

UNITED WAY OF METROPOLITAN ATLANTA

REQUEST FOR PROPOSALS
COMMUNITY IMPACT FUND GRANTS
FUNDING YEAR 2011-2012

HEALTH FOCUS AREA

Deadline: Thursday, April 28, 2011 – 2:00 p.m.

In order for proposals to be considered complete and on time, the complete electronic copy (via ODM) and any required supplemental materials must be submitted by the deadline.

CONTENTS

INTRODUCTION 3

 ABOUT UNITED WAY OF METROPOLITAN ATLANTA 3

 PURPOSE OF THIS REQUEST FOR PROPOSALS 3

COMMUNITY IMPACT FUND GRANTS PROCESS 4

 ELIGIBILITY 4

 OVERVIEW OF PROCESS 4

 REVIEW PROCESS COMPONENTS 5

 COMMUNICATION OF FUNDING 7

FUNDING DIRECTION AND CORE EXPECTATIONS: STRATEGY GUIDANCE LETTERS 8

 Strategy: Primary Health 8

 Strategy: Mental Health 12

 Strategy: Home Based Support 18

 Strategy: Substance Abuse Treatment 22

 Strategy: Prevention Education 28

 Strategy: Life Skills 32

PROPOSAL TIMELINE & QUESTIONS 36

INTRODUCTION

ABOUT UNITED WAY OF METROPOLITAN ATLANTA

Our Vision: Metro Atlanta is a place where all individuals and families thrive.
 Our Mission: Engage all segments of our community to drive sustainable change in education, income, health and homelessness, while continuing to address urgent and basic human care.

In June 2009, United Way of Metropolitan Atlanta unveiled a new strategic plan aimed at addressing four broad social challenges — education, income, health and homelessness — and six specific goals over the next five years:

- Children enter school ready to learn and graduate prepared for careers;
- Young people avoid risky behaviors;
- Families are self-sufficient;
- Babies are born healthy;
- People have access to primary health care; and,
- Homeless people are housed within one year.

This plan was developed through thoughtful consideration, research and planning, and it guides our work. It is premised on the idea that these six goals are interrelated, community issues; to be successful we need to address them together as a community, not in isolation from each other. And in doing so, we can create opportunities for holistically transforming the lives of individuals and families in our metropolitan region – so that they can thrive.

PURPOSE OF THIS REQUEST FOR PROPOSALS

United Way of Metropolitan Atlanta (UWMA) seeks to improve the quality of life of our metro region by showing measurable and sustainable progress on our community goals in the Focus Areas of Education, Income, Health and Homelessness. Therefore, we are accepting funding proposals to help address and realize those goals.

This RFP details core expectations and requirements for program proposals within the Health Focus Area. The Health strategies for which UWMA is accepting proposals for 2011-2102 funding are shown below.

Goal	Network Clusters	Strategies
<p style="text-align: center;">HEALTH</p> <p style="text-align: center;">People have access to primary health care.</p>	<p style="text-align: center;">Safety Net Services</p>	<p>Primary Health</p> <p>Mental Health</p> <p>Home Based Support</p> <p>Substance Abuse Treatment</p>
	<p style="text-align: center;">Health Education</p>	<p>Prevention Education</p> <p>Life Skills</p>

COMMUNITY IMPACT FUND GRANTS PROCESS

The Community Impact Fund Grants Process is one of the ways that UWMA makes strategic investments to drive measurable, sustainable change in Education, Income, Health, and Homelessness issues in our metropolitan community.

The Community Impact Fund is composed of contributions from donors who entrust UWMA with combining their gifts with the donations of others to invest in dynamic approaches and proven programs to create lasting, positive change. The process of investing through this fund includes an informed review by hundreds of dedicated, trained volunteers who help us ensure the most positive impact possible with the dollars raised.

ELIGIBILITY

To be eligible to apply and receive funding through the Community Impact Funds Grant Process, an Agency must meet all of the following criteria:

- Be recognized as an organization exempt from federal income tax under I.R.S Section **501(c)(3)** of the Internal Revenue Code 1986.
- Be primarily involved in **providing program(s) and services that are health, education or human-service related** and directly serve the UWMA 13-county service area residents and employers. **The agency must maintain a local office with regular office hours and telephone availability.**
- **Maintain a current registration with the Georgia Secretary of State office.**
- Have an independent **governing body consisting of at least nine voting members who are resident volunteers**, that has the authority to decide policy and strategic direction with respect to the agency's programs, administration and finances, in accordance with the organization's By-Laws, and who shall meet at least four times per year. **Paid staff must not be a voting member of the Board.**
- **Maintain a non-discrimination policy or plan** that does not discriminate on the basis of race, cultural heritage, religion, gender, national origin, age, marital status, sexual orientation, veteran status or status as a qualified disabled or handicapped individual.
- **Have an annual audit (if applicable) performed by a certified public accountant that is licensed and in good standing with the state of Georgia.**
- **Demonstrate financial management** - All financial statements must show evidence of accounting principals in accordance with Generally Accepted Accounting Procedures (GAAP) and **include full disclosures and appropriate notes for such things as leases, loans, investments and affiliated party transactions.**

OVERVIEW OF PROCESS

UWMA will distribute its funds through a competitive grant process among eligible applicants. Within this process, UWMA is seeking to identify and fund the highest quality programs that address our Community Goals and related strategies, and provide measurable, impactful outcomes.

UWMA Staff will review proposals submitted to ensure that they are complete and to determine that all basic eligibility requirements have been met. **Proposals that are incomplete or late will be removed from the grant process.** Investment Volunteers will then review and evaluate remaining proposals and conduct a Program Site Visit.

During the Site Visit, the Agency will make a presentation to provide a clear program description, will be prepared to answer questions and provide any requested supporting documentation for the Regional Focus Area Investment Committee. At final deliberations, the Regional Focus Area Investment Committees determine which proposals to recommend for funding using the written information provided and information presented at the Site Visit. Two additional volunteer committees will review the funding recommendations before final approval by the United Way of Metropolitan Atlanta Board of Directors.

REVIEW PROCESS COMPONENTS

The process of reviewing and funding proposals submitted to the Community Impact Fund Grants Process has seven components:

1. Financial Review;
2. Program Proposal Compliance Review;
3. Independent Review;
4. Volunteer Proposal Review;
5. Program Site Visit;
6. Funding Deliberations and Funding Recommendations;
7. Funding Approval.

Financial Review

A review of the agency financials will be completed by the Financial Review Committee (volunteer CPAs) to ensure the Agency's financial health. The Financial Review is a critical step in our process of ensuring that donor investments are distributed to organizations equipped to use those resources to deliver human services. United Way requires applicants to submit financial statements based on their annual revenue and fiscal year.

This year's Financial Review Process will be conducted by volunteers that have financial expertise and it includes four steps as follows:

1. Relevant financial information is gathered from grantees, entered into a worksheet and financial ratios are run to evaluate the following areas: reserve funds, debt burden, and administrative cost and operating expenses.
2. Organizations are flagged if their ratios are outside of the established tolerable range. These agencies are elevated to the financial review committee for further testing and review.
3. Financial review volunteers reconvene at the end of the evaluation period to present/discuss findings that were of particular concern and discuss next steps, which could include withholding United Way funds, contingencies, follow-up requirements, etc.
4. Follow up meetings with the organization to address the concerns raised during volunteer evaluation.

Program Proposal Compliance Review

The questions listed below will be completed by UWMA Community Engagement staff in order to ensure proposal compliance. Proposals that are incomplete or late will be removed from the grant process. Staff findings will be shared with the volunteer committees.

Compliance Questions	Considerations
<ol style="list-style-type: none"> 1. Was the application submitted on time? 2. Was the program proposal complete (including all required components)? 	<p>Deadlines: All components of the application are submitted by the published deadline, April 28, 2011 at 2pm.</p> <p>Contingencies: Additionally any concerns that were identified during the last Impact Fund Process (e.g. contingencies – listed in the grant agreement) must be addressed.</p>
<ol style="list-style-type: none"> 3. Does the proposed program align with a Community Goal? (using the UWMA Proposal Evaluation Tool) 4. Does the proposed program align with a Focus Area/Goal Strategy? (using the UWMA Proposal Evaluation Tool) 5. Does the proposed program align with at least one of the prescribed Community Metrics under the strategy the program was submitted to? 	<p>Target Population: Serving the jurisdiction in which it has applied in a meaningful way; operating at or near full capacity.</p> <p>Alignment: All proposals submitted in response to this RFP must achieve measurable impact in Health outcomes in our community. For a proposal to be considered for funding, it must align with at least one of the strategies, outcomes and metrics outlined in this RFP.</p>

Independent Review

Once the Compliance Review has been completed, proposals will be reviewed by an independent Review Panel comprised of volunteers with solid expertise and a professional background in a given Focus Area. This Committee will use the UWMA Proposal Evaluation Tool to give feedback to the appropriate Regional Focus Area Investment Committee.

Volunteer Proposal Review

In addition to the independent review, all program proposals will be evaluated by the applicable Regional Focus Area Investment Committee. These Committees have representation from all thirteen counties within the UWMA service area.

The Regional Focus Area Investment Committee members will individually evaluate and score each proposal provided for their review using the related Strategy Guidance Letter and UWMA Proposal Evaluation Tool. These scores are then shared with other members of that Investment Committee at the Site Visit, along with any questions and comments.

Program Site Visit

Agency staff will be contacted by UWMA staff via email and/or phone regarding the date, time and location of the visit. During the Site Visit, the Agency will make a presentation to provide a clear program description, will be prepared to answer questions and provide any requested supporting documentation for the Regional Focus Area Investment Committee. The agency will be notified 3 – 5 business days prior to the site visit if additional supportive documentation is required.

Agency board members are welcome at the Site Visit but are not required to be present or part of the presentation. It is recommended and highly encouraged that the following Agency staff be present to help answer any questions the panel volunteers may have: President, Program Staff, and Finance Staff.

A minimum of two volunteers must be in attendance to conduct a Site Visit. If only one volunteer is present, the UWMA staff member will contact the other volunteers and wait 15 minutes before canceling the visit.

Funding Deliberations and Recommendations

The Regional Focus Area Investment Committee will discuss each proposal and evaluate them taking into consideration both the written proposal and the program presentation at the Site Visit. A score and recommended grant amount are determined.

Once all Site Visits have been completed for a given Focus Area, Regional Focus Area Investment Committees will convene for final funding deliberations. Together, they discuss all proposals and make funding recommendations.

Funding Approval – Volunteer Leadership Reviews

The recommendations of the Regional Focus Area Investment Committees will be reviewed and ratified by the UWMA Community Investment Committee (CIC) and Community Engagement Council, and then approved by the UWMA Board of Directors.

COMMUNICATION OF FUNDING

Upon final approval by the UWMA Board, each Agency will be emailed the amount of their UWMA grant funding as well as any Specific Care amounts. This communication does not require a response from the Agency.

CHANGES IN REPORTED INFORMATION

If reported information changes during the Community Impact Grants Process (after submission of the application but before funding has been awarded), the Agency must submit written (preferably via email) notification to UWMA immediately after the Agency becomes aware of the change: what the change has been, why the change was made, and what are the effects of the change on the program/proposal.

If reported information changes after the proposal has been funded (after the grant has been awarded and Agency has started to receive funding), the Agency must submit notification to UWMA within 30 days after the Agency becomes aware of the change: what the change has been, why the change was made, and what are the effects of the change on the program.

FUNDING DIRECTION AND CORE EXPECTATIONS: STRATEGY GUIDANCE LETTERS

FY11-12 Strategy Guidance Letter

Impact Area: Health: People have access to primary health care

Strategy: Primary Health

Cluster: Safety Net

Impact Area Outcome: *Reduce the number of preventable Emergency Room visits by 84,000 visits*

Context: Good health begins with access to primary health care services. Primary Health Access is dependent on many factors including: access to a medical home in your community, transportation, language, and access to low cost providers and ancillary services. These barriers present complex challenges for the uninsured and underinsured. Often when barriers present themselves, individuals find themselves at the emergency department which is the most expensive way to receive primary care. Investing in primary health care needs of our children and neighbors is critical in building a thriving community.

Strategy Description: The Primary Health strategy will focus on implementing activities and programs that strengthen an individual’s ability to access and utilize a medical home. The primary health strategy will work to expand services to health professional shortage areas, reduce barriers that prevent individuals from accessing care, invest in established facilities to increase their capacity to serve as a medical home, and provide critical health services to the uninsured and underinsured.

A. Target Populations

All programs that receive funding must serve at least one of the following populations at a meaningful level¹:

1. Low-income individuals and families
2. Uninsured or Underinsured
3. Pregnant women
4. Communities designated as health professional shortage areas (information available in the Health Disparities Report, Department of Community Health, 2008)

B. Required Program Components

All programs that receive funding must demonstrate the following key components of effective programming that relate to the selected service priority:

Required Program Components – policies, practices and /or activities that:	Examples
Demonstrated implementation of a consumer driven agency program philosophy that maximizes client participation and involvement in service, planning, delivery, and quality assurance. Program must be central to the organization’s mission.	<ul style="list-style-type: none"> • The organization has a guiding program philosophy, and it is appropriate for the target population. • Board/Advisory groups include active participation from consumers and the membership reflects the community served

¹ Words formatted with italics and underlined can be referenced in the Glossary for further explanation
 UWMA RFP – Community Impact Fund Grants - Health Focus Area

Required Program Components – policies, practices and /or activities that:	Examples
	<ul style="list-style-type: none"> • The provider conducts consumer/client satisfaction surveys at regular intervals.
<p>The program can provide evidence of its alignment to the United Way’s goal to increase access to primary care services and our larger, broader target to decrease the number of preventable ER visits.</p>	<ul style="list-style-type: none"> • The program actively tracks the impact of its work on their clients ability to access to primary care services • The program can identify the barriers their clients face in accessing primary care and how their program addresses it.
<p>Maximize access to services for program target population</p>	<ul style="list-style-type: none"> • Assists persons to identify their priority health needs, learn how to take care of their health needs, and provide access to primary health care services • Program is clear about its target population and their resources and limitations • Provides services in the early morning, evenings and weekends • Service locations are in the communities where target populations resides/has convenient access • Ensure that services are affordable for the target population
<p>Ensure that the program is collecting and compiling data on client demographics. Additionally, ensure that services are culturally and linguistically responsive to meet the needs of the target population served.</p>	<ul style="list-style-type: none"> • Provide evidence of program’s data collection methods and/or reports. • Agency demonstrates sensitivity to issues involving age and disability • Agency provides services in the primary language of the client • Staff reflect the community and are culturally responsive to the program participants.
<p>Ensure access to medication</p>	<ul style="list-style-type: none"> • Program offers sliding scale fees for medication • Program provides medicine on site • Provides vouchers to clients to obtain medicine somewhere else • Provide referrals for medications and follow up to make sure they are received • Program has partnership with another agency or pharmacy to provide discounted drugs • Program refers clients to a program that offers discounted or free medicines (i.e. Georgia Partnership for Caring, American Diabetes Assoc, etc)

Required Program Components – policies, practices and /or activities that:	Examples
Track <u>referrals</u> to treatment and healthcare coverage	<ul style="list-style-type: none"> • Demonstrates capacity to effectively link to treatment • Follow up with a sample of established referral partners to assess how many participants followed through on program’s referrals.
Program should have a focus on collaboration with other health organizations, including local hospitals, health centers, health departments	<ul style="list-style-type: none"> • Tracking of the impact of program on preventable ER visits through a partnership with a local hospital • Take an active role in a county collaborative focused on health access/coordination
Provides ongoing health education in the health care setting	<ul style="list-style-type: none"> • Patient education, disease management, decision making skills • Clients participate in educating other clients about health care issues

C. Preferred Program Components

Preference will be given to programs that, in addition to the required components, are able to demonstrate the following preferred components:

Preferred Program Components – policies, practices and /or activities that:	Examples
Demonstrates effective collaboration with other programs and services to achieve maximum client self-sufficiency, including taking part in United Way’s Health Access Network.	<ul style="list-style-type: none"> • Program staff are active participants in UWMA’ s Health Access Network • Provider has written protocols for linking families to needed resources provided by other agencies • Provider has written memoranda of understanding with agencies that can make services available to families
Services that are provided in areas with limited access to primary care services for the uninsured.	<ul style="list-style-type: none"> • Areas that have high rates of preventable ER visits
Provides linkages to other services that impact access	<ul style="list-style-type: none"> • Program owns or has access to a vehicle to transport program participants. • Program offers discounts or tokens on public transportation.
Provide community outreach to reach the target population and provide health services	<ul style="list-style-type: none"> • Program coordinates or participates in community outreach activities such as health fairs and festivals • Mobile health units

D. Required Indicators:

All programs that receive funding under Primary Health must select one of the three paths below; then measure and report on all of the indicators related to that path.

Path	Initial	Intermediate	Long Term
Acute Care	Number patients that receive care for acute care needs	Number of persons whose acute care needs are met.	Number of these patients that return for a non-acute care visit
Chronic Care Management	Number of persons who are accessing consistent care for chronic conditions	Number of persons that see improvement or maintenance of their chronic condition	Number of patients that report a reduction in their usage of the ER
Medical Home	Number of patients that consider your facility their medical home (1-2 visits a year for non-acute care)	Number of patients that maintain good preventative medical and/or dental health care practices	Number of patients that report a reduction in their use of the ER

Glossary of Terms

Health Professional Shortage Area: This designation comes from the Health Resources and Services Administration and it denotes areas, by zip code or county that lack sufficient clinicians to meet the primary care needs. Information for Georgia Health professional Shortage Areas can be found in Department of Community Health’s Health Disparity Report.

Health Screening-Providing initial ‘tests’ or ‘assessments’ where individual can learn if they might be at risk for a particular health issue (such as diabetes) or might have that health issue and need further health care services.

Meaningful level-As a general guideline, United Way considers meaningful as 35% or more of those served by UW funded programs should be from one or more high priority populations.

Referral-Directing someone to additional assistance, treatment or information.

FY11-12 Strategy Guidance Letter

Impact Area: Health: People have access to primary health care

Strategy: Mental Health

Cluster: Safety Net

Impact Area Outcome: *Reduce the number of preventable Emergency Room visits by 84,000 visits*

Context: Mental Health Services are varied and complex. Addressing the mental health concerns of metro Atlanta’s residents is critical in maintaining communities that are productive, happy and healthy. In many of our communities, there is a significant lack of services to meet the mental health need. This barrier combined with those individuals that delay care because of cost or lack of transportation contributes to an increase in acute mental health needs that could have been prevented with early identification and support. Increasing access to mental health services will help improve the quality of life for those dealing with mental health conditions.

Strategy Description: To support appropriate identification and referral of children and adults who are at risk for mental health problems or emotional disturbances. To enable children and adults who are experiencing mental health problems or emotional disturbances to show evidence of making progress in daily functioning and their quality of life.

A. Target Populations

All programs that receive funding must serve at least one of the following populations at a meaningful level²:

1. Individuals with a co-occurring disorder (substance abuse, mental health, developmental disability/delay)
2. Low income individuals and families
3. Areas that are designated as Mental Health, Health Professional Shortage areas (this information can be found in GA’s Department of Community Health, Health Disparities Report)

B. Required Program Components

All programs that receive funding must demonstrate the following key components of effective programming that relate to the selected service priority:

Required Program Components – policies, practices and /or activities that:	Examples
Maximize access to services for program target population.	<ul style="list-style-type: none">• Provide services in the early morning, evenings and weekends.• Service locations are in the communities where the target population resides/has convenient access• Services are provided in clients’ homes, places of employment, training, or education.

² Words formatted with italics and underlined can be referenced in the Glossary for further explanation.

Required Program Components – policies, practices and /or activities that:	Examples
	<p>Agencies' service plans match identified patterns of help-seeking behavior (how people look for help with mental health issues)</p> <ul style="list-style-type: none"> • Agency has identified individuals/groups that are not likely to seek care and has developed and implemented a plan or outreach to these groups. • Provides accommodations for those seeking help by providing access to childcare, transportation to and from services, and/or alternative sites.
<p>The program can provide evidence of its alignment to the United Way's goal to increase access to primary care services and our larger, broader target to decrease the number of preventable ER visits.</p>	<ul style="list-style-type: none"> • The program actively tracks the impact of its work on their clients ability to access to primary care services • The program can identify the barriers their clients face in accessing primary care and how their program addresses it.
<p>Ensure services are culturally and linguistically responsive to meet the needs of the target population served</p>	<ul style="list-style-type: none"> • Agency provides services in the primary language of the participants • Agency utilizes culturally responsive educational content and methods • Program demonstrates an understanding of how cultural customs of the target population may impact success in treatment • Cultural competency training is provided to all staff and volunteers on issues specific to the population served • Program schedule accommodates religious holidays • Religious and cultural dietary requirements are identified and accommodated • Staff reflect the community and culturally responsive to the program participants • Materials, written communication and menus all reflect cultural inclusiveness
<p>Ensure staff are <i>state licensed, certified</i> as required by law/profession</p>	<ul style="list-style-type: none"> • Organization or individual staff members possess appropriate certification • Organization has its own minimum requirements even if the state does not • Consumers have information regarding

Required Program Components – policies, practices and /or activities that:	Examples
	licensure <ul style="list-style-type: none"> • Program provides evidence that staff/volunteers are trained to assess the presenting need; apply agency criteria for various types of assistance, and link the client to appropriate services within the agency and through other programs.
Collaborate with courts on all aspects of treatment, and on court-ordered sanctions or conditions	<ul style="list-style-type: none"> • Program receives referrals from courts • Organization is prepared to serve individuals returning from incarceration
Meet Americans with Disabilities Act(ADA) requirements (post ADA facilities)	<ul style="list-style-type: none"> • This required component will be evaluated at the site visit • Program makes special provisions for individuals with physical health and developmental needs • Facility is physically accessible, or has the ability to accommodate persons with a disability in an affiliated program nearby • Facility is able to provide assistance to persons with a disability to meet their basic needs • If program is unable to meet requirements, it needs to show documentation explaining why and what steps are being taken to meet the requirements
Ensures that services are affordable for the target population	<ul style="list-style-type: none"> • Program is clear about its target population and what their resources and limitations are. • Payment plans are available. Plans including referral to other services if clients are unable to continue paying for treatment • Has the capacity to make linkages to affordable medication programs
Demonstrate the use of <u>evidence based techniques</u> or <u>promising practices</u>	<ul style="list-style-type: none"> • The organization has a guiding treatment philosophy and it is appropriate for the target population • Intervention techniques are documented. Staff is able to adjust the strategies that do not appear to be working for a child or family member.
Refer clients to other <u>“levels of care”</u> as needs change	<ul style="list-style-type: none"> • All services need not be on site, but agency must have clear, functioning referral systems established • There is a clear criteria for reducing or

Required Program Components – policies, practices and /or activities that:	Examples
	<p>increasing the level of care</p> <ul style="list-style-type: none"> • There is a process for referring to higher or lower levels of care • There is continuity of care during transitions to other levels of care • Provider has written memoranda of understanding with agencies that can make services available to families • Program has a policy for identifying and addressing abuse and neglect
Ensure the development and implementation of individualized treatment plans that meet client needs and show evidence of client involvement in their development and execution	<ul style="list-style-type: none"> • Ongoing treatment for as long as indicated by treatment plan • Treatment plans of care reflect sensitivity to cultural issues as appropriate
Ensure that service interactions between program staff and the client are conducted with respect for client privacy, dignity, and appropriate confidentiality	<ul style="list-style-type: none"> • The agency has clear, written confidentiality policies and procedures, and obtains written informed consent from the client prior to disclosing information to others • Private space is utilized for meeting with clients
Ensure that the program is collecting and compiling data on client demographics. Additionally, ensure that services are culturally and linguistically responsive to meet the needs of the target population served.	<ul style="list-style-type: none"> • Provide evidence of program’s data collection methods and/or reports. • Agency demonstrates sensitivity to issues involving age and disability • Agency provides services in the primary language of the client • Staff reflect the community and are culturally responsive to the program participants.

C. Preferred Program Components

Preference will be given to programs that, in addition to the required components, are able to demonstrate the following preferred components:

Preferred Program Components – policies, practices and /or activities that:	Examples
Demonstrates effective collaboration with other programs and services to achieve maximum client self-sufficiency, including taking part in United Way’s Health Access Network.	<ul style="list-style-type: none"> • Program staff are active participants in UWMA’ s Health Access Network • Provider has written protocols for linking families to needed resources provided by other agencies • Provider has written memoranda of understanding with agencies that can make

Preferred Program Components – policies, practices and /or activities that:	Examples
	services available to families
Demonstrate a commitment to staff development	
Ensure screenings for family violence issues are conducted and referrals/links to appropriate services are made	<ul style="list-style-type: none"> • Training of staff or volunteers to equip them with appropriate skills
Program is accredited	<ul style="list-style-type: none"> • <u>CARF</u> • <u>JCAHO</u> (Joint Commission on Accreditation of Healthcare Organizations)

D. Required indicators:

All programs that receive funding under Mental Health must measure and report on both indicators below:

Path:	Initial	Intermediate	Long Term
Intensive Mental Health Services (including residential/inpatient care)	Number of persons that have contributed to the completion of a treatment plan/case plan	Number of individuals that have made progress and/or achieved on goals outlined in treatment plan/case plan.	Number of clients that are able to increase their quality of life (maintain residence in a less restrictive setting, gain employment, increase academic performance, etc)
Long term Mental Health Support (3 months or longer)	Number of persons that are assessed and diagnosed with a mental health concern	Number of individuals that show progress on their treatment goals	Number of persons that show superior functioning in activities that are meaningful (work, school, social life)
Acute Mental Health Support	Number of persons screened and assessed with an acute mental health concern	Number of persons who have measurably increased their coping skills	Number of persons that demonstrate no or minimal problems functioning in activities that are meaningful (work, school, social life)

Glossary of Terms

Co-occurring disorder-A term used to describe a person who has two disabling conditions. Usually, this refers to a person who has both a substance use issues and a psychiatric diagnosis (formerly called “dual diagnosis”). These issues interact with one another and treatment should reflect a comprehensive approach to both illnesses. The term may also be used to describe a person with a developmental disability and a psychiatric diagnosis.

Evidence-based-Evidence-based practices and programs are those clinical practices or programs that have been proven to consistently produce specific, intended results. These practices have been studied in both research settings and in real world environments.

JCAHO-Pronounced “jay-co”, the Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations) is a US-based non-profit organization with a mission to maintain and elevate the standards of health care delivery through evaluation and accreditation of health care organizations.

The Joint Commission employs surveyors who are sent to health care organizations to evaluate their operational practices and facilities. Since 2006, all surveys are unannounced, as opposed to a scheduled evaluation which in the past allowed institutions to prepare for an evaluation. Organizations deemed to be in compliance with all applicable standards are "accredited" (previously organizations were given a score from 1-100, with 100 being a “perfect” score). Hospitals and some other types of health care organizations are highly motivated to do well during surveys, as accredited organizations are deemed by the Centers for Medicare and Medicaid Services to meet the Medicare and Medicaid certification requirements -- necessary for gaining reimbursement from Medicare and managed care organizations.

Levels of Care-A term used to describe the intensity of care delivered. Ideally, clients should be continually assessed and evaluated to ensure that they are receiving care that is matched to their level of need. It is expected that clients matched to the appropriate level of care will have better outcomes. Coordination may be required as an individual transitions to a higher (more intensive, frequent or restrictive) or lower (less intensive, frequent or restrictive) level of care.

Meaningful level-As a general guideline, United Way considers meaningful as 35% or more of those served by UW funded programs should be from one or more high priority populations.

Mental Health Health Professional Shortage Area: This is categorized by the Health Resources and Service Administration in three areas, including Mental Health. This measure denotes the number of resources(health professionals) dedicated to providing mental health services.

Promising practices-Many programs and practitioners do not use evidence-based practices or programs. Instead, they use clinical approaches that are widely accepted and that their clinical judgment and experience tells them will work, but do not have enough research support to demonstrate that they are evidence-based.

State licensed, certified-Depending on the service being provided, the state of Georgia has different types of requirements for different services. Sometimes the state does site visits to assess compliance and sometimes an agency just needs to submit appropriate paperwork.

FY 11-12 Strategy Guidance Letter

Impact Area: Health

Strategy: Home Based Support

Cluster: Safety Net

Impact Area Outcome: *Reduce the number of preventable Emergency Room visits by 84,000 visits*

Context: Home Based Support services are critical in maintaining an individual’s independence and health. Individuals that receive care in the home are taking preventive measures to ensure that not only their independence is maintained but that their health is a priority. Adults with limited or fixed incomes are often faced with difficult health decisions. The prevention focus of Home based care represents a proactive health care choice that enables individuals to maintain their independence and improve both their short and long term health.

Strategy Description: Services that help people stay in their own home. Such services include but are not limited to: in home medical visitation and transportation.

A. Target Population

All programs that receive funding must serve at least one of the following populations at a meaningful³level:

1. Low income individuals or families
2. Individuals transitioning from institutional care(nursing home, state hospital, rehabilitation facility, and congregate living/group homes/personal homes) into their own home
3. Individuals at greatest risk of institutional care as demonstrated by an ADL/IADL assessment, or equivalent.
4. Communities (counties) that have a high rate of preventable ER visits.

B. Required Program Components

All programs that receive funding must demonstrate the following key components of effective programming that relate to the selected service priority:

Required Program Components – policies, practices and /or activities that:	Examples
Demonstrated implementation of a consumer driven agency program philosophy that maximizes client participation and involvement in service, planning, delivery, and quality assurance. Program must be central to the organization’s mission.	<ul style="list-style-type: none"> • The organization has a guiding program philosophy, and it is appropriate for the target population. • Board/Advisory groups include active participation from consumers and the membership reflects the community served

³ Words formatted with italics and underlined can be referenced in the Glossary for further explanation
UWMA RFP – Community Impact Fund Grants - Health Focus Area

Required Program Components – policies, practices and /or activities that:	Examples
	<ul style="list-style-type: none"> • The provider conducts consumer/client satisfaction surveys at regular intervals.
<p>The program can provide evidence of its alignment to the United Way’s goal to increase access to primary care services and our larger, broader target to decrease the number of preventable ER visits.</p>	<ul style="list-style-type: none"> • The program actively tracks the impact of its work on their clients ability to access to primary care services • The program can identify the barriers their clients face in accessing primary care and how their program addresses it.
<p>Ensure the development and implementation of individualized service plans that meet client needs and show evidence of client involvement in their development and execution</p>	<ul style="list-style-type: none"> • The services provided are determined by the consumer’s needs and priorities. • The consumer participates actively in development of <i>individual service plans</i>, and agrees to the support and implementation to be received. This is not required for mandated intervention situations • All care plans incorporate and reflect changes in client needs as they occur • All service plans include both services provided by the agency as well as appropriate referrals to meet additional needs • Staff is able to adjust the strategies that do not appear to be working for a client or family member
<p>Demonstrated adherence to applicable federal, state and local regulations</p>	<ul style="list-style-type: none"> • Home Visitation – no regulatory requirements (i.e. friendly visitor program) • Personal Care- Requires licensure through Office of Regulatory Services when a person’s service involves client contact. • Home Health – Requires Certificate of Need (CON) • Assistive Technology – Meet “ADA” standards (Americans with Disabilities Act) • Transportation- Appropriate safety, driver selection, and liability insurance
<p>Provides effective training and support to staff and volunteers. Program must have at least one dedicated paid staff person.</p>	<ul style="list-style-type: none"> • Program provides evidence that staff/volunteers are trained to assess the presenting need; apply agency criteria for various types of assistance, and link the client to appropriate services both within the agency and through other programs • Continuing education encouraged for relevant staff. Evidence of at least two trainings a year

Required Program Components – policies, practices and /or activities that:	Examples
	<ul style="list-style-type: none"> for paid staff. • Provider has written protocols for linking families to needed resources provided by other agencies • Program has written policy for identifying and addressing abuse and neglect.
Utilize program fees as appropriate to motivate clients, but fees do not create a barrier to housing retention	<ul style="list-style-type: none"> • Service is free or fees are based on a client’s ability to pay • Use a sliding fee scale or other method to offer affordable services
Ensure that the program is collecting and compiling data on client demographics. Additionally, ensure that services are culturally and linguistically responsive to meet the needs of the target population served.	<ul style="list-style-type: none"> • Provide evidence of program’s data collection methods and/or reports. • Agency demonstrates sensitivity to issues involving age and disability • Agency provides services in the primary language of the client • Staff reflect the community and are culturally responsive to the program participants.

C. Preferred Program Components

Preference will be given to programs that, in addition to the required components, are able to demonstrate the following preferred components:

Preferred Program Components – policies, practices and /or activities that:	Examples
Demonstrates effective collaboration with other programs and services to achieve maximum client self-sufficiency, including taking part in United Way’s Health Access Network.	<ul style="list-style-type: none"> • Program staff are active participants in UWMA’ s Health Access Network • Provider has written protocols for linking families to needed resources provided by other agencies • Provider has written memoranda of understanding with agencies that can make services available to families
Three or more years experience delivering quality in-home services to the target population.	
Provides services to consumers living outside UWMA’s central urban areas (Fulton and DeKalb)	
Have incorporated or are connected to 24/7 emergency services	
Opportunities for consumers/caregivers to volunteer with the program and gain leadership skills	

D. Required Indicators

All programs that receive funding under Home Based Support must select one of the two paths below; then measure and report on all of the indicators related to that path.

Path	Initial	Intermediate	Long Term
Medical Care	Number of people demonstrating a positive change in Activities for Daily Living (ADLs) assessment scores over time	Number of people that are able to maintain or improve their health status	Number of people that avoid hospitalization
Transportation	Number of people that are rely on this mode of transportation to receive medical services	Number of people reporting that they are safe, healthy, and happy in their own home (including apartments)	Number of people that are able to maintain or improve their health status
Skills Maintenance	Number of people demonstrating positive change in their Activities for Daily Living (ADLs)		Number of people whose ADL needs are met. Using the <u>Determination of Need measure (DON L)</u> or similar measure.

Glossary of Terms

ADL-(Activities of Daily Living) This is measured by scoring a level of impairment and a level of needs **not** being met that requires assistance due to impairment in each activity.(i.e. eating, personal care, transferring etc.)

DON-R-(Determination of Needs) This is a measurement of both the combination of ADL and IADL scores to determine and individuals need for assistance.

Individual Service Plan-In various social service and health care fields, clients/consumers are assisted in creating a personalized plan to help them achieve their life and/or health goals. When a person has disabilities, the provider works with the consumer to assist them in creating a plan that will help them achieve their independence goals.

IADL-(Instrumental Activities of Daily Living) This is measured by scoring the level of impairment and level of impairment and a level of needs **not** being met that requires assistance due to impairment in each activity. (i.e. finances, healthcare, household chores etc)

Low Income-Household income is at or below 200% of the federal poverty level.

Meaningful level-As a general guideline, United Way considers meaningful as 35% or more of those served by UW funded programs should be from one or more high priority populations.

FY11-12 Strategy Guidance Letter

Impact Area: Health – People have access to primary health care

Strategy: Substance Abuse Treatment

Cluster: Safety Net

Impact Area Outcome: *Reduce the number of preventable emergency room visits by 84,000*

Context: Issues relating to substance abuse treatment are varied and complex. Substance abuse treatment allows for both the physical and mental health needs of a person be addressed. Individuals that receive treatment for substance abuse and are able to maintain abstinence are often able to lead productive, healthy lives. Accessing substance abuse treatment provides individuals with an opportunity to improve their health and participate as fully as possible in society.

Strategy Description: Substance abuse treatment⁴ is a formal set of services that begin with diagnostic assessment by a qualified professional, and detoxification under medical supervision if needed, where the goals are for individuals to live a stable and meaningful life. Treatment may be outpatient (provided at a location outside of the individuals’ residence) or residential (provided in a housing ore residential setting). The level of intensity of services provided will vary according to individuals’ treatment needs.

A. Target Populations

All programs that receive funding must serve at least one of the following populations at a meaningful level:

1. Youth with an emphasis on homeless youth
2. Children of substance abusers (K-12th grade)
3. Pregnant Women
4. Substance abusers with dependent children
5. Individuals with co-occurring disabilities

B. Required Program Components

All programs that receive funding must demonstrate the following key components of effective programming that relate to the selected service priority:

Required Program Components – policies, practices and /or activities that:	Examples
Maximize access to services for program target population	Assists persons In the target population to successfully cope with addiction by improving the individual’s ability to: <ul style="list-style-type: none"> • Complete treatment • Maintain abstinence • Resolve conflicts/crisis • Maintain daily activities of living, and • Participate as fully as possible in society • Program is clear about its target population and their resources and limitations

⁴ Words formatted with italics and underlined can be referenced in the Glossary for further explanation
 UWMA RFP – Community Impact Fund Grants - Health Focus Area

Required Program Components – policies, practices and /or activities that:	Examples
	<ul style="list-style-type: none"> • Provides services in the early morning, evenings, and weekends • Service locations are in the communities where the target population resides/has convenient access • Ensures that services are affordable for the target population • Payment plans are available. Plans include referral to other services if clients are unable to continue paying for treatment
<p>Demonstrated implementation of a consumer driven agency program philosophy that maximizes client participation and involvement in service, planning, delivery, and quality assurance. Program must be central to the organization’s mission.</p>	<ul style="list-style-type: none"> • The organization has a guiding program philosophy, and it is appropriate for the target population. • Board/Advisory groups include active participation from consumers and the membership reflects the community served • The provider conducts consumer/client satisfaction surveys at regular intervals.
<p>The program can provide evidence of its alignment to the United Way’s goal to increase access to primary care services and our larger, broader target to decrease the number of preventable ER visits.</p>	<ul style="list-style-type: none"> • The program actively tracks the impact of its work on their clients ability to access to primary care services • The program can identify the barriers their clients face in accessing primary care and how their program addresses it.
<p>Ensure that service interactions between program staff and the client are conducted with respect for client privacy, dignity, and with appropriate confidentiality</p>	<ul style="list-style-type: none"> • The agency has clear, written confidentiality policies and procedures, and obtains written informed consent from the client prior to disclosing information to others • Private space is utilized for meeting with clients • Case plans are developed in partnership with the client • The agency has clear, written grievance procedure for clients that are posted in public places as well as given to clients • Written standards for deactivation of client for non-participation, non-compliance, or other causes
<p>Ensure the development and implementation of individualized treatment plans that meet client needs and show evidence of client involvement in their development and execution</p>	<ul style="list-style-type: none"> • Ongoing treatment for as long as indicated by treatment plan • Residential treatment should be at least 90 days • Length of stay is client-centered. The program

Required Program Components – policies, practices and /or activities that:	Examples
	<p>structure and philosophy should reflect that longer a length of stay is associated with greater treatment success and plans should reflect the individual’s needs</p> <ul style="list-style-type: none"> • Individual is involved in the treatment planning. It is not adequate to simply sign a staff only pre-approved plan • Treatment plans of care reflect sensitivity to cultural issues as appropriate
<p>Provide specific services to help family members learn about addiction and the treatment process, including their role in supporting the family member’s recovery.</p>	<ul style="list-style-type: none"> • Family members are included in the intake process and treatment planning when appropriate • There are specific services to help family members cope with the impact of their loved one’s addiction on them and the family unit
<p>Provide wrap around services, including case management, that support client’s success.</p>	<p>A program may offer or assist clients in finding services such as</p> <ul style="list-style-type: none"> ▪ Transportation ▪ Safe housing, if needed, ▪ Job training or job search assistance ▪ Referrals for medical care outside scope of program
<p>Ensure that the program is collecting and compiling data on client demographics. Additionally, ensure that services are culturally and linguistically responsive to meet the needs of the target population served.</p>	<ul style="list-style-type: none"> • Provide evidence of program’s data collection methods and/or reports. • Agency demonstrates sensitivity to issues involving age and disability • Agency provides services in the primary language of the client • Staff reflect the community and are culturally responsive to the program participants.
<p>Track <u>referrals</u> to treatment and healthcare coverage</p>	<ul style="list-style-type: none"> • Demonstrates capacity to effectively link to treatment • Follow up with a sample of established referral partners to assess how many participants followed through on program’s referrals.
<p>Provides or ensures linkages to peer support or self-help groups</p>	<ul style="list-style-type: none"> • Program makes information available and referrals to self-help groups for issues that impact the target population • Program provides literature, posts community meeting schedules and/or provides space for self-help groups to meet on site

Required Program Components – policies, practices and /or activities that:	Examples
	<ul style="list-style-type: none"> • Staff and volunteers are oriented to self-help groups, have attended open meetings as appropriate • Staff and volunteers include individuals who are themselves in recovery and have been trained and can comfortably advocate the use of self-help groups

C. Preferred Program Components

Preference will be given to programs that, in addition to the required components, are able to demonstrate the following preferred components:

Preferred Program Components – policies, practices and /or activities that:	Examples
Demonstrates effective collaboration with other programs and services to achieve maximum client self-sufficiency, including taking part in United Way’s Health Access Network.	<ul style="list-style-type: none"> • Program staff are active participants in UWMA’ s Health Access Network • Provider has written protocols for linking families to needed resources provided by other agencies • Provider has written memoranda of understanding with agencies that can make services available to families
Collaborate with drug courts on all aspects of treatment, and on court-ordered sanctions or conditions	
Provide community outreach to reach the target population and conduct health education programs in a variety of settings for at-risk populations	<ul style="list-style-type: none"> • School-based activities • General community education
Support early identification and intervention for persons needing (including referral)	
Ensure access to Detox services, provided directly or through referral	
Conduct screenings for family violence issues and provides participants with links to appropriate services	<ul style="list-style-type: none"> • Program staff and volunteers are trained in how to address family violence issues • Program staff are able to provide clients that present with issues of family violence with appropriate support and program linkages
Transitional housing program meets state licensure and accreditation standards. Licensure and accreditation standing(s) are included in supplemental information	<p>Quality of Facility – the component below will be evaluated at the site visit</p> <ul style="list-style-type: none"> • Licenses, accreditations, certifications are prominently displayed at the facility

Preferred Program Components – policies, practices and /or activities that:	Examples
	<ul style="list-style-type: none"> Any deficiencies are corrected in timely manner

D. Required Indicators

All programs that receive funding under Substance Abuse Treatment must select at least two of the required indicators to measure and report on. All programs must measure indicator 1. Additionally, programs can report on both 2 and 3, but must measure at least one of the two.

Path	Initial	Intermediate	Long Term
Successfully coping with addiction	Number of participants who successfully complete the treatment program	Number of participants who maintained their abstinence for six (6) months	Number of participants who their abstinence for at least one (1) year

Glossary of Terms

Co-occurring disorder-A term used to describe a person who has two disabling conditions. Usually, this refers to a person who has both a substance use issues and a psychiatric diagnosis (formerly called “dual diagnosis”). These issues interact with one another and treatment should reflect a comprehensive approach to both illnesses. The term may also be used to describe a person with a developmental disability and a psychiatric diagnosis.

Detoxification-Medical management and other supports for stabilizing the physical and psychological processes associated with the withdrawal from alcohol and/or other drugs. Clients completing detox should be discharged directly to treatment and the recovery continuum.

Homeless-An individual who lacks a fixed, regular, and adequate nighttime residence; and an individual who has a primary nighttime residence that is -

- (a) supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
- (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or
- (c) A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

The term "homeless" or "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law

Meaningful level-As a general guideline, United Way considers meaningful as 35% or more of those served by UW funded programs should be from one or more high priority populations.

Outpatient treatment-*Could mean any of the following:*

Outpatient – ASAM Level I Regularly-scheduled sessions of six to eight hours per week.

Intensive Outpatient – ASAM Level II Regularly-scheduled sessions of nine or more hours per week.

Partial Hospitalization – ASAM Level II.5 Regularly-scheduled sessions of 20 or more hours per week. In Georgia, this model previously was called substance abuse day treatment.

Referral-Directing someone to additional assistance, treatment or information.

Relapse-Relapse is a return to using alcohol and/or other drugs after a person has previously achieved and maintained abstinence for some period of time after withdrawal. Relapse begins with a gradual, unconscious onset of thinking and behaving that leads to using; the actual use is the last step in the process. Relapse prevention establishes pre-planned actions to identify the early signs of impending relapse, and steps to interrupt this process and return the person to actively following their recovery program.

Some relapses are very brief and are followed by immediate return to abstinence and intensified resolve to follow the recovery plan. These occasions are sometimes called “testing” or “therapeutic relapse.”

FY11-12 Strategy Guidance Letter

Impact Area: Health - People have access to primary health care

Strategy: Prevention Education

Cluster: Health Education

Impact Area Outcome: *Reduce the number of preventable Emergency Room visits by 84,000 visits*

Context: Prevention Education is a critical component in ensuring that our communities have access to primary care services and understand how to navigate the health systems. Preventing disease and understanding our health before it becomes critical will help build healthy families and communities. This strategy includes programs that focus on education and health screenings.

Strategy Description: This strategy is meant to help persons identify their priority health needs, to learn how to take care of their health needs, to prevent illness through connection to primary care services and health screenings. Support in this area will include prevention education in the following arenas: Reproductive Health, Nutrition Education, Substance Abuse, and disease management classes, self-care, stress, etc.

A. Target Populations:

All programs that receive funding must serve at least one of the following populations at a meaningful level⁵:

1. Low income individuals and families
2. Individuals suffering from chronic disease
3. Uninsured and underinsured
4. Areas designated as Health Professional Shortage Areas

B. Required Program Components

All programs that receive funding must demonstrate the following key components of effective programming that relate to the selected service priority:

Required Program Components – policies, practices and /or activities that:	Examples
Demonstrated implementation of a consumer driven agency program philosophy that maximizes client participation and involvement in service, planning, delivery, and quality assurance. Program must be central to the organization’s mission.	<ul style="list-style-type: none"> • The organization has a guiding program philosophy, and it is appropriate for the target population. • Board/Advisory groups include active participation from consumers and the membership reflects the community served • The provider conducts consumer/client satisfaction surveys at regular intervals.
The program can provide evidence of its alignment to the United Way’s goal to increase access to primary care services and our larger, broader target to decrease the number of preventable ER visits.	<ul style="list-style-type: none"> • The program actively tracks the impact of its work on their clients ability to access to primary care services • The program can identify the barriers their

⁵ Words formatted with italics and underlined can be referenced in the Glossary for further explanation
 UWMA RFP – Community Impact Fund Grants - Health Focus Area

Required Program Components – policies, practices and /or activities that:	Examples
	clients face in accessing primary care and how their program addresses it.
Maximize access to services or program target population	<ul style="list-style-type: none"> • Assists persons to identify their priority health needs, learn how to take care of their health needs, and provide access to primary health care services. • Service locations are in communities where the target population resides/has convenient access • Ensures that services are affordable for the target population
Ensure that the program is collecting and compiling data on client demographics. Additionally, ensure that services are culturally and linguistically responsive to meet the needs of the target population served.	<ul style="list-style-type: none"> • Provide evidence of program’s data collection methods and/or reports. • Agency demonstrates sensitivity to issues involving age and disability • Agency provides services in the primary language of the client • Staff reflect the community and are culturally responsive to the program participants.
Tracks <u>referrals</u> to treatment and healthcare coverage	<ul style="list-style-type: none"> • Demonstrate a capacity to effectively link to treatment • Follow up with a sample of established referral partners to assess how many participants followed through on program referrals. • Program has a list of resources, known to staff, that can be used to refer clients to other programs and agencies that may help them with related issues.
Provides ongoing <u>Patient Education</u>	<ul style="list-style-type: none"> • Patient Education, disease management, decision making skills • Clients participate in educating other clients about health care issues
Implement multiple teaching methods, including an <u>active, skills based component</u> (for health education focused programs only)	<ul style="list-style-type: none"> • Helping participants develop their cognitive skills, their ability to communicate assertively, and the ability to negotiate resisting the problem behavior • Provide hands-on experience for participants. Rather than only depending on sharing information and discussion, effective programs facilitate activities that allow participants to develop and practice their skills
Ensure sufficient exposure to or <u>dosage</u> (quantity) of information to participants for it to have an	<ul style="list-style-type: none"> • A series of sessions, full day vs. one-hour

Required Program Components – policies, practices and /or activities that:	Examples
effect (for health education focused programs only)	<p>sessions. Dosage can be measured by the number of contact hours, including the number of sessions, and the length of each session. Effective programs on average provide more contact with participants than ineffective programs</p> <ul style="list-style-type: none"> • Effective prevention programs provide some type of follow-up or booster sessions to help sustain the effects of the original intervention. The effects of most strategies diminish over time. Booster sessions support the continued use of information and skills learned in the original activity.

C. Preferred Program Components

Preference will be given to programs that, in addition to the required components, are able to demonstrate the following preferred components:

Preferred Program Components – policies, practices and /or activities that:	Examples
Demonstrates effective collaboration with other programs and services to achieve maximum client self-sufficiency, including taking part in United Way’s Health Access Network.	<ul style="list-style-type: none"> • Program staff are active participants in UWMA’ s Health Access Network • Provider has written protocols for linking families to needed resources provided by other agencies • Provider has written memoranda of understanding with agencies that can make services available to families
Clearly focuses the program on one of the following health issues: Cancer, Diabetes, Hypertension, other chronic conditions	
Provides transportation and other services/linkages to increase access to program	
Provide community outreach to reach the target population and provide health services, screening and health education	<ul style="list-style-type: none"> • Program coordinates or participates in community outreach activities such as health fairs and festivals • Mobile health vans
Provides incentives	<ul style="list-style-type: none"> • Program offers incentives such as discounts, vouchers and rewards for program completion
Provides and/or gives referrals for adaptive equipment	<ul style="list-style-type: none"> • Provides participants with glasses, or wheel chairs, etc.

D. Required Indicators:

All programs that receive funding under Prevention Education must select one of the following two paths below; then measure and report on all indicators related to that path.

Path	Initial	Intermediate	Long Term
Health Education	Number of persons who achieve an effective level of knowledge on priority health issues.	N/A	Number of persons that maintain or improve their health status
Health Screenings	Number of persons screened and diagnosed with a chronic disease/health issue	Number of individuals connected with the appropriate follow up /referral information	Number of individuals that access a continued source of care for their chronic disease/health issue

Glossary of Terms

Active Skill Based Component-When education is provided in an interactive manner to a program participant. For example, some things can be taught by just verbally explaining it, however, in many health care issues it is more helpful to provide demonstrations (CPR, exercise, etc.) or asking a patient to describe what they would do in different life scenarios to prevent negative health behavior (avoiding unhealthy food temptation, avoiding drinking and driving, etc.). The Active Skill Based Component goes beyond just increasing the knowledge of the participant and focuses on helping the participant develop skills that they can use in real life situations. They are much more likely to retain the information they have been given and have more confidence using it.

Dosage-Dosage refers to the quantity of education provided to a program participant. Depending on the complexity of the health issue or the profile of the participant, different amounts of dosage may be required to be effective in helping the participant to learn and use the information. For example, if a teenager has a lot of distractions in their life (family problems, having to work, dating problems, etc.) they will be more distracted and much less likely to care about or listen to information that might help them with an important and relevant health issue (diabetes, STDs/HIV, alcohol, etc.). A program should be assessing the overall dosage (quantity) of education for the population they serve, and also be able to adjust it for each participant they serve.

Health Professional Shortage Area: This designation comes from the Health Resources and Services Administration and it denotes areas, by zip code or county that lack sufficient clinicians to meet the primary care needs. Information for Georgia Health professional Shortage Areas can be found in Department of Community Health’s Health Disparity Report.

Health Screening-Providing initial ‘tests’ or ‘assessments’ where individual can learn if they might be at risk for a particular health issue (such as diabetes) or might have that health issue and need further health care services.

Meaningful level-As a general guideline, United Way considers meaningful as 35% or more of those served by UW funded programs should be from one or more high priority populations.

Referral-Directing someone to additional assistance, treatment or information.

FY11-12 Strategy Guidance Letters

Impact Area: Health – People have access to primary health care

Strategy: Life Skills

Cluster: Health Education

Impact Area Outcome: *Reduce the number of preventable Emergency Room visits by 84,000 visits*

Context: Life Skills Support offers critical support to individuals looking to maintain their health and independence. Life skills support provides education opportunities for individuals that want to understand their physical development, health, self-care and nutrition. Individuals that are able to improve their activities of daily living will be better poised to recognize their priority health concerns and receive the appropriate treatment.

Strategy Description: Services that teach/promote activities of daily living and the necessary skills to increase personal independence through working with individuals and family members, as appropriate; and serves individuals living with their families as well as those living in institutions and making arrangements for living in the community. The following skills may be taught: physical development and health, self-care, and nutrition.

A. Target Populations: All programs that receive funding must serve at least one of the following populations at a *meaningful level*⁶:

1. Low income individuals and families
2. Services that assist limited English speaking families including refugees and immigrant

B. Required Program Components

All programs that receive funding must demonstrate the following key components of effective programming that relate to the selected service priority:

Required Program Components – policies, practices and /or activities that:	Examples
Assure that the services provided are determined by the consumer’s needs and priorities.	<ul style="list-style-type: none">• The consumer participates actively in development of individual of <i>individual service plans</i> and agrees to the support and implementation to be received. This is not required for mandated intervention situations.• All care plans should incorporate and reflect changes in client needs as they occur.• Staff is able to adjust the strategies that do not appear to be working for a child or family member• The provider conduct consumer/client satisfaction surveys at regular intervals

⁶ Words formatted with italics and underlined can be referenced in the Glossary for further explanation
UWMA RFP – Community Impact Fund Grants - Health Focus Area

Required Program Components – policies, practices and /or activities that:	Examples
The program can provide evidence of its alignment to the United Way’s goal to increase access to primary care services and our larger, broader target to decrease the number of preventable ER visits.	<ul style="list-style-type: none"> • The program actively tracks the impact of its work on their clients ability to access to primary care services • The program can identify the barriers their clients face in accessing primary care and how their program addresses it.
Demonstrated implementation of a consumer driven agency program philosophy that maximizes client participation and involvement in service, planning, delivery, and quality assurance. Program must be central to the organization’s mission.	<ul style="list-style-type: none"> • The organization has a guiding program philosophy, and it is appropriate for the target population. • Board/Advisory groups include active participation from consumers and the membership reflects the community served • The provider conducts consumer/client satisfaction surveys at regular intervals.
All individual support/care plans must show evidence of activities and results that include actions by the family/caregiver and other support systems	<ul style="list-style-type: none"> • Consumers and/or caregivers are able to apply what they have learned • Caregivers are satisfied with the effectiveness of services provided to the person they care for.
Service interactions between the program and the client are conducted with respect for client privacy, dignity, and with appropriate confidentiality	<ul style="list-style-type: none"> • The agency has clear, written confidentiality policies and procedures, and obtains written informed consent from the client prior to disclosing information to others. • Private space is utilized for meetings with clients.
Program implementation incorporates all services necessary for success in the consumer’s life skills, including both in agency services and appropriate referrals/linkages to meet additional needs.	<ul style="list-style-type: none"> • Individual education Plan/Transition Plan is actively used to guide students with special needs as they move from school to adult life. • Student-focused planning and development is being achieved through teaching students about having more control over their own lives and supporting what students and families want to happen with the community resources and training they need.
Ensure that the program is collecting and compiling data on client demographics. Additionally, ensure that services are culturally and linguistically responsive to meet the needs of the target population served.	<ul style="list-style-type: none"> • Provide evidence of program’s data collection methods and/or reports. • Agency demonstrates sensitivity to issues involving age and disability • Agency provides services in the primary language of the client • Staff reflects the community and are culturally responsive to the program participants.

Required Program Components – policies, practices and /or activities that:	Examples
Provides effective training and support to staff and volunteers. Program must have at least one dedicated paid staff person.	<ul style="list-style-type: none"> • Program provides evidence that staff/volunteers are trained to assess the presenting need; apply agency criteria for various types of assistance, and link the client to appropriate services both within the agency and through other programs • Continuing education encouraged for relevant staff. Evidence of at least two trainings a year for paid staff. • Provider has written protocols for linking families to needed resources provided by other agencies • Program has written policy for identifying and addressing abuse and neglect.

C. Preferred Program Components

Preference will be given to programs that, in addition to the required components, are able to demonstrate the following preferred components:

Preferred Program Components – policies, practices and /or activities that:	Examples
Demonstrates effective collaboration with other programs and services to achieve maximum client self-sufficiency, including taking part in United Way’s Health Access Network.	<ul style="list-style-type: none"> • Program staff are active participants in UWMA’ s Health Access Network • Provider has written protocols for linking families to needed resources provided by other agencies • Provider has written memoranda of understanding with agencies that can make services available to families
Three or more years experience delivering quality life skills services to the target population.	
Opportunities are provided for consumers/caregivers to volunteer with the program and gain leadership skills	
Provides training in a natural environment vs. only in a classroom setting	
Provides services in areas that are lack low cost of free health care providers	

D. Required Indicators:

All programs that receive funding under Life Skills must select one of the two paths below and then measure and report on all of the indicators related to that path.

Path	Initial	Intermediate	Long Term
Improved Skills	Number of people demonstrating a positive change in Activities for Daily Living (ADLs) assessment scores over time.	Number of people reporting that they are safe, healthy and happy and living in their own home (including apartments)	Based on the person's exit from the program, indicate the number of people that show an improved quality of life (i.e., increased employability, behavior change, etc)
Skills Maintenance	Number of people demonstrating a positive change in Activities for Daily Living (ADLs) assessment scores over time.	Number of people whose ADL needs are met, using the Determination of Need measure (DON-R) or similar measure	Number of people that show they have maintained quality of life (i.e., increased employability, behavior change, etc)

Glossary of Terms

ADL-(Activities of Daily Living) This is measured by scoring a level of impairment and a level of needs **not** being met that requires assistance due to impairment in each activity.(i.e. eating, personal care, transferring etc.)

DON-R-(Determination of Needs) This is a measurement of both the combination of ADL and IADL scores to determine and individuals need for assistance.

Individual Service Plan-In various social service and health care fields, clients/consumers are assisted in creating a personalized plan to help them achieve their life and/or health goals. When a person has disabilities, the provider works with the consumer to assist them in creating a plan that will help them achieve their independence goals.

Low Income-Household income is at or below 200% of the federal poverty level.

Meaningful level-As a general guideline, United Way considers meaningful as 35% or more of those served by UW funded programs should be from one or more high priority populations.

PROPOSAL TIMELINE & QUESTIONS

RFP RELEASE

Wednesday, March 16, 2011

RFP TRAINING

RFP Training is optional but highly encouraged. Space is limited and RSVP is required to attend.

Please RSVP online via the United Way of Metro Atlanta website,
<http://www.unitedwayatlanta.org/OurWork/Pages/INVESTMENTPROCESS.aspx>.

You will be required to RSVP for each person attending. These dates will close when seating is full, so please RSVP as soon as possible. Please bring your own copy of the RFP to the session. **To save resources copies will not be provided.**

PROPOSAL SUBMISSION DEADLINE

Program proposals must be submitted online via the Online Database Manager (ODM) **by 200 pm on Thursday, April 28, 2011.** Late submissions will not be accepted.

PROGRAM SITE VISITS

Site Visits will be held at various times from May 5 through June 29.

FUNDING APPROVALS

Funding recommendations are approved by the UW volunteer governance committees with the United Way Board of Directors giving final approval in July. Notification will be sent by mid-July.

FUNDING PERIOD

July 1, 2011 – June 30, 2012

QUESTIONS

If you have questions regarding the 2011 – 2012 Community Impact Fund Grants Process please submit them via e-mail to grantee@unitedwayatlanta.org.

When submitting questions please indicate the category in the SUBJECT line of your email; the categories are as follows:

- General
- Financials
- Site Visits
- EDUCATION
- HEALTH
- INCOME
- HOMELESSNESS