Facilitating Behavioral Health Care Access through Behavioral Health Navigation Request for Proposals (RFP)

Background

Beth Israel Lahey Health (BILH) brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery – academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care – in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

BILH is committed to its WE CARE Values:

Wellbeing. We provide a health-focused workplace and support a healthy work-life balance.

Empathy. We do our best to understand others' feelings, needs and perspectives.

Collaboration. We work together to achieve extraordinary results.

Accountability. We hold ourselves and each other to behaviors necessary to achieve our collective goals.

Respect. We value diversity and treat all members of our community with dignity and inclusiveness.

Equity. Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.

Based upon its 2022 and 2025 Community Health Needs Assessment (CHNA) process, BILH identified community behavioral health access as the system priority across its Community Benefits Service Area (CBSA). Preliminary data from the 2025 CHNA further reinforce that this priority continues to be a need throughout the CBSA. Using the CHNA results, BILH undertook a process to identify opportunities to collaboratively work with community partners to address barriers faced by community residents when accessing behavioral health (mental health and substance use) care and services.

In response to the input from community residents and partners throughout this process, BILH is investing in strategies that elevate messaging, amplify mental health topics and foster and fund behavioral health navigation across its CBSA. These strategies are in addition to the efforts individual BILH hospitals are conducting in collaboration with community partners. All strategies align with the BILH Community Benefits Guiding Principles of *accountability, community engagement, equity and impact*.

This Request for Proposals (RFP) seeks to provide grants to two (2) organizations with the capacity to implement a community-based Behavioral Health Navigator program in the Massachusetts Gateway Municipality of either Chelsea and/or Lowell. Grant funding will be focused on creating and implementing a community-based Behavioral Health Navigator model to increase community residents' connections to behavioral health services and supports and provide education to the broader community about mental health and substance use resources.

Request for Proposals (RFP) Process Overview and Timeline

Dates	Deliverable
June 2, 2025	RFP release date
June 2 - June 20, 2025	Question and Answer (Q & A) period*
June 18, 2025 @ 3:00 PM ET	Virtual information session (optional). BILH staff will provide an overview of the RFP and answer questions about the application process. Registration required. To register, click here.
June 23, 2025	FAQs posted to BILH Community Health Grants*
July 31, 2025 @ 5:00 pm ET	Applications due
By Sept 22, 2025	Final notification of decision to full Proposal Applicants
October 15, 2025	3-year grant term begins
October 14, 2028	Grant Term ends

*Applicants may contact Michelle Snyder at Michelle.Snyder@bilh.org with any questions. Questions and answers will be posted on the BILH website here by June 23, 2025. No questions will be accepted after June 20, 2025.

How to Apply

All applications must be submitted online through BILH's Community Benefits Database ("CBD"). To request access to the database, please complete this form: https://forms.office.com/r/jZyD5F8dAD. Applications missing materials and not submitted in the CBD by the deadline will be considered incomplete and will not be reviewed.

Appendix A contains the application questions and **Appendix B** contains the scoring criteria. For questions specific to the application process or CBD, please contact Michelle.Snyder@bilh.org**.** Applications are due no later than 5:00pm ET on July 31, 2025**.**

RFP Core Principles

The core principles guiding this RFP are:

- IMPACT: Support evidence-based and evidence-informed strategies and programs that positively and meaningfully impact neighborhoods and populations that face the greatest health inequities.
- COMMUNITY: Build community cohesion and capacity by actively engaging with community residents and other stakeholders, including those who face the greatest health inequities.
- EQUITY: Apply an equity lens to achieve fair and just treatment so that all communities and people can achieve their full health and overall potential.
- SUSTAINABILITY: Encourage sustained program impact through strategies that may include: leveraging funding to continue program activities, strengthening organizational and community capacity and forming innovative partnerships and/or cross-sector collaborations that lead to permanent community change.

Evidence-based/Evidence-informed Strategies

BILH is committed to funding programs that have evidence of their efficacy or impact. To be considered evidence-based or evidence-informed, the program should be based on research about effective practice in the area or current evaluations showing positive outcomes for participants.

Eligibility

To be eligible to apply for the RFP, organizations must be tax-exempt (501 (c) (3) status) or a public agency. Eligible institutions may include community-based organizations, community health centers, schools, coalitions, faith-based organizations, and city agencies. In addition, organizations must currently serve individuals who live, learn, work or play in or across one or more of the following Massachusetts Gateway Municipalities that have been specifically identified as a high priority for this RFP:

1. Chelsea
2. Lowell

The priority cohorts for this RFP, determined based on BILH's most recent Community Health Needs Assessment (CHNA), are:

- Youth
- Older adults
- Low-resourced populations
- Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQIA+) individuals
- Racially, ethnically and linguistically diverse populations.

Funded grantees will be expected to hire, train and support a community-based Behavioral Health Navigator who will identify, understand and effectively connect community residents from at least one of the cohorts above who are experiencing mental health and substance use issues to appropriate support and assistance. Grantees will be expected to conduct educational activities with the broader community to increase knowledge and awareness of available mental health and substance use services and supports. Grantees are also expected to participate in a no-cost training(s) on how to help people navigate services and supports (including digital options) for mental health and well-being, provided by BILH experts.

Funding Availability

BILH's goal for this funding is to have the greatest impact possible. To this end, BILH plans to award $300,000 grants over a 3-year period to a maximum of two (2) community organizations, in either Chelsea and/or Lowell. BILH anticipates that each grant will be awarded in two installments, with all funds fully disbursed by October 30, 2027.

BILH will review grants at the end of each year to determine continued funding for years 2 and 3 based upon availability of funds and fulfillment of grant requirements, including evaluation and reporting.

Evaluation and Reporting

Grant recipients will be required to submit reports twice a year via BILH's Community Benefits Database that includes program updates, evaluation data and a financial update. Modifying what is provided in Appendices D and E, grant recipients will submit a logic model and evaluation plan to provide evaluation data over the course of the project. In general, the evaluation will answer:

- To what extent has the community-based Behavioral Health Navigator model shown success in connecting individuals experiencing mental health and/or substance use issues from the selected priority cohort(s) to appropriate behavioral health referral, screening, assessment and treatment services and supports?

- To what extent have educational activities conducted with the broader community increased knowledge and awareness of available behavioral health services and supports?

Grant recipients are required to identify an evaluation lead at the organization and report on program-specific evaluation measures to BILH. Metrics to be collected and tracked by each grantee could include, but are not limited to:

- Number and demographics of individuals utilizing the behavioral health navigation services.
- Number of individuals screened and referred to services.
- Successful access and utilization of the recommended resources by navigation participants.
- Number of community members attending educational activities.
- Increased knowledge about the resources available to participants through educational activities.

Grant recipients will report on progress toward answering the above evaluation questions and fulfilling the individual learning and evaluation plan semi-annually in October and May. These reports may be a mixture of meeting/site visits and written materials.

During the RFP Information Session on June 18th, BILH will review RFP evaluation requirements and be available to respond to questions.

Funding Guidelines and Budget

Grant funds may be used for planning, reporting, project staff salaries, data collection and analysis, meetings, supplies, related travel, and other direct project-related expenses. Indirect expenses (i.e. items that are associated with running the organization, such as administrative staff salaries and benefits, rent, utilities, office supplies, etc.) may not exceed 15% of the total budget. Grant funds may not be used to provide medical services, to support clinical trials, to construct or renovate facilities, for capital expenses, or as a substitute for funds currently being used to support similar activities.

Applicants will be asked to identify the staff member responsible for data management and evaluation-related activities. Applicants should specify evaluation expenses in the proposed budget to accommodate on-site evaluation activities, such as systems implementation for data collection. Include costs for project evaluation activities, such as use of evaluation consultants, data collection tools, and other costs for evaluation. BILH recommends that evaluation expenses total approximately 10% of an applicant's budget.

Funding Disbursement Timeline

Approximate Funding Distribution Schedule (subject to change)	
October 15, 2025	$150,000
October 30, 2026	$150,000

Upon notice of an award, grant recipients will be required to submit an invoice to BILH to receive the grant funds, identify BILH as a co-sponsor of the project in any media, community and/or public relations efforts, and submit semi-annual reports to BILH in the Community Benefits Database on agreed upon metrics and progress on the project.

Contact Information

If you have any questions, contact the BILH Community Benefits and Community Relations team at michelle.snyder@bilh.org. BILH will respond to emails within two business days.

Appendix A: Application Questions

Note: Responses to these questions will be submitted in the BILH Community Benefits Database ("CBD").

1. **Organization Overview**
    a. Provide a brief overview of the lead organization, including its mission and the primary needs the organization addresses. (150 words maximum)
    b. Upload the following documents:
        - Organizational budget for the current year.
        - Internal Revenue Service Form 990 for the last **two** fiscal years.
        - Most recent audited financial statement.
2. **Project Lead and Staffing**
    a. Primary contact person for this application (Name and contact information)
    b. Secondary contact person (Name and contact information)
3. **Priority Community**: Identify which priority community (below) the organization will focus its behavioral health navigation and community education activities in (select one):
    a. Chelsea
    b. Lowell
4. **Cohorts Served:** Identify which of the cohorts(s) below the organization will focus its behavioral health navigation and community education (check all that apply):
    a. Youth
    b. Older adults
    c. Low-resourced populations
    d. Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQIA+) populations
    e. Racially, ethnically and linguistically diverse populations (Note: there will be space to add additional descriptions/details for each of the below options).
        - African
        - American Indian/Alaskan Native
        - Asian
        - Black
        - Caribbean Islander
        - European
        - Hispanic/Latino

- Middle Eastern
- Native Hawaiian/Pacific Islander
- White
- Other (please list)

5. **Project Overview**
    a. Project Context:
        - Describe how the organization will address key behavioral health navigation challenges facing the selected priority community and cohort(s). (100 words maximum)
        - Briefly describe examples of the work the organization has done in the selected priority community, including any current partnerships with organizations located in the community. (100 words maximum)
    b. Project Staffing: List the key people who will be involved in project implementation and briefly describe their roles.
    c. Anticipated Reach: Please provide an expected range for the number of individuals the organization will reach or impact through the project, beyond the number currently served. Please note: a minimum of 80% of individuals reached or impacted through the project should be from the selected priority community.
    d. How does the organization plan to ensure that project resources are deployed towards those that need them the most? (100 words maximum)

6. **Project Goals**
    a. Please provide up to three SMART (specific, measurable, attainable, relevant, and timely) goals for the project (See **Appendix C** for guidance on developing SMART goals). If applicable, please include a goal for how the project will address upstream Social Determinants of Health (SDoH).

7. **Equity and Community Engagement**
    a. Discuss how the organization plans to engage with the cohort(s) with which it will be working. Please specify the level(s) of community engagement the project utilizes based on Table 1 on page 11 of the Massachusetts Department of Public Health Community Engagement Standards for Community Health Planning. (150 words maximum)
    b. How will the funds be used to address health outcomes? (100 words maximum)

8. **Budget**
    a. Upload an itemized project budget and an accompanying budget narrative (up to a ½ page) using the template provided in the Community Benefits Database. The budget should include direct and indirect costs, including staff time.
9. **Partners (if applicable):** List all partner organizations key to this project's success. Include the sector they represent (e.g. workforce development, behavioral health, housing, education, etc.) and a brief description of their involvement in the project. Describe how the collaboration(s) will increase the impact of the project. (250 words maximum)
10. **Evaluation Capacity and Experience**

    This section is about your organization's/partnership's existing evaluation capacity and experience with evaluation (e.g., data collection, tracking, monitoring, reporting). You may include references to past evaluations, such as recent program evaluations.

    a. Please describe your organization's/partnership's current capacity to conduct evaluation activities, including any internal staff FTEs and external contracts, as applicable (300 words maximum)
        i. What types of data are currently collected (if any)?
        ii. How does your organization collect data (if applicable)?
        iii. How does your organization use these data to inform outcomes and improve programming/initiatives? How does your organization currently measure success?
        iv. How does your organization incorporate the client and community voice in its evaluation activities?
    b. Who will be the grant recipient's evaluation contact for this project? (150 words maximum)
        i. Position title
        ii. Description of current evaluation responsibilities (if any)
        iii. Any relevant evaluation skills, knowledge, and experience (if any)
    c. Upload the following documents:
        i. Logic Model
        ii. Evaluation Plan

11. **Sustainability**

BILH encourages applicants to think creatively about how the funds from this request can be leveraged to create permanent community change. Please be explicit as to how metrics and outcomes will lead to sustainability beyond the grant term, aside from applying for additional funds. Indicate whether your organization is committed to building programmatic costs into the operating budget and/or if this program will create future revenue.

a. Describe how the organization will leverage this funding to support the sustainability of the project(s). (100 words maximum)
b. How will this project contribute to improved community health past the initial funding period? (100 words maximum)
c. Describe any challenges to sustainability the organization anticipates and how the challenges might be addressed. (150 words maximum)

Appendix B: Scoring Criteria

As applications are scored,* reviewers will keep the following core principles in mind:

- IMPACT: Support evidence-based and evidence-informed strategies and programs that positively and meaningfully impact neighborhoods and populations in the focus community that face the greatest health inequities.
- COMMUNITY: Build community cohesion and capacity through actively engaging with community residents and other stakeholders, including those who face the greatest health inequities.
- EQUITY: Apply an equity lens to achieve fair and just treatment so that all communities and people can achieve their full health and overall potential.
- SUSTAINABILITY: Encourage sustained impact of programming through strategies that may include: leveraging funding to continue program activities, strengthening organizational and community capacity and forming innovative partnerships, and/or cross-sector collaborations that lead to permanent community change.

Applications will be scored on a scale of 1 to 4, where 1 = Disagree, 2 = Somewhat Disagree, 3 = Somewhat Agree, and 4 = Agree, using the scoring criteria below.

Scoring Criteria:

1. Organizational mission aligns with core principles
2. History of working in priority municipality and selected priority cohort(s)
3. Proposed project plan is feasible
4. Proposed project meets a demonstrated community need
5. Goals are reasonable and aligned with core principles
6. Proposed project plan addresses health inequities
7. Requested funding is reasonable for proposed activities
8. Partners and/or collaborators listed would increase the impact of the project (if applicable)

**Please note: incomplete applications will not be reviewed by the committee.*

Appendix C: SMART Goals

Program Goals provide a sense of direction, motivation, a clear focus, and clarify importance. By setting program goals, you are providing your organization, staff, and participants with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**imely. Therefore, a SMART goal incorporates all of these criteria to help focus your program efforts and increase the chances of achieving your goal.

SMART Goals should be created with collaborators and revisited regularly to ensure the program is on target to complete the goal. SMART goals should be updated as needed and new ones should be written once previous SMART goals have been met.

Overarching Goal:

A broad statement about the long-term expectation of what should happen as a result of your program (the desired result) serves as the foundation for developing your program's SMART goals. Criteria: 1) Specifies the social determinants of health or health-related social need; 2) Identifies the target population(s) for your program.

SMART Goal (sometimes called SMART Objective):

SMART Goals are statements describing the results and the manner in which they will be achieved. You usually need multiple SMART goals to address the overarching goal. Criteria: SMART attributes are used to develop a clearly defined goal.

SMART Goals

Specific	Goals that are specific have a significantly greater chance of being accomplished. To make a goal specific, the three "W" questions must be considered: 1. Who: Who is the intended population for this goal? 2. What: What does the program want to accomplish? 3. Where: Where is this goal to be achieved?
Measurable	A SMART goal must have criteria for measuring progress. If there are no criteria, you will not be able to determine the program's progress and if you are on track to reach your goal. To make a goal measurable, ask yourself: 1. How many/much? 2. How do I know if the program has reached my goal? 3. What is my indicator of progress?
Achievable	Your goals should be achievable and attainable given your program resources and planned implementation. 1. Do I have the resources and capabilities to achieve the goal? If not, what am I missing? 2. Have others done it successfully before?
Relevant	Your goal, even after meeting all the prior criteria, must now align with other relevant goals because success requires the support and assistance from everyone on the project team. 1. Does it match other program or agency needs? 2. Is it aligned with current economic or social trends? 3. Does it align with the participants' needs and strengths?
Timely or Time-bound	Your goals should be defined within a timeframe. Here the focus is on "when" the goal will be met. Specifying a timeframe in the goal will help you in both planning and evaluating your program. 1. Does my goal have a deadline? 2. By when do you want to achieve your goal?

SMART Goals can be Process or Outcome focused

Process SMART Goals describe the activities/services/strategies that will be delivered as part of implementing the program.

Outcome SMART Goals specify the intended effect of the program in the intended population or end result of a program.

Outcome SMART Goals can be classified as short-term, intermediate, or long-term.

Well-written and clearly defined SMART goals will help you monitor your progress toward achieving your overarching program goal.

- Short-term outcome goals are the initial expected changes in your intended population(s) after implementing certain activities or interventions (e.g., changes in knowledge, skills, and attitudes).
- Intermediate outcome goals are those interim results that provide a sense of progress toward reaching the long-term goals (e.g., changes in behavior, norms, and policy).
- Long-term goals are achieved only after the program has been in place for some time (e.g., changes in mortality, morbidity, quality of life).

SMART Goal Examples

Sample Goal 1: Collaborate with 11 community partners.

The list below shows how this goal is and is not a SMART goal.

- Is it Specific? It is clear but it could be more specific in terms of who will do it and what "collaboration" means.
- Is it Measurable? Yes, but how it will be measured needs to be stated.
- Is it Attainable? Yes, if you have the time and resources needed.
- Is it Relevant? Yes, collaborating with other agencies improves the chance that changes will be made and contributes to sustainability.
- Is it Time bound? No, it does not specify a timeframe for completing the goal.

Sample SMART Goal 1: Project director will obtain Memoranda of Understanding that spell out the terms of agency collaboration with 11 community partners involved with youth by August 31, 2021.

Sample Goal 2: Continue to educate our community that suicide is a public health problem.

Sample SMART Goal 2: The project team will speak once a month at 9 community meetings from January-September 2021, to educate our community that suicide is a preventable public health problem.

Sample Goal 3: Increase consumption of fruits and vegetables among youth.
Sample SMART Goal 3: By September 1, 2022, 75% of Grade 6-8 classrooms in Boston will provide a fruit or a vegetable to all students during snack time at least 3 school days a week. (Process)

Sample SMART Goal 3: By May 2023, 60% of middle school youth in Boston will report consuming at least 5 servings of fruits and vegetables a day, as indicated on the Youth Risk Behavior Survey. (Outcome)

Appendix D: Logic Model – Facilitating Behavioral Health Care Access through Behavioral Health Navigation

Program Name:

Overarching Goals:

1. The community-based Behavioral Health Navigator model will demonstrate success in connecting individuals experiencing mental health and/or substance use issues from the selected priority cohort(s) to appropriate behavioral health referral, screening, assessment and treatment services and supports.
2. Educational activities conducted with the broader community will show increased knowledge and awareness of available behavioral health services and supports.

Target Pop/Aim	Inputs	Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes	Anticipated Impacts
Who will benefit? What is our intention?	**Resources needed**	**What we do**	**Direct products of activities**	**Immediate changes**	**Behavior changes**	**Changes in policies, practices, conditions**	**Longer term indicators of impact**
Behavioral Health Navigator model will show success in connecting individuals experiencing mental health and/or substance use issues from the selected priority cohort(s) to appropriate behavioral health referral, screening, assessment and treatment services and supports			• Number and demographics of individuals utilizing the behavioral health navigation services. • Number of individuals screened and referred to services.	Participants will be referred to appropriate services	Successful access and utilization of the recommended resources by navigation participants.		Participants will report a decrease in mental health symptoms

Educational activities conducted with the broader community will show increased knowledge and awareness of available behavioral health services and supports			•Number of community members attending educational activities. • Number of community partners engaged throughout the grant period.		Increased knowledge about the resources available to participants through educational activities.		Enhance community support and collaboration

Appendix E: Evaluation Plan – Facilitating Behavioral Health Care Access through Behavioral Health Navigation

IMPLEMENTATION EVALUATION PLAN				
Evaluation Question	**Indicator**	**Data Collection Method/Source**	**Time**	**Responsible Party**
REQUIRED OVERARCHING INDICATORS				
Program Specific Indicators				
To what extent has the organization reached the BILH priority populations and how?	• *Sociodemographic data* -Zip code -Race and Ethnicity -Primary language and/or preferred language -Gender identity - Sexual Orientation -Age -Insurance status -Educational attainment -Current Employment Status -Immigration status			
	• *# of participants enrolled in program* • *Referral sources*			
	• *# of participants served by program* • *Types of services provided* • *Start date/End dates of service(s) provided*			
What is the perceived quality of the program?	• *Participant perceptions of program successes, challenges, and opportunities for improvement*			

Community outreach/forums/collaboratives specific indicators				
To what extent has the organization increased knowledge and awareness of available behavioral health services among community members?	• *# and type of community outreach activities* • *# of partners* • *# of partner meetings/activities /HUBs/collaborations*			
To what extent has the organization increased referral, screening, assessment, and engagement in appropriate behavioral health treatment among community members?	**Behavioral Health Resource connection**: • *Number of community members screened and referred to behavioral health services* • *Assess whether individuals successfully accessed and utilized the recommended resources*			
To what extent has the organization increased referral, screening, assessment, and engagement in appropriate social services among community members?	**Health-Related Social Needs Resource connection**: • *Number of community members screened and referred to social services* • *Type of health-related social needs identified*			