United Way of Central Illinois

2020-2023 Health Strategic Investment Plan

Activating and Inspiring our community to get healthy and stay healthy

Estimated Funding Range: 18-22%

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

Priorities:

Individuals are supported, connected, and activated to lead healthy lives	Individuals will have access to needed mental health services	United Way will advocate on behalf of health issues aligned with selected priorities/strategies	
All Ages	All Ages	Program Coordination	n/a
Portion of focus: 50-70%	Portion of focus:30-50%	Portion of focus: One grant to be awarded for mental health system of care development	Portion of focus: Unfunded Priority

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

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.)
- # 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

Suggested Program Outputs:

- # of individuals served
- # of assessments/screenings completed
- # of pre/post surveys
- # of health action plans created
- # of referrals
- # of successful referrals
- # of primary care visits
- # of emergency department visits deterred
- Other(s) as appropriate

- # 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

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

- # and % of stakeholders demonstrating an increase in knowledge of available resources
- # and % of stakeholders demonstrating an increase in identified skills
- # and % of stakeholders who have helped increase individual engagement/Individual contacts?
- Other(s) as appropriate

Target Population Outcomes

- # and % of individuals reporting an increase in connectedness and social supports within their community
- # and % of individuals reporting greater follow-through on referrals given
- # and % of individuals reporting 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
- # of pre/post surveys
- Other(s) as appropriate

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

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

Suggested Program Outcomes

- # and % of individuals that report understanding their diagnosis and/or treatment plan
- # and % of individuals will improve their initial intake value
- Average margin of improvement among clients increases
- # and % of individuals maintaining treatment as defined by their individualized treatment plans
- Average wait time for services decreased
- Other(s) as appropriate

Suggested Program Outputs:

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

(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
- Creation of mental and behavioral health system of care plan

Suggested Metrics

- Surveys/reports

Unfunded 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

- # and % of individuals increasing knowledge of the importance of donating nutrient dense foods.
- # and % of individuals increasing knowledge of healthy lifestyles
- # and % of individuals increasing 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 through the development of a community wide system of care

Indicators of successful implementation

- Collaborative applicants identify a coordinating body for the development of this mental health system of care
- Coordinator position is filled
- Community Organizations are gathered regularly to develop a community-wide plan
- Community wide mental and behavioral health plan is developed which includes indicators of successful implementation/coordination for preventative and intervention type mental health and ancillary services as needed (Initial indicators may include successful effect on suicides, overdose, ER usage for mental health crisis, jail usage for mental health crisis)
- Types of organizations engaged
- # and types of meetings held
- Level of engagement of organizations engaged
- Sustainability/Long-term plan for continuation beyond three years