Beth Israel Lahey Health
Beth Israel Deaconess Plymouth

Beth Israel Deaconess (BID) Hospital-Plymouth FY26 Community-based Health Initiative (CHI)

Request for Proposals

Background

A member of Beth Israel Lahey Health (BILH), Beth Israel Deaconess Hospital – Plymouth (BID Plymouth) is committed to improving the health and well-being of residents within our Community Benefits Service Area (CBSA). The hospital's Community Benefits and Relations Department works with residents and key community health stakeholders to address prioritized community health needs identified through its triennial Community Health Needs Assessment (CHNA) which was last conducted in 2025.

Between 2026 and 2029, BID Plymouth is investing a total of $1,606,039.94 through its Community-Based Health Initiative (CHI) for its Determination of Need (DoN) through Beth Israel Deaconess Medical Center (BIDMC) to relocate and expand the hematology-oncology and infusion clinics to Cordage Park. CHI efforts will focus on upstream activities to address social determinants of health – conditions in which people are born, live, work, and play.

After a robust and transparent community engagement process that drew upon information collected from secondary data, community surveys, interviews, focus groups and listening sessions as part of the BID Plymouth 2025 Community Health Needs Assessment (CHNA) and FY26-28 Implementation Strategy (IS), the BID Plymouth Community Benefits Advisory Committee (CBAC) voted to allocate funds to two priorities: $803,019.97 to be allocated to address Housing (1 grant to be awarded) and $803,019.97 to be allocated to address Equitable Access to Care (up to 3 grants to be awarded). All grants will be awarded through this competitive Request for Proposals (RFP).

BID Plymouth's efforts seek to positively impact the social determinants of health. BID Plymouth recommends that applicants review the 2025 Community Health Needs Assessment and Implementation Strategy (see links above). All funded programs must align with the hospital's 2026-2028 Implementation Strategy and must report on standard process activities and outputs (see Appendix C. for further details). All strategies must align with the BILH Community Benefits Guiding Principles of *accountability, community engagement, equity and impact (more details in Appendix B)*. Also, applicants are advised to review the term "upstream" before submitting a response to this RFP. To learn more about the term "upstream," click here.

BILH is committed to its WE CARE Values and its Community Benefits investments align with these

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.

Request for Proposal (RFP) Process Overview and Timeline

Date/Time	Deliverable
March 5, 2026	RFP release date
March 13, 2026, 11AM -12PM	Virtual information session (optional). BID Plymouth staff will review the RFP and address questions about the application process. Register for session here: https://us02web.zoom.us/meeting/register/IXqZoLNuRqSqFTCwM1n7sA
March 5 – March 18, 2026	Q&A period*
March 20, 2026	FAQs posted to website: https://bidplymouth.org/about/community-benefits-needs/community-health-grants
April 13, 2026, 5 PM	Proposals due
End of May 2026	Final notification of decision to full Proposal Applicants
July 1, 2026	3-year grant term begins (3-month planning phase)
September 30, 2029	Grant Term ends
December 31, 2029	Community-based Health Initiative Ends

*If unable to attend virtual information session, Applicants may submit questions to Karen Peterson at kpeterson@bilh.org. Questions and answers will be posted at https://bidplymouth.org/about/community-benefits-needs/community-health-grants on March 20, 2026. No questions will be accepted after March 18, 2026.

How to Apply

Application materials can be found on the BID Plymouth website at https://bidplymouth.org/about/community-benefits-needs/community-health-grants. Completed materials, including application and budget templates, must be submitted to Karen Peterson at kpeterson@bilh.org by 5:00 p.m. on April 13, 2026. **Applications missing materials and not submitted by the deadline will be considered incomplete and will not be reviewed**.

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Appendix A contains the application questions and **Appendix B** contains the scoring criteria. For questions specific to the application process, please contact Karen Peterson at kpeterson@bidplymouth.org.

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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 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.
- MOVING UPSTREAM: Address the fundamental causes, or upstream factors, of poor health.
- SOCIAL VALUE: Positively improve the wellbeing, stability, and long-term outcomes of communities.

RFP Priority Areas for Funding

This RFP will award up to three (3) grants that will address the CHNA Priority/Sub-priority and Strategies in the table below. Funding will be awarded based upon the CHNA Priority/Sub-Priority and Strategies focusing on housing and equitable access to care:

- **Housing**: one (1) 3-year grant for a total of $803,019.97
- **Equitable Access to Care**: up to three (3) 3-year grants for a total of $803,019.97

Organizations should apply for the maximum amount of funding they will need to fully and completely implement the program over the full three years of funding. ***Please note, this funding is for new or the expansion of existing programs and may not be used to support existing programs or replace lost funding.***

Evidence-based/Evidence-informed Strategies

BID Plymouth is committed to funding programs that have evidence demonstrating their 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. The table below outlines some examples of evidence-based programs based upon the CHNA Priority/Sub-priority area. Proposals must address the chosen priority health need and be able to demonstrate measurable impact within the program implementation timeframe.

CHNA Priority/Sub-Priority	Strategy Name	Brief Strategy Description	Program Examples
Social Determinants of Health/ Housing	Support programs that stabilize housing and promote access to affordable housing.	Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement and increase homeownership.	• Programs/strategies that increase affordable housing • Home ownership education & counseling • Housing Trust Funds • Permanent Supportive Housing • Rapid Re-housing
Equitable Access to Care	Expand and enhance access to health care services by strengthening existing service capacity and connecting residents to health insurance, essential medications and financial counseling.	Expand and enhance access to community-based healthcare services, including mental health, by strengthening existing service capacity and connecting residents to health insurance, essential medications and financial counseling.*	• Community Health Worker/Navigator programs • School-based health services • Community-based interventions • Federally Qualified Health Center (FQHC) interventions

***Note:** These upstream initiatives are expected to impact the social determinants of health, including employment, education, social environment, and the built environment.

Eligibility

To be eligible to apply for the RFP, organizations must be tax-exempt (organization with 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. **Organizations must currently serve individuals who live, learn, work or play in or across the Town of Plymouth**.

Priority Populations

The priority populations for this RFP, determined based on BID Plymouth's most recent 2025 Community Health Needs Assessment and discussions with the Community Benefits Advisory Committee, are:

- Youth
- Older adults
- Low-resource populations

- Individuals living with disabilities
- Racially, ethnically and linguistically diverse populations

Evaluation and Reporting

Grant recipients will develop an evaluation and learning plan that aligns with their program design. Grant recipients will do so in collaboration with the external evaluator (hired and paid by BILH) and BILH Manager of Program Design and Evaluation and BID Plymouth Community Benefits and Community Relations Manager.

The evaluation and learning plan will be guided by process and outcome evaluation questions to understand the reach, effectiveness, and efficiency of the program. For example, the following illustrative evaluation questions could be tailored to the grant recipient's program, as applicable:

- Process evaluation: To what extent have the priority populations been reached?
- Outcome evaluation: To what extent have the priority populations experienced positive outcomes, as contributed from their participation by their participation in the program?
- Outcome evaluation: What progress has been made toward policy change?

BILH standard process and outcome metrics that grant recipients will be required to select from are provided in Appendix D.

Throughout the grant period, grant recipients will rely on the evaluation and learning plan as a roadmap to guide data collection, strengthen program improvement efforts, and fulfill reporting requirements to BILH. Grant recipients will be required to submit metric data on a quarterly basis and report on progress, evaluation data and financial updates twice a year in BILH's Community Benefits Database. Interviews or site visits may also be required as part of the reporting process.

<u>Collaboration with External Evaluator and BILH</u>

Grant recipients will work closely with the external evaluator (hired and paid by BILH). The external evaluator will:

- Collaborate with each grant recipient to support the development of their learning and evaluation plan. The plan will include program-specific evaluation elements that grant recipients will report to BID Plymouth. Depending on the funded project(s), the evaluation and learning plan may include elements for an overarching evaluation conducted by the external evaluator.
- Provide technical assistance to grant recipients (in both individual and group sessions) as they implement their individual evaluation and learning plans and submit quarterly data and bi-annual progress reports.
- Provide final summary evaluation report to BILH, documenting the effectiveness and lessons learned from technical assistance activities. This report will include metrics outlined in Appendix

During the three-month planning process, grant recipients will:

- Work with external evaluator to understand evaluation needs and capacity.
- Collaborate with external evaluator to create/revise a logic model and develop an evaluation and learning plan.
- Participate in monthly individual and group technical assistance and learning sessions, which will be a combination of both virtual and in-person.
- As applicable, participate in identifying common metrics all grant recipients can collect.

Note: Program implementation and data collection cannot begin prior to completion and approval of the three-month planning period deliverables.

During grant implementation, grant recipients will:

- Begin program implementation and data collection as defined in the evaluation and learning plan and submit complete quarterly metric data and semi-annual progress reports for the duration of the grant period.
- Participate in technical assistance (individual and group) and learning sessions with external evaluator.
- Engage in regular communication with external evaluation, BILH Manager of Program Design and Evaluation and BID Plymouth Manager of Community Benefits and Community Relations to discuss any proposed changes and barriers/challenges to program implementation, data collection and reporting.

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 as a whole, such as administrative staff salaries and benefits, rent, utilities, office supplies, etc.) may not exceed 15% of the total budget. Grant funds cannot be used for direct clinical service delivery and funds may not be used to provide medical services, to support clinical trials, to construct or renovate facilities or capital expenses, or as a substitute for funds currently being used to support similar activities.

Applicants will be asked to identify the staff members 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. BID Plymouth recommends that evaluation expenses total approximately 10% of an Applicant’s budget.

Grants will be awarded for a three-year period, which will include a designated planning phase of three months. The planning phase will give the grant recipients(s) time to hire staff, if needed, engage partners and community residents and create an evaluation and learning implementation plan. The planning phase will also enable the external evaluator to provide capacity building and technical

assistance to grant recipients(s) to ensure readiness for implementation and evaluation.

After the initial planning period/funding, funding will be awarded twice a year after submission of completed progress report deliverables, as outlined in the table below.

Deliverable	Due Date	Payment
Year 1		
Signed agreement	Upon award	1 of 6
Evaluation and learning plan, with logic model	By end of three-month planning period	
Mid-year report		2 of 6
Quarterly metric data submission		
Year 2		
Annual report – Year 1		3 of 6
Quarterly metric data submission		
Mid-year report		4 of 6
Quarterly metric data submission		
Year 3		
Annual report – Year 2		5 of 6
Quarterly metric data submission		
Mid-year report		6 of 6
Quarterly metric data submission		
Annual report – Year 3		

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.

Contact Information

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

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Appendix A: Application Questions and Required Documents

Note: Responses to the questions below will be submitted in the fillable PDF: see link on website. Applicants are also required to submit the populated budget (see link on website) as well as organizational budget for the current year; Internal Revenue Service Form 990 for the last two fiscal years; most recent audited financial statement; and W9.

Please indicate which health priority area you are applying for:

1. Housing
2. Equitable Access to Care

1. Organization Overview

a. Organization overview and mission: Please provide a brief overview of the lead organization, including its mission and the primary needs the organization addresses. (200 words maximum)

b. Link to website: If available, please provide a link to your organization's website and/or social media platform.

c. Primary contact person: Name, role, and contact information

d. Secondary contact person: Name, role, and contact information

2. Project Overview

a. Program name: P*lease provide a one sentence title that reflects the nature of the proposed project (1 sentence maximum).*

b. Program description: Please provide a brief description of the project(s) the organization is seeking to fund (300 words maximum).

c. Program need: Why are you looking to implement this program? What gap does this program fill? (50 words maximum)

d. Communities of focus: Include who you hope to reach with this program. How many people do you anticipate reaching? What are their key demographics? Why do they need this program? Please specify if you will work with any of the following: youth, older adults, low resourced populations, individuals living with disabilities; racially, ethnically and linguistically diverse populations. Please specify what communities you will work in: Quincy. (150 words)

e. Key challenges: Why do they need this program? How will this program meet community needs? (150 words)

f. Maximizing resources: How does the organization plan to ensure that project resources are deployed towards those that need them the most? (100 words maximum)

g. *Upstream Efforts:* Explain how the project addresses the social determinants of health, including housing, employment, education, social environment and the built environment. (150 words maximum)

h. Program history and community relevance: Please share any research and evaluation findings related to this program's efficacy. If relevant, please share any experience implementing this program as well as how and to whom this program will be expanded. Briefly describe examples of the work the organization has done in the selected communities including any current partnerships with organizations located in Quincy. What success have you seen to date? (200 words maximum)
i. Project Staffing: List the key people who will be involved in project implementation and briefly describe their roles and their level of effort. (200 words maximum)

3. **Project Goals:** Please provide up to three outcome SMART (specific, measurable, attainable, relevant, and timely) goals for the project and supporting activities (See Appendix C for guidance on developing SMART goals and supporting activities). If applicable, please include a goal for how the project will address upstream Social Determinants of Health (SDoH). Propose process and outcome metrics for measuring activity completion and goal progress, respectively.

    a. SMART goal 1 and timeline: What do you hope to achieve? Include start date to completion date.
        i. Activities: What will you do to achieve your goal? In bullet points, list and briefly describe the activities. Note who (role(s)/job title(s)) is responsible for the activity(ies).
        ii. Proposed Metrics: How will you track progress? Please refer to Appendix D for BILH's standard metrics. Please be sure to include both process and outcome metrics.
    b. SMART goal 2 and timeline: What do you hope to achieve? Include start date to completion date.
        i. Activities: What will you do to achieve your goal? In bullet points, list and briefly describe the activities. Note who (role(s)/job title(s)) is responsible for the activity(ies).
        ii. Proposed Metrics: How will you track progress? Please refer to Appendix D for BILH's standard metrics. Please be sure to include both process and outcome metrics.
    c. SMART goal 3 and timeline: What do you hope to achieve? Include start date to completion date.
        i. Activities: What will you do to achieve your goal? In bullet points, list and briefly describe the activities. Note who (role(s)/job title(s)) is responsible for the activity(ies).
        ii. Proposed Metrics: How will you track progress? Please refer to Appendix D for BILH's standard metrics. Please be sure to include both process and outcome metrics.

4. **Health Equity and Community Engagement**
    a. Community engagement: 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. Community health improvements: *How will the funds be used to improve health outcomes (100 words maximum)*

5. **Budget:** Upload an itemized project budget and an accompanying budget narrative (up to a ½ page) using the template provided. The budget should include direct costs and indirect costs, including staff time.

6. **Partners (if applicable)**
   a. Partners: List all partner organizations that are key to the success of this project. Include the sector they represent (e.g. workforce development, behavioral health, housing, education, etc.) and a brief description of their involvement in the project. (150 words)
   b. Value of collaboration: Describe how the collaboration(s) will increase the impact of the project. (150 words)

7. **Evaluation Capacity/Experience:** This section is about your organization's/partnership's existing evaluation capacity and experience with evaluation as well as how your organization optimizes both evaluation and funding to support learning and sustainability.

   a. Evaluation capacity: Describe your organization's/partnership's current capacity to conduct evaluation activities, including any internal staff FTEs and external contracts, as applicable. Do you have an evaluation and learning plan? How often is this updated? Does your evaluation and learning plan include a logic model? (200 words maximum)
   b. Data collection methods: Describe your organization's current qualitative and quantitative data collection practices. How does your organization incorporate the client and community voice in its evaluation activities? (150 words)
   c. Process metrics: Please list your current process metrics. (150 words)
   d. Outcome metrics: Please list your current outcome metrics. (150 words)
   e. Data use and learning: How does your organization use data to improve programming/initiatives? Please provide an example. (150 words)
   f. References (optional): You may include references or links to past evaluations, such as recent program evaluations. (150 words)
   g. Organization evaluation lead and contact information: Name, position title, email address.

8. **Sustainability:** BID Plymouth 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. Leveraging BIDP funding to support project sustainability: Describe how the organization will leverage this funding to support the sustainability of the project(s). (100 words maximum)
   b. Sustaining community health outcomes: How will this project contribute to improved community health after the initial funding period? (100 words maximum)
   c. Actions to support sustainability: Describe what actions will be taken to overcome challenges related to sustainability at the beginning, middle, and end of the project. (250

words maximum)

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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 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 inequities.
- 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
- 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
- MOVING UPSTREAM: Address the fundamental causes, or upstream factors, of poor health. To learn more about the term "upstream," click here.
- SOCIAL VALUE: Positively improve the wellbeing, stability, and long-term outcomes of communities.

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. Examples of previous work in priority city/town/neighborhood(s)
3. Proposed project is feasible
4. Proposed project meets a demonstrated community need
5. Proposed project improves health outcomes
6. Proposed project is evidence-based or evidence-informed
7. Goals and intended impact, as defined by process and outcome measures, are reasonable and aligned with guiding principles
8. Requested funding is reasonable for proposed activities
9. Partners and/or collaborators listed would increase the impact of the project (if applicable). Additional consideration given for leveraging outside resources (i.e.. Community Investment Tax Credits)
10. Proposed project will address upstream social determinants of health

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

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Appendix C: Outcome SMART Goals and Activities

Outcome SMART goals describe the specific changes a program intends to achieve for participants or the community within a defined timeframe, focusing on measurable shifts in knowledge, behaviors, skills, health or social conditions, or stability (housing, employment). These goals clearly articulate what will change, for whom, and how success will be measured, ensuring that the expected results are both realistic and aligned with the program's purpose. By being Specific, Measurable, Achievable, Relevant, and Time-Bound, outcome SMART goals support demonstrating the intended impact of a program and provide a clear basis for evaluation and accountability. Outcome SMART Goals can be classified as short-term, intermediate, or long-term.

SMART Goal template: By [date/timeframe], [percentage or number] of [target population] will [achieve X change or outcome], as measured by [survey, data system, assessment tool].

Specific	• What exactly do you plan to accomplish? • Who is the intended population for this goal? • Where is this goal to be achieved?
Measurable	How will you measure progress and/or success? • What metric(s) are important? • What data is important?
Achievable	• Why is this goal realistic with your resources and timeline? • Do I have the resources and capabilities to achieve the goal? If not, what am I missing? • Have others done it successfully before?
Relevant	• How does this goal advance the program's focus? • Does this goal advance the identified community needs? • Does it match organizational needs? • Is it aligned with current economic or social trends? • Does it align with the participants' needs and strengths?
Timely or Time-bound	• When will you achieve this goal?

Examples of SMART goals include the following:

	Housing Programs	Access to Care Programs
Short-term	By June 2026, 75% of participants enrolled in the housing stabilization program will demonstrate increased knowledge of tenant rights and available housing resources, as measured by pre/post workshop surveys.	By the end of Year 1, 70% of participants will report increased confidence in accessing healthcare services, measured through pre/post surveys.
Medium-term	By December 2027, 70% of program participants will obtain or maintain stable housing for at least six consecutive months, as verified by case manager follow-ups and housing status documentation.	By December 2027, 60% of enrolled individuals will demonstrate improved adherence to follow-up care or chronic disease management plans, as measured by appointment attendance and clinical indicators.
Long-term	By the end of the grant period in 2028, 55% of participants will sustain stable housing for at least 12 months, as measured by housing retention data.	By the end of the grant period, disparities in missed appointments between the program's target population and the overall clinic population will be reduced by 20%, based on annual clinic utilization reports.

Program Activities

Program activities are intentionally designed to drive progress toward the proposed SMART goals by providing the structure, resources, and supports necessary to achieve the outlined SMART goals. Activities serve as the operational steps that make the goals achievable, while clear timelines, defined roles, and data collection processes ensure that progress can be measured and monitored. By linking activities to the desired outcomes, the program creates a coherent pathway from implementation to impact, increasing the likelihood of achieving meaningful, time-bound improvements for the populations served.

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Appendix D: Process and Outcome Evaluation

By supporting grantees in collecting meaningful data, setting benchmarks, and evaluating both outcomes and implementation quality, we gain deeper insight into what works, for whom, and under what conditions. This commitment enables us to make informed, equitable, and impactful funding decisions—maximizing the value of our resources and advancing long-term community health and well-being.

Process and outcome evaluation are essential components of understanding the effectiveness and quality of community programs. Process evaluation helps assess how a program is being implemented—whether activities are delivered as intended, who is participating, and what barriers or facilitators exist. Outcome evaluation, on the other hand, focuses on the results of the program, measuring changes in knowledge, behavior, health status, or other key indicators.

Together, these approaches provide a comprehensive picture: process evaluation ensures that the program is on track and responsive to real-world conditions, while outcome evaluation tells us whether the program is making a meaningful difference. This dual focus supports continuous improvement, accountability, and informed decision-making. Both will be incorporated into your evaluation and learning plans:

Evaluation and learning plan	
Process Evaluation	*Outcome Evaluation*
Logic model, which ties together the program's theory of change and the implementation model, from inputs to impact;	
• Process evaluation questions monitoring program activities • Process metrics, including BILH's standardized process metrics • Qualitative data collection methods	• Outcome evaluation questions assessing program SMART goals • Outcome metrics, including BILH's standardized outcome metrics • Qualitative data collection methods

BILH Standard Process Metrics

Process metrics help us understand how a program was carried out: what was actually delivered, to whom, and in what ways. The goal is to make sure the program is being implemented as intended and to identify what is working well and what might need adjustment. By gathering this information, process metrics support organizations to improve their programs in real time, ensures resources are being used effectively, and provides context for understanding the program's outcomes.

All grant recipients will include process metrics as part of their evaluation and learning plans. Grant recipients will, at minimum, track the number of unique individuals served. Grant recipients are encouraged to include other process metrics as applicable to their programs in their evaluation and

learning plans.

	Alignment with program design	Count required	Rationale
Process metrics	Activities	6-9	Shows implementation progress: • How is the program being implemented? • Under what conditions does the program work? • Is the intended population participating at expected levels? • Can the program be replicated?

Please refer to table below for BILH's standard process metrics. These are required for use.

Process Metrics
• Number of unique individuals served, disaggregated by demographics As applicable to the program: • Number of services delivered • Number of activities or events conducted to a group or at the community level • Number of participants attending activities or events conducted to a group or at the community level • Number of organizations and/or providers engaged throughout the grant period, disaggregated by activity and existing/new. If applicable: • Number of products/weight of products/units delivered • Number of staff hired current staff roles continued • Number of staff trained • Number/percent of recipients reporting satisfaction and/or program meeting their needs among those enrolled/eligible Optional: • Number of perceived implementation facilitators by staff & qualitative description • Number of perceived implementation barriers by staff & qualitative description

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BILH Standard Outcome Metrics

Outcome metrics help us understand the results of a program—what changed for participants, organizations, or communities because the program existed. While process metrics show how the work was carried out, outcome metrics focus on whether the program is making the difference it set out to make.

The outcome metrics listed in the tables below represent BILH's standard outcome metrics. ***Applicants will be expected to select the metrics that are most relevant and applicable to their program.*** The table below guides selecting short-term (3-6), medium-term (3-6), and long-term outcome metrics (3-4).

	Alignment with program design	Count required	Rationale
Short-term outcomes	SMART goals	3-6	Immediate changes: what participants learn or how their attitudes shift early in a program. • Affective change – Changes in attitudes or feelings toward a behavior • Learning change – Acquisition of new knowledge or awareness
Medium-term outcomes	SMART goals	3-6	Intermediate changes: what participants do differently as a result of the program. • Behavior change – Adoption of new behaviors or practices
Long-term outcomes	SMART goals	3-4	Longer-term change: broader, more sustainable improvements that typically take longer to achieve. • Environmental conditions – Increased access to healthier choices (e.g., smoke-free policies, improved built environment) • Status change – Improved health outcomes or indicators

Programs may align with more than one area of focus. Grant recipients may select outcome metrics from other program areas that may provide a clearer picture of their program's impact. The goal is to ensure that programs report on outcomes that best reflect the change they aim to create in the community.

The tables below categorize BILH's standard outcome metrics by program type.

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Permanent Supportive Housing and Rapid Re-Housing Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
• Number/percent of individuals enrolled who report [increased] satisfaction with housing situation (enrollment vs. endline) among those enrolled/eligible • Number/percent of individuals enrolled who report [increased] ability to afford housing (enrollment vs. endline) among those enrolled/eligible • Number/percent of individuals enrolled who report their housing status	• Number/percent of individuals enrolled who report increased agency related to own's housing status (enrollment vs. endline) among those enrolled/eligible • Number/percent of individuals enrolled who report increased confidence related to own's housing status (enrollment vs. endline) among those enrolled/eligible	• Number/percent of individuals enrolled who report their housing status (endline & endline vs. baseline) o Same living situation o Different living situation o Shift from temporary to more stable living situation o Shift to homeownership • Number/percent of individuals enrolled who report retention in stable housing situation among those eligible • Number/percent of individuals indicating improvements in physical and/or mental health • Number/percent of individuals who report having a sense of belonging in their community

Homeownership Counseling and Education Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
• Number/percent of participants that report increased knowledge • Number/percent of participants that report intent to apply knowledge	• Number/percent of participants that report improved financial behaviors • Number/percent of participants that report increased mortgage readiness • Number/percent of participants that report purchasing a home	• Number/percent of individuals enrolled who report their housing status (endline & endline vs. baseline) o Shift to homeownership • Number/percent of individuals enrolled who report sustained homeownership • Number/percent of individuals who report having a sense of belonging in their community • Number/percent of individuals indicating improvements in physical and/or mental health

Affordable Housing Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
As applicable: • Number of new affordable housing units funded through housing trust funds/other affordable housing development program funds • Number of affordable housing units funded to be renovated through housing trust funds/other affordable housing development program funds	*As applicable:* • Number of affordable housing units built • Number of affordable housing units preserved • Number/percent of affordable housing units available for occupancy	• Number/percent of individuals enrolled who report their housing status (endline & endline vs. baseline) o Same living situation o Different living situation o Shift from temporary to more stable living situation o Shift to homeownership • Number/percent of individuals enrolled who report retention in affordable housing units funded through housing funds/other affordable housing development program funds • Number/percent of individuals who report having a sense of belonging in their community • Number/percent of individuals indicating improvements in physical and/or mental health

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Integrated Care & Care Coordination Models and Community-Based Clinical Access Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
Transitional Care Models/Programs and Case Management, as applicable: • Number/percent of follow-up appointments scheduled before discharge • Number/percent of individuals-patients-reporting satisfaction with transitional care/case management • Number/percent of individuals-caregivers-reporting satisfaction with transitional care/case management *Primary Care & Behavioral Health Integration* • Number/percent of individuals reporting experiencing coordinated care among primary care providers, case managers or behavioral health consultants, and mental health specialists • Number/percent of individuals-patients-reporting satisfaction with care • Number/percent of patients with a documented comprehensive care plan • Number/percent of patients of patients who report experiencing warm handoffs between medical and behavioral health • Number/percent of patients screened for social needs (food, housing, transportation, utilities, safety) • Number/percent of patients with positive screens who receive referrals *Medical Homes* • Number/percent of individuals-	*Transitional Care Models/Programs and Case Management, as applicable:* • Number/percent of individuals who report care plan adherence (appointments, medication, diet, etc.) • Number/percent of individuals who report improved day-to-day functioning • Number/percent of individuals who report retention living in their own home • If applicable: Number/percent of individuals who report having a sense of belonging in their community *Primary Care & Behavioral Health Integration & Medical Homes* • If applicable: Number of days from referral to first behavioral health appointment • Number/percent of individuals who report care plan adherence (appointments, medication, diet, etc.) • Number/percent of patients who report their care team understands their goals/values • If applicable: Number/percent of referrals successfully closed or resolved *Mobile Clinics* • Number/percent of referrals successfully closed or resolved • Number/percent of individuals reporting experiencing coordinated care among providers at the mobile clinic and providers to whom they were referred *All, if applicable:* • Number of new relationships	*Transitional Care Models/Programs and Case Management; Primary Care & Behavioral Health Integration; Medical Homes; Mobile Clinics* • Number/percent of individuals indicating improvements in physical health • Number/percent of individuals who report improved mental and emotional well-being • Number/percent of individuals who report fewer hospitalizations and/or ED visits *Mobile Clinics* • Number/percent of individuals indicating improvements in physical health • Number/percent of individuals who report improved mental and emotional well-being • Number/percent of individuals who report fewer hospitalizations and ED visits *All, if applicable:* • Established, sustainable linkages of care: Number of relationships with community organizations sustained through end of funding

patients-reporting satisfaction with care • Number/percent of individuals reporting experiencing coordinated care across: preventive, acute, and chronic health care needs *Mobile Clinics* • Number/percent of individuals-patients-reporting satisfaction with care • Number/percent of patients screened for social needs (food, housing, transportation, utilities, safety) • Number/percent of patients with positive screens who receive referrals • Number/percent of referrals successfully closed or resolved *All, if applicable:* • Number of new linkages made with community organizations and/or providers & qualitative description (business cards exchanged, introduced at community event, etc.)	with community organizations established & qualitative description (MOU, contract, partnership agreement, joint activities, referrals etc.)	

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Health Insurance and Financial Literacy and Support Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
Health insurance enrollment support programs • Number/percent of individuals who report increased knowledge of health insurance options and key definitions • Number/percent of individuals who report feeling more equipped to select health insurance plan that meets their needs • Number/percent of individuals who report feeling equipped to navigate health insurance benefits • Number/percent of individuals who report completing application for health insurance *Health insurance literacy programs* • Number/percent of individuals who report increased knowledge of health insurance options and key definitions • Number/percent of individuals who report feeling more equipped to select health insurance plan that meets their needs *Financial education/literacy programs* • Number/percent of individuals who report increased knowledge of budgeting and savings strategies • Number/percent of individuals who report increased knowledge of increased confidence in managing finances • Number/percent of individuals who report intending to apply knowledge of budgeting and savings strategies in their daily lives	*Health insurance enrollment support programs* • Number/percent of individuals who report now having health insurance • Number/percent of individuals who report now having a primary care provider (if required) *Health insurance literacy programs* • Number/percent of individuals who report feeling more equipped to navigate health insurance benefits *Financial education/literacy programs* • Number/percent of individuals who report applying budgeting practices	*Health insurance enrollment support programs* • Number/percent of individuals who report continued coverage with same health insurance provider *Health insurance literacy programs* • If delayed follow-up (3 to 6 months) is possible: Number/percent of individuals who report more ease in navigating care *Financial education/literacy programs* *Improved long-term financial stability* • If delayed follow-up (3 to 6 months) is possible: Number/percent of people who report feeling positive about the progress they have made since taking the class • If delayed follow-up (3 to 6 months) is possible: Number/percent of people who report reduced financial related stress

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Individual and Organizational Level Health Literacy and Digital Health Literacy Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
Individual-level models: *Health literacy* • Number/percent of individuals who report increased knowledge of content covered • Number/percent of individuals who report increased awareness of resources for reputable health information • Number/percent of individuals who report increased confidence in ability to access health information *Digital literacy* • Number/percent of individuals who report increased confidence in using patient portals • Number/percent of individuals who report increased confidence in using telehealth for virtual appointments *Organizational-level health literacy models* • Number/percent of staff trained in ways to promote and support patients in health literacy	Individual-level models: *Health literacy* • Number/percent of individuals who report increased confidence in ability to ask providers health-related questions *Digital literacy* • Number/percent of individuals who report increased use of patient portals • Number/percent of individuals who report increased use of telehealth for virtual appointments *Organizational-level health literacy models* • Number/percent of staff that apply best practices to promote health literacy among patients	*All* • Number/percent of individuals reporting satisfaction with patient/provider communication • Number/percent of individuals reporting that decisions made reflected shared decision making

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School-Based Health Centers

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
• If applicable: Number/percent of individuals newly covered with health insurance • Number/percent of individuals who report easy access to care at school-based health center • If applicable: Number/percent of individuals screened & qualitative description (mental health, substance use, food assistance, etc.) • If applicable: Number/percent of individuals referred & qualitative description (mental health, substance use, food assistance, etc.) • Number/percent of individuals who report increased health knowledge • Number/percent of individuals who report increased awareness of when to go to school-based health center • Number of new linkages made with community organizations and/or providers & qualitative description (business cards exchanged, introduced at community event, etc.)	• Number/percent of individuals who report improved health behaviors • Number/percent of individuals who report improved health seeking behaviors • Number of new relationships with community organizations established & qualitative description (MOU, contract, partnership agreement, joint activities, referrals etc.)	• Number/percent of individuals who report increased attendance at school • Number/percent of individuals who report improved grades • Number/percent of individuals indicating improvements in physical health • Number/percent of individuals who report improved mental and emotional well-being • Number/percent of individuals who report fewer hospitalizations and/or ED visits • Established, sustainable linkages of care: Number of relationships with community organizations sustained through end of funding

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Chronic and Complex Conditions: Community Health Worker/Navigator Model Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
Outputs: • Number/percent of individuals screened • Number/percent of individuals referred • Number/percent of patients with positive screens who receive referrals Short-term outcomes: • Number/percent of referrals successfully closed or resolved • Connection to care: Percent of individuals who use resources recommended by navigator/CHW, disaggregated by health care and social supports • Number of days from referral to access to services (as indicated by appointment made) • Number/percent of participants that indicate increased knowledge of available community resources, disaggregated by health care and social supports • Number/percent of participants that indicate increased knowledge of chronic disease symptoms • Number/percent of participants that indicate increased awareness of when to seek care for chronic disease symptoms • Help seeking behavior: Number/percent of individuals initiating care for chronic-disease related concerns • Number of new linkages made with community organizations and/or providers & qualitative description (business cards exchanged, introduced at community event, etc.)	• Decreased time between referral and access to services: Number of days from referral to appointment (comparison of quarterly averages) • Number/percent of individuals enrolled in health insurance, disaggregated by public/private • Number/percent of individuals enrolled in social safety net programs among those eligible • Number/percent of participants that indicate increased confidence for managing chronic disease symptoms • Number/percent of participants that indicate intention to continue help seeking behaviors • Optional: Number/percent of participants that indicate increased confidence for managing chronic disease symptoms • Number/percent of individuals who report increased health behaviors to manage chronic disease symptoms (diabetes: diet, physical activity, medication adherence; HIV: medication adherence) • Number of new relationships with community organizations established & qualitative description (MOU, contract, partnership agreement, joint activities, referrals etc.)	• Improved physical health outcomes: number/percent of individuals reporting physical health symptoms (baseline vs. endline) • Improved mental health outcomes: number/percent of individuals reporting mental health symptoms (baseline vs. endline) • Established, sustainable linkages of care: Number of relationships with community organizations sustained through end of funding term

Transportation Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
• Number/percent of individuals who report awareness of available transportation methods • Number/percent of individuals who report transportation option meeting their needs • Number/percent of individuals who report transportation option accessible • If applicable: Number/percent of individuals who report transportation option affordable	• Number/percent of individuals who report making it to health/medical/ mental health/social worker appointments • Number/percent of individuals who report being able to fill prescriptions • Number/percent of individuals who report to having access to resources and opportunities (food, physical activity, social activities, or other services)	• Number/percent of individuals indicating improvements in physical and/or mental health • If applicable: Number of changes in policies and legislation due to the transportation service (for example, land use and safety regulations)*

Behavioral Health Navigator, Community Health Worker, and Peer-to-Peer Support Programs

Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
Connection to care: • Percent of individuals who use resources recommended by navigator, disaggregated by behavioral health and social supports • Number of days from referral to access to services (as indicated by appointment made) • Number/percent of participants that indicate increased **knowledge of available community resources**, disaggregated by behavioral health and social supports • Number/percent of participants that indicate increased **knowledge of behavioral health symptoms** • Number of new linkages made with community organizations and/or providers & qualitative	• Number of **new relationships with community organizations** established & qualitative description (MOU, contract, partnership agreement, joint activities, referrals etc.) • **Decreased time between referral and access to services**: Number of days from referral to appointment (comparison of quarterly averages) • Number/percent of participants that indicate increased confidence for managing behavioral health concerns • Number/percent of participants that indicate intention to continue help seeking behaviors	• **Improved mental health outcomes:** number/percent of individuals reporting mental health symptoms (baseline vs. endline) • **Established, sustainable linkages of care:** Number of relationships with community organizations sustained through end of grant *Substance Use (if applicable)* • **Improved substance use outcomes:** Number/percentage of individuals reporting abstinence from substances after treatment or intervention

description (business cards exchanged, introduced at community event, etc.) *Substance Use (if applicable)* • Number/percent of participants that indicate increased **knowledge of available community resources**, disaggregated by substance use, behavioral health, and social supports • Number/percent of participants that indicate increased **knowledge of substance disorder symptoms**	*Substance Use (if applicable)* • Number/percent of participants that indicate increased confidence for managing substance use concerns	

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Appendix E: Evaluation Capacity Measurement

Throughout the funding period, the external evaluator will conduct evaluation capacity assessments with each funded partner to understand their current strengths, skills, and support needs related to evaluation. These assessments will guide the evaluator in tailoring technical assistance, coaching, and tools so that each organization receives support that is appropriate to their experience level and program model. In addition to using the assessments for customization, the evaluator will also measure and track changes in evaluation capacity over time. This information will be summarized and reported to highlight progress, identify common challenges, and inform future capacity-building efforts across the portfolio.

The following metrics will capture this information:

Outputs	Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes/Impact
#/% of partners engaged in technical assistance indicating increased knowledge/skills on evaluation related topics	#/% of partners engaged in technical assistance reporting intent to use/apply knowledge/skills gained	#/% of partners engaged in technical assistance reporting using/applying knowledge/skills gained #/% of partners reporting adapting programs based on their program data	#/% of partners engaged in technical assistance reporting improved practices