United Way of Central Illinois

2018-2020 Health Request for Applications

Activating and Inspiring our community to get healthy and stay healthy

Thank you for your interest in partnering with United Way of Central Illinois (UWCIL) to activate and inspire our community to get healthy and stay healthy. Through this Request for Application (RFA), UWCIL will provide funding to high quality human service programs aligned with the priorities and strategies outlined herein under the issue area of Health for the July 2018-June 2020 funding cycle.

To successfully apply, please review this RFA in its entirety, along with the documents provided online. These documents include:

- Health Strategic Investment Plan
- Health Procedure and Key Dates
- Organization/Financial Review Checklist
- Sample Application
- Sample Narrative Response Checklist for the Application
- Survey Tool (All programs will use this tool as part of their evaluation process)
- Budget Definitions
- Demographic Step-by-Step Completion Guide
- Scoring Rubric
- History and Background of United Way of Central Illinois
- Community Investment Policies and Procedures

Investing in our Community

UWCIL is issuing this RFA as part of a long-term commitment to achieve the goal of activating and inspiring our community to get healthy and stay healthy. To do this, priorities for addressing at-risk and/or medically underserved populations were selected. The first Health priority challenges our community to support underserved and at-risk individuals and families by helping them better understand their health and assist them in knowing how to effectively access and utilize the social and medical services available to them. The second Health priority focuses on addressing unmet mental health needs in our community. In addition to funding, United Way will focus on health-related advocacy as a third priority. This includes advocating for the procurement of nutrient-dense foods for local food programs, as well as advocating for greater support and understanding of the need for mental health programs. The Priorities and Strategies outlined in this RFA represent a multi-year funding plan that was developed in partnership with community leaders and service providers.

Health Activation and Why it Matters

While many of us have heard patient/client activation and engagement used interchangeably, these two terms, do represent a key shift in the patient/client lifecycle.

Patient engagement can be summarized as client participation in activities that help improve their health such as going to medical appointments, taking medications, etc.

However, patient activation is the key shift that takes the client from the passenger seat, to the driver seat of their own health care. When patients are activated, they recognize their health as a priority, they know what they need to do to maintain and improve their health, they know how to take the needed steps and when to take them, and they actively work to maintain and improve their health in times of stress.

Community level change, in most cases, takes a great deal of time to happen. However, any change that will happen is driven by individual success in creating a healthier and more activated life for oneself. In an effort to more effectively communicate this change, the Health Vision Council will require each program/collaborative to use a standardized pre and post survey tool with clients. The survey tool they have chosen is a free, publicly available, evidence supported, standardized pre/post survey created by the Hospital for Special Surgery as a means to collect

a patient's self-perceptions on their current health, which measured overtime will help us determine their health progress.

Core Funding Criteria

This RFA serves as a cohesive strategy, in partnership with our community, to address the needs of at-risk and medically underserved populations in Sangamon and Menard Counties. These strategies also support the need to further develop a strong community support network which helps to advance the social connectedness and health outcomes of our community.

This RFA is designed to provide funding for high-quality, evidence based or promising programs or program pilot models which will effectively address the priorities and strategies described within this document.

UWCIL is seeking partners who share our commitment to the following:

1. A commitment to community and population level outcomes focused on geographic and demographic locations with the greatest need as defined by data;
2. A commitment to work collaboratively with UWCIL and other initiative partners in developing effective, cohesive strategies;
3. A commitment to strategies that demonstrate long term success using evidence based models or those identified as promising practices;
4. A commitment to evaluate and share program level data, best practices, and lessons learned; and
5. A commitment to sustainability.

Our commitment to funding requires that partners draw from any and/or all of the following sources when proposing interventions to address community need: scientific research, including controlled studies; outcome evaluations, including local program outcome data; field knowledge with proven results; and consumer perspectives that take into account the culture, values, opinions, and experience of community members and program participants.

Collaboration

While collaboration is not required, UWCIL believes that strong collaboration between nonprofits, business and government partners is necessary for our community to realize outcomes that will effect positive change. Partners are strongly encouraged to demonstrate their commitment to community change by incorporating collaborative opportunities into their identified program model.

Programs that rely on third-party organizations to accomplish stated program goals (i.e. school districts) are required to provide letters of commitment from the third-party organization. Letters must be uploaded in the online grant system.

In the instance requests are submitted by collaborating organizations, one application should be submitted clearly outlining each respective partner and the structure in which they will operate to achieve collective goals. A separate section of the online application has been included for detailed information outlining how each collaborative partner will operate, including fiscal and program management structure. During the funding review process all collaborative partners will be involved and additional documentation may be required for review.

Our Community's Health Priorities and Strategies

Priority 1 (H1): INDIVIDUALS ARE SUPPORTED, CONNECTED, AND ACTIVATED TO LEAD HEALTHY LIVES.

Despite having a strong presence of medical professionals to care for those who reside in Sangamon and Menard counties, our region still experiences a slew of poor health outcomes.

A white paper released by the Institute of Healthcare Improvement, discussing the Care Coordination Model as a way to provide better care at a lower cost for individuals with multiple health and social needs, identified that the needs in themselves were not complex, but rather in great numbers which created the complexity.

Time and again, teams have come to the realization that the needs that individuals have are not complex — they are remarkably simple, but often numerous. Typical needs may include transportation to appointments, a refrigerator for storing medications, a telephone to communicate with care providers, nourishing food, and a place to call home. Specialty care for people with diabetes, cancer, or asthma, methadone treatment, mental health treatment, and issues with food security and housing stability are not in and of themselves complex challenges; the complexity arises when the tasks of making connections among multiple care providers and linking each intervention to the individual's overall care plan fall in the lap of the individual alone without effective partnering or support.

While the white paper describes why communities should embrace the Care Coordination Model, it also concludes that in order to have the most effective model, the care coordinator must be engaged in a trusting relationship with the client.

It is also clear that the advancement of the community's health cannot be the sole responsibility of care coordinators, direct service/medical providers, and the individuals by themselves. While medical providers may be the experts in equipping individuals with the knowledge they need to change their health, they often lack the ability to gain the trust of their patient and/or readily follow-up with them to create a meaningful relationship. Instead, the Health Vision Council seeks to insure individuals are surrounded by health champions or key individuals such as faith leaders, police, teachers, hairdressers, social service providers etc., that are trained to serve as lightning rods in their communities to promote health and wellness. In a community with the capacity to change, these stakeholders (health champions) are be provided with the information and skills needed to address health concerns of an individual and promote health and wellness to those they serve.

Applicants addressing Priority 1, (H1), must effectively describe how their programs are locating, activating, and supporting their target population. Regardless of the selected strategy(ies), applications must clearly identify and measure how the services being provided through direct client engagement and/or stakeholder (health champion) engagement are improving the target population's access to care, follow-through, social determinants of health, and ultimately their health outcomes.

Priority 1 (H1): Individuals are supported, connected, and activated to lead healthy lives

Community Level Indicators for United Way programs:

- Number of individuals participating in UW funded programs
- Number of individuals reporting improvement in health outcomes
- Number of individuals reporting greater connectedness and accessing social supports within their community
- Number of identified stakeholders supporting better health outcomes

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Priority 1, Strategy 1 (H1.S1): Provide peer navigation, community health worker services, and/or other methods aimed at locating, activating and supporting targeted, at-risk populations in improving their access to care, follow-through, social determinants of health, and ultimately health outcomes.

Care Coordination Models can take a variety of different forms and the Health Vision Council is not prescribing a specific intervention model. The key element that the Vision Council will be looking for is the program's ability to locate and engage, activate, and support its target population in improving health outcomes. The table below provides examples of programs addressing different problems with different interventions. Developing a table, like the one after this text, for the program applying for funding is highly encouraged.

Name of Program	Care Coordination Model Intervention Type	Target Population	Location and Engagement Method	Activation Method	Support Method	Intended Client Benefits/Proven results
Maryland Faith Health Network (http://healthcareforall.com/get-involved/maryland-faith-community-health-network/)	Modeled after Congregational Health Network program in Memphis, TN Employed faith community health navigators Volunteer network liaisons	Individuals of congregations signed up as members of the Faith Health Network Individuals of the congregation who may be ailing and are served at the specific network hospital	Places of worship encourage members to enroll Enrolled members receive a network card. When a member is admitted to the participating hospital they notify the hospital to activate their congregation.	When the congregant goes home, the congregant and representative will have a single point person at the hospital to contact to resolve any issues, questions or complications.	An appointed representative at the congregation receives a call from the hospital notifying them that someone was admitted and would like a call or a visit from someone at the congregation and any other support the congregation can offer.	Decrease the amount of potentially avoidable hospitalizations Improve a patient's overall wellness Cut down on the cost of medical services
Nurse Navigator and Recovery Specialist Outreach Program (https://www.ruralhealthinfo.org/community-health/project-examples/822)	A referral system that utilizes Community Health Workers (CHWs) in a drug and alcohol treatment setting Consortium made up of the Armstrong-Indiana-Clarion Drug and Alcohol Commission (AICDAC) and 9 partners.	Individuals from Pennsylvania who have problems with substance abuse in the counties of Armstrong, Clarion, and Indiana	Individuals call to schedule an assessment and must agree to actively participate in drug and alcohol treatment, abstain from all substance use, attend support group meetings, attend physician appointments, participate in case coordination services with a case manager	Case managers evaluate an individuals' strengths and needs Help them set goals Link individuals to services Advocate for the client's rights Coach individuals as they work toward goals	Client education Provider education Coordination between a client's physical and behavioral health providers	Decrease substance abuse Improve clients' perceptions of their overall health and wellness Improve coping strategies and symptom management Improve communication between clients and their physicians and treatment providers, Reduce the number of emergency visits and hospitalizations.

Strategy 1 (H1.S1): Provide peer navigation, community health worker services, and/or other methods aimed at locating, activating and supporting targeted, at-risk populations in improving their access to care, follow-through, social determinants of health, and ultimately health outcomes.

Target Population:

Strategy 1: Sangamon and Menard County residents who are at-risk and/or medically underserved

Suggested Program Outcomes

- # and % of individuals who develop a health action plan which addresses the following, but is not limited to:
    - Access to health care
    - Social support
    - Care plans as recommended by physicians
    - Individually identified health goals (i.e. weight loss, quit smoking, etc.)

Suggested Program Outputs:

- # of individuals served
- # of assessments/
- screenings completed
- # of health action plans created

- # and % of individuals demonstrating progress toward health action plan goals
- # and % of individuals maintaining their improved state of health and/or health lifestyle for:
    - 90 days
    - 180 days
    - 365 days
- # and % of individuals increasing use of primary care services
- # and % of individuals increasing health literacy
- # and % of individuals increasing their connectedness and social supports within their community
- Other(s) as appropriate

- # of referrals
- # of successful referrals
- # of primary care visits
- # of emergency department visits deterred
- Other(s) as appropriate

Priority 1, Strategy 2 (H1.S2): Engage Stakeholders (Health Champions) to locate, activate and support a targeted, at-risk population by providing knowledge, skills, and resources to stakeholders to improve health outcomes.

Stakeholder engagement may be included in the identified care coordination model from H1.S1. However, stakeholders represent a different tactic for patient activation and support. Stakeholders (Health Champions) are individuals who are specifically trained with the knowledge and skills to support a target population's health because of their proximity and relationship with the target population. While their specific purpose is to not provide case management, they do serve as credible sources for referral information and other resources needed to promote and improve the target population's health. Programs wishing to apply under this strategy need to show how their program is locating and engaging, activating, and supporting it's target population in improving health outcomes. Developing a table like the one below is highly encouraged for programs applying for funding.

Name of Program	Stakeholder Model Intervention Type	Target Population	Location and Engagement Method	Activation Method	Support Method	Intended Client Benefits/Proven results
Maryland Faith Health Network (http://healthcareforall.com/get-involved/maryland-faith-community-health-network/) (Example of care coordination model with an embedded stakeholder model)	Volunteer Network Liaisons called Health Ministry Teams/ Committees Volunteers receive training to help understand their role and support tactics.	Individuals of congregations signed up as members of the Faith Health Network Individuals of the congregation who may be ailing and are served at the specific network hospital	When a member is admitted to the participating hospital a congregant representative will deploy a volunteer network liaison to visit the admitted in the hospital.	Volunteers will provide check-ins and support as decided by the congregant and the congregant representative.	Volunteers call and/or visit	Decrease the amount of potentially avoidable hospitalizations Improve a patient's overall wellness Cut down on the cost of medical services
Health Coaches for Hypertension Control (https://www.ruralhealthinfo.org/community-health/project-examples/753)	Health Coaches (Trained volunteers) Volunteers receive 30-hour training that covers each topic area included in the small group sessions they would be leading	Individuals over the age of 60 with diagnosed hypertension in South Carolina's Oconee County, located in rural Appalachia, surpassed the state and national average.	Individuals attended an 8 week workshop series Individuals had the option of attending an additional 8 week workshop series for a total	Health coaches provided the following services to participants: • Assistance developing an Individualized Action Plan • Peer-led educational classes • Telephone counseling • Group support	Program participants received activity notebooks, blood pressure monitors, pedometers, cookbooks, and relaxation CDs.	Clients improved systolic blood pressure, weight, and fasting glucose, greater knowledge of hypertension, and improved self-reported behaviors.

				• Use of personal health diary • Civic engagement benefits for health coaches		
Barber Shop Blood Pressure Control (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/226700)	Barbers Training provided in taking blood pressure and having model-based conversations	African-American men with uncontrolled hypertension	Identify barber shops in areas with high rates of hypertension	Barbers survey their clients on attending doctors appointments	Barbers conducted blood pressure tests every week Every conversation they share model-based examples	Increase the number of African-American men effectively controlling their hypertension

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Strategy 2 (H1.S2): Engage Stakeholders to locate, activate and support a targeted, at-risk population by providing knowledge, skills, and resources to stakeholders to improve health outcomes.

Target Population:

Strategy 2: Community Stakeholders identified to promote health outcomes

Suggested Program Outcomes

Stakeholder Outcomes

- Stakeholders will demonstrate an increase of knowledge of available resources
- Stakeholders will demonstrate an increase in identified skills
- Stakeholders will help increase individual engagement/Individual contacts?
- Other(s) as appropriate

Target Population Outcomes

- Individuals will report an increase in connectedness and social supports within their community
- Individuals will report greater follow-through on referrals given
- Individuals will report having a better health outlook

Suggested Program Outputs:

- # of trainings conducted
- # of training attendees
- # of stakeholders
- # of individuals served
- # of individual contacts
- # of referrals
- # of successful referrals
- Other(s) as appropriate

Priority 2 (H2): Individuals will have access to needed mental health services

Today, mental health conditions account for about one-third of the world's disabilities due to health problems in adults, reflecting marked societal and personal suffering and enormous socioeconomic costs. By 2020, depression, a type of mental health disorder, is expected to be the second leading cause of disability worldwide, second only to heart disease. *(2012 Advances in Integrative Medicine, Integrative Mental Healthcare White Paper: Establishing a new paradigm through research, education, and clinical guidelines)*

Accessing mental health services is crucial in embracing the philosophy of least intensive interventions first and helping to address the underlying causes for a lack of patient activation. Just as it is important to see your primary care physician once a year, it is also a necessity for some to see a mental health professional for checkups to monitor mental health issues.

Also, while UWCIL could never take the place of government funding, it is important for our community to continue to invest in these types of services when supporting at-risk and/or underserved populations.

United Way seeks to support programs which will support and improve the mental health of the at-risk and/or underserved.

Priority 2 (H2): Individuals will have access to needed mental health services

Target Population: Sangamon and Menard County residents who are at-risk and/or medically underserved

Community Level Indicators for United Way programs:

- Number of individuals showing improvement in mental health outcomes
- Number of individuals who have received appropriate treatment
- Number of individuals who have maintained appropriate treatment

Suggested Metrics:

- Global Assessment of Functioning
- Other(s) as appropriate

Priority 2, Strategy 1 (H2.S1): At-risk/underserved individuals will have access and increase engagement in needed mental health services

To successfully apply under Priority 2, Strategy 1, programs must clearly identify how their target population is underserved and or at-risk, and must also demonstrate why the program provides an unmet, necessary service in our community.

The Health Vision Council seeks to support programs effectively addressing access, working to provide supports to increase engagement, and which effectively help move clients forward. Mental Health programs able to demonstrate promising, evidence based interventions which help individuals overcome trauma and improve their mental health are preferred.

Strategy 1 (H2.S1): At-risk/underserved individuals will have access and increase engagement in needed mental health services

Suggested Program Outcomes

- Individuals will report understanding their diagnosis and/or treatment plan
- Individuals will improve their initial intake value
    - # and % of individuals will improve their initial intake value
    - Average margin of improvement among clients
- Individuals will maintain treatment as defined by their individualized treatment plans
- Other(s) as appropriate

Suggested Program Outputs:

- # of individuals served
- # of assessments/ screenings completed
- # of plans created
- # of successful referrals
- Other(s) as appropriate

Unfunded Priority 3 (H3): United Way will advocate on behalf of health issues aligned with selected priorities/strategies

Providing financial support is only one method in which UWCIL can effectively create positive change in our community. United Way also has the ability to leverage community support through the donation of goods, time, and voice.

By prioritizing advocacy efforts involving nutrition and mental health services/programs, United Way hopes to increase the number of individuals educated in these areas in order to make improvements in their own lives as well as actively supporting local initiatives.

Unfunded Priority (H3): United Way will advocate on behalf of health issues aligned with selected priorities/strategies

Community Level Indicators for United Way programs:

- Reporting the effects of public awareness campaigns

Suggested Metrics

- Surveys/reports

Strategy 1 (H3.S1): Support and drive public awareness around healthy lifestyles and donating nutrient dense foods to increase access to healthy food for all

Suggested Program Outcomes

- Individuals will increase knowledge of the importance of donating nutrient dense foods.
- Individuals will increase knowledge of healthy lifestyles
- Individuals will increase knowledge of local organizations they can volunteer with and/or support to enhance nutrition in our community.
- Other(s) as appropriate

Suggested Program Outputs:

- Pounds of nutrient dense foods donated
- # of volunteers
- # of organizations helped
- Other(s) as appropriate

Strategy 2 (H3.S2): Advance solutions to support Mental Health programs

Suggested Program Outcomes

- Individuals will increase knowledge about the need for mental health services/programs
- Individuals will increase knowledge of the importance of mental health services, therefore decreasing the stigma associated with accessing these services
- Individuals will increase knowledge of local organizations they can volunteer with and/or support to enhance mental health in our community.
- Other(s) as appropriate

Suggested Program Outputs:

- # of interactions
- # of volunteers
- # of organizations helped
- Other(s) as appropriate