

Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

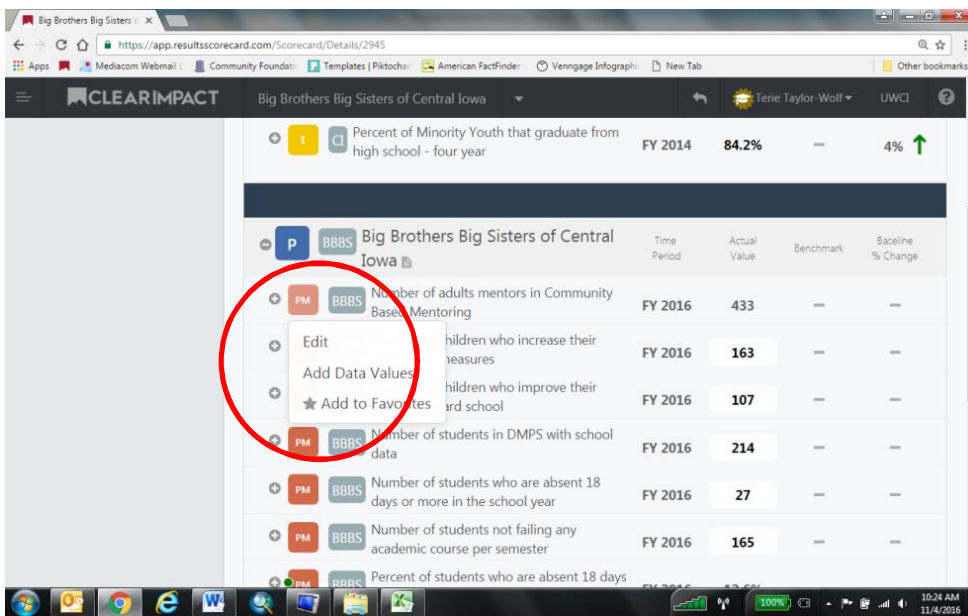
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FY 2011	496	—	—

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Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"

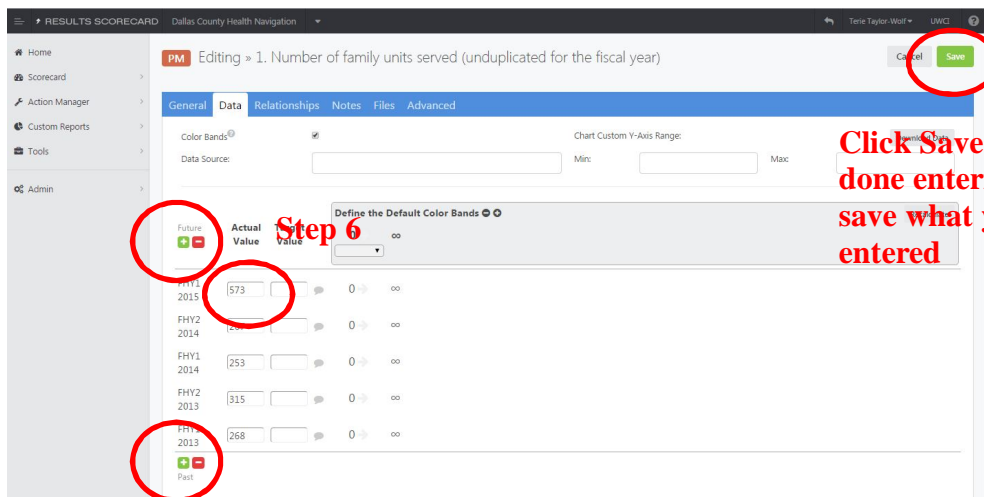


Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s)). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays forecast, target, and actual values from FY2 2015 to FY2 2020. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a text area and a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section. The text area is now populated with a detailed narrative about the Health Navigation Program's target measure, including information about underreporting, staff training, and benchmarking. A disk icon in the bottom right corner of the text area is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

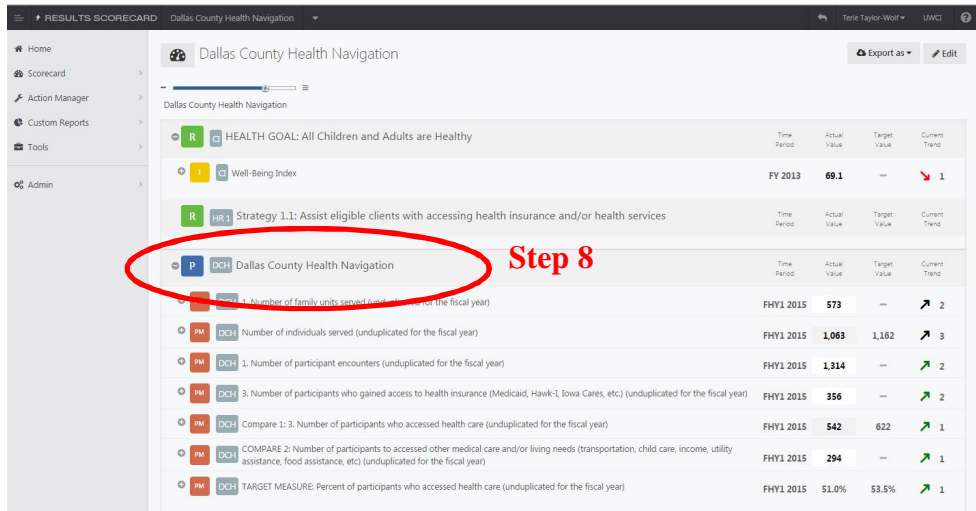
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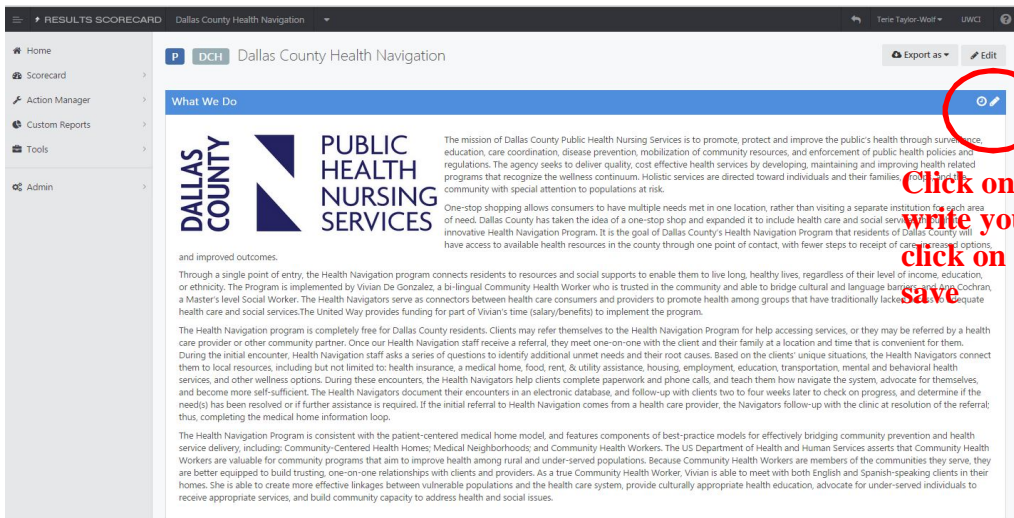
1. What We Do
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4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



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Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and/or services and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



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Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

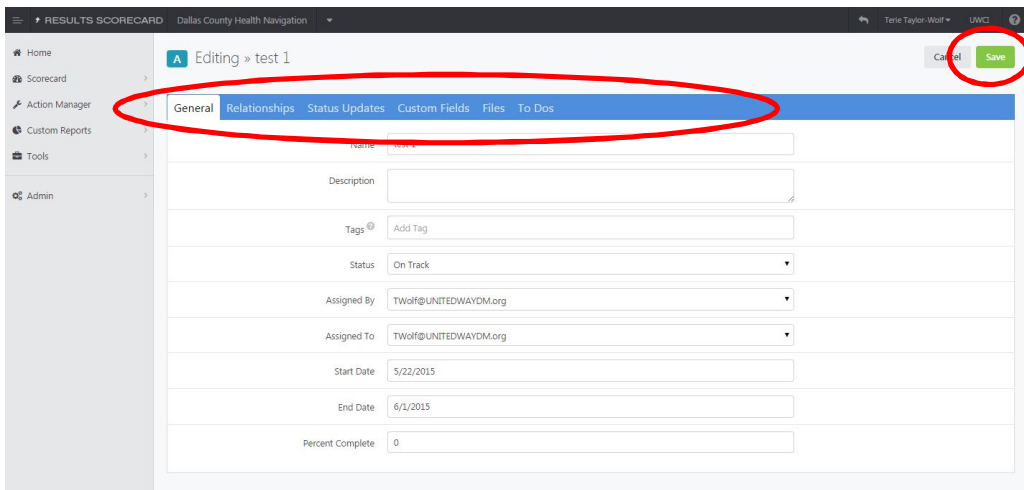


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
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Results Scorecard View:

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number of clients served	7	3	10
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Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
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Target Measure	14%	200%	70.0%

Question?

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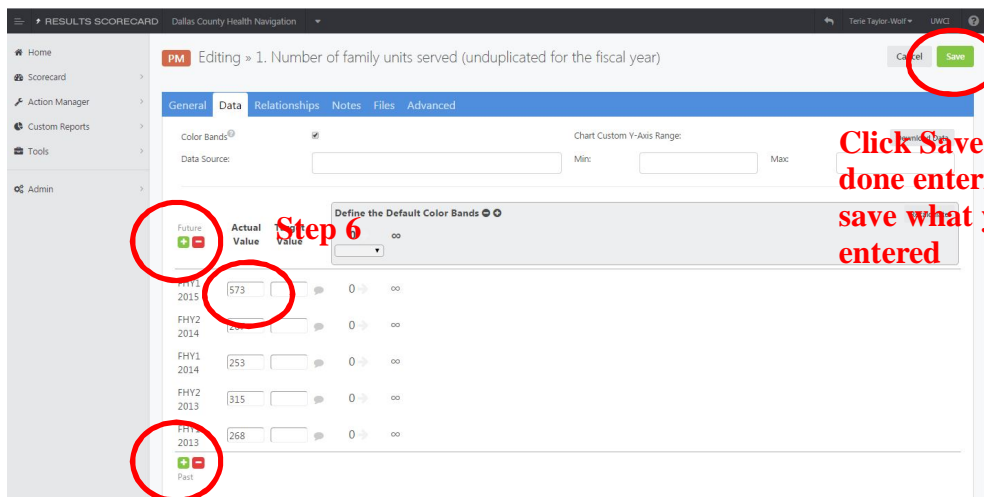
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Click Save button when done entering data to save what you have entered

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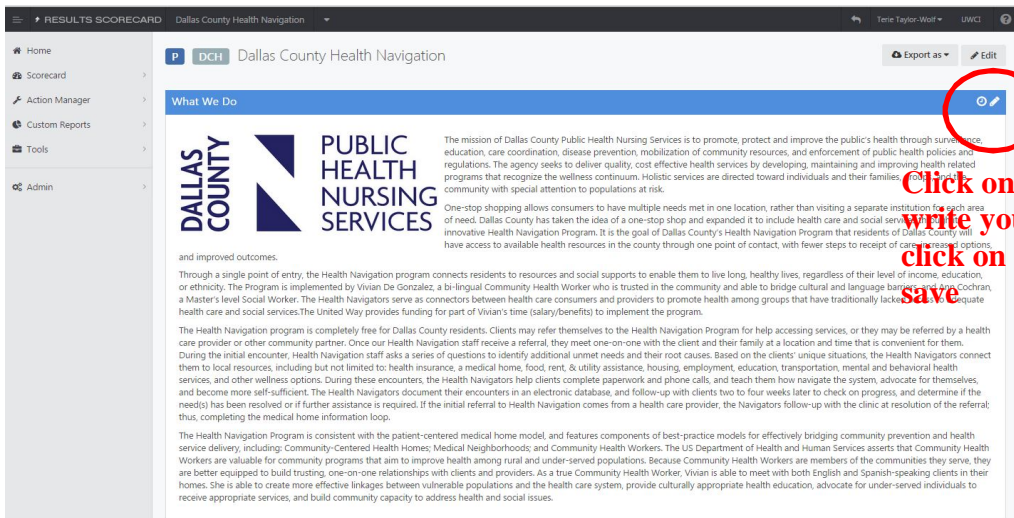
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What We Do

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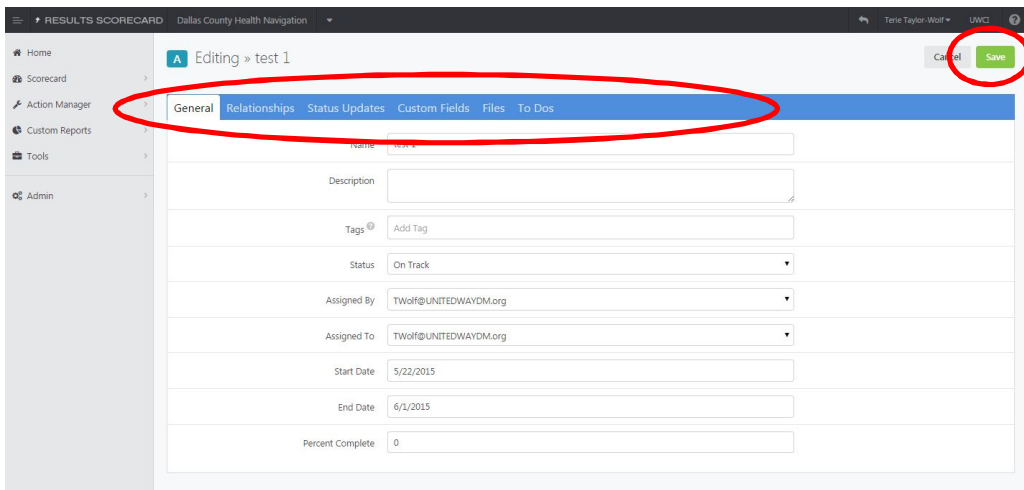


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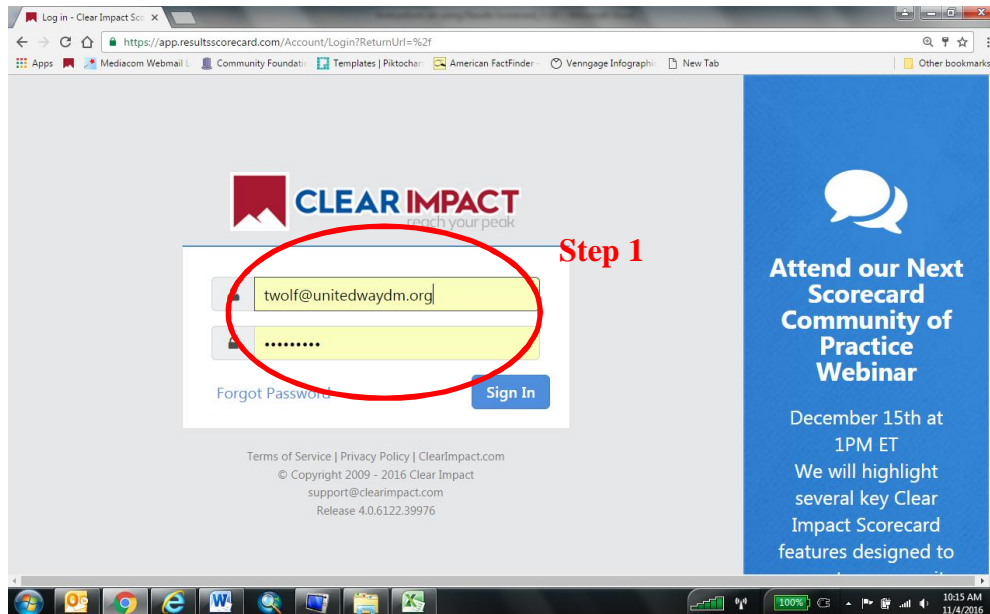
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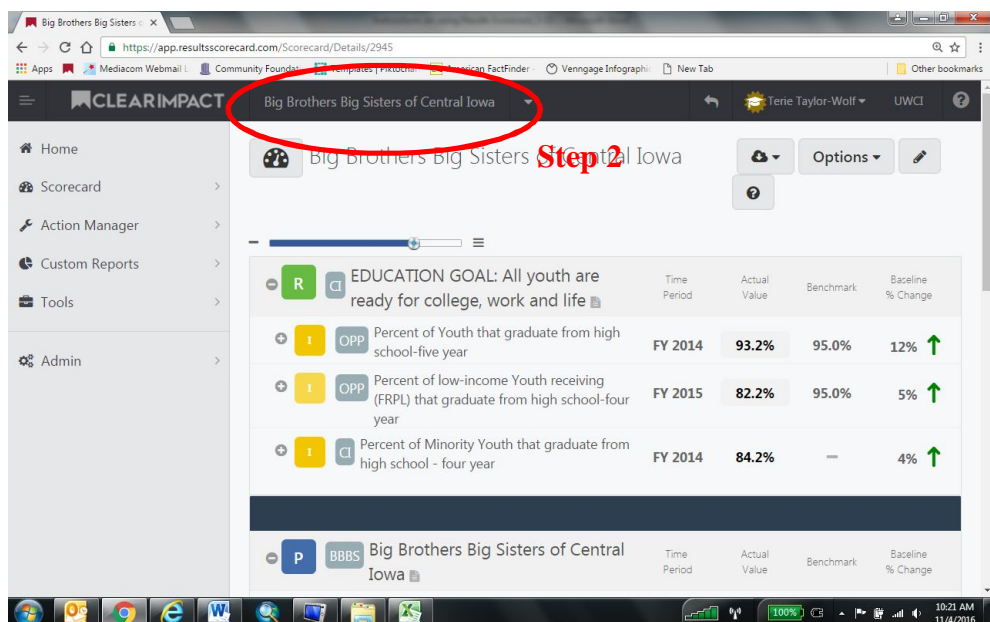
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+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

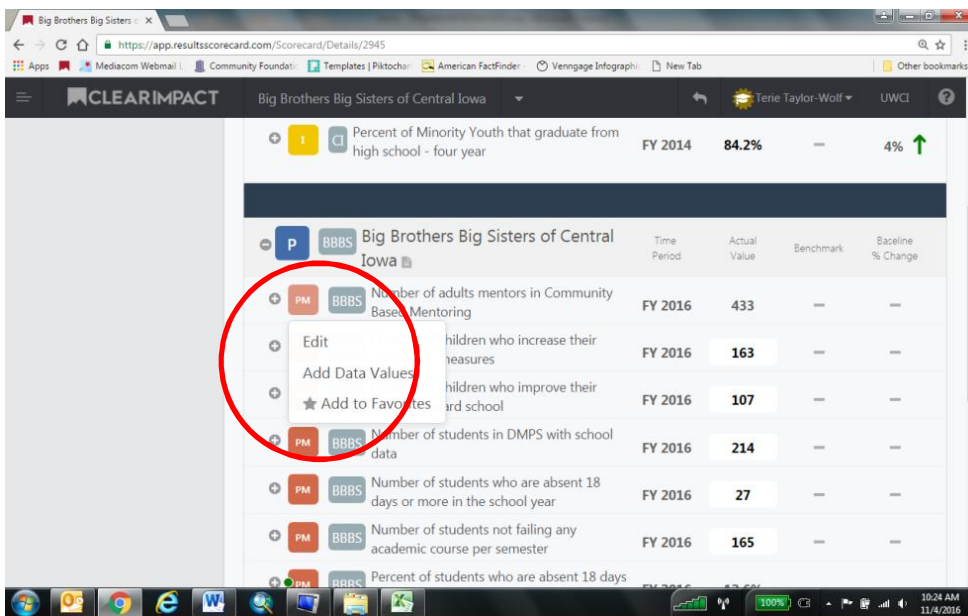
PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
		FY 2012	515	—	—
		FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

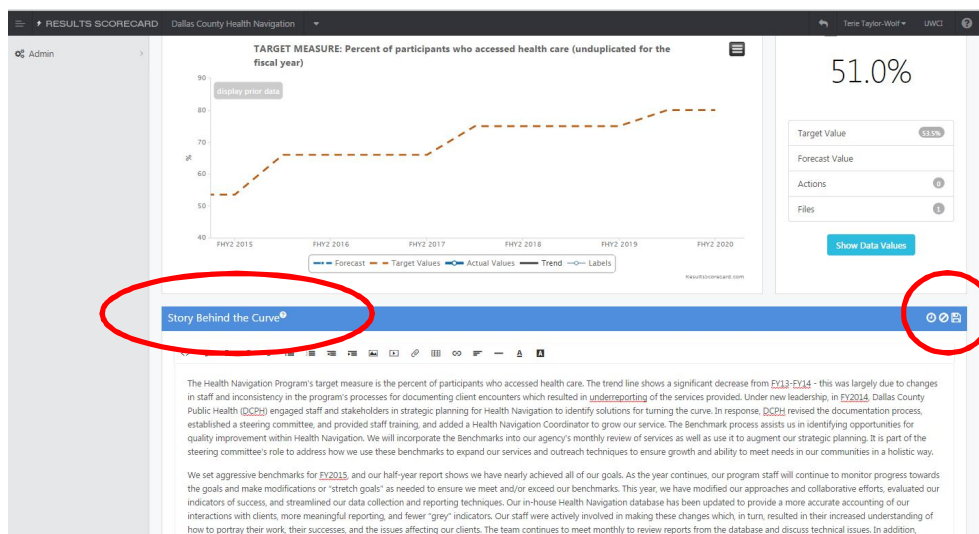
TimeFrame	Date Range
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Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

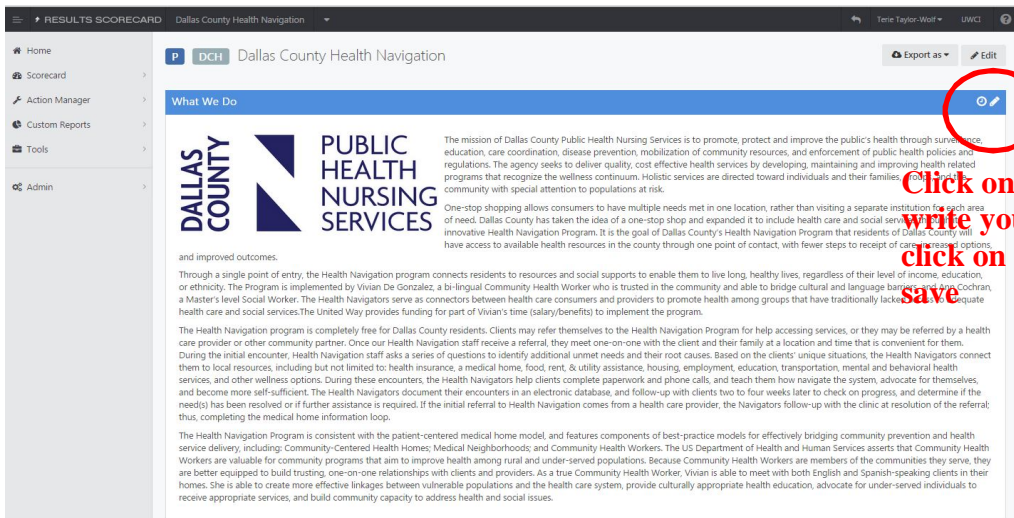
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

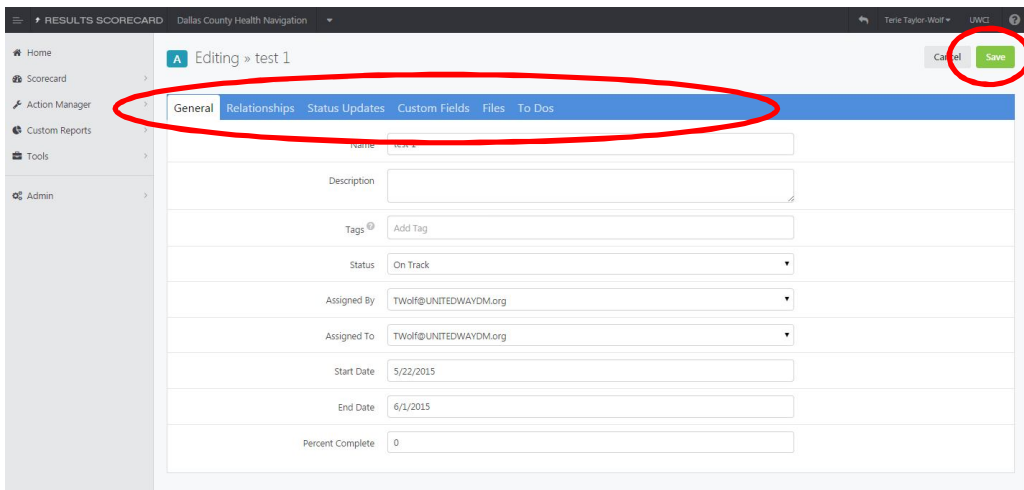


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

For Income Programming, contact Corinne Lambert at 246-6542 or e-mail at clambert@unitedwaydm.org

Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is Terie Taylor-Wolf. The scorecard displays a list of performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph shows the trend data for this measure from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The table below shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
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FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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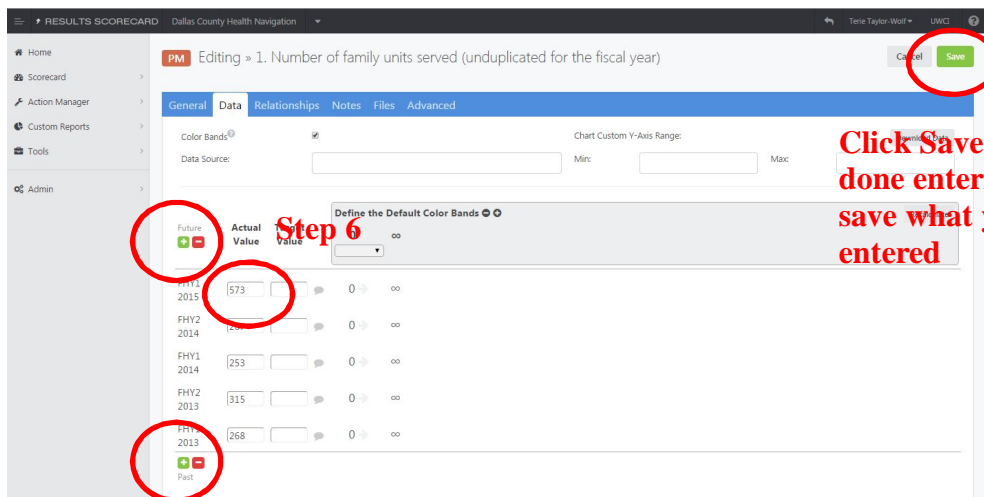
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Step 5
Click on the Data tab

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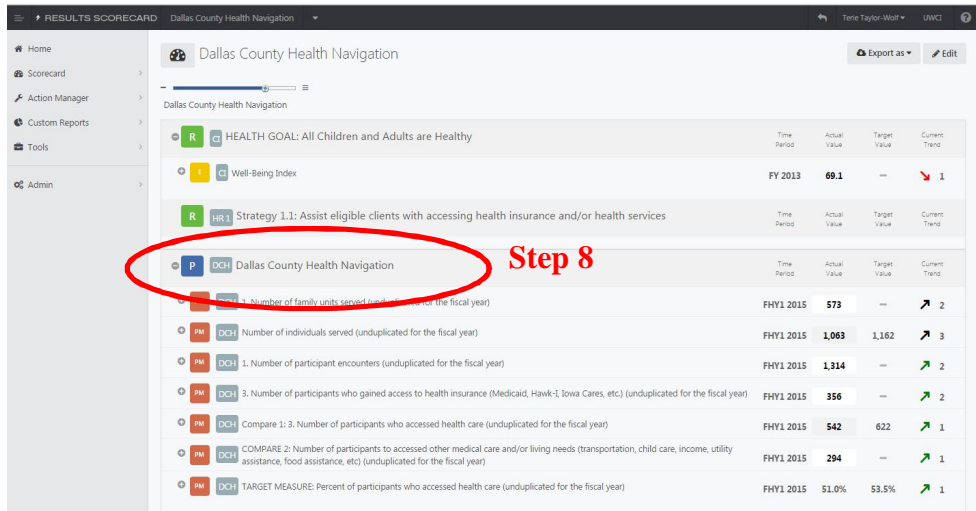
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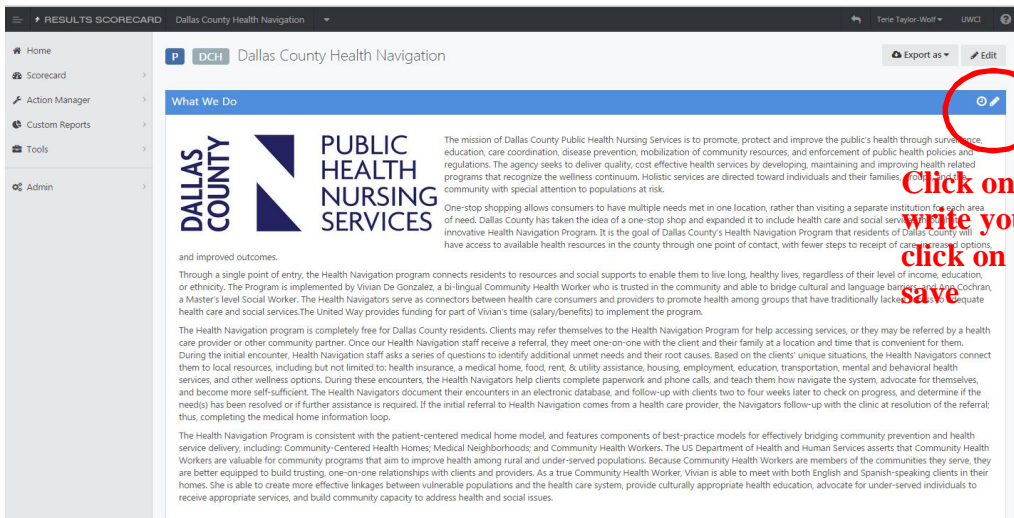
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Program	Time Period	Actual Value	Target Value	Current Trend
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Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
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Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
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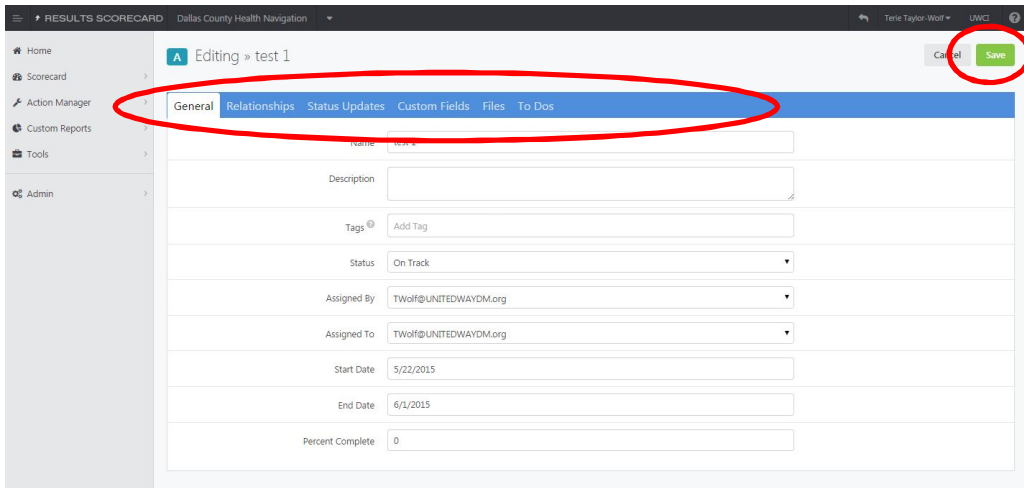


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Kane	1st half	1st half	Jody	1st half	1st half
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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. A red "Step 3" label is visible in the top right. A list of performance measures is shown, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A trend line graph is displayed, showing the number of adult mentors from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a decline in FY 2015. The table to the right of the graph shows the following data:

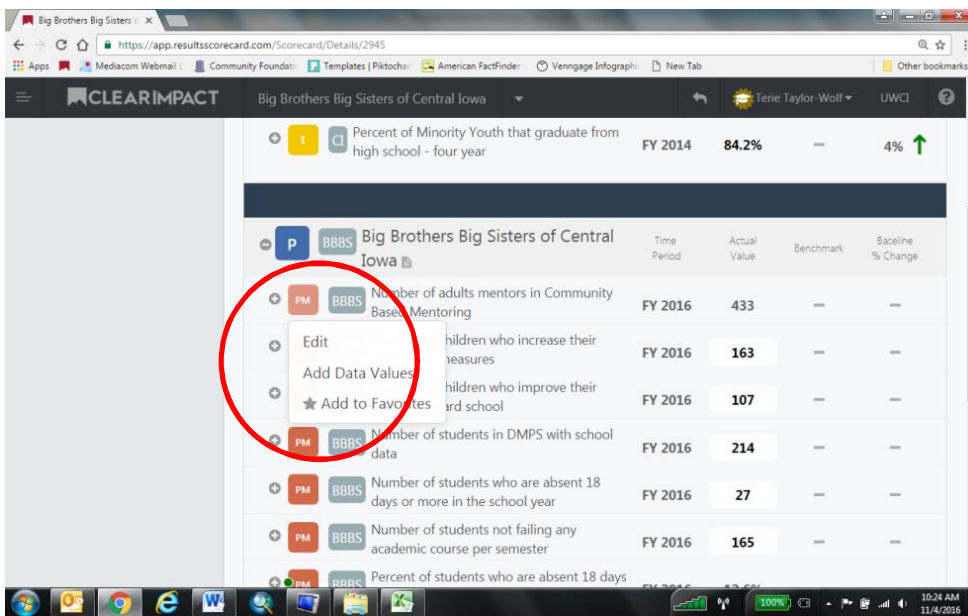
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
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FY 2014	535	—	—
FY 2013	591	—	—
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Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.

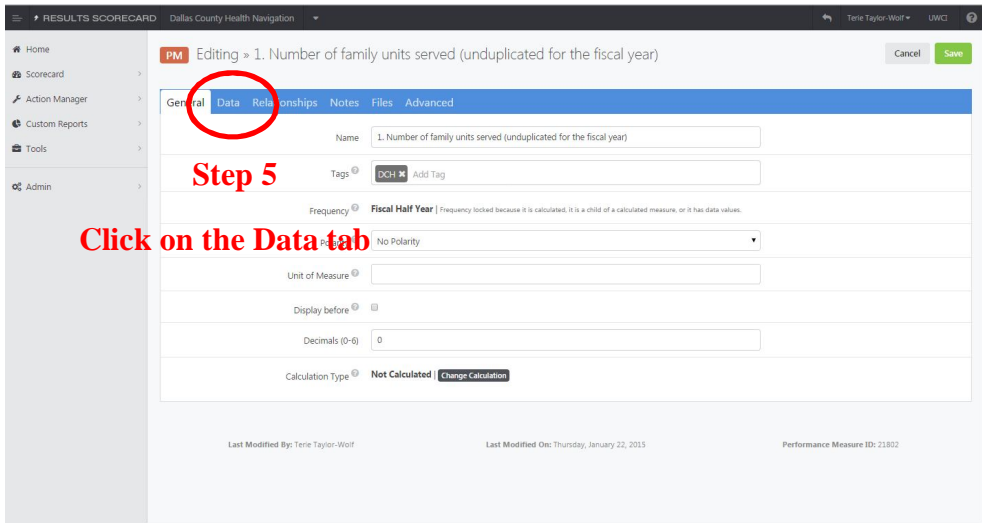


Step 4

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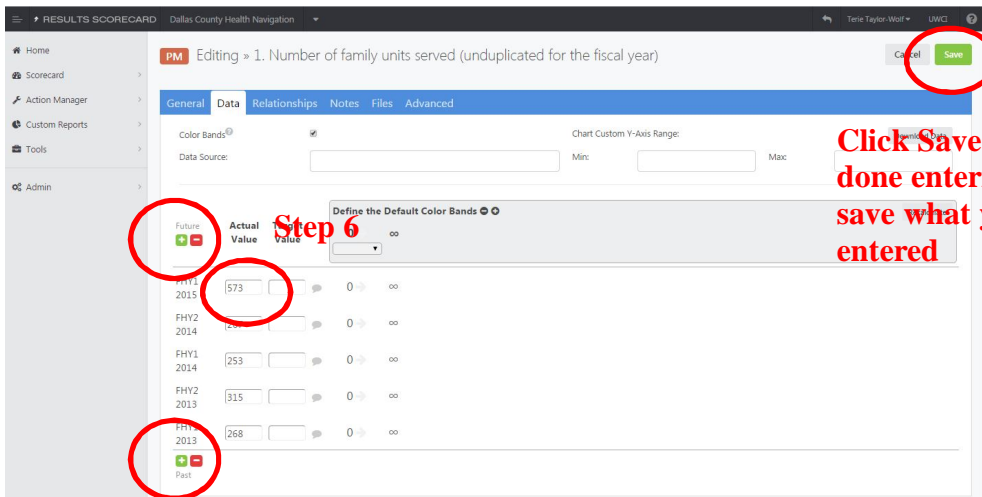
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Step 5
Click on the Data tab

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Click Save button when done entering data to save what you have entered

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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HY1	July 1-Dec. 31
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Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart shows the trend from FY2 2015 to FY2 2020. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a text box and a pencil icon circled in red.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous one, but with the text box expanded and a disk icon circled in red, indicating the save action.

Click disk icon to save your written material

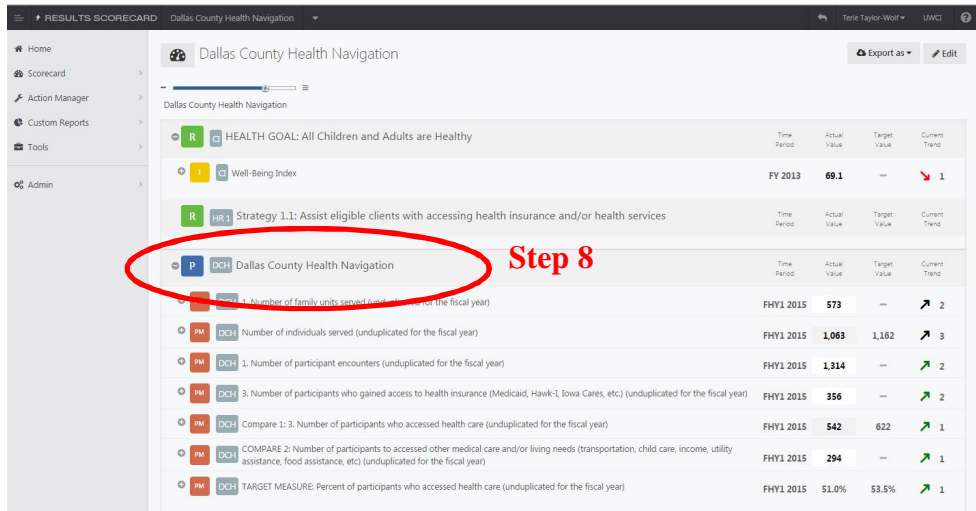
Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

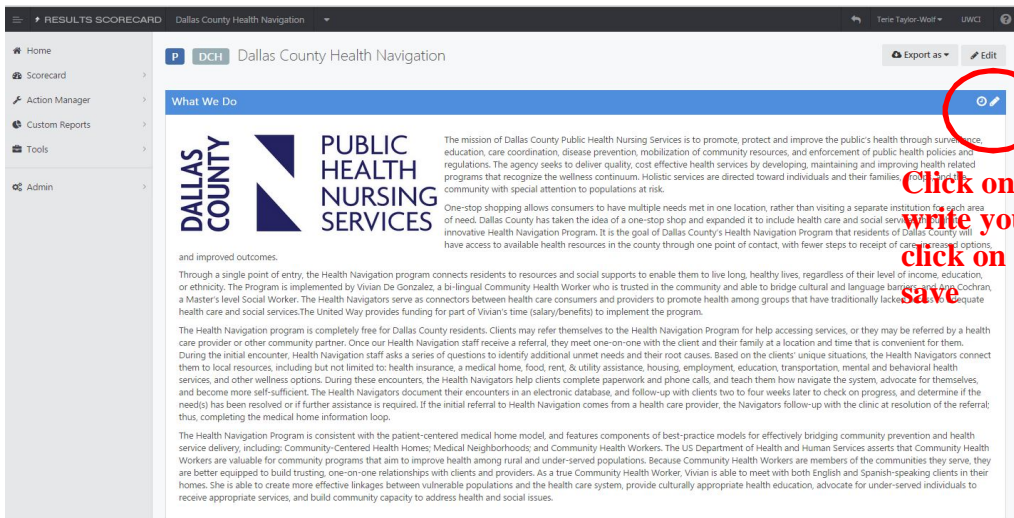
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

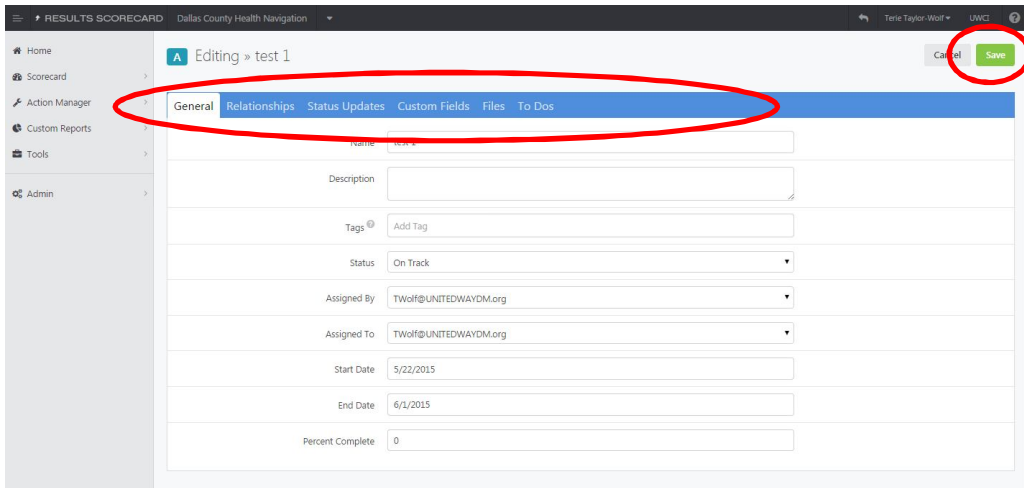


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
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Tony	1st half	1st half	Bill	1st half	No outcome
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John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
		FY 2012	515	—	—
		FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.

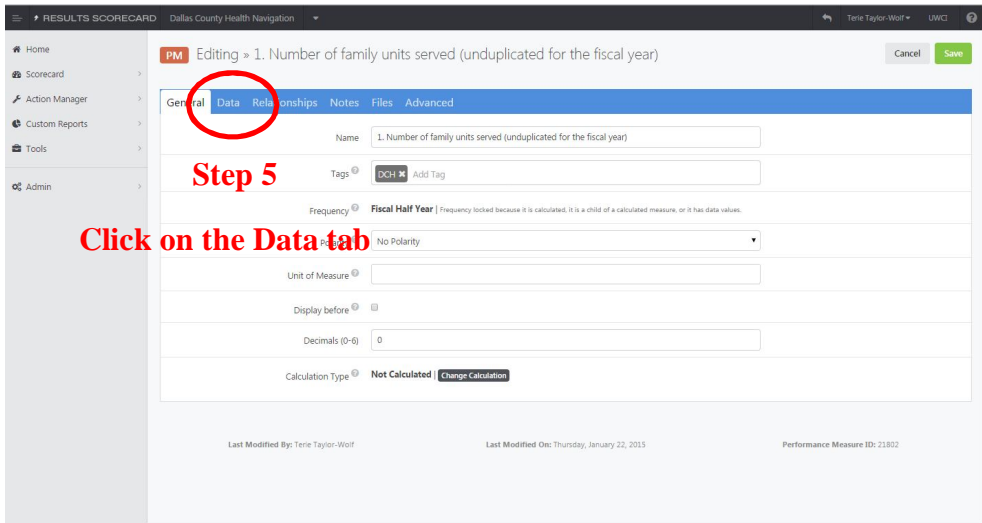


Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"

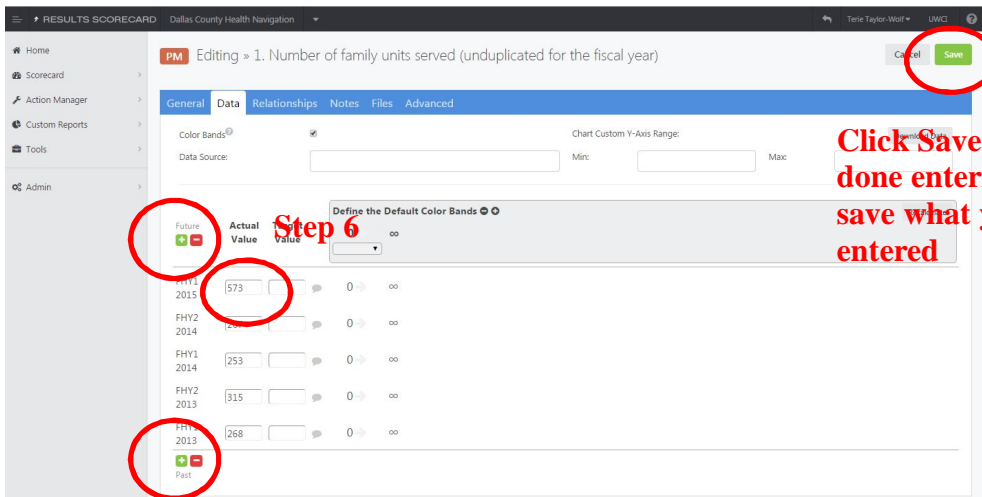


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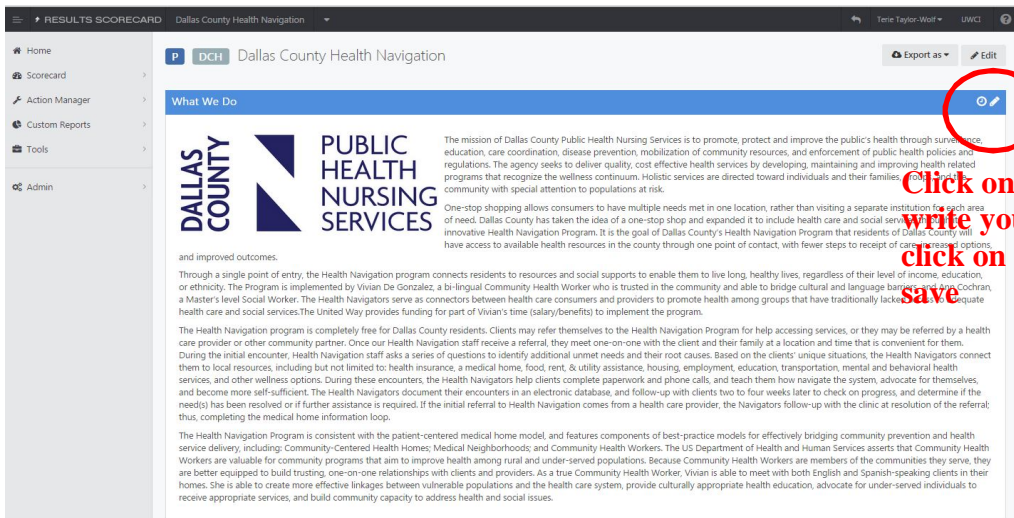
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Step 9

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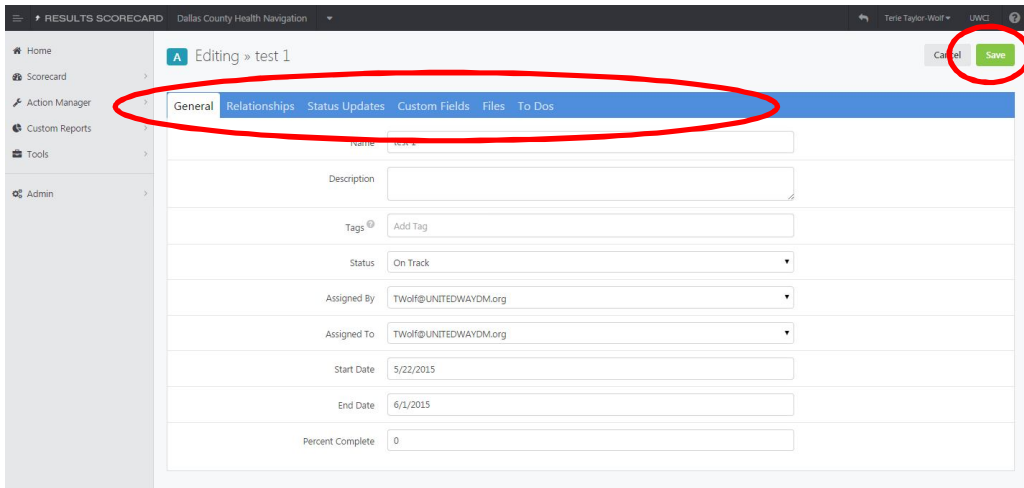


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Target Measure	57%	133%	80.0%

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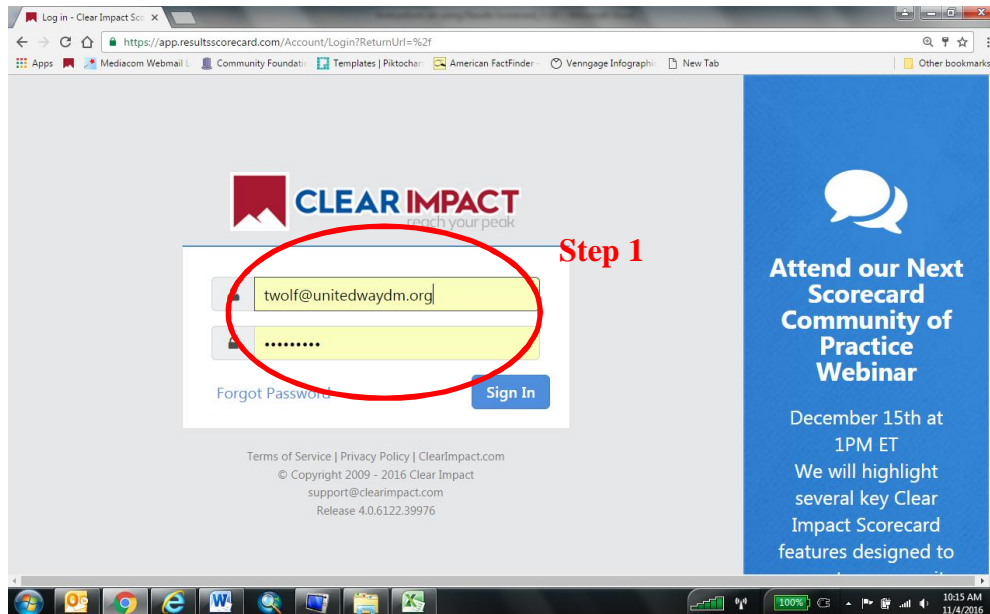
Instructions on using Results Scorecard

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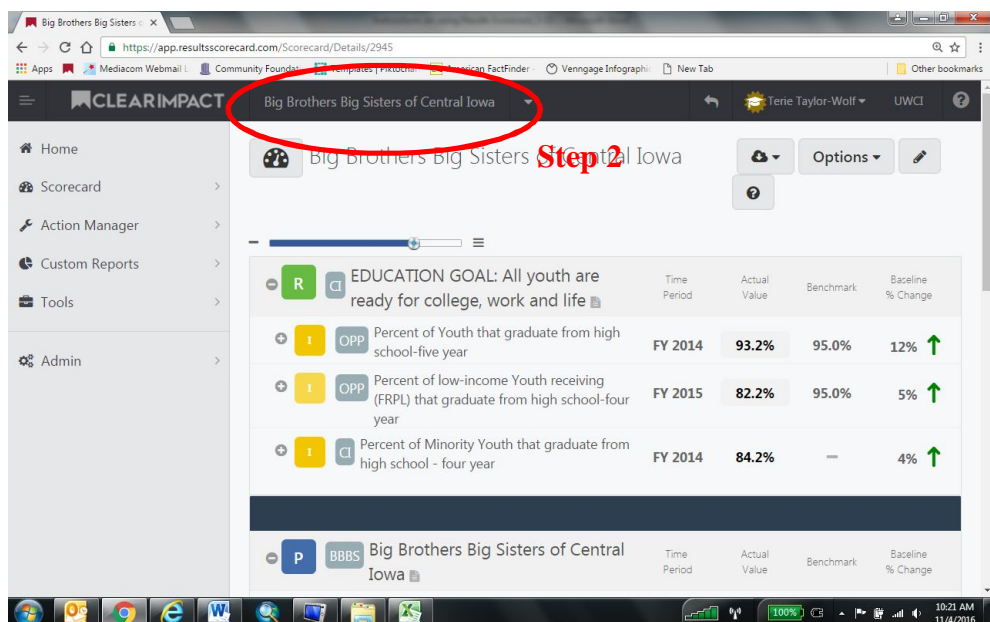
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Your username is your e-mail address. If you forget your password, follow these instructions:

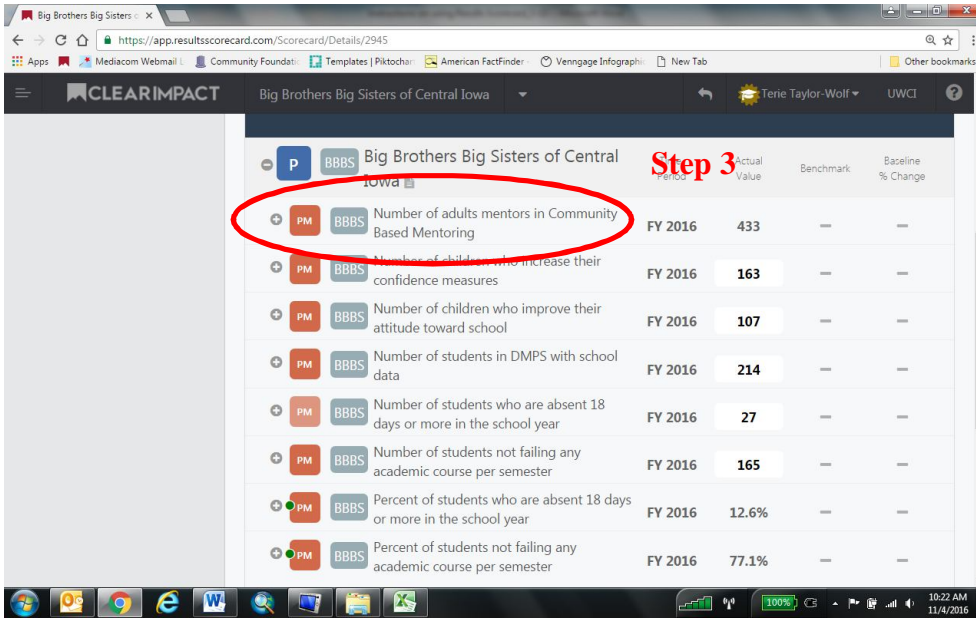
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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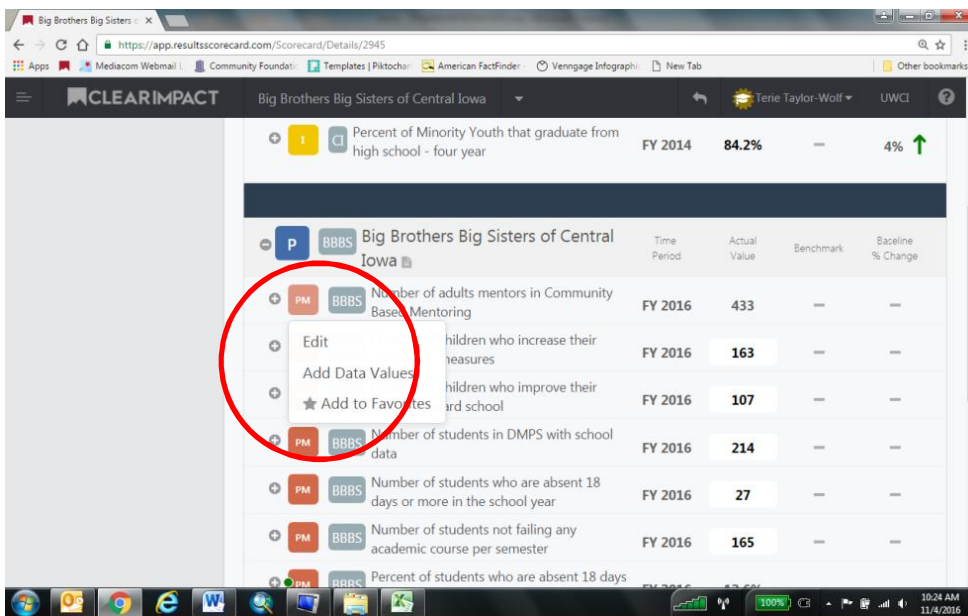


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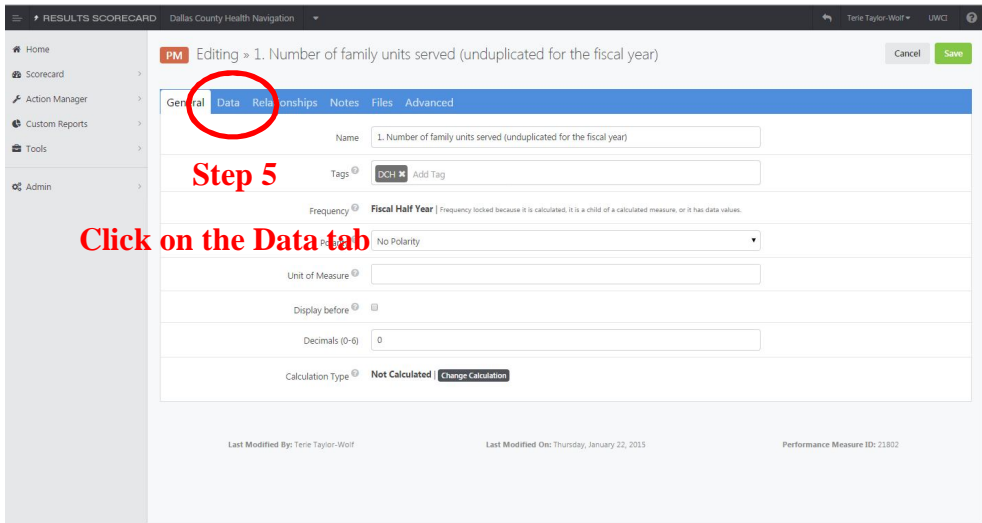


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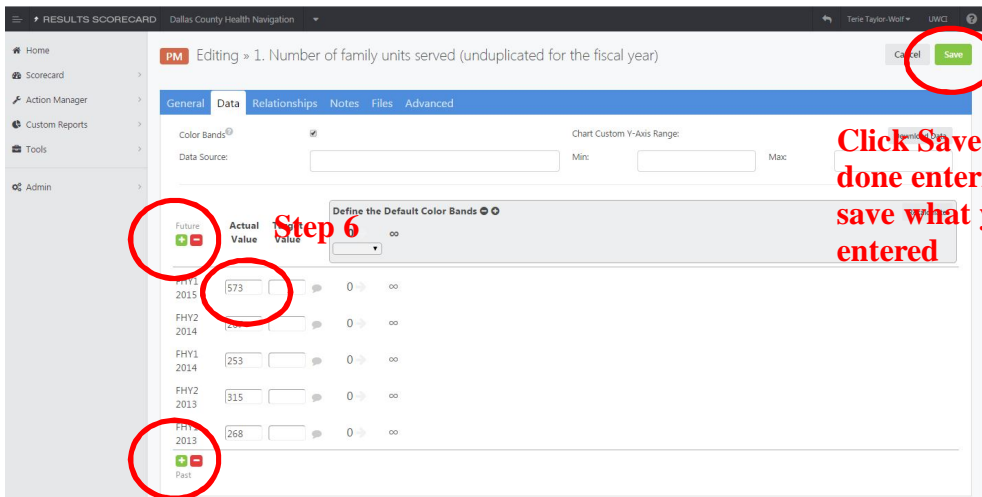
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Step 5
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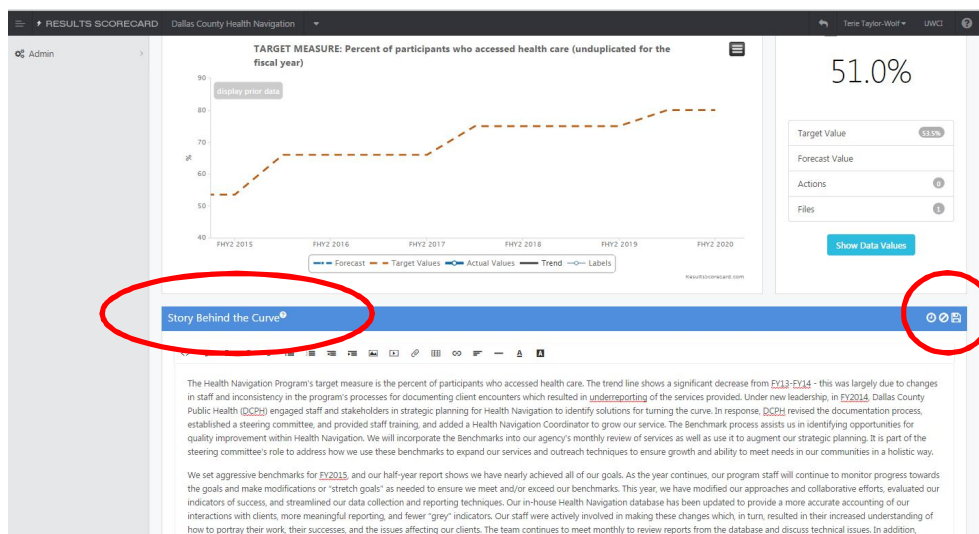
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Click disk icon to save your written material

Step 7

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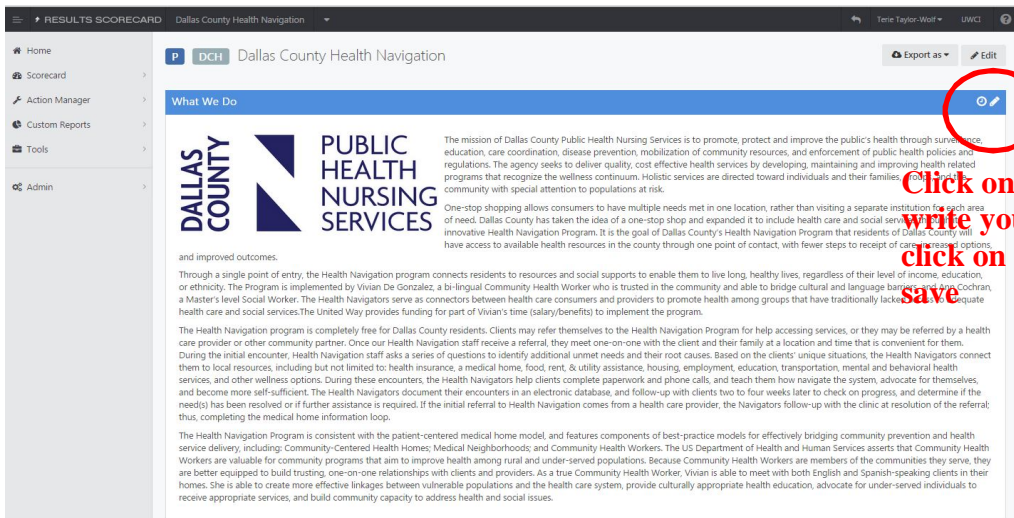
1. What We Do
2. Who We Serve
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4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

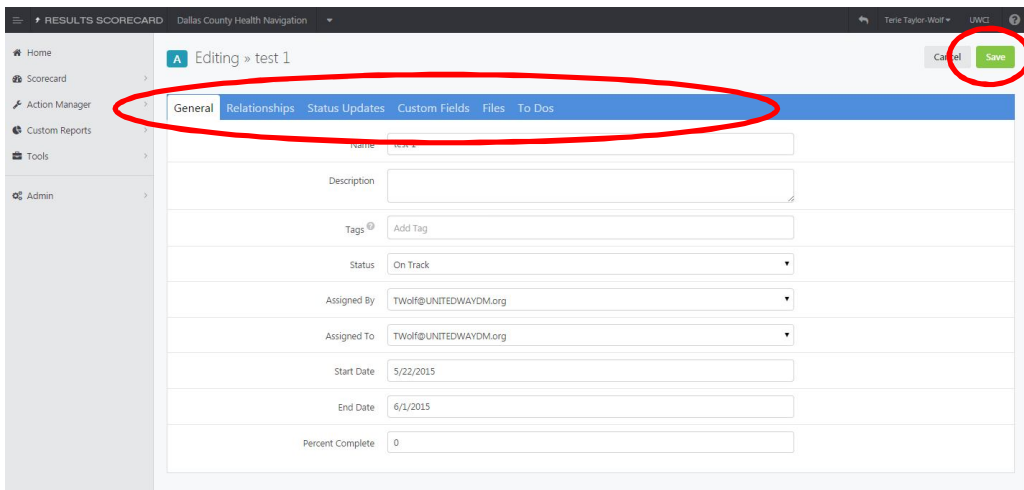


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is 'Big Brothers Big Sisters of Central Iowa'. The main content area lists several performance measures (PM) with their corresponding values for FY 2016. The first measure, 'Number of adults mentors in Community Based Mentoring', is circled in red. A red 'Step 3' label is positioned in the top right corner of the scorecard area.

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure 'Number of adults mentors in Community Based Mentoring' is expanded to show trend data. A red circle highlights the '+' sign to the left of the measure name. A line graph displays the number of adult mentors from FY 2011 to FY 2015. The data points are: FY 2011 (496), FY 2012 (515), FY 2013 (591), FY 2014 (535), and FY 2015 (467). The graph shows a peak in FY 2013 and a decline in FY 2015.

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
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FY 2013	591	—	—
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FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

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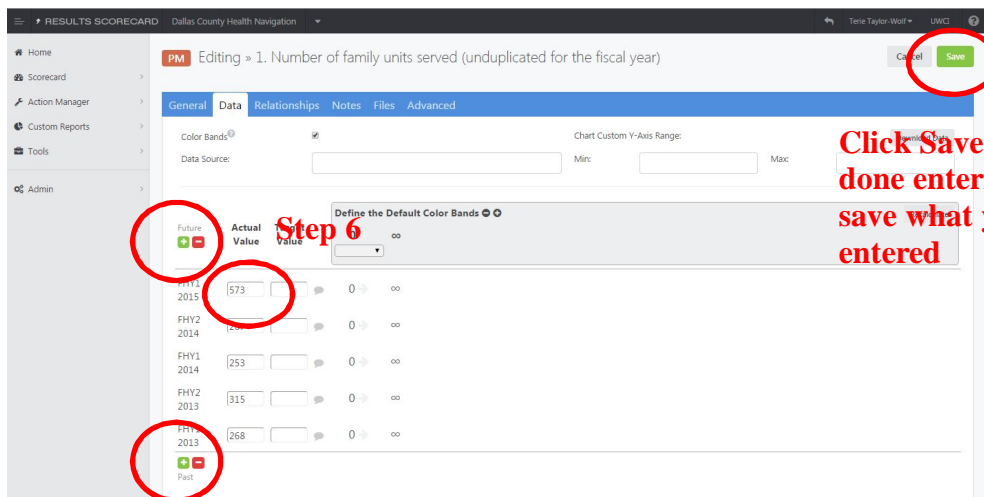
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Step 5
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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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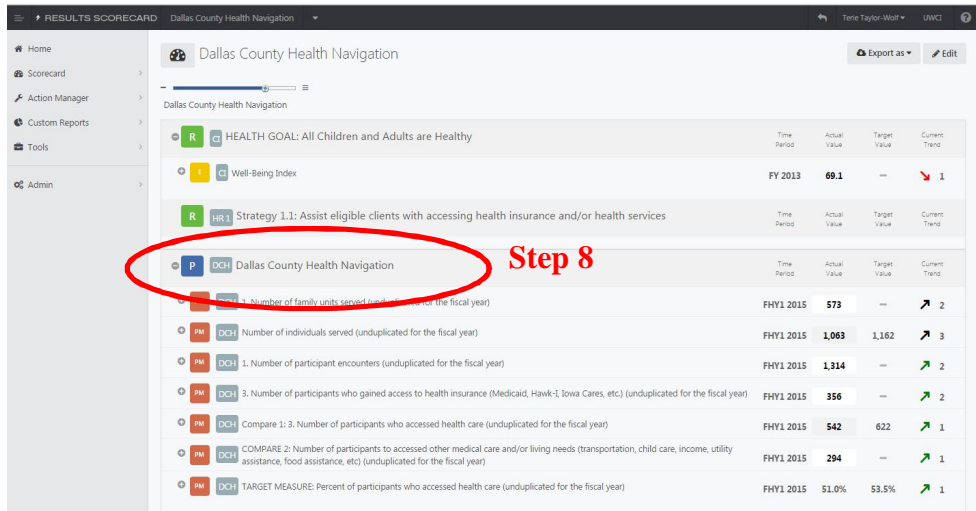
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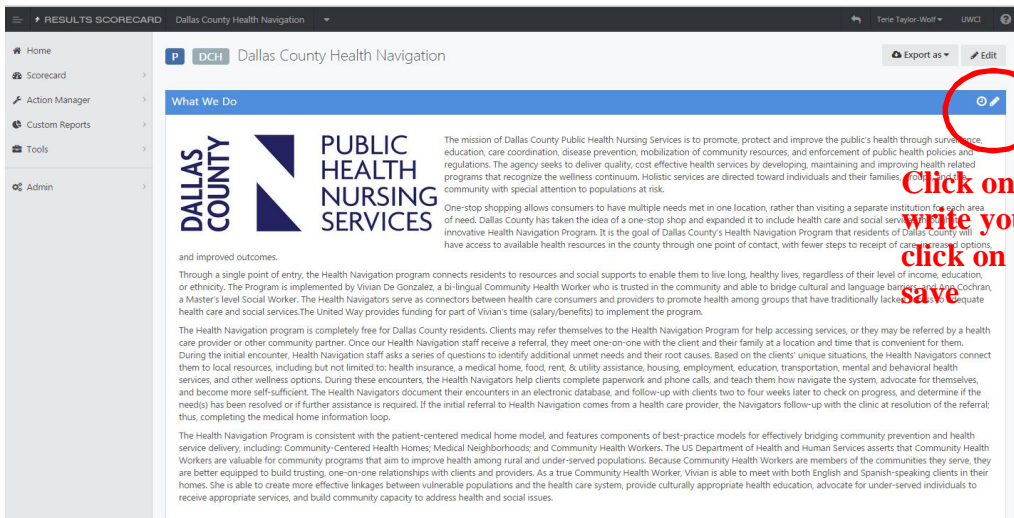
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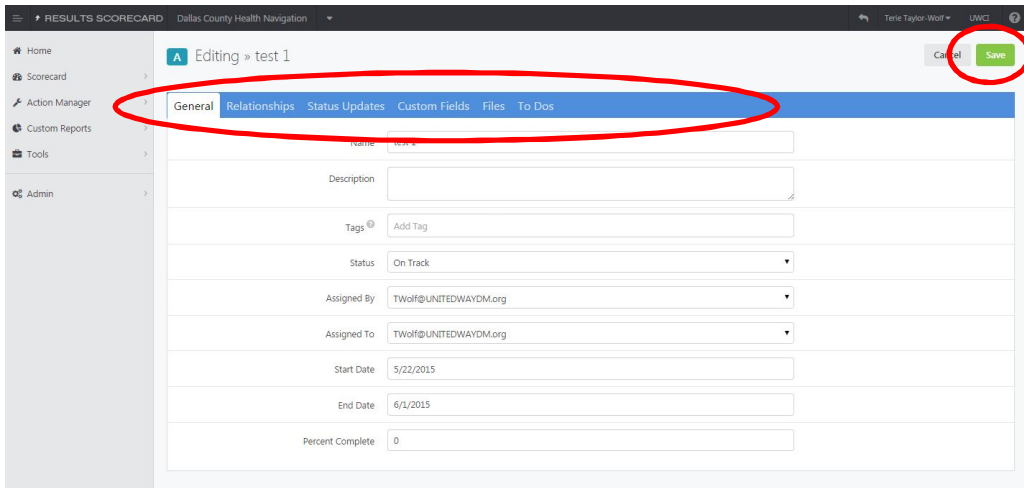


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The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. A red "Step 3" label is visible in the top right. A list of performance measures is displayed, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
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Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
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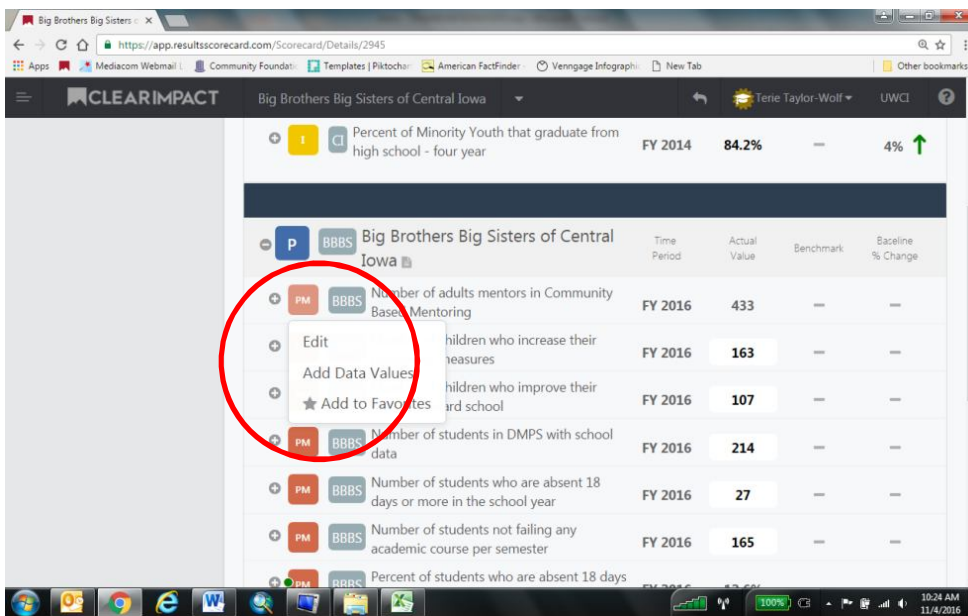
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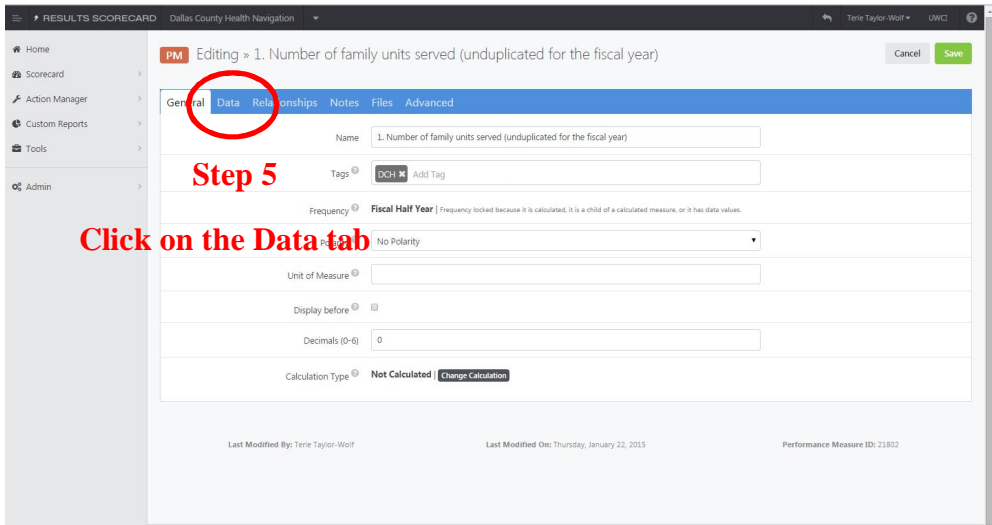
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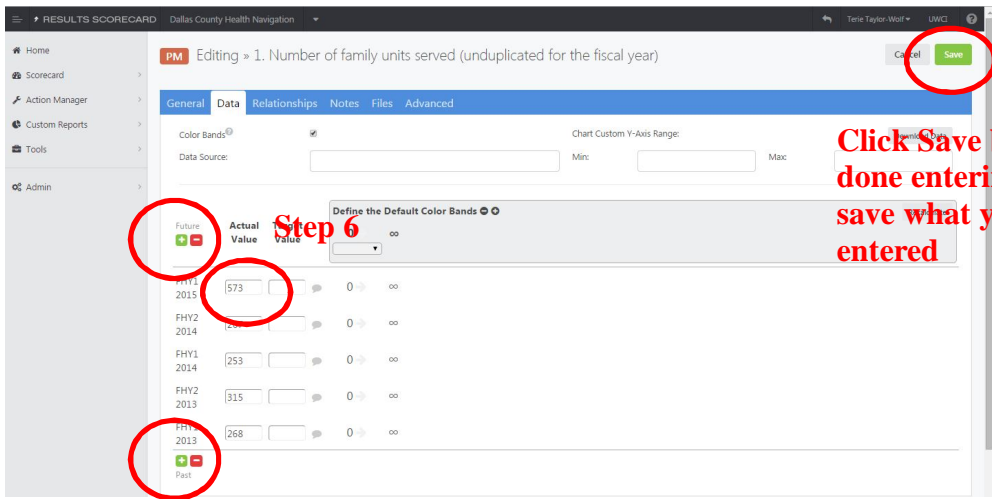
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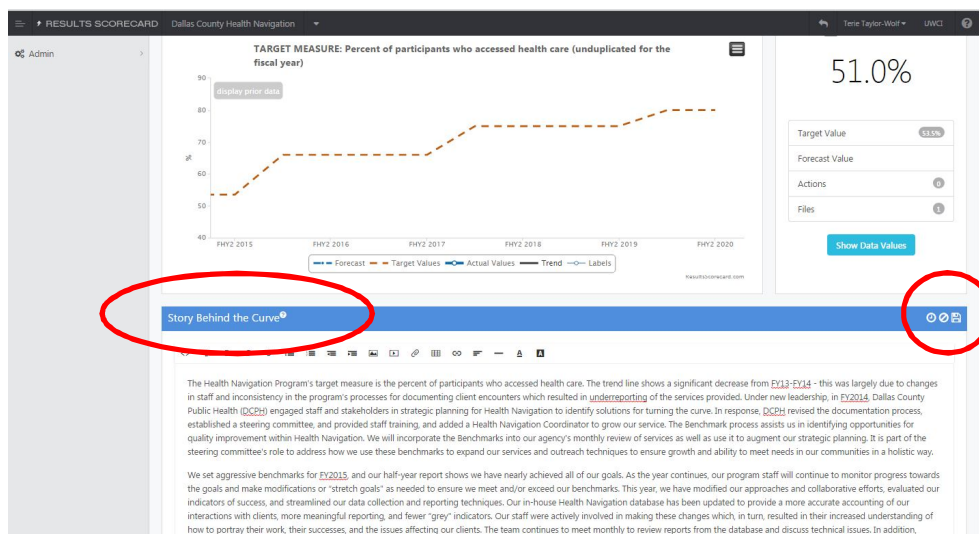
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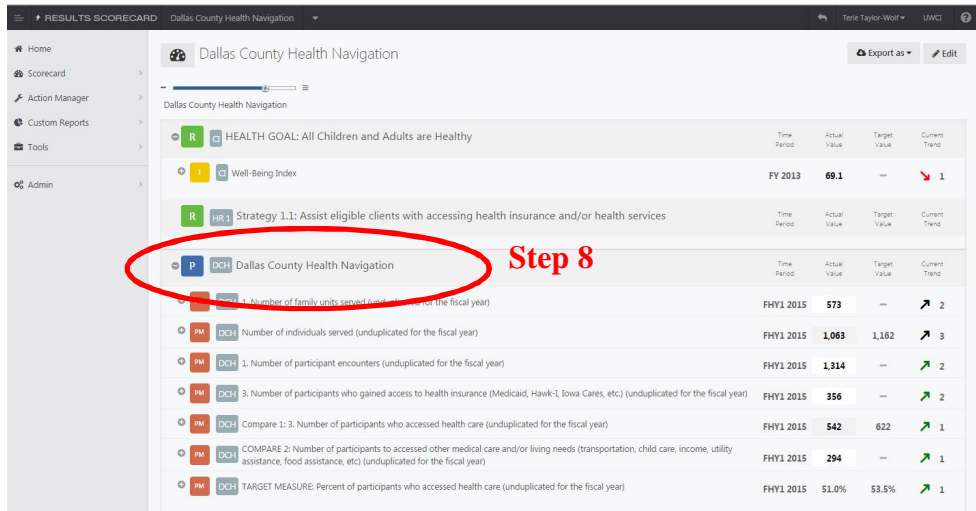
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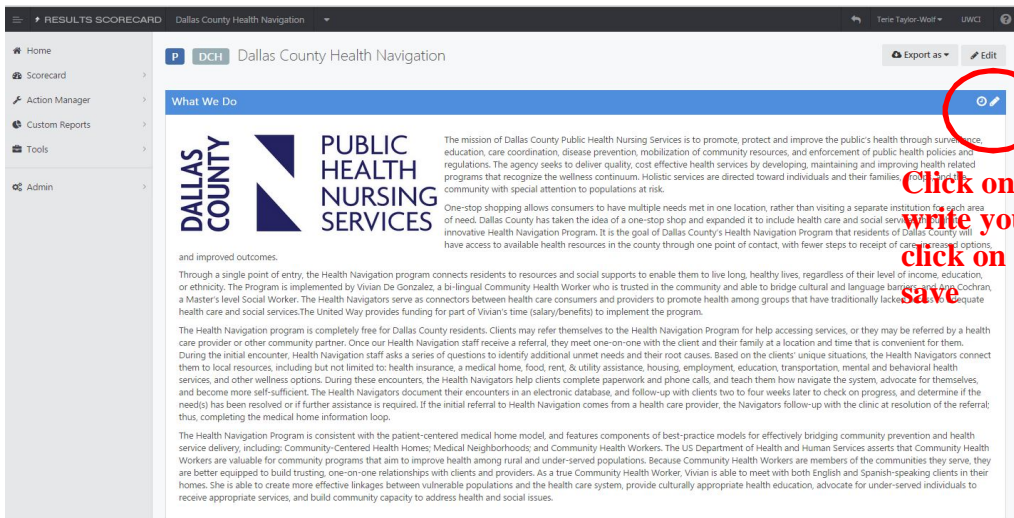
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Program	Time Period	Actual Value	Target Value	Current Trend
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DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

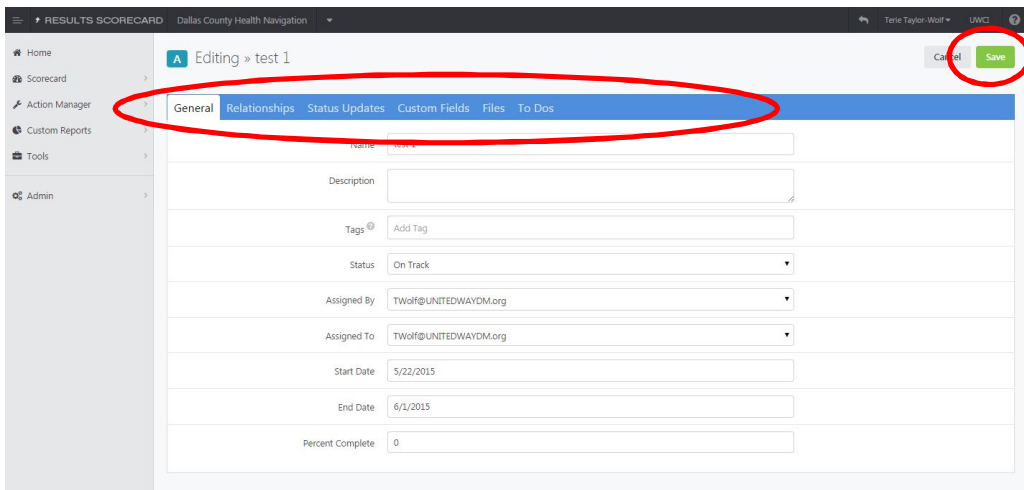


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

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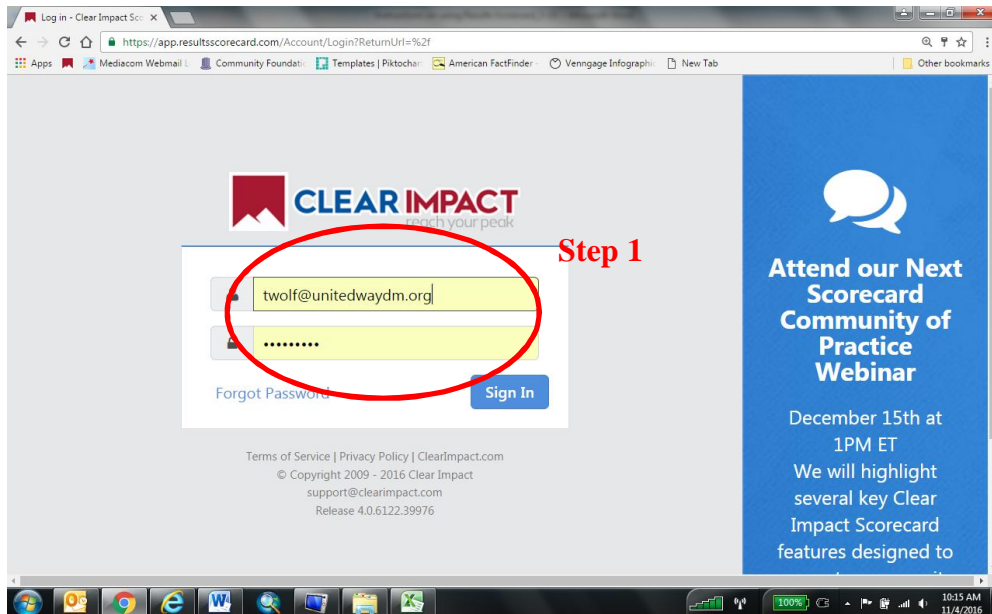
Instructions on using Results Scorecard

Step 1: Login

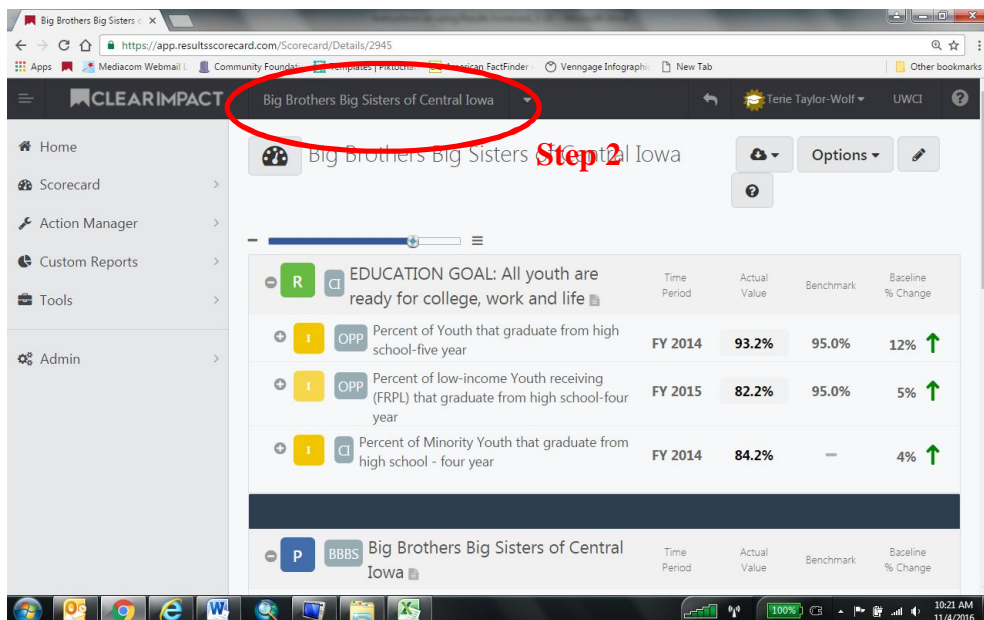
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

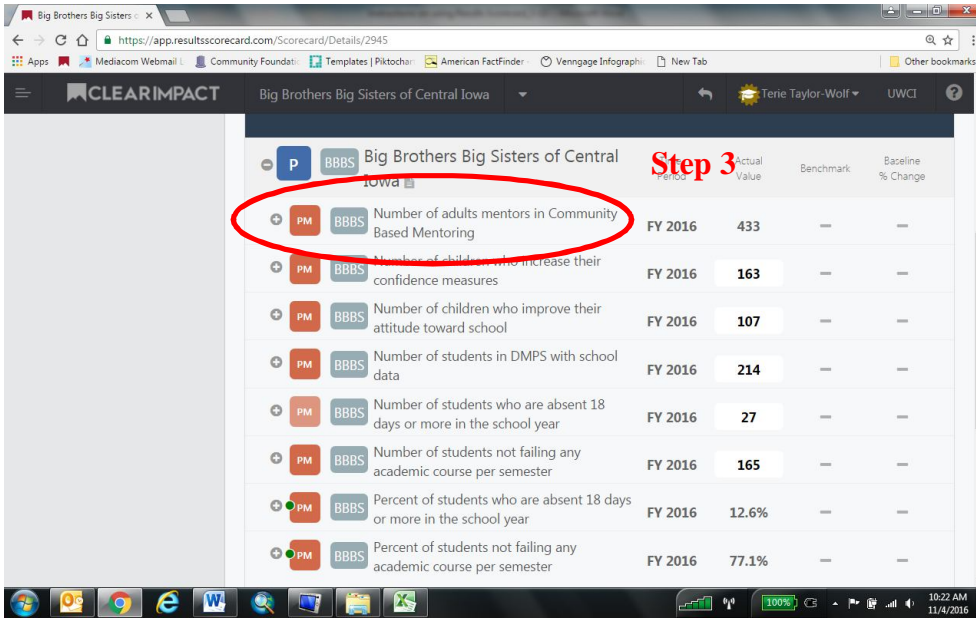
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.



By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance



Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.

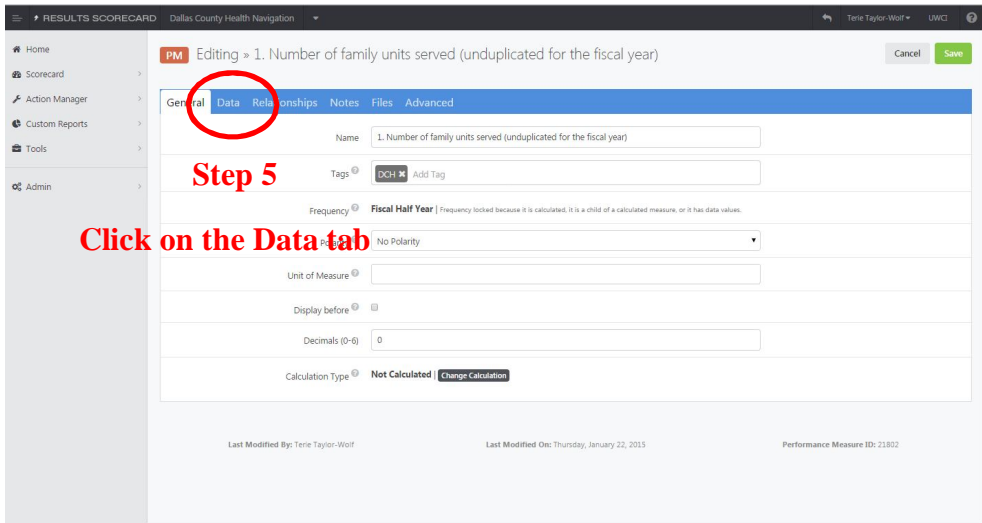


Step 4

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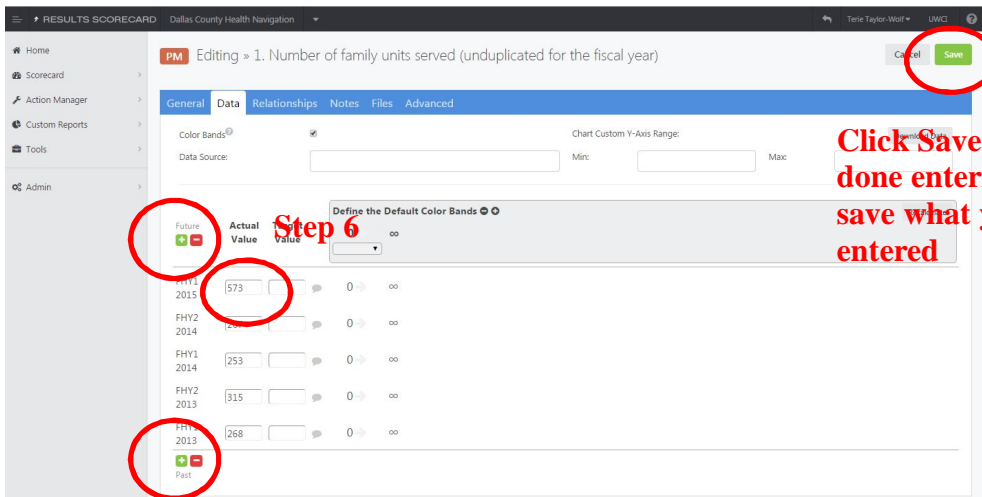


Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
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HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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Step 7



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Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

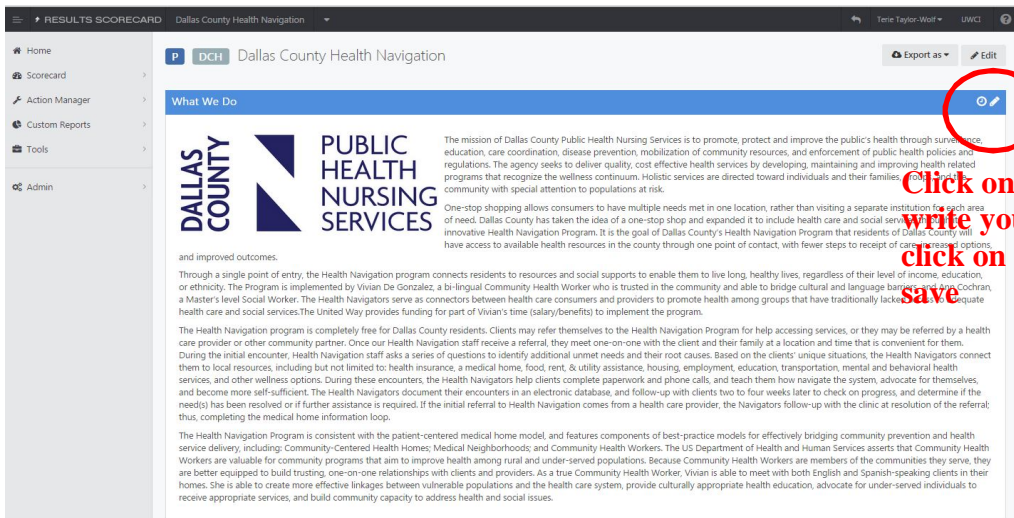
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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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Step 8

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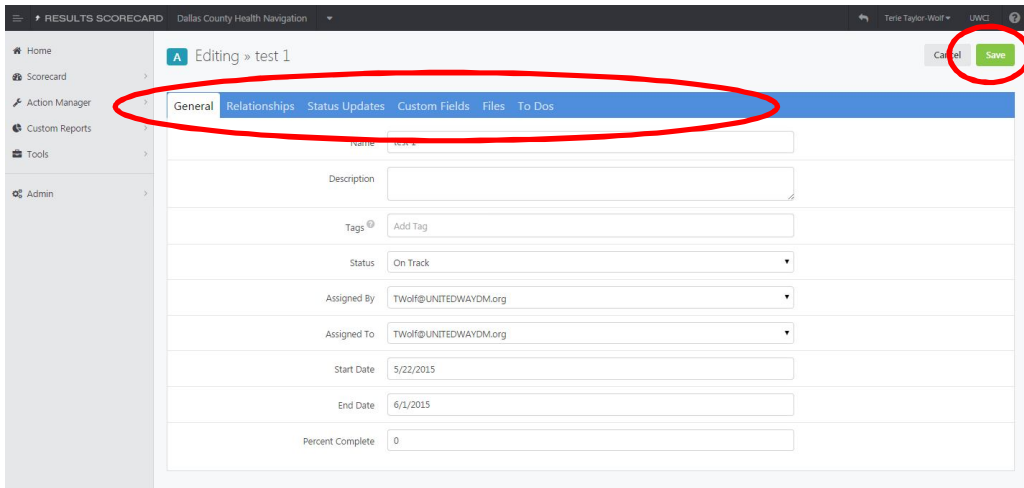


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Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

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number of clients served	7	3	10
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Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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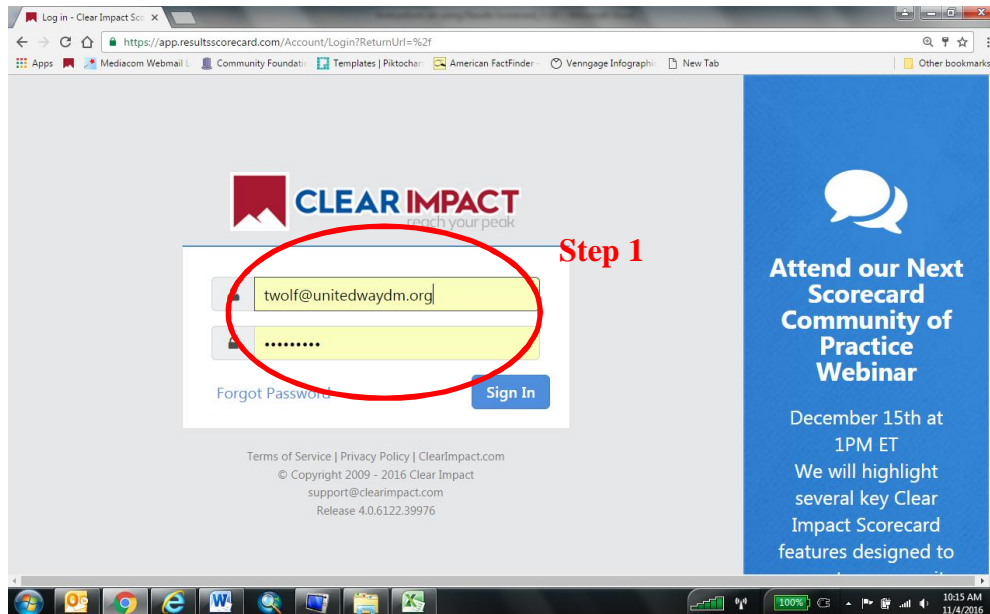
Instructions on using Results Scorecard

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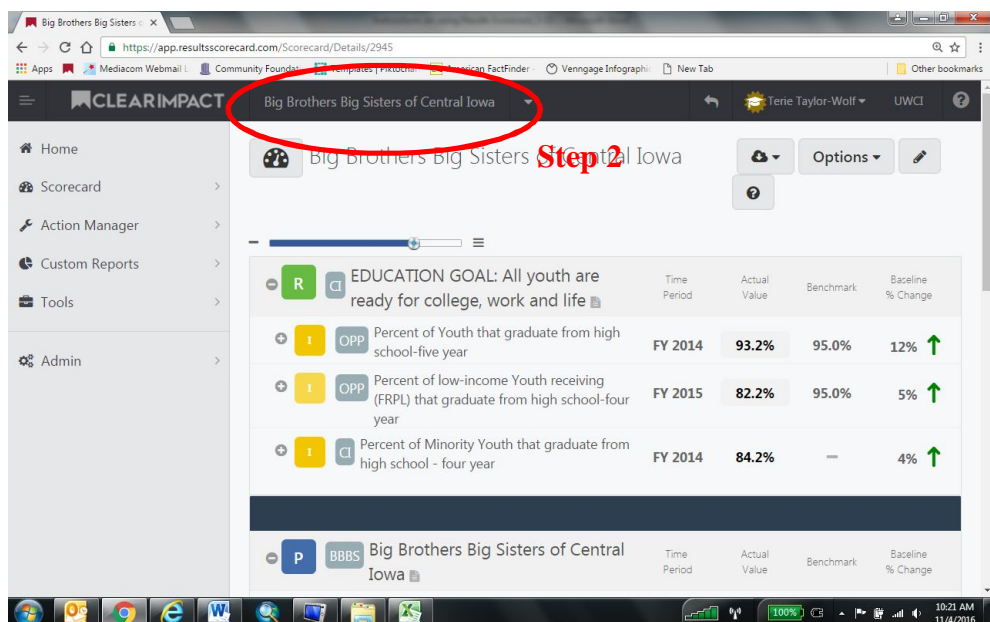
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

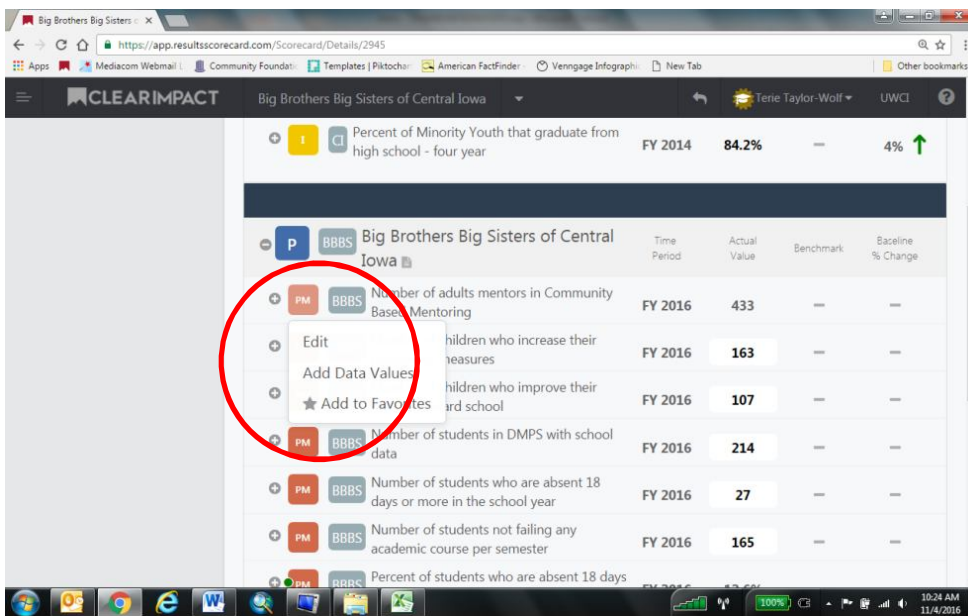
The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays data from FY2 2015 to FY2 2020, with an actual value of 51.0% and a target value of 63.5%. Below the chart is the 'Story Behind the Curve' section, which contains a text box and a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image. The text box is now populated with a detailed narrative about the Health Navigation Program's target measure, its challenges, and the steps taken to improve it. A disk icon in the bottom right corner of the text box is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

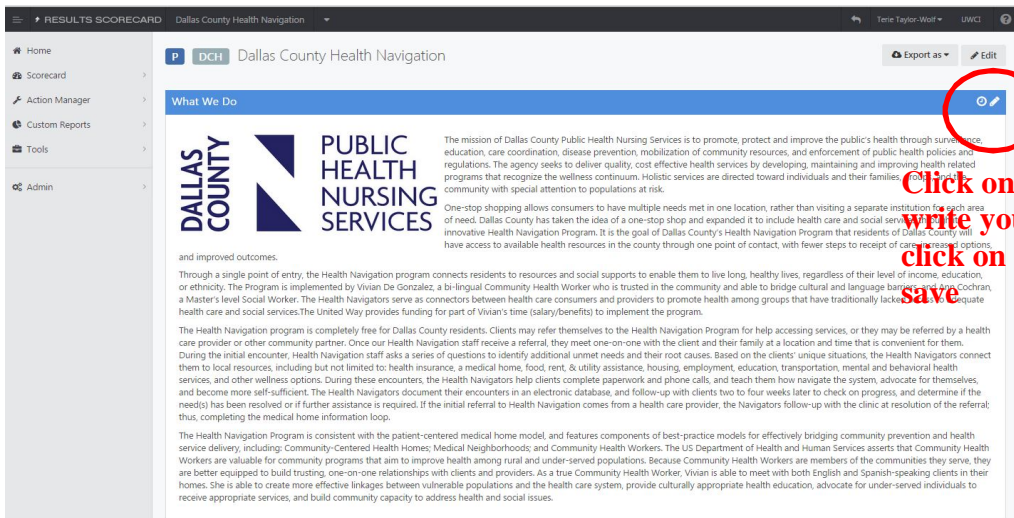
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You will find these areas by clicking on the program name



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HEALTH GOAL: All Children and Adults are Healthy				
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Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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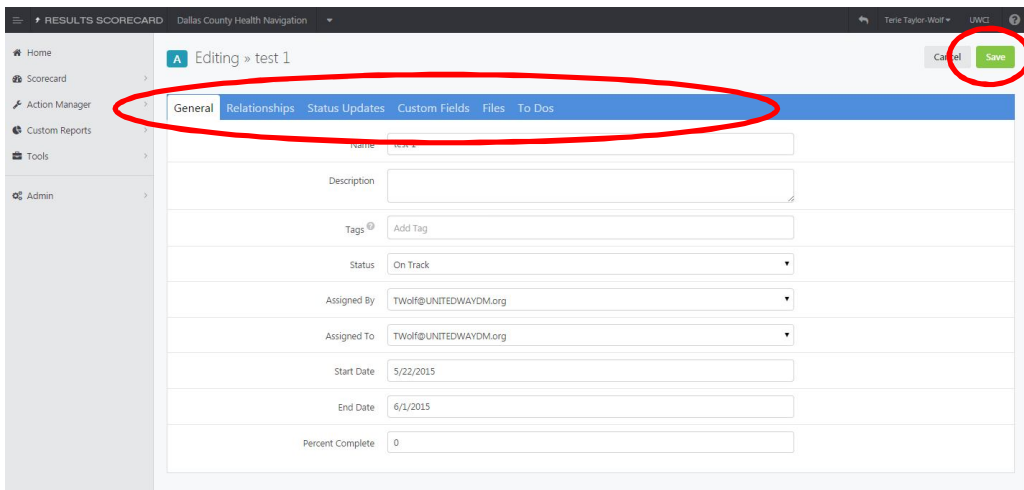


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Target Measure	57%	133%	80.0%

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The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard displays a list of performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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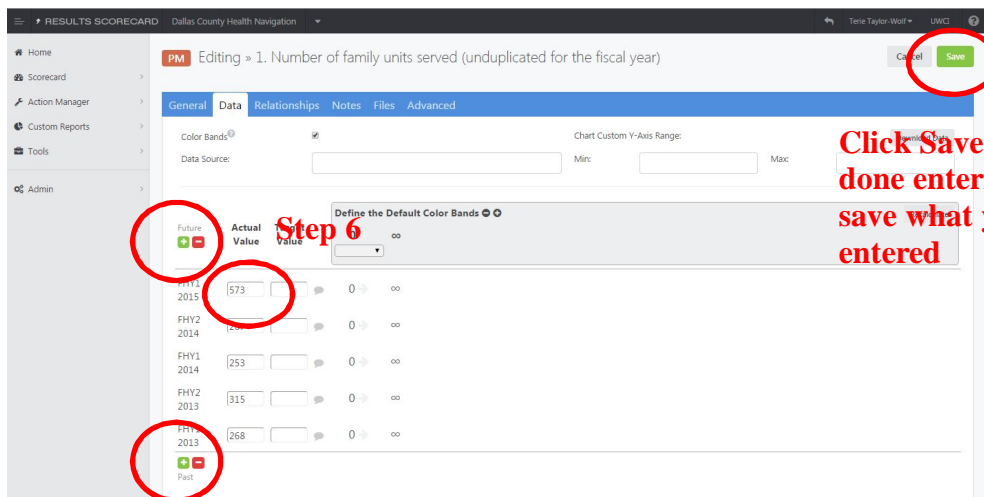
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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

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Click pencil icon to write or paste narrative

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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
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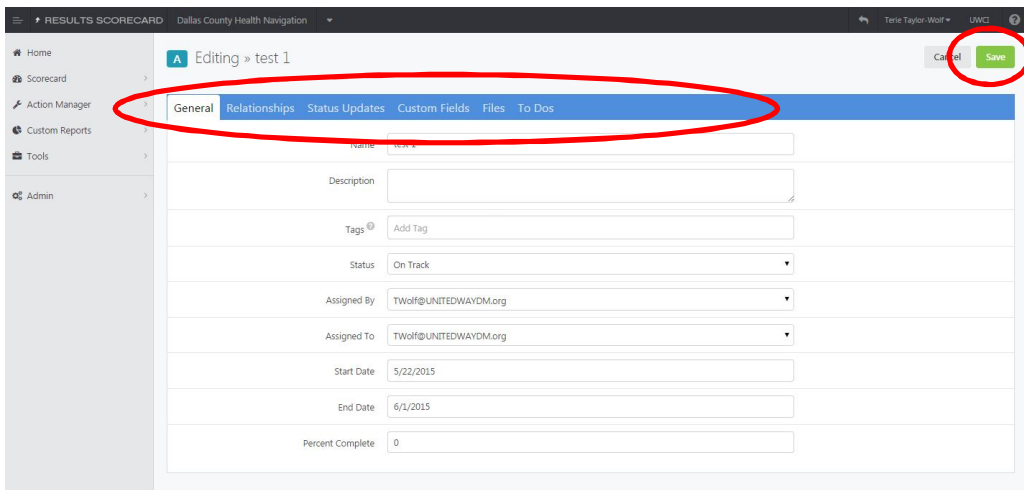


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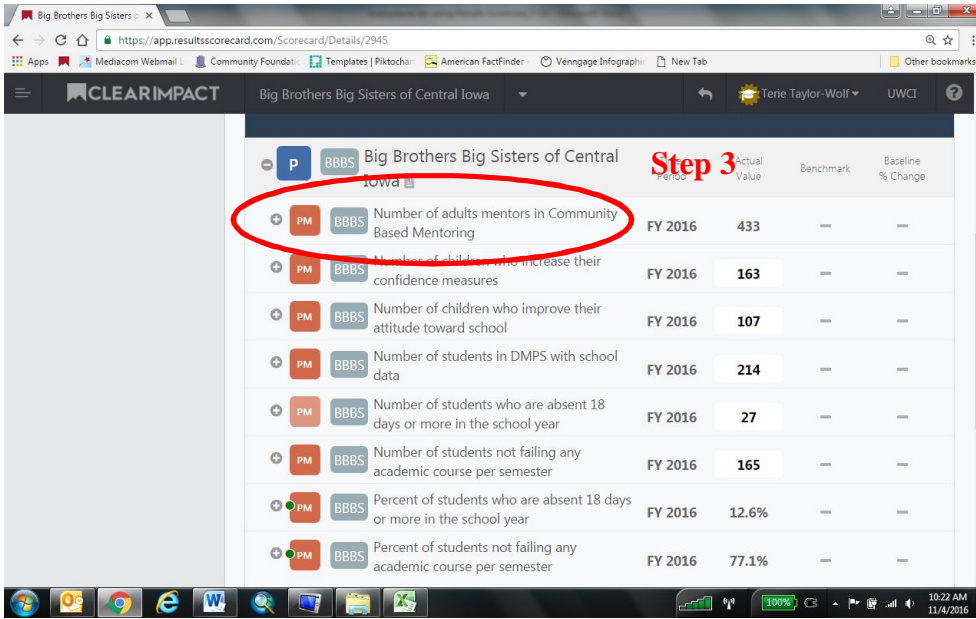
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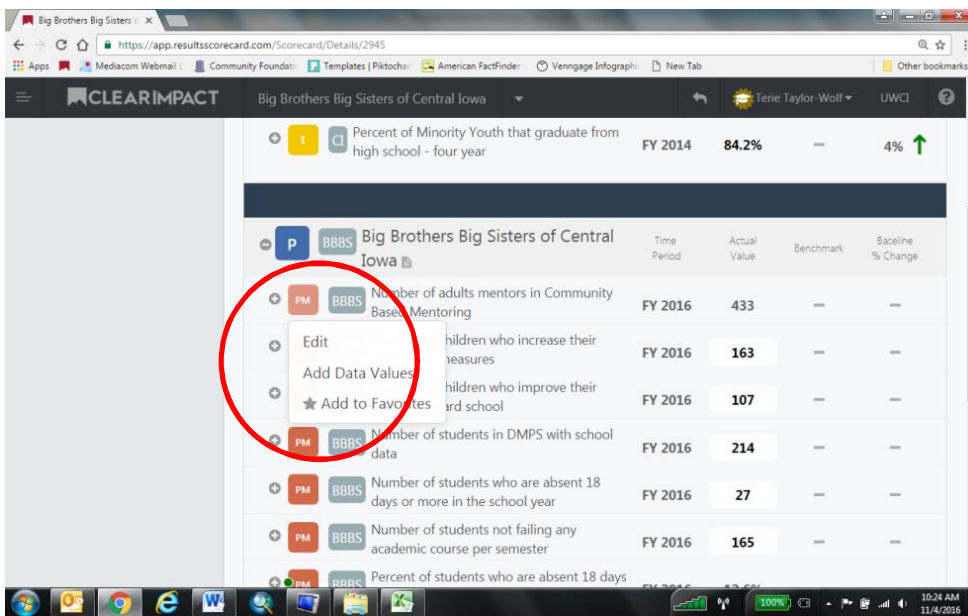


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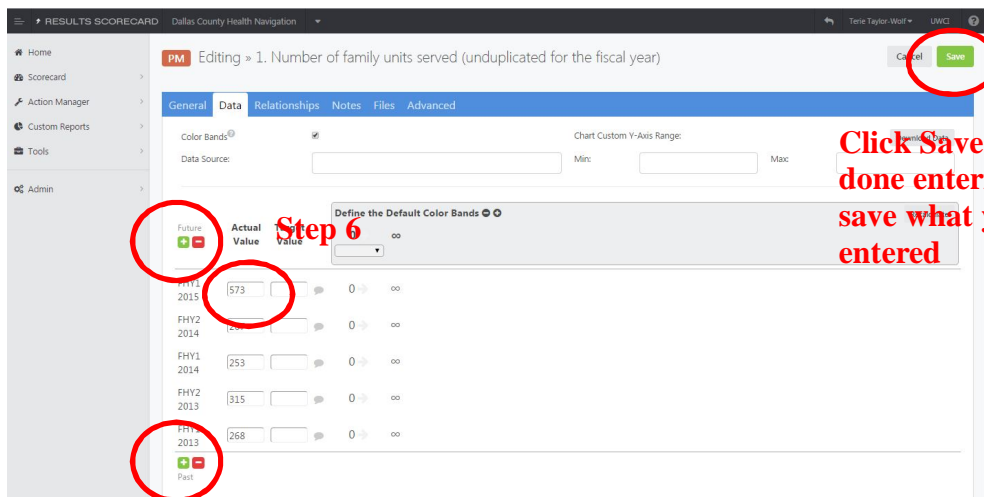
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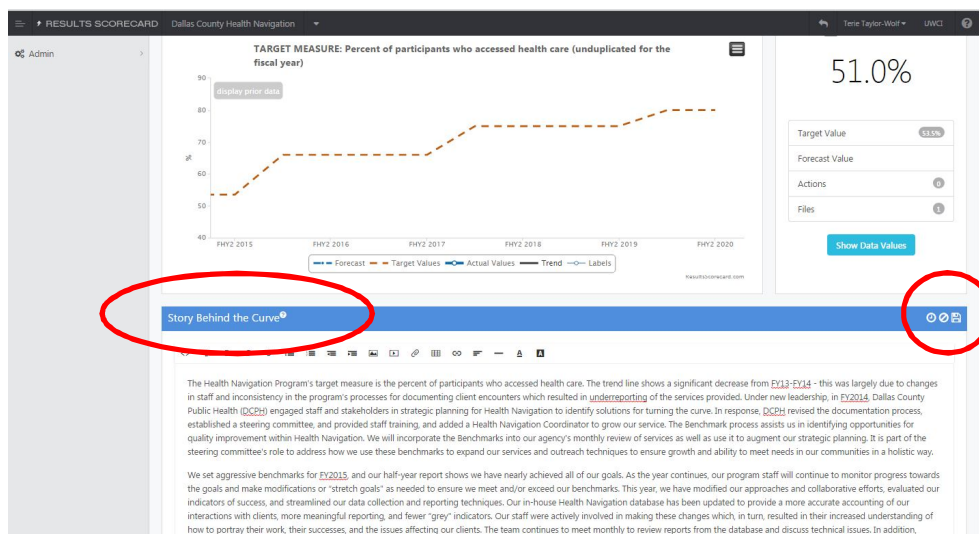
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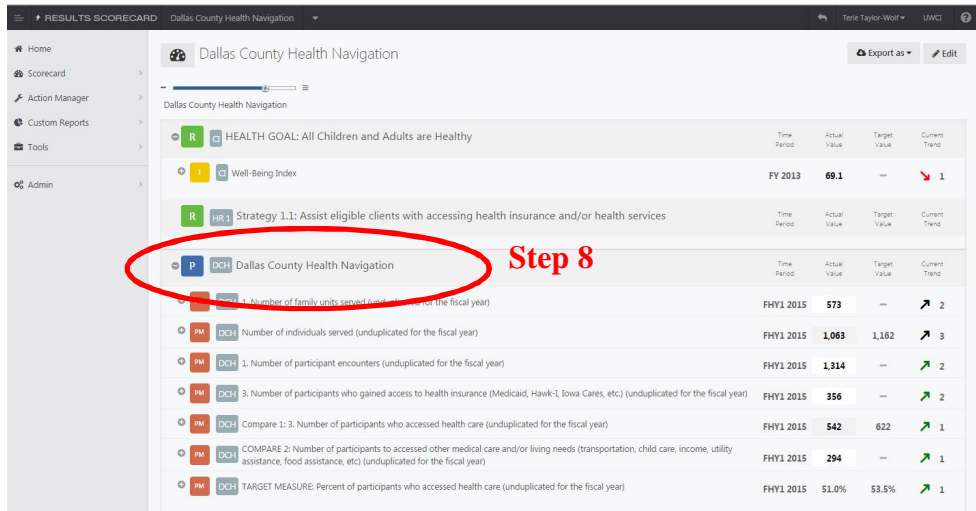
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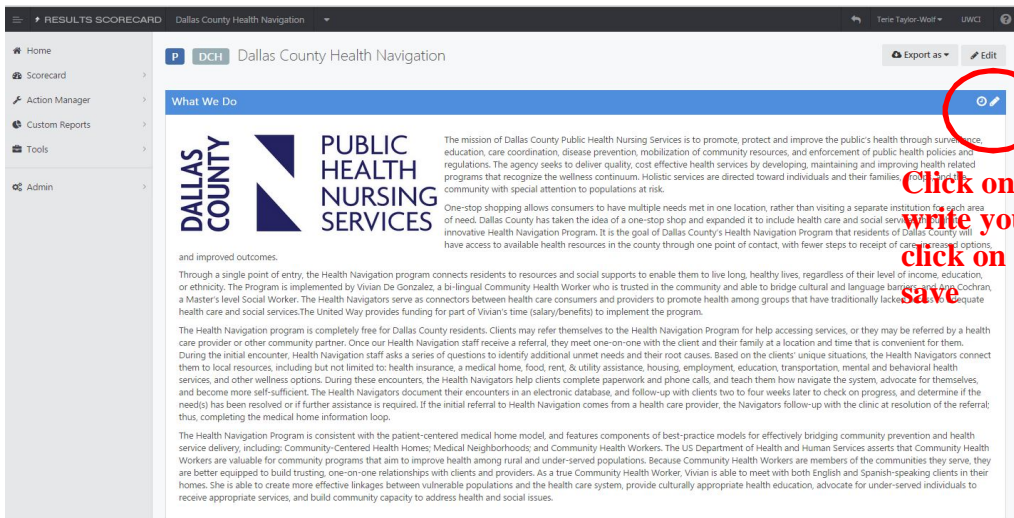
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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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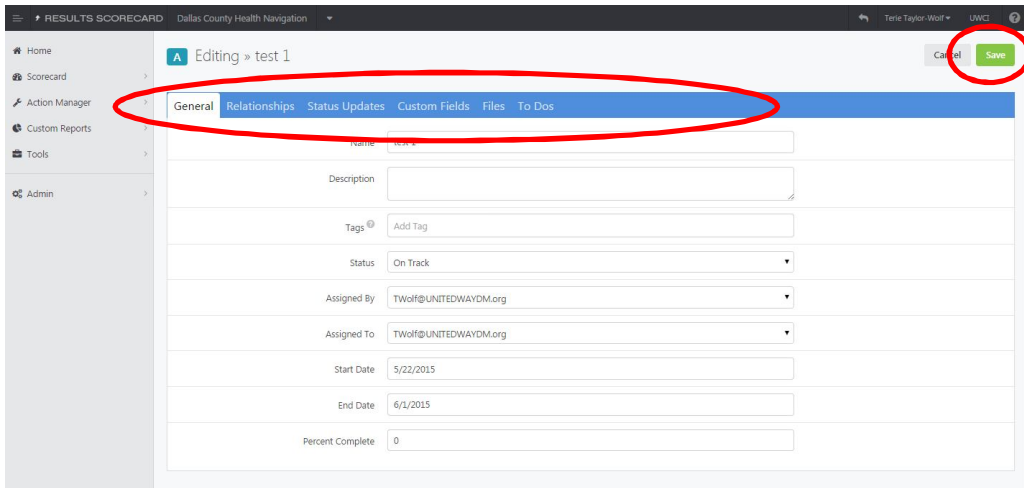


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The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
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Step 4

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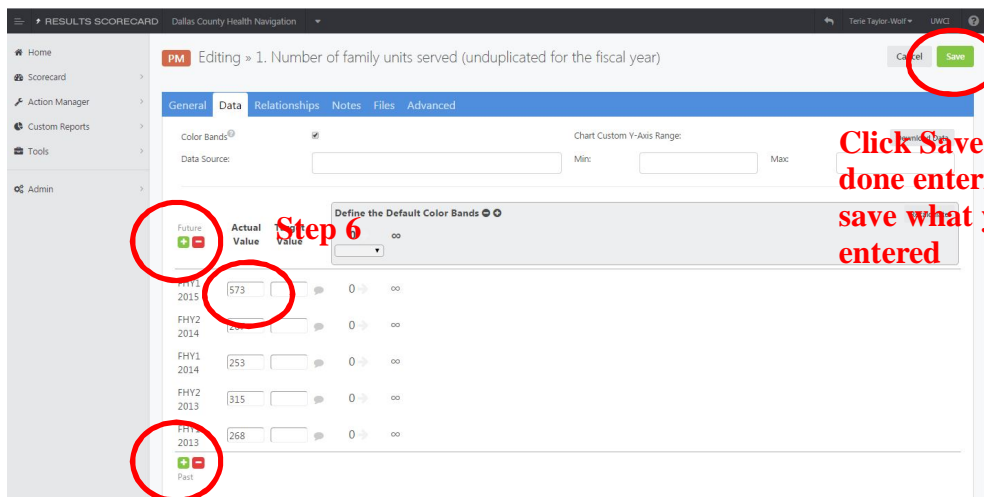
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Step 5
Click on the Data tab

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Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
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Q2	Oct. 1-Dec. 31
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HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

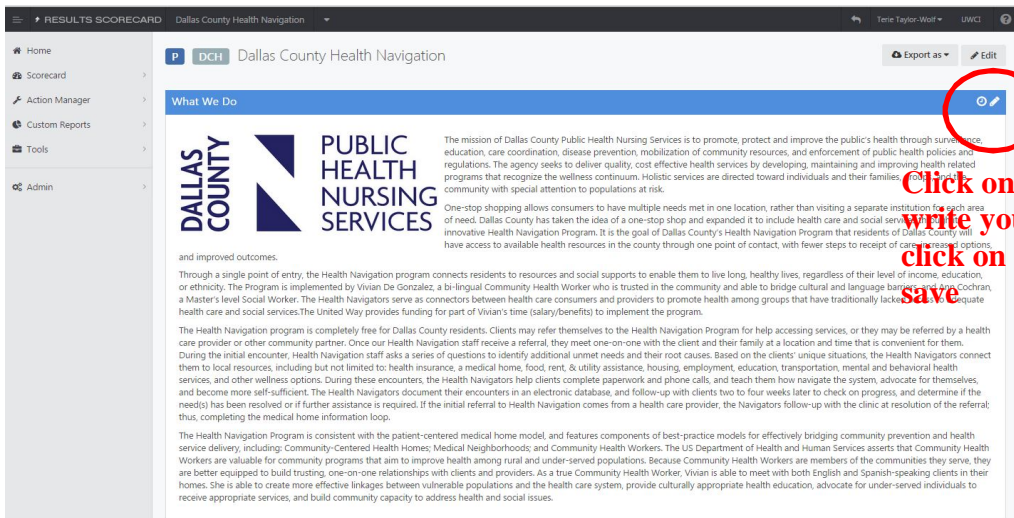
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

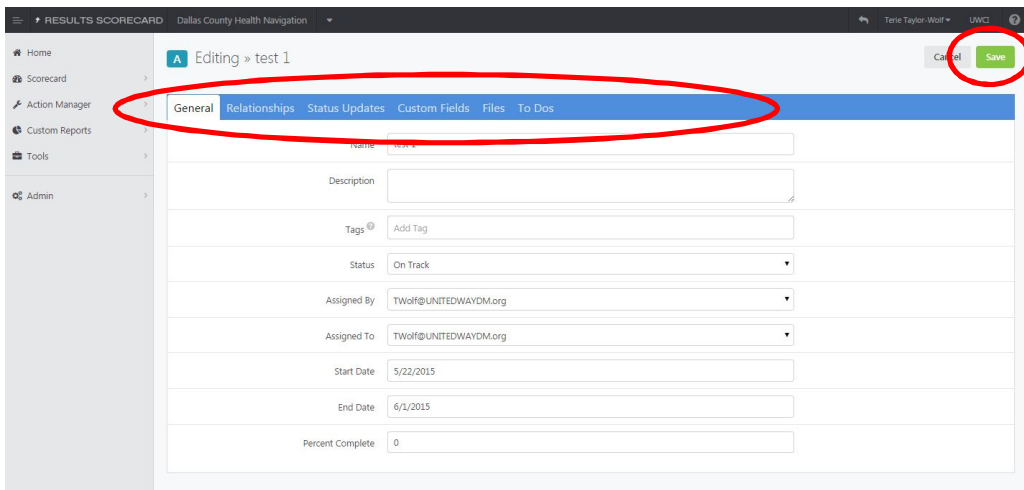


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

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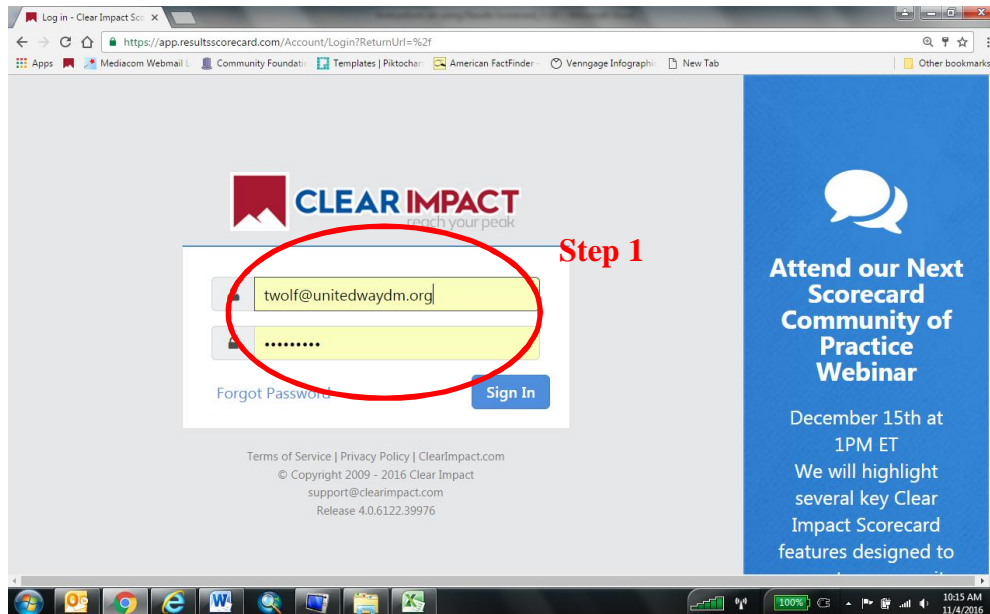
Instructions on using Results Scorecard

Step 1: Login

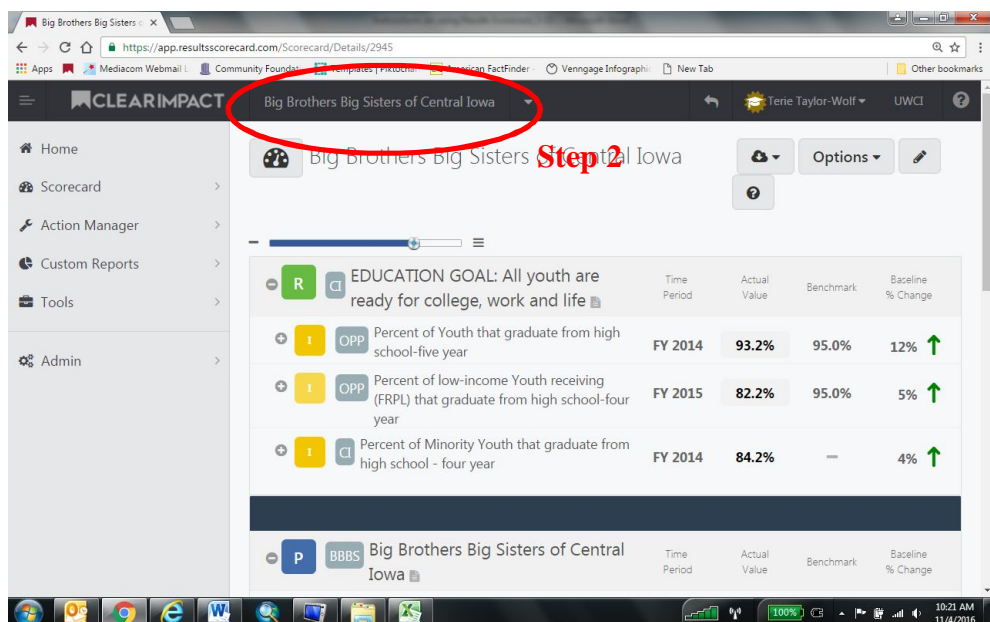
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

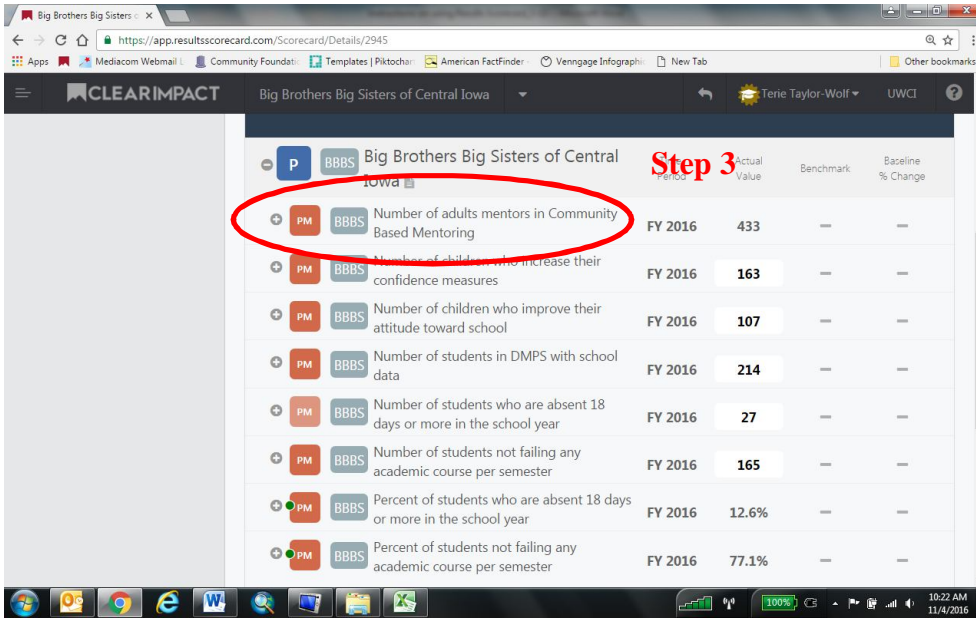
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.



By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

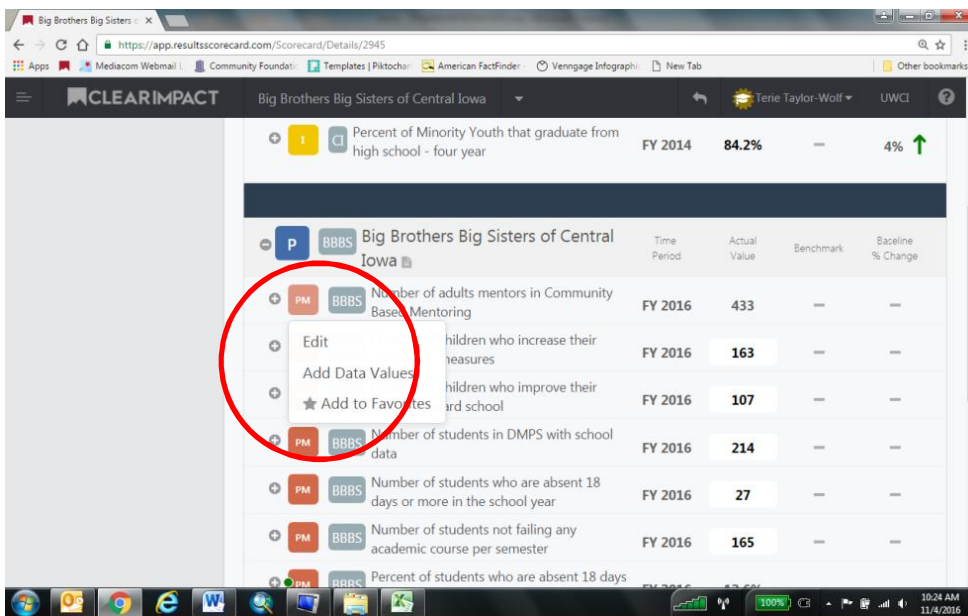


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Step 4

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Step 5
Click on the Data tab

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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays data from FY2 2015 to FY2 2020, with an actual value of 51.0% and a target value of 63.5%. Below the chart is the 'Story Behind the Curve' section, which contains a text area and a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image. The text area is now populated with a detailed narrative about the Health Navigation Program's target measure, including information about underreporting, staff training, and benchmarking. A disk icon in the bottom right corner of the text area is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

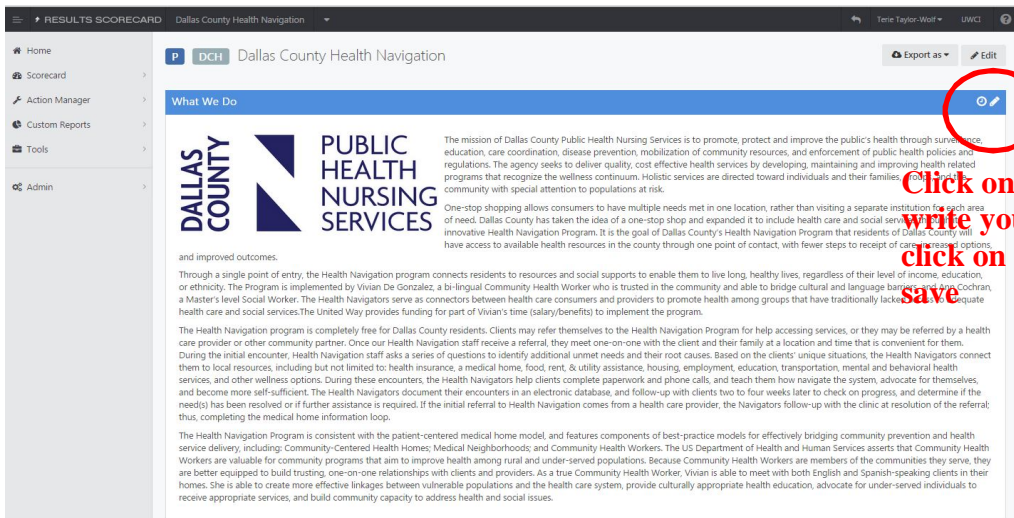
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Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
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Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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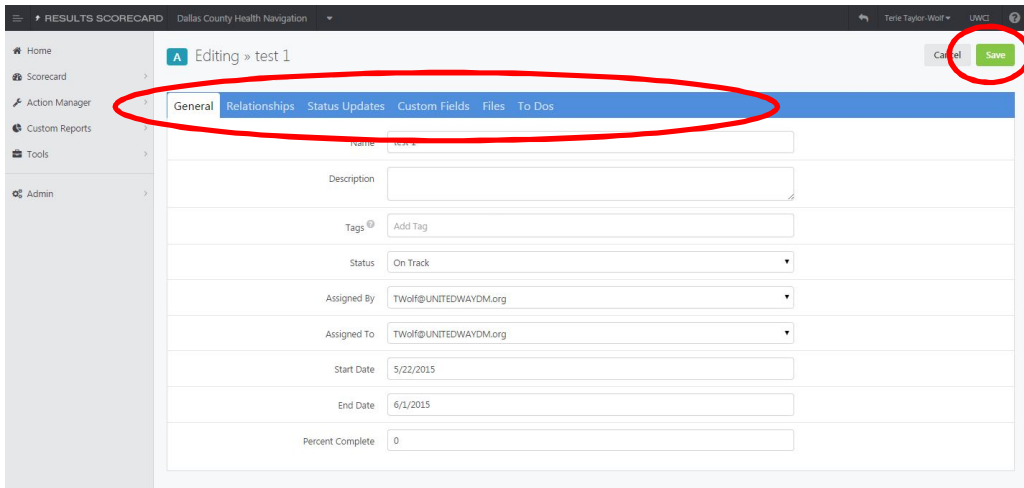


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Tim	1st half	1st half	Myra	1st half	2nd half
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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
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number of clients served	7	3	10
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Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
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For Income Programming, contact Corinne Lambert at 246-6542 or e-mail at clambert@unitedwaydm.org

Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

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The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
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Step 4

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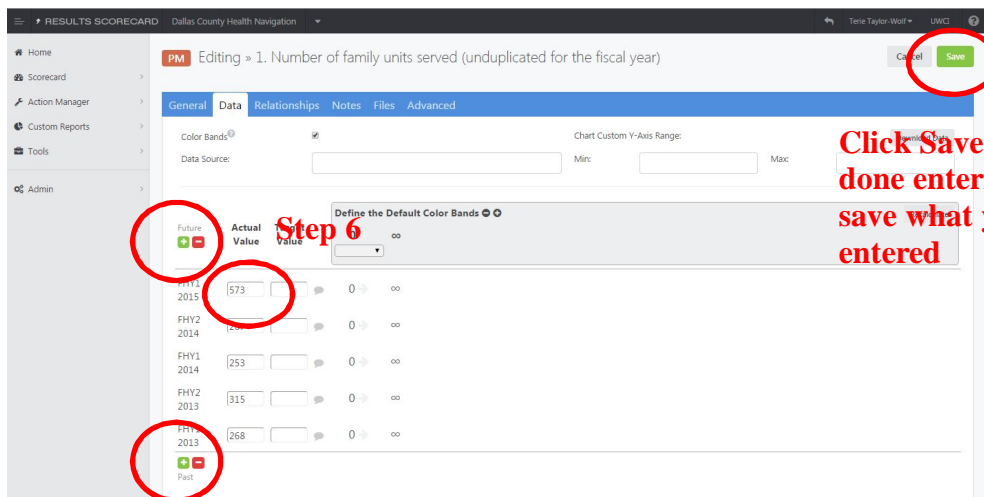
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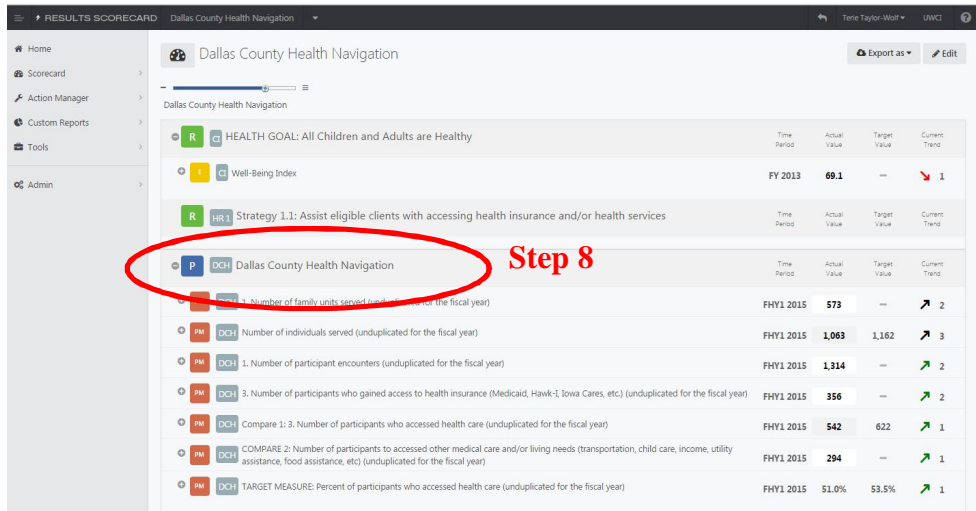
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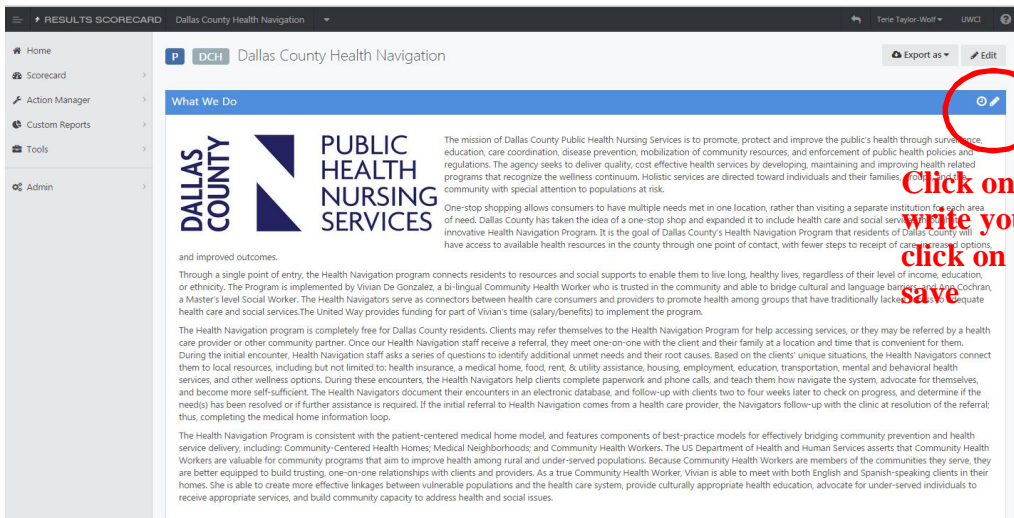
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
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Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

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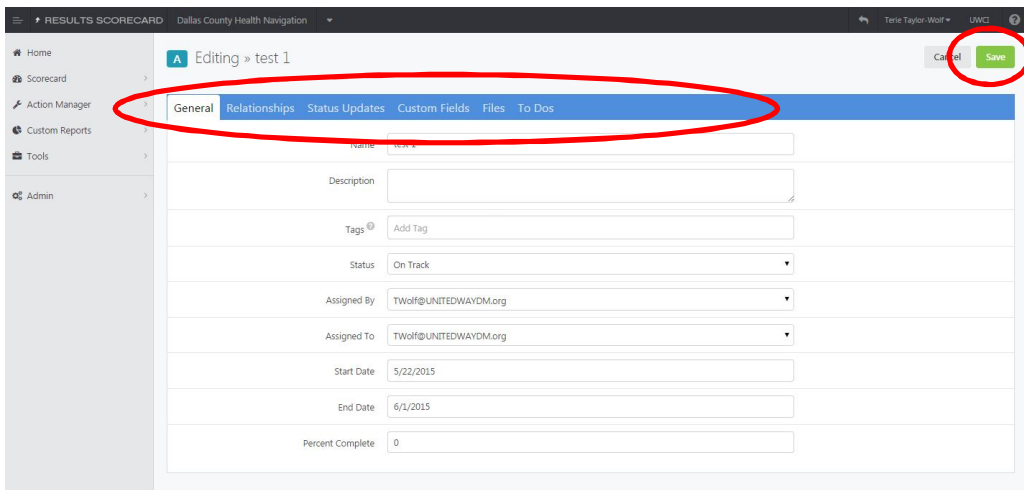


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
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Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
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Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. The scorecard displays a list of performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
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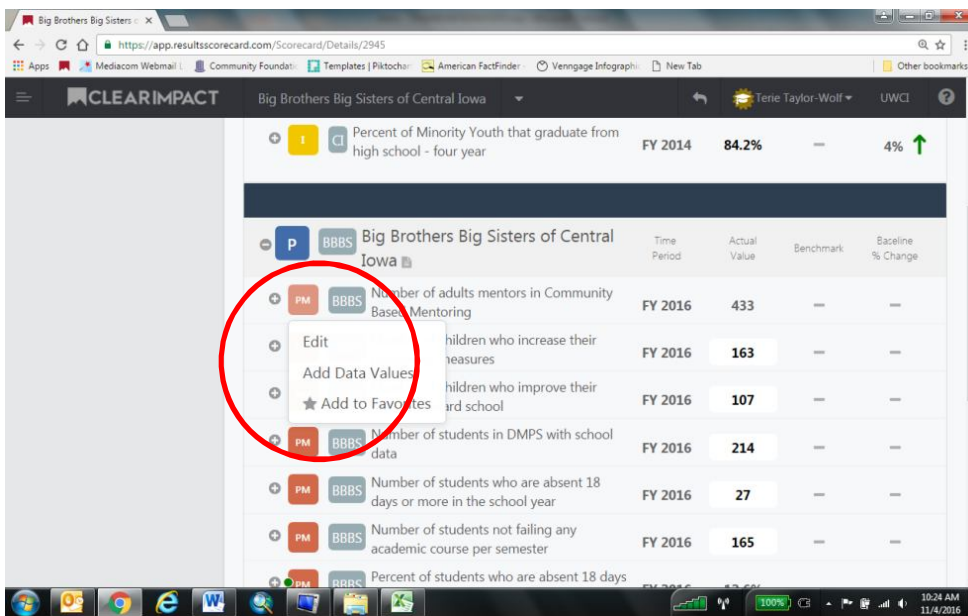
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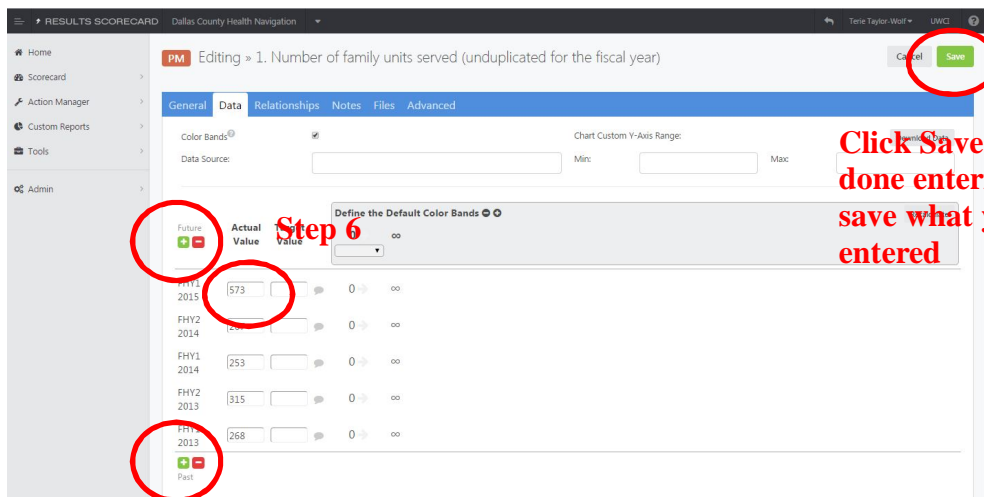
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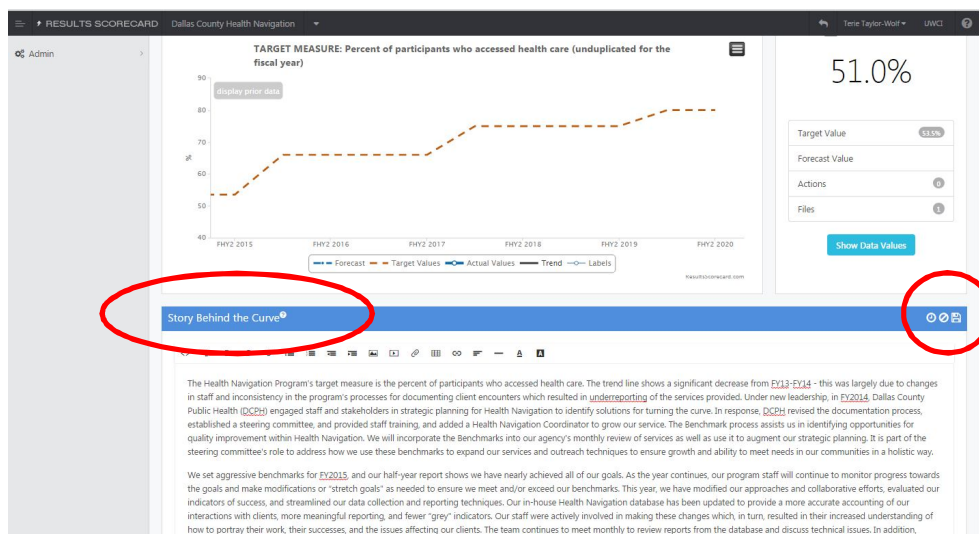
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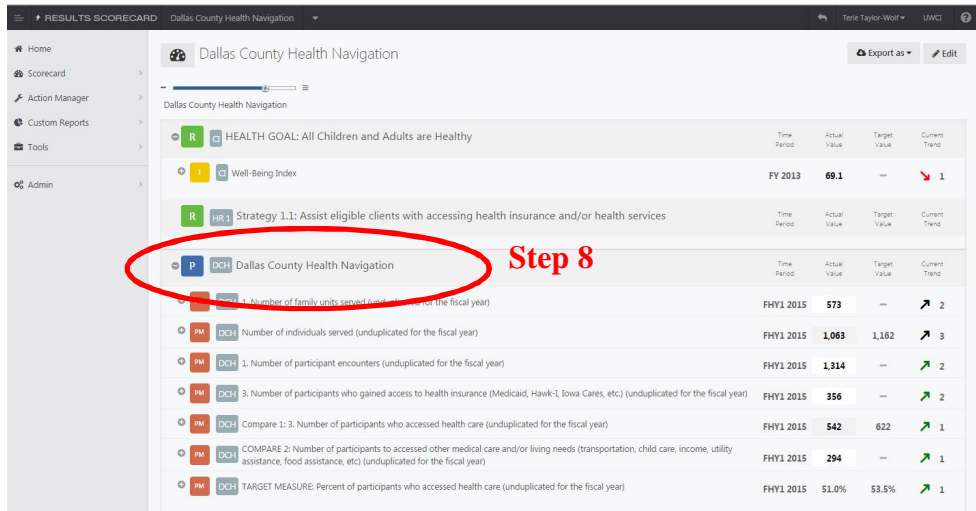
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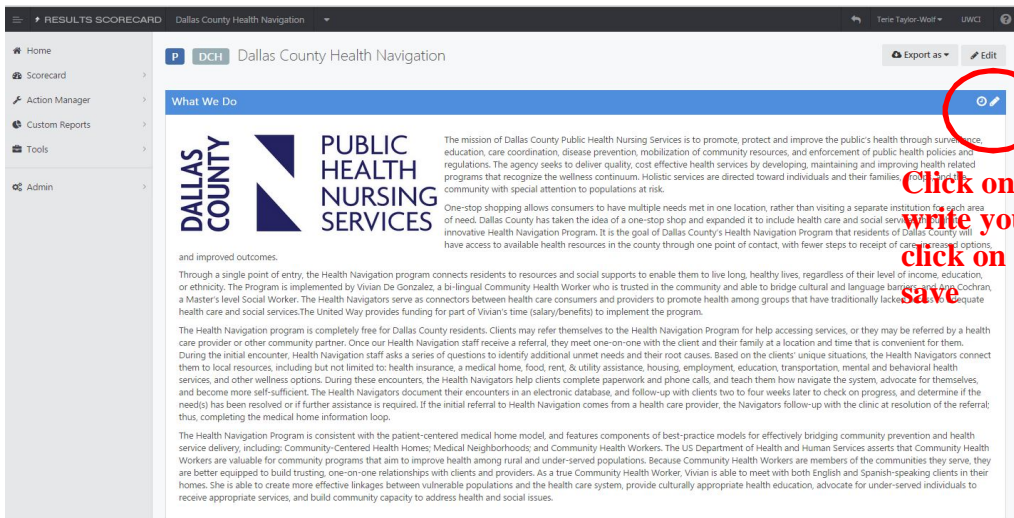
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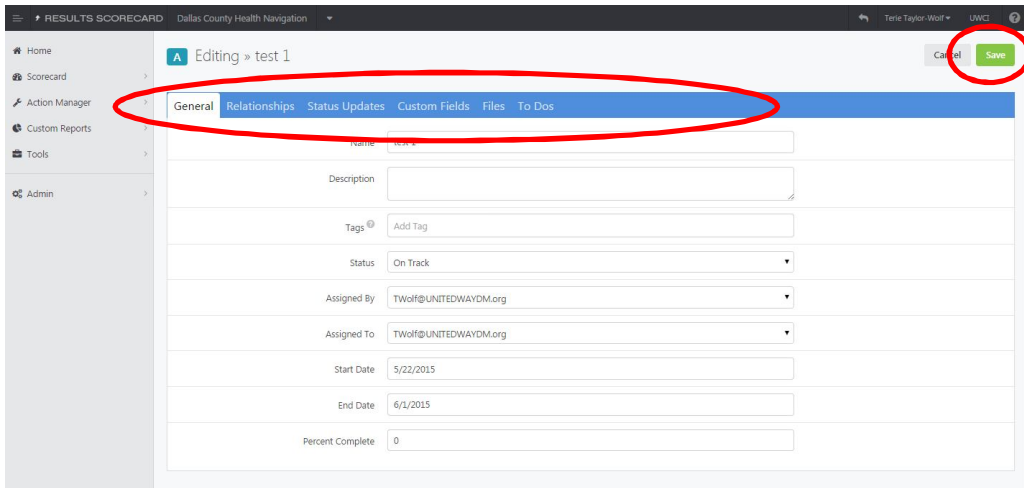


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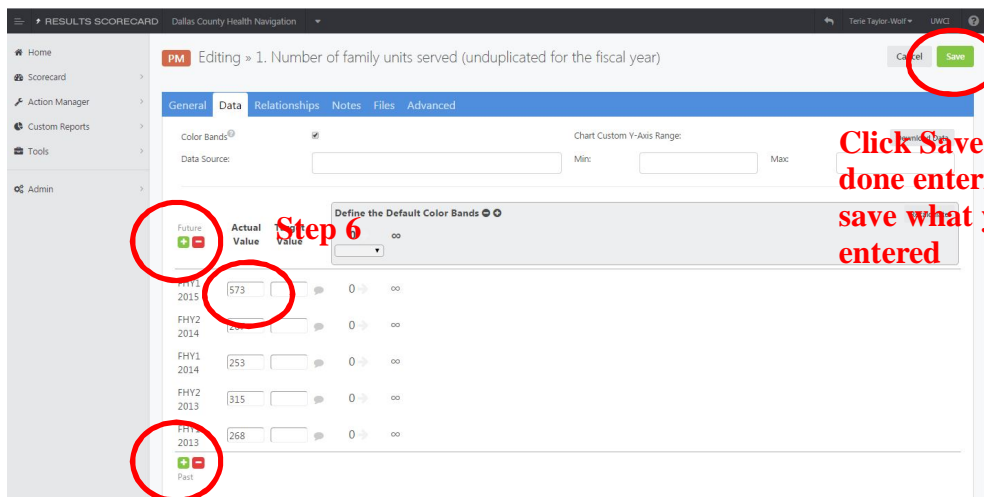
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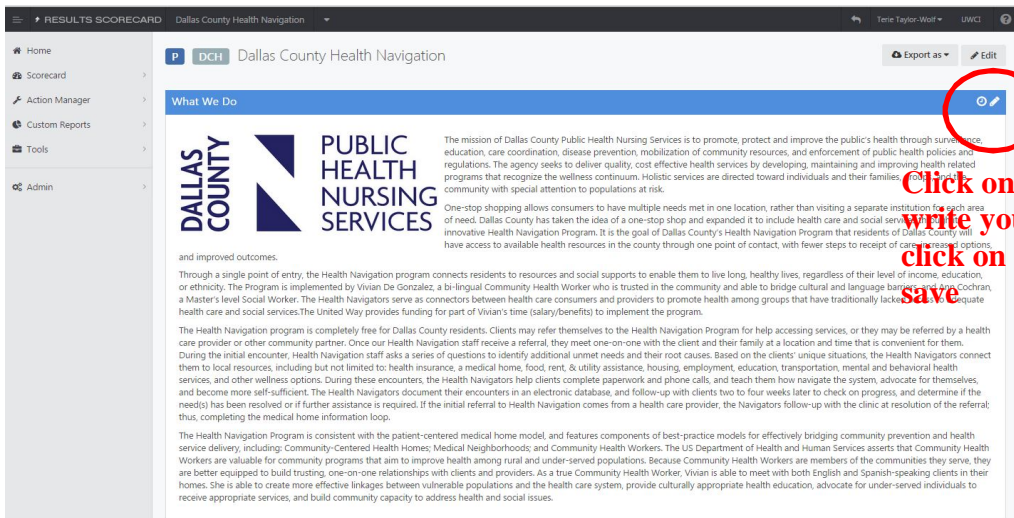
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Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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Step 8

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

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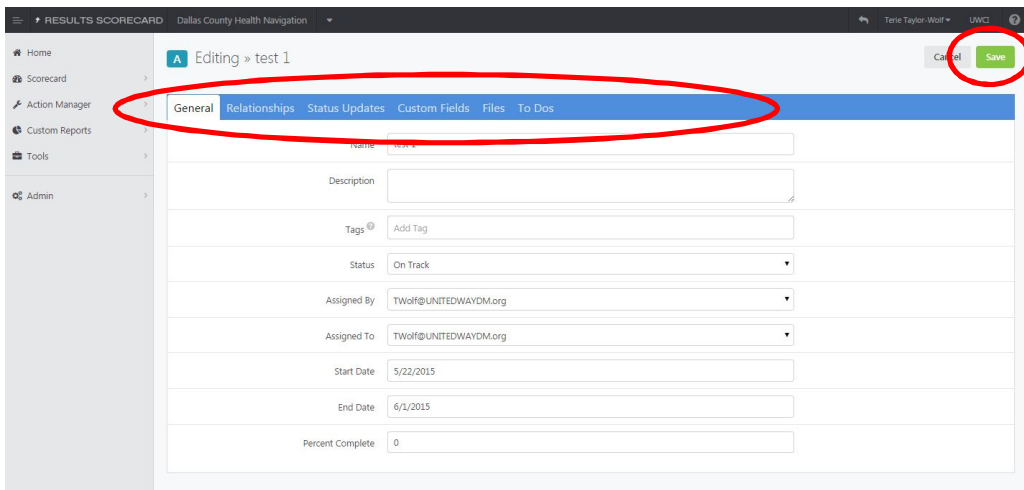


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Jane	2nd half	No Outcome	Tim	2nd half	2nd half
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Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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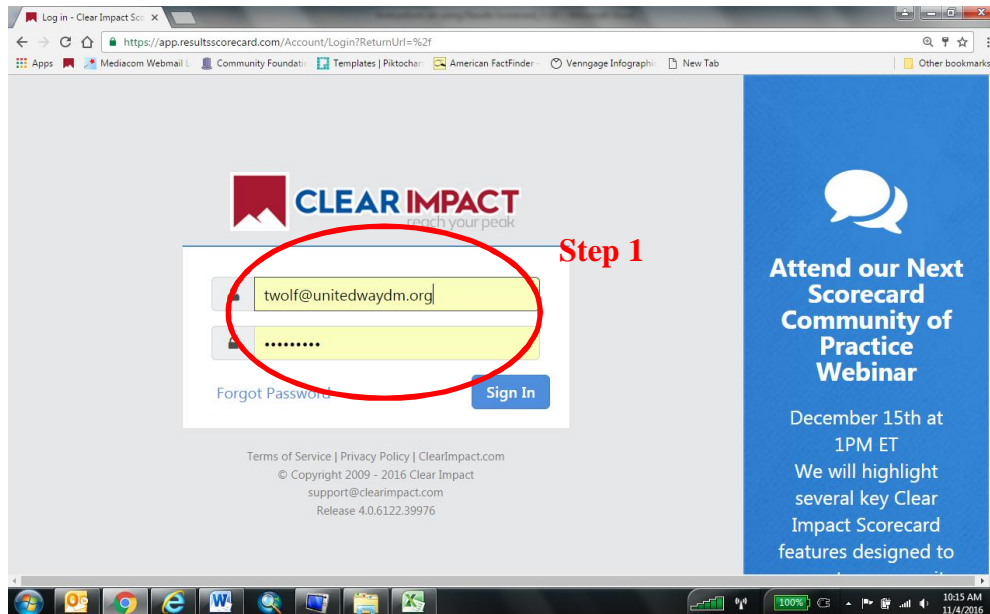
Instructions on using Results Scorecard

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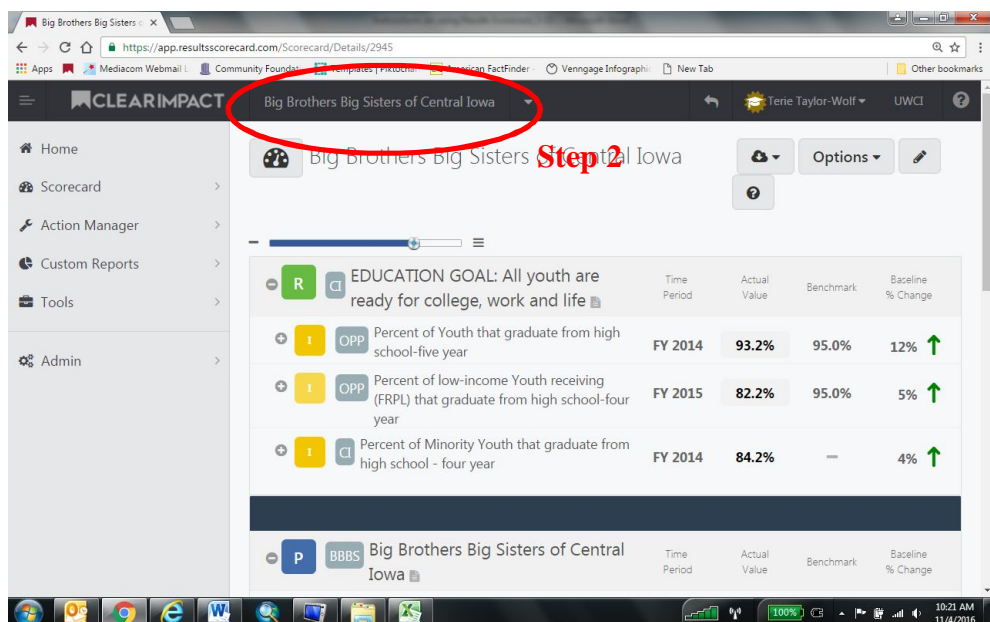
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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. A red "Step 3" label is in the top right. A list of performance measures is shown, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph shows the trend data for this measure from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

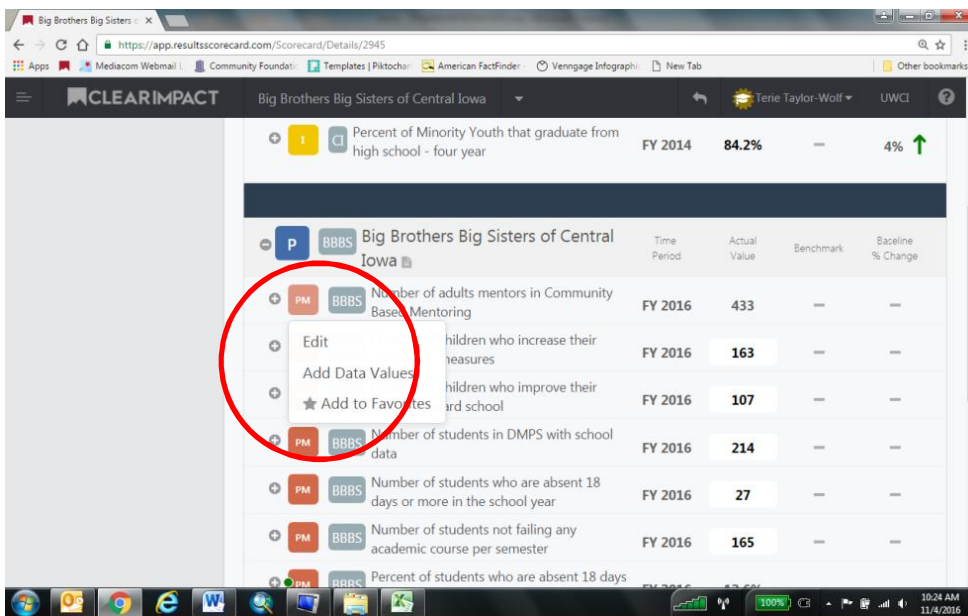
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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Step 4

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Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

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You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

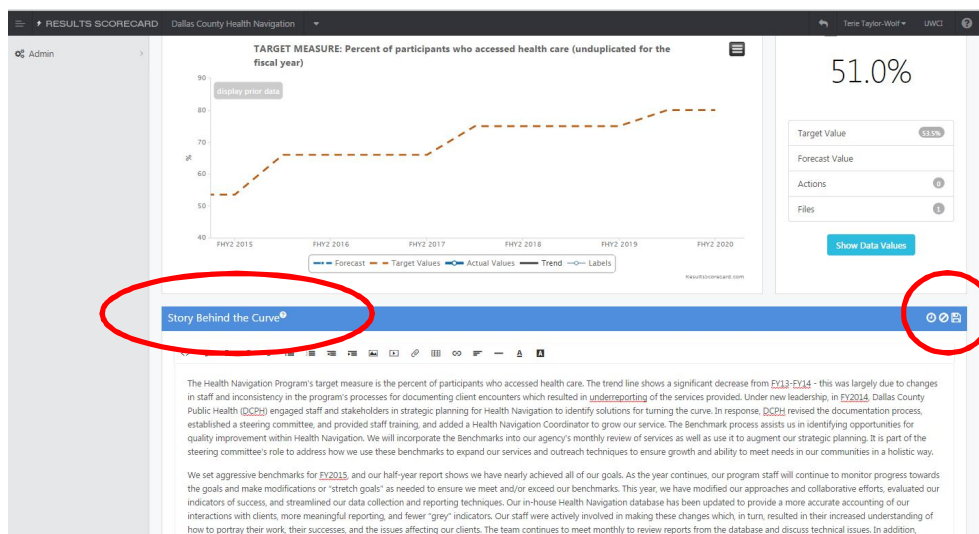
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s)). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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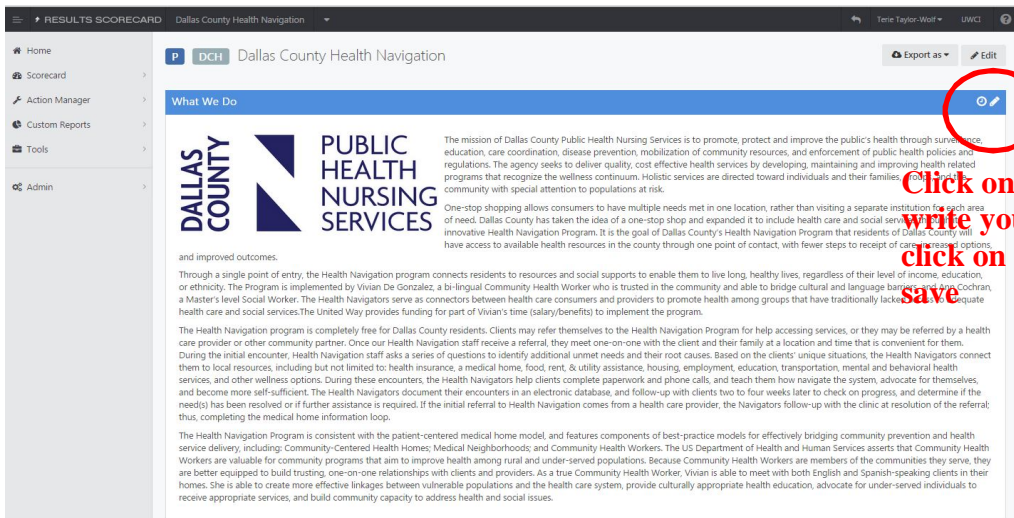
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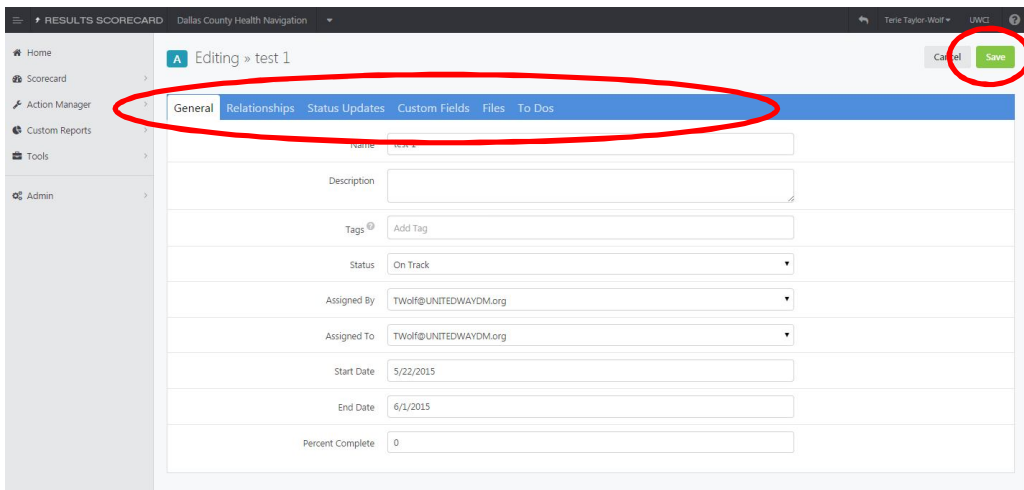


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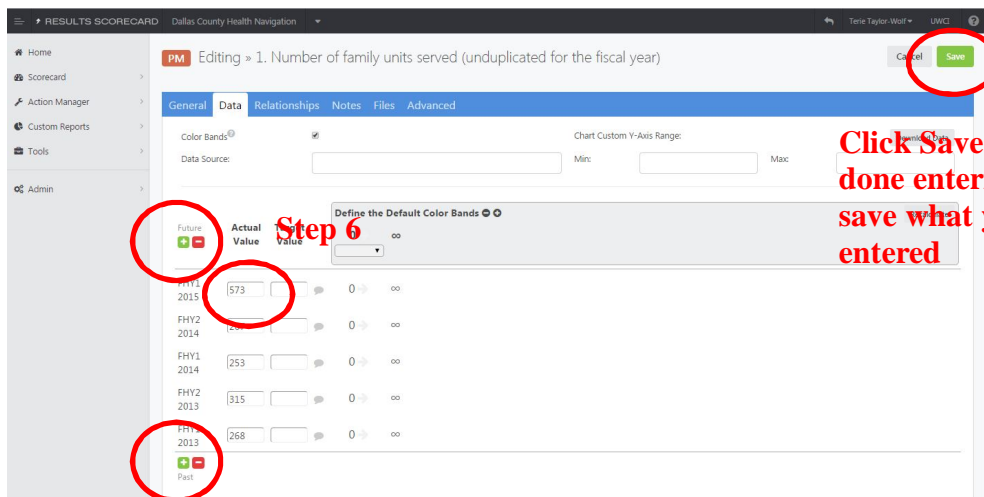


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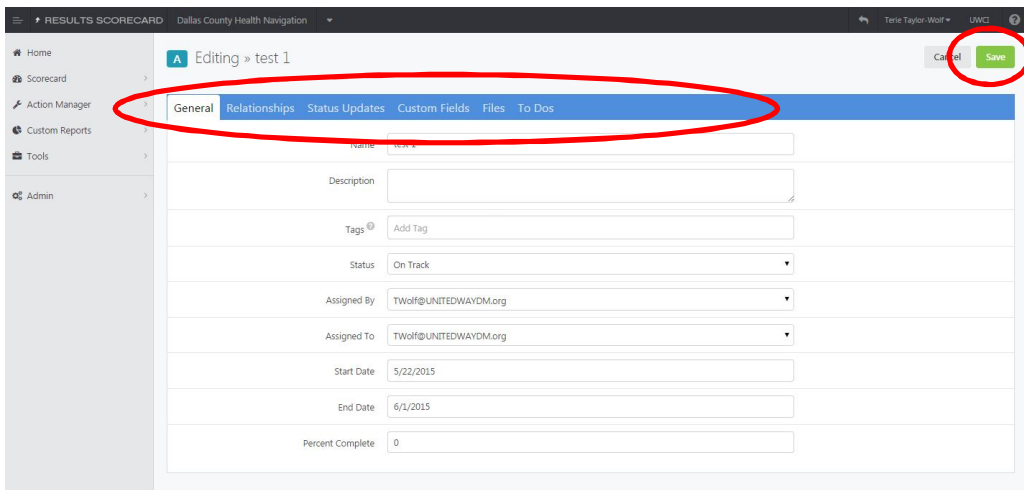


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Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
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Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend from FY 2011 to FY 2015. The data points are: FY 2011 (496), FY 2012 (515), FY 2013 (591), FY 2014 (535), and FY 2015 (467). The graph shows a peak in FY 2013 and a decline in FY 2015. The table to the right of the graph shows the following data:

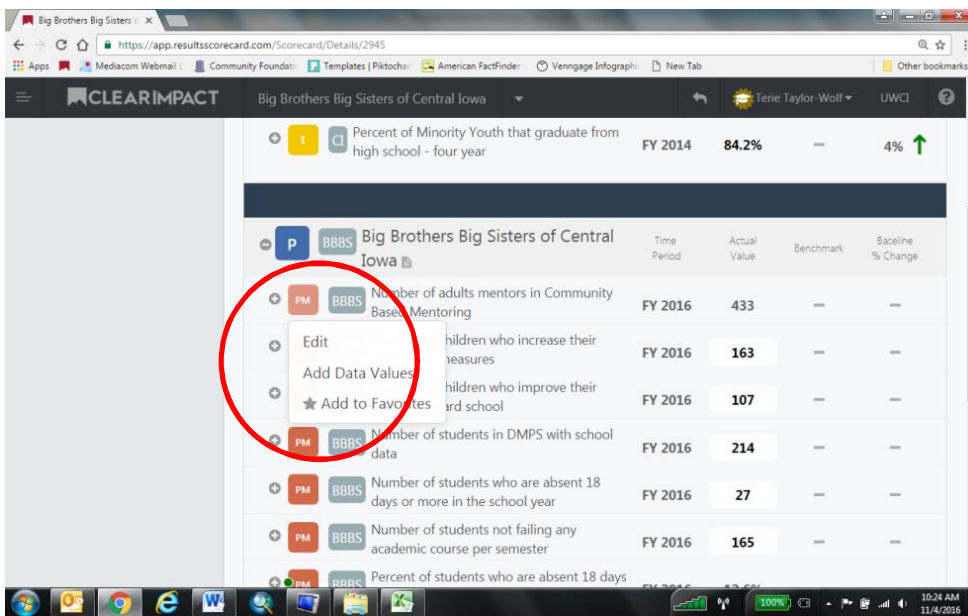
PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2015	467	—	—
+	BBBS	FY 2014	535	—	—
+	BBBS	FY 2013	591	—	—
+	BBBS	FY 2012	515	—	—
+	BBBS	FY 2011	496	—	—

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Step 4

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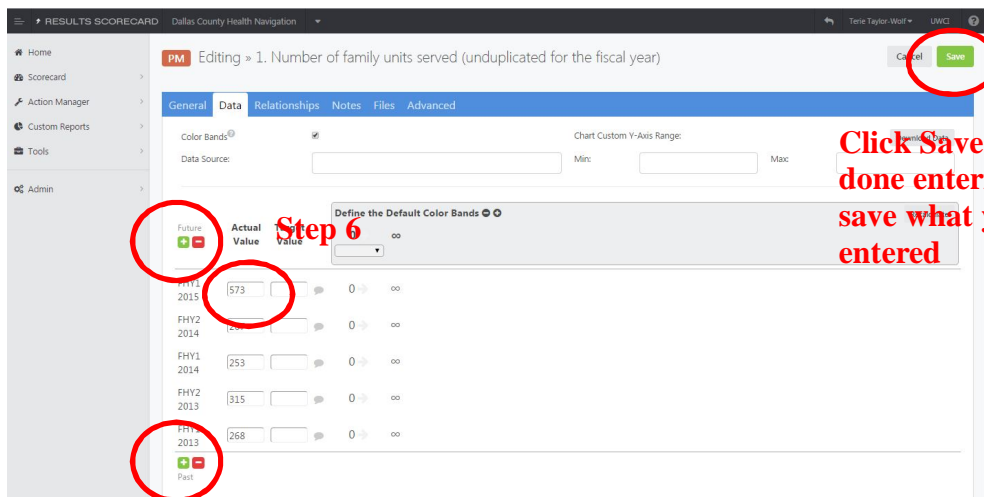
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Step 5
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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

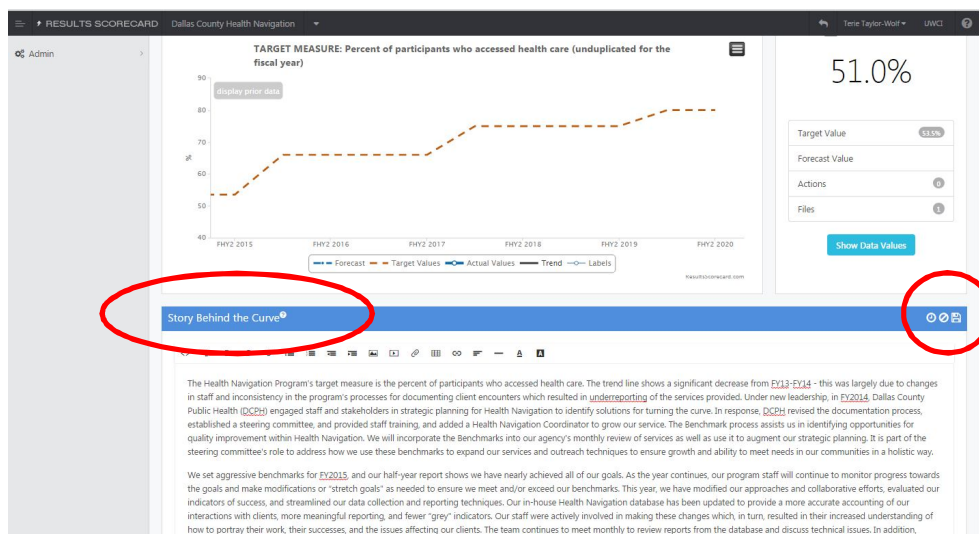
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Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

1. What We Do
2. Who We Serve
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4. Success Story

You will find these areas by clicking on the program name

Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
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COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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Step 8

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

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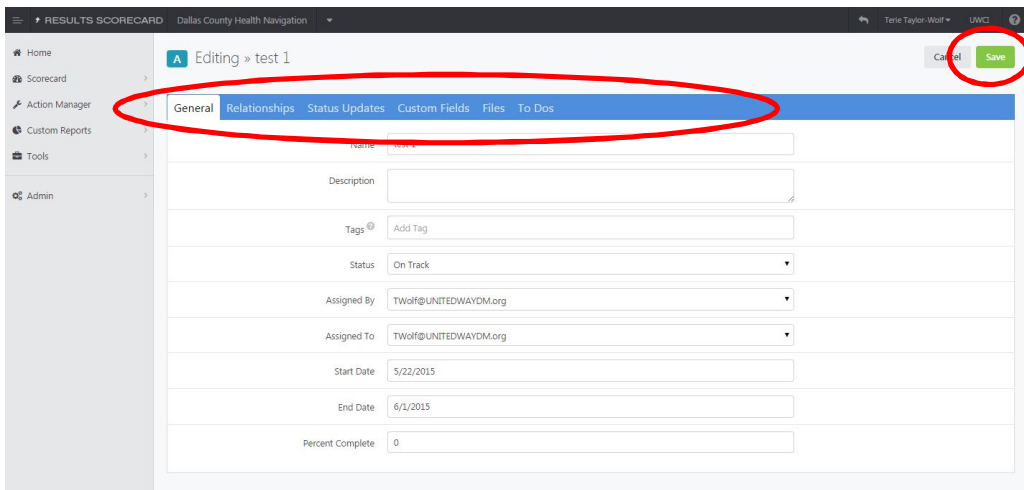


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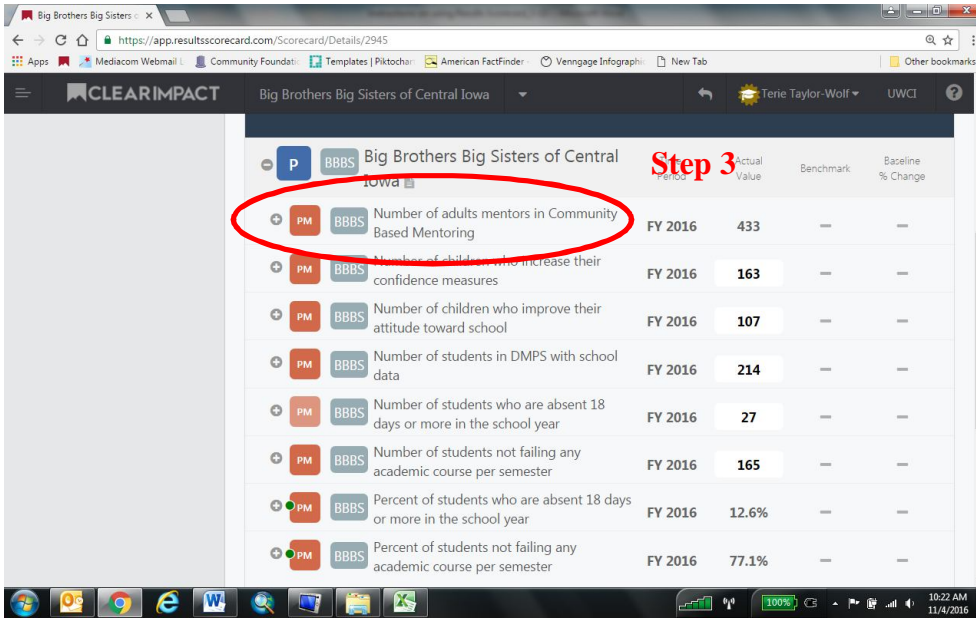
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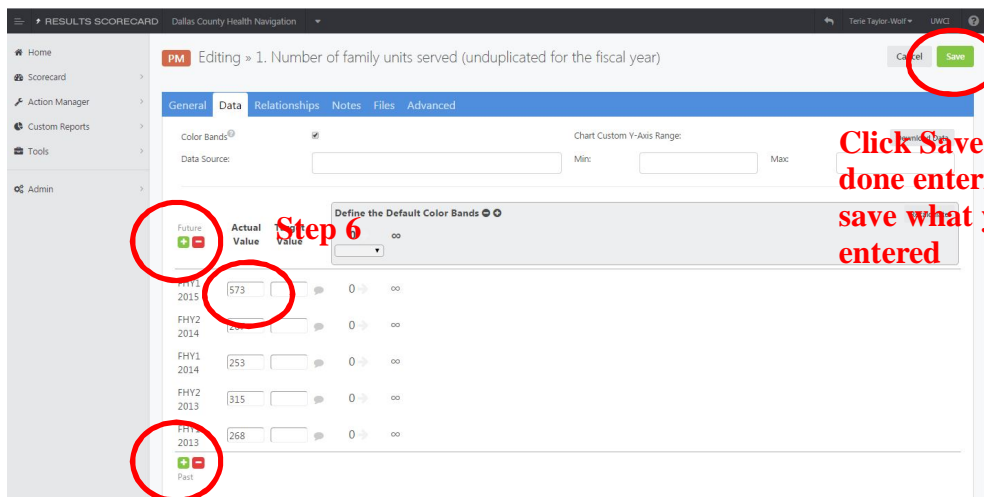
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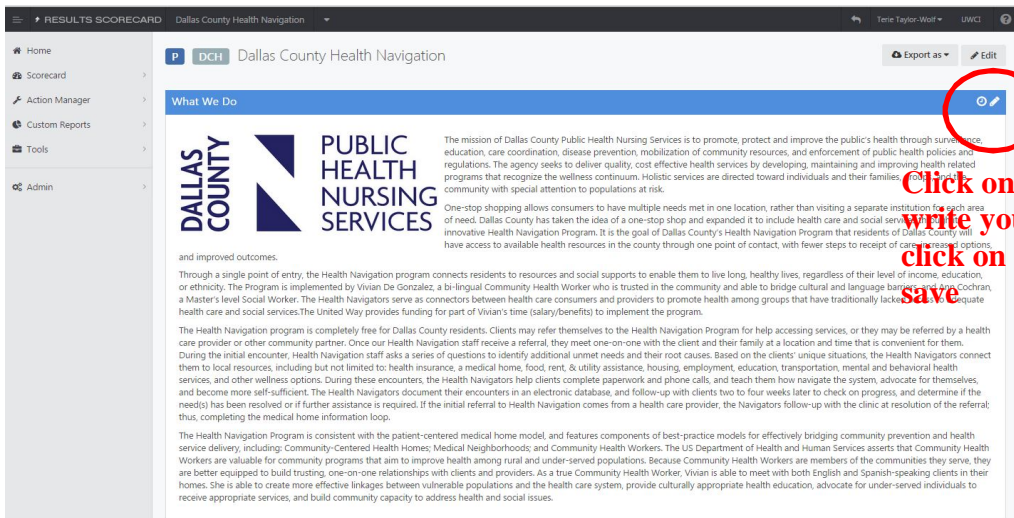
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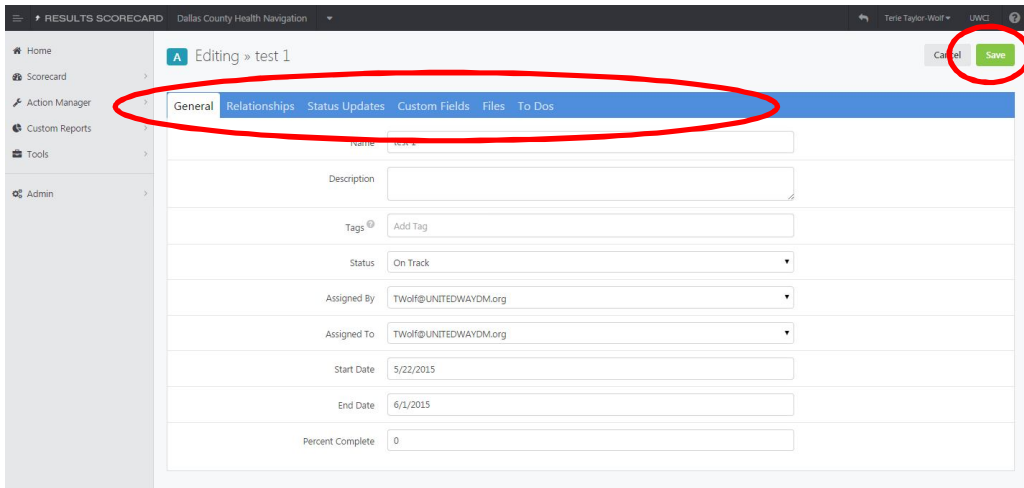


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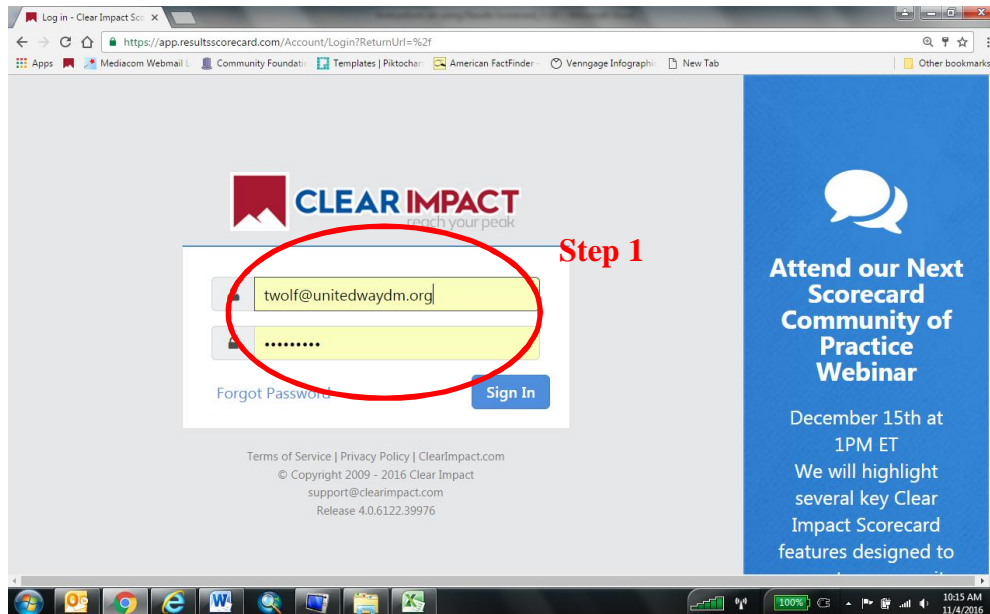
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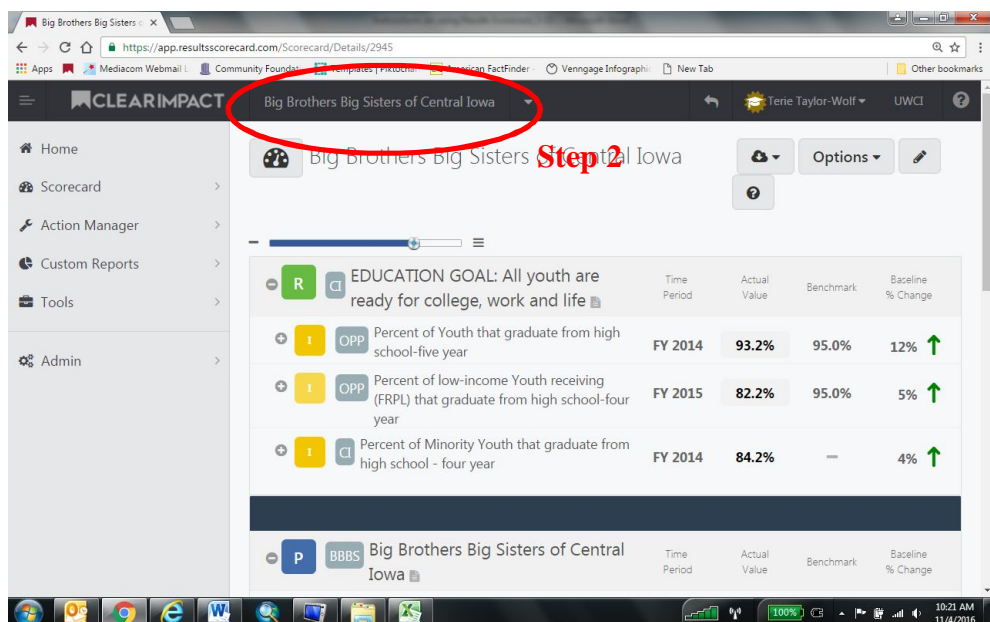
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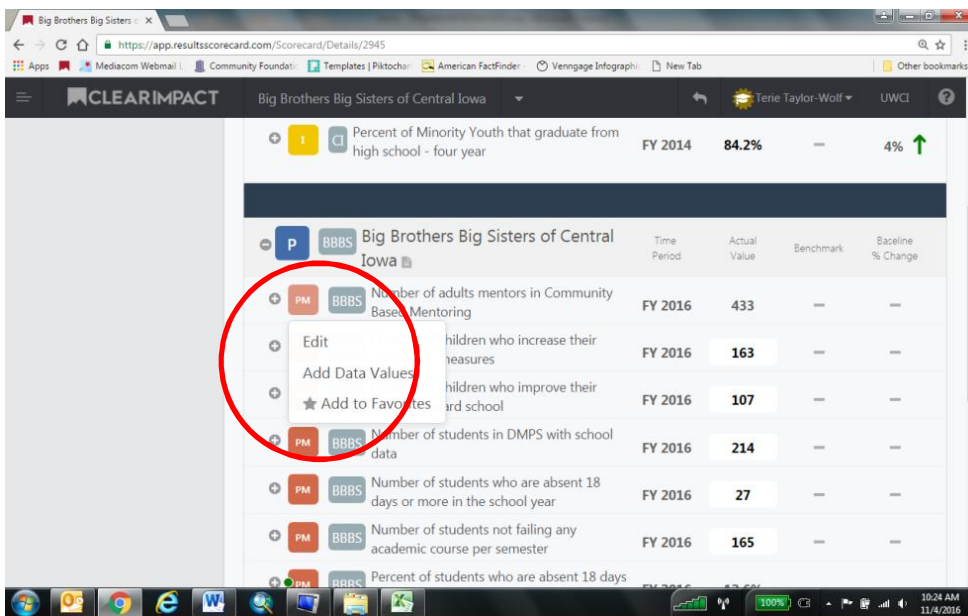
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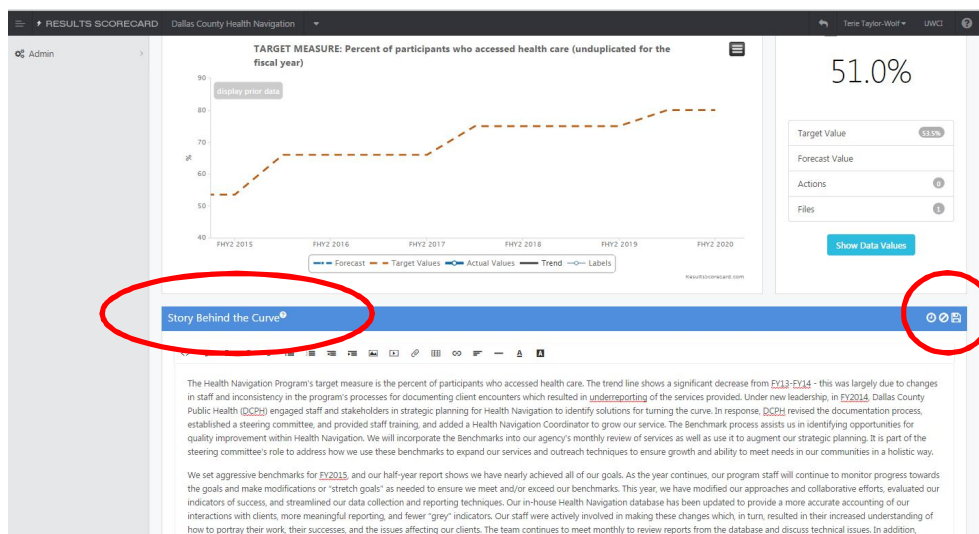
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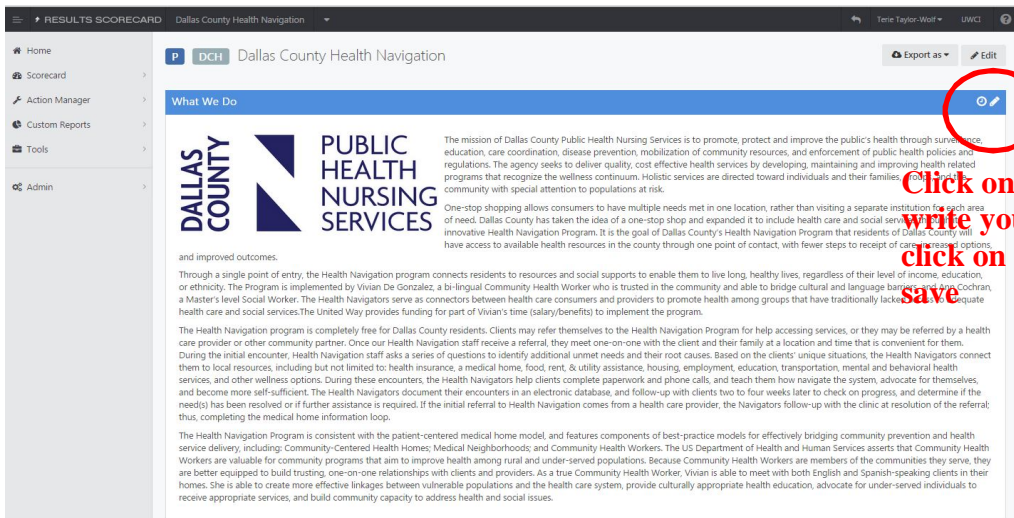
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DCH Dallas County Health Navigation				
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DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and/or services and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

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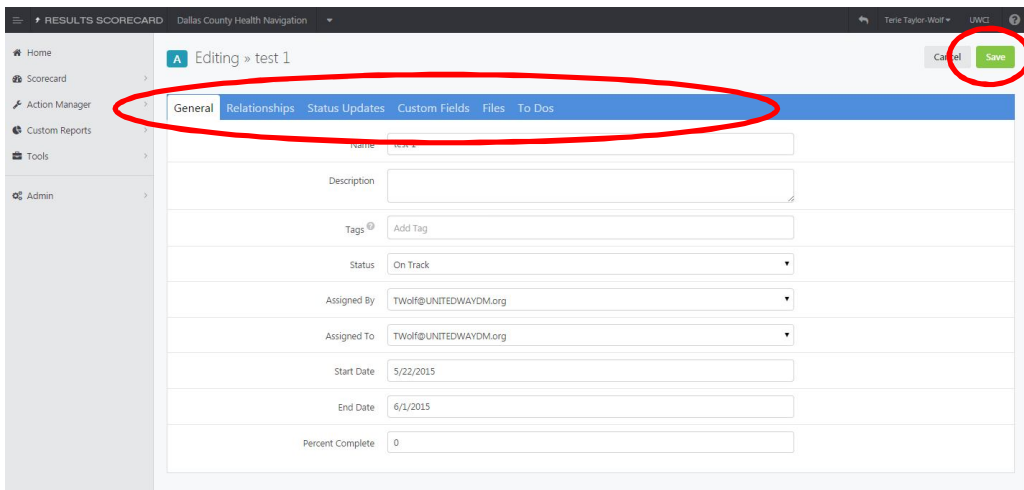


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Kane	1st half	1st half	Jody	1st half	1st half
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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
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Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
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Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
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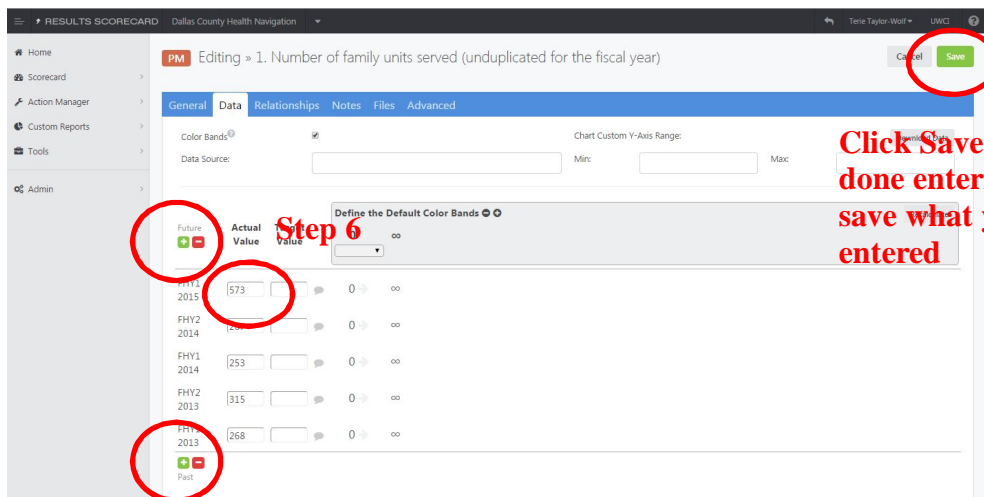
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The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section, but now with a text area containing a narrative. A disk icon in the bottom right corner of the text area is circled in red, indicating where to click to save the changes.

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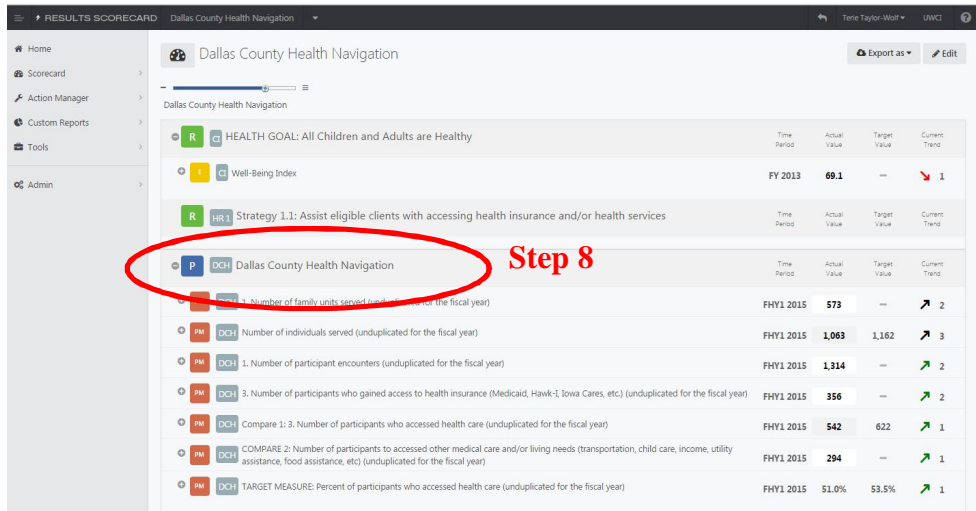
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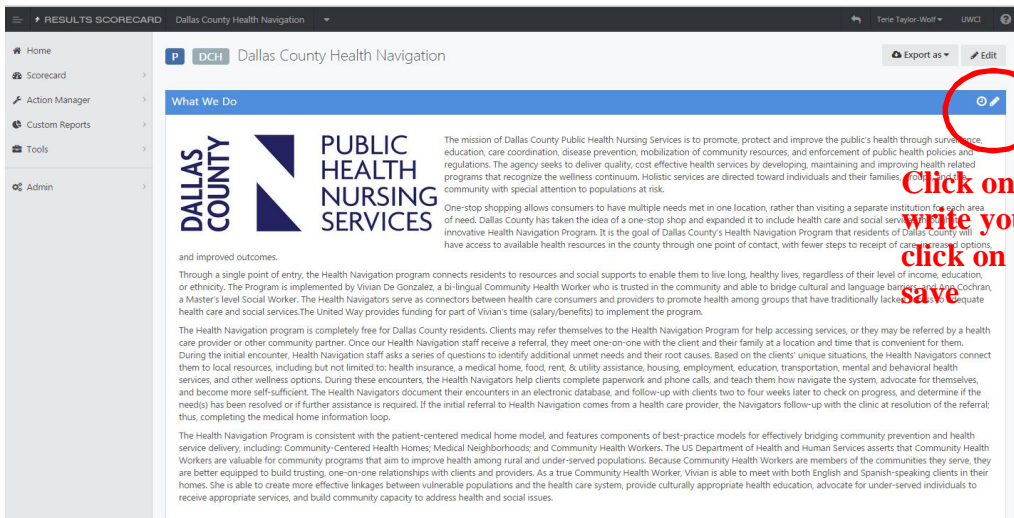
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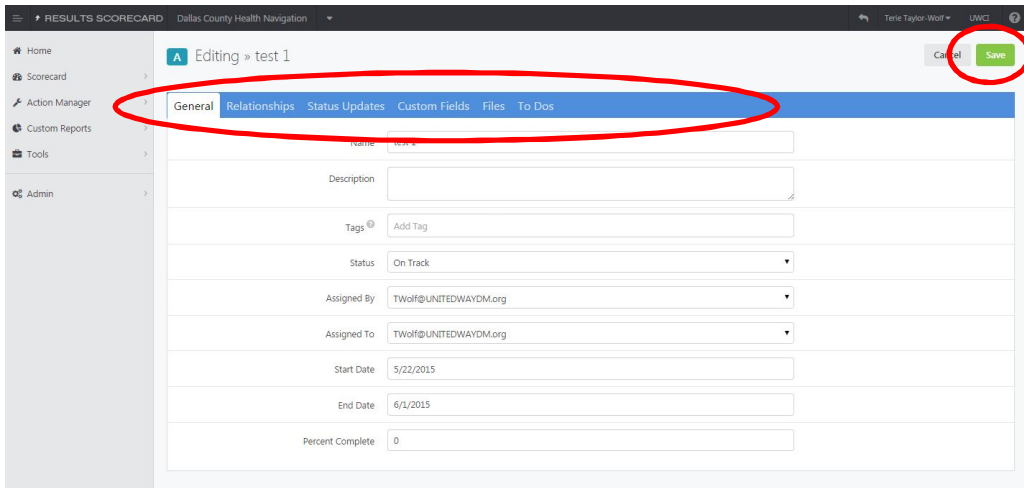


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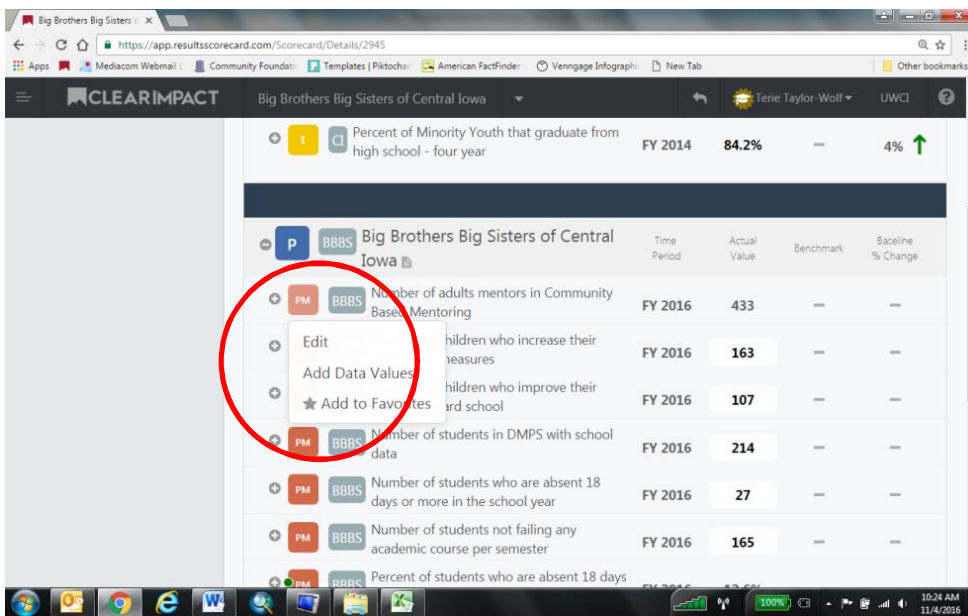
PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
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		FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.

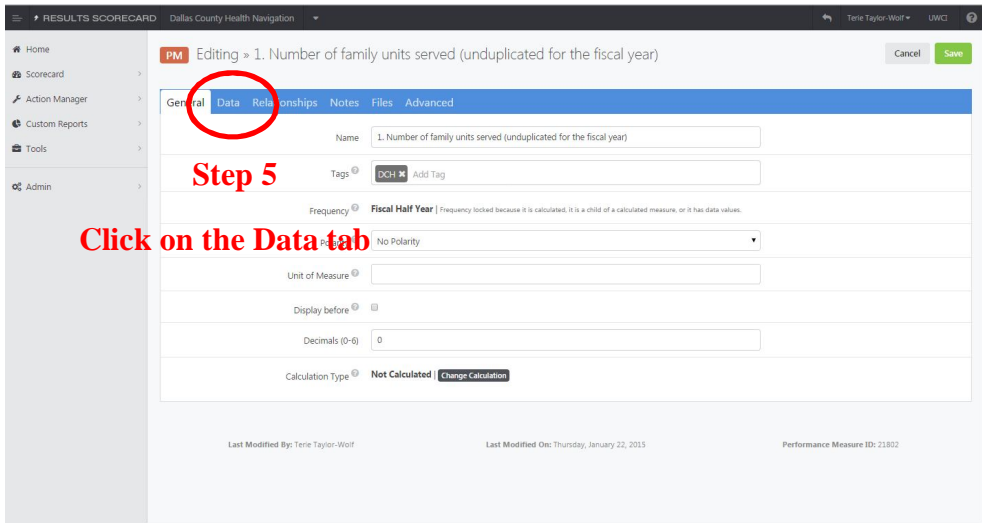


Step 4

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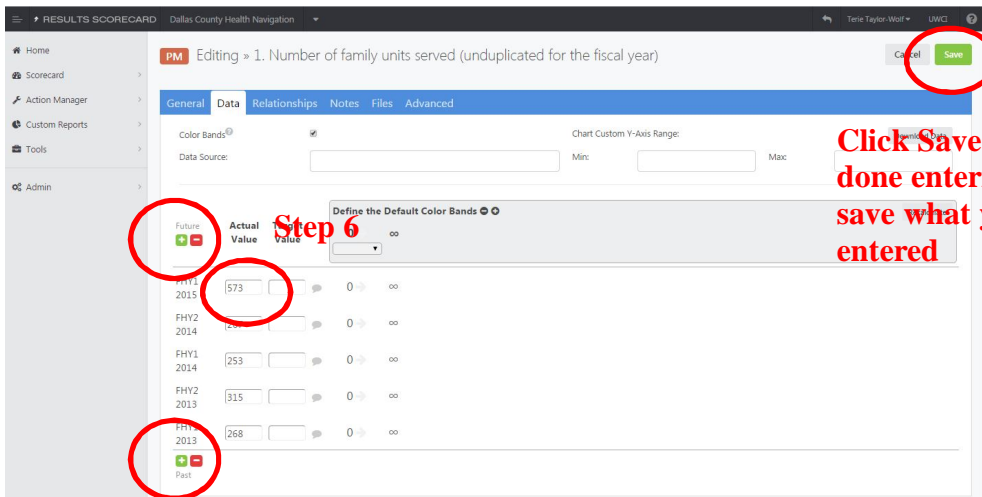
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Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Click Save button when done entering data to save what you have entered

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

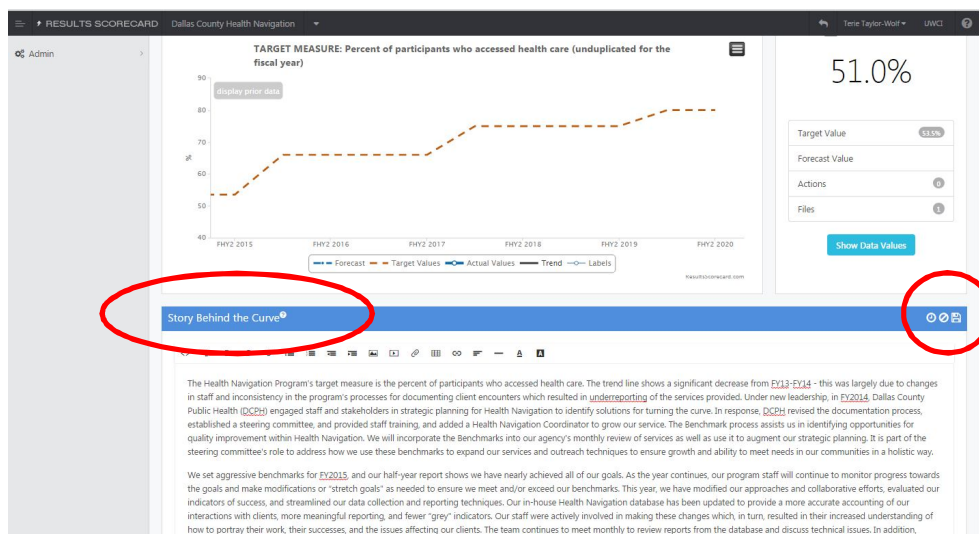
TimeFrame	Date Range
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Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



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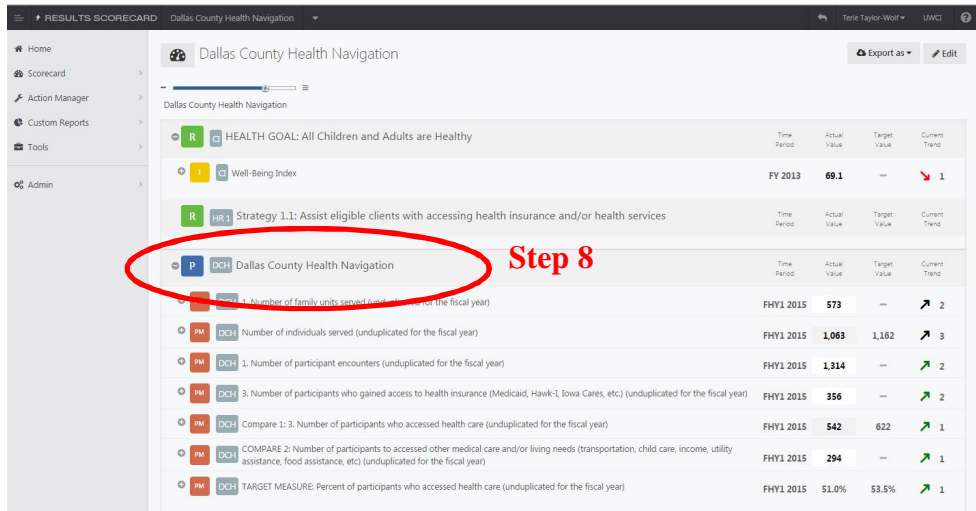
Step 7

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You will need to review and edit or answer the following questions pertaining to your program:

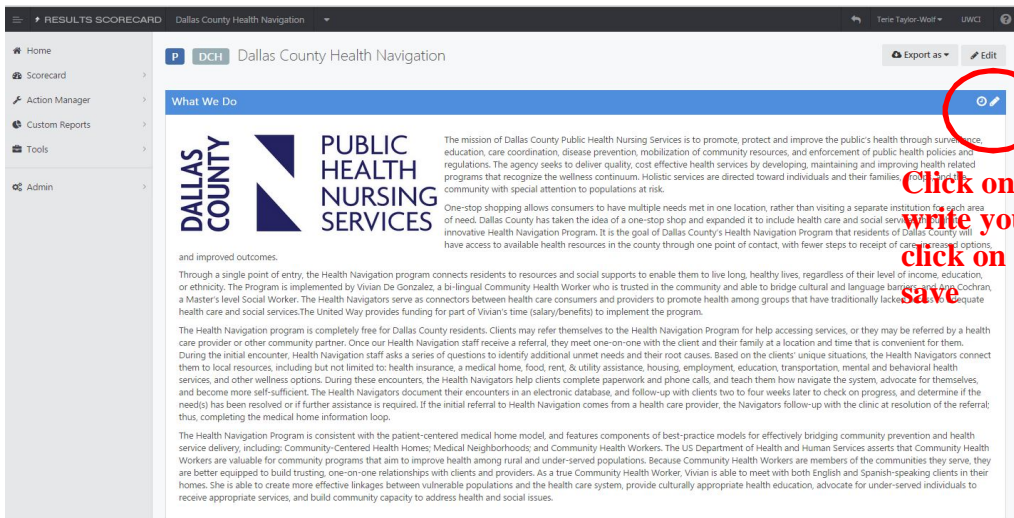
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

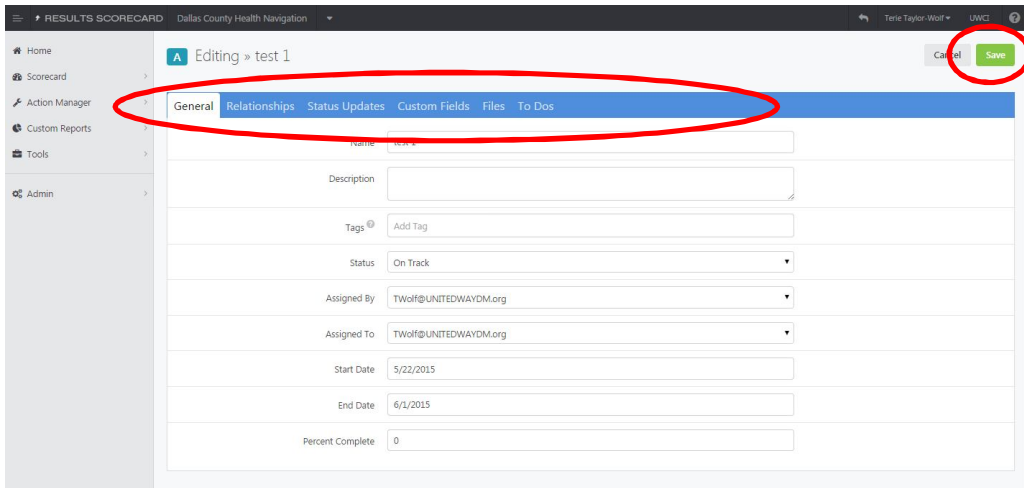


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

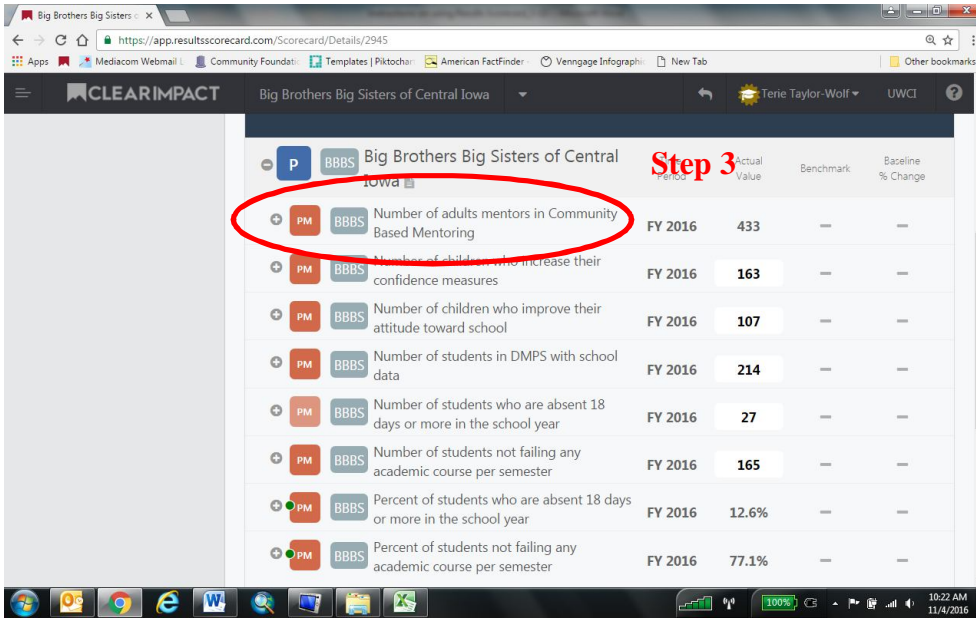
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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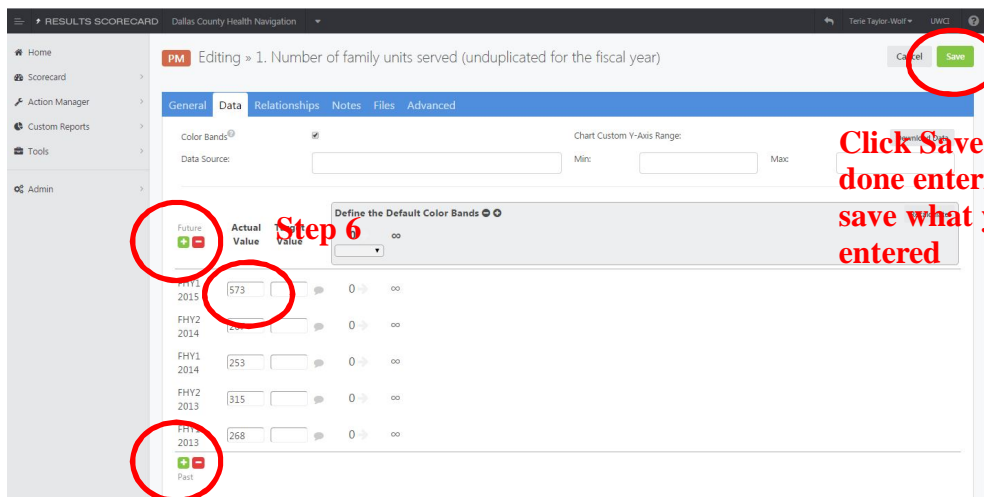
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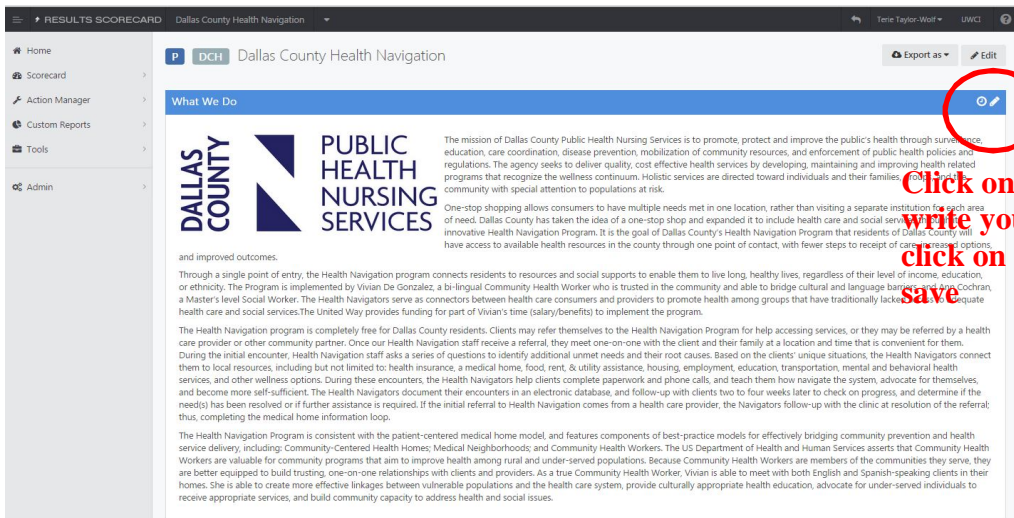
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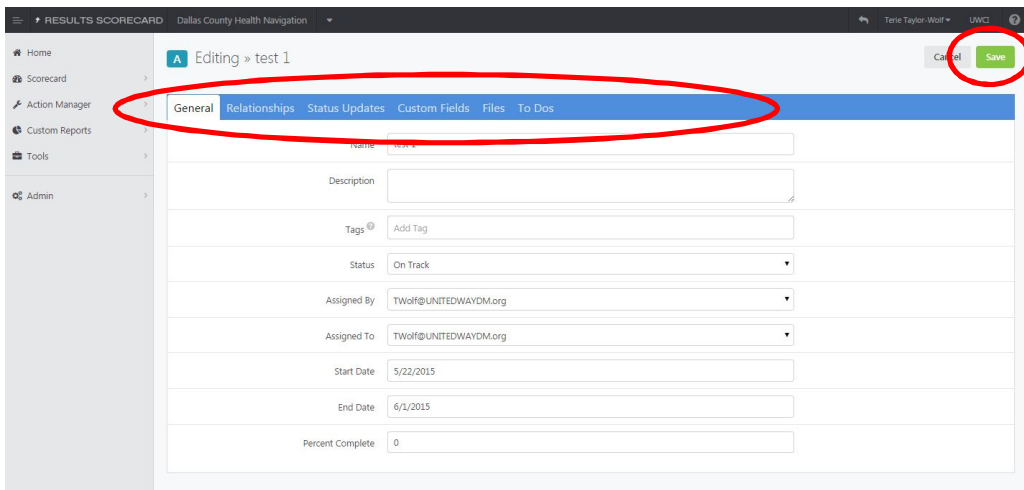


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Kane	1st half	1st half	Jody	1st half	1st half
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Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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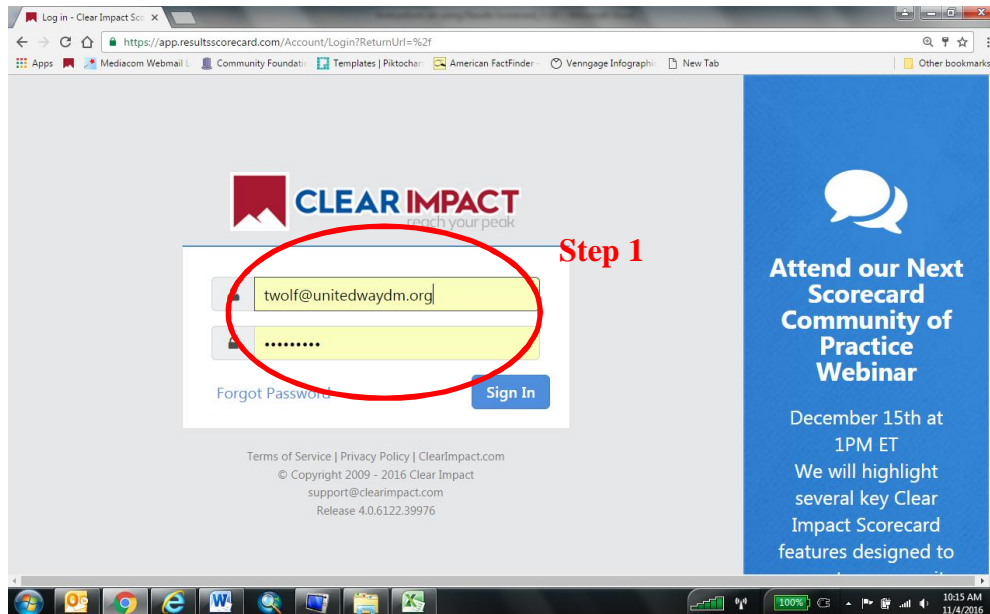
Instructions on using Results Scorecard

Step 1: Login

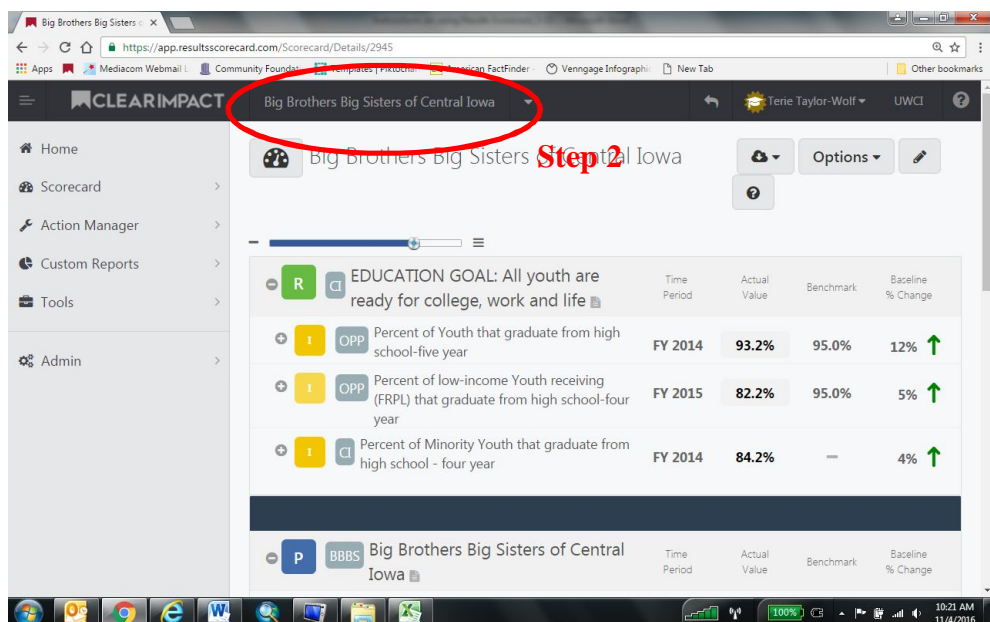
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table below shows the following data:

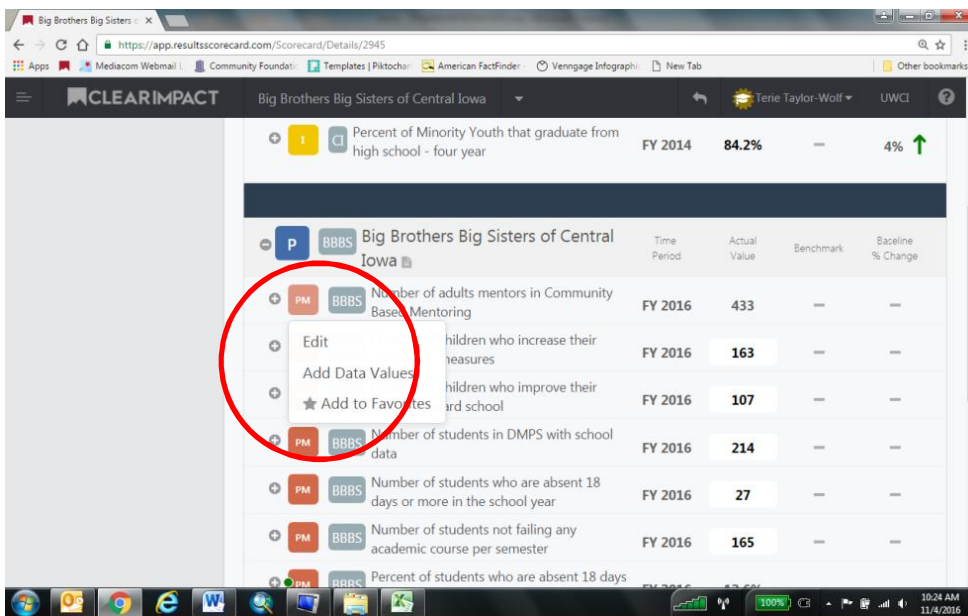
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
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HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a pencil icon circled in red. The text in this section describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to address these issues.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image, but with the text area expanded. The text describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to address these issues. A disk icon is circled in red at the bottom right of the text area, indicating where to click to save the narrative.

Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name

Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
DCH COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
DCH TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



Step 9

Optional Step 10: For those of you who want to track “Actions” from your Action Plan, click on “New Action” to create an action or “Existing Action” if you already have an assigned action you wish to review or edit.

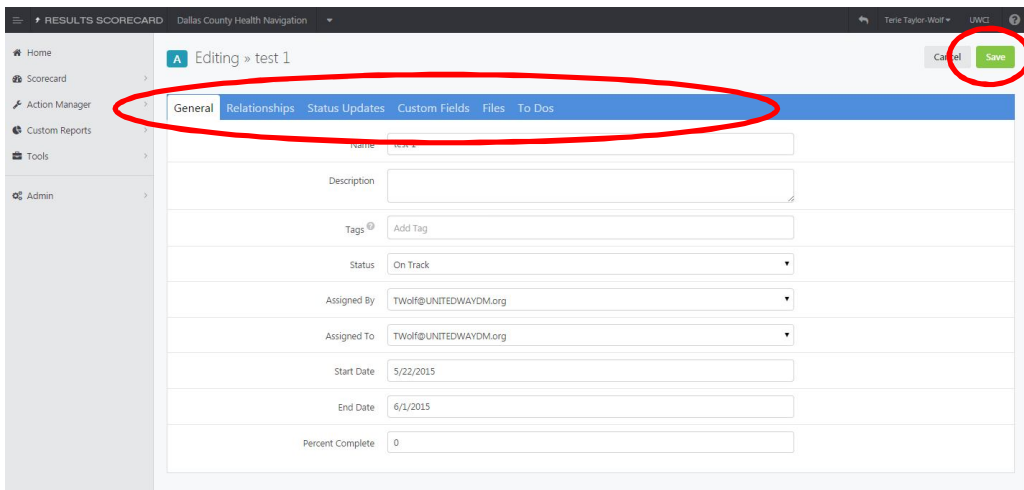


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
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Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

For Income Programming, contact Corinne Lambert at 246-6542 or e-mail at clambert@unitedwaydm.org

Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"

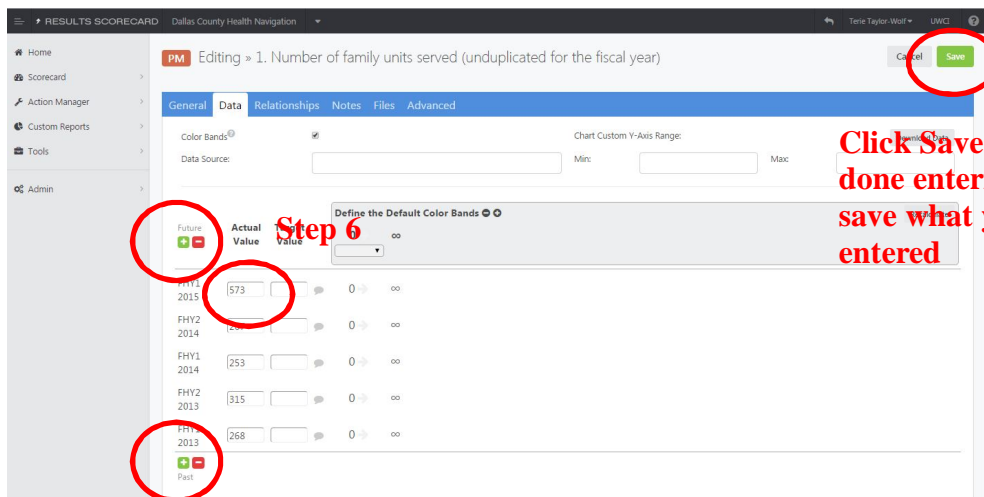


Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
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HY1	July 1-Dec. 31
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



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Step 7

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HEALTH GOAL: All Children and Adults are Healthy				
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1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
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One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

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Step 9

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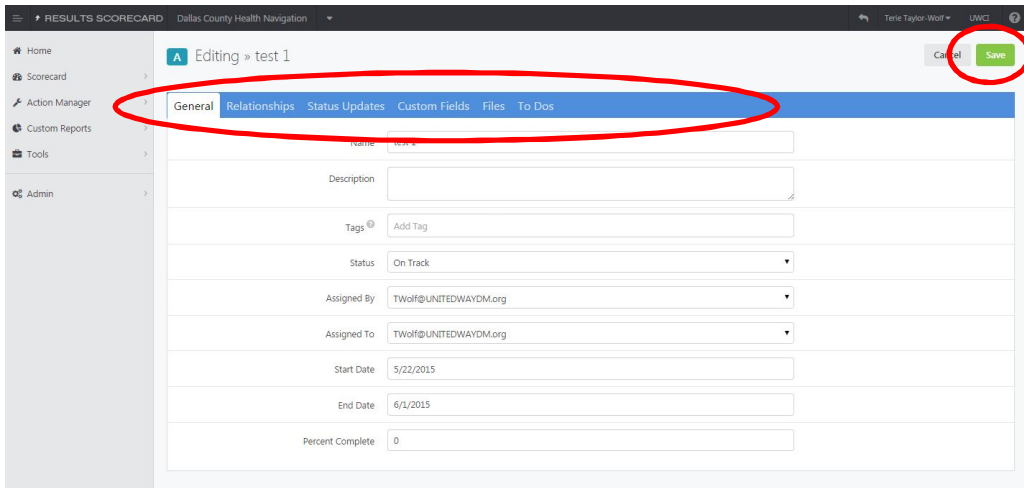


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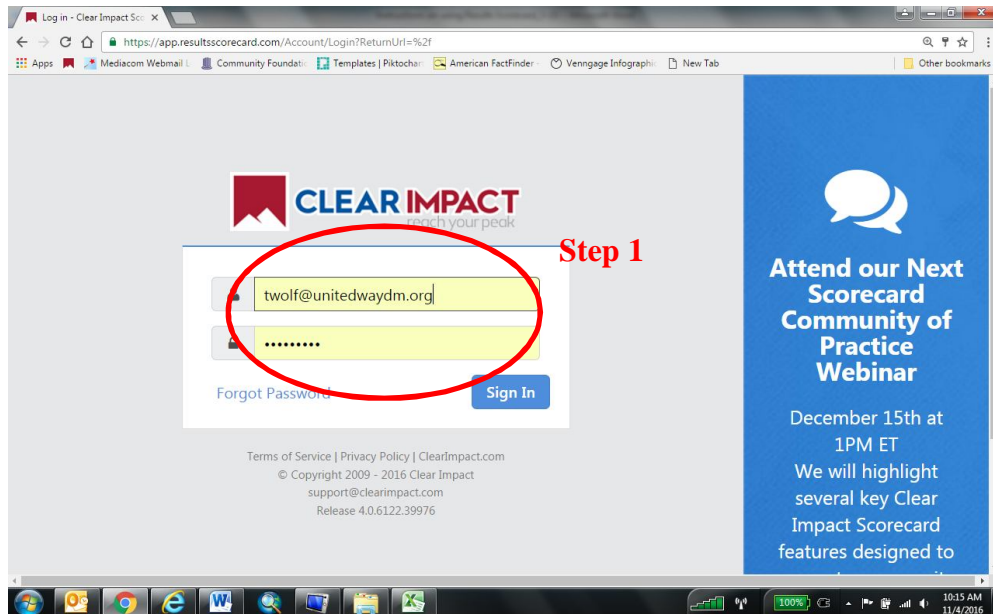
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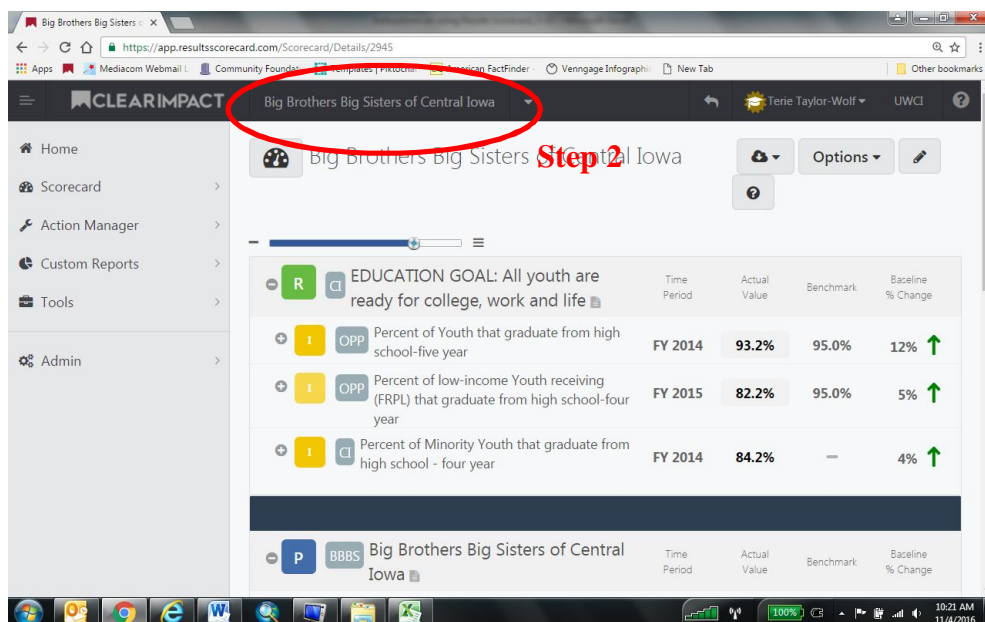
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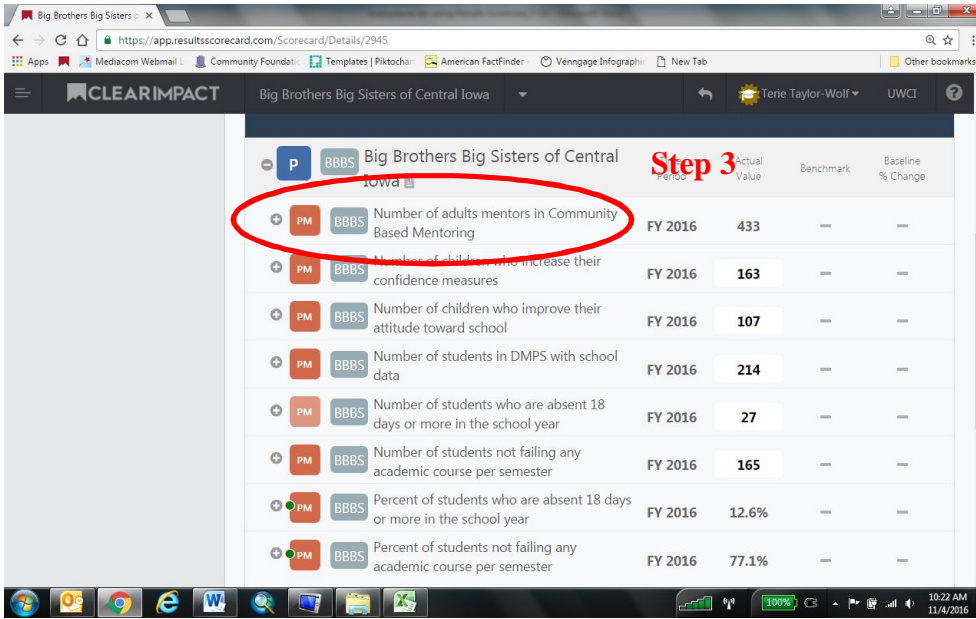
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



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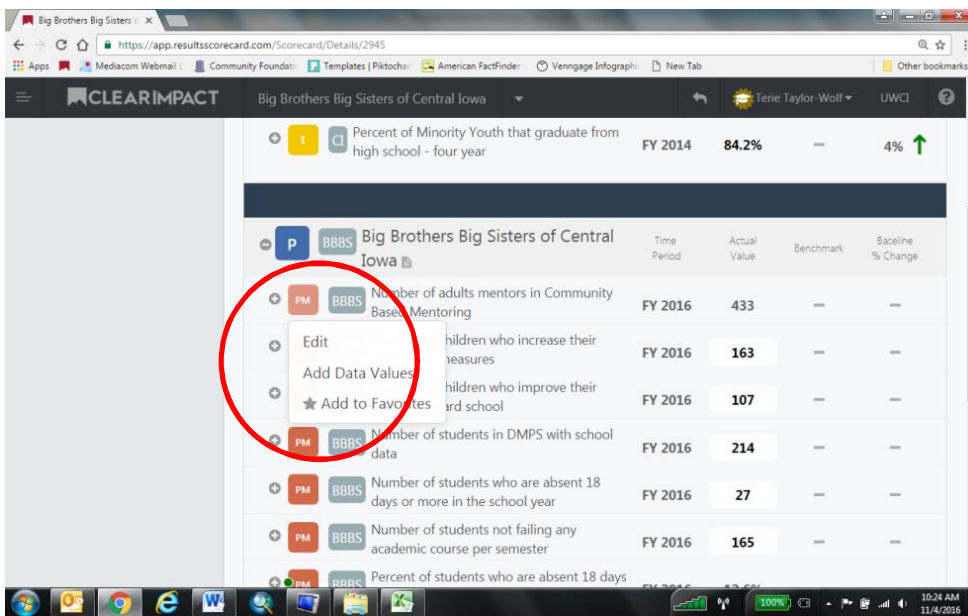


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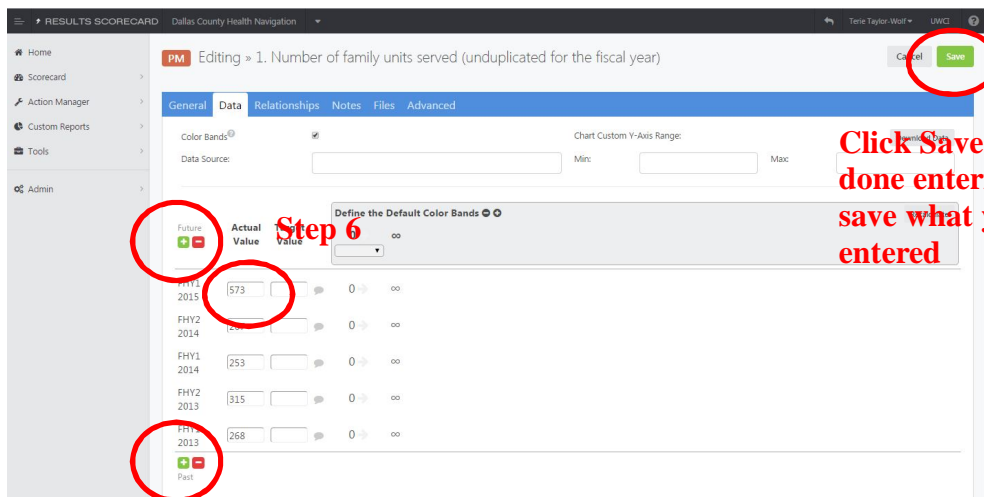
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Step 5
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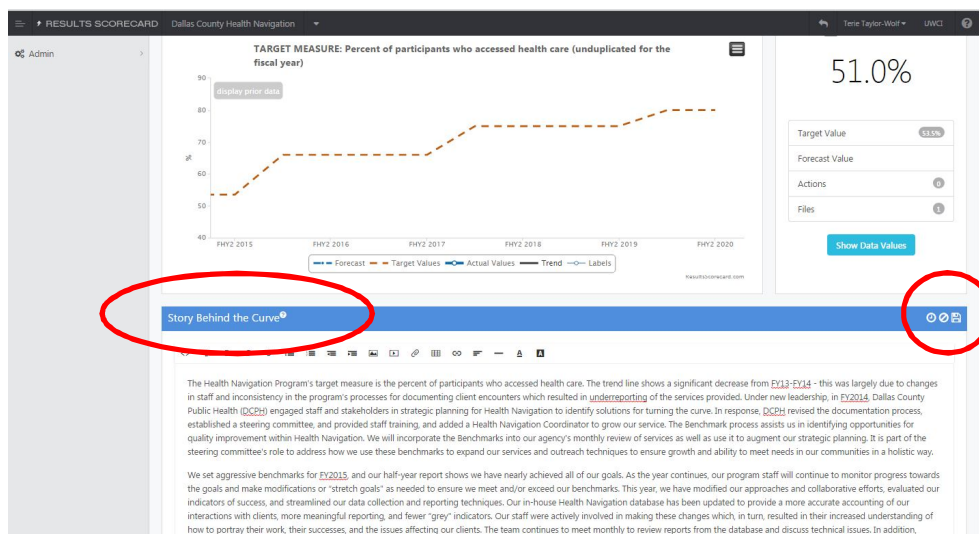
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Step 7



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Step 7

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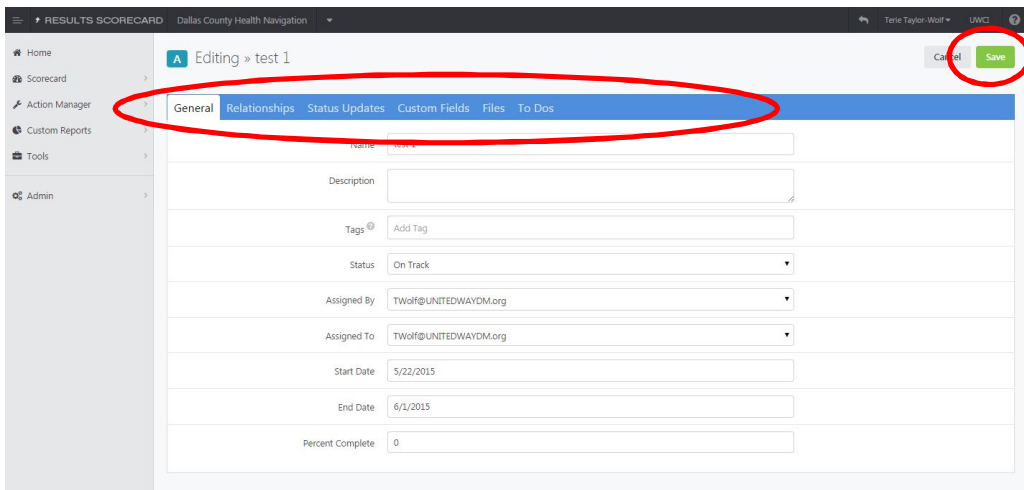


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Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
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FY 2012	515	—	—
FY 2011	496	—	—

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Step 4

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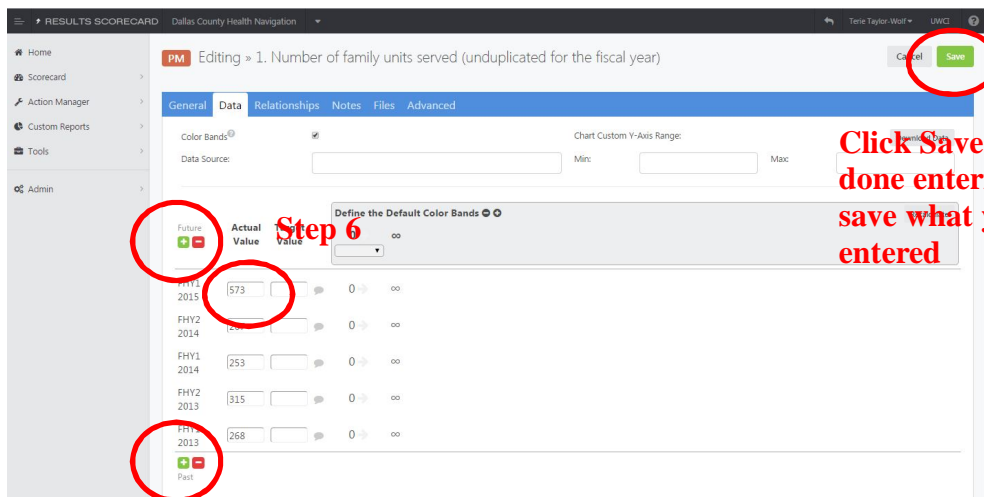


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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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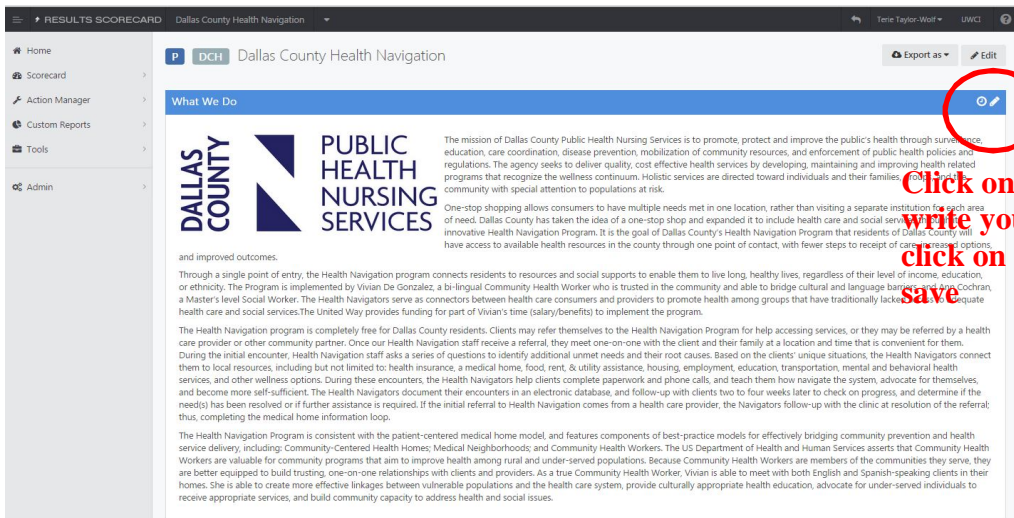
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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

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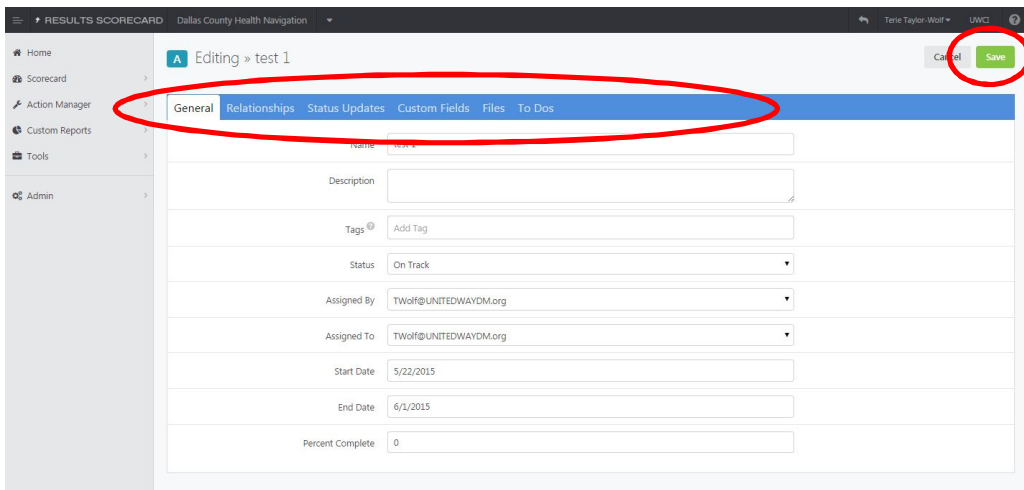


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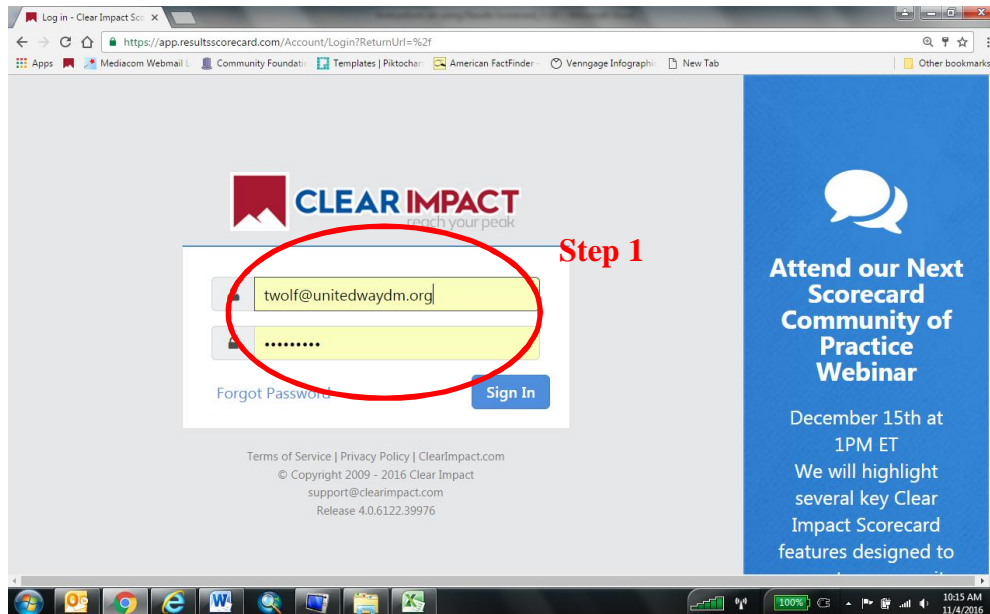
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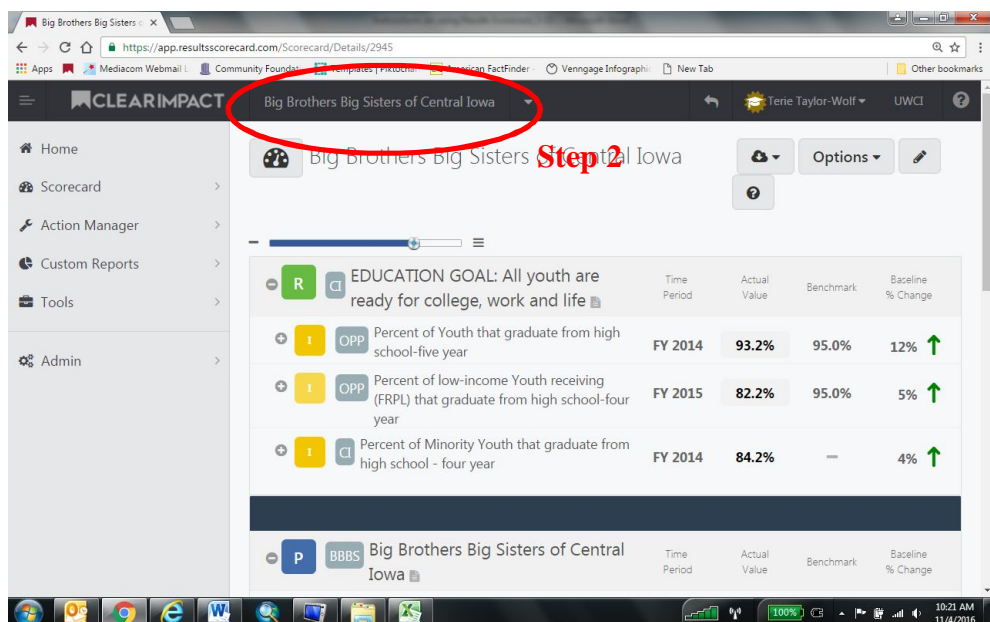
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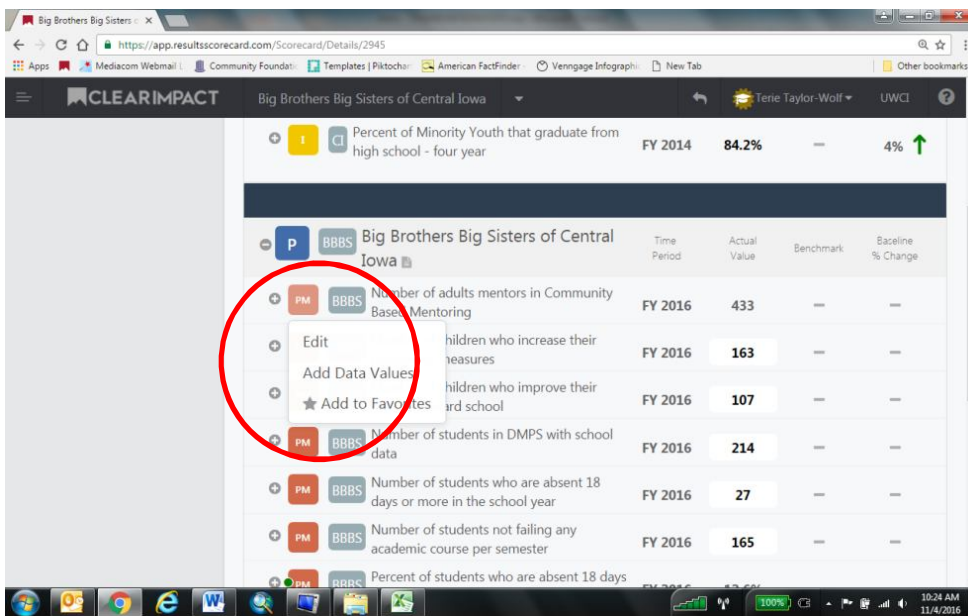
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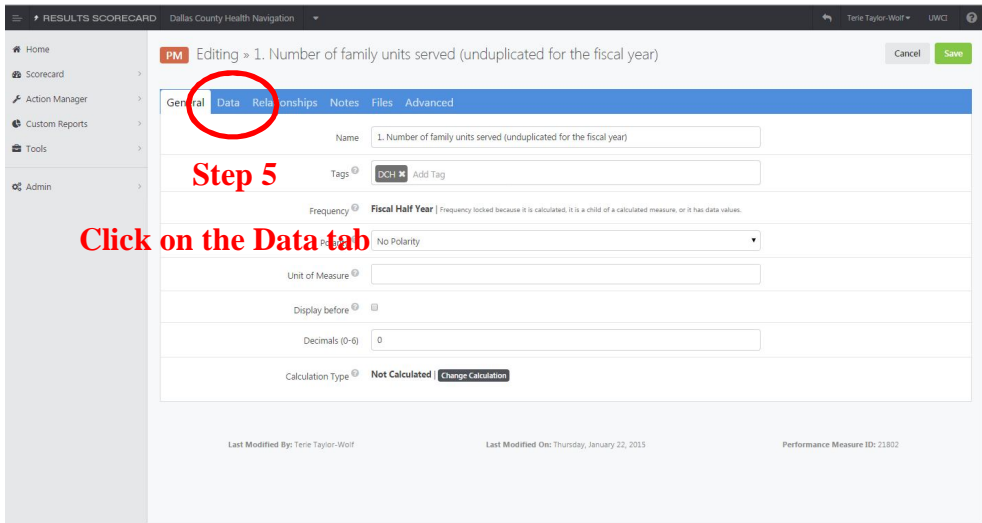
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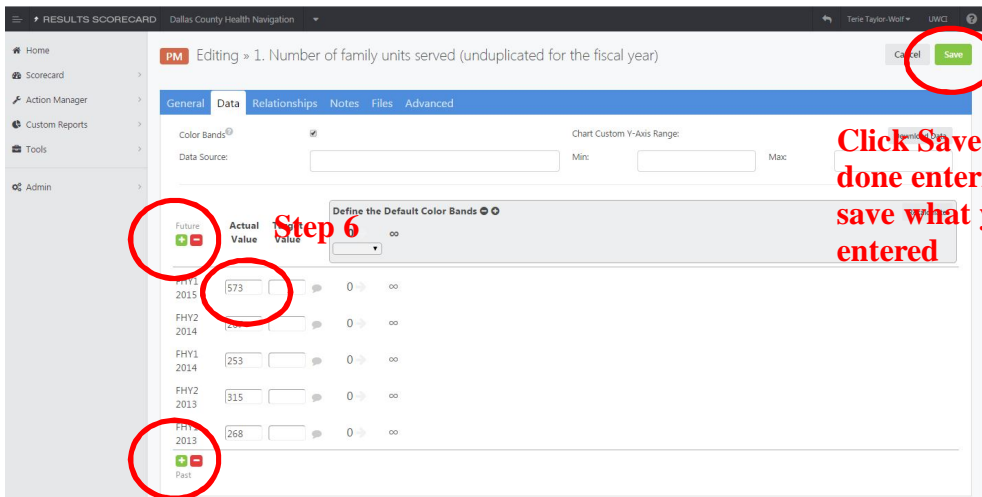
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Step 5
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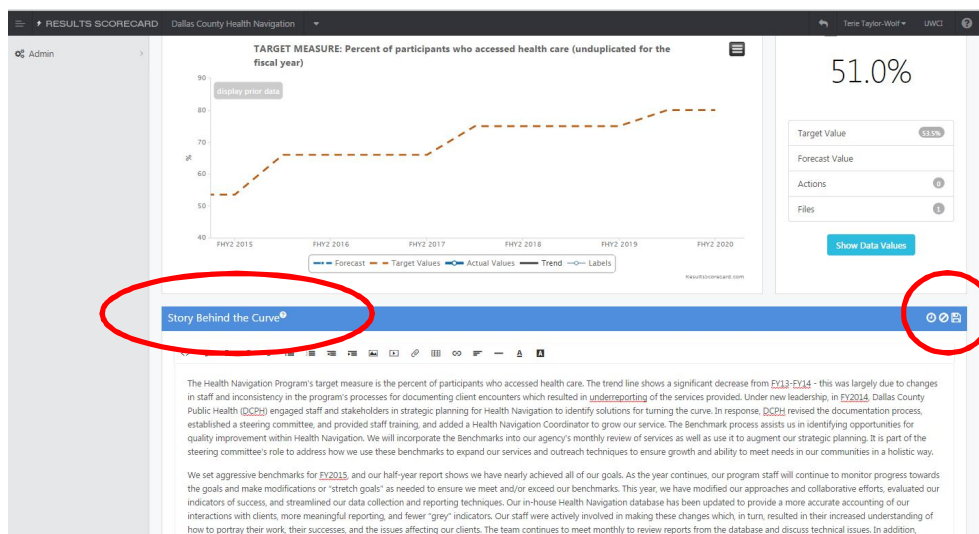
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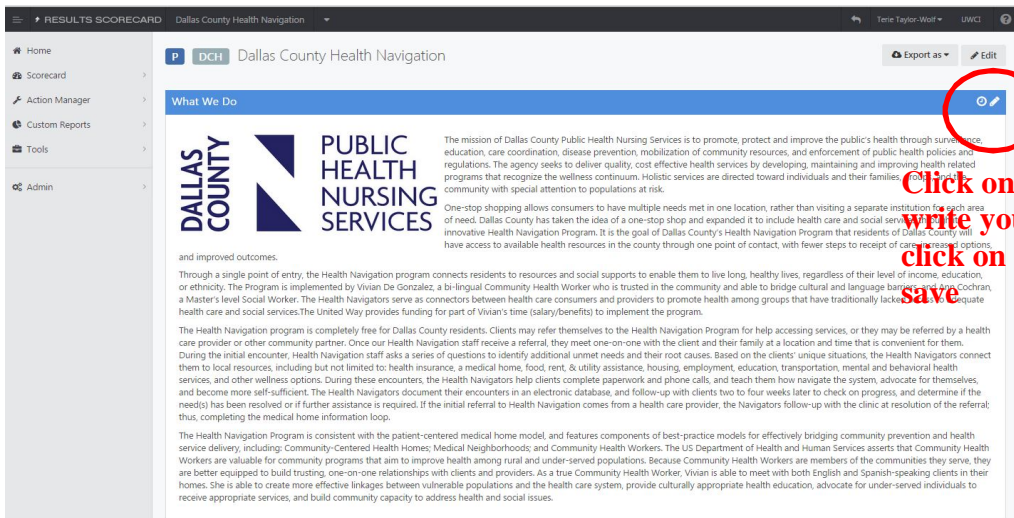
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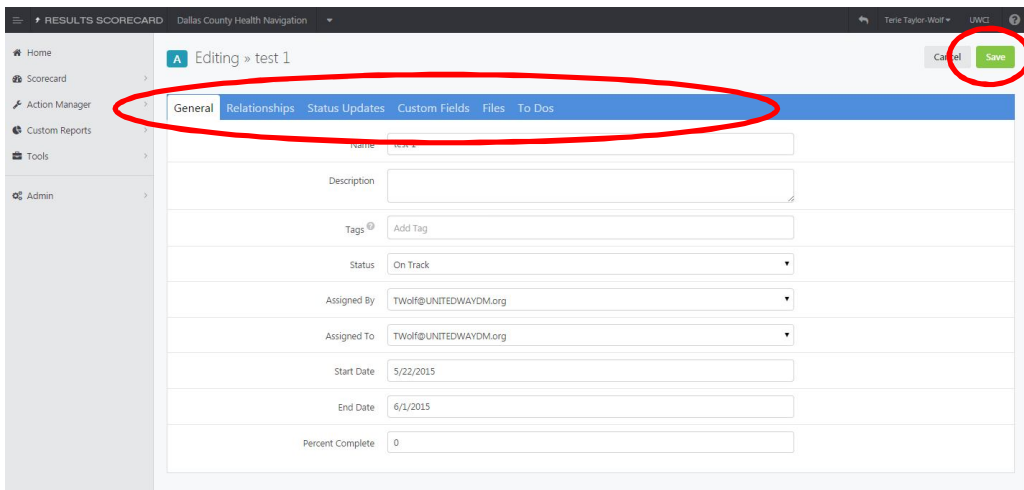


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Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
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Tim	1st half	1st half	Myra	1st half	2nd half
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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure. A line graph displays the data from FY 2011 to FY 2016, showing a peak in FY 2013. The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
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Step 4

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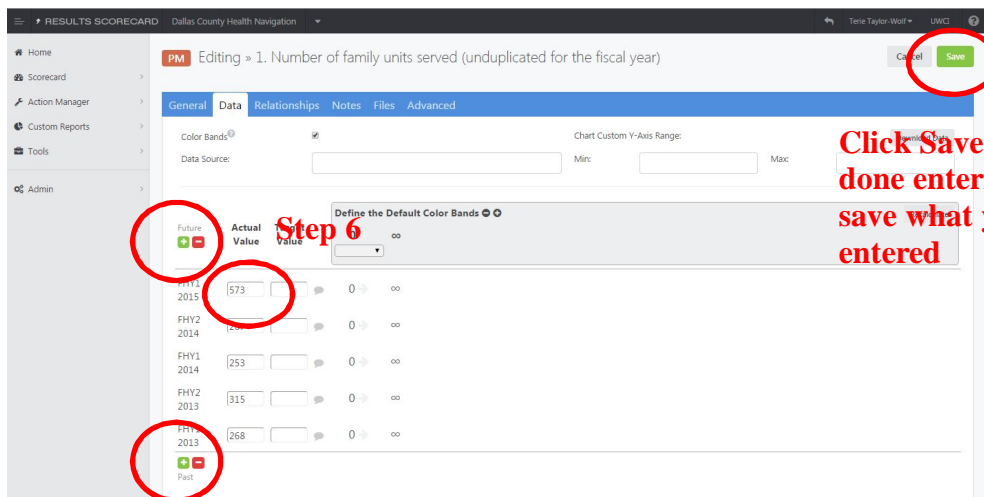
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Step 5
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Click Save button when done entering data to save what you have entered

Step 6

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Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s)). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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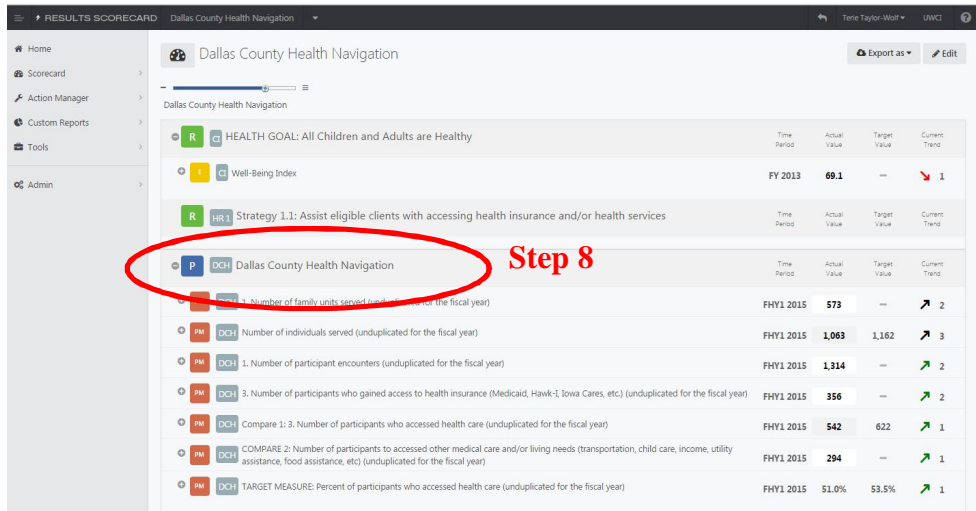
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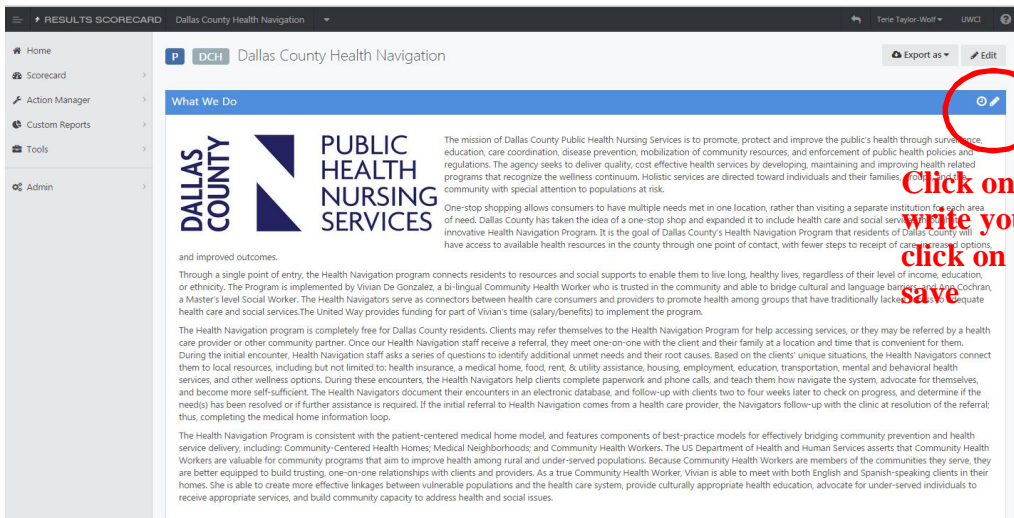
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Program	Time Period	Actual Value	Target Value	Current Trend
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Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
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1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

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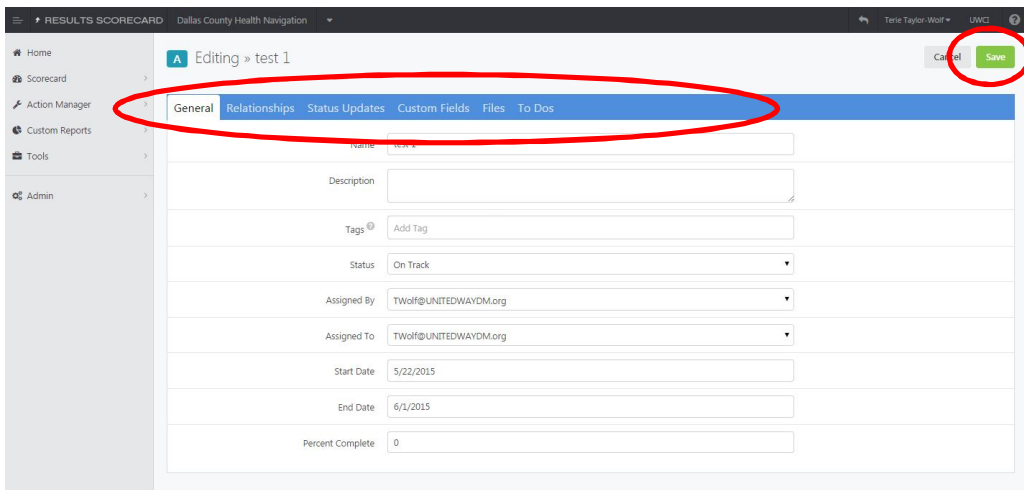


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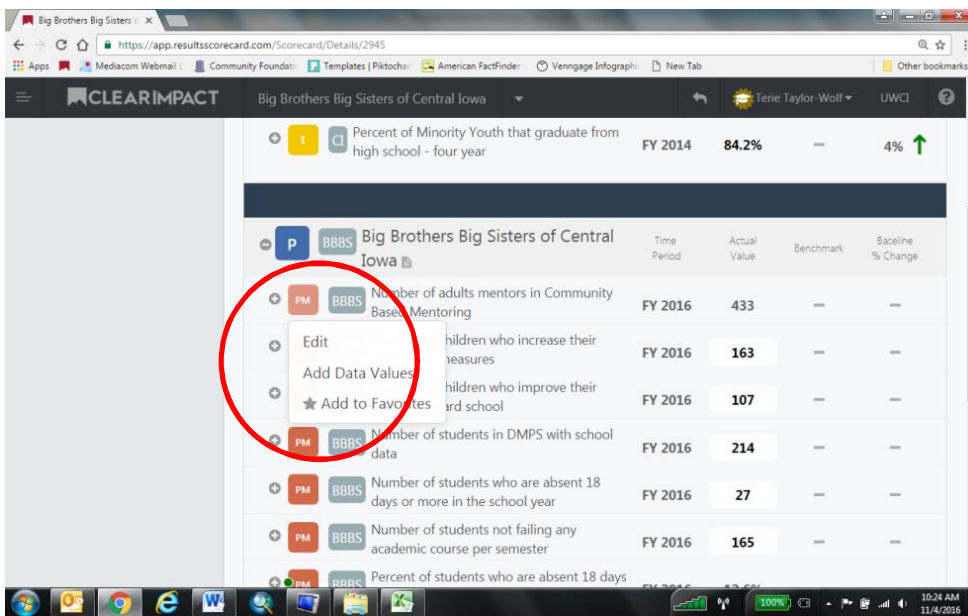
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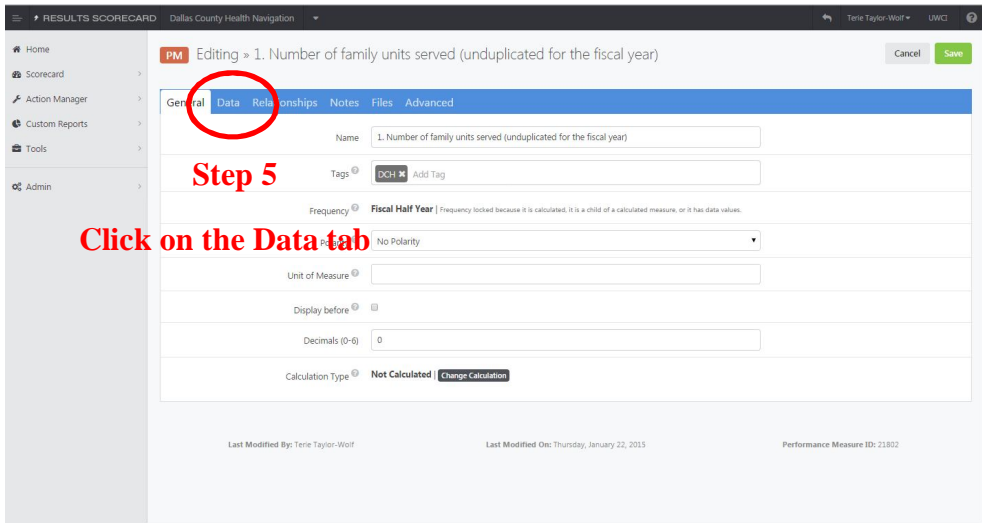


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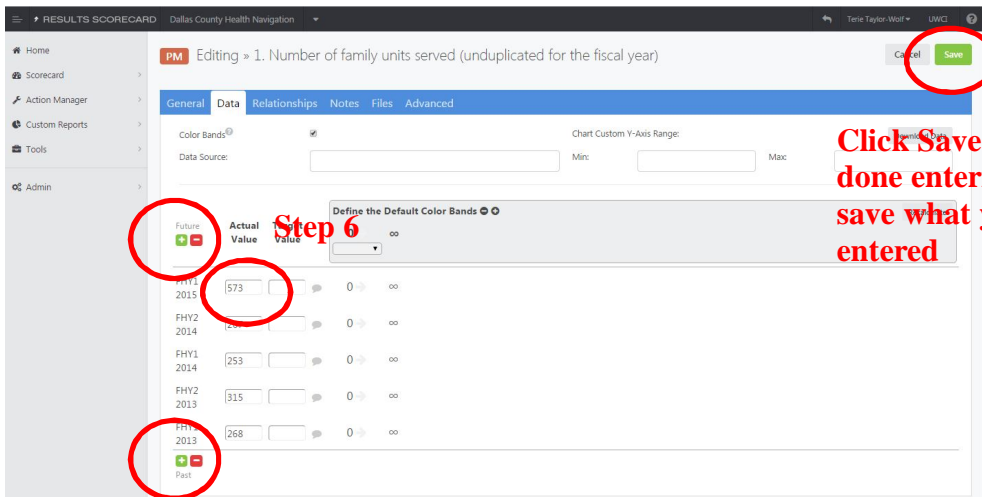


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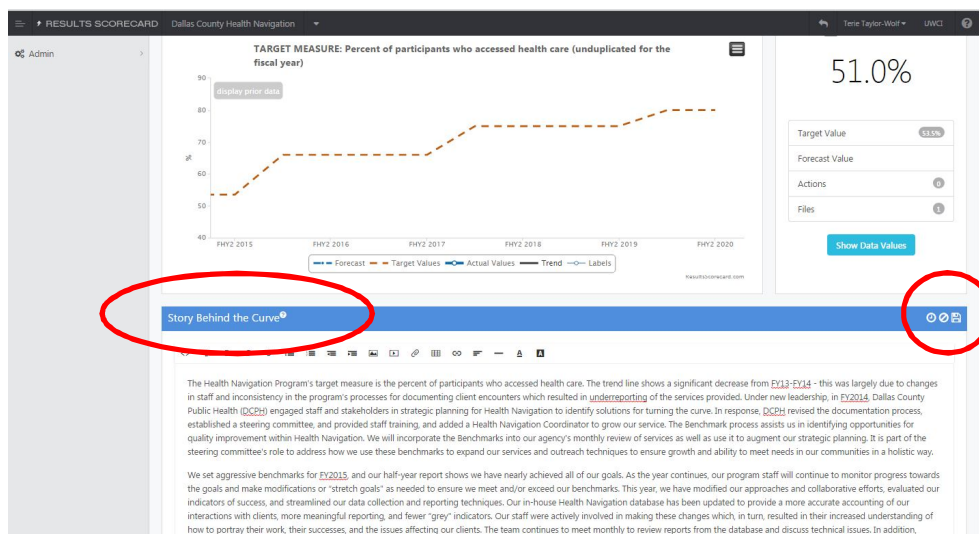
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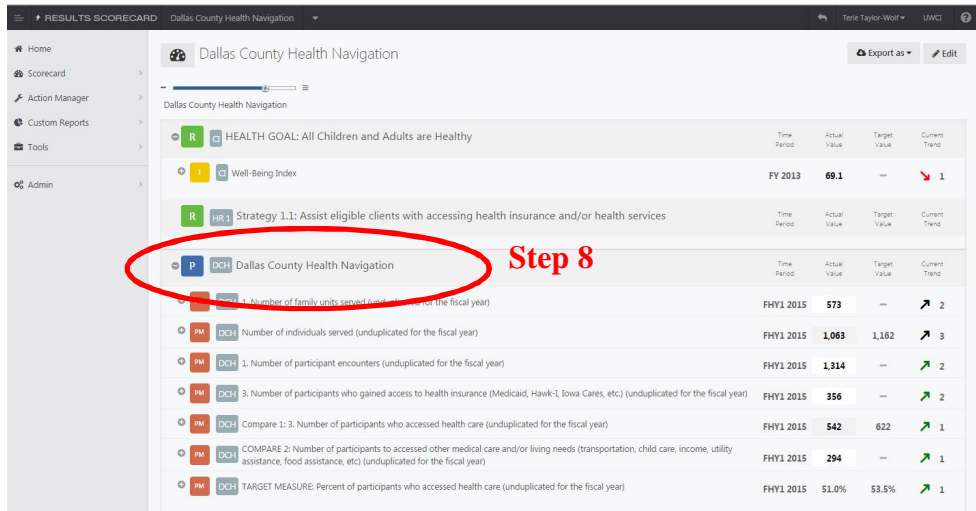
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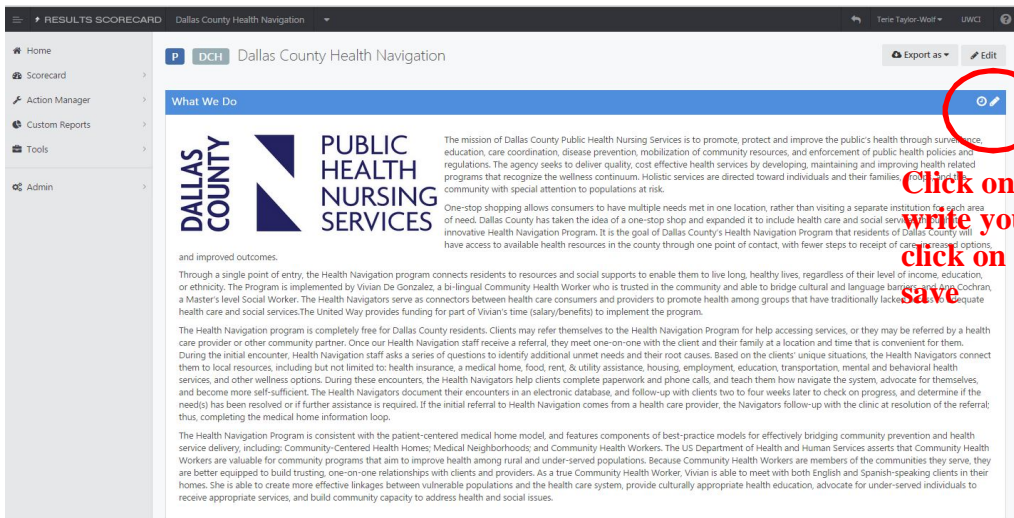
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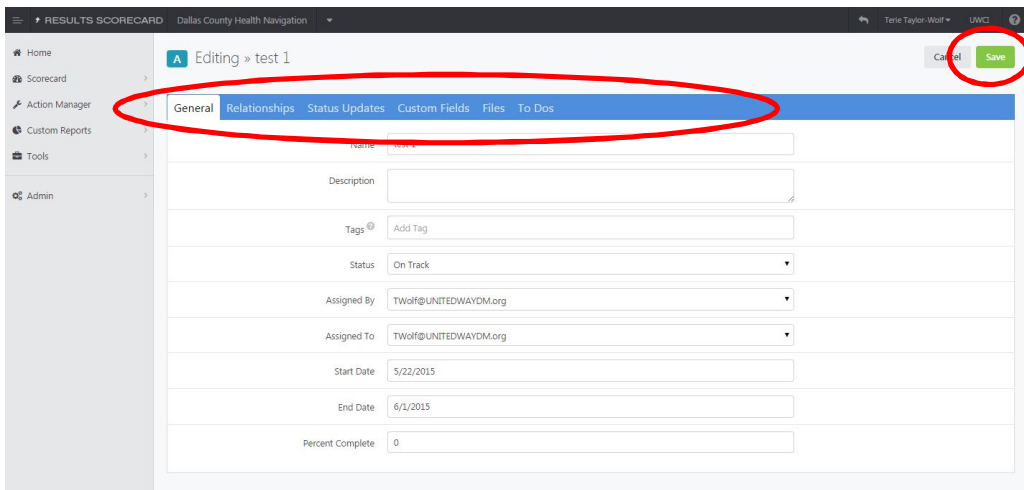


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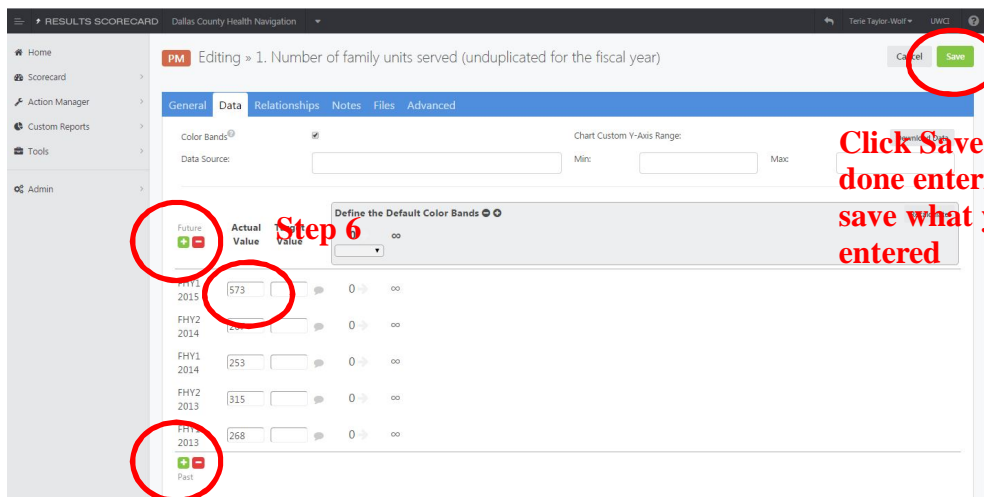
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Click Save button when done entering data to save what you have entered

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1. What We Do
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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

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Step 8

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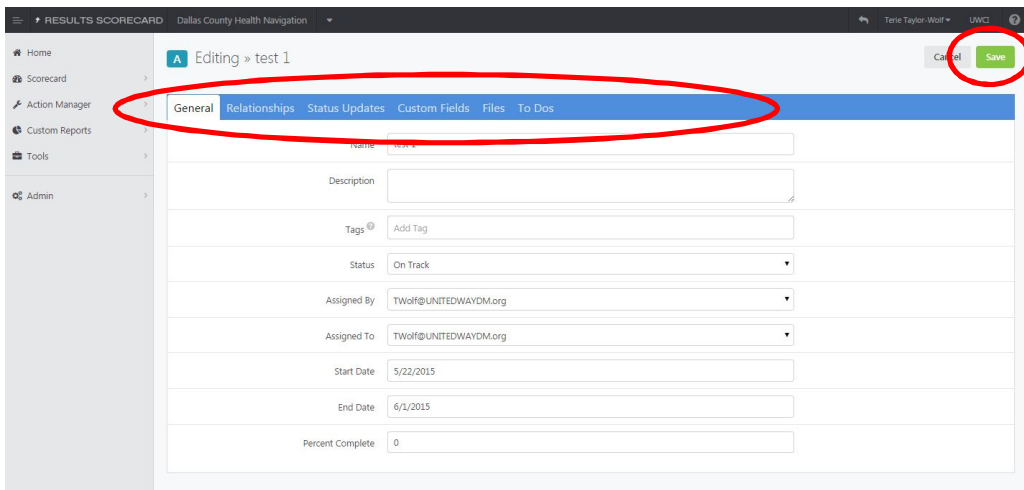


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Target Measure	57%	133%	80.0%

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# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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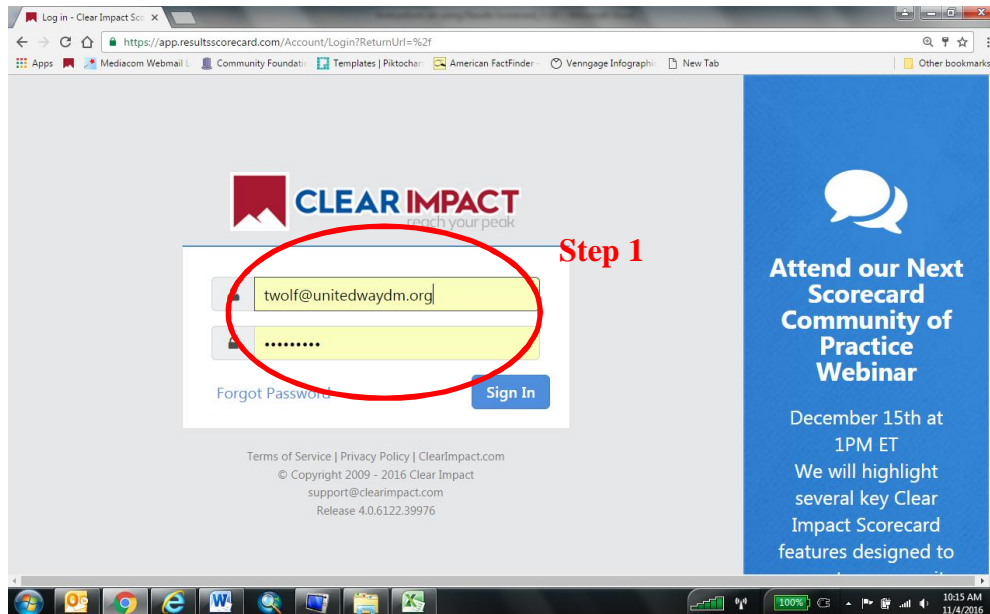
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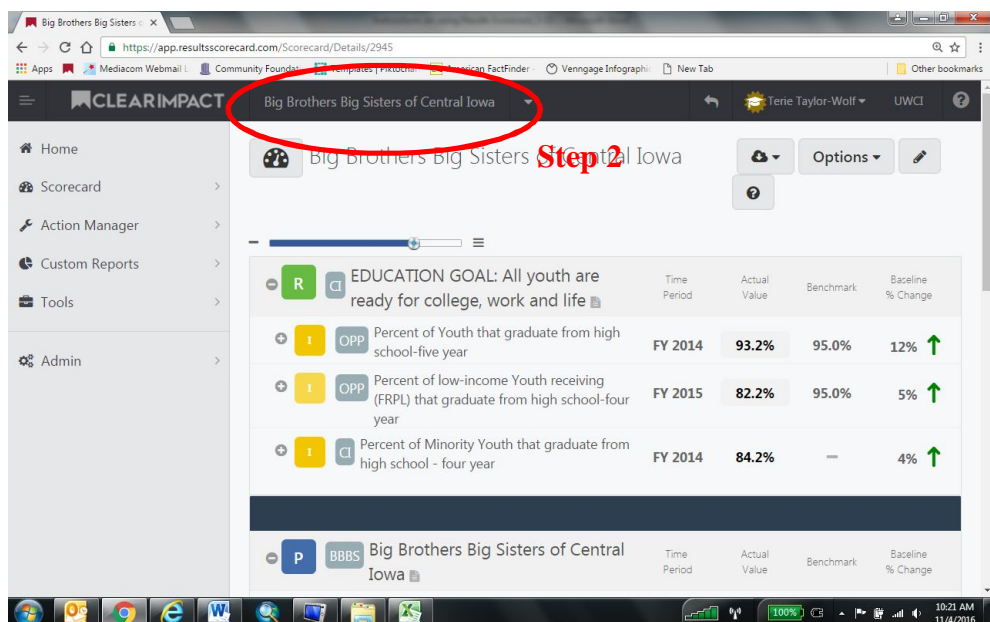
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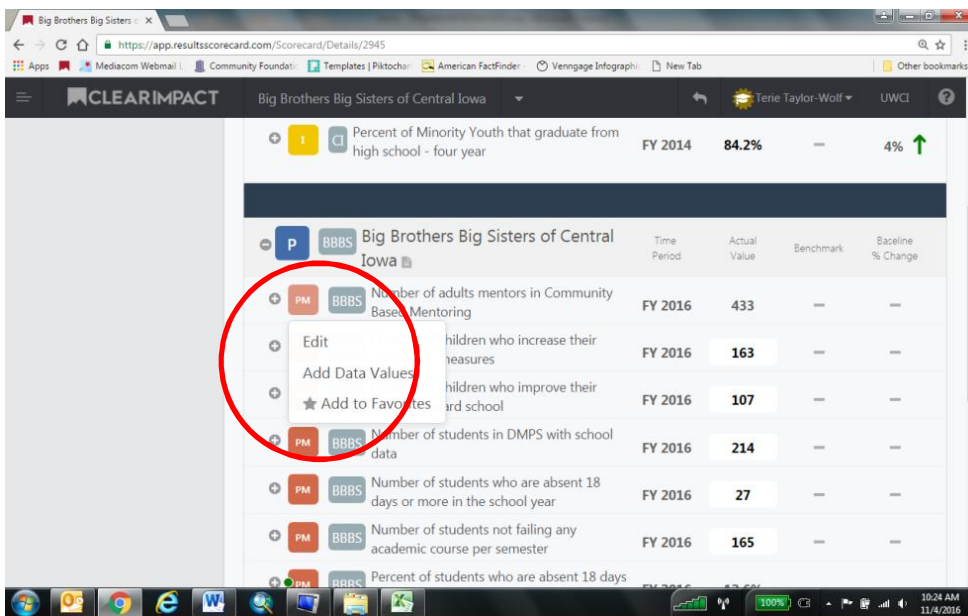
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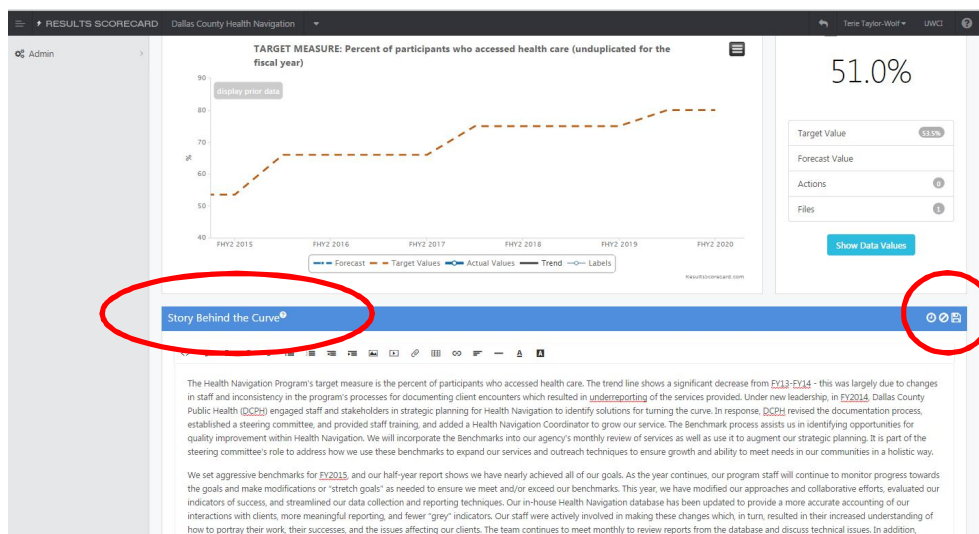
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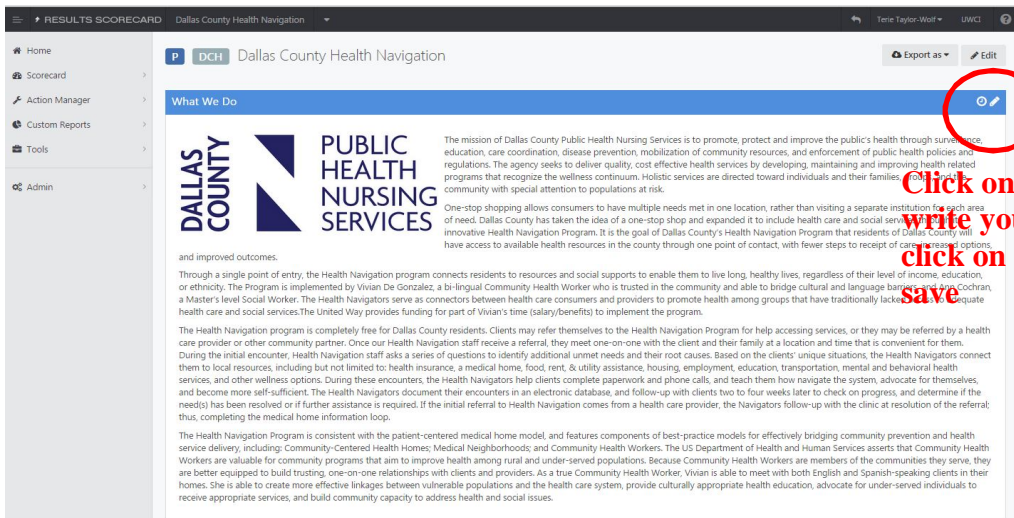
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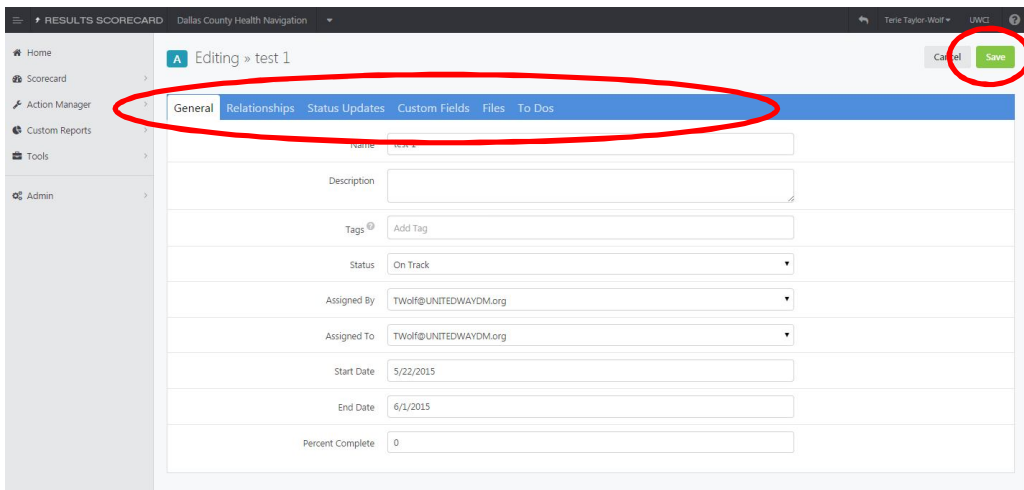


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Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
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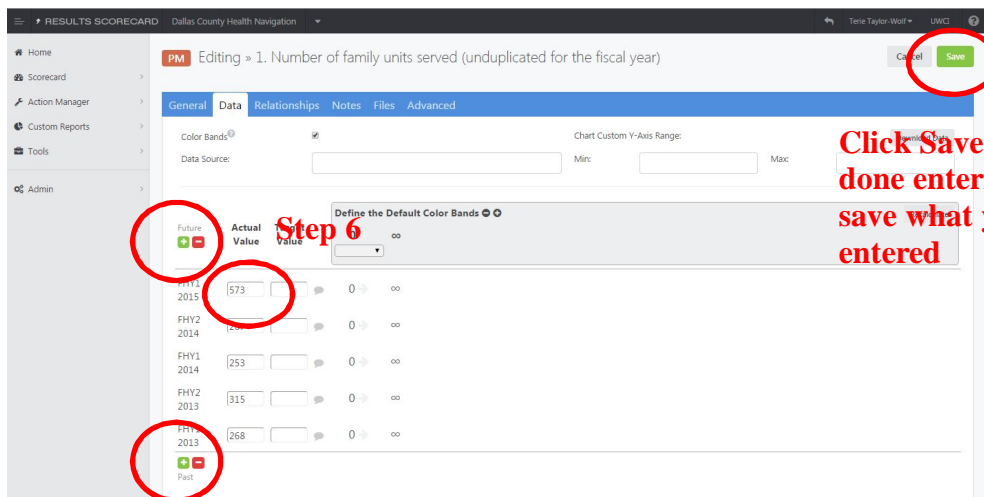
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Step 5
Click on the Data tab

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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s)). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

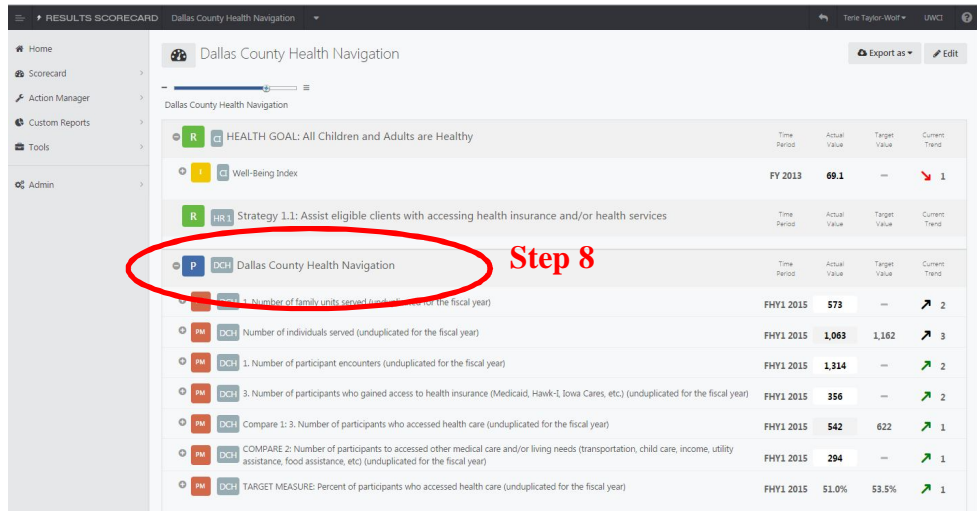
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You will need to review and edit or answer the following questions pertaining to your program:

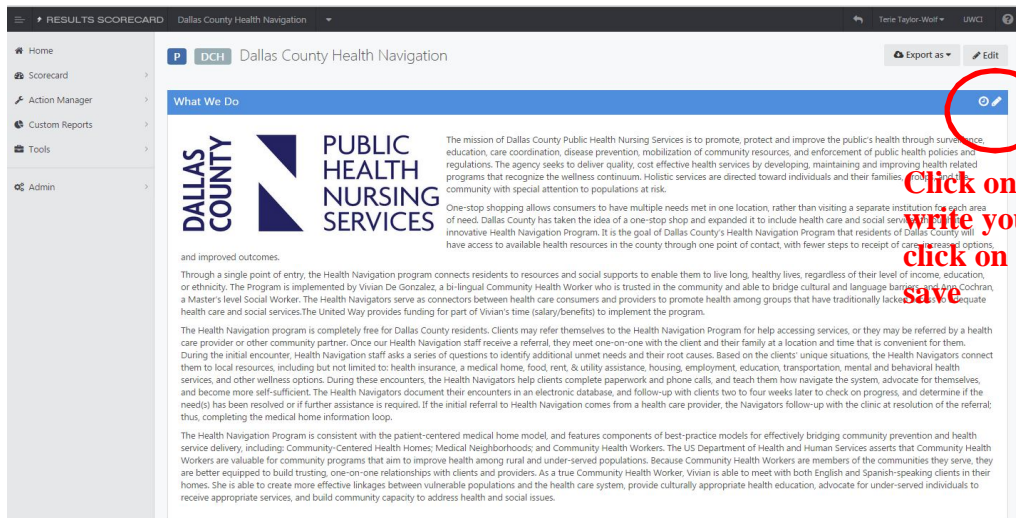
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

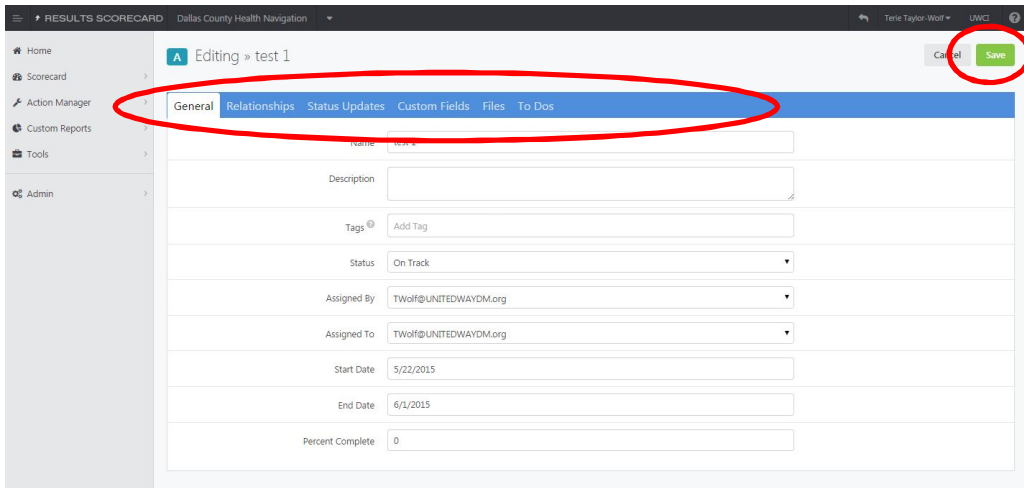


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

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Instructions on using Results Scorecard

Step 1: Login

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Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. A red "Step 3" label is visible in the top right. A list of performance measures is shown, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

Performance Measure	FY 2016	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	FY 2016	433	—	—
Number of children who increase their confidence measures	FY 2016	163	—	—
Number of children who improve their attitude toward school	FY 2016	107	—	—
Number of students in DMPS with school data	FY 2016	214	—	—
Number of students who are absent 18 days or more in the school year	FY 2016	27	—	—
Number of students not failing any academic course per semester	FY 2016	165	—	—
Percent of students who are absent 18 days or more in the school year	FY 2016	12.6%	—	—
Percent of students not failing any academic course per semester	FY 2016	77.1%	—	—

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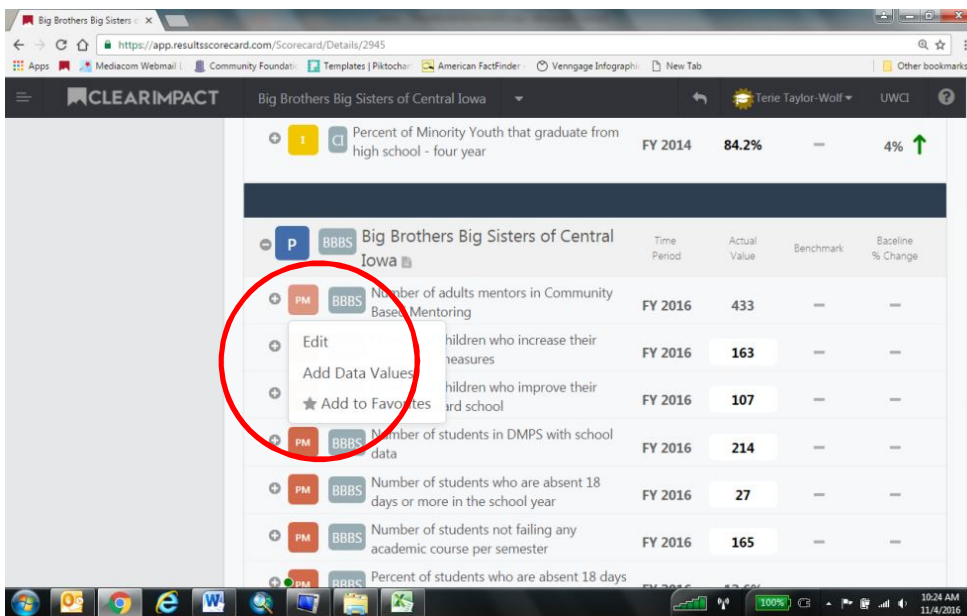
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

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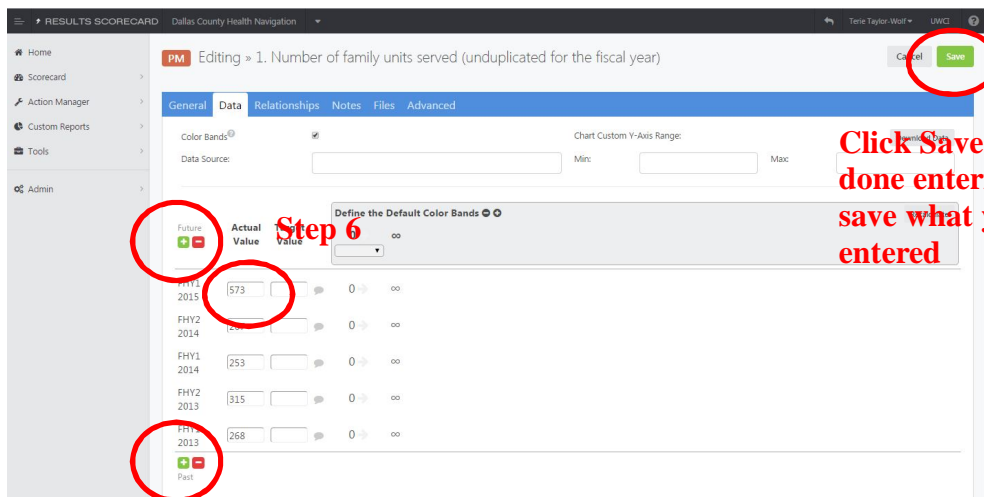
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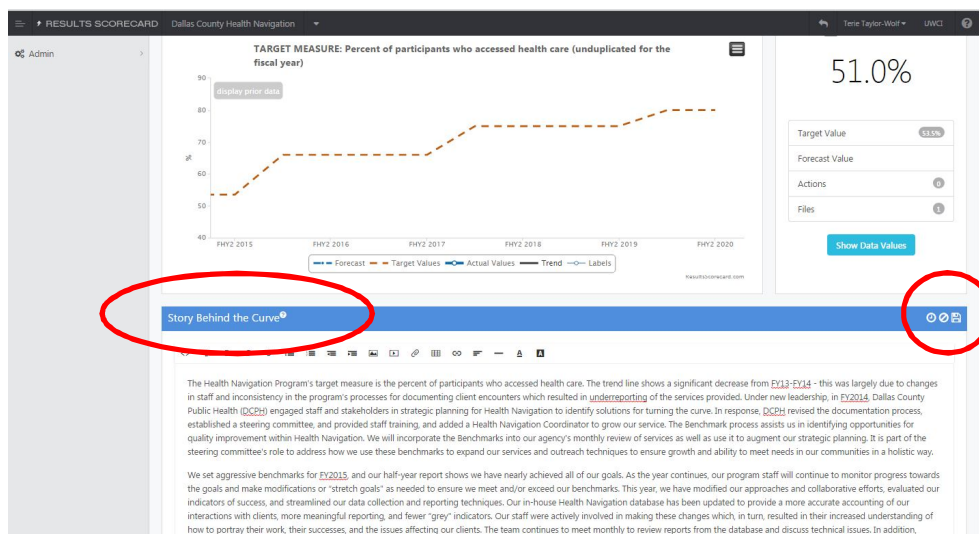
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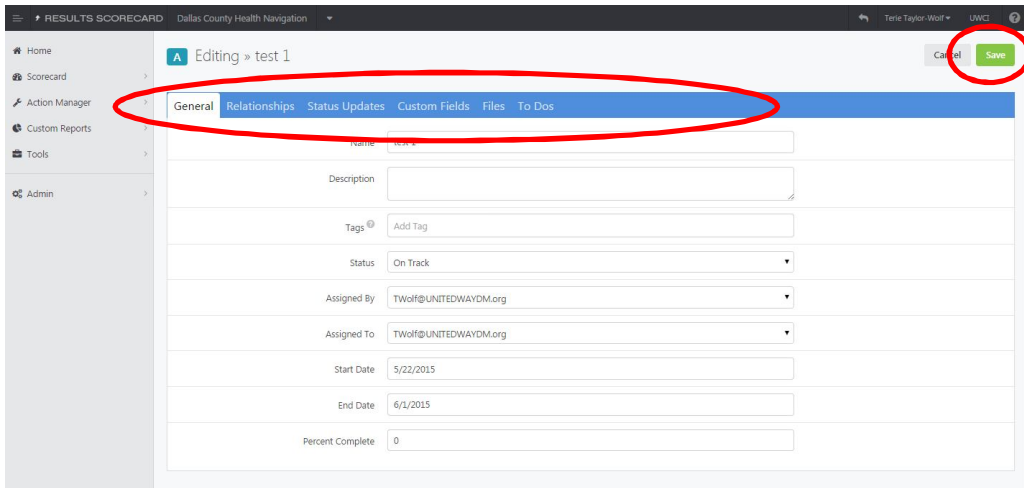


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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

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Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Step 3" and it displays a table of performance measures. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table includes columns for the performance measure, time period, actual value, benchmark, and baseline % change.

Performance Measure	Time Period	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	FY 2016	433	—	—
Number of children who increase their confidence measures	FY 2016	163	—	—
Number of children who improve their attitude toward school	FY 2016	107	—	—
Number of students in DMPS with school data	FY 2016	214	—	—
Number of students who are absent 18 days or more in the school year	FY 2016	27	—	—
Number of students not failing any academic course per semester	FY 2016	165	—	—
Percent of students who are absent 18 days or more in the school year	FY 2016	12.6%	—	—
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Time Period	Actual Value	Benchmark	Baseline % Change
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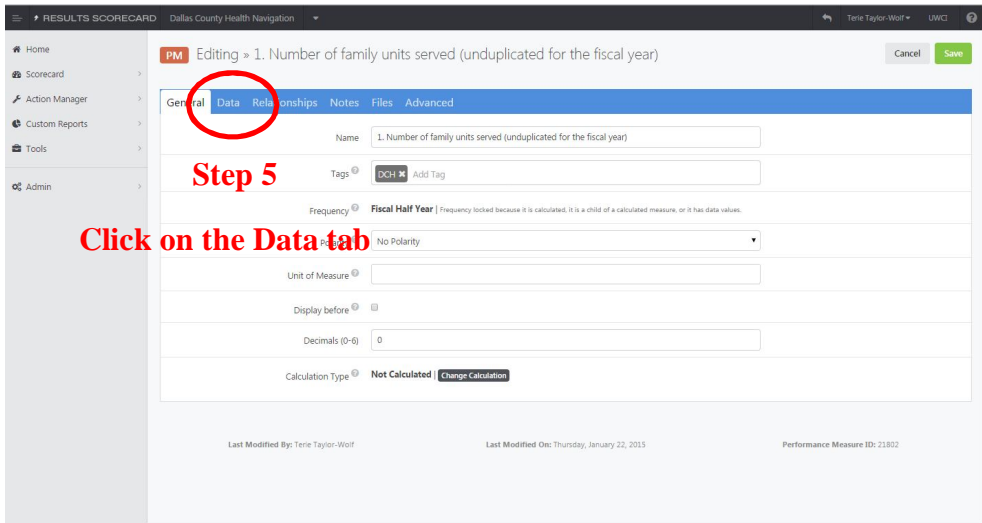


Step 4

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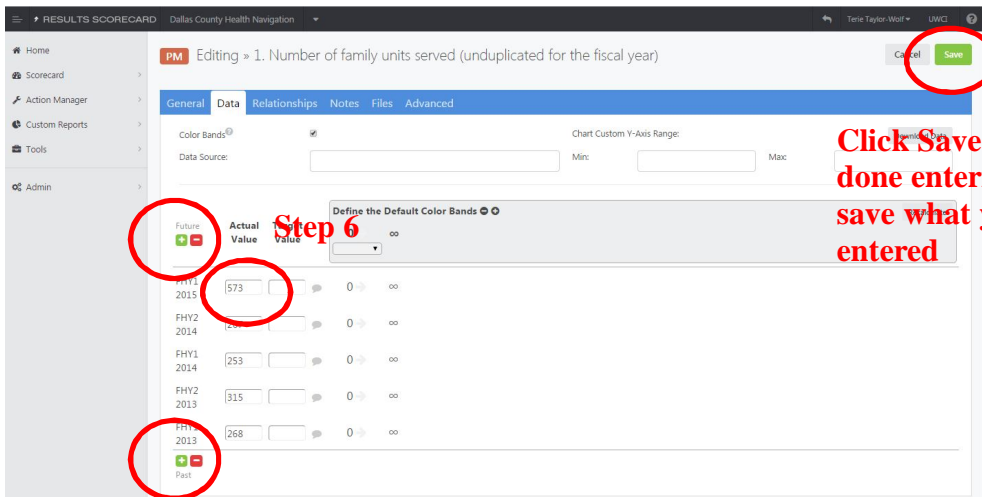
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Step 5
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TimeFrame	Date Range
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name

Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The result is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral, thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

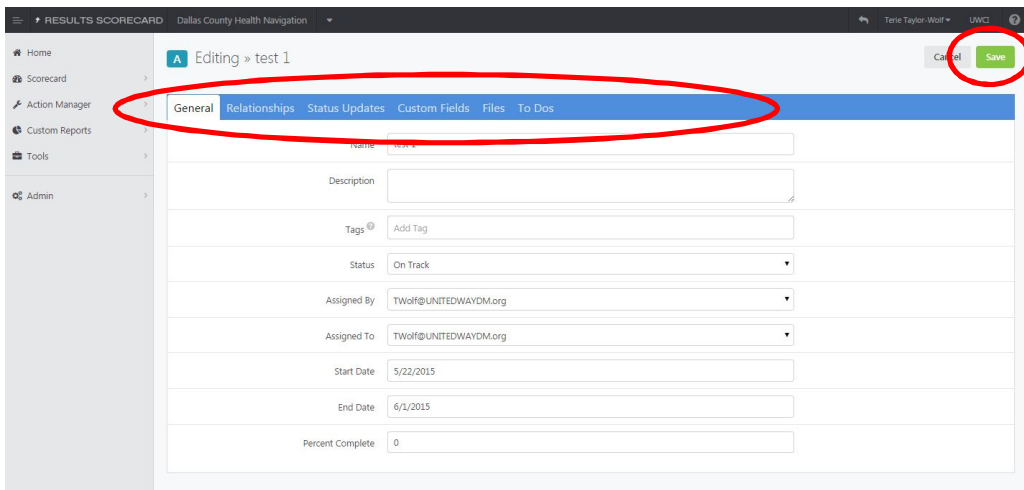


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

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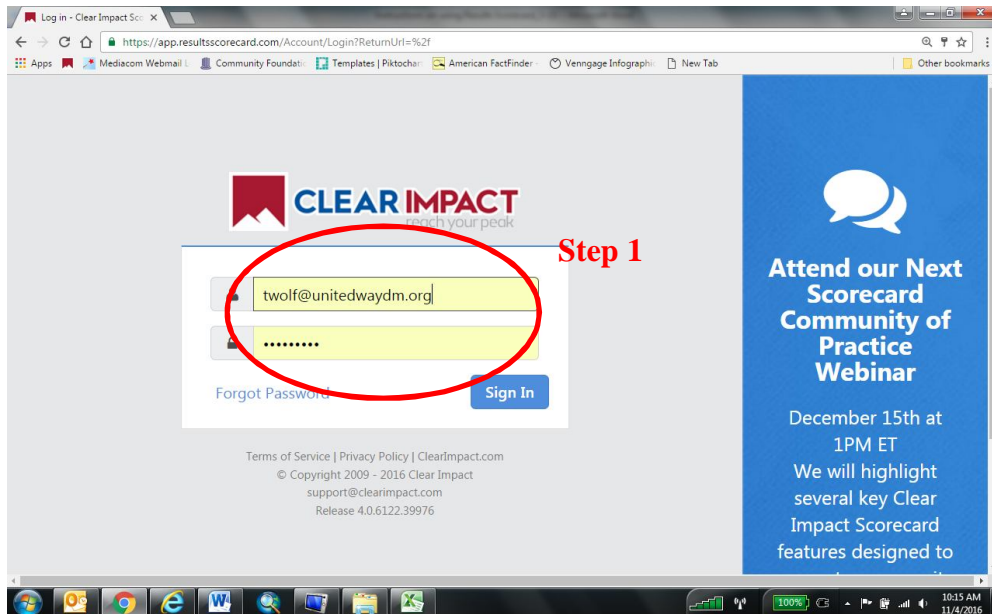
Instructions on using Results Scorecard

Step 1: Login

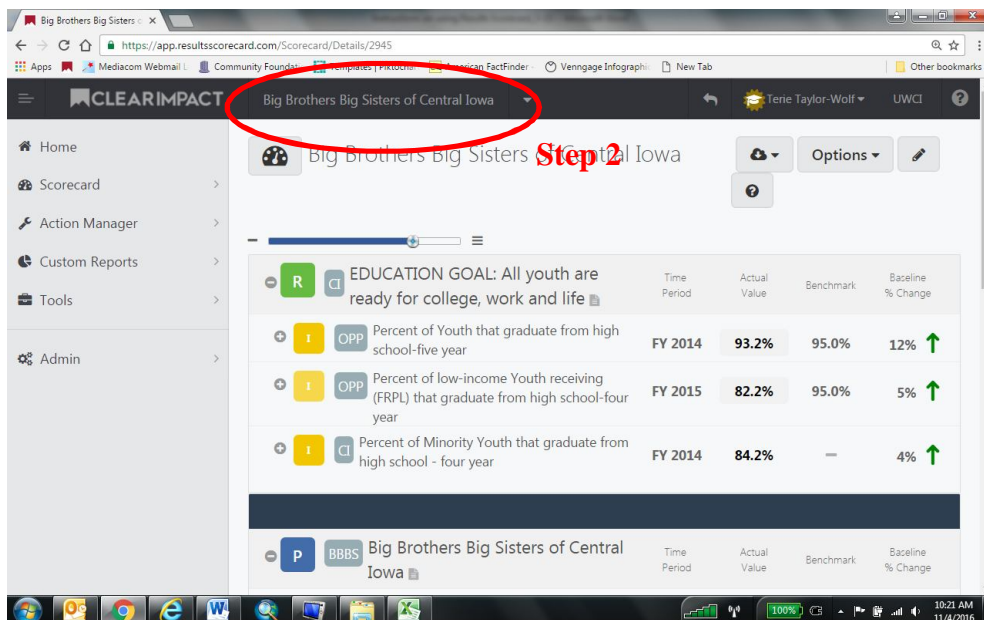
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure. A line graph shows the trend data from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

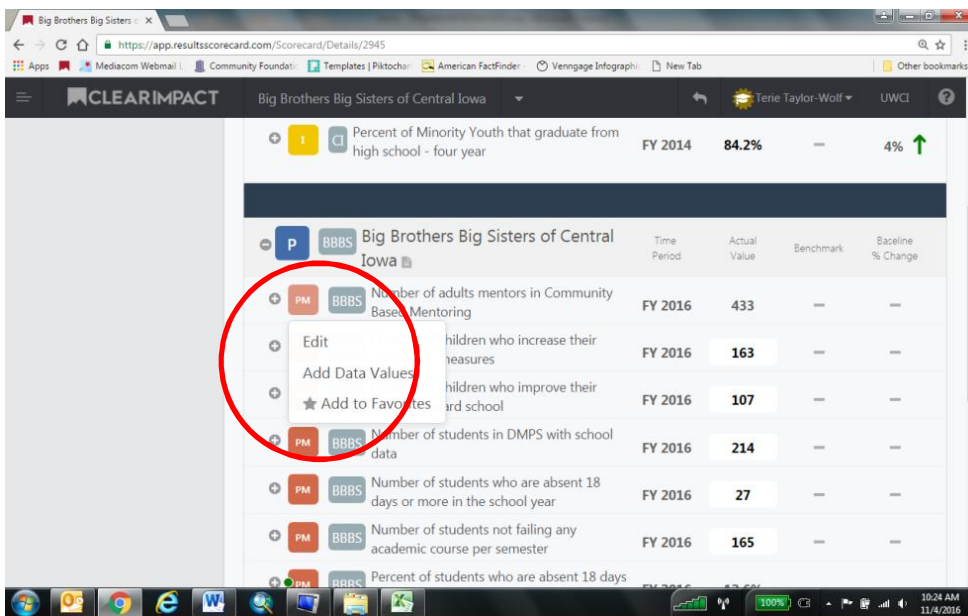
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.

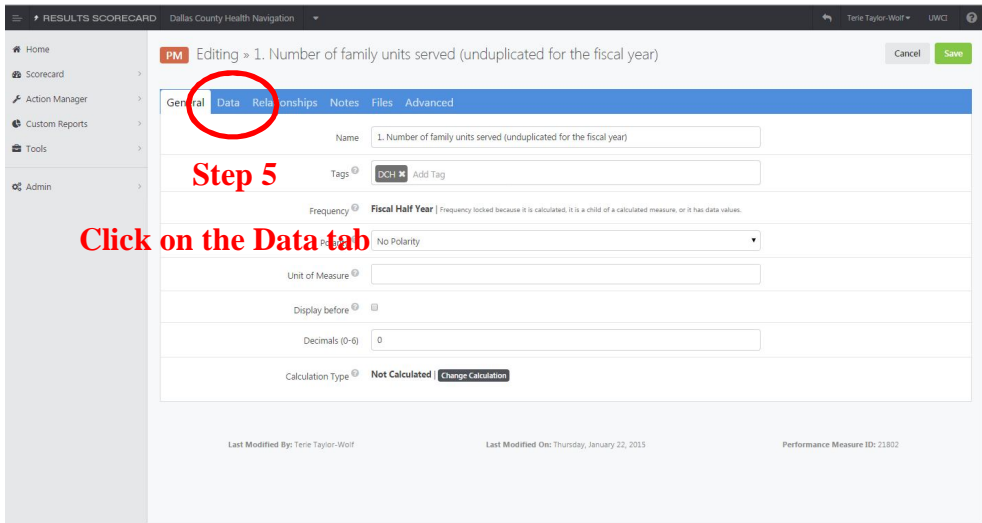


Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"

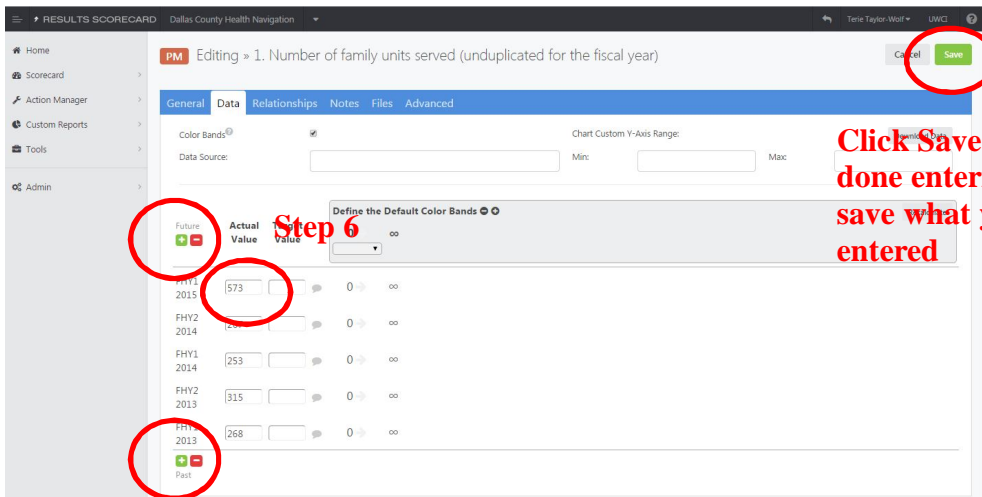


Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

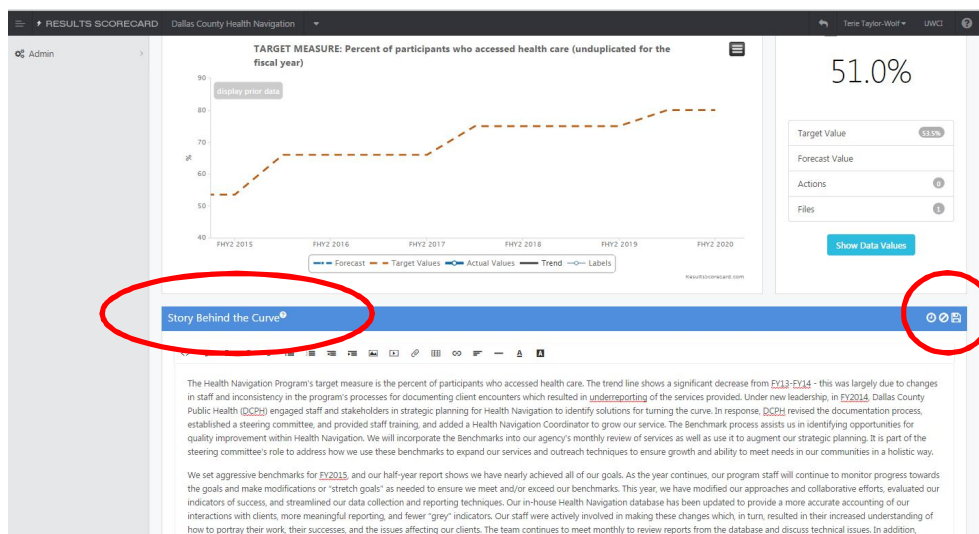
TimeFrame	Date Range
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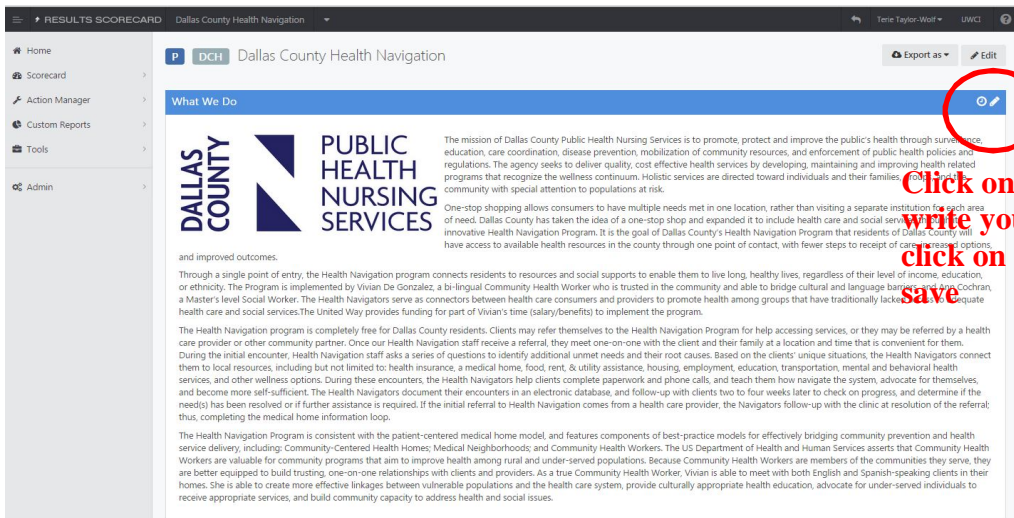
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HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
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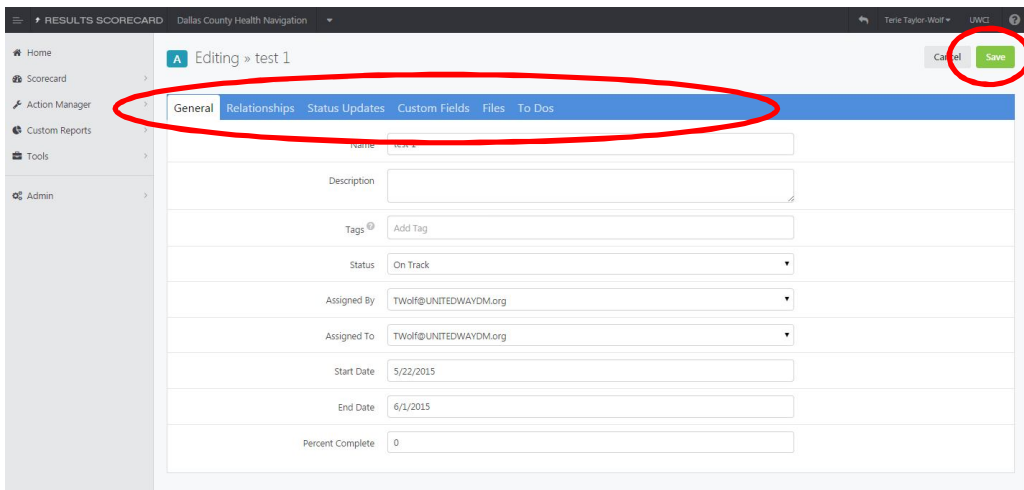


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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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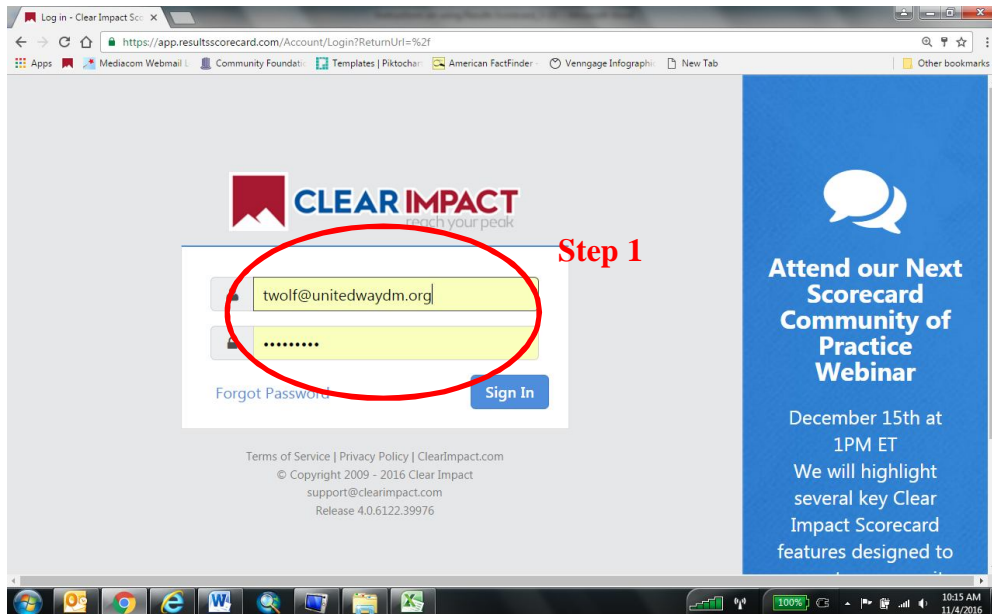
Instructions on using Results Scorecard

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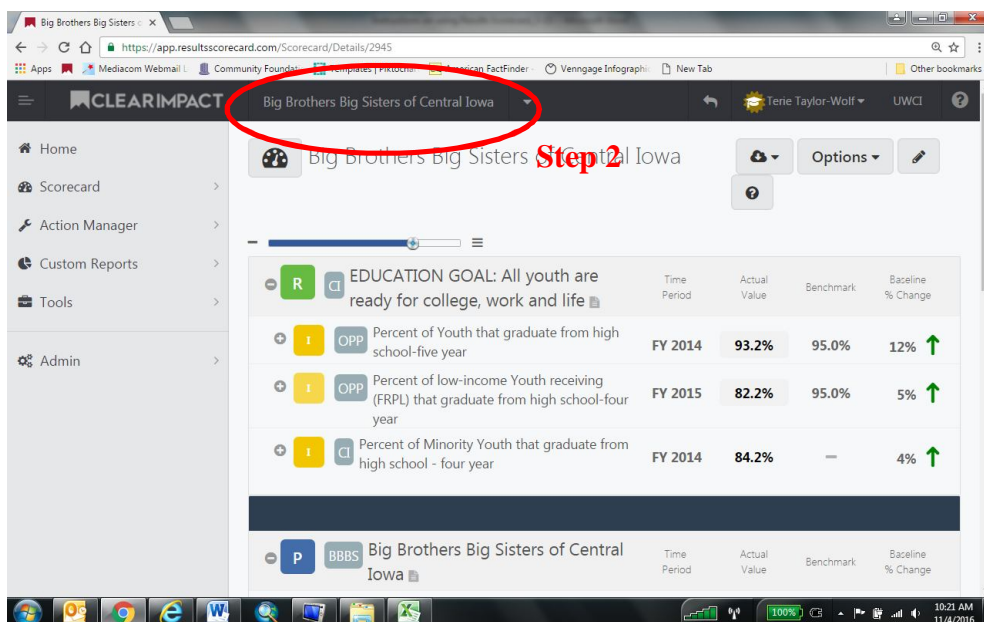
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Step 3 Actual Value Benchmark Baseline % Change". A list of performance measures is displayed, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The data points are as follows:

Fiscal Year	Actual Value
FY 2011	496
FY 2012	515
FY 2013	591
FY 2014	535
FY 2015	467
FY 2016	433

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Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"

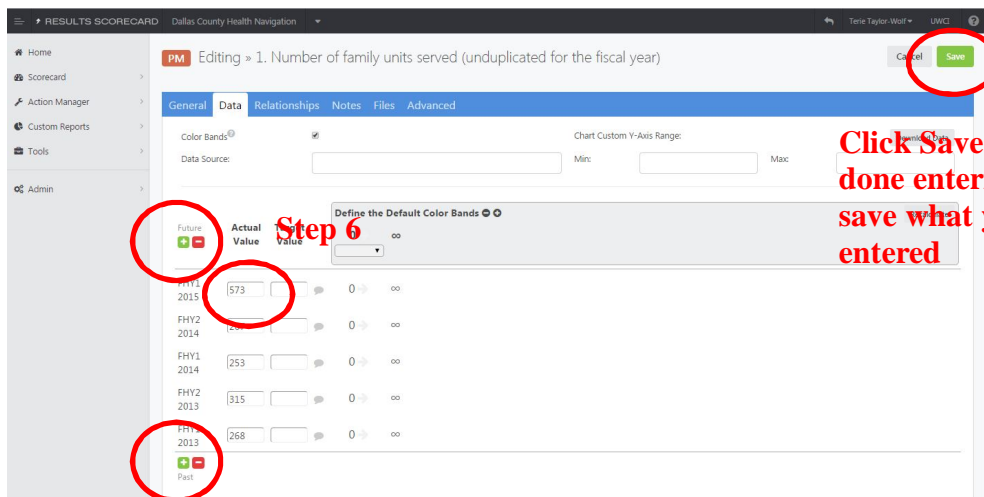


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Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
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Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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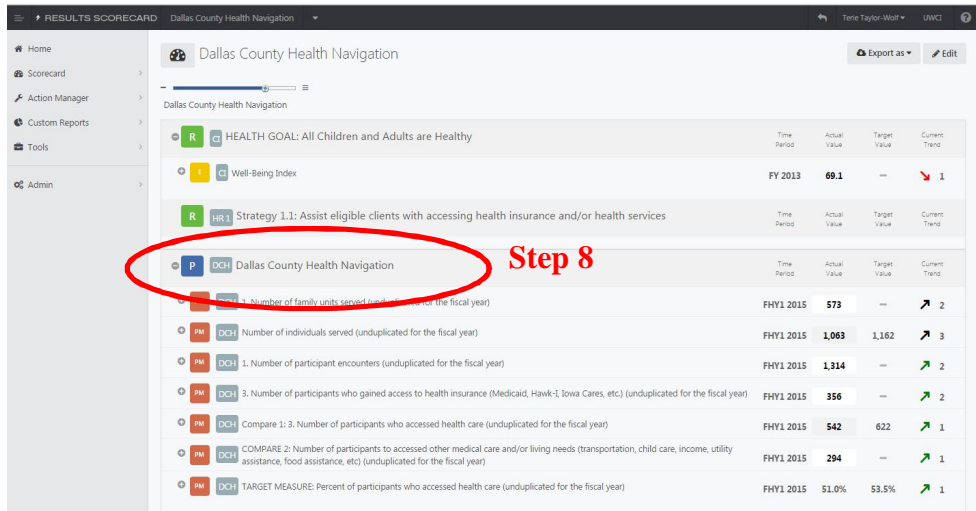
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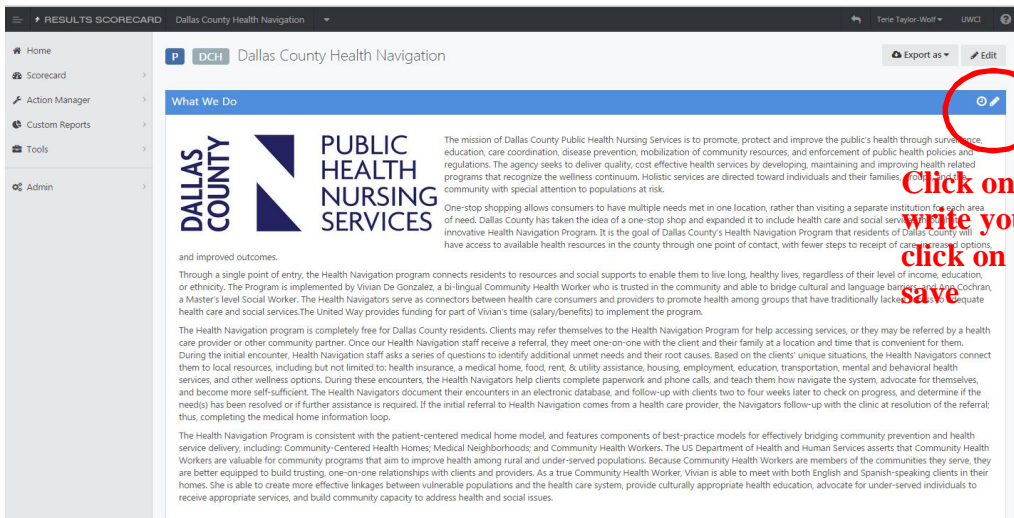
1. What We Do
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3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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Step 8

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



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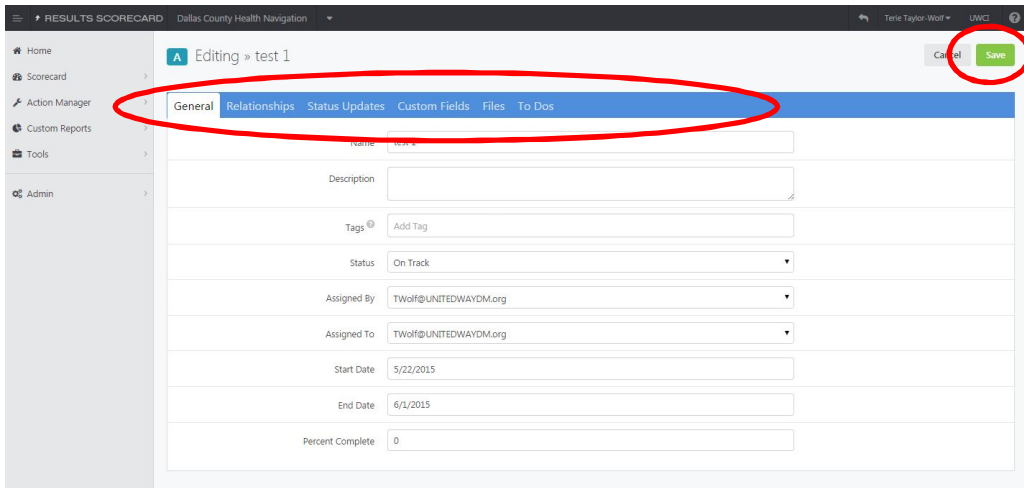


Step 10

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It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure. A line graph shows the trend data from FY 2011 to FY 2016. The graph shows a peak in FY 2013 (591) and a low in FY 2016 (433). The table to the right of the graph shows the following data:

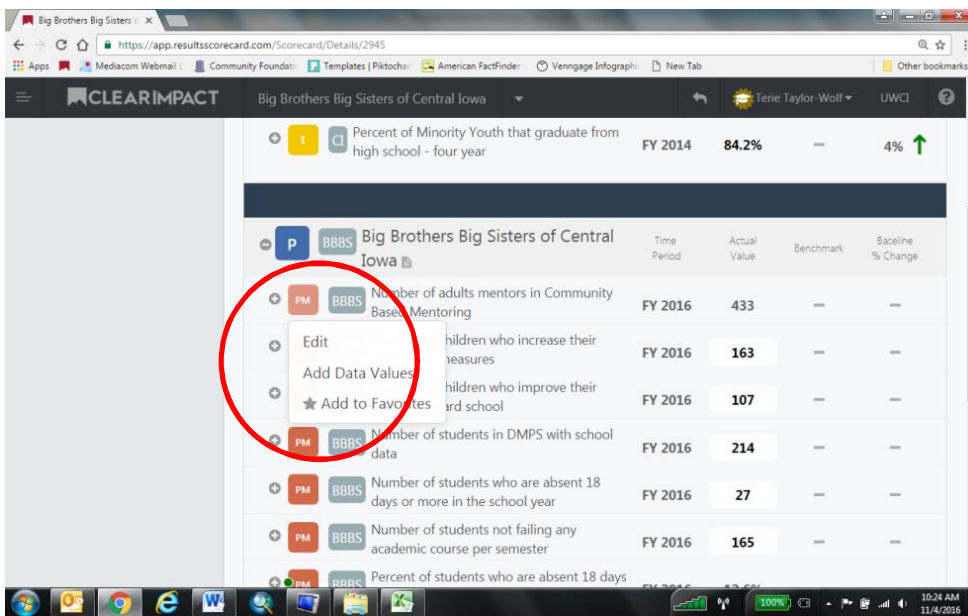
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
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FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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Step 4

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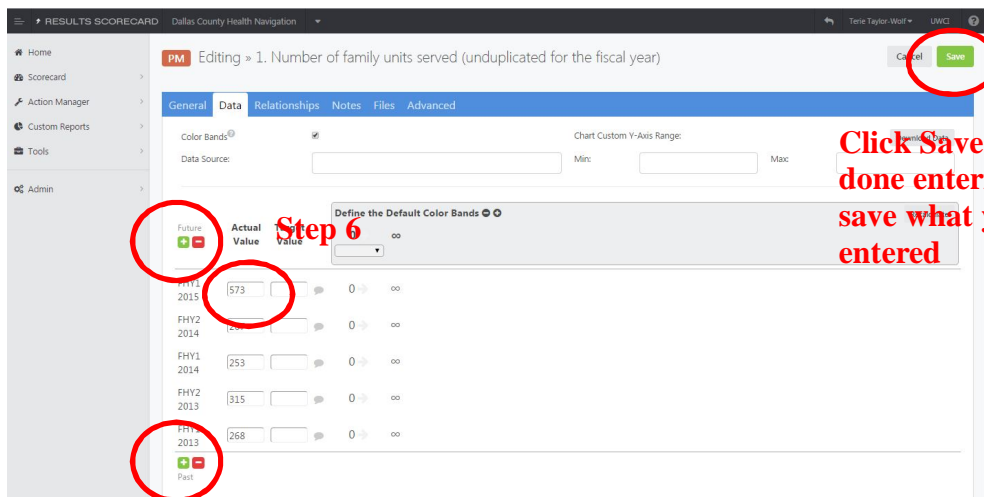
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Step 5
Click on the Data tab

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

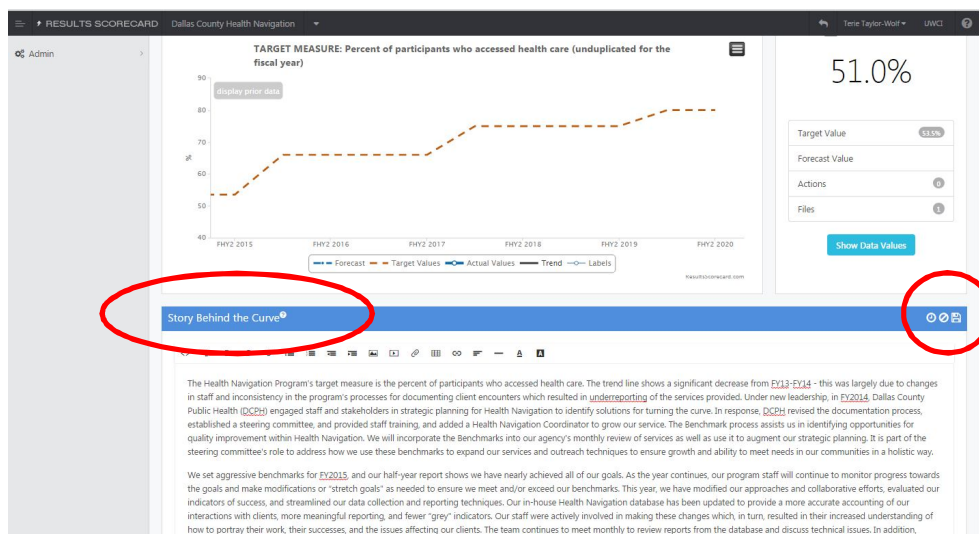
TimeFrame	Date Range
Q1	July 1-Sept. 30
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Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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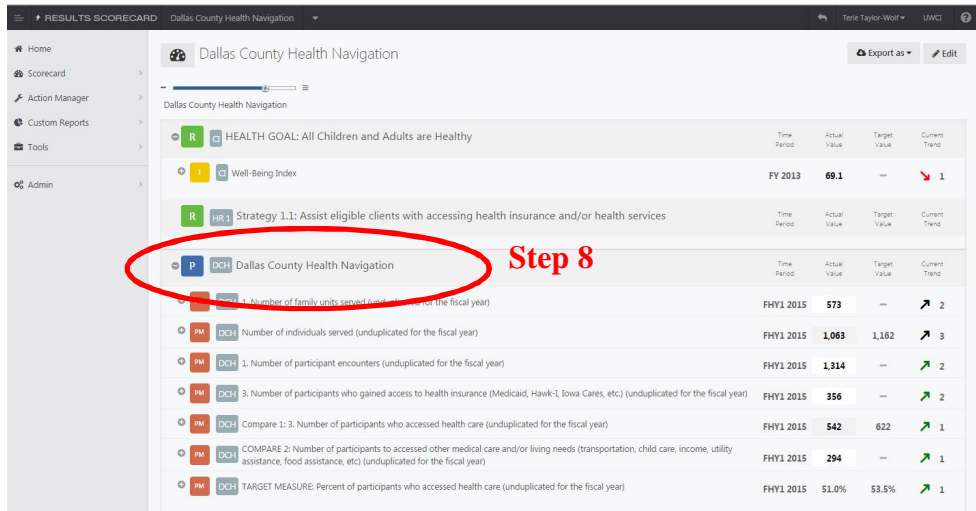
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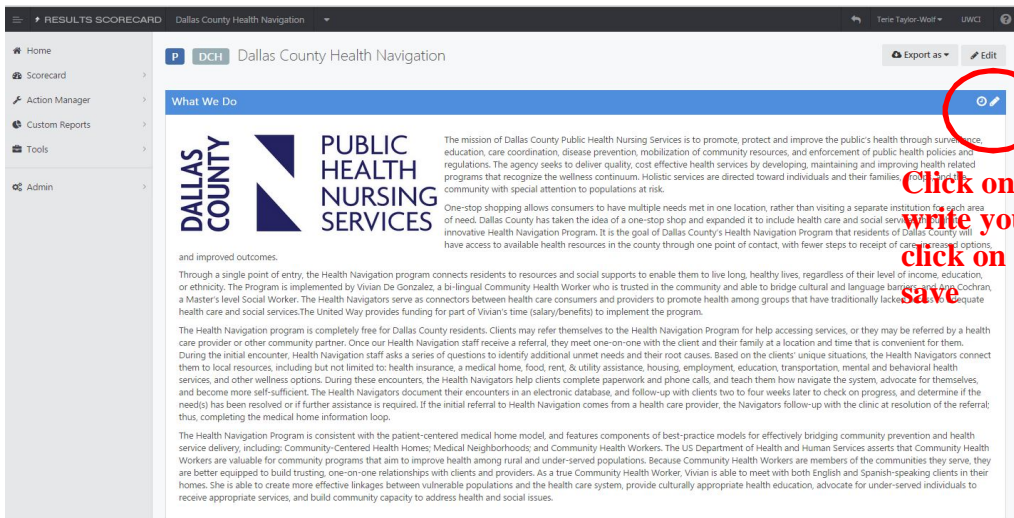
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Program	Time Period	Actual Value	Target Value	Current Trend
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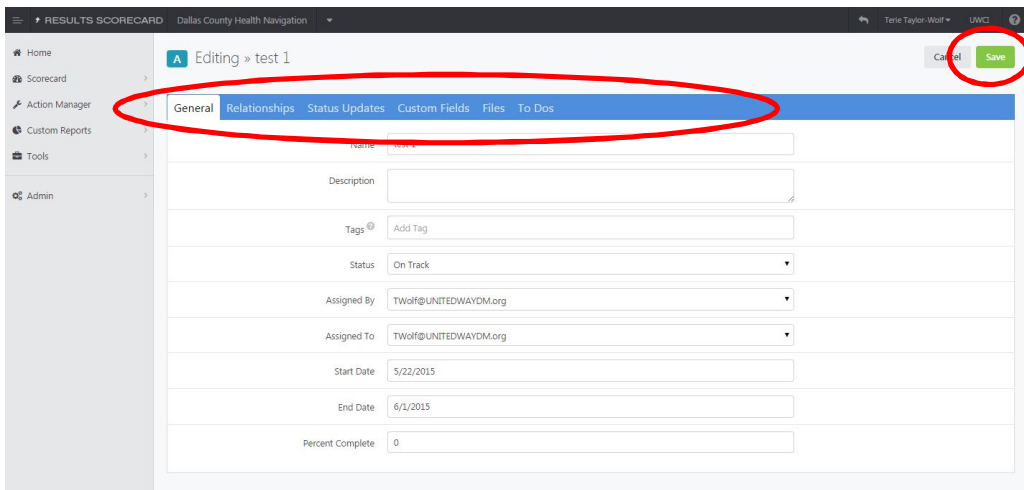


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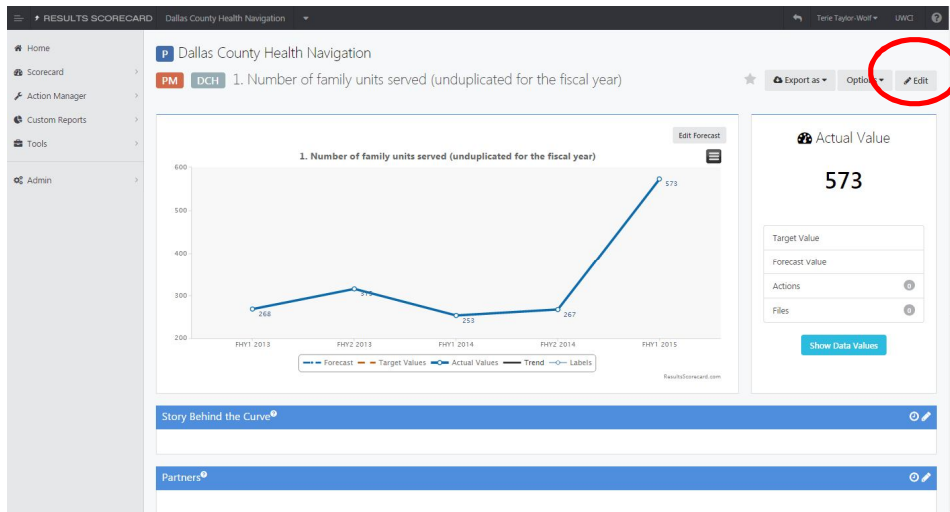
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Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
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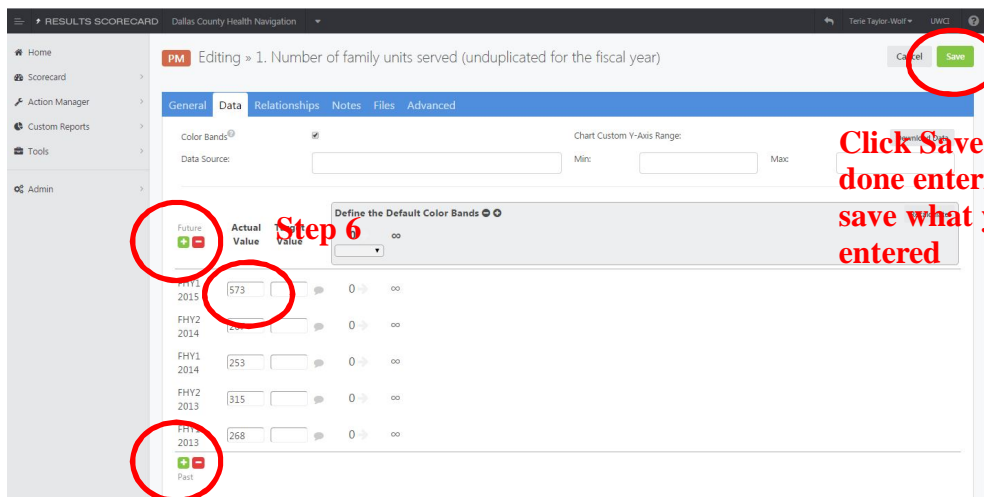
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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

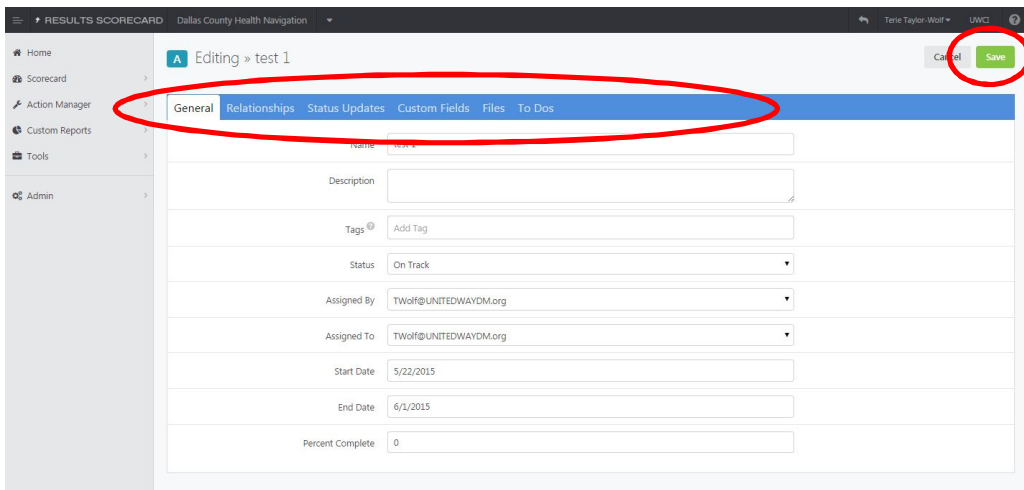


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
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John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

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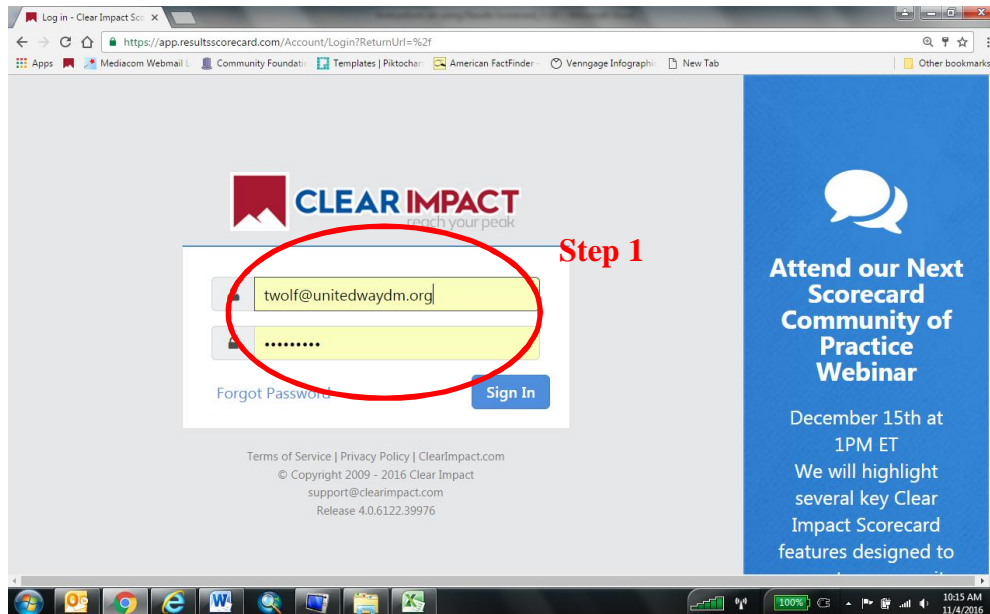
Instructions on using Results Scorecard

Step 1: Login

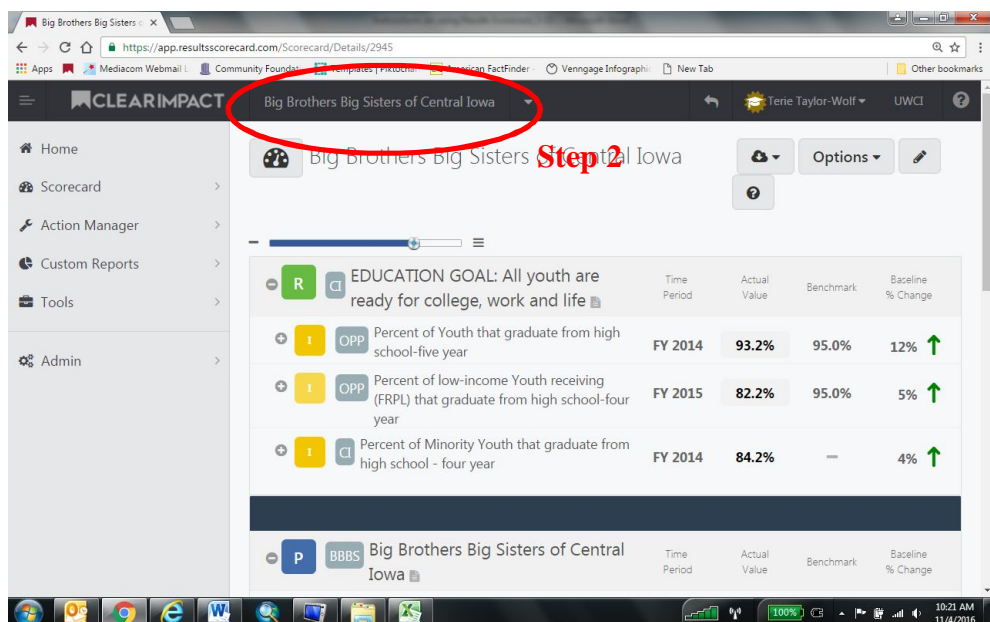
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

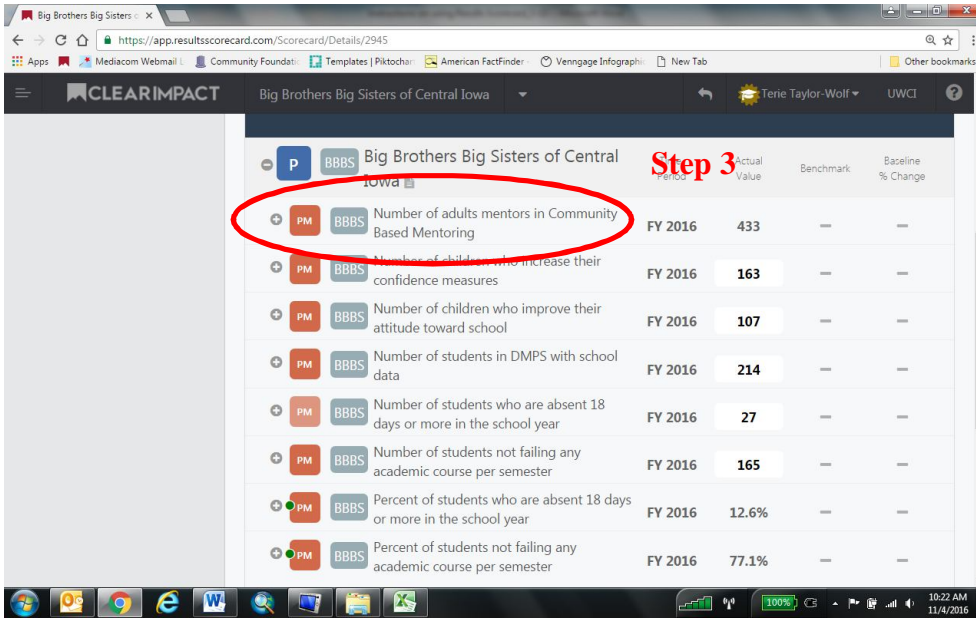
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



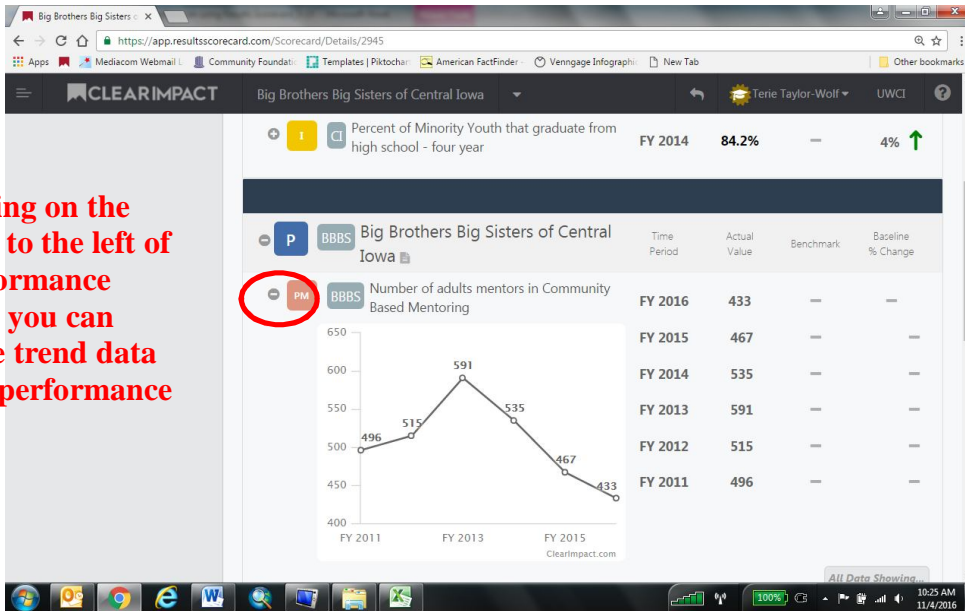
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

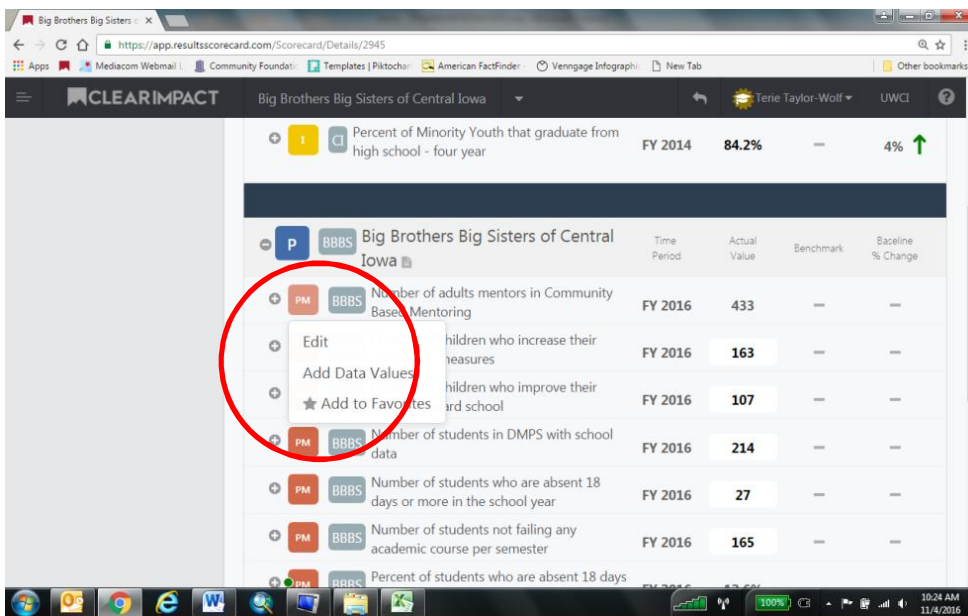


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Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

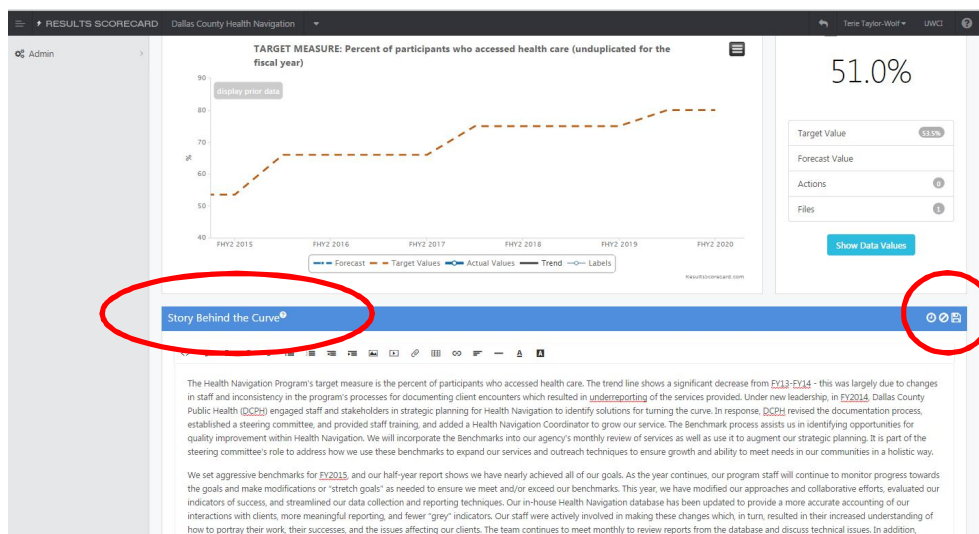
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HY1	July 1-Dec. 31
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

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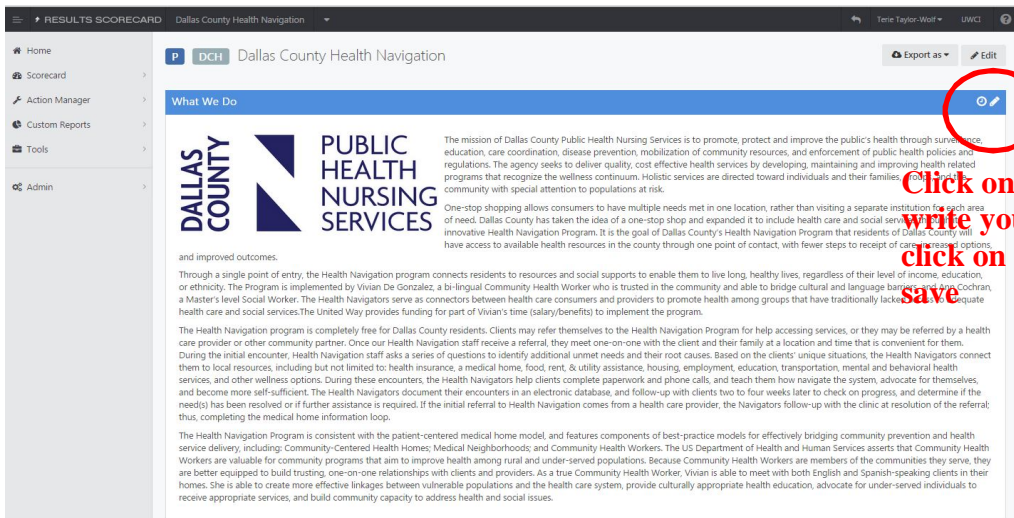
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Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
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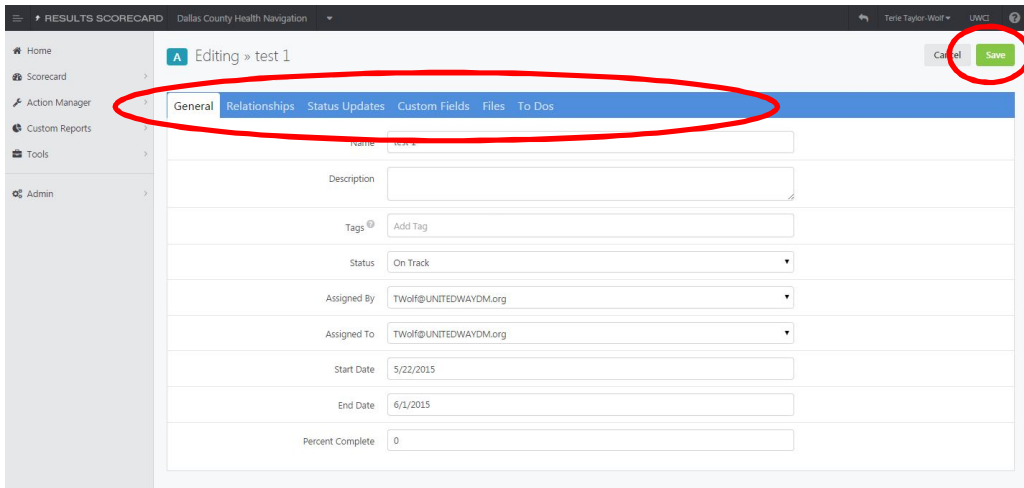


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Rosy	2nd half	2nd half			

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

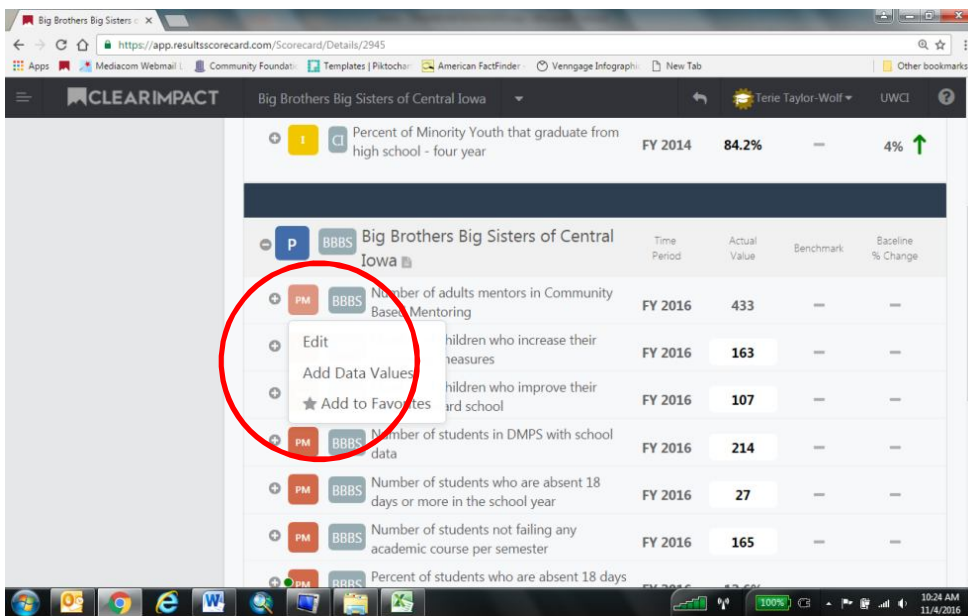
The screenshot shows the same scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph shows the trend data for this measure from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



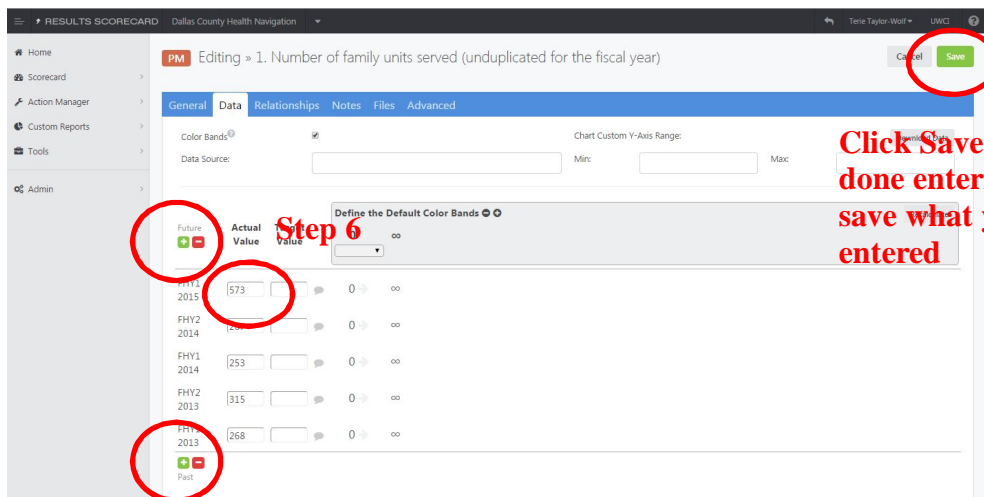
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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
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HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays data from FY2 2015 to FY2 2020, with an actual value of 51.0% and a target value of 63.5%. Below the chart is the 'Story Behind the Curve' section, which contains a text box and a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous one, but with the text box containing a narrative about the Health Navigation Program's target measure and the challenges faced. A disk icon in the bottom right corner of the text box is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

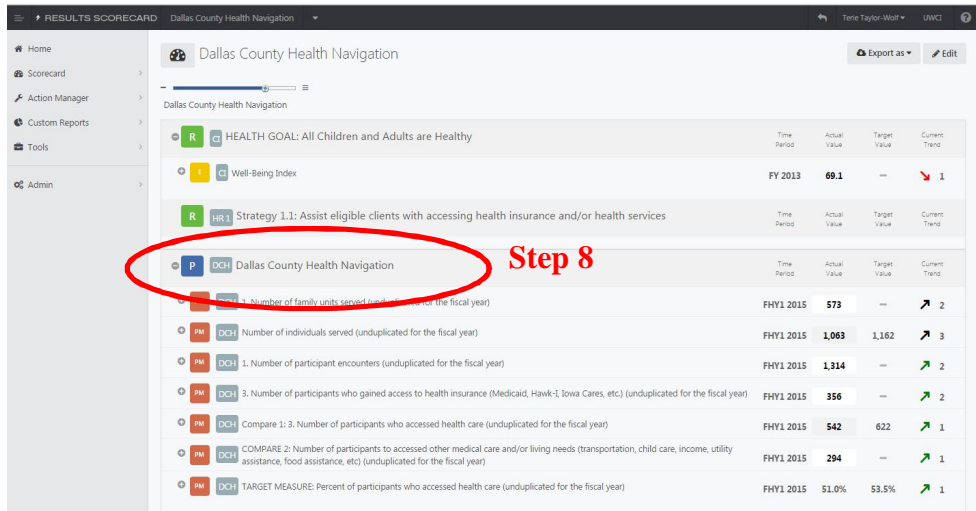
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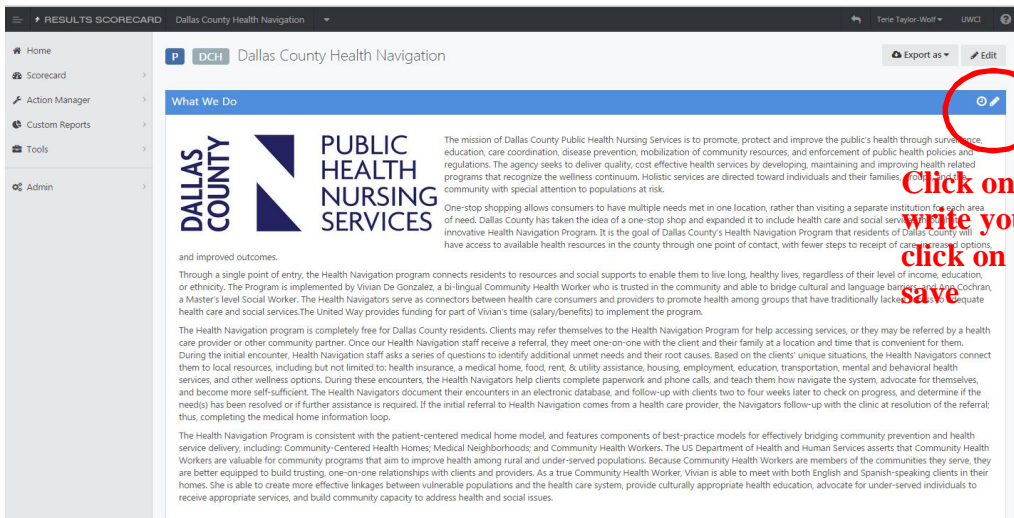
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

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Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



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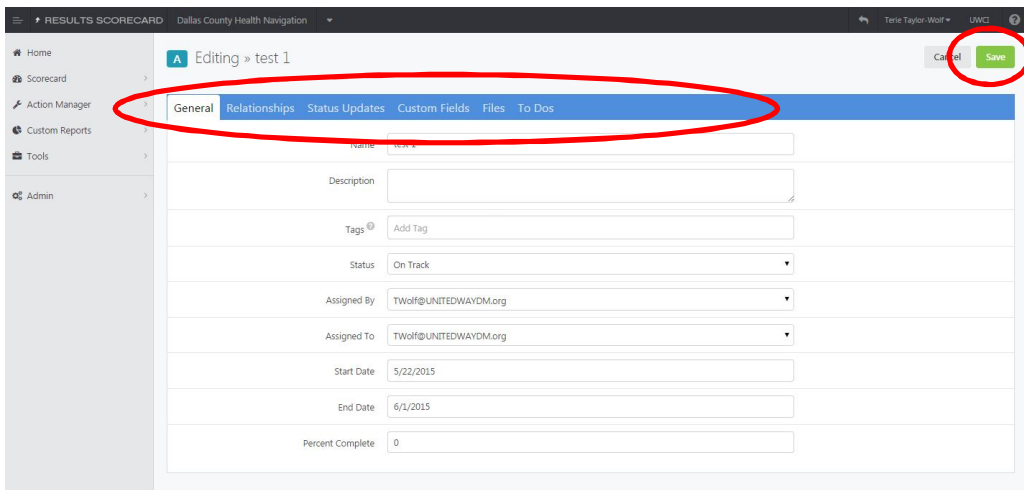


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Kane	1st half	1st half	Jody	1st half	1st half
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Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
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Target Measure	57%	133%	80.0%

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Question?

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The screenshot shows the CLEARIMPACT dashboard for Big Brothers Big Sisters of Central Iowa. A list of performance measures is displayed. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

Performance Measure	FY 2016	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	FY 2016	433	—	—
Number of children who increase their confidence measures	FY 2016	163	—	—
Number of children who improve their attitude toward school	FY 2016	107	—	—
Number of students in DMPS with school data	FY 2016	214	—	—
Number of students who are absent 18 days or more in the school year	FY 2016	27	—	—
Number of students not failing any academic course per semester	FY 2016	165	—	—
Percent of students who are absent 18 days or more in the school year	FY 2016	12.6%	—	—
Percent of students not failing any academic course per semester	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the CLEARIMPACT dashboard for Big Brothers Big Sisters of Central Iowa. The performance measure "Number of adults mentors in Community Based Mentoring" is selected, and its trend data is displayed. A line graph shows the number of mentors from FY 2011 to FY 2016. The table below shows the following data:

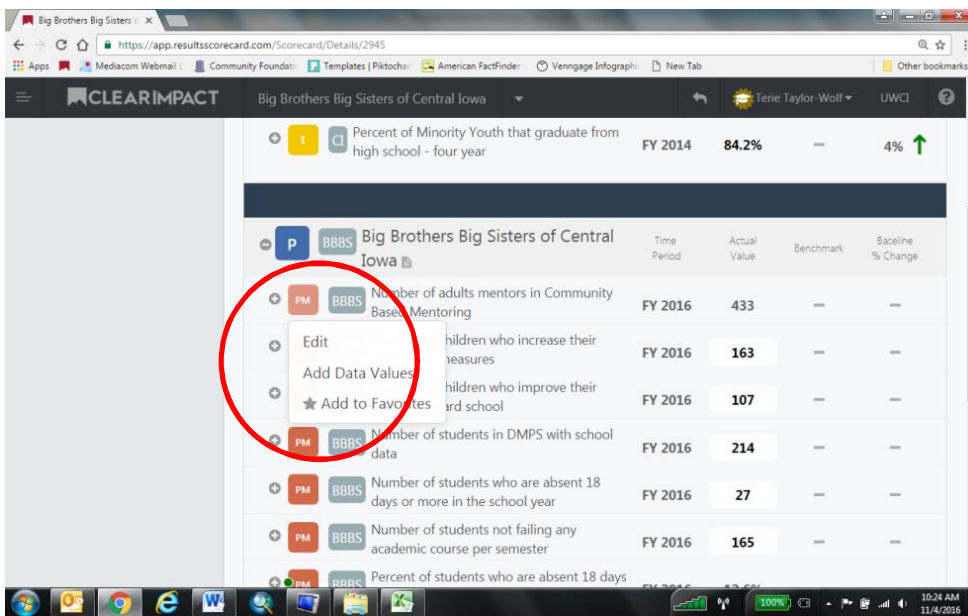
Time Period	Actual Value	Benchmark	Baseline % Change
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FY 2012	515	—	—
FY 2011	496	—	—

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Step 4

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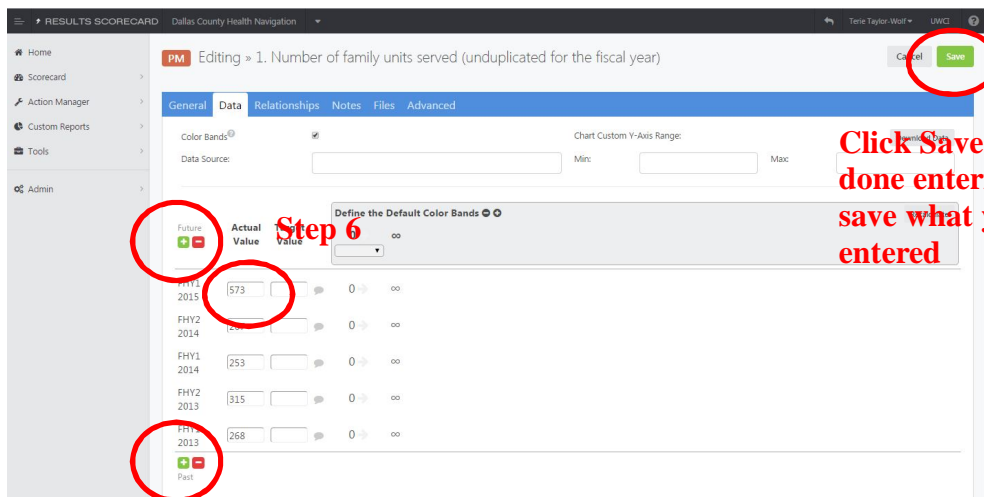
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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

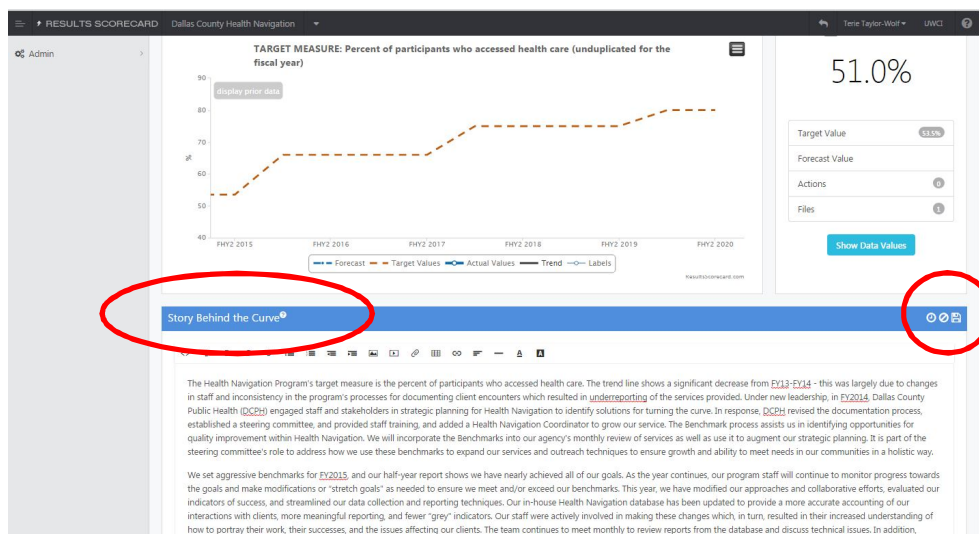
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Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

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1. What We Do
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3. How We Impact
4. Success Story

You will find these areas by clicking on the program name

Category	Item	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL	All Children and Adults are Healthy				
	Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1	Assist eligible clients with accessing health insurance and/or health services				
DCH	Dallas County Health Navigation				
	1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
	Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
	1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
	3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
	Compare 1.3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
	COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
	TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)

Step 8

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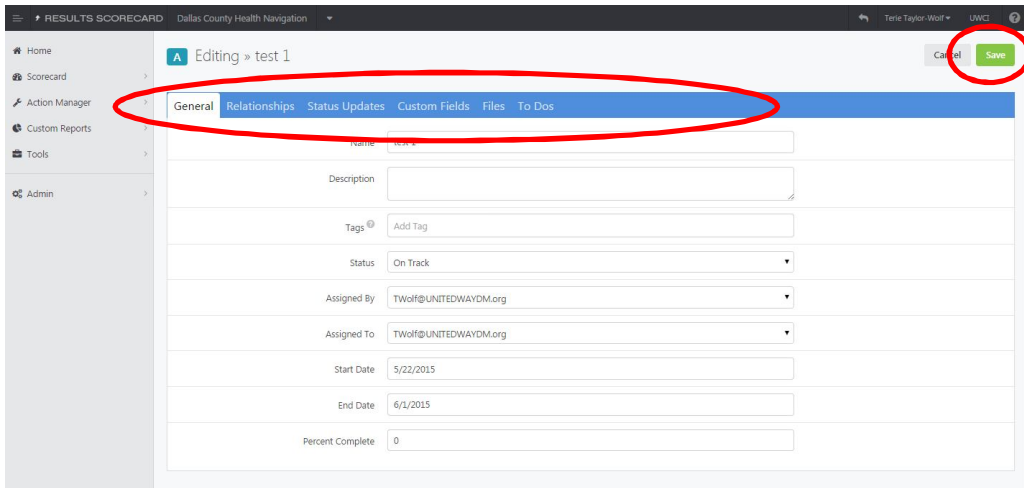


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Results Scorecard View:

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The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. A red "Step 3" label is in the top right. A list of performance measures is shown, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

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Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
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Number of students who are absent 18 days or more in the school year	27	—	—
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The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph shows the trend data from FY 2011 to FY 2015. The data points are: FY 2011 (496), FY 2012 (515), FY 2013 (591), FY 2014 (535), and FY 2015 (467). The current value for FY 2016 is 433. The table to the right of the graph shows the following data:

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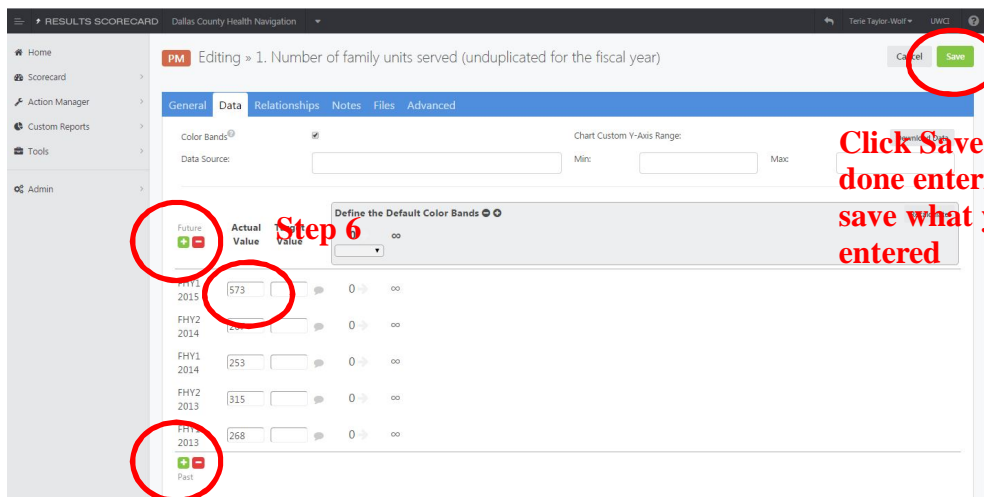
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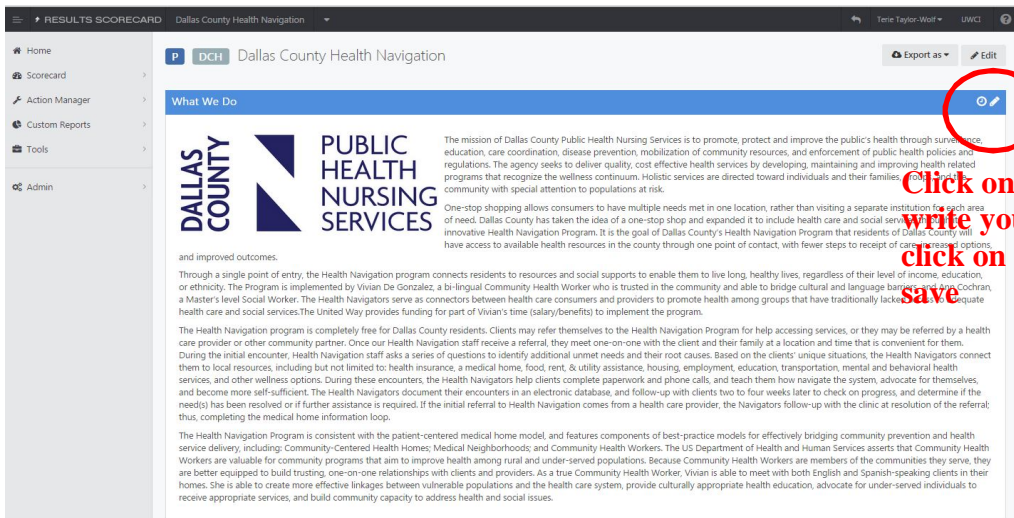
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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
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1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

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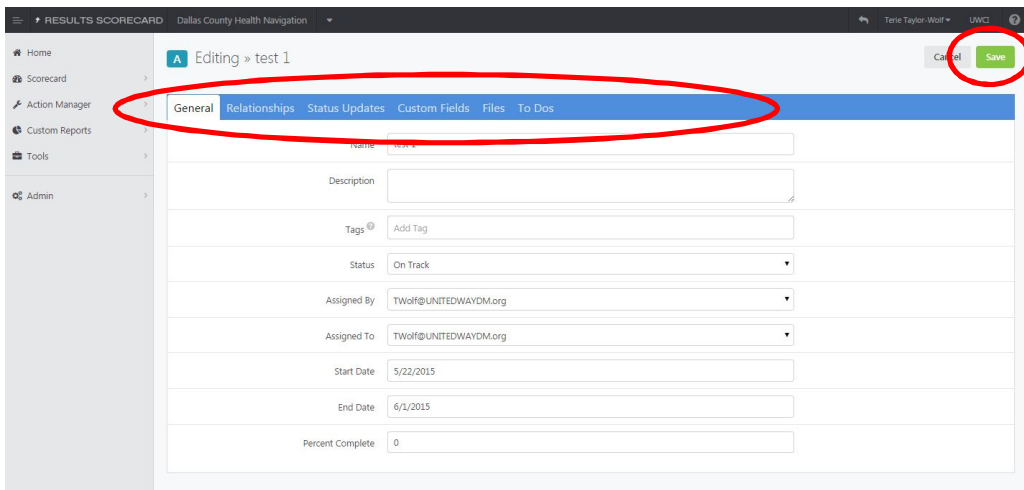


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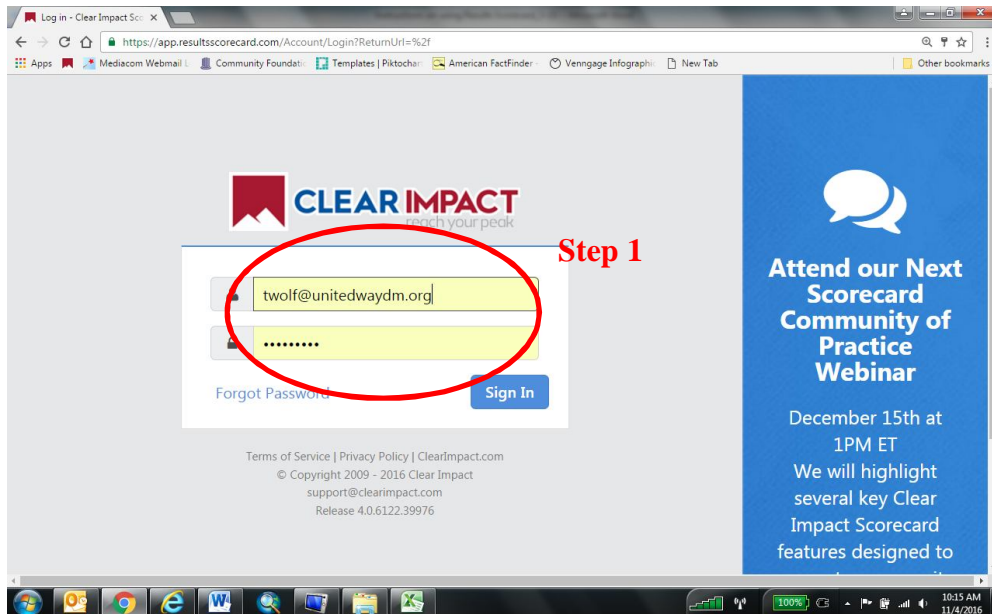
Instructions on using Results Scorecard

Step 1: Login

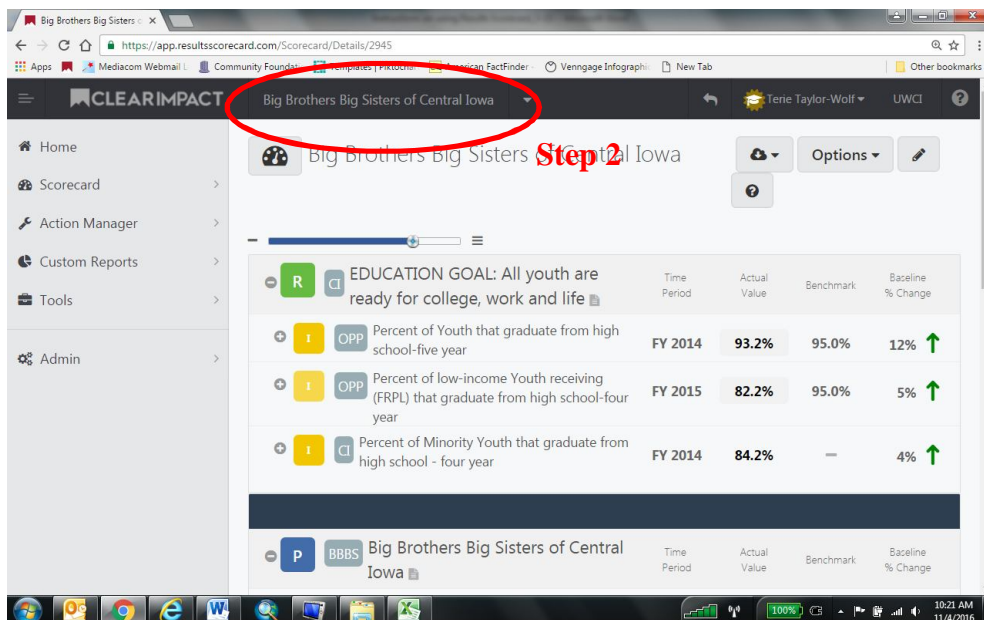
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Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa". The main content area shows a list of performance measures. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. To its right, the data for FY 2016 is shown as 433. A red "Step 3" label is positioned in the top right corner of the scorecard area. Other measures include "Number of children who increase their confidence measures" (163), "Number of children who improve their attitude toward school" (107), "Number of students in DMPS with school data" (214), "Number of students who are absent 18 days or more in the school year" (27), "Number of students not failing any academic course per semester" (165), "Percent of students who are absent 18 days or more in the school year" (12.6%), and "Percent of students not failing any academic course per semester" (77.1%).

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the number of adult mentors from FY 2011 to FY 2015. The data points are: FY 2011 (496), FY 2012 (515), FY 2013 (591), FY 2014 (535), and FY 2015 (467). The current value for FY 2016 is 433. The graph shows a peak in FY 2013 and a general downward trend since then.

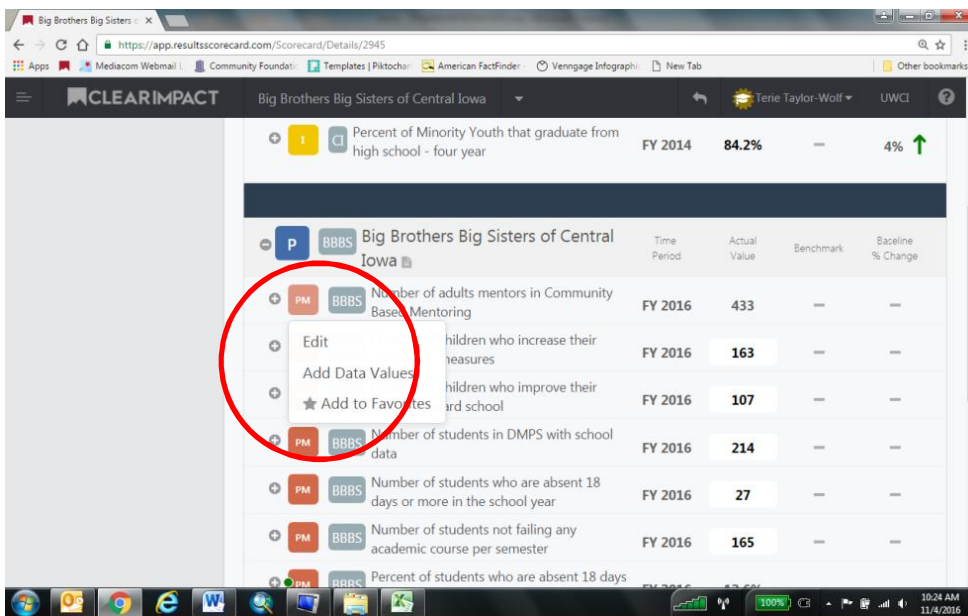
Fiscal Year	Actual Value
FY 2011	496
FY 2012	515
FY 2013	591
FY 2014	535
FY 2015	467
FY 2016	433

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section, but now with a text area containing a narrative. A disk icon in the bottom right corner of the text area is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

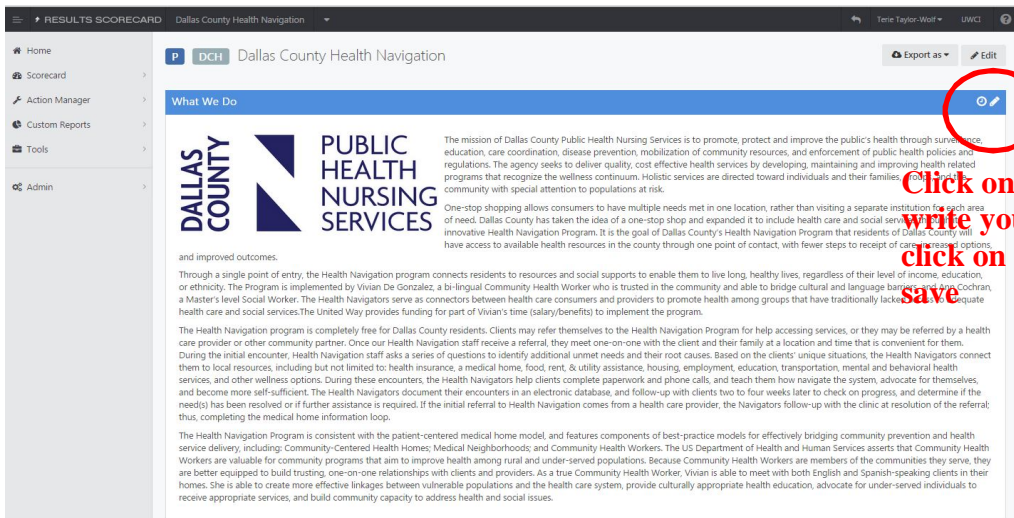
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

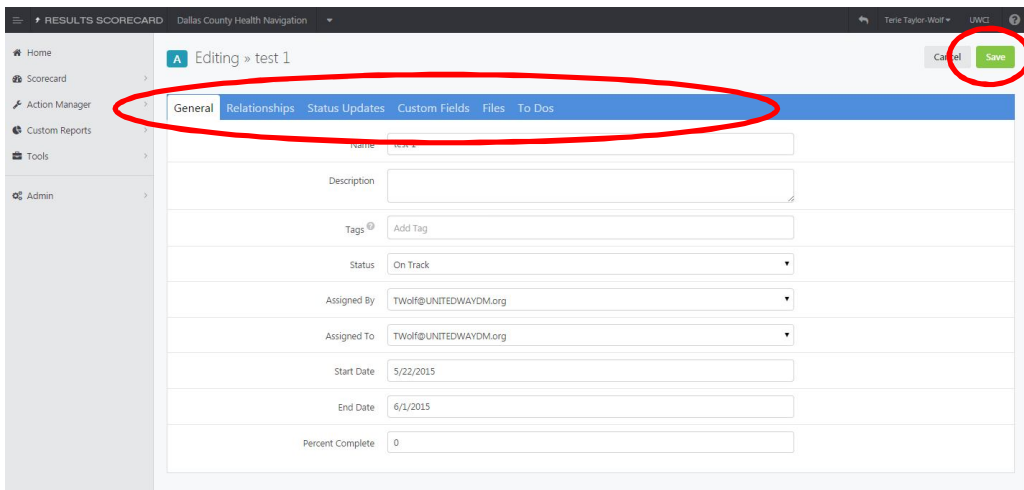


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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The screenshot shows the CLEARIMPACT dashboard for Big Brothers Big Sisters of Central Iowa. A list of performance measures is displayed. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

Performance Measure	FY 2016	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	FY 2016	433	—	—
Number of children who increase their confidence measures	FY 2016	163	—	—
Number of children who improve their attitude toward school	FY 2016	107	—	—
Number of students in DMPS with school data	FY 2016	214	—	—
Number of students who are absent 18 days or more in the school year	FY 2016	27	—	—
Number of students not failing any academic course per semester	FY 2016	165	—	—
Percent of students who are absent 18 days or more in the school year	FY 2016	12.6%	—	—
Percent of students not failing any academic course per semester	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the CLEARIMPACT dashboard for Big Brothers Big Sisters of Central Iowa. The performance measure "Number of adults mentors in Community Based Mentoring" is selected, and its trend data is displayed. A line graph shows the number of mentors from FY 2011 to FY 2016. The table below shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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Step 4

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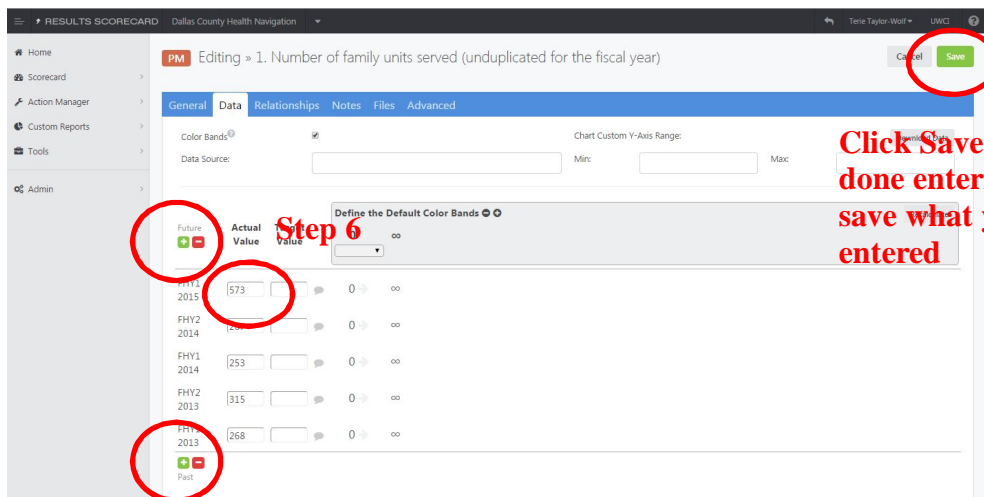
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Step 5
Click on the Data tab

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Click Save button when done entering data to save what you have entered

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Click pencil icon to write or paste narrative

Step 7



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Step 7

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You will find these areas by clicking on the program name

Category	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
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DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
DCH COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
DCH TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)

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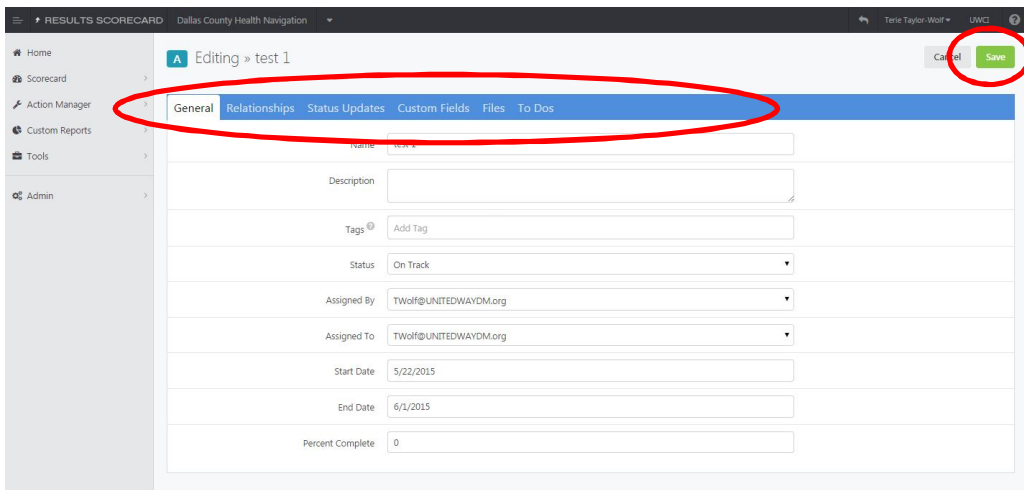


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Results Scorecard View:

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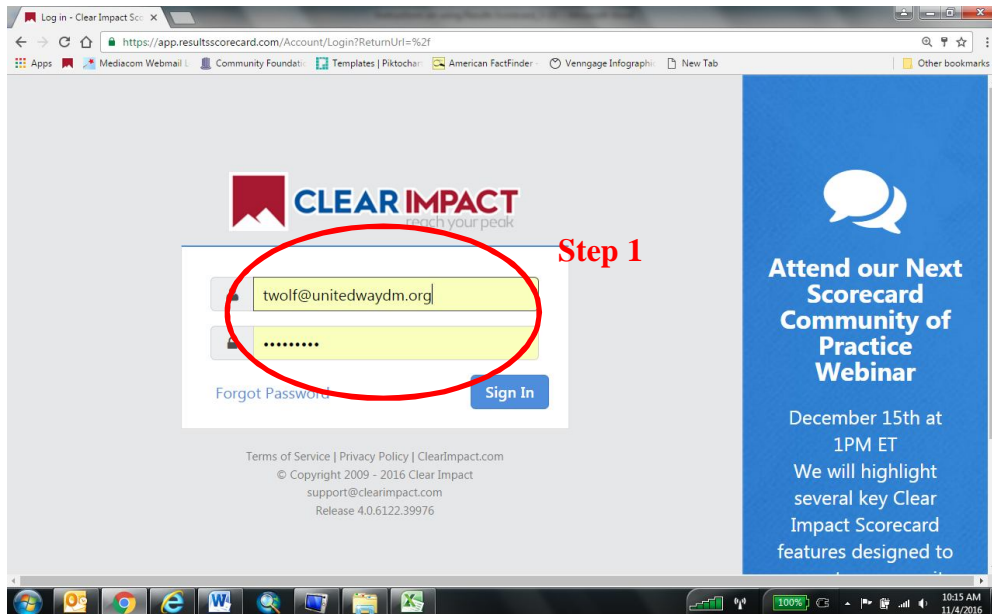
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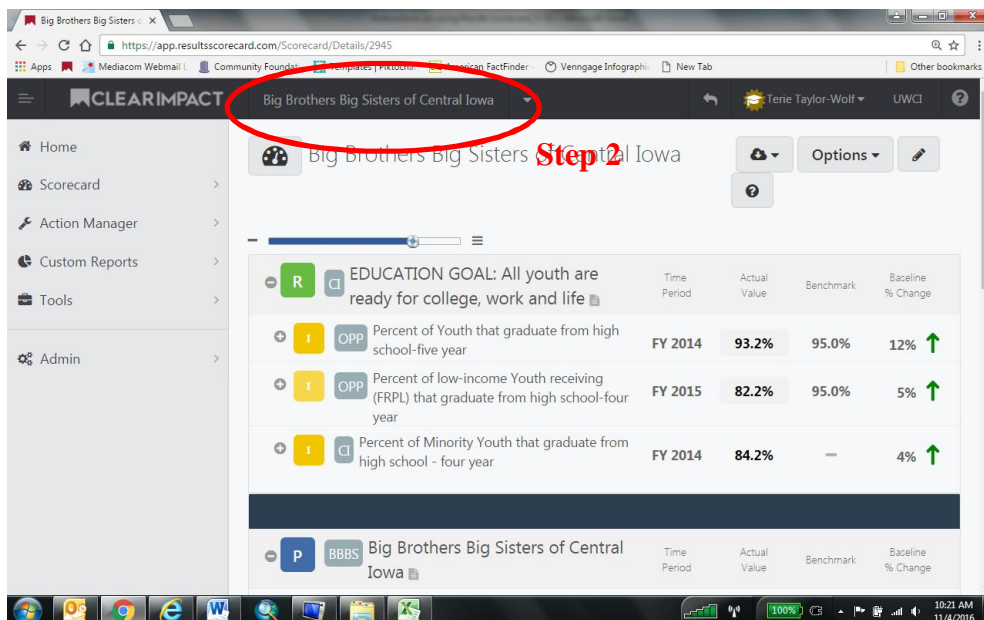
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The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The data points are as follows:

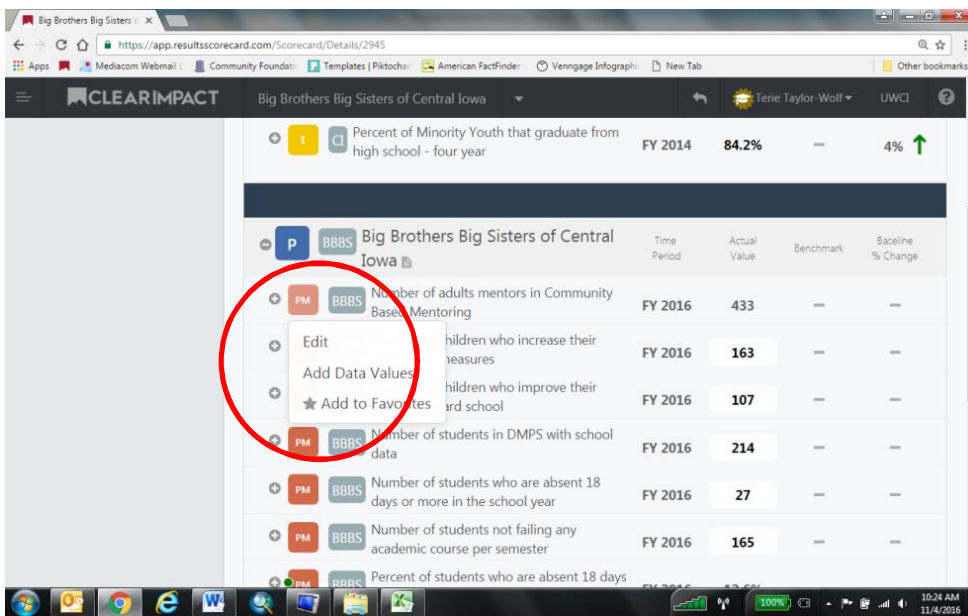
Fiscal Year	Actual Value
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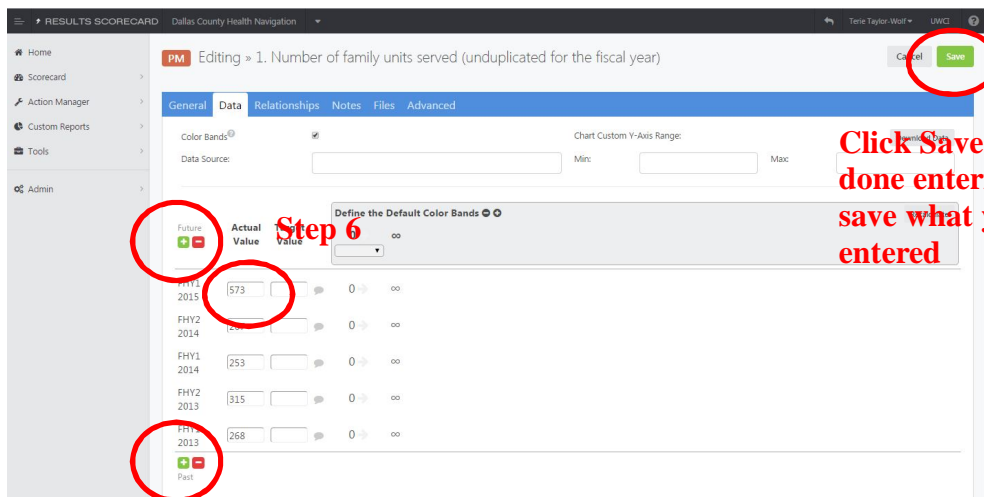
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Click Save button when done entering data to save what you have entered

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
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Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a pencil icon circled in red. The text in this section describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to address these issues.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image, but with the text area expanded. The text describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to address these issues. A disk icon is circled in red at the bottom right of the text area, indicating where to click to save the narrative.

Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name

Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The result is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



Step 9

Optional Step 10: For those of you who want to track “Actions” from your Action Plan, click on “New Action” to create an action or “Existing Action” if you already have an assigned action you wish to review or edit.

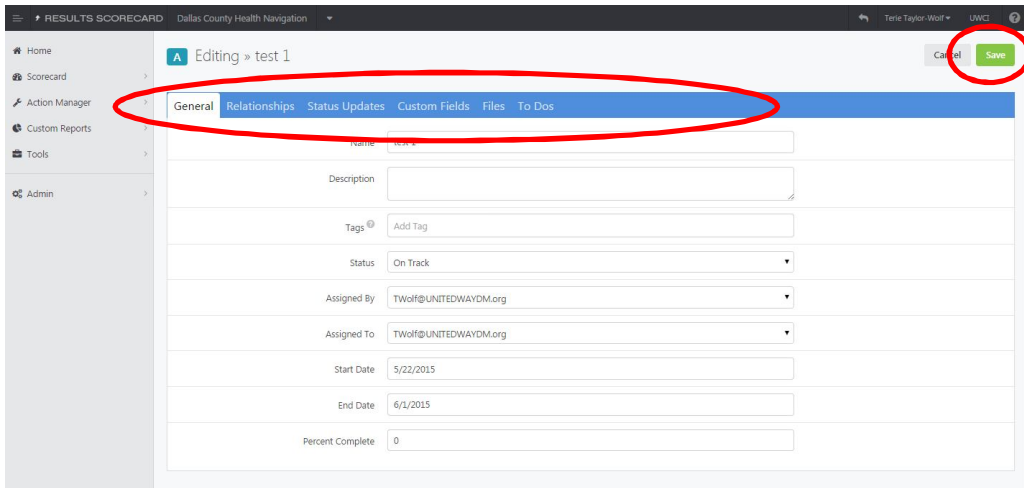


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

For Income Programming, contact Corinne Lambert at 246-6542 or e-mail at clambert@unitedwaydm.org

Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015. The table shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



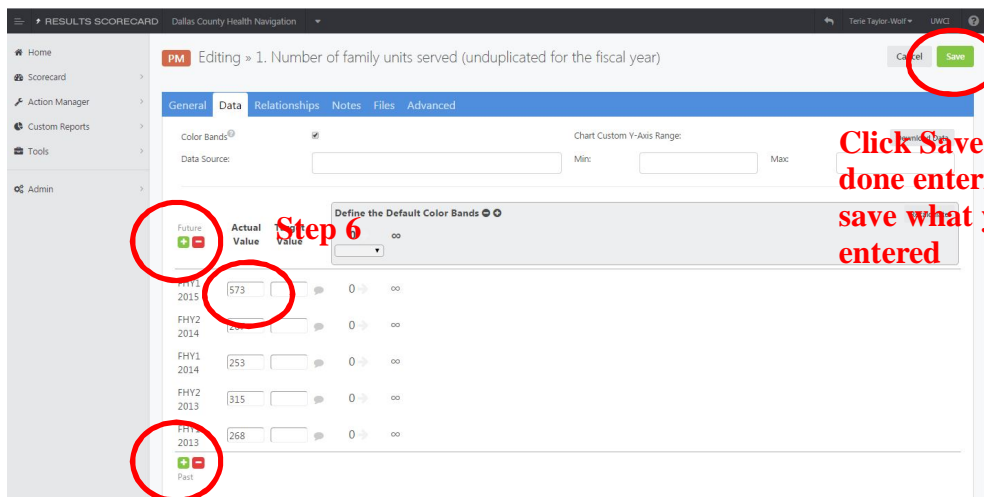
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Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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Step 7



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Step 7

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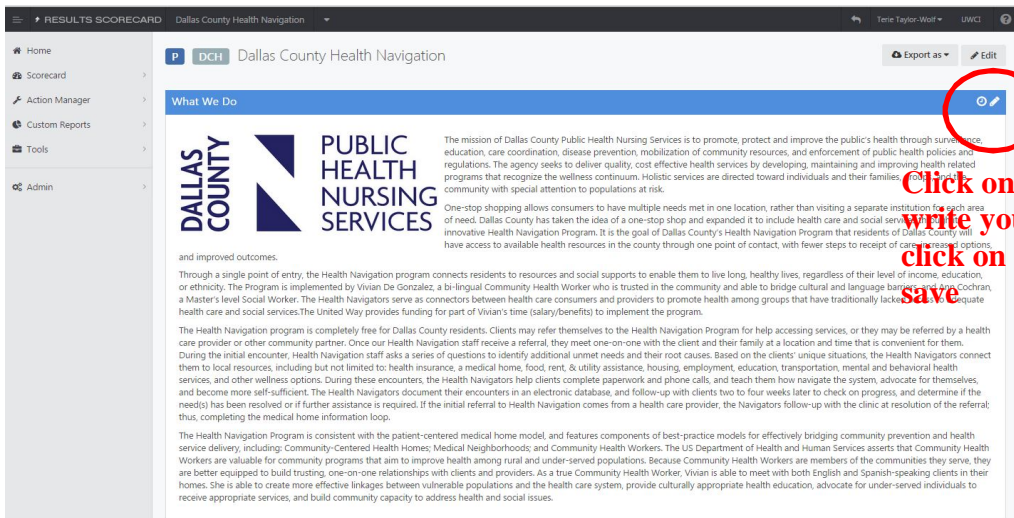
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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
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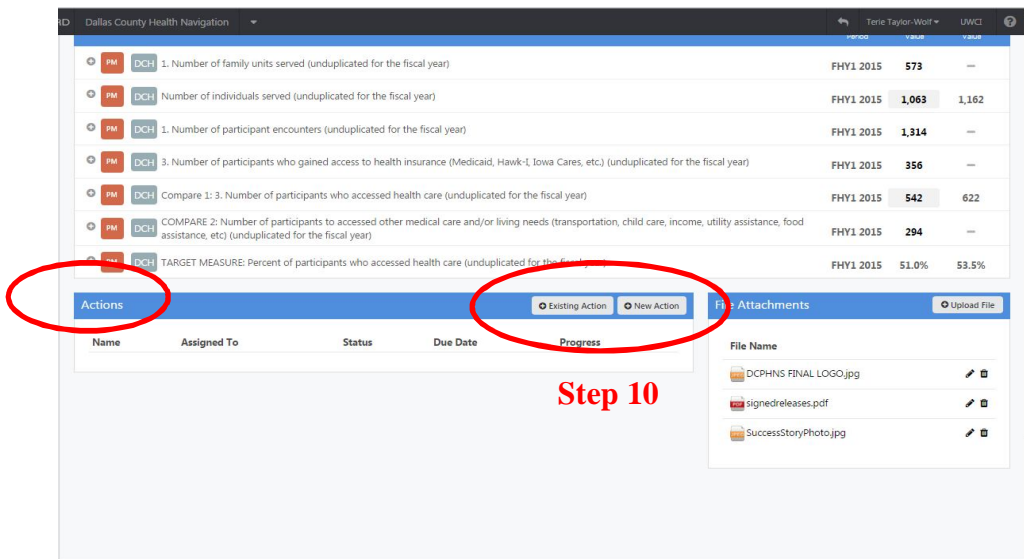
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Step 9

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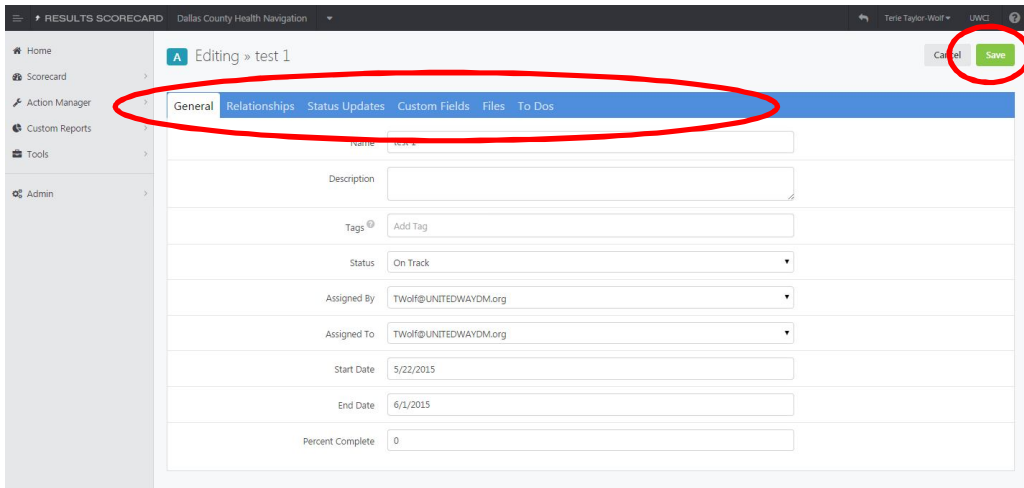


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Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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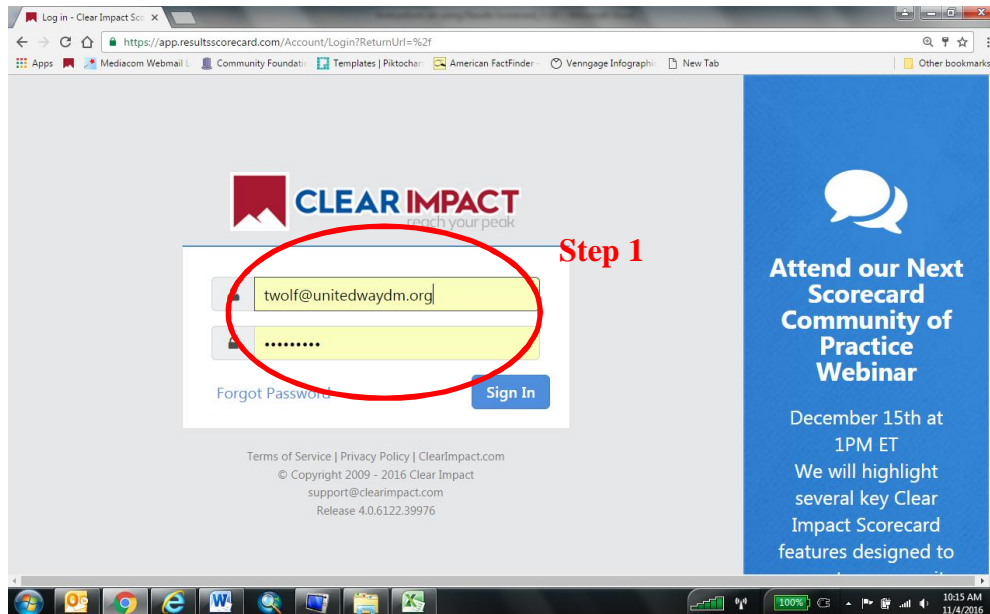
Instructions on using Results Scorecard

Step 1: Login

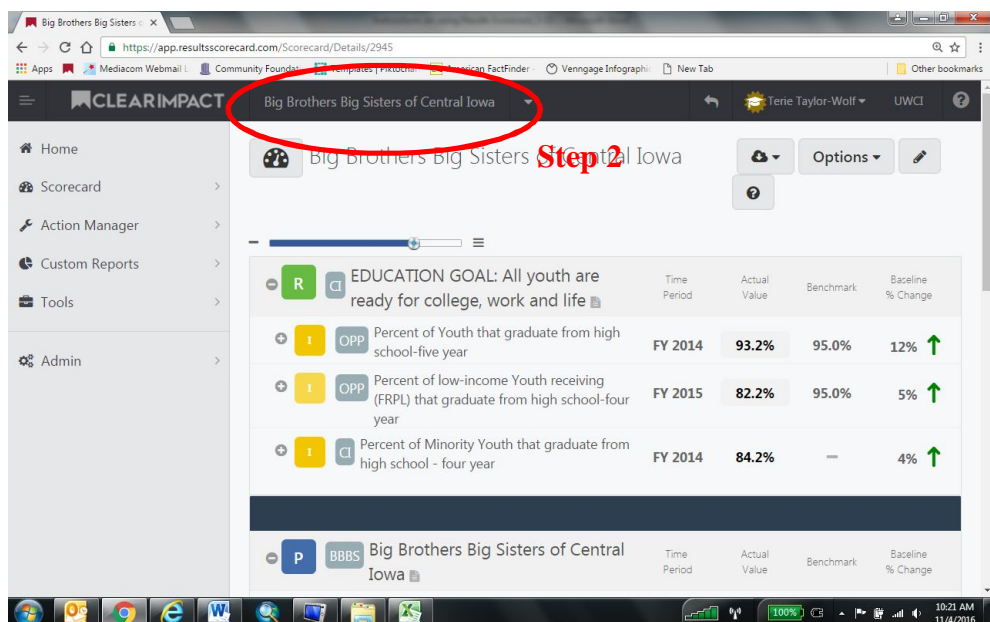
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

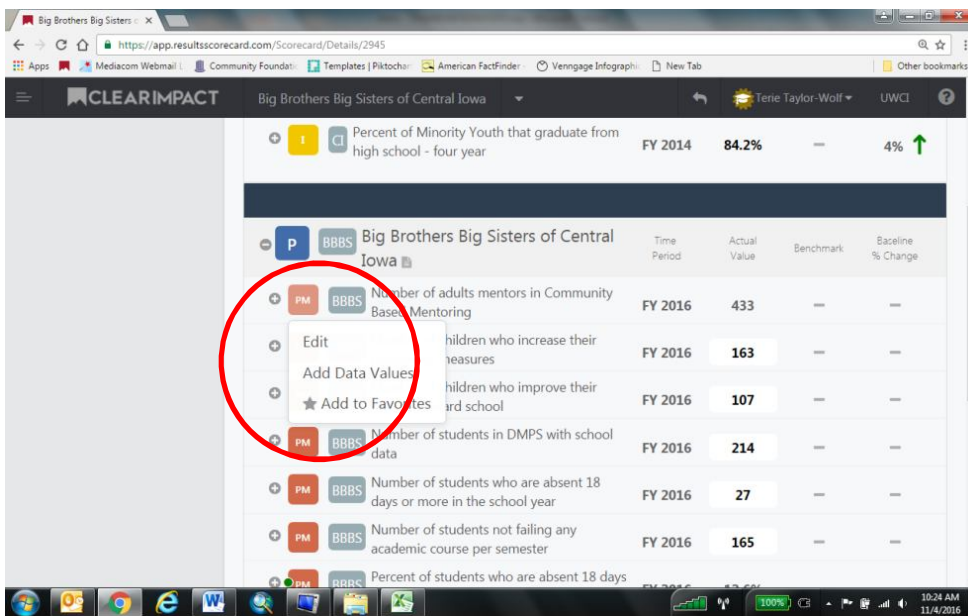
The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure. A line graph shows the trend data from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

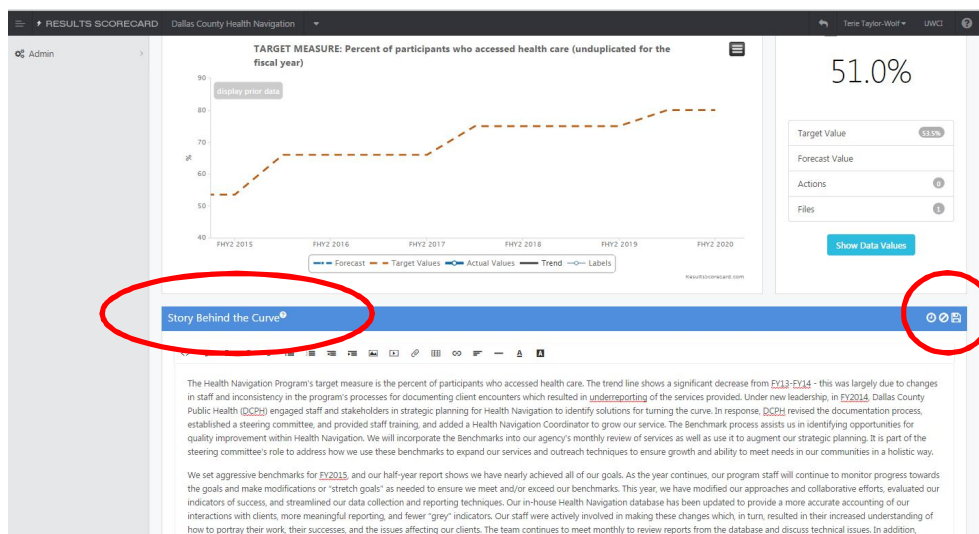
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Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

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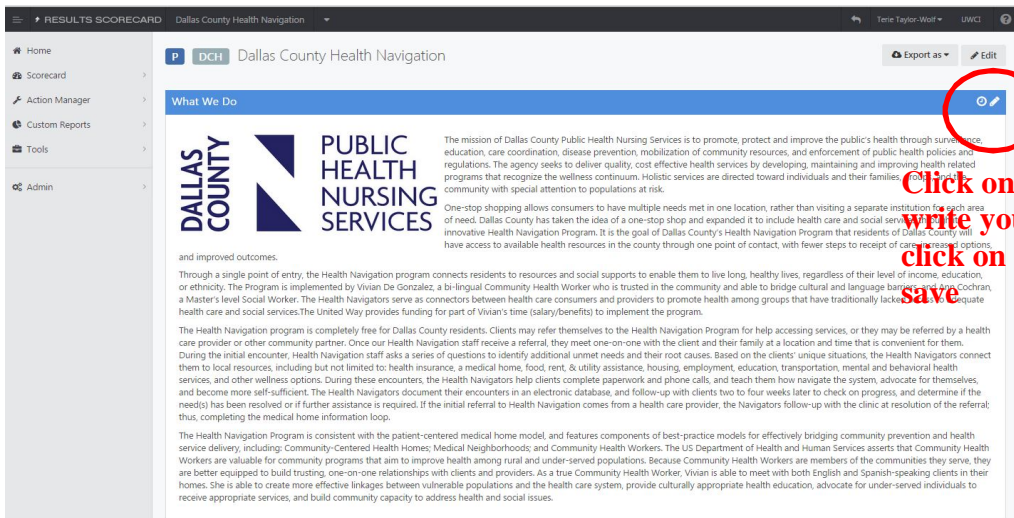
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



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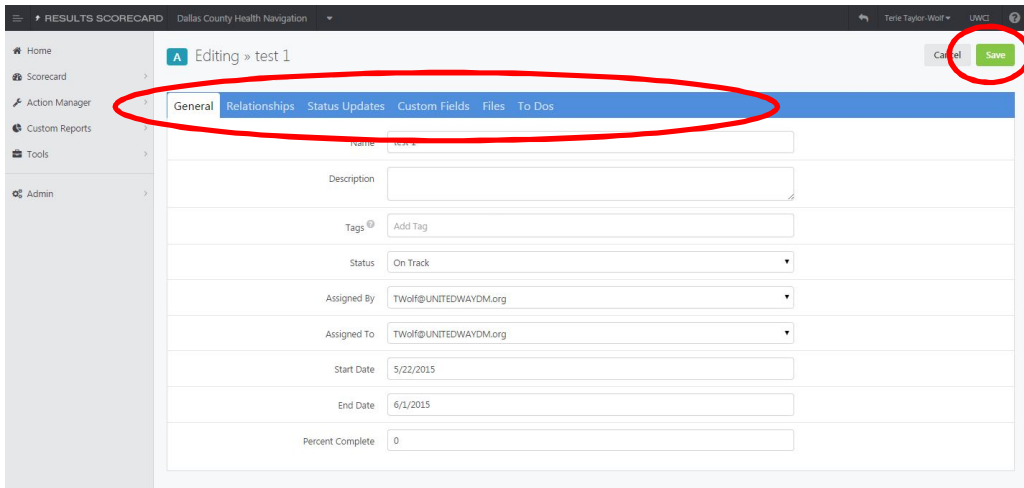


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

For Income Programming, contact Corinne Lambert at 246-6542 or e-mail at clambert@unitedwaydm.org

Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa". The main content area shows a list of performance measures. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. To its right, a table shows the actual value for FY 2016 as 433, with no benchmark or baseline values. A red "Step 3" label is visible in the top right corner of the scorecard area.

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. To the left of the table, a line graph shows the trend data for this measure from FY 2011 to FY 2016. The graph shows a peak in FY 2013 (591) and a low in FY 2016 (433). To the right of the graph, a table shows the actual values for each fiscal year.

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

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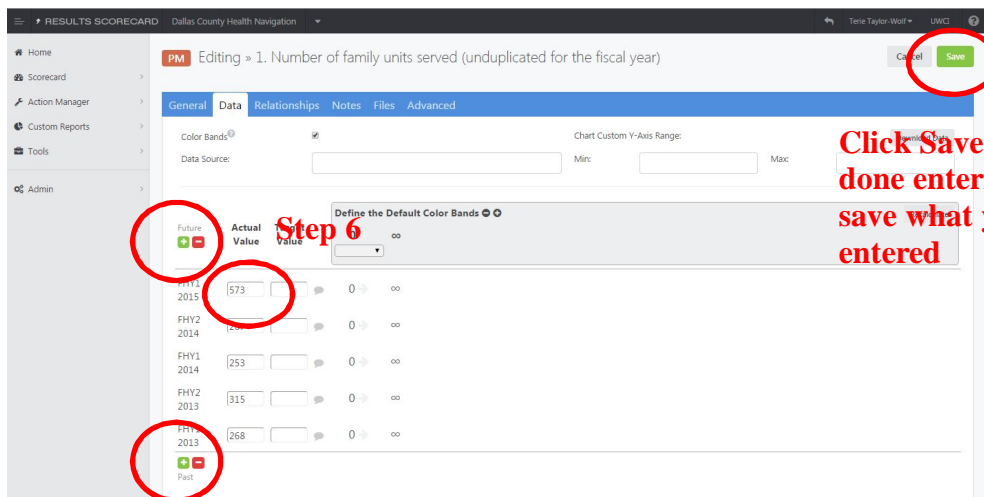
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Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

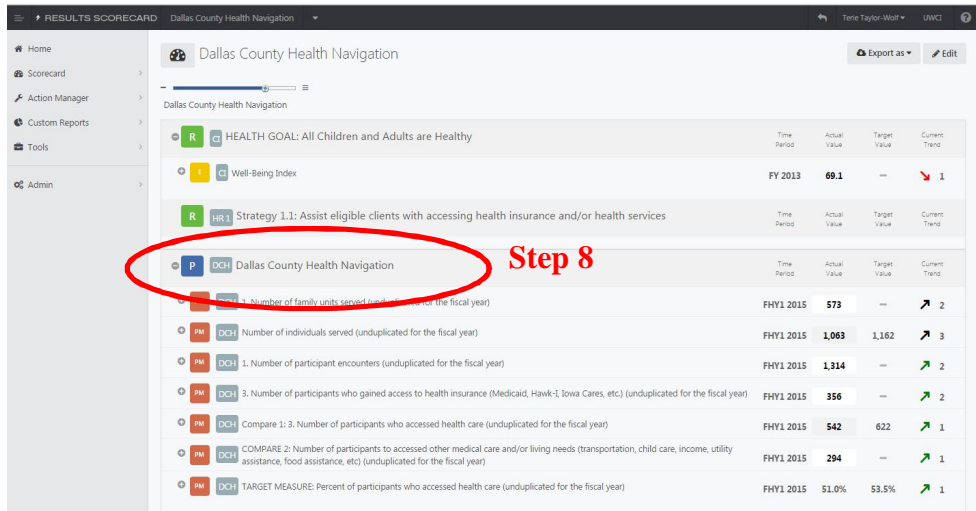
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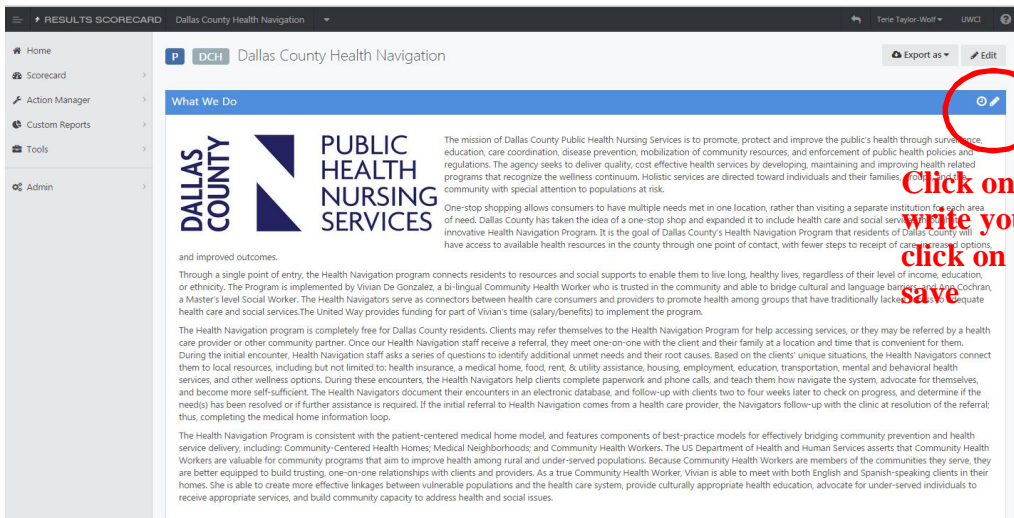
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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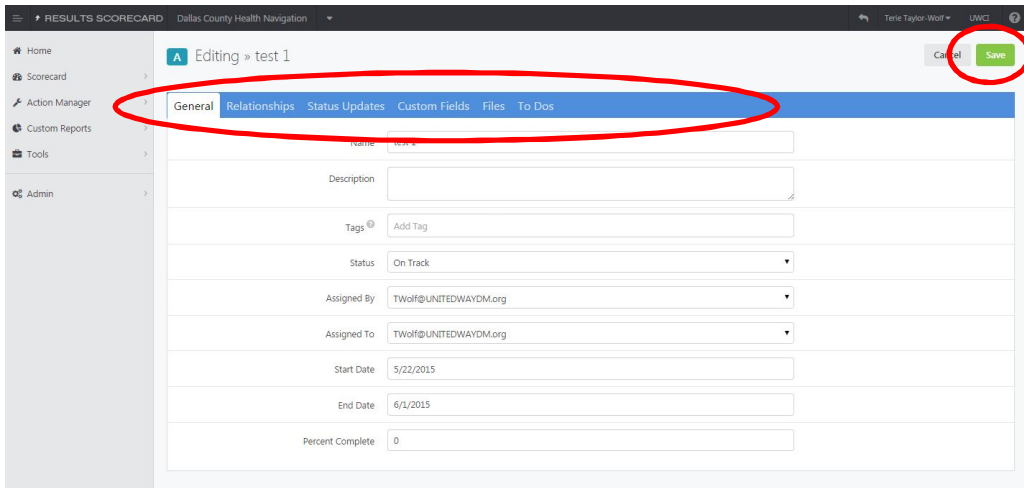


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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

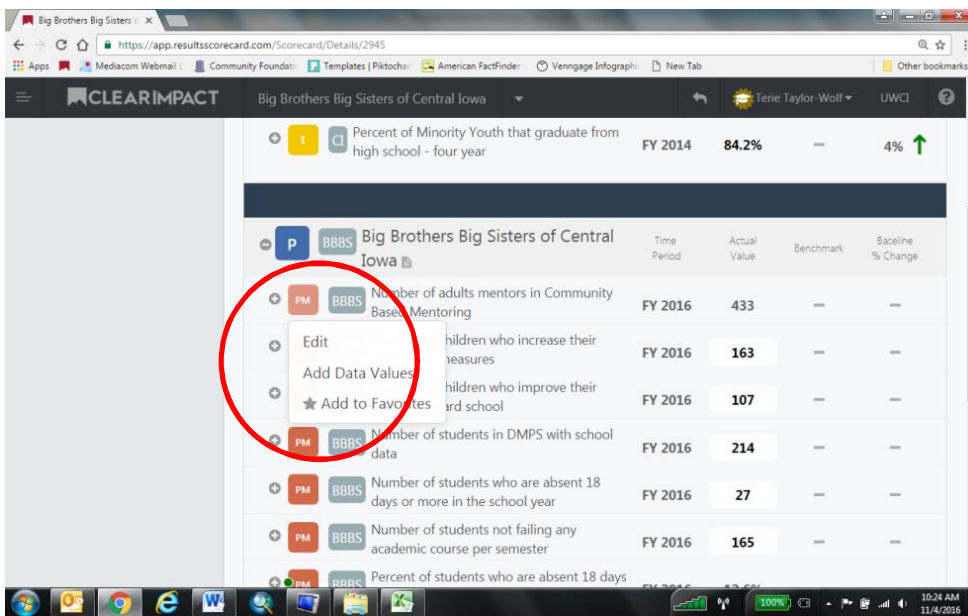
PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
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		FY 2015	467	—	—
		FY 2014	535	—	—
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		FY 2011	496	—	—

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Step 4

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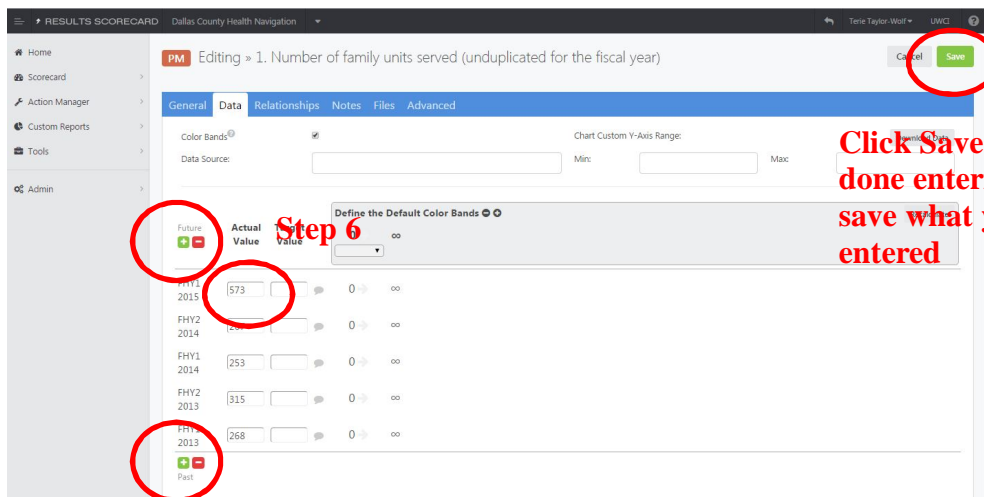


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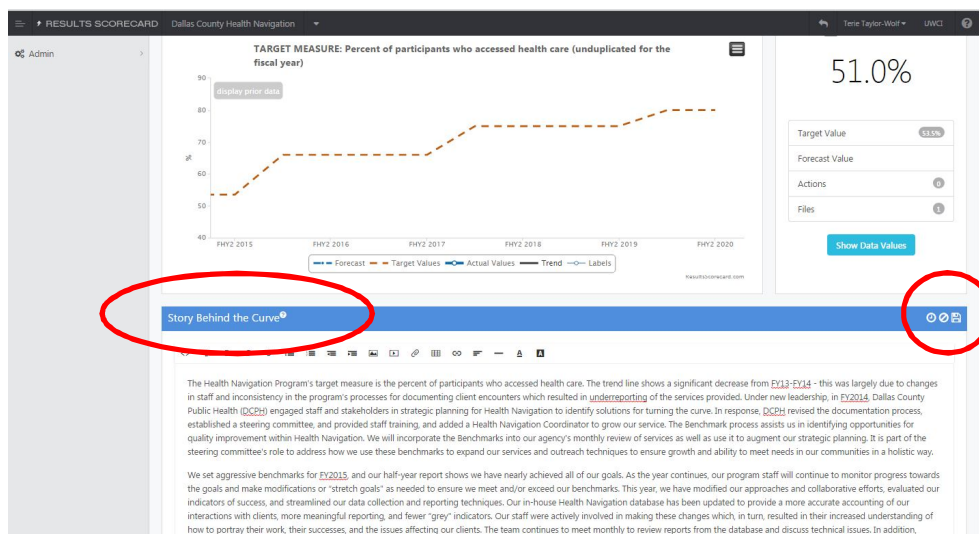
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Step 7

Step 8: Updating Program information

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1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name

Category	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
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Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
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DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
DCH COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
DCH TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)

Step 8

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Step 9

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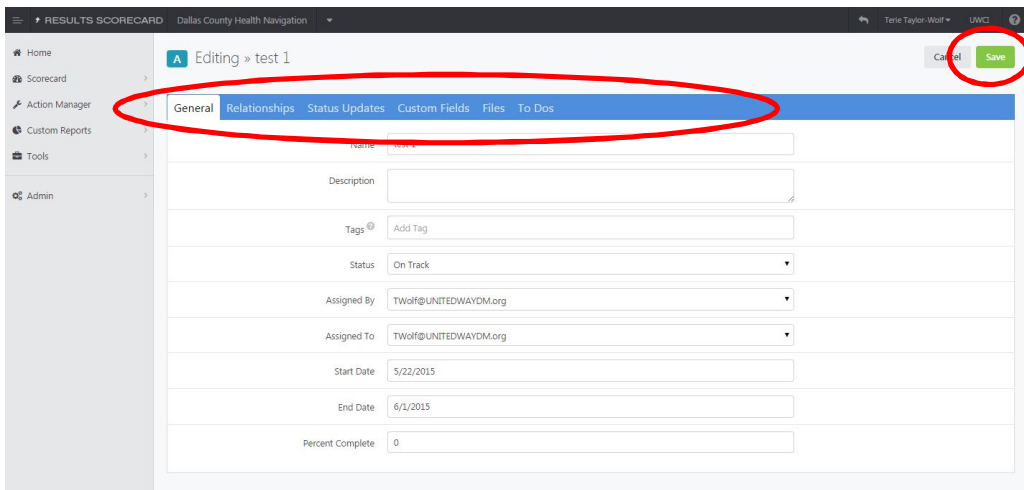


Step 10

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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows the CLEARIMPACT dashboard for Big Brothers Big Sisters of Central Iowa. A list of performance measures is displayed. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

Performance Measure	FY 2016	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	433	—	—
Number of children who increase their confidence measures	163	163	—	—
Number of children who improve their attitude toward school	107	107	—	—
Number of students in DMPS with school data	214	214	—	—
Number of students who are absent 18 days or more in the school year	27	27	—	—
Number of students not failing any academic course per semester	165	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the CLEARIMPACT dashboard for Big Brothers Big Sisters of Central Iowa. The performance measure "Number of adults mentors in Community Based Mentoring" is selected, and its trend data is displayed. A line graph shows the number of mentors from FY 2011 to FY 2016. The table below shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

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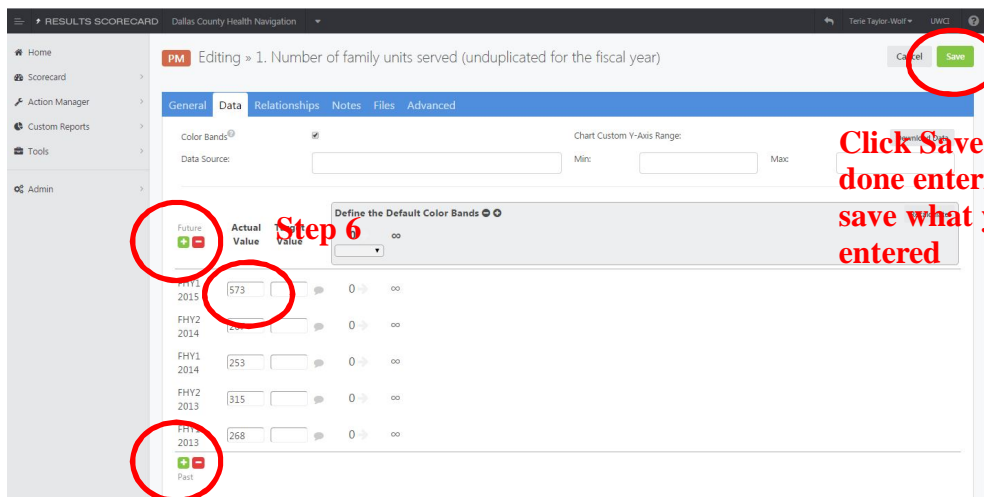
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Step 5
Click on the Data tab

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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s)). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

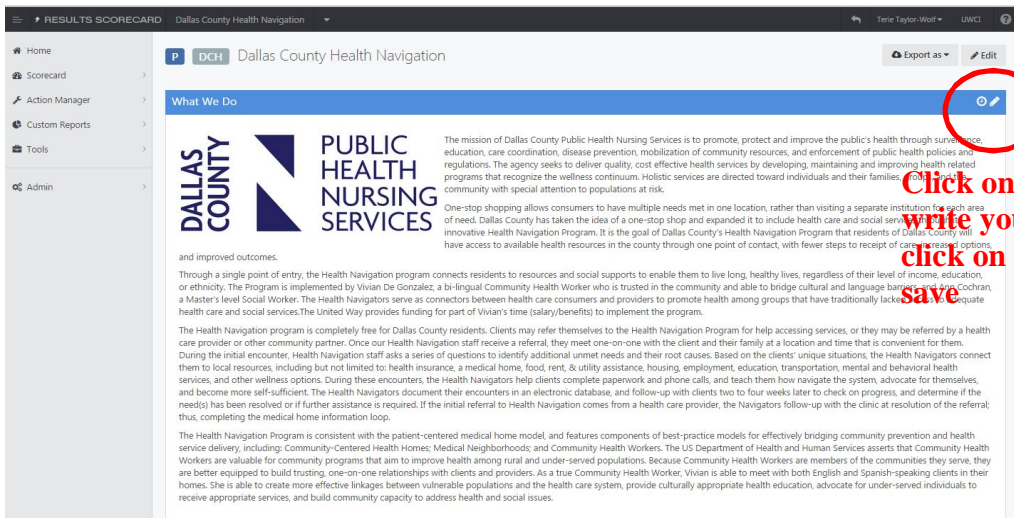
You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

Step 8

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

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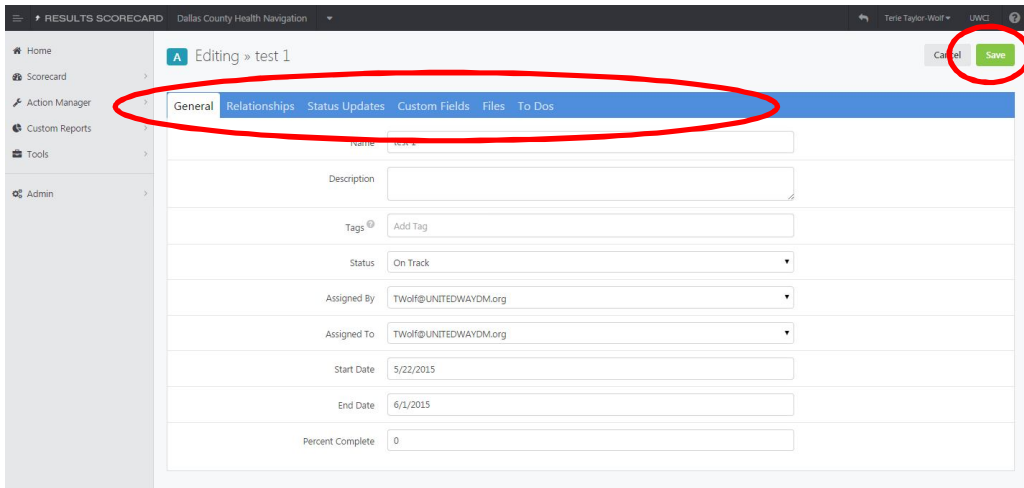


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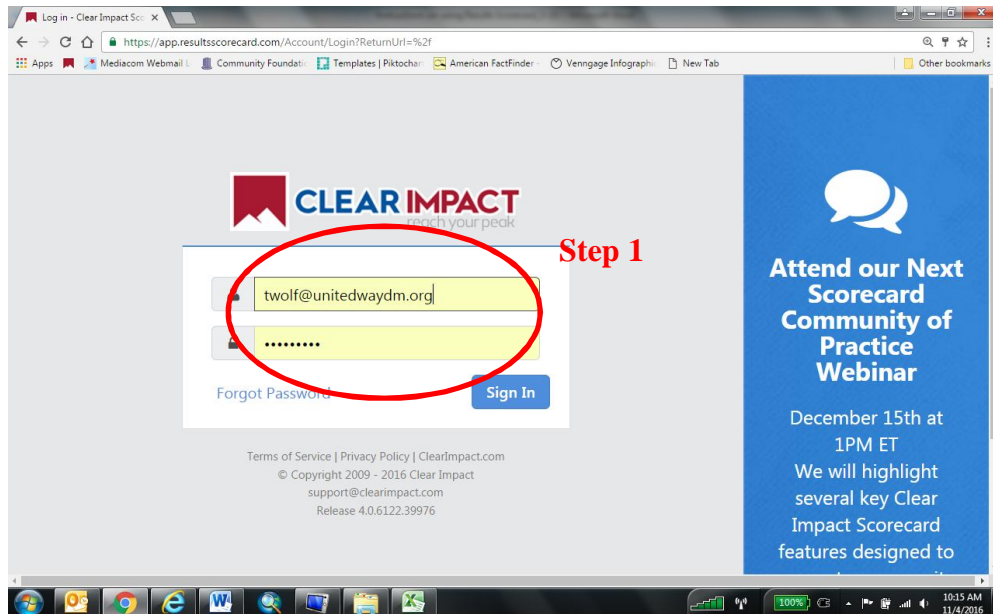
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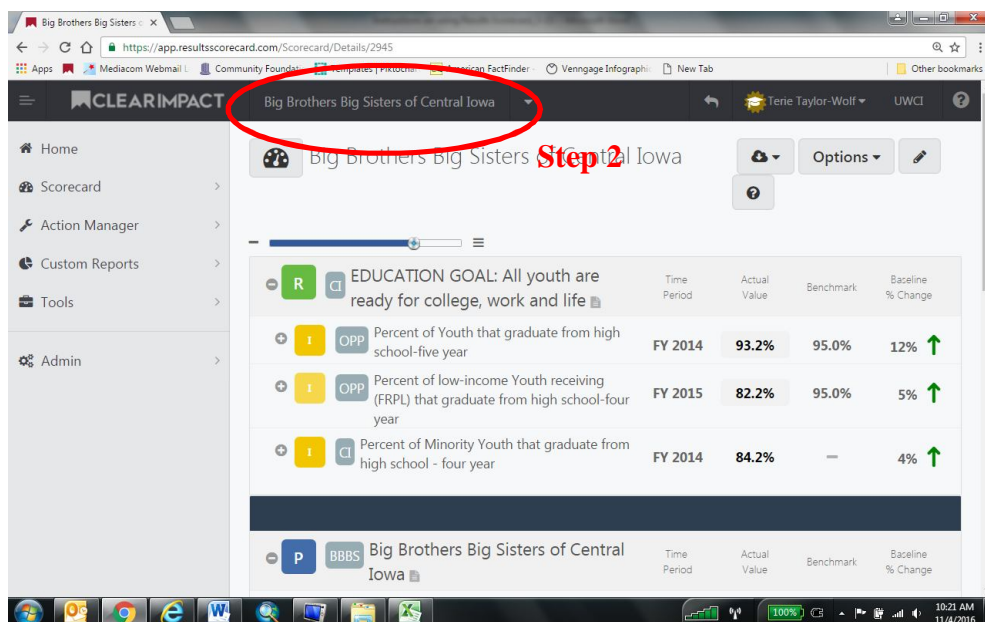
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

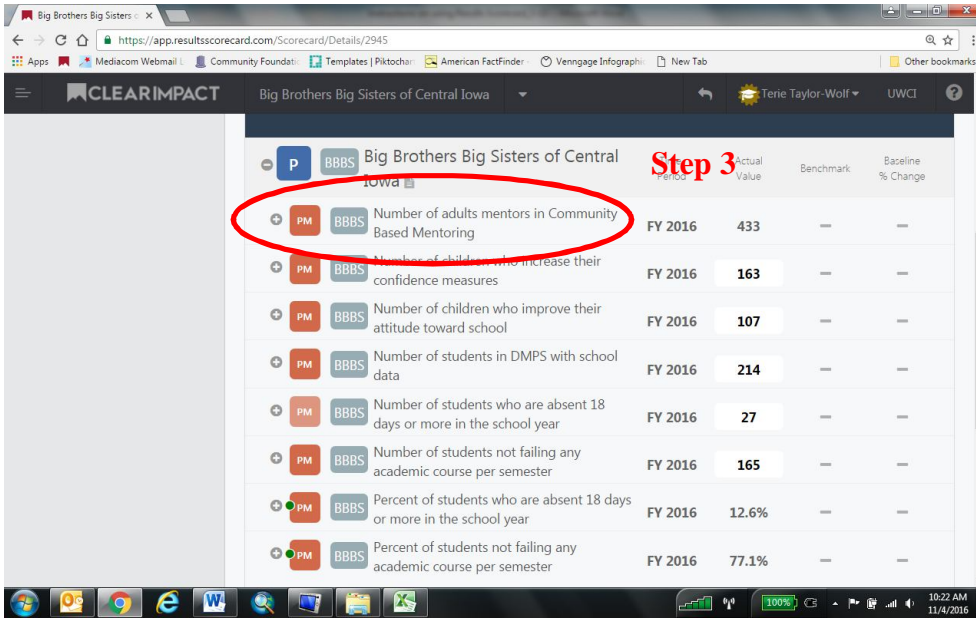
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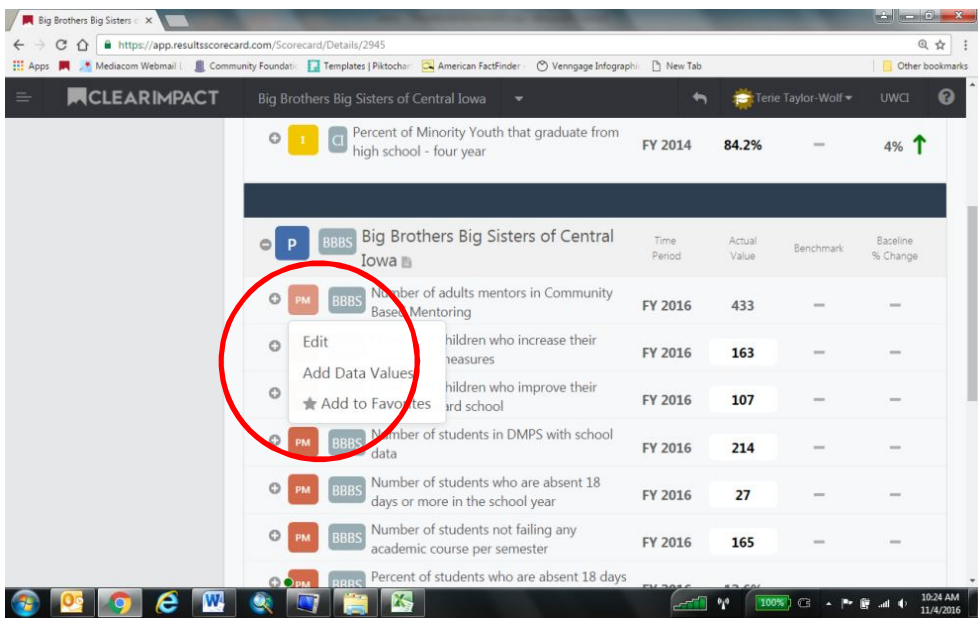
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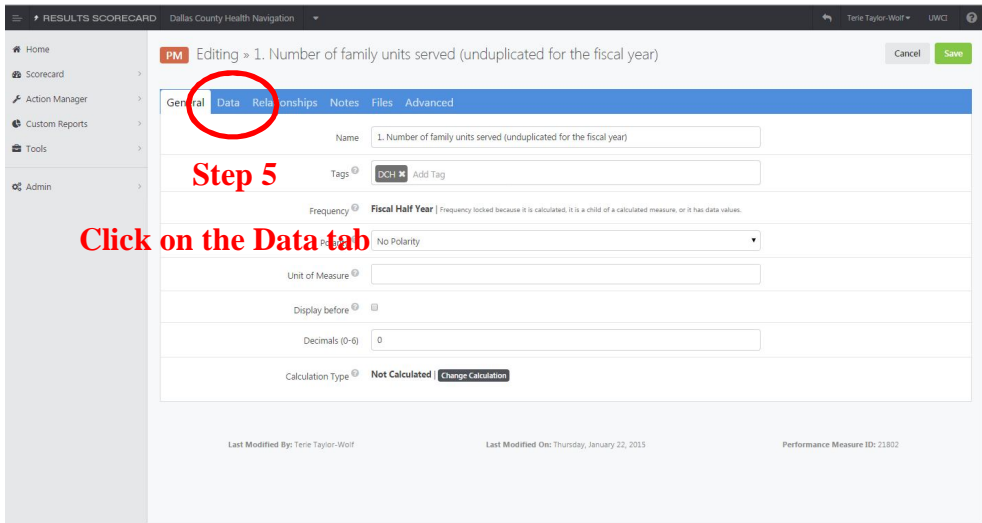
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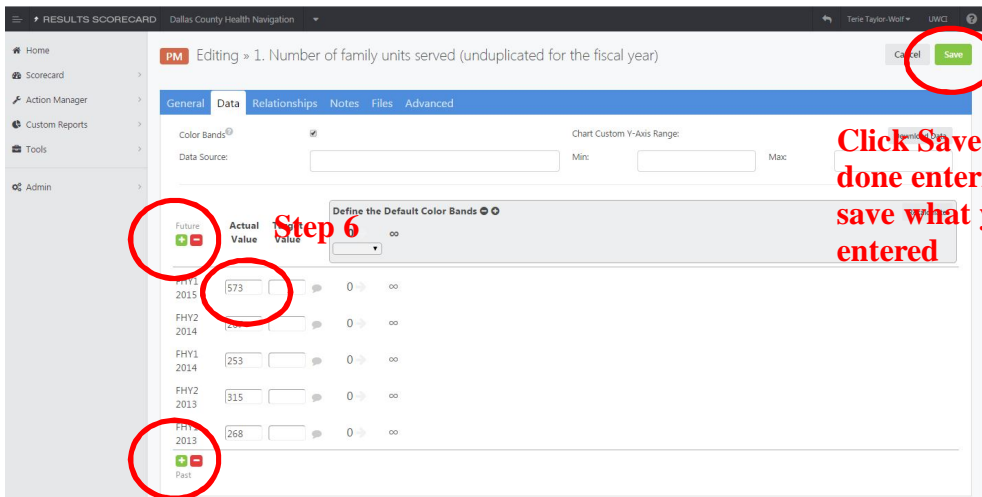
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays 'Forecast', 'Target Values', 'Actual Values', 'Trend', and 'Labels' from FY2 2015 to FY2 2020. The 'Actual Value' is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a text box and a pencil icon circled in red.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same interface as the previous one, but with the 'Story Behind the Curve' text box expanded. The text box contains a detailed narrative about the Health Navigation Program's target measure, including information about staff changes, benchmarking, and outreach techniques. A disk icon in the bottom right corner of the text box is circled in red.

Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

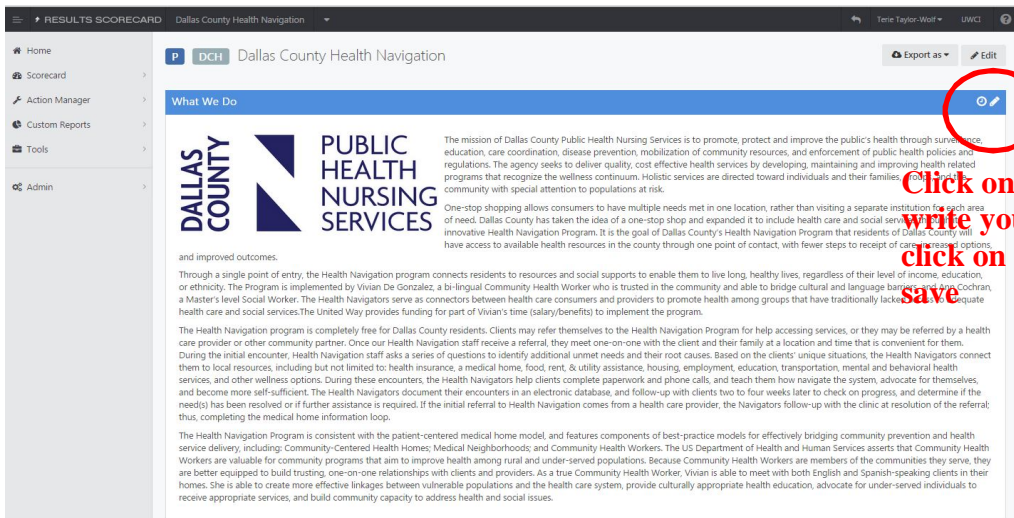
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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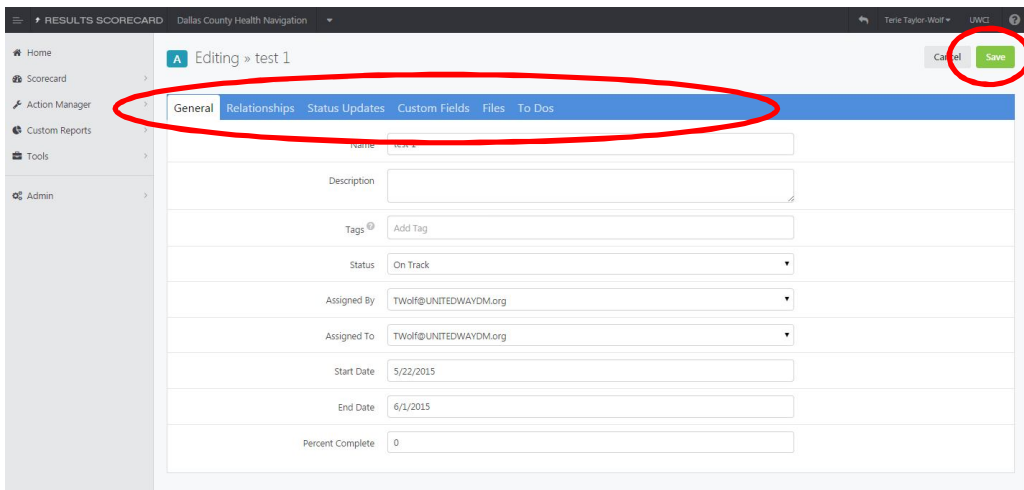


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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



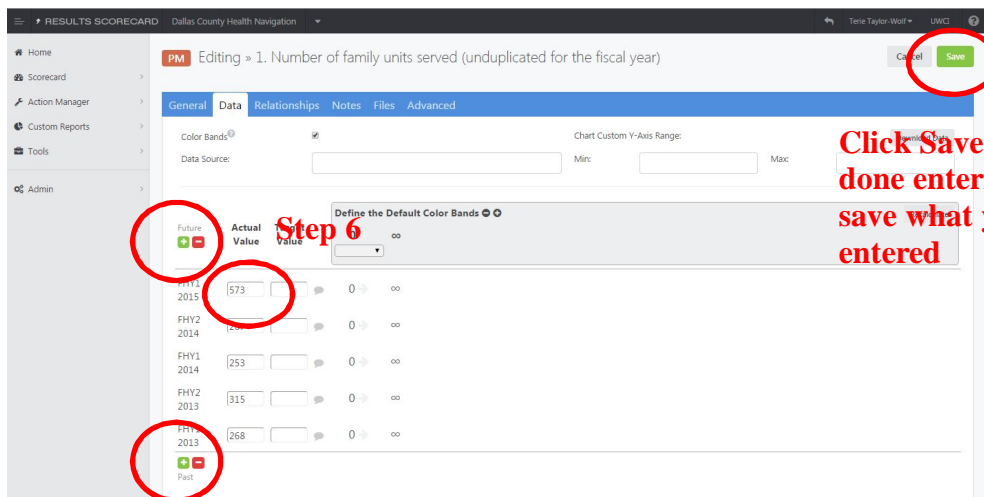
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Step 5
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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a pencil icon circled in red. The text in this section describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to improve the situation.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image, but with the text area expanded. The text describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to improve the situation. A disk icon is circled in red at the bottom right of the text area, indicating where to click to save the narrative.

Click disk icon to save your written material

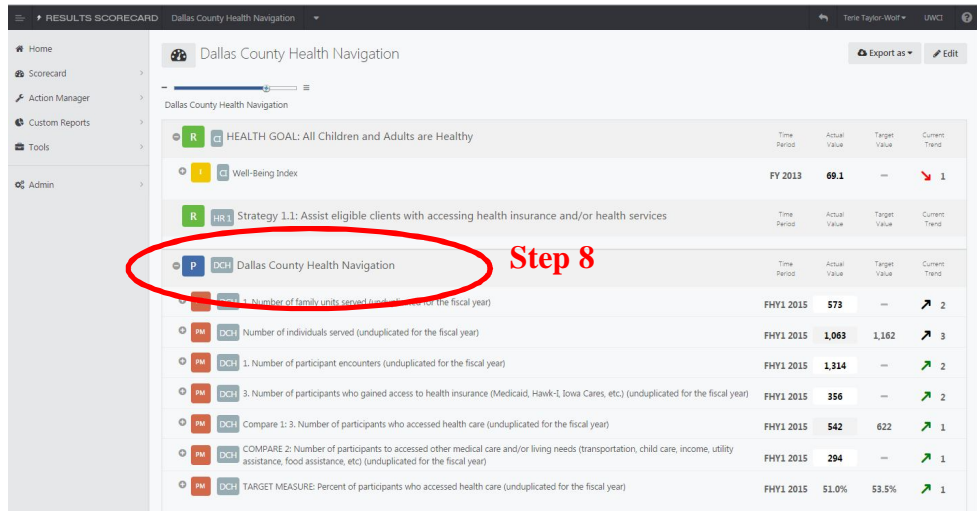
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1. What We Do
2. Who We Serve
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4. Success Story


You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	---	1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	---	2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	---	2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	---	2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	1
DCH COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	---	1
DCH TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	1

Step 8

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the "disk icon" on the far right to save. Scroll down and do the same for all four areas. ("What We Do", "Who We Serve", "How We Impact", "Success Story")



What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if the need(s) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 8

Click on the pencil icon to write your narrative material, click on the "disk icon" to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



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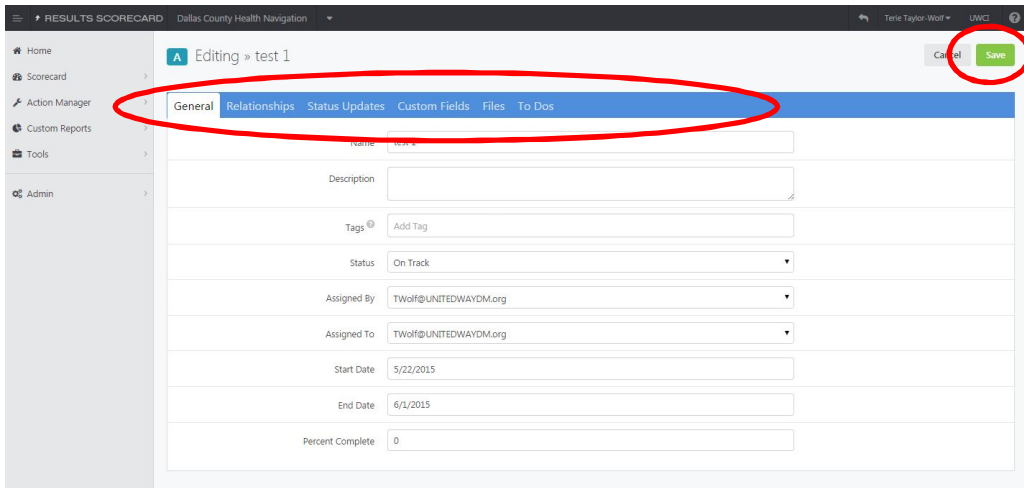


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Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change	
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+	PM BBBS	Number of students in DMPS with school data	FY 2016	214	-	-
+	PM BBBS	Number of students who are absent 18 days or more in the school year	FY 2016	27	-	-
+	PM BBBS	Number of students not failing any academic course per semester	FY 2016	165	-	-
+	PM BBBS	Percent of students who are absent 18 days or more in the school year	FY 2016	12.6%	-	-
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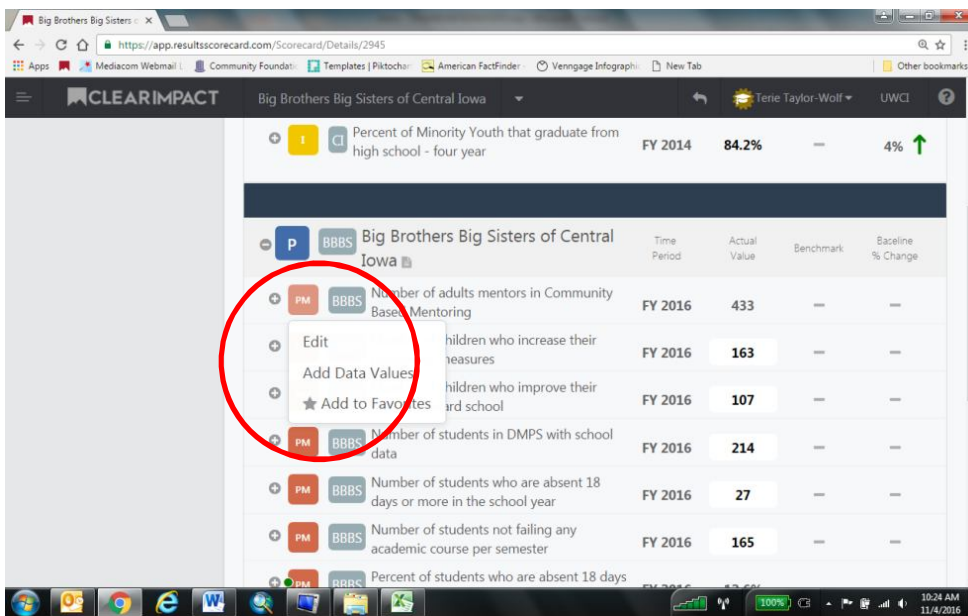
The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change	
+	PM BBBS	Percent of Minority Youth that graduate from high school - four year	FY 2014	84.2%	-	4% ↑
+	PM BBBS	Number of adults mentors in Community Based Mentoring	FY 2016	433	-	-
		FY 2015	467	-	-	
		FY 2014	535	-	-	
		FY 2013	591	-	-	
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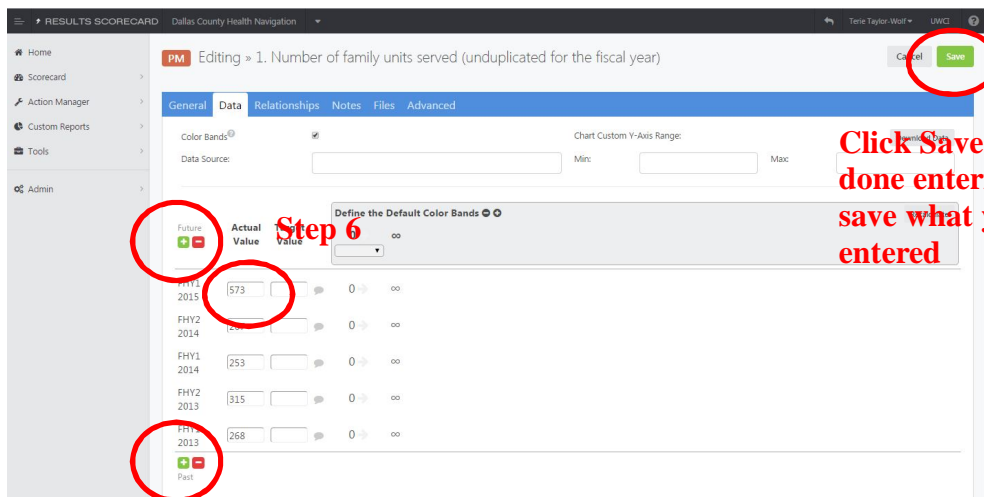
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Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

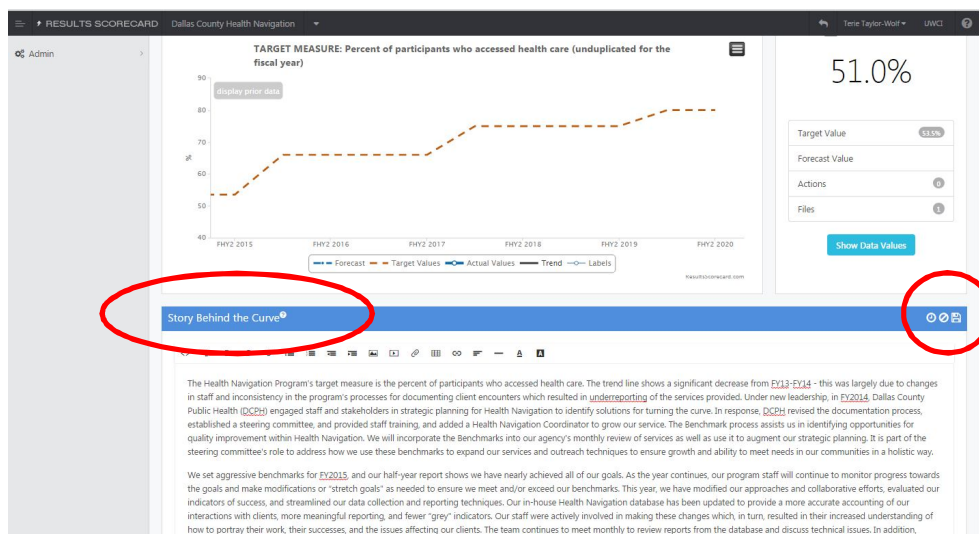
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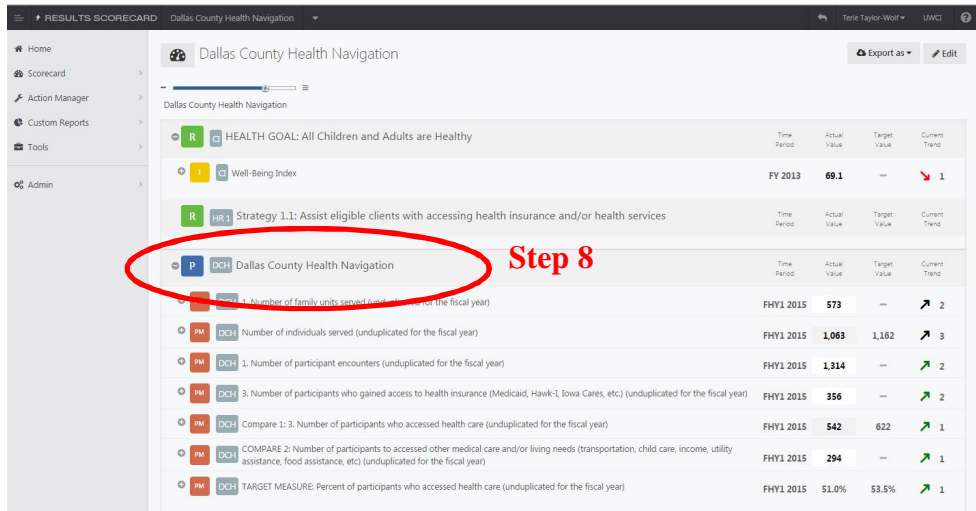
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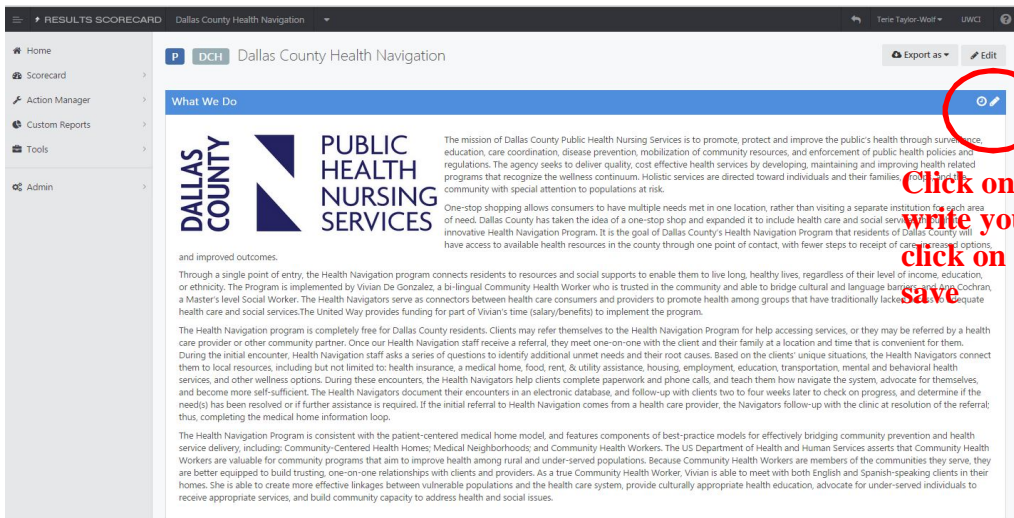
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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
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1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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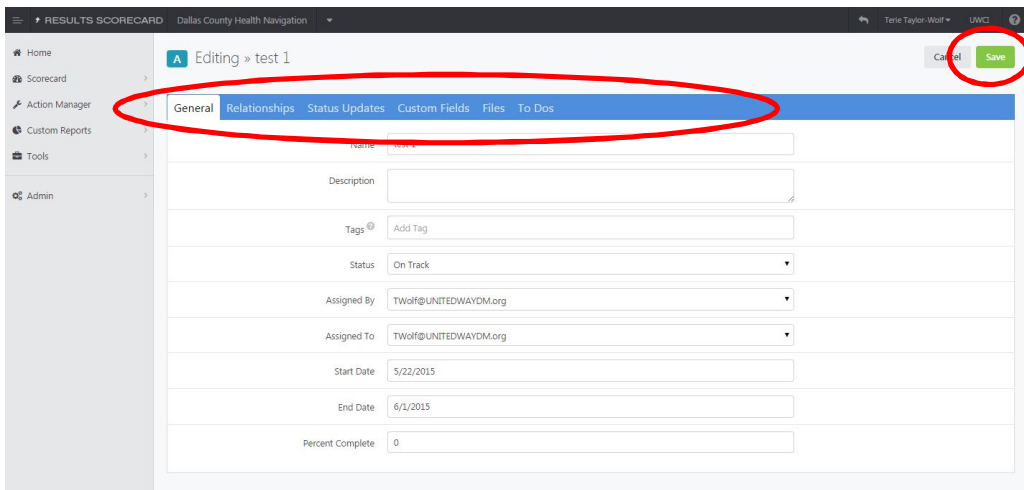


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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table below shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"

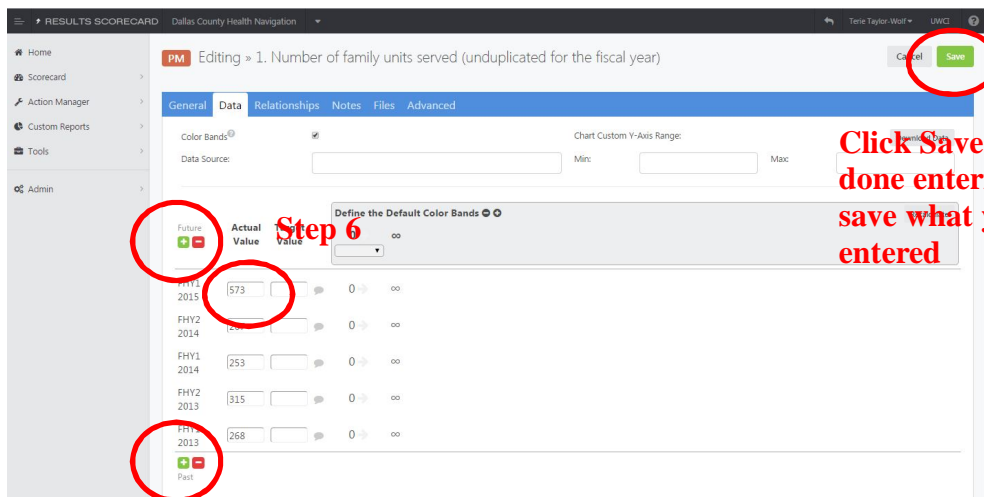


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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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Q1	July 1-Sept. 30
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays forecast, target, and actual values from FY2015 to FY2020. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a text area and a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image. The text area is now populated with a detailed narrative about the Health Navigation Program's target measure, including information about staff changes, benchmarking, and outreach techniques. A disk icon in the bottom right corner of the text area is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

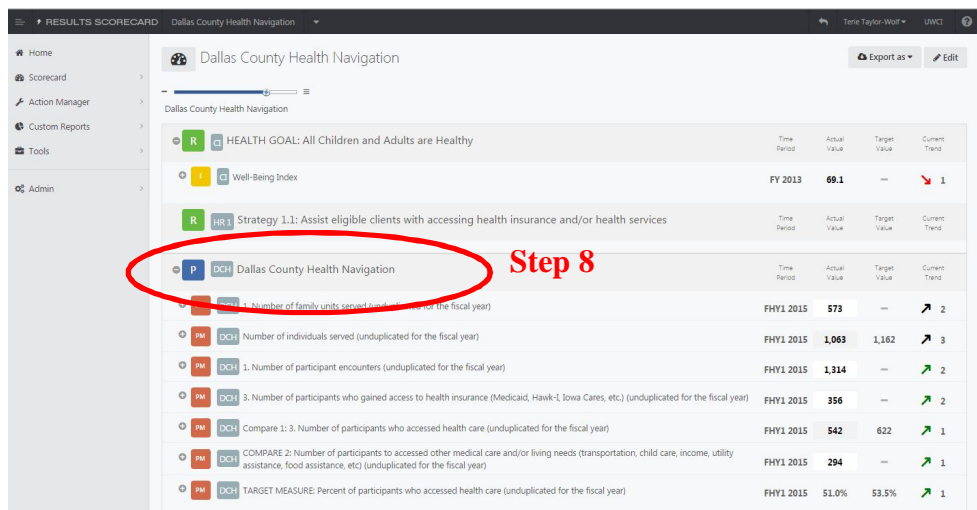
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Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

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4. Success Story

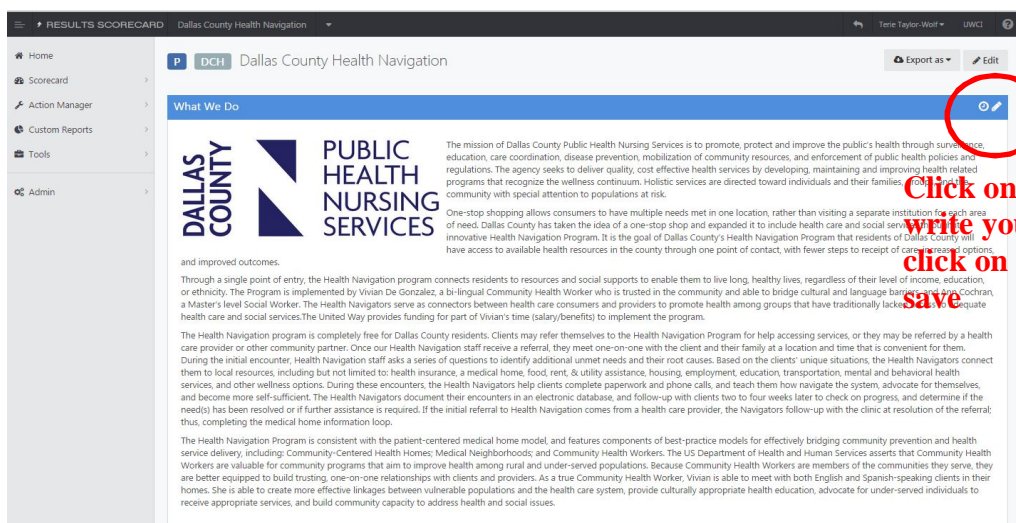
You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

Step 8

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services under one roof. An innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

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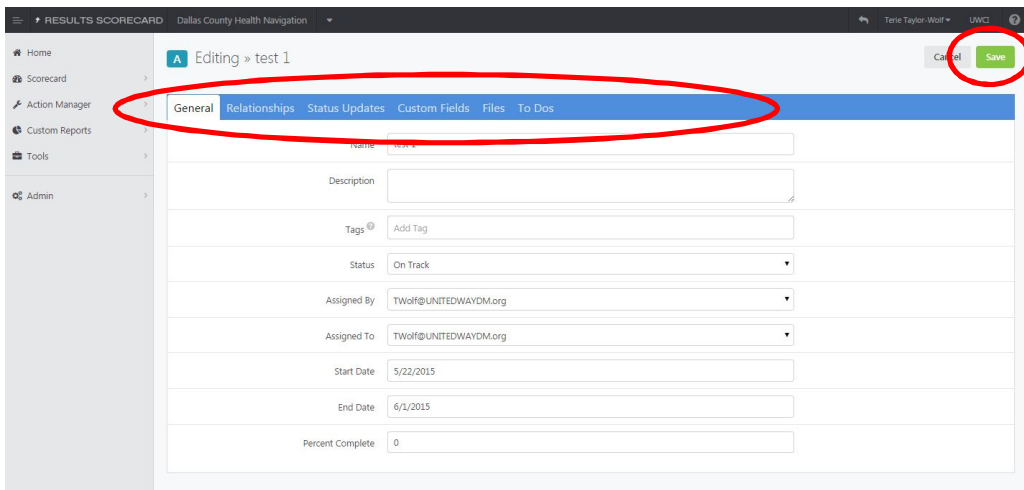


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

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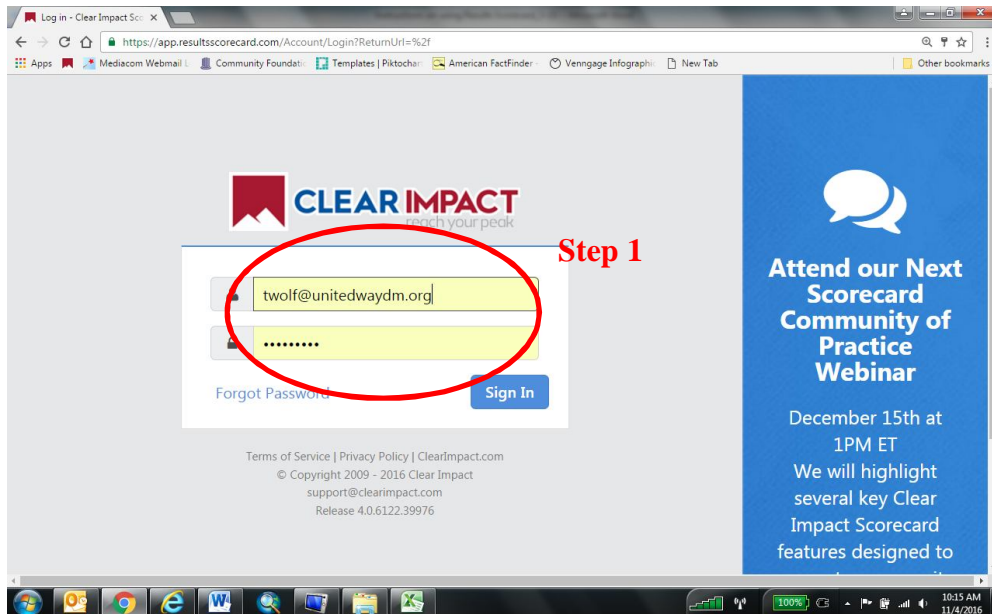
Instructions on using Results Scorecard

Step 1: Login

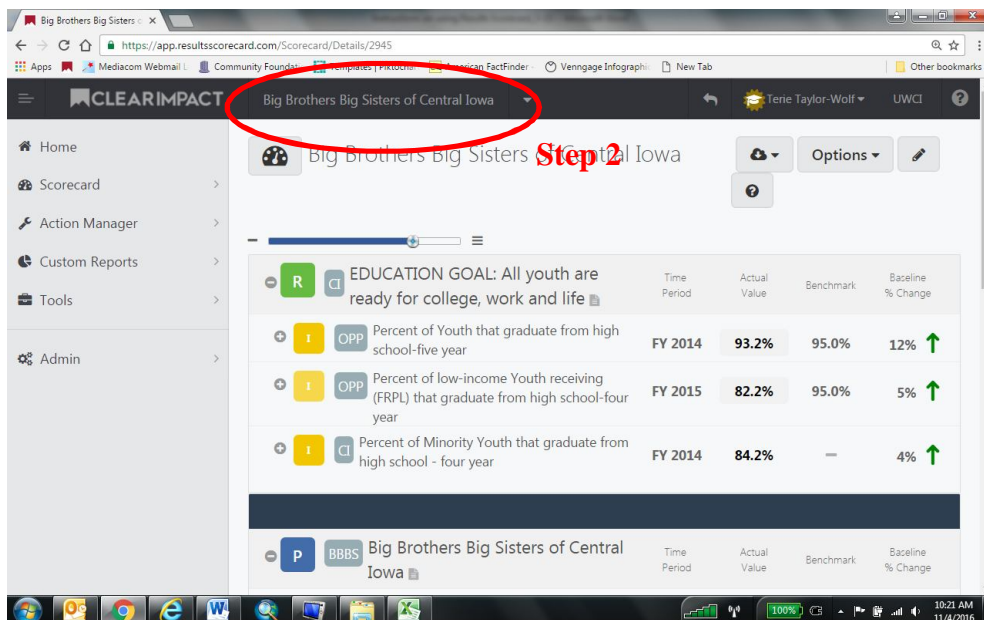
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PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

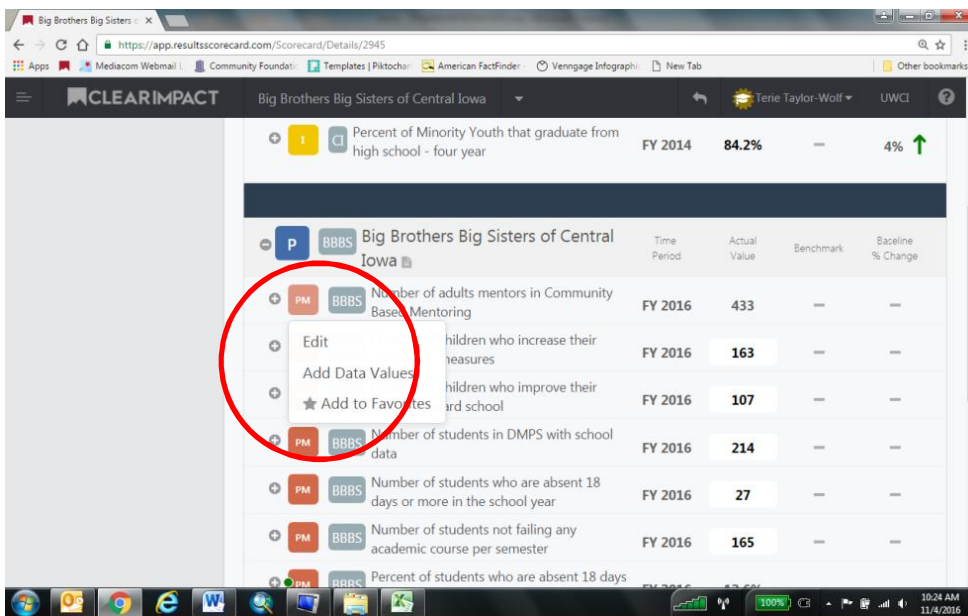
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Step 4

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Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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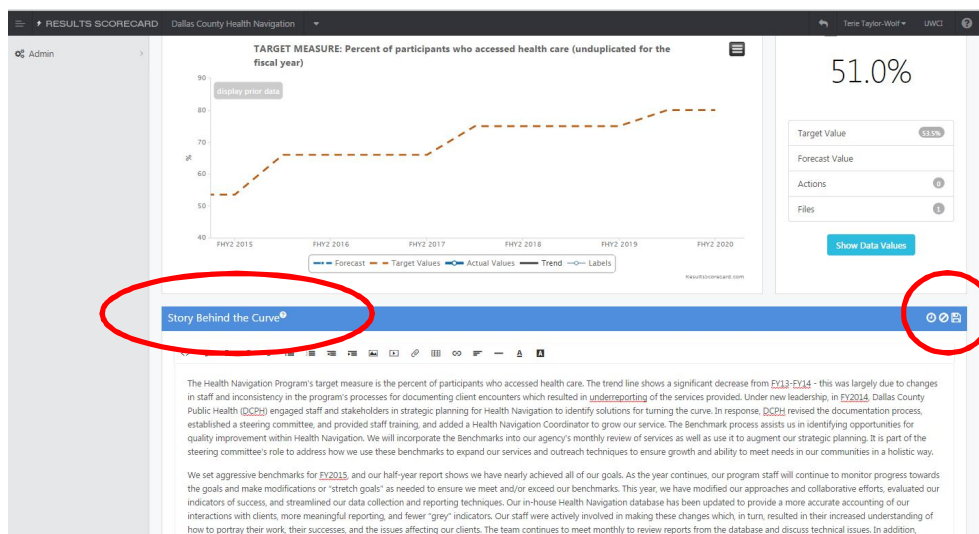
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Step 7



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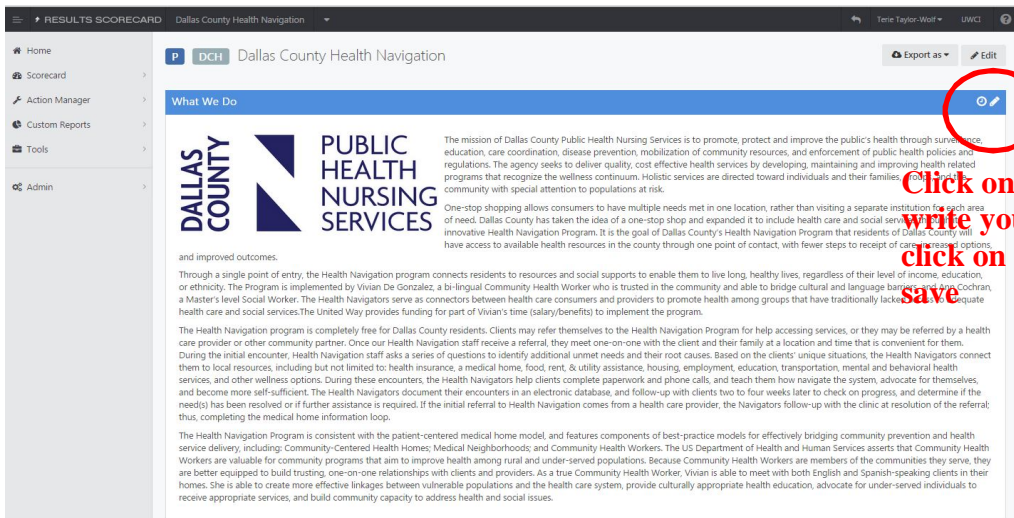
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Program	Time Period	Actual Value	Target Value	Current Trend
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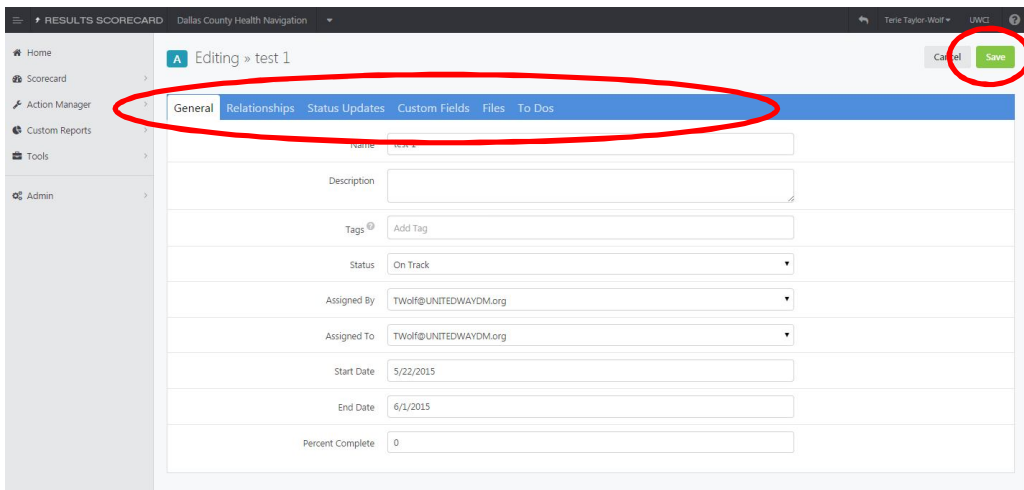


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Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
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Target Measure	57%	133%	80.0%

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Percent of students who are absent 18 days or more in the school year	12.6%	—	—
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The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a decline in FY 2015.

Time Period	Actual Value	Benchmark	Baseline % Change
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FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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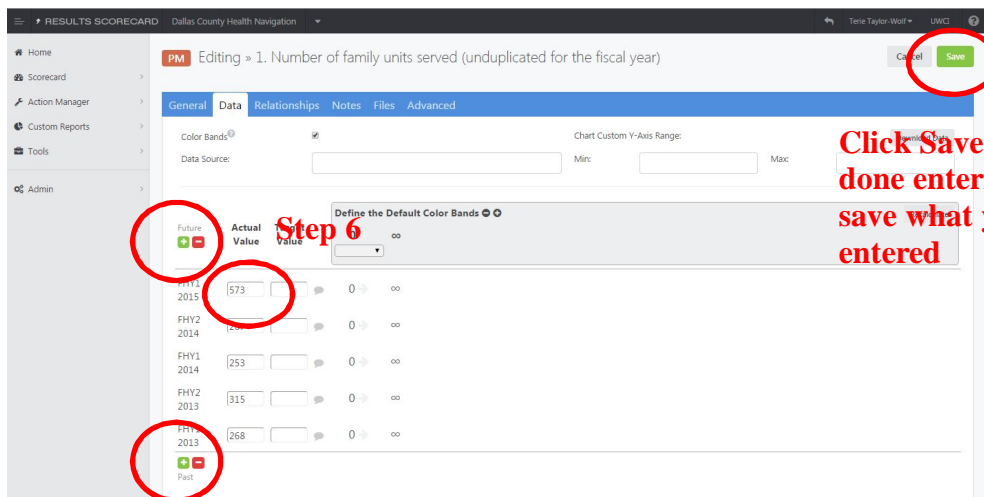
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Step 7

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1. What We Do
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Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
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COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

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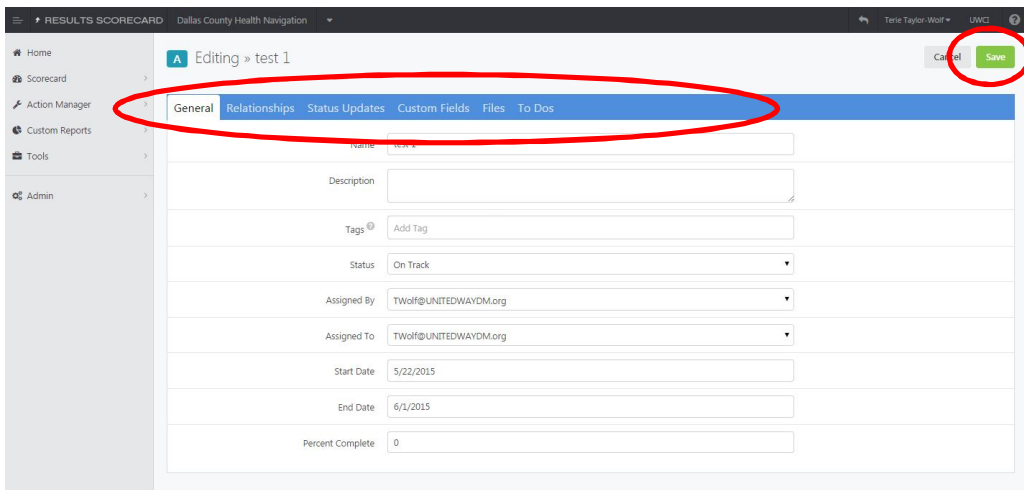


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It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
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Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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The screenshot shows a web browser window displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

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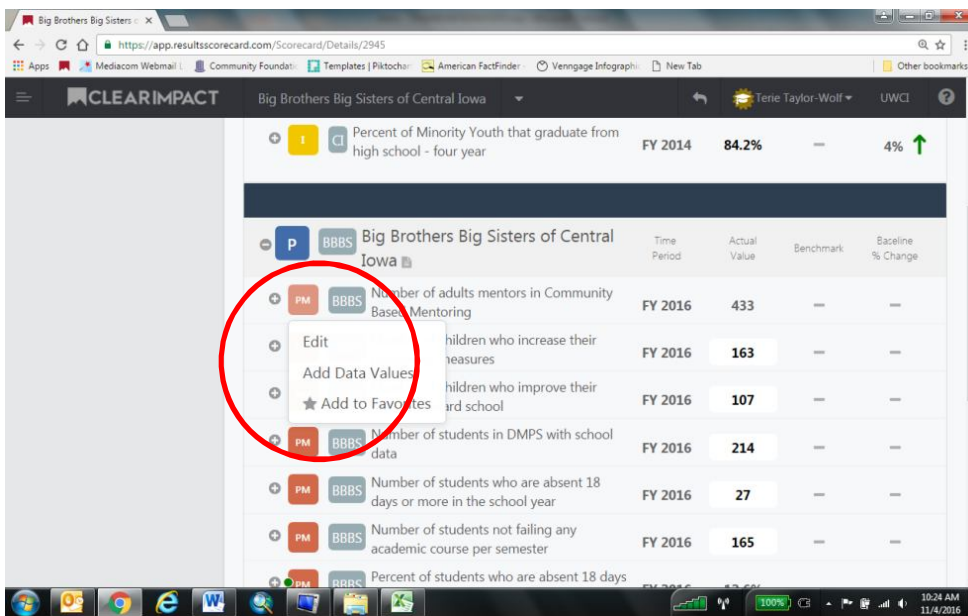
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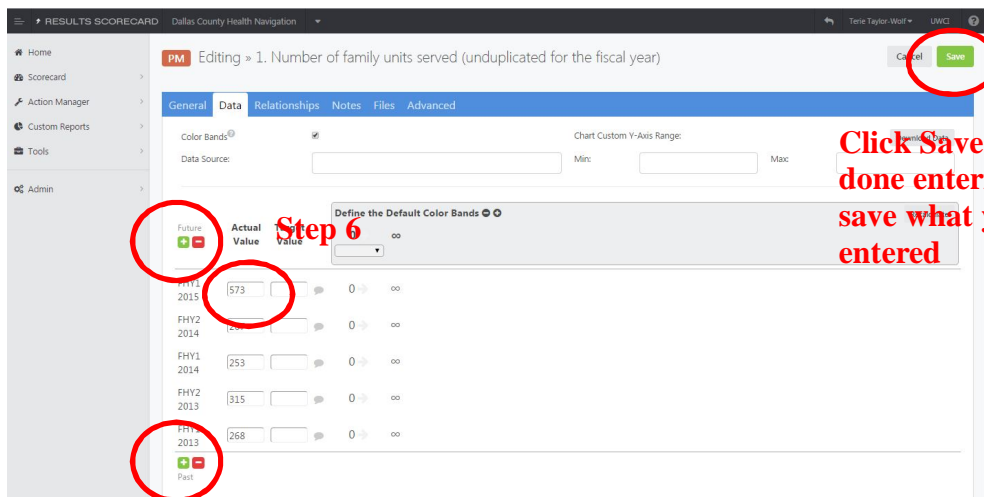
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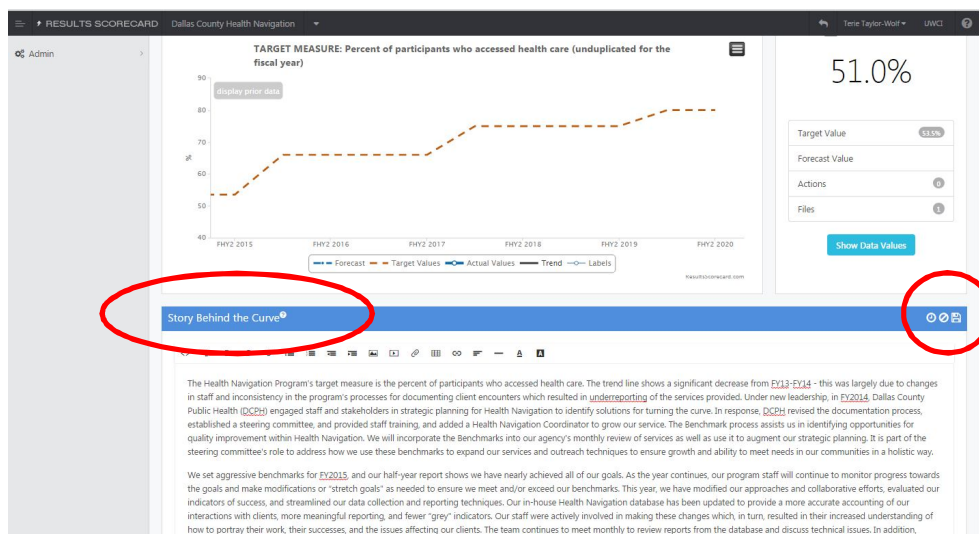
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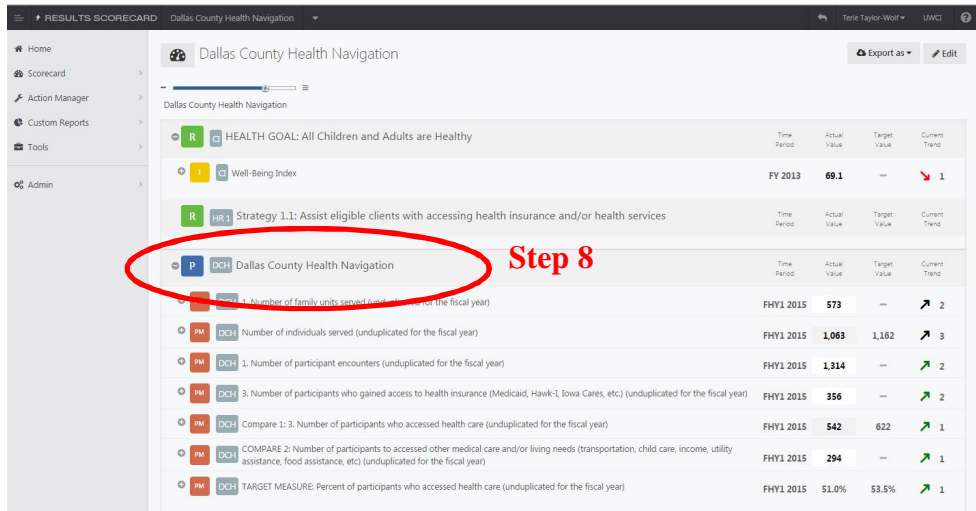
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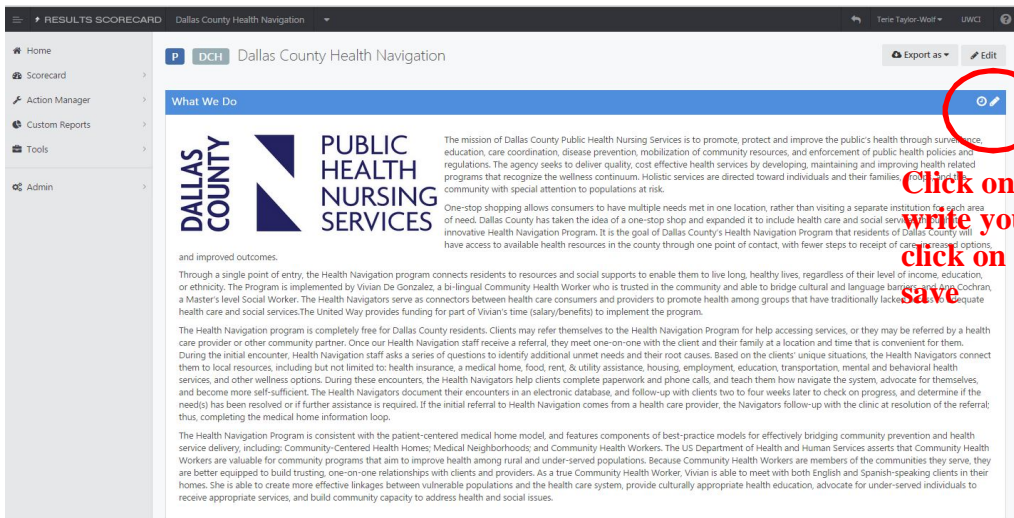
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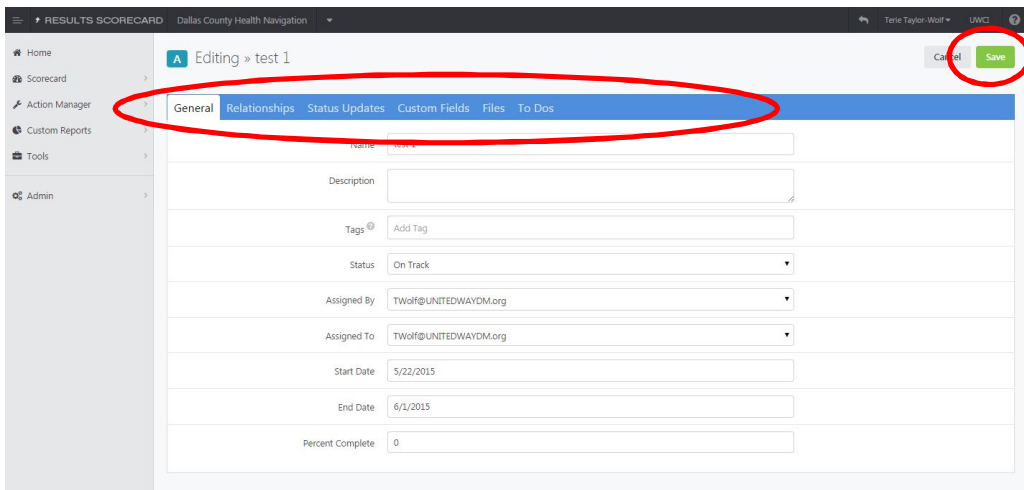


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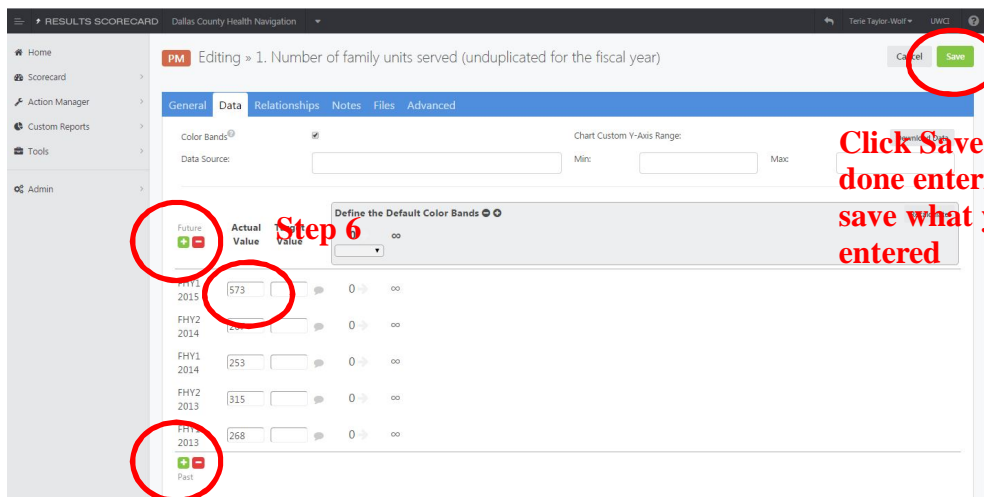
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. The current actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a text box and a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section, but now the text box is expanded and contains a detailed narrative. A disk icon in the bottom right corner of the text box is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

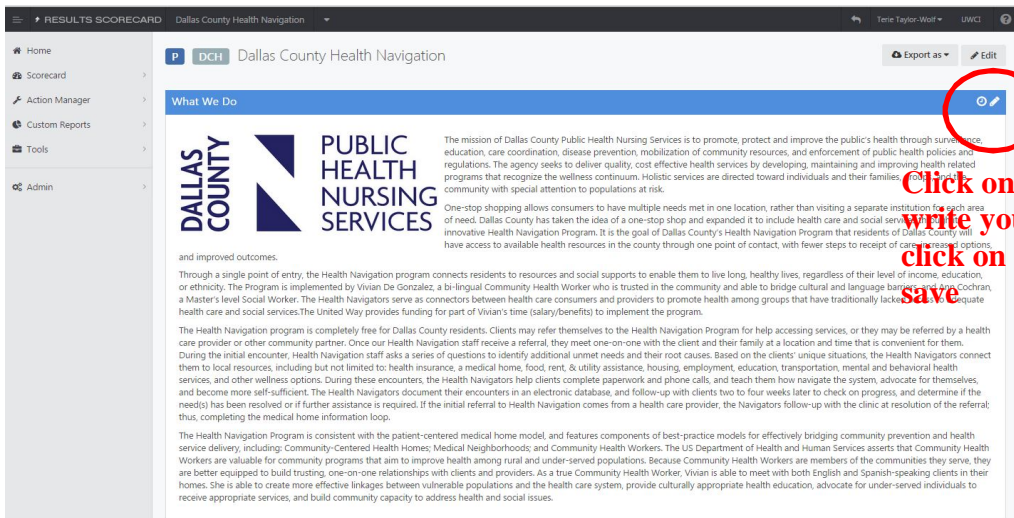
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral, thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



Step 9

Optional Step 10: For those of you who want to track “Actions” from your Action Plan, click on “New Action” to create an action or “Existing Action” if you already have an assigned action you wish to review or edit.

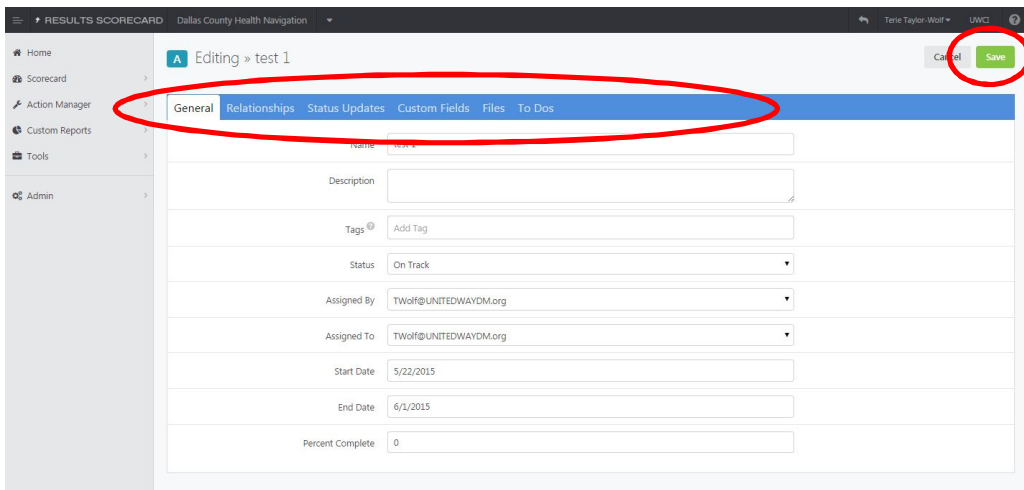


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

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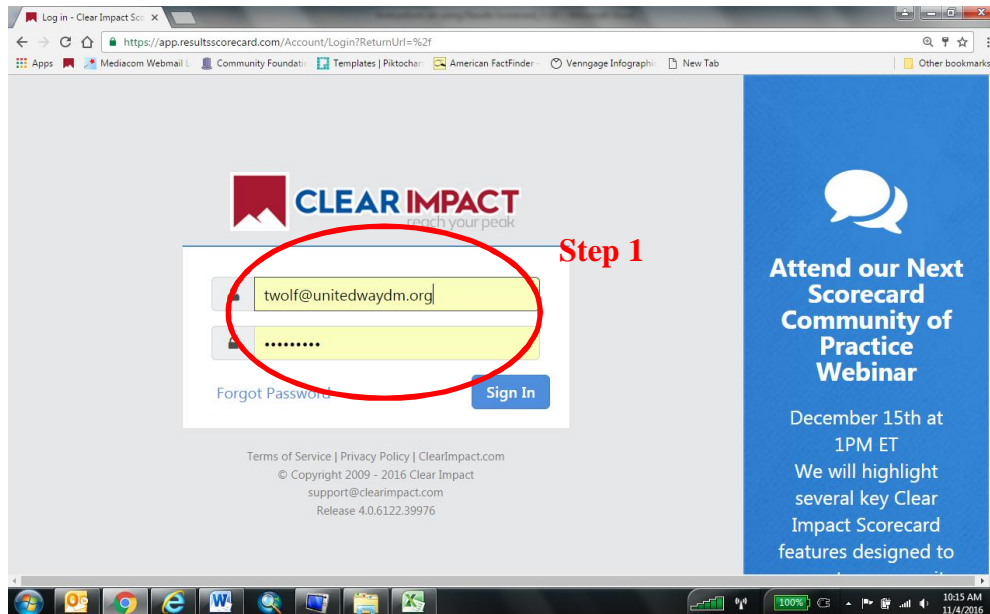
Instructions on using Results Scorecard

Step 1: Login

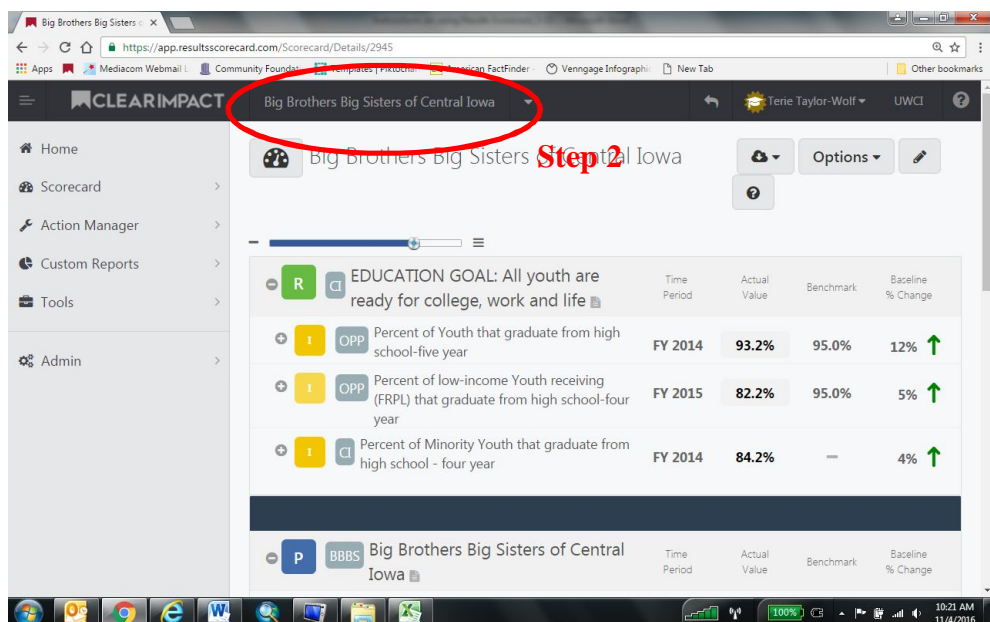
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

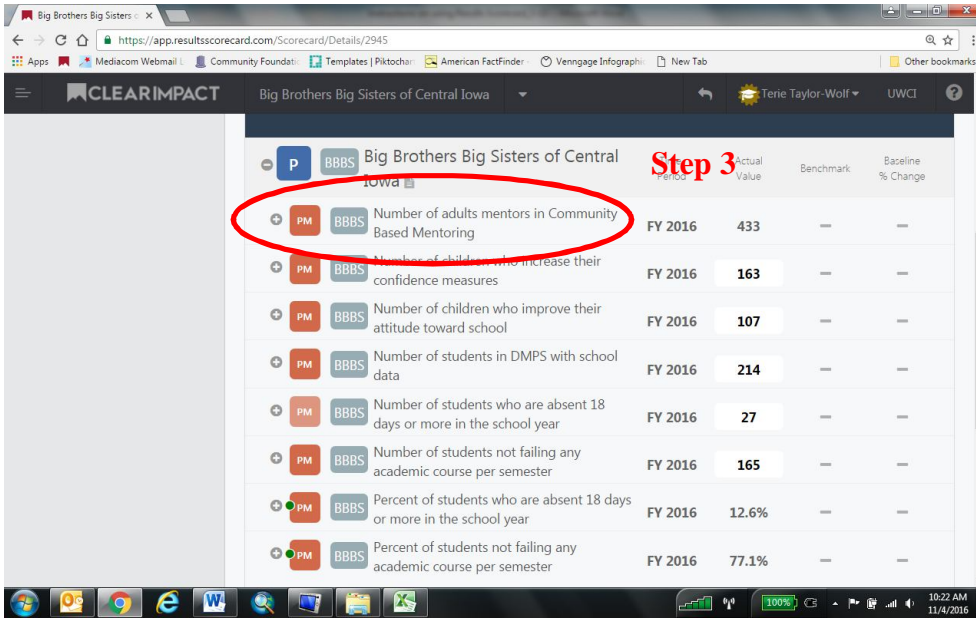
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.



By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

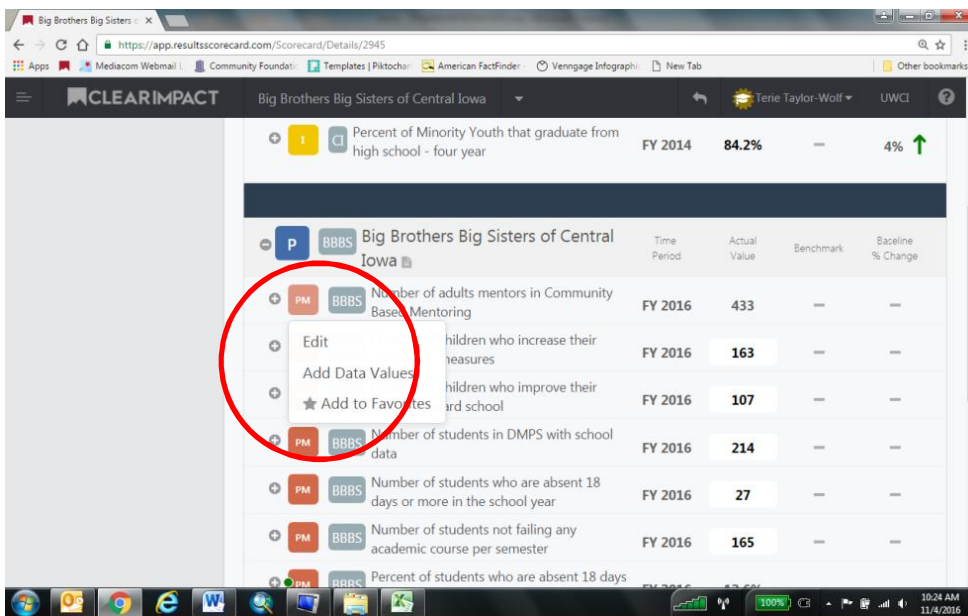


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Step 4

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Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

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Click Save button when done entering data to save what you have entered

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

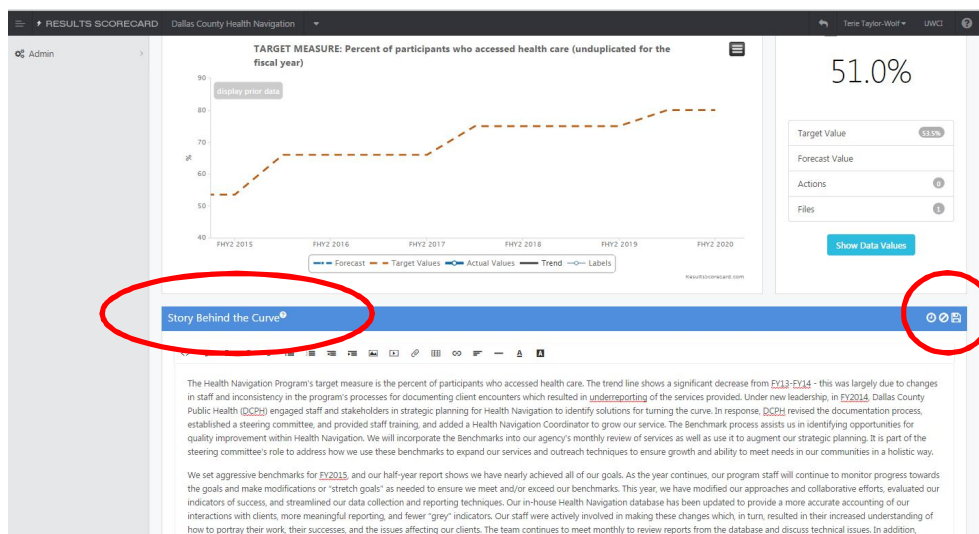
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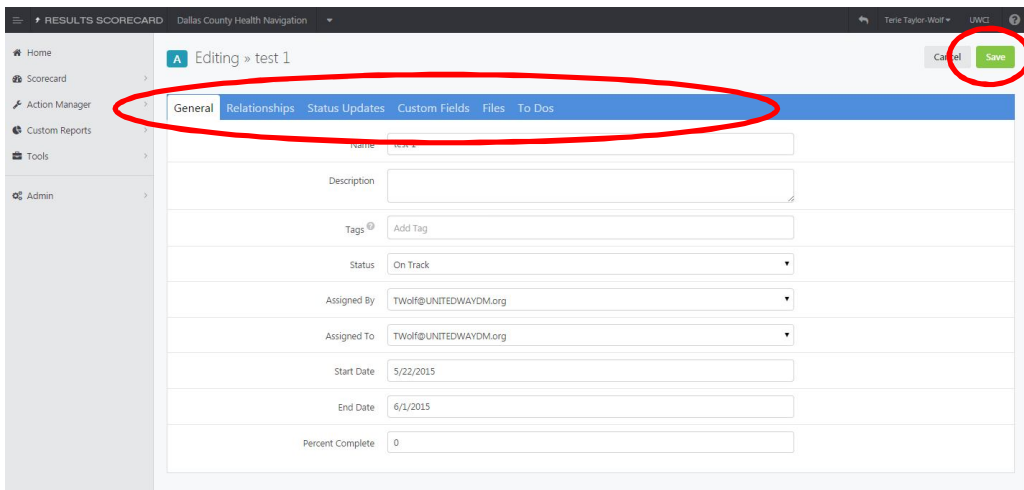


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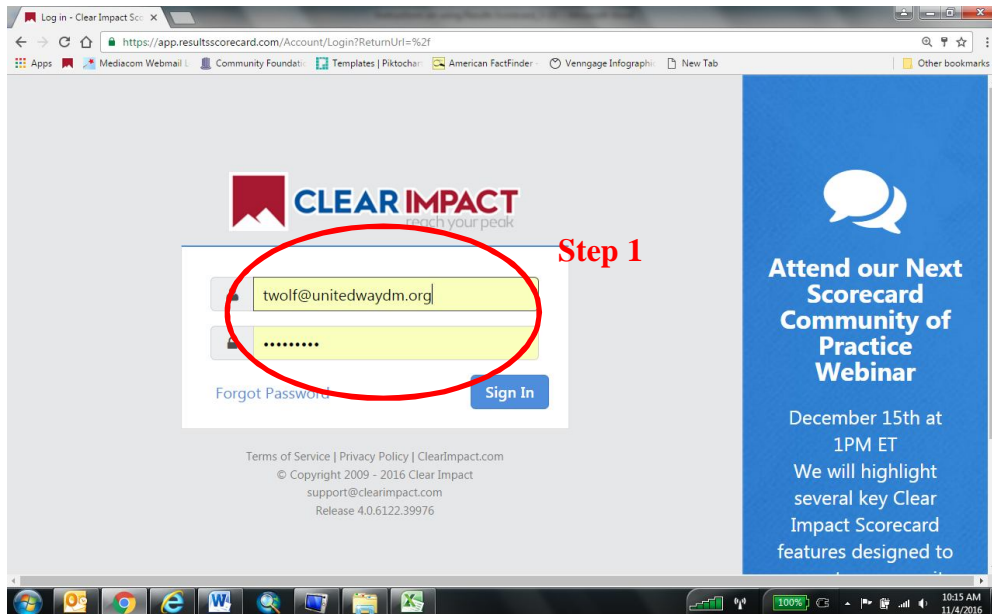
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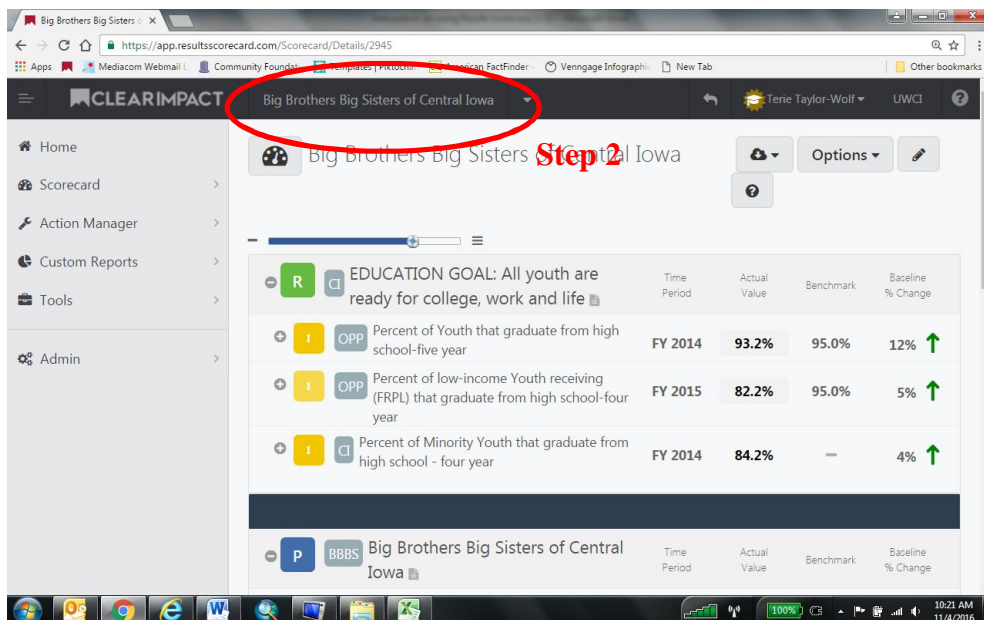
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is Terie Taylor-Wolf. The scorecard displays a list of performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

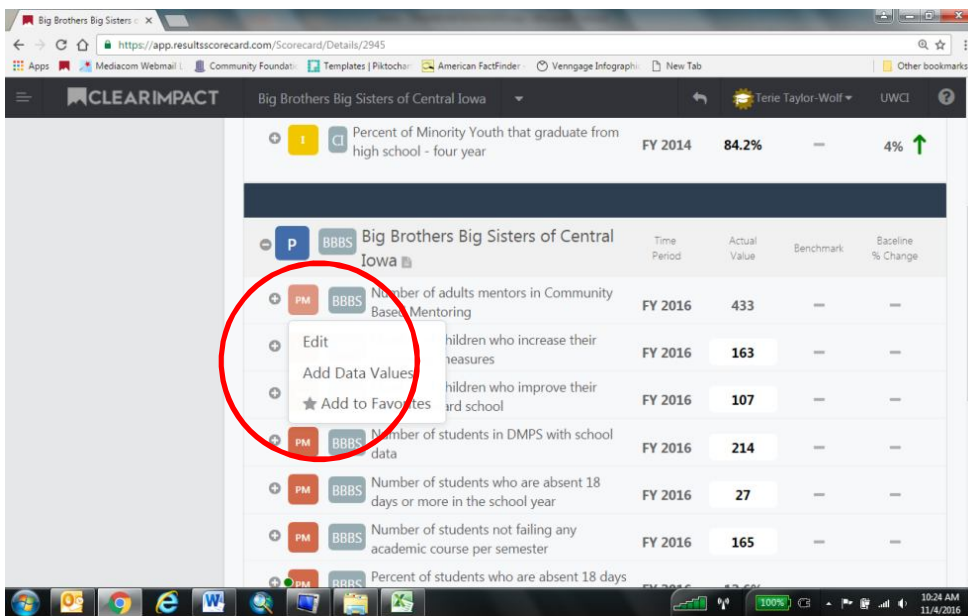
The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph shows the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
		FY 2012	515	—	—
		FY 2011	496	—	—

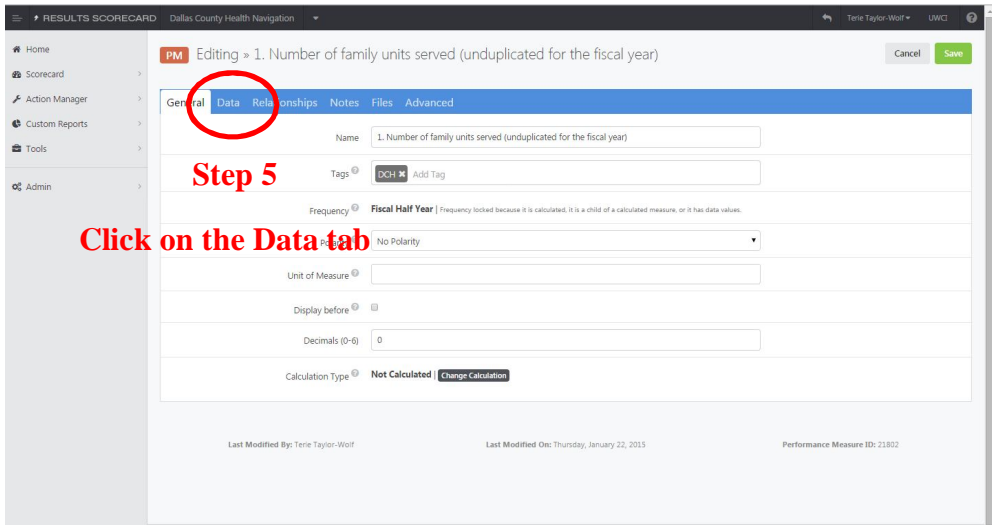
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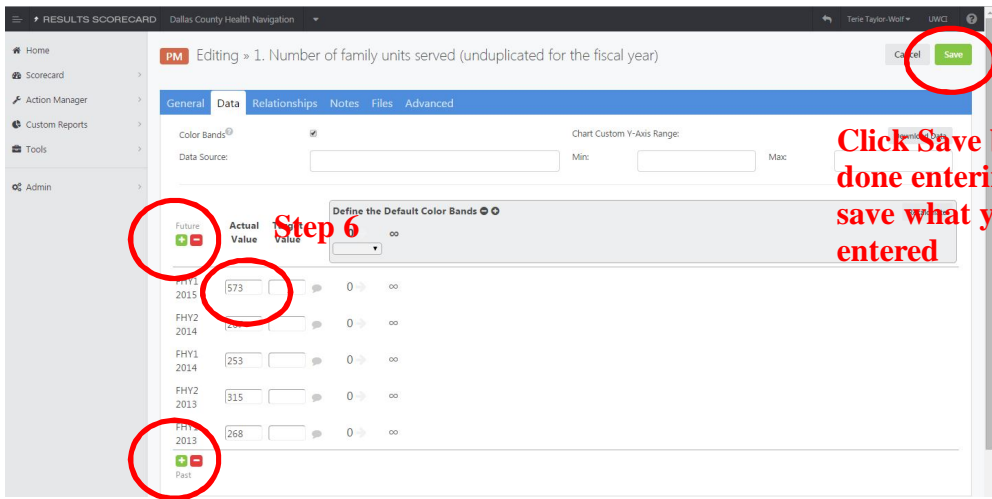


Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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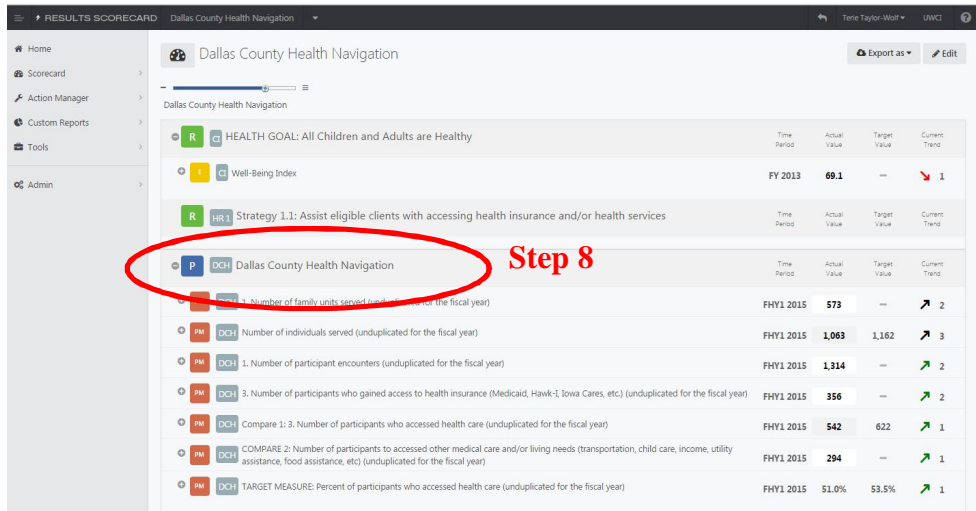
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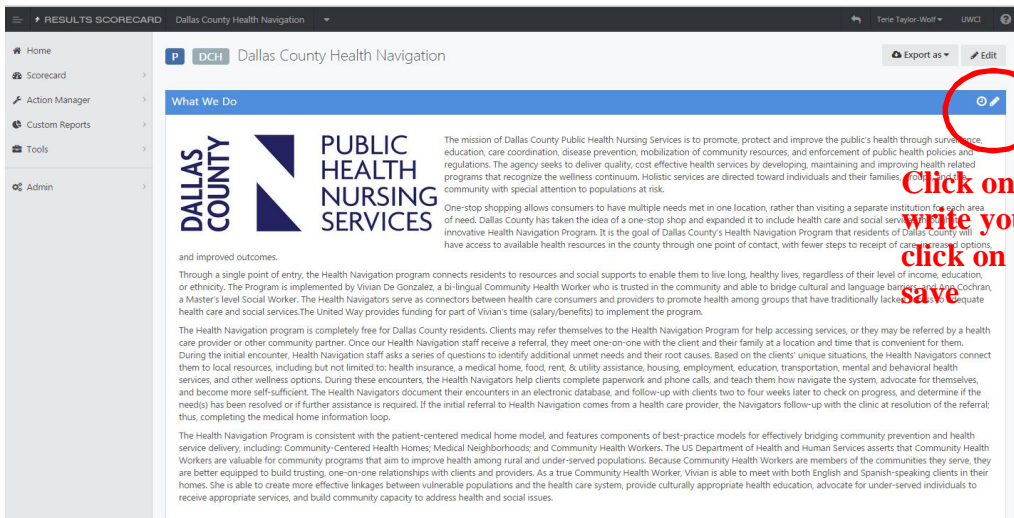
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DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

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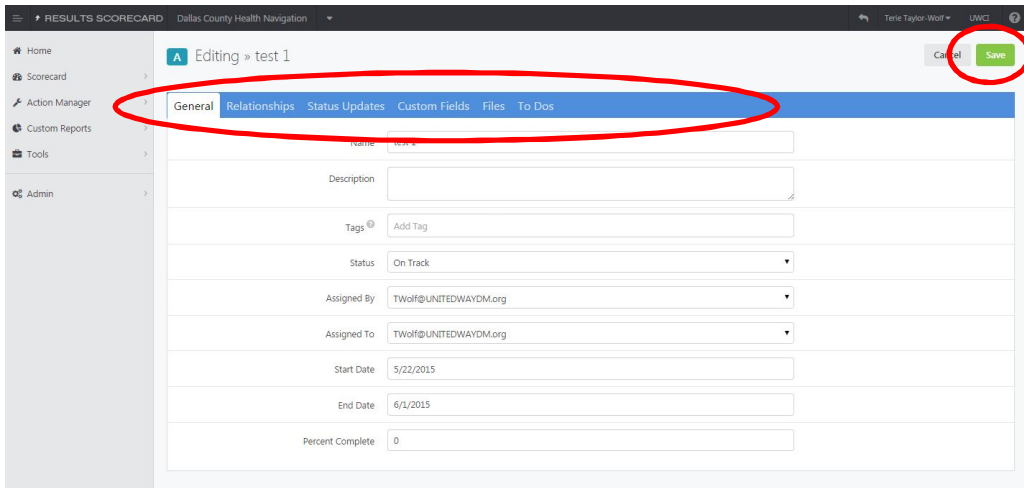


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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

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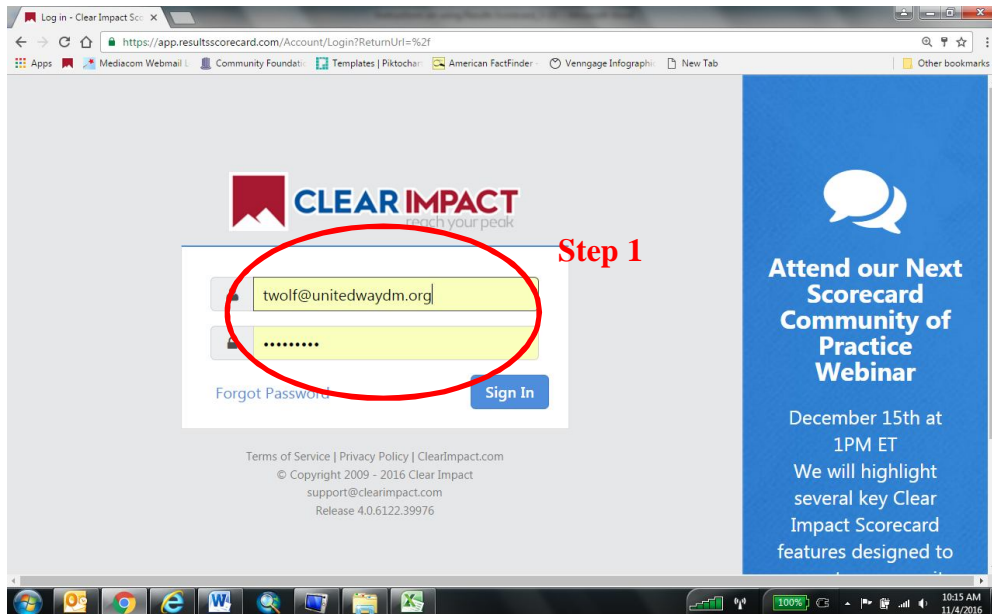
Instructions on using Results Scorecard

Step 1: Login

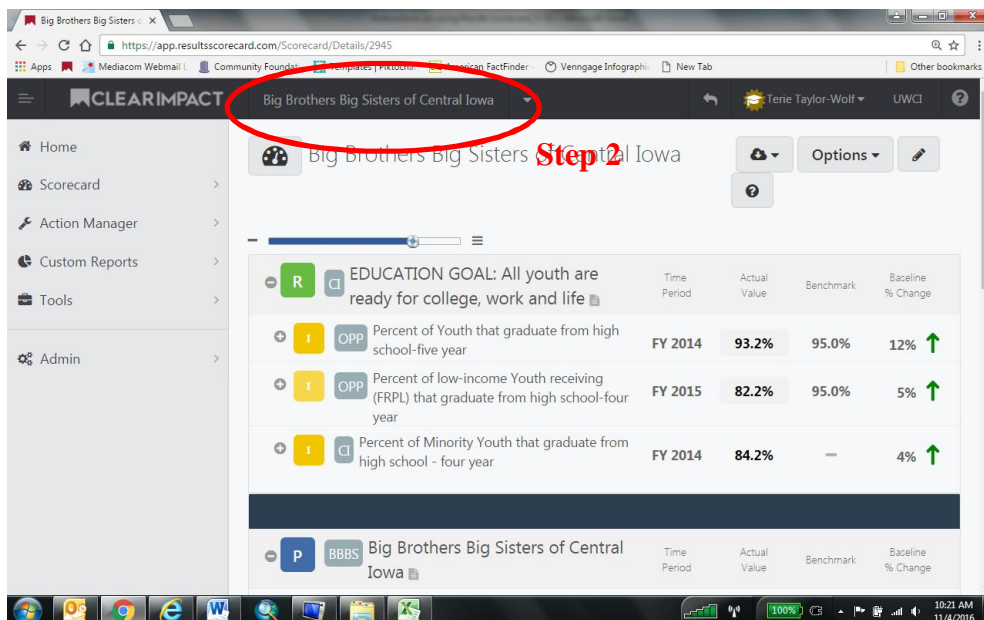
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. A red "Step 3" label is visible in the top right. A list of performance measures is shown, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

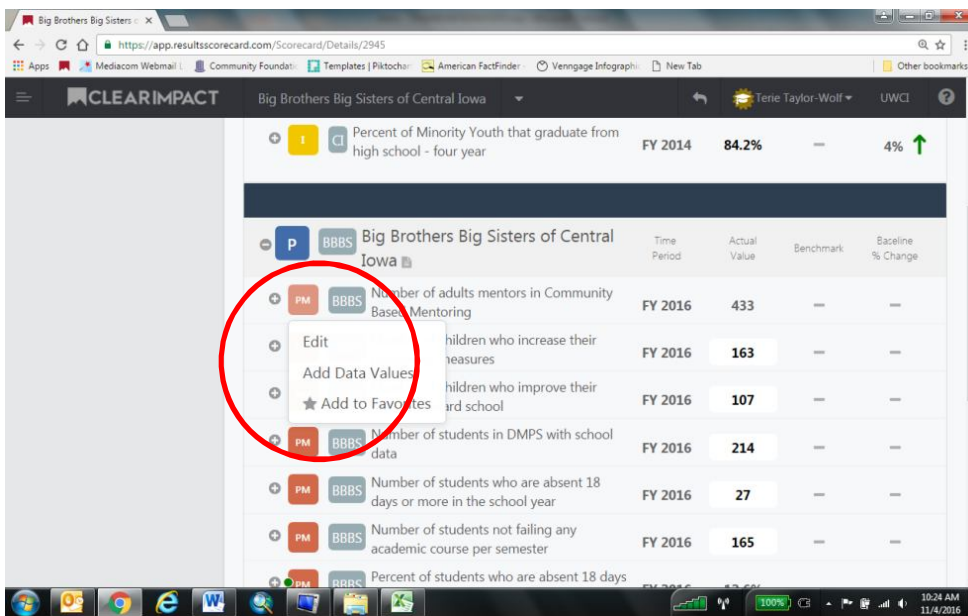
The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The data points are as follows:

Fiscal Year	Actual Value
FY 2011	496
FY 2012	515
FY 2013	591
FY 2014	535
FY 2015	467
FY 2016	433

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"

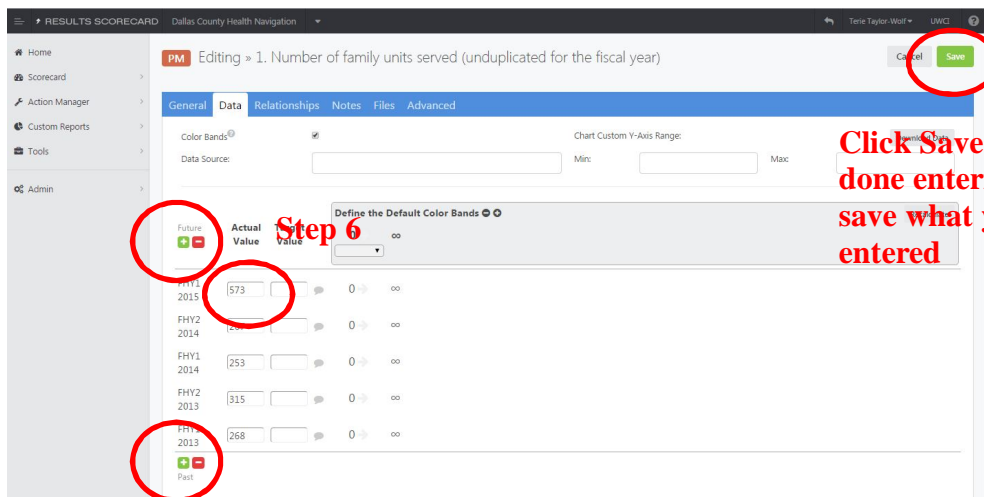


Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



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You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays data from FY2 2015 to FY2 2020, with an actual value of 51.0% and a target value of 63.5%. Below the chart is the 'Story Behind the Curve' section, which contains a text area and a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image. The text area is now populated with a detailed narrative about the Health Navigation Program's target measure, including information about underreporting, staff training, and benchmarking. A disk icon in the bottom right corner of the text area is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

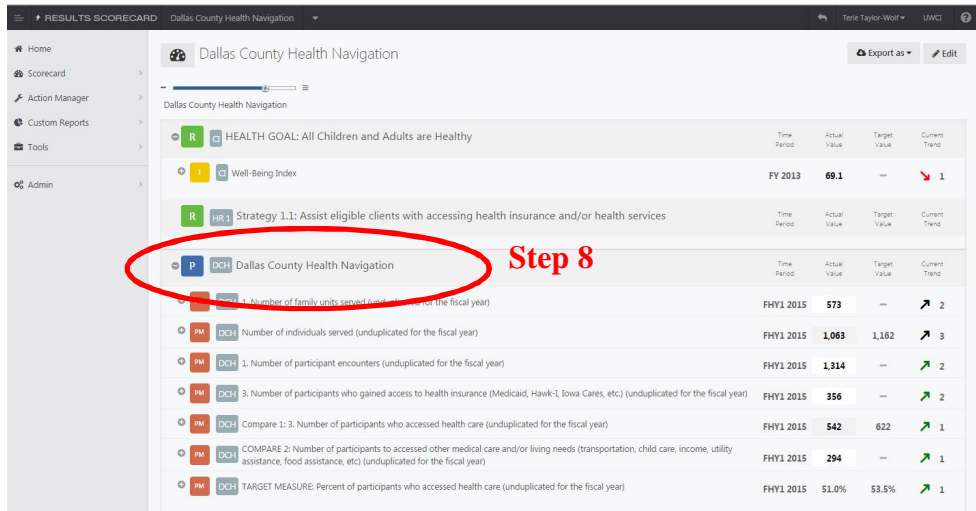
Step 7

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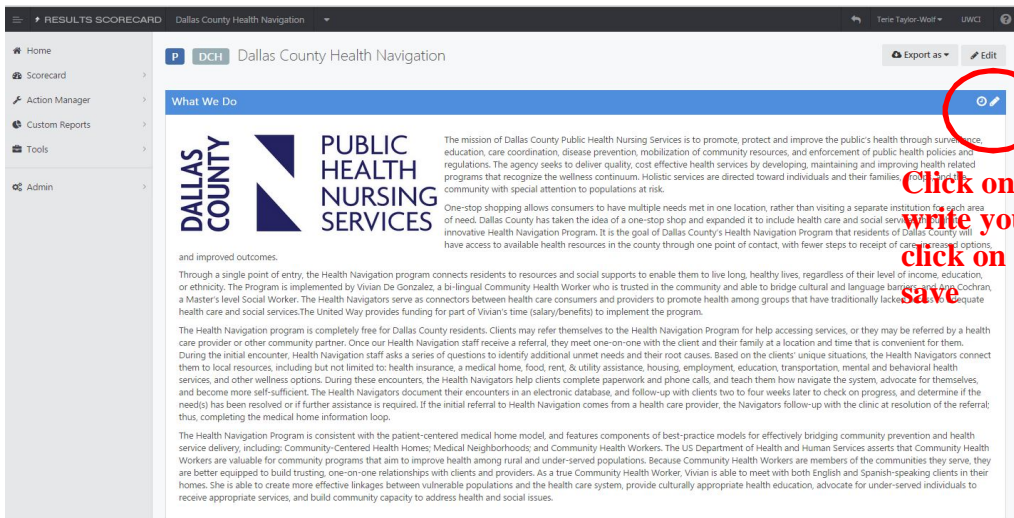
1. What We Do
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
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What We Do

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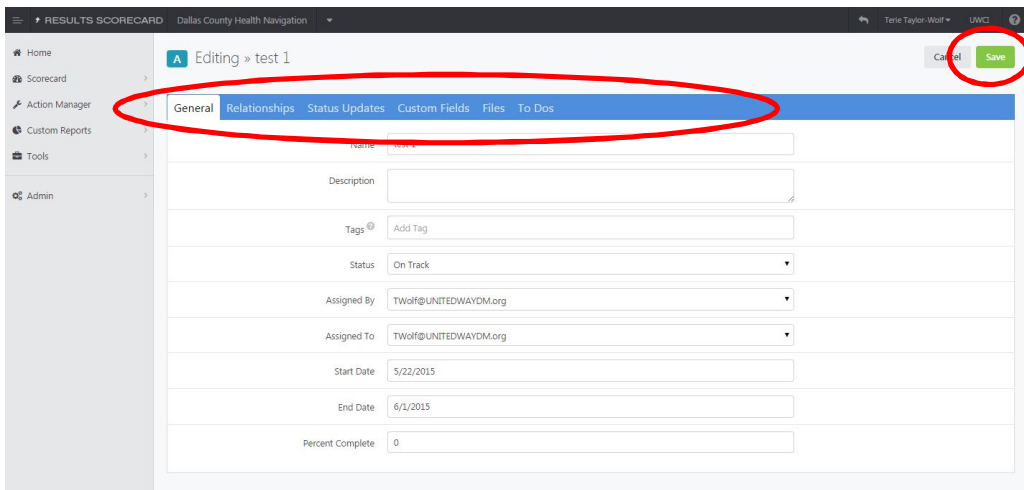


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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

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PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
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		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
		FY 2012	515	—	—
		FY 2011	496	—	—

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Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



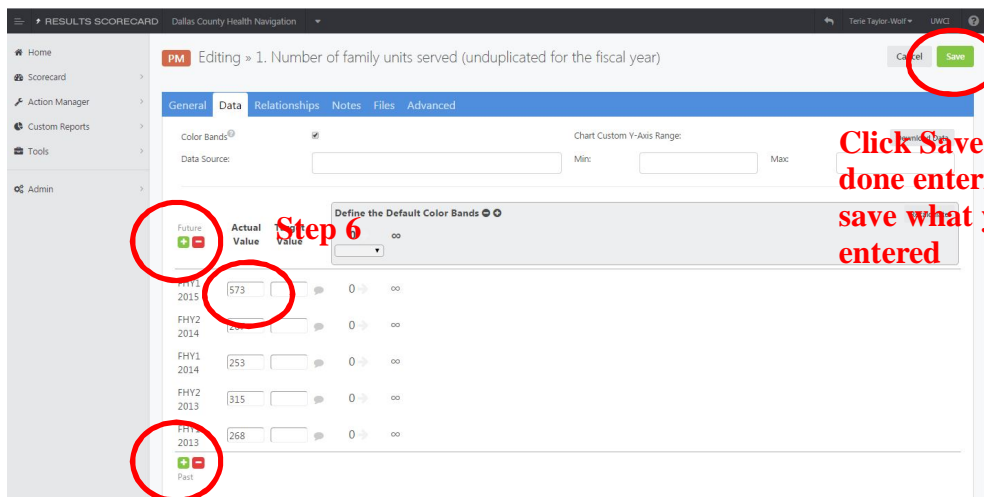
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Step 5
Click on the Data tab

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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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Step 7



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Step 7

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You will find these areas by clicking on the program name

Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
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Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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Step 8

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

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The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

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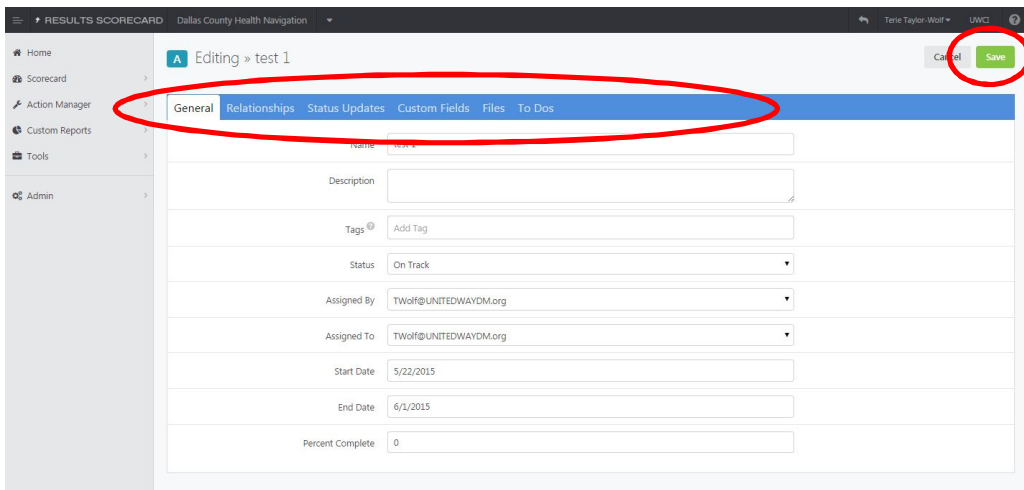


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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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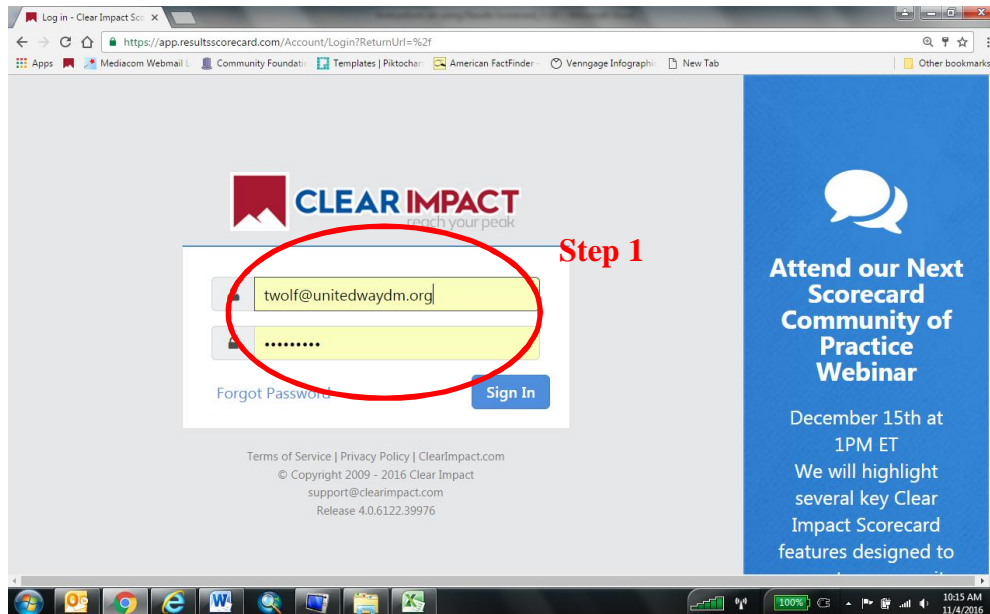
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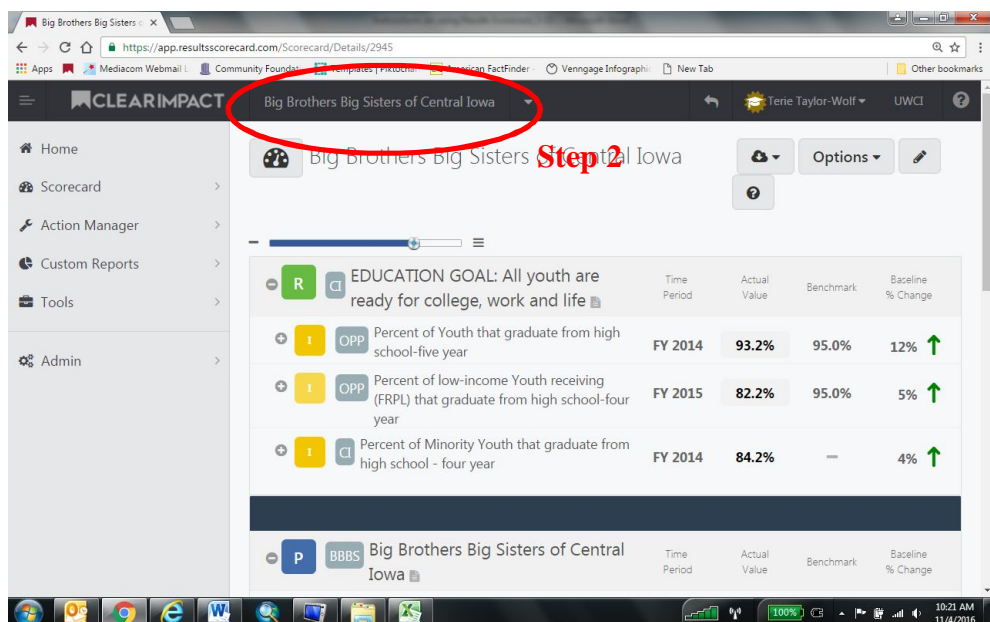
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Your username is your e-mail address. If you forget your password, follow these instructions:

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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. A red "Step 3" label is in the top right. A list of performance measures is shown, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

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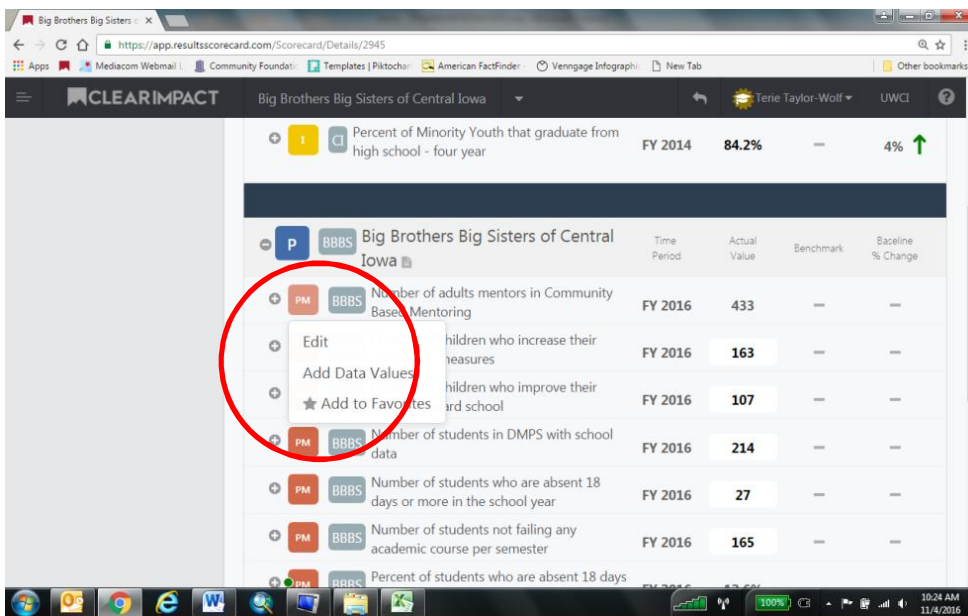
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
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FY 2012	515	—	—
FY 2011	496	—	—

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Step 4

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Step 5
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Click Save button when done entering data to save what you have entered

Step 6

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Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

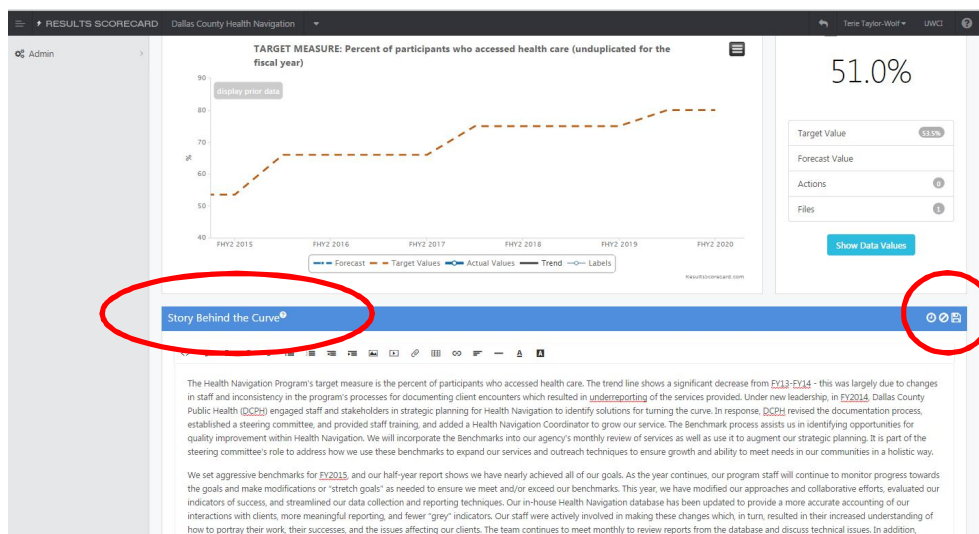
TimeFrame	Date Range
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Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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Step 7



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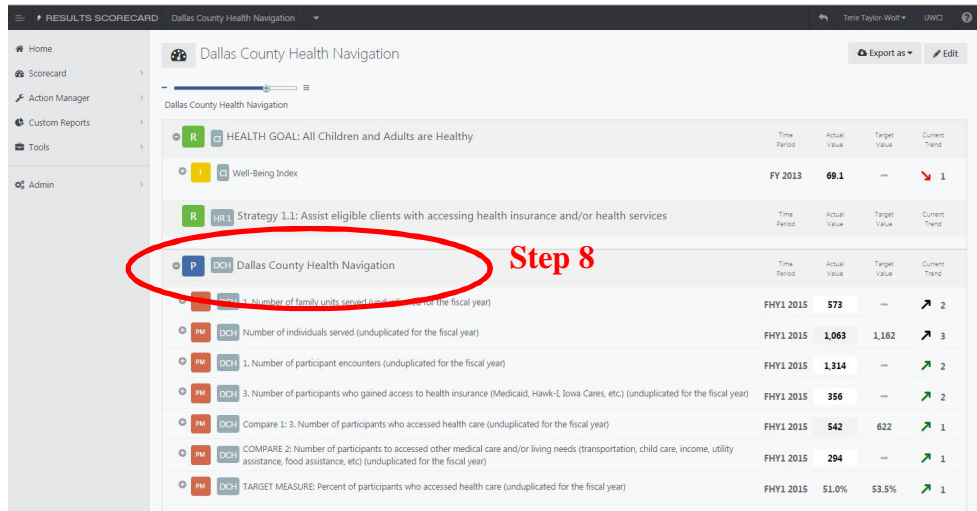
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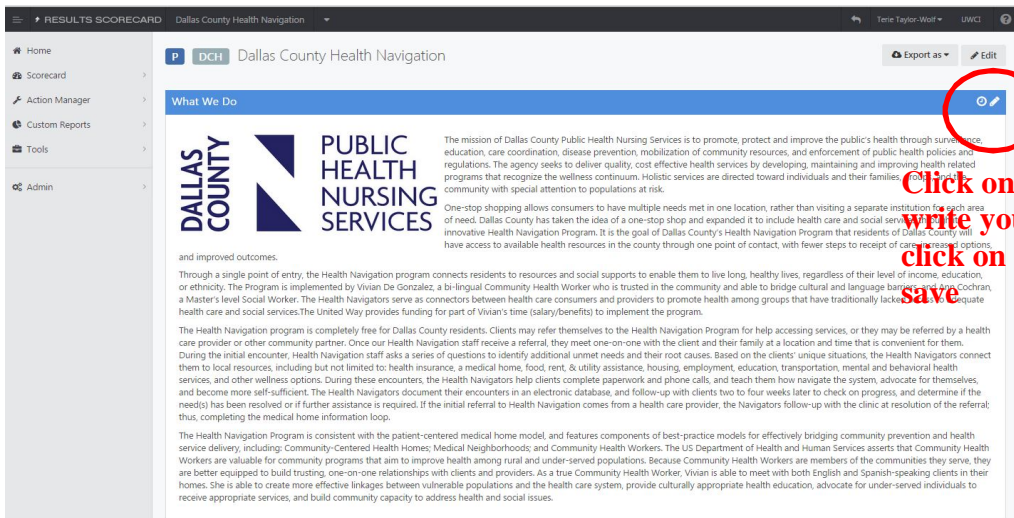
1. What We Do
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
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COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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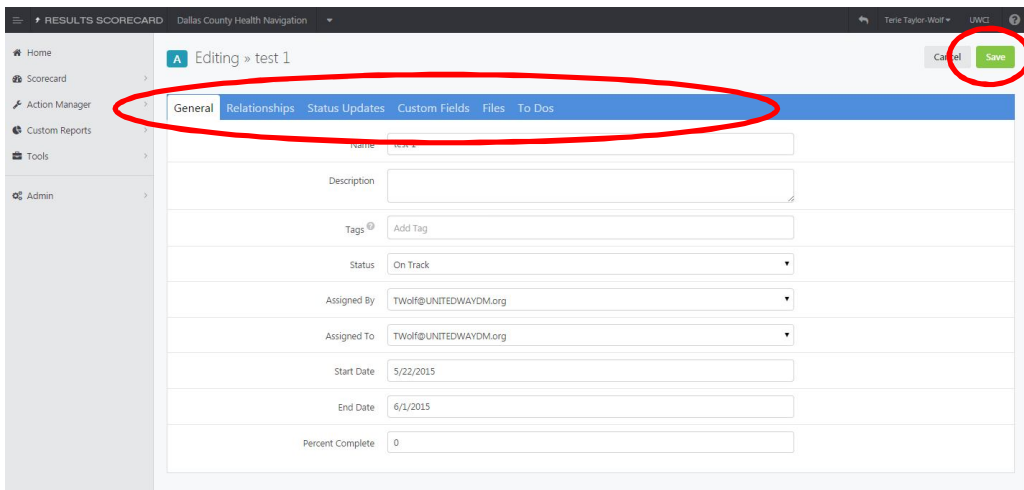


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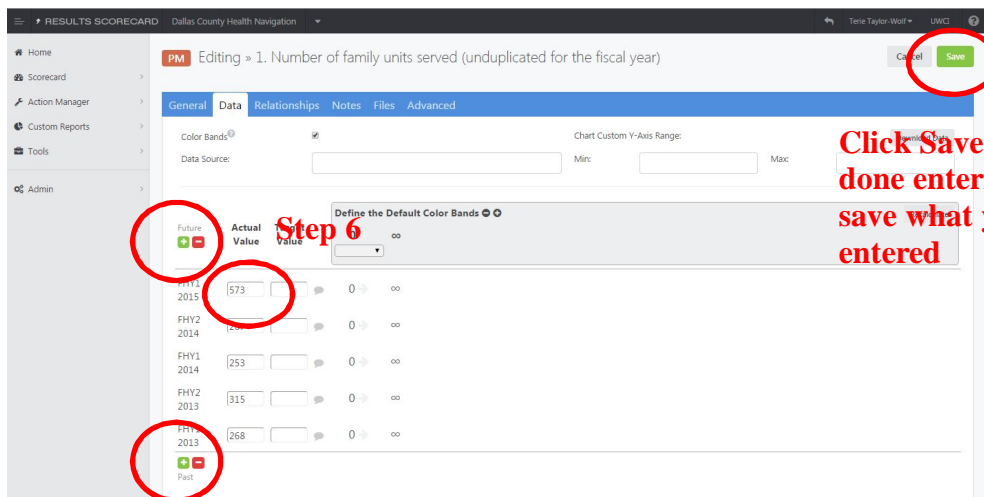
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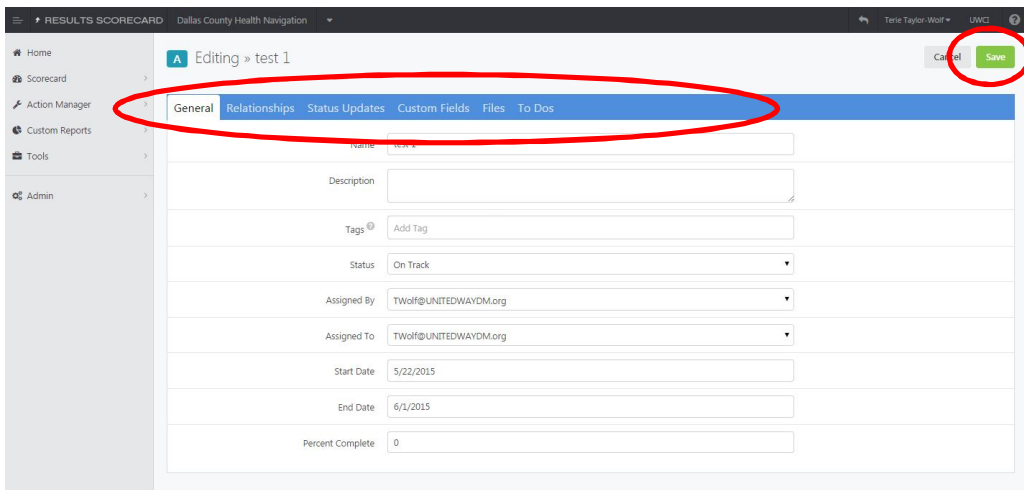


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Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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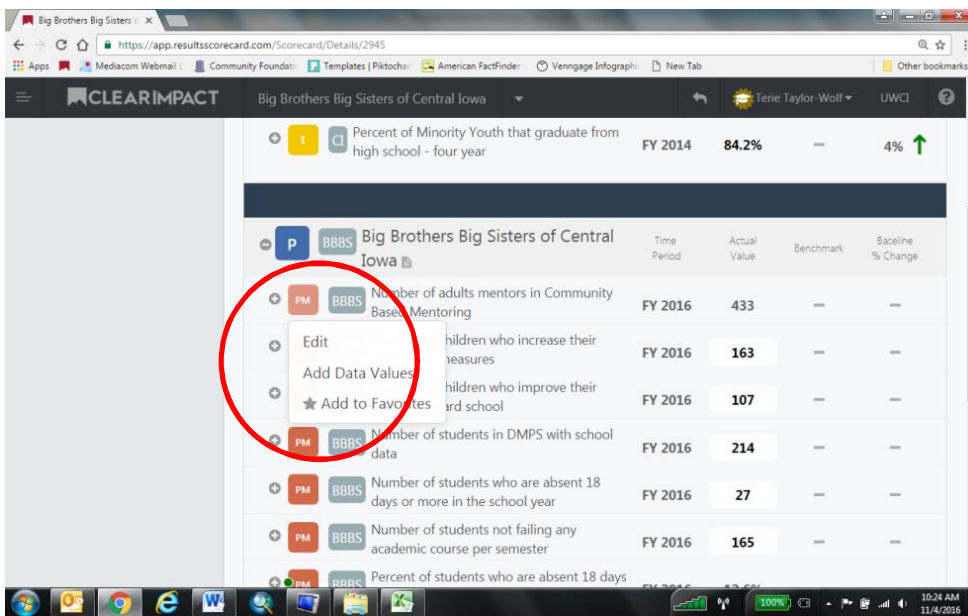
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Step 4

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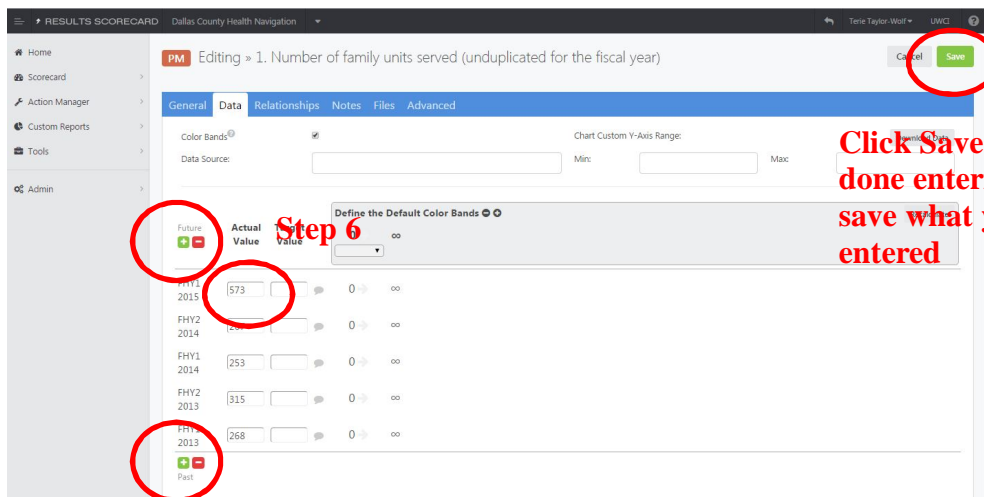


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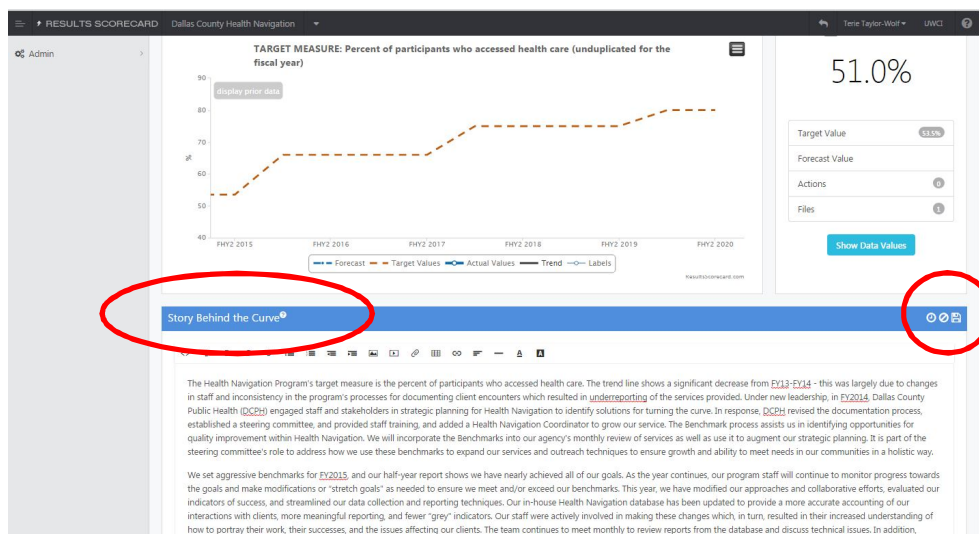
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Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

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DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The result is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

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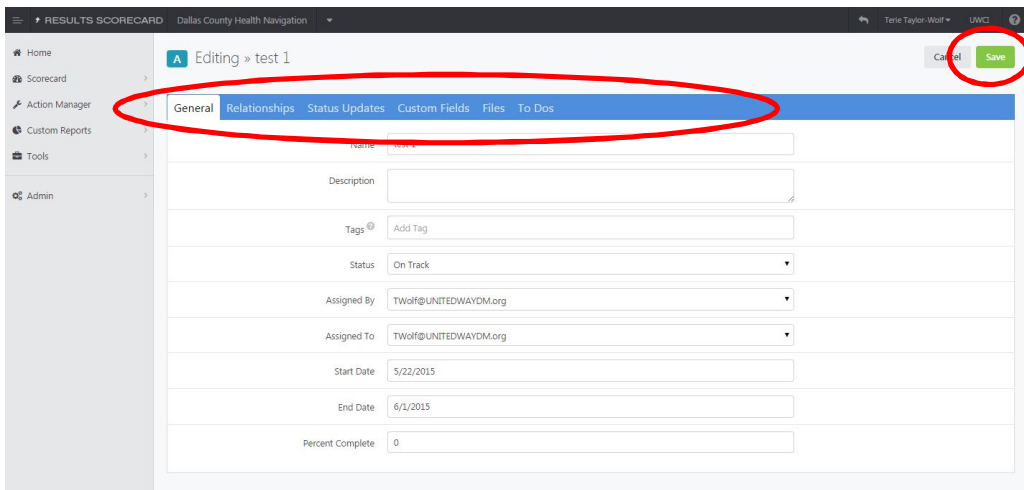


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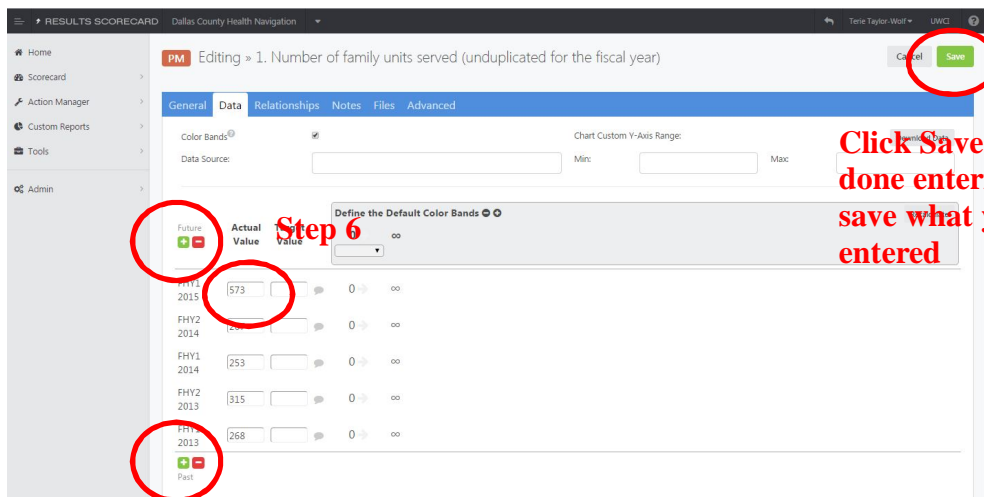


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The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a pencil icon circled in red. The text in this section describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to improve the situation.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image, but with the text area expanded. The text describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to improve the situation. A disk icon is circled in red at the bottom right of the text area, indicating where to click to save the narrative.

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Step 7

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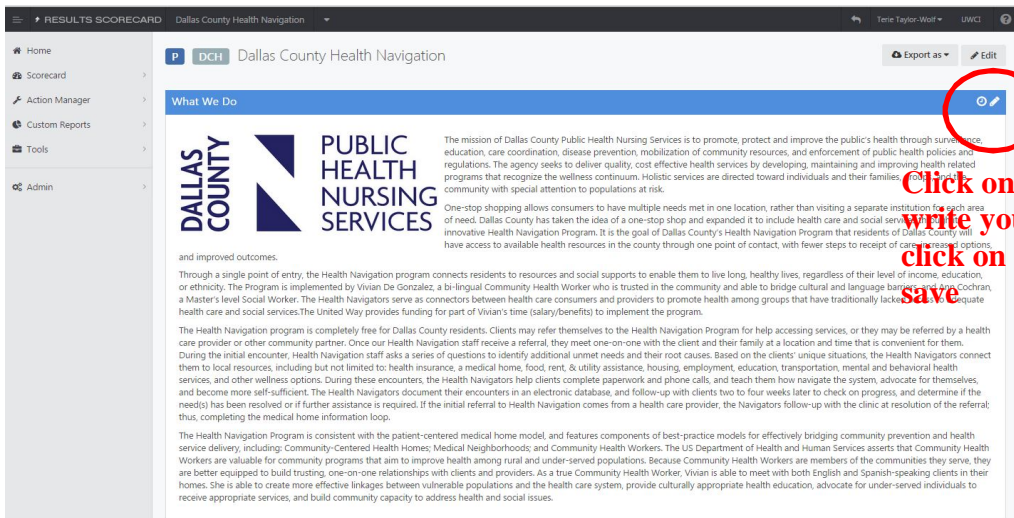
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What We Do

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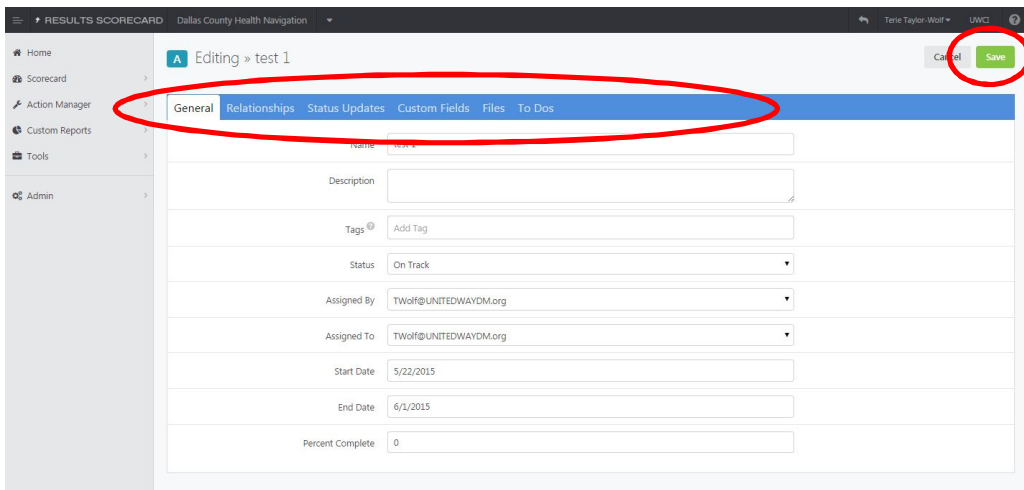


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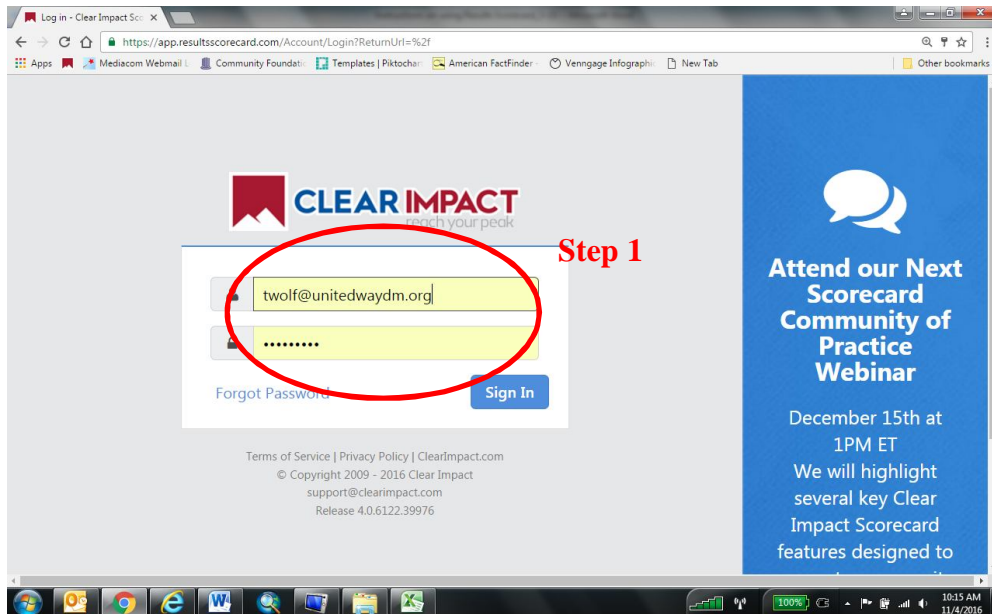
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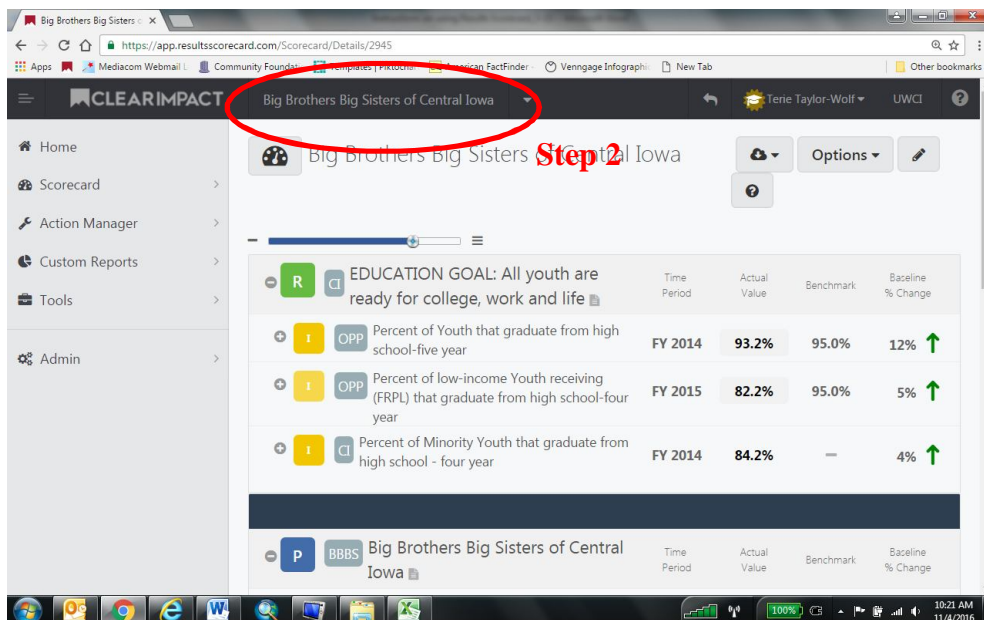
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Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa". The main content area shows a list of performance measures. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. To its right, the data for FY 2016 is shown as 433. Other measures include "Number of children who increase their confidence measures" (163), "Number of children who improve their attitude toward school" (107), "Number of students in DMPS with school data" (214), "Number of students who are absent 18 days or more in the school year" (27), "Number of students not failing any academic course per semester" (165), "Percent of students who are absent 18 days or more in the school year" (12.6%), and "Percent of students not failing any academic course per semester" (77.1%). A red "Step 3" label is visible in the top right corner of the scorecard area.

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

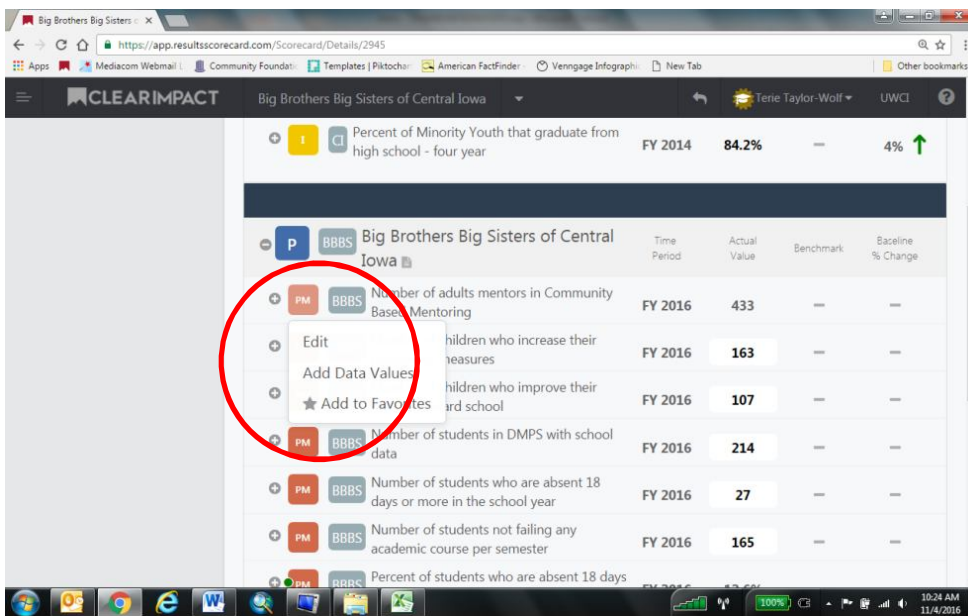
The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the data from FY 2011 to FY 2016. The graph shows a peak in FY 2013 (591) and a low in FY 2016 (433). To the right of the graph, a table lists the actual values for each fiscal year.

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

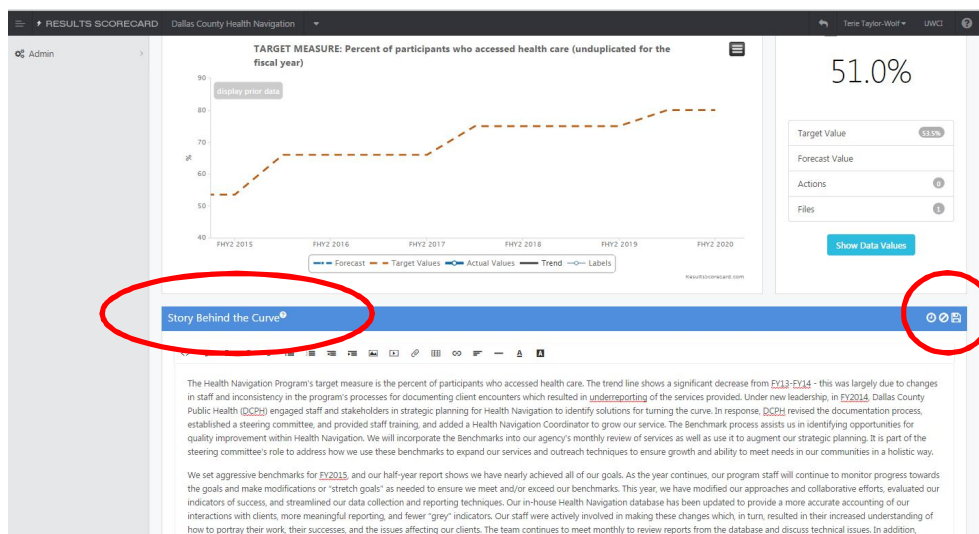
TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

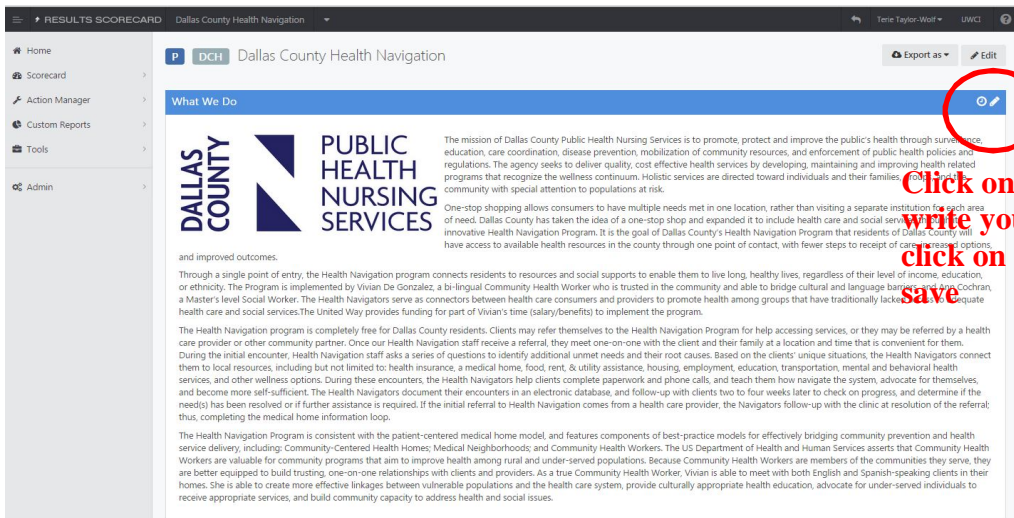
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

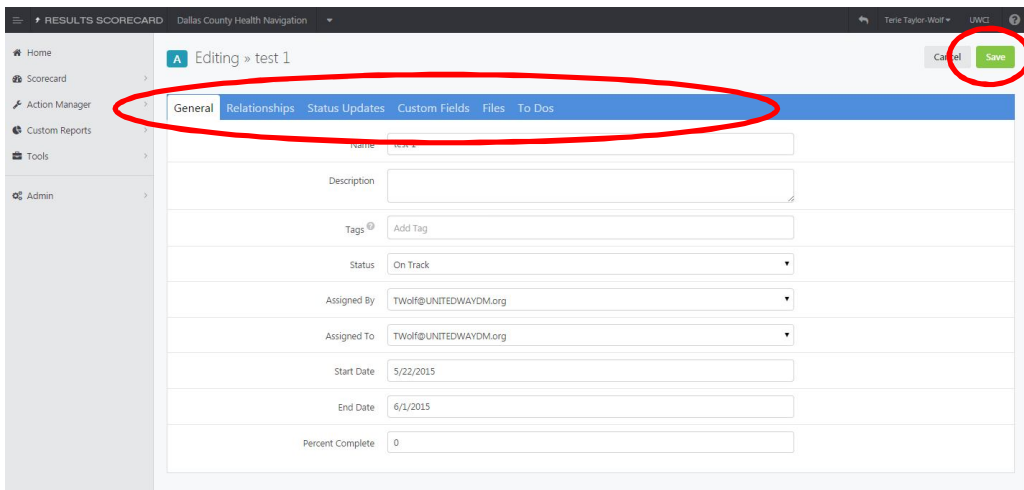


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

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Instructions on using Results Scorecard

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Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as Terie Taylor-Wolf. A red "Step 3" label is visible in the top right. A list of performance measures is shown, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
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Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a decline in FY 2015. The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
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Step 4

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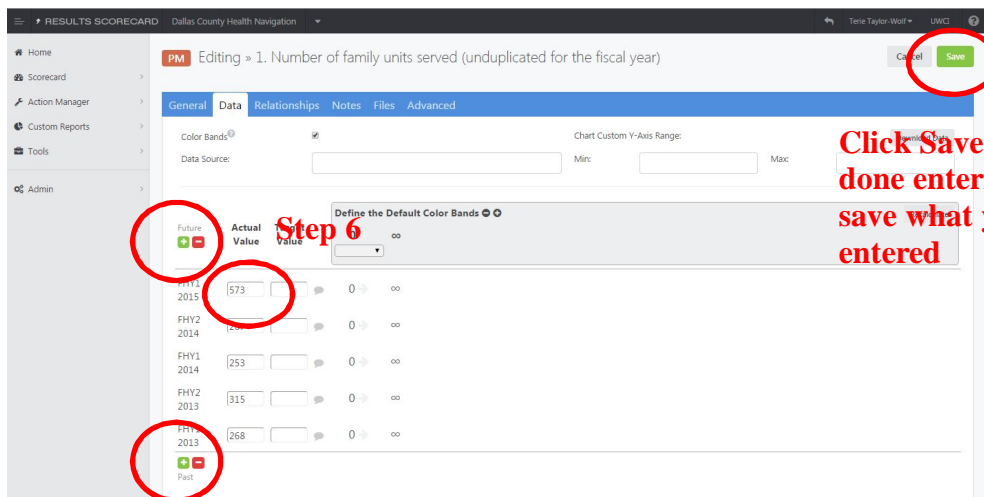
Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

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Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



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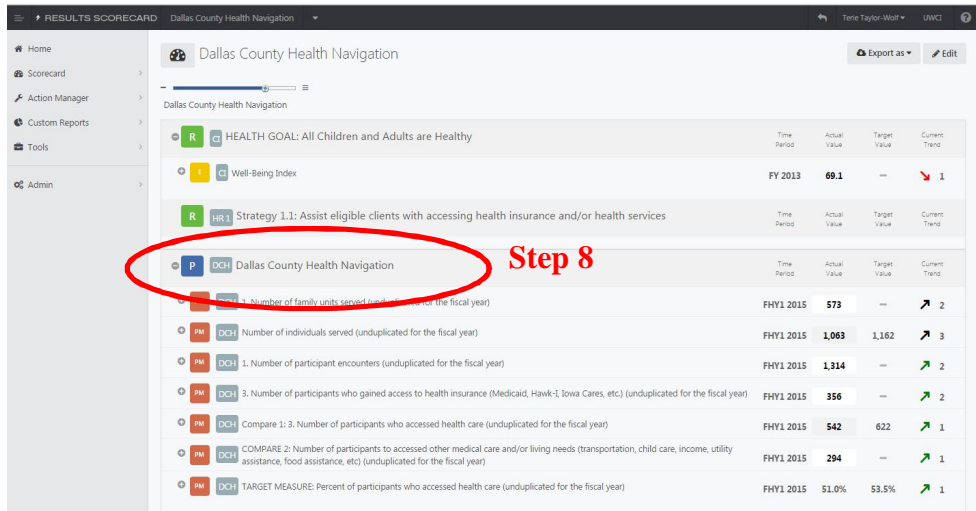
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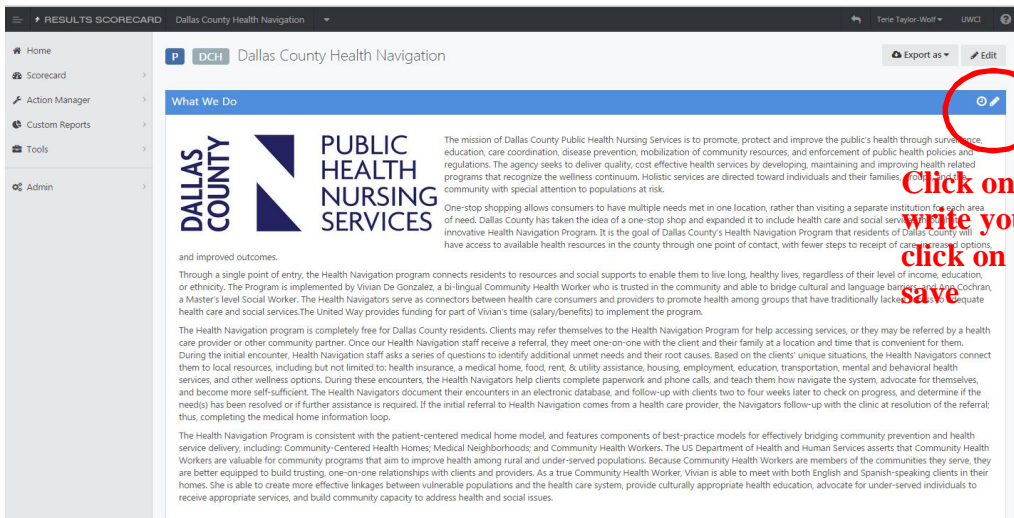
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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
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Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
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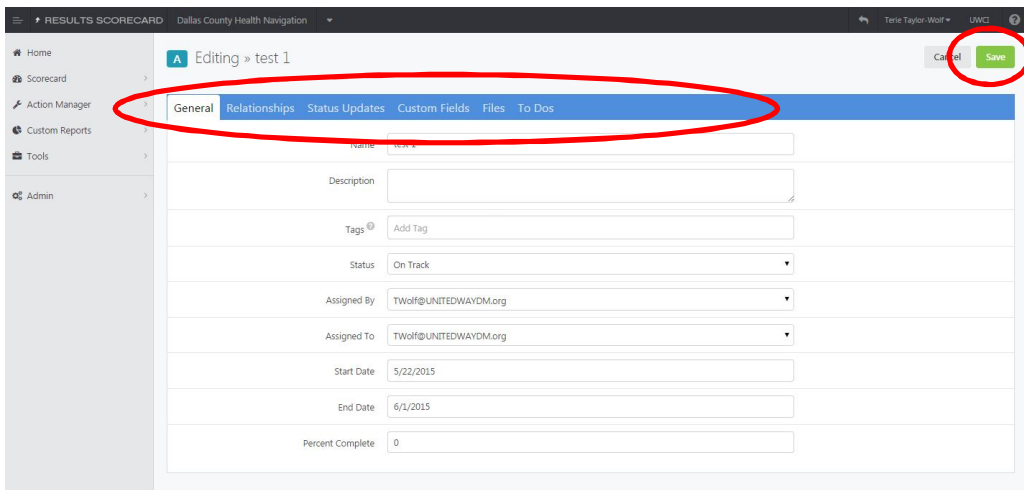


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Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



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Kane	1st half	1st half	Jody	1st half	1st half
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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend from FY 2011 to FY 2015. The data points are: FY 2011 (496), FY 2012 (515), FY 2013 (591), FY 2014 (535), and FY 2015 (467). The graph shows a peak in FY 2013 and a decline in FY 2015. The table to the right of the graph shows the following data:

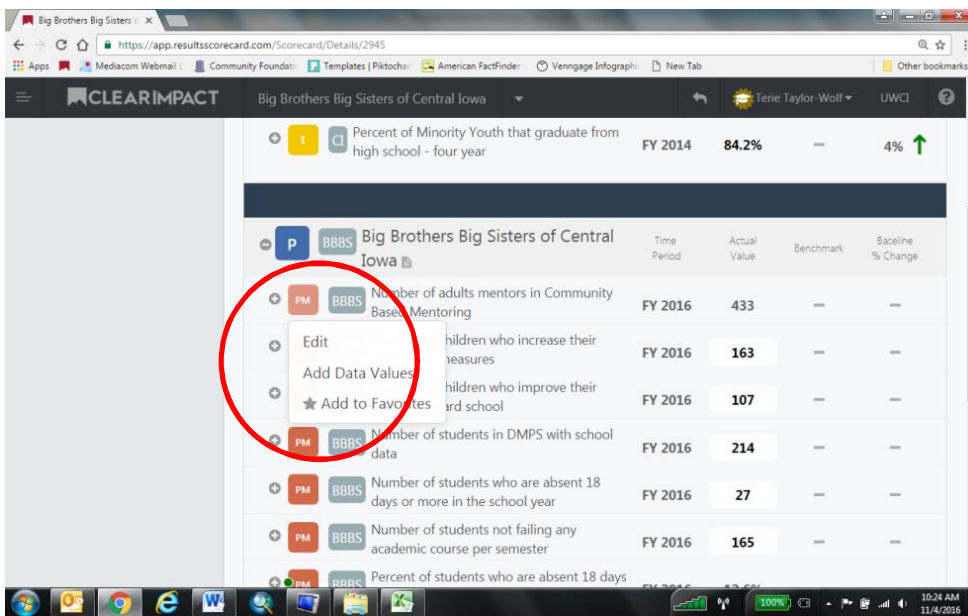
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



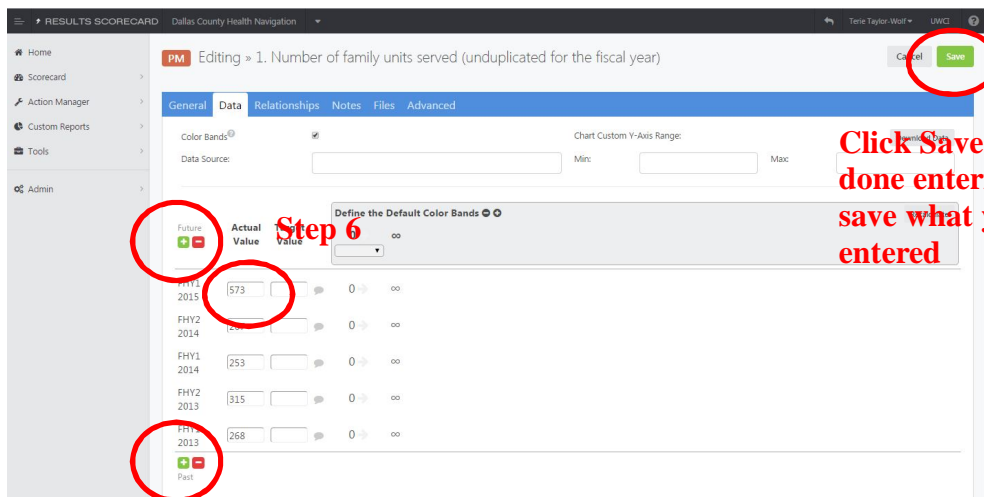
Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

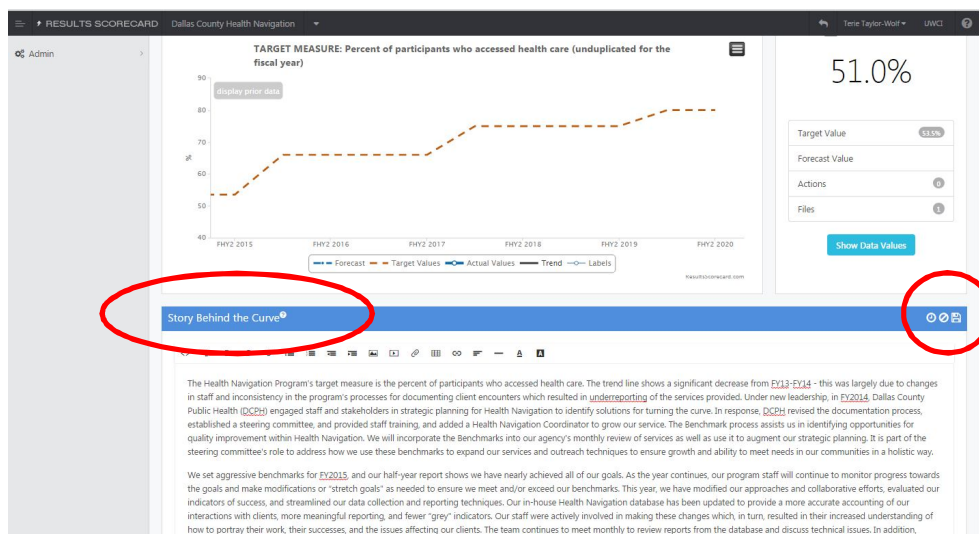
TimeFrame	Date Range
Q1	July 1-Sept. 30
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s)). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name

Category	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
DCH COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
DCH TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)

Step 8

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Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



Step 9

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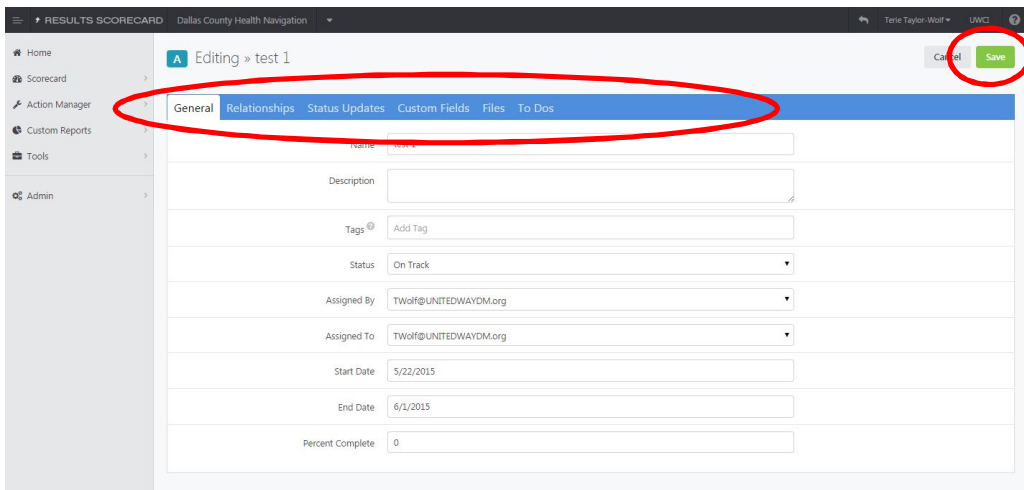


Step 10

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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
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Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

For Income Programming, contact Corinne Lambert at 246-6542 or e-mail at clambert@unitedwaydm.org

Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

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Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
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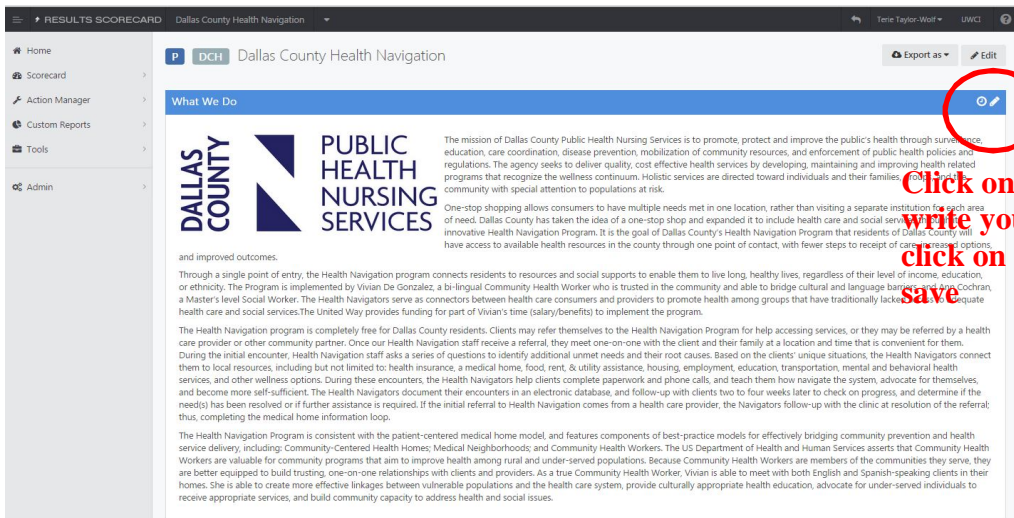
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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral, thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



Step 9

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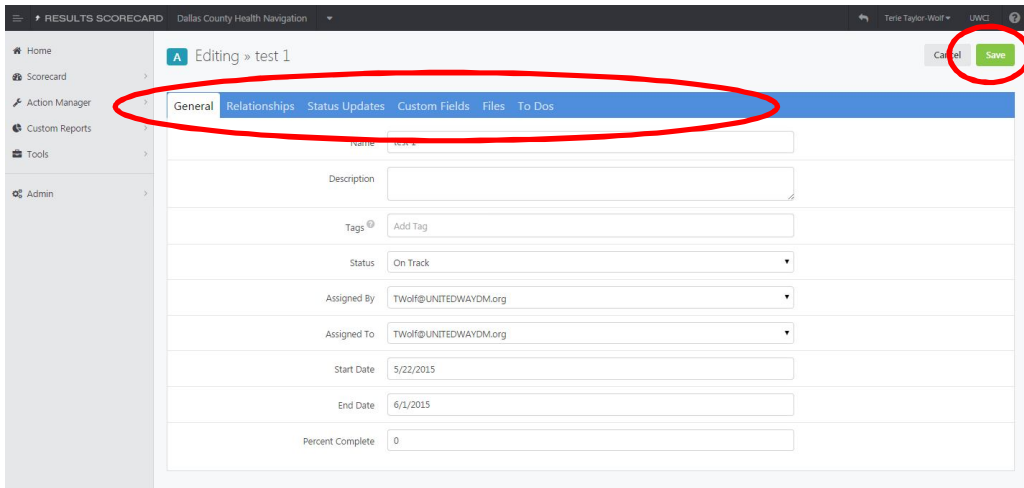


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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
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Results Scorecard View:

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number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

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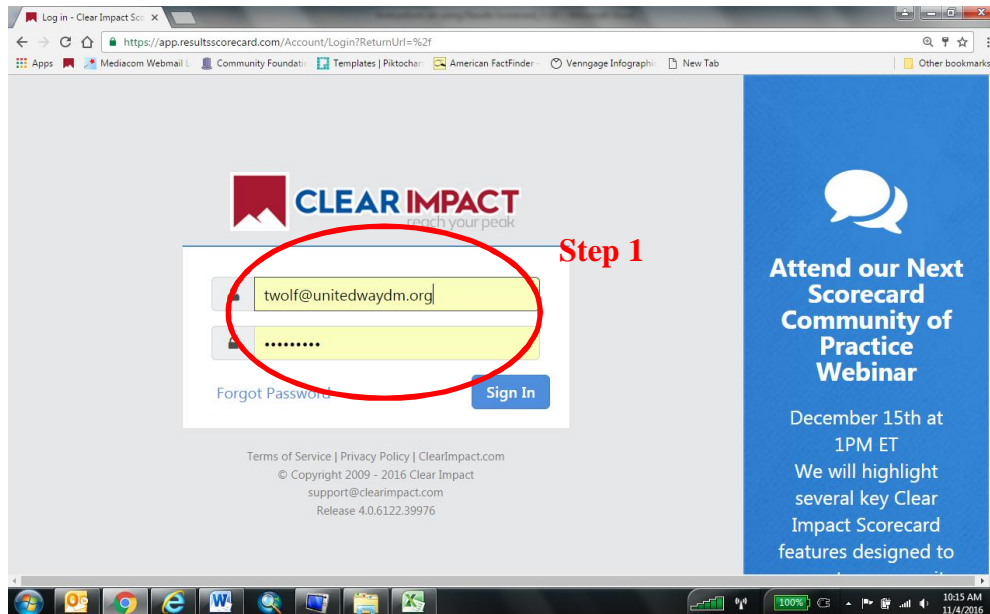
Instructions on using Results Scorecard

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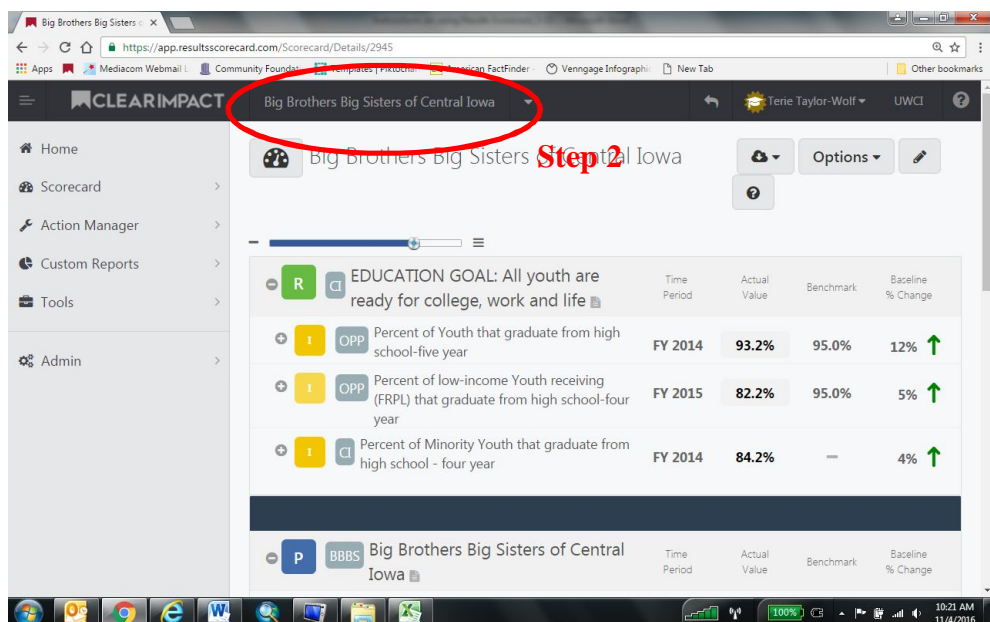
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa". The main content area shows a list of performance measures. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. To its right, a table shows the actual value for FY 2016 as 433, with no benchmark or baseline values. A red "Step 3" label is visible in the top right corner of the scorecard area.

Performance Measure	FY 2016	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
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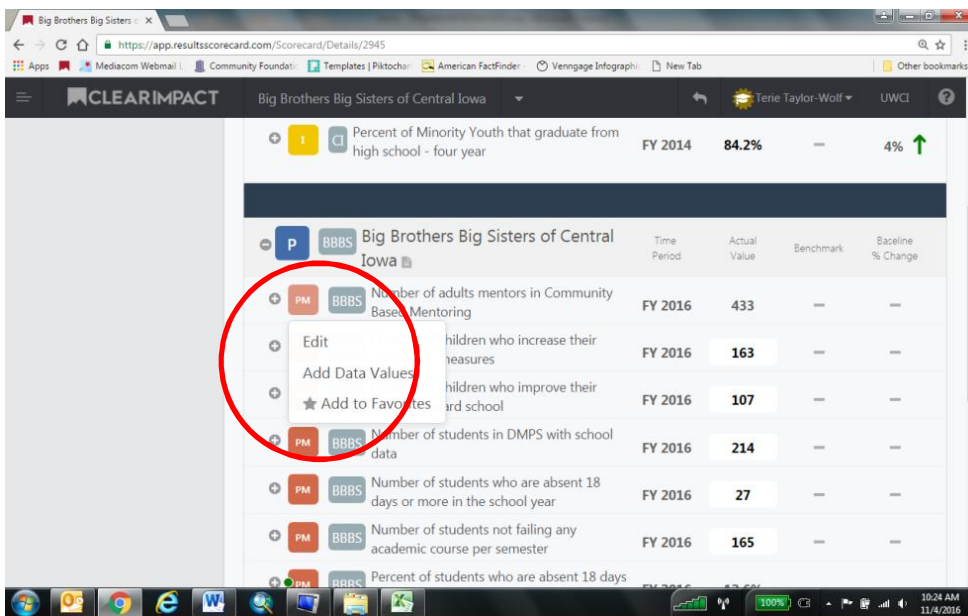
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Click Save button when done entering data to save what you have entered

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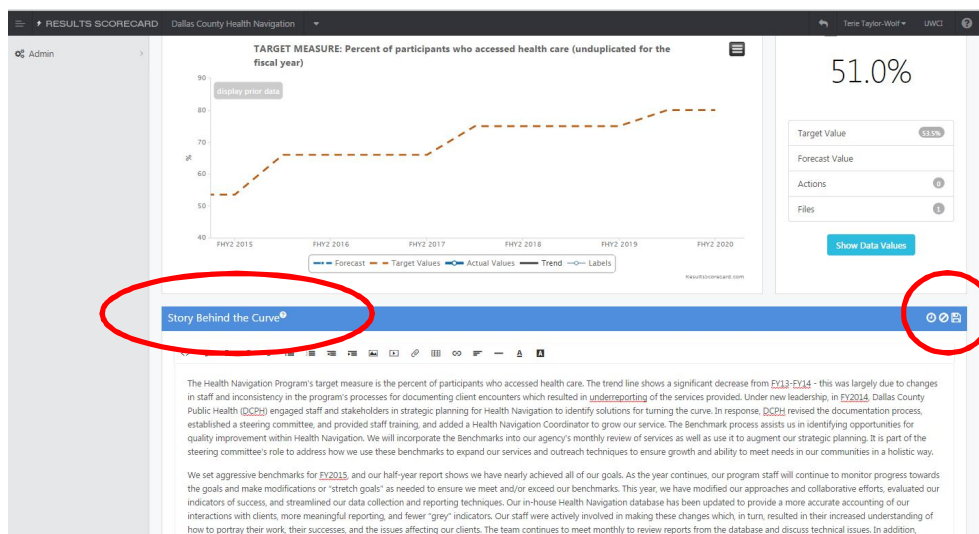
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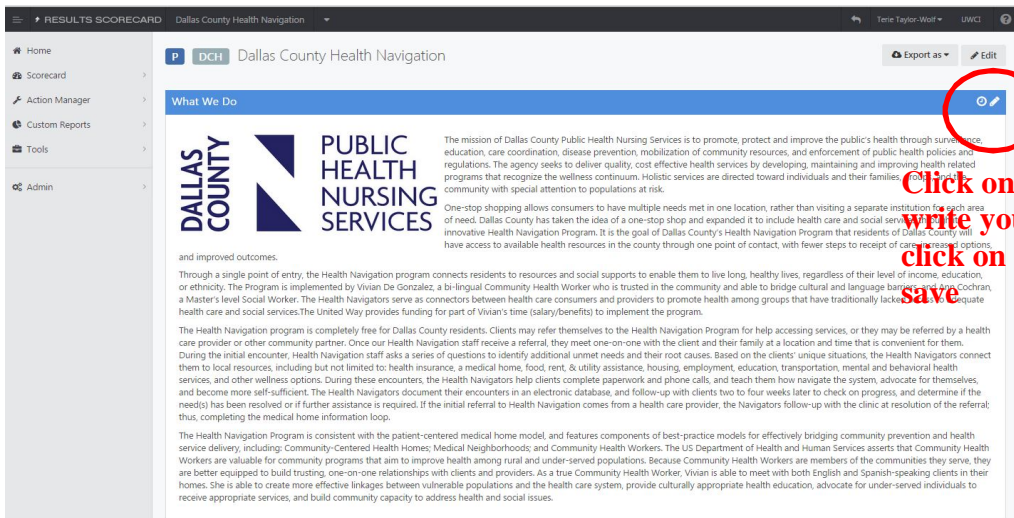
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The result is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

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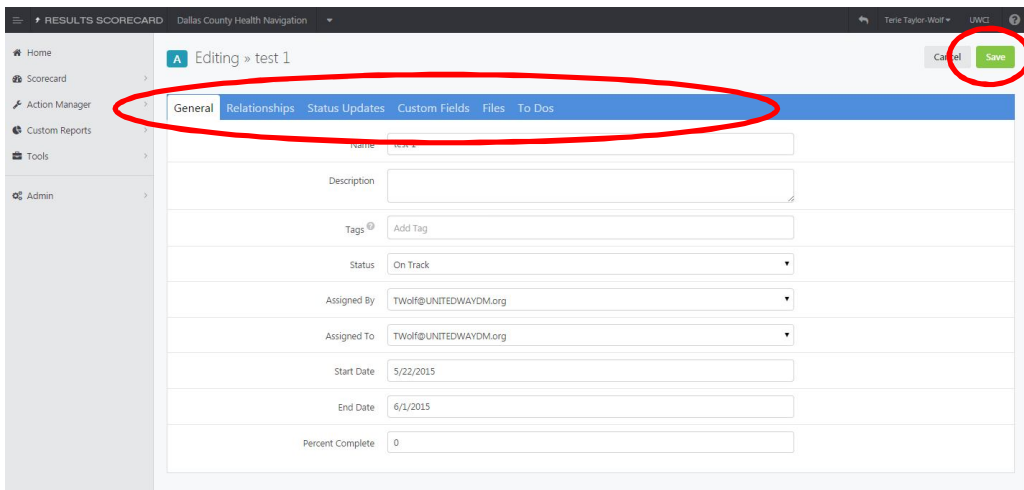


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Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
		FY 2012	515	—	—
		FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

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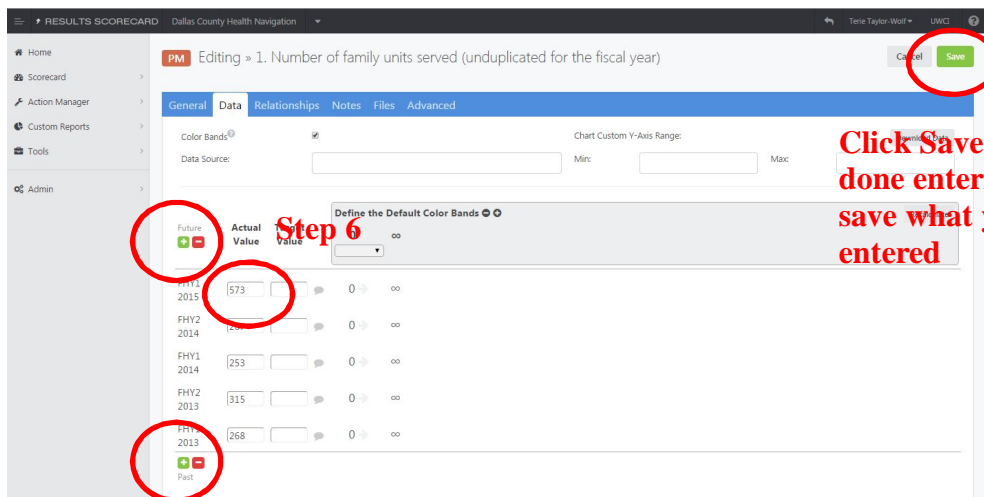
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Step 5
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Click Save button when done entering data to save what you have entered

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

1. What We Do
2. Who We Serve
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4. Success Story

You will find these areas by clicking on the program name

Category	Item	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL	HEALTH GOAL: All Children and Adults are Healthy				
	Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy	Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
Program	DCH Dallas County Health Navigation				
	1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
	Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
	1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
	3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
	Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
	COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
	TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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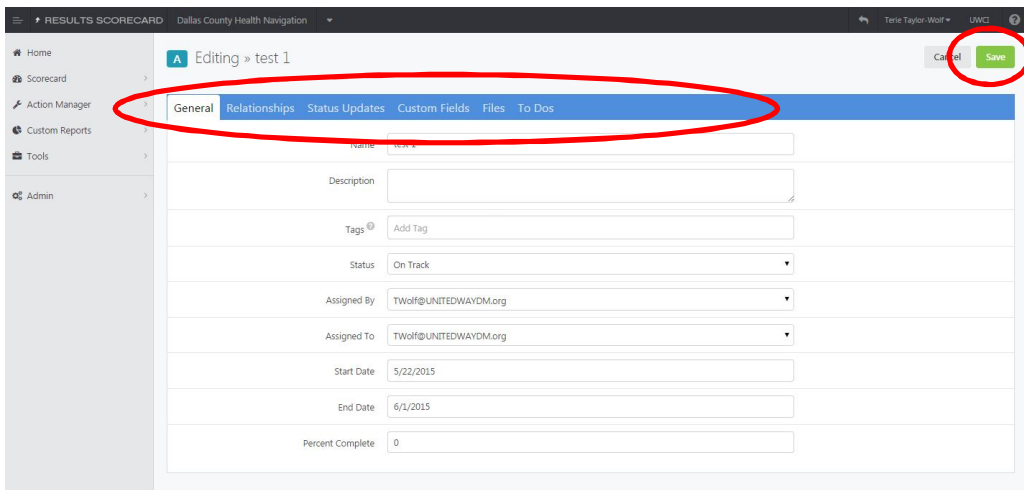


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The screenshot shows the CLEARIMPACT dashboard for Big Brothers Big Sisters of Central Iowa. A list of performance measures is displayed. The first measure, 'Number of adults mentors in Community Based Mentoring', is circled in red. The table below shows the data for this and other measures.

Performance Measure	FY 2016	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	433	—	—
Number of children who increase their confidence measures	163	163	—	—
Number of children who improve their attitude toward school	107	107	—	—
Number of students in DMPS with school data	214	214	—	—
Number of students who are absent 18 days or more in the school year	27	27	—	—
Number of students not failing any academic course per semester	165	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	77.1%	—	—

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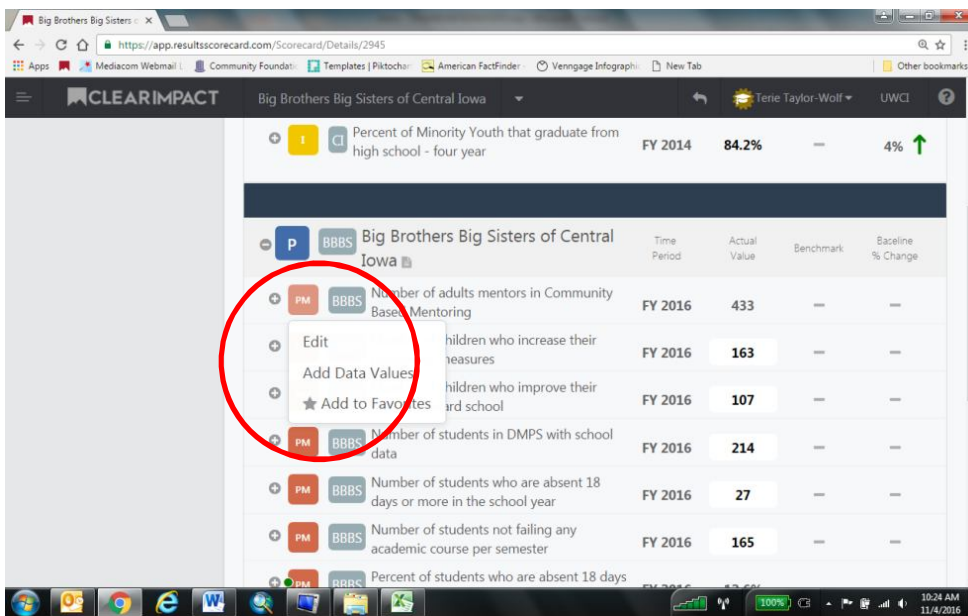
The screenshot shows the CLEARIMPACT dashboard for Big Brothers Big Sisters of Central Iowa. The performance measure 'Number of adults mentors in Community Based Mentoring' is selected, and its trend data is displayed. A line graph shows the number of mentors from FY 2011 to FY 2016. The table below shows the data for this measure.

Time Period	Actual Value	Benchmark	Baseline % Change
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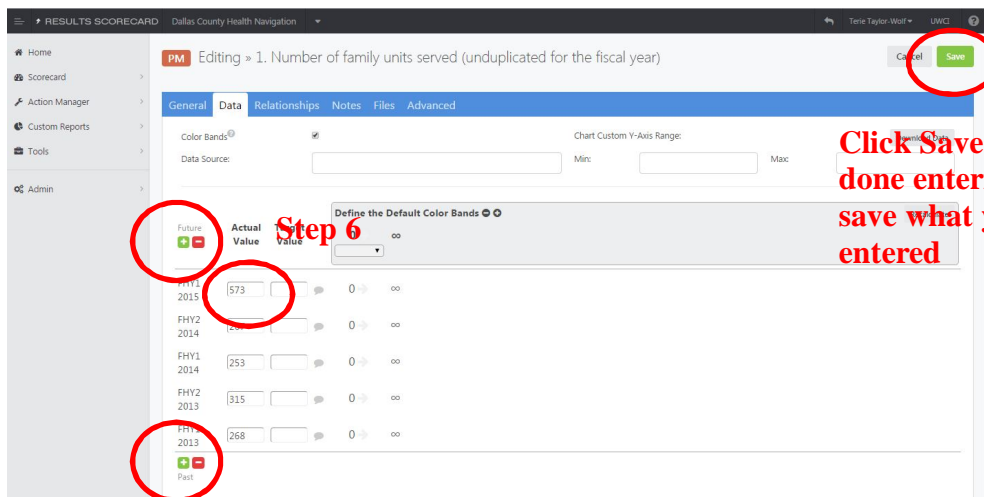


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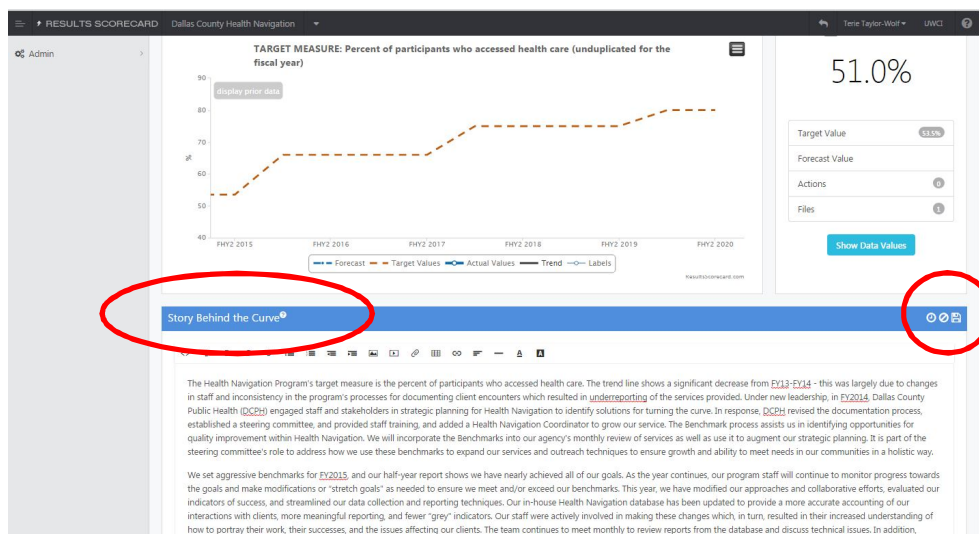
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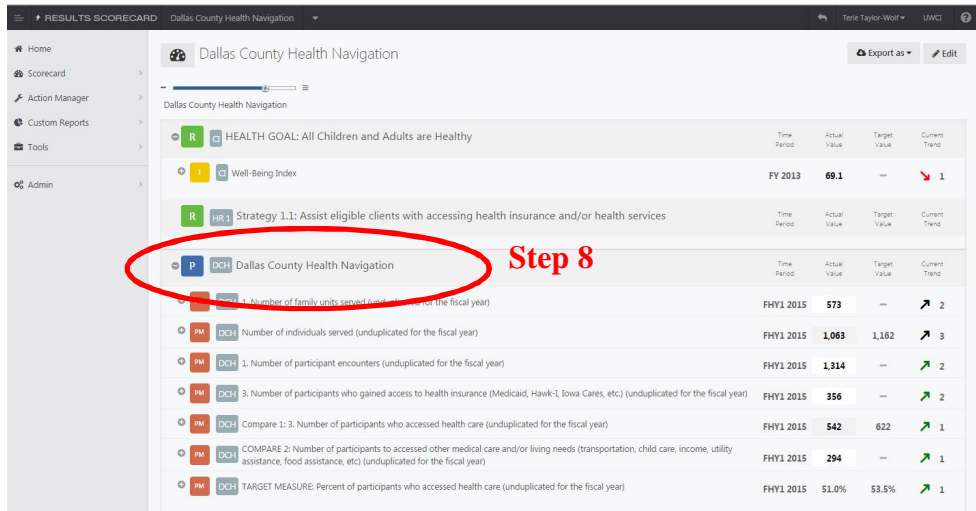
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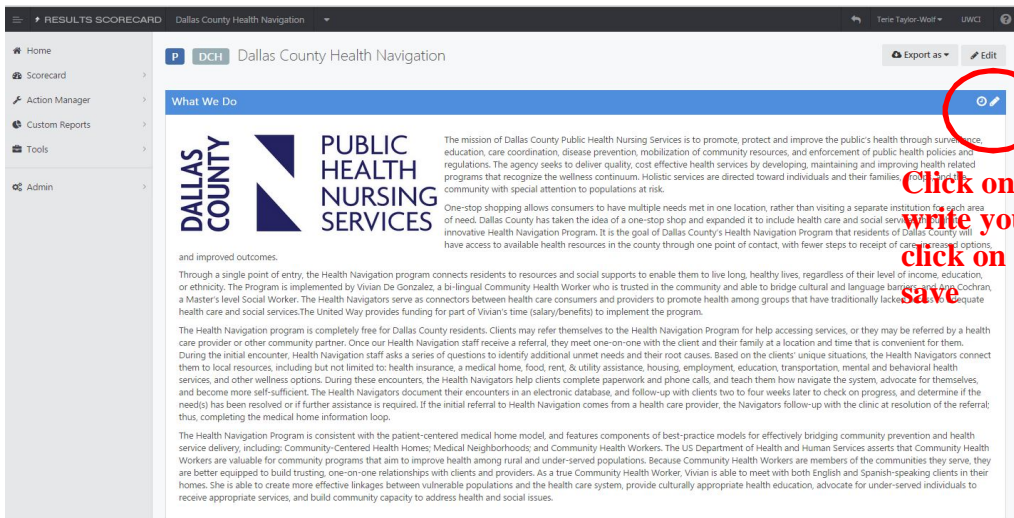
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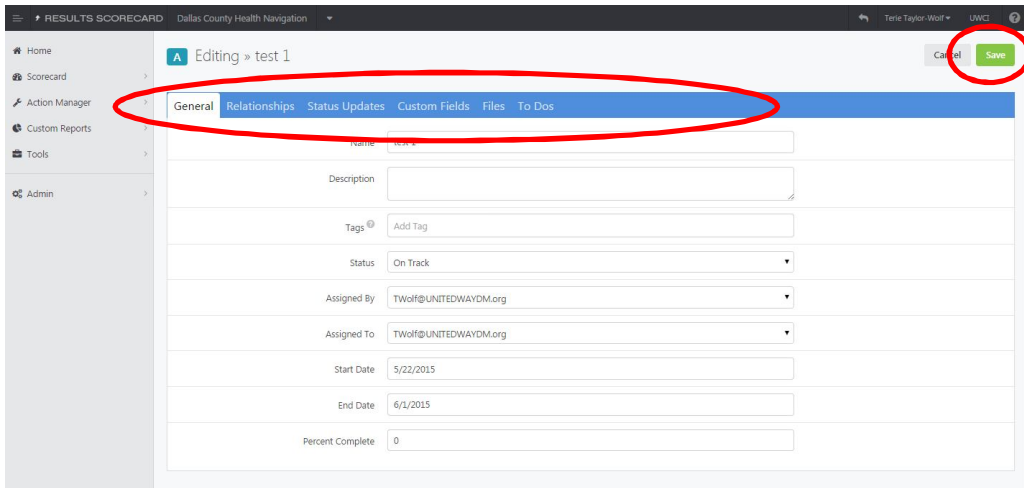


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# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

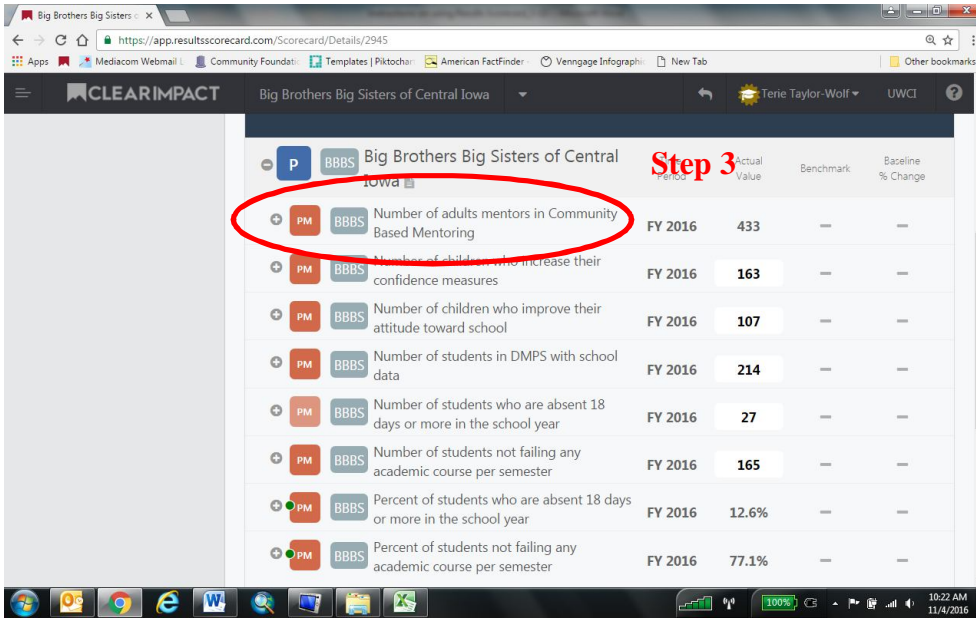
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



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Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.



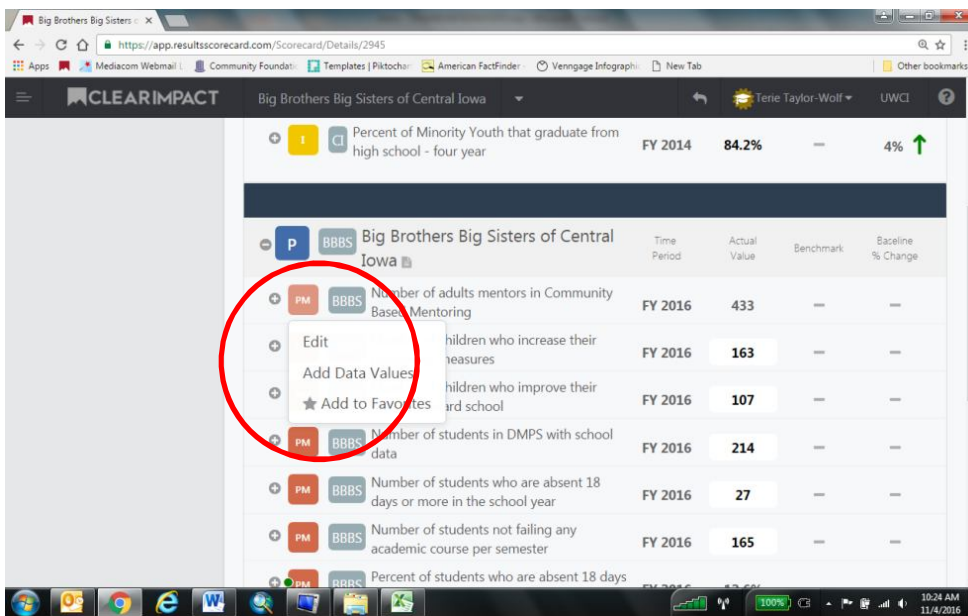
By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance



Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



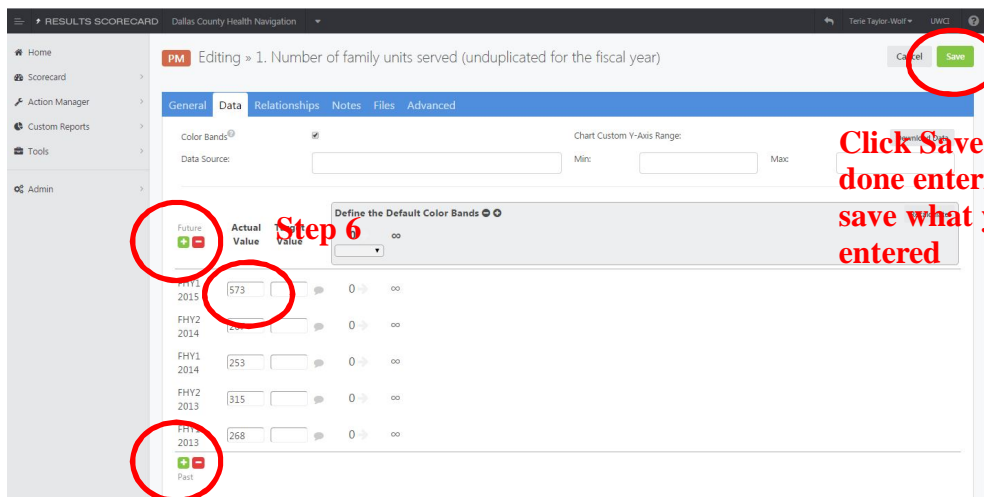
Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

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TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
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HY1	July 1-Dec. 31
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Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

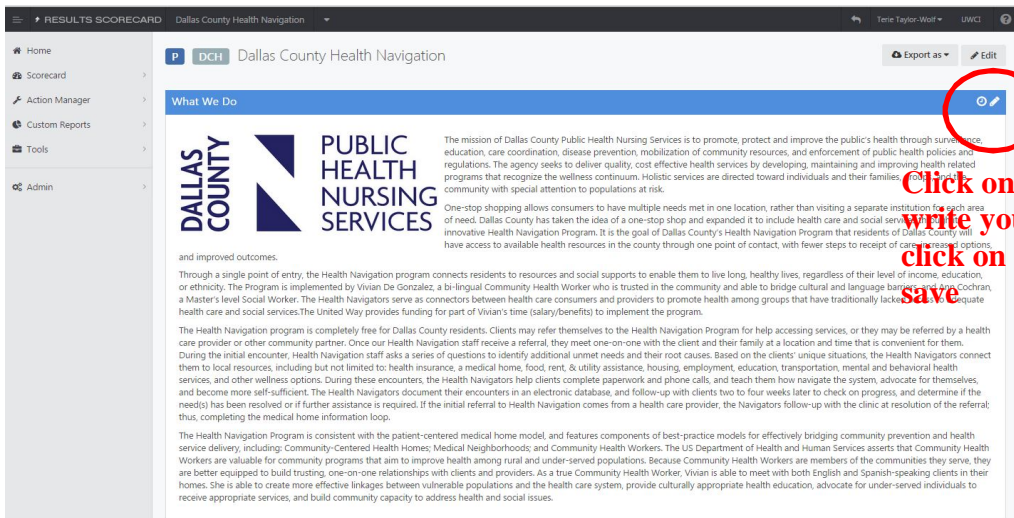
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral, thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



Step 9

Optional Step 10: For those of you who want to track “Actions” from your Action Plan, click on “New Action” to create an action or “Existing Action” if you already have an assigned action you wish to review or edit.

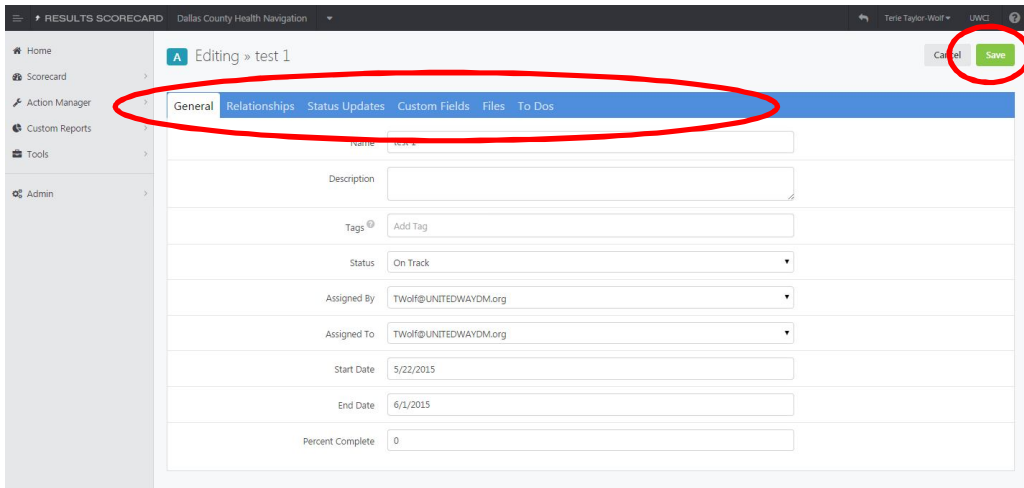


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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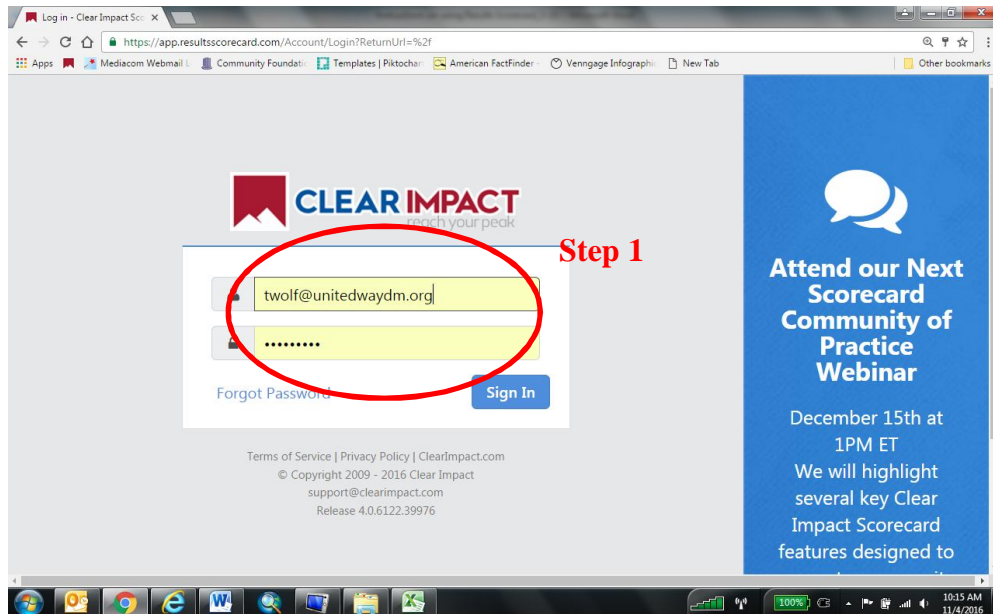
Instructions on using Results Scorecard

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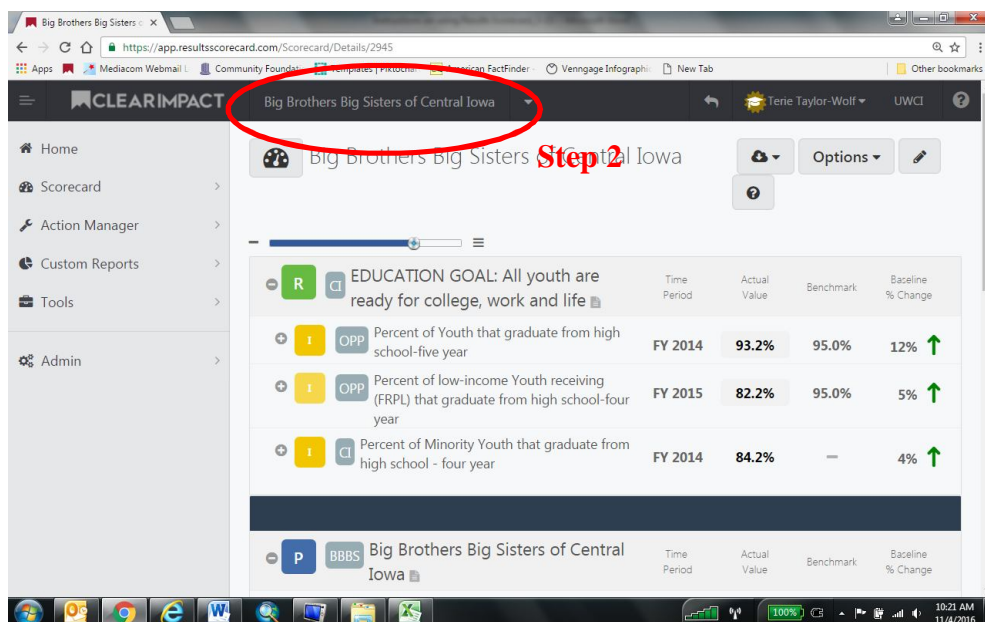
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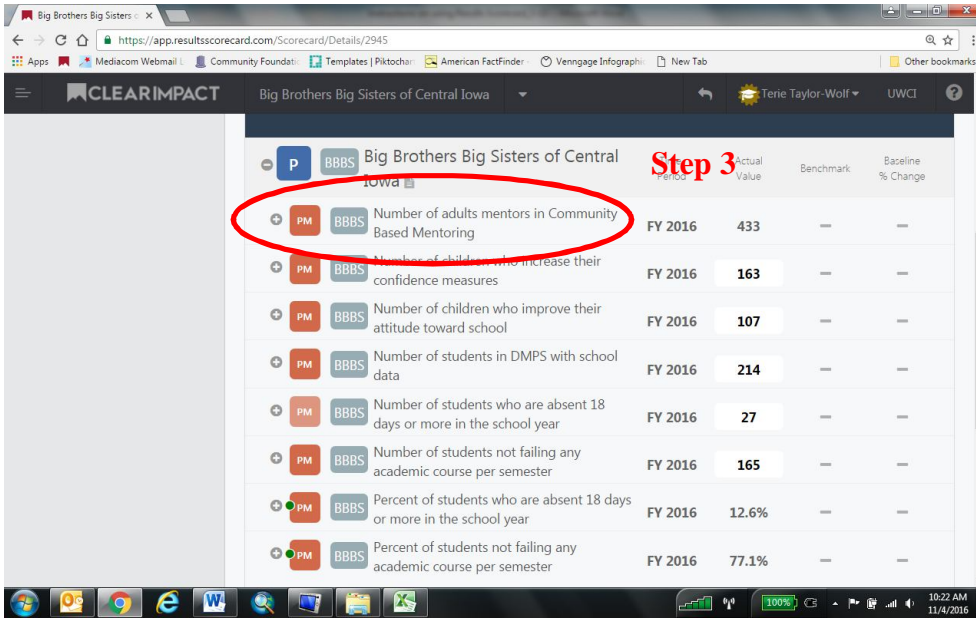
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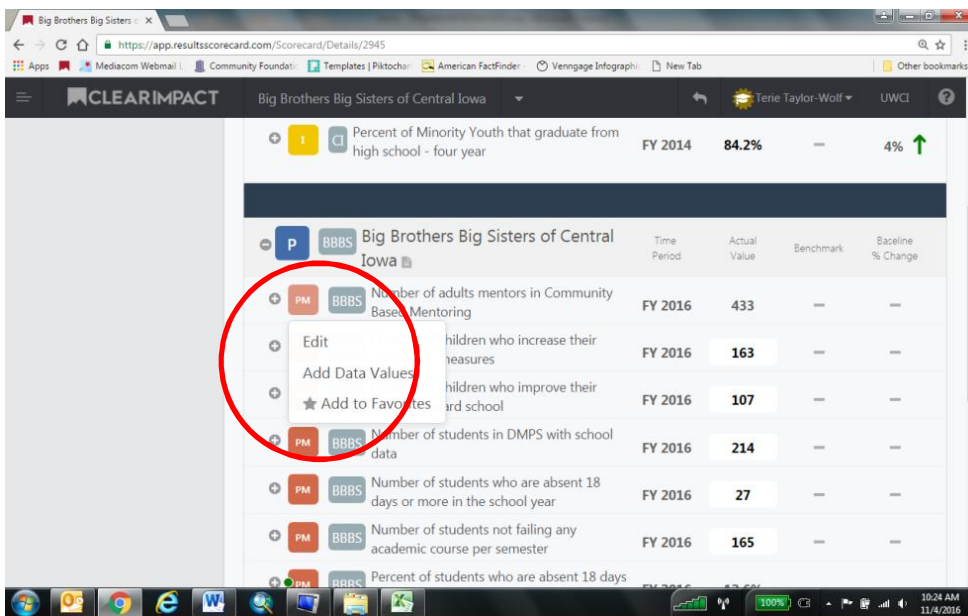


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Step 4

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Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
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The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. The actual value is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a pencil icon circled in red. The text in this section describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to improve the situation.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image, but with the text area expanded. The text describes the program's target measure and the challenges faced in FY13-FY14, such as changes in staff and underreporting of services. It also mentions the implementation of a steering committee and staff training in FY2015 to improve the situation. A disk icon is circled in red at the bottom right of the text area, indicating where to click to save the narrative.

Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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Step 9

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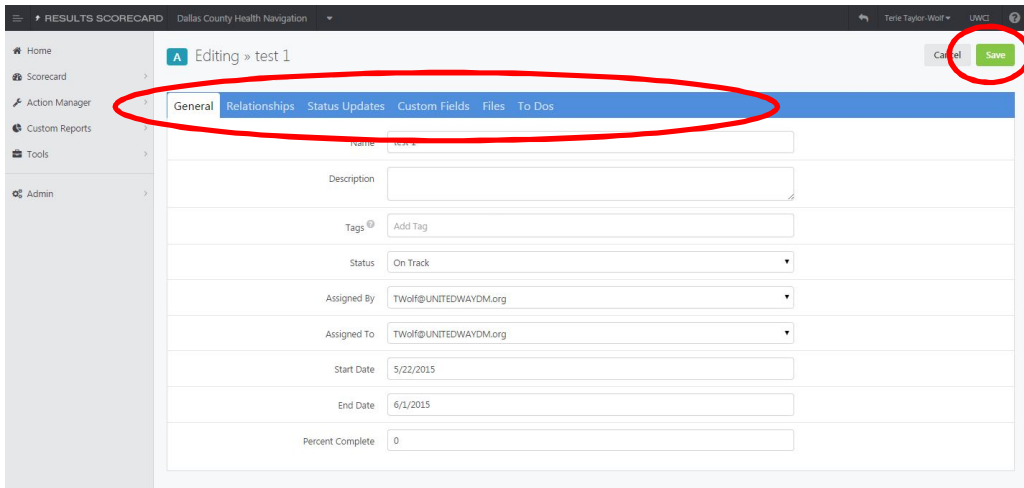


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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

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Target Measure	14%	200%	70.0%

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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser window displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

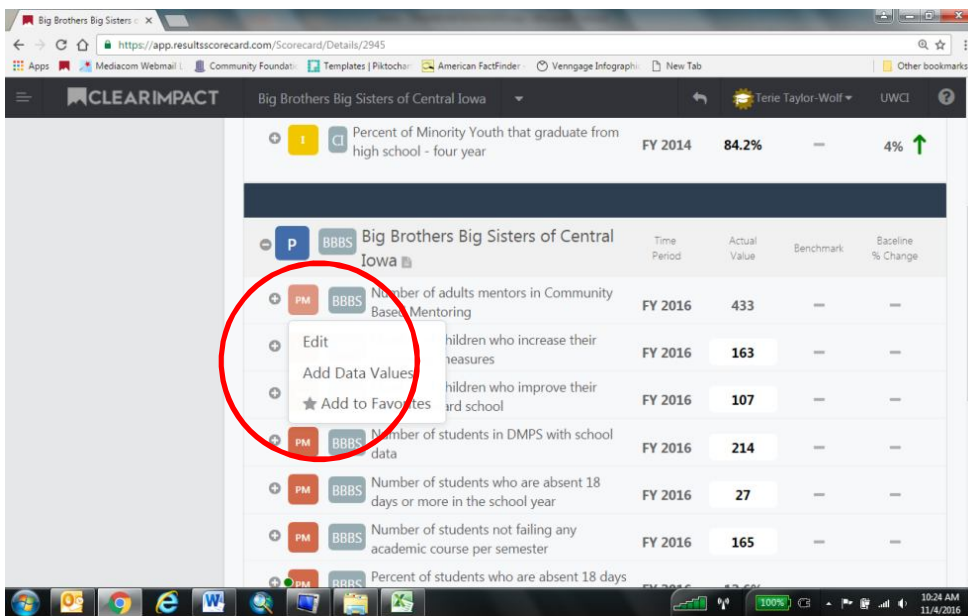
The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a decline in FY 2015.

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

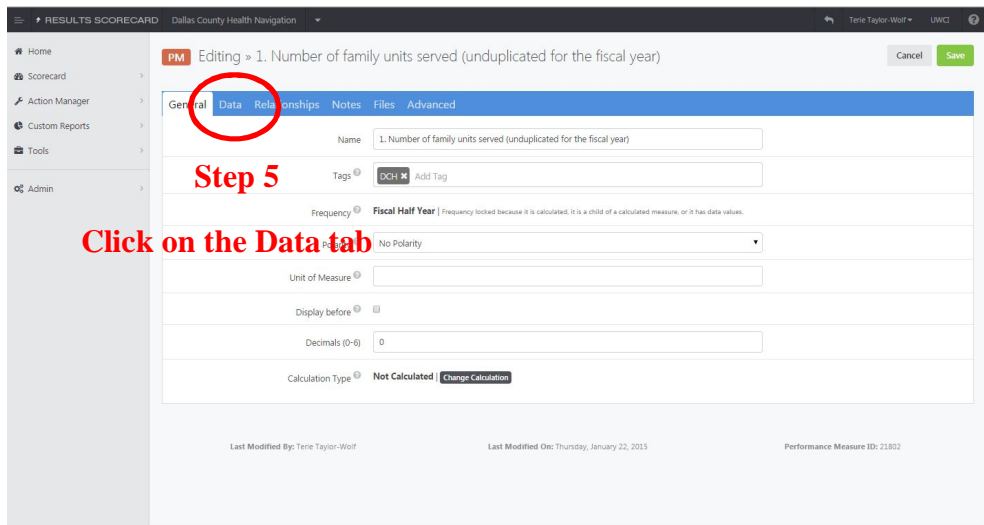
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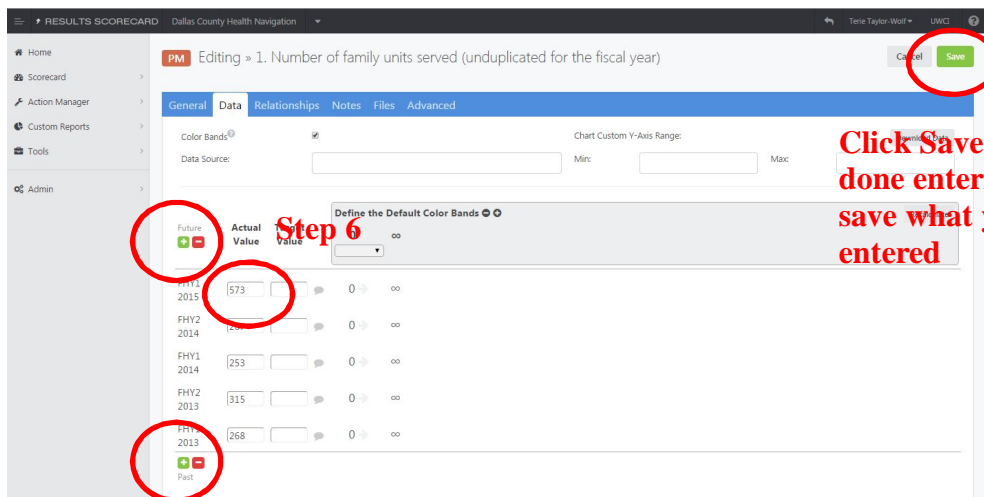
Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays data from FY2 2015 to FY2 2020, with an actual value of 51.0% and a target value of 63.5%. Below the chart is the 'Story Behind the Curve' section, which contains a text area and a pencil icon circled in red, indicating where to click to edit the narrative.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image. The text area is now populated with a detailed narrative about the Health Navigation Program's target measure, its challenges, and the actions taken to improve it. A disk icon in the bottom right corner of the text area is circled in red, indicating where to click to save the changes.

Click disk icon to save your written material

Step 7

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1. What We Do
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4. Success Story

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Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
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DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)

Step 8

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The result is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

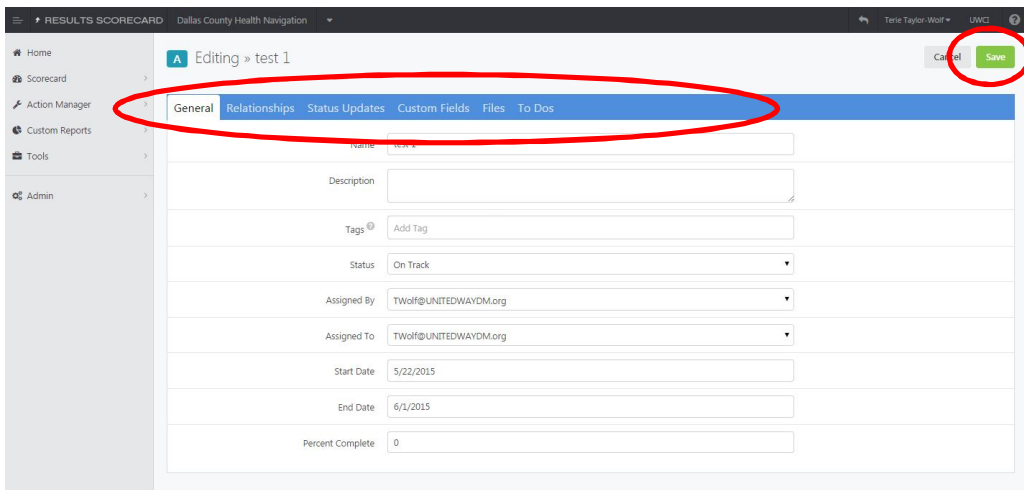


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
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Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
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Tim	1st half	1st half	Myra	1st half	2nd half
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Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

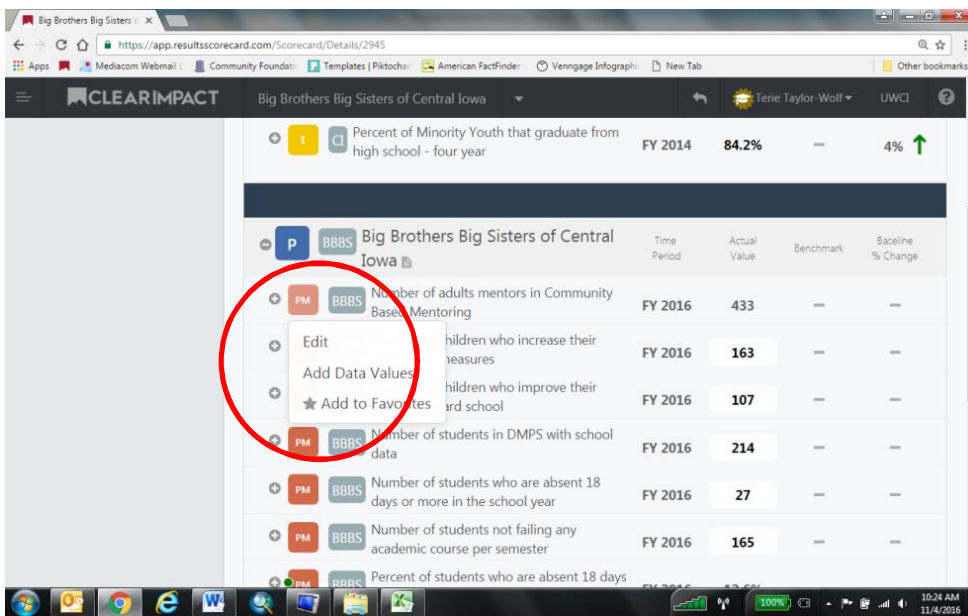
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FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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Step 4

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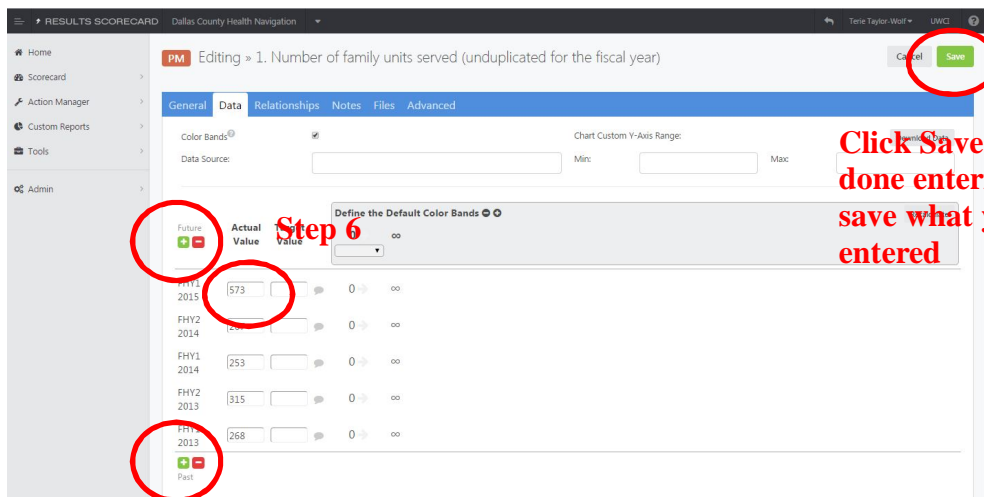
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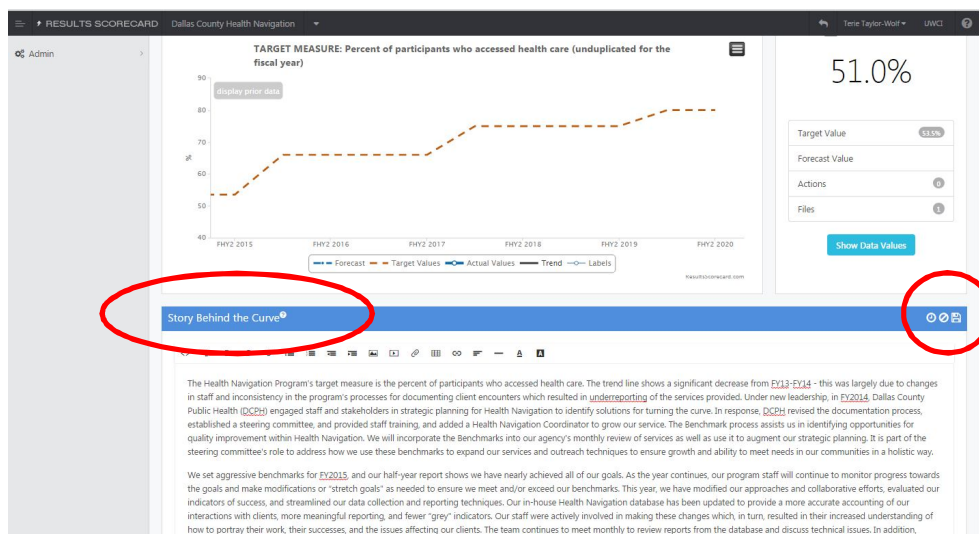
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Step 7



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Step 7

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You will find these areas by clicking on the program name

Category	Item	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL	HEALTH GOAL: All Children and Adults are Healthy				
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Strategy	Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
Program	DCH Dallas County Health Navigation				
	1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
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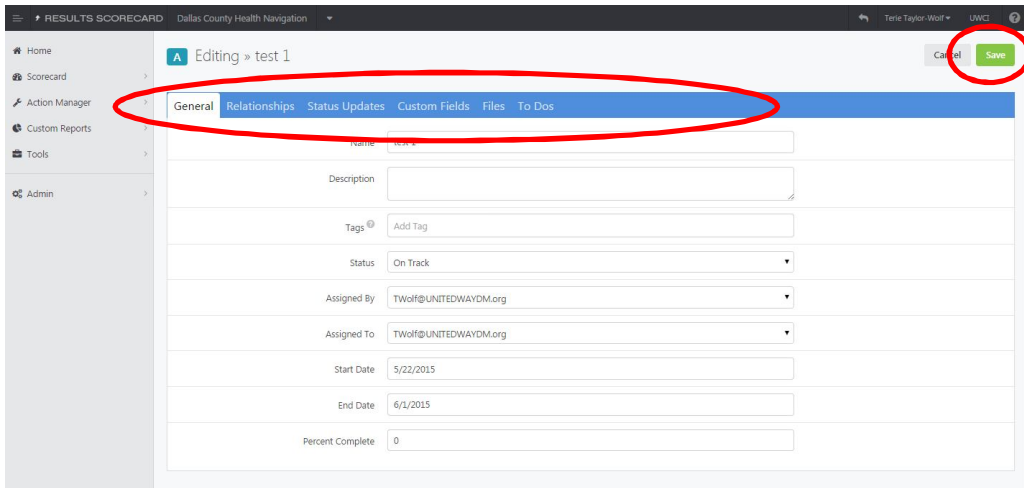


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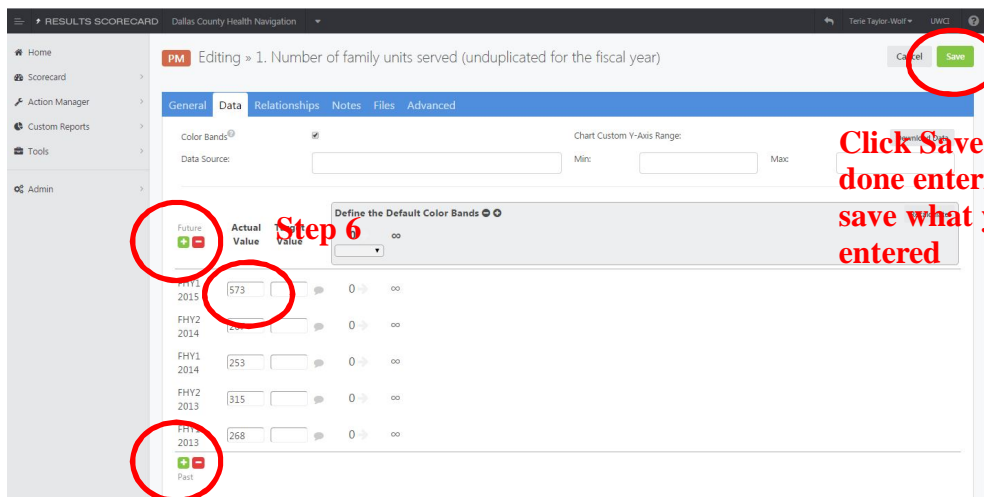
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Click pencil icon to write or paste narrative

Step 7

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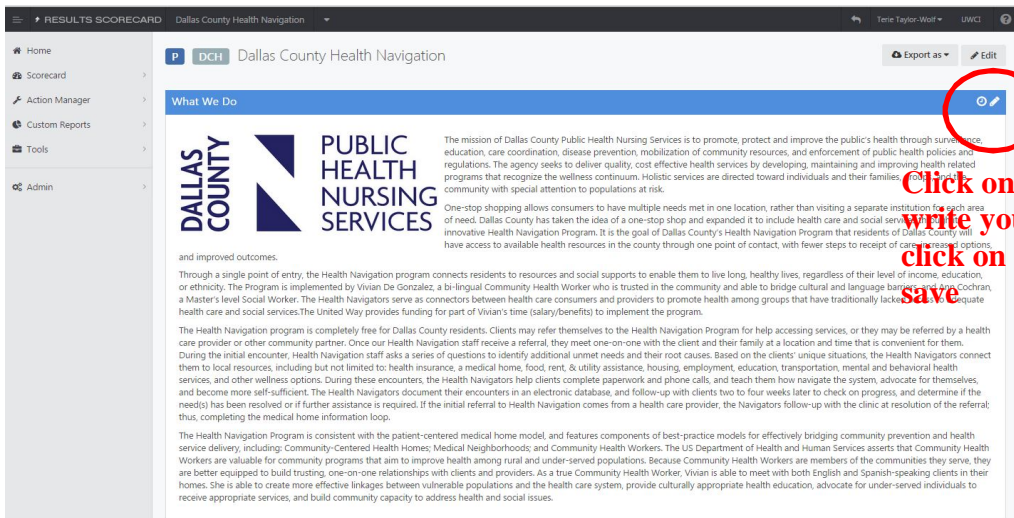
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What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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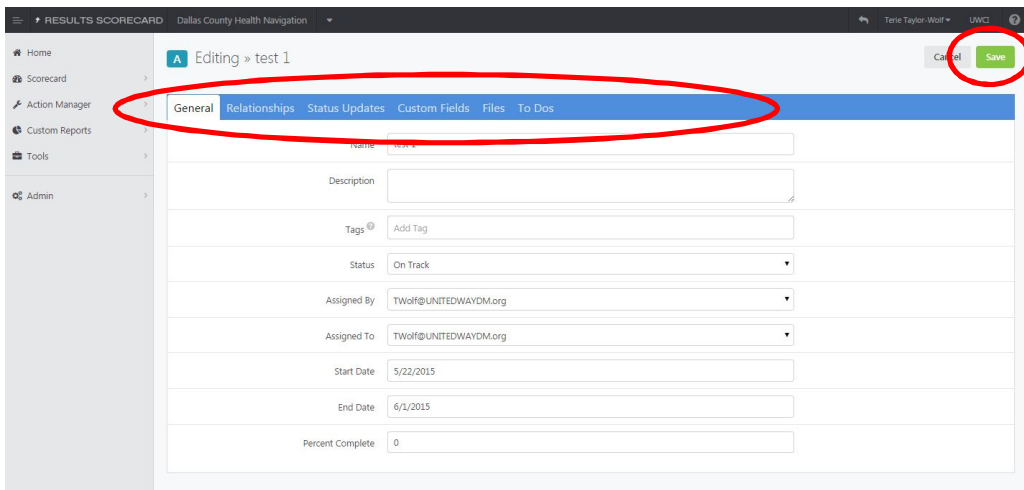


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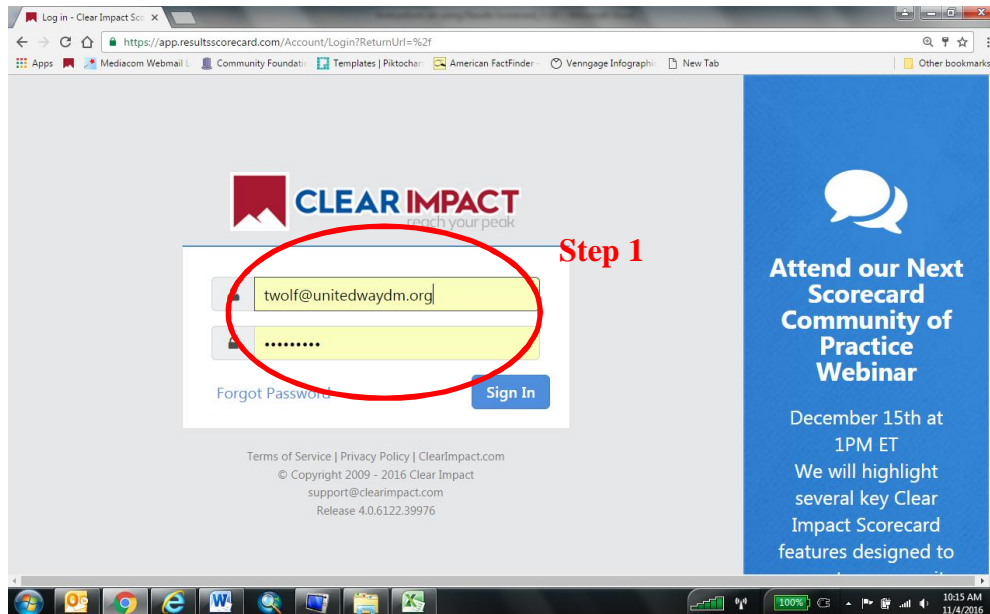
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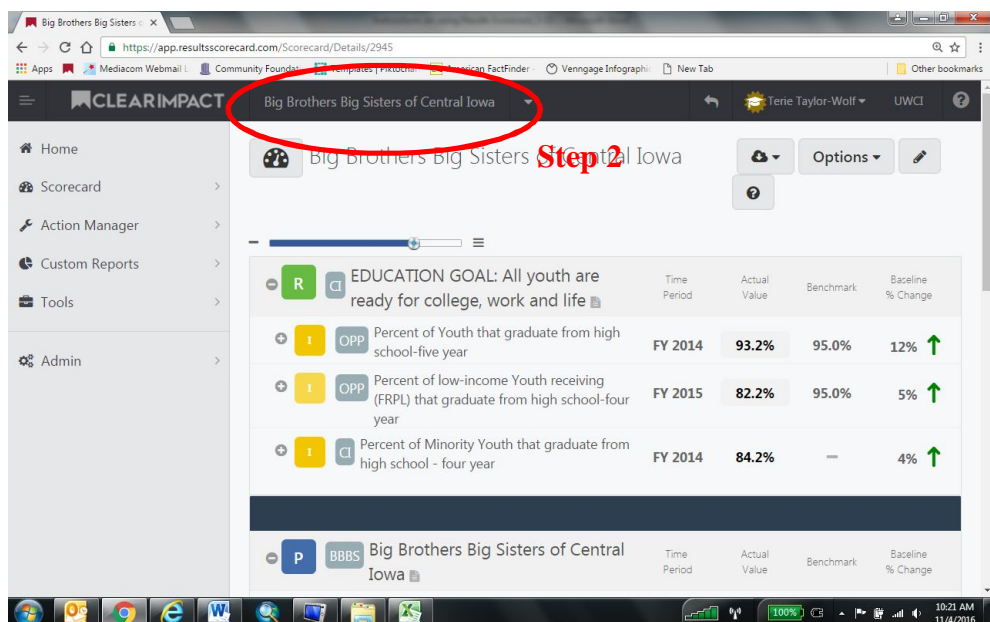
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The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is Terie Taylor-Wolf. The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph shows the trend data for this measure from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The table below shows the following data:

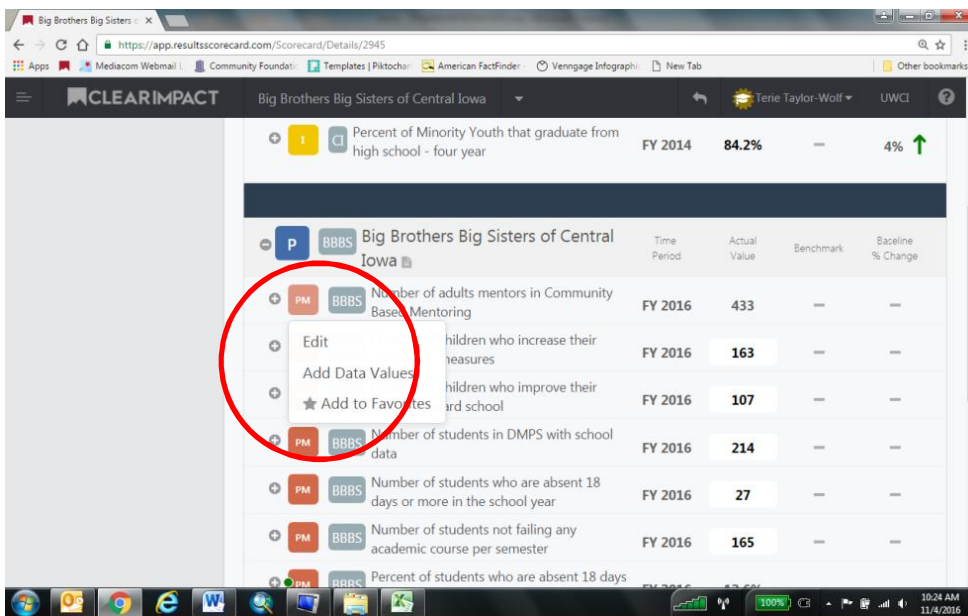
PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
		FY 2012	515	—	—
		FY 2011	496	—	—

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Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



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Step 5
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Click Save button when done entering data to save what you have entered

Step 6

Congratulations! You have added your data to your scorecard.

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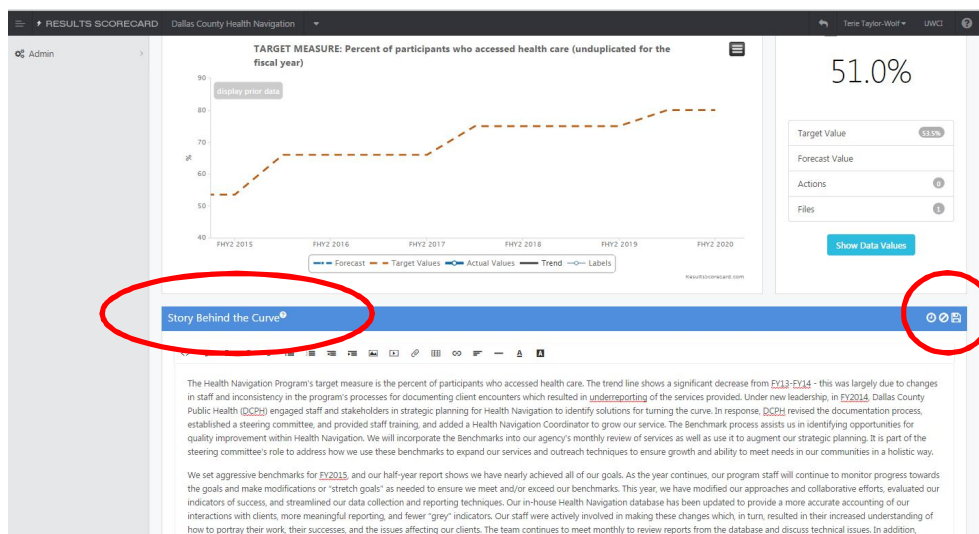
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Step 7

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1. What We Do
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You will find these areas by clicking on the program name

Category	Item	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL	HEALTH GOAL: All Children and Adults are Healthy				
	Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy	Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
Program	DCH Dallas County Health Navigation				
	1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
	Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
	1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
	3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
	Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
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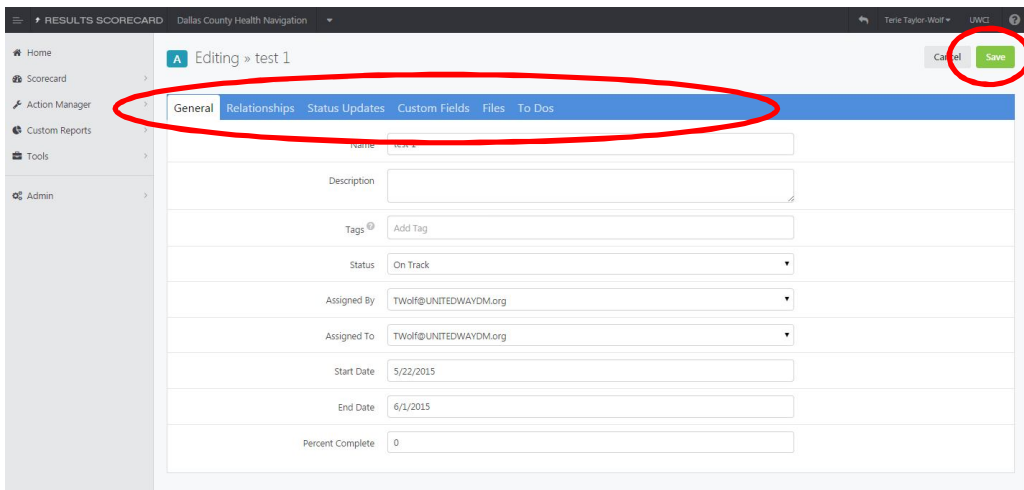


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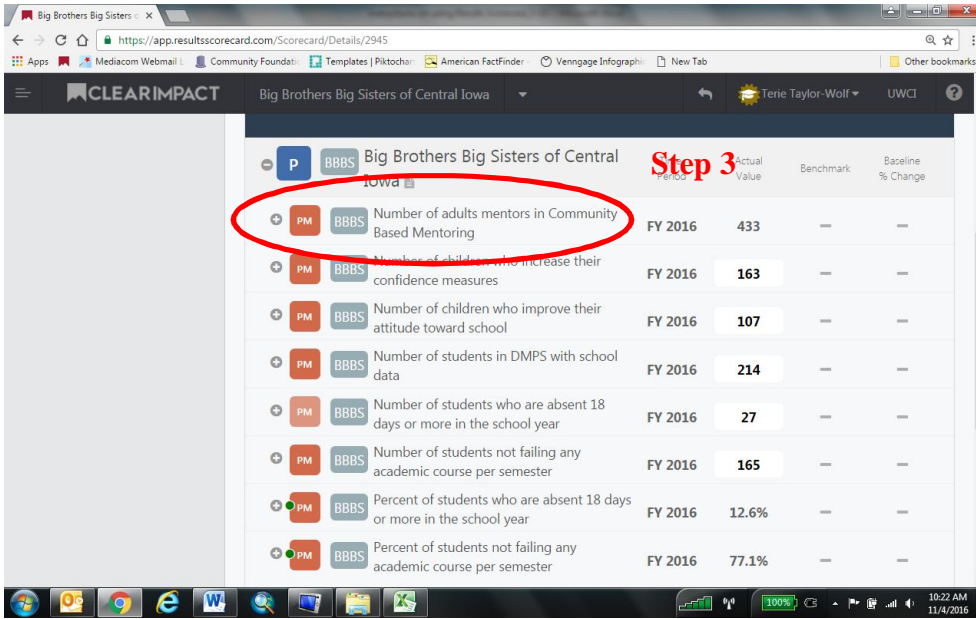
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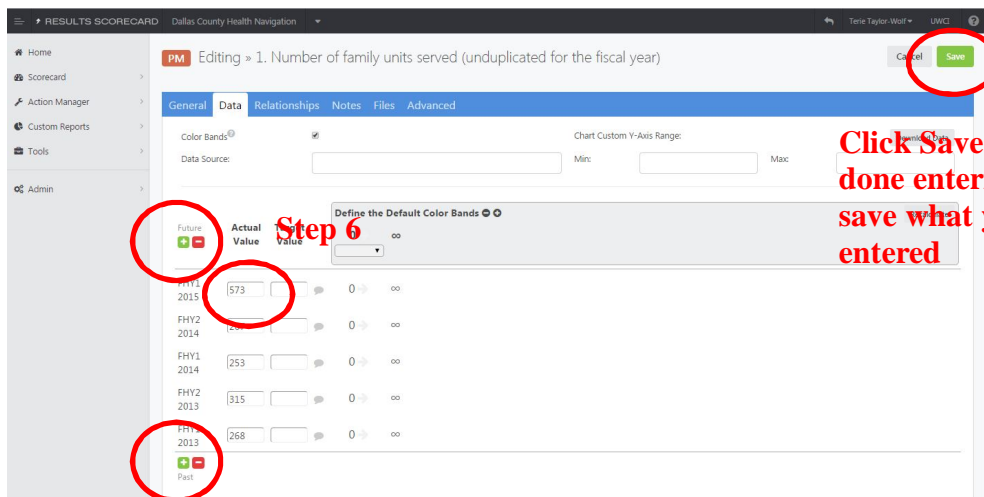


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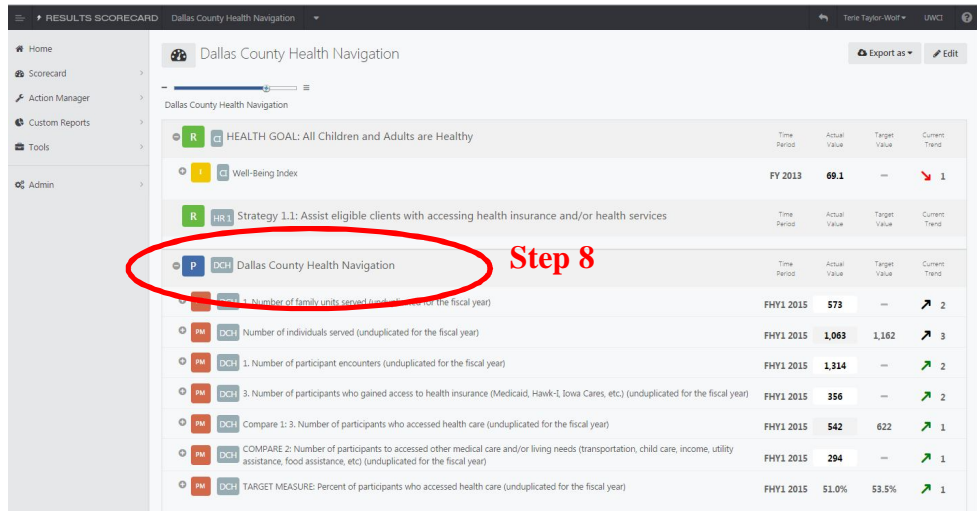
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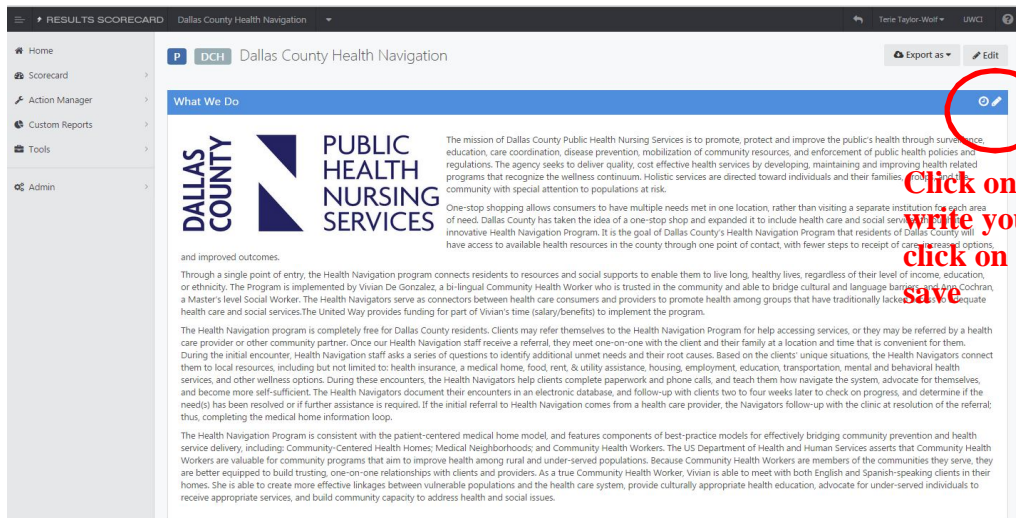
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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

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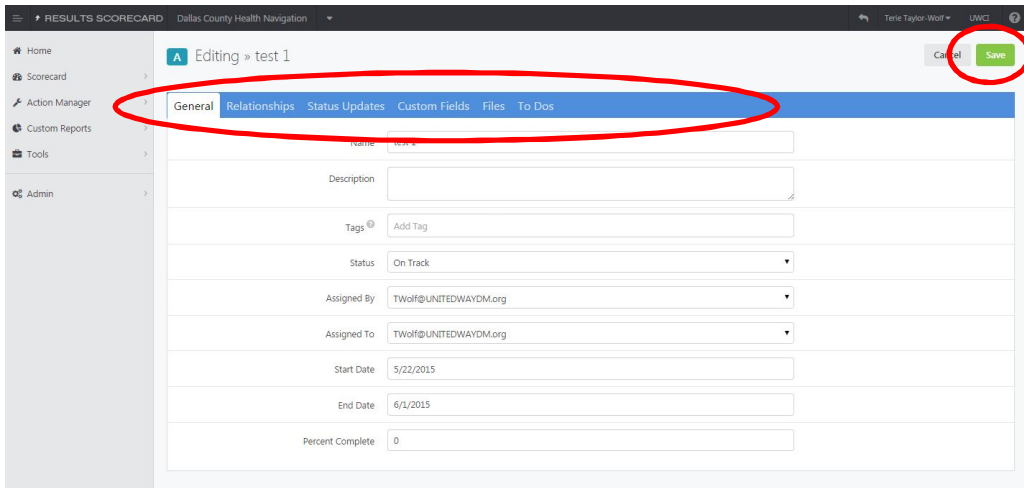


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Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

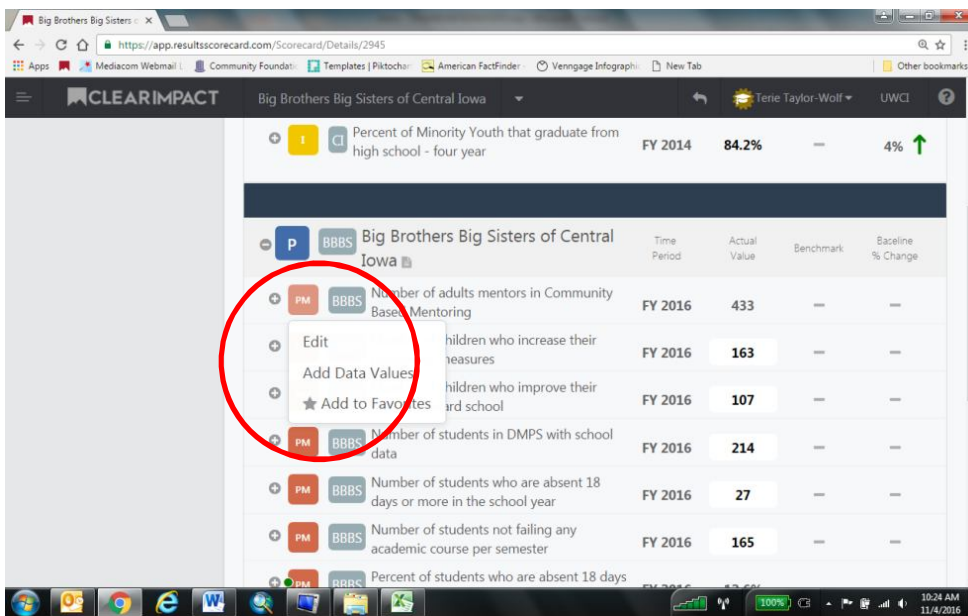
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Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
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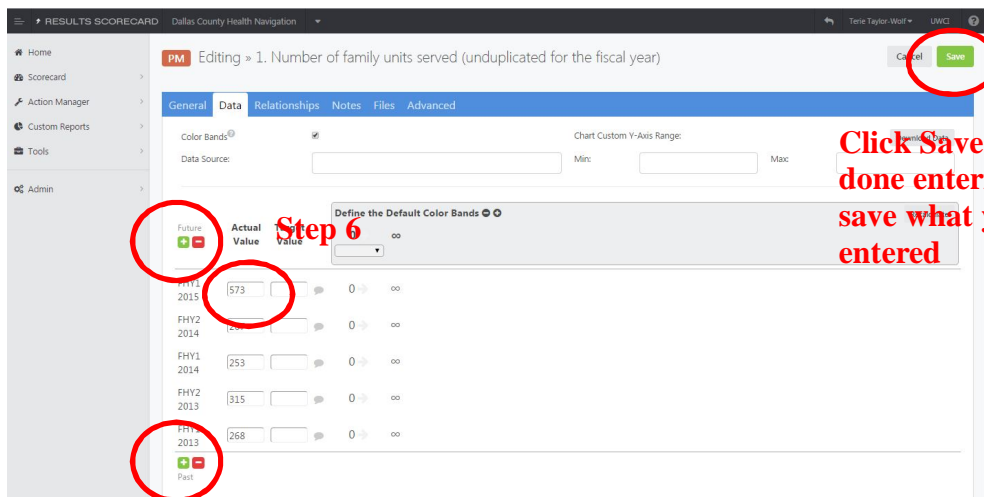
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Step 5
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Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.

The screenshot shows the 'RESULTS SCORECARD' for 'Dallas County Health Navigation'. The target measure is 'Percent of participants who accessed health care (unduplicated for the fiscal year)'. A line chart displays 'Forecast', 'Target Values', 'Actual Values', 'Trend', and 'Labels' from FY2 2015 to FY2 2020. The 'Actual Value' is 51.0%. Below the chart is the 'Story Behind the Curve' section, which contains a text area and a pencil icon circled in red.

Click pencil icon to write or paste narrative

Step 7

This screenshot shows the same 'Story Behind the Curve' section as the previous image, but with the text area expanded. The text describes the Health Navigation Program's target measure and the challenges faced, such as underreporting. A disk icon in the bottom right corner of the text area is circled in red.

Click disk icon to save your written material

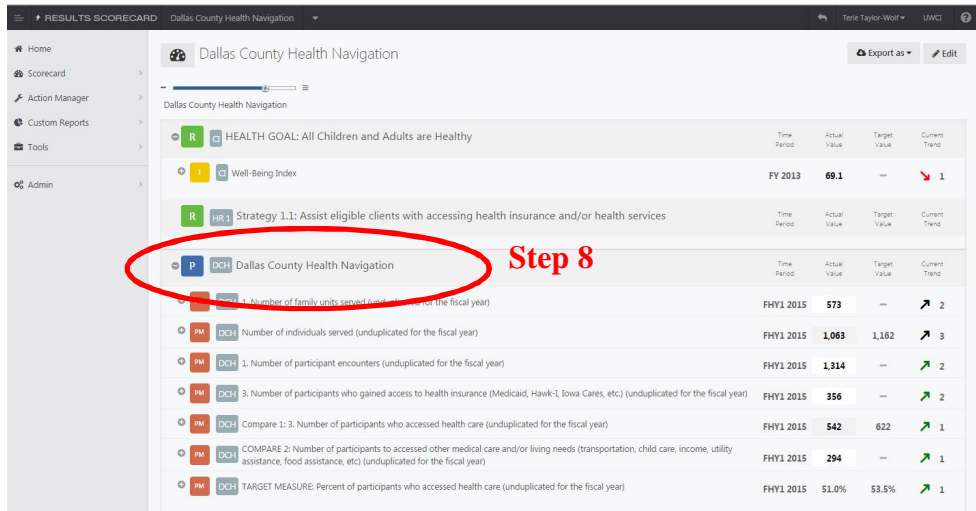
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Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

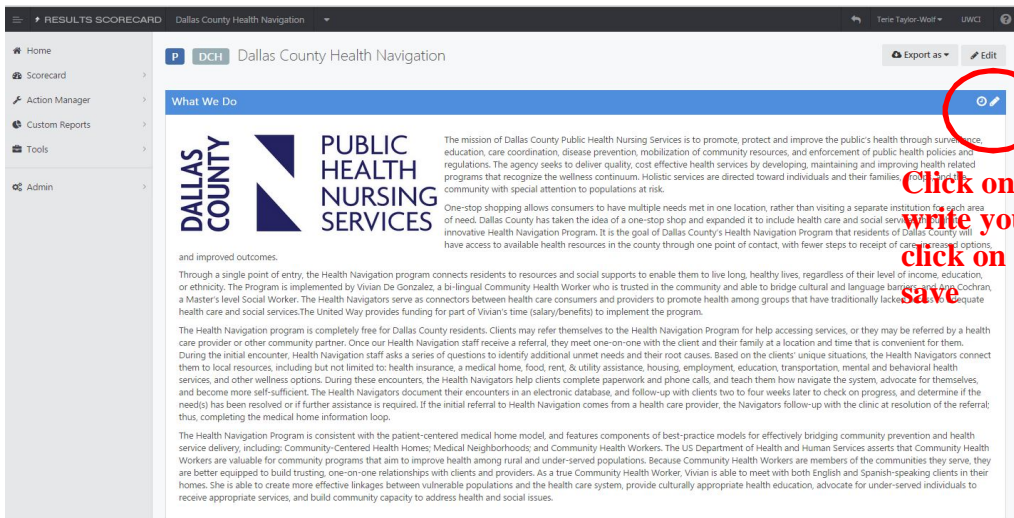
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

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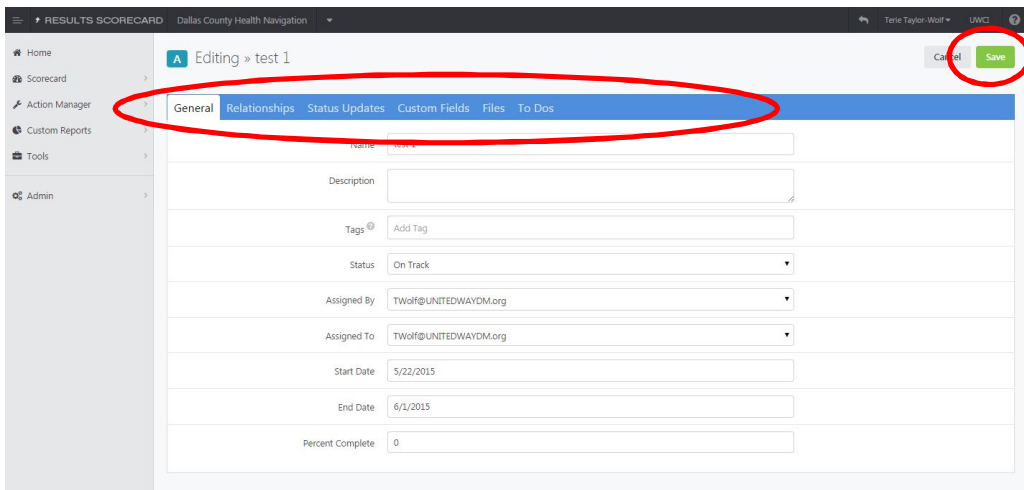


Step 10

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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
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Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

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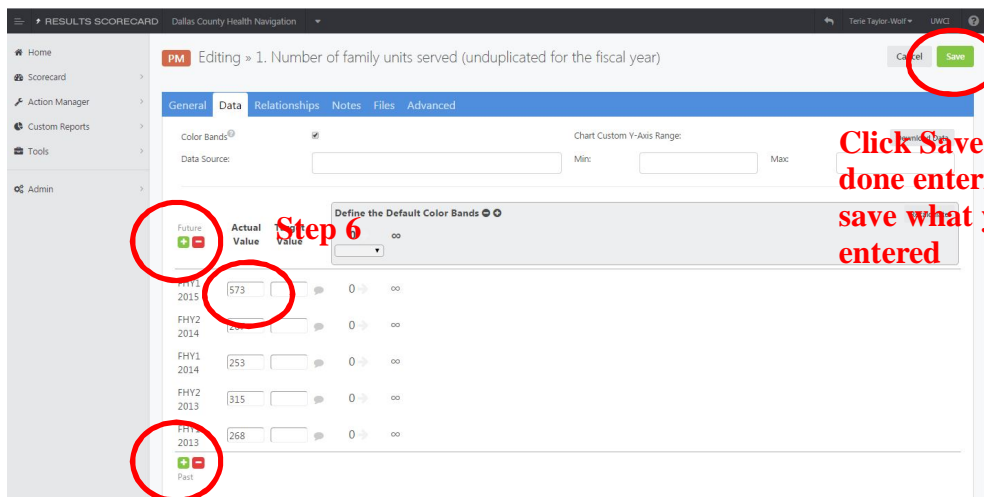
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Step 7

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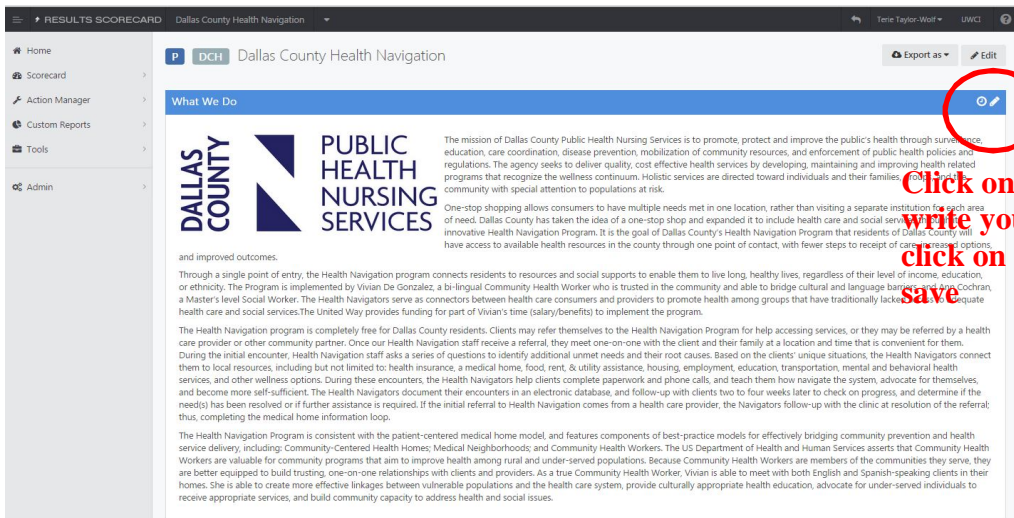
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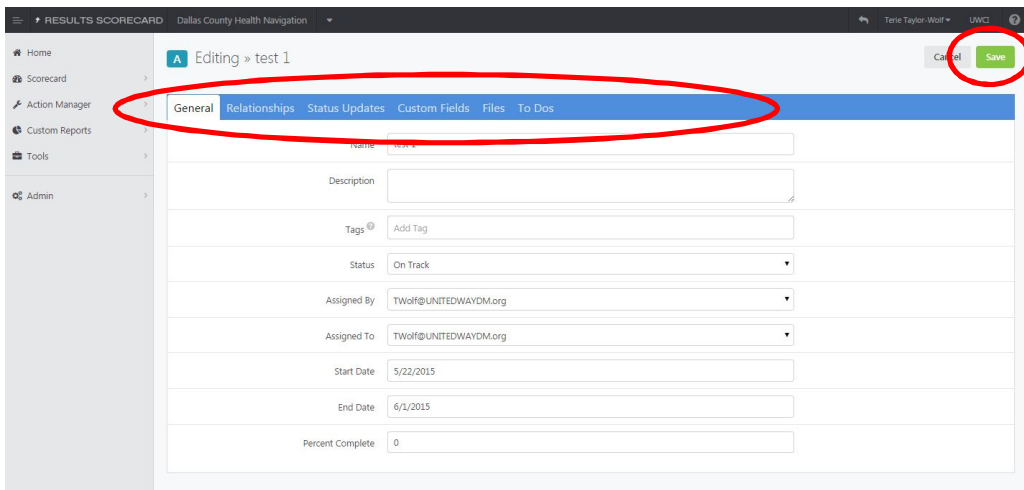


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Target Measure	57%	133%	80.0%

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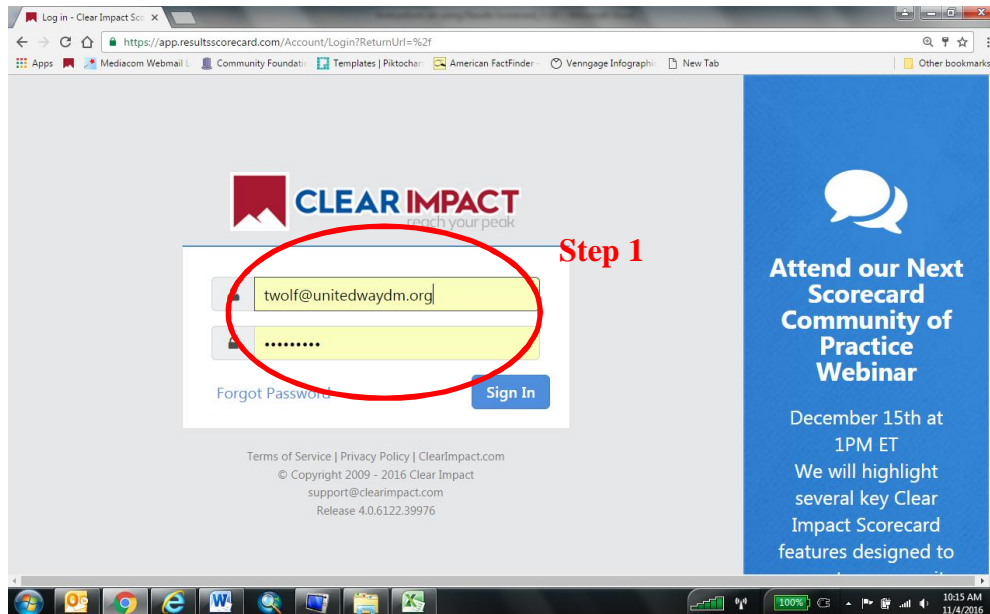
Instructions on using Results Scorecard

Step 1: Login

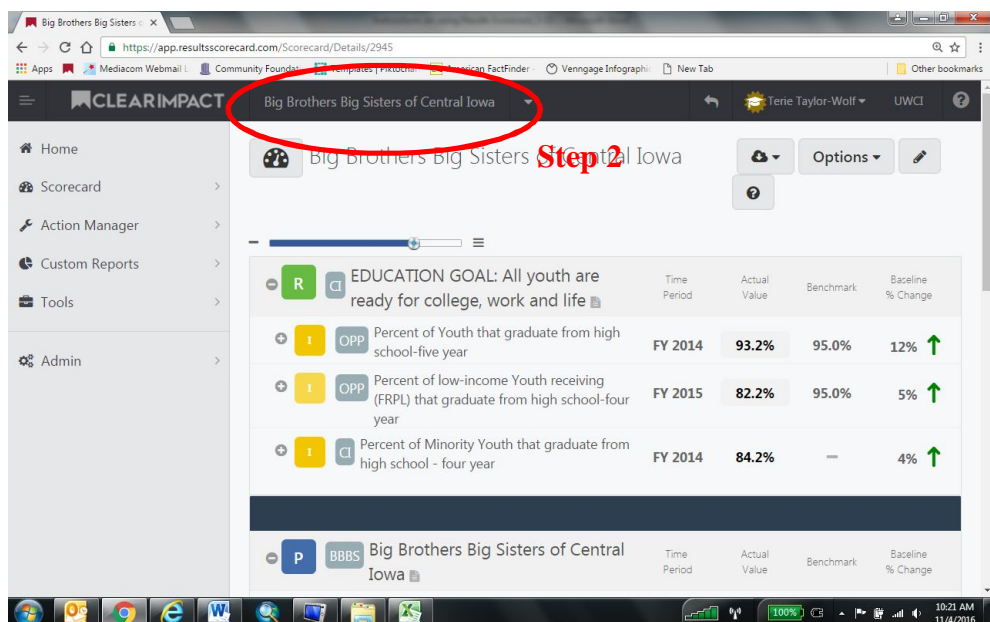
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The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". A red "Step 3" label is visible in the top right. A list of performance measures is shown, with the first one, "Number of adults mentors in Community Based Mentoring", circled in red. The table below shows the following data:

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Number of children who improve their attitude toward school	107	107	—	—
Number of students in DMPS with school data	214	214	—	—
Number of students who are absent 18 days or more in the school year	27	27	—	—
Number of students not failing any academic course per semester	165	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure. A line graph shows the trend data from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

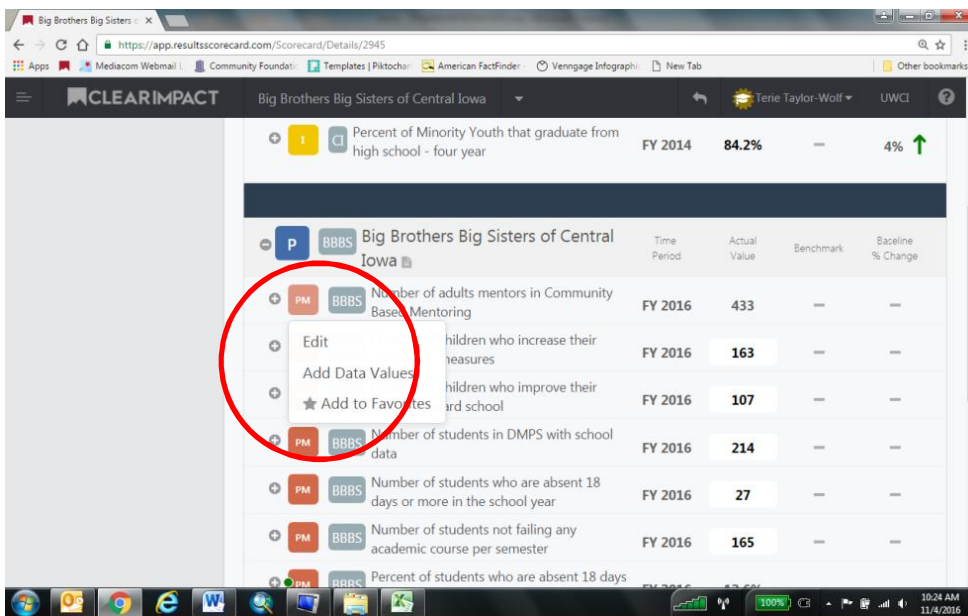
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
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FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

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Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

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You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Click Save button when done entering data to save what you have entered

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Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

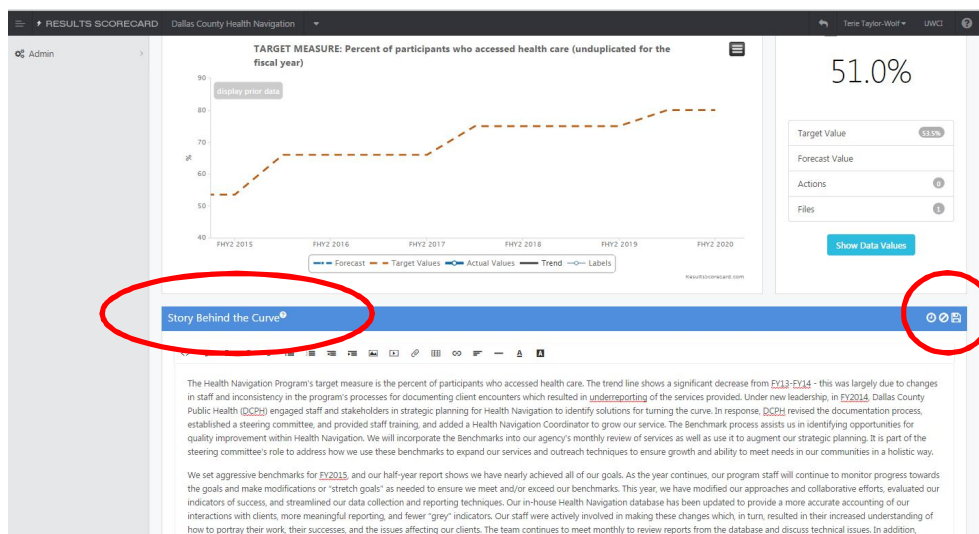
TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

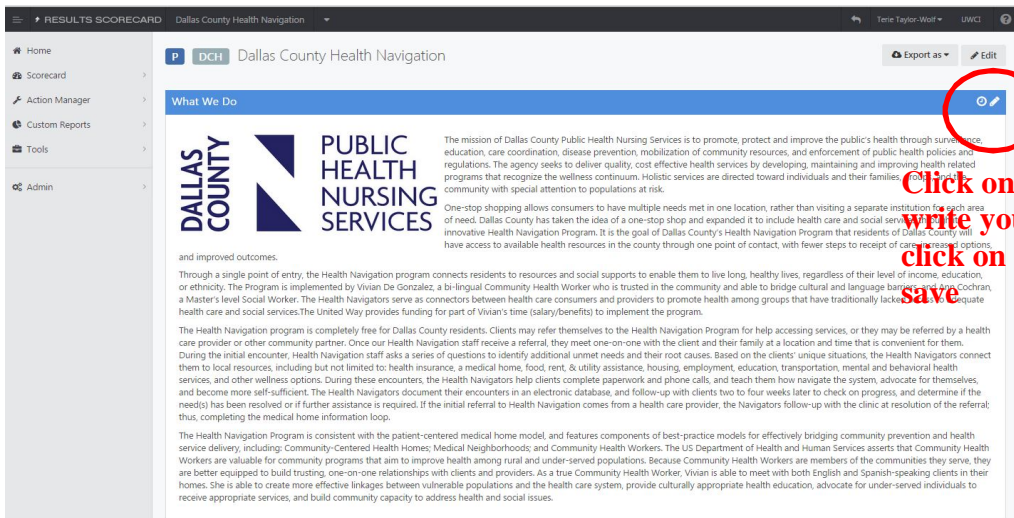
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

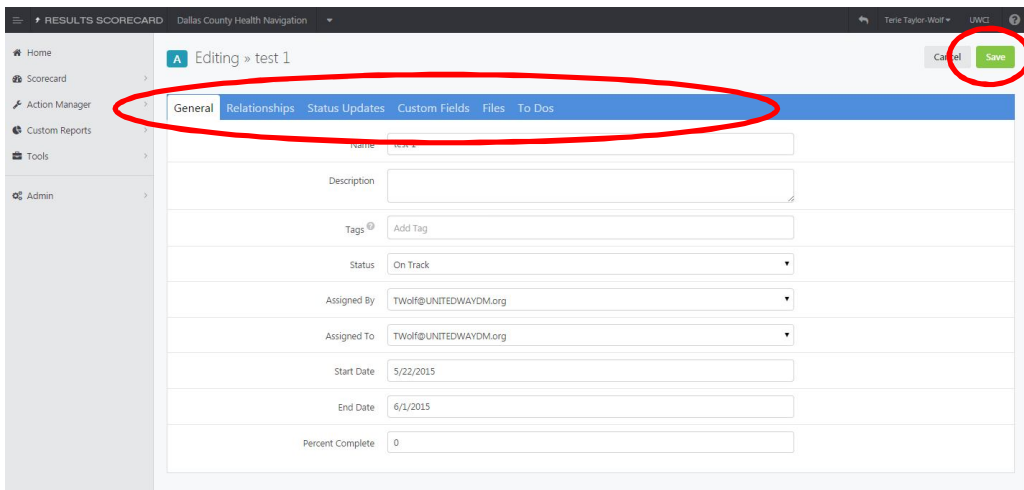


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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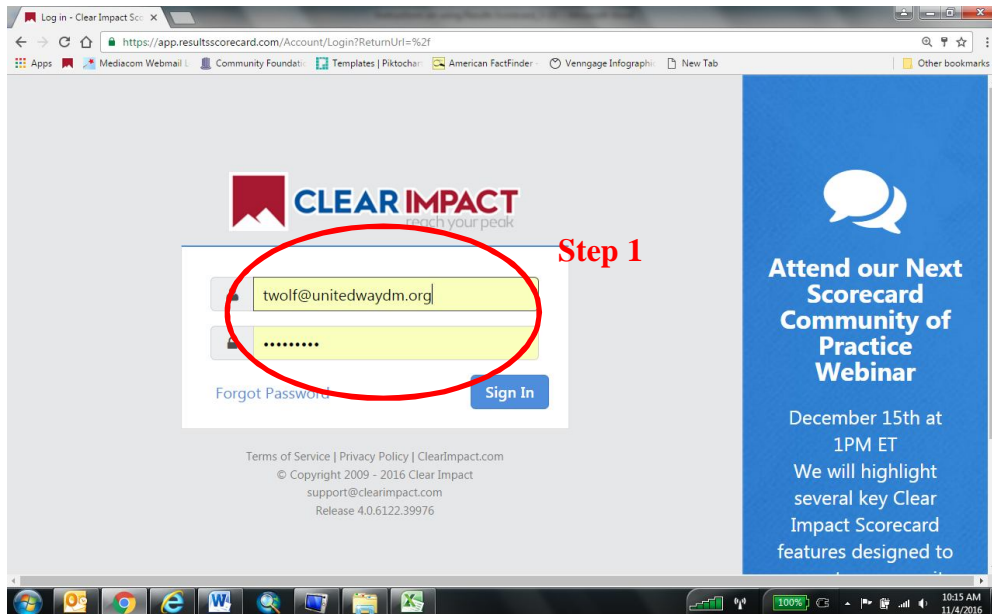
Instructions on using Results Scorecard

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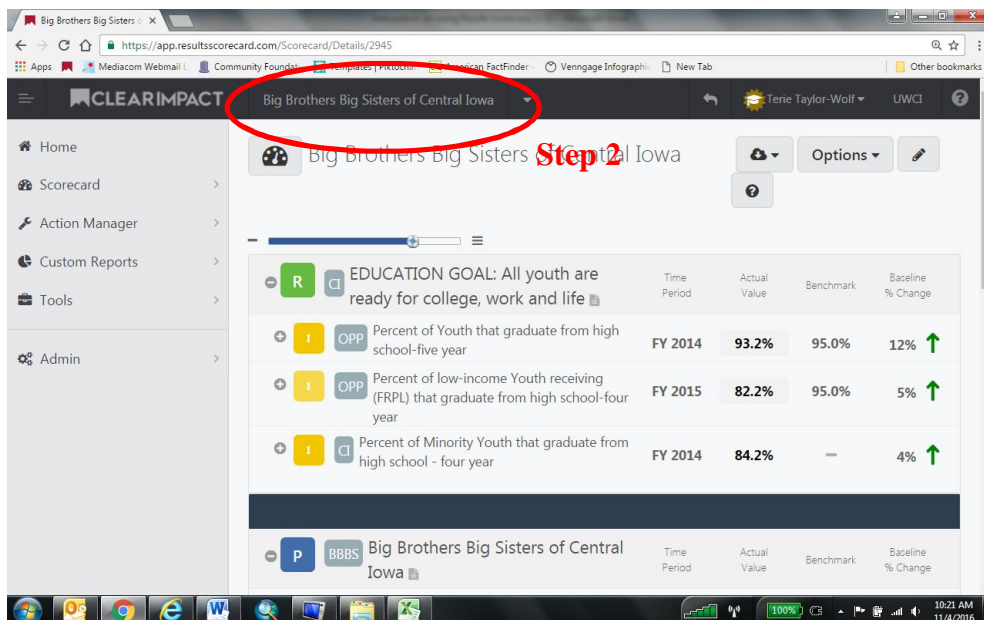
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

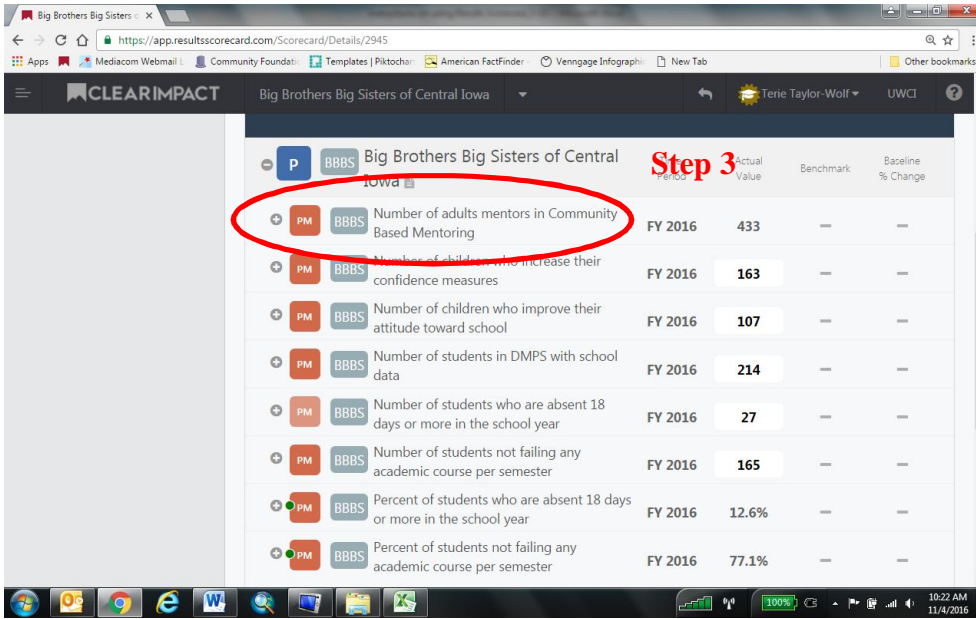
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.



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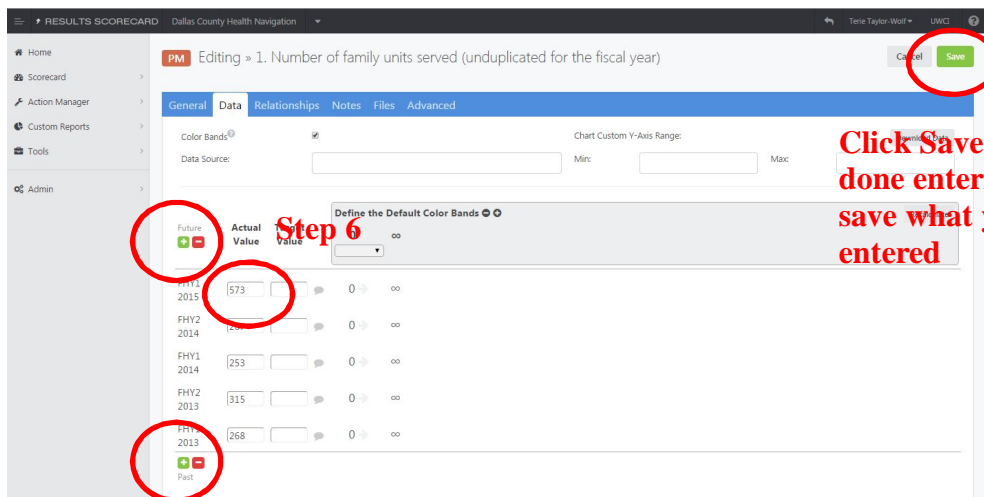
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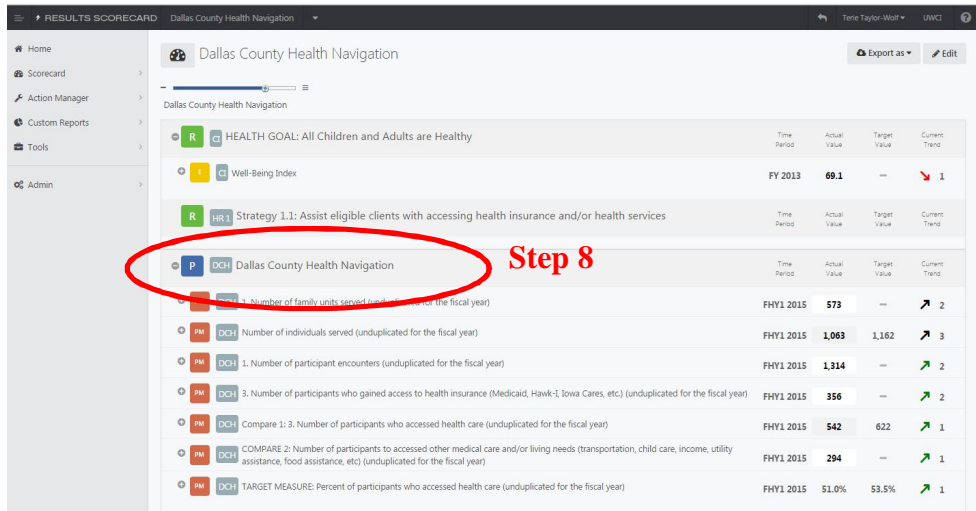
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Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
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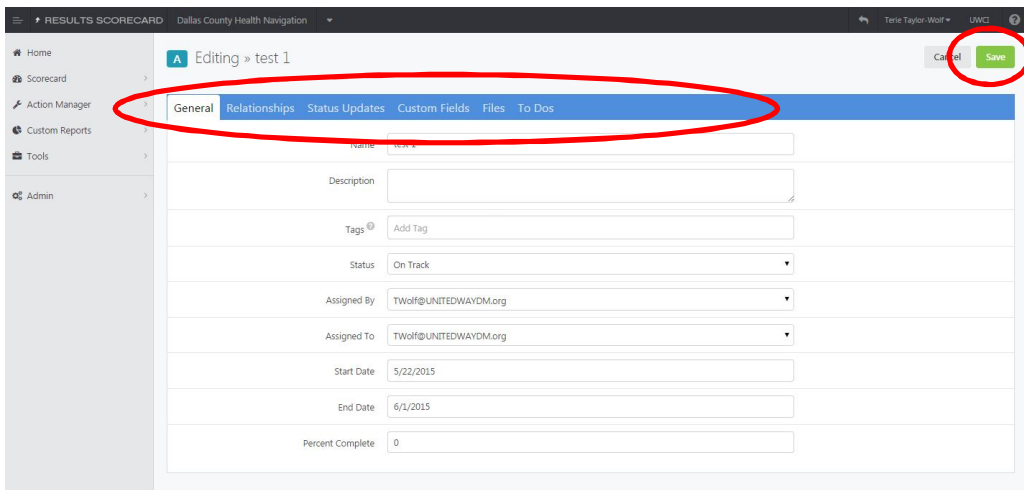


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Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

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number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
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Target Measure	14%	200%	70.0%

Question?

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For Income Programming, contact Corinne Lambert at 246-6542 or e-mail at clambert@unitedwaydm.org

Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS Iowa. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

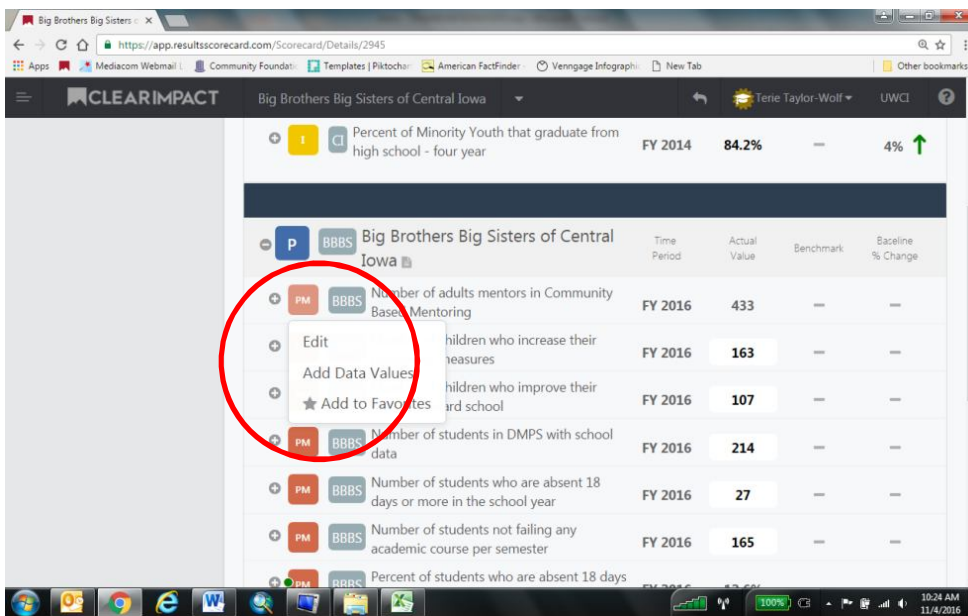
The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
		FY 2012	515	—	—
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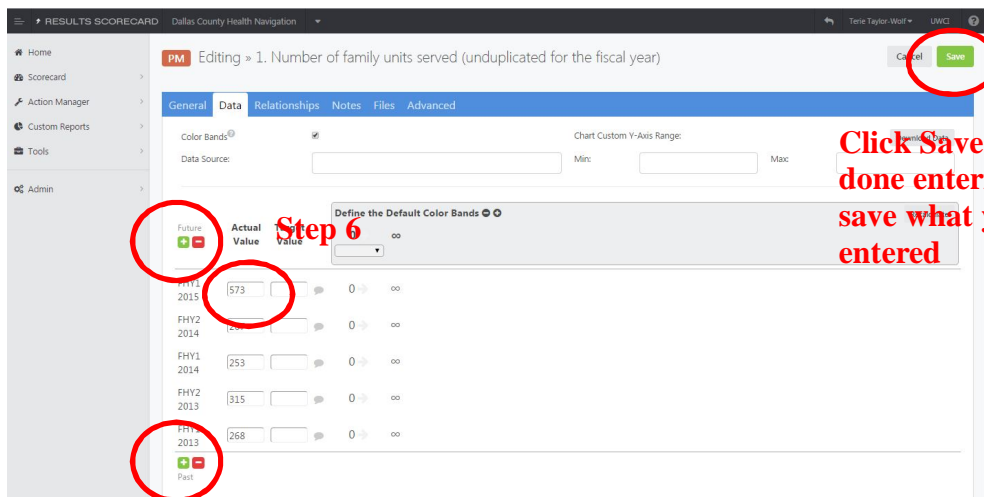
Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

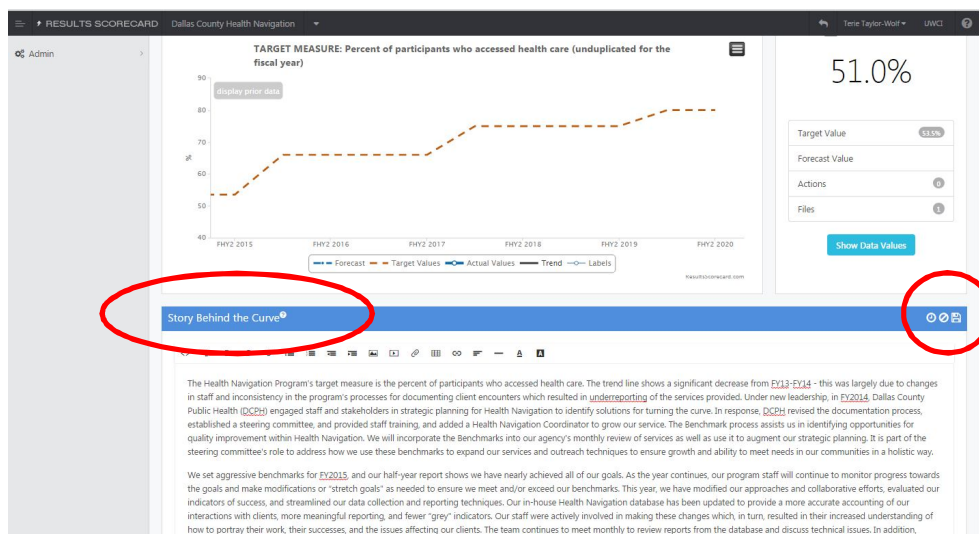
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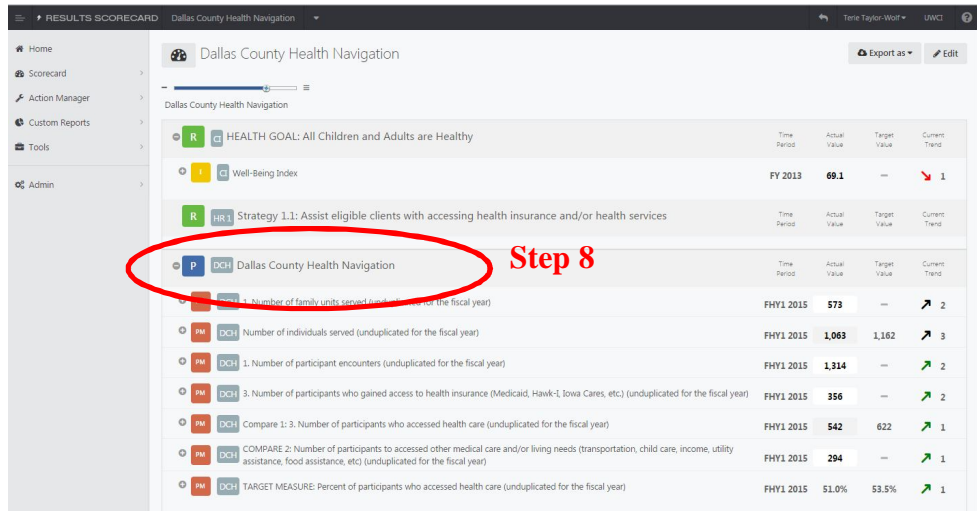
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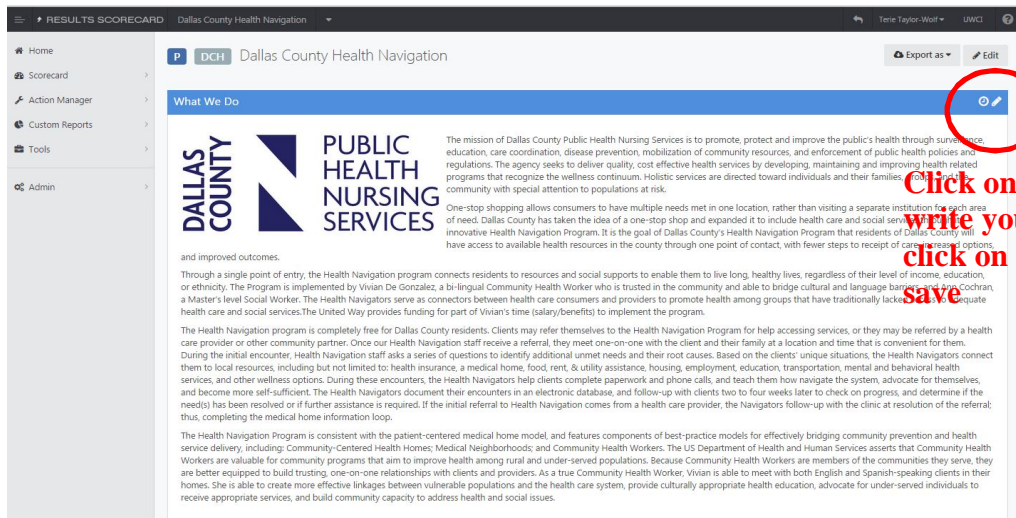
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

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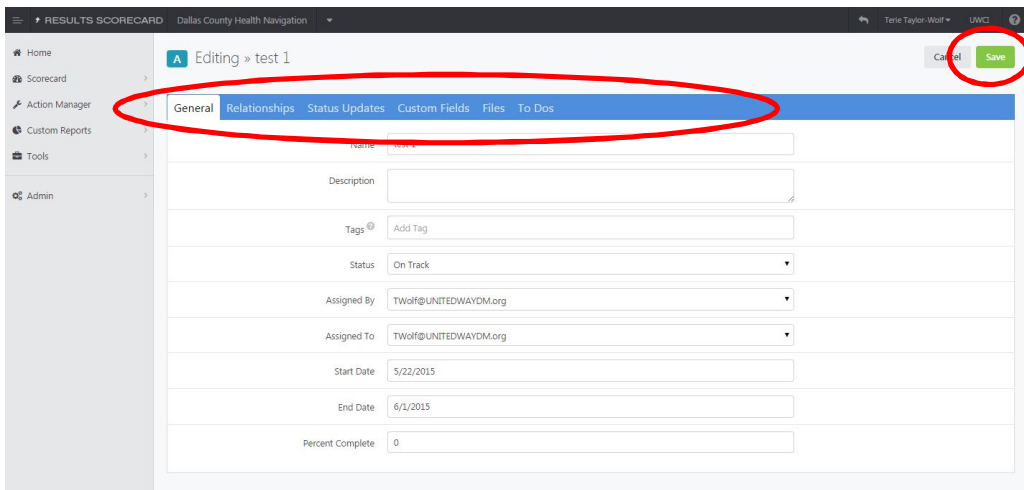


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How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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Kane	1st half	1st half	Jody	1st half	1st half
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Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
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Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
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Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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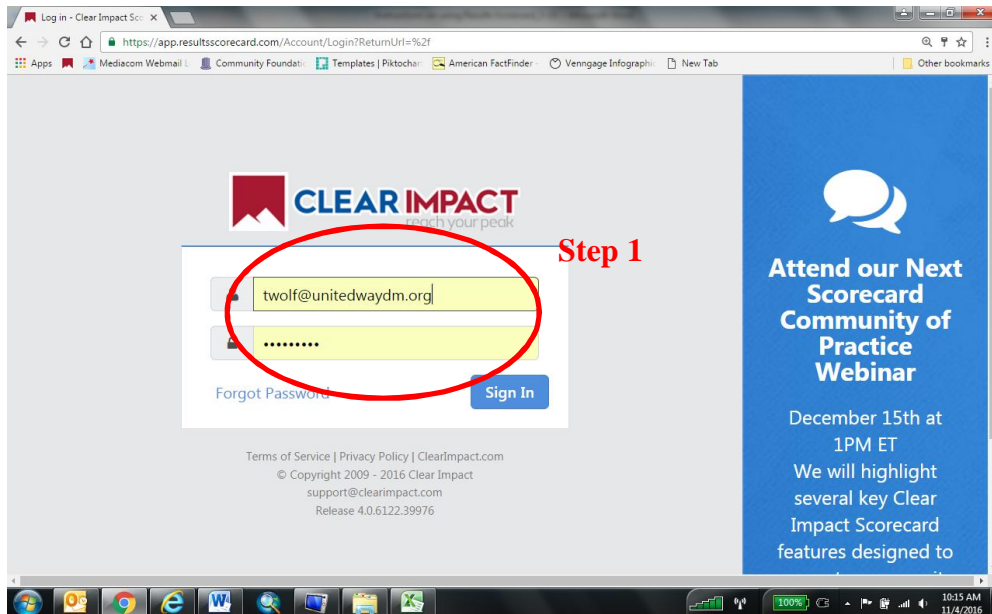
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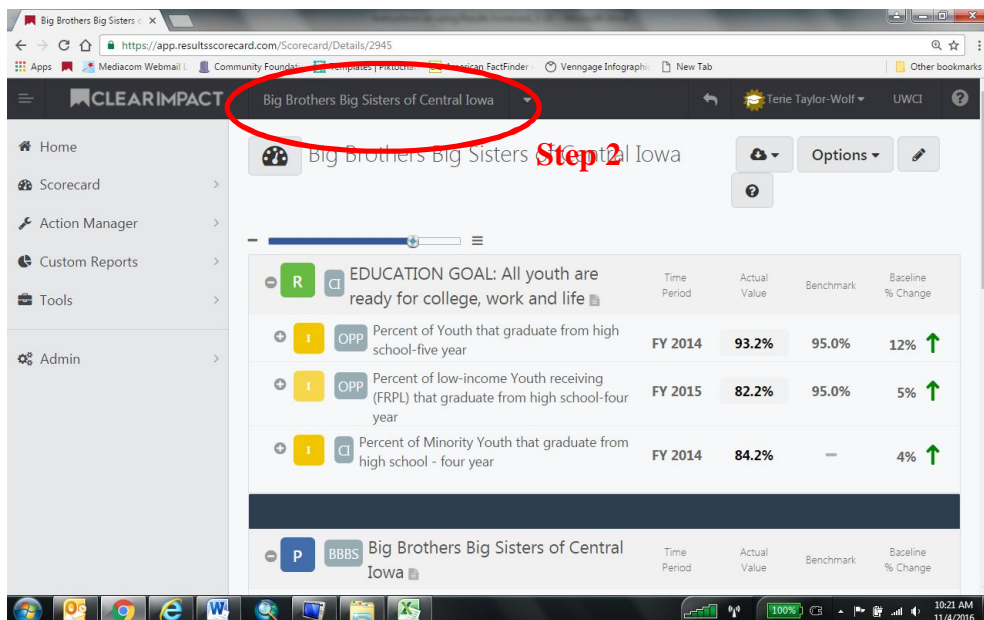
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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Number of students who are absent 18 days or more in the school year	27	—	—
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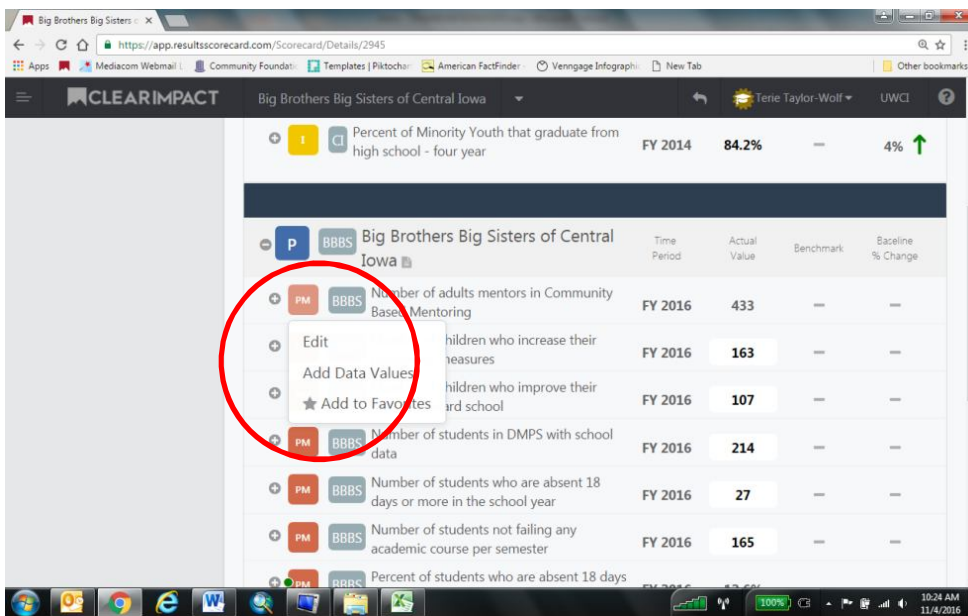
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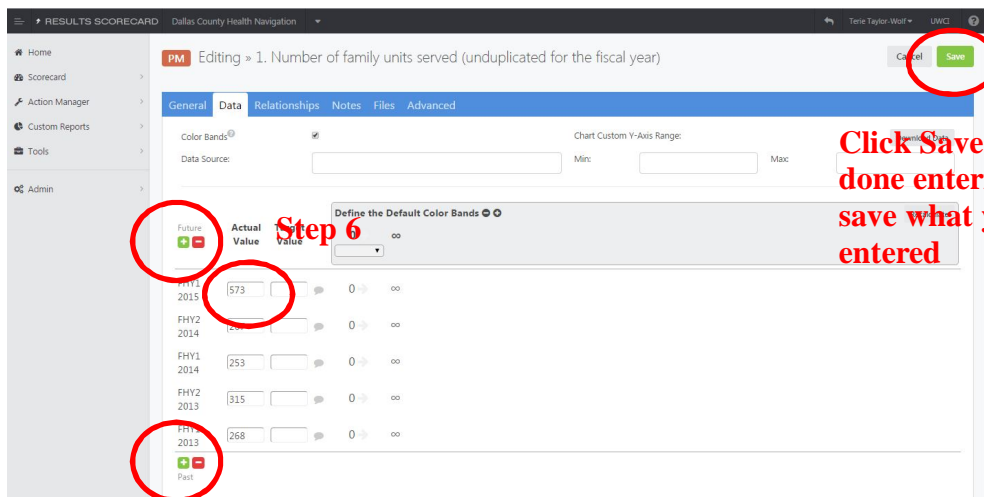


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Congratulations! You have added your data to your scorecard.

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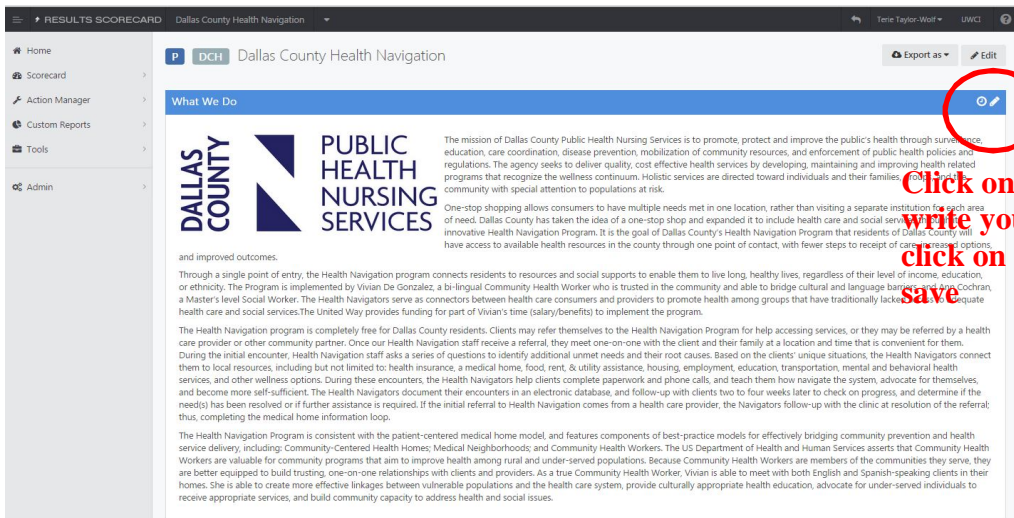
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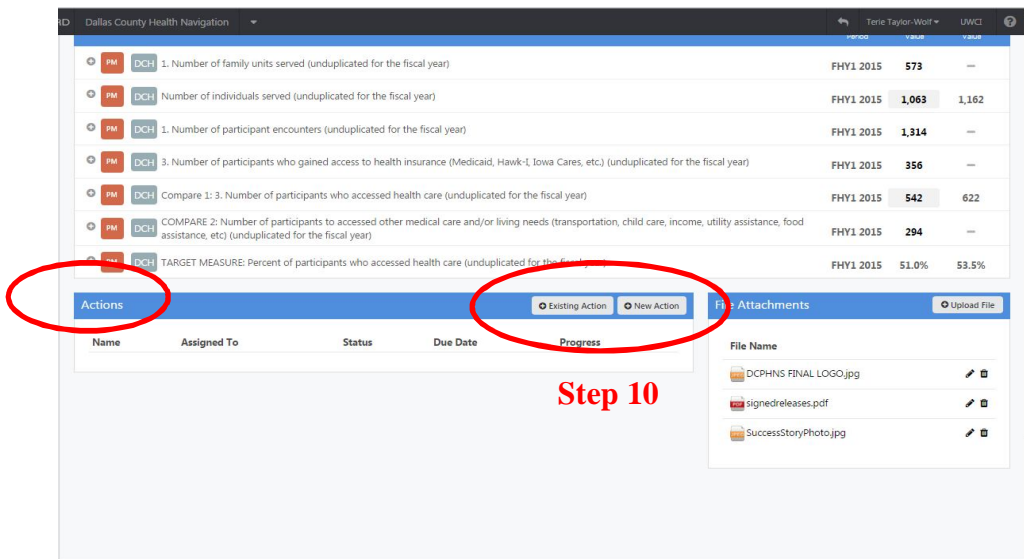
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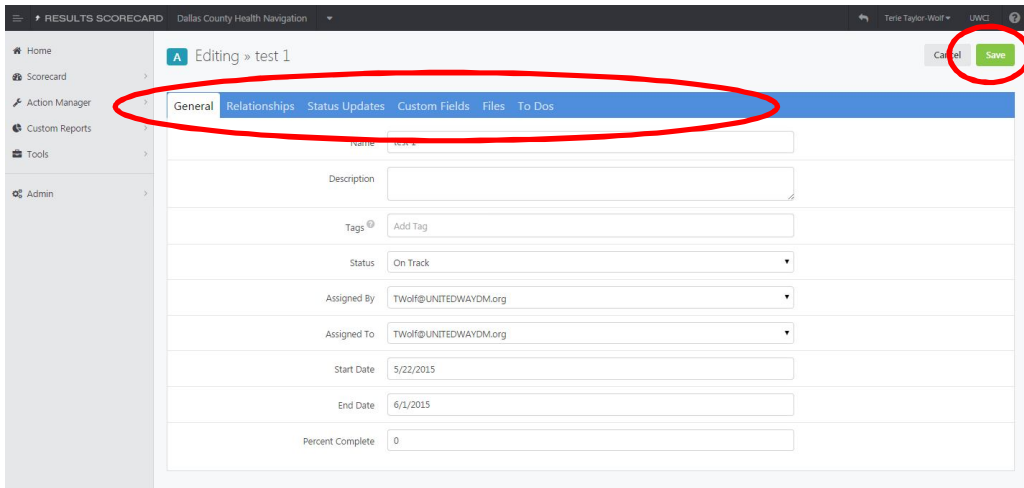


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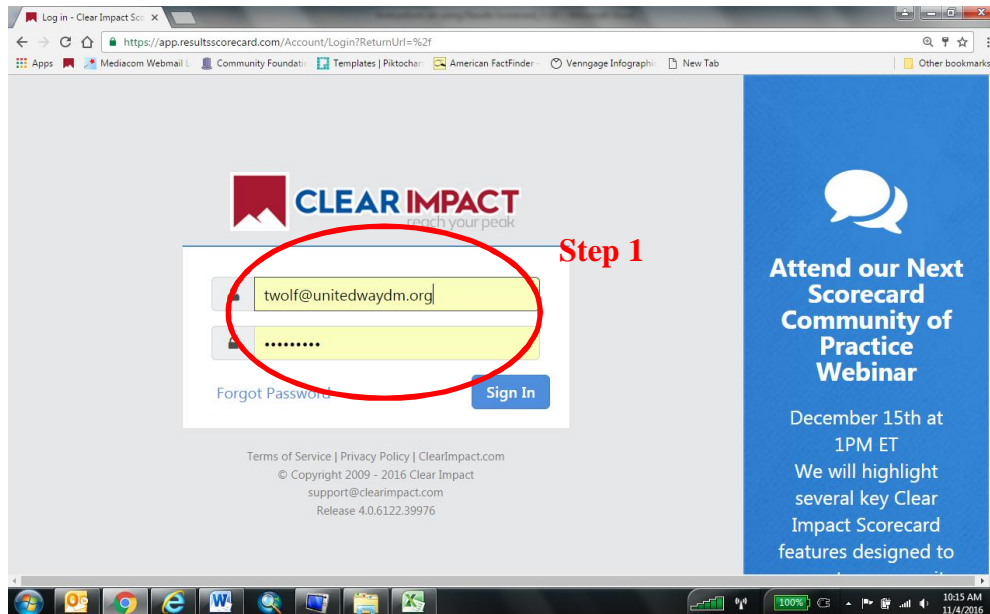
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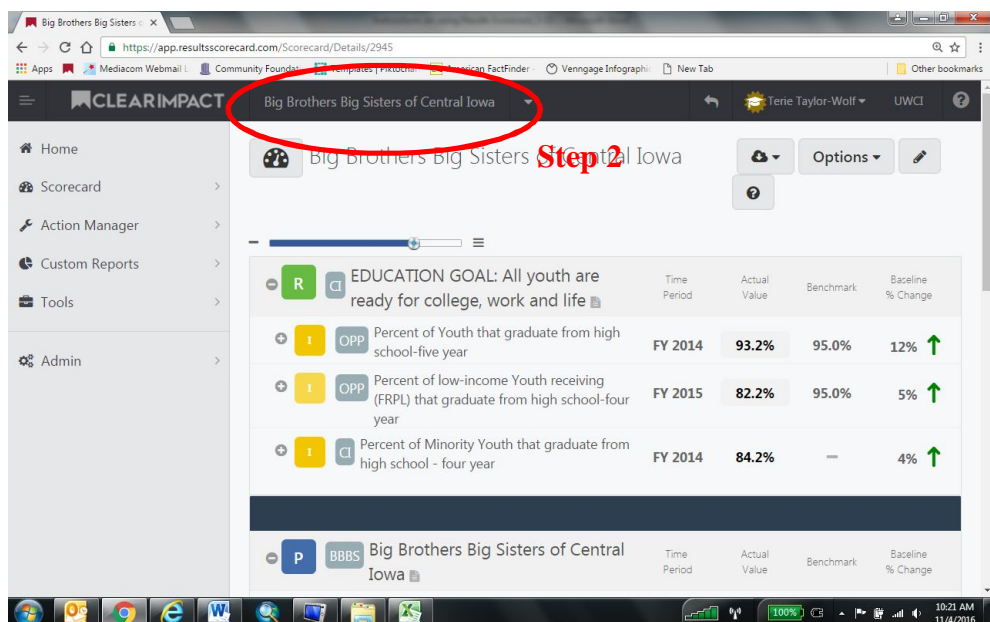
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



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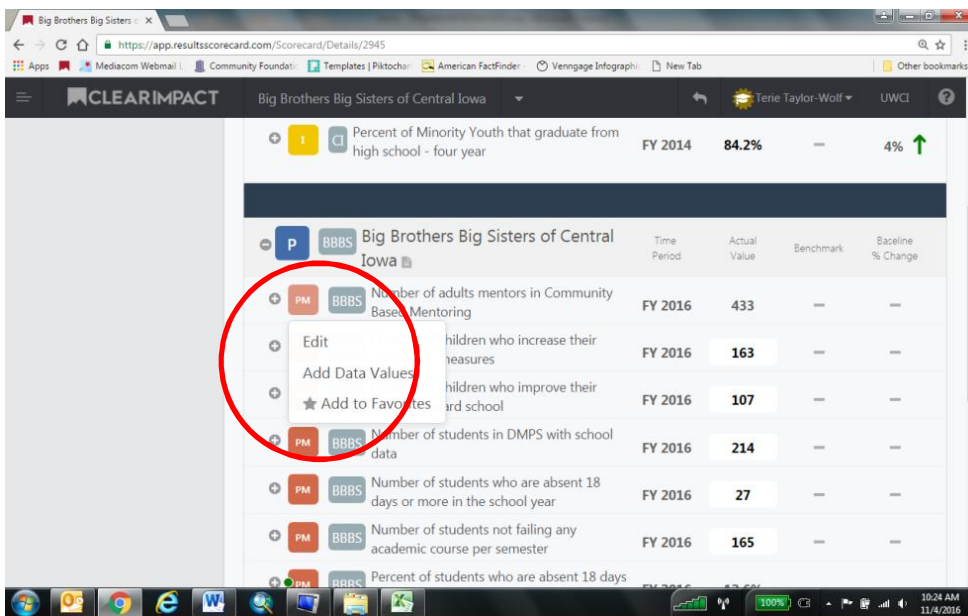
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Click Save button when done entering data to save what you have entered

Step 6

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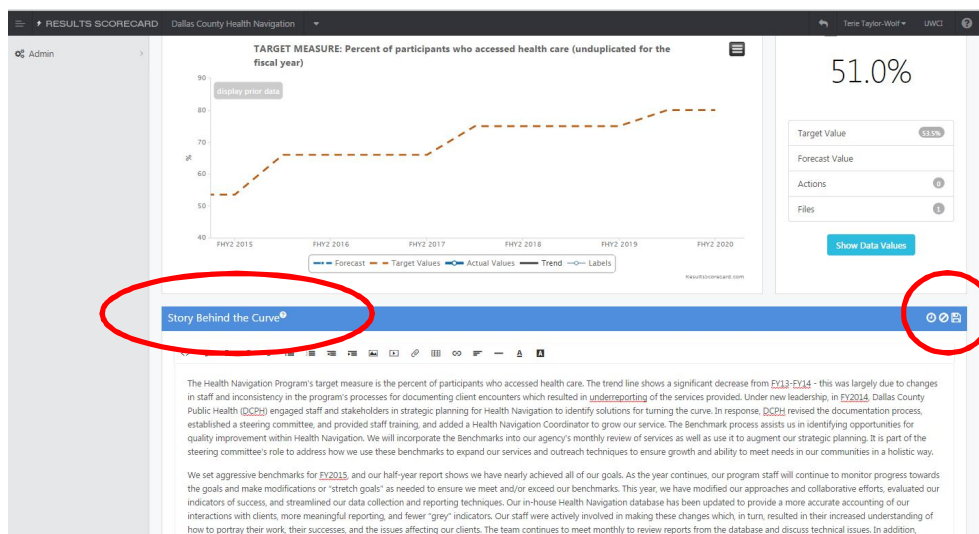
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Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

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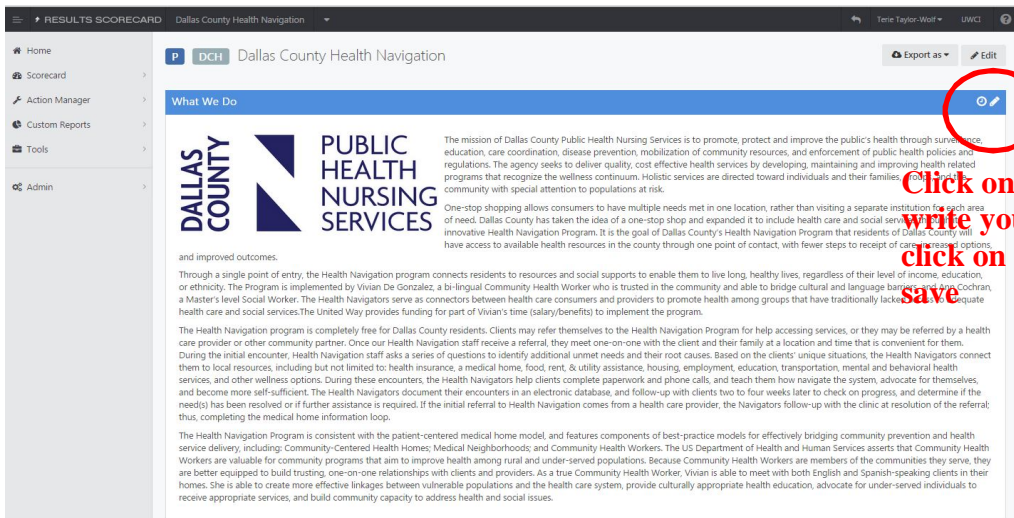
1. What We Do
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4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

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Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and/or services and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"

The screenshot shows the Dallas County Health Navigation interface. At the bottom, the 'Attachments' panel is visible, featuring an 'Upload File' button circled in red. The 'Actions' panel below it has a table with columns: Name, Assigned To, Status, Due Date, and Progress.

PM	DCH	Metric	FY	Value	Target
PM	DCH	1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—
PM	DCH	Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162
PM	DCH	1. Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—
PM	DCH	3. Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—
PM	DCH	Compare 1: 3. Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622
PM	DCH	COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc) (unduplicated for the fiscal year)	FHY1 2015	294	—
PM	DCH	TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%

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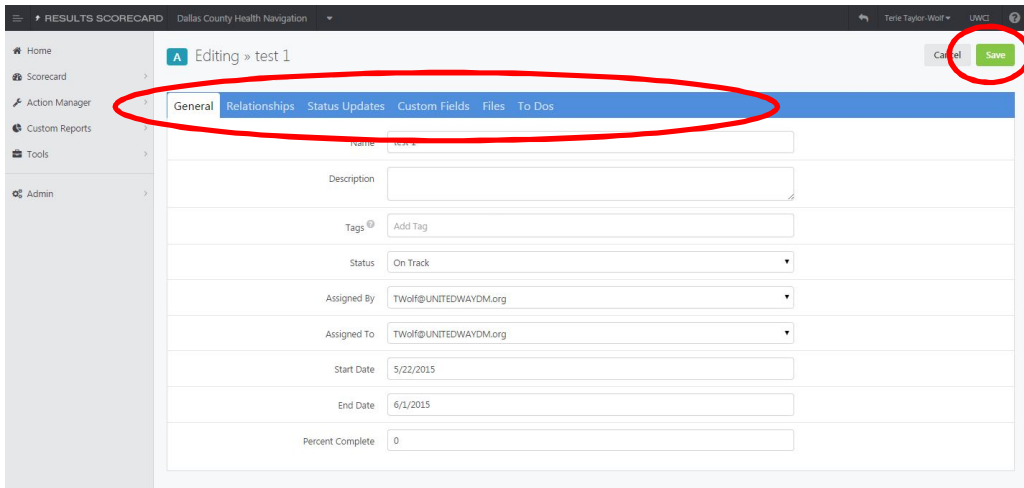
The screenshot shows the Dallas County Health Navigation interface. The 'Actions' panel at the bottom has two buttons, 'Existing Action' and 'New Action', both circled in red. The 'Attachments' panel is also visible on the right side.

Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
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Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	Actual Value	Benchmark	Baseline % Change
Number of adults mentors in Community Based Mentoring	433	—	—
Number of children who increase their confidence measures	163	—	—
Number of children who improve their attitude toward school	107	—	—
Number of students in DMPS with school data	214	—	—
Number of students who are absent 18 days or more in the school year	27	—	—
Number of students not failing any academic course per semester	165	—	—
Percent of students who are absent 18 days or more in the school year	12.6%	—	—
Percent of students not failing any academic course per semester	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a low in FY 2016. The table below shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

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Step 4

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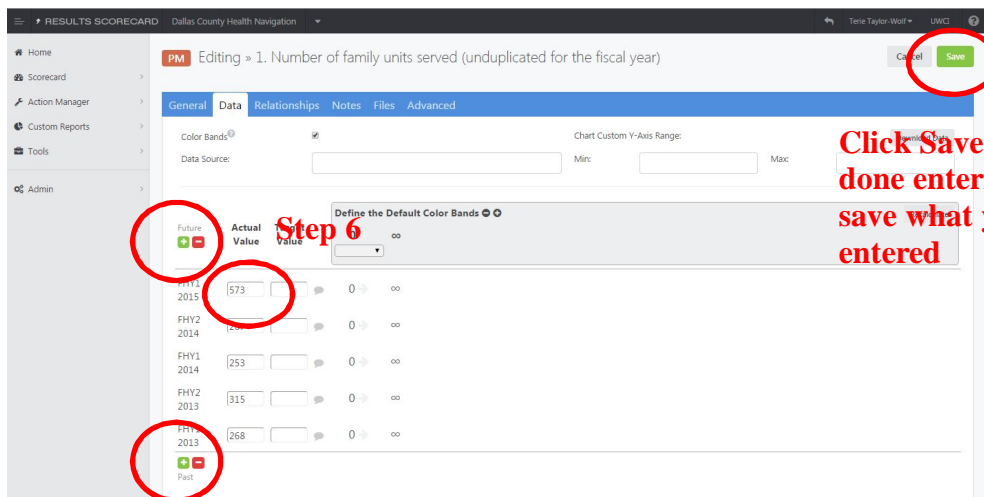
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Step 5
Click on the Data tab

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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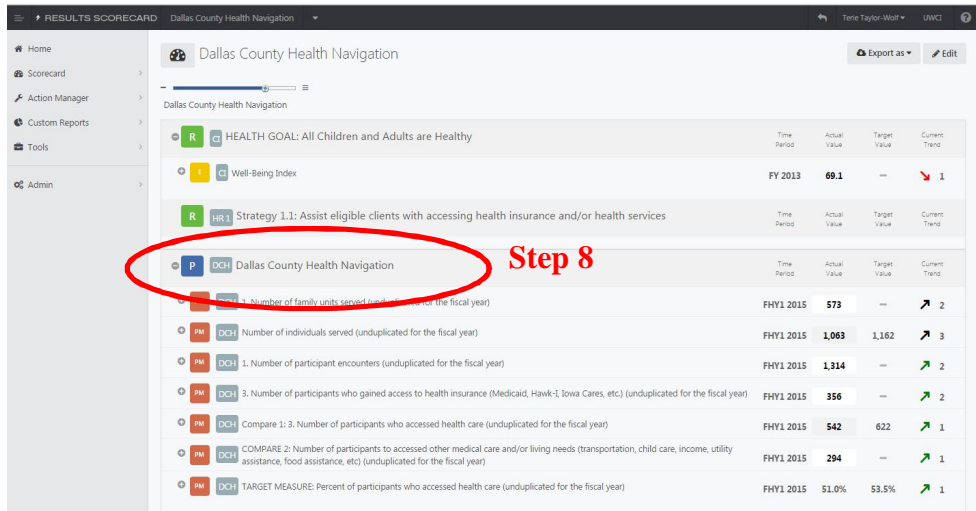
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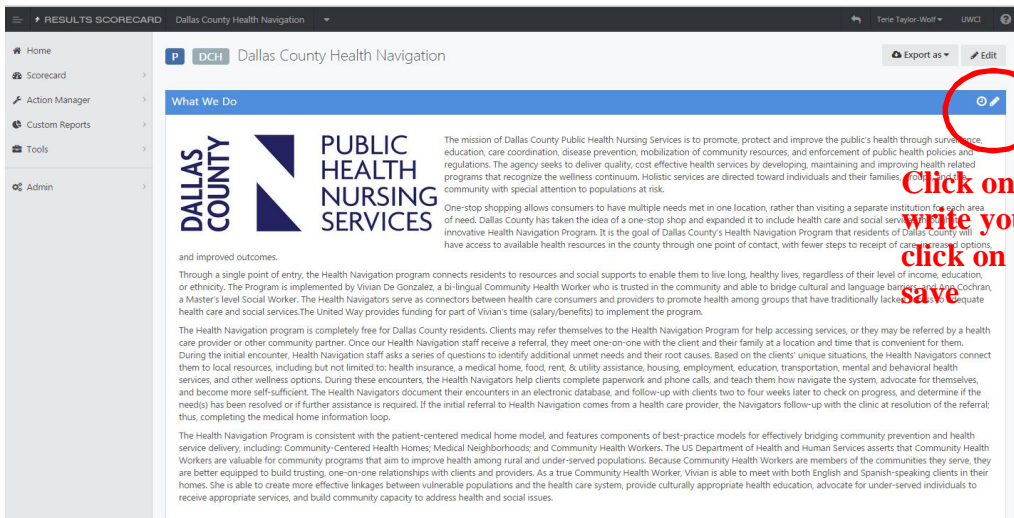
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What We Do

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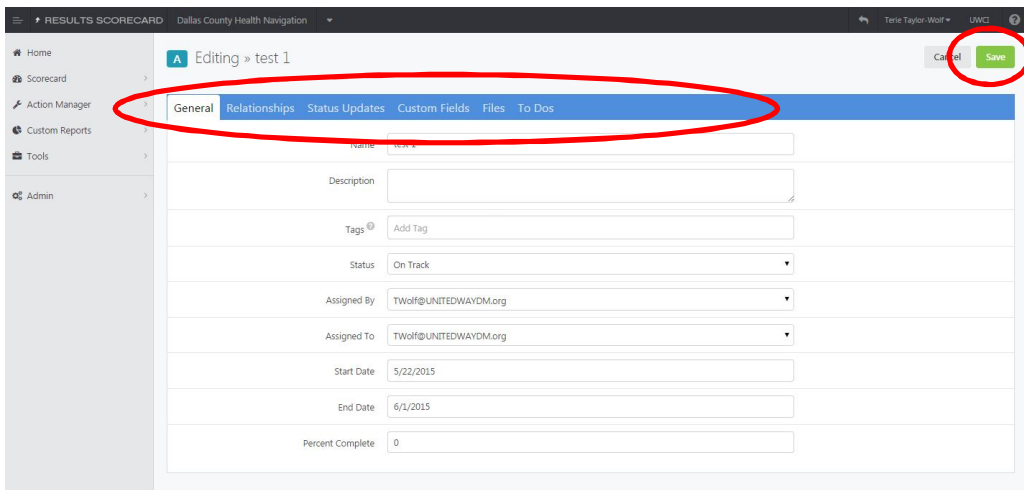


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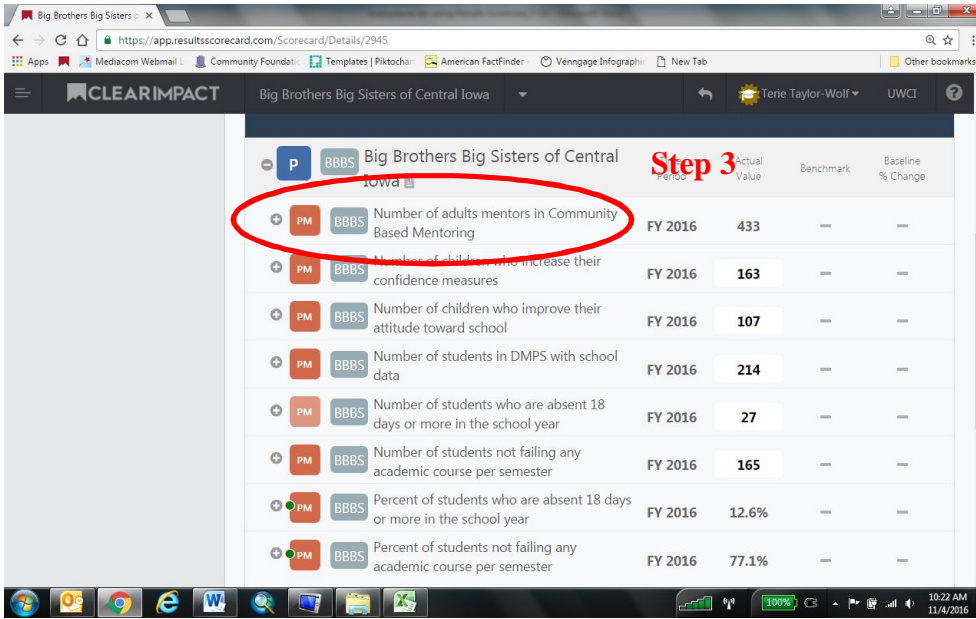
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.



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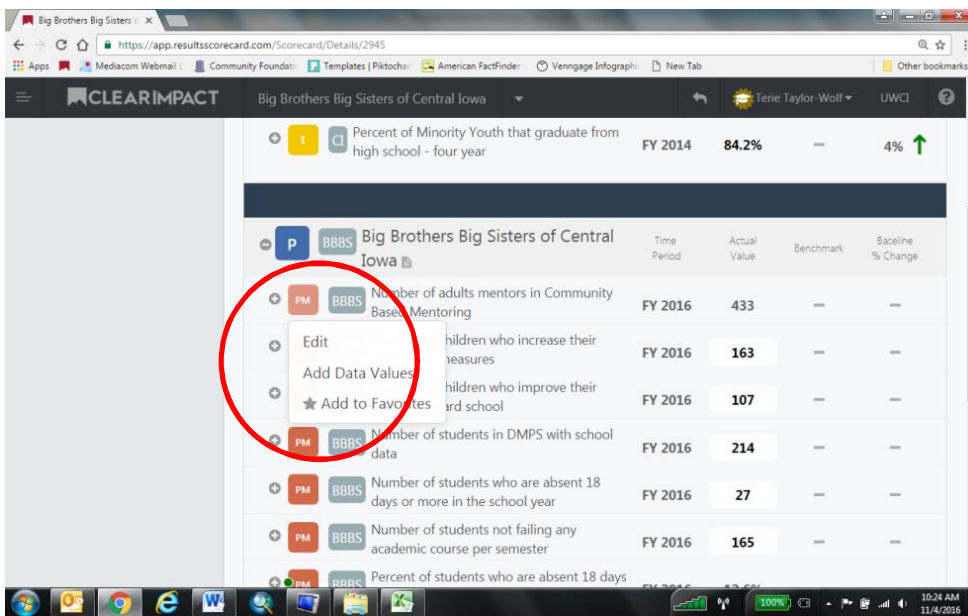


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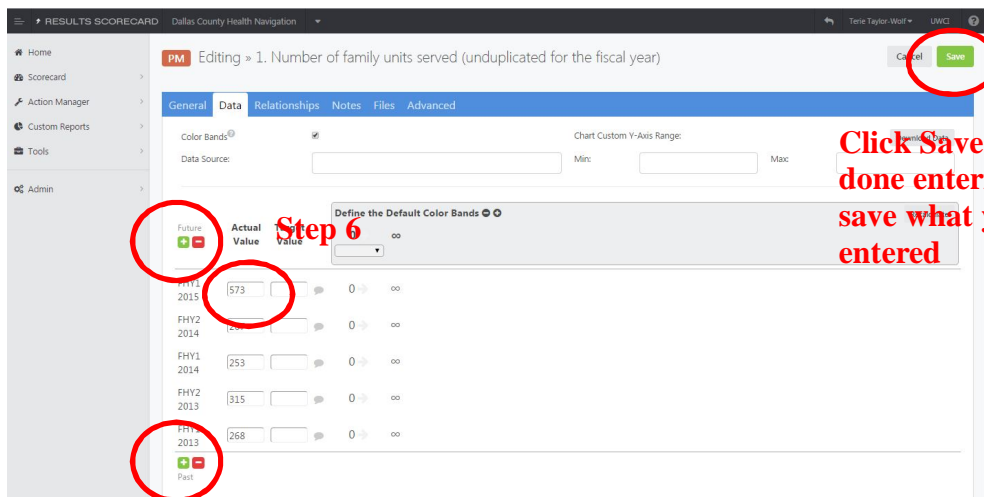
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Click Save button when done entering data to save what you have entered

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

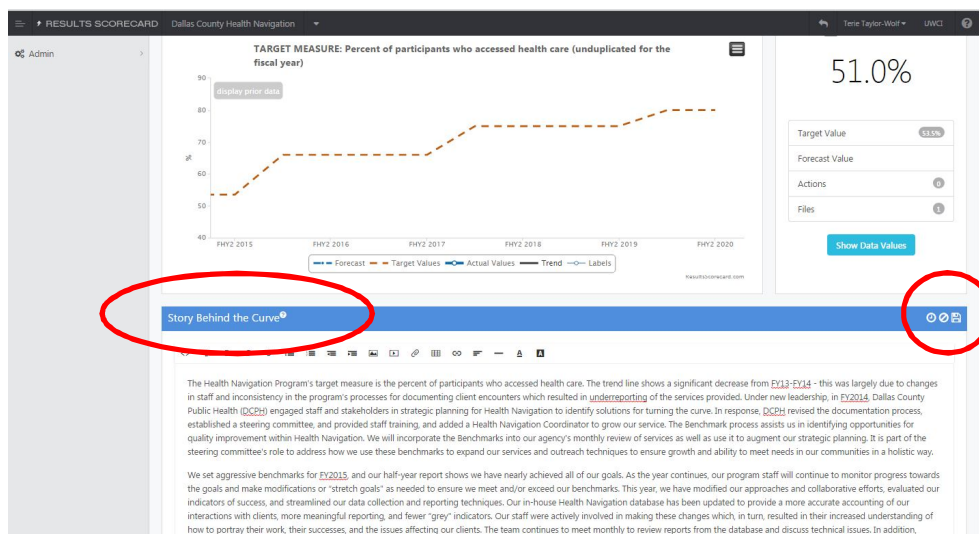
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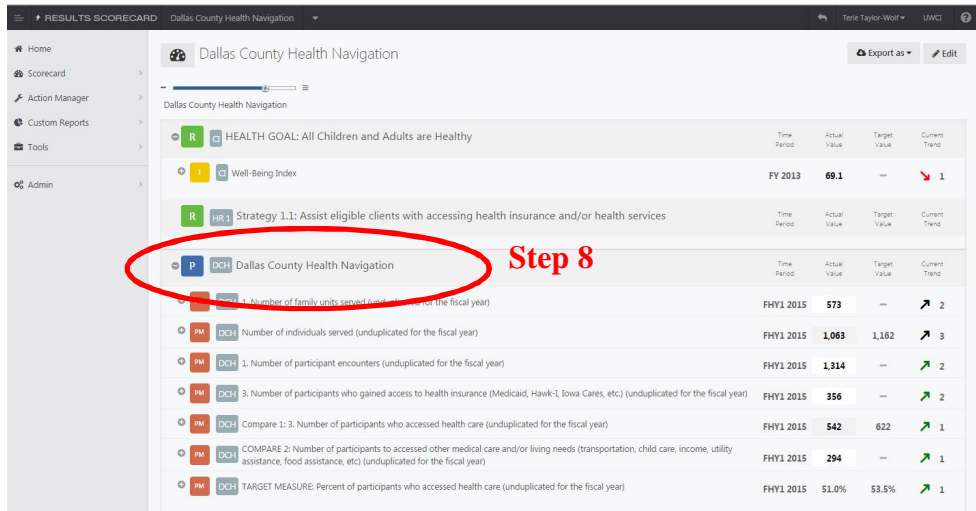
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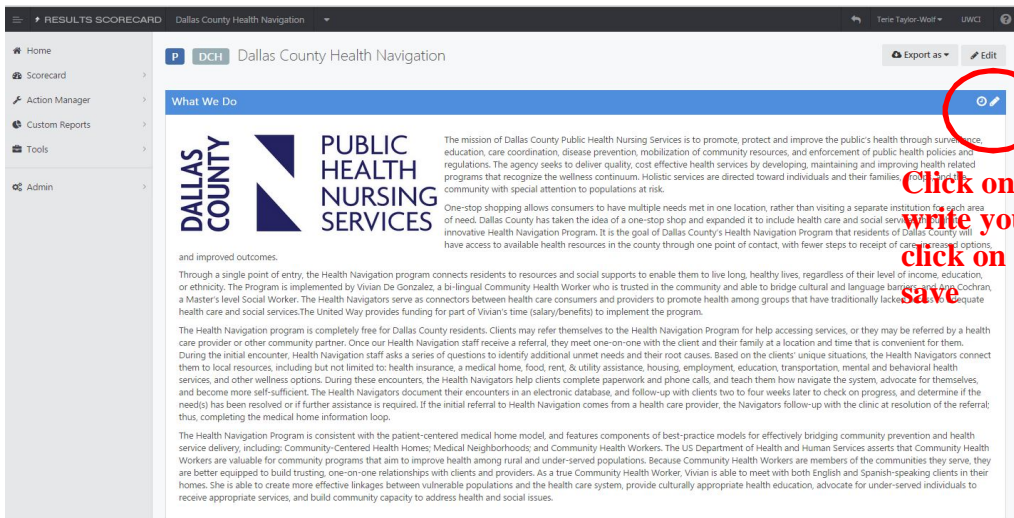
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TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



What We Do

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. This is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



Step 9

Optional Step 10: For those of you who want to track “Actions” from your Action Plan, click on “New Action” to create an action or “Existing Action” if you already have an assigned action you wish to review or edit.

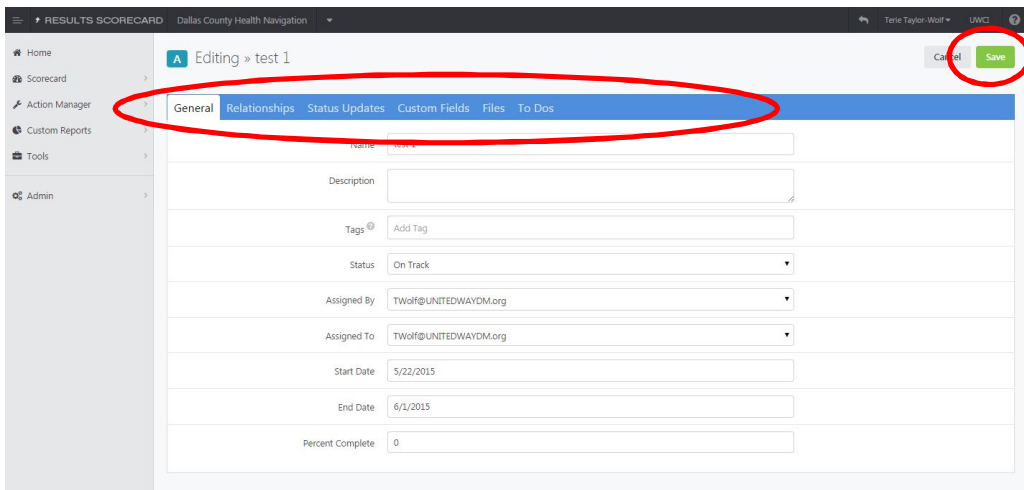


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
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Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Instructions on using Results Scorecard

Step 1: Login

<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

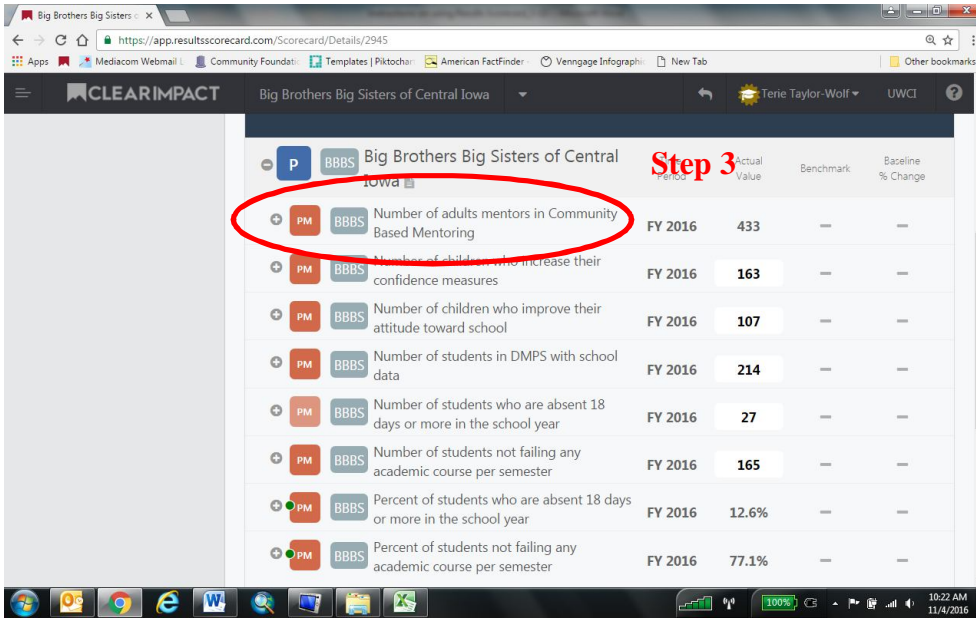
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



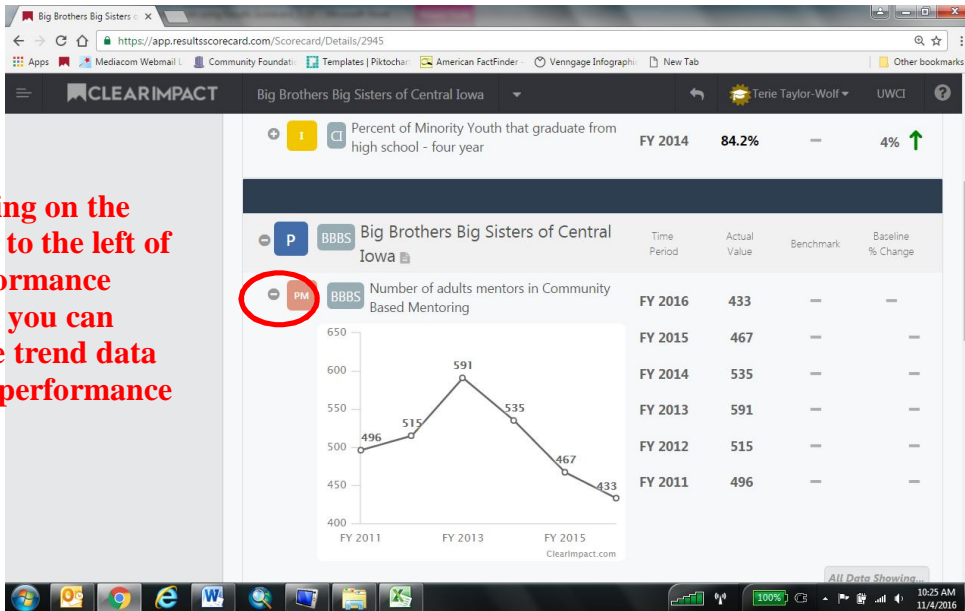
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance



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Step 4

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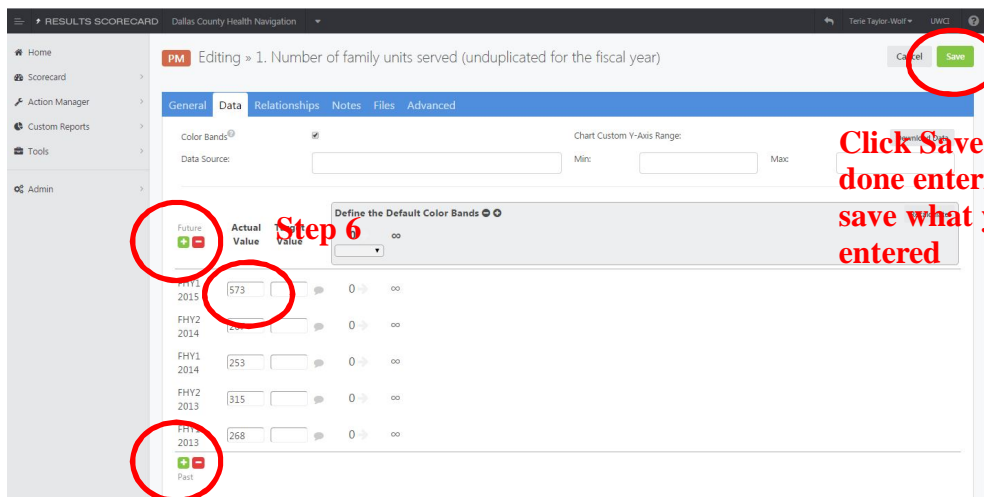
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Step 5
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Click Save button when done entering data to save what you have entered

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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s)). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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Step 7

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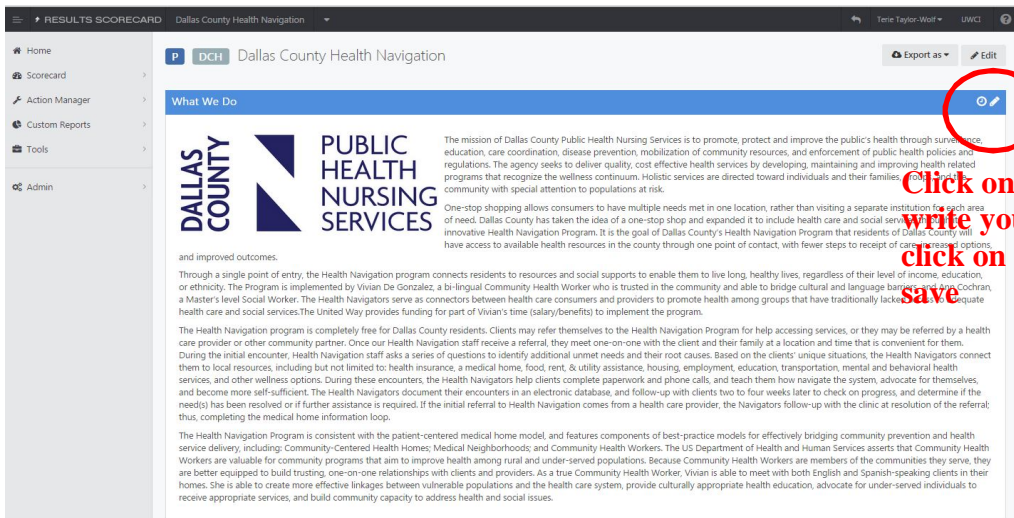
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Program	Time Period	Actual Value	Target Value	Current Trend
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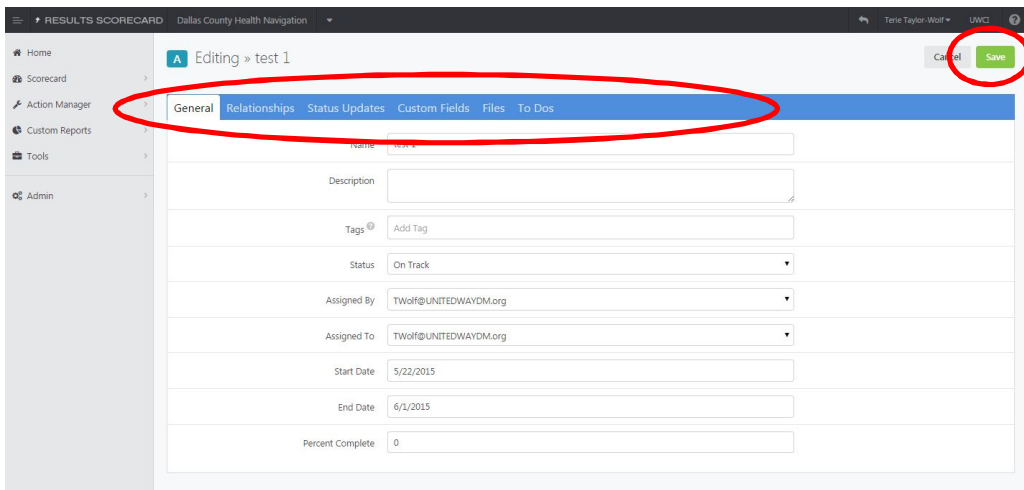


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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
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Results Scorecard View:

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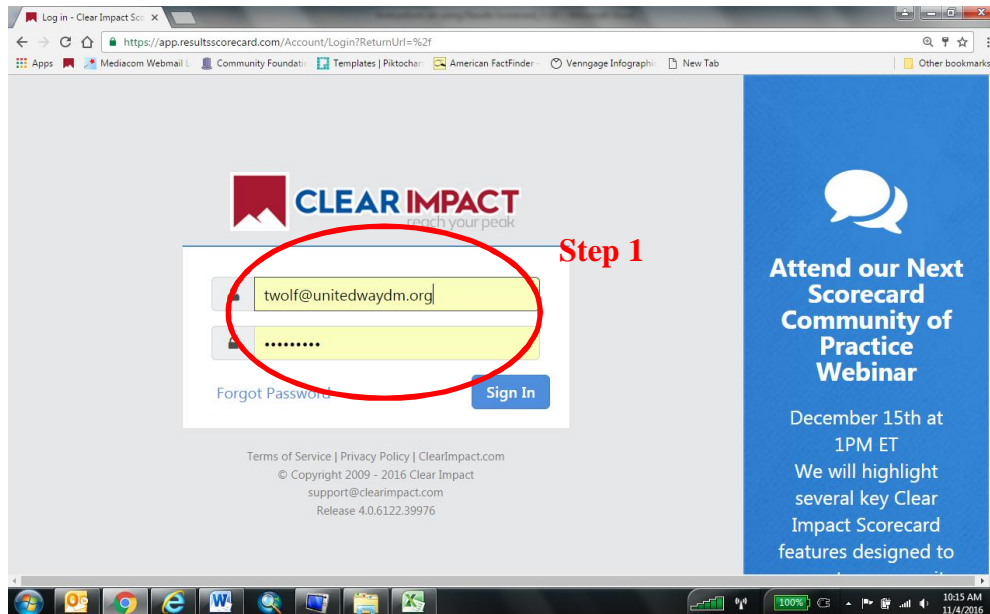
Instructions on using Results Scorecard

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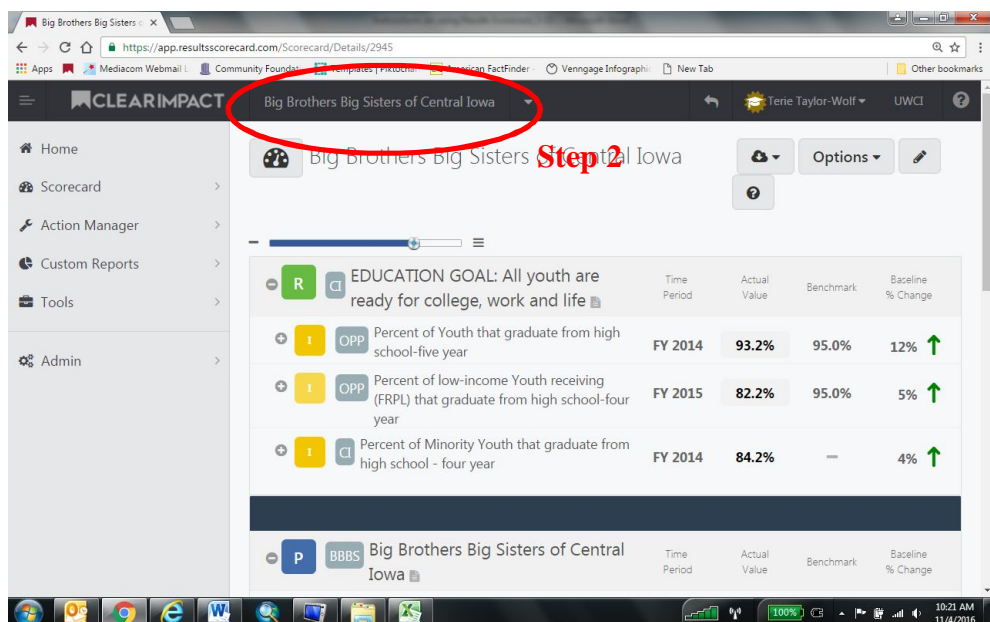
<https://app.resultsscorecard.com>

Your username is your e-mail address. If you forget your password, follow these instructions:

Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



Step 3: Adding Data: Click on the performance measure to add data, or to add narrative.

The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the data from FY 2011 to FY 2016. The graph shows a peak in FY 2013 and a low in FY 2016. The table to the right of the graph shows the following data:

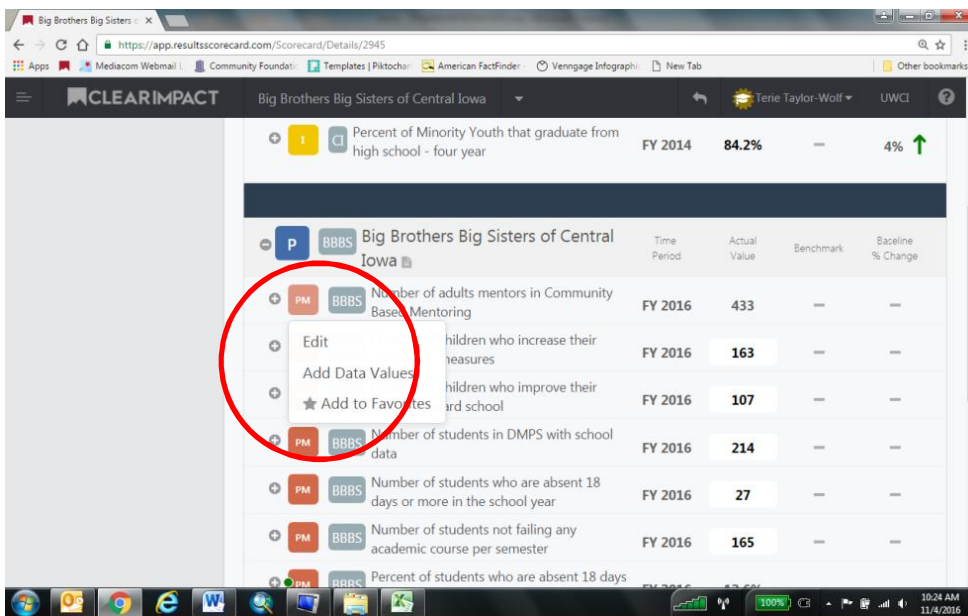
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		FY 2015	467	—	—
		FY 2014	535	—	—
		FY 2013	591	—	—
		FY 2012	515	—	—
		FY 2011	496	—	—

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Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
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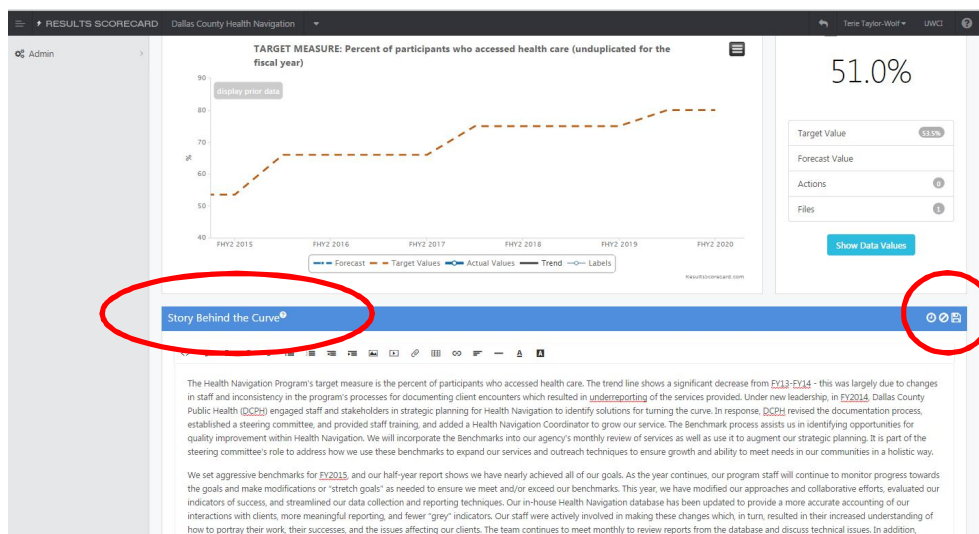
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Step 7

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What We Do

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Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



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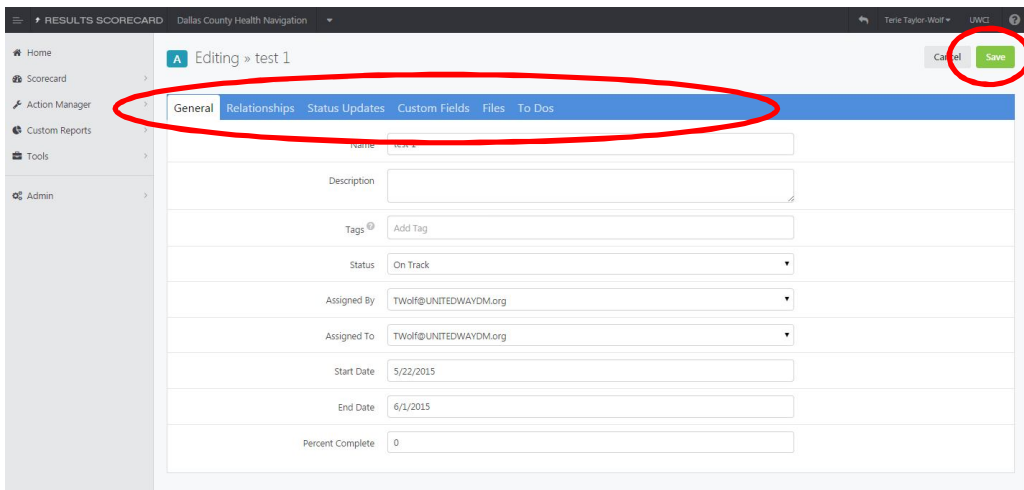


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It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

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Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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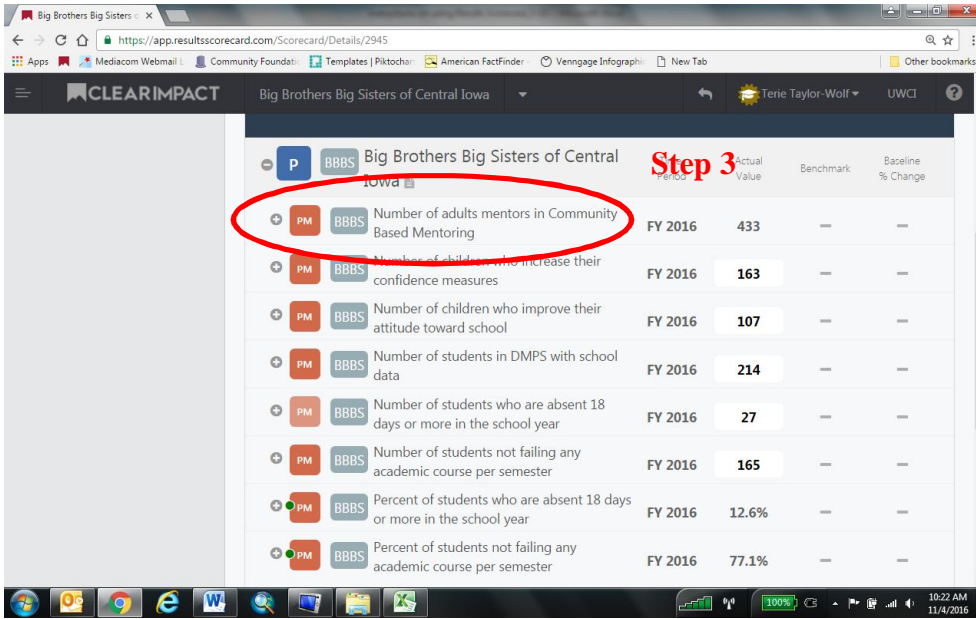
Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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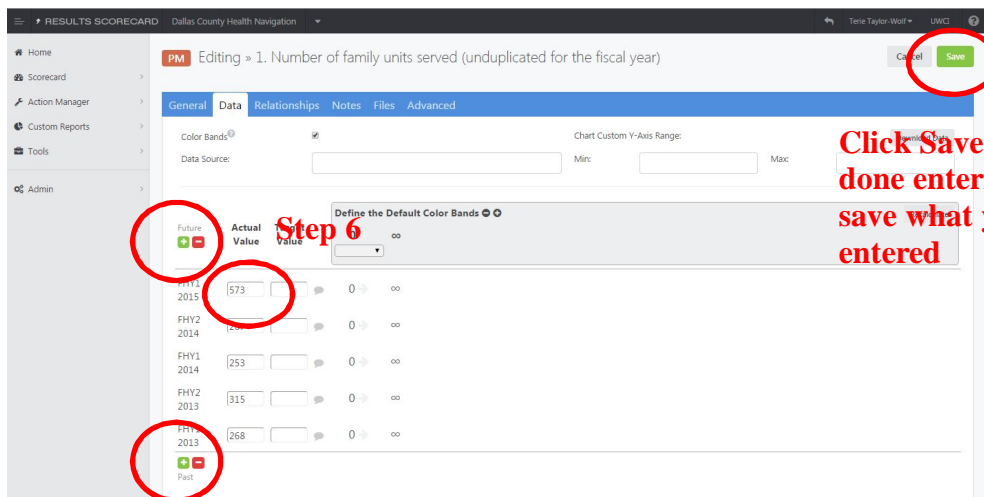
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TimeFrame	Date Range
Q1	July 1-Sept. 30
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Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



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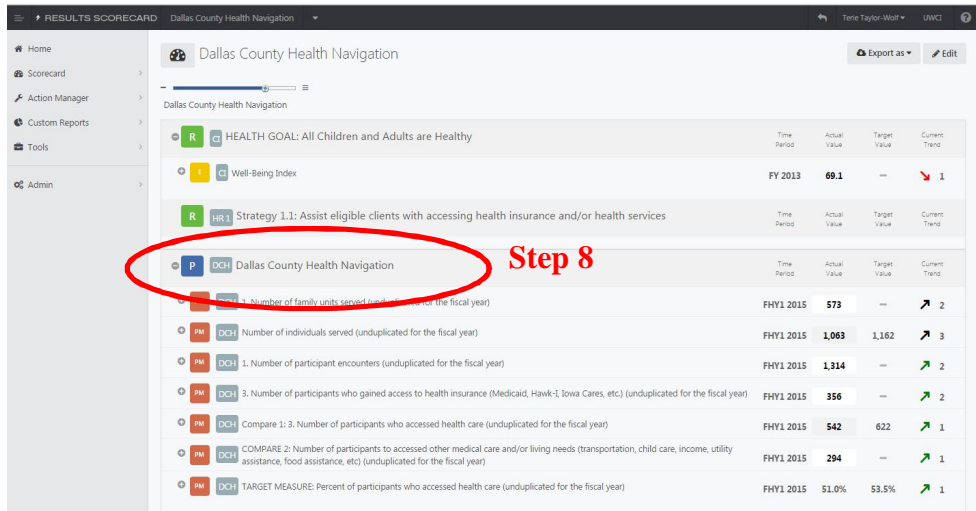
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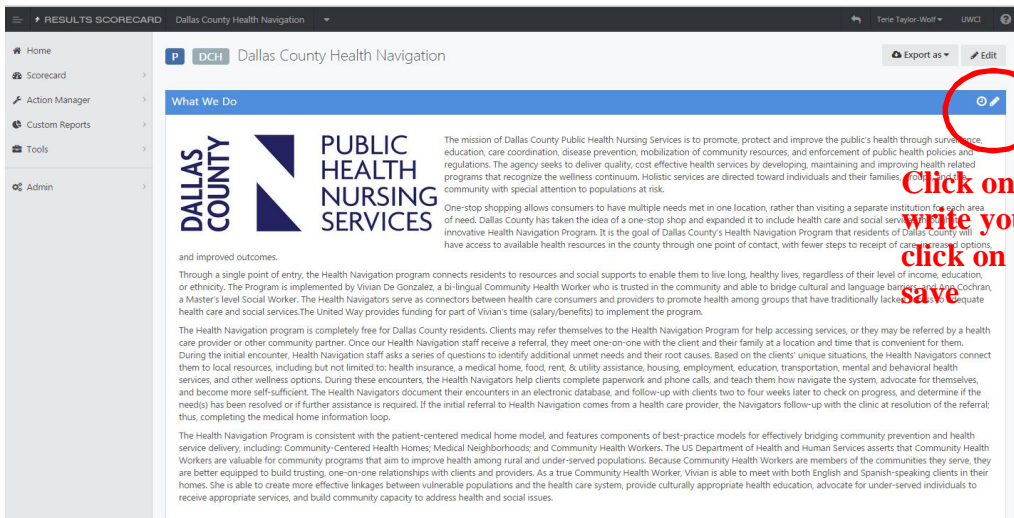
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
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Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
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DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

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One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The result is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

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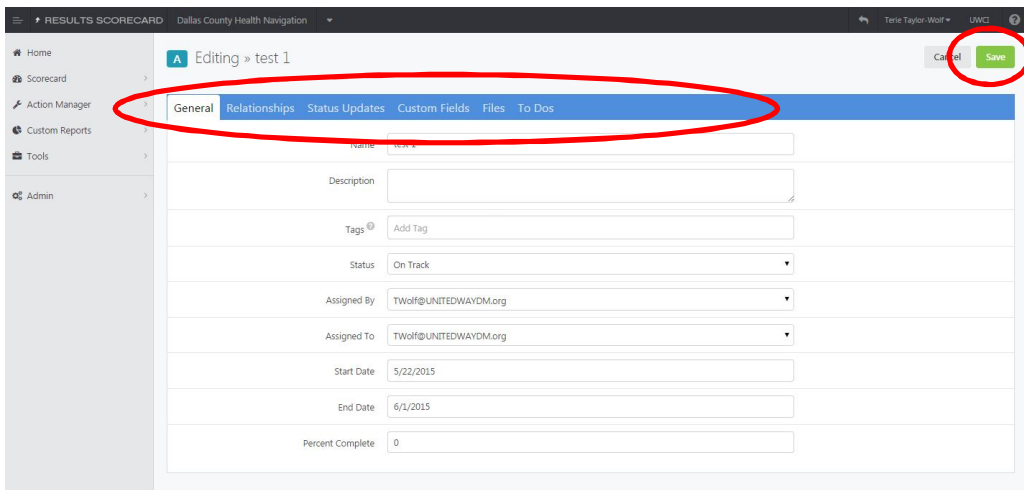


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The screenshot shows a web browser window displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
+	BBBS	FY 2016	214	—	—
+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
+	BBBS	FY 2016	12.6%	—	—
+	BBBS	FY 2016	77.1%	—	—

By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a decline in FY 2015.

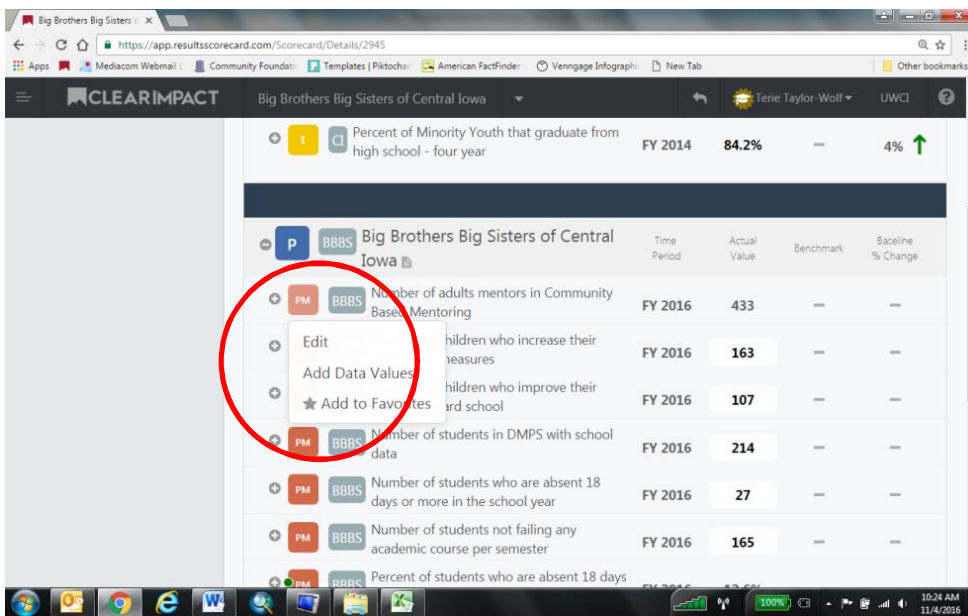
Time Period	Actual Value	Benchmark	Baseline % Change
FY 2011	496	—	—
FY 2012	515	—	—
FY 2013	591	—	—
FY 2014	535	—	—
FY 2015	467	—	—
FY 2016	433	—	—

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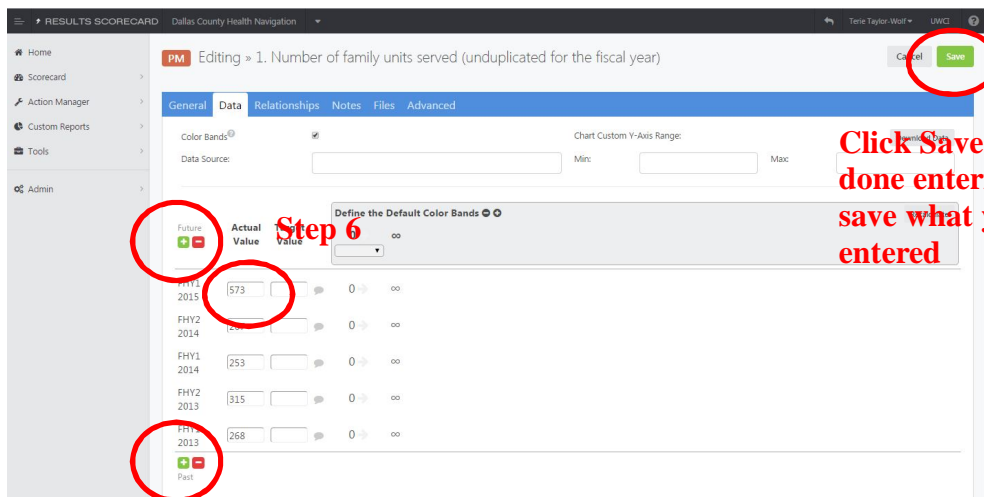
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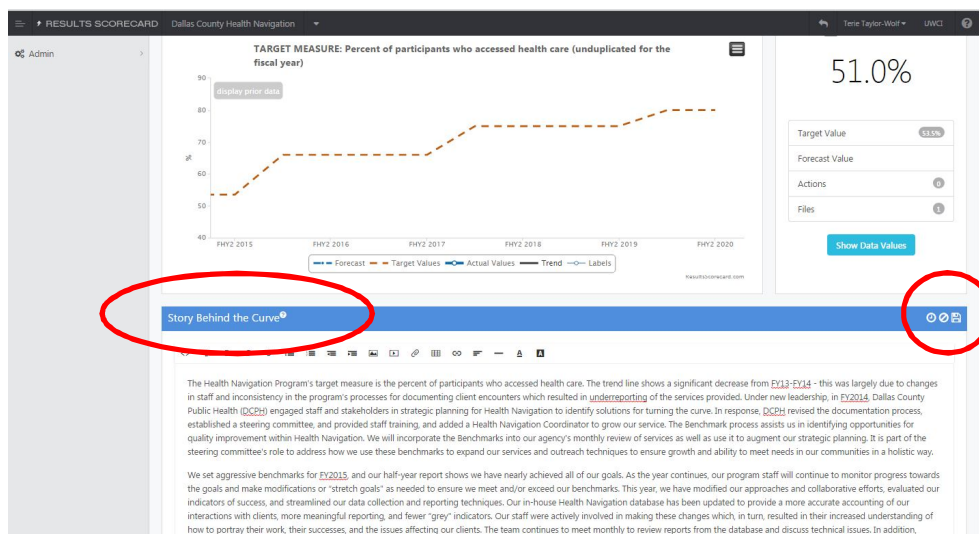
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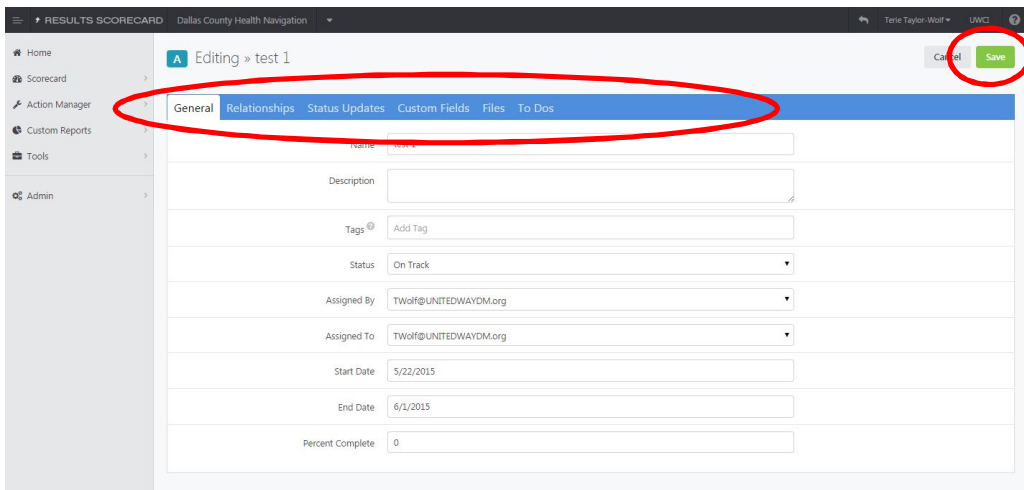


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John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

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Go to the login page, enter their username/login and then select "forgot password". It will reset and send a new password to the user's email. It will be from HostedServices@resultsscorecard.com (check "junk mail" if not in regular mail)



Step 2: Click on the Scorecard you want to edit. If you have access to more than one Scorecard, you may need to click on the drop down arrow to access the correct Scorecard.



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The screenshot shows a web browser window with the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard displays a list of performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
+	BBBS	FY 2016	433	—	—
+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
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+	BBBS	FY 2016	27	—	—
+	BBBS	FY 2016	165	—	—
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded. A red circle highlights the "+" sign to the left of the measure name. A line graph displays the trend data for this measure from FY 2011 to FY 2015. The graph shows a peak in FY 2013 and a decline in FY 2015. The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
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FY 2013	591	—	—
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FY 2011	496	—	—

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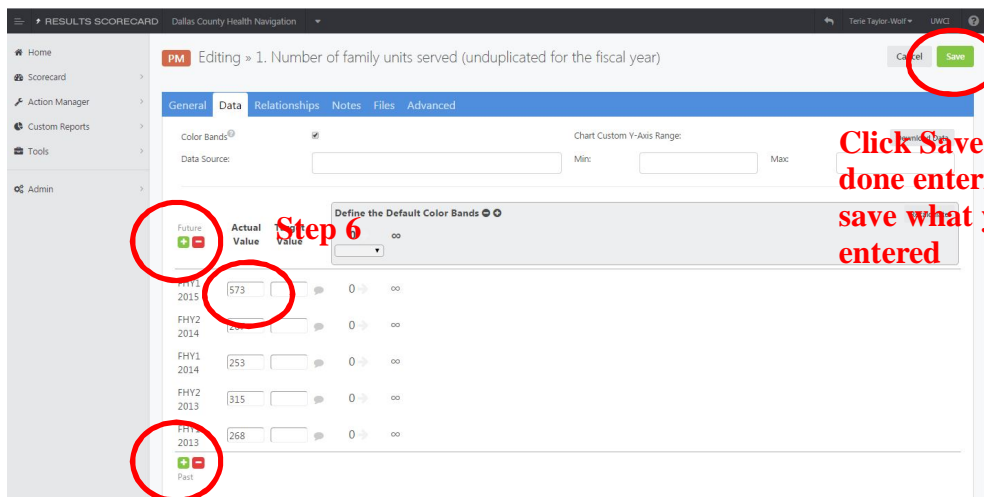
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Step 5
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Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

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Q2	Oct. 1-Dec. 31
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Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

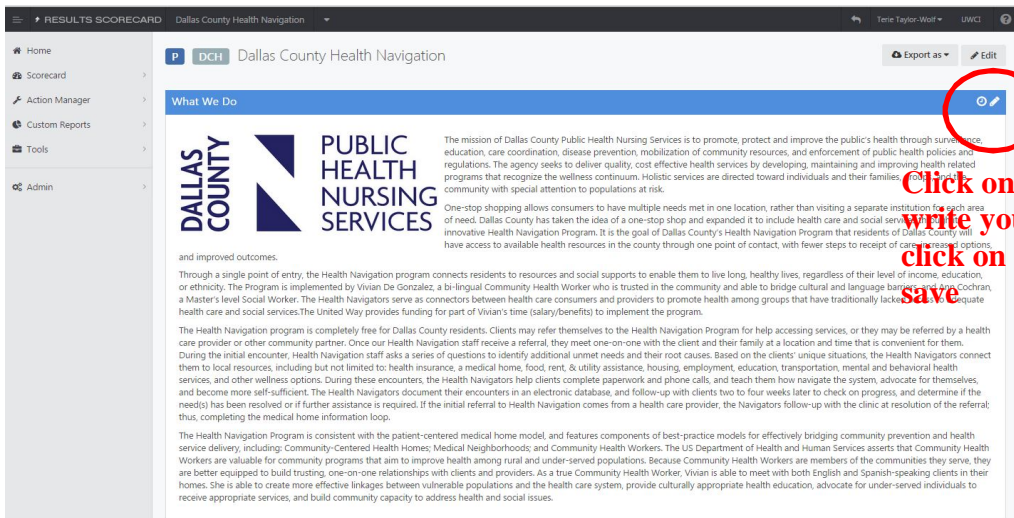
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You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↔ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↔ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↔ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↔ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↔ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↔ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↔ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral, thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed "Photo lease Form"



Step 9

Optional Step 10: For those of you who want to track "Actions" from your Action Plan, click on "New Action" to create an action or "Existing Action" if you already have an assigned action you wish to review or edit.

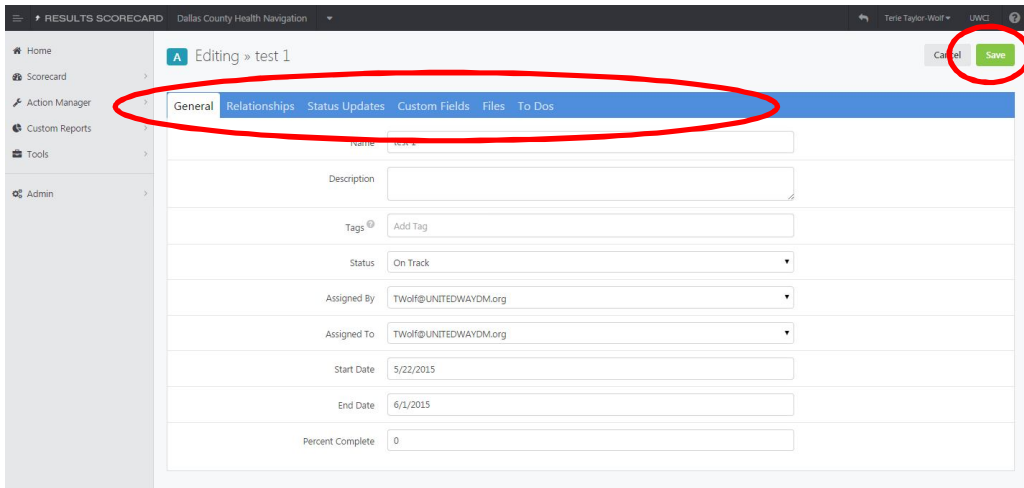


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



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How to Unduplicate clients

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Data collected by you:

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Tim	1st half	1st half	Myra	1st half	2nd half
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Results Scorecard View:

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number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

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number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

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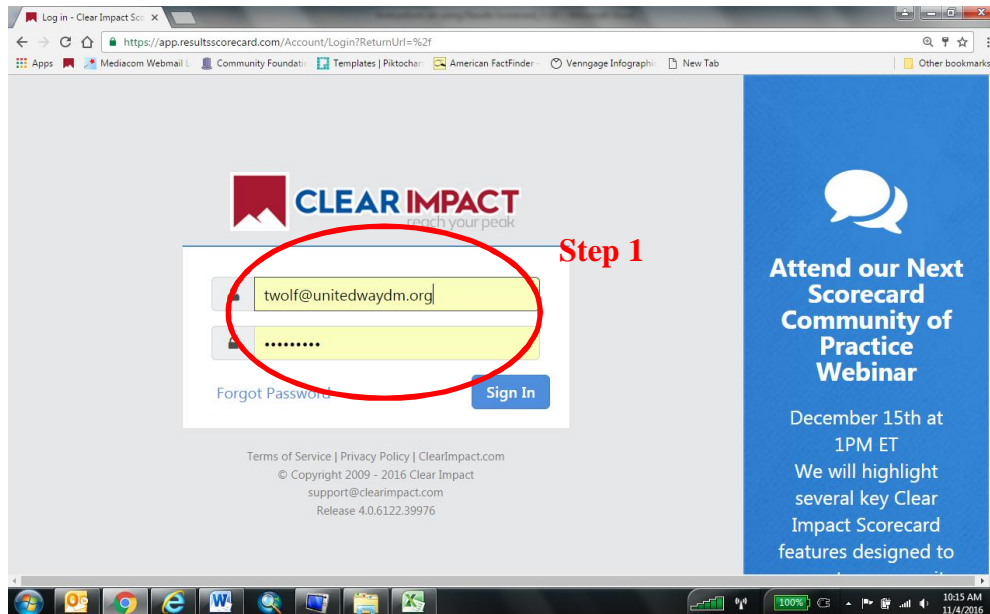
Instructions on using Results Scorecard

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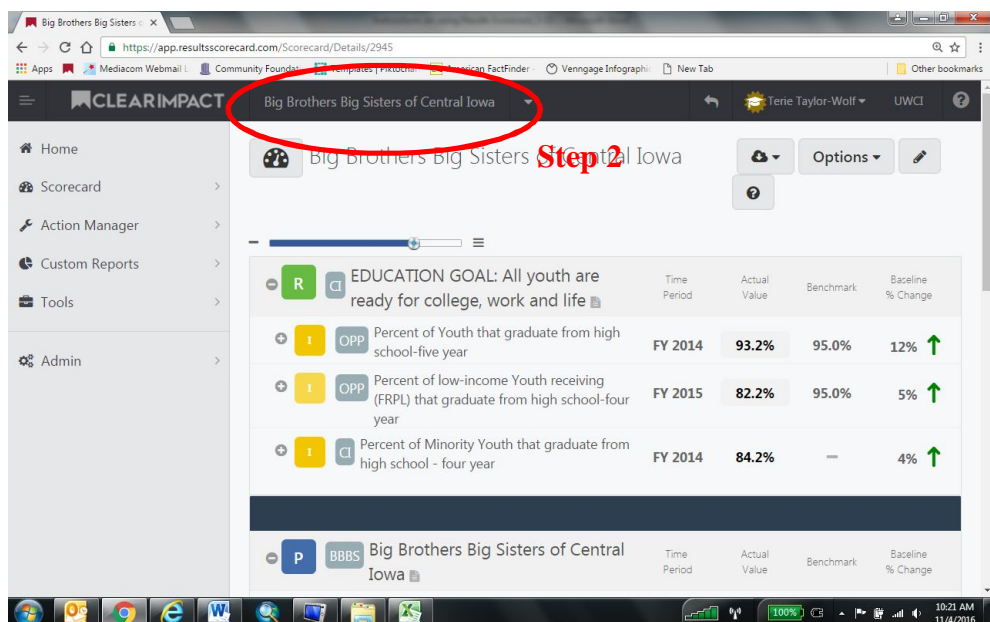
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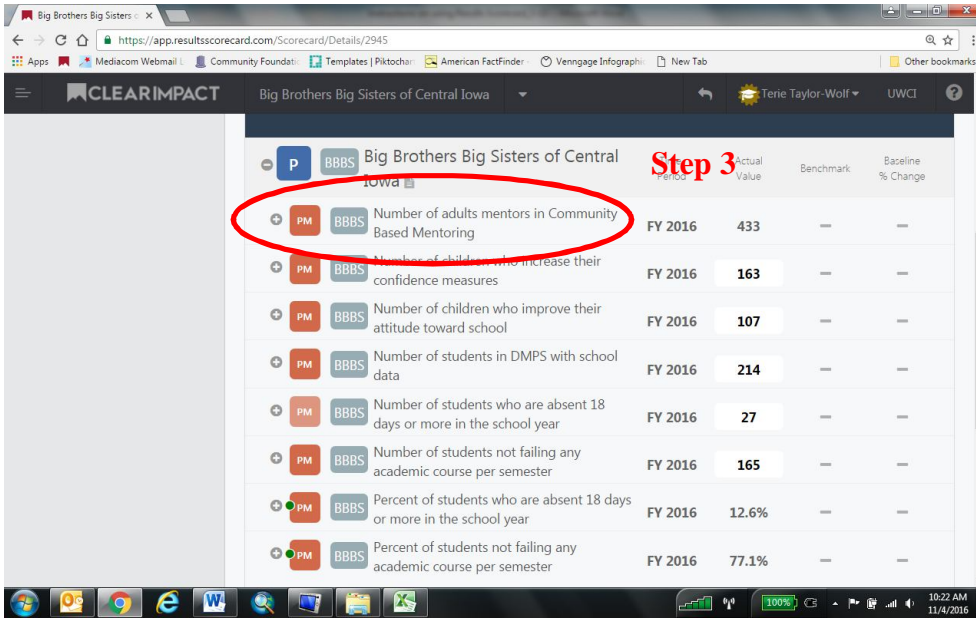
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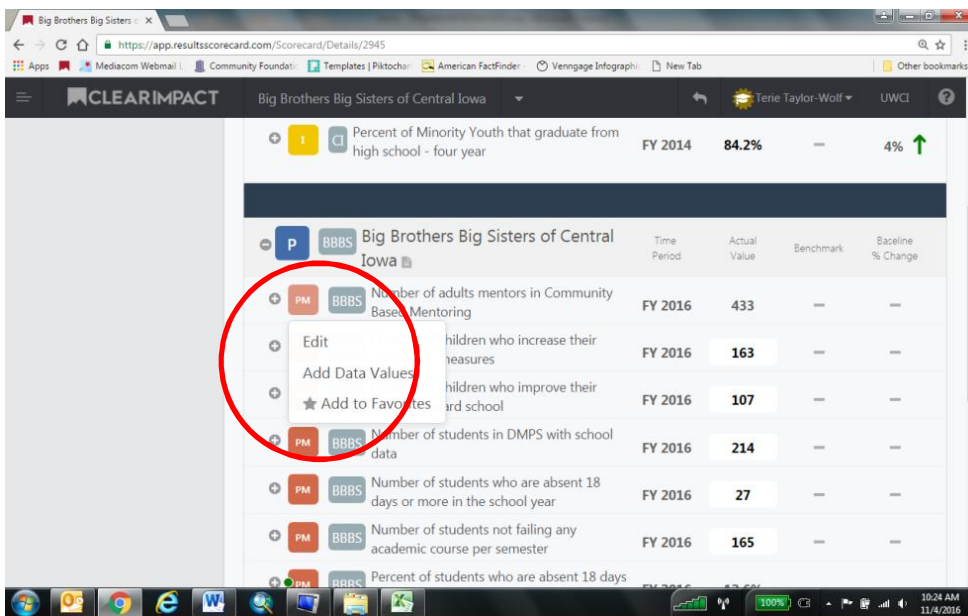


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Click Save button when done entering data to save what you have entered

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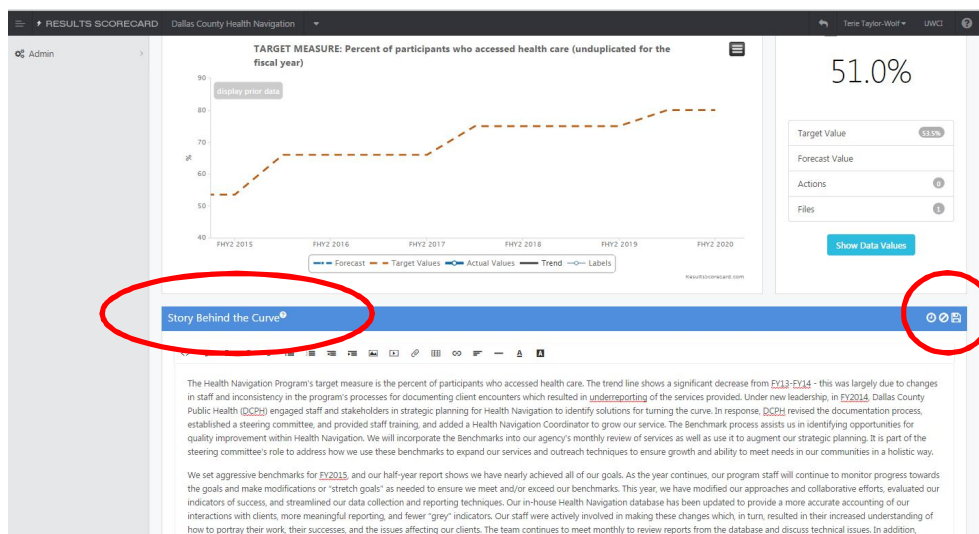
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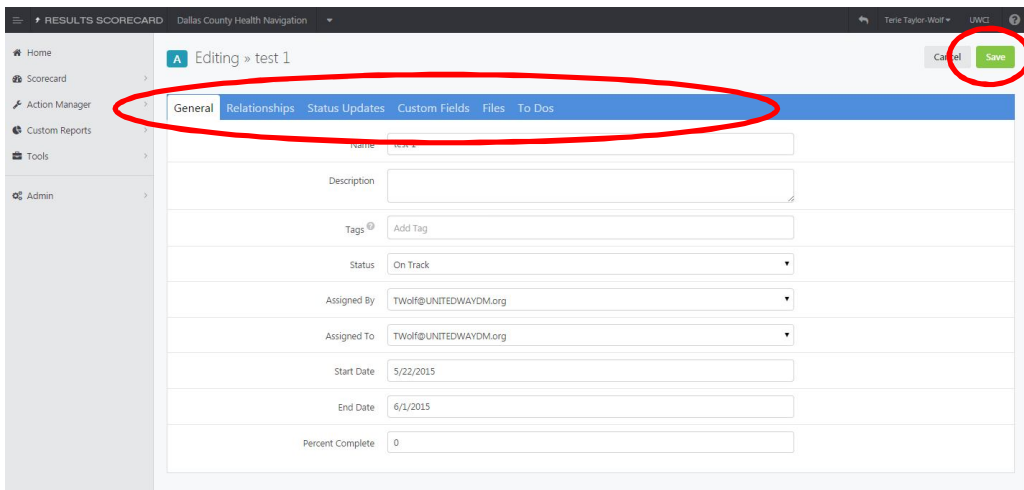


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The screenshot shows a web browser displaying the CLEARIMPACT scorecard for Big Brothers Big Sisters of Central Iowa. The page title is "Big Brothers Big Sisters of Central Iowa" and the user is identified as "Terie Taylor-Wolf" from "UWCI". The scorecard lists several performance measures (PM) for BBBS. The first measure, "Number of adults mentors in Community Based Mentoring", is circled in red. The table below shows the following data:

PM	BBBS	Time Period	Actual Value	Benchmark	Baseline % Change
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+	BBBS	FY 2016	163	—	—
+	BBBS	FY 2016	107	—	—
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By clicking on the “+” sign to the left of the performance measure you can show the trend data for that performance

The screenshot shows the same CLEARIMPACT scorecard, but now the performance measure "Number of adults mentors in Community Based Mentoring" is expanded to show trend data. A red circle highlights the "+" sign to the left of the measure name. The trend data is displayed as a line graph and a table. The graph shows the number of mentors from FY 2011 to FY 2015, with values: 496 (FY 2011), 515 (FY 2012), 591 (FY 2013), 535 (FY 2014), and 433 (FY 2015). The table to the right of the graph shows the following data:

Time Period	Actual Value	Benchmark	Baseline % Change
FY 2016	433	—	—
FY 2015	467	—	—
FY 2014	535	—	—
FY 2013	591	—	—
FY 2012	515	—	—
FY 2011	496	—	—

Step 4: There are 2 ways to enter data into Scorecard. The first way is to Click on Edit in the upper right hand corner.



Step 4

or you can click on the "orange-PM" box to the left of the performance measure and select "Add Data Values"



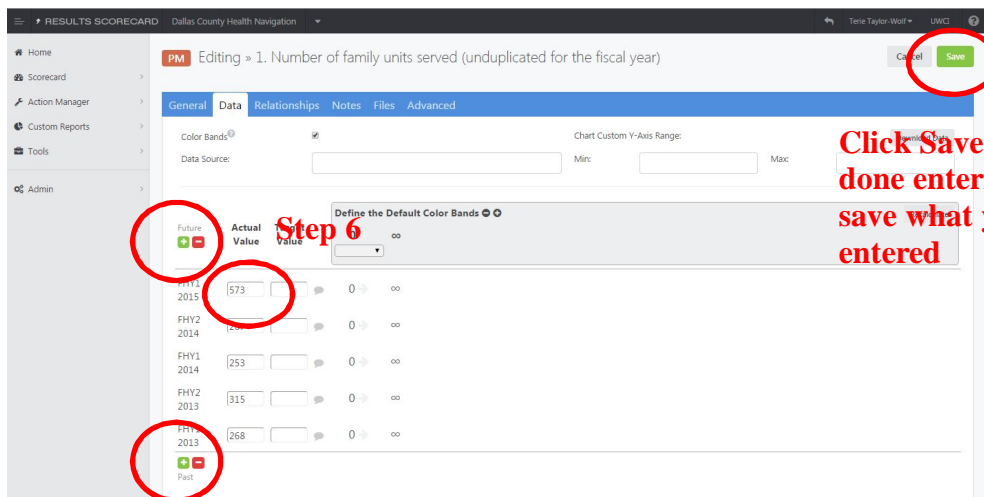
Step 5: Click on the Data tab (do not enter data or make any changes in the general tab)



Step 5
Click on the Data tab

Step 6: Make sure that the Data tab is highlighted. To add data, click on the + sign under “Future” to add more time periods, click on the + sign under “Past” adds more time periods in the past. Put data value in the “Actual Value” box. Then click “Save” to save your data. **WARNING:** If you click on “-” sign it will delete the time period and your data. Leave target value empty. **UWCI will enter benchmark data where needed.**

You will not be able to add numerical values to the performance measures that begin with “Percent” or end with “ANNUALIZED”. These measures have a formula associated with them, based upon other performance measures. When you enter data into these other performance measures, the calculated performance measure will automatically change.



Click Save button when done entering data to save what you have entered

Congratulations! You have added your data to your scorecard.

Below is a table to assist with the timing of entering data into Results Scorecard. The Fiscal Year is the year ending on June 30. For example, July 1, 2016 – June 30, 2017 is FY17.

TimeFrame	Date Range
Q1	July 1-Sept. 30
Q2	Oct. 1-Dec. 31
Q3	Jan. 1-March 31
Q4	April 1-June 30
HY1	July 1-Dec. 31
HY2	Jan. 1-June 30
Y	July 1-June 30

Step 7: Click on your 'TARGET MEASURE' (It typically will be the "Percent" performance measure(s). Scroll down until you see the boxes for "Story Behind the Curve," "Partners," "What Works," and "Action Plan". Click the "pencil icon" on the right. A text box will open and you can write your narrative section. When done click on the "disk icon" to save. **WARNING:** You can copy and paste narrative from a word document but keep in mind that the text box does not always paste special formatting such as bullets, tables, etc. If you want to use bullets, tables, etc. those should done in the text box.



Click pencil icon to write or paste narrative

Step 7



Click disk icon to save your written material

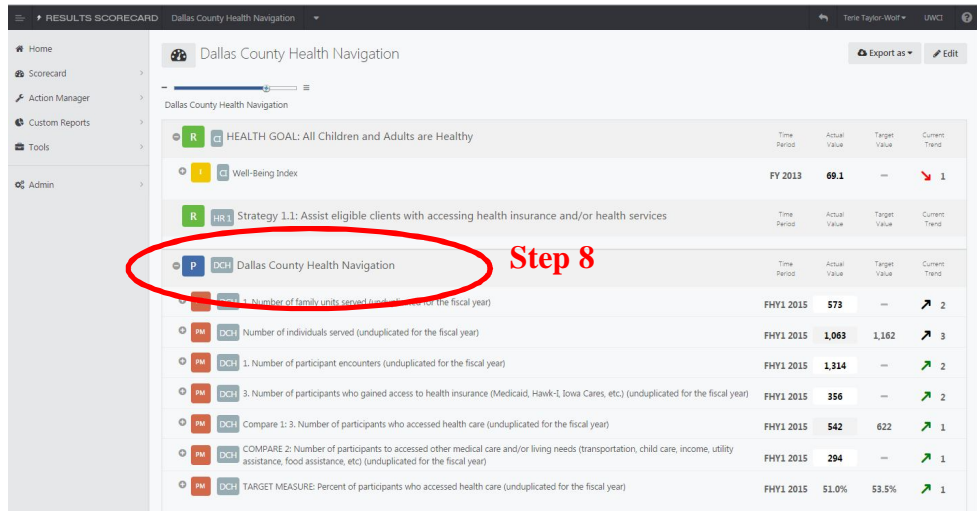
Step 7

Step 8: Updating Program information

You will need to review and edit or answer the following questions pertaining to your program:

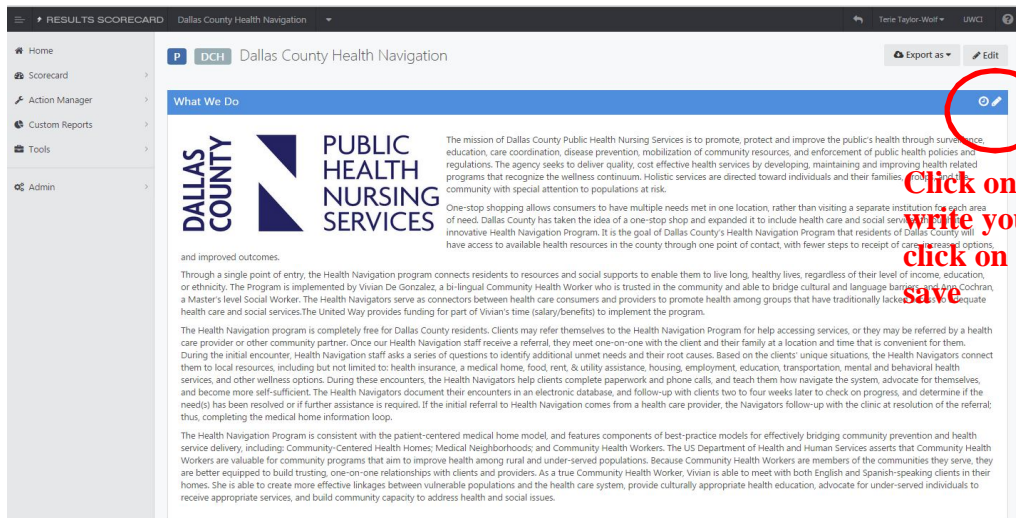
1. What We Do
2. Who We Serve
3. How We Impact
4. Success Story

You will find these areas by clicking on the program name



Program	Time Period	Actual Value	Target Value	Current Trend
HEALTH GOAL: All Children and Adults are Healthy				
Well-Being Index	FY 2013	69.1	—	↓ 1
Strategy 1.1: Assist eligible clients with accessing health insurance and/or health services				
DCH Dallas County Health Navigation				
1. Number of family units served (unduplicated for the fiscal year)	FHY1 2015	573	—	↑ 2
DCH Number of individuals served (unduplicated for the fiscal year)	FHY1 2015	1,063	1,162	↑ 3
DCH 1: Number of participant encounters (unduplicated for the fiscal year)	FHY1 2015	1,314	—	↑ 2
DCH 3: Number of participants who gained access to health insurance (Medicaid, Hawk-1, Iowa Cares, etc.) (unduplicated for the fiscal year)	FHY1 2015	356	—	↑ 2
DCH Compare 1: 3: Number of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	542	622	↑ 1
COMPARE 2: Number of participants to accessed other medical care and/or living needs (transportation, child care, income, utility assistance, food assistance, etc.) (unduplicated for the fiscal year)	FHY1 2015	294	—	↑ 1
TARGET MEASURE: Percent of participants who accessed health care (unduplicated for the fiscal year)	FHY1 2015	51.0%	53.5%	↑ 1

This screen below will open. Click on the pencil figure to open the writing area. When finished, click on the “disk icon” on the far right to save. Scroll down and do the same for all four areas. (“What We Do”, “Who We Serve”, “How We Impact”, “Success Story”)



Step 8

Click on the pencil icon to write your narrative material, click on the “disk icon” to save

DALLAS COUNTY PUBLIC HEALTH NURSING SERVICES

The mission of Dallas County Public Health Nursing Services is to promote, protect and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations. The agency seeks to deliver quality, cost effective health services by developing, maintaining and improving health related programs that recognize the wellness continuum. Holistic services are directed toward individuals and their families, and toward the community with special attention to populations at risk.

One-stop shopping allows consumers to have multiple needs met in one location, rather than visiting a separate institution for each area of need. Dallas County has taken the idea of a one-stop shop and expanded it to include health care and social services. The Health Navigation Program is an innovative Health Navigation Program. It is the goal of Dallas County's Health Navigation Program that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by Vivian De Gonzalez, a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers. Vivian is a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate health care and social services. The United Way provides funding for part of Vivian's time (salary/benefits) to implement the program.

The Health Navigation program is completely free for Dallas County residents. Clients may refer themselves to the Health Navigation Program for help accessing services, or they may be referred by a health care provider or other community partner. Once our Health Navigation staff receive a referral, they meet one-on-one with the client and their family at a location and time that is convenient for them. During the initial encounter, Health Navigation staff asks a series of questions to identify additional unmet needs and their root causes. Based on the clients' unique situations, the Health Navigators connect them to local resources, including but not limited to: health insurance, a medical home, food, rent, & utility assistance, housing, employment, education, transportation, mental and behavioral health services, and other wellness options. During these encounters, the Health Navigators help clients complete paperwork and phone calls, and teach them how to navigate the system, advocate for themselves, and become more self-sufficient. The Health Navigators document their encounters in an electronic database, and follow-up with clients two to four weeks later to check on progress, and determine if (the needs) has been resolved or if further assistance is required. If the initial referral to Health Navigation comes from a health care provider, the Navigators follow-up with the clinic at resolution of the referral; thus, completing the medical home information loop.

The Health Navigation Program is consistent with the patient-centered medical home model, and features components of best-practice models for effectively bridging community prevention and health service delivery, including: Community-Centered Health Homes; Medical Neighborhoods; and Community Health Workers. The US Department of Health and Human Services asserts that Community Health Workers are valuable for community programs that aim to improve health among rural and under-served populations. Because Community Health Workers are members of the communities they serve, they are better equipped to build trusting, one-on-one relationships with clients and providers. As a true Community Health Worker, Vivian is able to meet with both English and Spanish-speaking clients in their homes. She is able to create more effective linkages between vulnerable populations and the health care system, provide culturally appropriate health education, advocate for under-served individuals to receive appropriate services, and build community capacity to address health and social issues.

Step 9: At the very bottom, you will find the Upload File button. Click on the button and upload your completed “Photo lease Form”



Step 9

Optional Step 10: For those of you who want to track “Actions” from your Action Plan, click on “New Action” to create an action or “Existing Action” if you already have an assigned action you wish to review or edit.

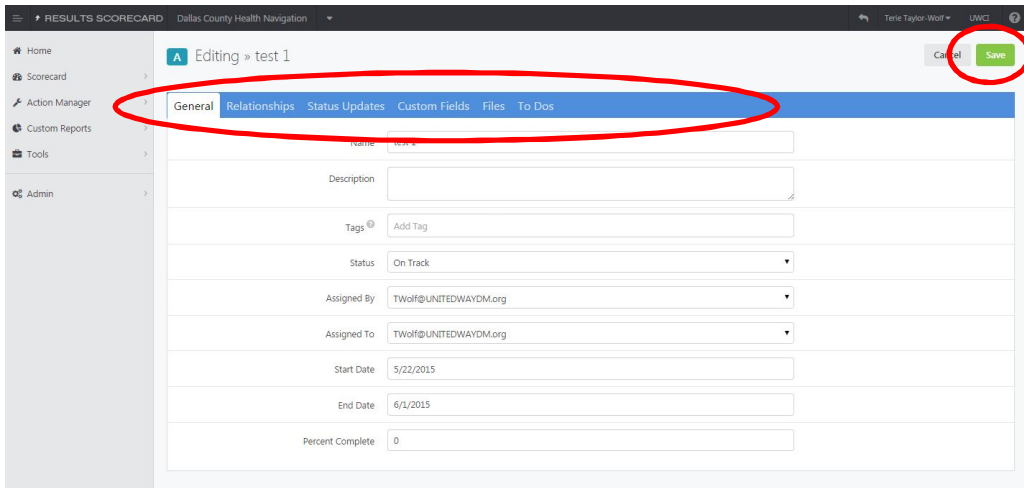


Step 10

Enter the "Name" of the action, who it is "Assigned to", the "Status" and finally a "Due Date" of the action. Click on the green check mark to save the Action. If you choose to "edit" the Action, select the "blue box" on the left hand side and select "edit".



After selecting "edit", the screen below will open. In this screen, you are able to identify "Relationships", complete a "Status Update", create custom fields that you want to track, upload files, and identify "To Dos" that need to be done in order to complete the action. Click on "Save" when you are done editing.



How to Unduplicate clients

It is really important to unduplicate your clients so your "TARGET MEASURE" does not show over 100%. The following should help with understanding how to do that. If you have questions, please contact your data lead.

Data collected by you:

Yr1	Enrollment measure	outcome measure	Yr2	Enrollment measure	outcome measure
Phillip	1st half	1st half	Kate	1st half	No outcome
Tony	1st half	1st half	Bill	1st half	No outcome
Kyle	1st half	2nd half	Walker	1st half	No outcome
John	1st half	2nd half	Kristin	1st half	2nd half
Kane	1st half	1st half	Jody	1st half	1st half
Myra (1st time enrollment in Aug and left in Sept)	1st half	No Outcome	Jane	2nd half	2nd half
Myra (reenrolled in Nov)	1st half but do not count Myra	No Outcome	Josh	1st half	2nd half
Tim	1st half	1st half	Myra	1st half	2nd half
Jane	2nd half	No Outcome	Tim	2nd half	2nd half
Josh	2nd half	2nd half	Rosy	2nd half	2nd half
Rosy	2nd half	2nd half			

Results Scorecard View:

Year 1	at the end of 1st half	at the end of the year	Annual
number of clients served	7	3	10
# achieved outcome	4	4	8
Target Measure	57%	133%	80.0%

Year 2	1st half	2nd half	Annual
number of clients served	7	3	10
# achieved outcome	1	6	7
Target Measure	14%	200%	70.0%

Question?

For Health Programming, contact Terie Taylor-Wolf at 246-6529 or e-mail at twolf@unitedwaydm.org

For Education Programming, contact Marian Rueter Godwin at 246-6581 or e-mail mruetergodwin@UNITEDWAYDM.org

For Income Programming, contact Corinne Lambert at 246-6542 or e-mail at clambert@unitedwaydm.org