Washtenaw Coordinated Funders

Ann Arbor Area Community Foundation

ST. JOSEPH MERCY ANN ARBOR
SAINT JOSEPH MERCY HEALTH SYSTEM

RNR FOUNDATION

ONE COMMUNITY

United Way of Washtenaw County

coordinatedfunders.org

FY2018 PROGRAM OPERATIONS GRANTS CYCLE

PROGRAM STRATEGIES AND OUTCOMES SUMMARY

Published: 10.27.17

Revised: 1.16.18 This date reflects the timing of revisions, which will be infrequent and occur based on the evolving nature of this work.

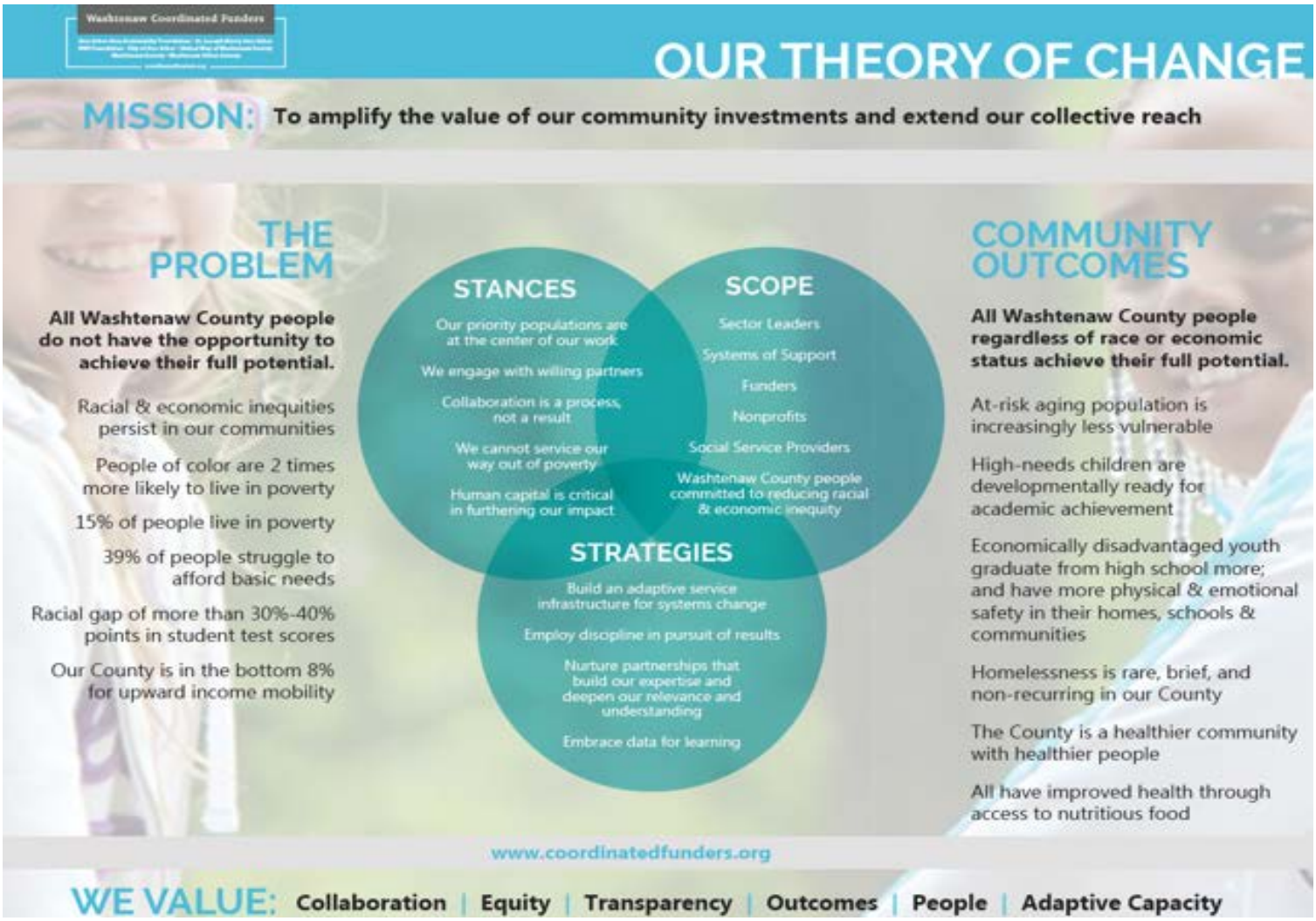
Table of Contents

ABOUT THE WASHTENAW COORDINATED FUNDERS

HISTORY

The Washtenaw Coordinated Funders is a funding collaborative established in 2010. Its partners now include United Way of Washtenaw County, the Ann Arbor Area Community Foundation, Saint Joseph Mercy Ann Arbor, the RNR Foundation, Washtenaw County, the City of Ann Arbor, and the Washtenaw Urban County (represented by the Office of Community and Economic Development).The partnership focuses its collective funding within four (4) priority areas through three (3) funding components intended to: support human services programming; build nonprofit capacity; foster community collaboration and systems-level change. We articulate our mission, vision, impact, and activities in our Theory of Change, featured below.

THEORY OF CHANGE



OUR VALUES

- *Collaboration* - We embrace long-term interactions based on shared mission and goals; and shared decision making and resources
- *Equity* - We pursue greater access to opportunities and resources for all
- *Transparency* - We are open about our policies and practices
- *Outcomes* - We invest in evidenced-based interventions
- *People* - We keep Washtenaw County people at the center of our work
- *Adaptive Capacity* - Our model will sustainably flex and evolve over time in response to changing community conditions

KEY ASSUMPTIONS ABOUT OUR WORK

The Washtenaw Coordinated Funders . . .

. . . are part of the community, and are one participant in many community efforts to improve the community

. . . take a long-term approach to affecting community-level outcomes, and acknowledge that changes to those outcomes may be incremental

. . . recognize that to affect community-level outcomes requires changes in many community factors; many of these factors may be outside the Washtenaw Coordinated Funders' influence

. . . work together with community partners to select program-level strategies, outcomes and indicators in which direct short-term change can and should be seen.

UNDERSTANDING EQUITY

The Washtenaw Coordinated Funders use the following definitions of social, racial, and economic equity to guide our work:

- *Social Equity* - Social equity means that all persons in Washtenaw County have fair and equal access to livelihood, education, resources, and other social securities; full participation in the political and cultural life of the community; self-determination in meeting fundamental needs; and equal status and rights under the law. To achieve social equity, measures must be taken to eliminate enforced social class and discrimination in systems, based on unchangeable parts of a person's identity, such as race, gender, age, place, sexual orientation, origin, class, or income.
- *Economic Equity* - Economic equity is the state in which goods and incomes are fairly distributed among all persons in Washtenaw County. Currently, large differences exist in relative incomes for people of different races, ethnicities, and presenting genders. To achieve economic equity, actions must be taken to eliminate poverty and differences in income currently sanctioned by systems, policies, and institutions, and then replaced with systems that produce equal opportunity for all to achieve the American dream of prosperity in return for hard work and a universal system of support that includes an adequate safety net for those in need.

- *Racial Equity* **-** Racial equity is the state in which race and ethnicity no longer adversely shape an individual or group's experience with power, access to opportunity, treatment and outcomes.

HOW WE INVEST OUR RESOURCES

We invest in best-practice program strategies decided through a collaborative process with grantees and stakeholders. Each strategy evaluates grantee's movement on measurable program outcomes. Achievement on these program outcomes is in service of our community-level outcomes.

To best deliver on our value as a grant making collaborative, we will:

1. Identify effective strategic priorities, priority populations, program outcomes and program strategies
   - Set measurable program outcomes in collaboration with our grantees
   - Determine key drivers for change and incorporate them into our funding strategies
   - Select and execute best-practice strategies that will create the most impact

2. Partner with others
   - Collaborate closely with organizations from all sectors to advance on our community-level outcomes
   - Invite others to "co-invest" with us to achieve our community-level outcomes

3. Evaluate our progress
   - Report to the community on our progress towards our community-level outcomes, including the efficacy and effectiveness of our strategic priorities to address them
   - Engage the community to influence how we improve our model and processes
   - Adjust our approach as needed

We employ a variety of strategies, beyond grant making, to achieve our strategic priorities including:

- Advocacy- we raise our collective voices in support of policies that positively affect our priority populations
- Co-investment- we collectively invest resources to advance on our community-level outcomes
- Collaboration- we work together with community partners in service of our community-level outcomes
- Convening- we hold space for enriching peer-learning opportunities and provide technical assistance
- Building Public Awareness- we increase knowledge through sharing valuable resources with the community
- Relationships-we work hard to ensure our community relationships are meaningful and driven by a collective purpose
- Research-we keep ourselves abreast of the most up-to-date research affecting our investment areas to assure we are making the most meaningful impact possible

FY18 PROGRAM OPERATIONS FUNDING STRATEGY

The Washtenaw Coordinated Funders seek to achieve a state in which all persons in Washtenaw County are able to achieve their full human potential regardless of race or socio-economic status. To this end, grant funds awarded through the Request for Proposals for the Coordinated Funding 2018 Program Operations Grant Cycle will be deployed through a funding strategy that prioritizes those persons and groups with the greatest needs in our community. The funding strategy is a tool to integrate grant investments across our four priority areas (aging/older adults, housing & homelessness, safety-net health & nutrition, and cradle to career) and focus our finite community resources on those who are in crisis or at-risk of being in crisis. This cycle, our grant investments (estimated $4.5M annually) will take shape along these guidelines:

Prevention/Intervention

Prevention Services & Programs: Focus on mitigating or reducing the likelihood of negative outcomes that affect quality of life.

- *Target Percentage Dollar Allocation:* ***35% - 45%***

Crisis Intervention Services & Programs: Address community issues as they currently exist: treating the immediate crisis for the individual or family as they arise.

- *Target Percentage Dollar Allocation:* ***55% - 65%***

Priority Populations

As a core tenant of the Coordinated Funding Theory of Change – Priority Populations are at the center of our work. Below are the boundary and priority area spanning populations that the Washtenaw Coordinated Funders are prioritizing across the funding portfolio. ***NOTE****: "Target Percentage Dollar Allocations" provide a range for the named priority population, but does not function as a relative portion for the entirety of the Coordinated Funding grant investment portfolio.*

Individuals and families residing in the zip codes of 48197 & 48198

- *Target Percentage Dollar Allocation: 70 – 75%*

Individuals and families residing in census tracts with a low or very low opportunity score rating on the Washtenaw Opportunity Index

- *Target Percentage Dollar Allocation: 25 -50%*

Individuals and families with annual incomes at or below 200% of the Federal Poverty Level

- *Target Percentage Dollar Allocation: 75 - 85%*

Families with newborns enrolled in Medicaid and/or families with children enrolled in the MIChild program

- *Target Percentage Dollar Allocation: 20-35%*

Homebound Seniors: Estimation of those seniors served by COFU investments that are homebound

- *Target Percentage Dollar Allocation: 20 – 35%*

Individuals and families experiencing chronic homelessness

- *Target Percentage Dollar Allocation: 15-30%*

OUR COMMUNITY-LEVEL OUTCOMES, PROGRAM STRATEGIES AND PROGRAM OUTCOMES

Following are our community-level outcomes*, program strategies and program outcomes. Additionally, we have identified secondary data and rationale for investment in our priority areas.

At the onset of the 2018-2020 funding cycle, Sector Leaders (lead organizations for a given priority area) and the Washtenaw Coordinated Funders engaged the network of providers and stakeholders working within each priority area to review, assess, and refine the program strategies and outcomes to:

- Understand how the landscape supporting services in this priority area has changed since the advent of the prior funding cycle
- Identify new or evolved research and best practices in program strategies or outcome measurements
- Co-create and collectively affirm the program strategies and outcome measures that the Washtenaw Coordinated Funders will resource through the 2018-2020 grant cycle

The majority of grant investments will be made through a competitive process. Some of our investments will resource "systems-level" organizations within our priority areas through a non-competitive process. These are organizations that are cornerstones of the systems in which they work, disruption of which would destabilize the system as a whole.

We commit to working with our grantees and community partners in assessing and understanding our progress towards achieving community goals, systems-level change and program outcome achievement.

** We will continue to modify the Community Indicators associated with community-level outcomes as new measures of community well-being become available and are disaggregated by race, income, and other demographic information.*

COMMUNITY-LEVEL OUTCOMES

All our investments and actions are anchored to the following community-level goals. We acknowledge that positive change on these outcomes will require more than grant funding alone from the Washtenaw Coordinated Funders. Achievement of these community-level outcomes will require aligned funding, advocacy, and systems-change by the ecosystem of human services funders and organizations in Washtenaw County.

PRIORITY AREA	COMMUNITY-LEVEL OUTCOME	OUTCOME INDICATORS
EARLY CHILDHOOD	Increase the developmental readiness of children with low incomes[1] (0-5) so they can succeed in school at the time of school entry.	• % of (single birth) babies born at low birthweight • # of children 0-8 who are substantiated victims of abuse or neglect • # and % of children entering kindergarten ready to learn The Kindergarten Readiness Assessment[2] • Third grade reading scores of children from economically disadvantaged families • Third grade reading scores of African American children
SCHOOL-AGED YOUTH	Increase the high school graduation rate of economically disadvantaged[3] youth.	• % of students who graduate high school from MiSchoolData • % of students attending/absent from school from MI SchoolData • % of students proficient in reading and math on state standardized tests
	Increase the physical and emotional safety of economically disadvantaged children and youth in their homes, schools and communities.	• # of youth arrested or seen at juvenile court for a violent offense • # of runaway reports filed with local law enforcement agencies • # of students expelled from school as reported on MI School Data • % of students who felt depressed in the last 12 months from MiPHY • % of students who ever seriously considered attempting suicide from MiPHY • % of students who feel safe at school from WISD Senior Exit Survey
SAFETY NET HEALTH & NUTRITION	Increase access to health services and resources for people with low-incomes.	• % of people with low incomes (household income below $35k) with health insurance • % of people with low incomes who report 10 or more days in month when mental health not good • % of people reporting general health is 'excellent, very good, or good
	Increase food security[4] for people with low incomes.	• Percentage of people with low incomes (household income below $35k) who consume 5 or more servings of fruits or veg per day from HIP Survey

[1] Low-income is defined as at or below 200% of the Federal poverty limit (FPL)
[2] The Kindergarten Readiness Assessment is to be fully implemented in Washtenaw County public and charter schools in the fall of 2018.
[3] Economically disadvantaged is defined as qualifying for the free or reduced lunch program and/or from families with incomes below 185% of FPL
[4] Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food-insecure households are not necessarily food insecure all the time. Food insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods.

		• Percentage of adults who accessed food stamps/SNAP within the past 12 months from U.S. Census Bureau • Percentage of people with low incomes who are food secure from Feeding America's Map the Meal Gap
HOUSING & HOMELESSNESS	Reduce the number of people who experience homelessness.	• % of households that maintained housing after receiving housing stabilization services • % of households that were successfully diverted to safe and appropriate alternatives to emergency shelter • % households permanently and/or positively housed from emergency shelter/transitional housing and/or street outreach • % households that increase or maintain income and/or benefits • The average or median time that households experience homelessness (emergency shelter and transitional housing) • % of households that exit rapid re-housing and remained housed for at least 6 months • % of households enrolled in permanent supportive housing (PSH) that remain successfully enrolled in PSH or exit to other permanent housing
AGING	Increase or maintain independent living factors for vulnerable adults 60 years of age and older, with low incomes.	• % of vulnerable older adults that increase quality of life score on the 60+ Survey • % of older adults concerned about losing their housing as reported in Health Improvement Plan and 60+ Survey • # of days/month older adults reported healthy mental health • # of days that older adults reported mental health preventing engagement in usual activities

PROGRAM STRATEGIES AND OUTCOMES BY PRIORITY AREA

Note: Applicants must report out on all outcomes associated with a selected program strategy. For each program outcome, there is one or more outcome indicator. Applicants need only select one outcome indicator to track progress towards an outcome, but are welcome to select and report out on more than one outcome indicator for a program outcome.

New this cycle, applicants are invited to select the program strategies that best demonstrate the impact of the proposed program on their participants across priority areas. Selecting multiple program strategies (and corresponding outcomes) does not increase the likelihood of grant funding being awarded.

PRIORITY AREA	EARLY CHILDHOOD
COMMUNITY-LEVEL OUTCOME	Increase the developmental readiness of children (0-5) with high needs so they can succeed in school at the time of school entry.
KEY RESULTS	• High needs children in Washtenaw County have access to quality early childhood education. • High needs children in Washtenaw County enter kindergarten ready to learn.
PRIORITY POPULATIONS	Children with high needs include: children from birth through kindergarten entry who are from low income families (at or below 200% FPL), families living in low equity/opportunity neighborhoods and/or otherwise in need of special assistance and support. Specifically those children 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.
PROBLEM & KEY DATA	From infancy through high school, children's educational outcomes are dependent on the quality of their learning experience. Quality early childhood education, in particular, has been shown to have a significant positive effect on future success, because brain circuits are developing actively then.[5] In fact, 85% of the brain's development happens before a child enters kindergarten.[6] However, thousands of children in Washtenaw County start school without the skills needed to succeed which can eliminate the achievement, or "opportunity" gap. At present, 66.5% of children in Washtenaw County aged 0-5 live with two parents or single parents who work[7]. An increasing trend shifting care from parent to provider underscores the need for more high quality early care and learning outside of the home. However, for many families, particularly those with low incomes, the demand for early care not only exceeds the available supply, but also costs more than they can afford. For a family with an infant

[5] Center for the Developing Child. "National Scientific Council on the Developing Child," 2010.
[6] Winter, Suzanne M., and Michael F. Kelley. "Forty Years of School Readiness Research: What Have We Learned?," 2008.
[7] American Community Survey, 2015 Estimate

	and a preschooler in full-time care, the average cost in Washtenaw County is $16,116 annually[8], forcing many families to place their children with family and friends in informal care settings.
RATIONALE FOR THIS PRIORITY AREA	High-quality early childhood education is the highest leverage investment in education. Attendance in high-quality early care and education settings is proven to substantially increase the number of children who start school ready to succeed. Every public dollar invested generates a return of up to $16.[9] This includes increased economic productivity and reduced reliance on social service programs. The foundation built by early childhood education strongly influences a child's future academic performance. Research indicates that when children receive quality early childhood education, they are more likely to read at grade level by 3rd grade.[10] The number of words a child knows at age 3 strongly correlates with reading and comprehension levels at ages 9 and 10.[11] By age 4, children in high-income homes have heard an estimated average of 48 million words while children in the poorest households have heard just 13 million. Ensuring all children are ready for kindergarten helps their peers and the entire education system by reducing the need for expensive remedial education, disruptive discipline and special education programs. Children who are school ready by age 5 are more likely to grow up to be productive in the workplace, a key to economic growth.
PROGRAM STRATEGY #1	**Family Engagement and Parenting Education**
PROGRAM COMPONENTS	Programs with the greatest likelihood of funding should exhibit some of all of the following components: • Uses a research- or evidence-based program design • Adheres to structure & content of program model to ensure fidelity • Is culturally responsive to caregivers and families • Focuses on family strengths rather than deficits • Provides evidence that it will effectively educate caregivers about parenting, child health and development in all domains (including language development and communication and/or the impact of trauma and toxic stress and ways to build child resilience • 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; and social/emotional competence of children • Includes a two-generation approach: 1. quality early education for children, 2. workforce training and/or post-secondary education for their parents and 3. a focus on family literacy • Staffed with professionals trained in the program design who are credible with families

[8] ALICE Report, Washtenaw County
[9] National Education Policy Center, November 2011
[10] *The importance of early brain development*. (2012). Retrieved from http://www.readyazkids.com/
[11] Ibid.

	• Includes strategies to engage & connect with families who are economically disadvantaged • Includes a curriculum-based assessment used to inform instruction, monitor progress and evaluate the program
OUTCOME 1A.	Improved caregiver engagement in their child's learning
OUTCOME INDICATORS	• **OI-1:** #/% of caregivers who increase participation in activities that increase protective factors (knowledge, skills, supports, parent-child bonding, family stability) which reduce toxic stress for their young children • **OI-2:** #/% of caregivers that engage in activities and parental supports identified in the selected curricula that encourage optimal learning for their children
OUTCOME 1B.	Increased capacity of families to navigate community supports that bolster their child's success
OUTCOME INDICATORS	• **OI-3:** #/% of caregivers who are referred to needed safety net services • **OI-4:** #/% of caregivers with increased knowledge of safety net services • **OI-5:** #/% of caregivers who feel more confident navigating safety net services • **OI-6:** #/% of caregivers with increased literacy skills
PROGRAM STRATEGY #2	**Access to High-Quality Early Learning**
PROGRAM COMPONENTS	Programs with the greatest likelihood of funding should exhibit some of all of the following components: • Provide scholarships to children and their families so they can access high-quality early care and learning programs • Scholarships can only be used with programs that 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 .Programs must also use a recognized evidence-based curriculum and child assessment tool for measurement of child development. • Includes family engagement components and demonstrates cultural sensitivity and responsiveness and support for English Language Learning parents. • Scholarship programs must include: o Clear eligibility requirements o Prioritize children with highest need
OUTCOME 2A.	Improved quality of early learning programs
OUTCOME INDICATORS	• **OI-7:** Agency demonstration of a plan for a higher Star Rating in the Great Start to Quality • **OI-8:** # of training hours completed by staff on an annual basis.
OUTCOME 2B.	Increased kindergarten readiness of children birth - age 4
OUTCOME INDICATORS	• **OI-9:** #/% of children demonstrating age appropriate progress, with the use of a screening or assessment tool such as COR, TS-GOLD or ASQ-3. • **OI-10:** #/% of children with high needs who have a documented developmental delay, who are connected with intervention services • **OI-11:** #/% of children with high needs participating in high quality early learning programs
OUTCOME 2C.	Increased family financial stability

OUTCOME INDICATORS	• **OI-12:** #/% of families who report a reduction in financial burden as a result of receiving a childcare scholarship • **OI-13:** #/% of families who report a reduction in stress as a result of receiving a childcare scholarship
PROGRAM STRATEGY #3	**Strengthen Parenting & Home Environments**
PROGRAM COMPONENTS	Programs with the greatest likelihood of funding must meet the DHHS criteria for an evidence-based home visiting program model (per the Home Visiting Evidence of Effectiveness, HomVEE). The evidence based program chosen must be one that has demonstrated 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. Funded programs must demonstrate dosage and fidelity to the evidence-based model.
OUTCOME 3A.	Increased kindergarten readiness of children birth – age 4
OUTCOME INDICATORS	• **OI-14:** #/% of children demonstrating age appropriate progress, with the use of a screening or assessment tool such as COR, TS-GOLD or ASQ-3. • **OI-15:** #/% of caregivers with increased knowledge about child development • **OI-16:** #/% of children served through home visiting programs
OUTCOME 3B.	Improved parenting skills
OUTCOME INDICATORS	• **OI-17:** #/% of caregivers who increase participation in activities that increase protective factors (knowledge, skills, supports, parent-child bonding, family stability) which reduce toxic stress for their young children • **OI-18:** #/% of caregivers who feel more confident in their ability to care for their children • **OI-19:** #/% of caregivers who achieve their family improvement goal
OUTCOME 3C.	Improved caregiver engagement in their child's learning
OUTCOME INDICATORS	• **OI-20:** #/% of caregivers who report engaging regularly in developmentally-appropriate activities with their children such as reading • **OI-21:** #/% of caregivers that engage in activities and parental supports identified in the selected curricula that encourage optimal learning for their children

PRIORITY AREA	SCHOOL-AGED YOUTH - GRADUATION
COMMUNITY-LEVEL OUTCOME	Increase the high school graduation rate of economically disadvantaged youth.
KEY RESULTS	• Economically disadvantaged youth graduate on time • Economically disadvantaged youth are equipped with the knowledge and skills necessary to succeed in college or career.
PRIORITY POPULATIONS	Economically disadvantaged youth, 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. The following populations will be further prioritized for services: children and youth living in low equity/opportunity neighborhoods, youth from single-parent households, youth with incarcerated parents, youth of color, youth disconnected from work and school, homeless youth, and/or court-involved youth.
PROBLEM & KEY DATA	Education is a lifelong experience that begins well before a child ever sets foot in a classroom and continues long past a cap-and-gown commencement. It is the broadest avenue to opportunity and the most influential factor in ensuring that children will grow up to do as well or better than their parents. But today's young Americans are less likely to earn a diploma than their parents, a distinction not shared by any other industrialized country.[12] Although the on-time graduation rate for non-economically disadvantaged youth in Washtenaw County is well above the state average (89% versus 79.6%), wide socioeconomic disparities persist. Only 72% of students on free/reduced lunch graduate on time.[13]
RATIONALE FOR THIS PRIORITY AREA	Children are learning to read until fourth grade; after that, they're reading to learn.[14] Students who don't read on grade level by the time they are in fourth grade typically don't catch up, and are four times as likely to drop out of high school.[15] During the 2016-17 school year, 65% of non-economically disadvantaged 3rd graders in Washtenaw County were proficient in reading, compared to only 24% of economically disadvantaged students.[16] A successful transition into middle school, a year when many students are held back or drop out, is especially important to high school success.[17] If students do not experience success in middle grades, they are much less likely to experience success later on. By eighth grade, gains in student achievement made during elementary school are often diminished. Notably, during the 2016-17 school year, 75% of non-economically disadvantaged 8th graders were proficient in reading as compared to 38% of economically

[12] Organization for Economic Cooperation and Development. (n.d.). Education at a Glance 2007: OECD Indicators, Indicator A1, Table A1.2a.
[13] Washtenaw Alliance for Children & Youth, 2017 Report Card
[14] Craig D. Jerald, Identifying Potential Dropouts: Key Lessons for Building an Early Warning Data System.
[15] Donald J. Hernandez. Double Jeopardy: How Third-Grade Reading Skills and Poverty Influence High School Graduation. The Annie E. Casey Foundation; Center for Demographic Analysis, University at Albany, State of New York; Foundation for Child Development, 2012.
[16] 2017 WACY Report Card
[17] Wheelock, Anne, and Jing Miao. "The Ninth- Grade Bottleneck: An Enrollment Bulge in a Transition Year that Demands Careful Attention and Action." School Administrator, 2005.

	disadvantaged students. Similarly, the percentage of non-economically disadvantaged 8th graders who were proficient in grade-level math was 63% as compared to 19% of economically disadvantaged 8th graders. We know that middle school students who are held back are seven times more likely to drop out, and 80% of students who repeat a class more than once are likely to drop out as well.[18]
PROGRAM STRATEGY #1	**Intervention Programming to Foster Literacy, Academic Success, and School Attendance and Engagement**
PROGRAM COMPONENTS	**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 • Programs that engage parents, guardians or caretakers either in programs along with youth or in separate programs with aligned goals, specifically related to improving academic performance and school engagement • Attendance initiatives • Positive peer groups and/or youth-driven engagement • Evidence-based mentoring for improved academic outcomes • 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. Programs that 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).
OUTCOME 1A.	Improved school attendance among chronically absent youth[19]
OUTCOME INDICATORS	• **OI-22:** #/% of youth who increase school attendance, as measured by PowerSchool or report cards • **OI-23:** #/% of youth who maintain school attendance, as measured by PowerSchool or report cards
OUTCOME 1B.	Improved academic achievement of youth
OUTCOME INDICATORS	• **OI-24:** #/% of youth who are proficient in core academic subjects (math, English language arts, science, and/or social studies), as measured by PowerSchool, report cards, or research-based and normed pre/post-assessment for the specific subject being targeted to be chosen by the agency. • **OI-25:** #/% of youth who earn passing grades in core academic subjects (math, English language arts, science, and/or social studies), as measured by PowerSchool, report cards, or research-based and normed pre/post-assessment for the specific subject being targeted to be chosen by the agency. • **OI-26:** #/% of youth who maintain passing grades in core academic subjects (math, English language arts, science, and/or social studies), as

[18] Alexander, Karl, Doris Entwisle, and Nader Kabbani. "The Dropout Process in Life Course Perspective: Early Risk Factors at Home and School." Teachers College Record 103, no. 5 (2001).
[19] "Chronic absence" is defined as students who miss 10% or more days of school per academic year. This definition aligns with the Michigan Department of Education.

	measured by PowerSchool, report cards, or research-based and normed pre/post-assessment for the specific subject being targeted to be chosen by the agency.

PRIORITY AREA	SCHOOL-AGED YOUTH - SAFETY
COMMUNITY-LEVEL OUTCOME	Increase the physical and emotional safety of economically disadvantaged children and youth in their homes, schools and communities
KEY RESULTS	Economically disadvantaged children and youth will experience a decrease in their exposure to trauma, which adversely affects their ability to thrive in and out of school
PRIORITY POPULATIONS	Economically disadvantaged youth, 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. The following populations will be further prioritized for services: children and youth living in low equity/opportunity neighborhoods, youth from single-parent households, youth with incarcerated parents, youth of color, youth disconnected from work and school, homeless youth, and/or court-involved youth.
PROBLEM & KEY DATA	We know that when children are nurtured and well cared for, particularly during their early years, they have better social-emotional, language and learning outcomes. Social-emotional development includes building positive relationships with others (also known as "attachment"), positive peer interactions, self-regulation, and social problem solving.[20] These skills have a far-reaching impact, as they are predictive of success in school and positive life-long outcomes. In Washtenaw County, 29% of students are economically disadvantaged, with particularly high percentages in Whitmore Lake (36.5), Lincoln (44.6), and Ypsilanti (74.4). We know that Adverse Childhood Experiences (ACES) can negatively affect someone's overall quality of life and well-being throughout the lifespan. According to Kids Count and the Michigan League for Public Policy, rates of confirmed victims of abuse and neglect have been steadily rising from 2009-2015 (6.2 to 10.7%, respectively). In the 2015-16 school year, 1258 youth experienced homelessness and there were 750 confirmed cases of abuse or neglect in Washtenaw County. Washtenaw County also experienced an alarming uptick in the number of completed suicides in 2016: 17 students, aged 15-24, died by suicide. This is the highest number on record at the Washtenaw County medical examiner's office.[21]
RATIONALE FOR THIS PRIORITY AREA	Good social-emotional and mental health is a key component of healthy youth development. Poverty, trauma, and inadequate treatment are three

[20] Services, S. C. (2012). Investment to Impact: Building the Future. Early Learning Division Outcomes Report 2011-2012.
[21] MLive, http://www.mlive.com/news/ann-arbor/index.ssf/2017/08/key_takeaways_youth_sucide.html

	factors that have been shown to have a sustained, negative impact on children's social, emotional and mental health.[22] Nationally, just over 20 percent of children (or 1 in 5) have either currently or at some point in their lives experienced a seriously debilitating mental disorder. Child mental health disorders are not only common but can also begin at a very young age, and if undiagnosed and treated, can have long-term consequences. Statistically, children and youth with mental health problems have lower educational achievement, greater involvement with the criminal justice system and fewer stable and longer-term placements in the child welfare system than children with other disabilities.[23] Adverse childhood experiences (ACEs) are stressful or traumatic events--such as childhood abuse, homelessness, extreme poverty and household dysfunction-- that occur between birth and age 18.[24] ACEs can cause changes in the brain that potentially lead to school failure, substance abuse and anti-social behaviors. The more ACEs one has, the greater one's likelihood of engaging in high-risk behaviors and performing poorly in school. In turn, failing at school, using drugs and engaging in criminal behaviors create a fast track to low wage jobs, chronic unemployment and other conditions leading to poverty.[25]
PROGRAM STRATEGY #1	**Out-of-School Programming**
PROGRAM COMPONENTS	**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. • Utilize 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. • Provide programs that prioritize high-risk hours (evenings and weekends). • Provide opportunities for youth to develop and apply social emotional skills including self-awareness, self-management, responsible decision-making, relationship skills, and social awareness. • Provide programs that engage parents, guardians or caretakers either in programs along with youth or in separate programs with aligned goals. • Plan for communication and coordination among schools and other systems in which youth are involved. • Staff are trained in cultural proficiency and service delivery is culturally responsive to youth and families served. Staff trained are trained in positive youth development practices and trauma-informed care.

[22] Center for the Study of Social Policy (2012). Results-based public policy strategies for promoting children's social, emotional and behavioral health.
[23] Ibid.
[24] Burchill-Blaisdell, W., Goldbaum, G., & Serafin, N. (2011). The effects of adverse childhood experiences in Snohomish county.
[25] Washington State Family Policy Council. (n.d.). Adverse Childhood Experiences. Retrieved from www.fpc.wa.gov.

OUTCOME 1A.	Increased youth safety at home and community
OUTCOME INDICATORS	• **OI-27A:** #/% of youth who report feeling safe at home, as measured by youth self-reporting. • **OI-27B:** #/% of youth who report feeling safe in their community, as measured by youth self-reporting.
OUTCOME 1B.	Improved perception of mental health among youth
OUTCOME INDICATORS	• **OI-28:** #/% of youth who report an increase in positive well-being, as measured by youth self-reporting.
PROGRAM STRATEGY #2	**Programming that facilitates youth-adult relationships**
PROGRAM COMPONENTS	**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 opportunities for youth to develop and apply social emotional skills including self-awareness, self-management, responsible decision-making, relationship skills, and social awareness. • 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. • Utilize 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, such as connecting youth with an employment opportunity. Other relationships may be more open-ended and include participation in a variety of activities. • Provide adults specific training with clear expectations and on-going support. • Establish processes for monitoring and closing of relationships. • Provide programs that engage parents, guardians or caretakers either in programs along with youth or in separate programs with aligned goals. • Staff are trained in cultural proficiency and service delivery is culturally responsive to youth and families served. Staff trained are trained in positive youth development practices and trauma-informed care.
OUTCOME 2A.	Increased youth safety at home or in community
OUTCOME INDICATOR	• **OI-29A:** #/% of youth who report feeling safe at home, as measured by youth self-reporting • **OI-29B:** #/% of youth who report feeling safe in their community, as measured by youth self-reporting
OUTCOME 2B.	Increased supportive youth-adult relationships

OUTCOME INDICATORS	• **OI-30:** #/% of 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-reporting • **OI-31:** #/% of parents, guardians or caretakers engaged as a part of program services
OUTCOME 2C.	Improved perception of mental health among youth
OUTCOME INDICATORS	• **OI-32:** #/% of youth who report an increase in positive well-being, as measured by youth self-reporting
PROGRAM STRATEGY #3	**On-Site School Programming**
PROGRAM COMPONENTS	**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. • Provide opportunities for youth to develop and apply social emotional skills including self-awareness, self-management, responsible decision-making, relationship skills, and social awareness. • 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. • Programs that engage parents, guardians or caretakers either in programs along with youth or in separate programs with aligned goals. • Staff are trained in cultural proficiency and service delivery is culturally responsive to youth and families served. Staff trained are trained in positive youth development practices and trauma-informed care.
OUTCOME 3A.	Increased youth safety in school
OUTCOME INDICATOR	• **OI-33:** #/% of youth who report feeling safe in school, as measured by youth self-reporting
OUTCOME 3B.	Improved perception of mental health among youth
OUTCOME INDICATORS	• **OI-34:** #/% of youth who report an increase in positive well-being, as measured by youth self-reporting

PRIORITY AREA	**SAFETY NET HEALTH**
COMMUNITY-LEVEL OUTCOME	Increase access to health services and resources for people with low incomes.
KEY RESULTS	• People can more easily access and obtain benefits for which they are eligible • People have access to quality services to necessary to maintain their health and wellbeing
PRIORITY POPULATIONS	People with low incomes, immigrants, refugees and those residing in 48197 & 48198 zip codes and western Washtenaw County.
PROBLEM & KEY	Poverty is considered a “key driver of health status.” Poverty makes it harder

DATA	to access health care, healthy food, and other necessities that contribute to health.[26] Nearly one-third of all K-12 public school students enrolled in Washtenaw County are eligible for free or reduced-price lunch, used as a proxy for poverty. Schools with the highest eligibility are located in the City of Ypsilanti, Ypsilanti Township, and Ann Arbor.[27] Further, we know that health inequities persist in Washtenaw County. The average age of death for white people (age 75) is higher than that of Black or African American people (age 62) and 20 years longer than that of Hispanic or Latino people (age 55).[28] In Washtenaw County, 92% of residents aged 0-64 years have health coverage; 8% are uninsured.[29] Those in Washtenaw County at highest risk for being uninsured include: Hispanics or Latinos; Black or African Americans; individuals with less than high school education; the unemployed; immigrants and refugees. Many Washtenaw County immigrants are low-income adults under 65 years of age that do not qualify for government health coverage because they have not been permanent legal residents for at least five years. Many immigrant families have children eligible for Medicaid. Approximately 19% of people of all ages (or 9%) in Washtenaw County have a disability categorized that limits their activity due to a physical, mental or emotional problem. Nearly half of all adults in the US will be diagnosed with a mental illness in their lifetime and 26% of adults. Forty seven (47%) of HIP 2015 Survey respondents reported that cost/insurance coverage was the reason for not accessing mental health treatment.
RATIONALE FOR THIS PRIORITY AREA	Individuals with access to healthcare services, on a timely basis, have better health outcomes. Limited access to needed healthcare services can results in reduced health outcomes and potentially unnecessary health complications, including premature death. Removal of barriers to health services and social supports are key factors in facilitating the behavioral changes that can lead individuals of all ages towards improved health and well-being.[30] Research demonstrates that reducing health care costs, including Medicare and Medicaid, is beneficial both for society and the consumer. Lowering medical expenses and improving health so that costly medications are no longer needed increases one's ability to purchase other necessary items such as food, housing and chore services.
PROGRAM	**Benefits Advocacy and Referral Coordination**

[26] Community Commons, Community Health Assessment www.chna.org.
[27] US Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe File. Accessed from www.chna.org.
[28] MDHHS 2011
[29] 2015 HIP survey data
[30] Farley, Tom, & Cohen, Deborah. (2005). *Prescription for a healthy nation: a new approach to improving our lives by fixing our everyday world*. Boston: Beacon Press.

STRATEGY #1	
PROGRAM COMPONENTS	Programs with the greatest likelihood of funding will: • Assess eligibility for and assist eligible clients in enrolling in and maintaining benefits including: o Health benefits - Medicaid, Marketplace, VA, Medicare o Food benefits - SNAP, WIC, other food programs o Federal and State financial benefits - child care, State Emergency Relief, SSI, SSDI o Local programs—Fare Deal, Washtenaw County ID, utility assistance • Demonstrate the ability to not only assist with initial applications but also handle trouble-shooting and advocacy with relevant agencies to ensure individuals obtain and maintain the benefits for which they are eligible **-- 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, and disability needs *All program proposals should include benefits education and health literacy education.*
OUTCOME 1A.	Increased or maintained access to federal, state, and local benefits and income supports
OUTCOME INDICATORS	• **OI-35:** #/% of individuals who are assessed for benefits eligibility and income supports • **OI-36:** #/% of individuals who completed or received assistance with applications (e.g. assistance with turning in supporting documentation) • **OI-37:** #/% of individuals who are approved for benefits and income supports
OUTCOME 1B.	Improved connection of priority population to healthcare and social services
OUTCOME INDICATORS	• **OI-38:** #/% of health referral connections made for individuals • **OI-39:** #/% of individuals who are referred to needed social services • **OI-40:** #/% of individuals with increased knowledge of healthcare and social service system navigation • **OI-41:** #/% of individuals who feel more confident navigating the healthcare and social service systems
PROGRAM STRATEGY #2	**Positive Maintenance of Services**
PROGRAM COMPONENTS	Funding will support maintenance of services that contribute to improved health or to the diagnosis, treatment and rehabilitation of low-income individuals. Services include, but are not limited to: primary care, dental care, mental health services, substance use disorder services, and services to people with disabilities. ***Note:*** *A proposed program could still qualify for maintenance of effort funding if it was previously funded outside of Coordinated Funding, to do so it must*

	demonstrate a prior track record and articulate the community need for maintenance services.
OUTCOME 2A.	Positive maintenance of services to priority populations
OUTCOME INDICATORS	• **OI-42:** #/% of individuals [insert priority population name] in [insert geography name] who receive [type of] services • **OI-43:** #/% of individuals reporting a positive experience
PROGRAM STRATEGY #3	**Expansion of Services or Pilot Programs**
PROGRAM COMPONENTS	Funding will support: • • Expanded organizational capacity for services, and/or services to a specific geographic or priority population. Services include but are not limited to: primary care, dental care, mental health services, substance use disorder services, and services to people with disabilities • Examples of expansion include o adding nontraditional hours o adding staff time o adding language or other translation capacity o expanding an existing program to a new geography or population **-- OR –** • Evidence-based pilot programming to a particular geography and/or priority population. ***Note:*** *Expansion refers to a program which demonstrates a documented need for increased capacity. A pilot refers to a program or service that is new to the organization, although it should be an evidence-based practice.*
OUTCOME 3A.	Increased access to services for priority populations
OUTCOME INDICATORS	• **OI-44:** #/% of individuals [insert priority population name] in [insert geography name] who receive [type of] services • **OI-45:** #/% of individuals reporting a positive experience

PRIORITY AREA	**NUTRITION**
COMMUNITY- LEVEL OUTCOME	Decrease food insecurity for people with low incomes
KEY RESULTS	• All people in Washtenaw County have improved access to nutritious food • Barriers to people with low incomes preparing and consuming nutritious food are reduced
PRIORITY POPULATIONS	People with low incomes, immigrants, refugees and those residing in 48197 & 48198 zip codes and western Washtenaw County.
PROBLEM & KEY DATA	There is still much work to be done to reach those people who struggle with hunger in our community. There are 49,170 food insecure people in Washtenaw County, which translates to a food insecurity rate of 13.9%.[31] Of these households, only 61% qualify, based on estimated household income,

[31] Map the Meal Gap 2015, Feeding America

	for SNAP or other federal nutrition programs. This figure is low compared to 74% of food insecure households statewide who qualify for SNAP or federal nutrition programs. We know that each year over 44,000 people in Washtenaw County turn to Food Gatherers' network of food pantries and meal service programs to feed themselves and their families. This includes 9,717 children and 2,829 seniors.[32] Food Gatherers distributes more than 2.4 million pounds of produce each year; however, we know that people with low incomes have low intake levels of fresh fruits and vegetables. Surveys done in FY15 revealed that Food Gatherers' pantry clients consumed on average less than 2 cups of fruits and vegetables per day (compared to the recommended 4.5 cups). These clients reported very high interest in consuming more fruits and vegetables, yet struggled with the affordability and accessibility of fresh foods. African-Americans in Washtenaw County have 15% higher obesity levels than their white neighbors, and have the highest rates of diabetes throughout the county (2010 Washtenaw County Health Equity Index Report Card) These diseases can be a consequence of poor diet, and show up at higher levels in areas of concentrated poverty. While we are living longer, healthier and more functional lives, a large portion of older adults continue reporting a variety of nutrition-related chronic health conditions. Access to an adequate, safe and healthy diet affects both the health and well-being of an individual as well as the ability to remain at home, which is the desire of most older adults[33]. Food insecure older adults are 50% more likely to have diabetes, 60% more likely to have congestive heart failure or a heart attack, twice as likely to report fair/poor health, twice as likely to have asthma and three times more likely to suffer depression.[34] Even being marginally food insecure ages individuals by nearly 14 years, such that a 64-year old suffering from hunger is likely to have the functional limitations of someone who is 78.[35]
RATIONALE FOR THIS PRIORITY AREA	Access to nutritious food— through food pantries, home delivery programs, or community gardengs-- help alleviate hunger immediately, and it also helps individuals and families with low incomes manage scarce resources. When an individual or family receives free groceries they are able to spend available cash on medical expenses, utilities, transportation or education instead of facing an impossible spending trade-off decision. Furthermore, we know that providing reliable and consistent of access to healthy food resources improves nutrition outcomes and the likelihood of behavior change when it comes to nutritional choices made.[36] Re-allocating resources like fresh, healthy food to communities and

[32] Hunger in America 2014, Feeding America
[33] Anyanwu et. al., 2011
[34] Ibid.
[35] Ziliak et. al., 2008
[36] As written by Food Gatherers in their FY16 year-end report to the Washtenaw Coordinated Funders.

	populations that have experienced the consequences of persistent racial and socio-economic inequity creates the opportunity for more of Washtenaw County people to lead healthier lives. Professor and aging activist Dr. Fernando M. Torres-Gill (1996) sums up the impact of senior hunger best when he says "Malnutrition costs. It costs older people by exacerbating disease, by increasing disability, by decreasing their resistance to infection, and by extending their hospital stays. It costs caregivers by increasing worry and caregiving demands. The entire country pays health care costs related to this increase in complication rates, increasing hospital stays, and increasing mortality rates. Malnutrition costs people and it costs dollars."
PROGRAM STRATEGY #1	**Hunger Relief** *[Directed Investment. Noncompetitive.]*
PROGRAM COMPONENTS	Food Gatherers seeks to leverage county, state and federal resources along with private philanthropy for the maximum benefit of people experiencing food insecurity in our community. In service of hunger relief, Food Gatherers will strengthen the food security system in the following ways: Maintain and strengthen the Food Security Network (FSN), a coordinated system comprised of strategic partner pantries that provide community members easy access to a variety of foods, including fresh fruits and vegetables, protein, and non-perishable items in a choice-style pantry. FSN sites provide referrals to additional services to help support individuals on their path to food security. Provide FSN partners with: • Healthy food for their pantries and free food deliveries • Ongoing technical assistance to optimize operations including free trainings and peer-learning opportunities • Prepare FSN partners to react to policy changes and coordinate countywide efforts to adjust services • Collect and share data between Food Gatherers and the FSN on programs and individuals served in order to understand the impact of programs and opportunities to collaborate • Promotion of the FSN partners through the Need Food page, phone line, flyers, and coordination of community outreach with other service providers such as schools and health clinics in order to reach underserved populations
OUTCOME 1A.	Increased consumption of fruits and vegetables among populations served by Food Security Network partners
OUTCOME INDICATORS	• **OI-46:** Total pounds of food distributed • **OI-47:** Total pounds of produce distributed • **OI-48:** Total pounds of healthy food distributed (F2E or Produce/Protein)
OUTCOME 1B.	Improved capacity of Food Security Network members to address hunger relief in Washtenaw County
OUTCOME INDICATORS	• **OI-49:** Total monetary value of food and services provided to FSN members through the Annual Benefits of Membership Report

	• **OI-50:** # and type of technical assistance offerings provided to to FSN members • **OI-51:** # and type of advocacy opportunities provided by GF to FSN members • **OI-52:** Positive changes to the food security system made by Food Gathers and/or FSN members
PROGRAM STRATEGY #2	**Enhancement of Food Security and Nutrition Education**
PROGRAM COMPONENTS	Programs with the greatest likelihood of funding will: • Prioritize individuals with low incomes for services • Demonstrate use of evidence-based practices and/or prior program impact • Include some or all of the following components: o Distribute home-delivered meals to eligible people. o Deliver groceries to eligible individuals who can prepare food themselves o Provide training, support, and supplies for people who would like to grow their own food • Show support for the Dietary Guidelines for Americans • Provide nutrition education in combination with the distribution of food or support of home gardening • Enhance, not duplicate, services provided by SNAP-Education or other existing nutrition education programs • Proposed food distribution services must: o Use written eligibility criteria which prioritizes people with greatest need o Cooperate with other home delivered meal programs in the program area so that services are not duplicated o Clearly describe how many days' worth of meals will be delivered as well as delivery frequency • Other strategies can be proposed and must effectively demonstrate the capacity to enhance food security and nutrition education *Note: Eligible people are those who are home-bound (e.g. unable to leave his/her home under normal circumstances), unable to participate in a congregate nutrition program due to physical or emotional difficulties, unable to obtain food or prepare complete meals*
OUTCOME 2A.	Increased access to healthy foods, including fruits and vegetables
OUTCOME INDICATORS	• **OI-53:** #/% of participants that improve their health and/or nutritional status through Meals on Wheels • **OI-54:** #/% of participants able to remain safely in their own homes as a result of the nutrition and daily volunteer contact received through home-delivered meals • **OI-55:** #/% of participants who reduce frequency of skipping meals • **OI-56:** #/% of participants getting fruits/vegetables through the program • **OI-57:** #/% of participants who engage in home and/or community gardening
OUTCOME 2B.	Increased client awareness of nutritional choices
OUTCOME	• **OI-58:** #/% of participants who report a change in intent to consume fresh

INDICATORS	fruits and vegetables • **OI-59:** #/% of participants who increase frequency of fruit and vegetable consumption • **OI-60:** #/% of participants who report selecting and cooking foods lower in fat, sugar, and salt • **OI-61:** #/% of participants who report cooking/preparing fresh fruits and vegetables • **OI-62:** #/% of participants who report an increase in knowledge around healthy food choices

PRIORITY AREA	**HOUSING & HOMELESSNESS**
COMMUNITY-LEVEL OUTCOME	Decrease the number of people experiencing homelessness
KEY RESULTS	• A reduction in the number of people experiencing homelessness for the first time • People experience homelessness for brief periods of time (less than 45 days) • A reduction in the number of people who experience recurring homeless episodes, following a permanent placement • A reduction in the number of people counted during the annual Point-In-Time Count
PRIORITY POPULATIONS	• Individuals and families experiencing chronic homelessness • Individuals and families with disabling conditions • Individuals and families disproportionately impacted by homelessness in Washtenaw County (per local trend data)
PROBLEM & KEY DATA	It is generally good to live in Washtenaw County, where high-level analysis reflects a healthy, wealthy, and thriving populace compared to other counties in the state and nation. In fact, Washtenaw County was ranked the third "hottest housing" market in the country. While the County's housing market presents as a thriving metro area for those with assets and incomes above AMI, safe and affordable housing remains a precious and limited commodity for individuals and families in Washtenaw County with low incomes. The 2016 Annual Homeless Count report revealed that 5,346 people accessed homeless services in Washtenaw County. Deeper analysis highlighted that 3,425 people resided in an emergency shelter, transitional housing program or a place not designed for human habitation. Additionally, the 2017 Annual Point-In-Time Count (PIT) revealed that 300 people experienced homelessness in Washtenaw County on January 26, 2017. This point-in-time data can be used to paint the picture of what homelessness looks like on any given night in Washtenaw County. Further analysis of the PIT data revealed disparities when considering race and disability. Over 50% of those counted identified as African American, and nearly 40% reported having a disabling condition.
RATIONALE FOR THIS PRIORITY AREA	Homeless services and housing programs provide a critical safety net for people experiencing homelessness in Washtenaw County. Not only do these services and programs address the immediate housing insecurity, but they provide much needed stabilization in other basic need domains (food,

	medical and behavioral health, and employment and benefits), as persons experiencing homelessness are often unable to address other needs until their immediate shelter needs are resolved. Decades of research indicates that ending homelessness begins and ends with housing. Homeless services and housing programs are leveraged to end homelessness for: families, unaccompanied youth, veterans, seniors, people surviving domestic violence and human trafficking, individuals with disabilities and those experiencing chronic homelessness. To that end, we must continue to invest resources in homeless services and housing programs that aid in ensuring that homelessness is rare, brief and non-recurring in Washtenaw County.
PROGRAM STRATEGY #1	**Homelessness Prevention and Diversion**
PROGRAM COMPONENTS	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 for 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: Programs should make efforts to maximize the number of households able to be served by providing households with the financial assistance in a progressive manner, providing only the assistance necessary to stabilize in permanent housing. • Provide diversion services to find safe and appropriate housing alternatives to entering shelter through problem-solving conversations, identifying community supports, and offering lighter touch solutions.
OUTCOME 1A.	60% of households served maintained existing housing, or moved to other permanent housing, after receiving direct financial assistance for housing-related payments and/or housing stabilization services as measured by the homeless management information system (HMIS)
OUTCOME INDICATOR	• **OI-63:** #/% of households served that maintain their housing or move to other permanent housing post intervention
OUTCOME 1B.	60% of households served remained stably housed for 3 months after service intervention as measured by HMIS
OUTCOME INDICATOR	• **OI-64:** #/% of households that remain stably housed post intervention (financial assistance and/or non-financial housing stabilization supports)
OUTCOME 1C.	For Diversion programs, 33% of households who receive diversion assistance were diverted to safe and appropriate alternatives to emergency shelter as measured by HMIS
OUTCOME INDICATOR	• **OI-65:** #/% of household assisted with diversion assistance that are successfully diverted from emergency shelter
PROGRAM STRATEGY #2	**Emergency Shelter, Transitional Housing and/or Homelessness Outreach**

PROGRAM COMPONENTS	Research indicates that programs should have some or all of the following best practice components: • Provide low-barrier, short-term and housing-focused interventions designed to move people quickly 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 *Recent research suggests that transitional housing should be used only for populations "in transition". It is recommended only for youth and those in substance abuse recovery.*
OUTCOME 2A.	60% of leaver households exit to permanent and/or positive housing (including RRH and PSH) as measured by HMIS
OUTCOME INDICATOR	• **OI-66:** #/% of households that exit to permanent housing from emergency shelter, transitional housing and/or street outreach
OUTCOME 2B.	50% of leaver households increase or maintain income and/or benefits as measured by HMIS
OUTCOME INDICATORS	• **OI-67:** #/% of households that acquired income and/or benefits during emergency shelter, transitional housing, and/or street outreach during program enrollment • **OI-68:** #/% of households that increase or maintain their income and/or benefits after exiting emergency shelter, transitional housing, and/or street outreach
OUTCOME 2C.	The average and median lengths of time households are homeless (which includes time spent in ES and TH) is less than 45 days, as measured by HMIS
OUTCOME INDICATOR	• **OI-69:** #/% of households who exit emergency shelter and transitional housing in 45 days or less
PROGRAM STRATEGY # 3	**Rapid Re-Housing (RRH)**
PROGRAM COMPONENTS	Research indicates that programs should have some or all of the following best practice components: • Intake and assessment through HAWC and all referrals made by the HAWC Community Housing Prioritization (CHP) Committee • Housing identification services: Help households access units that are desirable and sustainable by recruiting and retaining landlords and housing managers willing to rent to program participants who may otherwise fail to pass typical tenant screening criteria • Move-in and Rent assistance: Provide short-term help to households so they can pay for housing, including paying for security deposits, move-in expenses, rent, and utilities. • Case management and services: help participants obtain and move into permanent housing, support participants to stabilize in housing, and connect them to community and mainstream services and supports if needed. • Progressive engagement approach to case management: Programs should make efforts to maximize the number of households it is able to serve by providing households with the financial assistance in a

	progressive manner, providing only the assistance necessary to stabilize in permanent housing. • 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".
OUTCOME 3A.	Reduce the length of time households remain homeless: households served by the program should move into permanent housing in an average of 30 days or less from referral date to lease-up, as measured by HMIS
OUTCOME INDICATOR	• **OI-70:** #/% of households served in RRH that move into permanent housing within 30 days or less from program referral date
OUTCOME 3B.	80% of leaver households exit to a permanent housing destination (defined in the glossary of terms) as measured by HMIS
OUTCOME INDICATOR	• **OI-71:** #/% of households to exit to a permanent housing destination
OUTCOME 3C.	60% of leaver households increase or maintain income and/or benefits as measured by HMIS
OUTCOME INDICATORS	• **OI-72:** #/% of households that exit RRH with increased or stable income and/or benefits • **OI-73:** #/% who acquired income and/or benefits during RRH program enrollment
OUTCOME 3D.	85% of households that exit a rapid re-housing program to permanent housing will not become homeless again within 6 months, as measured by HMIS
OUTCOME INDICATORS	• **OI-74:** #/% of households that exit RRH to permanent housing • **OI-75:** #/% of households that exit RRH who maintain permanent housing for at least 6 months following RRH exit
PROGRAM STRATEGY# 4	**Permanent Supportive Housing (PSH)**
PROGRAM COMPONENTS	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 and all referrals made by the HAWC Community Housing Prioritization (CHP) Committee • Provides tenant households with a lease or sublease identical to non-supportive housing — with no limits on length of tenancy, as long as lease terms and conditions are met • 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"
OUTCOME 4A.	90% of all leaver and stayer households served retain permanent housing or move to other permanent housing, as measured by HMIS
OUTCOME INDICATOR	• **OI-76:** #/% of households who remain housed in PSH programs or exit to other permanent housing destinations

OUTCOME 4B.	60% of adult leavers and stayers served increase or maintain income and/or benefits as measured by HMIS
OUTCOME INDICATOR	• **OI-77:** #/% of adults who exit from PSH that increase or maintain their income
PRIORITY AREA	**AGING**
COMMUNITY- LEVEL OUTCOME	Increase or maintain independent living factors* for vulnerable adults with low incomes 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.*
KEY RESULTS	• Vulnerable older adults with low incomes are able to age in place with a better quality of life • Vulnerable older adults with low incomes have increased access to services that maintain or improve their quality of life
PRIORITY POPULATIONS	Older adults with low incomes at or below 200% of the federal poverty level (FPL) who are residing in rural townships, subsidized housing units, mobile home communities, homebound, non-native English speaking, as well as those living alone.
PROBLEM & KEY DATA	There are an estimated 65,756 individuals who are 60+ in Washtenaw County based on SEMCOG datasets. In the next 25 years, it is projected that the older adult population will increase to 108,129 people – with the majority of individuals being over 75 years old. Roughly 4,300 seniors in Washtenaw County are living at our below 125% of the Federal Poverty Level. To qualify for this category, the senior's individual or household income ranged between $14,000 - $19,000. For older adults to maintain independent living in Washtenaw County without public or private assistance, the following financial considerations need to be taken into account. Based on the Elder Economic Security Standard Index (which includes costs for housing, medical care, food, transportation), a single older adult that rents needs an annual income of $26,184 and a couple that rents needs an annual income of $38,604 to maintain independent living without any support.[37] For many of the estimated 4,300 low income older adults, this in not attainable. Also in Washtenaw County, we know that older adults that reside in the zip codes of 48197, 48191, 48160, and 48198, have a projected life expectancy below 79 years of age. Compared to seniors that reside in the zip codes of 48104 and 48105 live on average 5 years more than their counterparts. Additionally, when we factor in race, White or Caucasian individuals have a life expectancy of 80 years, compared to People of Color who have a life expectancy of 66 year – in total a 14 year disparity in life expectancy in Washtenaw County.
RATIONALE FOR THIS PRIORITY AREA	Today older adults across our County, especially those on fixed incomes, are forced to make the difficult choice between food, medicine, or housing. On top of that, they must learn to navigate an incredibly complex health and social support system in order to meet their needs. Vulnerable older adults

[37] Elder Economic Security Standard Index: https://www.ncoa.org/economic-security/money-management/elder-index/

	in particular, have difficulty accessing and utilizing the services that are available in our community, especially when they are in a crisis. We can do better as a community to make sure that older adults have the support network that they need not only during a crisis, but also in times of stability.
PROGRAM STRATEGY #1	**Senior Crisis Intervention** Movement by older adults with low incomes from crisis to a more stable condition as measured by the self-sufficiency assessment tool.
PROGRAM COMPONENTS	Information, support, resources, referral and benefits access and advocacy for seniors who are in imminent risk for losing their independence. **Programs with the greatest likelihood of funding will employ some of all of the following:** • Strategies or tools for identifying *at-risk seniors* (e.g. current case loads, outreach, referrals, waitlists) • Strategies or tools for *client and crisis needs assessment* (e.g. self-sufficiency assessment tool) • Use an *integrated services team approach* in crisis intervention planning • Provide urgent and intensive case management (e.g. *coordination of services*, sharing of resources, capitalizing on subject-matter expertise of providers) • Strategies for personal contact with client (e.g. in-home, telephone, or other technology) • Strategies for re-assessment for continuation of service or discharge • Use *Motivational Interviewing* techniques to achieve positive environment and behavior change • Strategies to ensure crisis interventions are *person-centered* and *culturally competent* • Assess the intervention's outcome (e.g. post-intervention self-sufficiency assessment) • Engage in short-term interventions (≤6 months)
OUTCOME 1A.	Improved stability of vulnerable adults with low incomes
OUTCOME INDICATORS	• **OI-78:** # of participants served • **OI-79:** #/% of participants who became more stable as a result of services (moved along the self-sufficiency continuum) • **OI-80:** #/% of participants who exited services at the safe and thriving levels *Outcome measurement tool: Abbreviated Arizona Self Sufficiency Scale Derivative*
OUTCOME 1B.	Increased or maintained access to federal, state, and local benefits and income supports
OUTCOME INDICATORS	• **OI-81:** #/% of individuals who are assessed for benefits eligibility and income supports • **OI-82:** #/% of individuals who completed or received assistance with applications (e.g. assistance with turning in supporting documentation) • **OI-83:** #/% of individuals who are approved for benefits and income supports • **OI-84:** Average cash value of benefits received per participant as a result of intervention (excluding intervention costs)

	• **OI-85:** Total cash value of benefits received by participants annually as a result of intervention (excluding intervention costs) *Outcome Measurement Tool: Tracking of cash and cash equivalents as measured in market value and/or cash equivalents.*
PROGRAM STRATEGY #2	**Senior Service Network Navigation** Increased or maintained protective factors and decreased risk factors for vulnerable, low-income older adults as measured by the self sufficiency assessment tool and economic status enhancement reports
PROGRAM COMPONENTS	**Programs with the greatest likelihood of funding will employ some of all of the following validated or best-practice components:** • Strategies or tools for *client service needs assessment* (pre-intervention self sufficiency assessment tool) • 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 (e.g. bereavement, decline in health, change in housing/finances) - Focuses on fostering supportive environments (e.g. access to aging services network and social support) • Strategies to ensure ease of access to benefits and navigation of senior service network (i.e. visible presence in community, on bus line, hours of operation, benefit application assistance, ADA accessible, staff availability, etc.) • Awareness and promotion of local aging resources • Utilization of *Motivational Interviewing* techniques enhance self management skills and achieve positive environment and behavior change. • Strategies to ensure services are *person-centered* and *culturally competent* • Protocol for routine follow-up with clients • Assess the intervention's outcome (e.g. post-intervention self-sufficiency assessment and economic status enhancement) • Strategy #2 services are typically less intensive than Strategy #1 services.
OUTCOME 2A.	Increased financial stability of vulnerable adults with low incomes

OUTCOME INDICATORS	• **OI-86:** #/% of individuals who are assessed for benefits eligibility and income supports • **OI-87:** #/% of individuals who completed or received assistance with applications (e.g. assistance with turning in supporting documentation) • **OI-88:** #/% of individuals who are approved for benefits and income supports • **OI-89:** Average cash value of benefits received per participant as a result of • **OI-90:** #/% of participants that experienced enhanced economic status from accessing new benefits • **OI-91:** Average cash value of benefits received per participant as a result of intervention (excluding intervention costs) • **OI-92:** Total cash value of benefits received by participants annually as a result of intervention (excluding intervention costs) *Measurement Tools: Service navigation benefit value calculator & benefits access return on investment report*
OUTCOME 2B.	Maintained independence of vulnerable adults with low incomes
OUTCOME INDICATORS	• **OI-93:** #% of participants who report the program helped them get needed services • **OI-94:** #/% of participants who report the services received were needed to enable them to stay in their home *Measurement Tool: Program assessment tool*
PROGRAM STRATEGY #3	**Senior Social Integration** Improved or maintained senior social integration as measured by the Center for Disease Control Health Related Quality of Life (HRQOL) Healthy Days Symptoms Module
PROGRAM COMPONENTS	Provide outreach, activities, information, resources, referral and advocacy to help seniors improve or maintain social integration. Programs with the greatest likelihood of funding will employ some of all of the following validated or best-practice components: • Provision of preventive, community based services in an individual or group format (e.g. adult-day programs, senior centers) • 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 and achieving positive environment and behavior change • 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 using the CDC HRQOL Healthy Days Symptoms Module • Provide longer-term services (≥6 months)
OUTCOME 3A.	Improved quality of life among vulnerable adults with low incomes
OUTCOME INDICATORS	• **OI-95:** #/% of participants who report an increase in number of days they feel good/healthy • **OI-96:** #/% of participants who report an increase in number of days with healthy mental health as reported in HRQOL Healthy Days Symptoms

	Module factors for depression, anxiety • **OI-97:** #/% of participants who report same number of days with healthy mental health as reported in HRQOL Healthy Days Symptoms Module factors for depression, anxiety • **OI-98:** #/% of participants who report a decrease in number of days that mental health prevents them from engaging in usual activities *Measurement Tool: HRQOL Healthy Days Symptoms Module*
OUTCOME 3B.	Reduced social isolation among vulnerable adults with low incomes
OUTCOME INDICATORS	• **OI-99:** #/% of participants who report participation in program activities helped maintain their *social integration* status

Washtenaw Coordinated Funders Points of Contact

Questions regarding the grants cycle may be directed to any of the below Coordinated Funding staff:

	POINTS OF CONTACT
REQUEST FOR INFORMATION (RFI) PROCESS	*United Way of Washtenaw County* Bridget Healy bhealy@uwwashtenaw.org Amanda Reel areel@uwwashtenaw.org
REQUEST FOR PROPOSAL(RFP) PROCESS	*Office of Community & Economic Development* Mercedes Brown brownmer@ewashtenaw.org Kimson Johnson johnsonk@ewashtenaw.org
CAPACITY BUILDING	*Ann Arbor Area Community Foundation* Jillian Rosen jrosen@aaacf.org Katie Van Dusen kvandusen@aaacf.org
TCC EVALUATION AND OTHER INQUIRIES	Elisabeth Vanderpool, Saint Joseph Mercy Ann Arbor elisabeth.vanderpool@stjoeshealth.org

Questions regarding the program strategies, components, program outcomes and measurements can be directed to the below Coordinated Funding staff:

PRIORITY AREA	POINTS OF CONTACT
EARLY CHILDHOOD	Bridget Healy bhealy@uwwashtenaw.org
SCHOOL-AGED YOUTH	Jillian Rosen jrosen@aaacf.org
SAFETY NET HEALTH & NUTRITION	Elisabeth Vanderpool elisabeth.vanderpool@stjoeshealth.org
HOUSING & HOMELESSNESS	Mercedes Brown brownmer@ewashtenaw.org

AGING	Jillian Rosen jrosen@aaacf.org