

# Narratives

## Executive Summary

Mayor's Fund to Advance New York City

Lead intermediary: Mayor's Fund to Advance New York City (MF)

Partners: Center for Economic Opportunity (CEO) and NYC Department of Health and Mental Hygiene (DOHMH)

Geographically-based SIF (Healthy Futures)

Grant amount and period: \$2M for Year 1; \$6M for three years

The Mayor's Fund to Advance New York City (MF), an existing grantmaking institution, and its local government partners the Center for Economic Opportunity (CEO), and the NYC Department of Health and Mental Hygiene (DOHMH) (the Collaborative), propose a geographically-based Healthy Futures initiative to meet widespread unmet mental health needs by delivering services at New York City community based organizations (CBOs) already serving at-risk individuals. Through this initiative, CBOs will integrate a model of evidence-based mental health interventions into their existing programming through training, coaching, and co-location of mental health services with other social services. The project will include a rigorous evaluation to demonstrate the effectiveness of this strategy for organizations in New York City serving low-income and high-risk populations that often suffer from undiagnosed and untreated mental illness.

Timely access to mental health services is critical in preventing the negative effects of mental illness. Increased awareness, intervention, service coordination and support, and the reduction of barriers remain the most highly recommended course of action in treating and supporting individuals with mental illness, and new delivery models are needed to achieve this (Health Management Associates 2011). These models need to expand the capacity of non-mental health providers to adopt mental health skills and capabilities that enable them to offer initial steps in a chain of care. Such alternative settings for care reach groups that are particularly vulnerable to common mental disorders, and may be more credible and accessible initial sources of care to them.

Connections to Care (C2C)

The Collaborative's SIF initiative, Connections to Care (C2C) will reach high-risk populations by supporting the integration of evidence-based mental health services into social service CBOs. In this geographic-based SIF initiative, subgrantees will apply as CBO and licensed mental health provider

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(MHP) partnerships to enable a package of evidence-based mental health practices to be part of CBO staff routine work and skills. CBO staff will be trained to provide a minimum package including: screenings for common disorders, motivational interviewing, mental health first aid, and psycho-education. While all partnerships will utilize the same core practices, the model is flexible and adaptable to allow the partnerships to tailor the services to the populations they serve. The MHP will support and mentor the CBO in their use of these practices, and together will implement protocols to apply the set of services, and linking the practices with escalated referrals and integration with the more specialized services of the MHP partner. C2C will be rigorously evaluated for impact on health indicators, CBO program outcomes, the CBO's organizational capabilities and partnership, and related cost/spending.

The MF requests \$2M for the first SIF year, with the initial three-year award totaling \$6M. The proposed project spans five years. MF expects to request continuation funding of an additional \$4M for years four and five. Intermediary match funding provided in the first year will total at least \$2M to match the federal award. Partners anticipate subgrantees will need to raise an additional \$2.1M per year to match subgrant awards. Major sources of match funding include philanthropic partners the Perelman Family and Chapman Perelman Foundations, Benificus Foundation, and the Mayor's Fund to Advance NYC. In addition, CEO will invest resources from its city tax levy-supported Innovation Fund in C2C. The proposed budget is well-aligned with the replication and evaluation plans as it is grounded in the collaborators' direct experience in NYC and elsewhere. The total annual project budget will be \$6.5M for the first SIF year, or approximately \$32.5M over the five year initiative.

Citation:

Health Management Associates 2011, <http://www.ttbh.org/Documents/BudgetCutsCommunity.pdf> &#8195;

### Program Design

#### B1: RATIONALE AND APPROACH

Although roughly 10 million people in the US suffer from mental illness, certain vulnerable populations have higher rates and patterns of unmet needs, and are at higher risk of suffering the consequences of inadequate access to and low uptake of care (Szabo 2014). The Surgeon General reports the unmet need for mental health services is greatest among traditionally underserved groups, including elderly persons, racial/ethnic minorities, those with low incomes, and those without health

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insurance (Kessler, Berglund, Demler, Jin, Merikangas, Walters 2015). These subgroups are often in most need of successful connections to care, but also are among the hardest to reach. (CDC 2013). The burden of unmet mental health needs is not only devastating to individuals who suffer with mental illness; it is also a preventable strain on the national economy. In 2002, the Centers for Disease Control and Prevention placed the economic burden of mental illness in the United States at \$300 billion (CDC 2011).

Many clients connected to social service organizations are not successful because mental health challenges undermine their motivation or functional capabilities. To improve the rate of successful outcomes for social service clients and address their unmet mental health needs, the Mayor's Fund to Advance New York City (MF), the Center for Economic Opportunity (CEO) and the NYC Department of Health and Mental Hygiene (DOHMH) ("the Collaborative") propose to integrate a discrete set of mental health services directly into social service programming, where clients are already engaged, through an innovative model called Connection to Care (C2C).

Rather than seek treatment, social service clients often do not access traditional mental health services for a variety of reasons: they perceive a stigma to mental health counseling, they do not trust unfamiliar mental health providers, or the mental health services are not available or are unaffordable. Unmet mental health needs reduce the effectiveness of CBO work in other areas, increase costs of mental and physical health care, and make it more difficult for CBOs to achieve other outcomes for participants. There is substantial evidence that individuals need to be in good mental health to reach higher educational levels, maximize their work and earnings, develop strong interpersonal relationships, and maintain their physical health (World Health Organization 2010; RAND 2014), and that mental health prevention and intervention programs can help reduce non-academic barriers to learning, leading to the academic gains (Dix, Slee, Lawson, & Keeves 2012; Massey, Armstrong, et al. 2005).

In New York City, 41 percent of adults reported in 2012 that they did not receive needed mental health treatment over the previous year (NYC Department of Mental Health and Hygiene 2012). It is estimated that each month 34,000 (5.3 percent) adult New Yorkers experience serious psychological distress, with higher prevalence among low income individuals, the uninsured, and those on public insurance (NYC Department of Mental Health and Hygiene 2013). Of adults, 267,000 individuals (4.2 percent) report that their mental illness interferes with their life or activities--and among these

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individuals, 27 percent reported that they did not receive the treatment they needed in the past year (NYC Department of Mental Health and Hygiene 2013). In NYC, issues arising from unmet mental health needs are the sixth leading cause of hospitalizations (St. John's Episcopal Hospital 2014). NYC has a significantly lower provider ratio of mental health providers when compared to New York State, at 26.6 compared to 42.1 mental health providers for every 100,000 individuals (Mount Sinai Hospital 2013).

City government has been exploring new ways to meet these needs. DOHMH organized Stakeholder Listening Sessions across all five boroughs of New York City to share its proposed Take Care New York 2016 agenda and gather feedback on improving existing health interventions and employing novel approaches to achieve public health goals. Stakeholders cited integration of mental health services into existing services as a top priority in the Take Care New York 2016 agenda (NYC Department of Health and Mental Hygiene 2013). On January 28th, 2015, New York City First Lady Chirlane McCray, together with the Mayor's Fund to Advance New York City and the NYC Department of Health and Mental Hygiene (DOHMH) launched an effort to develop a New York City Mental Health Roadmap to better coordinate care and address the need for a comprehensive, unified approach to mental health services. As a result of these and other efforts, the Collaborative has developed the proposed initiative.

The proposed Connections to Care (C2C) aims to improve access to mental health care for low-income populations. In C2C, nonprofits will partner with mental health providers to address unmet mental health needs, adopting a package of four evidence-based mental health interventions, coupled with ongoing coaching and mentoring to sustain their use. As part of the model, nonprofit community-based organizations (CBOs) will develop strong, substantive relationships with licensed mental health providers (MHPs). MHPs will support CBO staff in their adoption and continued mastery of these practices as well as either supporting that existing staff to make referrals to the MHP when CBO clients need further steps in care, or through locating a MHP clinician on-site.

Front-line staff at community organizations often receive one-off training in mental health issues, but not the ongoing coaching and support from experts necessary to bridge the knowledge divide and help CBOs meaningfully sustain new practices. They may also face institutional barriers to implementing new practices including identifying the needed time and will to implement, maintain skills, adhere to

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new workflows, and complete necessary paperwork, and other constraints including lack of high level management buy-in for this change in practice and organizational culture. Similarly, CBOs adopting new skills that stretch their mission might not have the needed substantive partnerships with mental health providers to sustain this work, resulting in low use of referrals to mental health care and appropriate application of skills. With more deeply embedded systems for training front-line staff in evidence-based clinical mental health practices through a strong ongoing connection with mental health providers, CBOs have the potential to not only provide early steps in a chain of care, but to provide the support to make sure clients schedule and follow-up with appointments and treatment plans.

Through C2C, the Collaborative will provide subgrants totaling \$1M a year to an estimated 12 competitively-selected, high-performing New York City CBOs to integrate the package of evidence-based mental health practices (detailed below) into their current services. Selected subgrantees will represent a diverse group of multi-service providers serving low-income populations including those at greater risk for mental health issues such as victims of domestic violence, veterans, disconnected youth, the unemployed, the elderly, or the previously-incarcerated. Because these community settings are not typically viewed as health/mental health facilities, they can be a more credible, comfortable, or accessible resource than a formal mental health treatment setting. The selection of CBOs will also be informed by the NYC Mental Health Roadmap. The Roadmap, scheduled for release this summer, will include findings from a community needs study identifying populations and neighborhoods within the city most in need of these services.

By expanding the provision of mental health services and reducing barriers to access--including physical barriers and social stigma--C2C will increase mental health up-take and retention, reduce avoidable hospitalizations, and increase the health stability of CBO clients. Further, it is expected that C2C will also increase clients' ability to achieve other targeted program-specific outcomes in areas such as employment, housing stability and independence.

### THE CONNECTION TO CARE (C2C) MODEL

During this period of significant health care reform and service model delivery redesign, it is crucial to identify models that leverage existing resources in ways that reduce service gaps, and improve access for individuals that are difficult to reach or engage in care. Mental illness burdens are enormous for

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individuals, families and communities, and current systems are failing to reach those most in need. Creating innovative ongoing partnerships between community organizations and clinical mental health providers is a way to identify effective approaches to increase mental health resources for those in need, with implications for healthcare delivery and social policy at multiple levels.

The C2C partnerships incorporate unique practices: each is a defined and proven methodology that can be delivered by non-mental health professionals after a short training. The practices have demonstrated utility with various populations and applicability to a broad audience. Importantly, evidence has shown that non-specialist staff can be trained to successfully implement these interventions. Each modality has a robust evidence base behind it, with a preliminary evidence base for the effectiveness of their integration:

\* Motivational Interviewing (MI): MI has been shown to be effective for comorbid psychiatric and substance abuse disorders (Barrowclough, Haddock, Tarrier et al 2001), adolescents with substance use disorders (Jensen, Cushing, Aylward 2011), and peer violence reduction (Cunningham, Chermack, Zimmerman, Shope, Bingham, Blow, Walton 2012) among other conditions. MI is a collaborative, person-centered, and directive method of eliciting and enhancing motivation to behavior change. MI has been used effectively to facilitate health behavior change in multiple medical and psychiatric conditions including anxiety, depression, and PTSD (Burke, Arkowitz, Menchola 2003; Lundahl, Kunz, Brownell, Tollefson, Burke 2010).

\* Mental Health First Aid (MHFA): Designed specifically to be conducted by lay and non-mental health specialists, RAND (2015) conducted a review and found that MHFA is effective for improving knowledge, attitudes, and promoting helping behavior toward individuals with mental health conditions and/or symptoms.

\* Psychoeducation: Studies have shown markedly higher reductions in relapse and re-hospitalization rates among consumers whose families received psycho-education than among those who received standard individual services with differences ranging from 20 to 50 percent over two years. For programs of more than three months' duration, the reductions in relapse rates were at the higher end of this range. In addition, the well-being of family members improved patients' participation in vocational rehabilitation increased, and the costs of care decreased" (American Psychiatric Association

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2003).

\* Screenings: In low-income settings, screenings for mental health conditions conducted by non-clinical staff that has undergone adequate training have been shown to result in population-level gains including: greater mental health coverage, more effective use of health care staff and resources, and reductions in stigma (Kagee, Tsai, Lund, Tomlinson, 2013).

Staff conducting the screenings will be trained to identify when to use the modalities mentioned above and when to refer for more intensive clinical services. The CBO/MHP relationship will facilitate an enhanced process for follow-up on the results of screenings, with CBO and MHP staffs coordinating to ensure clients are connected to appropriate treatments. Together, this package of services will address the needs of clients along a chain of care.

Through C2C, CBOs will identify a licensed MHP they will partner with throughout the duration of the SIF. To support the integration of this work into ongoing practice, the MHP will work with the partnering CBOs non-clinical program staff and deliver ongoing training and coaching through regular in-person sessions in the C2C modalities. The MHP training and coaching will also ensure service fidelity and support frontline staff and senior management in making the necessary changes and task-shifting to implement this new service.

Some subgrantees will also have the capacity to work with their MHP to hire clinical staff to work on-site at their service location, rather than be available by referral, in order to more fully address the continuum of care for those with higher needs at the service site. To add this modality an organization must demonstrate that they can meet specified criteria that include available private space for clinical counseling sessions, a high number of clients with intensive mental health needs, and capacity to raise the match for a larger subgrantee budget.

### APPROPRIATENESS OF THE APPROACH

There is also evidence that non-mental health professionals, with training and supervision, are able to detect, screen for, and provide initial support and care for individuals living with mental illness (Kakuma, Minas, van Ginneken, Dal Poz, Desiraju, Morris, Saxena, Scheffler 2011). Such practices have also been shown to be a cost effective practice in low resource settings (Peterson et al 2012). C2C would provide evidence for a more comprehensive approach that incorporates multiple strategies that

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have been assessed individually but not collectively.

Training non-professional mental health workers and lay community workers to conduct basic counseling, screening, and referral--or "task-shifting"--is still a relatively new practice in the United States. However, task-shifting has been demonstrated in several global health initiatives, in particular for physical health issues, and the utility and effectiveness have been assessed in a range of countries (Kazdin 2013). Questions still remain as to optimal uses of task-shifting effects on uptake of mental health services in the United States. The evaluation of C2C discussed in later sections will look at uptake of mental health services as a result of task-shifting. This proposal will build on the current preliminary evidence for task-shifting and co-location to test the integration of mental health and human service provision, increasing the level of evidence for this approach from preliminary to moderate (see below under PROPOSAL FOR EVALUATION).

A growing body of evidence suggests that co-locating services improves mental health outcomes. A study conducted in a geriatric facility showed that co-locating resulted in increased engagement and utilization of specialized mental health services compared to a group that received only an enhanced referral system (Bartels, Coakley et al 2013). Similarly, co-located behavioral and pediatric care, compared to only providing referrals, has been shown to correspond with increased treatment engagement and retention as well as improvement of behavioral problems in children (Kolko, Camp et al, 2013). That said, co-location in some cases has been shown to be overly complex and inefficient at the organizational level (Lawn, Lloyd, Sweet, Gum 2014). Further, most studies look into co-locating mental health in primary healthcare services. C2C will specifically build evidence about the effectiveness of co-locating mental health services in a CBO setting.

The Collaborative will implement C2C practices and rigorously measure 1) whether clients have improved mental health outcomes--such as improved mental and physical health indicators, improved reported quality of life, reduced substance abuse, and decreased preventable hospitalizations; and 2) whether clients achieve their intended social service outcomes at a greater rate than clients with mental health needs who do not receive the services.

If C2C can demonstrate that discrete mental health interventions can be integrated into social services and delivered by non-clinical staff, then the impact will be twofold: 1) NYC can dramatically scale the number of people who receive much-needed mental health services; and 2) NYC can improve the

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effectiveness of different types of mental health programs.

### THE COLLABORATIVE VALUE-ADDED ACTIVITIES

The Collaborative will support the selected subgrantees and their partners as they incorporate the evidence-based practices into their existing service strategy. The Collaborative will do this through the provision of technical assistance (TA) in a variety of areas: adopting the C2C model, financial management and federal compliance, match fundraising, data driven management, and partnership development. The TA provided by the Collaborative will supplement the programmatic TA that subgrantees will receive from their MHP, as described above, to directly build subgrantee capacity around delivering ongoing integrated mental health services. The Collaborative will also provide extensive oversight of subgrantees, and will manage a Learning Community, both discussed in more detail in Section C.

TA elements will be delivered by members of the Collaborative based on their particular areas of expertise. Each subgrantee partnership, comprised of the CBO and MHP, will receive support from a "team," comprised of staff from the Collaborative. CEO/DOHMH will convene meetings for each selected subgrantee to orient staff to the SIF and discuss their C2C approach in-depth. Program staff (described below in Section C1) will be assigned by the Collaborative to work closely with each subgrantee over the life of the initiative. The Collaborative team structure enables CEO/MF/DOHMH each to leverage its expertise and provide the subgrantees with support for all elements of the project, from program design to fiscal compliance.

MF staff will direct grant management and compliance, and provide capacity building TA around financial management and federal compliance.

DOHMH will provide subgrantees with TA focused on adapting C2C to their site and population-specific context, in addition to TA for marketing to and recruiting target groups; partnership development with clinical partners; client intake and service flow; staffing plans; program services and procedures; and mental health performance measures. DOHMH and the MHP will work together to support fidelity of implementation by the CBO.

CEO will provide TA on match fundraising, data-driven management, and partnership development. Subgrantee program managers will also be eligible for and encouraged to complete CEO's Managing

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for Innovation Course, which has defined a set of common high-priority capabilities and competencies of program directors and provides a framework and network to support their professional growth.

The Collaborative will continuously monitor implementation, evaluation, compliance, and performance of subgrantees, sharing findings to ensure TA is data-driven and holistic strategies are developed to improve performance. MF/CEO have honed this approach in their partnership on a 2010 SIF grant, and have a strong track record of balancing these roles and communicating results internally and externally.

Subgrantees will be accountable for match fundraising and fidelity to the model, with ongoing support from the Collaborative--more on this below in section C.

### **B2: PROPOSAL FOR SUBRECIPIENT SELECTION**

**SUBGRANTEE SELECTION:** The Collaborative will manage a two-stage, six-month competitive process to select subgrantees, selecting approximately 12 nonprofit community-based organizations in NYC, to each receive an initial estimated three-year subgrant of \$525,000, subject to two one-year renewals, for a total of five years. The size of the grant will vary based on the size of the organization, and whether the nonprofit also chooses to address higher-level clinical mental health needs by hiring an on-site mental health professional. Subgrantees will need to match subgranted funds 1:1.

The goal of this selection process will be to identify organizations that have the track record, capacity, commitment, and leadership to effectively implement and sustain the integration of mental health services and participate in the SIF. MF and CEO will seek well-run, financially stable organizations with a commitment to data-driven management, a culture of learning and continuous improvement, and demonstrated senior level commitment and staff level buy-in to integrating mental health services into the existing service framework. These organizations would need to demonstrate the ability to recruit and track study participants, successful track record of working with low income populations, and an appropriate level of need identified among their clients. The strongest applicants will also demonstrate a relationship with a mental health provider with whom they will partner as their MHP, and demonstrate experience participating in previous evaluations. Applicants, including both the CBO and MHP, must commit to participate in the evaluation, led by the CEO/MF-

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competitively chosen independent evaluator.

The selection process will assess five areas: 1) agency history, mission and alignment with the model; 2) leadership capacities and commitment including organizational leadership and the experience of managers selected to launch and lead the project and overall staffing commitment to the partnership, and commitment to supporting the necessary organizational change to integrate mental health services; 3) commitment to learning and continuous improvement, as demonstrated by data on program performance of similar programs or services to similar populations, including number of low-income participants served, track record of achieving outcomes, use of performance data in programmatic decisions, results of prior evaluations, and examples of how evaluation findings influenced service delivery; 4) overall financial management and health including recent external audit results, financial and management information systems, technological capacities, budget, assets, funding sources, and data security systems to protect participants' personal identifiable information; and 5) approach to implementation and feasibility of work plan for program start up and implementation, including strength of relationship with the proposed MHP, adoption of the modalities in ways that meet the needs of their clients, including demonstrating a credible sustainability strategy for continued partnership and use of new mental health practices, and proposed treatment pathways and protocols describing a chain of care linking CBO roles with escalation to referred treatment(s).

The Collaborative recognizes that subgrantees implementing this work require a shift in organizational culture and a willingness to adjust staffing time and responsibilities to allow for the necessary additions in session time with clients, added administrative responsibilities, and dedicated time for training and coaching of front-line staff. This commitment to success will be an important part of the subgrantee selection process through the application and follow-up site visits with finalists.

It is important to note that the package of interventions is a basic start-up package intended to spark uptake of mental health related knowledge, skills, and service provision. However, applicants can build upon this minimum package as needed. Additional components may be added that enhance the competencies and optimize the skills of CBO staff to address the specific needs of their client population. For example, once the basic package has been adopted, applicants may choose to add relaxation training to their repertoire of new skills based upon the knowledge that their client

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population struggles with high levels of stress. Demonstrating the ability to flexibly tailor their approach to best serve clients will result in a more competitive application.

Applicants will submit reference letters from knowledgeable community leaders to demonstrate their ability to enter into partnerships and to effectively serve participants.

**EFFECTIVENESS OF THE SUBGRANTEE SELECTION APPROACH:** Together, MF and CEO have decades of experience selecting subgrantees through competitive site selection processes to implement innovative programs. As discussed in the History of Competitive Grantmaking section, the partners collaborated on subgrantee selection for the 2010 SIF award, selecting 18 organizations across eight cities, and CEO and MF have both engaged in fair, competitive and successful selection processes. The selection process described here is informed by these experiences and lessons from the 2010 subgrantee selection process and those of other SIF grantees. For example, in-person forums and site visits were not a part of the MF/CEO 2010 selection process but will be in 2015 in order to foster engagement with local communities at the earliest stages of the grant, to orient all stakeholders to the SIF model at the beginning of the project, and to better assess the capability of partners to incorporate and deliver the C2C model.

**SUBGRANTEE SELECTION TIMELINE:** Partners will submit their subgrantee selection plan to CNCS for review within one week of receiving notice of the award. This timeline assumes the plan is approved approximately one month from submission. Six weeks after notice of the SIF award, partners will launch the selection process--with the release of the notice of the opportunity and distribution of application materials. Two weeks after the competition launch (eight weeks after notice of the award), partners will host an Applicants' Forum. Representatives of the MF, CEO, and DOHMH will jointly host these forums with local partners. LOIs will be due approximately one week later, and applications will be due six weeks after the launch of the competition. Reviewers, comprised of representatives from the Collaborative and funding partners, will have four weeks to review materials before convening to select finalists. Site visits to finalists will follow soon after, with subgrantees selected approximately five months after MF received notice of the SIF award. Below is the proposed timeline:

- \* Week 1 -- the Collaborative submits Subgrantee Selection Plan to CNCS
- \* Week 5 -- CNCS approves plan

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- \* Week 6 -- Competitions launched -- Request for Proposals released
- \* Week 8 -- Applicant Forum held
- \* Week 9 -- LOIs due to MF
- \* Week 12 -- Applications due to MF
- \* Week 16-17 -- the Collaborative and funding partners meet to select finalists
- \* Week 18-19 -- the Collaborative conducts fiscal and programmatic site visits
- \* Week 22-23 -- Final subgrantee selection is approved by the Collaborative leadership
- \* Week 24 -- Subgrantees announced

### B3: PROPOSAL FOR EVALUATION

CEO is dedicated to assessing the impact of all its programs, and with its evaluation partners has completed over 70 program evaluations, including qualitative studies, cost studies, quasi-experimental outcome studies, and random assignment studies. To evaluate C2C, the Collaborative will conduct a competitive bid to select an independent evaluation firm with a strong record of conducting rigorous analysis for social policy research. The resulting evaluation will achieve a moderate level of evidence of the effectiveness of C2C, using a quasi-experimental approach. In addition to an impact study, the evaluation of C2C will include implementation and cost analyses.

CEO and partners have extensive experience selecting and working with evaluation partners to develop distinct evaluation strategies for each program. CEO's monitoring and evaluation activities are led by an in-house team in partnership with City agencies and external research organizations. CEO currently works with a pool of nine nationally recognized and competitively selected evaluation firms (for example MDRC, the Urban Institute, Abt Associates, RAND Corporation, and Westat) specializing in various issue areas and methodologies. Evaluations inform program and budget decision-making, and contribute to public policy and program development in the human service field more generally.

Reflecting the high priority it places on evidence, CEO's continued funding of initiatives is contingent on evaluation results. Successful programs are sustained or expanded; unsuccessful programs are terminated. For example, a highly successful community college completion program was significantly expanded--quadrupled in size--based on evaluation results, while ineffective programs serving noncustodial parents were terminated. To date, 12 programs and initiatives have been declared

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successful and 25 have been discontinued through CEO's application of performance data and evaluation findings. CEO also uses evidence to establish performance targets to guide program improvements and provide TA, and the partners will repeat this process again.

In the 2010 SIF grant, evaluations being implemented by MF/CEO include three Randomized Control Trials (for the Family Rewards conditional cash transfer program, the SaveUSA tax time savings program, and the WorkAdvance workforce training and advancement program), as well as implementation analyses, analyses of participant outcomes, and cost-benefit analyses for all five programs. As part of this work, CEO and its evaluation partners provided technical assistance to the subgrantees to enhance their capacity to participate in the evaluation and collect data. For each of the five programs, CEO and its evaluation partner prepared a detailed Subgrantee Evaluation Plan (SEP), which were all approved by CNCS with minimal changes required. All five SEPs are on-track to be completed within the expected timeframe.

CEO/MF has produced a significant number of reports and evaluations during the first four years of its first SIF grant. All are available on CEO's website (<http://www.nyc.gov/html/ceo/html/data/reports.shtml>) and have been shared widely. CEO has active evaluation dissemination policies, which include informing policymakers, academics, and other partners about findings, convening stakeholders to discuss the policy relevance of findings, presenting at conferences, and broad public dissemination through digital media and other venues. MF's partners also post evaluation results on their websites, distribute printed reports, and all partners actively communicate findings at conferences.

MF/CEO will hold a national competition to select an evaluation partner. Evaluation firms (including those already in CEO's pool of firms) and academic institutions with a history of conducting rigorous research studies will be eligible to apply. The chosen evaluator will have expertise in evaluating health care provision models and necessary evaluation methodologies. In their proposal, prospective evaluators must demonstrate their capabilities and a robust approach to evaluate outcomes at the client and organizational level for each subgrantee partnership, as well as substantial experience in implementation science research, client level outcome studies, and cost studies.

The evaluator will assist the Collaborative in determining appropriate research questions, metrics, and adequate sample sizes to detect reasonable impacts at the city level, as well as for specific subgroups.

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Ideally, the evaluator will be in place in time to play a key role in provider selection in a manner that ensures optimal strength of the evaluation design. The evaluator, together with the Collaborative, will work with selected subgrantees and deliver needed technical assistance to support participation in the evaluation, such as messaging to participants and staff, establishing common metrics and definitions to be measured across all sites for the study, setting up appropriate databases and data tracking systems, and protecting data privacy. Technical assistance for the evaluation will be most heavily provided to sites during the first six to nine months of the program, and will then continue in an ongoing manner throughout the period of the SIF as needed.

Under C2C, the Collaborative will advance the evidence that informed the development of the initiative (see PROGRAMMING STRATEGY under B1) in order to build a moderate level of evidence for how these combined mental health interventions, delivered in the context of a nonprofit CBO and through a sustained partnership approach, impact client outcomes. The study will build on the evidence base for task-shifting and co-location of mental health services by demonstrating how these improve access to and retention in care, retention in existing social services, and reduce perceived stigma for receiving services--resulting in greater utilization of mental health services and improved related client outcomes. Further, while each of the components of the proposed intervention has a substantial evidence base, this initiative will build new evidence for a combined approach to delivering, and improving and broadening, this package of mental health modalities in a CBO setting. The research will also generate data and support shared learning about the workflows, business models, staff optimization, etc. that could inform reimbursement and other sustainability strategies.

In partnership with the selected evaluation firm, the Collaborative will utilize a mixed method and multi-tiered evaluation strategy to build evidence regarding this combined approach and innovative partnership model. The research will consist of three core elements: an implementation study, a cost effectiveness assessment, and a quasi-experimental participant impact study. The implementation study will employ qualitative and quantitative methods to examine fidelity of implementation of the model, the ability of nonprofits to successfully implement this novel type of partnership, the capacities required of both CBOs and mental health providers to build successful relationships, client perspectives on accessing mental health services in these settings, and will identify best practices across the partnerships. Furthermore, the study will examine which of the evidence-based model components are most heavily utilized and how component utilization varies by site and population served--

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information that will also inform the quantitative impact study to understand the collective impact of the package of services delivered.

The cost study will look at what resources are required to operate the evidence-based components of the model and will estimate the average per-person cost in relation to mental health and programmatic outcomes. The study will also estimate anticipated cost savings to the nonprofits and to government (for example in Medicaid spending, ER visits, reduced hospitalization rates, and missed appointments) resulting from improved participant outcomes, as well as increased revenues to city, state, and federal government through potential increased earnings for participants as they are better equipped to enter the workforce and maintain employment, for example.

The quasi-experimental impact study will examine participant outcomes in mental health as well as key programmatic outcomes related to the host CBO (e.g. retention in program, educational achievement, employment status, housing stability). All of these outcomes are achievable within the five year period of the SIF. Data will be drawn from a range of sources and the Collaborative will work with the evaluation firm to identify an appropriate counter-factual for the evaluation design to be able to compare client outcomes with those of comparable individuals that do not have access to similar services. This quasi-experimental design will employ rigorous statistical analysis to estimate effectiveness and impact, reaching a moderate level of evidence. The evaluation will include all funded subgrantee sites, and where appropriate, will seek to understand differential impacts by subgroup (e.g., victims of domestic violence, veterans, disconnected youth, or the previously incarcerated). As C2C will engage a range of CBOs and MHPs, the study is expected to produce highly generalizable findings. This study will also test the partnership arrangement by examining proportion of referrals for mental health services that are successfully completed, duration of retention in mental health treatment following referral, and retention in the non-mental health program services. Using the Interagency Collaboration Scale or a similar standardized and validated measure of collaboration, the study will measure the robustness of the collaboration between the nonprofit and the mental health provider as a key factor that could impact outcomes.

As previously described, CEO has worked with external evaluation firms to conduct over 70 evaluations ranging from focus groups to randomized control trials. The proposed evaluation budget reflects CEO's considerable expertise in managing evaluation projects.

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### B4: PROPOSAL FOR GROWING SUBGRANTEE IMPACT

MF and CEO have a demonstrated track record of building capacity and growing impact at the subgrantee level, through the 2010 SIF and other work. CEO's scaling theory is based in the principle that public funds should be invested in programs that work to improve the lives of low-income families. To do this, CEO works with partners to develop and build evidence for innovative program models. If the models develop evidence of impact, CEO identifies pathways to further replication and scale for that model.

Within the 2010 SIF, several providers incorporated elements of the SIF models into their organization-wide efforts because they found the strategies so effective. For example, one subgrantee provider had a track record of providing training and job placement services in New York, and, through support and TA provided by the SIF initiative, enhanced its services and adopted a more robust worker advancement coaching model to clients in its SIF program. Making those programmatic changes deepened its understanding of the target population's need for more intensive long-term support after job placement; through its experience successfully implementing strategies to promote career advancement, the nonprofit elected to incorporate those strategies into its agency-wide services. In another example, two subgrantees delivering the program model for disconnected youth have now incorporated elements of the model into the rest of their programming--namely a cohort-based approach to services and setting requirements for strong attendance in the program's education services as a pre-condition for other program benefits.

Outside of the SIF, CEO has demonstrated its ability to work with partners to expand and grow evidence-based programs through its work with Sector-Focused Career Centers. CEO worked with the New York City Department of Small Business Services (SBS) to fund the City's first industry-focused career centers, tailoring workforce services to the transportation and healthcare industries based on evidence that sector-based interventions can help prepare low-wage workers for high-paying, sustainable jobs in high demand occupations, thereby helping workers move out of poverty in the long term. A quasi-experimental study built the evidence for this approach in NYC, and demonstrated that the sector-specific program increased job placements and wages for participants compared to participants in standard programming. As a result of the successful outcomes, SBS subsequently added two new sector centers, and re-oriented its entire system of Workforce1 Career Centers to focus on a

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smaller range of targeted industries to develop stronger employer relationships, bringing this approach to a significantly greater number of low-income New Yorkers. After using local tax dollars from CEO's Innovation Fund to launch the initial sector center and prove the effectiveness of the approach, SBS now dedicates Workforce Investment Act funding to support these initiatives as well -- an important step toward achieving scale for the programs. Drawing on the evidence learned in these programs, this past fall the Mayor's Jobs for New Yorkers Taskforce advocated for a sector-based approach as a central recommendation in their Career Pathways report- a report that redesigns the City's entire workforce system. Progress is now underway to integrate the sector strategy throughout City agency workforce programs across multiple City agencies. This success was highlighted this year in a CNCS blogpost about MF/CEO entitled "CEO and Mayor's Fund Help Shape Policy with Evidence". The post notes that the CEO/MF track record emphasizing building evidence "makes them a natural fit for the SIF".

The Collaborative expects that C2C subgrantees will increase their capacity to delivery mental health services and improve mental health outcomes for their clients. In turn, improved mental health outcomes will lead to increased non-mental health outcomes such as employment and education- which would also further the nonprofit's ability to attract future funding. Subgrantees will be required to demonstrate a track record of success (i.e. strong performance outcomes) in their core service strategy, and MHP partners must demonstrate successful mental health outcomes. This will ensure that subgrantees are prepared to expand or adjust their service models to accommodate the mental health integration.

As it has shown many times with programs that have demonstrated success, the Collaborative will seek funding beyond the SIF to replicate effective integration at similar organizations citywide (or perhaps targeted, as appropriate). Findings will also inform activities implemented in response to the Mental Health Roadmap, a comprehensive review of mental health disparities and service led by DOHMH and MF.

Finally, by participating in evaluations of their work through the SIF, subgrantees will become deeply familiar with the ways that evaluation can be used to demonstrate impact and improve program delivery. As a result, they will increase their ability to participate in evaluations and evaluate their own work. Importantly, they will also build their capacity to collect data and use both performance data

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and evaluation results to improve program performance for both the programs in question and for other programs outside of the SIF, and to use those findings to secure additional funding.

To capture and share best practices, MF/CEO developed a Learning Community (LC) during the 2010 SIF grant which will serve as a model for this subsequent cohort of SIF grantees. The LC is an important resource for program providers, researchers, local city partners, and other stakeholders to share best practices among each other and with the public. The LC engages stakeholders, including national experts and policy makers, to advance broader program replication and/or sustainability; fosters communication among a community of program providers so they may share challenges and experiences (such real time learning improves program design and delivery, making programs more effective and easier to replicate); and shares best practices and evidence with the field, so that promising approaches, successful techniques, and evidence can be accessible and available to inform ongoing anti-poverty programming. The LC features an annual convening of all subgrantees and periodic convenings of providers within program areas.

The Mayor's Fund and CEO currently share learnings from the SIF program models with a range of stakeholders by participating in conferences throughout the year. SIF partners have joined colleagues at conferences hosted by organizations including the Association for Public Policy Analysis and Management, the Corporation for Enterprise Development, the National Association of Welfare Research and Statistics, the Clinton Global Initiative, the National Association of Workforce Boards, the United Hospital Fund Symposium on Health Care Services, among others, often by invitation. Partners also present at conferences hosted by government agencies such as the U.S. Department of Health and Human Services, the Corporation for National and Community Service, and more.

CEO and MF also have significant experience building capacity among subgrantee organizations. To ensure that staff can improve on the skills needed to operate innovative programming, CEO partnered with the CUNY School of Professional Studies to create the CEO Program Management Forum, a series of professional development courses and tools to assist program directors in developing the following core competencies: Strategy and Planning; Leading People and Building Teams; Collaboration and Partnerships; Analysis and Decision-Making; Program Knowledge; Contract Management and Budgeting; and Personal Management. Staff from NYC-based SIF subgrantees have completed this course, offered in-kind, with costs paid by CEO. This course will be offered to

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program directors for C2C.

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### Organizational Capability

#### C1: ORGANIZATIONAL BACKGROUND AND STAFF CAPACITY

The Collaborative will successfully support the approach and outcomes as proposed. These members of the Collaborative, in partnership and individually, have an extensive track record of success managing and supporting innovative, outcomes driven, anti-poverty and public health programs. MF and CEO are in their fifth year of a successful SIF program, and DOHMH has significant experience managing federally- and privately-funded community based programs.

The Mayor's Fund to Advance New York City is a 501(c)(3) not-for-profit grantmaking organization that relies on individuals, foundations, corporations and non-city public resources to support public programs in areas including youth development, financial empowerment, health, volunteerism, the environment and the arts. In coordination with CEO, MF monitors the performance and expenditures

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of subgrantees and evaluators on the 2010 SIF grant (more information below).

CEO was established in 2006 with a mission to identify effective ways to reduce poverty in NYC. CEO manages a dedicated annual Innovation Fund and works collaboratively with City agencies and other partners to create, implement, and advocate for a range of new anti-poverty programs, policy proposals, and research projects that represent nationwide best practices (e.g. sector-focused workforce strategies), adaptations of models proven outside of NYC (e.g. Jobs-Plus), and cutting-edge ideas (e.g., conditional cash transfers through Opportunity NYC). CEO's strategies all share a common goal: to end the cyclical nature of poverty and promote self-sufficiency. CEO's in-house evaluation team works with nationally-recognized, independent evaluation firms and City agencies to rigorously measure program impacts and provide objective evidence to inform decisions of whether to replicate, eliminate, or scale up programs.

The mission of DOHMH is to protect and promote the health of all New Yorkers. DOHMH has the overall responsibility for the health of the residents of New York City. It also acts as an oversight agency to monitor various healthcare related operations within NYC. DOHMH serves over 300,000 New Yorkers annually through contracts with 210 community-based organizations. Innovative and outcomes-focused policies of DOHMH include programs and policies such as a ban on artery-clogging trans fats in restaurant food, a prohibition on smoking in bars and restaurants, and a requirement that restaurant chains post calorie counts broke ground and established new norms that have extended across the country. These strategies, combined with many other approaches utilized by DOHMH, have contributed to a reduction of heart disease, cancer, and H.I.V. infection among New Yorkers and an increase in life expectancy by 1.9 years from 2000 to 2010 (Preston and Elo 2013). Together these three entities are deeply committed and well-positioned to meet the objectives of the SIF; have complementary missions well-aligned to SIF goals; have collective experience supporting, administering, monitoring, and evaluating programs and experience building the capacity of subgrantees; share a commitment to and a track record for replicating and expanding effective programs; and have histories of community investment and involvement.

Therefore, the Collaborative has a strong capacity to collect and analyze data for performance monitoring, evaluation, continuous program improvement, compliance, and other purposes. CEO's professional staff, all of whom have masters' degrees, include program officers and a Senior

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Management Advisor who collect monthly narrative and quarterly data reports from all agency and CBO partners for over 30 programs. Data is regularly analyzed and grantees always receive feedback on submitted reports. To accommodate variation among a range of partners with varied Management Information Systems, CEO uses a MS Excel-based data reporting system that partners populate from their preferred format.

The average annual budget for the last three years is \$49.7M, so the initial \$1M grant would be 2 percent of the annual budget. The plan for managing and staffing the proposed SIF activities, including oversight activities, leverages the collaborators' respective strengths and builds on their history of working together on the 2010 SIF and past programs.

Overall leadership responsibility for SIF activities will reside in MF/CEO/DOHMH intermediary partnership. Collectively, they will conduct the competitive process for selecting subgrantees and negotiate grant requirements for subgrantees. As grantmaker, MF will be responsible for funding decisions, disbursement, and reporting to the Corporation, as well as private fundraising. MF will also monitor the fiscal performance of subgrantees, including reviewing expenditures, performing due diligence functions, and controlling payments. CEO and DOHMH will oversee and monitor programmatic design and performance of subgrantees, provide TA, and assist with implementation. CEO will also lead the Learning Community and all information dissemination efforts, with significant input and participation of MF and DOHMH.

The 2010 SIF grant provides evidence of successful MF and CEO collaboration, demonstrating that the parties have developed the staff expertise, organizational capacities, processes and procedures to meet the goals and requirements of the SIF. The 2010 SIF initiative is an ambitious project, with partners replicating five diverse program models in eight cities nationwide. The initiative is achieving the stated goal for these five models, as it is demonstrating their effectiveness in diverse urban settings, and informing larger City and federal policy efforts. The initiative is building evidence for each of these models through rigorous evaluations, including three RCTs. Early impact evidence from one RCT of the SaveUSA model points to the effectiveness of this model in increasing savings among low-income families. The US Department of Housing and Urban Development is now investing \$15M in another of these models, Jobs-Plus, which is proven to increase employment outcomes for public housing residents. Evidence from a third model, WorkAdvance, is informing the reform of the New York City

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workforce system. CNCS has looked to MF and CEO for examples of best practices for risk-based subgrantee monitoring and subgrantee support. Work under the 2010 SIF grant will continue during a portion of the proposed timeframe for this grant and the collaborators will dedicate additional staff and resources to operate the two grants concurrently if awarded. The staffing plan outlined in this proposal reflects a structure that will fully fund and staff both grants separately. However, the SIF management expertise that has developed over the last five years will inform the 2015 SIF.

Sinead Keegan, SIF Director, will assume overall responsibility for the program. Ms. Keegan has been with MF since 2010. She currently manages the 2010 SIF grant which will begin winding down as it enters the final year. While a staff member of MF and funded through the SIF grant, Ms. Keegan is located with program staff at CEO and is a member of the CEO senior staff.

Upon initiation of a 2015 SIF grant, Ms. Keegan would spend approximately 50 percent of her time on the 2010 SIF grant and 50 percent on the 2015 SIF grant, as reflected in the proposed budget. Her time will be increased at the close of the 2010 grant, and CEO in-kind staff time will be reduced as Ms. Keegan's time increases. For the 2015 grant, Ms. Keegan will oversee staff dedicated to SIF fiscal, program, and learning community management, and subgrantee selection, including oversight of SIF fiscal consultant Brigit Beyea. Ms. Keegan reports to Kate Dempsey, CEO's Director of Strategy and Operations who has been with CEO since 2009, and has played a leadership role on the SIF initiative since its inception. Ms. Dempsey will continue to oversee the SIF initiative, and ensure staffing is sufficient and efficient.

Fiscal staff will include one fiscal officer dedicated 100% to fiscal monitoring and compliance working under the direction of Ms. Beyea. Ms. Beyea is a consultant monitoring fiscal activities and compliance for the 2010 SIF initiative, with prior experience in federal grants management and compliance, including two years as a grants officer at CNCS and experience as a CNCS grantee. Upon initiation of a 2015 SIF grant, Ms. Beyea would dedicate approximately 50 percent of her time to the 2015 grant. The new fiscal officer will have a bachelors degree and a minimum of two years of experience with non-profit financial management, with experience in federal compliance.

Program staff will include two program managers working with DOHMH to oversee program implementation and evaluation. They will oversee the subgrantees and be responsible for program design, implementation planning, data collection, supporting subgrantee fundraising/sustainability,

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and troubleshooting. They will also work directly with the evaluation and TA partners. Oversight of staff will reside with the Mental Hygiene Division of the New York City Department of Health and Mental Hygiene. This division is responsible for policy, programs, and provider oversight related to mental health; alcohol and drug use; developmental delays and disabilities; and early intervention services. Director of Quality Improvement--Dr. Amy Douglass, DrPH, an experienced supervisor of programmatic staff and data analysts, having led research and technical assistance projects for large Federal agencies, will supervise the staff. The new staff, including a C2C Coordinator and Advisor, will each have a masters degree in public health or social work (or an equivalent degree), and a minimum of 1 to 2 years of experience overseeing a public health or mental health initiative.

Program staff will report regularly to Ms. Keegan who will be supported by David Berman, CEO's Director of Programs and Evaluation. With masters' degrees in public administration and public health, Mr. Berman has been with CEO since 2007 and has overseen the design and publication of over 50 CEO evaluations. His time will be provided in-kind and will not be charged to the SIF grant.

CEO has a staff of 18, including an Executive Director, fundraising, and policy advisors, program development and evaluation staff, and researchers who lead CEO's poverty measurement work. CEO reports to Mindy Tarlow, the Director of the Mayor's Office of Operations, who provides day-to-day guidance and support. Matthew Klein, CEO's Executive Director, will provide leadership for the overall execution of the SIF. He has many years of experience fostering social innovation, including as the Executive Director of the Blue Ridge Foundation. Both have ample experience with the SIF. In her former role as Executive Director of the Center for Employment Opportunities, Ms. Tarlow was a subgrantee of two different SIF intermediaries. Mr. Klein's former foundation provided matching funds for another SIF intermediary.

Support for contracting, fiscal monitoring, and performance management will be provided in-kind by Mayor's Fund staff--including Krystelle Carroll, Director of Finance and Administration and Toya Williford, Director of Programs--to Ms. Keegan and Ms. Beyea and the Collaborative.

SIF is a high-priority program of MF and that will continue with the 2015 grant. MF has a 45-member Board of Advisors, comprised of NYC business, corporate, and nonprofit leaders. The Board of Directors includes NYC's First Lady, the Chief of Staff to the Mayor, and the Deputy Mayor for

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Strategic Policy Initiatives. For the SIF effort, the Board of Advisors will help to leverage private funds and provide academic and intellectual capital. MF has a staff of nine, including three staff members and one consultant hired exclusively to work on the 2010 SIF grant.

As part of the proposed SIF work, MF/CEO/DOHMH will apply existing ongoing organizational self-assessment methods to improve the SIF collaboration's management, staffing, operating systems, and other capacities. These include systematic annual staff performance reviews, and engaging with outside experts to support organizational performance, obtain the views of key stakeholders, and propose improvement plans. For the SIF, the collaborators will regularly assess their achievements in such key areas as selection of qualified sites, supporting quality implementation, approved and completed evaluation plans, monitoring subgrantee performance, and maintaining fiscal controls. Ultimately, CEO measures itself on its ability to establish programs in a short timeframe and demonstrate positive results through impartial evidence. As an example, CEO commissioned a report from the Rockefeller Institute of Government at the State University of New York to assess CEO's role and function in local government. The Institute describes CEO as "more than an anti-poverty agency. It is an ongoing experiment in governance, one that addresses a complex public problem through innovation, testing, and problem measurement." The report goes on to consider CEO as a potential national model in making government policy smarter and more effective. (See: [http://www.nyc.gov/html/ceo/downloads/pdf/2014-03-NYC\\_CEO\\_Report.pdf](http://www.nyc.gov/html/ceo/downloads/pdf/2014-03-NYC_CEO_Report.pdf)).

MF/CEO has strong systems in place to manage federal grants and monitor subgrantees to ensure compliance with all CNCS grant requirements. MF/CEO provides in-person and web-based trainings and a thorough guidance document for SIF subgrantees entitled "Managing Your Social Innovation Fund Award Guidelines for Subgrantees," which outlines subgrantees' roles and responsibilities, including applicable CNCS requirements. CNCS has shared this document with other grantees as a best practice. It also uses a detailed National Service Criminal History Check (NSCHC) Checklist, which must be completed for any person charged to the grant at both Intermediary and subgrantee levels. MF and CEO require a completed Checklist on file prior to disbursement of funding to subgrantees, a policy which ensures full compliance from the start of the grant. MF/CEO's monitoring of subgrantees includes: review of quarterly progress reports and detailed financial reports prior to reimbursement of grant funds; review of audited financial statements and A-133 audits, and confirmation that relevant findings with corrective action are addressed in a timely manner; and

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performance of periodic grants management site visits and desk audits, based on risk assessments (more below). CNCS' program reviews have found this to be a "comprehensive and effective" approach for managing a SIF grant.

A critical component of its monitoring systems is a structured process to conduct due diligence reviews and assess subgrantee risk. A SIF-specific Risk Assessment tool is used prior to making subgrantee awards and as a regular monitoring tool. This identifies appropriate risk indicators related to subgrantee organization, staffing, programmatic, financial, and compliance issues. The results of this tool determine the follow-up level of monitoring and technical assistance. For example, higher risk priority level subgrantees may be subject to annual or more frequent on-site reviews, desk audits, routine monitoring, and training and technical assistance, while lower risk priority level subgrantees may be subject to desk audits and routine monitoring.

MF's and CEO's commitments to long-term relationships with subgrantees have been strong through the 2010 SIF and will remain so through the 2015 grant. MF/CEO has provided ongoing and consistent support to 16 subgrantees in eight cities through dynamic and responsive TA, regular and open communication and feedback, ample opportunities for shared learning and professional development and mid-course corrections to ensure success.

The Collaborative will work with subgrantees to develop realistic work plans that give staff time to receive training and launch the program while delivering services to program participants as close to the start of the grant as possible. The Collaborative will work with subgrantees to establish short-term and long-term output and outcome targets, and regularly monitor data to assess performance. After program service launch, if program needs arise, the Collaborative will determine how to support the subgrantees' success through additional TA, training or adjustments such as staff changes or revision of performance targets.

### C2: SUBGRANTEE SUPPORT, MONITORING, AND OVERSIGHT

In the 2010 SIF grant, CEO/MF managed subgrants totaling approximately \$50 million to 18 subgrantees. Of that amount, 40 percent was covered with federal and 60 percent with private funding. In addition to these efforts, as part of the first class of SIF grantees, CEO/MF contributed to the design and establishment of systems and processes between CNCS and grantees and thus has strong capacity to leverage that experience to manage an additional SIF grant.

MF provides fiscal oversight for all of its programs. All nonprofit service providers have formal

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contracts with clearly defined scopes of work and project budgets. MF tracks every payment request against approved budgets and expected deliverables, while contracting with an external accounting firm to process all checks and to ensure accurate records. MF undergoes an external audit annually and convenes regular meetings of the Audit Committee of its Board of Directors.

On the 2010 SIF grant, MF staff conducts a range of fiscal monitoring activities, including reviews of subgrantee application budgets, assumptions, and supporting documentation against proposed work plans and timelines; ensuring the financial terms and conditions of grants made between MF and subgrantees complied with MF and SIF requirements; and provision of fiscal TA to ensure that subgrantees can meet management and reporting requirements. MF staff coordinates with CEO to provide significant support for fiscal monitoring, including assessments of organizational capacity and infrastructure of subgrantees through visits to these organizations, the review of subgrantee financial systems, and other due diligence activities. CEO reviews subgrantee expense reports against budgets and ensures that reported expenses are allowed by the terms and conditions of the grant and reports this information to MF as they make payments to subgrantees. MF will use the Grants Management System custom designed and built for the 2010 SIF to receive and process subgrantee expense reports.

For the 2010 SIF grant, to support subgrantees' effective implementation of the five program models, and in other initiatives, CEO and MF provide extensive Technical Assistance (TA). The TA focuses on ensuring that lessons learned from previous implementations are passed along, and that the model is replicated at the maximum scale permitted by the available funding with quality that meets or exceeds the best examples from the original programs. This TA takes many forms, including: in-person site visits, regular conference calls, webinars and other forms of training, design papers, manuals in some cases, guidance regarding staffing levels, protocols and systems, and data collection. Periodically, CEO hosts group meetings with multiple providers to set expectations, review performance data, and share best practices.

To monitor subgrantee progress toward goals, MF/CEO currently use regular performance reporting and performance assessments which will be used in this second SIF grant in ways similar to the 2010 grant. The relationship between MF/CEO/DOHMH and subgrantees will be governed by a subgrantee agreement, which will require reporting on monthly programmatic performance measures and expenditures. CEO and DOHMH will again work with its independent evaluator and subgrantees to

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identify appropriate metrics and performance targets covering such outcomes as the number of person contacts, modalities delivered, mental health status, program outcomes (e.g., wages/hours), and retention in-program and treatment, and incorporate them into subgrantee agreement. Subgrantees will meet regularly with their site liaison to identify strategies for improving performance. The programs must also demonstrate that they are fully entering data into their tracking systems, confirmed by formal assessments. CEO will conduct regular phone calls--in many cases weekly-- and site visits.

The independent evaluator also will conduct regular assessments to evaluate program operations and implementation. Findings from these assessments will be shared with the sites including program staff and organizational leadership through person debriefings and detailed memos. The assessments will include data reviews, as well as interviews with and observation of staff and interviews with subgrantee partners. The assessments will examine whether subgrantee strategies are sufficient to meet recruitment and other growth goals, and inform the TA that is provided.

The 2010 SIF grant offers numerous examples of the collaborative's TA efficacy. In one, through close contact with the provider, monthly data snapshots and quarterly programmatic reports, CEO/MF noticed that a New York City-based youth development provider was struggling to implement elements of the program according to the model (specifically High School Equivalency [HSE] classes and internships for participants). The partners analyzed the elements of subpar performance, met with staff and organizational leadership to set the provider on a "corrective action plan," and began intensive TA to address the programmatic deficiencies. The provider adapted its programming to internalize the suggestions made through TA, such as hiring an in-house HSE instructor. The intensive TA has continued through the duration of the 2010 SIF grant and the provider now stands as one of the strongest Project Rise implementers, boosting HSE attainment rates and other performance measures.

### C3: STRATEGY FOR SUSTAINABILITY

As previously discussed, the scaling theory for C2C is driven by the commitment to identify and grow cost-effective and replicable mental health strategies in NYC. Co-locating mental health services in nonprofits across the City will expand promising strategies while growing the evidence base for this particular model under diverse conditions with new populations--a precondition for further replication

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or expansion. Ultimately, if it has evidence of impact and cost effectiveness, the approach is more likely to be adopted as key components of local, state, and federal human service contracts with CBOs.

To further the continuity of new services offered through C2C, the partnering MHP will leverage their existing knowledge to develop a feasible plan for sustainability beyond life of funding. This plan will build on MHP expertise in reimbursement systems (for those CBOs that can feasibly integrate permanent mental health staff and wish to become licensed MHPs themselves), funding sources, enhancement of existing revenue streams to fund new services, seeking additional collaborative partnership opportunities, and optimizing workflow of providers to meet clients' needs. The Learning Community will likewise directly build subgrantee capacity around the delivery of ongoing integrated mental health services by sharing best practices developed through the course of the project on topics such as 1) partnership strengthening strategies; 2) client messaging and recruitment for services; 3) staff support; 4) optimal application of modalities, effective use, and ongoing development of a set of CBO skills and steps in care pathways; and 4) workflows, staffing business plans, etc. to inform sustainability including better understanding of costing with which to engage Medicaid managed care Plans. Competitive subgrantee applicants will include a long-term plan in their proposals that incorporates strategies leveraging existing resources and developing new resources as an outcome of the partnership.

The Collaborative will employ a strategy for sustainability similar to those it has used for other data-driven public health programs it has grown from pilot to scale, including many described above (see Section B4 GROWING SUBGRANTEE IMPACT). NYC Shop Healthy is a recent example. This model partners with community based organizations and local businesses to address the widespread, well-documented lack of access to affordable, healthy foods in low-income communities (Dannefer, Williams, Baronberg, Silver 2012). Thanks to a partnership model and positive evaluation findings, Shop Healthy is expanding to more NYC communities, and becoming a model for other jurisdictions and the federal government. By partnering with food retailers, community groups, and food distributors on Shop Healthy, this partnership between CEO and DOHMH has increased the availability and prominence of healthier foods in target communities, while educating communities to make healthier choices. The program, which began in 2007, uses an innovative community-based and community-focused approach to: 1) provide food retailers with technical support and marketing materials to increase the availability and prominence of healthy foods in stores; 2) empower

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community residents as partners in creating healthy food retailers through the "Adopt a Shop" program; and 3) partner with major food distributors to facilitate the wholesale purchasing and distribution of healthy foods while highlighting healthy food items available to food retailers.

Evaluations have found that Shop Healthy increased the stock and promotion of healthier foods in neighborhood stores and raised awareness about healthy eating among store owners and community residents. Specifically, evaluation findings showed that Shop Healthy increased advertising for healthy products; increased the stock and promotions of healthy foods and beverages; promoted healthier purchases; increased sales and profits; increased knowledge about healthy foods among food retailers; developed relationships with suppliers; and extended their reach to community groups (NYCDOH 2014). With such promising results, CEO is supporting DOHMH's abilities to expand Shop Healthy to new communities, and is sharing learning with other cities, national nonprofits, hospitals and recently with the Centers for Disease Control and Prevention's Healthier Food Retail Strategies leadership team.

The Collaborative is aware that bringing effective programs to scale requires the alignment of interest and commitment from policymakers and support from a broad range of stakeholders. The concurrent rollout of Medicaid Managed Care for behavioral health in New York State positions the Collaborative to broker and encourage payment arrangements which could potentially support integrative models such as C2C. The C2C model also captures other local efforts spearheaded by New York City First Lady Chirlane McCray to support these kinds of comprehensive mental health service models.

### Citations

Preston, Elo, 2013 <http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4457.2013.00648.x/abstract>

Dannefer, Williams, Baronberg, Silver 2012,

<http://www.nyc.gov/html/doh/downloads/pdf/pan/shop-healthy-implementation-guide.pdf>

New York City Department of Health and Mental Hygiene, 2014.

<http://www.nyc.gov/html/doh/downloads/pdf/pan/shop-sealthy-report.pdf>

New York City Department of Health and Mental Hygiene. Shop Healthy NYC Year 1 - West Farms and Fordham, Bronx Final Evaluation Report. Accessed 23 Oct 2014.

<http://www.nyc.gov/html/doh/downloads/pdf/pan/shop-sealthy-report.pdf>

# Narratives

## Budget/Cost Effectiveness

### D1 BUDGET JUSTIFICATION

This proposal's budget includes resources for the Collaborative's intermediary partnership, subgrantee program operations, and collaborator and other support costs for the selected independent evaluator and TA providers. The budget includes 12 months of intermediary costs and 12 months of subgrantee operations.

All expenses referenced below support the eGrants budget submission, which does not include an in-kind contribution from CEO of approximately \$100,000 per year. The Year 1 budget of \$4.4M will be spent on subgrantee site selection and due diligence reviews, start-up activities to adapt the program to local conditions, evaluation design work, systems-building to support an evaluation, staff training and program piloting activities, and service delivery. (With annual subgrantee match of \$2.1M, the TOTAL project budget will be \$6.5M.)

Personnel + Fringe -

\$340,120

The SIF Director, Sinead Keegan, will ensure that all SIF requirements are met in the implementation and evaluation of C2C, drawing on her four years of experience managing MF's 2010 SIF grant -- a five year, \$85 million program. Two program managers, located at DOHMH, will be hired to work with the evaluators to ensure performance management standards are met and to facilitate appropriate TA. One new Fiscal Monitor will be hired to conduct fiscal monitoring activities and to help ensure that subgrantees' fiscal systems are adequate under the direction of the Fiscal Management Consultant.

Travel -

Grantee Industry and Stakeholder Conferences = \$8,000

To communicate with key stakeholders in the public health, government, and evidence-based funding sectors, Collaborative staff members will participate in conferences throughout the year. Estimated at \$800 per conference, the budget includes funds for 10 staff to attend per year.

Annual SIF Grantee Convening = \$3,910

Five staff members will attend the annual SIF Grantee Convening: 5 people (Executive Director, SIF Director, Project Lead, Evaluation Lead, and Fiscal Advisor) X \$216 ground transportation + \$106

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meals + \$260 lodging + \$200 conference fee = \$3,910

Equipment -- No equipment will be purchased in year 1 of the SIF grant

Office Supplies -

\$1,000

Expenses include shipping costs for mailings such as sending applications to reviewers during the subgrantee selection process; printing of flyers and educational material to publicize the subgrantee applications; and meeting expenses for subgrantee review committees.

Contractual and Consultant Services -

\$1,533,280

Evaluation and technical assistance services will be contracted to competitively selected partners with a demonstrated track record of success. The Year 1 budget of \$1.45 million includes approximately \$300,000 for TA activities. The projected budget for evaluation includes evaluation design, site visits, data collection (baseline data, administrative records from multiple state and local agencies), observations, in-depth qualitative interviews with staff and participants, data processing and coding, analysis, and dissemination of results. Findings will be shared with the Corporation via memos, briefings, and reports.

Learning Community -

In Year 1 the Learning Community will support one all-site convening in New York City that will kick off C2C. The event will introduce representatives from across the citywide network to each other and the collaborative will present its goals for the project. In addition, the collaborative will provide TA related to compliance, program implementation and evaluation.

Learning Community Event budget for 40 people = \$10,000 for space, food, and photo/video.

20 site representatives; 8 MF/CEO/DOHMH staff, 5 evaluator staff, 5 NYC Government Partners; 6 Funders/external partners

In addition, the Collaborative will coordinate smaller cross-site events as needed to foster site-to-site learning communities. Estimated budget = \$3,100.

Fiscal Management Consultant -

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Brigit Beyea is the Fiscal Management Consultant for SIF at MF. Her rate is \$585/day. For C2C, MF staff (including one newly hired Fiscal Advisor) will conduct all due diligence, fiscal monitoring, and oversight under Ms. Beyea's direction. Ms. Beyea will ensure that fiscal systems are sufficient at the intermediary level to manage both the 2010 and 2015 SIF grant. She and the team will also work with subgrantees to ensure their systems are adequate and that they are compliant with federal guidelines.

### Grants Management System Transfer -

At the beginning of the 2010 SIF grant, evaluation and technical assistance partner MDRC custom-built the GMS for MF and MDRC staff reviewed and approved all expenses before submission to MF. These professional services for fiscal monitoring were necessary because of the large size and complexity of the \$85 million, 18-subgrantee 2010 grant. For SIF C2C -- estimated to be a \$32.5M program with 12 subgrantees - MF will conduct all fiscal monitoring activities. We estimate the Year 1 transfer costs to be \$7,000.

### Other Costs

Criminal History Checks -- CHCs are budgeted for the 3 MF staff and 1 fiscal consultant who will be paid with SIF funds, with additional CHC's budgeted in the case of employee turnover.

Program Subgrants -- C2C's budget includes subgrants totaling \$2.1M (to be matched 1:1 by subgrantees). Program operating costs were estimated using data from programs that have similarly co-located mental health services and from programs that have integrated other types of services into social service programming. In addition, DOHMH oversees mental health services and so estimates were based on rates at agency centers.

In keeping with the Corporation's priorities, over 80 percent of the federal award will be provided as subgrants. Approximately \$2.1M (including additional Intermediary funds) would be awarded to subgrantees in the first year.

### D2. CAPACITY TO RAISE MATCH

Overall, MF raised approximately \$58 million in intermediary and subgrantee funds on behalf of the 2010 SIF grant from over 30 philanthropic partners.

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Fundraising for C2C will be led by Matt Klein, Executive Director of CEO, Darren Bloch, Executive Director of MF, and Gabrielle Fialkoff, Director of the Office of Strategic Partnerships and Senior Advisor to Mayor Bill de Blasio. This proposal aligns with the NYC Mental Health Roadmap, a top priority of the Chair of the Board of the Mayor's Fund, First Lady Chirlane McCray.

With support from program staff not funded with SIF resources, they will leverage the opportunity provided by the grant award to generate private sector funds in each partner city to meet the match requirement of the SIF. As in the 2010 grant, MF and CEO will liaise with government and private sector leaders and highlight the advantages of participation in C2C -- which include opportunities to collaborate on the shared anti-poverty agenda and contributing to finding solutions to inequality.

The Collaborative has already raised \$1 million as match for this application from the following sources: \$250,000 from the Perelman Family and Chapman Perelman Foundations; \$250,000 from the Benificus Foundation; \$350,000 Center for Economic Opportunity (unrestricted city tax levy); \$150,000 from Mayor's Fund to Advance NYC (unobligated cash-on-hand).

Given that improving mental health outcomes for low income New Yorkers is a top priority for the Mayor's Fund and its Board of Directors, and for CEO and the Department of Health and Mental Hygiene, the Collaborative is confident that it will meet the total fundraising goal for C2C.

### Clarification Summary

#### PROGRAMMATIC

1. The application provides a variety of general outcomes for this program. Please identify the specific outcomes and provide more detail on the outcomes that this initiative desires to realize.

By increasing access to mental health services, this initiative aims to improve the mental health of participants, and in turn increase participants' likelihood of successfully achieving positive results in the social services in which they are enrolled. We would therefore track both mental health outcomes, and participants' respective social service programmatic outcomes.

These outcomes would include:

A. Increased access to and uptake of mental health services

- Number of mental health screenings conducted
- Number of referrals for mental health services internal to organization, and completion of referral
- Number of referrals for mental health services external to organization, and completion of referral

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- Mental health service attendance (attending scheduled appointment at mental health services following referral)
- Decreased client perception of stigma in accessing mental health services
- Adherence to mental health medications and therapy

### B. Improved mental health

- Reduction in self-reported mental health-related symptoms such as depression, anxiety, posttraumatic stress disorder, and substance abuse
- Improved self-reported quality of life

### C. Program specific outcomes (for relevant populations):

- Increased retention in programmatic services (duration)
- Increased social stability as relevant to specific CBO populations including:
  - Housing: housing stability (days homeless)
  - Criminal justice involvement: reduced recidivism
  - Employment: job placement rates, retention, and earnings
  - Education: educational persistence and achievement

In addition to participant level outcomes, the CBO and MHP will also report regularly on organizational level performance and outcomes. Our goal is to understand the implementation challenges associated with integrating additional mental health services into programmatic strategies to inform broader adoption, should the evidence warrant it. MHPs/CBO organizational outcomes to be tracked include, but are not limited to:

- Increased capacity to delivery mental health services and improve mental health outcomes for their clients;
- Increase in the delivery of mental health care services (counseling/therapy sessions/medication(s)) by their patients
- Increase in the coordination of care with CBOs that enroll their patients
- Number of staff starting and completing training in mental health modalities
- Number of therapy modalities delivered
- Decrease in their patients barriers to care
- Reported change in staff's ability to implement mental health services (screenings, modality implementation)
- Number of staff hours devoted to mental health services (task shifting)

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The selection process will be designed to ensure that SIF sub-recipients are prepared for the significant data analysis that our model will entail. During the subgrantee selection process, applicants will be asked to demonstrate a track record of data collection for program management and improvement, and describe how data collection for this initiative will be incorporated into their existing processes and systems.

Using data reported by subgrantees, MF/CEO/DOHMH will use an array of outcomes pre-determined with subgrantee input to conduct on-going performance management. This performance monitoring will regularly track participant demographics, service participation and completion, and basic outcome data.

The selected independent evaluator will track additional metrics, using data from subgrantees and a range of sources. The evaluator will specifically be tasked with measuring changes over time from baseline over the course of the evaluation. Metrics and targets for the independent evaluation will be refined in partnership with MF/CEO/DOHMH, subgrantees, and the selected evaluation firm.

2. Contracted partners, such as MHPs will need to be identified during the subrecipient selection process by organizations applying to be subrecipients. Given the centrality of the MHPs to the success of the C2C initiative, please confirm that Mayors Fund intends to require that subrecipients contract with MHPs in accordance with the procurement requirement outlined in the NOFA (please provide detail on how the applicant will ensure that this requirement will not hinder the timeline of the selection or the quality of the subapplicants), MHPs will be assessed on their capacity to deliver services, and MHPs will be part of the evaluation. Additionally, please provide detail on the role MHPs will play in the evaluation.

The subrecipient selection process will be structured to ensure that the strongest applications include a qualified subgrantee in partnership with a qualified MHP. Subgrantees will be asked to demonstrate that their selected MHP partner has the capacity to deliver the required services, a track record of success with similar projects or populations, appropriate state licensing, and other standards. Subgrantee applications will be assessed in part on the quality of the MHP partner and the strength of the partnership. For example, the application will request evidence of successful outcomes related to mental health services from the MHP, and will request evidence of prior successful collaborative

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projects between the subgrantee and the MHP. The subgrantee selection process will be completed in six months, as required by the NOFA and the terms of this award. In line with its due diligence, TA and monitoring functions, MF/CEO will ensure and monitor that subgrantees contract with MHPs in accordance with the procurement standards required by the grant.

The full partnership (including the lead subgrantee and the MHP) will be central to the program's evaluation. MF and the selected evaluation partner will seek input from the subgrantee and MHP on the evaluation design. Like the subgrantee, the MHP will provide qualitative and quantitative data on participant outcomes, as appropriate, and organization-level changes. While the primary focus of the evaluation will be on the individual level outcomes described above, the evaluation will also assess the quality of the partnership to determine strong and replicable strategies for building effective partnerships between MHPs and social service programs. Research into task-shifting and mental health service co-location are central to the evaluation and understanding how this strategy can be scaled if determined to be effective. Information on the MHPs will look at how the intervention affects their client flows, and how it affects their healthcare reimbursement rates and revenues. The study will also assess the best practices of the MHPs in delivering training and support to CBO staff.

For example, C2C will specifically build evidence about the effectiveness of co-locating mental health services in CBO settings by engaging with MHPs to investigate the following:

- 1) Whether clients have improved mental health outcomes (such as improved mental and physical health indicators, improved reported quality of life, reduced substance abuse, or preventable hospitalizations)
  - 2) Whether clients achieve their intended program outcomes at a greater rate than clients with mental health needs who do not receive the services
  - 3) Finding the average per-person cost in relation to mental health and programmatic outcomes (The study will also estimate anticipated cost savings to the nonprofits and to government (for example in Medicaid spending, ER visits, reduced hospitalization rates, and missed appointments) resulting from improved participant outcomes, as well as increased revenues to city, state, and federal government through potential increased earnings for participants as they are better equipped to enter the workforce and maintain employment, for example.)
  - 4) What resources are required to operate the evidence-based components of the model?
- MHP data across funded CBOs will also be analyzed to examine differences in subpopulations, to

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understand how the interventions may have different impacts by gender, race, socio-economic status, or other demographic factors.

3. The application states that CEO will provide subrecipients with technical assistance to meet its match. Since match funding must be derived from new or unobligated funds, please provide details on the types of tools/assistance that CEO will provide to subrecipients that may struggle with competing organizational priorities.

CEO will provide subgrantees with general fundraising technical assistance in the areas of communications, using data to tell their story, and general outreach and donor cultivation skills development. For example, should a CBO need to expand their fundraising base to funders focused on mental health, CEO will enlist the Mayor's Fund in brokering collaborative partnerships among subgrantees and specialized funders. Additionally, CEO will assist in the development of fundraising materials and attend fundraising meetings at the subgrantee's request. CEO/MF will also convene funders for briefings about the project and continue to highlight it as a priority project for the First Lady.

4. Please explain how CEO will provide TA to subrecipients that will need to compete with each other to identify funders in the same region to allocate funds to their specific SIF programming.

In addition to brokering funding relationships, Mayor's Fund will also work to organize and eliminate competition among subgrantees where need be. Improving mental health outcomes is a core priority of NYC First Lady Chirlane McCray, who is Chair of the Mayor's Fund Board. The Mayor's Fund/CEO, with experience in successfully raising over \$50 million for its first SIF award, will be engaging with a wide array of donors and foundations to raise the intermediary match, and during this time they can assist in brokering matches for subgrantees to ensure that the fundraising process is coordinated rather than competitive. There are funders who prefer to directly fund a subgrantee rather than funding intermediary costs, and MF/CEO will introduce those funders to subgrantees. MF/CEO will also work to segment subgrantees according to geographic area of the city and/or area of core service delivery expertise (e.g. young adults, employment) and foster connections with funders aligned with those geographic and service areas.

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### BUDGET

1. In your budget narrative- H. Other Costs: Please add in sub grantee match. The intermediary has a 1:1 match and the sub-grantees have a 1:1 match.

This has been addressed in eGrants.

### Continuation Changes

N/A