AGENDA FOR COMMUNITY IMPACT

United Way
Trident United Way
June 2011
For the last two years, volunteers, supporters and staff of Trident United Way have been working together to create a new framework for transforming our community – an Agenda for Community Impact.

As you will see in the pages that follow, this is the next logical step in our evolution as a community problem solver; focused on education, financial stability and health; guided by research and anchored by measurable results; all in the service of changing conditions in our community to improve the lives of all of us in the Lowcountry.

Three community goals for 2020 form the lynchpin of our plan. They involve reducing the dropout rate, reducing poverty and increasing healthy living in our community. This effort will require a concerted community effort that involves all of us giving, advocating and volunteering. Trident United Way offers to lead with a broad vision, and also to collaborate, support and follow, whenever appropriate.

This report is a complete vision, with a plan to achieve our goals. And yet, it is simply a starting point; there is so much more to learn and act upon in the next 10 years. I invite you to take a look at the report and think about how you would like to become engaged. Together we really can LIVE UNITED.

Lonnie Carter  
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Board Chair, Trident United Way
Trident United Way (TUW) is grateful for the commitment and support of the following community volunteers who served as the architects for the Agenda for Community Impact (Impact Agenda). The TUW Board of Directors empowered the following groups to create this high-level, comprehensive community plan. These volunteers contributed hundreds of hours to the model development, strategy formation and outcome evaluation plan that will guide the successful implementation of the Impact Agenda.

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After the Impact Councils and Board of Directors created the global framework for the Impact Agenda, Trident United Way (TUW) held eight community listening sessions to solicit feedback from stakeholders. The recommendations made by the following individuals greatly refined and enhanced the strategic direction for TUW over the next decade. A special Thank You is dedicated to these volunteers.

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Throughout its history, Trident United Way (TUW) has focused on improving lives by mobilizing the financial resources of businesses and donors to support direct service programs in the community. Fundamental to TUW’s mission, this approach will continue to be a core part of its business into the future. However, after more than a decade of successfully enhancing individual programs’ outcomes, it is evident that this approach is not comprehensive enough to produce long-lasting change on critical issues in the community. Despite all of the services provided each year, the disparity in the quality of life among individuals in our region has continued to grow.

To address larger, more systemic issues, it will be necessary for the community to focus on the conditions or root causes that perpetuate the problems. Toward this end, in 2006, TUW adopted a two-pronged approach to improving lives by adding a focus on the creation of lasting changes in community conditions by mobilizing people, time and talent and leveraging relationships, expertise, technology and funding. The graphic depicts the traditional approach of funding community programs, as well as the systemic approach to community impact.

At that time, TUW decided to use its work in Children and Youth Services as a pilot. With the creation of the Children and Youth Services Impact Agenda, TUW began to look at the ways in which it could influence community attitudes, networks, neighborhoods and organizations toward systemic change. Using a portion of its resources, TUW leveraged its relationships to build partnerships among multiple community organizations, governmental entities and businesses to launch initiatives aimed at greater community impact than individual programs could achieve on their own. An example of these efforts was a project called 4KNow!!, where TUW led a series of community mobilization events focused on the need for expanded access to high-quality four-year-old kindergarten programs. TUW also launched Links to Success, a collaborative service delivery and funding model that created a coordinated approach to delivering evidence-based private and public sector services in high-poverty, low-performing schools.
These successful early efforts led the TUW Board of Directors to examine how community impact efforts could be incorporated into all of TUW’s work. To effectively do so, it became evident that TUW would need to move away from what historically had been an age continuum with impact areas focused on early childhood through later adulthood. Instead, it would need to narrow its focus to a few pressing community issues.

In 2008, TUW adopted Education, Income and Health (E-I-H) as its priority impact areas, with two supporting areas, Safety Net and Connecting the Community. Our community’s consistently high number of families living in poverty, low graduation rate and number of individuals without access to health care led to E-I-H being identified as a primary focus during the next several years.

The TUW Board also recognized the need for a comprehensive community plan to mobilize the human and financial resources necessary for lasting community change. TUW revitalized its Impact Councils and Community Impact Committee with the addition of several new community leaders. These groups were empowered to engage the community to create a high-level action plan that establishes the goals, strategies, policy changes, measurements and resources necessary to have a fundamental impact on outcomes in Education, Income and Health. These efforts led to the development of this Agenda for Community Impact (the “Impact Agenda”). More than 100 community volunteers have been the primary architects in its creation.

LISTENING TO THE COMMUNITY

In December 2009, the Board approved the global strategic direction proposed by the Impact Councils and formed a Resource Development Task Force to examine the human and financial resources that would be necessary to fully implement the Impact Agenda. During the first four months of 2010, TUW hosted a series of Community Listening Sessions to solicit feedback from more than 100 additional stakeholders on the proposed Impact Agenda and resource development strategies.

TUW listened carefully to the stakeholders’ suggestions on how to make the Impact Agenda stronger. This critical feedback resulted in a number of refinements:

- “Community Impact” has replaced “Community Building” in staff and volunteer committee titles to more accurately reflect the work of these groups. The Impact Agenda falls under the auspices of these groups.
- The Income impact area has been renamed Financial Stability to add clarity to the purpose and work of this area.
- The focus of Safety Net has been refined to the coordination of basic needs and development of basic skills. It is no longer a stand-alone impact area, as it has been integrated with the work of Income to create the new Financial Stability impact area.
- As a result of these changes, TUW’s priority focus has been narrowed to Education, Financial Stability and Health. A focal point for innovation will be on the creation of Integrated Community Strategies and Systems that influence change across all three impact areas. This will include strategies that change systems, environments and policies.

In addition to creating impact on these key issues, stakeholders also encouraged TUW to lead efforts in developing the infrastructure for systems designed to have community-wide impact, such as:
• **A multi-faceted system for volunteerism.** The focus of Connecting the Community has been narrowed to creating this enhanced volunteer system under 2-1-1 Volunteer Connection. It is no longer a separate impact area.

• **Advocacy at the public policy level.** Policy change is essential to having positive community impact on systems related to education, health care, public supports and economic prosperity. An integrated Public Policy Agenda is under development and will significantly impact TUW’s work in the future.

• **A fully-integrated system for measuring and reporting community outcomes.** TUW is one of the founding members of the national collaborative that created Community Issues Management (CIM), an information management and mapping system organized around key community issues. CIM will be a cornerstone of TUW’s enhanced focus on measuring community-level impact and tracking outcomes longitudinally.

The stakeholders who participated in the Community Listening Sessions strongly encouraged TUW to take a leadership role in mobilizing the community around improving conditions related to Education, Financial Stability and Health. They encouraged TUW to:

• **Approach these issues from a neutral, unbiased position:** discourage organizational agendas.

• **Share openly:** everyone should be expected to bring all of their resources to the table.

• **Think as entrepreneurs:** seek aggressive ways to maximize return on investment.

• **Insist on measurable results:** investments should be based on performance against identified community goals.

• **Focus on capacity building and collaboration:** look at ways organizations, programs and individuals can cooperatively benefit from each other to build greater overall capacity.

• **Demonstrate a willingness to change:** the courage to shift resources from what’s not working to what is.

**BOLD GOALS FOR BOLD CHANGE**

In 2008, United Way Worldwide (UWW) set forth bold 10-year “Goals For The Common Good” by challenging America as a nation to:

• Cut by half the number of young people who drop out of high school.

• Cut by half the number of lower-income families that lack financial stability.

• Increase by a third the number of youth and adults who are healthy and avoid risky behavior.

UWW established these targets in Education, Financial Stability and Health as “the building blocks of a good life.” Everyone deserves a quality education that leads to a stable job, enough income to support a family and good health.
As defined in this Agenda for Community Impact, TUW has agreed to accept UWW’s challenge to establish bold “Goals For The Common Good” on behalf of the Berkeley, Charleston and Dorchester communities.

With the belief that what gets measured gets done, by the end of 2020:

- **Education** – 88% of students enrolled in 8th grade will graduate high school five years later prepared for higher education and/or employment.

- **Financial Stability** – 30% of tri-county residents living at or below 200% of poverty will move into financial stability.

- **Health** – 25% more tri-county residents will adopt a healthy lifestyle and reduce preventable conditions.

To achieve these goals, every facet of our community will need to come together around a common purpose. Setting aside special interests, it will be critical to enhance partnerships among businesses, elected officials, non-profits, academia, the health industry, financial institutions, the faith community, media, parents, neighbors and our youth. Only by working together can we achieve transformational community change in a way no organization, government or individual can accomplish on its own.

**KEY PRINCIPLES OF THE AGENDA FOR COMMUNITY IMPACT**

While Trident United Way (TUW) remains committed to funding non-profit organizations that demonstrate a defined impact on the 10-year goals described above, it is also committed to bringing fundamental change to community systems in the tri-county region. The Agenda for Community Impact lays out a plan to help non-profits and other organizations develop systemic solutions built on new ways of thinking and new ways of delivering services. Toward this end, TUW has established the following principles that will guide what it funds, what it leads and with whom it partners:

1. **Partnerships/Collaborations/Integrated Approaches**

   Partnerships and collaborations will be the hallmark characteristics of programs and initiatives that TUW will fund and lead. These collaborations will go beyond traditional referral practices between organizations to focus on systemic change. TUW is interested in supporting fully integrated service delivery systems that improve access to and the quality of services by combining the expertise of multiple organizations. TUW will help facilitate the creation of integrated approaches that create bridges among Education, Financial Stability and Health. TUW does not see these as individual silo areas, but rather highly inter-related sectors that must work together to effectively serve the individuals in the community with the greatest need.

   In 2008, the TUW Board adopted an **Integrated Community Impact Model** that has been updated to incorporate changes described in this Impact Agenda. The Impact Agenda highlights Community Impact Initiatives that create integrated service delivery systems utilizing multiple partners. The Impact Agenda also focuses on initiatives that integrate the areas of **Education**, **Financial Stability** and **Health**. Together, these approaches target the center of the model—**Integrated Community Strategies and Systems**. It is anticipated that the greatest growth in funding will be to initiatives that embrace collaborative and integrated approaches.
2. **Innovation Based on Evidence**

TUW is particularly interested in supporting innovative approaches in the areas of Education, Financial Stability and Health that use rigorous evaluation methods to demonstrate their effectiveness in helping the community achieve the 10-year goals. TUW will expand its focus on program evaluation, funding programs that clearly tie evidence-based strategies to specific goals and employ well-established performance measurement methods. Data will drive decisions across all levels of the organization and should be used to continuously improve services. TUW will also help incubate promising new programs that have a clear Theory of Change and have built in program evaluation strategies to test the effectiveness of its interventions. Each of the impact areas has established Strategies and Outcome Statements with Performance Measures that will be used in making funding decisions.

3. **Replication and Sustainability**

TUW will help programs that demonstrate strong effectiveness to replicate their success in other tri-county communities, particularly in areas that are underserved. Currently, there is a disparity among the three counties in the number of programs that produce strong outcomes, as many are focused on Charleston County only. In addition to replicating strong programs, TUW will take greater steps during the next several years in helping successful programs create long-term sustainability plans.

4. **Capacity Building**

TUW recognizes that these new methods will require training and technical assistance for community programs to be successful. During the past several years, TUW has systematically developed the content expertise around each of the target issues and expanded its program evaluation methodologies. This has greatly enhanced TUW’s
ability to offer technical assistance and program development support to community partners and to execute a plan of this scope. Furthermore, the tri-county area is rich in experience and talents with its many businesses, institutions of higher learning and retired professionals from all over the world. TUW will leverage its relationships to engage these resources to help community organizations become stronger.

In addition to these key investment principles, community ownership and diversity and inclusiveness will remain central over-arching principles that will guide everything that TUW does.

### STRUCTURE OF THE AGENDA FOR COMMUNITY IMPACT

The Agenda for Community Impact is structured around four primary sections: Education, Financial Stability, Health, and Integrated Community Strategies and Systems. The outline for these sections is as follows:

**Education, Financial Stability and Health**
- 10-Year Goal
- Model of Community Change
- Target Issues
  - Annual Community Indicators
  - Current Status of Indicators
  - Multi-Dimensional Strategies
    - Systemic Change
    - Rationale for Strategic Direction
    - Community Impact Initiatives
    - Funded Programs Strategies and Outcome Statements with Performance Measures
    - Advocacy/Public Policy
  - Strategic Partnerships

**Integrated Community Strategies and Systems**
- Integrated Community Impact Initiatives
  - Links to Success
  - Integrated Strategies for Education, Financial Stability and Health
- Place Based Initiative
- Integrated Community Systems
  - Integrated Volunteer System
  - Community Issues Management (CIM)
  - CharityTracker
  - The Benefit Bank of South Carolina
- Integrated Public Policy Agenda
Education

Helping youth achieve academic and life success.

10-Year Goal: 88% of youth enrolled in 8th grade will graduate five years later prepared for higher education and/or employment.

Impact of Improved Graduation Rates

- Current Tri-County Average Graduation Rate
- Community Goal Achievement Tri-County Graduation Rate

While the average graduation rate for our region, including all public, charter and private schools was 70.5% in 2010, it is important to note that some schools in high poverty areas are graduating less than 43% of their students on time. Additionally, students of color are disproportionately represented in the drop out rate, as are children who have experienced crisis.

Assuming the graduating class of 2020 is the same size as 2010, 1,271 additional students will graduate in 2020.
To reach the 10-year goal, it will be necessary for the community to continue to work collaboratively to achieve multi-faceted change, across multiple domains affecting individual educational achievement. Collaborative partnerships and multi-faceted change were key components of the Children and Youth Services Impact Agenda that was launched in 2006.

To build on the successes of the earlier Impact Agenda, a research-based Education Impact Model has been created.

Research affirms that intervention across varied domains, including work with the individual child, the child’s family and the child’s school, is needed for sustained impact resulting in increased graduation rates (Suh and Suh, 2007). Therefore, the Educational Impact Model begins with, and centers on, the individual child’s progression toward becoming an empowered, productive, engaged adult. Specific measures for assessing that growth surround the inner circle of the model – each individual child – and include: starting school ready; reading on grade level by third grade; graduating high school on time with academic, social and civic skills; work or higher education by age 21 and actively passing on skills for the next generation. The spheres of influence then expand to Strong Families, Effective Education and Invested Communities creating levels of support for the individual child’s development and transitions. Broad goals, operationalized in multiple spheres of influence, are articulated in the margins of the model with arrows indicating the spheres of influence in which they apply. These broad goals include: supporting children wherever they are; employing data-driven plans and evaluation; fostering collaboration; creating strong educational policies; mobilizing the community to support education; and building lasting solutions. Bi-directional arrows are used to connote the dynamic interaction of all systems on the child’s development and opportunities.
% increase in child care providers demonstrating enhanced quality level of child care as determined by the South Carolina ABC Child Care Program (ABC Level) and/or achieving National Association for the Education of Young Children (NAEYC) accreditation.

% increase in children testing ready for kindergarten.

% increase in first grade promotion rate.

Currently, less than 20 percent of licensed child care centers and family group homes in our region have achieved “B” level status and only two area centers have achieved the highest level, an “AA,” with the Department of Social Services (DSS) ABC monitoring service. Additionally, only nine child care centers in our area have attained National Association for the Education of Young Children (NAEYC) accreditation. More than 50 percent of child care centers and family group homes in the tri-county region have met only the minimum standard, level C, to be eligible to accept ABC vouchers for child care.

South Carolina has a history of national recognition for attempts to measure school readiness objectively using the Cognitive Skills Assessment Battery (CSAB) and the South Carolina Readiness Assessment (SCRA), however, both instruments are now defunct. There is an Executive Order (2010-06) by then Governor Sanford assigning the South Carolina Early Childhood Advisory Council responsibility for developing an indicators-based measure of school readiness. When available, TUW will use this measure as a community indicator. In the interim, TUW will use first grade promotion rates and the kindergarten readiness measures used by each district (DIAL 3, etc.) as the best currently available measure of school readiness. The most recent area-wide available data for school readiness at kindergarten enrollment, using the 2001 Cognitive Skills Assessment Battery (CSAB), indicated that, on average, 19.6 percent of new kindergarten students in the tri-county region tested “not ready” using early literacy and early math skill indicators. First grade promotion rates for the tri-county region, in the 2008-2009 school year, averaged 94.1 percent, with an average retention rate of 5.9 percent. However, the average first grade retention rate for children who qualify for free and reduced lunch was 7.3 percent.

Systemic Change

Education, business and community partners work collaboratively to coordinate a system of services and messaging designed to enhance parental awareness of, and children’s achievement of, school readiness skills.

Rationale for Strategic Direction

Currently, access to quality child care is severely impeded by multiple systemic issues: South Carolina does not employ a quality rating system; licensure is not required for child care providers; financial assistance for child care is severely
limited and resources for off-shift, weekend, sick and special needs child care are negligible.

Similarly, access to parent education supports is very limited. Parents who qualify for special programs, such as the Nurse-Family Partnership, may access supports during pregnancy through their child’s second birthday and families with a child in Head Start may access the services of a Parent Support Specialist throughout their child’s enrollment in the program. However, there are very few low-cost options for parents to access ongoing parent education and support services to develop the family stabilization, child nurturance, early literacy promotion, positive communication and positive discipline skills that foster optimal early childhood development.

Early intervention services are available for children with identified developmental delays at no cost to the family; however, the children who are at highest risk for developmental delays – those born to parents with addiction, mental illness, cognitive delays, generational poverty and high transience – are most likely not to have medical insurance and preventive health care.

The link between high quality child care and lasting improvements in educational attainment/employment status has been made by several longitudinal studies specifically focused on the “long reach of childhood poverty” (Duncan and Magnunson, 2011). Parents in low-income households need access to child care to transition back to work following the birth of their children and children raised in poverty benefit from the cognitive and social stimulation of quality early education which supports critical brain development in the early years of life.

Research also indicates that one of the clearest determinants of children’s early literacy development is being read to by a caring adult (Gisler and Eberts, 2009). Many families living in poverty struggle with low parental literacy, lack of access to developmentally appropriate books for children, and high crisis management needs that inhibit the parent’s ability to prioritize this activity. Community strategies are needed to inculcate a culture of learning that surrounds children with adults who read to them in all primary environments.

**Community Impact Initiative**

**CHILD CARE RESOURCE AND REFERRAL**

Child Care Resource and Referral of the Lowcountry (CCR&R) is a program that promotes quality improvement in, and access to, affordable child care via:

1. Technical assistance to enhance ABC Level attainment and/or pursue National Association for the Education of Young Children (NAEYC) accreditation for child care providers.
2. Telephone and internet referral with written resource follow-up to parents and caregivers seeking quality child care in their area.
3. Provision of training for child care workers (center-based and family home providers).
4. Participation in the CCR&R Network, a statewide system, to promote common goals, share resources and coordinate public policy initiatives.

Since 2008, the role of CCR&R in promoting access to and enhancing the quality of child care has been expanded via targeted focus on technical assistance related to specific training for child care providers. Participation in training and technical assistance, which is voluntary for providers, often results in enhancement of their ABC Level with a related increase in reimbursement per
child. CCR&R has increased training access for providers, and initiated the creation of Family Home Provider Networks to meet the needs of these small business owners who do not have access to the scheduling and financial resources of center-based care.

Quality child care is linked to all three impact areas. Access to child care is necessary for parents to pursue and maintain employment, and quality child care promotes early literacy, school readiness, well child care and the formation of healthy eating and active living habits for a lifetime. During the infant, toddler and pre-kindergarten stages of development, children engage in more rapid brain, language, social, and physical development than at any other stage of life; therefore, quality child care is a significant contributor to a child’s holistic development and lifelong well-being. As a result, this initiative impacts the individual, family, and invested communities domains of the Education Impact model.

**Funded Programs Strategies and Outcome Statements with Performance Measures**

Funded community programs also play a key role in improving the community indicators associated with the **Children Enter Kindergarten Ready to Succeed** target issue. TUW has identified evidence-based strategies and outcome statements with performance measures for use by programs under this target issue (Appendix A).

**Advocacy/Public Policy**

Trident United Way is committed to advocacy efforts that promote quality child care as a cost-effective family support, poverty reduction, community development and early childhood education strategy. As part of its community impact strategies, TUW will endorse policies related to:

- Developing and implementing a statewide quality rating system for child care programs and other policies related to improving child care standards.
- Creating quality universal 4K programs for all South Carolina children as part of our community’s commitment to ensuring opportunities for every child to enter kindergarten ready to succeed.

**Strategic Partnerships**

The following strategic partnerships help to advance the strong families domain of the Education Impact Model.

**Parent Information and Resource Center**

A strategic initiative created by The Children’s Trust of South Carolina (formerly Voices for South Carolina’s Children), the Charleston County School District and Trident United Way, the Parent Information and Resource Center (PIRC) is focused on increasing parents’ involvement in their child’s education via a comprehensive array of services to prepare and support their children for success in school. The current model includes a home visitation program using the Parent Child Home curriculum, a curriculum-based family literacy program, parenting skills workshops, GED testing and a range of support services that promote family safety, stability and success.
**MUSC Family Literacy Program**

The Family Literacy Program (FLP) at the Medical University of South Carolina (MUSC) provides four core literacy skill development components: early literacy (vocabulary) development for children, adult literacy, parent-child interactive literacy, and parenting skills development. The goal of this program is to actively support parents as their children’s first teachers. Using creative thematic units and practical, affordable materials made from common household items, as well as literacy bags that include bi-lingual books and support materials, parents are equipped to help develop their child’s listening and language skills, encourage creativity and prediction skills, and enhance the child’s questioning and conversational skills.

**Nurse-Family Partnership**

The Nurse-Family Partnership is a national program, implemented locally by the tri-county Department of Health and Environmental Control (DHEC) and First Steps. It provides services to first-time mothers and their babies from pregnancy through the first two years of life. Ongoing home visits from registered nurses, to low-income, first-time moms enhance healthy pregnancy outcomes and increase their knowledge of infant and toddler development and care needs, while promoting enhanced economic self-sufficiency. As an evidence-based community health program, Nurse-Family Partnership’s outcomes include long-term family improvements in health, education, and economic self-sufficiency; therefore, it supports TUW’s integrated impact agenda.

**Countdown to Kindergarten**

Countdown to Kindergarten is a collaborative partnership among the four area school districts, Trident United Way, Head Start, First Steps and several other non-profit agencies. It engages families, educators, service providers and businesses in a community-wide effort to celebrate and support the transition into kindergarten. An event held annually focuses on the school registration process, school readiness activities and the critical need for parental involvement in children’s education. Primary activities include communications explaining the importance of kindergarten, visits to classrooms, rides on a school bus, vision and hearing screenings, resources for early literacy activities and information on numerous services available to help parents prepare their child for kindergarten.

The last two strategic partnerships listed also support the invested communities domain of the Education Impact Model.

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**TARGET ISSUE**

**YOUTH GRADUATE HIGH SCHOOL ON-TIME, PREPARED FOR HIGHER EDUCATION AND/OR EMPLOYMENT**

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**ANNUAL COMMUNITY INDICATORS**

- % increase in students reading and math proficiency at or above grade level in 3rd, 6th and 8th grade.
- % decrease in the effective drop out rate of 9th graders.
- % increase in the high school graduation rate.
- % enrolled in post secondary education directly after high school.
Since the implementation of the 2006 Children and Youth Services Impact Agenda (2006 Impact Agenda), there has been a significant increase in graduation rates. The exact percentage of increase is difficult to calculate because the data collection systems have changed; however, the average graduation rate reported for the Trident region in 2004 was 53.25 percent and since the implementation of Annual Yearly Progress (AYP) measures, the average graduation rate for our region has increased annually. As indicated under the 10-year goals, the current graduation rate for the tri-county region is 70.5 percent.

Interim indicators of academic achievement will be measured by grade-level proficiency in 3rd, 6th, and 8th grades using annual Measures of Academic Performance (MAPS) and PASS (Palmetto Assessment of State Standards) scores across the tri-county region.

The 2009 proficiency rates for the tri-county region are:

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</thead>
<tbody>
<tr>
<td>PASS Scores</td>
<td>3rd Grade</td>
<td>20.57%</td>
<td>30.10%</td>
</tr>
<tr>
<td></td>
<td>6th Grade</td>
<td>27.10%</td>
<td>30.80%</td>
</tr>
<tr>
<td></td>
<td>8th Grade</td>
<td>35.90%</td>
<td>41.90%</td>
</tr>
</tbody>
</table>

Successful transition from middle to high school is a strong predictor of graduation. Locally, an average of 4.9 percent of 8th grade students effectively “drop out” of school between middle school and high school. Due to compulsory education requirements by age, these students may still be registered at school; however, these students fail the year based on lack of attendance and related failure to complete assignments and testing. Compounding that problem is the fact that, across our tri-county region, 36.7 percent of students in the 9th grade fail at least one core subject and 29.8 percent fail two or more core subjects. This failure to transition from middle school to high school successfully is considered, in both national and local research, to be a reliable indicator of risk for high school drop out (NCES, 2009).

The 2008 transition and graduation rates are as follows:

<table>
<thead>
<tr>
<th>Transition and Graduation Rates</th>
<th>Current Average for the Tri-county Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Middle School to High School — Core Course Failure</td>
<td>36.70%</td>
</tr>
<tr>
<td>Graduation Rate</td>
<td>70.50%</td>
</tr>
<tr>
<td>Transition High School to Post-Secondary *</td>
<td>71.00%</td>
</tr>
</tbody>
</table>

* While the average across all graduating seniors who have post-secondary education plans is 71 percent, only 36 percent of seniors in Title I schools had post-secondary education plans.
To effectively measure progress longitudinally toward the 10-year goal, it will be necessary to help the area school districts collect and synthesize student achievement data more uniformly using objective, quantifiable methods shown in national research to be of predictive value.

**MULTI-DIMENSIONAL STRATEGIES**

**Systemic Change**

Education, business and community partners work together to create a system to connect and extend services across the tri-county area. **Key message**: Quality public education is a shared concern requiring attention from the entire community.

**Rationale for Strategic Direction**

Current research indicates that children confronting two or more risk factors, without intervention, are at higher risk for high school dropout and that multiple risk factors both contribute to and accelerate risk (Croninger and Lee, 2001) and (Farmer, *et al*, 2004). Related studies show that using multi-dimensional strategies to address several co-existing risks is preferred. Children experience greater and more sustainable change when exposed to at least two intervention methodologies concurrently (Gonzales, 2009). This research informs both the development of our Community Impact Initiatives and funded partner strategies.

Research also demonstrates a strong correlation between parental influences and a child’s educational outcomes from school readiness through college completion (Kim, 2008). Positive family support, healthy family boundaries and parental involvement in school are each listed among the 40 developmental assets identified by the Search Institute for promoting resiliency, responsibility, relationship skills and achievement in children and youth. The longitudinal research of the Search Institute firmly establishes a positive correlation between asset building and risk reduction in children of every age from pre-school through young adulthood (Roehlkepartain, *et al*, 2003). Therefore, outreach to, and intervention with parents are core components of our strategic focus.

Interventions to promote positive family processes including: nurturing routines, clearly defined rules and roles, and positive communication and discipline skills have been affirmed by current research, at the National Academies in Washington, DC, as effective in mediating the effects of social adversity including childhood poverty and crisis. Further, this research suggests that additional supports at childhood and adolescent transition points are important due to the shifting contexts and increased potential for developmental “turning points” these transitions present (Gonzales, 2009). This research undergirds the Impact Agenda’s key program strategies of providing parent education throughout the child’s development, supporting at-risk children and their families, supporting childhood and adolescent transitions, and promoting linkage with adult mentors, as well as our focus on using developmental assets attainment as a performance measure across several strategies in this impact area.

**Community Impact Initiative**

**Links to Success**

Links to Success is a strategic model for delivering academic, behavioral, financial stability, family and health support services in high-poverty, low-performing schools in the tri-county area. Links to Success is also a funding model that
creates and supports teams of diverse services working together to establish community learning centers and achieve shared, measurable outcomes that lead to sustainable community impact: higher graduation rates, successful transition of students to higher education and/or employment, and transformation of the targeted schools and neighborhoods within a generation.

Currently, Links to Success is in 11 Title I schools in Berkeley, Charleston and Dorchester Counties. A full-time site coordinator conducts a school’s needs assessment and coordinates the services of multiple programs to address these needs, including: hands-on learning experiences, life skills development, after school programs, mentoring, tutoring, literacy development, behavioral health, parent education, and weekend feeding, among many other programs.

Progressively, since Links to Success’s inception, integrated strategies in the development of a full Community Learning Center model have been implemented. These include:

- Adult education classes for family members.
- Screening for financial supports via The Benefit Bank.
- Introduction of the Financial Stability Project in select sites.
- Emergency assistance to remediate risks before they escalate.
- Assistance with enrollment of uninsured children in Medicaid.

As Links to Success continues progression toward a Community Learning Center model, fully developing the following will also be areas of focus:

- Evening and weekend access to programming provided in school facilities.
- School and community team formation drawing together parents, teachers, principals, business partners, neighborhood residents and youth to implement activities that promote both high educational achievement and a culture of learning and support for youth in the community.
- Infusion of skill-based volunteers to work directly with students and families and to transform the schools and surrounding neighborhoods.
- Full implementation of the school-based Financial Stability Project which helps parents with positive parenting, preparing for and accessing employment, housing stabilization and safety, financial literacy and benefits application, and referral for other service needs.
- Promotion of healthy choices toward the prevention of chronic illness in children and families.

As such, the Links to Success initiative focuses on all four domains of the Education Impact Model – empowerment of the individual student, strong families, effective education and invested communities, and demonstrates integration between the three impact areas necessary for enhanced quality of life: education, financial stability and health.

Funded Programs Strategies and Outcome Statements with Performance Measures

Funded community programs will also play a key role in improving community indicators associated with the Youth Graduate High School On-Time, Prepared for Higher Education and/or Employment target issue. TUW has identified evidence-based strategies and outcome statements with performance measures for
use by programs under the high school graduation (Appendix A) and Links to Success (Appendix D) target issues.

**Advocacy/Public Policy**

TUW supports advocacy efforts that prioritize high quality educational access for all children and youth, including policies related to:

- Enhancing state education standard from “minimally adequate” to “high quality.”
- Promoting equitable education funding formulas as part of comprehensive tax reform.
- Advocating for increased funding for school guidance personnel.
- Advocating for periodic testing for high school reading levels.

**STRATEGIC PARTNERSHIPS**

The following strategic partnerships support the Effective Education domain in the Education Impact Model for educational impact.

**The Education Foundation**

The Education Foundation, an initiative of the Charleston Metro Chamber of Commerce, fosters partnerships between the business community and schools to help prepare students for success in the work place. With technical assistance from the Ford Foundation, the Education Foundation and local school districts are currently creating a master plan for the implementation of certified career academies in area high schools. Based upon economic development needs of the region, the academies will focus on STEM (Science, Technology, Engineering and Mathematics) education, health care and culinary arts. By providing relevant, hands-on learning experiences, the Education Foundation will play a key role in helping students graduate from high school and be prepared for higher education and/or employment.

**New Day for Learning**

New Day for Learning (NDL) is a nationwide initiative, funded by the Charles Stewart Mott Foundation in 10 cities, which seeks to promote expanded learning opportunities for youth to prepare them for the expectations of the changing workplace. There are five key elements to this initiative: expanding the definition of student success to include the development of analytical and problem solving skills as well as applied learning, employing research-based models that respond to different learning styles, fostering collaboration in support of successful educational and adult transitions, integrating education approaches and places, and promoting professional leadership and development for educators.

Led by the College of Charleston, the local NDL effort is a collaborative partnership that includes the Mayor’s offices for the cities of Charleston and North Charleston, Communities In Schools, the Charleston County School District and Trident United Way. Annually, NDL sponsors a professional development institute for local school staff and administrators and provides technical assistance to 14 low-income, low-performing schools.
Charleston Promise Neighborhood (CPN) is an initiative created by the Charleston County School District, the cities of Charleston and North Charleston and Charleston County. The CPN is modeled on the very successful Harlem Children’s Zone project and seeks to create academic, social and economic transformation within a generation in a 5.6-mile neighborhood of Charleston County which is anchored by four high-poverty, low-performing elementary schools: James Simmons, Sanders-Clyde, Mary Ford and Chicora. The CPN is creating partnerships with outcomes-based, socially-conscious organizations to create a culture of learning that leads to a culture of success in this historically disenfranchised area. Partner organizations include: College of Charleston, Medical University of South Carolina, The Citadel, Metanoia, Wings for Kids, Coastal Community Foundation, Blackbaud and Trident United Way, among many others.

Trident United Way has been active in the development of the CPN since the project’s inception and is committed to continuing support via program development and program evaluation consultation, volunteer recruitment, and the provision of Links to Success sites in the four anchor elementary schools.
Helping families and individuals at 200% or below of poverty gain and maintain financial stability.

10-Year Goal: 30% of tri-county residents living at or below 200% of poverty will move into financial stability.

Financial stability, referenced in the 10-year goal, will be measured by examining several factors including: household income, savings, housing costs, home ownership and access to financial education.

Given the cost of living in the tri-county region, a family needs to earn at least 2.5 times the Federal Poverty Level to be considered financially stable. Currently 187,550 tri-county individuals live at or below 200% of poverty. When we meet the 10-year goal, an additional 56,265 individuals will be financially stable. (2006-2008 American Community Survey 3-Year Estimates)
To achieve the 10-year goal, it will be necessary for the community to work collaboratively to create multi-faceted intervention strategies across several areas. To aid in this process, the Financial Stability Impact Council has adapted a model originally created by United Way Worldwide.

The Financial Stability Framework is sequential and interrelated. The framework is designed as a continuum to help move and support families and individuals in becoming and/or maintaining financial stability. The framework is anchored by financial literacy/education, which includes: credit counseling and budgeting; benefits access (Earned Income Tax Credit (EITC), Supplemental Nutrition Assistance Program (SNAP), Medicaid, etc.); traditional banking products education; establishing, monitoring and maintaining savings and checking accounts; and legal education and homeownership services to gain and maintain assets.

Berkeley, Charleston and Dorchester Counties have geographic regions with high concentrations of poverty, therefore, **address basic needs** is a critical first step in this continuum. The goal of this step is not only to stabilize families and individuals in crisis by addressing their most immediate needs, but also to provide opportunities and resources that help families and individuals prevent cyclical crises. The next step, **increase basic skills**, includes improving basic financial education, literacy and computer skills. Without basic skills, obtaining employment is difficult and increasing earning potential is nearly impossible.

With a foundation of basic skills, families and individuals can focus on **increase income** by obtaining work supports and benefits for which they are eligible. Programs, such as Volunteer Income Tax Assistance (VITA), help families receive Earned Income Tax Credits. Workforce development programs increase employability through job training and
certification services. By increasing income, families and individuals can begin to save and utilize traditional banking products, which help them avoid the predatory lending institutions that lead to high debt. Increasing savings by just $300 is the difference between a family thrust into crisis by an unexpected emergency and a financially stable family who can maintain monthly obligations when unexpected expenses arise. Therefore, families and individuals who have savings are less likely to need emergency assistance. Establishing savings accounts helps build banking relationships, which open the door to investments in appreciable assets, such as homes. At this level of stability, to gain and sustain assets through educational and legal means is also critical.

**SYSTEMIC CHANGE**

Efforts across the three target issues described below will focus on a common systemic change goal: *All agencies and community partners will work collaboratively in partnership to create a continuum of services that leads to financial stability.*

**TARGET ISSUE**

COORDINATION OF BASIC NEEDS

**ANNUAL COMMUNITY INDICATORS**

- % increase of basic needs providers using CharityTracker.
- % increase in emergency assistance dollars tracked in CharityTracker.
- % increase of providers using The Benefit Bank.
- % increase in work support benefits dollars tracked by The Benefit Bank.

**CURRENT STATUS OF INDICATORS**

CharityTracker is a web-based database that allows partners to input client information and track service delivery in the provision of basic needs (described in detail below). Since the implementation of CharityTracker in 2009, more than 100 providers have documented over $2 million in basic needs assistance in the tri-county area. This does not include food, clothing or furniture.

The Benefit Bank of South Carolina (TBB-SC) is a web-based software tool that populates multiple applications for benefits (Supplemental Nutrition Assistance Program (SNAP), Medicaid, Free Application for Federal Student Aid (FAFSA), Income Taxes and Earned Income Tax Credit (EITC)) in one in-take process (described in detail below). In Berkeley, Charleston and Dorchester Counties, over 350 counselors have been trained and have currently established over 65 sites. As of October 2010, the average Supplemental Nutrition Assistance Program (SNAP) award was approximately $2,625 per family, per year. Currently, Free Application for Federal Student Aid (FAFSA), Income Taxes and Earned Income Tax Credit (EITC) are submitted electronically, and dollars received are tracked through The Benefit Bank reporting system. Electronic submission is not yet available for the Supplemental Nutrition Assistance Program (SNAP) and Medicaid. TBB-SC is working with the State Department of Social Services (DSS) and the State Department of Health and Human Services (DHHS) to implement electronic submission. With the implementation of electronic submission, the number of benefit dollars received can be reported in detail.
Community Impact Initiatives

CharityTracker

In 2008, the Trident United Way (TUW) Safety Net Vision Council created a plan to enhance the coordination of basic needs. They defined basic needs as: “targeted services that address the immediate needs of individuals and families that include food (served meals or other food), shelter (temporary shelter, housing, rent, mortgage, and utilities), clothing, and access to other community resources.” A collaborative partnership between TUW and the Human Needs Network was formed that led to the launch of CharityTracker in Berkeley, Charleston and Dorchester Counties. CharityTracker is a web-based system designed to assist agencies and communities of faith in tracking clients, reducing duplication and increasing communication and collaboration among those providing basic needs in the community. The system allows providers to track where clients have received assistance and to network with other providers in a more coordinated and efficient way.

As part of a comprehensive plan to fully implement CharityTracker throughout the tri-county area, the partnership will continue to:

- Recruit and increase the number of basic needs providers and communities of faith utilizing CharityTracker.
- Mobilize churches by providing Human Needs Network geographic trainings.
- Provide monthly and on-site trainings as needed.
- Share client data in order to more holistically care for people in need and reduce duplication of service.
- Collect more comprehensive data on basic human needs being provided in Berkeley, Charleston and Dorchester Counties.
- Partner with Simon Solutions, creator of CharityTracker, to continue to improve the tool and develop the case management component.

Safety Net Assistance Network

As a result of the efforts related to the launch of CharityTracker described above, the Safety Net Assistance Network (SNAN) was formed. This network, composed of more than 100 basic needs providers, communities of faith, and other human services organizations, was developed as a collaborative partnership between TUW and the Human Needs Network to address the collective issues of those providing basic needs.

The next phase of development for SNAN will include:

- Increasing the number of basic needs providers and communities of faith that join the network.
- Integrating partners focused on increasing income and gaining and sustaining assets to provide holistic financial stability services.
- Building the capacity of all partners by identifying funding and referral sources that collectively move clients from crisis to stability.
The Benefit Bank of South Carolina (TBB-SC) is a statewide initiative being implemented by the South Carolina Office of Rural Health (SCORH). Developed as a web-based counselor-assisted program, TBB-SC is a community-wide response to poverty that assists families and individuals in preparing applications for work supports including Earned Income Tax Credit, income tax returns, FAFSA (Free Application for Federal Student Aid), Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) and Medicaid.

TBB-SC is available in English and Spanish and can incorporate local programs and unique partnerships, thus becoming a broad vehicle for safety-net deployment.

Trident United Way has partnered with TBB-SC to assist in implementation of The Benefit Bank (TBB) in Berkeley, Charleston and Dorchester Counties. Through this partnership we will continue to:

- Utilize Community Issues Management (CIM-described on page 45) to identify and analyze the greatest needs – financially and geographically.
- Reduce the barriers to receiving work supports in our community.
- Increase the availability of TBB sites.
- Coordinate and provide training in Berkeley, Charleston and Dorchester Counties including certification training in Medicaid documentation.
- Coordinate site consultation, as needed.
- Participate in the SNAP (Supplemental Nutrition Assistance Program) Outreach Program.
- Integrate TBB with other financial stability services to provide holistic work supports to families and individuals.
- Train TBB counselors to utilize the Income Tax module.

The Safety Net Assistance Network (SNAN) has been a key partner in the implementation of The Benefit Bank (TBB) locally. TBB is a core component of the Financial Stability Project described under the Increase Income section below.

Funded Programs Strategies and Outcome Statements with Performance Measures

Funded community programs will also play a key role in improving the community indicators associated with the Coordination of Basic Needs target issue. TUW has identified evidence-based strategies and outcome statements with performance measures for use by programs under this target issue (Appendix B).

Advocacy/Public Policy

TUW will support advocacy efforts that improve access to work supports and basic skills development such as: supporting electronic application submissions capability for The Benefit Bank of South Carolina and the expansion of adult education programs.
The strategic partnerships for this target issue are the same as those described under the Increasing Income target issue below.

**TARGET ISSUE**  
**INCREASE INCOME**

**ANNUAL COMMUNITY INDICATORS**

- % increase in low to moderate income individuals claiming Earned Income Tax Credit (EITC).
- % decrease in the number of households paying 35% or more of income on rent.
- % increase of eligible individuals claiming benefits.
- % change of lower income families and individuals moving between levels in the poverty index (e.g., from 150%-200%).
- % increase in median income.
- % increase in income by gender.

**CURRENT STATUS OF INDICATORS**

The U.S. Census American Community Survey released September 2010, estimates that Dorchester County matches the national poverty rate at 14.3 percent. Berkeley County’s rate is 15.7 percent and Charleston County’s rate is 16 percent. According to the 2009 U.S. Census Bureau State and County QuickFacts, approximately one-third of the 659,191 residents in the tri-county area of Berkeley, Charleston and Dorchester Counties are living below 200 percent of the federal poverty level. The combined unemployment rate for July 2010 for these same counties was 9.4 percent.

Finding affordable housing in the tri-county area is a challenge. In Dorchester County, 48.1 percent of residents pay more than 35 percent of the household income on rent. Charleston and Berkeley Counties trail only slightly behind at 45 percent and 40.9 percent, respectively.

Another significant problem is the disparity between median incomes for tri-county men and women. The 2008 American Community Survey reports the average wage difference between the sexes was $12,200 per year. This means that women, on average, earn 37 percent less than men in Berkeley, Charleston and Dorchester Counties. The 2000 Census reported 15 percent of households were headed by single mothers. Therefore, this difference in median income represents an additional poverty risk factor for families.

The Internal Revenue Service estimates that approximately $16 million in Earned Income Tax Credit (EITC) are left unclaimed in Charleston, Berkeley and Dorchester Counties. The Benefit Bank estimates that only 7.2 percent of households eligible for the Earned Income Tax Credit (EITC), Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps), subsidized health insurance and child care subsidies claim all four. In South Carolina, over $800 million in benefits go unclaimed every year.
Unclaimed benefits result in higher poverty and increased reliance on emergency assistance services, such as rent and utility assistance.

**MULTI-DIMENSIONAL STRATEGIES**

**Community Impact Initiative**

**FINANCIAL STABILITY PROJECT**

The Financial Stability Project (FSP) uses the framework described above (under Model of Community Change) to create sustainable change. The framework begins with addressing basic needs, then increasing basic skills, followed by increasing income, increasing savings and finally gaining and sustaining assets. Financial education is the underpinning of the continuum and thus an essential area in which the FSP will build capacity in two phases of implementation. The FSP is supported by several networks and coalitions and utilizes shared information and service delivery systems.

**Phase I** of the FSP was designed to create community hubs that deliver financial stability services where targeted populations live and work. These hubs include TUW Links to Success sites (schools), community centers and TUW Service Centers in Berkeley and Dorchester Counties. Service Center staff provide quick checks using The Benefit Bank to identify families and individuals who may qualify for benefits. The clients are then referred to more comprehensive financial stability services as needed.

The Links to Success program is a successful, school-based model of intervention for at-risk children and their families into which the Financial Stability Project is integrated. These include five sites in Charleston County and three in Berkeley County; all are in Title I schools. Through these Links to Success sites, Family Navigators work with school-based service coordinators and school district parent advocates to identify families and individuals in need of FSP services, most of which are provided directly in the school.

AmeriCorps members, serving as FSP Family Navigators, help individuals and families gain access to resources that mitigate financial or family crisis and support stability. These resources are reflected in the FSP Framework and include access to benefits, opportunities to acquire basic skills and services that increase income. Family Navigators also serve as a referral resource for agencies that provide financial stability services, such as financial and adult education classes. Additionally, Family Navigators are trained to provide free tax preparation services through The Benefit Bank and the Volunteer Income Tax Assistance (VITA) program in the community at large and in their hubs. Finally, Family Navigators work with service providers, churches and community groups to identify community-wide opportunities for financial stability-promoting education.

**Phase II** of the Financial Stability Project will create an integrated service delivery system that utilizes the services of multiple providers working in partnership.

Research evaluating several models of intervention indicates that the strongest outcomes occur in programs that bundle two or more financial stability services in the same location. The essential services include:

- Access to benefits, income, Earned Income Tax Credit (EITC) and work supports for which individuals are eligible.
- Access to financial coaching, education, and services.
- Access to high quality employment and education-related services.

Strategies to access benefits include The Benefit Bank, access to Volunteer Income Tax Assistance (VITA) programs and inter-agency referrals. Strategies to access financial education include personal finance workshops, financial education coaching and homeownership counseling. Lastly, strategies that support access to quality employment and education services include job readiness workshops, educational counseling and basic computer courses.

Models for one-stop centers that provide multiple services differ in management and operations. However, the bundling of services is the common thread that is predictive of success. According to Financial Stability Through Integrated Service Delivery: Highlights from the United Way System, research results indicate that individuals who receive bundled services are five to six times more likely to obtain better stability outcomes. In the Single Agency Management Model, a lead agency is responsible for all facets of center management and operations, including communications, marketing, outcome measurement, and partnership management. The Collaborative Management Model involves sharing leadership and management responsibilities, as well as service provision with a group of partners. Finally, the Network and Intermediary Model utilizes United Ways and/or other community-based organizations to provide resources and assistance to a network of agencies that operate under a common framework.

Trident United Way and its community partners will visit established financial stability centers and evaluate the effectiveness of each model. Once the research is completed, a customized integrated service delivery model that best addresses the critical needs in the tri-county area will be implemented during the next three years.

To fully implement both phases of the Financial Stability Project, the expertise and services of several coalitions will be utilized, including the Financial Stability Coalition (FSC), Safety Net Assistance Network (SNAN), the Volunteer Income Tax Association (VITA) Coalition, Banking Partner Coalition, The Benefit Bank Coalition and Emergency Food and Shelter Program (EFSP). Membership in these groups includes TUW funded partners, and corporate, nonprofit, municipal, and community partners who collectively develop policies and procedures and provide access, support, education and products that help move individuals out of poverty. Funded partners who provide basic needs, as well as EFSP recipients, are required to use CharityTracker and encouraged to use The Benefit Bank as a means of coordinating services. These groups are described in detail under Strategic Partnerships below.

**Funded Programs Strategies and Outcome Statements with Performance Measures**

Funded community programs will also play a key role in improving community indicators associated with the Increase Income target issue. TUW has identified evidence-based strategies and outcome statements with performance measures for use by programs under this target issue (Appendix B).

**Advocacy/Public Policy**

TUW is committed to advocacy efforts that promote strong economic vitality for the tri-county region and improve salaries and tax credits for working individuals.
as well as access to job training and education programs. As part of its Integrated Public Policy Agenda, TUW will endorse policies related to:

- Supporting a state Earned Income Tax Credit (EITC).
- Supporting tri-county efforts for job creation, employable skills training, and higher education for low to moderate income persons.

FINANCIAL STABILITY COALITION

The Financial Stability Coalition (FSC) is composed of leaders of 26 corporate, nonprofit and municipal partners. This Coalition focuses on community-wide coordination of services and awareness efforts as they relate to the Financial Stability Framework.

SAFETY NET ASSISTANCE NETWORK

The Safety Net Assistance Network (SNAN) is a network of over 100 programs and communities of faith collaborating to provide community-wide basic needs with a vision of creating a fundamental, lasting change in the clients they serve in Berkeley, Charleston and Dorchester Counties. SNAN, a collaborative partnership between TUW and the Human Needs Network, has made landmark strides in the coordination of basic needs through the implementation of CharityTracker, a web-based system that allows agencies to electronically share available basic needs services that they previously could track only through an informal telephone network. All TUW funded partners, as well as EFSP recipients, are required to use CharityTracker if they provide basic needs services. The Financial Stability Coalition will examine expanding the use of this tool to track all services offered through the financial stability continuum.

BANKING PARTNER COALITION

The Banking Partner Coalition is composed of banks that have agreed to provide financial education, support and non-traditional banking products for low-income individuals and families. This group works in tandem with the Financial Stability Coalition (FSC).

VOLUNTEER INCOME TAX ASSISTANCE COALITION

The Volunteer Income Tax Assistance (VITA) program provides free tax preparation services and asset-building education for low-to-moderate income families and individuals in Berkeley, Charleston and Dorchester Counties. The VITA Coalition provides oversight and strategic direction to the program in the tri-county area.

THE BENEFIT BANK COALITION

The Benefit Bank (TBB) Coalition provides strategic direction in the implementation of TBB in the tri-county area.

EMERGENCY FOOD AND SHELTER PROGRAM

The Emergency Food and Shelter Program (EFSP) is a Federal program administered by the U.S. Department of Homeland Security’s Federal Emergency Management Agency (FEMA). The purpose of the program is "to supplement and expand ongoing efforts to provide shelter, food and supportive services" for the nation’s hungry.
homeless, and people in economic crisis. EFSP provides approximately $450,000 annually in basic needs funding to Berkeley, Charleston and Dorchester Counties. Funding is determined by the unemployment figures for the previous year by county. Funds must be used to supplement feeding, shelter, rent/mortgage and utility assistance efforts. A local board reviews applications and makes decisions on funding.

### TARGET ISSUE  GAIN AND SUSTAIN ASSETS

#### ANNUAL COMMUNITY INDICATORS

- % change of median home price and qualifying income for home purchase.

#### CURRENT STATUS OF INDICATORS

The Center for Housing Policy’s 2009 report ranks Charleston, South Carolina, 73 out of 207 markets for the most expensive homes, with an average median home price of $190,000. Given that salaries have not increased in proportion to home prices, purchasing an affordable home is impossible for a large portion of the workforce, particularly service and tourism workers, who typically have unpredictable or irregular work schedules.

The 2000 U.S. Census reported that 12,870 persons in Berkeley County, 8,059 residents in Charleston County and 8,686 residents in Dorchester County resided in rental housing. More recently, a 2006 housing study conducted by the Charleston Metro Chamber of Commerce reported over 77,000 existing households in the tri-county area were found to pay more than they can afford on mortgage or rent costs. Specifically, 14.5 percent of lower-income, tri-county families and individuals pay over 50 percent of their income to cover housing costs. A large number of tri-county families and individuals are economically disadvantaged and require innovative solutions to address the problems that undergird generational poverty. Comprehensive and readily accessible financial education and support services are essential in helping individuals increase their income and ultimately gain and sustain assets, building the foundation for long-term financial stability.

#### MULTI-DIMENSIONAL STRATEGIES

The Gain and Sustain Assets Target Issue utilizes the same community impact initiative and strategic partnerships described above under the Increase Income Target Issue.

**Funded Programs Strategies and Outcome Statements with Performance Measures**

Funded community programs will also play a key role in improving the community indicators under the **Gain and Sustain Assets** target issue. TUW has identified evidence-based strategies and outcome statements with performance measures for use by programs under this target issue (Appendix B).

**Advocacy/Public Policy**
TUW will support advocacy efforts that improve affordable housing and other asset-building services. As part of its Integrated Public Policy Agenda, TUW will endorse policies related to:

- Advocating against legislation and incentives that support the state predatory lending industry.
- Supporting state legislation that provides economic incentives for homeownership and entrepreneurship for low-income persons.
Helping individuals get the right care at the right time in the right setting.

10-Year Goal: 25% more tri-county residents will adopt a healthy lifestyle and reduce preventable conditions.

Currently 35% of the total population (228,000) has a Body Mass Index (BMI) in the recommended range. When we meet the 10-year goal, an additional 57,000 tri-county individuals will meet the recommended BMI. (SC Behavior Risk Surveillance Survey [SC BRFSS, CDC 2009]).

Healthy lifestyle is defined as meeting the recommendations for lifestyle modifiable behaviors as surveyed in the Center for Disease Control and Prevention’s Behavior Risk Factor Surveillance Survey (CDC BRFSS).
To reach the 10-year goal, it will be necessary for the community to work collaboratively to achieve multi-faceted change across several domains. To help in the creation of a community-wide plan, the Health Impact Council adopted a model created by the Centers for Disease Control and Prevention called the Health Socio-Ecological Model.

The **Socio-Ecological Model** considers the multiple domains where change must occur if there is to be true impact on the health of our community. As much as individual behavior change strategies are important for individuals to build the knowledge and skills to make healthy choices, new behaviors must be supported in the social and physical environments where people live, learn, work and play. As we look at targeted interventions for individuals, we must also implement broader strategies to create the social, environmental, and policy changes that will support healthy choices.

The five domains targeted for change under the Socio-Ecological Model are:

**Individual**

Motivating change in individual behavior by increasing knowledge, influencing attitudes, or challenging beliefs.

**Interpersonal**

Interpersonal interventions to target groups that provide social identity and support, such as family members or peers.
Organizational

Changing the policies, practices, and physical environment of an organization (e.g., a school / child care center, a faith organization, a workplace, a health care setting or another type of community organization) to support behavior change.

Community

Coordinating the efforts of all members of a community—organizations, community leaders, and citizens—to bring about changes that support healthy behaviors.

Public Policy

Developing and enforcing state and local policies that can increase beneficial health behaviors. Developing media campaigns to promote public awareness of health needs and advocate for change.

TARGET ISSUE  INCREASING ACCESS TO HEALTH CARE

ANNUAL COMMUNITY INDICATORS

- % decrease in uninsured Emergency Department visits.
- % decrease in uninsured in-patient visits.
- % increase of patients in identified medical home.
- % increase in eligible children enrolled in Medicaid.

CURRENT STATUS OF INDICATORS

At any given time, more than 20 percent of the tri-county population is uninsured—and the numbers are growing. The region has been hit hard by the national economic downturn. Regional unemployment numbers are among the highest in the country. As more people lose their jobs, they also lose their health insurance. Across Berkeley, Charleston, and Dorchester Counties, hospital emergency departments and health clinics are seeing increasing numbers of uninsured patients. Shrinking resources and overburdened clinics make it difficult for uninsured residents with multiple chronic conditions to find basic primary care much less the diagnostic testing and specialized services they require.

In a community Health System Profile conducted in January 2010, Amy Brock Martin, Dr. P.H., Deputy Director, University of South Carolina, Office of Rural Heath Research, found that as many as 150,000 tri-county residents are uninsured, with 90 percent living below 200 percent of the Federal Poverty Level (FPL). This is the highest rate in the state (SC ORS, 2008). The effects are unnecessary suffering, being sick more frequently and for longer periods of time, and a 10–15 percent increased mortality rate.

The uninsured are postponing routine and preventive care and bringing their acute care needs to the emergency department. This is a costly practice. The estimated annual cost of charity care provided by local hospitals is more than $114 million. In-patient discharges for preventable reasons rank diabetes as the number one condition affecting uninsured people ages 18 to 64 in the tri-county region. A typical hospital admission for
a patient who presents with uncontrolled diabetes and no other complications results in a three-day stay and costs more than $6,000.

Studies show that poverty and poor health outcomes are closely linked. Children under age 17 are living in poverty in the tri-county area: 26 percent in Dorchester County, followed by 21 percent in Charleston County and 13 percent in Berkeley County, (American Community Survey, 2009). Increased unemployment, 12 percent at its peak, and the recession, have pushed more children into poverty and Medicaid eligibility. Medicaid enrollment for eligible children has risen by approximately 9.5 percent. Agency enrollment of parents has remained relatively flat despite the dramatic increase in unemployment (SC Appleseed Legal Justice Center, 2010).

Studies indicate that children in households where parents do not have insurance are less likely to get needed medical care or have a medical home. No county-level data is routinely collected regarding the number of youth with inadequate healthcare, but for children in families with income of 200 percent of the Federal Poverty Level or below in South Carolina, the uninsured rate is 11.2 percent. Estimates from the 2009 American Community Survey suggest that 16,250 tri-county children under the age of 18 are eligible for Medicaid but not enrolled, with two times as many children without a medical home.

MULTI-DIMENSIONAL STRATEGIES

Community Impact Initiatives

ACCESSHEALTH TRI-COUNTY NETWORK

Systemic Change

The medical community works together within a coordinated system that makes health care accessible to low-income, uninsured people in the tri-county area.

Rationale for Strategic Direction

For more than 20 years, partners across the tri-county have made attempts to create a community-wide system of care that improves access to healthcare services for low-income, uninsured people in Berkeley, Charleston, and Dorchester Counties. Several regional health alliances, prompted by a broad range of civic leaders and healthcare providers, were not successful in reaching full implementation due to a lack of resources and shared vision.

Across the country, the patient centered medical home (PCMH) model has proven to reduce preventable hospital admissions / readmissions and emergency department visits, reduce the cost of health care services, and improve health outcomes. The foundation of the patient centered medical home model is an ongoing doctor—patient relationship which is the gateway to all other coordinated health services. Project Access in Buncombe County, North Carolina, is a best practice model that demonstrated a 15 percent decrease in the total value of charity care provided by area hospitals. Emergency department utilization by Project Access patients is one-third that of low-income populations in similar-sized cities, and about half that of the general population.

A July 2009 report from The Commonwealth Fund details the significant health outcomes achieved by Partners Community HealthCare, a coordinated system serving greater Boston and eastern Massachusetts:
The proportion of patients receiving optimal diabetes care increased from 4 percent to 25 percent by promoting adherence to an evidence-based “bundle” of treatment goals.

Achievement of cardiovascular risk-reduction targets by one in five patients with diabetes, high blood pressure, or heart disease contributed to 4,000 fewer deaths overall among this group, and to 100 fewer heart attacks, 740 fewer eye complications, and 140 fewer amputations annually among patients with diabetes.

A 17 percent improvement in rates of six-month medication adherence among patients diagnosed with depression was attributed to a disease management program that provides patient education and medication refill reminders for patients and physicians.

Self-reported tobacco use declined by almost half, from 25 percent using tobacco in 1998 to 13 percent in 2008, and parent-reported secondhand smoke exposure among children of plan members fell from 23 percent to 5 percent exposed.

**Plan of Action**

In June of 2009, Trident United Way took on the role of neutral convener for a group of more than 25 tri-county organizations and healthcare providers that came together with one common purpose: to develop a system that improves access to healthcare services for low-income, uninsured adults in Berkeley, Charleston, and Dorchester Counties.

Developing into the AccessHealth Tri-county Network (The Network), it was awarded a planning grant from The Duke Endowment that provided technical assistance from AccessHealth SC to create a community plan.

The central premise of the AccessHealth Tri-county Network is that every client has an appropriate and affordable medical home that is the gateway to all other health services. The operations will be facilitated through a central hub which will coordinate care using client navigation. Client navigators will ensure a smooth transition into the medical home, and work with the provider to develop appropriate linkages with needed services outside the practice. The hub will: 1) devise a system to assign clients to the next available medical home consistent with geography, provider capacity and provider fee scales; 2) work with medical homes to develop appropriate linkages to specialty care and additional services, such as community-based prevention and health education programs, and; 3) ensure that referrals to these providers are limited according to the capacity of the practice and a “fair share” rule that providers will help develop.

The Network will develop the Hub database and referral system in conjunction with the Trident United Way 2-1-1 database to assure development of a fully integrated, not parallel, system of information.

**Community Impact Measures for the Network**

- Improved health care utilization, which will reduce the overall burden of unfunded care for primary and specialty services including dental care, vision care, behavioral health care, and diagnostics.

**Long-term Outcome Measures for the Network**

- Improved perceptions of the local healthcare system by engaged clients in The Network.
- Improved health outcomes and quality of life for engaged clients in The Network.

**HEALTH CARE COVERAGE FOR CHILDREN**

**Systemic Change**
Individuals in the community have a simplified process for accessing public health benefits.

**Rationale for Strategic Direction**
According to a 2010 report from the South Carolina Appleseed Legal Justice Center, despite an annual state appropriation of $20,000,000, the Department of Health and Human Services (DHHS) has enrolled only 16,000 out of a possible 70,000 eligible children in Medicaid (formerly known as CHIP, Children’s Health Insurance Program). Billions of dollars in public funds go untouched each year because applying for state and federal benefits such as Medicaid is confusing, time consuming, and, at times, intimidating.

**Plan of Action**
To ensure that all tri-county children have access to health care, it will be necessary to make it easier for families to enroll eligible children in the health supports available to them, by removing the common obstacles that keep them from enrolling and re-enrolling. The Financial Stability Impact Area has worked with the S.C. Office of Rural Health to develop a community plan to remove these obstacles by using The Benefit Bank (TBB). Through a counselor-assisted in-take process multiple applications for benefits are completed at one time, making sustainability of basic needs a reality for people.

In Berkeley, Charleston and Dorchester Counties, more than 350 counselors have been trained with 65 TBB intake sites established in the tricounty area. There will be a continued focus on engaging community partners to utilize TBB to increase the number of eligible children enrolled in Medicaid. Thinking of access to care as the essential first step, promoting ongoing linkages to medical homes for Medicaid-enrolled children will also be a focus.

**Funded Programs Strategies and Outcome Statements with Performance Measures**

Funded community programs will also play a key role in improving the community indicators associated with the Increasing Access to Health Care target issue. TUW has identified evidence-based strategies and outcome statements with performance measures for use by programs under this target issue (Appendix C).

**Advocacy/Public Policy**
 TUW is committed to advocacy efforts that help improve access to health care for uninsured individuals such as: removing state barriers to public health benefits enrollment.
ACCESSHEALTH TRI-COUNTY NETWORK

Community partners representing four local hospital systems, federally qualified health centers, free clinics, health safety net providers, behavioral and mental health agencies, medication providers, private physicians, and other health care organizations have come together to develop a coordinated network of care for low-income uninsured people in the tri-county area. The impetus for this collaboration was the recently formed AccessHealth South Carolina, an initiative of the South Carolina Hospital Association, working in concert with The Duke Endowment, to develop community networks of care.

S.C. OFFICE OF RURAL HEALTH (THE BENEFIT BANK)

Trident United Way is partnering with The S.C. Office of Rural Health to establish Benefit Bank sites throughout the tricounty. The Benefit Bank (TBB) is a web-based software tool that completes multiple applications for public benefits in one intake process. In Berkeley, Charleston and Dorchester Counties, more than 350 counselors have been trained with 65 TBB intake sites established.

TARGET ISSUE EARLY PREVENTION OF CHRONIC DISEASE

ANNUAL COMMUNITY INDICATORS

- % increase in physical activity.
- % increase in consumption of 5+ servings of fruits & vegetables daily.
- % decrease in Body Mass Index (BMI).
- % decrease in new cases of Type II diabetes in children and youth.
- % decrease in tobacco use.

CURRENT STATUS OF INDICATORS

In 2007, the leading causes of death among South Carolinians were heart disease, cancer, stroke, accidents, chronic lower respiratory disease and diabetes. South Carolina ranks 10th in cases of diagnosed diabetes compared with other states. Risk factors that contribute to high incidence of heart disease, cancer and diabetes are overweight, physical inactivity and unhealthy diet. Research studies indicate that South Carolina has the seventh worst obesity rate in the nation, with 65 percent of all South Carolina adults either overweight or obese (BRFSS, 2007).

Physical inactivity coupled with poor nutrition is a growing health concern in South Carolina where 62 percent of high school students did not meet the recommended levels of physical activity and 83 percent eat fewer than five servings of fruits and vegetables per day. During the 2006-2007 academic year, 49 percent of students ages 3-12 in Title I schools in Charleston County School District were overweight or already obese, compared with 32 percent of students in non-Title I schools (College of Charleston, 2007).
The Learning Connection, a 2004 report issued by the Action for Healthy Kids coalition, describes how poorly-nourished children tend to have weaker academic performance and score lower on standardized achievement tests. Poor nutrition and hunger interfere with cognitive function and are associated with lower academic achievement, regardless of a child’s weight. Teachers have reported higher levels of hyperactivity, absenteeism, and tardiness among hungry/at-risk children than among their peers who were not hungry.

Physical activity has also been linked to academic performance. In 2004 the California Department of Education analyzed results of physical fitness testing and compared them with the Stanford Achievement Test. The analysis showed higher achievement was associated with higher levels of fitness at each of the three grade levels measured (www.cde.ca.gov, June 2004).

Another significant risk factor for preventable chronic disease is tobacco use. The South Carolina Youth Tobacco Survey (SCYTS) reports that 21 percent of middle school students who have ever tried smoking had their first cigarette before age 11. Almost half of all students reported that at least one of their parents smoked.

Nationwide, youth smoking has declined dramatically since the mid-1990s, but that decline has slowed considerably in recent years. In South Carolina, tobacco use among middle and high school students has continued to decline every year.

<table>
<thead>
<tr>
<th>Current Smokers</th>
<th>2005</th>
<th>2006</th>
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<tr>
<td>Middle School</td>
<td>11.2%</td>
<td>9.0%</td>
<td>8.7%</td>
</tr>
<tr>
<td>High School</td>
<td>24.4%</td>
<td>19.1%</td>
<td>18.7%</td>
</tr>
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</table>


**MULTI-DIMENSIONAL STRATEGIES**

**Community Impact Initiative**

**School Health Promotion Project**

**Systemic Change**

Individuals in the community value nutritious foods and physical activity and change their behavior to adopt a healthy lifestyle.

**Rationale for Strategic Direction**

In May 2009, during early planning to develop integrated health services in select schools, TUW conducted a survey with school administrators and parents to ascertain what kinds of health supports / health services they would find useful in school settings.

Parents’ top requests for health services offered at schools were:

1. Regular visits from mobile health providers, e.g., dental van, health screenings, visits from primary providers.
2. Exercise classes.
3. Cooking classes.

Research in this area strongly indicates that prevention efforts must occur early—meaning both before individuals have developed chronic disease, and at young ages, before lifetime behaviors that lead to chronic disease are formed. Drawing from the mandate of the 2005 S.C Student Health and Fitness Act, this initiative will create interventions to: 1) Increase knowledge and adoption of healthy food choices; 2) Increase opportunities and supports for daily physical activity; and 3) Build school-based capacity to support healthy behaviors.

Plan of Action

The Links to Success initiative began in 2007 by addressing academic and life skills for a defined cohort of students in high-poverty, low-performing Title 1 schools in the tri-county. In 2010, the Financial Stability Project incorporated additional support services through Links to Success sites to address basic needs, basic skills and financial stability for families. Research indicates that healthy students are better learners, and so the long range plan for Links to Success is to develop a health component that would build on established relationships and complete the integration of supports for education, financial stability and health in this targeted population. The Socio-Ecological Model illustrates the multiple domains where strategic interventions must take place in order for social and environmental supports to develop and become the norm for our community.

The health component for Links to Success will develop specific strategies to engage parents and others who provide supportive social networks for the students, with a specific focus on interventions to reverse the current alarming trends in physical inactivity and poor nutrition in Title 1 schools. In addition, the Health impact area will coordinate efforts through the Links to Success service delivery system to offer mobile primary care services, such as dental care and health screenings and referrals, as appropriate, for children and their families.

Funded Programs Strategies and Outcome Statements with Performance Measures

Funded community programs will also play a key role in improving the community indicators associated with the Early Prevention of Chronic Disease target issue. TUW has identified evidence-based strategies and outcome statements with performance measures for use by programs under this target issue (Appendix C).

Advocacy/Public Policy

TUW is interested in supporting advocacy efforts that help to prevent unhealthy behaviors such as:

- Advocating for smoke-free laws.
- Advocating for increased taxes on tobacco and fast food with proceeds directed to health initiatives.
- Advocating for changes in school menus to increase nutritional values and eliminate unhealthy choices and empty calories.

STRATEGIC PARTNERSHIPS

The tri-county area is home to a multitude of health care resources, including four hospitals, multiple health care providers and organizations to support the health care industry. This resource-rich area has helped to foster the development of a number of
collaborations and health-focused initiatives with a specific interest in school-based interventions.

At the time of publication, several partnerships and initiatives were under development that will likely play key roles in the achievement of the objectives of the Early Prevention of Chronic Disease target issue.

**Charleston County Medical Society (CCMS) School Health Committee**

The School Health Committee of the Charleston County Medical Society is working with the Charleston County School District to support schools in the implementation of the 2005 School Health and Fitness Act. Fifty-two of the District’s 80 schools presently have an active Wellness Committee, a mandate of the 2005 Student Health and Fitness Act. CCMS is recruiting private physicians for the “Docs-Adopt” initiative to support wellness activities in schools.

**Charleston County School District Coordinated School Health Advisory Committee (CSHAC)**

Mandated by the 2005 Student Health and Fitness Act, the Coordinated School Health Advisory Council (CSHAC) assesses, plans, implements, and monitors district and school health policies and programs, including the development of a district wellness policy.

**Department of Health and Environmental Control (DHEC) Region 7**

The mission of the Region 7 Public Health Office is to promote, protect and improve the health and environment for the citizens of Berkeley, Charleston and Dorchester Counties. Because their three county service area matches that of Trident United Way they are a natural partner in efforts to address healthy eating and active living in schools throughout the region.

**Eat Smart Move More Charleston Tri-County**

Local government agencies, health organizations and businesses are coming together to form Eat Smart Move More Charleston Tri-County, a new local chapter of the state’s Eat Smart Move More South Carolina Coalition. The state-wide coalition coordinates obesity-prevention efforts across the state and is responsible for implementing South Carolina’s State Obesity Prevention Plan.

**Healthy North Charleston (ACHIEVE Community North Charleston)**

The Centers for Disease Control and Prevention launched ACHIEVE communities (Action Communities for Health, Innovation, and Environmental change) to develop and implement policy, systems, and environmental change strategies that can help prevent or manage health risk factors for heart disease, stroke, diabetes, cancer, obesity, and arthritis. The vision for Healthy North Charleston is a community that has safe access to a healthy lifestyle that includes healthy eating, active living and a clean environment where people live, learn, work and play.
As referenced earlier in the introduction, Trident United Way (TUW) is interested in working with partners across many sectors to create systems change at the community level. A focal point for innovation is on strategies that create integrated service delivery systems utilizing multiple partners and initiatives that integrate education, financial stability and health services in one location.

This section summarizes: (1) community impact initiatives described elsewhere in the Impact Agenda that integrate services for two or more impact areas; (2) a new integrated Place Based Initiative to be piloted during the 2012-2015 funding cycle; (3) an integrated systems approach to the coordination of volunteerism across the tri-county area; (4) systems and tools available to funded partners, and; (5) an integrated public policy agenda.
Links to Success began as a school-based initiative under the Education Impact area, and has systematically expanded services to encompass all impact areas. With the inclusion of a school health promotion project that is currently under development, it will become a fully integrated service delivery system. A full description of Links to Success can be found on page 14.

Links to Success is currently in 11 tri-county schools. It is a high priority project that will expand as rapidly as resources are available to support the expansion. Organizations providing school-based education, financial stability, and health services, are encouraged to explore the possibility of becoming a Linking Partner or an Integrated Service Provider. Funded program strategies and outcome statements with performance measures are located in Appendix D.

INTEGRATED STRATEGIES FOR EDUCATION, FINANCIAL STABILITY AND HEALTH

Several of the Community Impact Initiatives, described under the impact area narratives, also have comprehensive service delivery systems that involve multiple organizations. Others integrate two or more impact areas. The following chart summarizes the integrated initiatives/systems that are described within the Impact Agenda.

<table>
<thead>
<tr>
<th>Initiative/System</th>
<th>Education Component</th>
<th>Financial Stability Component</th>
<th>Health Component</th>
<th>Volunteer Component</th>
</tr>
</thead>
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<td>Child Care Resource &amp; Referral</td>
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<td>Under development</td>
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<td>AccessHealth Tri-county Network</td>
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<tr>
<td>School Health Promotion Project</td>
<td>Under development</td>
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<td>2-1-1 Volunteer Connection</td>
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<td>2-1-1 Hotline</td>
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<td>Integrated Public Policy Agenda</td>
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The success of the Links to Success initiative has highlighted the benefits of fully integrated systems. Some of the benefits of integrated models that use the strengths and talents of multiple partners are: increased collaboration among non-profits, businesses and other organizations; improved communication; reduced duplication of services; shared strategies; one-stop services for families; cross training; leveraged resources; and stronger outcomes.

Trident United Way (TUW) is interested in expanding its support of integrated models by working with one or two existing place-based organizations. Eligible partnerships for this initiative will be defined as “an established comprehensive service delivery system for a defined geographic region that provides fully integrated education, financial stability and health services across a wide range of participants using multiple providers in one setting.” Preference will be given to organizations that have an extensive history in demonstrating outcomes and working with TUW.

The initiative will be created as a social innovation opportunity outside of the regular funding process. It will pilot the development of a model that can be rigorously evaluated, improved and ultimately replicated.

Eligible organizations must:

- Integrate the services of several organizations in a defined geographic region.
- Have demonstrated outcomes in at least two of the three priority areas (Education, Financial Stability, Health) with a written plan to incorporate the third area within six months of funding.
- Be willing to serve as a Beta site for research purposes to evaluate the success of specific interventions in achieving outcomes.
- Commit to being part of a collaborative to develop a system for gathering and reporting on integrated outcomes.
- Meet the funding directives under the chosen target issues in Education, Financial Stability and Health.
- Utilize at least one strategy and the corresponding performance measures under Education, Financial Stability and Health.

**INTEGRATED COMMUNITY SYSTEMS**

**Global Focus**

Engage our diverse community of volunteers, turning their good intentions into greater impact.

**Model of Community Change**

Through 2-1-1 Volunteer Connection, TUW is working to create a stronger local culture of service, making volunteering a natural part of what we do, talk about and value community wide. To this end, we are building a comprehensive, integrated system to
mobilize volunteers through strengthened collaboration with corporate, government and non-profit partners. The system will be built on proven strategies that focus on the three key elements that drive volunteer engagement: Motivation, Access and Effective Engagement. Using the business concept of “supply and demand,” the system will cultivate excellence in both volunteer opportunities and talent deployment. This comprehensive volunteer system will facilitate broad engagement and targeted recruitment of volunteers to achieve the goals of the Agenda for Community Impact.

Many local groups currently work independently to cultivate volunteer engagement for their particular constituency. Going forward, the Integrated Volunteer System will support and incorporate the work of existing programs and create new strategies to enhance capacity for increased success. Most importantly, efforts will be organized through a central hub that serves as the go to point for volunteer engagement best practices, information, tools and outcomes measurement methodologies. Community partners will track the number of new volunteers engaged, how they learned of the opportunity, how well they felt matched and trained for the role, and how they would rate their overall experience. We will also measure the impact of the volunteer’s work on the identified target areas of Education, Financial Stability and Health. Feedback loops and ongoing communication among partners will ensure a continuous quality improvement process.

**Multi-Dimensional Strategies**

**Community Impact Initiative**

**2-1-1 VOLUNTEER CONNECTION**

**Systemic Change**

The community works collaboratively to effectively leverage the talent and resources of volunteers for greater community impact.

**Rationale for Strategic Direction**

Community work requires volunteer engagement; monetary resources alone are not enough to create true community impact on critical issues. An effective volunteer system will be key to leveraging resources to ensure success of strategies identified in the Agenda for Community Impact.

The Independent Sector and Census data report South Carolina’s volunteer rate as 28.8 percent, slightly above the national average. Research indicates that people most often volunteer because they were asked and that this recruitment generally occurs through friends, family, workplace or religious affiliation. Identifying with a mission or cause is also a strong motivator. However, people often cite not knowing where to look or how to get involved as a barrier. Non-volunteers also report seeing themselves as different from volunteers, imagining that they do not have the time or talent to meaningfully contribute.

In addition to getting people involved, retention is another important factor. Unfortunately, some studies report that up to one-third of volunteers leave and don’t return to service each year. Many report a “bad experience,” specifically noting they were not utilized effectively, experienced poorly organized programs, were not contacted when they expressed interest, or could not see if they were making a difference.
Furthermore, new research suggests a growing corporate commitment to social responsibility that includes an interest in workplace volunteer programs. Companies find volunteerism boosts morale, aids recruitment and retention, increases public image and offers valuable leadership development for its employees (Deloitte Volunteer IMPACT Survey, 2010). Research also illuminates the need for non-profits to embrace new “talent development” thinking and more sophisticated approaches to volunteer engagement for best results (Eisner, Grimm, Maynard & Washburn, 2009). Clearly, non-profits and corporations can partner for mutual benefit and greater community impact.

**Plan of Action**

Based on these findings, the 2-1-1 Volunteer Connection will create a compelling call to action through broad messaging about service and targeted asks for volunteers to help address critical needs. Information will be provided about opportunities and ways for people to invest their time and talents for community impact. Media partners will be engaged and community leaders will be asked to put volunteerism on the agenda at key public events. Current volunteers will be highlighted as a way to inspire others, and cultivate spokespersons to put a face on volunteerism to which everyone can relate. Social media tools will be employed and partners will be supported in implementing their own robust marketing plans.

To make volunteering easy in our community, this system will focus on providing access to opportunities through multiple channels. A comprehensive database of information will support phone, print and web access and make information available through work places, places of worship, schools and community centers. For individuals or groups that need more support finding the right fit, the system will offer one-on-one consultation and matching. A calendar of service opportunities will be featured on the web and Community Days of Service will be used to give people an entry point to volunteering and follow-up will facilitate further engagement.

To ensure effective engagement and utilization of volunteers, the system will work directly with non-profit partners and the Lowcountry Association of the South Carolina Association for Volunteer Administration (LASCAVA) to strengthen their capacity through toolkits, training and technical assistance. Tools will be used to help them assess their current volunteer management practices and support them in strategies for improvement. Utilizing shared instruments to track and evaluate the volunteer’s experience and impact, it will be possible to analyze and report on results for further refinement. The system will proactively facilitate partnerships for initiatives demonstrating use of best practices and addressing identified critical needs.

**Funded Programs Strategies and Outcome Statements with Performance Measures**

Funded community programs will also play a key role in the creation of a fully **Integrated Volunteer System** by using evidence-based strategies and consistent outcome statements with performance measures provided in Appendix D.
Strategic Partnerships

**Corporate Volunteer Council**

The Corporate Volunteer Council (CVC) will increase the pool of volunteer talent by developing workplace volunteer programs. The CVC, led by a volunteer Leadership Team, will provide a forum to exchange ideas through tool kits, mentoring or technical assistance and quarterly meetings.

**Leadership Connection Pilot**

In partnership with The Metro Chamber of Commerce, the Leadership Connection Pilot will train and connect emerging leaders with volunteer Board and other leadership roles within local non-profits. The initial pilot will draw talent from graduates of Leadership Charleston and members of Charleston Young Professionals. The program is being designed and tested with a vision for replication among other targeted groups.

**TriCounty Youth Service Day**

Tricounty Youth Service Day (TYSD) is the local implementation of Global Youth Service Day, a worldwide event engaging children and youth to address unmet needs in their communities. TYSD encourages teams of youth with adult supervision to identify, address and take ownership in the solutions to local needs through service. We know that youth who engage in service are more likely to become adults who volunteer and that service builds leadership skills. TUW leads the local coalition that oversees TYSD.

**Lowcountry Association of SC Volunteer Administrators**

Lowcountry Affiliate of South Carolina Association for Volunteer Administrator (LASCAVA) focuses on professional development of local volunteer programs and the staff that administer them. LASCAVA provides networking opportunities, training and advocacy to promote standards of excellence and competence in the field of volunteer management. TUW participates at a leadership level and will work to develop complimentary programs going forward.

**Retired and Senior Volunteer Programs**

Retired and Senior Volunteer Program (RSVP) is a program of the Corporation for National and Community Service sponsored locally by the Carolina Lowcountry Chapter of the American Red Cross. RSVP engages adults age 55 and older in utilizing their life experiences and skills to address community needs. Older adults are a growing segment of our local community with tremendously rich skill sets and one of the highest levels of engagement, making an active partnership with RSVP key to overall community volunteer engagement.

**Voluntary Organizations Active in Disaster**

Trident Voluntary Organizations Active in Disaster (VOAD) is the tri-county chapter of NVOAD (National VOAD) and SCVOAD (South Carolina VOAD). Trident VOAD focuses on communication, coordination, cooperation and collaboration among local non-profit and government entities to ensure efficient and effective response and recovery in times of disaster. TUW leads the group and is actively compiling an integrated community disaster plan specifying the role of local non-profits.
**COUNTY EMERGENCY MANAGEMENT DEPARTMENTS**

County Emergency Management Departments are the lead entities in local disaster response and recovery. TUW works very closely with these departments in both the give and get help arenas. 2-1-1 plays a key role in getting information to citizens in need and mobilizing volunteers to ensure community resiliency. Disaster drills throughout the year support readiness and improvement of the systems needed in times of disaster. As chair of the local VOAD, TUW also spearheads government and community non-profit collaboration.

**COMMUNITY ISSUES MANAGEMENT**

Community Issues Management (CIM) is a web-based tool that serves as a repository for a massive amount of data related to Education, Financial Stability and Health, as well as census and other demographic data. Data, available through CIM, can be coded using geospatial technology so that the data can be displayed on geographic maps. By using color coding, the density of a particular community attribute such as poverty, or areas where the achievement gap is greatest, can be displayed on a map to identify needs. Also, any entity that has a physical location (e.g., schools, churches, businesses, non-profit organizations, public services, etc.) can be coded to identify assets and gaps in services. The availability of GIS data has virtually eliminated the need for TUW to conduct periodic needs and asset assessments. Each of the impact areas has an established work group section that allows community partners to access the data sets in CIM, map an area using relevant data and post information related to a project in the issues library. As such, CIM allows TUW to track changes in identified community outcomes over time. It can also provide a historical perspective of the evolution of outcomes produced by a funded program. By measuring program and initiative outcomes against the change in community indicators, TUW is able to assess whether its investments have had a positive impact on the 10-year goals.

CIM will be available to all funded programs and community partners involved in an initiative. Funded programs and partners will be required to define their geographic service area using CIM to help the community track assets and gaps in services delivery. CIM is available to local partners at no cost.

**CHARITYTRACKER**

CharityTracker is a web-based program that is used by basic needs providers and communities of faith to increase collaboration, reduce duplication, and focus their resources on people in need. Providers can easily search for an existing client, add a new client, and network utilizing the bulletin feature in CharityTracker. CharityTracker is managed in partnership with Trident United Way (TUW) and the Human Needs Network (HNN). There is no cost to the providers to utilize CharityTracker and some initiatives and target issues require partners to use the system. For a more comprehensive description of how CharityTracker is integrated into TUW’s work, please see page 21.
THE BENEFIT BANK OF SOUTH CAROLINA

The Benefit Bank of South Carolina (TBB-SC) is a program of the SC Office of Rural Health supported through a grant provided by the Blue Cross Blue Shield Foundation. Developed as a counselor-assisted program, TBB-SC helps individuals prepare and electronically file applications for work supports including the Earned Income Tax Credit, income tax returns, FAFSA (Free Application for Federal Student Aid), Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps), Medicaid (Medicaid for children was formerly known as CHIP, Children’s Health Insurance Program). The TBB-SC is available in English and Spanish and has the flexibility to incorporate local programs and unique partnerships, thus becoming a broad vehicle for safety-net deployment. A more complete description of how The Benefit Bank is integrated into the work of Education, Financial Stability and Health is provided in the impact area narratives. Using The Benefit Bank technology is required for some initiatives and is provided to community partners at no cost.

INTEGRATED PUBLIC POLICY AGENDA

Trident United Way has established a Public Policy Committee that is responsible is for developing an Integrated Public Policy Agenda, incorporating the advocacy recommendations detailed under the Education, Financial Stability and Health target issues.

The Public Policy Committee will:

- Identify priority policy issues annually to be acted upon.
- Meet with members of the local delegation to strengthen the policy positioning.
- Join forces with other United Ways, Chambers of Commerce and Advocacy organizations to promote select advocacy issues.
- Identify the level of engagement that TUW will provide for each policy issue, defining the human and financial resources dedicated to each issue.
- Create information packets and talking points for each issue.
- Create/adopt a Call to Action system to mobilize supporters of policy issues.

The most current Board-approved Integrated Public Policy Agenda can be found on TUW’s website www.tuw.org/work.asp, beginning in the fall of 2011.
To access the following documents, please go to TUW’s website as directed.

- Call for Investments Guide: www.tuw.org/work.asp
- Funded Partner Standards & Policies: www.tuw.org/work.asp
- Integrated Public Policy Agenda: www.tuw.org/work.asp

APPENDICES

**Appendix A**  
Education Target Issues, Strategies and Outcome Statements with Performance Measures.

**Appendix B**  
Financial Stability Target Issues, Strategies and Outcome Statements with Performance Measures.

**Appendix C**  
Health Target Issues, Strategies and Outcome Statements with Performance Measures.

**Appendix D**  
Integrated Community Initiatives and Systems, Strategies and Outcome Statements with Performance Measures (i.e., Links to Success Initiative and Integrated Volunteer System).
## EDUCATION

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</th>
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<tbody>
<tr>
<td><strong>TARGET ISSUE</strong></td>
<td><strong>Children enter kindergarten ready to succeed</strong></td>
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<tr>
<th>STRATEGIES</th>
<th>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</th>
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<tbody>
<tr>
<td><strong>1. Children with identified developmental needs receive early intervention services that mitigate risks.</strong></td>
<td>80% of children receiving early intervention services in funded programs will demonstrate meaningful and measurable gains across a minimum of two targeted developmental domains (e.g., gross motor, cognitive, language, social, emotional) at stage-appropriate intervals using the Parents As Teachers (PAT) Ages and Stages questionnaire.</td>
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</table>
| **2. Adults read to and with children.** | 75% of children in funded programs will be read to by or will read with supportive adults for a minimum of 30 minutes per week as demonstrated by program attendance records and lesson plans, parent logs, family worker case notes, or a combination of these and other accountability measures.  
  80% of these children will demonstrate language gains between pre- and post-testing using the Peabody Picture Vocabulary Test (PPVT). |
| **3. Provide parent education and support services to promote parent-child bonding and parental skill in promoting early literacy.** | 85% of parents/caregivers completing a multi-session parent education program will demonstrate gains across two or more parenting skill domains between pre- and post-testing using the Adult and Adolescent Parenting Inventory (AAPI).  
  *Note:* Programs targeting a specific subset of the population (i.e., teen parents, parents of children with special needs, et. al.) may substitute and/or add an alternate, standardized instrument for pre- and post-testing that is correlated to the curriculum used and approved by TUW at the time of funding. |
| **4. Exposure to other children with supports for language, social and gross motor skill development.** | 50% of children receiving program services will participate in supervised activities with age peers at least weekly for 30 minutes, as documented by attendance and lesson plan records, parent logs, family worker case notes or a combination of these and other accountability measures. |
## EDUCAZION

### TARGET ISSUE
Youth graduate high school on-time, prepared for higher education and/or employment

### STRATEGIES

#### OUTCOME STATEMENTS WITH PERFORMANCE MEASURES

1. **Provide targeted academic supports to promote:**
   - Measures of Academic Progress (MAP) scores, tracked annually as an outcome, and at key grades with cohort comparison as an impact measure. In circumstances where a district does not use MAP testing, the standardized measure chosen by the school district will be substituted.

   - **a.** Reading at grade level at grade 3, 6 and 8.
     - 95% of students demonstrating grade level proficiency will maintain grade level proficiency.
   - **b.** Math skills at grade level at grade 3, 6 and 8.
     - 80% of students with proficiency below grade level will enhance their MAPS scores by 5 points between fall and spring testing.
   - **c.** Completion of algebra by grade 10.
     - % of 10th graders who have successfully completed algebra as demonstrated by report card data.

2. **Provide extra-curricular, interest-based school and community supports:**
   - 80% of youth will demonstrate gains in two developmental asset areas between pre- and post-testing using the Search Institute’s Developmental Assets Profile (DAP), or similar standardized measure **and all of 2.a. and 2.b.**

   - **a.** Linked with interest-based extra-curricular or community-based activities by age 10.
     - 70% of youth linked with interest-based extra-curricular or community-based activities will participate in that activity, with adult support, a minimum of 10 times per school year.
     - % of these youth with improved school attendance.
   - **b.** Youth participate in service learning opportunities.
     - % of youth participating in four or more service learning projects who demonstrate improved school attendance.

3. **Support child development and family transitions:**
   - 80% of youth demonstrating gains in two developmental asset areas between pre- and post-testing using the Search Institute’s Developmental Assets Profile (DAP) **and one sub-strategy-specific measure below:**

   - **a.** Provide stage-specific parent education and support services.
     - 80% of parents completing a multi-session parent education program will demonstrate gains across at least two parenting skill domains between pre- and post-testing using the Adult and Adolescent Parenting Inventory (AAPI), or similar, curriculum-specific standardized measure approved at the time of funding.
   - **b.** Increase parent involvement in school activities and youth resources in the community.
     - 25% of parents will increase their attendance at parent-teacher conferences, PTO meetings and events involving their child.
   - **c.** Promote safety planning by caregivers for children.
     - 50% of parents will complete safety plans for their children that reduce family safety and stability risks at their point of intake with Links services and annually thereafter.
   - **d.** Provide adult mentors for academic and interest-based learning.
     - % of youth with match and encounter records documenting 10 or more mentor contacts.
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<th>STRATEGIES</th>
<th>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</th>
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<tr>
<td>e. Provide opportunities for student leadership with a focus on equality and social justice.</td>
<td>Activity attendance records and student outcome surveys. *</td>
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<tr>
<td>f. Provide character education with a focus on personal responsibility and conflict resolution among peers and/or families.</td>
<td>Group attendance records and curricula review. Pre- and post-testing using standardized curricula approved at the time of funding. 80% of youth participating in eight or more sessions of character education will demonstrate gains between pre- and post-testing using a standardized measure (approved at time of funding).</td>
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<tr>
<td>g. Provide positive communication and positive discipline training for children and their caregivers with a focus on strengths affirmation, developing self esteem and making healthy choices.</td>
<td>Group attendance records and curricula review. Pre- and post-testing using standardized curricula approved at the time of funding. 80% of youth/parents participating in eight or more sessions of positive communication and/or positive discipline training will demonstrate gains between pre- and post-testing using a standardized measure (approved at time of funding).</td>
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<tr>
<td>4. Support adolescent development and transitions:</td>
<td>80% of youth will demonstrate gains in two developmental asset areas between pre- and post-testing using the Search Institute’s Developmental Assets Profile (DAP) and</td>
</tr>
<tr>
<td>a. Provide stage-specific parent education and support services.</td>
<td>80% of parents will demonstrate gains across at least 2 parenting skill domains between pre- and post-testing using the Adult and Adolescent Parenting Inventory (AAPI), or similar standardized measure.</td>
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<tr>
<td>b. Increase parent involvement in school activities and youth resources in the community.</td>
<td>25% of parents will demonstrate increased attendance at parent-teacher conferences, PTO and school events involving their child.</td>
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<tr>
<td>c. Provide adult mentors for academic and interest-based learning.</td>
<td>% of youth with match and encounter records documenting 10 or more mentor contacts. *</td>
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<tr>
<td>d. Provide opportunities for student leadership with a focus on equality and social justice.</td>
<td>Activity records and student outcome surveys. *</td>
</tr>
<tr>
<td>e. Provide character education with a focus on integrity, responsibility and conflict resolution among peers and/or families.</td>
<td>Group attendance records and curricula review. Pre- and post-testing using standardized curricula approved at the time of funding. 80% of youth participating in eight or more sessions of character education will demonstrate gains between pre- and post-testing using a standardized measure (approved at time of funding).</td>
</tr>
<tr>
<td>f. Provide positive communication and positive discipline training for children and their caregivers with a focus on strengths affirmation, setting high expectations, interpersonal competence and decision making.</td>
<td>Group attendance records and curricula review. Pre- and post-testing using standardized curricula approved at the time of funding. 80% of youth/parents participating in eight or more sessions of positive communication and/or positive discipline training will demonstrate gains between pre- and post-testing using a standardized measure (approved at time of funding).</td>
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### STRATEGIES

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<tr>
<th>5. Empower positive parenting for the next generation:</th>
<th>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Provide parenting awareness activities for youth.</td>
<td>Pre- and post-testing using the Search Institute’s Developmental Assets Profile (DAP) for each child and sub-strategy specific measure below:</td>
</tr>
<tr>
<td>b. Provide teen pregnancy prevention services.</td>
<td>Measures to be developed by applicant using standardized scales. *</td>
</tr>
<tr>
<td>c. Provide home-based parent support services for parents of teens and pre-teens.</td>
<td>Measures to be developed by applicant using standardized scales. *</td>
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<th>6. Link youth with employment readiness supports:</th>
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<tbody>
<tr>
<td>a. Provide opportunities for summer youth employment.</td>
<td>75% of youth demonstrating gains in at least three skill areas between pre- and post-testing using a standardized Employment Readiness Scale (ERS).</td>
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<tr>
<td>b. Provide business and professional mentors for youth.</td>
<td></td>
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<tr>
<td>c. Provide college tutors and experiences for youth.</td>
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</tr>
<tr>
<td>d. Provide college readiness programming to promote first generation college attendance</td>
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<th>7. Support children and families in crisis.</th>
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<tbody>
<tr>
<td></td>
<td>80% of families will demonstrate enhanced family stability/cohesion between pre- and post-testing using a standardized family stability scale.</td>
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*The threshold for these outcome statements with performance measures will be set following a review of aggregate data across funded programs for the 2012-2013 funding year. Once set, programs will be required to strive to meet or exceed the threshold.*
# FINANCIAL STABILITY

## TARGET ISSUE
Coordination of Basic Needs

## STRATEGIES
1. Coordination and provision of basic needs services through system creation, collaboration and management:
   - a. Basic needs assistance providers will use a formal referral process to provide financial and basic skills education for the individuals and families they serve.  
     - % of eligible individuals to which basic needs services are provided who also participate in financial or basic skills education classes. *
     - % of individuals who demonstrate increased knowledge of basic skills in pre- and post-tests using a pre-approved curriculum/course outline or nationally recognized curriculum. *
   - b. Provide a combination of financial stability services, which includes a formal referral process that promotes individual and family stability.  
     - % of individuals that demonstrate stability based on a pre- and post-test or a nationally recognized assessment/index. *
   - c. Link all eligible residents with public benefits and work supports (SNAP, Medicaid, Medicare Part D low-income subsidies for seniors, LiHeap, Disability benefits, EITC, Taxes, FAFSA)  
     - % increase (or maintain 100 percent of benefits) for the number of eligible individuals who complete the application process for benefits and/or work supports as documented by The Benefit Bank reporting tool. *

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* The threshold for these outcome statements with performance measures will be set following a review of aggregate data across funded programs for the 2012-2013 funding year. Once set, programs will be required to strive to meet or exceed the threshold.
# Financial Stability

<table>
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<tr>
<th>Target Issue</th>
<th>Increase Income</th>
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<tr>
<td>Strategies</td>
<td>Outcome Statements with Performance Measures</td>
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</table>

1. Families increase income by obtaining work supports, employable skills and financial education:

   All programs must demonstrate use of sub-strategies 1.a. and 1.b. Programs may elect to demonstrate sub-strategy 1.c. and/or 1.d.

   a. Increase access to work supports using The Benefit Bank (FAFSA, EITC, SNAP, Taxes, Medicaid).

      65% of eligible individuals who increase income by obtaining work supports through The Benefit Bank.

   b. Provide a combination of financial stability services, which includes a formal referral process that promotes individual and family stability.

      % of individuals that demonstrate stability based on a pre- and post-testing or a nationally recognized assessment/index. *

   c. Increase level of education (e.g., Employment preparedness, GED, WorkKeys, Technical Certification or higher education).

      90% increase in knowledge of skills needed to enhance employment status using pre- and post-testing using nationally recognized or pre-approved curriculum/course outline.

      68% of individuals demonstrate an increased level of education as documented by GED completion, 53% WorkKeys certification, technical certification or diploma.

   d. Increase access to employment services and enhance employment status (e.g., part-time to full-time, level of job, or type of job).

      % of individuals increasing in employment status as evidenced by job promotion, starting a new business or salary/hourly pay increase documentation. *

* The threshold for these outcome statements with performance measures will be set following a review of aggregate data across funded programs for the 2012-2013 funding year. Once set, programs will be required to strive to meet or exceed the threshold.
# Financial Stability

## Target Issue

Gain and Sustain Assets

## Strategies

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<th>STRATEGIES</th>
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<tr>
<td><strong>1.</strong> Families increase savings by gaining access to traditional banking products and services and financial education <em>(applicants must provide the first two sub-strategies together):</em></td>
<td>Must demonstrate sub-strategies 1.a. and 1.b. Applicants may elect to demonstrate sub-strategy 1.c.</td>
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</tbody>
</table>
| a. Increase access to and education on traditional banking products. | % of individuals who demonstrate increased knowledge about banking products in pre- and post-tests using a pre-approved curriculum/course outline or nationally recognized curriculum. *  
% of individuals who stop using predatory lending institutions within six months. *  
% of individuals who establish and follow a budget for six months and one year. *  
% of individuals who open an account within 30 days of financial education course completion and maintain an account with a traditional bank measured at intervals beginning at six months. * |
| b. Provide education on how to improve credit and credit score or assist consumers with repairing credit and increasing credit score. | % of individuals who demonstrate increased knowledge about credit and credit score improvement in pre- and post-tests using a pre-approved curriculum/course outline or nationally recognized curriculum. *  
45% increase of individuals whose credit score improves after receiving credit repair instruction.  
% of individuals who obtain credit within one year after receiving credit repair services. * |
<p>| c. Increase access to and utilization of savings campaigns. | % of individuals completing a financial education program who open and appropriately utilize an Individual Development Account (IDA) or alternate savings campaign. * |
| <strong>2.</strong> Families obtain and retain financial assets, such as homes, long-term savings and investments: | Must demonstrate at least three sub-strategies. |
| a. Increase awareness and education about asset building and asset protection. | % of individuals who demonstrate increased knowledge about asset building and asset protection in pre- and post-tests using a pre-approved curriculum/course outline or nationally recognized curriculum. * |
| b. Increase services to build and maintain families’ economic assets (homes, long-term savings and investments). | % of individuals who acquire and/or maintain one or more economic asset. * |
| c. Increase housing retention through foreclosure prevention and financial education. | 80% of individuals who complete a foreclosure prevention program and whose homes do not go into foreclosure. * |</p>
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</thead>
</table>
| d. Increase awareness and access to free legal services that protect individuals’ assets (wills, clear titles, loss mitigation, disability benefits, small business service). | % of individuals whose assets are protected by utilizing free legal services. *  
% of individuals whose financial stability is strengthened by utilizing free legal services. * |

* The threshold for these outcome statements with performance measures will be set following a review of aggregate data across funded programs for the 2012-2013 funding year. Once set, programs will be required to strive to meet or exceed the threshold.
## HEALTH

<table>
<thead>
<tr>
<th>TARGET ISSUE</th>
<th>Increasing Access to Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIES</td>
<td>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</td>
</tr>
<tr>
<td>1. Provide a fully-integrated system of care that improves access to primary and specialty health care services, through formal agreements with providers spanning all levels and intensity of care.</td>
<td>Must demonstrate all measures:</td>
</tr>
<tr>
<td></td>
<td><strong>Initial:</strong></td>
</tr>
<tr>
<td></td>
<td>Evidence of contracts with providers across the continuum of care.</td>
</tr>
<tr>
<td></td>
<td><strong>Intermediate:</strong></td>
</tr>
<tr>
<td></td>
<td>% increase in access to primary care through placement in a medical home as evidenced by patient reports in system database. *</td>
</tr>
<tr>
<td></td>
<td>% increase in access to specialty care by referral to specialist as evidenced by patient reports in system database. *</td>
</tr>
<tr>
<td></td>
<td>% increase in Ambulatory Care Sensitive Conditions being addressed in primary care settings as evidenced by visit code reports from system database. *</td>
</tr>
<tr>
<td></td>
<td><strong>Long-Term:</strong></td>
</tr>
<tr>
<td></td>
<td>% decrease in ER (emergency room) utilization for Ambulatory Care Sensitive Conditions as evidenced by utilization reports from S.C. Office of Research and Statistics (SCORS). *</td>
</tr>
<tr>
<td></td>
<td>% decrease in IP (in-patient) utilization for Ambulatory Care Sensitive Conditions as evidenced by utilization reports from S.C. Office of Research and Statistics (SCORS). *</td>
</tr>
<tr>
<td>STRATEGIES</td>
<td>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2. Provide a coordinated support service that improves access to health care by removing one or more barriers.</td>
<td>Programs addressing barriers other than Medicaid application assistance must demonstrate measures 2.a. and 2.b.:</td>
</tr>
<tr>
<td></td>
<td>a. % increase in clients for whom support services reduced barriers to health care as evidenced by activity logs and client rosters of numbers served. *</td>
</tr>
<tr>
<td></td>
<td>b. % increase in client’s sense of security to access care when needed as evidenced by self-report on pre-and post-tests. *</td>
</tr>
<tr>
<td></td>
<td>c. Specific to Medicaid application assistance. Must demonstrate both measures below:</td>
</tr>
<tr>
<td></td>
<td>% increase in completion rates for first time and/or re-enrollment applications for Medicaid as evidenced by TBB-SC reporting. *</td>
</tr>
<tr>
<td></td>
<td>% increase in eligible clients enrolled in Medicaid and approved for benefits as evidenced by formal tracking system. *</td>
</tr>
<tr>
<td>3. Provide primary care and coordinate specialty care through an ongoing doctor/patient relationship in a patient-centered medical home setting.</td>
<td>Must demonstrate all three measures:</td>
</tr>
<tr>
<td></td>
<td>% of patients who meet recommendations for preventive care in accordance with accepted practice guidelines, as evidenced by clinical records. *</td>
</tr>
<tr>
<td></td>
<td>% increase in patients with clinical indicators for specialty care who follow through and seek care, as evidenced by completion rates. *</td>
</tr>
<tr>
<td></td>
<td>% increase in patient’s sense of security to utilize care when needed as evidenced by self-report on pre-and post-tests. *</td>
</tr>
<tr>
<td>4. Provide specialty care services (e.g., diagnostic testing, pharmaceuticals, dental care, etc.) for underserved populations outside of the medical home setting.</td>
<td>Must address both measures:</td>
</tr>
<tr>
<td></td>
<td>% of patients who meet recommendations for preventive care in accordance with accepted practice guidelines, as evidenced by clinical measures. *</td>
</tr>
<tr>
<td>STRATEGIES</td>
<td>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5. Provide health education services in community-based, non-traditional</td>
<td>* <strong>Must address all three measures:</strong></td>
</tr>
<tr>
<td>settings (e.g., churches, schools, neighborhood centers, etc.) to</td>
<td><strong>Initial:</strong></td>
</tr>
<tr>
<td>develop appropriate behaviors for health maintenance and/or chronic</td>
<td>% increase in knowledge, attitude and skills to practice behaviors to maintain good health as evidenced</td>
</tr>
<tr>
<td>disease control in high-risk populations.</td>
<td>by self-report in pre- and post-tests. *</td>
</tr>
<tr>
<td></td>
<td><strong>Intermediate:</strong></td>
</tr>
<tr>
<td></td>
<td>% increase in coping and adaptive behaviors to reduce symptoms or delay onset of chronic disease as</td>
</tr>
<tr>
<td></td>
<td>evidenced by self-report in pre- and post-tests. *</td>
</tr>
<tr>
<td></td>
<td><strong>Long-term:</strong></td>
</tr>
<tr>
<td></td>
<td>Increase of those in Intermediate above, who show improved clinical outcomes for target disease, as</td>
</tr>
<tr>
<td></td>
<td>defined by applicant, as evidenced by pre- and post-test clinical measures (e.g., blood pressure, HbA1C,</td>
</tr>
<tr>
<td></td>
<td>cholesterol, BMI, etc.). *</td>
</tr>
</tbody>
</table>

* The threshold for these outcome statements with performance measures will be set following a review of aggregate data across funded programs for the 2012-2013 funding year. Once set, programs will be required to strive to meet or exceed the threshold.
# HEALTH

## TARGET ISSUE
Early Prevention of Chronic Disease

## STRATEGIES

1. **Provide education, training and support for the development of healthy eating patterns and regular, age-appropriate physical activity to promote life-long health and fitness.**

   **OUTCOME STATEMENTS WITH PERFORMANCE MEASURES**

   **Must demonstrate all three measures:**
   - **a.** Increase toward developing healthy eating patterns as evidenced by pre- and post-testing in participant surveys, activity logs, etc., using 2010 Dietary Guidelines for Americans [www.dietaryguidelines.gov](http://www.dietaryguidelines.gov) *
   - **b.** Increase toward the practice of regular physical activity as evidenced by pre- and post-testing in participant surveys, activity logs, etc., based on 2008 Physical Activity Guidelines for Americans [www.health.gov/paguidelines](http://www.health.gov/paguidelines) *
   - **c.** Decrease in lifestyle modificable risk-factors/markers for chronic disease (e.g., hypertension, elevated blood glucose, BMI, etc.) as defined by applicant, as evidenced by pre- and post-testing, participant surveys, activity logs, etc. *

2. **Provide education, training and support to keep children and youth tobacco-free by preventing initiation of tobacco use or correcting for tobacco use.**

   **Must demonstrate measure 2.a. and choose to demonstrate 2.b. and/or 2.c.:**
   - **a.** Increase of children and youth who have the knowledge, attitude and skills to practice tobacco refusal as evidenced by pre- and post-testing using nationally recognized or pre-approved curricula (e.g., T.N.T. Project, or N-O-T on Tobacco). *
   - **b.** Reduction in initiation of tobacco use in children and youth as evidenced by self-report on pre- and post-tests (e.g., 2009 SC Youth Tobacco Survey). *
   - **c.** Increase in smoking cessation attempts by children and youth smokers as evidenced by self-report on pre- and post-tests (e.g., 2009 SC Youth Tobacco Survey). *

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# INTEGRATED COMMUNITY INITIATIVES AND SYSTEMS

This documentation focuses on strategies, outcome statements, and performance measures related to the Links to Success Initiative. The initiative aims to build community learning centers to high-poverty, low-performing schools. The document outlines strategies, outcome statements, and performance measures for three primary areas:

1. **Provide targeted academic supports to promote**:
   - **STRATEGIES**:
     - Reading at grade level at grade 3, 6, and 8.
     - Math at grade level at grade 3, 6, and 8.
   - **OUTCOME STATEMENTS WITH PERFORMANCE MEASURES**:
     - 95% of students demonstrating grade level proficiency will maintain grade level proficiency between fall and spring testing.
     - 80% of students with proficiency below grade level will enhance their MAPS scores by a minimum of five points between fall and spring testing.

2. **Provide extra-curricular, interest-based school and community supports**:
   - **STRATEGIES**:
     - Linked with interest-based extra-curricular or community-based activities by age 10.
     - Youth participate in service learning opportunities.
   - **OUTCOME STATEMENTS WITH PERFORMANCE MEASURES**:
     - 80% of youth demonstrating gains in two developmental asset areas between pre- and post-testing using the Search Institute’s Developmental Assets Profile (DAP), or similar standardized measure.
     - 70% of youth linked with interest-based extra-curricular or community-based activities will participate in that activity, with adult support, a minimum of 10 times per school year.
     - % of these youth with improved school attendance.
     - % of youth participating in four or more service learning projects who demonstrate improved school attendance.

3. **Support childhood and adolescent development**:
   - **STRATEGIES**:
     - Provide stage-specific parent education and support services.
     - Increase parent involvement in school activities and youth resources in the community.
   - **OUTCOME STATEMENTS WITH PERFORMANCE MEASURES**:
     - Pre- and post-testing using the Search Institute’s Developmental Assets Profile (DAP) for each child and one specific sub-strategy with performance measure below:
     - 80% of parents completing a multi-session parent education program will demonstrate gains across at least two parenting skill domains between pre- and post-testing using the Adult and Adolescent Parenting Inventory (AAPI), or similar, curriculum-specific standardized measure approved at the time of funding.
     - 25% of parents will increase their attendance at parent-teacher conferences, PTO meetings and events involving their child.
<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Promote safety planning by caregivers for children.</td>
<td>50% of parents will complete safety plans for their children that reduce family safety and stability risks at their point of intake with Links services and annually thereafter.</td>
</tr>
<tr>
<td>d. Provide adult mentors for academic and interest-based learning.</td>
<td>% of youth with match and encounter records documenting 10 or more mentor contacts. *</td>
</tr>
<tr>
<td>e. Provide opportunities for student leadership with a focus on equality and social justice.</td>
<td>Activity attendance records and student outcome surveys. *</td>
</tr>
<tr>
<td>f. Provide character education with a focus on integrity, responsibility and conflict resolution among peers and/or families.</td>
<td>Group attendance records and curricula review. Pre- and post-testing using standardized curricula–approved at the time of funding. 80% of youth participating in eight or more sessions of character education will demonstrate gains between pre- and post-testing using a standardized measure (approved at time of funding).</td>
</tr>
<tr>
<td>g. Provide positive communication and positive discipline training for youth and their caregivers with a focus on strengths affirmation, setting high expectations, interpersonal competence and decision making.</td>
<td>Group attendance records and curricula review. Pre- and post-testing using standardized curricula approved at the time of funding. 80% of youth/parents participating in eight or more sessions of positive communication and/or positive discipline training will demonstrate gains between pre- and post-testing using a standardized measure (approved at time of funding).</td>
</tr>
<tr>
<td>4. Provide screening for financial supports.</td>
<td>% of families with a child enrolled in a Links to Success service who complete The Benefit Bank screening and follow through with benefit application as deemed eligible. *</td>
</tr>
<tr>
<td>5. Provide linkage with the Financial Stability Project (FSP) where available and appropriate.</td>
<td>% of families with a child enrolled in a Links to Success Service who complete intake and at least one unit of service with the Financial Stability Project. *</td>
</tr>
<tr>
<td>6. Provide emergency assistance and/or referral for emergency assistance, as needed, to remediate risks before they escalate.</td>
<td>75% of families receiving emergency assistance will complete a Financial Stability Project intake and The Benefit Bank enrollment screening.</td>
</tr>
<tr>
<td>7. Promote enrollment of uninsured children in Medicaid or private insurance.</td>
<td>% of children without active insurance enrolled in Links to Success services who receive health insurance within 90 days of program enrollment. * Health insurance status for all children enrolled in Links to Success services will be updated twice per year.</td>
</tr>
</tbody>
</table>

Agenda for Community Impact
Appendix D – Integrated Community Initiatives and Systems

Trident United Way
June 2011
<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>OUTCOME STATEMENTS WITH PERFORMANCE MEASURES</th>
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</thead>
</table>
| 8. **Promote healthy choices toward the prevention of chronic illness in children.** | 75% of children in after school programs in Links to Success sites who participate in 30 minutes of active play/exercise every two hours of programming four to five days per week.  
% of children participating in Links services with verified current immunizations, physicals, dental exams and ophthalmological screenings.  
75% of children receiving Links services will participate in, minimally, four healthy choices trainings per year for Links to Success participants (e.g., nutrition awareness, safety choices, active lifestyle, etc.).                                                                 |

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## INTEGRATED COMMUNITY SYSTEM

The **Integrated Volunteer System** is a coordinated community-wide system that strategically uses volunteers to achieve the goals of the Agenda for Community Impact.

### STRATEGIES

<table>
<thead>
<tr>
<th>Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Utilize systematic approach to recruit and match volunteers to community need.</td>
</tr>
<tr>
<td>2. Utilize a structured training and volunteer support system.</td>
</tr>
<tr>
<td>3. Utilize a structured system to measure volunteer retention.</td>
</tr>
<tr>
<td><strong>Recipients of Service</strong></td>
</tr>
<tr>
<td>4. Utilize a structured system for measuring service recipient outcomes</td>
</tr>
</tbody>
</table>

### OUTCOME STATEMENTS WITH PERFORMANCE MEASURES

<table>
<thead>
<tr>
<th>Volunteers</th>
<th>Outcome Statements with Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Utilize systematic approach to recruit and match volunteers to community need.</td>
<td>% increase in number of volunteers recruited. *&lt;br&gt;% increase in average number of hours served per year per volunteer. *&lt;br&gt;% volunteers rate that the matching system “meets or exceeds expectations” on a set of identified indicators. *</td>
</tr>
<tr>
<td>2. Utilize a structured training and volunteer support system.</td>
<td>90% of volunteers rate the training program as “meets or exceeds expectations” on a set of identified indicators.&lt;br&gt;90% of volunteers rate the ongoing support as “meets or exceeds expectations” on a set of identified indicators.</td>
</tr>
<tr>
<td>3. Utilize a structured system to measure volunteer retention.</td>
<td>90% of volunteers rate their overall volunteer experience as “meets or exceeds expectations.”&lt;br&gt;75% of volunteers who fulfill the duration of their volunteer commitment.&lt;br&gt;60% of volunteers who remain a volunteer with the organization for one year or longer.</td>
</tr>
<tr>
<td><strong>Recipients of Service</strong></td>
<td>90% of service recipients who rate the volunteer service as “meets or exceeds expectations” on a set of identified indicators.</td>
</tr>
</tbody>
</table>

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Bibliography


Corporation for National and Community Service focus groups and analysis of data from the US Census Bureau Current Population Survey Volunteer Supplement 2008


South Carolina Budget and Control Board, Office of Research & Statistics (ORS). Health and Demographics Section, 2008.


South Carolina Office of Rural Health; The Benefit Bank of South Carolina, 2009. 
http://www.thebenefitbank.com


The 2010 Deloitte Volunteer IMPACT Survey, Deloitte Development LLC

The Children’s Budget Behind the Numbers: *Devastating Budget Cuts and Their Impact on the Lives of South Carolina’s Children*. Focus on Kids, a project of the South Carolina Appleseed Legal Justice Center, January 2010.


21st Century Technology
Access to digital information from the internet including current and commonly used computer software.

Access to Health Care
The ability for individuals or families to enter and use the health care system.

Action Research
Action research is a set of practices which empower “learning by doing” - a group of people identify a problem, do something to resolve it, see how successful their efforts were, and adjust the intervention as needed to attain the goal.

Advocacy
The act of representing the interests of another. Often related to advancing Public Policy.

Agenda for Community Impact
A high-level action plan to change community conditions developed with multiple community organizations and leaders. This comprehensive, research-based document prioritizes desired community outcomes and outlines the multi-dimensional strategies needed to achieve them.

Area Median Income
The median income of households in an area being measured. The area described in this document includes Berkeley, Charleston and Dorchester Counties in the state of South Carolina.

Assets
Any activity or tangible item that helps families increase income or gain and sustain financial stability. This includes, but is not limited to, a home, reliable vehicle, emergency savings, long-term savings, affordable housing and education (diploma, degree, certifications).

Baseline
Clearly defined starting point from where implementation begins, improvement is judged, or comparison is made.

Basic Needs
The immediate needs of individuals and families that include food (served meals or other food), shelter (temporary shelter, housing, rent, mortgage, and utilities), clothing, and access to other community resources.

Chronic Disease
A long lasting or recurrent condition.

Community Impact
Improving lives by mobilizing communities to create lasting changes in community conditions.

Community Impact Initiative
An effort, project, or plan designed to mobilize communities in order to create lasting changes in a specified community condition.
**Community Indicator**
A specific observable, measurable characteristic or change that represents achievement of the outcome.

**Continuous Quality Improvement (CQI)**
This management philosophy contends that most processes can be improved. At the core of CQI is serial experimentation (the scientific method) applied to everyday work to meet the needs of those we serve and improve the services we offer. Continuous improvement is most effective when it becomes a natural part of the way every-day work is done.

**Developmental Assets**
Building blocks of healthy development that help young people grow up healthy, caring and responsible. Through extensive research, the Search Institute (2004) has identified 40 age specific developmental assets, infancy through adolescence.

**Earned Income Tax Credit (EITC)**
The Earned Income Tax Credit (EITC) is a refundable federal income tax credit for low to moderate income working individuals and families. When EITC exceeds the amount of taxes owed, it results in a tax refund to those who claim and qualify for the credit. To qualify, taxpayers must meet certain requirements and file a tax return, even if they do not have a filing requirement.

**Evidence-based Practice (EBP)**
Intervention based on systematic, empirical research that has produced statistical evidence of effectiveness. Controlled studies with sophisticated data analysis techniques are required to meet the standards of EBP.

**Family Engagement**
Efforts to reach, involve in planning, and advance the interests of each member of a family.

**Federal Poverty Guidelines**
The federal poverty guidelines, often referred to as Federal Poverty Level (FPL), are issued each year, in the Federal Register by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds used by the U.S. Census Bureau and are used for administrative purposes—for example, determining financial eligibility for certain federal programs. (Please visit website for current guidelines: [http://aspe.hhs.gov/poverty/11poverty.shtml](http://aspe.hhs.gov/poverty/11poverty.shtml).)

**Financial Stability**
An initiative of United Way that promotes community-change strategies to help families meet their basic needs, while gaining the financial capability to plan for, and accomplish, their long-term financial goals.

**Formal Referral Process**
A referral process with a written agreement between two or more service delivery partners that outlines specific procedures and expectations for sharing and serving clients. This written document may include but not be limited to: the number of clients to be served, timeframe for service delivery, accountability for tracking outcomes and data; and shared policies and procedures as they relate to client service.

**Individual Development Account (IDA)**
IDA is a matched savings account that enables low-income American families to save, build assets, and enter the financial mainstream. IDAs supplement the savings of low-income households with matching funds drawn from a variety of private and public sources. Matched IDA savings accounts are typically restricted to three uses: purchasing a first home; pursuing post-secondary education; starting or expanding a small business.
**Inputs**
What goes into the program: resources and contributions that are invested. Inputs include such elements as staff, money, time, equipment, partnerships and the research base.

**Integrated Community Impact Model**
A model developed by Trident United Way to depict the naturally occurring intersection points between the priority areas of Education, Financial Stability and Health. The integrated core of the model is the focus of TUW’s strategic work in creating integrated community strategies and systems.

**Integrated Service Provider (ISP)**
The lead organization coordinating services among multiple providers in Trident United Way’s Links to Success sites.

**Model of Community Change**
An image used to depict the “theory of change” at a community level to show visually the domains to be effected and the processes/services/systems necessary for community change to occur.

**Multi-dimensional strategies**
To achieve community impact, strategies must be employed at multiple levels, including systems and policy change, in addition to direct service program strategies.

**Outcome Statement**
States the specific, measurable, achievable, relevant, and time-limited (SMART) desired results of the program.

**Outcomes**
What results: the value or changes for individuals, families, groups, agencies, businesses, communities, and/or systems. Outcomes include short-term benefits such as changes in awareness, knowledge, skills, attitudes, opinions and intent. Outcomes include medium-term (intermediate) benefits such as changes in behaviors, decision-making and actions. Outcomes include long-term benefits (often called impact) such as changes in social, economic, civic, and environmental conditions.

**Outputs**
What we do and whom we reach: activities, services, events, products and the people reached. Outputs include such elements as workshops, conferences, counseling, products produced and the individuals, clients, groups, families and organizations targeted to be reached by the activities.

**Patient Centered Medical Home (PCMH):**
A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes.

**Place-based**
An established comprehensive service delivery system for a defined geographic region that provides fully integrated education, financial stability and health services across a wide range of participants using multiple providers in one setting.

**Public Policy**
Resource allocation decisions within political, economic, and social systems and institutions.
**Research-based Practice (RBP)**
Intervention based on a fund of knowledge, developed by multiple reliable sources in the practice literature, with longitudinal evidence of effectiveness in defined populations experiencing a specific problem or set of problems. Controlled studies are not required. Data analysis is usually related to pre- and post-test measures using standardized scales.

**Strategic Partnership**
Formal alliance between community partners with diverse skills and resources working cooperatively to achieve common goals.

**Sustainable Change**
Capacity to endure and maintain without continuing intervention, often with positive generational impact.

**System**
A combination of interrelated components, such as policies, organizations and communities that work together.

**Systemic Change**
Targeted change at the systems (i.e., policy, organizational, community) level to improve a community condition. Typically the change focuses upon the way in which multiple organizations interact, policies that affect large numbers of people, or community conditions.

**Target Issue**
A clearly defined focus for which community impact will be achieved.

**Theory of Change**
The Theory of Change demonstrates the multiple levels of intervention necessary to produce sustainable community change. They link outcomes and outputs to explain how and why the desired change is expected to occur.