WASHTENAW COORDINATED FUNDERS

COMMUNITY-LEVEL OUTCOMES (2016 – 2018)

Priority Area	Community-Level Outcome	Measurement Tool(s)
Early Childhood	**Increase the developmental readiness of children with high needs* so they can succeed in school at the time of school entry.** **Children with high needs are defined as: children from birth through kindergarten entry who are from low-income families (i.e., at or below 200% FPL) or otherwise in need of special assistance and support. Specifically those who have disabilities or developmental delays; those who are English learners; those who are migrant, homeless, or in foster care; and/or those who are the children of teen mothers.*	*Under Development*
School-Aged Youth	**Increase the high school graduation rate of economically disadvantaged youth.*** **Economically disadvantaged youth are defined as those who qualify for the free or reduced lunch program, or youth from families with incomes below 185% of the federal poverty limit (FPL), particularly youth living in low equity/opportunity neighborhoods.*	MI School Data
	Increase the physical and emotional safety of economically disadvantaged children and youth* in their homes, schools and communities. **Economically disadvantaged children and youth are defined as those who qualify for the free or reduced lunch program and/or children and youth from families with incomes below 185% of the federal poverty limit (FPL), particularly children and youth living in low equity/opportunity neighborhoods.*	MI School Data, Michigan Profile for Healthy Youth (MiPHY), and WISD Senior Exit Survey
Safety Net Health and Nutrition	**Increase access to health services and resources for low-income residents.*** **Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*	Medicaid Green Book, and the American Community Survey (ACS)
	Decrease food insecurity* for low-income residents.** **Food insecurity is defined as the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.* ***Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*	Feeding America Survey
Housing and Homelessness	**Reduce the number of people who are experiencing homelessness.** *Individuals living at or below 30% AMI are the target population for programs that align with this outcome.*	Point-in-Time (PIT) Count and Homeless Management Information System (HMIS)
Aging	**Increase or maintain independent living factors for vulnerable, low-income* adults who are 60 years of age and older.** **Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).* *Note: Geographic Catchment and Housing Area Priorities are rural townships, subsidized housing units, mobile home communities, and community dwellers who reside alone.*	*Under Development*

Priority Area: **Early Childhood**

Sector Leader Entity: **Cradle to Career Collaborative – Success by 6**

Increase the developmental readiness of children with high needs* so they can succeed in school at the time of school entry. *Children with high needs are defined as: children from birth through kindergarten entry who are from low-income families (i.e., at or below 200% FPL) particularly families living in low equity/opportunity neighborhoods and/or otherwise in need of special assistance and support. Specifically those who have disabilities or developmental delays; those who are English learners; those who are migrant, homeless or in foster care; and/or those who are the children of teen mothers. Measured by the pilot program of the Kindergarten Entry Assessment (KEA).		
Program Strategy #1: **Parent Engagement and Education** *[Competitive Funding]*	**Program Strategy #2:** **Access to High-quality Early Learning** *[Competitive Funding]*	**Program Strategy #3:** **Strengthen Social Emotional Health** *[Competitive Funding]*
Research indicates that programs should have some or all of the following best practice components: • Uses a research-based program design • Adheres to structure & content of program model to ensure fidelity • Is culturally responsive to parents • Focuses on family strengths rather than deficits • Effectively educates parents about parenting, child health & and development in all domains (including language development & communication) • Incorporates one or more of the protective factors of the Strengthening Families Approach: parental resilience; social connections; knowledge of parenting & child development; concrete support in times of need; & social and emotional competence of children • Focus on a two-generation approach which includes quality early education for children and workforce training and/or post-secondary education for their parents and a focus on family literacy • Staffed with professionals trained in the program design who are credible with targeted families • Includes strategies to engage & connect with families with high need • Includes a curriculum-based assessment used to inform instruction, monitor progress and evaluate the program.	**Research indicates that programs should have some or all of the following best practice components:** • Provide scholarships to children and their families to give them access to high-quality early care and learning programs • Scholarships can only be used with programs than participate in a quality improvement or rating system, such as NAEYC accreditation or participate in the Great Start to Quality and have a Quality Improvement Plan or a 3, 4 or 5 Star Rating. The programs must also use a recognized evidence based curriculum and child assessment tool for measurement of child development • Early Learning Programs are encouraged to have family engagement components and demonstrate cultural sensitivity and responsiveness. Scholarship programs must include: • Clear eligibility requirements • Prioritize children with highest need.	**Programs must meet the DHHS criteria for an evidence-based home visiting program model (per the Home Visiting Evidence of Effectiveness, HomVEE) and have recognized positive outcomes for child development and school readiness.** Program examples include: • Child FIRST • Early Head Start – Home Visiting (EHSHV) • Early Start (New Zealand) • Family Check-Up • Healthy Families America (HFA) • Home Instruction for Parents of Preschool Youngsters (HIPPY) • Nurse Family Partnership (NFP) • Parents as Teachers (PAT) • Play and Learning Strategies (PALS) • Project 12-Ways/SafeCare Evidence-based curricula should include a curriculum-based assessment used to inform instruction, monitor progress and evaluate the program.
Early Childhood Program Outcome **1A.** Increased number of parents developing measurably stronger parenting skills & knowledge of child development, as measured by curriculum evaluation tool* and program attendance.	**Early Childhood Program Outcome** **2A.** Increased number of children with high needs participating in high-quality child care and preschool programs, as measured by program attendance.	**Early Childhood Program Outcome** **3A.** Increased number of parents participating in home visiting programs, as measured by program attendance. In addition, outcomes should align with those of the evidence-based program model being implemented.

Priority Area: **School-Aged Youth**

Sector Leader Entity: **Cradle to Career Collaborative – Washtenaw Alliance for Children and Youth**

Increase the high school graduation rate of economically disadvantaged youth.

**Economically disadvantaged youth are defined as those who qualify for the free or reduce lunch program and/or youth from families with incomes below 185% of the federal poverty limit (FPL), particularly children and youth living in low equity/opportunity neighborhoods*

Progress on this outcome is measured by the % of students who graduate high school from MiSchoolData; the % of students attending/absent from school from MiSchoolData; and the % of students proficient in reading and math on state standardized tests.

Program Strategy #1 **Intervention Programming to Foster Literacy, Academic Success, and School Engagement** *[Competitive Funding]*	**Program Strategy #2** **21st Century Skills and Youth Leadership Development Programming** *[Competitive Funding]*

Research indicates that programs should have some or all of the following best practice components:
• Academic-focused programs led by trained tutors using evidence-based approaches that are aligned with school-curriculum
• Family engagement, including supporting a 2-generational approach
• Attendance initiatives
• Positive peer groups and/or youth-driven engagement
• Evidence-based academic mentoring
• Educational support, including enrollment assistance and advocacy, accessing tutoring services, test preparation, credit recovery, academic monitoring and other activities to achieve educational goals
• Programs offered outside the classroom and in summer.
	Research indicates that programs should have some or all of the following best practice components:
	• Engage youth in programming that supports the development of 21st Century skills that help them graduate from high school prepared for college, work and life
	• Engage youth in high-quality programming that supports the development of voice, self-efficacy, and sense of agency by providing opportunities for youth collaboration, leadership, planning, choice, and reflection (see Youth Program Quality Assessment)
	• Strategies, curriculum and opportunities should build competencies in the areas of:
	  ◦ Learning and Innovation Skills: Creativity and innovation; critical thinking and problem solving; and communication and collaboration
	  ◦ Information, Media and Technology Skills: Information literacy; media literacy; and ICT (Information, Communications and Technology) literacy
	  ◦ Life and Career Skills: Flexibility and adaptability; initiative and self-direction; social and cross-cultural skills; productivity and accountability; and leadership and responsibility
	• Programs offered outside the classroom and in summer.

Youth Graduation Program Outcomes **1A.** Increased/maintained school attendance among youth who missed 10% or more days of school, as measured by PowerSchool or report cards. **1B.** Increased youth showing academic improvement of at least one grade level, as measured by a research-based and normed pre/post assessment for the specific area being targeted, to be chosen by the agency (see the QRI, TABE, or National Assessment of Educational Progress as examples). **1C.** Decreased letter grades of D's and F's (or elementary equivalent) and/or maintained letter grades of A's and B's that individual students earn, as measured by PowerSchool or report cards.	**Youth Graduation Program Outcomes** **2A.** Increased/improved 21st Century Learning Skills acquisition among youth, as measured by a research-based and normed pre/post assessment for the specific area being targeted, to be chosen by the agency (e.g. the Youth Experiences Survey 2.0). **2B.** Increased youth who report feeling greater sense of agency and opportunities for meaningful youth voice and engagement, as reported by Youth Self Report.

Priority Area: **School-Aged Youth**

Sector Leader Entity: **Cradle to Career Collaborative**

Increase the physical and emotional safety of economically disadvantaged children and youth* in their homes, schools and communities. *Economically disadvantaged youth are defined as those who qualify for the free or reduce lunch program and/or youth from families with incomes below 185% of the federal poverty limit (FPL), particularly children and youth living in low equity/opportunity neighborhoods.* Measured by the # of youth arrested or seen at juvenile court for a violent offense; the # of runaway reports filed with local law enforcement agencies; the # of students expelled from school as reported on MiSchoolData; the % of students who felt depressed in the last 12 months from MiPHY; the % of students who ever seriously considered attempting suicide from MiPHY; and the % of students who feel safe at school from WISD Senior Exit Survey		
Program Strategy #1 **Out-of-School Programming** *[Competitive Funding]*	**Program Strategy #2** **Programming that Facilitates Youth-Adult Relationships** *[Competitive Funding]*	**Program Strategy #3** **On-Site School Programming** *[Competitive Funding]*
Research indicates that programs should have some or all of the following best practice components: • Ensure safe out-of-school and community time and space through structured, supervised spaces and activities for children and youth • Curriculum on social emotional and other life skills as well as harm reduction approaches, evidence-based family-focused services and crisis care, and evidence-based preventive care, treatment, and aftercare • Programming will prioritize high-risk hours (evenings and weekends). • Culturally competent staff and staff trained in positive youth development practices • Plan for communication and coordination with schools and other systems in which youth are involved.	**Research indicates that programs should have some or all of the following best practice components:** • Build relationships between youth and positive, supportive adults who serve as role models, supporters, advocates and/or mentors; relationship is not academic-based • Provide for regular contact between mentors and mentees for a minimum of one year • Provide short-term, but high-impact opportunities for youth to build relationships and interact with community members who serve as role models, supporters, advocates and/or mentors such as life skills workshops, internships, job shadows, and career panels • A youth-driven approach that focuses on the needs of youth and aims to develop their competence and potential, including opportunities for youth to inform and drive the relationship and mentorship process such as during the matching process, relationship goal setting, and other support • Interactions may focus on helping the young person reach a goal. Other relationships may be more open-ended and include participation in a variety of activities • Adults receive specific training with clear expectations and on-going support • Establish processes for monitoring and closing of relationships.	**Research indicates that programs should have some or all of the following best practice components:** • Support safe school environments through on-site programming • Focused on conflict resolution, evidence-based restorative practices, positive interactions and violence prevention • Efforts foster accountability, community safety, and build social competency skill development • Promotion of alternative disciplinary responses to enhance communication, explore issues, and resolve conflict such as circles, peer juries, mediation, counseling, and community service • Student engagement initiatives.
Youth Safety Program Outcomes **1A.** Increased youth who report feeling safe at home, as measured by Youth Self Report. **1B.** Increased social competency skills and behaviors among youth as measured by pre/post-test survey (e.g. Social Competence Teen Survey). **1C.** Increased positive well-being (mental health) among youth, as measured by Youth Self Report. **1D.** Reduced drug/alcohol usage or frequency of use in the past 30 days among youth, as measured by Youth Self Report.	**Youth Safety Program Outcomes** **2A.** Increased youth who report feeling safe at home, as measured by Youth Self Report. **2B.** Increased youth who report at least one adult outside of their immediate family, as a result of participation in the program, who provides practical and emotional support, as measured by Youth Self Report. **2C.** Increased social competency skills and behaviors among youth as measured by pre/post-test survey (e.g. Social Competence Teen Survey). **2D.** Increased positive well-being (mental health) among youth, as measured by Youth Self Report. **2E.** Reduced drug/alcohol usage or frequency of use in the past 30 days among youth, as measured by Youth Self Report.	**Youth Safety Program Outcomes** **3A.** Increased youth who report feeling safe at home, as measured by Youth Self Report. **3B.** Increased youth who report feeling safe in school, as measured by Youth Self Report. **3C.** Increased social competency skills and behaviors among youth as measured by pre/post-test survey (e.g. Social Competence Teen Survey). **3D.** Increased positive well-being (mental health) among youth, as measured by Youth Self Report. **3E.** Reduced drug/alcohol usage or frequency of use in the past 30 days among youth, as measured by Youth Self Report.

Priority Area: **Safety Net Health and Nutrition**
Sector Leader Entity: **Washtenaw Health Plan**

<table>
<tr><td colspan="2">Increase access to health services and resources for low-income residents.*
*Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL) as measured by proxies for "access" such as the Medicaid Green Book to indicate Medicaid enrollment at a county level, and/or the American Community Survey to report annually on the level of insurance coverage.</td></tr>
<tr><td>Program Strategy #1
Benefits Advocacy and Referral Coordination
[Competitive Funding]</td><td>Program Strategy #2
Accessing Care Services
[Competitive Funding]</td></tr>
<tr><td>Research indicates that programs should have some or all of the following components:
• Assess eligibility for and assist eligible clients in enrolling in public benefits (e.g. Medicaid, ACA Marketplace enrollment with subsidies, SNAP, WIC, food programs, etc.) including local programs (e.g. Fare Deal)
And/or
• Provide care management or care navigation activities to assist individuals in finding providers and other assistance for medical, dental, mental health, substance use disorder, & disability needs.

Note: Benefits education and health literacy education should be included in any proposals.</td><td>Funding will support one of both of the following:
• Expanded organizational capacity for primary care, dental care, mental health services, substance use disorder services, and services to people with disabilities, to meet distinct population needs, through:
-- adding nontraditional hours
-- adding staff time
-- adding language or other translation capacity
And/or
• Maintenance of effort resources for primary care, dental care, mental health services, substance use disorder services, and services to people with disabilities to target individuals' needs.</td></tr>
<tr><td>Safety Net Health Program Outcomes
1A. Eligible individuals are enrolled and/or re-enrolled in publicly funded programs, including Medicaid, SNAP benefits, WIC, congregate meals, summer food programs, local benefits, etc., as measured by program-level data (i.e., participant tracking of applications).*
1B. Increased and/or maintained individuals who have providers/places for services for their medical, dental, mental health, substance use disorder, and/or disability needs, as measured by program level data (e.g. participant tracking).*</td><td>Safety Net Health Program Outcomes
2A. Increased or maintained access to health care services for the uninsured and for those with Medicaid or other health coverage, as measured by the organization's tracking of assistance to clients.*

*The Safety Net Health & Nutrition Sector Leader Group members will come together to develop agreed-upon metrics for participant tracking after grants have been awarded in May of 2016.</td></tr>
</table>

Priority Area: **Safety Net Health and Nutrition**

Sector Leader Entity: **Washtenaw Health Plan**

Decrease food insecurity* for low-income residents.** **Food insecurity is defined as the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.* ***Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty limit (FPL).*		
Program Strategy #1 **Hunger Relief** *[Non-Competitive Funding]*	**Program Strategy #2** **Nutrition Education Enhanced Produce Distribution** *[Competitive Funding]*	**Program Strategy #3** **Home-Bound Food Distribution** *[Competitive Funding]*

Distribute at least 6 million pounds of food, at least 50% of which is protein, fruits and vegetables, through Food Gatherers' network of food pantries, giving preference to programs that provide:
- Client choice pantries
- Nutritious foods, including fresh produce
- Culturally competent services
- Referral services
- Adequate hours of service
	Funded programs should have some or all of the following components:
	• Provide nutrition education in combination with the distribution of produce
	  - Possible programming includes: meal planning on a budget, disease-specific diet education, healthy cooking education, produce education, etc.
	  - Nutrition education programming should be specific to the target population
	  - When possible, nutrition education programming should be tested and evaluation materials validated
	  - Nutrition Education activities should not duplicate services provided by the existing network of SNAP-Education programming (http://www.map2healthyliving.org/)
	• Measure client barriers to healthy eating, and consumption of produce, and target programming to address these barriers
	• Work in partnership with Food Gatherers to coordinate nutrition programming and distribution services
	  - When possible, grant funds should be used to purchase produce through Food Gatherers
	• Funds can be used for:
	  - Staff time and operating costs associated with the nutrition education/produce distribution program,
	  - Produce, and produce distribution supplies,
	  - Nutrition education materials (including handouts, signs, cookbooks, supplemental cooking tools and ingredients, etc.)
	• Comply with all applicable local safety requirements for food storage, food distribution, and food service.
	Preference will be given to:
	- Programs serving participants primarily residing in the 48197, 48198 and 48108 zip codes
	- Existing produce distribution sites and programs.
	Note: Program must provide both nutrition education programming and distribution of produce. The Coordinated Funders will not fund proposals for education-only, produce distribution only, or pantry-only programs.
		Funded programs should have some or all of the following components:
		• Distribute home-delivered meals to all eligible low-income people. Eligibility means a person must be home-bound (i.e., is unable to leave his/her home under normal circumstances), unable to participate in a congregate nutrition program because of physical or emotional difficulties, or unable to obtain food or prepare complete meals
		• Use written eligibility criteria which prioritizes serving persons in greatest need
		• Demonstrate cooperation with congregate and other home delivered meal programs in the program area
		• Provide at least five days' worth of meals per week to clients, in the form of meals or equivalent groceries for those who can prepare food themselves
		• Comply with applicable food safety requirements for the preparation and transport of meals
		• Make liquid meals available to program participants when ordered by a physician
		• Complete a prioritizing pre-screen for each individual placed on the waiting list
		• Document client assessment data.
		
		Note: The Coordinated Funders will not fund direct operating costs for food pantries.

Nutrition Program Outcomes **1A.** Increased fruit and vegetables distribution to targeted low- income populations (at or below 200% FPL), as measured by pounds of produce distributed and percent of locations providing fresh produce.	**Nutrition Program Outcomes** **2A.** Increased consumption of fruits and vegetables among targeted low-income populations (at or below 200% FPL) at organizations that also provide fresh/perishable food distribution, as measured by nutrition risk assessment and consumer survey adopted by Food Gatherers. **2B.** Decreased nutritional risk for low-income (at or below 200% FPL) residents, as measured by nutrition risk assessment and consumer survey adopted by Food Gatherers.	**Nutrition Program Outcomes** **3A.** Decreased nutritional risk for low-income (at or below 200% FPL) residents, as measured by the reduction or elimination of waiting lists.

Priority Area: **Housing and Homelessness**

Sector Leader Entity: **Washtenaw Housing Alliance**

Reduce the number of people who are experiencing homelessness *The target population for programs that align with this outcome is persons at or below 30% AMI.*			
Program Strategy #1 **Homelessness Prevention** *[Competitive Funding]*	**Program Strategy #2** **Emergency Shelter, Transitional Housing and/or Homelessness Outreach** *[Competitive Funding]*	**Program Strategy #3** **Rapid Rehousing (RRH)** *[Competitive Funding]*	**Program Strategy #4** **Permanent Supportive Housing (PSH)** *[Competitive Funding]*
Research indicates that programs should have some or all of the following best practice components: • Provide financial assistance and support services to quickly stabilize those most at-risk of homelessness • Intake and assessment through Housing Access of Washtenaw County (HAWC) • Housing search assistance as needed • Housing placement services as needed • Linkage to appropriate support services as needed • Progressive engagement approach to case management.	**Research indicates that programs should have some or all of the following best practice components:** • Provide short-term, housing-focused interventions designed to move people into permanent housing • Intake and assessment through HAWC or coordination through existing system of care • Engage people experiencing homelessness in support services through targeted outreach Transitional housing is recommended only for youth and those in substance abuse recovery.	**Research indicates that programs should have some or all of the following best practice components:** • Provide financial assistance and support services to quickly re-house and stabilize those currently experiencing homelessness • Intake and assessment through HAWC Housing search assistance • Housing placement services Housing support services • Progressive engagement approach to case management • A Housing First model in which "housing assistance without preconditions or service participation requirements, and rapid placement and stabilization in permanent housing are primary goals".	**Research indicates that programs should have some or all of the following best practice components:** • Provide homeless persons with safe, decent, affordable housing units attached to the supports and case management necessary to keep people with significant challenges (such as mental illness, and substance use disorder) housed • Intake and assessment through HAWC Evidence-based approaches to case management, such as Critical Time Intervention • A Housing First model in which "housing assistance without preconditions or service participation requirements, and rapid placement and stabilization in permanent housing are primary goals".
Housing Program Outcomes **1A.** Increases number of people who maintained housing for at least 6 months after receiving direct financial assistance for housing-related payments and/or housing stabilization services as measured by HMIS*. **1B.** Increased number of people who remained stably housed for 6 and 12 months after service intervention as measured by HMIS*.	**Housing Program Outcomes** **2A.** Increased exits to permanent and/or positive housing (including RRH and PSH) as measured by HMIS*. **2B.** Increased or maintained income and/or benefits as measured by HMIS*. **2C.** Decreased length of time people are homeless (which includes time spent in ES and TH) as measured by HMIS*. **Or a comparable aggregate database, for agencies that exclusively serve victims of domestic violence and legal service agencies.*	**Housing Program Outcomes** **3A.** Increased exits to permanent and/or positive housing (including RRH and PSH) as measured by HMIS*. **3B.** Increased or maintained income and/or benefits as measured by HMIS*. **3C.** Increased number of people who remained stably housed for 6 and 12 months after service intervention as measured by HMIS*.	**Housing Program Outcomes** **4A.** Increased exits to permanent and/or positive housing (including RRH and PSH) as measured by HMIS*. **4B.** Increased or maintained income and/or benefits as measured by HMIS*. **4C.** Increased number of people who remained stably housed for 6 and 12 months after service intervention as measured by HMIS*.

Priority Area: **Aging**

Sector Leader Entity: **Blueprint for Aging**

<table>
<tr><td colspan="3">Increase or maintain independent living factors* for vulnerable, low-income** adults who are 60 years of age and older.
*Independent living factors are those that lead to an older adult's ability to age in the location of their choosing (age in place). Factors can include matters related to finance, housing, physical and mental health, social support, transportation, and personal care.
**Low-income residents are defined as individuals or households that are at or below 200% of the federal poverty level (FPL). Note: Geographic Catchment and Housing Area Priorities are rural townships, subsidized housing units, mobile home communities, and community dwellers who live alone.</td></tr>
<tr><td>Program Strategy #1
Senior Crisis Intervention
[Competitive Funding]</td><td>Program Strategy #2
Senior Service Network Navigation
[Competitive Funding]</td><td>Program Strategy #3
Senior Social Integration
[Competitive Funding]</td></tr>
<tr><td>Provides information, support, resources, referral and advocacy for seniors who are in imminent risk for losing their independence.
Programs will demonstrate the following best-practice components:
• Strategies or tools for identifying at-risk seniors (i.e. current case loads, referrals, waitlists)
• Strategies or tools for client and crisis needs assessment (pre-intervention Senior Snapshot survey)
• Utilization of Wraparound approach in crisis intervention planning
  - Provide intensive case management by multiple providers (i.e. coordination of services, sharing of resources, capitalizing on subject-matter expertise of providers)
  - Strategies for personal contact with client (i.e. in-home, telephone, or other technology)
  - Strategies for re-assessment for continuation/discharge
• Utilization of Motivational Interviewing techniques
• Strategies to ensure crisis interventions are person-centered and culturally competent
• Assessment of intervention outcome (post-intervention Senior Snapshot survey)
• Interventions are short term (≤6 months).</td><td>Provides services, information, support, resources, referral and advocacy to prevent seniors from losing their independence.
Programs will demonstrate the following best-practice components:
• Strategies or tools for client service needs assessment (pre-intervention Senior Snapshot survey)
• Provision and coordination of in-home or community based services in an individual or group format
• Utilization of Resiliency approach
  - Focuses on identifying and developing protective factors
  - Targets at-risk seniors
  - Targets during times of transition and stress (i.e. bereavement, decline in health, change in housing/finances)
  - Focuses on fostering supportive environments (i.e. access to aging services network and social support)
• Strategies to ensure ease of access to and navigation of senior service network (i.e. visible presence in community, on bus line, hours of operation, ADA accessible, staff availability, etc.)
• Awareness and promotion of local aging resources
• Utilization of Motivational Interviewing techniques
• Strategies to ensure services are person-centered and culturally competent
• Protocol for routine follow-up with clients
• Assessment of intervention outcome (post-intervention Senior Snapshot survey)
• Services are short term (<6mo) or longer (≤9mo). Strategy #2 services are typically less intensive than Strategy #1 services.</td><td>Provide activities, information, resources, referral and advocacy to help seniors improve or maintain social integration.
Programs will demonstrate the following best-practice components:
• Provision of preventive, community based services in an individual or group format (i.e. adult-day programs, senior center)
• Orientation of evidence-based programs and activities around the Six Dimensions of Wellness Model
• Utilization of Motivational Interviewing techniques to assist in assessing participant social isolation risk
• Provision of person-centered, culturally appropriate information, resources, and referral to other community programs/ services based on identified participant needs and preferences
• Routine assessment of participant social integration status (2x year Senior Snapshot)
• Services are long-term (≥6 months).</td></tr>
<tr><td>Program Outcome
Increased stabilization of vulnerable, low-income** older adults as measured by the Senior Snapshot.</td><td>Program Outcome
Increased or maintained protective factors and decreased risk factors for vulnerable, low-income** older adults as measured by the Senior Snapshot.</td><td>Program Outcome
Improved or maintained senior social integration as measured by the Senior Snapshot.</td></tr>
<tr><td>Outcome Indicators
1A. Number or percent of clients seeking and receiving critical senior services.
1B. Number or percent of clients who report the program helped them get the services they needed to move from crisis to stabilization (i.e. maintain independence).</td><td>Outcome Indicators
2A. Number or percent of clients seeking and receiving protective senior services.
2B. Number or percent of clients who report the program helped them get the services they needed to maintain their independence.</td><td>Outcome Indicators
3A. Number or percent of people participating in program activities.
3B. Number or percent of participants who report participation in program activities helped maintain their social integration† status.</td></tr>
</table>

Glossary: Aging Priority Area

“At risk” senior – Older adults may become vulnerable and live at risk of losing independence because of cognitive, psychosocial, and/or physical problems. Vulnerability is influenced by internal and external factors. Internal factors can include increasing age, multiple medical disorders, and cognitive, sensory or physical impairment. External factors can include lack of social support network, dependence on others for care, lack of community resources, financial, nutritional or housing insecurity, and adverse life events.

Client – In the context of maintaining factors of independence for older adult, caregivers have an integral role. Serving older adults with their caregivers as a dyad/family unit has theoretical and empirical support. Therefore, program strategies include the older adult *and* their caregiver as the “client.”

Coordination of Services – deliberate process of assessment, planning, facilitation and advocacy across multiple service sectors. Comprehensive, coherent, cost-effective, and continuous (when appropriate) response to a senior’s unique needs.

Cultural Competence – capacity of the provider and/or the program to present services to clients who have diverse social, cultural and linguistic needs.

Crisis Needs Assessment – formal identification of client crisis, needs, assets, and plans of care.

Independent Living Factors – Factors that lead to an older adult’s ability to age in the location of their choosing (age in place). Can include housing/ living circumstances, financial stability, functional capacity, social environment, health (physical and mental), personal attributes, and/or resources. There can be individual and cultural differences in these factors.

Motivational Interviewing (MI) – evidence-based conversational approach to eliciting desired behavior change. MI is collaborative and person-centered. Provider assesses client readiness, confidence, and importance of change. MI strategies for providers also include rolling with resistance, reflective listening, and supporting self-efficacy. MI is particularly useful for older adults because older adults exhibit symptoms, emotions, motives, and beliefs that are important to behavior change. Further, older adults value collaborative communication with providers and may sustain behavior change more effectively following interventions that emphasize collaboration.

Person-centered – intervention is respectful of and responsive to individual preferences, needs, and values and ensures the client’s values guide all decisions.

Protective Factors for Older Adults (Strategy 2) - collection of personal, social, and environmental factors that promote an individual’s ability to increase or maintain independence. Examples could include; service accessibility and delivery (transportation, healthcare, material resources), safe and affordable housing, linkages (kinship, support networks, and social bonds), personal development (education, volunteerism, physical activities), build confidence (sense of purpose and identity, self-efficacy), support self-sufficiency (ability to live within desired level of independence).

Resiliency Approach (Strategy 2) – Model focuses on an individual’s strengths and resources as opposed to strictly risk-based approaches. Activities support an individual’s ability to lessen the negative effects of stressful events and promote positive adaptation. This resilience is improved by the presence of protective factors. Rather than focusing solely on decreasing risk factors, services should also aim to promote an older adult’s independent living factors. This can limit the negative impact a risk factor has on an older adult’s independence.

Risk Factors for Older Adults (Strategy 2) – collection of personal, social, and environmental factors that decrease an individual’s ability to increase or maintain independence. Examples could include; personal loss (bereavement, divorce), physical or mental setbacks (mobility, sensory decline, chronic illness/pain, depression, cognitive impairment), toxic home life (alcoholic or abusive family member), unstable housing, tedium (idleness could result from isolation or too much free time), change in familiar roles or surroundings, and financial/legal stress.

Six Dimensions of Wellness Model – represents six interconnected categories of healthy living; emotional, spiritual, intellectual, social, physical and occupational. The Model is an effective approach to collaborative, prevention-focused initiatives because it addresses a range of needs in the diverse older adult population.

†Social Integration (Strategy 3) – the degree to which an individual is involved in social exchanges with others (family, friends, community) and perceives a sense of belonging (i.e. personal connection in the social system) to those groups.

Social Isolation (Strategy 3) - considered a risk factor in the development of negative health outcomes. It is evidenced by reports of loneliness, and/or absence of social interactions, contacts, or meaningful relationships with others.

Wraparound approach (Strategy 1) – form of intensive care coordination, uses a strength-based planning approach that considers the complex nature of the crisis and utilizes multiple layers of service and support in attaining the most impactful crisis resolution.