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Executive Summary

METHODIST HEALTHCARE MINISTRIES OF SOUTH TEXAS, INC.

OVERVIEW

Methodist Healthcare Ministries of South Texas, Inc. (MHM) is an existing grantmaking institution, applying as an issue-based intermediary in Healthy Futures to address integrated behavioral health (IBH) and prevent physical and behavioral health comorbidities. We will also address two SIF optional funding priorities: Collective Impact and Targeting Traditionally Underserved and Underrepresented Geographic Areas. Subgrantees will be selected from 25 counties in two South Texas subregions: Rio Grande Valley (RGV) and Coastal Bend/Corpus Christi (CBCC). MHM has partnered with FSG, nationally recognized expert in Collective Impact, to catalyze Collective Impact projects for IBH in South Texas. We seek a \$10 million/year, five-year SIF award. MHM will contribute \$8 million in matching funds, has secured a commitment of \$250,000 from The Meadows Foundation and is in conversation with The Kresge Foundation and United Health Plans for similar commitments.

PROJECT SUMMARY

MHM will distribute \$16 million/year to 15-20 subgrantees to fund tested, replicable IBH models that address physical and behavioral comorbidities and transform treatment. Selected programs will be part of Collective Impact projects that build cross-sector partnerships, ensuring community ownership and post-SIF sustainability.

IBH improves identification and treatment of behavioral health problems and chronic disease. The National Comorbidity Survey Replication found that 68% of adults with mental disorders also had medical disorders and 29% of adults with medical disorders also had mental disorders (Druss et al. 2011). The depression rate in South Texas among Hispanic patients with Type 2 diabetes was 39% (Mier et al. 2008).

The MHM-SIF theory of change (TOC) is that IBH models, used with Collective Impact strategies, will lead to region-wide improvements in behavioral health and chronic disease. Measurable outcomes (to be finalized by Collective Impact stakeholders) will achieve improvement in depression and diabetes over 5 years, including reductions in the proportion of adults who experience major

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depressive episodes and in the proportion of persons with diabetes with HbA1c levels greater than 9%.

MHM's subgrant strategy will build a portfolio of IBH solutions that will be replicable nationwide, by means of SIF's four pillars: 1) investing in innovative solutions; 2) building evidence through evaluation; 3) supporting programs ready to scale their services; and 4) building cross-sector partnerships to ensure program sustainability, through Collective Impact.

To that end, our open, competitive RFP process will select high-performing applicants that are aligned with our TOC, are capable of rigorous evaluation and have high potential for program growth. Our multi-tiered evaluation strategy will build evidence regarding the effectiveness of each subgrantee IBH program, the combined impact of all MHM-SIF interventions and the components of Collective Impact that contribute to that impact. We will support subgrantees' growth through capacity building in evaluation, fund development, IBH systems & management and strategic planning and by brokering cross-sector relationships. All growth strategies will expand the selected solutions so that more people in low-income communities derive substantial, measurable benefit.

MHM has a track record as a strategic grantmaker, working with grantees to achieve measurable progress on outcomes that align with our strategic priorities. Through intensive coaching, technical assistance and funding, we play an active role in building grantee capacity for evaluation, impact and sustainability. Our Community Grants and Accounting departments have demonstrated experience in evaluation, nonprofit management, monitoring & compliance and federal grants management. Our proposed staffing plan will augment these capacities.

MHM is the largest private funding source for healthcare to low-income families and the uninsured in South Texas, having awarded over \$181 million in 964 grants throughout the region. As one-half owner of the Methodist Healthcare System - the largest healthcare system in South Texas - MHM has a stable source of revenue for its programs and grants.

Program Design

1A: GOALS AND OBJECTIVES

Methodist Healthcare Ministries, Inc. (MHM) is seeking a \$10 million/year Social Innovation Fund (SIF) award in the Healthy Futures category for five years to reduce the risk factors that lead to poor behavioral and physical health outcomes in South Texas. MHM seeks an issue-based award to address

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comorbidities of physical and behavioral health problems in 25 low-income, medically-underserved counties in South Texas. MHM-SIF will also address two Optional Funding Priorities: A Collective Impact approach and targeting Traditionally Underserved and Underrepresented Geographic Areas.

MHM is under consideration for a National Prevention Partnership Award from HHS Office of the Assistant Secretary for Health (CFDA 93.311). That proposal is programmatically and geographically distinct from SIF because it promotes physical activity, nutrition and smoking cessation in Victoria County.

MHM improves the physical, mental and spiritual health of those least served in South Texas. Our mission is achieved through grants to organizations with similar missions and through programs owned and operated by MHM. In 2014 from MHM's \$72 million budget, we will distribute nearly \$23 million in grants and provide \$35 million in direct programs and services. MHM programming and investments serve 30% of the state, and many of the 76 counties in our South Texas service area are among the poorest in the country. For example, Cameron Park, Texas (RGV) is the poorest community of its size or larger in the nation with per capita income of \$4,115, which is less than Mexico or El Salvador.

The MHM SIF will target the counties in two subregions of this vast, high need area: the Rio Grande Valley (RGV) (Cameron, Hidalgo, Starr, Willacy, Kenedy, Brooks, Jim Hogg, Zapata, Duval, Jim Wells, Kleberg and Webb counties) and the Coastal Bend/Corpus Christi (CBCC) region (Nueces, San Patricio, Aransas, Bee, Live Oak, McMullen, Atascosa, Wilson, Karnes, Gonzales, Guadalupe, Caldwell and Bastrop counties). These communities were selected in alignment with MHM's Board-approved Healthcare Delivery Redesign and Collective Impact strategies.

These regions are Traditionally Underserved and Underrepresented Geographic Areas: all 25 counties are federally-designated Medically Underserved Areas (MUA) and Health Professional Shortage Areas (HPSA) for mental health, and 92% contain a Health Professional Shortage Area for primary care. They are also not currently being served by the Social Innovation Fund: there are no SIF intermediaries in Texas and only 8 subgrantees (in Houston, San Antonio and Austin). Further exposing the underserved nature of region, MHM's analysis of national foundation grants to Texas for health and social services shows that few dollars reach South Texas. Excluding funds to the major

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metropolitan counties that include Austin and San Antonio, South Texas receives only 2-3% of the national foundation funding to the state. RGV and CBCC target regions receive 1.6% and 0.3% respectively.

The predominantly Hispanic communities of RGV and CBCC are characterized by high poverty, low educational attainment, and high rates of diabetes, behavioral health conditions and their risk factors. The population of the target area is 2,466,077 (American Community Survey 2012). 28% of the population is estimated to be below the poverty level. In some counties, the poverty rate is as high as 40% (ACS 2012). Approximately 19% of the population over age 25 has less than a 9th grade education (ACS 2012). The uninsured rate is similarly high: in all but two of the target counties it is higher than the national average of 18% (Cline & Murdock 2012). In over half of the target counties, more than 1 in 4 residents are uninsured. Cameron County's (RGV) Hispanic Cohort Study reveals that only 20% of non-elderly Mexican-American adults in the study had health insurance (Brownsville Community Needs Assessment 2012).

Hispanics/Latinos account for 76.6% of the target region's population, a significant demographic for multiple reasons. They are at higher risk for depression, anxiety and substance abuse and are less likely to access mental health treatment. Half of Hispanic clients that seek treatment will not return after the initial session. Of Hispanics with mental/behavioral health disorders, fewer than 5% use services from mental health specialists and fewer than 20% see general healthcare providers (NAMI Multicultural Action Center).

The target regions experience high rates of depression, diabetes and associated risk factors. In CBCC, chronic conditions such as obesity, diabetes, asthma and psychological problems were the most common conditions seen by providers. 70% of respondents were overweight/obese, compared to 65.8% in 2010, and "suicidal ideation" was one of the most common diagnoses in local Emergency Departments (Coastal Bend Needs Assessment 2012). The Cameron County (RGV) Hispanic Cohort Study found that 31% of study participants had diabetes and 81% were obese or overweight. The Brownsville Needs Assessment (RGV) found the chronic depression rate was 48% higher than the national average of 27% (2012). The combined average for both target regions of poor physical health days in the past 30 days is 4.1, compared to 3.7 statewide and a national benchmark of 2.6. 25.2% of respondents said their health was poor/fair, compared to 18% in Texas and a national benchmark of

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10% (County Health Rankings, BRFSS data 2013).

Additionally, behavioral-physical comorbidity - the co-incidence of physical and behavioral health conditions - is a significant problem in South Texas. The rate of depression among Hispanic patients in South Texas with Type 2 diabetes was 39% (Mier et al. 2008). This comorbidity may be caused by mutual risk factors, such as low income levels or poor educational attainment (significant issues in the target region).

Health risk behaviors - especially tobacco, alcohol or drug use, physical inactivity and poor nutrition - are also risk factors for comorbidity (Druss, et al. 2011). 27% of South Texans are inactive and 17% of adults in South Texas are smokers (BRFSS 2013). Those with behavioral health disorders are at increased risk of practicing these behaviors and of having difficulty managing disease once it emerges (CDC 2012). Whether physical or behavioral, incidence of one disorder increases the risk of for incidence of the other. The National Health Interview Survey found that depression risk increases with each comorbid chronic disease. With no chronic disease, depression prevalence is 5%. With one chronic condition, it increases to 8%; with two, 10%; and with three or more, 12%. Evidence also exists of the reverse: having diabetes doubles the likelihood of having depression (Egede 2007).

The population with comorbid behavioral disorders and chronic disease is at-risk for poor quality of care. Those with behavioral health conditions are less likely to receive preventive screenings, while behavioral health conditions are often not identified in primary care settings (Druss et al. 2011). Co-occurring conditions have been linked with early mortality, decreased quality of life and exacerbation of symptoms. The combined impact of comorbidity can be "greater than the sum of the individual conditions" (Druss, et al. 2011). Collins et al. (2010) report that coordinating primary care and behavioral healthcare can address and reduce these risks.

Our SIF investment and evaluation approach will seek evidence-based interventions that address our priority issue of integrated behavioral healthcare (IBH). Because there are infinite models of integration, we are not applying with a pre-identified intervention. Instead, we seek models that fall on the "Six Levels of Collaboration/Integration" continuum, as defined by the SAMHSA-HRSA Center for Integrated Health Solutions (2013). Level 1 represents the least intensive integration, and Level 6, the most. Evidence suggests that higher levels of integration lead to increased effectiveness. Subgrants

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may be awarded for interventions in Levels 2-6, if applicants present at least preliminary evidence of effectiveness of their model.

The South Texas landscape includes adequate models with at least preliminary levels of evidence that are ready to be brought to scale by increasing number of patients served, replicating programs in new locations and/or more fully integrating services for more effective care. In 2013 over 20 Medicaid 1115 Waiver proposals in the target region related to IBH interventions. A 2008 UT Hogg Foundation for Mental Health survey of community health centers, Mental Health and Mental Retardation (MHMR) centers and related organizations found that 62% of respondents were implementing integrated strategies. The most common strategies were screenings, referrals, general counseling and training primary staff on behavioral health issues. 70% of respondents provided co-treatment by primary care and behavioral health providers. Depression was the most commonly targeted condition.

Upcoming research will further illuminate the extent and diversity of IBH models in South Texas. The Meadows Mental Health Policy Institute (MMHPI) is beginning an investigation of the evidence-based practices in use by IBH programs in Texas. FSG, MHM's consultant for Collective Impact, will create a system landscape map related to IBH in the RGV to highlight key IBH actors, programs and data. See section 2F (MMHPI) and below in this section (FSG) for more detail.

Current IBH services are not performing at the scale needed to address the great mental health need and high comorbidity rates. In Hogg's survey of Texas' IBH efforts, although 62% were using some coordinated or integrated strategies, only 13% described their integration as "complete" (Hogg Integrated Health Resource Guide 2008). The most common IBH models in practice focus on referrals or co-location of services. While both are important elements of an IBH model, alone neither referrals nor colocation produce lasting, positive patient outcomes.

Also, evidence is lacking of the role of IBH for Hispanic populations. The St. David's Foundation reports in their 2008 evaluation of two Austin-based IBH programs that there is little evidence of IBH effectiveness in Hispanic populations. While their evaluation found that one clinic's IBH services created a significantly greater decrease in depression scores among Spanish speakers than among English speakers, MHM's SIF strategy is positioned to fill this gap in evidence.

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THEORY OF CHANGE (TOC) and OUTCOMES

The MHM-SIF TOC is that integrated behavioral healthcare (IBH) models, used in conjunction with Collective Impact strategies, will lead to region-wide improvements in both behavioral health conditions and chronic disease. Fuller integration will have a greater impact on patient outcomes and treatment of comorbidities.

Grant results will be evaluated using shared, measurable outcomes that will be finalized by diverse stakeholders in a community-engaged process (Collective Impact, described below). The outcomes we expect to pursue are:

YEAR 1: Program-level outcome: 80% of patients diagnosed with depression, who are in the program for a minimum of 6 months, will show 3 or more points of reduction on their PHQ-9 scores (national standard patient survey used to assess depression).

BY YEAR 5: Population-level outcome: Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (Healthy People 2020 objective MHMD-4.2).

YEAR 1: Program-level outcome: 30% of diagnosed diabetic adult patients with HbA1c levels greater than 9% (measured within the past 12 months) will demonstrate a 10% decrease in HbA1c levels (must have been patients at least 6 months at the time of the post-test).

YEAR 5: Population-level outcome: Reduce the proportion of persons with diabetes with HbA1c level greater than 9% from 17.9 to 16.1% (Healthy People 2020 objective D-5.1).

MHM will invest in effective IBH models and work with subgrantees to advance their models towards fuller integration, enabling them to provide effective behavioral health and primary care to more people.

MHM will support subgrantee success in achieving these outcomes by integrating capacity building services, utilizing Collective Impact and committing significant resources to evaluation (13% of SIF budget). Assistance will include comprehensive capacity assessments of subgrantee organizations and individualized capacity building plans that incorporate one-on-one coaching, workshops and reference toolkits. The Capacity Building Specialist will be responsible for these value-added services, leveraging the expertise of the Evaluation Specialist, Project Impact Lead, Sustainability Liaison (SL) and contracted IBH specialist to provide high-level content in evaluation, fund development and IBH.

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Additional detail provided in section 2D's Capacity Building Plan and section 3A's Personnel descriptions.

STRATEGY FOR COLLECTIVE IMPACT (CI)

In alignment with SIF's optional funding priority to test models using a Collective Impact (CI) Approach, the MHM-SIF will be grounded in CI, where cross-sector stakeholders work together on a common agenda to solve a complex social problem. MHM's CI approach will be included in the rigorous MHM-SIF evaluation plan to isolate the causal effects of CI by implementing a quasi-experimental design that controls for selection bias (see 1B.b).

With assistance from FSG, MHM is initiating a Board-approved CI project focused on IBH in the Rio Grande Valley (RGV). FSG, a nonprofit consulting firm specializing in strategy, evaluation and research, is a nationally recognized leader in CI. Under this contract, FSG will advise and assist MHM's Collective Impact team in mapping assets, challenges and key players related to IBH in the RGV, researching effective IBH collaborations, convening key stakeholders, developing a common agenda, identifying a "backbone" organization and blueprint for implementation and establishing working groups and strategies. This work will be completed by early 2015, in time for SIF subgrantees to align efforts with CI priorities. FSG's work will focus specifically on the RGV, one of the two target regions for this SIF proposal.

Coastal Bend/Corpus Christi (CBCC) is well-positioned to undertake CI because of current successful collaborations and existing research to map assets, challenges and key players. MHM's CI Strategist for CBCC will work closely with both FSG consultants and the CI Strategist for RGV to replicate the design.

MHM has significant experience leveraging the CI approach with existing backbone entities. In 2009, MHM convened cross-sector South Texas partners to address cancer prevention and attract state funding to the region. Partners reorganized into sub-regional collaborations, and MHM assisted four backbone organizations with resources, guidance on CI and technical assistance related to each group's goals. The groups were successful in increasing cancer prevention activity in South Texas and continued collaboration afterward. With MHM's assistance, the groups received \$14.2 million from the Cancer Prevention & Research Institute of Texas (CPRIT), approximately 38% of CPRIT

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prevention awards statewide during that time period.

MHM is positioned to support the goals and approach we propose: this investment in CI strategies is enhanced by our successful South Texas grantmaking and productive relationships with Texas and national funders.

1B DESCRIPTION OF ACTIVITIES

1B.a SUBGRANTEE SELECTION

MHM will operate a competitive RFP process, open to eligible nonprofit and public organizations beyond our existing grant portfolio. Organizations selected through this competition will have developed and/or implemented innovative solutions to address comorbidities of behavioral health conditions and chronic disease. Successful applicants may be: Federally-Qualified Health Centers; institutions of higher education, including medical schools; healthcare clinics; MHMRs; public health departments; state health services; school-based health services; county health services. They will have proven initiatives and a demonstrated track record of achieving IBH outcomes. They will provide a well-defined plan for replicating, expanding or supporting the initiatives funded; will have sufficient budget to sustain the initiatives after the subgrant period concludes; will have strong leadership and financial and management systems; will implement and evaluate innovative initiatives; and will demonstrate capacity to meet the requirements for matching funds. These organizations will also be "high-performing": they will be well-run and financially healthy with capable leadership, clear goals and clear objectives; will diligently collect quality data and that they use to understand their effectiveness; and will make adjustments to their approach to continuously improve. Our comprehensive subgrantee selection process will assess these characteristics.

Approximately 15-20 subgrants will be awarded at \$250,000-\$2,000,000 in Year 1. As subgrantees increase their evidence of effectiveness and scaling during their 3-5 year award timeline, it is likely that award amounts will increase in subsequent years. Alternatively, if an initial award includes capital dollars for replication and expansion of services, subsequent awards to that subgrantee may be lower.

Subgrantee selection will be completed within 7 months of grant award in Year 1 and will include: recruitment of external reviewers (by October 1, 2014); RFP development (October 1-November 15);

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RFP publication (November 15); due date for Notice of Intent to Apply (December 5); applications accepted (December 6-February 13); multi-phase review process (February 16-April 16); and announcement of awards (April 17), with an award start date of May 1. This process will be overseen by the Grants & Research Manager and Project Impact Lead.

The multi-stage review process will ensure that subgrantees are high-performing, aligned with MHM's theory of change, capable of conducting rigorous evaluations and of achieving MHM-SIF outcomes and have high potential for program growth and scaling.

The following information will be available to all potential applicants in RFP announcements: desired characteristics and eligibility requirements of subgrantees; how to obtain and submit an application; selection criteria weight for each criterion; requirements for program growth and evaluation; and MHM's evaluation strategy, including evaluation-related budget requirements.

In Phase 1, "Eligibility Review" (February 16-February 27), MHM's Grants Management Specialists and Grants Accountants will review each application for evidence of: nonprofit or public status; favorable budget assessment (amount of request as percent of organizational budget); proposed IBH intervention; demonstration of match or willingness to seek; absence of current investigation of applicant by a government agency; adequate financial controls; cost allocation plan; most recent financial statement; previous 3 years audited financial statements; federal grant audits, if any; inclusion of completed Organizational Capacity Assessment and Monitoring & Evaluation Assessment (see section 2D); and inclusion in budget of criminal history check and external evaluation costs. Applicants meeting these basic criteria will be forwarded to Phase 2, "Program Review."

In Phase 2 (March 2-March 20), a committee of external reviewers and MHM staff (including Project Impact Lead, Evaluation Specialist and Sustainability Liaison) will use a rubric to rate and rank each application on the criteria that follows. To assess alignment with MHM's SIF TOC, program reviewers will evaluate the level of integration of the proposed intervention (following SAMHSA-HRSA CIHS continuum). Applicants' capacity to participate in a rigorous evaluation and achieve outcome goals will be scored on methodological quality of past evaluations included with their application, results of the Monitoring & Evaluation Capacity Assessment, adequacy of proposed budget for evaluation, strength of data collection and use and qualifications of the staff/contractor identified to lead subgrantee evaluation. To assess evidence of effectiveness, reviewers will examine subgrantees' prior

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evaluations and rate the innovative and transformative potential of proposed interventions. Applicants will be scored as insufficient, preliminary, moderate or strong.

Evidence of being a "high-performing" institution with high organizational capacity will be scored based on the results of the applicant's Organizational Capacity Assessment, strength of organizational structure described in the proposal (sturdy IT systems, sound financial systems, skills training, fundraising processes and a diverse, qualified board), experience/readiness to work collectively with other stakeholders, and existence of conflict of interest standards.

Phase 2 reviewers will assess applicants' readiness for program growth and impact using the following scales and criteria: plan for or implementation of Electronic Medical Records (EMR) and electronic exchange of health records (HIE); financial management and managerial systems; board governance; strength of TOC; clear demonstration of Community Return on Investment; cost effectiveness of proposed program; potential for speed to impact; likelihood of results; and likelihood of project sustainability.

Project Impact Lead and VP for Strategic Planning and Growth will conduct thorough site visits of the highest scoring applications to assess organization capacity, alignment with MHM-SIF, the IBH model and other relevant criteria. Site visit reports will be included with final recommendation to the Board.

In Phase 3 (March 23-April 10) of the review process, "Value of Award," Project Impact Lead, Grants Accounting Manager, and Grants & Research Manager will assign each application a potential award amount according to criteria in 4 main categories: 1) level of evidence; 2) degree of integration; 3) potential to scale; and 4) financial maturity and capacity.

(1) Level of evidence: If the program provides an evaluation demonstrating at least preliminary evidence of the effectiveness of their TOC and identifies elements that led to success, the applicant will be poised to scale the delivery or applicability of their program. Greater levels of evidence (moderate or strong) are indicators that subgrantees are capable of more substantial growth and will be eligible for increased funding accordingly. Preliminary levels of evidence include outcome studies that measure participants' responses at the end of the program, or third-party pre- and post-test research that

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measures participants' improvement on outcomes. Moderate evidence will be demonstrated by an experimental or quasi-experimental study that supports the effectiveness of the intervention with limited generalizability or by correlational research with strong statistical controls. Strong evidence will be demonstrated by more than one experimental or quasi-experimental study or by one randomized, controlled, multisite trial (RCT) that supports the effectiveness of the intervention.

(2) Degree of integration: Following the SAMHSA-HRSA Center for Integrated Health Solutions' "Six Levels of Collaboration/Integration," higher funding amounts will be allocated to subgrantees that propose interventions at higher levels of integration. Levels 2-6 are eligible for funding, and Level 6 "Full Collaboration" will receive the highest level of funding. This aligns with MHM's SIF TOC, which holds that fuller integration has a greater impact on patient outcomes and treatment of comorbidities (see section 1A).

(3) Expected scaling: As part of SIF subgrant proposals, applicants will describe their plans to scale delivery or applicability of their intervention, including estimates of the number to be served and/or number of new sites. Funds will be allocated in accordance with reasonable estimates of cost/person or cost/site. Should the subgrantee candidate propose to increase scaling after Year 1, they would be eligible to receive increasing funds when they reapply in accordance with expected growth.

(4) Financial capacity: The applicant's financial capacity will also determine award size. Primary considerations will be adequacy of applicants' internal controls and amount requested (including matching funds) as a percentage of their organizational budget. Agencies deemed to have the capacity to find or be eligible for higher matching funds will also be eligible for higher awards.

Following phase 3, the Project Impact Lead, Grants & Research Manager and Grants Accounting Manager will assemble a subgrant portfolio, including suggested award amounts, and provide recommendations to MHM's Board Program Monitoring Committee. This committee will make final selection of subgrantees by April 16, 2015.

1B.b: PROPOSAL FOR EVALUATION EVALUATION STRATEGY

Our multi-tiered evaluation strategy will build evidence regarding 1) the effectiveness of each

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subgrantee's IBH program; 2) the combined impact of all MHM-SIF interventions; and 3) the components of Collective Impact that contribute to that impact. Subgrantees will implement more than one intervention, and all subgrantees will participate in the same evaluation.

(1) Assessment of outcomes and program growth from multiple sites will provide evidence of effectiveness of various IBH interventions, improving the evidence base of funded models. This will allow comparison of models with varying integration levels and their associated impact on health outcomes.

(2) By aggregating outcomes and program growth data from multiple sites, our evaluation strategy will establish the combined impact of all MHM-SIF interventions and allow for sub-regional comparison and analysis of impact on sub-populations, such as Hispanics.

(3) By evaluating the unique components of Collective Impact in each target region, our strategy will isolate the causal effects of this approach.

The evaluation plan will utilize correlational research with strong statistical controls for selection bias and for discerning the influence of internal factors to ensure that each funded model achieves at least moderate levels of evidence in 3-5 years. The strategy will include the use of statistical analysis (CHAID, t-tests, etc.) to determine correlational factors and identify segments of the population achieving significantly better results.

TECHNICAL ASSISTANCE IN EVALUATION

To ensure subgrantee capacity to participate in the rigorous evaluation design, MHM will assess needs for and provide technical assistance. As described in section 1B.a, applicants will include multiple indicators of their evaluation capacity with their application, including the Monitoring and Evaluation Capacity Assessment and the Organizational Capacity Assessment Tool (described in section 2D). These tools will identify specific areas for evaluation-related technical assistance, including performance measurement systems, availability of baseline data and use of sound data sources.

Based on results of the assessments, MHM's Evaluation Specialist, Project Impact Lead and Capacity Building Specialist will provide technical assistance and training to subgrantees as they design,

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implement and monitor evaluations of their program models. Services will include workshops, webinars, one-on-one coaching and custom-designed toolkits (see section 2D for full description of technical assistance).

ROLE OF EVALUATION PARTNER

MHM will use both an external evaluation consultant and a SIF-funded Evaluation Team to design and implement a rigorous evaluation. The evaluation consultant will assist with development of the evaluation criteria specified in the RFP, determine the technical design of the evaluation plans for assessing program fidelity and impacts, and provide ongoing support and advising to MHM evaluation staff during implementation of CNCS-approved evaluation plans.

MHM will use a competitive bid process, in accordance with federal requirements, to identify the appropriate evaluation partner. This partner will be identified by October 31, 2014, to ensure their participation in the development of the RFP's evaluation requirements. MHM has existing partnerships with several evaluators that represent the expertise and experience that we will seek, including Department of Epidemiology and Biostatistics at University of Texas Health Science Center San Antonio, and Health Management Associates (HMA), an independent, national research and consulting firm.

The MHM-SIF funded Evaluation Team, including the Project Impact Lead, Evaluation Specialist, Capacity Building Specialist and Research Intern, will oversee all aspects of subgrantee participation in the evaluation plan (designed in coordination with evaluation consultant and CNCS). Activities will include coordination of subgrantee evaluation employees' or contractors' efforts, data cleaning and analysis, interpretation and use of analyzed data, reporting to CNCS, sharing evaluation results with subgrantees and providing technical assistance to subgrantees to improve evaluation capacity and data quality.

BUDGET FOR EVALUATION

Approximately 13% of the budget (including match dollars) will be allocated to the costs of rigorous evaluation activities. Additional evaluation costs incurred by subgrantees will be included in the subgrants they receive. Evaluation items budgeted in our proposal include:

*New personnel (Project Impact Lead, Evaluation Specialist, Capacity Building Specialist)

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*Contracted evaluation consultant

*Statistical software, including SAS Visual Analytics and Angoss KnowledgeSeeker (CHAID analysis) for data analysis and identification of correlational factors. This software will also be used to create data portals showing project progress to share with stakeholders and engage the MHM-SIF subgrantee community in continuous learning and improvement.

*Travel costs to target regions for evaluation design, data collection and evaluation-related technical assistance to subgrantees.

EXAMPLES OF PROGRAM MODELS TO BE EVALUATED

Models will be evaluated based on the TOC described in section 1A. Following the SAMHSA-HRSA CIHS continuum of integration, program models eligible for subgrants include those operating at Levels 2-6 that provide at least preliminary evidence of effectiveness. Examples of some eligible models are below (not an exhaustive list). For those models with strong levels of evidence, MHM-SIF evaluation would examine whether the findings remain true for the target region's unique population.

A Level 2 model "Medical-provided behavioral healthcare" occurs when a medical provider incorporates limited counseling (such as exercise recommendations for a depressed patient) and screens for depression or other conditions. There is significant evidence of effectiveness of this model on some behavioral health conditions, including depression (Collins, et al. 2010).

"Disease management" focuses on identification of those at-risk for chronic disease and provision of educational resources for self-management and prevention with follow-up by a care manager. This Level 4 model has strong evidence of effectiveness: multiple RCTs have demonstrated that disease management models with care managers are clinically and cost-effective (Collins et al. 2010).

"Unified primary care and behavioral health" is a Level 6 model in which psychiatric services and primary care are provided in one place with integrated medical records and shared treatment plans. An RCT has proven positive outcomes in physical health status and continuity of care for patients treated in a VHA mental health clinic that integrated primary care with this model (Collins et al. 2010).

1B.c: PROPOSAL TO IDENTIFY INNOVATIVE, MORE EFFECTIVE SOLUTIONS

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As described in section 1A, integrated behavioral healthcare (IBH) is an important issue in South Texas because of high incidence of both physical and behavioral health problems, high incidence of comorbidities of these conditions and the risks associated with treating them in isolation. Integrated care addresses all conditions concurrently.

IBH models are an opportunity to fill a gap in evidence of effectiveness and expand the body of evidence for South Texas' unique population. Though many IBH models operate in Texas, many services lack the characteristics indicative of fuller integration. In addition, South Texas' majority Hispanic population provides an opportunity to build on limited evidence of IBH effectiveness among this unique group. MHM will identify subgrantees that are ready to expand innovative, effective solutions to the problem of comorbidities in behavioral health and chronic disease. These solutions will be faster, cost-effective, data-driven and lead to better results for the public good.

MHM will attract these innovative and transformative solutions through broad promotion of the RFP in multiple regional networks. We will distribute the RFP: 1) by email to existing grantees, and behavioral health coalition partners; 2) via MHM's website and websites of healthcare and nonprofit associations, such as Texas Association of Community Health Centers, NAMI Texas, Association for Community Health Improvement, Texas Association of Nonprofits, Texas Association of Health Plans and Texas Department of State Health Services; 3) through community networks of MHM field staff in the target regions; and 4) through networks of diverse stakeholders convened for Collective Impact.

Announcements will stress the Collective Impact approach and the need for innovative and transformative solutions. The RFP will describe the criteria to select potentially transformative solutions, as described in section 1B.a.

1B.d: PROPOSAL FOR GROWING SUBGRANTEE IMPACT

As described in section 1A, MHM's theory of change engages subgrantees in addressing both behavioral health conditions and chronic disease using various IBH strategies. As stated above, there is higher evidence of effectiveness with increasing levels of integration. MHM will work with subgrantees to move them through the continuum of integration to more effective IBH. Our approach involves three types of growth: expanding services at existing sites, replications of the program to new sites in different communities, and/or increasing the effectiveness of their existing

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services by heightening the level of integration they practice. All growth strategies will involve expanding the selected solutions so that more people in low-income communities derive substantial, measurable benefit.

MHM will select subgrantees based on the potential for growth and evidence of effectiveness. Because we expect to see a direct, positive relationship between the level of evidence that subgrantees possess at the time of their selection for funding and their capacity to grow their impact, the first characteristic to be examined will be level of evidence. As described in 1B.a, subgrantees with strong levels of evidence are more likely to be able to reach higher growth targets, and will receive larger funding awards. Additional characteristics of capacity for program growth include: a strong theory of change (in alignment with MHM-SIF theory of change) that aligns program inputs, activities and outcomes; support from key program stakeholders for expansion of their services to more clients, replication of their program in additional sites and/or increasing the level of integration of their services; sufficient human capital, financial management systems, managerial systems and a committed, diversified board to support program expansion; and mature IT systems, or inclusion of appropriate budget items in proposal.

MHM will support subgrantee growth through capacity building. We will first assess subgrantee baseline capacities using the Monitoring & Evaluation Capacity Assessment and the Organizational Capacity Assessment Tools, both described in section 2D. We anticipate, from our experience with nonprofit agencies in South Texas, that few will be advanced in terms of evaluation capacity. Since evidence of effectiveness is our first consideration in subgrantee potential for growth, we anticipate much of our capacity building will address this area. Based on results of these assessments, MHM will provide meaningful capacity building in organizational capacity, IBH management, fund development, strategic planning; and will align the efforts of subgrantees in each region through Collective Impact. The following services will be provided as appropriate: workshops and webinars; downloadable toolkits; and one-on-one coaching by our Capacity Building Specialist, Sustainability Liaison and Evaluation Specialist. Further description of these services is provided in section 2D.

MHM is committed to helping subgrantees plan for effective growth that results in long-term sustainability of their expanded programs. A Sustainability Liaison will improve subgrantees' capacity for fund development and sustainable growth by providing training and building subgrantees' network

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of cross-sector relationships. For direct fundraising needs, the Sustainability Liaison will refer subgrantees to MHM's Funding Alternatives team (not grant-funded). The technical assistance provided by the Capacity Building Specialist (described in 2D) will build tools and infrastructure to sustain the expanded programs. Because IBH typically involves sophisticated information technology systems, the System Analyst will provide IT assistance. Through a contracted IBH specialist we will provide resources and consultation on logistical and programmatic issues related to scaling an integrated behavioral health system, such as billing procedures and legal frameworks. Through development of solid administrative and financial systems, subgrantees may also develop funding for program growth through program income (private and public insurance).

Organizational Capability

2A: HISTORY OF COMPETITIVE GRANTMAKING

Since its inception in 1996 MHM has awarded over \$181 million in 964 grants throughout South Texas; it is the largest private funding source for community healthcare to low-income families and the uninsured in South Texas. Approximately 37% of the MHM program budget is distributed via grants to community partners. These awards include capital, operating, program and multi-year grants. Throughout MHM's history, our grantmaking vision has been "Nonprofit agencies serving those least served will have sufficient resources, expertise and capacity to maximize their impact." This vision directly aligns with the intent of the SIF program, and informs the subgrantee selection processes described fully in section 1B.a.

While much of MHM's competitive grantmaking has been solicited by invitation, there is precedent for open competition, which demonstrates MHM's ability to identify innovative, evidence-based solutions. When the Board of Directors identifies a new or distinctive strategic focus, MHM issues competitive RFPs, with information disseminated both in writing and through in-person meetings, to seek partners. For example, in 2011 MHM issued an RFP to Bexar County mental health providers specifically to fill gaps in the mental health system. As a result of this competitive process, \$9.4 million in multiyear grants (2012-2015) were awarded. The competitive process is also used when new organizations or programs express interest in partnering with MHM (similar to LOI). Inquiries are reviewed by staff throughout the year and those in line with MHM Funding Priorities are invited to submit competitive applications.

MHM has comprehensive grantmaking procedures that enable us to identify innovative, evidence-

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based solutions. Finance staff conduct thorough reviews of current financial statements and external audits, including A-133 audits, and program staff assess the state and capacity of programs. During the selection process, requests are rated and tiered according to their degree of fit with MHM priorities and recommendations are made to the Program Monitoring Committee of the Board. This committee forwards recommendations to the full Board for final approval. The MHM-SIF Subgrantee Selection Committee will review applications solicited from an open, competitive process and will be composed of an interdisciplinary team.

MHM uses a grant application system to process applications, contracts and reports. MicroEdge GIFTS is the market leader in grants management software and has been in use at MHM since 2008. This system is shared by grants management and grant accounting staff to facilitate application submission and review, compliance controls and reporting.

2B: EXPERIENCE GROWING PROGRAM IMPACT

MHM has significant experience in and capacity to support subgrantee growth and impact. For more than a decade, MHM has provided technical assistance (TA) and capacity building services to grantees and other community partners. By leveraging our investments in these organizations and participating in capacity building in fund development, partners have acquired \$34 million in grants from other sources. With grant-seeking TA from MHM, 94% of participants received the grant they were working on, and 99% learned from the process. A 2013 survey found that MHM assistance helped over 90% improve their ability to write proposal documents. Our capacity building work has also encompassed logic models, strategic planning and other core skills for program growth, further described in 2C.

Example: With consistent core operating support and TA from MHM, The Texas Diaper Bank has expanded substantially. Beginning in 1997 with an operating budget of \$100,000 to provide safety net services, they have grown to an operating budget of over \$1.6 million with three programs to address health, wellness and basic needs for families. MHM provided in-kind staff for programs and capacity building assistance in program development and proposal writing. This assistance was instrumental in both the creation and expansion and in the organization's winning of Bank of America's Neighborhood Builders Award. In 2014, they project to serve more than 15,000 families in Bexar County, Texas, a 300% increase from 1997.

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Example: With MHM support, the Federally Qualified Health Center, Community Health Centers of South Central Texas (CHCSCT), has greatly expanded rural health services. From a volunteer clinic with one part-time physician and nurse in 1996, CHCSCT has grown to 90 full and part time employees, and offers dental services, specialist physician referrals, referrals for substance abuse and mental health counseling, and anticipates serving over 17,000 patients in 2014 through five clinics. MHM staff have provided capital support, research and proposal writing assistance, including support to develop an evaluation. Today, four of these clinics are practicing integrated healthcare, with two practicing Level 3 and two practicing Level 4 or above.

Example: WINGS is the only organization in the nation to offer comprehensive breast cancer treatment at no charge to the patient. It was founded in 2000 with a budget of \$300,000, serving 46 patients. We have leveraged our grants and substantial TA to contribute to their growth: in 2000 MHM grants to WINGS provided 30% of their annual budget. Today, MHM grants to WINGS comprise only 12% of their more than \$2 million budget to serve over 800 patients.

As these examples demonstrate, MHM provides significant resources of the type needed for development and strategic scaling of transformative programs. The proposed budget includes vital resources to provide support for subgrantee growth. The MHM-SIF Sustainability Team will build capacity of subgrantees in fund development to ensure sustained program growth beyond the end of the grant period. This team will include the Sustainability Liaison, Capacity Building Specialist and existing MHM staff such as the Grants and Research Manager. MHM will also contract with a partner in IBH to provide consultation for subgrantees to increase their impact. In addition, we propose travel funds to allow program staff to provide one-on-one and group TA and capacity building services to subgrantees in their efforts to grow their programs. Because of the long distances required for travel to the target regions, we also budget for an upgraded Vimeo account to provide high-quality capacity-building videos and screencasts.

MHM has multiple strategies to capture and share best practices from subgrantees. MHM-SIF subgrantees will convene twice annually at the MHM-SIF Subgrantee Learning Community Conference to learn together and share best practices. We will conduct a "bright spot analysis." In the past, for example, when four grantees exceeded Healthy People 2020 goals for blood pressure control,

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we conducted interviews to learn from their accomplishments and published a newsletter sharing their best practices with all grantees. MHM's Communications department regularly produces written and online educational reports and videos about grantee and MHM successes. The best practices of SIF subgrantees will be similarly featured to share with the whole subgrantee community.

Importantly, the Collective Impact (CI) process will identify best practices. Because each subgrantee will be part of their regional CI project, their best practices will be disseminated throughout their communities. The results of subgrantee evaluation activities will inform the activities and priorities of each CI project. Subgrantee progress on outcomes, growth targets and performance measures will be included in a CI Scorecard for each region. This Scorecard, which will be available on MHM's website, will provide information by topic, region or subgrantee. SAS Visual Analytics will be used to generate on-the-fly graphics for users.

2C: EVALUATION EXPERIENCE

MHM's Community Grants department has significant experience managing and supporting evaluations of our grantees' program models. All grantees are required to identify and report on client outcome goals and submit quarterly reports on progress toward impact goals. Clinic grantees are required to align outcome goals to Healthy People 2020 objectives. We regularly assess grantees' progress to identify course corrections and inform our investment decisions. When they are slow to meet goals, we provide in-depth consultation to identify barriers and solutions. Those that continue to underperform are ranked lower on our grant portfolio tiering system and receive lower funding priority for continuation grants. When grantees exceed goals, we share successful strategies through the "bright spot analysis" described in section 2B.

We play a key role in influencing grantees' use of evidence to improve program performance through capacity building. We provide coaching to all 75 grantees on evaluation principles and determining outcome goals, and provide outcome measurement workshops. Through our three-year initiative to build a common language around logic models, we provided logic model workshops to funders and nonprofits throughout our service area. One year after attending the workshops, 79% of nonprofits participating said they had used a logic model in a grant proposal, and 88% of all participants said they had gained and retained skills.

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Through a combination of existing and SIF-funded staff and external consultants, MHM will have the capacity to ensure successful evaluations of subgrantee programs. The expected qualifications for the SIF-funded Evaluation Team are described in section 3A and the evaluation consultant's role is described in 1B.b. Anne Connor, MA, CFRE, Director of Community Grants, will be a key member of this team. She has a graduate level background in research design and statistical analysis. She had an eight year career in data mining and analysis, particularly database segmentation and predictive modeling, before joining MHM. She led the shift at MHM from measuring clients served to evaluating client outcome measures for MHM programs and grants. Existing staff (not grant-funded) will be an occasional resource for the SIF team. For example, Amanda Orahoske, MS, RN-BC, MHM's Health Informatics Manager, is a board certified registered nurse in nursing informatics. She oversees all Electronic Health Record activities; including reporting practices and sustained measurement development with end users and MHM leadership.

2D: ABILITY TO PROVIDE PROGRAM SUPPORT AND OVERSIGHT

WORKING WITH GRANTEES TO SET GOALS AND BUILD CAPACITY

Since its inception, MHM has included grantmaking as a key strategy in accomplishing its mission to improve the health of those least served. The Department of Community Grants mission statement is to "advance MHM's mission to serve those least served, through capacity-building and financial support of our partners." The department's key objectives are to promote collaborative relationships, leverage outside dollars through expert assistance with grant seeking, ensure compliance through internal controls while providing high-quality customer service, promote community good, and promote the innovative and respectful pursuit of our mission. MHM's approach hinges on a high degree of engagement with grantees and has facilitated grantees' ability to convert sizeable grants into increased scale and improved programs by helping set and implement program goals.

For example, MHM assisted WINGS, the breast cancer treatment program described above, with goal-setting through one-on-one coaching to help craft measurable outcomes and set realistic targets. As noted, WINGS' reach grew from 46 individuals in 2001 to over 800 individuals today. In 2013 MHM aligned grantee and program goals with Healthy People 2020 and began developing a Unified Intake System to promote collaboration and organization-wide tracking of client outcomes. MHM staff have coached MHM's grantee agencies on evaluation and measurement techniques, to help bring about this shift. For example, as part of the Strategic Mental Health Initiatives competitive RFP,

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described in 2A, MHM awarded funding for a Transitional Care Clinic (TCC) at UT Health Science Center. MHM worked with TCC to set a goal of a 50% decrease in Crisis Clinic and Emergency Room visits by patients who complete the program. They achieved a 52% decrease.

The TCC is also an example of MHM's experience operating and overseeing programs comparable to those proposed in our priority issue area of integrated behavioral healthcare (IBH). TCC provides treatment to patients in crisis by combining services of behavioral health specialists and medical professionals. TCC is an integrated, interdisciplinary team, including psychiatrists, psychologists, advanced practice nurses, psychiatric social workers, licensed mental health counselors and a physician's assistant. In addition to the successful outcome noted above, fewer than 10% of patients at the TCC require re-hospitalization in the 90 days after discharge. As recognition of their success, the TCC was awarded an 1115 Medicaid Waiver to expand their model of service. Another example of MHM's experience overseeing IBH and behavioral health programs is the Family Service Association. MHM was the initial funder of their Early Childhood Well-being Project. The project fills gaps in medical and behavioral health services for children and families by integrating early childhood mental health consultation into childcare and pediatric settings. Since its start in 2011, the project has grown to integrate these services in 28 Head Start centers (serving over 1600 at-risk children), a homeless shelter's childcare center and, in 2014 to pediatric settings. CHCSCT, described fully in 2B, is another excellent example of MHM's work in integrated health.

CAPACITY BUILDING PLAN

MHM has provided significant capacity building to support grantees in achieving goals. MHM will continue to provide targeted capacity building for SIF grantees. Using results from subgrantee responses on the Marguerite Casey Foundation Organizational Capacity Assessment Tool (OCAT) and Monitoring and Evaluation (M&E) Capacity Assessment Tool, the Capacity Building Team will create individualized plans for subgrantees in the areas of evaluation, program growth, scalability and sustainability. The M&E self-assessment tool focuses specifically on capacity for evaluation. The OCAT self-assessment instrument helps identify organizational strengths and challenges, establish capacity building goals and track capacity over time. Characteristics to be assessed include: 1) Leadership Capacity (mission, vision, financial judgment); 2) Adaptive Capacity (strategic planning, evaluation, performance measurement, organizational learning, program growth & replication, partnerships & alliances); 3) Management Capacity (recruiting, development, retention of management and staff; volunteer management); 4) Operational/Technical Capacity (staffing levels, skills, fundraising

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performance, communications strategy, technology).

Tools to build capacity include: one-on-one coaching by phone, email, and in-person in areas of program development (growth and scalability), evaluation and sustainability; general workshops on evaluation, performance measurement, scalability and sustainability; and customized workshops based on individual assessments. As mentioned above, contracted specialists in IBH and evaluation, and in-house specialists in IT, evaluation and sustainability, will be available to provide TA on specific issues.

Each year, subgrantees will re-take the assessments (OCAT and M&E) to determine changes in capacity and for SIF staff to realign approaches to ensure capacity for evaluation, growth and sustainability. Incorporated through SIF, TA will remain available afterward through MHM's existing capacity building program.

PERFORMANCE MEASUREMENT, COMPLIANCE MONITORING & ACCOUNTABILITY

Development of a performance measurement system will be integrated with development of our evaluation plan so that data drives decision-making. Shared metrics identified through Collective Impact (CI) will ensure that data and results are measured consistently across subgrantees for comparison and aggregation. Initially, the MHM-SIF Evaluation Team will conduct a performance measurement audit of all subgrantees. Then, in alignment with each regional CI strategy and in coordination with the MHM-SIF CI Team, they will choose shared indicators of organizational health, program performance and social/economic impact. Subgrantees will report on the selected indicators through MicroEdge GIFTS. MHM-SIF teams will use the SAS Visual Analytics dashboard to review results and monitor performance. In the interest of transparency, this dashboard will have a public-facing component--the Collective Impact Scorecard, described above--which will be visually accessible, interactive and regularly updated to demonstrate longitudinal progress. It will demonstrate the Community Return on Investment generated by grant activities. Extensive data will be used to improve subgrantee performance according to the capacity building plan, described above.

MHM has been awarding grants and monitoring program compliance since 1996 and has a strong system of internal controls to ensure both programmatic and financial compliance. Grantees are held accountable for meeting program goals, including volume goals (number of patients, number of visits,

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etc.) and patient outcomes goals (currently aligned with Healthy People 2020 objectives) and by reporting quarterly on all goals and deliverables. If a grantee is off-target on any goal, they must submit a Variance Report giving detailed explanations of the contributing factors and a plan to correct the situation. MHM conducts a portfolio analysis of all grants, particularly client outcomes, by aggregating results and reviewing by topic, type of agency and geographic area. By looking at patient outcomes in aggregate, we hold ourselves accountable for selecting and funding the most effective agencies. Reports are made quarterly to the Program Monitoring Committee of the Board.

MHM will utilize a similar approach in holding SIF subgrantees and ourselves accountable. We will monitor the progress of each subgrantee toward its goals, and progress of the CI project as a whole. MHM will require quarterly performance measurement and evaluation reporting by subgrantees . Should a subgrantee be off-target on any goal, MHM will provide the TA needed to improve performance.

QUALIFIED ROSTER OF STAFF

MHM's qualified roster of staff demonstrates exceptional experience and capacity. Board members, directors, managers and program staff work together to effectively implement and manage programs. MHM-SIF will utilize existing staff and Board expertise, hire highly qualified staff and work with contracted consultants and volunteer experts. MHM-SIF will be implemented through engagement of 7 functional teams: Subgrantee Selection, Collective Impact, Capacity Building, Evaluation, Financial Management/Compliance, Program Management/Compliance and Subgrantee Sustainability.

KEVIN MORIARTY, CEO, has been a central figure in San Antonio's healthcare and human services for four decades. Moriarty's implementation of the Board of Director's strategy for community health has grown from one program of \$300,000 for 1,100 clients in 1996, to a budgeted expenditure of nearly \$72 million in 2014. In addition, Moriarty oversees the quality and charitable management of the Methodist Healthcare System, of which MHM is half owner, and which consists of 26 health care facilities, with value of over \$2 billion and nearly 8,000 employees. MHM has been recognized by lawmakers as a critical voice and advocate for low-income families and the uninsured. Prior to joining MHM, Moriarty worked for the City of San Antonio for over twenty years, as head of health and human services, economic development, human resources and community action, leveraging funding to serve South Texas. Moriarty received a MS from CUNY in Urban Studies with a concentration in

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public administration and began his career as a Peace Corps Volunteer in West Africa.

ANTHONY LOBASSO, CPA, will join MHM in April 2014 as CFO. Most recently he was Regional VP Finance for Christus Santa Rosa Health System since 2009, where he worked with state and federal healthcare grants. Prior, as Sr. VP Support Services and Administration at University Health System, he managed grant-funded research with UT Health Science Center San Antonio and UHS for 14 years. Lobasso also worked for 10 years in a multinational public accounting firm with experience in state and federal grants including A-133 compliance audits.

PEGGY CARY, CPA, FHFMA, Senior VP of Finance and Internal Audit, recently transitioned to a new position to include a focus on grants compliance after serving as CFO since 1996. Previously, Cary has 12 years' experience in public accounting with Ernst & Young in audit and tax work for non-profit healthcare providers. In 2013, Cary received the Annual San Antonio Business Journal award for Best CFO for Largest Charitable Organization.

Other FINANCE AND ACCOUNTING staff expertise is described below in 2E.

REBECCA BRUNE, VP for Strategic Planning and Growth, oversees MHM's strategic planning, community investments and public policy initiatives. Brune has more than 20 years experience working at local, national and international levels building public-private partnerships to support innovative programming and leverage community investments. As a Woodrow Wilson Fellow, Brune earned a master's degree in public affairs from the Maxwell School of Citizenship and Public Affairs at Syracuse University, and a master's degree in business administration from the Bill Greehey School of Business at St. Mary's University in San Antonio, Texas. Brune will lead the MHM-SIF Collective Impact Team.

ANNE CONNOR, Director of Community Grants & Evaluation, oversees grantmaking, evaluation and fundraising at MHM. In addition to Connor's evaluation expertise, described in section 2C, she also has 15 years experience in development and nonprofit management. She is a Certified Fund Raising Executive, served as United Way's Division Chair for Program Review and is a member of the Association of Fundraising Professionals, the San Antonio Funders' Group, and Grants Management Network. Her degrees are from Dartmouth College and the University of New Mexico. Connor will be

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a key member of the MHM-SIF Evaluation Team and will oversee the Sustainability Liaison, Grants & Research Manager and Project Impact Lead.

KATRIN LUDWIG, Grants & Research Manager, manages the MHM grant portfolio, including application, selection, monitoring and reporting processes. She also oversees the capacity building program. Ludwig holds a bachelor's degree from Northwestern University, a Certificate in Advanced Accounting and is completing a master's in nonprofit administration. She is a member of the Grant Managers Network, Association of Fundraising Professionals and San Antonio Funders Group. Ludwig will oversee the MHM-SIF subgrantee selection process and Program Compliance Team.

EVALUATION expertise of existing staff is described above in 2B. Qualifications of SIF-funded evaluation positions are described in section 4A.

The 30-member BOARD OF DIRECTORS includes one social services and seven medical professionals. The Program Monitoring Committee is responsible for regular monitoring and evaluation of operated programs and funded programs, and recommends grantee funding to the Finance Committee and Board of Directors.

NEW POSITIONS will directly support MHM-SIF and are described fully in 3A Budget Justification.

2E: ABILITY TO PROVIDE FINANCIAL SUPPORT AND OVERSIGHT STAFFING PLAN AND STAFF CAPACITY

MHM is a mature organization with a strategic mix of staff skills, expertise and infrastructure to provide financial support, oversight and management at both the intermediary and subgrantee level. MHM is also unique in that the Board has just this year voted to diversify its funding sources to include federal and foundation grants. As half owner of the Methodist Healthcare System, MHM has developed significant experience as a grantmaker. In 2014, MHM will award \$23 million in grants to approximately 75 organizations that provide more than 500,000 client encounters. Since its inception in 1996, MHM has provided more than \$181 million in 964 grants throughout the regions; it is the largest private funding source for community health care to low-income families and the uninsured in South Texas.

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As such, MHM employs a team of seasoned finance and accounting professionals well versed in funds management and grant management and compliance. The proposed program will expand the MHM grant portfolio from 75 to approximately 90 organizations and increase award expenditures by 80%. Sufficient funds have been requested, and matching funds budgeted, to ensure the quantity and quality of program and financial staff who have the capacity to successfully manage the MHM-SIF at both the intermediary and subgrantee level, and to incorporate subgrantees with fiscal oversight, management and compliance procedures.

The MHM Accounting department consists of CFO, Senior VP of Finance & Internal Audit (described in 2D), Director of Accounting/Controller, Compliance & Accounting Manager, and seven Accountants, including a Grant Accounting Manager. MHM recently added new positions in procurement and grants accounting, and MHM-SIF will add one grant accountant for each of two target regions. Grants Accounting Manager VENESSA MEDINA brings considerable experience managing federal grants, reports to the Director of Accounting/Controller, and with two grant accountants, will be responsible for financial oversight of subaward compliance. Her qualifications include an MBA from University of Texas SA and 4 years of direct management of federal grants. Compliance & Accounting Manager OSCAR DE LUNA has 17 years accounting experience, including grant compliance monitoring at MHM and Austin Independent School District. He holds a bachelor's of business administration from Texas A&M. During 17 years with MHM, Director of Accounting/Controller CINDY MCCLOY has provided oversight of the 964 external grants MHM has awarded. She holds a bachelor's of business administration-accounting from the University of Texas and served on the Board of Directors of the South Texas Chapter of the Healthcare Financial Management Association.

In addition to hiring seasoned finance professionals, MHM is committed to ongoing staff development. This year, MHM's Accounting and Community Grants departments participated in training sessions and conferences on federal grant compliance & reporting, time & effort reporting, Supercircular, and general grants monitoring and compliance. In addition, four SIF staff and a representative from each subgrantee organization will attend federal grants management training.

PLANS FOR ENSURING COMPLIANCE WITH FEDERAL GUIDELINES

Upon award, the Financial Management/Compliance Team will hold a kick-off meeting to review

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approved budget, grant terms, milestones, deliverables, reporting requirements, allowable costs and other federal regulations. As standard practice, MHM enters into formal written agreements with each subgrantee to ensure programmatic, administrative, financial and reporting requirements are met, including those necessary to ensure compliance with all applicable Federal regulations and policies. As mentioned in the previous section, compliance training will be provided to subgrantees.

MHM has in place detailed Internal Controls, which are followed for all grant and subgrant applications, disbursements and reporting. Quarterly reports demonstrate progress on projected goals and deliverables and financial compliance. In-depth variance reports are required in cases of variance beyond set tolerance limits. Summary reports are presented quarterly to the MHM Board's Program Monitoring Committee. Program and budget change requests follow standard criteria and decision-making processes and require written permission. Subgrantee disbursements are contingent upon meeting reporting and documentation requirements; both program and finance staff must approve disbursement requests. To assist with standardization, shared access to information and internal cross-checks, MHM has utilized MicroEdge GIFTS (market leader in grantmaking software) since 2008. The GIFTS database provides access to shared information and uploaded attachments, makes certain requirements conditions of payment, verifies IRS data each time an agency logs in to submit a report or an application, and tracks field audits. MHM reviews the financial health of grantees by reviewing Form 990, operating budgets and audited financial statements, and by requesting written reports on any adverse findings by government agencies or other grant funders.

The MHM-SIF will leverage the solid infrastructure, protocols and approaches for fiscal oversight, which have proven successful for grant management and reporting. MHM has a successful track record in monitoring grants, reporting to the Board and achieving outcomes, and in accordance with federal guidelines and requirements, will ensure federal fiscal compliance and success of the expanded subgrantee program.

COMMUNITY MATCH AND FUNDRAISING CAPACITY

During the 2013 strategic planning session, the MHM Board approved an integrated strategy called Regionalization. The Board also approved a plan for Funding Alternatives, which for the first time in the organization's history includes federal and foundation grantseeking. Regionalization takes a community-wide, or regional, approach to health improvement, with intentional investment in each

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region. Regional collaborative work engages cross-sector stakeholder groups to produce asset maps of the entire region, and utilizes the Collective Impact framework to develop a community solution addressing integrated behavioral health (IBH) and prevention of physical and behavioral health comorbidities.

MHM is committed to achieving IBH outcomes throughout our service region, which includes sharing the fundraising burden of our subgrantees. As described in 2B, MHM has demonstrated a serious commitment to share and successfully overcome the fundraising burden of our subgrantees. As noted in 3B, MHM's commitment to providing the majority of our match from our half ownership of Methodist Healthcare System will allow funds raised by the Funding Alternatives team to generate additional private sector funds to meet MHM and subgrantee match. The Funding Alternatives team is not funded by CNCS or MHM contributions to SIF.

MHM will leverage a range of relationships, from new to well established. Several large national and regional foundations support priorities for integrated care and mental health, including several with which MHM has forged relationships: Kresge Foundation, Meadows Foundation, Hogg Foundation, United Health Plans and others. A major trend in national foundation funding priorities encourages cross-sector collaboration and large-scale social change, a strategy we plan to maximize throughout South Texas. Additionally, the initiative coordinated by the Meadows Mental Health Policy Institute (see 2F) will produce data vital to integrated healthcare implementation. MHM participation with MMHPI will allow our subgrantees access to the latest data, assisting project sustainability and capacity for match. Moreover, MMHPI data will likely be used to inform national funding priorities.

In addition to directing national philanthropic funds to South Texas, MHM also works with local networks of funders and supporters. The Regional Academic Health Center and UT Health Science Center San Antonio align with MHM initiatives to improve health throughout the region. Looking ahead, the new University of Texas Rio Grande Valley, both an undergraduate institution and medical school, will enroll its first class in August 2015. Valley Baptist Legacy Foundation is a new conversion foundation that supports programs that promote healthy lifestyles and increase access to healthcare in Cameron, Hidalgo, Starr and Willacy counties. Their first grant cycle begins July 2014.

Similar to our efforts in RGV, MHM is actively building relationships with corporate and community

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foundations in the Coastal Bend/Corpus Christi (CBCC) region. In June 2013, MHM convened nine CBCC funders to explore impact funding and coordination of our funding priorities throughout the region. As a result of this meeting, MHM has begun laying the groundwork for cross-cutting field building and investment strategies through data sharing with United Way of Coastal Bend Area and Moore Family Foundation. MHM also plans to leverage private sector partnerships related to the Port of Corpus Christi and the region's proximity to Eagle Ford Shale resources. Early conversations have begun with key private sector partners, specifically NuStar Energy Corporation.

MHM holds three South Texas regional meetings per year, each in a different region. These meetings engage local funders, including local United Way chapters, Community Foundations, and family foundations to align priorities and reach common outcomes. Many other partnerships will grow organically from MHM's regional Collective Impact work. In support of this growth and development, the CEO leads an 8-member executive staff team, including the VP for Strategic Planning and Growth. The VP for Strategic Planning and Growth oversees the Departments of Community Grants and Policy & Research. The new Sustainability Liaison, Collective Impact Strategists, Evaluation Specialist, MHM-SIF Project Impact Lead and Capacity Building Specialist will join the Strategic Planning and Growth team. The cross-sector networks established and supported by these team members' efforts will provide subgrantees with ample connections to acquire matching funds.

2F: STRATEGY FOR SUSTAINABILITY

MHM'S COMMITMENT TO INVESTMENT PRIORITIES

MHM is committed to continue our SIF investment priorities in integrated behavioral healthcare (IBH) and prevention of the risk factors of comorbidity beyond the life of this grant. This commitment is demonstrated through our 1) regional strategic plan to build a network of healthcare providers, organizations, policymakers; 2) multi-region, community-driven Collective Impact initiative addressing the need for IBH; and 3) commitment to the priorities of the new Meadows Mental Health Policy Institute of Texas.

(1) One way MHM's regional strategic plan supports SIF investment priorities is by building infrastructure to facilitate integrated care. To improve access and care coordination throughout South Texas, MHM has committed initial start-up costs for all clinical grantees and MHM programs to subscribe to HASAReferrals, a web-based referrals application. The HASA network increases

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connectivity and continuity of care among regional providers, including specialty care.

(2) MHM's Board-approved Healthcare Delivery Redesign, Regionalization and Collective Impact strategic initiatives demonstrate significant commitment to the SIF investment priorities. MHM will initiate cross-sector efforts to increase IBH strategies throughout our service area, beyond the two SIF-targeted regions. Our approach to Collective Impact is inherently community-driven, which builds sustainability by increasing community ownership of priorities and by building networks that outlast the grant timeline.

(3) MHM is a founding partner of the Meadows Mental Health Policy Institute (MMHPI), which formed in 2013 to "provide high quality, nonpartisan and objective policy research and development to improve mental health services in Texas." MMHPI will conduct research to identify evidence-based IBH programs throughout Texas. MMHPI's research will inform our future grantmaking decisions and priorities.

STRATEGY TO ENSURE CONTINUED EVALUATION AND PROGRAM GROWTH

MHM has a comprehensive strategy to ensure subgrantees are positioned to continue evaluation and sustain program growth beyond the life of the grant. This strategy is comprised of 1) subgrant requirements and 2) capacity-building services in evaluation, fund development and program growth.

(1) SIF subgrantees will be expected to work toward participation in their local/regional electronic records-sharing system (also known as an HIE), with higher priority for funding given to those already participating. This expectation is included both for effective implementation and scaling of the intervention and to position subgrantees for fundability at the end of the SIF timeline. Many subgrantees will be eligible for funding under the Medicaid 1115 waiver, which requires HIE membership. By funding participation electronic records-sharing systems (and associated IT upgrades) with SIF subgrants, MHM seeks to support subgrantees' eligibility for this and other funding. Electronic records-sharing also allows for collaboration with additional providers, establishing an infrastructure that will sustain program growth and increase continuity of care.

Subgrantees will also be required to participate in the rigorous MHM-SIF evaluation. Through their participation in its development and implementation, subgrantees will improve their evaluation

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infrastructure, which will last beyond the grant timeline. If not fully developed before award, subgrantees will implement a standardized data-collection system to document financial, operational and clinical outcomes. All evaluation tools created for data collection for the SIF grant will become property of subgrantees for their continued use after grant cessation. Evaluation results will also contribute to program growth as subgrantees will have improved evidence of the effectiveness of their models, useful to pursue funding for scaling and replication.

(2) MHM will provide intensive capacity building to subgrantees, as described in section 3.D. This training will build subgrantees' competencies for participating in rigorous MHM-SIF monitoring and evaluation, which they will retain after the grant. The MHM-SIF Capacity Building Specialist, with a contracted IBH expert will also provide technical assistance to subgrantees regarding administrative and billing best practices for IBH that can result in increased efficiencies and cost-effectiveness. By assisting subgrantees in developing efficient systems, MHM will position subgrantees for continued program growth and competitiveness for funding. The Sustainability Liaison will provide capacity building geared toward sustaining program growth and providing training in fund development practices.

Budget/Cost Effectiveness

3A: BUDGET JUSTIFICATION (* = Evaluation cost)

PERSONNEL

Project Impact Lead: Evaluation lead for MHM-SIF, responsibility for Evaluation Team, including external evaluator, ad hoc member of all other Teams to ensure alignment of SIF goals and activities. Candidate will have master's degree and 7 years experience or bachelor's degree and 10 years in a field such as program evaluation, knowledge management or research and data analysis. Project management skills and evaluation skills will be required and expertise in Collective Impact will be highly preferred. *1.0FTE

Evaluation Specialist will have at least 2 years experience in research or evaluation and college degree that includes background in research and evaluation, outcome measurement or statistics.*1.0 FTE

Director of Community Grants & Evaluation (existing staff) will contribute expertise to MHM and subgrantee evaluation. Brings 11 years MHM and previous evaluation experience.* 0.30 FTE

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Grants & Research Manager (existing staff): Oversee subgrantee portfolio and manage open, competitive subgrant award process; subgrantee reporting processes; and activities of Sustainability Liaison and Grants Management Specialists. 30% time has been allocated to SIF grant management. Qualifications described in 2D.*0.30 FTE

Grants Management Specialists (RGV, CBCC): Manage and evaluate grantmaking, ensure programmatic accountability and compliance, maintain MicroEdge GIFTS database and responsible for subgrantee reporting. Candidates will have bachelor's degree and 3 years grant experience.* 2.0 FTE

Chief Financial Officer (existing staff): Oversee and approve MHM-SIF financial outcomes. Brings 30 years experience outside MHM. 0.10 FTE

Sr. Vice President for Finance and Internal Audit (existing staff): Ensure compliance with audit requirements and overall financial compliance of MHM-SIF. Brings 19 years MHM experience 0.30 FTE

Grant Accounting Manager (existing staff): Fiscal oversight and compliance of MHM-SIF and subgrantees. 30% time allocated to SIF grant oversight with support from two accountants. Qualifications described in 2E. 0.50 FTE

Grants Accountants (RGV, CBCC): Ensure fiscal compliance as directed by Grant Accounting Manager, conduct site visits and audits of subgrantees and assist Capacity Building Specialist to build capacity of subgrantees. Candidates will have bachelor's degree in accounting or business administration and five years experience in general accounting/finance. 2.0 FTE

Vice President for Strategic Planning and Growth (existing staff): Oversee and direct regional collective impact efforts. Brings more than 20 years national and international experience. 0.3 FTE

Collective Impact Strategists (RGV, CBCC): Cultivate and sustain cross-sector alignment with government, elected officials, nonprofit, philanthropic and corporate sector partners to achieve large-scale community change, define and execute CI strategies in RGV and CBCC regions. Candidates will

Narratives

have bachelor's degree in public health, human services, public administration, political science, health care, education or related field and 10 years experience in policy analysis, community development, health or human services or master's degree in related field with 7 years experience. 2.0 FTE

Capacity Building Specialist: Provide and arrange capacity building services to SIF subgrantees on range of topics needed for organizational effectiveness, program growth and sustainability. Qualifications include bachelor's degree, 3 years nonprofit experience, experience in strategic planning, board development, program development and program evaluation planning. 1.0 FTE

Sustainability Liaison: Provide technical assistance and capacity building to subgrantees in areas of fund development techniques to ensure sustainability of program growth. Note: SL will not actively raise funds for subgrantees or MHM. Qualifications include knowledge and experience in prospect management, research, proposal writing and fund development. Position will require bachelor's degree and 5 years experience in development professional position. 1.0 FTE

Support staff (IT, Communications, Administrative and Research): Industry-standard qualifications. Technical Services Manager (existing staff): Contribute expertise to IT at MHM and subgrantee level, including oversight of IT personnel.* 0.10 FTE

IT Systems and Data Security Analyst (existing staff): Ensure data systems functionality and security across and among networks for MHM and subgrantees.* 0.30 FTE

IT Systems Analyst: Support IT integration and functionality of network and IT resources for MHM and subgrantees; sustain implementation of IT solutions generated by SIF subgrantees.*1.0 FTE

Administrative Assistant: Support day-to-day operations of MHM-SIF; typical administrative duties such as receptionist, travel arrangements, submitting reimbursements. 1.0 FTE

Research Intern: Provide research assistance to Project Impact Lead, Evaluation Specialist and Sustainability Specialist in support of subgrantee program growth and development.*0.50 FTE

Narratives

Contracted consultants include FSG (role described in 1A), IBH expert (role described in 1B.d) and external evaluator (role described in 1B.b). Subgrantees will contract with external evaluators. External reviewers will be recruited with expertise in behavioral health, primary care, IBH, evaluation.

TRAVEL: Lodging calculated using GSA rates plus 7% local tax for Rio Grande Valley region, 9% for Corpus region and 10.75% for San Antonio, and excludes 6% state tax. Per diem calculated using standard GSA rates. Mileage calculated using current IRS rate of \$0.56/mile. For SIF National Meeting, actual costs are estimated.

SIF National Annual Meeting \$9,452

(Estimated for 4 personnel at \$2,363 each = \$9,452)

MHM-SIF Subgrantee Learning Community Conferences: 2 @ \$15,584 = \$31,168*

Estimate 16 subgrantee organizations, 2 people per organization, 2 meetings per year, 2-day conference requires 1 overnight stay per conference, catering expense calculated in Other section below.

From CBCC 16 travelers @ \$327 = \$5,232

(Mileage \$160; Lodging 1 night @ \$122; M&IE breakfast \$11 and dinner \$34)

From RGV 16 travelers @ \$647 = \$10,352

(Airfare and ground transportation \$480; Lodging 1 night @ \$122; M&IE breakfast \$11 and dinner \$34)

SIF Personnel travel to sites: \$113,787

Distance to Corpus Christi is approximately 285 miles round trip; therefore, estimates include mileage reimbursement. Distance to Harlingen (Rio Grande Valley) is approximately 520 miles round trip; therefore, estimates include airfare.

Application workshops for potential applicants \$2,203*

Project Impact Lead and Community Grants and Research Manager will make 1 trip to each of 2 regions to present the subgrant opportunity. Includes refreshments for 75 attendees @ \$3 per attendee = \$225

Narratives

CBCC 1 trip x 2 people @ \$317 = \$634

(Mileage reimbursement \$160; Lodging 1 night @ \$106; M&IE 1 day @ \$51)

RGV 1 trip x 2 people @ \$672 = \$1,344

(Airfare and ground transportation \$525; Lodging 1 night @ \$91; M&IE 1 day @ \$56)

Application Site Visits by Project Impact Lead, VP Strategic Planning and Growth, Community Grants and Research Manager and Grants Accounting Manager for subgrantee selection process \$11,200

Estimate 2 trips per region at 3 days each for 4 people.

CBCC 2 trips x 4 people @ \$525/trip/person = \$4,200

(Mileage reimbursement \$160; Lodging 2 nights @ \$106 = \$212; M&IE 3 days @ \$51 = \$153)

RGV 2 trips x 4 people @ \$875/trip/person = \$7,000

(Airfare and ground transportation \$525; Lodging 2 nights @ \$91 = \$182; M&IE 3 days @ \$56 = \$168)

Project Management & Evaluation assistance for subgrantees \$26,496*

Estimate 6 trips per region at 3 days each for 3 people. Project Impact Lead, Evaluation Specialist and VP Strategic Planning and Growth. Minimal snacks budgeted for 432 @ \$3/person = \$1,296

(16 organizations x 9 people at each meeting x 3 meetings/organization/year = 432)

CBCC 6 trips x 3 people @ \$525/trip/person = \$9,450

(Mileage reimbursement \$160; Lodging 2 nights @ \$106 = \$212; M&IE 3 days @ \$51 = \$153)

RGV 6 trips x 3 people @ \$875/trip/person = \$15,750

(Airfare and ground transportation \$525; Lodging 2 nights @ \$91 = \$182; M&IE 3 days @ \$56 = \$168)

Subgrantee Learning Community Meetings, CI/Capacity Building Activities and Training Workshops.

Estimate 4 community meetings, 4 CI activities, and 6 training activities per region. \$34,128

4 Large Community meetings include 4 people per trip: CI Strategist, Project Impact Lead, VP Strategic Planning and Growth and Sustainability Liaison.* Minimal snacks for 50 people per meeting @ \$3 = \$600

CBCC 2 trips x 4 people @ \$368/trip/person = \$2,944

(Mileage reimbursement \$160; Lodging 1 night @ \$106; M&IE 2 days @ \$51 = \$102)

Narratives

RGV 2 trips x 4 people @ \$728/trip/person = \$5,824

(Airfare and ground transportation \$525; Lodging 1 night @ \$91; M&IE 2 days @ \$56 = \$112)

6 Focused Cross-Sector Collaboration Meetings \$26,304

Estimate 6 trips per region for 4 people each trip to include Project Impact Lead, Sustainability Liaison, Regional CI Strategist and VP of Strategic Planning and Growth

CBCC 6 trips x 4 people @ \$368/trip/person = \$8,832

(Mileage reimbursement \$160; Lodging 1 night @ \$106; M&IE 2 days @ \$51 = \$102)

RGV 6 trips x 4 people @ \$728/trip/person = \$17,472

(Airfare and ground transportation \$525; Lodging 1 night @ \$91; M&IE 2 days @ \$56 = \$112)

4 Collective impact activities include 5 people per trip: Project Impact Lead, Regional CI Strategists, and VP Strategic Planning and Growth, plus Capacity Building Specialist, Sustainability Liaison, Grants Management Specialists, Grants Manager, or Grants Accounting Manager. Minimal snacks for 50 people per meeting @ \$3 = \$600

CBCC 2 trips x 5 people @ \$368/trip/person = \$3,680

(Mileage reimbursement \$160; Lodging 1 night @ \$106; M&IE 2 days @ \$51 = \$102)

RGV 2 trips x 5 people @ \$728/trip/person = \$7,280

(Airfare and ground transportation \$525; Lodging 1 night @ \$91; M&IE 2 days @ \$56 = \$112)

6 Training activities to build capacity and teach new skills include the Project Impact Lead plus two other people, according to the topic.* Minimal snacks for 20 people per meeting @ \$3 = \$360

CBCC 3 trips x 3 people @ \$368/trip/person = \$3,312

(Mileage reimbursement \$160; Lodging 1 night @ \$106; M&IE 2 days @ \$51 = \$102)

RGV 3 trips x 3 people @ \$728/trip/person = \$6,552

(Airfare and ground transportation \$525; Lodging 1 night @ \$91; M&IE 2 days @ \$56 = \$112)

Subgrantee Program Audits & Evaluation \$8,400*

Estimate 16 subgrantees require one program audit per subgrantee per year by Project Impact Lead, Evaluation Specialist and VP Strategic Planning and Growth. 2 trips per region, 3 days each for 3 people

CBCC 2 trips x 3 people @ \$525/trip/person = \$3,150

Narratives

(Mileage reimbursement \$160; Lodging 2 nights @ \$106 = \$212; M&IE 3 days @ \$51 = \$153)

RGV 2 trips x 3 people @ \$875/trip/person = \$5,250

(Airfare and ground transportation \$525; Lodging 2 nights @ \$91 = \$182; M&IE 3 days @ \$56 = \$168)

Financial Audits \$8,032

16 subgrantees require 2 financial audits per subgrantee per year by audit teams (manager & regional accountant).

CBCC 2 trips x 2 people @ \$839/trip/person = \$3,356

(Mileage reimbursement \$160; Lodging 4 nights @ \$424; M&IE 5 days @ \$51 = \$255)

RGV 2 trips x 2 people @ \$1,169/trip/person = \$4,676

(Airfare and ground transportation \$525; Lodging 4 nights @ \$91 = \$364; M&IE 5 days @ \$56 = \$280)

EQUIPMENT

Workstations for new employees 11 @ \$6,750 = \$74,250.

SUPPLIES

Software Licenses \$92,275

Additional licenses for GIFTS 6 licenses @ \$3,250 = \$19,500*

SAS Visual Analytics 10 licenses (smallest package available) @ \$45,000*

Angoss KnowledgeSEEKER 9.0 CHAID analysis software 3 license package = \$24,995*

Bizinsights License 4 @ 495 = \$1,980

eRequester License 4 @ \$200 = \$800

See 1B.b: Budget for Evaluation for detailed explanation of uses for software

Software Upgrades \$34,882

MicroEdge GIFTS Upgrade with Alta Blueprint \$34,882*

Networking for new employees: \$25,788

Cisco 2911 Router \$1,700

Cisco 3560 Switch \$3,275

Narratives

Cisco 3502 WAP \$837

Remote site AD server 1 @ \$3,500

Network connectivity: \$1,100/mo. \$13,200

Printer-Leased: \$273/mo. \$3,276

Computer Equipment \$35,280

Desktop/Laptop/Tablet Computers with software for new staff and intern positions 13 @ \$2,310 = \$30,030. Portable devices allow accurate remote evaluation data entry; web only, no data.

Tablet Computers for existing staff to conduct SIF work in field 7 @ \$750 = \$5,250

Publication/Education Materials \$25,000

Estimate \$25,000 to support MHM-SIF program & subgrantees, including printed and online education materials and program documents

Office Supplies \$9,650

For new employees 11 @ \$750 = \$8,250

MHM-SIF Subgrantee Learning Community Conferences (supplies): 2 @ \$700 = \$1,400

CONTRACTUAL AND CONSULTATION SERVICES

FSG \$898,260*

A recognized leader in collective impact (CI), FSG has led efforts to create successful social change, most recently in Texas' Rio Grande Valley (RGV) to increase post-secondary graduation rates. Drawing on synergies in place, FSG will assist MHM in collecting, analyzing and synthesizing RGV data on health outcomes to identify strengths, gaps and opportunities. FSG will map the landscape of need and cross-sector players with a role in delivery of health care services. Through this process staff will learn critical components required of successful CI projects and operationalize CI framework as a core driver in MHM operations.

External Evaluation/Research Contract \$850,000*

Factors affecting evaluation cost: existing population level data available, will conduct data analysis and interpretation using sophisticated statistical methods, and disseminate deliverables. High degree of technical expertise required. Internal utilization of findings and external communications included in

Narratives

Personnel budget. Travel required; multiple sites in two neighboring regions of South Texas; distance between sites ranges 230 to 550 miles round trip. Subgrantees required to include additional evaluation costs in subgrantee budget requests to increase use of evaluation findings in decision making. Additional MHM financial resources may be available for evaluation in subsequent years.

Additional support for subgrantee evaluation \$160,000*

These funds allocated based on subgrantee capacity assessments. We anticipate many subgrantees will require assistance to build healthcare informatics capacity, including specific training in health informatics and consultation for EMR configuration for accurate reporting. Estimate 16 subgrantees @ \$10,000 each in Year 1.

External Integrated Behavioral Health (IBH) Expert \$21,600

Contracted IBH specialist will provide resources and consultation on logistical and programmatic issues related to scaling IBH systems, such as billing procedures, legal frameworks and other implementation. Estimated at 240 hours @ \$90/hour.

Web development and communications \$13,699*

Internal and external communications about MHM-SIF, including cost of public-facing SAS Visual Analytics dashboard and development of SIF online interfaces, group space, file sharing network, constituent and project management \$13,500. Increase Vimeo contract for video communications about MHM-SIF and for SIF capacity building modules \$199/year.

TRAINING \$45,300

Data Mining with KnowledgeSEEKER on-site 2 day training \$6,000*

SAS Visual Analytics on-site training 1 day @ \$5,000*

Online training for Angoss KnowledgeSeeker 9.0 CHAID analysis software \$2,700*

GIFTS Training Session \$1,600 (additional online training no cost)*

Federal Grants Management Training for 4 SIF staff and 1 representative from each subgrantee organization 20 @ \$1,500 = \$30,000

OTHER COSTS

Subgrants \$16,000,000: Distributing approximately \$16m annually to 15-20 subgrantees at \$250,000

Narratives

to \$2m each. Subgrantees will be required to include evaluation costs for evaluation of individual projects

Cost of audit \$20,000: Quote provided by MHM auditor, Padgett Stratemann

Criminal history checks \$550: Required criminal history and background checks 11 @ \$50 = \$550

MHM-SIF Subgrantee Learning Community Conferences (other costs) \$6,468

Conference meals for participants and presenters include Day 1: lunch \$16, dinner \$34. Day 2: breakfast \$11, lunch \$16 = 42 @ \$77 x 2 conferences = \$6,468

Office space \$192,500

Leased space for 11 new SIF employees includes office rental (3,000 sq ft x \$22.50/sqft annual) \$67,500

Renovations-one time cost \$125,000

Phones \$14,149

Office phones for new SIF staff positions 11 @ \$239 = \$2,629

Mobile phones for full time SIF staff 12 @ \$80 x 12 = \$11,520

Administrative Costs Provisional F&A rate by HHS at 10% of personnel budget only = \$97,810.

Entered as direct costs per CNCS instructions.

EVALUATION COSTS

Evaluation costs indicated by asterisk, include items directly related to evaluation totaling \$2,523,519, approximately 13% of total budget.

SOURCE OF MATCHING FUNDS

MHM Previously Undesignated funds \$8,000,000

Meadows Foundation commitment \$250,000

Other anticipated foundation commitments \$1,750,000

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3B: DESCRIPTION OF MATCH SOURCES & CAPACITY

We have provided evidence in our match verification letter of \$8,000,000 in cash on hand. MHM has secured a commitment for \$250,000 from The Meadows Foundation, and is in conversation with The Kresge Foundation and United Health Plans for similar commitments. Our plan to secure the total match commitment and to satisfy the match in future years relies on our half ownership of the Methodist Healthcare System (MHS) and our Funding Alternatives strategy, described in 2E (fundraising activities take place outside SIF budget and match as required by 2 CFR 230).

Our half ownership of MHS provides predictable, unrestricted funds that will be used for the majority of MHM's match. We anticipate \$8,000,000 to be allocated for SIF match each year through our budget process. This significant commitment from MHM will allow the majority of funds garnered through our Funding Alternatives initiative (see section 2E) to be used to assist subgrantees in securing their required match. The Sustainability Liaison will be dedicated to this task and will build subgrantees' capacity by brokering relationships with funders and providing training in fund development.

Clarification Summary

Responses to Clarifying Questions

1. If our budget decreased by 50%, we would focus our efforts in one region instead of two; therefore, we would go from 25 counties to 12. Specifically, we would work with the Rio Grande Valley (RGV) and postpone rollout of the Coastal Bend region. The reduced program would engage about half as many subgrantees: approximately 8 instead of the proposed 16 subgrantees.

We would hire approximately half as many staff to support the project, specifically:

Where we had planned to hire two people to help monitor subrecipients, one for RGV and one for Coastal Bend, we would instead hire one grant management specialist for RGV. We would take a similar approach with regard to the grant accountant positions, one for RGV instead of two for both regions.

We had planned to hire two collective impact (CI) strategists, one for each region. The CI strategist position for Coastal Bend would be postponed. Evaluation is key to this program; therefore, we would

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maintain the evaluation specialist role. If necessary, we would consider leveraging another funding source for the CI strategist for RGV. Instead of hiring a separate capacity building specialist, we would consider incorporating capacity building duties into the grant management specialist, grant accountant and collective impact strategist positions.

We would consider not hiring additional IT staff and instead current staff would assume any additional tasks.

Other budget cuts could include: We could forego the upgrade to the GIFTS system but would still need two additional licenses for the existing system, to accommodate new staff. Fewer new staff members mean we could forego new workstations and could reconfigure workstations to combine spaces for existing staff with new hires. For the same reason, we would not need networking or additional computers.

2. The FSG contract was signed on May 16, 2014 and the project officially launched June 2014 with a one-year timeline. The consulting costs total \$898,260. Co-funding in support of the contract by the Meadows Foundation and Meadows Mental Health Policy Institute was secured May 2014. The scope of the FSG contract is to provide guidance on implementing the collective impact framework with high fidelity to the model, in the following four counties: Cameron, Hidalgo, Starr and Zapata, which comprise the Lower Rio Grande Valley (LRGV).

With SIF support, we will implement the collective impact framework in 21 additional counties in the Rio Grande Valley (RGV) and Coastal Bend regions. This will be accomplished by using what we learn from FSG and the products we develop to engage the other counties as well. This process will be simultaneous, not linear (i.e. while FSG is working in the LRGV's 4 counties, our CI Strategists will adapt and model FSG's activities for the broader RGV region and the Coastal Bend region).

3.a. An evaluation of the CI model is not currently in place. We are putting in place shared metrics and a data management infrastructure which will be used to measure the progress of the initiative and could provide inputs to an evaluation but do not themselves constitute an evaluation. If there were to be an evaluation of CI at a later date, it would not be done by FSG. Formative and summative evaluations are not well-suited for the early stages of CI, but we have seen development evaluation

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conducted which may merit consideration for our work. In all cases, contractors will be hired by and report directly to MHM, not to FSG.

3.b. MHM plans to evaluate all proposed subgrantee IBH models to target a moderate level of evidence. MHM will contract and pay for the third party evaluator following federal procurement regulations. Evaluation contractors will report directly to MHM, not to FSG. The current estimated expenses related to evaluation total just over 15% of the subgrantee budget. If necessary, we would consider reallocating or leveraging funds to increase this commitment.

4. MHM has been working as a trusted partner with South Texas communities for 17 years. MHM and partner organizations have used many of the collective impact strategies informally. We officially launched the Collective Impact strategy in July 2014.

From September to December 2014, we will identify and map assets, conduct gap analysis, identify key players (who may become subgrantees), hone the area of focus and make the case for change. Six to 7 community meetings will take place during this Initiate Action phase. From January to March 2015, the common agenda will be set, vision established and shared metrics defined and aligned. April to May 2015 will establish the backbone organization. June and July 2015 will finalize the transition to the community-based backbone. SIF Subgrants will be awarded in April and start dates are May 1, 2015. The first quarterly reports will be due in August 2015 to verify all subgrantees are up, running and ready for evaluation.

An Infrastructure for collaboration (systems change and CI work) already exists in the region. Many collaborative efforts are underway in the RGV region, including a successful two-year CI project focused on increasing postsecondary attainment with Educate Texas serving as the backbone organization; LRGV Development Council (a council of local governments), RGV LEAD (an economic development initiative), and University of Texas Rio Grande Valley Medical School (combining 4 regional university campuses). The Dean of the newly formed UT-RGV Medical School has agreed serve as a member on our core leadership and strategy group to help grantmaking achieve sustainability. These and other efforts have leveraged potential partners, including the Marguerite Casey, Ford and Bill and Melinda Gates Foundations.

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5. Hispanic populations are not new to MHM. We offer a great deal of experience adopting models for Hispanic populations and working with Hispanic communities. Hispanics/Latinos account for 76.6% of the proposed 25-county target region's population. In the 12-county RGV region, about 90% of the total population is Hispanic, and in the LRGV, Hispanics comprise an even greater proportion of the population. MHM employees have delivered direct services and worked with non-profit organizations throughout South Texas for the past 17 years. In fact, about two-thirds of MHM's employees are Hispanic, mirroring the majority-minority population of our nation's seventh largest city, San Antonio, where MHM corporate office is located. MHM not only brings culturally and linguistically relevant expertise to bear on the proposed project; we are also poised to offer support and mentorship to other SIF intermediaries. In a 2013 report, "Mapping the Latino Population," the Pew Research Center noted that "Latino population growth between 2000 and 2010 accounted for more than half of the nation's population growth" and is expected to double by 2050.

MHM currently supports several organizations implementing IBH models successfully in the proposed service area and there are many others that have not yet received MHM support but are implementing successful IBH models. For example, Community Health Centers of South Central Texas (CHCSCT), in collaboration with the local MHMR (Bluebonnet Trails), has been identified as a "Level 5" on the IBH continuum (highly integrated). Gateway Community Health Center, Hope Family Health Center and Nuestra Clinica del Valle in Rio Grande City, Mercedes, Alton-Memorial, and San Juan are operating at a current integration Level 4. Atascosa Community Health Center, El Milagro Clinic and Brownsville Community Health Center operate at Level 3. Both Level 3 and 4 are considered moderate levels of integration. As part of the subgrantee selection process, applicant readiness will be assessed along this continuum.

Other organizations that may be assessed in the 25-county area include Amistad Community Health Center, Community Action Corp of South Texas, Corpus Christi Metro Ministries, Mercy Ministries of Laredo, Migrant Health Promotion, Mission of Mercy, Su Clinica, Timon's Ministries, Valley Aids Council, Valley Primary Care Network and others. In 2013, more than 20 Medicaid 1115 Waiver proposals in the target region related to IBH interventions. A 2008 UT Hogg Foundation for Mental Health survey of community health centers, Mental Health and Mental Retardation (MHMR) centers and related organizations found that 62% of respondents were implementing integrated strategies.

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6. MHM grantees are located throughout a 74-county, 82,595 square-mile service area, many in rural, frontier and border counties. We have successfully provided training to broadly distributed grantees using screencasts (videos that simulate workshops) and electronic materials. We will use this method to assist SIF subgrantees in complying with federal requirements. This information will be reinforced during in-person group and individual trainings and distribution of written materials. All potential subgrantees will have completed risk and capacity assessments. Agencies that are already familiar with or have had to comply with federal requirements will be a consideration for funding. A comprehensive grant administration manual is currently in development and will be shared with all subgrantees in hard copy and located on our website.

7. MHM staff paid by a federal sponsor are prohibited from engaging in lobbying or advocacy work. MHM produces annual reports on lobbying activities for the Texas Ethics Commission and the IRS. These reports incorporate logs of all staff activities classified as lobbying, and time spent on them. These logs will be cross-referenced against the roster of SIF-paid staff to verify that there is no overlap. Both the RFP and the subaward contracts will specify that subgrantees must not use SIF funds for lobbying or advocacy work. Verbal presentations, both in-person and via screencast, will reiterate the prohibition of using federal funds for lobbying and advocacy work. The Policy department offers a more advanced training course for employees and community members who want to learn more about lobbying and advocacy guidelines, including federal rules. The MHM Onboarding Program includes a presentation by the Policy department. This presentation includes an explanation of lobbying and advocacy work and makes clear which employees are permitted to engage in these activities. Lobbying and advocacy rules, including rules specific to federally-paid employees, are included in the employee handbook of operating procedures.

8. The project title will be *Sí Texas: Social Innovation for a Healthy South Texas*
In Spanish, *sí* means yes.

9. COMMON AGENDA: Those responding to the RFP will commit to the common agenda of improving community health through integrated behavioral health care. Common agenda will be fine-tuned through community meetings in the months leading up to the RFP process.

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SHARED MEASUREMENT: The RFP will require that all applicants submit proposals based on evidence-informed or evidence-based practices. Specific, shared, measurable objectives will be agreed upon through facilitated community meetings, and tracking those results will be a condition of funding. Results will be reflected back to all participants through visual analytics embedded in our web site and graphics and reports e-mailed to all subgrantees. Regular steering committee meetings will feature these results and create a culture of accountability. After the first three months of subgrantee operations, we will begin collecting quarterly data on shared measurements.

MUTUALLY REINFORCING ACTIVITIES: Selection of subgrantees will take into account how all activities will contribute to collective impact goals. We will utilize a strategy map (created during the Initiate Action stage) that organizes the project into the categories of: Community Assets; Processes and Learning; Community Implementation; Outcomes. Participant activities will be categorized under Community Implementation and mapped to show how activities fit together and where gaps still exist.

CONTINUOUS COMMUNICATION: Regular community meetings will facilitate effective communication, trust building, motivation and accountability. In addition to meetings, we will use regular e-mail and web site communications. Through the web site, one will be able to track overall project progress, with the ability to drill down by topic, community, subgrantee agency and outcome type. We will create a blog and landing page for our Collective Impact (CI) work. Other groups providing different levels of communication include: Core Group (the strategy team); Steering Committee (community stakeholders maintaining shared vision); and Organizational Working Group (MHM key leadership and staff to facilitate and manage collective impact process).

SUSTAINABILITY: MHM will coach, train and support subgrantees in how to develop infrastructure and plan for sustainability. MHM selected the following organizations to be a part of the CI Leadership and Core Groups, to build sustainability and community investment: Meadows Mental Health Policy Institute (investing over \$20 Million in evidence based IBH programming and research statewide over the next 10 years, to inform changes to public policy and build provider capacity); the Meadows Foundation (committed to providing \$10 Million in grants to organizations operating evidence-based IBH programs); and the UT-RGV Medical School, which plans to start an IBH residency, with placements at FQHCs funded and in partnership with MHM.

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EVALUATION AND ACCOUNTABILITY: MHM is committed to continuous process improvement and to using data to inform strategic decision making. We realize the importance of evaluation in assuring that the right community solutions will be achieved. MHM will engage an evaluation consultant and hire additional staff skilled in evaluation. We will analyze results using SAS analytics. We will isolate causal effects through CHAID analysis and other statistical tests. We anticipate that interaction effects will be of paramount importance in an approach as complex as Collective Impact. Lastly, a key reason MHM hired FSG to guide us through the CI model and process was to assure MHM puts into place the internal evaluation infrastructure needed to launch and sustain future CI initiatives throughout our 74 county area, as a means to large scale innovation and systems change work.

BACKBONE: Initially, MHM/FSG will perform the backbone function until a community-based backbone organization is fully in place. In the 4-county area covered by FSG's contract, this work will be performed jointly by MHM and FSG. Separate, complementary roles are outlined by a Table of Initial Backbone Duties. In the other 21 counties, MHM will serve as initial backbone. We will transition the backbone role as soon as is practicable and before the beginning of Year 2. The Steering Committee will not at any point perform the functions of a backbone. FSG has extensive experience in supporting others (including Educate Texas) to build capacity and transition backbone functions to local backbone organizations. By working jointly in the 4-county Lower Rio Grande Valley region, FSG will build MHM's capacity for this work in the other 21 counties.

Transitioning the Backbone:

Two distinct processes relate to the strategy for transitioning the backbone role by Year 2.

a. Backbone Selection: The steering committee will determine the process through which the backbone organization is selected. FSG will support the process, but will not participate in selecting the backbone. Selection will be based on a set of criteria determined by the steering committee, such as capacity and potential for sustainability. Backbone selection should occur after the common agenda and shared metrics have been finalized by the steering committee. Past initiatives have successfully used an RFP, with selections made in phases by a subcommittee and then the full steering committee.

Narratives

b. Capacity Building and Transition: This process begins in earnest once local backbone staff have been hired or identified. The initial backbone organization works closely over a period of months with local backbone staff to hand over materials, provide context and background, educate in collective impact methodologies and approaches, and ensure that the local backbone is positioned for success. Backbone transition is not done as a separate, discrete process, but rather takes place through the daily work of establishing and managing workgroups, developing the measurement system, managing the steering committee and the other critical tasks of the backbone. Over the months of the handover, the initial backbone takes less and less of the lead in these processes and transitions it to the backbone while providing the backbone with the necessary support. The transition typically requires 3 to 6 months, depending on how familiar the local backbone staff is with the collective impact process.

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Budget Issues for Clarification

Supplies: The \$6,750 includes desk, filing, storage, cubicle dividers and chairs. No computers. Also noted in Item/Purpose column under Equipment section in e-grants budget form.

Contractual Services: Calculations have been added to the Calculation column in the Contractual Services section in the e-grants budget form.

Other Costs: Calculation has been added to the Purpose column in Other Costs section in the e-grants budget form.

Criminal History Checks: Budget form has been amended to reflect new calculation: increased from 11 new personnel to 21 all SIF personnel.

Continuation Changes

N/A