines its work to improve the health of Wake County's residents, we should consider how to best align with NCDHHS to leverage state tools and funding.

Exploring Social Determinants of Health in Wake County — The John Rex Endowment and NCIPH

On a local level, the John Rex Endowment released a report in March 2018 assessing needs in Wake County[6]:

> The North Carolina Institute for Public Health (NCIPH[7]) recently completed an assessment and online Story Map[8] commissioned by the John Rex Endowment to describe how conditions in Wake County such as the number of high-quality child care centers, existence of food deserts, and high housing costs (defined as a family spending more than 30 percent of their income on housing) can affect children and their families' health and wellbeing. Information from the chapters of the report will be used during the 2018 strategic planning process to define future funding priorities toward creating an environment where children and families in greater Wake County live healthy lives.

The Story Map provides a guided description and narrative on twelve indicators that impact the health and wellbeing of children and families in Wake County. The indicators are categorized into four areas: economy and work, education, neighborhood and physical environment, and family and household environment.



Source: Mapping Social Determinants of Health for Children and Families in Wake County[9]

[6] http://www.rexendowment.org/news/exploring-the-social-determinants-of-health-in-wake-county
[7] https://sph.unc.edu/nciph/nciph-home/
[8] http://files.www.rexendowment.org/learning/mapping-social-determinants-of-health-in-wake-county-the-link-and-user guide/Exploring_SDOH_in_Wake_County_JRE.pdf
[9] https://unc.maps.arcgis.com/apps/MapSeries/index.html?appid=5eb9f9d962914ab19e5b454b30637104

Those indicators are mapped to identify areas of strengths and areas needing improvement, providing insight on the best way to focus attention and investments. Ten important themes emerged from the assessment:

1. Connections within communities are of high value.
2. Housing affordability is at a tipping point for vulnerable families.
3. Housing, food, transportation, employment, child care, and health care access are intertwined.
4. Immediate service needs take precedence over prevention.
5. Immigrant families face challenges in a changing context.
6. Investment in organizational capacity building is appreciated.
7. Leaders call for coordination and integration of services and referrals.
8. Mental health service capacity is inadequate to meet children's growing needs.
9. Organizations would benefit from improved prioritization and alignment.
10. Root causes go beyond poverty.

The Population Health Task Force commends the John Rex Endowment and NCIPH for this important work and agrees with the report's findings, especially those around improved coordination and prioritization. The report stated, "Key informants spoke of their desire for countywide efforts to be more focused, to take on fewer priority areas at a time and to align efforts. The Community Health Assessment plan for how to address priority areas should be communicated with community-level organizations." The Task Force agrees with the need for communication and further believes there must be accountability for developing and implementing action plans to address those priority areas.

Other Models

The Task Force also reviewed promising models, practices, and approaches to guide this report.

Building A Culture of Health[10]
The Robert Wood Johnson Foundation offers this "Action Framework," focusing on working together to create scalable solutions and take action in our communities. This framework emphasizes four components: making health a shared value; fostering cross-sector collaboration; creating healthier, more equitable communities; and strengthening integration of health services and systems. The intended outcome is to improve population health, wellbeing, and equity.

National Academy of Medicine Vital Directions Initiative[11]
The mission of the National Academy of Medicine (NAM), part of an independent, science-based organization chartered by Congress in 1863, is to provide objective, nonpartisan and evidence-based assessments, policy priorities and potential solutions. The NAM's recent ***Vital Directions for Health and Health Care*** position paper focused on systemwide challenges facing health and healthcare. A key priority area was activating local communities to collaborate in mobilizing resources for health progress. The importance of social determinants of health in contributing to an aggregate decline in population-wide life expectancy in association with health disparities was emphasized. The NAM called for policy reforms to:

- Invest in local leadership and infrastructure capacity for public health initiatives (including ongoing collaboration with business, education, housing and transportation stakeholders)
- Expand community-based strategies targeting high-need individuals
- Provide strong state-based capacity for guidance, assistance and synergy for local health efforts

[10] https://www.rwjf.org/en/cultureofhealth.html
[11] https://jamanetwork.com/journals/jama/fullarticle/2612013

Live Well San Diego[12]

This vision plan from the County of San Diego aligns the efforts of individuals, organizations, and government to help residents live well and bring about positive change. The vision includes three components: *Building Better Health* by improving the health of residents and supporting healthy choices; *Living Safely* by protecting residents from crime and abuse, making neighborhoods safe, and supporting resilient communities; and *Thriving* by cultivating opportunities for all people to grow, connect, and enjoy the highest quality of life.

Two characteristics of the *Live Well San Diego* model particularly resonated with the Task Force. First, it is crucial to develop a shared vision and to align work among organizations and individuals that promote health. Second, a strategic marketing campaign to promote healthy living can encourage a culture of health and wellness.

Health in All Policies: A Guide for State and Local Governments[13]

This guide was created by the Public Health Institute, the California Department of Public Health, and the American Public Health Association. It encourages a collaborative approach to improving population health by incorporating health considerations into decision-making processes across sectors and policy areas. The goal of *Health in All Policies* is to ensure that decision-makers are informed about the health, equity, and sustainability impact of various policy options.

Several aspects of this model have informed the work of the Task Force. First, we acknowledge the importance of local government policy in creating structural and institutional change that can promote health. Second, we understand that many different sectors play a role in shaping our community and therefore have a role in promoting the health of our community residents. And last, we know that engaging a diverse group of stakeholders is necessary when developing policies and systems for meaningful health improvements.

The Silicon Valley Triage Tool[14]

Destination: Home[15], an organization in Santa Clara County, utilizes the Silicon Valley Triage Tool in their work to end homelessness. As they explain:

> "The Silicon Valley Triage Tool is a new and highly accurate screening tool capable of predicting the high cost users in our public safety net system and allows communities to prioritize them for supportive housing. Forecasting the future costs of homeless residents means critical, lifesaving interventions can be provided to the most vulnerable in our community. Using the Triage Tool means communities can spend less resources while achieving better outcomes."

This model informs the Task Force's research on how to identify and connect with vulnerable populations and familiar faces. We also recognize the importance of analytics as well as the need to build local systems to capture these data.

The Task Force chose these attributes of other community initiatives as worth emulating:

- Employs a broad definition of "health" that includes social factors and is focused on all populations
- Recommendations are data-driven, and they have impact and accountability measures in place
- Uses collective impact strategies that coordinate and align many community partners including government, nonprofits, and businesses
- Community engagement approaches are inclusive
- Employs effective marketing of health
- Structured emphasis on accountability and transparency is built in
- The plans evolve over time - they are not "one and done"

[12] http://www.livewellsd.org/
[13] http://www.phi.org/resources/?resource=hiapguide
[14] https://economicrt.org/publication/silicon-valley-triage-tool/
[15] https://destinationhomesv.org/the-silicon-valley-triage-tool/

RECOMMENDATIONS

The Population Health Task Force offers the following recommendations for improving the population health of Wake County. The specific recommendations of the three Work Groups are attached as Appendix I.

1. Sustain and expand the scope of the Community Health Needs Assessment (CHNA) and increase the focus on implementation.

We recognize that the Community Health Needs Assessment is a powerful and successful tool for Wake County, and we do not wish to duplicate efforts by creating a separate assessment process for population health. As such, **the CHNA should remain central to identifying and tracking critical county health needs and priorities**. The process is inclusive of community concerns and is open and transparent. The process enjoys the support of critical health stakeholders but needs more staff resources to support this effort.

The CHNA has relied largely on traditional health metrics and should focus more intensively on social determinants of health as identified through a population health model. In doing so, we will better address wellness and prevention by connecting with other community efforts that address important needs such as education, community and economic development, criminal justice, and human services.

Going forward, the CHNA should create and prioritize an implementation plan with community-based health improvement strategies and measurable outcomes. Such strategies should be tied to identified population health priorities, include accountability measures, and be sufficiently resourced. The significant Community Benefit investments provided by local nonprofit hospitals are a valued resource in Wake County. These investments should align with CHNA population health priorities, including supporting the public/private partnership established to support the recommendations of this Task Force.

2. Ensure the alignment of population health initiatives with cross-county efforts, statewide efforts, and appropriate data metrics.

The Task Force learned of several initiatives already underway that impact the health of Wake County's residents, but those initiatives are not aligned or coordinated. In some cases, the health component of the initiative was not identified or understood. Disparate initiatives can lead to duplication of efforts or gaps in services. At best, they can mean missed opportunities to address key health issues.

Wake County currently has no entity tasked with ensuring the alignment of cross-county initiatives or overseeing the implementation of population health strategies. A public/private partnership should be identified or created for this purpose (see recommendation #3).

As the responsible entity oversees the implementation of strategic efforts, they should consider not only the alignment of county-based initiatives, but also alignment with state and other initiatives. For example, the State of North Carolina is working to implement standard screening for social determinants of health and to enhance communication among providers of medical and social services. The State of North Carolina's Health and Human Services Director and the Chief Medical Officer have both defined ACEs and opioids as a critical focus. There are many other policy efforts with similar intentions. It makes sense, whenever appropriate, to align Wake County's work with the broader work of other funders to improve health.

The responsible entity should ensure that appropriate data inform the creation of both action plans and accountability measures. Strong data is generally available through the CHNA and other sources, and it is important that such analytics inform resource allocation decisions, as well as the assessment of outcomes and effectiveness.

3. Designate a public/private partnership Implementation Team to operationalize, coordinate, and evaluate population health initiatives. (Appendix II)

There is a passion for improving the health of Wake County's residents, especially our county's most vulnerable and potentially vulnerable populations. But there is no single organization responsible for designing, coordinating, and implementing a comprehensive approach to improve the health of Wake County; to keep those priorities front and center; or to tell the story of this work and its results. **A public/private partnership needs to be charged with meeting this need.** The Task Force believes that this organization should be established immediately, and its leadership must be diverse and representative of all in Wake County. The partnership must be committed to a mission of improving the health for everyone in Wake County but must be nimble when determining how best to do that. It should be assured adequate financing to accomplish its work and to firmly establish itself and its work within Wake County. The capacity to coordinate work across county agencies and partner organizations, and to earn outside grants is also important. This entity could be an expansion of an existing organization's work or a new organization that is highly integrated into the county processes for improvement. It should not be a branch of government unless no other option is available.

The initial work of that organization would include:

1. Developing and implementing a clear, transparent, and inclusive mission statement and governance model
2. Developing a sustainability model that includes seeking grants and other external funding
3. Implementing the recommendations of the Task Force
4. Implementing a communications process to achieve its work, support Wake County's goals, and update the Board of Commissioners on progress

Improving the health of Wake County's residents requires a holistic approach, defining health as much more than access to medical care. This broader conception must be expanded and embedded in all of Wake County's work.

In developing new programs, consideration should be given to their potential impact on overall community health. This analysis should also include actions by the state, federal government, and other entities that would affect or align with Wake County programs and activities. This will help ensure that new programs address real gaps in care rather than duplicate efforts. Although Wake County will have some unique needs, programs should align with statewide goals as much as possible.

Additionally, there should be a plan for investing new or "saved" resources into initiatives that have demonstrated real contribution to this broader understanding of health. Wake County and/or the organization accountable for overseeing and implementing these recommendations should seek grant and other funding to support this work.

Conclusion

The Task Force has fulfilled its charge and recommends the Commissioners continue to improve health and allocate resources needed to accomplish these goals. By adopting the Task Force's recommendations, the Board of Commissioners demonstrates a commitment to the health and wellbeing of all its residents.

APPENDIX I:

WORK GROUP RECOMMENDATIONS

Healthy Wake

Wake County should define specific health measures that align with benchmarks at the local, state, and national level and work toward definitive improvement objectives for the overall health of the county by 2030.

The Task Force recognized that continued work is needed to identify appropriate metrics for this goal. Health should be defined to include the broader determinants of wellbeing, not just traditional medical indicators. By establishing one year/ three year/ and five-year benchmarks, Wake County and partners can reach the 2030 goal and aggressively address health inequities. The goal should reflect improved outcomes, lower costs, and better patient and provider experiences in the traditional healthcare environment.

Establish and adequately resource a public/private partnership to coordinate the Healthy Wake initiative by July 2019. Designate a public/private partnership Implementation Team to operationalize, coordinate, and evaluate population health initiatives.

A public/private partnership should serve as the backbone of the Healthy Wake initiative. It will seek to engage a range of partners to implement the policy recommendations of this report, coordinate county and community programs, and provide an annual report of the initiative's progress. The goals of the Familiar Faces and Vulnerable Populations Work Groups would be pursued by the Healthy Wake Initiative.

Recommended Healthy Wake partners include:

- Wake County Human Services
- Wake County Planning
- Wake County EMS
- Local Municipalities
- Business Leaders
- Nonprofits
- Faith Community Leaders
- Hospitals and Medical Provider Groups
- Education Community

Suggested implementation steps:

- Host an education to engagement summit on the state of health in Wake County.
- Engage existing organizations in the formal proposal and chartering of a Healthy Wake organization.
- Identify funding resources.
- Develop a website for Healthy Wake.
- Work to develop and launch a public relations campaign for the initiative.
- Prepare an annual report of outcomes and progress.

Develop the 2019 and future Wake County Community Health Needs Assessments through an increased participation process that creates actionable strategies that will address the wellness and healthcare needs of the county.

The Wake County Community Health Needs Assessment is an existing mechanism that provides for ongoing evaluation of the health of the community along with the development of strategies to address community health needs and concerns. This platform should be promoted and enhanced to capture increased community engagement both in the development and implementation of actionable plans that will drive the overall goal to improve the health of the county. This platform should include the broadest definition of health, including the determinants of health.

Recommended partners to engage include:

- Wake County Human Services
- Community nonprofits (American Heart Association, other nonprofits)
- Hospitals
- Housing
- Education Community
- Faith Communities
- Employer Roundtable
- WakeUP Wake County
- Advocates for Health in Action
- Law Enforcement
- Other Community Organizations

Implementation steps:

- Develop a strategy for CHNA to reflect recommendations from the Population Health Task Force and balance social determinants, wellness and healthcare needs.
- Identify multiple approaches to community engagement.
- Engage the education community.
- Formulate clear and accountable strategies and resources for action plans and implementation development.
- Develop public relations campaign to assist with implementation of actionable strategies.
- Monitor data to inform plans so that quality interventions are achieving desired results.
- Establish use of specific data sets to measure outcomes. Examples such as CHNA metrics, HOPE Initiative Measures, RWJF County Health Rankings, NC Healthy People 2030, and others.

By 2030 create physical and educational environments that support healthy behaviors by "making the healthy choice the easy choice".

Physical and educational environments play a critical role in the health of the county. Zoning and local land use policies help foster the creation of equitable, safe, and healthy communities. These include such initiatives as safe routes to school, complete streets, multi-modal transportation, transit, water and air quality, green spaces, access to healthy foods, and more. In addition, education is instrumental in informing and encouraging healthy behaviors. Combined, these initiatives work together to create the overall daily environments that make healthy choices easy and popular.

Recommended partners to engage include:

- Wake County Community Services Department
- Wake County Environmental Services Department
- Wake County Human Services Public Health Division
- North Carolina State University
- Triangle Transit
- WakeUP Wake County
- Capital Area Friends of Transit (CAFT)
- Environmental Partners (Sierra Club, etc.)
- Capital Area Food Network (CAFN)
- Hospitals
- Nonprofits (American Heart Association, YMCAs, etc.)
- Education Community
- Urban Land Institute

Areas of work:

- Elimination of food deserts
- Tobacco-free policies
- Support for transit
- Support for bike and pedestrian pathway development
- Greenways and parks development
- Open use agreements
- Water and air quality
- Community and school-based educational programs to address obesity, hunger, substance abuse, physical exercise, and environmental preservation.
- Establishment of ongoing data sets to measure outcomes. Possible data sets: RWJF County Health Rankings, CDC, Smart Growth America (Complete Streets)

Vulnerable Populations

Vulnerable populations are groups of people most likely to be negatively impacted by a shift/change/degradation of a community resource. Individuals may be vulnerable because of age, illness, disability, or impact from social determinants of health. Often their economic fragility is such that built public environments (landscape architecture/public space/public transportation) have a disproportionate impact on their day-to-day life.

The Vulnerable Populations Work Group recommendations are designed to create equitable county systems and environments where each resident is empowered to thrive in all areas of health.

Within the broader context of vulnerable populations, the work group identified a special focus on youth under 18 years of age eligible for free and reduced school and summer meals, their household members, and the communities where they reside.

Wake County has strong organizations doing exceptional work to improve the lives of people in vulnerable communities. The work group recognizes the importance of supporting and aligning the work that is already underway.

The work group identified strategic factors that must be addressed to achieve the progress. The issues were grouped by the identified focus areas which included:

Youth with a focus on:

- Interaction with the justice system
- Education/Success
- Addressing bullying
- WCPSS policies on suspensions and expulsions
- Gang participation
- Sexual health and safety
- Teen employment (opportunities and training)
- Developing mentoring programs

Household stability throughout the stages of life:

- Affordable and safe housing
- Adequate food
- Sufficient income
- Accessible healthcare
- Support for families with a household member who is incarcerated

Community for persons of all ages:

- Safe places (mobile parks and recreation centers, libraries)
- Community gardens
- Exposure to the arts

Fulfilling these recommendations will require long term effort; they will improve the social and environmental living conditions of youth thereby improving health outcomes in populations of Wake County over time.

Develop a community grant fund to support initiatives geared to improve population health.

Encourage all businesses, philanthropic organizations, and other donors to support the fund by investing fiscal or human capital in communities identified as most vulnerable by use of a data driven methodology. The grant funding should address the HOPE (Health Opportunity and Equity) continuum of indicators for health outcomes, socioeconomic factors, social environments, physical environments, and access to health care. (Appendix lll) The grant funding should also address Community Health Needs Assessment priorities in vulnerable communities.

Create safe and stimulating environments by reducing barriers to accessing food, transportation, and housing.

Strategies include:

- Universal breakfast and lunch and supplemented summer food sites
- Students ride transit at no cost
- County-wide, promote new housing developments with a mix of affordability

Reduce over-criminalization that removes children from schools and parents from homes: decrease incidence of ACEs, reduce incarceration, support continued engagement in community and economy.

Strategies include:

- Prioritize diversion training for all law enforcement and school officials
- Support existing and pilot new diversion programs for adults

Encourage early childhood brain development: create a healthy, well educated workforce.

Strategies Include:

- Institute high quality early education and development for all children.
- Implement later start times for middle and high school students.

Important baseline measures to track success include:

- Grade level proficiency
- Number and percent of households spending 30 percent or more of income on housing
- Number of residents earning and jobs paying up to $1,250/month, $1,251-$3,333/month
- Number and percent of adults with no high school diploma/GED
- Number and percent of unemployed residents, including youth

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Familiar Faces

The Familiar Faces Work Group's vision is to lead an innovative, collaborative and analytics-driven process that identifies, connects with, and provides appropriate interventions to support our community's most vulnerable residents.

Familiar faces are a relatively small group of people who cycle through a variety of services because they have persistent and unaddressed physical, mental, and behavioral health challenges and social needs. This population interacts with multiple systems in Wake County such as hospitals, homeless shelters, mental health service providers, and emergency medical services (EMS) to seek high-cost and episodic care. The county currently lacks the intense coordinated information-sharing and support that familiar faces need in order to achieve better outcomes in their health and quality of life.

The Task Force identified familiar faces as being a population health priority for Wake County for three reasons:

First, familiar faces are individuals living in Wake who currently are, or are at-risk of, experiencing poor health outcomes. Poor health outcomes adversely affect the quality of life for individuals who are experiencing them and place tremendous stress on their families and communities. Additionally, these outcomes are costly to emergency medical services and healthcare organizations, and they impact other stakeholders such as law enforcement.

Second, focusing on the needs of familiar faces improves the county's capacity to identify and address persistent underlying causes of poor health, including social drivers. This work aligns with the state's Department of Health and Human Services focus on Social Determinants of Health, the State Opioid Plan, the Wake County Behavioral Health Summit goals, and with the objectives of the Wake County Drug Overdose Coalition.

Third, the potential return on investment (ROI) is significant both for human and monetary impact. Through improved stakeholder coordination and a common aim to reduce recidivism in the justice system, EMS calls, and frequent high cost emergency care, Wake County can realize significant cost savings. This money can then be invested into upstream initiatives that improve overall population health.

Wake County needs a consistent approach to identify and connect to the familiar faces population. The Familiar Faces Work Group identified several strategic issues that describe challenges and barriers for this population and the stakeholder organizations who interact with them. These barriers include data challenges. Wake County has an abundance of information about how people are utilizing services and systems. However, there is not a single repository for collecting data across different stakeholders and systems. Each stakeholder group that interacts with familiar faces has its own definition for identifying individuals who fall into this category or are at-risk of becoming familiar faces. Within stakeholder groups, key information that is needed for identification and intervention is also kept in separate systems. For example, systems that screen for Social Determinants of Health needs are different than the ones healthcare organizations use for electronic health records. How could Wake County develop agreements and a system that collects and links data between stakeholders to identify our most vulnerable residents and to coordinate interventions?

Wake County currently lacks resources for people transitioning from key institutions back into the community. The county's jails lack key reentry services like Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) Outreach Access and Recovery (SOAR) counseling. Additionally, pharmacy services for mental and physical healthcare are separate. Understanding how to navigate between resources can be extremely complicated for someone who is experiencing multiple health and social challenges. Lack of coordination leads to ineffective connection and intervention with individuals who are at risk of becoming or currently are familiar faces. With appropriate collaboration between stakeholder organizations, we can promote long-term recovery and support these individuals in breaking from the frequent cyclical use of high-cost criminal justice system and emergency health services.

There are also challenges unique to the familiar faces population. These include inconsistent housing and communication technology, social isolation, and stigma toward people who have mental and behavioral health challenges. Wake County is similar to every county in North Carolina with issues surrounding access to mental and behavioral health services. Individuals have the right to refuse services, and those who have persistent mental illness might not be able to provide consent. Engagement of this population with community resources is a challenge, particularly for those who struggle with one or a combination of mental health and behavioral health troubles due to distrust and lack of coordination and social support.

The work group identified four necessary steps and questions to develop recommendations for improving the health of familiar faces. They include:

1. Identify. Who are the most vulnerable community residents at-risk for avoidable and expensive health outcomes?
2. Connect. How do we appropriately interact and engage with these residents after they have been identified?
3. Intervene. How do we work with familiar faces to address their underlying and persistent health and social needs?
4. Support resilience. What ongoing support do we need to put into place so that more people can stabilize, and fewer people will be at-risk of becoming familiar faces?

The work group explored three promising models to learn how other communities are tackling this challenge. These included the Silicon Valley Triage Tool, the Camden Coalition of Healthcare Providers' Housing First Pilot, and the Parkland Center for Clinical Innovation in Dallas, Texas. The work group also engaged the SAS Institute and N.C. State University during the planning process, and the Task Force convened a focus group consisting of healthcare professionals with expertise in working with this population.

The recommendations of the work group are:
Organize a Wake County Familiar Faces Work Group.

Develop business agreements/collaboration with local hospitals, jail system, EMS, Alliance and Health Management Information System to share and link data. Develop a predictive analytics tool to identify residents at highest risk for future cost liability.

Build data repository that will feed into a system similar to Silicon Valley Model. Consider issuing a Request for Proposals to identify a lead organization that could coordinate existing organizations and/ or manage a database. Implement in phases, and map strengths (resources) and gaps in transitions.

Design a uniform enrollment process to connect people to appropriate resources.

Develop a central agency to help coordinate the existing case management programs in the community to coordinate outreach and intervention via care management and peer support to identified high risk individuals that will help link existing community resources and healthcare to address underlying needs. Explore possible development of a linked client referral and management system with hospitals, government agencies, and community-based organizations to help coordinate care.

Work to standardize Social Determinants of Health screening domains.

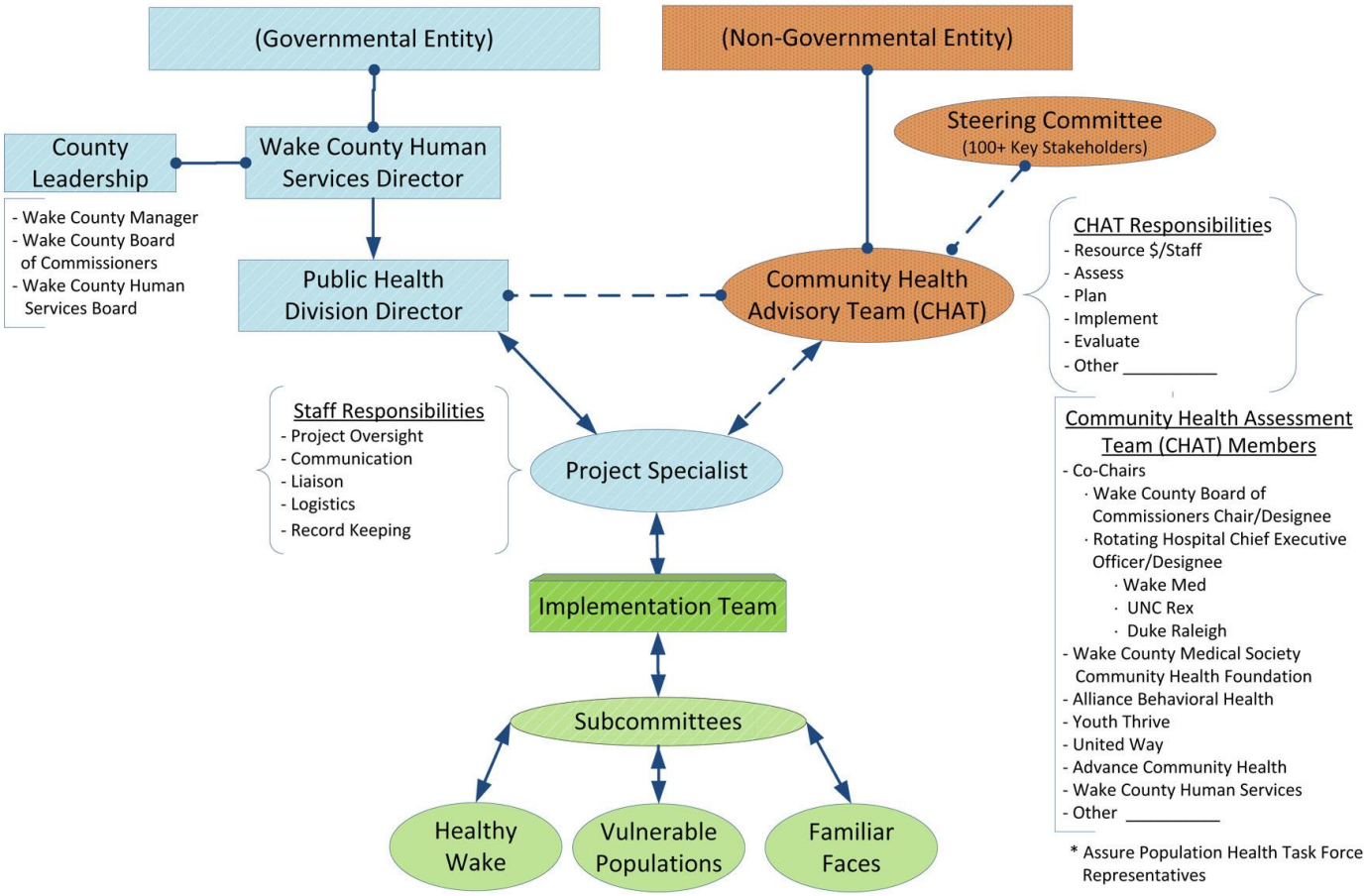
Develop an ROI model to demonstrate cost savings. Develop short- and long-term goals. Collect data and use it to track outcomes and identify community gaps/needs. This work will need sustainable funding because this population will require ongoing support.

Addressing the healthcare and social needs of familiar faces requires collaboration and innovation. This population will require a large investment because this is a group of people who have been left out of the existing systems that are in place. However, we believe that the benefits in both monetary and human value for our entire community will be significant. Through these efforts and our local talent, knowledge and resources we believe we can develop a leading national model.

APPENDIX II:

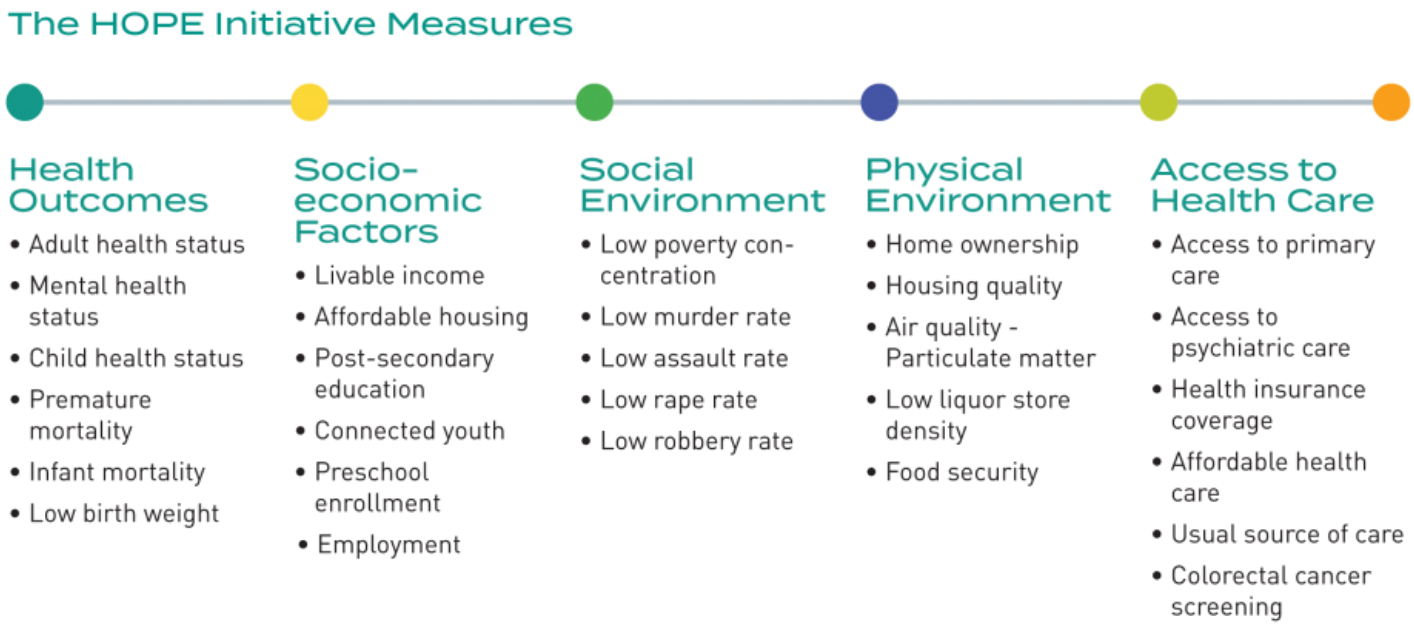
PROPOSED MODEL FOR PHTF/CHNA IMPLMENTATION TEAM STRUCTURE

Proposed Operational Model for Population Health Task Force/Community Health Needs Assessment (PHTF/CHNA) Implementation Team Structure
(Public/Private Partnership)



APPENDIX III:

THE HOPE INITIATIVE MEASURES



The Health Opportunity and Equity (HOPE) Initiative is funded by the Robert Wood Johnson Foundation. HOPE measures offer guidance to policymakers and community leaders on where they are doing well and where they can do better in making sure opportunity is available to everyone. The HOPE Initiative tracks 28 indicators that span the life course, including health outcomes and indicators related to opportunity such as socioeconomic factors, the physical and social environment, and access to health care at the state and national levels. Gaps in health do not develop by chance or by choice. These measures were chosen because they reflect the systems and policies that affect health equity. Data are also provided by race, ethnicity and socioeconomic status, making this the first tool of its kind.[16] Wake County should be able to track the same factors at the County and possibly regional levels. That will give the County national, state and local data for benchmarking and measuring success.

16 http://www.nationalcollaborative.org/our-programs/hope-initiative-project/