United Way of Metro Chicago

STRONG NEIGHBORHOODS IMPACT FUND 2022 MEASUREMENT FRAMEWORKS

BASIC NEEDS

MEASUREMENT FRAMEWORK OVERVIEW

United Way has identified key indicators of progress and success for each strategy that drive toward specific outcomes. The following pages contain a complete list of indicators, arranged by grant strategy model, as well as detailed definitions of terms. Partner agencies are required to report data for **all** of the indicators in each strategy for which funding is received. United Way utilizes outcome data to gauge the performance of an agency throughout the program year.

United Way does not fund on a fee-for-service basis, but rather funds programming that will deliver on identified outcomes. Therefore, organizations must agree to report on outcomes and indicators for **all participants** in United Way-funded programs, rather than some portion of client population served.

In addition to the strategy indicators, partner agencies will also be required to report annually on the following elements:

- *Strategy Narratives:* Qualitative questions associated with specific strategies.
- *Demographics:* Program participants' race/ethnicity (including Arab/Middle Eastern / North African, Asian / Pacific Islander, Black / African American, Hispanic / Latinx, Native American, White / Caucasian, Multi-Racial, and Unknown), age, gender, economic status, disability status (if available), sexual orientation (if available), veteran status (if applicable), homeless (if applicable), wards of the state/youth in foster care (if applicable), female heads of household (if applicable), immigrant or refugee status (if applicable), criminal background/re-entry population (if applicable). Reported by agency, not program.
- *Communities Served:* Number of people served living in each Chicago Community Area or suburban municipality within United Way's footprint. Reported by agency, not program.
- *Site Locations:* Name and address of locations where United Way-funded programs are conducted.
- *Success Story:* The story of one client who has successfully utilized the agency's United Way-funded program.

BASIC NEEDS: ACCESS TO HEALTHCARE Improve access to health services	
OUTCOME: People access health care; people overcome barriers to care	
INDICATOR	**DEFINITION**
For programs that provide Behavioral and Metal Health Services	
# behavioral and mental health screenings/ referrals to treatment	• A checklist or standardized process for determining presence potential mental disorders and/or need for further behavioral and mental health services
# of participants in behavioral and mental health sessions	• Sessions may include individual, group, or family therapy; crisis intervention; parenting skills training; or other sessions applicable to population served
# of households receiving additional services beyond behavioral and mental health intervention	• This refers to a participant's household receiving additional wraparound services, which could include early childhood education, financial literacy, physical health care, stable housing, access to government benefits, legal assistance, etc.
# of youth/adults assisted with gaining health insurance during the program year	This refers to clients who enter agency without health insurance and are given assistance/ navigation services by agency staff to apply for and receive health insurance
# of youth/adults assisted with retaining health insurance during the program year	This may include renewing coverage or assisting clients with redeterminations
Please describe the outcomes above in greater detail, including information about program successes, challenges, and other data that demonstrates the strength of your work.	Qualitative response to prior questions
<u>Test Metric for CY2022 – Required</u>	
# of participants in behavioral and mental health sessions demonstrating improvement	• "Improvements" can be determined via client self-report, client meeting goal(s) set by self or therapist/facilitator, and/or therapist/facilitator determining improvement in behavior/mental health and/or skills learned to address mental health concerns
For programs that provide Primary Care Health Services	
INDICATOR	**DEFINITION**
# people connected to a health provider/primary care physician/regular care	This may include researching, identifying, and/or contacting a primary care physician, specialist, or behavioral and mental health provider
# people who report their physical health has improved	Determined by self-report; potential to substitute physician evaluation of patient
# of participants in primary care services	• Number of participants in primary care services during the grant period, including well-person check ups and acute needs.

# of households receiving additional services beyond primary care services	• This refers to a participant's household receiving additional wraparound services, which could include early childhood education, financial literacy, behavioral and mental health services, stable housing, access to government benefits, legal assistance, etc.

*If your organization provides both Behavioral and Mental Health Services as well as Primary Care, please report on all of the metrics listed above.

BASIC NEEDS: HOUSING ASSISTANCE
Ensure basic housing needs are met

OUTCOME: Provide shelter for individuals experiencing homelessness or rental assistance to prevent homelessness; provide case management services to individuals to mitigate the likelihood of future homelessness

INDICATOR	DEFINITION
# of individuals provided with case management services	• "Case management" is a method of service delivery in which a qualified case manager conducts assessments of clients and their families. Based on the needs identified in an assessment, a case manager then arranges, coordinates and monitors multiple services from different providers to serve client needs
# of individuals eligible to leave program-supported housing with a permanent, stable destination	• Eligible clients are those who have the potential to achieve a permanent housing destination through housing programming (i.e. not those who require long-term supportive housing)
# of individuals who leave program-supported housing with a permanent, stable destination	• "Permanent" housing is community-based housing (i.e. private residence, group home) not supported by the partner agency (i.e. not long-term agency-supported housing)
% of individuals who leave program-supported housing with a permanent, stable destination	• # of individuals leave divided by # of individuals eligible
# of individuals screened for benefits	• "Benefit screening" is using a web or in person tool to determine an individuals' eligibility for public or private benefits • "Benefits" include: TANF, tax credits, SSI/SSDI, SNAP/LINK, WIC, subsidized housing (public, Section 8), LIHEAP, weatherization, utility, eviction prevention, subsidized fare cards and vouchers, childcare subsidies, Medicaid, Medicare, and All Kids
# of individuals assisted in applying for and/or maintaining benefits	• "Assistance" in applying for benefits is using a web or in person tool to assist clients in completing the application(s) for public or private benefits • "Assistance" in maintaining benefits can include assisting the individual in reapplying for benefits after they have expired, or assisting in maintaining benefits program eligibility • "Benefits" include: TANF, tax credits, SSI/SSDI, SNAP/LINK, WIC, subsidized housing (public, Section 8), LIHEAP, weatherization, utility, eviction prevention, subsidized fare cards and vouchers, childcare subsidies, Medicaid, Medicare, and All Kids
# of households receiving additional services beyond housing intervention	• This refers to a participant's household receiving additional wraparound services, which could include early childhood education, financial literacy, mental/physical health care, access to government benefits, legal assistance, etc.
Please describe the outcomes above in greater detail, including information about program	Qualitative response to prior questions

successes, challenges, and other data that demonstrates the strength of your work.	
<u>Test Metric for CY2022 – Required</u>	
# of participants exiting program that have increased financial resources	• Increase in financial resources can be made via obtaining or improving a job, accessing public or private benefits, decreasing debt, increasing savings, etc.

BASIC NEEDS: SAFETY FROM ABUSE Address immediate safety needs	
OUTCOME: Provide crisis services to victims of abuse; provide case management services to individuals to mitigate the likelihood of future abuse	
INDICATOR	**DEFINITION**
# of individuals accessing safe, stable living situation	• Participant is either able to return to their own housing without the abuser present; or is able to access new housing without abuser present
# of adults provided with case management services	• "Case management" is a method of service delivery in which a qualified case manager conducts assessments of clients and their families. Based on the needs identified in an assessment, a case manager then arranges, coordinates and monitors multiple services from different providers to serve client needs
# of individuals screened for benefits	• "Benefit screening" is using a web or in person tool to determine an individuals' eligibility for public or private benefits • "Benefits" include: TANF, tax credits, SSI/SSDI, SNAP/LINK, WIC, subsidized housing (public, Section 8), LIHEAP, weatherization, utility, eviction prevention, subsidized fare cards and vouchers, childcare subsidies, Medicaid, Medicare, and All Kids
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# of households receiving additional services beyond safety from abuse intervention	• This refers to a participant's household receiving additional wraparound services, which could include early childhood education, financial literacy, mental/physical health care, stable housing, access to government benefits, legal assistance, etc.
Please describe the outcomes above in greater detail, including information about program successes, challenges, and other data that demonstrates the strength of your work.	Qualitative response to prior questions

BASIC NEEDS: FOOD ASSISTANCE Meet basic food needs	
OUTCOME: Provide food assistance	
INDICATOR	**DEFINITION**
# of individuals receiving food assistance	• "Food assistance" includes food pantries, congregate meals, at home deliveries for individuals who would struggle to attend a food distribution site, and food banks
# of meals served	• Agencies may use pounds-to-meals conversion rate as recommended by Feeding America if they distribute food via pantry model
# of adults screened for benefits	• "Benefit screening" is using a web or in person tool to determine an individuals' eligibility for public or private benefits • "Benefits" include: TANF, tax credits, SSI/SSDI, SNAP/LINK, WIC, subsidized housing (public, Section 8), LIHEAP, weatherization, utility, eviction prevention, subsidized fare cards and vouchers, childcare subsidies, Medicaid, Medicare, and All Kids
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# of households receiving additional services beyond food assistance intervention	• This refers to a participant's household receiving additional wraparound services, which could include early childhood education, financial literacy, mental/physical health care, stable housing, access to government benefits, etc.
Please describe the outcomes above in greater detail, including information about program successes, challenges, and other data that demonstrates the strength of your work.	Qualitative response to prior questions
<u>Test Metric for CY2022 – Required</u>	
# of individuals accessing nutrition education opportunities	This should include items such as attending nutrition education classes, grocery store tours, cooking

	demonstrations, etc. This should NOT include providing literature without active education component.