UNITED WAY OF METROPOLITAN CHICAGO

HEALTH & WELLNESS COMMUNITY IMPACT PLAN

JULY 1, 2010- JUNE 30, 2013

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UNITED WAY OF METROPOLITAN CHICAGO

REGIONAL EXPERT PANELS & GUIDANCE

United Way works to identify critical issues facing people and communities by convening internal and external thought leaders. It is our aim to identify innovative solutions to these challenges and put together the necessary resources—revenue, volunteers, and the best providers—to deliver positive and measurable community impact. The development of this new Health and Wellness Community Impact Plan would not have been possible without the guidance[1] of the following key volunteers:

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THANK YOU FOR YOUR VALUABLE CONTRIBUTIONS!

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[1] While UWMC recognizes these volunteers for their generous contributions of time and ideas, any errors or omissions are solely the responsibility of the writers and should not be construed to reflect the express opinion or wishes of any one volunteer, but rather a composite representation of a community impact planning process.

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HEALTH & WELLNESS COMMUNITY IMPACT PLAN

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HEALTH & WELLNESS COMMUNITY IMPACT PLAN

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
-The World Health Organization[2]

EXECUTIVE SUMMARY

United Way of Metropolitan Chicago (UWMC) is committed to helping people in the Chicago Metropolitan region live longer, healthier lives. The quality and years of healthy life have increased steadily over the past century[3], but dramatic differences in quality and length of life remain across groups. Moreover, we know that people living at or near poverty, racial and ethnic minorities, and those with lower levels of education experience significantly worse health outcomes and are more likely to die prematurely[4]. This means that these groups experience the same health problems as the general population, *only more so*. Therefore, in order to maximize the impact of donors' contributions—time, skills, and financial—UWMC will focus its resources on those most at risk of poor health around the Chicago Metropolitan region.

Recognizing that "helping people live longer, healthier lives" is a bold objective, UWMC is nevertheless committed to 'moving the needle' in the area of Health and Wellness for lower-income families. Therefore, through a year-long planning process that included input from regional health and crisis response experts, dedicated volunteers, local Member United Way representatives, and countless other community stakeholders, UWMC has formed a new Health and Wellness framework that will deliver positive and measurable community impact. Specifically, UWMC will develop and support programs, initiatives and policies around the region that are most likely to achieve the following goals:

- Connect underserved communities and populations with health services
- Reduce the risk of chronic disease
- Meet safety and essential needs

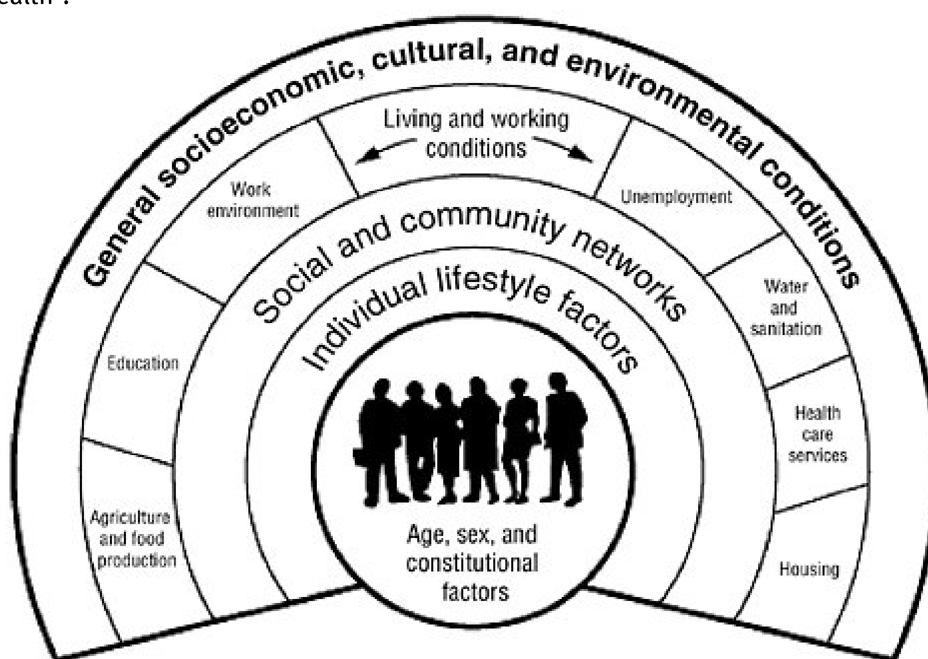
In addition to the formulation of a new investment framework in Health and Wellness around the goals listed above, UWMC has challenged itself and its partners to think about the three dimensions of health—physical, mental, and social—as captured by the World Health Organization definition included above. In order to be effective at improving Health and Wellness in this context, UWMC has committed to the development of multi-disciplinary approaches that:

- Focus on individual and community change for deep and long-lasting impact
- Link people to on-going support services to build effective community networks
- Facilitate access to comprehensive or integrated health services—mental, physical, and social—for improved service delivery
- Encourage outreach and collaboration across sectors for maximum impact
- Acknowledge and leverage cultural strengths

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
[3] At the beginning of the 20th century, life expectancy at birth was 47.3 years and today it is approx. 77 years.
[4] DHHS Agency for Healthcare Research & Quality 2005 National Healthcare Disparities Report.

1.1 Determinants of health

It is well established that the determinants of health—individual biology and behavior, physical and social environments, policies and interventions, and access to quality health care—have a strong influence on the health of individuals and communities[5]. Through the community impact planning process, it became particularly clear that any UWMC strategy to improve Health and Wellness would include a consideration of these determinants, with a particular focus on the underlying social factors. These social determinants of health have been defined as "life enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines the length and quality of life[6]". The Institute of Medicine has used the chart below to illustrate the complex network of social factors that impact health[7].



UWMC will work to actively address these social factors that underlie poor health outcomes by:

- Ensuring adequate food, shelter, and safety as a foundation for Health and Wellness
- Facilitating access to comprehensive health services
- Connecting people to economic opportunity (financial stability & education issue areas)
- Promoting positive behavioral and social norms change
- Utilizing multi-disciplinary strategies focused on improving the health environment
- Increasing equity by prioritizing lower-income communities and communities of color

[5] Healthy People 2010.
[6] Source: James S. Social determinants of health: implications for intervening on racial and ethnic health disparities. Paper presented at: Minority Health Conference, 2002; University of North Carolina.
[7] Institute of Medicine. (2003). The Future of the Public's Health in the 21st Century. Washington, D.C.: National Academies Press. Original source: Dahlgren G, Whitehead M. 1991. Policies and Strategies to Promote Social Equity in Health.Stockholm, Sweden: Institute for Futures Studies.

1.2 Chronic disease

The three leading causes of death and disability in Illinois are chronic diseases[8]—heart disease, cancer, and stroke. In 2005, these diseases accounted for 56% of all deaths in Illinois and also caused major limitations in daily living for many people[9]. However, though chronic diseases are costly in terms of lives and money, they are also the most preventable.

Many efforts to address poor health focus on specific diseases, such as diabetes, cancer, and HIV, thereby encouraging disease-specific remedies. However, in order to save lives, reduce disability and lower the costs of treatment for chronic disease, one must also address the most common underlying risk factors—nutrition, physical activity, obesity/overweight, and tobacco use—thereby attending to the *actual causes* of those diseases. For example, it is well established that a poor diet and physical activity patterns are a key factor in the development of heart disease, cancer, stroke, and diabetes[10]. Furthermore, it is known that when people eat nutritious foods, increase their physical activity, and avoid tobacco use; they can prevent or control the worst effects of these diseases[11].

The Centers for Disease Control and Prevention (CDC) conducts an annual survey to track chronic disease indicators and risk factors[12] [13] [14] to monitor the impact of chronic disease on the population. In 2007, the CDC released the following statistics that compare Illinois to the nation across chronic disease indicators.

- Physical activity: Only 49% of adults and 44% of youth got the recommended amount of physical activity in Illinois, compared to 50% of adults and 35% of youth in the nation.
- Healthy eating: Only 25% of adults and 21% of youth ate the recommended amounts of fruits and vegetables (5 servings per day) in Illinois and the nation as a whole.
- Cigarette smoking: 20% of adults and youth in Illinois and the nation currently smoke
- Health status: 16% of adults report that they have “fair” or “poor” health in Illinois and the nation, compared to “good” or “very good”.

Physical Activity

According to Healthy People 2010, physical activity is a risk factor for chronic disease, independent of obesity. Increasing regular physical activity has the following benefits:

- lowers death rates for adults of any age, even when only moderate levels of physical activity are performed
- decreases risk of death from heart disease, risk of developing diabetes, and risk of colon cancer
- helps prevent high blood pressure
- helps reduce blood pressure in persons with elevated levels
- increases muscle and bone strength
- increases lean muscle and helps decrease body fat
- enhances psychological well-being and may reduce risk of developing depression
- appears to reduce symptoms of depression and anxiety to improve mood
- increases the ability of people with certain disabling conditions to perform activities of daily living

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[8] Taken from Illinois Department of Health website on 7/30/09 at 2pm: http://www.idph.state.il.us/health/bdmd/leadingdeaths06.htm
[9] Source: Taken from the Center for Disease Control website on 8/3/09 at 2pm: http://www.cdc.gov/nccdphp/states/pdf/illinois.pdf
[10] Taken from Prevention Institute website on 7/28/09 at 4:00pm: http://preventioninstitute.org/pdf/health_disparities.pdf
[11] Healthy People 2010.
[12] CDC Chronic Disease Indicators: http://apps.nccd.cdc.gov/cdi
[13] CDC Risk Trends: http://apps.nccd.cdc.gov/BRFSS-SMART
[14] Behavioral Risk Factor Surveillance System (CDC- updates annually from survey): http://www.cdc.gov/BRFSS/

In addition, it is important to note that certain populations tend exhibit lower rates of physical activity, as listed[15]:

- Women generally are less active than men at all ages.
- People with lower incomes and less education are typically not as physically active as those with higher incomes and education.
- African Americans and Latinos are generally less physically active than whites.
- People with disabilities are less physically active than people without disabilities.
- Older adults: by age 75, one in three men and one in two women engage in *no* regular physical activity.

Healthy Eating

A diet high in fruits and vegetables is also associated with decreased risk for chronic diseases[16]. In addition, because fruits and vegetables have low energy density, eating them as part of a reduced-calorie diet can be beneficial for weight management[17]. According to Healthy People 2010, "overweight and obesity are major contributors to many preventable causes of death". Unfortunately, over the past 20 years obesity rates across geographic regions and populations have steadily climbed. Therefore, in order to help people live longer, healthier lives it is apparent that UWMC must focus its efforts carefully to prevent chronic disease.

1.3 Access to health services

The health of individuals and communities depends greatly on access to quality health services. Therefore, UWMC recognizes that expanding access to integrated or comprehensive—physical, mental, and social—health services is important to help people live longer, healthier lives. Health services include not only those services received through health and human service providers, but also health information and services received through other resources in the community. According to Healthy People 2010, "strong predictors of access to health services include having health insurance, a higher income level, and a regular primary care provider or other source of ongoing health care".

Integrated Health Services[18]

UWMC is committed to providing support for quality direct service programs in the community, but is also interested in seizing opportunities for the integration of mental, physical, and social health services to improve health outcomes. Practically speaking, it is most common to see serious mental illness and substance abuse problems that co-occur along with medical illnesses like heart disease, cancer and diabetes[19]. Furthermore, research suggests that those with serious behavioral health conditions experience earlier death as a result of those undertreated medical conditions[20].

According to the Substance Abuse and Mental Health Services Administration (SAMHSA)[17], there are many occasions for integration and improvement in health service delivery: "integration between primary care and mental health/substance use services; primary and specialty care for persons with

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[15] Source: Healthy people 2010

[16] US Department of Health and Human Services, US Department of Agriculture. Dietary guidelines for Americans, 2005. 6th ed. Washington, DC: US Government Printing Office; 2005. Available at http://www.health.gov/dietaryguidelines.

[17] Rolls BJ, Ello-Martin JA, Tohill BC. What can intervention studies tell us about the relationship between fruit and vegetable consumption and weight management? Nutr Rev 2004;62:1--17.

[18] Source: SAMSHA (January 2008). Compendium of Primary Care and Mental Health Integration Activities across Various Participating Federal Agencies. Taken from website on 7/30/09: http://www.samhsa.gov/Matrix/MHST/Compendium_Mental%20Health.pdf

[19] Institute of Medicine (2005).

[20] Surgeon General's Report (1999)

mental illnesses; integration with specialized services for children, seniors, and other sub-populations such as veterans; integration with schools, churches, community centers or other sites where individuals receive services on a regular basis; and integration with providers of transportation and other basic needs."

Barriers to Access

People face many different kinds of barriers to accessing comprehensive and integrated health services[21]:

- Financial: not having health insurance, not having enough health insurance to cover needed services, or not having the financial capacity to cover services outside insurance plan
- Structural: lack of primary care providers, medical specialists, or other health professionals to meet special needs; transportation, or the lack of health care facilities
- Personal: cultural or spiritual differences, language barriers, not knowing what to do or when to seek care, or concerns about confidentiality or discrimination.

Health Insurance

Health insurance obviously helps to provide access to health services. However, in 2006, 14 percent of all people in Illinois lacked health insurance[22]. According to the Healthy People 2010 plan:

- At least 44 million persons (15%) in the US do not have health insurance, including 11 million uninsured children.
- Over the past decade, the percentage of uninsured nationally has remained at 15%
- 1/3 of adults under age 65 years with incomes below the poverty level are uninsured.
- 1/3 of Latinos are without coverage, with Mexican-Americans at 40%

Primary or Usual Sources of Care

A comprehensive, high-quality continuum of care depends upon long-term relationships between people and the professionals who provide entre into the health system. According to an annual Department of Health and Human Services survey[23], many Americans lack this kind of primary care relationship, as illustrated by the statistics below:

- 19% of people have a primary source of care, but this varies greatly by income group, race, ethnicity, insurance, and education levels.
- Certain groups are more likely to lack a primary care provider than the general population:
  - Ages 18-44 (33%)
  - Uninsured (52%)
  - Latinos (34%)
  - Asians (34%)
  - Individuals with less than a high school education (29%)
  - Poor: people living in poverty (24%)
  - Low-income: people with incomes between 100-200% of the FPL (25%)
- Certain subgroups are even more likely to lack a primary care provider:
  - Uninsured: Asians (75%), poor (60%), Latinos (64%), low-income (45%)
  - Latinos: uninsured (64%), ages 18-44 (51%), less than a h.s. education (48%), males (41%)
  - Asians: low-income and poor (54-56%)

[21] Healthy People 2010.
[22] Source: Centers for Disease Control: http://www.cdc.gov/nchs/data/hus/hus08.pdf#151
[23] Medical Expenditure Panel Survey taken from U.S. DHHS website on 8/24/09 at 5pm: http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=1&subcomponent=0&year=-1&tableSeries=6&searchText=&searchMethod=1&Action=Search

1.4 Health disparities

The diversity of the Chicago Metropolitan region is one of its greatest assets, but it also represents an array of challenges in the area of Health and Wellness, which must be addressed by individuals, communities, and the society as a whole. Of particular concern are the health disparities—differences in disease, health outcomes, and access to care—that exist among certain segments of the population. These disparities have been well documented[24], and occur by income, race, ethnicity, disability, geographic location, gender, age and/or sexual orientation, such as the following[25]:

- Poverty is associated with risk factors for chronic health conditions
- Lower-income adults report multiple serious health conditions more often than those with higher incomes.
- Premature death rates from cardiovascular disease (i.e., between the ages of 5 and 64) are substantially higher in minority zip codes than in non-minority zip codes.
- Education correlates strongly with health. Adults with less than a high school education are four times as likely to report poor or fair health (vs. good) than college graduates.

Moreover, the differences in access and quality of care for lower-income people are also very clear[26].

- 40% more likely to receive lower quality care
- 250% more likely to have worse access
- 67% more likely to lack a primary care provider
- 600% more likely to lack health insurance

UWMC recognizes that multidisciplinary approaches are essential to effectively address health disparities, and endorses the Healthy People 2010 statement that "the greatest opportunities for reducing health disparities are in empowering individuals to make informed health care decisions and in promoting community-wide safety, education, and access to health care". Furthermore, UWMC aims to reduce health disparities by supporting programs that serve those populations that are at the greatest risk for poor health (see section 3.2 for summary of priority population).

[24] Healthy People 2010 website on 7/29/09 at 5:00pm.
http://www.healthypeople.gov/data/midcourse/html/execsummary/Goal2.htm
[25] Institute of Medicine Roundtable (May 2009). A Time of Opportunity; Local Solutions to Reduce Inequities in Health & Safety (p. 35). Taken from website on 7/29/09 at 6:00pm:
http://www.iom.edu/CMS/3793/44963/67179/67181.aspx
[26] DHHS Agency for Healthcare Research & Quality 2005 & 2007 National Healthcare Disparities Reports.

SECTION 2. OUR NEW APPROACH IN HEALTH AND WELLNESS

2.1 Community Impact Planning Process

During 2009, UWMC conducted a community impact planning process to identify the best possible solutions to create community impact in Health and Wellness around the Chicago Metropolitan Region, utilizing the following key processes and discoveries:

- Identification of those *most at risk* of poor health
- Recognition that UWMC must *focus its resources* for impact
- Engagement of local health, and crisis *experts* for impact planning process
- Reaching out for community and agency *input*
- Review of research for most *effective strategies*
- Exploration of strategic opportunities to *leverage* the most resources for impact
- Development of framework that will deliver positive and *measurable community change*

The community impact planning process yielded an investment framework for Health & Wellness that includes multi-level strategies—program funding, community-based initiatives, and public policy work—to move the needle in health for those at most risk of poor health outcomes. Specifically, UWMC will invest in three critical impact areas, with more detail provided below:

- **Response:** Meet safety and essential needs
- **Access:** Connect underserved communities and populations with health services
- **Prevention:** Reduce the risk of chronic disease

Note: See Section 6 for information about promising practices by impact area.

2.2 Response: Meet safety and essential needs

What is it?

Response activities will meet safety & essential needs by reducing exposure to crisis and violence; providing adequate food and shelter; planning for community safety; linking to on-going supports; educating the public; and advocating for changes that address the underlying causes of crisis and instability—poverty, inequality, violence, etc. UWMC will support programs, services, and policies that actively work not only to meet essential needs, but also to identify and connect individuals and families to on-going support systems in the community. These linkages may take different forms depending upon the individual, but all will have the goal of addressing barriers to short- & long-term stability.

Why is it important?

Safety, adequate housing, and nutritious food provide a foundation for basic community and personal well-being. People and communities have to meet these needs before they can focus effectively on addressing other health needs. In addition to the obvious personal challenges, serious displacement and disruption from crisis affect an individual's ability to function, as demonstrated by these statistics on domestic abuse[27]:

- Lost productivity and earnings from domestic abuse account for $1.8 billion each year
- Survivors of domestic abuse lose nearly 8.0 million days of paid work each year, which is the equivalent of 32,000 full-time jobs
- 78% of human resource directors identify domestic abuse as a substantial problem
- 60% of senior executives said that domestic abuse has a harmful effect on their company's productivity

[27] Source: American Institute on Domestic Violence Workplace stats taken from website on 8/4/09 at 7pm: http://www.aidv-usa.com/statistics.htm

2.3 Access: Connect underserved communities and populations with health services

What is it?

Access activities will connect underserved populations and communities to integrated or comprehensive health services by addressing barriers; linking to comprehensive care; integrating mental, physical, and social health services; reaching out to underserved communities and populations; and encouraging community-level activities to increase the integration and quality of health services. Specifically, UWMC will continue to fund a variety of critical direct services in health around the region, but will emphasize coordination and linkage to care *within* those programs for impact. Specifically, we would support those programs that work to maximize the availability and quality of services in two ways:

- Connect people to primary care providers/medical homes: involves *at a minimum* accessibility, long-term person-focused care, comprehensive care, and coordination for specialty care.
- Increase the integration of different kinds of health services: improvements around the coordination and the delivery of health services to maximize resources, enhance care, increase participant satisfaction, and ensure cost-effectiveness.

Why is it important?

The World Health Organization and Healthy People 2010 both present a great deal of evidence to support the positive **benefits of primary care**, as listed below. Accumulated over the past 20 years, this evidence demonstrates *measurable* differences in relief from suffering, prevention of illness and death, and improved health equity, and these results hold true within and across countries[28].

- More likely to identify common life-threatening conditions
- Reduces severity of illness, as demonstrated by fewer & shorter hospitalizations
- Participants are more likely to receive a variety of preventive services
- Lower overall health costs for similar health outcomes
- Greater patient satisfaction/ ranking of quality

Specifically, with regard to lower costs, research also shows that care provided in emergency departments for non-urgent conditions *costs 2-3 times* that for the same care in other settings, such as through a primary care provider. In 1993, the nationwide estimate of excess charges was $5-$7 billion[29].

Research also reveals that the **integration of services** saves money and has a multitude of positive health benefits[18]:

- Improved access to high quality health services
- Increased participant and provider satisfaction and improved compliance
- Cost effectiveness and cost savings
- Improved patient Health and Well-being
- Enhanced service outcomes for persons with or at risk of mental illness

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[28] Sources: World Health Report 2008 Primary Health Care taken from WHO website on 4/10/09: http://www.who.int/whr/2008/en/index.html
HP 2010 Access Section: http://www.healthypeople.gov/Document/HTML/Volume1/01Access.htm
Starfield, B. ; Shi, L. (2004). "The Medical Home, Access to Care, and Insurance: A Review of the Evidence". Taken from American Journal of Pediatrics website on 8/24/09 at 4pm: http://www.pediatrics.org/cgi/content/full/113/5/S1/1493

[29] Baker, L. & Schuurman-Baker, L: Excess Cost Of Emergency Department Visits For Nonurgent Care by Laurence C. Baker and Linda Schuurman Baker. Taken from Health Affairs website on 6.15.09: http://content.healthaffairs.org/cgi/reprint/13/5/162.pdf

- Increased ability to maintain mental wellness and prevent the occurrence of mental distress or the exacerbation of existing mental illnesses

2.4 Prevention: Reduce risk of chronic disease

What is it?

UWMC aims to use primary prevention strategies to reduce the first occurrence of specific chronic diseases—heart disease, stroke, diabetes, and cancer—thereby reducing the overall burden of disease to the individual and community. Prevention activities will use the most effective strategies available to reduce the risk of chronic disease by increasing healthy eating and physical activity; integrating primary prevention into other community-based services; providing education in the workplace and community; and creating community-level change to improve the health environment.

While substance abuse, mental illness, especially depression, and HIV/AIDS are all important and, often, chronic illnesses, United Way is focusing in this case on those physical diseases which research shows are most preventable and most likely to increase long term health outcomes *for our target population*.

Why is it important?

People living at or near poverty experience worse health outcomes and are more likely to die prematurely[30]. By focusing on the key underlying factors—in this case nutrition and physical activity—communities can help prevent a variety of chronic diseases. Identifying and responding to the actual causes of death and their underlying factors provides an undeniable opportunity for action that saves lives and money:

- Prevention saves lives:
  - According to the World Health Organization, "interventions to remove major risk factors of disease are often neglected, even when they are particularly cost effective: they have the potential to decrease premature death by 47% and increase life expectancy by 9.3 years"[31].
  - 80% of premature heart disease, stroke, and diabetes can be prevented[32]
  - Higher body weights are associated with higher death rates[33]
- Prevention saves money:
  - An investment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion in annual health care costs within five years[34]
  - There is a substantial return-on-investment in prevention—For every $1 invested in community-based prevention, the return amounts to $5.60[25]
  - In 2000, the total cost of obesity in the United States was estimated to be $117 billion—$61 billion for direct medical costs and $56 billion for indirect costs[35].
  - If 10% of adults began a regular walking program, $5.6 billion in heart disease costs could be saved[37].
  - A sustained 10% weight loss will reduce an overweight person's lifetime medical costs by $2,200–$5,300 by lowering costs associated with hypertension, type 2 diabetes, heart disease, stroke, and high cholesterol[37].

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[30] Pamuk E, Makuc D, Heck K, Reuben C, Lochner K. Health United States, 1998: With Socioeconomic Status and Health Chartbook.. Hyattsville, MD: National Center for Health Statistics; 1998.

[31] World health survey: internal calculations. Geneva, World Health Organization, 2008 (unpublished).

[32] World Health Organization report: Preventing Chronic Disease- a vital investment, taken from WHO website on 7/31/09: http://www.who.int/chp/chronic_disease_report/contents/part1.pdf

[33] Source: Healthy People 2010.

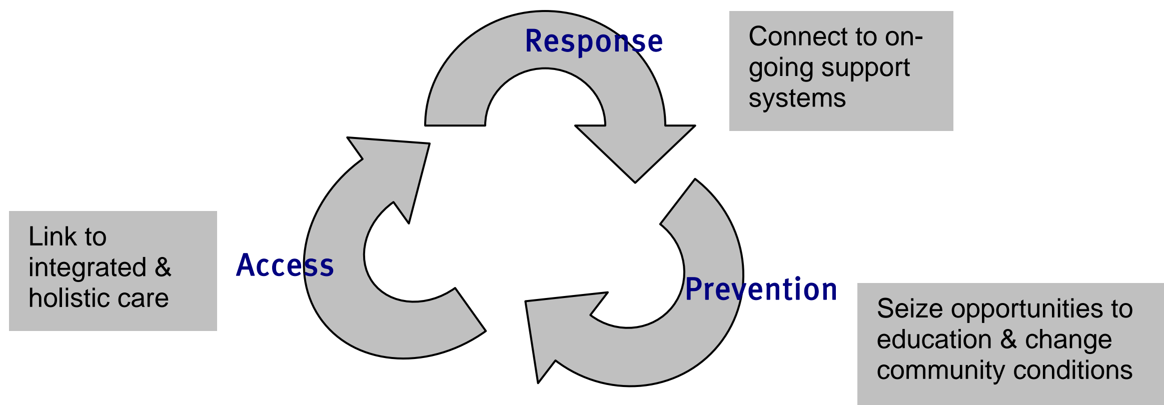
[34] Source: Taken from Prevention Institute websites on 8/4/09 at 7pm: http://preventioninstitute.org/documents/preventionforahealthieramerica_7_08.pdf &

[35] Source: Center for Disease Control website on 9/2/09: http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/obesity.htm

SECTION 3. REGIONAL MEASUREMENT FRAMEWORK

3.1 Overall Intended impact

United Way will improve the Health and Wellness of people and communities by addressing basic needs, targeting prevention and linking individuals to health services. This impact will be achieved through multi-level strategies in program funding, community-based initiative development, and public awareness/policy advocacy. In the UW Health and Wellness model shown below, individuals and communities may be assisted at any point on a continuum of interventions, from services that respond to crisis (Response) and those that link and provide health services (Access), to efforts that avert poor health (Prevention).



3.2 Priority beneficiaries

The UWMC Health and Wellness issue area will prioritize programs that serve those populations with the greatest risk of poor health outcomes and health disparities. Specifically, resources will be directed to activities that address the needs of individuals and families with household income below 200% of the federal poverty line[36] , and who also exhibit one or more of the following characteristics:

- Uninsured or underinsured
- Cultural or language differences
- Disability
- Lower educational level
- Lack of primary care provider/usual source of care
- With/at risk for mental illness or chemical dependency
- Access barriers: isolation, transportation, communication, etc.

3.3 Program Outcomes[37]

United Way has determined that it can best impact the Health and Wellness of people and families by focusing its resources to achieve certain key outcomes, as summarized below. Note: Each program, initiative and policy position in Health and Wellness that is sponsored by UWMC will be selected for its ability to deliver on the UWMC outcomes in one or more of the three impact areas—Access, Prevention, and Response. Demonstration of community-level impact (above and beyond program services) will be required for all programs funded. (Please see Attachment A for more information).

[36] In 2009, 200% of the Federal poverty level: 1- #21,660, 2-$29,140, 3-$36,620, 4-$44,100.
[37] See UWMC Health & Wellness Measurement Framework for more detail about measurement expectations, indicators, definitions, etc.

Impact Area: Access

- **Goal:** Connect underserved communities and populations with health services
- **Individual-level Outcomes:** Funded programs must address at least one of the following individual outcomes.
  - **Outcome: Overcome or eliminate access barriers**[38]
    Indicator #1: # people decreasing barriers to care
    Indicator #2: # people acquiring health insurance
  - **Outcome: Connect to and receive necessary care**
    Indicator #1: # people with usual source of care
    Indicator #2: # people connected to primary care provider
    Indicator #3: # people utilizing coordinated care
    Indicator #4: # people using integrated health services
- **Community-level Outcome:** This outcome is required for all funded programs.
  - **Outcome: Improve integration of health services**
    Criteria: Engage in community initiatives
    Indicators TBD: Programs will define their own indicators to measure innovations in one or more or more of the following areas:
    - identifying & filling gaps in services
    - increasing system capacity
    - changing public policy
    - developing effective new practices
    - increasing awareness of issues
    - changes in community conditions

Impact Area: Prevention

- **Goal:** Reduce risk of chronic disease
- **Individual-level Outcomes:** Funded programs must address at least one of the following individual outcomes.
  - **Outcome: Increase physical activity**
    Indicator #1: # of increased adults getting recommended physical activity[39]
    Indicator #2: # of increased youth getting recommended physical activity[32]
    Indicator #3: # of people decreasing their Body Mass Index (BMI)
  - **Outcome: Improve healthy eating habits**
    Indicator #1: # of adults increasing recommended fruit & vegetable intake
    Indicator #2: # of youth increasing recommended fruit & vegetable intake
    Indicator #3: # of people decreasing their Body Mass Index (BMI)
- **Community-level Outcome:** This outcome is required for all funded programs.
  - **Outcome: Improve overall health environment**
    Criteria: Engage in community initiatives
    Indicators TBD: Programs will define their own indicators to measure innovations in one or more or more of the following areas:
    - identifying & filling gaps in services
    - increasing system capacity
    - changing public policy

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[38] Summary of barriers to health services listed in Section 1.3.
[39] Using CDC Behavioral Risk Factor Surveillance System Chronic Disease Indicators, which can be found here: http://apps.nccd.cdc.gov/cdi Note: The UWMC youth indicator will include children under 18, which differs fro m the CDC indicator. These indicators are based on the CDC dietary and physical activity guidelines.

- developing effective new practices
- increasing awareness of issues
- changes in community conditions

Impact Area: Response

- **Goal:** Meet safety and essential needs
- **Individual-level Outcomes:** Funded programs must address at least one of the following individual outcomes.
  - **Outcome: Resolve immediate crisis**
    Indicator #1: # people meeting balanced food need
    Indicator #2: # people provided with emergency housing or financial assistance
    Indicator #3: # people made safe from abuse
  - **Outcome: Achieve and maintain stability**
    Indicator #1: # people receiving ongoing support services
- **Community-level Outcome:** This outcome is required for all funded programs.
  - **Outcome: Create safe environments**
    Criteria: Engage in community initiatives
    Indicators TBD: Programs will define their own indicators to measure innovations in one or more or more of the following areas:
    - identifying & filling gaps in services
    - increasing system capacity
    - changing public policy
    - developing effective new practices
    - increasing awareness of issues
    - changes in community conditions

SECTION 4. A FOCUS ON LOCAL NEEDS

The United Way of Metropolitan Chicago (UWMC) service area covers the City of Chicago, Suburban Cook County, DuPage County, and portions of Lake, McHenry, Kane, and Will Counties. While the Health & Wellness regional community impact plan identifies the overall outcomes and investment priorities of the whole region, it is very important for UWMC to maintain a local presence and understanding of the particular needs of areas within that larger footprint. Therefore, each of the local Member United Ways—Chicago/Leyden-Proviso, DuPage, Oak Park, North Shore, North Suburban, Northwest, South-Southwest, West Suburban—have identified local priority needs to help guide decision-making within the broader, regional framework.

4.1 City of Chicago

General Program Funding Caps: In Chicago, no single program will receive more than $300,000 (developed using 5% of estimated available HW Chicago funding, based on FY10 campaign resources). Likewise, no single agency will receive more than $500,000 (developed using 8% of total available HW Chicago funding, based on FY10campaign resources.

4.2 DuPage Area

Maximum request/award per program: $250,000

Local Needs	Description
1. vulnerable populations	DuPage Federation on Human Services Reform ' Important Facts About Poverty in DuPage County,' 2008 lists **minority** and **elderly** populations as groups for whom the need for services will continue to increase.
2. populations facing several types of illness (such as mental illness and substance abuse), especially those at 'moderately ill' level	Reports show that these populations are underserved due to fragmentation and lack of resources (IPLAN 2010, Mental Health Conditions, p. 8; DuPage Federation, Mental Health Profile, esp. pgs 15-16).
3. population over 65	Those 85 and over have risen at double the rate of the total population since 1990 (US Census) and the over 65 population is most at risk for heart disease and cancer, the two main causes of death in DuPage County (DuPage IPLAN 2010, Community Health Assessment). We are interested in programs connecting seniors with physical, mental and/or social care, whether they are senior-specific or integrate the senior population with other age groups.
4. outreach to underserved areas	Programs should make efforts to be easily accessible in underserved areas by having a network of locations available, providing transportation, working with schools, etc. (informed in part by map of public transit routes compared to location of lower income areas by DuPage Federation-Who are the New Neighbors, p.28).

4.3 Leyden-Proviso Service Area

General Program Funding Caps: In Leyden-Proviso, no single program will receive more than $23,430 (developed using 10% of estimated available HW Leyden-Proviso funding, based on FY10 campaign resources). Likewise, no single agency will receive more than $46,860 (developed using 20% of total available HW Leyden-Proviso funding, based on FY10campaign resources.

United Way

4.4 North Shore

Maximum request/award per program: $40,000
Maximum request/award per agency: $90,000

Local Needs	Description
1. access is lacking	To target outcomes towards areas where United Way of the North Shore can make the most difference, we will invest just over half of available funding in Access, a third in Response, and seed outcomes in Prevention.
2. marginalized and under-resourced groups	UWNS will give equal consideration to all programs applying, understanding that there are different health and wellness needs to be addressed for all populations. However, in order to achieve the greatest overall impact, we will give preference to those programs working with medically underserved communities in the region (using demographics of the population living below 200% federal poverty level and www.raconline.org/maps/.
3. transportation, fee assistance, and child care for clients	We will prioritize programs demonstrating flexibility in response to the needs of their target population, working with others to provide more holistic care, and providing integrated services. In particular, programs who assist with transportation, fees, and childcare so that their clients may receive necessary services will be more competitive in our process.

4.5 North Suburban

Funding Caps: none

Local Needs	Description
1. vulnerable populations	We will favor programs that offer comprehensive **mental health** services integrated with family counseling where appropriate. Our community forums have found that the availability of such services is lacking for clients who are low-income, from diverse ethnic groups, or living in dysfunctional family environments. Additionally, these forums found that **seniors** often face impersonal, disjointed, and/or limited access to services, and that their caregivers suffer from an inability to access the programs and services that they need. Therefore we will seek programs that offer multi-disciplinary strategies to help seniors and their families or care givers gain access to services. Finally, we will look favorably on programs that connect physical wellness with social and mental wellness for populations living with **developmental disabilities**, with a special emphasis on improving quality of life.
2. domestic violence	Our forums also identified domestic violence as a special concern because of the multiple barriers survivors face in accessing help—therefore we will prioritize programs combining programs or services with other agencies to offer more comprehensive help (legal assistance, medical help, and counseling, for example).

4.6 Northwest Suburban

Maximum request/award per program: approximately $60,000 or 5% of available $
Maximum request/award per agency: approximately $130,000 or 10% of available $

Local Needs	Description
1. vulnerable populations	We convened an expert panel meeting and conducted one on one interviews in August of 2009. The findings from these sessions led us to believe that **mental health** is a priority concern for the Northwest suburbs, in particular building the capacity of agencies serving these needs to take new clients. (Northwest Community Hospital, Access Health Clinic). Studies also show that many people suffer from more than one mental disorder at a given time. In particular, depressive illnesses and tend to co-occur with substance abuse and anxiety disorders. (http://www.rush.edu/rumc/page-1098987326575.html) US Census figures show that 11.7% of population in Northwest Suburbs is over 65. Additionally, the needs of the **senior population** are unique including multi-generational homes, more active and tech-savvy 'new seniors,' chronic disease prevention needs, etc. (The Maturing of Illinois: Getting Communities on Track for Aging Population)
2. language barriers	Estimates are that over 100 languages and dialects are spoken in our area, in many cases within one community. 27.9% of population over the age of 5, speaks a language other than English at home according to 2000 US Census. North Shore University HealthSystem spends $830,872 on translation services at 4 hospitals. Therefore we are looking for programs who use innovative strategies to address this need through partnerships, translation services, and other means of overcoming language barriers. (Northwest Suburban United Way Community Assessment)
3. transportation barriers	Particularly in the northwest and far northwest part of the service area, public transportation is scarce, and so programs will need to demonstrate that they can provide transportation for clients, meet the client where they reside or work, or, alternatively, provide a 'one stop shop.' (Pace (http://www.pacebus.com/ default.asp); Human Care Council Northwest Suburban Transportation Consortium Survey)
4. domestic violence	In this region, it is difficult to find services that are accepting new clients or with waiting lists shorter than 2-3 months. 20,000 cases of Family Abuse are estimated to occur in the Third Municipal Court District of Chicago's Northwest Suburbs annually. (Rolling Meadows, Illinois Courthouse; Police Neighborhood Resource Center) Therefore we will look favorably on programs that provide services for those who are working to get out of a violent situation.

4.7 Oak Park, River Forest, Forest Park

Funding Caps: none

Local Needs	Description
1. addressing mental, physical, and emotional health	Comprehensive health services including primary care, behavioral health, oral health, and social health services will take priority in our region (Community Needs Assessment; Oak Park Health Department; Illinois State School Data).
2. innovations and collaborations	Holistic needs of the community are best met by maximizing linkages, resources, and partnerships, resulting in effective, efficient, and coordinated services. This includes rallying the community (including residents, businesses, organizations, etc) to utilize best practices and bring new ideas and collaborations to improve health services (Surgeon General's Report on Mental Health, 2000; Surgeon General's Report on Oral Health, 2002; Healthy People 2010, 2020).

4.8 South-Southwest

Maximum request/award per program: $200,000

Local Needs	Description
1. lack of health care providers	Our region lacks health providers as well as ambulatory, outpatient, specialty, and trauma services—this is a severe barrier to improved health in our region, and so Access will receive over half of available funding, with a third of funding going to Response, and the remainder going to Prevention. (Southland Coordinating Council; Crossroads Coalition; www.southcook/movesmart.org; Chicago Community Trust Report on the Chicago Region's Health and Human Services Sector, 2007)
2. fragmentation of health services	Our region suffers from fragmentation in health and human services, therefore we will prioritize organizations that collaborate, integrate services, and share information to provide more comprehensive care (Southland Coordinating Council; Crossroads Coalition; www.southcook/movesmart.org; Chicago Community Trust Report on the Chicago Region's Health and Human Services Sector, 2007) .
3. displaced populations	Our region has been disproportionately affected by the economic recession and displacement of marginalized populations from the city, resulting in the social service infrastructure experiencing escalating demand in crisis support. Therefore we will prioritize organizations providing multi-faceted crisis support, using effective community collaboration, and demonstrating diversified revenue in support of long term viability (RealtyTrac Foreclosure statistics; South Suburban Council on Homelessness Study, 2009; US Census Statistics 2007; South Cook IASA (statistics on homeless school children); 2008 Report on Illinois Poverty; Data Analysis on South Suburbs, Homelessness, & Human Services).

4.9 West Suburban

Funding Caps: none

Local Needs	Description
1. access is lacking	Our region's most urgent needs are in linkage to medical and health services through access, therefore we will direct just over half of available funding to Access, a third to Response, and the remainder to Prevention (Agency forum and stakeholder discussions).
2. vulnerable populations	**Underserved geographies** have additional barriers to care. Additionally, **undocumented residents** have access barriers. We will encourage programs that reach into communities that are underserved (demographics/geographies of the medically underserved—http://www.raconline.org/maps/)
3. transportation and language barriers	Because our area experiences special transportation and language issues, we will prioritize agencies that change models of service delivery and location in response to the needs of their population, improve collaboration among providers, and take steps to ensure that communication with clients is accurate and culturally appropriate (Chicago Metropolitan Health Care Council Agency Forum).

SECTION 5. PROGRAM FUNDING PROCESS

5.1 Guiding Principles

In order to be effective at improving Health and Wellness of people and communities, UWMC is committed to the support of programs, projects, and policies that:

- Focus on individual and community change for deep and long-lasting results
- Link people to on-going support services to build effective community networks
- Facilitate access to comprehensive or integrated health services—mental, physical, and social—for more effective and efficient service delivery
- Encourage outreach and collaboration across sectors for maximum impact
- Acknowledge and leverage cultural strengths

Note: UW will concentrate its program funding on programs and projects that impact the Health and wellness of the community, and will use internal resources and relationships to address policy change.

4.2 FY11-13 Health & Wellness Funding Timeline

It is the intent of United Way to provide multi-year Health and Wellness grants for FY11, FY12, and FY13, subject to agencies' delivery on outcomes, timely reporting, and the availability of funding. The selection process for FY11-13 program funding will follow the timeline (subject to change) provided below with a July 1, 2010 start date on grant agreements:

- October 5, 2009: Request for Information (RFI) released
- October 5-9, 2009: Agency RFI workshops
- October 23, 2009: RFI due
- December 7, 2009: notification to programs who submitted RFIs and will pass on to application stage, notification to programs who submitted RFIs and will not pass on to application stage
- December 7, 2009: Application released to selected programs
- January 15, 2010: Application due
- April, 2010: Program funding decision-making
- May, 2010: Award letters sent

4.3 Directional Funding Targets

It is UWMC's intent to fund three impact areas in Health & Wellness—Response, Access, and Prevention—and the *estimated* directional funding targets by impact area are included below. Though UWMC will work to balance the investment across impact areas according to these funding targets, there may be some variation in the final grant allocations, due to applications received, campaign results, local priorities, etc. However, this breakdown may be used by agencies to understand the relative regional funding available by impact area. Note: The dollar figures below are estimates based on FY10 program funding, and may go up or down based on the current year fundraising campaign and board direction. Also, since these are targeted percentages to represent the *region as a whole*, funding by impact area will vary by Member United Way.

	Response	Access	Prevention	Total
Estimated Funding Available	$3.86M	$6.44M	$2.15M	$12.45M
% Target	31%	52%	17%	100%
Note: Response category does not include $2.4M allocated to the Red Cross for disaster preparedness. When included, the response category is $6.27M and the total available is $14.86M.				

4.4 Program Funding Evaluation Criteria

In assessing the relative merits of various requests for support, United Way will place a heavy emphasis on the following criteria:

- **Alignment:** Can the program deliver on UWMC's overall goal in Health and Wellness—to increase the number of people living healthier, longer lives?
- **Priority Population:** Does the program directly address the needs of the population identified by UWMC?
- **Performance Measurement:** Can the program collect and report on all required outcomes for its participants?
- **Collaboration/integration/linkage of services:** Does the program or initiative involve collaboration, integrated service delivery, and/or the linkage to services?
- **Effectiveness/Efficiency:** Is the project likely to produce a definite and desired effect? Is the project likely to produce the desired effect with a minimum of expense or waste?
- **Community-level change:** Does the project not only treat the symptoms of a given condition, but also begin to address the underlying factors that give rise to that condition?
- **Evidence-Based:** Is the project's approach validated by documented research or by reference to other demonstrable "promising practices"?
- **Sustainability:** Is there a reasonable likelihood that the project will continue once United Way funding has ended?
- **Leverage:** Does the project demonstrate an ability to secure additional funds and other resources sufficient to achieve a true community impact?

4.5 Funding Limits

Due to the current funding climate, all general program funding decisions in Health and Wellness around the region will be subject to the following limits and restrictions:

- **UWMC basic requirements:** all agencies must meet basic requirements for funding, as detailed in the UWMC Agency Manual found here: http://www.uw-mc.org/agency-resources/program-funding
- **Grant floor:** The minimum grant request and funding amount will be $10,000 per Member United Way per program.
- **Grant as % of program budget:** Grant requests and UWMC HW funding may not exceed 40% of the total program budget.
- **Grant ceilings:** See Section 4 of this plan for information on funding ceilings by Member United Way.
- **Grant applications by agency:** No agency may submit more than 3 applications/programs per agency per Member United Way.

4.6 Reporting Expectations

All programs selected for funding in Health and Wellness will be required to measure the performance[40] of those programs and report the results using the UWMC online application and reporting system. Reporting will involve a projection of expected results, data entry, year-end reporting on outcomes, participant demographics, and efforts to ensure culturally competent service delivery. Note: Sustained funding for selected programs will be contingent upon timely and complete reporting.

[40] Note: The United Way of America Outcome Measurement Resource Network provides more information about performance measurement and reporting on their website: http://www.liveunited.org/outcomes.

More specifically, all programs receiving funding must:

- **Deliver on outcomes:** Though programs will not necessarily be *required* to report on all outcomes within an impact area (See complete list in Section 3.3), those programs that deliver on all or most outcomes within the selected impact area will be most competitive in the funding process.
- **Report on entire program:** UWMC does not fund on a fee-for-service basis, but rather funds programs that deliver on identified community outcomes. Therefore, agencies must agree to report on outcomes and indicators for *all participants* of the program submitted for funding, within the United Way geography, rather than some portion of total program (i.e. $10,000 for 100 participants, $15,000 for 150, etc). Additionally, UWMC does not value applications that serve more clients over those that serve fewer clients with more barriers or in a more long term and comprehensive way. UWMC does utilize outcome data to collect comparative results across programs and use this information to facilitate peer learning and capacity-building in the sector—these efforts will only succeed with the capture of all program participants in an outcome. Note: UWMC funding is unrestricted and can be used to support any part of the program operation, including administrative or overhead costs.

SECTION 6. PROMISING PRACTICES[41]

Promising practices are defined as evidence-based information on programs, practices, tools and resources to help citizens, service providers and policymakers improve on outcomes. Below you will find examples of promising practices for program funding, community based initiatives and policy advocacy/public awareness in the Health and Wellness issue area. Note: This is not a comprehensive list, but rather provides a sampling of the promising practices encountered by UWMC during its planning process. UWMC looks forward to an on-going conversation with providers to build promising practice knowledge across the sector.

6.1 Response: Meet safety and essential needs
Crisis programs that meet immediate health and safety needs and connect to on-going supports and community networks for long-term stability.
Domestic Violence Programs that work with victims/survivors to create a safety plan. Shelter programs should provide the following services to participants: • Shelter, a safe place to sleep • Basic needs, such as access to food and clothing • Advocacy and crisis intervention services e.g. crisis counseling and or support programs; and • Case management
Utilizing Supportive Housing (as an alternative to shelters or transitional housing) for people who face the most complex challenges—individuals and families who are not only homeless, but who also have very low incomes and serious, persistent issues that may include substance use, mental illness, and HIV/AIDS. See full definition in "working definitions".
Utilizing the "Housing First" approach of providing permanent supportive housing to single, homeless adults with mental illness and co-occurring substance-related disorders[42]. See full definition in "working definitions".
Hotlines that are staffed for 24 hours e.g. crisis lines. Staff should be trained on relevant issues.

[41] **Sources for Promising Practices:**
The Guide to Community Preventive Services. Diabetes prevention and control. http://www.thecommunityguide.org/index.html on 7/29/09.
Grant makers in Health, "Effective Community Programs to Fight Health Disparities", http://www.gih.org/
Illinois Public Health Institute, http://www.iphionline.org/
Illinois Maternal Child Health Coalition, http://www.ilmaternal.org/CAIC/AboutCAIC.htm
Otha S.A Sprague Memorial Institute, http://www.spragueinstitute.org/index.html
Stanford School of Medicine, Health & Medicine Policy Research Group, http://hmprg.org/
HUD (Housing First models): http://www.huduser.org/publications/homeless/hsgfirst.html
Corporation for Supportive Housing: http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=118

6.2 Access: Connect underserved communities and populations with health services

Projects that connect people with a "medical home" – i.e. a primary care provider which combines the following characteristics: • The nexus of all routine professional medical care; • A site of care that is located near the patient's home or work and is easily accessible to the patient; • Continuity of care over time by a single provider or team of health care professionals who have knowledge of the patient's history and family and social circumstances; • A resource to the patient for health information and guidance, preventive care, and other services that allow the patient to assume optimal accountability for the management of his/her own health; • The point of entry into the broader health care delivery system; • Coordination of care between the patient and the components of the broader health care delivery system; and • the provision of basic oral health, mental health, and/or pharmacy services.
Awareness and outreach to families for All Kids & other public insurance programs. **Linking people who have no or inadequate medical insurance with existing programs** and services and to develop new community-based medical resources to fill gaps where assistance is most needed.
School based health centers used as a way to link individuals to services such as, immunization, mental, dental and other health services.
Partnership with medical provider to utilize social networks to reach disadvantaged populations in underserved communities, through local barbershops and beauty salons and other community gathering places to provide health education and basic health screenings.
Embed nurse care managers within the primary care team working in the behavioral health setting, to support individuals with significantly elevated levels of glucose, lipids, blood pressure, and/or weight/BMI.
Create wellness programs within the behavioral health setting to utilize proven methods and materials developed for engaging individuals in managing their health conditions, adapted for use in the mental health setting, with peers serving as group facilitators.
Implementing Cultural Competency among health care organizations and conducting racially and culturally relevant health outreach and screenings. This also includes gaining a deeper understanding of community members' experiences, beliefs, and values around seeking health care services.
Assure regular screening and registry tracking/outcome measurement at the time of psychiatric visits for all individuals receiving psychotropic medications—check glucose and lipid levels, as well as blood pressure and weight/BMI, record and track changes and response to treatment, and use the information to obtain and adjust treatment accordingly.
Co-Locate medical nurse practitioners/primary care physicians in behavioral health facilities—provide routine primary care services in the behavioral health setting via a nurse practitioner or physician out-stationed from the full-scope healthcare home.
Utilizing community health workers, *promotores*, or navigators that serve as "bridges" between community members and the health and wellness services they need.
Linking or integrating existing community services in ways that increase effectiveness and/or efficiency by: • Creating plans for community-wide service integration, evaluation, and/or quality improvement. • Using "natural settings" frequented by community members (e.g. schools, faith-based organizations) to reach health and wellness goals • Integrating health and wellness services with other areas of United Way focus (e.g. financial stability, youth education) in innovative ways

6.3 Prevention[43]: Reduce risk of chronic disease

Worksite programs to control overweight/obesity that include:
- Informational and educational strategies that aim to increase knowledge about a healthy diet and physical activity. Examples include: Lectures, Written materials, & Educational software; and
- Behavioral and social strategies target the thoughts (e.g. awareness, self-efficacy) and social factors that effect behavior changes. Examples include: Individual or group behavioral counseling, skill-building activities such as cue control, rewards or reinforcement, inclusion of co-workers or family members

Behavioral interventions to reduce screen time, or time spent watching TV, videotapes, or DVDs; playing video or computer games; or surfing the internet.

Community-wide campaigns to increase physical activity that include:
- Involve many community sectors
- Include highly visible, broad-based, multi-component strategies (e.g., social support, risk factor screening or health education)
- May also address other cardiovascular disease risk factors, particularly diet and smoking

Individually-adapted health behavior change programs to increase physical activity teach behavioral skills to help participants incorporate physical activity into their daily routines. The programs are tailored to each individual's specific interests, preferences, and readiness for change and teach behavioral skills such as:
- Goal-setting and self-monitoring of progress toward those goals
- Building social support for new behaviors
- Behavioral reinforcement through self-reward and positive self-talk
- Structured problem solving to maintain the behavior change
- Prevention of relapse into sedentary behavior

Changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system, making contracts with others to complete specified levels of physical activity, or setting up walking groups or other groups to provide friendship and support).

Changes in community- or street-scale urban design land use policies and practices involve the efforts of urban planners, architects, engineers, developers, and public health professionals to change the physical environment of urban areas of several square miles or more in ways that support physical activity. Design elements that address: proximity of residential areas to stores, jobs, schools, and recreation areas; continuity and connectivity of sidewalks and streets; aesthetic and safety aspects of the physical environment; policy instruments such as zoning regulations, building codes, other governmental policies, and builders' practices

Point-of-decision prompts are motivational signs placed on or near stairwells or at the base of elevators and escalators to encourage individuals to increase stair use. These signs:
- Inform people about a health or weight loss benefits from taking the stairs, and/or
- Remind people already predisposed to becoming more active, for health or other reasons, about an opportunity at hand to do so

Stanford Chronic Disease Self-Management program: Community-based, peer-led self-management programs that provide individuals with the opportunity to improve the quality of their lives. These programs encourage individuals to take charge of their health by monitoring their conditions, educating themselves about their specific conditions, knowing what management and treatment options are available to them, and partnering with their doctors in tracking the progression of their disease. They can also be used as a primary prevention strategy in healthy eating/active living.

Creation of or enhancing access to places for physical activity involves the efforts of worksites, coalitions, agencies, and communities as they attempt to change the local environment to create opportunities for physical activity. Such changes include creating walking trails, building exercise facilities, or providing access to existing nearby facilities.

Enhancing physical education (PE) curricula by making classes longer or having students be more active during class to increase the amount of time students spend doing moderate or vigorous activity in PE class.

[43] Promising practices for the prevention of chronic disease were taken from the Center for Disease Control Community Guide on 7/17/09 at 4:30pm: http://www.thecommunityguide.org/index.html#topics

SECTION 7. WORKING DEFINITIONS

Access to health services is the ability to obtain appropriate services to diagnose and address mental, physical, and social health problems and symptoms, as determined by factors such as the availability of medical services, their acceptability to the individual, the location of health care facilities, transportation, hours of operation, and cost of care.

Barriers to care are any mental, physical, or psychosocial condition that prevents an individual from accessing needed health care. Examples include attitudes or biases, mental disorders or illnesses, behavioral disorders, physical limitations, cultural or linguistic factors, sexual orientation, and financial constraints.

Body Mass Index (BMI) is a formula that uses both weight and height to estimate body fat. For most people, BMI provides a reasonable estimate of body fat. Excess body fat is related to serious health conditions. BMI calculation does not actually measure percentage of total body fat, but it is a tool used to estimate what is considered a healthy weight based on a persons height. After performing a calculation of BMI, a person may be classified as underweight, normal, overweight, or obese. The CDC provides online calculators of BMI for Adults and Youth/Children and these can be found here: www.cdc.gov/bmi

Community is a group of individuals sharing one or more characteristics such as geographic location (e.g., a neighborhood), culture, age, or a particular risk factor.

Community-based interventions are conducted within and by members of a particular community (e.g., grassroots efforts, efforts by a local civic group). Can be done in conjunction with an outside group (e.g., nonprofit organization, research group).

Chronic diseases are non-communicable illnesses that are prolonged in duration, do not resolve spontaneously, and are rarely cured completely. Examples of chronic diseases include heart disease, cancer, stroke, diabetes, and arthritis (CDC definition).

Determinants of health are causal factors hypothesized to affect health outcomes. Determinants can refer to such factors as demographic and population (host) factors; environmental factors, such as disease vectors or transmission agents (e.g., food or water); social, economic, educational, healthcare, cultural, or other systems; and preventive interventions.

Guide to Community Preventive Services (Community Guide) The body of evidence and recommendations approved by the Task Force on Community Preventive Services, including the website, www.thecommunityguide.org.

Health Disparities are differences in the incidence, prevalence, mortality, and burden of disease and other health conditions that exist among specific population groups.

Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices. Of the three, supportive environments will probably have the greatest impact in producing lasting change". *(American Journal of Health Promotion)*

Housing First is a relatively recent innovation in human service programs and social policy regarding treatment of the homeless. Rather than moving homeless individuals through different "levels" of housing, known as the Continuum of Care, whereby each level moves them closer to "independent housing" (for example: from the streets to a public shelter, and from a public shelter to a shelter run by a state agency, and from there to a transitional housing program, and from there to their own apartment in the community) Housing First moves the homeless immediately from the streets or homeless shelters into their own apartments.

Integrated services improve coordination and the delivery of health services to maximize resources, improve care, increase participant satisfaction, while ensuring the cost-effectiveness of programming. Integration may involve the whole is spectrum of health services: integration between primary care and mental health/substance use services; between primary and specialty care for persons with mental illnesses; integration with specialized

services for children, seniors, and other subpopulations such as veterans; integration with schools, churches, community centers or other sites where individuals receive services on a regular basis; and integration with providers of transportation and other basic needs.

Life expectancy is the number of additional years an individual is expected to live at a given age.

Medically Underserved Areas/Populations (MUAs), established under the U.S. Public Health Service Act, are federal designations of a geographic area (usually a county or a collection of townships or census tracts) which meet the criteria as needing additional primary health care services. Designation as a MUA is based on the availability of health professional resources within a rational service area. The definition of a rational service area is usually based on a thirty-minute travel time. Other factors considered in the designation process are the availability of primary care resources in contiguous areas and the presence of unusually high need, such as high infant mortality rate or high poverty rate. HPSA designations usually apply to geographic areas, but may apply to population groups and facilities.

Medical home consists at the least, of accessibility for first-contact care for new problems or health needs; **long-term** person-focused care; **comprehensiveness** of care in the sense that care is provided for all health needs except those that are too uncommon for the primary care practitioner to maintain competence in dealing with them; and **coordination** of care in instances in which patients do have to go elsewhere. More detail and a comprehensive set of principles that define the best case "medical home" can be found here: http://www.medicalhomeinfo.org/Joint%20Statement.pdf

Mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community "(WHO).

Mental health services are those diagnostic, therapeutic, and preventive services provided to promote mental health. These services may include psychiatric care, counseling, substance abuse services, etc.

"One-stop shop" model of services is the provision of complementary services at one site for a designated population or service area, in order to enhance the coordination, ease of access, or effectiveness of individual programs for participants.

Physical health is the overall condition of a living organism at a given time, the soundness of the body, freedom from disease or abnormality, and the condition of optimal well-being.

Physical health services are those diagnostic, therapeutic, and preventive services provided to ensure physical health. They may include primary care, dental, long-term care, specialty health services, etc.

Prevention/Preventive services are interventions (activities) that prevent disease or injury or promote health. *Primary prevention* avoids the development of a disease. Most population-based health promotion activities are primary preventive measures. *Secondary prevention* activities are aimed at early disease detection, thereby increasing opportunities for interventions to prevent progression of the disease and emergence of symptoms. *Tertiary prevention* reduces the negative impact of an already established disease by restoring function and reducing disease-related complications.

Primary care is defined as the "medical home" for a patient (see definition above), ideally providing continuity and integration of health care. All family physicians and most pediatricians and internists are in primary care. The aims of primary care are to provide the patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives.

Primary care provider (PCP) is defined as a physician chosen by an individual to serve as his/her health-care professional and capable of handling a variety of health-related problems, keeping a medical history and records on the individual, and of referring the person to specialists, as needed.

Promotores and Promotoras are community members who promote health in their own communities. They provide leadership, peer education, support, and resources to support community empowerment, or capacitación. As members of minority and underserved populations they are in a unique position to build on strengths and to address unmet health needs in their communities. Promotores(as) integrate information about

health and the health care system into the community's culture, language and value system, thus reducing many of the barriers to health services.

Social determinants of health are life enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines the length and quality of life.

Social health of individuals refers to "that dimension of an individual's well-being that concerns how he gets along with other people, how other people react to him, and how he interacts with social institutions and societal mores." This definition incorporates elements of personality and social skills, reflects social norms, and bears a close relationship to concepts such as "well-being," "adjustment," and "social functioning.” The concept of social health is less intuitively familiar than that of physical or mental health, and yet, along with physical and mental health, it forms one of the three pillars of most definitions of health (Russell 1973, p. 75).

Social health services are those supportive services that ensure well-being, adjustment, and social functioning, which can include case management, respite, social supports, crisis services, etc.

Specialty Care are those health services provided by medical specialists who generally do not have the first contact with patients, but instead are referred to them by primary care and family physicians.

Supportive housing is a combination of housing and services intended as a cost-effective way to help people live more stable, productive lives. Supportive housing works well for those who face the most complex challenges--individuals and families confronted with homelessness and who also have very low incomes and/or serious, persistent issues that may include substance abuse, addiction or alcoholism, mental illness, HIV/AIDS, or other serious challenges to a successful life. Supportive Housing can be coupled with such social services as job training, life skills training, alcohol and drug abuse programs and case management to populations in need of assistance, including the developmentally disabled, those suffering from dementia, including Alzheimer's disease and the frail elderly. Supportive housing is intended to be a successful solution that helps people recover and succeed while reducing the overall cost of care.

Usual source of care is defined as a particular doctor’s office, clinic, health center, or other place where a person usually goes if he or she is sick or needs advice about personal health matters.

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ATTACHMENT A. COMMUNITY-LEVEL IMPACT

UW talks a lot about accomplishing Community Impact. What does that mean? How does it affect your program's work, and what are the best ways to articulate impact through United Way's application process?

UWMC sees Community Impact as mobilizing the community to take action on issues relevant to community members. It's an opportunity to engage people in organized action, to create a shared vision for positive change, and to initiate innovative strategies to achieve community level change. Community Impact long-term changes address the root causes of social ills, resulting in thriving, engaged communities.

UWMC asks three questions in the application process related to community level change:

- What are the systemic barriers that this program addresses related to prevention, access, and/or response?
- What kind of community change is this program designed to initiate?
- What is this program's strategy to address these systemic barriers? How will this program accomplish this community-level change?

An example of a community problem that requires community level changes:

> Your organization holds community meetings during which it becomes clear that a landlord in the area has been neglecting the upkeep for several buildings, thereby bringing down the neighborhood and creating spaces for illegal activities to take place. You organize a group of residents to knock on doors in the neighborhood, gathering signatures to petition the landlord to fix up his properties. Alternatively, you meet with the alderman to ask for new regulations regarding landlords' responsibilities in upkeep. You march outside the landlords' apartments. You perform community education sessions to inform people about the increases in incidences of crime when buildings in a neighborhood are abandoned. You lobby the apartment rental services in the area to boycott this landlord's buildings. Any number of activities can take place around this issue to create change—but most importantly, you listened to the issue most relevant to your constituents, and you organized, motivated, educated, or lobbied to create community level change on a problem that impacts their lives.

Systemic barriers could be:

- Lack of grocery stores in your community to access fresh foods
- No safe places for families to play
- Limited transportation to and from needed services

Community level changes to address those barriers could be:

- Meet with legislators to lobby for grocery stores, create a community c-oop farmer's market, or alter vendor licensing to allow fresh fruit vendors in close proximity to public schools
- Partner with Community Policing, residents and Park districts to develop safe zones at Park Districts, negotiate gang-free routes to school, or organize a neighborhood park clean-up day
- Organize community to petition CTA for additional bus routes implemented in areas with no or limited transportation, organize carpools to areas with more jobs for residents, or work with other service providers to offer more comprehensive programming in the community

We're looking to you to be creative and innovative with your community level change work—this is an opportunity for your organization to stand out in a very competitive crowd, so please give us your best!