B. Experience and Expertise (20 points)

Describe the qualifications and the successful experience of the applicant and the MHP as they relate to the preferred qualifications and experience described in Section III – Scope of Services and Requirements. This should include, but is not limited to:

For the lead applicant (CBO)

a. The history and mission of the organization, and populations served by the organization. Hetrick-Martin Institute (HMI) has been providing direct services to Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth since 1983. Service provision for the Institute began organically as the results of HMI's (then called the Institute for the Protection of Lesbian and Gay Youth) early advocacy efforts and highly visible presence which attracted the very youth the organization was representing. Today, we work with over 2,000 youth a year, offering a continuum of services designed to provide youth with the skills necessary for a productive transition into healthy adulthood. Our Youth Services Department (YSD) provides homeless outreach services, health & wellness, job readiness, academic enrichment and arts & cultural programming. Our services are offered year-round and at no cost to young people. Positive Youth Development (PYD) is the theoretical framework in which we ground our programming. We conduct HIV testing, and make housing and medical arrangements for homeless or marginally housed youth. We link youth at high risk for HIV/AIDS infection to community providers and offer a peer outreach program model in which youth use theater and performance art to communicate safe sex and HIV prevention messages to peers. Clinical testing services are provided through SUNY Downstate (HEAT program) and Callen-Lorde Community Health Center. HMI also offers substance abuse/ harm reduction interventions; high-impact HIV/STD/HCV testing; legal services, medical and housing referrals; hot meals, pantry, and other supportive services. HMI's After School Program provides education and services in Academic Enrichment, including a high school equivalency program; Job Readiness/Career Exploration; Health and Wellness; and Arts and Culture.

b. Details on the current level of the CBO's performance–including the number served, populations served, impact, the programmatic needs of the population(s) proposed to be served, key outcomes, and different services offered. HMI serves 2,000 LGBTQ youth annually, which includes approximately 600 new youth each year. Three hundred (300) youth participate annually in Arts and Culture programming and nearly 100% of HMI youth take part in our innovative Health and Wellness Program, including HIV-prevention. Last year we served 8,000 hot meals to the target population. From January through August of 2015, HMI served 1,200 unduplicated youth on site, of which 367 were new to HMI. We expect this number to increase to approximately 1,400 youth by the end of this year. However, our major focus in the proposed C2C program will be providing core mental health services to out of school, out of work young LGBTQ adults (16-14) and unemployed or underemployed low-income working-age adults ages 18 and over receiving employment-related services who we engage through targeted street outreach (3,672 youth to date); HIV prevention outreach (2,808 youth to date); and young adults engaged through our Community Outreach and Engagement program (875 youth). We are seeking C2C funds to provide core mental health services to these thousands of youth so that we may help them access services and most importantly engage in conversations and social media communication that de-stigmatizes mental illness. The most common reasons that LGBTQ young adults with mental health issues are not being helped are stigma, limited access to care, lack of education

about mental health, fear about how they will be treated as LGBTQ persons, and perceived consequences about what it could mean to disclose personal information to a provider. HMI's successes with LGBTQ young adults include a 92% graduation rate at Harvey Milk High School, which is a NYC Department of Education Transfer Public High School founded in 1985 by HMI and residing on its premises; a GED graduation rate of 82%, which is double that of NYC; 1,500 annual unduplicated instances of pantry utilization by homeless and runaway LGBT youth; a Health and Wellness track that tests more than 400 young people each year for HIV, STI/D and pregnancy and connects them to medical follow-up and care; a Job Readiness track that links more than 400 youth with over 150 corporate partners; as well as a mental-health based Arts and Culture track designed to instill self-resiliency and supportive services that include counseling and case management. The programmatic needs of this target population are many. Most youth require basic support services including: Clothing: 324 unduplicated youth received 288 clothing services; Emergency Food Packages: 224 unduplicated youth received 1,597 emergency food packages; Laundry and Shower services: 149 youth received 710 laundry and/or shower services; Hot Meals: 606 unduplicated youth received 5,575 hot meals in Café HMI; HIV Rapid Testing: 265 youth enrolled in the HIV testing program; Counseling: 174 youth received 1,913 counseling sessions;Group Intervention Sessions/Support Groups: 750 unduplicated youth participated in group sessions (average of 14 sessions per youth [10,792 services total]) and 244 youth participated in risk reduction services; and Academic Case Management: HMI provided 62 Harvey Milk High School students with 417 individual Academic Case Management services. The impact of our services include the reduction of homelessness among LGBTQ youth; an increase in youth graduating from high school, attending higher education and obtaining employment; an increase in the number of youth who receive primary health care and HIV testing and prevention services; a reduction in the number of youth exposed to sexual assault, street and intimate partner violence; a reduction in the number of youth with eating disorders and self-harming behaviors; and a reduction in the number of youth requiring psychiatric hospitalization.

c. The CBO's total staff size, as well as the number of direct service staff. HMI has 63 staff members, 50 of whom are direct service workers. Race/Ethnicity: Black – 39%; White – 28%; Latino – 22%; Asian – 6%; 2+ races – 3%. Age range: 30-39, 44%; 40-49, 19%; 20-29, 16%; 50-59, 14%; over 60, 6%. Sexual orientation: LGBTQ – 66%; Heterosexual – 14%; Unidentified – 19%.

d. The target population(s) to be served through C2C, and the contracts/programs of the CBO that currently serve them. List the service levels and outcomes for the past three years. Characteristics of the Target Population. HMI serves one of the country's most vulnerable populations. For instance, 92% of our members are youth of color and more than 80% are classified as living at or below the federal poverty line. The majority come from communities that are identified as being among the lowest income neighborhoods. Nearly all experience debilitating societal stigma. As a result of conflicts with family members, peers and other adults over issues of sexual orientation and gender identity, 30% of LGBTQ youth are forced out of their homes. In fact, 40% of HMI's young people report being chronically homeless (living on the street, not in an emergency shelter), with more than 80% having transient housing situations. This has led to disconnection from educational and community services that address such critical issues as poverty, depression, substance abuse and risky sexual behavior. Our youth experience exacerbated levels of trauma and stress unique to low-income communities. Traumatized children and youth

often sustain damage to critical elements of their development which manifests into adulthood. Important assets such as healthy attachment, social and emotional competency, self-esteem, confidence and independence can be undermined as a result of trauma. Many of the youth at HMI have witnessed or experienced violence and have been traumatized at the hands of a parent or caregiver. To make matters worse, over 80% of LGBTQ youth are verbally harassed at school, while 40% are physically attacked. HMI's intake data shows that 19% of our youth have been hospitalized for psychiatric reasons and 28% report suffering from depression. In fact, LGBTQ teens are three times more likely to attempt suicide and over 36% of the young people we serve already made at least one suicide attempt before coming to HMI. Add to this the knowledge that a disturbingly high number suffer from increased rates of homelessness, alcohol use, unsafe sex, incarceration and sexual exploitation. **Sexual orientation:** 20% of the youth and young adults identify as Lesbian; 20% identify as Gay; 30% identify as Bisexual; 2% identify as Queer; 15% identify as Heterosexual; 1% identify as Questioning; 2% identify as Other (Asexual and Pansexual). **Gender Identity:** 47% of the youth and young adults identify as Male; 45% identify as Female; 6% identify as Transgender Female; and 1% identify as Transgender Male. **Age Range:** 12% are 12 – 15 years old; 72% are 16 – 20 years old; 16% are 21 – 24 years old. This means that 88% of the target population fall between ages 16 and 24. **Employment:** 80% of the target population is out of work. **Education:** 60% are out of school. HMI currently holds contracts from New York State Department of Health (DOH), Public Health Solutions, DYCD, NYS Education Department, NYC Department of Health and Mental Hygiene, and the Dormitory Authority of NY. During the last 3 fiscal years HMI served 6000 LGBTQ youth, approximately 2000 for each year. 4,200 of this number received services at HMI and the others were engaged in the community. We provided clothing to over 900 youth and young adults; emergency food packages to over 650 young adults; laundry and shower services to 300 young people; hot meals to 1,800 unduplicated youth; HIV Rapid testing to over 800 youth; Counseling to over 500 youth; Academic enrichment services to 180 young people.

e. CBO applicants should not currently have mental health specific services on-site serving the target population. Confirm that the CBO does not have these services. Overall the CBO applicant should have limited experience in delivering mental health services[1]. HMI is applying for C2C funds because our capacity to provide mental health services far exceeds the need for the target population. As a result of our successful outreach and engagement efforts (one of the most successful and robust in the city), during which we engage upwards of 3,000 unduplicated youth and young adults annually, we have the potential to provide the C2C core mental health services to many hundreds of more LGBTQ young adults for which we currently have no capacity. Additionally, each year 600 new LGBTQ youth and young adults receive intakes at HMI, many of whom are unable to access mental health services at HMI due to capacity issues. While HMI does provide some supportive counseling services, and includes Licensed Clinical Social Workers and others on its staff, this capacity is too limited for us to bring core mental health services to thousands of young adults who are not currently engaged in services at HMI and with

[1] The Q&A issued in conjunction with this RFP states: "As stated in the question above regarding multi-service organizations, C2C is targeted to organizations with limited experience in mental health services. A multi-service nonprofit CBO with an article 31 clinic is eligible to apply [HMI does not have an Article 31], but the applicant must successfully demonstrate why and how C2C is needed for the organization to build capacity among non-mental health staff and why such cross-training and referral is not otherwise already occurring. The Mayor's Fund collaborative seeks CBOs with a significant need among their service populations and their staff for C2C."

whom we meet at community events. We are interested in using C2C funds to train our non-mental health team at HMI including those who engage LGBTQ young adults at community events, street fairs, through street outreach and Gay Pride celebrations so that they will be able to provide quality engagement around mental health needs, and bring disconnected young adults into a continuum of mental health care. HMI Youth Services staff work with CBO's and community partners to plan and implement Saturday youth conferences, or Youth Summits, for LGBTQ youth in each of the five boroughs of the city throughout the year, engaging hundreds of isolated and newly identified LGBTQ youth, particularly youth of color, throughout the city each year. We also would like to have the capacity to provide C2C mental health core services to the Ballroom Community (urban youth who congregate and compete in dance/voguing competitions).

For the MHP

a. The history and mission of the MHP entity, and its track record in the community proposed to be served, if applicable, and with low-income populations. Describe numbers served over the past three years and the portion of those that are low-income and/or related to the target community. Describe participant outcomes tracked and achieved. For over 47 years, the Mount Sinai Adolescent Health Center (the MSAHC) has provided confidential and free health care, mental health care, related services and supports to adolescents and young adults aged 10-24. Although the MSAHC services adolescents and young adults from all five boroughs of New York City, the majority of MSAHC's young people live in Harlem and the South Bronx. These are communities that are disproportionately poor. The poverty levels in Harlem are 29.5% for zip code 10027, 28% in zip code 10029, and 41.2% in zip code 10035. 40.3% live below the poverty level in the South Bronx. These areas are also home to a high percentage of unemployed (38.5% are employed as compared to the statewide average of 58.1%). The three zip codes in Harlem are home to 173,559 residents, of which over one third are under the age of 24. There are 87,723 residents in the South Bronx of which almost half are under the age of 24. The areas also contain a high percentage of non-white individuals with 44.05% identifying as Hispanic or African-American (as compacted to a statewide average of 34%). factfinder.census.gov, ACS demographic and housing estimates. MSAHC patients are a reflection of these statistics as 98% are from low income families, and 92% are people of color (Hispanic and African-American). These are needy and underserved communities. MSAHC has pioneered a youth development model that guides the services, supports and opportunities available to our young people. MSAHC's core belief is that young people need to be physically and emotionally healthy to make it in this world, and that high-quality care is their right and our responsibility. In the past few years, MSAHC has seen a dramatic increase in the number of LGBTQ youth and young adults accessing services, particularly transgender youth.

b. The MHP's experience with the core C2C modalities listed on page 5 and with any additional modalities proposed for C2C. Describe the training and credentials of staff in these areas, the supervision of staff in delivering these interventions, and any other relevant background in these areas. Screenings for common mental health conditions. The MSAHC provides comprehensive psychological and psycho-educational screening and testing. These evaluations use standardized and validated measures to assess cognitive, academic, neuropsychological and social-emotional functioning. Psychological testing enables them to provide further diagnostic clarity in order to guide treatment for their most complex patients. The MSAHC mental health professionals utilize various assessment tools as needed, including the

UCLA PTSD reaction index, BDI, BAI, CRAFT, and Conners Scale. These tools screen for depression, substance use problems, trauma and PTSD, and anxiety. The MSAHC mental health staff utilizes these tools, and have provided training so that non-mental health staff have a high proficiency in screening. This is particularly relevant in their primary care initiative in which medical personnel utilize mental health screening tools in order to evaluate the need for immediate mental health care, provided in a manner described as the "warm hand-off" from the medical provider to the mental health care practitioner.

Motivational Interviewing (MI) has as its basic tenet empowering the patient and allowing the patient to control and direct the process. It is a non-judgmental, flexible process. Patients are guided to make positive decisions or to identify needs. The MSAHC mental health professionals utilize MI and have taught non-mental health professions to do MI, including follow up questions and how to refer patients to care. This screening process has been particularly successful at the MSAHC where they have been successful in moving those patients assessed as needing Mental Health care into care by aiding them in making those decisions for themselves. This also has the benefit of increasing patient compliance and interest in reaching care outcomes. **Mental Health First Aid** is employed by non-mental health MSAHC staff, and MSAHC has provided trainings to non-mental health staffs at several community based agencies. The goal of this method and training to help non-mental health staff increase their knowledge of signs, symptoms and risk factors of mental illnesses and addictions. The training enables them to be able to identify multiple types of professional and self-help resources for clients with a mental illness or addiction; increase their confidence in and likelihood to help an individual in distress; and to show increased mental wellness themselves. Additional MSAHC staff are in the process of obtaining certification for training in Mental Health First Aid. **Psychoeducation.** MSAHC trains its staff, and non-mental health staff at other agencies on best methods to work effectively with the LGBTQ adolescent population. Part of the training is to learn how to provide information to patients in a way that destigmatizes a need for mental health and empowers the individual (and the family if appropriate) to reach decisions on the viability of mental health care, to find that mental health treatment is valuable and necessary, and to defeat any perceived emotional and societal barriers to care (i.e., that mental health treatment is a sign of weakness or that accessing mental health care is shameful or the patient is "crazy").

c. The MHP's current level of performance and how it has effectively used data to make significant programmatic changes in operations. MSAHC continues to evaluate, research, and enrich their comprehensive suite of mental health services. They review and assess treatment protocols, patient population, needs, and trends in care. MSAHC is also in the final phases of a five-year, rigorous, third-party evaluation of their service delivery model by ICF International. This study will help MSAHC's leadership determine the effectiveness, appropriateness and policy implications of their adolescent-centered, holistic, confidential health service delivery model. With the help of the New York State Health Foundation, MSAHC is also establishing a blueprint of their model in order to inform the design and delivery of services for young people nationwide.

d. The MHP's experience training lay (non-mental health) staff and/or providing technical assistance. Describe any specific experience with the modalities described in this RFP. If the MHP is engaging a TA partner or vendor, describe the experience of the partner or vendor. The MSAHC is a trusted partner to community based organizations and schools. They have collaborated with numerous New York City schools and community centers in providing

education to youth and young adults on various issues, including pregnancy prevention, HIV and safe decision making for over 25 years. Since 2010 MSAHC has provided a violence prevention and intervention twice a year at an alternative high school for students facing academic failure. The trainings are also aimed at the adults who come in contact with the youth, such as teachers and community leaders. MSAHC staff has also presented on understanding psychosocial and cultural stigma and risks facing LGBTQ youth and the practices and goals of therapeutic as well as therapeutic methods for addressing family rejection and promoting family acceptance. MSAHC staff has extensive experience in training medical students and residents on how to sensitively interview youth.

e. The configuration of its mental health service professionals, including the number of mental health delivery staff and current capacity for taking on new participants. MSAHC's mental health staff includes two Board Certified Child and Adolescent psychiatrists, three clinical psychologists and 15 licensed social workers, all trained in TF-CBT and brief strategic family therapy. Seven are trained in DBT. Their multidisciplinary teams include physicians, psychiatrists, psychologists, nurse practitioners, social workers, a legal consultant, and others with the expertise to engage our youth. MSAHC is in the midst of implementing their strategic plan to increase our patient level by 1,000 additional youth and young adults each year.

f. The MHP's (and any additional partner/vendor) experience participating in and/or managing collaborations. MSAHC has over 100 community based partners and long -established linkages with faith based organizations, schools, and youth serving institutions.

C. Organizational Capability (15 points)

Demonstrate the applicant's organizational (i.e., programmatic, managerial, and financial) capability to provide the work described in Section III – Scope of Services and Requirements.

1. Program Management (of lead applicant CBO)

a. Describe and demonstrate the effectiveness of how the applicant currently uses data to support decision-making in existing programs. HMI uses its intake tool to collect a vast amount of information about young people, allowing us to develop and refine programs designed to their life experiences and present conditions. With the recent development of our Advocacy & Capacity Building Department, we have created the opportunity to take a closer look at the information provided by youth and young adults at the point of intake and more importantly, begin to address and change barriers to service provision. Demographics are collected on various levels. Youth and young adults are asked to provide sex assigned at birth, as well as current gender identity, along with sexual orientation and pronoun preference. Race and ethnicity are identified separately to allow for a nuanced understanding of these limited categories. Youth and young adults are also asked to identify their involvement with child protective services, foster care and group home placement. The tool then allows for youth to choose from a list of areas they believe support would be helpful. Those areas include concrete survival areas, such as housing and food, along with safety issues, legal assistance and crisis counseling. This area includes a listing of 14 items which youth can identify as areas of need. Confidentiality is assessed in various locations throughout the tool.

b. Demonstrate how the applicant has effectively used data to make significant programmatic changes in operations. Provide two specific examples. Provide any relevant results of prior evaluations or examples of how evaluation findings influenced service delivery. Include any examples of experience with previous external evaluation activities, if any. We know from HMI intake data that 31% of youth reported suicidal thoughts with 13% reporting that these thoughts are regular; 15% of youth reported eating disorders including bulimia and anorexia; more than 70% of youth reported self-harming behaviors, including incidents of cutting and burning; 29% of youth reported physical abuse; 21% of youth reported sexual abuse; 11% of youth reported incidents of sexual assault; 18% of youth reported incidents of rape; 14% of youth reported incidents of dating violence; and 19% of youth have been hospitalized for psychiatric reasons. These troubling data has resulted in our efforts to expand our street outreach services from our current sites which include Lower Manhattan (Christopher Street Piers, Staten Island Ferry Terminal, Union Square Park, Tompkins Square Park, etc.) and Times Square/Port Authority Bus Terminal, sites in Brooklyn (Red Hook, Sunset Park and Coney Island) and the Rockaways. Expansion sites will include street outreach in Harlem, Fordham Road in the Bronx, and in Jackson Heights, Queens – all sites connected with the sex work industry – and other targeted spaces referred to us through city leadership. Once homeless and street-involved youth and young adults have been engaged and their critical, immediate mental health and other needs are addressed, HMI will determine the appropriateness of family reunification. We will provide C2C core mental health services for these LGBTQ young adults so they will be able to access the care that they need.

c. Demonstrate the applicant's capability to successfully perform the administrative responsibilities related to the delivery of the proposed services, including fiscal management, data collection, reporting and records management in an efficient, accurate and timely manner. Our Board is a diverse group of 17 concerned community leaders -- all but one of whom are LGBT self-identified and 25% are racial/ethnic minority -- who work in the industries of finance, fashion, media, youth services and academia. The Board's Program Committee includes Jeffrey Birnbaum, MD, MPH of SUNY Downstate Medical Center and John Steever, MD, Mount Sinai Adolescent Health Center, who will be integral to the C2C project. The Board works closely with the HMI Community Advisory Board (CAB) which consists of HMI participants, alumni, community supporters, popular opinion leaders and other individuals reflective of the population with which we work. HMI prides itself on employing a culturally diverse staff that is reflective of the population we serve in all aspects, including racial/ethnic identification, language, sexual orientation, gender identity and transgender experience, education and social-economic-status. Senior staff is diversified in terms of age, race/ethnicity, and age. Most are LGBTQ. Since 2011 alone, HMI has executed and reported on over 20 government grants. We have a sophisticated fiscal structure that manages the budgets of each grant (COO, CFO, Director of Grants and Fiscal Administration, and two staff accountants), as well as a Data and Quality department that evaluates and tracks all deliverables and maintains the required reporting systems (Directors of Data/Quality Assurance and IT plus 2 Data Coordinators). Program reports are prepared by these two departments and the Department of Youth Services.

d. Demonstrate technological capacity and data security systems to protect participants' personal identifiable information. Grants from Robin Hood and the Moody's Foundation are enabling HMI to implement a Salesforce database, installation of which is currently underway. Our

introduction of the Salesforce system into our operations marks an enormous leap forward in our ability to analyze and apply 35 years of robust client data, an information trove that constitutes a unique national resource for understanding and serving LGBTQ at-risk youth. Once completed, this new system will significantly increase our data reporting capability. It will also assist HMI in refining (and, in some cases, expanding) the design of our youth services to ensure that we provide the highest quality, measurable outcomes tailored to meet the needs of at-risk LGBTQ youth, while also maximizing our ability to respond to the changing landscape of mental health service provision. It will also allow HMI to monitor youth responses to services in each service area and provide us with a cross-sectional view of participant involvement levels throughout HMI programming.

e. Describe and demonstrate how executives at the applicant's organization will be able to and have the availability to play an effective role in developing, implementing, assessing and overseeing the program. HMI has a Data and Quality Assurance Department that will work closely with the C2C Program Research staff to evaluate processes and outcomes. HMI already has several tools and techniques in place that will be part of the Evaluation and Performance Measurement Plan for the proposed program. We intend that all be utilized in support of this project. HMI executives participate in the following activities designed to develop, implement, assess and oversee the program.

- Regular Reviews: HMI holds a bi-weekly Management Meeting, where all managers in programmatic, administrative and executive departments share progress reports on projects, strategize on approaches and conduct continuous quality improvement reviews.
- Debrief & Design: Each year, HMI programming is halted for a period of three days to allow staff to participate in our Debrief & Design (DnD) sessions. During DnD, the Executive team and program staff review data from all programs, debrief on the findings and use the resulting information to modify programs in ways that best meet projected outcomes.
- Leadership from Board of Directors: During bi-monthly meetings of HMI's Board of Directors Program Committee, the Executive team and board members review overarching progress, numbers served and programs implemented under the C2C project.
- Community Meetings: HMI hosts a monthly "Community Meeting" of all program participants. This enables informal assessments and data collection to occur between youth and staff/volunteers. HMI's Chief Executive Officer participates in these meetings, allowing him direct access to our youth community, so that feedback is received at the highest levels of management. Participants engaged in EBIs offered at HMI will be encouraged to attend.

f. Describe experience managing collaborations, and recent successful collaborations that have benefitted the applicant's participants. Describe the capability to manage this project. A large part of HMI's mission is to provide training and resources to other organization so they will be able to better serve LGBTQ youth and young adults. Central to our collaborative efforts is HMI's Center for LGBTQ Youth Advocacy and Capacity Building which advocates on behalf of LGBTQ youth by influencing policy on local, national and international levels, while helping to build the capacity of decision-makers, individuals and institutions that serve this marginalized population. The Center also shares best practices for working with LGBTQ youth in all aspects of their life and addressing the disparities in services available to them. Through the Center, HMI extends our decades of leadership in this field so that our experiences may serve as models and be

replicated for those in need. We collaborate with educational facilities to establish safer schools and communities to prevent bullying and victimization; develop more effective policies targeting the health and wellness of our young people; promote increased funding opportunities that better address the needs of LGBTQ youth; and create effective programs and services that address the needs of LGBTQ youth. As a Department of Health-designated Center of Expertise for Sexual Health and Gender Identity, HMI is able to take critical issues to the highest offices in government, as well as internationally through the State Department and USAID.

2. Fiscal Capability

a**. Describe the applicant's experience managing government grants or contracts, if any.** Since 2011 alone, HMI has executed and reported on over 20 government grants. We have a sophisticated fiscal structure that manages the budgets of each grant (COO, CFO, Director of Grants and Fiscal Administration, and two staff accountants), as well as a Data and Quality department that evaluates and tracks all deliverables and maintains the required reporting systems (Directors of Data/Quality Assurance and IT plus 2 Data Coordinators). Program reports are prepared by these two departments and the Department of Youth Services.

b. Describe whether current financial management systems are in compliance with 2 C.F.R. 200.302(b) and capable of identifying costs by grant, by program year and by budget category, and to differentiate between direct and indirect costs. If not, describe what changes or technical assistance would be required. HMI's fiscal management systems are in compliance with 2 C.F.R. 200.302(b) and capable of identifying costs by grant, by program year and by budget category, and to differentiate between direct and indirect costs.

c. Demonstrate that the applicant has the requisite financial strength and resources to handle a project of this scale and scope; and ability to comply with federal requirements. HMI's total agency budget for FY2016 is $7,969,451 with total government contracts in the amount of $1,981,620; and total private revenues in the amount of $5,085,852. Our ability to raise private revenue is impressive with $2,225,000 from fundraising events, $1,489,000 from private foundations, and $733,000 in individual contributions. Our total personnel costs are $4,811,867 including fringe benefits. We have long experience complying with government contracts, including federal awards, and have successfully administered both large and small projects.

d. If the applicant has received federal awards in the past, summarize expenses or costs disallowed in the last three years and the corrective actions taken. We have had no disallowances.

3. Leveraged Funding

a. Demonstrate how the applicant will help leverage additional private or public (non-federal) funding sources for the program. As noted earlier, this grant includes a 1 to 1 cash match requirement. Organizations without a fully-developed fundraising plan are invited to apply, as Mayor's Fund will provide some technical assistance or other support to awarded SIF C2C subgrantee providers toward their fundraising requirements. The strongest proposals will demonstrate the applicant's capacity to raise the required match levels.

HMI is currently prepared to provide the 1:1 matching funds in unrestricted cash.

D. Proposed Program Approach (55 points)
Describe in detail how you will provide the services described in Section III – Scope of Services and Requirements, and demonstrate that the proposed approach will fulfill the Mayor's Fund's goals and objectives.

a. An overall summary of the proposed approach for implementing Connections to Care. As the Mental Health Provider, the Mount Sinai Adolescent Health Center (MSAHC) will train HMI's non-clinical staff in the C2C core competencies: Screenings for common mental health conditions and substance use disorders and misuse; motivational interviewing; Mental Health First Aid; and psychoeducation particularly for youth dealing with PTSD and depression. During the course of the program MSAHC will help HMI non-clinical staff to achieve task-shifting so that mental health capacity can be increased in our non-clinical programs and services including Job Readiness, Academic Enrichment, High School Equivalency, College Prep, Health &Wellness, and Arts and Culture program tracks. Non-clinical staff to be trained also includes those responsible for community outreach and youth leadership programs including our Youth Summits series which takes place throughout the 5 boroughs of NYC. MSAHC will train HMI staff in the core mental health components of C2C: screenings, motivational interviewing, mental health first aid, and psychoeducational interventions (particularly for youth dealing with PTSD and depression) so that these staff can "task-shift" in the way that the RFA describes. HMI and MSAHC will also collaborate on the creation of seamless, trauma-informed care models of referral and linkage to licensed mental health care. It is anticipated that at least 200 LGBTQ young adults will receive direct mental health care and support and services at the MSAHC. Referral to the MSAHC will be by patient approved referral forms that will be emailed or faxed to a designated recipient and will be accompanied by a HIPPA compliant HMI patient release and transmittal form. If the circumstances require, the HMI staff may accompany the youth to the MSAHC in order to effectuate a personal and immediate transition. In the event the circumstances warrant additional care, the patient may be referred to the Mount Sinai Medical Center for inpatient care. MSAHC will provide technical assistance to facilitate task-shifting through onsite and teleconference and will send mental health providers to visit HMI and interact with our youth face-to-face, conducting group level education and engagement. These providers will participate in "Doc in a Box" events where they will conduct presentations and Q&A sessions with the young adults to help reduce stigma and fear around going to a mental health clinic, provide education on psychopharmacology and medication side effects, and discuss with youth issues pertaining to mental health, impact of trauma, PTSD, substance use, transgender mental health care, autism spectrum, learning disabilities, and other topics.

b. A description of the target population to be served and how this aligns with the definition of 'low-income community' on page 6. As described in the first section of this proposal, the target populations for the C2C program will be low-income LGBTQ young adults (16-24) who are out of work and out of school and unemployed or underemployed low-income working-age LGBTQ adults ages 18 and over receiving employment-related services. This population is almost universally of low-income, many are homeless and disconnected from their families and other sources of support. A graphic illustration of the poverty experienced by these young adults can be seen in the survival services that they access at HMI: Clothing: 324 unduplicated youth received 288 clothing services. Emergency Food Packages: 224 unduplicated

youth received 1,597 emergency food packages. Laundry and Shower services: 149 youth received 710 laundry and/or shower services. And hot Meals: 606 unduplicated youth received 5,575 hot meals in Café HMI.

c. The mental health service needs of your participants as identified through quantitative data collected by your organization and/or qualitative data that illustrates the need for this intervention at the CBO. As we described above, HMI young adult participants nearly all experience debilitating societal stigma. As a result of conflicts with family members, peers and other adults over issues of sexual orientation and gender identity, 30% of LGBTQ youth are forced out of their homes. In fact, 40% of HMI's young people report being chronically homeless (living on the street, not in an emergency shelter), with more than 80% having transient housing situations. This has led to disconnection from educational and community services that address such critical issues as poverty, depression, substance abuse and risky sexual behavior. Our young adults experience exacerbated levels of trauma and stress unique to low-income communities. Traumatized children and youth often sustain damage to critical elements of their development which manifests into adulthood. Important assets such as healthy attachment, social and emotional competency, self-esteem, confidence and independence can be undermined as a result of trauma. Many of the youth at HMI have witnessed or experienced violence and have been traumatized at the hands of a parent or caregiver. Over 80% of LGBTQ youth are verbally harassed at school, while 40% are physically attacked. HMI's intake data shows that 19% of our youth have been hospitalized for psychiatric reasons and 28% report suffering from depression. In fact, LGBTQ teens are three times more likely to attempt suicide and over 36% of the young people we serve already made at least one suicide attempt before coming to HMI. Add to this the knowledge that a disturbingly high number suffer from increased rates of homelessness, alcohol use, unsafe sex, incarceration and sexual exploitation. Distressingly, few social service providers focus on addressing the traumatic events experienced by the youth and young adults they serve, particularly LGBTQ youth. Since these young adults so often present in crisis, organizations tend to address immediate needs (provide food, shelter, clothing, substance abuse treatment, medical care; etc.) but are not able to screen for or address symptoms of post-traumatic stress disorder (PTSD). We see symptoms of PTSD among our client population including intrusive memories where youth will relive the traumatic event as if it were happening again (flashbacks); experience severe emotional distress; avoiding places, activities or people that remind them of the traumatic event(s); negative changes in thinking and mood including negative feelings about themselves or other people; the inability to experience positive emotions; feeling emotionally numb; lack of interest in activities they once enjoyed; feelings of hopelessness about the future; difficulty maintaining close relationships; and changes in emotional reactions (arousal symptoms). Many participants show irritability, angry outbursts or aggressive behavior; feel overwhelming guilt or shame; engage in self-destructive behavior such as unprotected sex and using substances; have trouble concentrating and sleeping; and being easily startled or frightened. Without treatment to heal from the symptoms of PTSD, young people suffer emotionally, cognitively and socially.

d. A description of need for mental health capacity-building among staff proposed to be trained through C2C. Because this initiative is designed to bring mental health services into settings where they are not currently available, the CBO applicant should have limited experience delivering mental health services. CBO applicants also should not currently have mental health specific services on-site serving the target population. As discussed in the first

section of this proposal, HMI does provide some mental health services onsite, but at a capacity far below the need in the target population of LGBTQ young adults. In fact, there are very few specialized LGBTQ-focused mental health programs in the city and HMI has developed an approach that helps to de-stigmatize mental health services for the target population. However our limited capacity severely restricts our ability to reach out to the thousands of young adults who attend our community events, and also to the many enrolled at HMI who heretofore have refused mental health care or even evaluation. This is why we are seeking C2C funds. Although we do provide mental health counseling to a small percentage of the population, we were motivated to seek C2C funds when we read in the Q&A (issued in conjunction with this RFP) that an applicant with severely limited capacity may apply as long as they demonstrate "why and how C2C is needed for the organization to build capacity among non-mental health staff and why such cross-training and referral is not otherwise already occurring." The Q & A also stated that "The Mayor's Fund collaborative seeks CBOs with a significant need among their service populations and their staff for C2C." We believe we fit within these parameters. As a result of our extensive outreach and engagement efforts (the most successful and robust in the city for the target population), during which we engage upwards of 3,000 unduplicated youth and young adults annually, we have the potential to provide the C2C core mental health services to many hundreds of more LGBTQ young adults for which we currently have no capacity. Additionally, each year 600 new LGBTQ youth and young adults receive intakes at HMI, many of whom are unable to access mental health services at HMI due to capacity issues. We are requesting C2C funds to train our non-mental health team at HMI including those who engage LGBTQ young adults at community events, street fairs, through street outreach and Gay Pride celebrations so that they will be able to provide quality engagement around mental health needs, and bring disconnected young adults into a continuum of mental health care. We also would like to have the capacity to provide C2C mental health core services to hundreds of members of the Ballroom Community (the "KiKi Coalition") who we encounter each year and who are often reluctant to engage in any mental health services. We are also seeking C2C funding in order to expand the capacity of our 41 non-mental health staff to do hospital advocacy and psychiatric ER triage. Currently, HMI staff calls 911 for an ambulance about 3 times a week because of substance induced psychosis, suicidality, homicidal ideation, homeless youth who are decompensating, youth who present with psychiatric trauma due to eating disorders, traumatic memories/flashbacks, sleep disturbances, housing crises, self-injury, and others. When youth go to the ER from HMI alone, they are often mistreated, misdiagnosed and discharged – without the care they should be getting, and discharged without any communication back to HMI staff. Whenever possible, HMI will send one of our social workers to accompany a youth member to the hospital, to act as an advocate. However the need far outruns our capacity and number of trained staff. C2C training of non-mental health staff will allow us to provide an HMI staff escort/advocate for all youth we send to the ER, especially youth who are transgender or gender non-conforming and youth who are experiencing homelessness. We are currently overwhelmed with the need for trained escorts on ambulances. We will train 41 non-mental health staff.

e. Roles of CBO, MHP, and any other partners and how the two (or more) organizations will partner together. Describe the proposed relationship between the CBO and the MHP. How will CBO staff be trained, coached, and mentored in an ongoing continuous manner by the MHP and how will TA be delivered? Describe the strategy for implementation and the frequency of contact. As the primary applicant, HMI will coordinate all program activities with

the Mental Health Provider, the Mount Sinai Adolescent Health Center (MSAHC). There will be no other direct partners in the C2C program. MSAHC will train HMI's non-clinical staff at HMI service locations in the C2C core competencies. During the course of the program MSAHC and HMI will work together to help HMI non-clinical staff to achieve task-shifting so that mental health capacity can be increased in our non-clinical programs. The 41 non-clinical staff to be trained also includes those responsible for community outreach and youth leadership programs including our Youth Summits series which takes place throughout the 5 boroughs of NYC. HMI and MSAHC will collaborate on the creation of seamless, trauma-informed care models of referral and linkage to licensed mental health care. LGBTQ young adults will receive direct mental health care and support and services at the MSAHC. MSAHC will provide technical assistance to facilitate task-shifting through onsite and teleconference and will send mental health providers to visit HMI and interact with our youth face-to-face, conducting group level education and engagement.

f. A description of how the program and the partnership will be managed, and how the CBO/MHP management will interact. HMI will hire a Coordinator for the C2C project, to manage all MSAHC on-site training and technical assistance activities, including supervision and consults provided regularly to HMI staff by the MSAHC clinicians. The Coordinator of the C2C project will also work with HMI staff from all the Youth Services Tracks to integrate monthly "Doc in a Box" programming into the milieu at HMI, to ensure that MSAHC providers (psychologists, psychiatrists, social workers, etc.) are all familiar faces to HMI youth. HMI will also identify a counselor to work with MSAHC clinicians to strengthen internal screening and assessment processes to identify mentally ill clients, particularly those with a higher level of need. This clinician will essentially be the front door through which the target population will enter mental health treatment at MSAHC, and the liaison who will assist HMI workers obtain updates on their client's treatment progress. There will be a weekly Project Management meeting between the MSAHC on-site staff and the Project Director to ensure smooth coordination of all trainings and technical assistance, and to respond to emerging and unanticipated issues. The HMI Directors of other programs will be integral members of the project management team since together they oversee all services at the agency. HMI's Director of Youth Services, who oversees all youth programming, the will supervise the Project Coordinator and maintain regular contact with the assigned Project Supervisor at MSAHC.

g. Details on the proposed plan that include:

i. The number of participants to be served by C2C. Low-income LGBTQ young adults (16-24) who are out of work and out of school: 500. Unemployed or underemployed low-income working-age LGBTQ adults ages 18 and over receiving employment-related services: 900.

ii. The service location and the geographic area to be served by C2C. The service location will be in lower Manhattan and the program will provide services to eligible young LGBTQ adults from all five boroughs of NYC.

iii. Estimates of the target population sizes and rationale for the estimates. There are no reliable estimates of the size of the target population of LGBTQ young adults. Estimates of the percentage of LGBTQ citizens in the United States range as low as 3% and as high as 10%. Even taken on the low end, this means there are millions of LGBTQ young adults in the country. But a

truer measure may be seen in overall estimates of homeless youth. Although national estimates range from 575,000 to 1.6 million, many leading experts conclude that the actual numbers of homeless youth remain unknown. New York City faces similar challenges in seeking to calculate its homeless youth population. Just as calculations of the total number of homeless youth vary, so do findings regarding the proportion of homeless youth who identify as LGBTQ. A cluster of studies show results ranging from 15 to 25 percent, but some advocates suggest figures as high as 40 percent. In any event, almost all studies indicate that LGBTQ youth are disproportionately represented among the homeless youth population. We do know, however, that HMI serves about 2000 LGBTQ youth each year, including approximately 600 new clients, and that approximately 50% of those youth are either homeless young adults or young people with housing instability.

iv. The program services into which C2C will be integrated. Include those programs' funding sources and start/end dates.

- Arts and Culture programs foster self-expression through dance, photography, painting and drawing, theater, music, and more. Funded by NY Women's Foundation which ends June 30, 2016.
- Health and Wellness programs range from hands-on instruction in how to cook healthy meals to learning more about STDs, pregnancy prevention, physical fitness, and preventing HIV. Funded by NYS Department of Health which ends June 30, 2016; Saturday Night Lights funded by the Manhattan District Attorney's Office, ends June 30, 2016.
- Academic Enrichment programs help our LGBTQ youth prep for college, get computer training, receive help with homework or prep for the HSE test (among countless activities). New York State Education Department, which ends June 30. 2016. High School Equivalency Program funded by Robin Hood Foundation which ends December 31, 2015.
- Job Readiness programs assist in building job skills, financial literacy, writing résumés, job search skills, paid internships at HMI, and career exploration. Major corporations, including AOL, M.A.C Cosmetics, TD Bank and The Huffington Post have led trainings. NYS DOH which ends June 30, 2016 and private donations.
- Outreach Homeless Services provides health screenings and HIV testing, emergency supplies of food & water, weather related supplies and education, and is instrumental in expediting copies of vital records to secure government issued identification, housing, employment or education for homeless youth. Funded by Public Health Solutions which ends February 28, 2016; NYS DOH ends June 30, 2016.

v. The strategies the CBO will use to engage participants in these services. How will the CBO recruit participants as they newly enroll at the CBO? How will the CBO enroll existing participants? Young LGBTQ youth participants at HMI will be engaged by the non-clinical staff providing direct services in the programs outlines above. This will be accomplished as a result of task-shifting trainings provided by MSAHC. Non-clinical staff will be able to draw upon the C2C core competencies to engage participants around issues pertaining to mental health. Because of fear and stigma, "light touch" conversations in non-medical settings have a greater chance to succeed. Client recruitment for the proposed program will take place at many different points of contact, which the community being one of the greatest sources of potential new clients. As described earlier, the program will train outreach workers to employ some of the core skills to engage people with little previous experience even discussing their mental health.

vi. The strategies the CBO will use to retain participants in these services and follow-up with participants if they stop attending the CBO. How will the CBO maintain contact with participants to keep them engaged in services and in the research study? HMI has an active and vital peer program in which trained members of the client population engage their peers around key issues and obstacles. Employing peers to discuss mental health issues with other peers, as the C2C program will help facilitate, permits engagement and retention in services of all kinds. We rely on trained peers to maintain contact with participants, which has proven to be far more effective than relying on staff. A participant is more likely to communicate with a peer than with a professional. Outreach and retention efforts are heavily accomplished through the use of social media, and much of our communication with participants and potential participants is done through twitter, Facebook, and other media.

vii. A clear explanation of how the core package of services will be implemented (if additional services are being proposed, provide a justification of their evidence from a peer reviewed journal of a randomized control study or quasi-experimental study); the fit between these services and their anticipated use with the needs of participants targeted; justification for any proposed adaptations to the core package or additional evidence based services. HMI will coordinate the implementation of program services in conjunction with MSAHC. HMI's Director of Youth Services is responsible for overseeing the entire project, supervising the C2C Program Coordinator, and working with the Directors of Arts and Culture, Job Readiness, Health and Wellness, and Academic Enrichment to monitor the progress of task-shifting. The C2C Program Coordinator will schedule all trainings, monitor their progress, and work with MSAHC staff to coordinate program activities. As described earlier, the core C2C core services will enable HMI non-mental health staff to engage LGBTQ young adults in the community and in non-clinical programs. The nurturing atmosphere of programs such as Arts and Culture, Job Services, Health and Wellness and Academic Enrichment provide a comfortable and non-threatening space in which to talk about mental health. Client who we assiduously avoid activities designed to teach about mental health will be more receptive to it in these less stressful environments.

viii. The number of front-line staff at the CBO that the CBO anticipates training and supporting in implementing mental health services through this initiative and their roles within the organization. Provide the ratio of the direct service staff that will participate to the service population size. MSAHC, our mental health provider, will train 41 non-mental health workers at HMI. These include 29 staff members who run HMI programs in Job Readiness, Health and Wellness, Arts and Culture, Academic Enrichment, High School Equivalency Prep Classes, and College Prep. The program will also train and support 5 Teaching Artists; 3 Sports Instructors (yoga etc.); and 4 DOE teachers from Harvey Milk High School who teach and tutor in at HMI afterschool. **Ratios:** Low-income LGBTQ young adults (16-24) who are out of work and out of school: 12:1. Unemployed or underemployed low-income working-age LGBTQ adults ages 18 and over receiving employment-related services: 22:1.

h. Staffing:

i. Overall, how does the CBO propose to staff this project to effectively enable direct service staff to take on these new tasks on top of their existing programmatic

responsibilities? What additional staff will be needed by the CBO to support implementation of this program? The staffing model for the C2C program is designed to facilitate training and task shifting in all program areas. The primary goal for the HMI C2C program is to integrate core mental health services in all parts of the agency. In order to do this, we are proposing the following staff:

- **Director of Youth Services:** This position supervises the C2C Project Coordinator.
- **C2C Project Coordinator:** Oversees day-to-day program activities.
- **Program Assistants, Receptionists (2):** This is where clients make their first contact with the agency and where many of them reveal very troubling reasons why they have arrived. The receptionist and assistant would be much more effective at helping distressed clients to remain calm until senior staff can engage them.
- **Director Of Grants and Fiscal Administration:** This individual will oversee all fiscal aspects of the program budget.
- **Administrative Coordinator:** This staff member will assist the program director in coordinated activities. She will have a great deal of contact with clients.
- **Assistant Director, Health & Wellness:** This staff member will integrate core services into the Health and Wellness program operations, and will work with the C2C Program Coordinator to ensure successful task-shifting.
- **Assistant Director, Academic Enrichment:** This staff member will integrate core services into the Academic Enrichment program operations, and will work with the C2C Program Coordinator to ensure successful task-shifting.
- **Coordinator, Job Readiness:** This staff member will integrate core services into the Job Readiness program operations, and will work with the C2C Program Coordinator to ensure successful task-shifting.
- **Program Coordinator, Stars of CHANGE:** This staff member will integrate core services into the Stars of CHANGE program operations, and will work with the C2C Program Coordinator to ensure successful task-shifting.

ii. Identify key staff that will manage the program (include resumes as attachments) including point of contact for data and evaluation. Describe any experience the CBO staff has currently with research and evaluation and in delivering any of the mental health modalities proposed, if any. Please note: staff are expected to have limited experience in delivering the mental health modalities in their current role. Key staff include the Director of Youth Services, the C2C Program Director, the Assistant Director, Health & Wellness; the Assistant Director, Academic Enrichment; and the Coordinator, Job Readiness; and the Director Of Grants and Fiscal Administration. These positions are described above. HMI has an experienced Research and Evaluation Department who will work closely with the assigned C2C evaluator.

iii. Experience and background of all key staff members, demonstrating that they comply with staff experience requirements laid out in Section III.B. The experience of managers selected to launch and lead the project.

Director of Youth Services: Bridget M. Hughes, MA, has been in this key position since 2011. She has over 20 years of experience working with target population. Prior to her current position she was the Director of Youth Services at The LGBTQ Community Center. She has an impressive and substantial resume which is attached.
C2C Program Director: TBH. This employee will have at least 5 years of leadership experience with the target population, and will be a licensed mental health provider (LCSW, or similar).
Assistant Director, Health & Wellness: Lazara G. Paz-Gonzalez, MPH, C.H.E.S. has over 5 years of experience working with the target population. Prior to her work at HMI, she was the Program Coordinator of Youth Initiatives for the National Latina Health Network.
Assistant Director, Academic Enrichment: Juan B. Williams, LMSW, was a Supervising Counselor at HMI prior to his current position. He was a Care Manager Supervisor at Partnership for the Children of Essex, and a Support Counselor at Community Access. He golds a MSW from NYU.
Coordinator, Job Readiness: Derrick V. Holloway holds one Master's Degree in Urban Studies and another in Education. His impressive resume, attached to this proposal, shows over 10 years of experience working with low income youth. Prior to HMI he worked at Union Settlement, Kips Bay Boy's and Girl's Club, East Harlem University Program and many others.

iv. Demonstrated senior level commitment and staff level buy-in and skills to integrate mental health services into the existing service framework. HMI recently completed a structured Strategic Planning Process that included senior managers and staff. One of the issues to emerge from this process was the need for mental health services. Direct service non-mental health staff told of their many challenging experiences trying to engage a client who showed symptoms. They felt that if they had the type of training offered in C2C, they would be better able to help these clients succeed in program services, and ultimately address their mental health issues. This proposal provides an opportunity to respond to this need. We have included Assistant Directors and Coordinators from all the non-mental health program areas because their involvement will be essential for the task-shifting processes.

v. Describe and demonstrate how executives at the CBO will play an effective role in developing, implementing, and overseeing the program. Key executives at HMI have been working on processes to create reach more young adults with mental health services. They see this potential opportunity as an important and much needed effort. The Director of Youth Services, reporting to the Executive Director, will be responsible for the success of the C2C program. She will work closely with heads of all non-mental health programs described above in order to help with task-shifting and the logistics related to engaging a large number of new clients with mental health needs. The Director of Youth Services will monitor all deliverables, communicate with the C2C researcher and the Mayor's Fund.

i. Where will participants receive mental health services on-site at the CBO? How will confidentiality be ensured? Mental health services will be provided in private counseling rooms. HMI adheres to all HIPAA requirements and has a well-developed culture of confidentiality. All paper case records are kept in locked cabinets and our electronic database is stored in "the cloud" and is protected by a powerful firewall system. Clients who are referred to MSAHC will be required to sign consent forms and HIPAA releases in order for HMI to case conference with the mental health provider.

j. How will the CBO and MHP handle emergencies or cases where participants reveal something reportable (e.g., suicidal/homicidal intent, child abuse or neglect, elder abuse or neglect)? Both MSAHC and HMI have deep experience in handling emergencies. Currently, HMI staff calls 911 for an ambulance about 3 times a week because of substance induced psychosis, suicidality, homicidal ideation, homeless youth who are decompensating, youth who present with psychiatric trauma due to eating disorders, traumatic memories/flashbacks, sleep disturbances, housing crises, self-injury, and others. All staff are trained in mandated reporting laws.

k. What mental health services will be provided on-site and what services will be delivered at the MHP location? How closely located are the CBO and MHP and how will participants be supported in making the transition in the case of external referrals? How will CBO participants be supported and encouraged to engage in off-site care if needed? How will the CBO enhance current referral protocols and management systems to make this connection to off-site care more successful? In the case of external referrals, how will data be shared between the CBO and MHP while ensuring compliance with HIPPA? For clients of the C2C program, all licensed mental health treatment will be provided at MSAHC. All trainings and technical assistance will take place at HMI. The Mount Sinai Adolescent Health Center is located on East 94th in Manhattan and HMI is located at 2 Astor Place in Greenwich Village. The east side Lexington Avenue subway stops near both of these locations. We plan to train peers in the C2C core services who will help clients make the transition in the case of external referrals. Trained peers will escort clients to their mental health appointments. They will also support and encourage them to maintain treatment. By training peers to support clients in their mental health care, we expect to greatly enhance our current referral protocols and management systems. Data will be shared between HMI and MSAHC through HIPAA compliant electronic record sharing software.

l. Anticipated impact and strategy for measuring and achieving the following goals:

i. Goals and rationale for improvement in ongoing performance areas. What specific programmatic measures in the areas specifically focused on the sub-population(s) that the CBO plans to work with does the CBO anticipate improvement in through the addition of these services? As a result of C2C services and capacity building, our agency-wide goals for our target population of LGBTQ young adults (who are out of school and out of work), are to see an annual 25% increase in the identification of mental health issues within the client population; a 50% increase in the first year of diagnosed LGBTQ young adults who engage in licensed mental health care at MSAHC, and a 25% increase in each additional year of the program; a 25% completion rate for participants receiving licensed mental health services; and a 20% annual increase in overall client retention in care. We will be interested in measuring improvements in overall mental health outcomes; the retention of clients in mental health services; a reduction in avoidable hospitalizations and emergency room visits; an increase in the health stability of participants; an increase in participants' ability to achieve other targeted program-specific outcomes in job training, education, arts, employment, substance use, and goals on individualized treatment plans. We are also interested in measuring and evaluating the degree to which successful task-shifting has taken place and improvements in the use of evidence-based mental health practices by HMI non-mental health staff.

ii. Goals and rationale for mental health service access and improvement. How will the CBO define success of this initiative both in terms of quantitative goals and in terms of increased organizational capacity? We expect to see quantitative and qualitative evidence of the positive impact of increased mental health organizational capacity. We are interested in measuring adherence to prescribed psychotropic medications and/or therapy; reductions in self-reported mental health-related symptoms such as PTSD, depression, anxiety, reactivity, substance and/or alcohol use; hospitalizations and emergency room use; improvements in self-reported quality of life, social and family relationships; and decreased participant perception of stigma in accessing mental health services.

iii. Goals and rationale for improved outcomes for the service population. Although the evaluator will measure impact on participant mental health outcomes across sites, CBOs individually should monitor a small number of feasible outcome measures as part of program performance-management. HMI is interested in also evaluating outcomes in other services and activities for participants in C2C. We will measure improvements in participation in Arts and Culture programs; the degree to which LGBTQ young adults foster self-expression through dance, film, photography, painting, theater, and more; whether our Health and Wellness programs improve overall health and in particular reduce STDs, HCV, HIV and stress; the number of young adults who complete high school and attend college; and the number of young adults who build job skills, financial literacy, write résumés, and land internships. We would like to track homeless youth who participate in this program to determine whether access to mental health care has improved their prospects for permanent housing and stability in the community.

m. Describe how the partnership will make use of performance data in programmatic decisions. Both MSAHC and HMI will collect data on the key indicators for the program, some of which have been discussed above. There will be monthly meetings between the Project Director and the onsite MSAHC staff to review this data to determine the degree of fidelity to the program model. Correction action will be determined in consultation with key executive staff at each agency, as described earlier.

n. Describe how participant and front-line staff feedback will be utilized to improve the service delivery and program implementation. Participant feedback may be provided through our Client Advisory Committee and satisfaction surveys. Front-line feedback is generally provided in individual and group supervision sessions.

o. Include a feasible work plan/timeline for program start-up and implementation that includes clear outlines for how service delivery will occur. Identify any potential challenges or barriers to implementation and suggest potential strategies for avoiding or overcoming them. We will begin program implementation upon notification of the award and program services will be fully operational within the first 30 days. Tasks and time frames are as follows (post-award notification):

Start week one: 1. HMI organization staff meetings to outline program services, the role of MSAHC, and the expectations of staff participation and performance. Staff will be asked to make recommendations as to how to most effectively roll out the program. 2. There will be a meeting between key MSAHC and HMI executive staff to kick-off the project.

Start week two: 1. Electronic data systems will be updated as needed to include program indicators. 2. Staff will be trained on new data collection requirements.
Start week three: 1. MSAHC program staff will make a presentation to HMI staff explaining the nature of the trainings and technical assistance to be provided. HMI and MSAHC will conduct an implementation planning session with each of the Program Directors at HMI with the goal of smooth integration of services. 3. Policy and procedures will be created to reflect new services and program activities.
Start week four: 1. A training schedule will be created. 2. Protocols for the provision of direct support to non-mental health workers will be finalized. 3. A clinical case conference between MSAHC and HMI will take place to review and identify mutual clients currently in treatment. 4. Trainings and other services will begin.

p. Describe the activities the partnership will undertake to support evaluation activities (including designating staff as points of contact for evaluators, collecting data, etc.). HMI Research and Evaluation staff will support the work of the C2C researchers in any way that is necessary. This department will oversee these activities.

q. The evaluation will include a quasi-experimental study: A comparison of outcomes for C2C participants against outcomes for a similar population that does not receive services through C2C. External evaluators will determine how to identify and define the comparison group of non-C2C participants, and the input of potential subgrantees is welcome. Does your organization serve members of the target population who will not be reached by C2C (for example at another service site location) that could potentially serve as a comparison group, or does your proposal reach all of the population served by your organization? The number of potential participants will likely exceed even the additional capacity of the C2C program which would provide an opportunity for a comparison group.

If proposing to serve a subset of the target population, please describe the projected numbers of C2C participants and the projected numbers of non-C2C participants during the grant period. Indicate whether the non-C2C participants could potentially serve as a comparison group for the evaluation, or why not. As stated above the number of potential participants will likely exceed even the addition capacity of the C2C program which would provide an opportunity for a comparison group.