



THE NEW YORK
COMMUNITY TRUST



Health and Behavioral Health Grantmaking Strategy

June 2016

INTRODUCTION

The Trust's health grants program began in the late 1970's. Over the next 10 years, grantmaking guidelines also were developed for specific issues or populations including mental health, substance abuse, children and youth with disabilities, and blindness and visual disabilities.

- In 1981 the Board approved a **strategy for mental health** to foster the independence of people with mental illness and encourage development of a community-based system of care.
- In 2003 the Board approved a **revised strategy for substance use treatment** that promoted coordinated drug treatment, particularly with other systems such as mental health and child welfare, and helped build capacity of treatment providers.
- In 2004, the board approved a **revised health grantmaking strategy** with three core objectives: promoting accessibility of basic health services, especially in minority and immigrant communities; strengthening health service providers, especially those serving the City's poorest residents; and promoting healthy lifestyles.

As federal and state health care reform imposes a more holistic approach for delivering services to all groups, The Trust's grant programs need to be streamlined into a comprehensive strategy that combines areas formerly managed in silos.

This presentation recommends a revised strategy to guide The Trust's grantmaking for the health and behavioral health programs*. It also provides the foundation for the People with Special Needs program, described in a separate document.

* Treatment for mental health problems and substance use disorders are now collectively referred to as behavioral health care.

Both documents were informed by a report prepared by a consultant who:

- examined reports and reference materials to determine the key policy issues;
- reviewed the Trust's grantmaking and other philanthropic activity; and
- conducted interviews with 30 funders and experts.

This presentation on The Trust's health and behavioral health competitive grants program:

- provides an overview of national health status, spending, and policy in an era of health care reform on pages 3 to 9;
- reviews the expansive health care reform ongoing in New York State and City on pages 10 to 13;
- reports the health status of New York City residents and the health systems that serve them on pages 14 to 20;
- describes grantmaking by The Trust and other foundations in New York City on pages 21 to 28; and
- recommends a modified grantmaking strategy on pages 29 and 30.

The strategy does not include our biomedical grants program, which we streamlined last year.

NATIONAL HEALTH AND HEALTH CARE SPENDING

Average life expectancy in the United States is now 78.8 years. Coupled with a nearly 20-year decline in cancer and heart disease—the two leading causes of death—Americans are now living longer and healthier lives than ever before.

As a nation, we are better equipped to:

- cope with the medical dangers of ever-evolving bacteria and new viruses such as Ebola and Zika;
- capitalize on advancements in early detection and improved treatments to manage deadly diseases better, e.g., cancer; and
- manage AIDS, making it a largely chronic condition now.

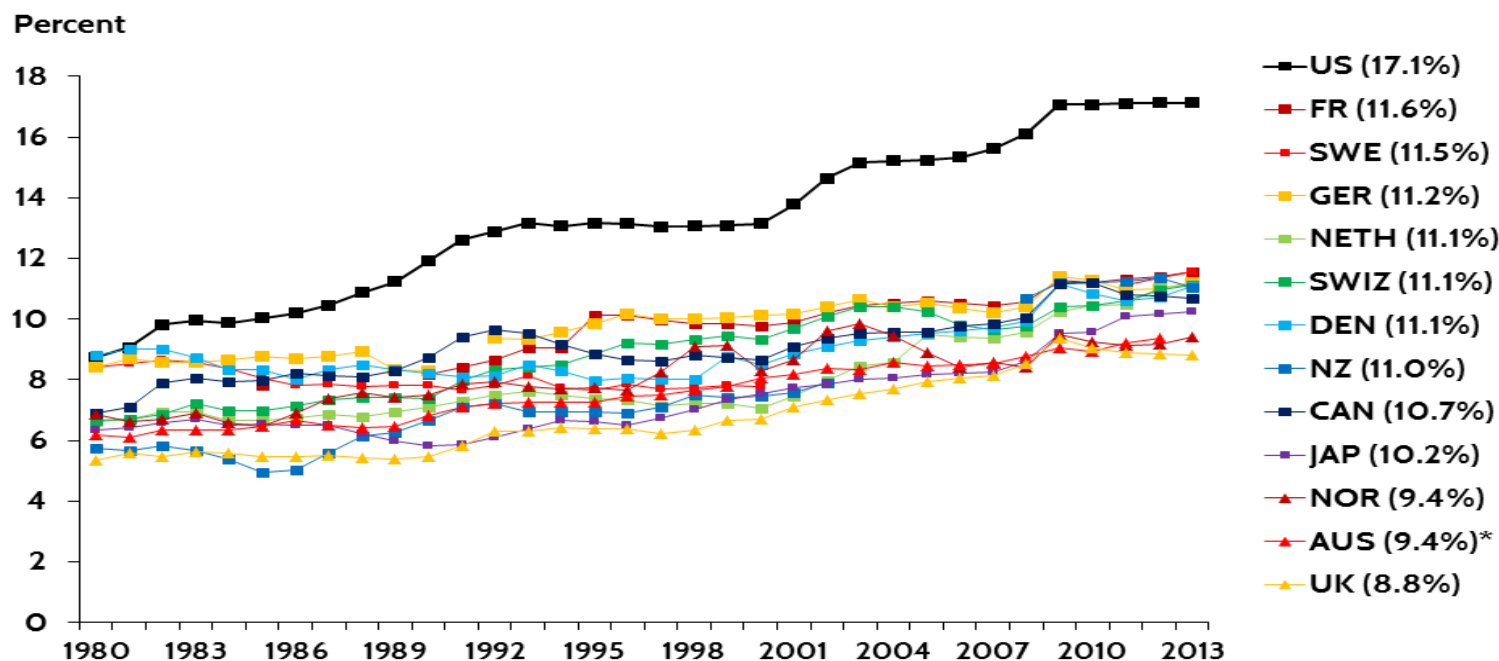
Chronic disease is more prevalent than acute illnesses in the United States.

- Sixty-eight percent of Americans age 65 or older suffer from at least two chronic conditions, compared to 33 percent in the United Kingdom and 56 percent in Canada.
- The largest portion of healthcare spending in the United States—and New York—is devoted to people with chronic disease, including diabetes, heart disease, and obesity, and behavioral health problems.

Total health care spending in the United States is roughly \$3 trillion or 17.5 percent of the economy, about \$9,000 per capita.

- It is the highest among the group of 13 industrialized nations and contributes to systemic wage stagnation, budget deficits, and individual personal bankruptcy.
- This high spending level crowds out other forms of social spending that support health, an imbalance that contributes to poorer health outcomes than in other industrialized nations.

The United States has an Expensive Health Care System



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

Most acute illnesses and injuries that afflict New Yorkers today can be treated successfully. However:

- Inequities in access to care and the quality of care remain, a divide attributed largely to poverty.
- Ethnic minorities are still more likely to fare worse in almost all aspects of health care access and treatment.

There are a number of non-medical factors, such as environmental conditions, and access to resources such as housing, good food, and education—referred to as the social determinants of health—that influence the health and wellness of individuals.

- Including these factors in the design and implementation of the health care delivery system can improve health outcomes.
- A person's zip code determines health access and outcomes far more than his or her genetic code.

These factors are illustrated in the graphic on the following page.

Social Determinants of Health



Source: Dalgrhen & Whitehead, 1991; "Policies and Strategies to Promote Social Equity in Health"; Stockholm, Sweden; Institute for Futures Studies.

FEDERAL HEALTH POLICY

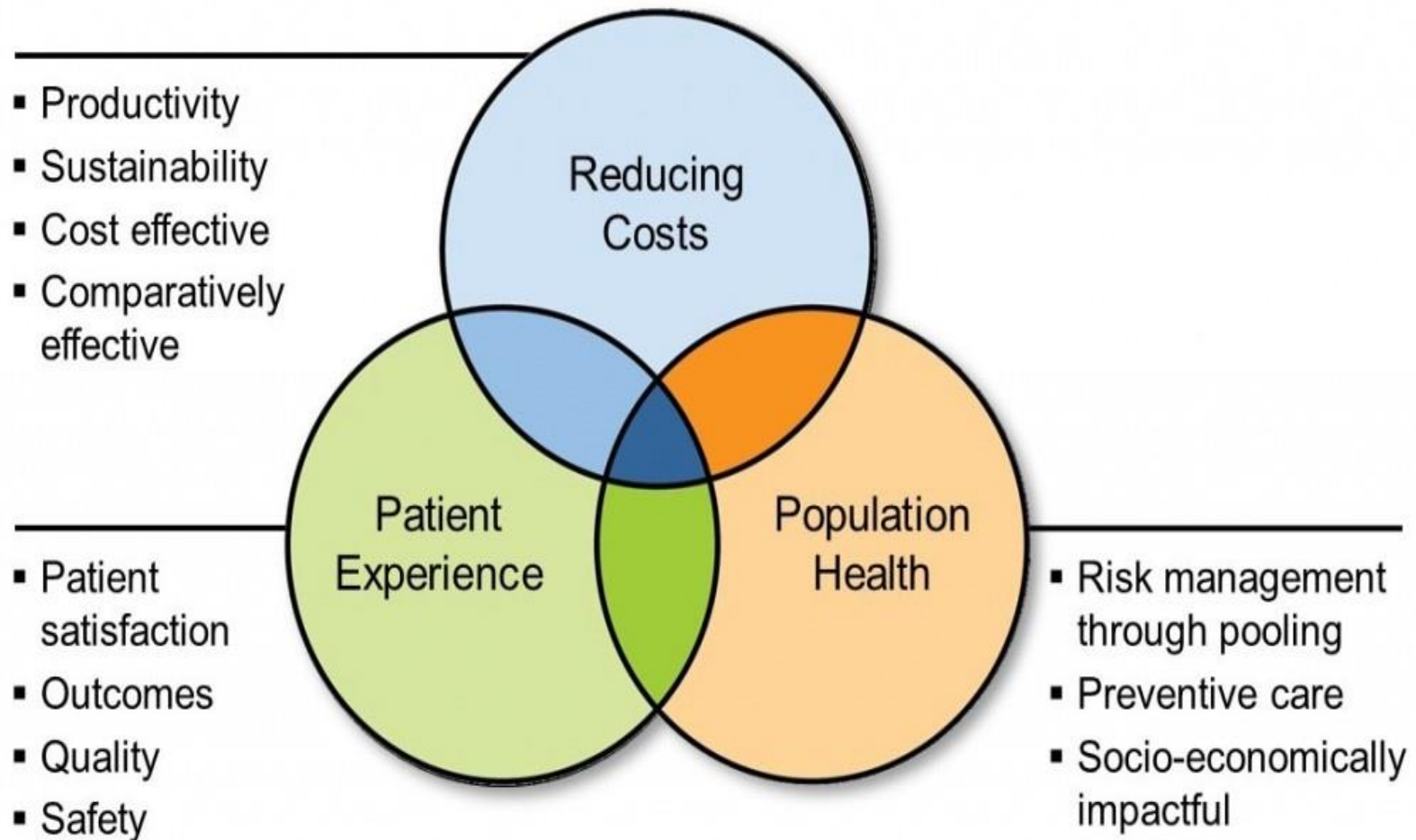
In the past 10 years, federal health policy has recognized that improving the U.S. health care system requires simultaneous pursuit of three objectives, collectively referred to as the triple aim:

- improving patients' health care experience;
- improving the health of whole groups of populations; and
- reducing per capita costs of providing health care and explicitly linking payment to outcomes.

The triple aim framework was developed by the Institute for Healthcare Improvement (a national policy-setting group). It is the basis for most current health policy improvement discussions.

The triple aim framework is depicted in the graph on the following page.

Triple Aim Framework for Better Health Care



Source: Berwick DM et al. *Health Affairs (Millwood)* 2008;27:759–769.

The federal Patient Protection and Affordable Care Act of 2010, known as the ACA, incorporates the triple aim framework in its core principles. It:

- increases the number of people insured through Medicaid expansion and removes coverage barriers for chronically ill people;
- uses data to develop best practices; and
- advances the concept of managing care for chronically ill people, by moving from fee-for-service to value-based payments.

There are many benefits associated with the ACA that are designed to keep Americans healthier.

- Free preventive care
- Prescription discounts for seniors
- Coverage of people with pre-existing conditions
- Access to insurance through state market health insurance exchanges
- Small business tax credits
- Protection against health care fraud
- Assistance to consumers to understand and navigate the system

NEW YORK STATE HEALTH POLICY

New York is one of 31 states that chose to expand Medicaid under the ACA using federal funds.

- It created a state health insurance exchange for people to compare insurance plans and get coverage subsidies.
- Three million people enrolled in insurance in just three years, lowering the uninsured statewide from 22 percent to 12 percent.

New York State's Medicaid program is expensive.

- At \$60 billion and covering 6.2 million people, it is the nation's most expensive program per capita and accounts for nearly a third of all State healthcare spending. Half of these funds come from the federal government.
- Frequent emergency room visits and hospitalizations account for most of the costs.
- The most expensive one percent of enrollees account for a quarter of Medicaid spending while the top five percent account for almost half of the State's Medicaid costs.
- Of these expensive users, more than 75 percent have a chronic health and/or behavioral health problem such as diabetes, high blood pressure, obesity, depression, or serious mental illness.

Three years ago, spurred by the ACA and New York’s burgeoning Medicaid budget, Governor Cuomo spearheaded the most significant State health care reforms since the advent of Medicaid in the 1960s. The aim of this reform is to:

- deliver care in community settings, such as health clinics; and
- coordinate across physical and mental health providers, and between hospital and community providers.

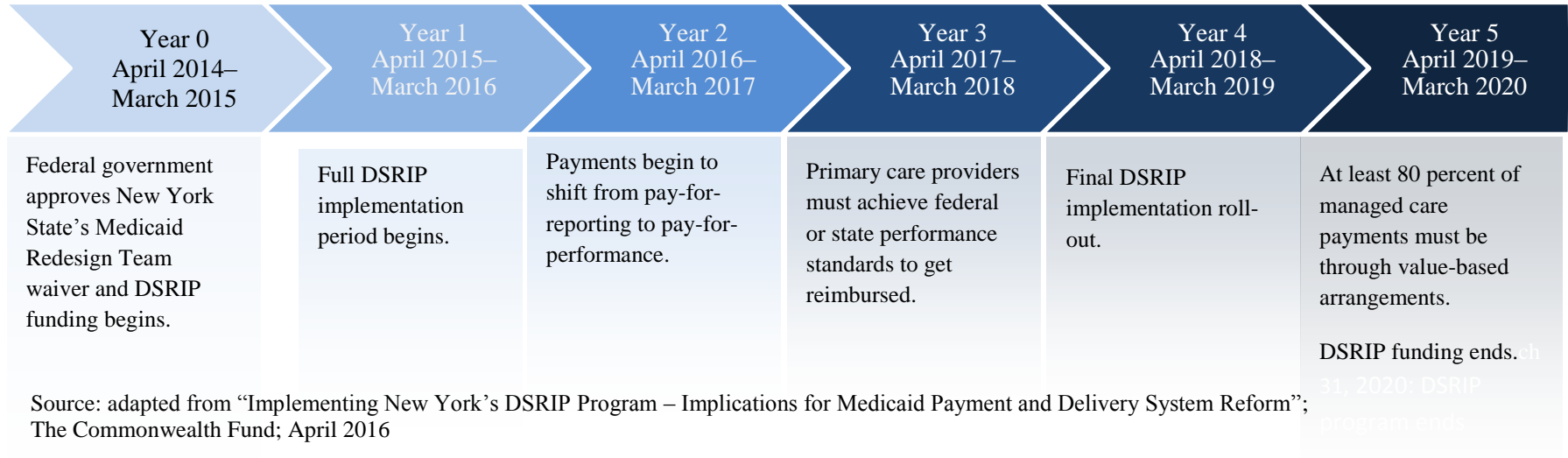
Governor Cuomo created the Medicaid Redesign Team (MRT) at the State Department of Health to lead the reform. In 2014, a federal waiver allowed the State to design a series of reforms through a five-year Delivery System Reform Incentive Payment (DSRIP) program.

- DSRIP funnels \$8 billion in special waiver funds from the federal Center for Medicaid and Medicare Services to build and operate networks of health, behavioral health, and social service providers known as Performing Provider Systems (PPSs), most of which are headed by hospital systems.
- These systems are charged with coordinating care for people with chronic health and behavioral health problems and have a dual goal—bend the cost curve and secure better clinical outcomes.

Community providers, such as federally qualified health centers, and social service agencies caring for elders and the disabled, have been scrambling to join multiple Performing Provider Systems.

- The State awarded its entire \$700 million in health care capital funds (part of DSRIP) to hospitals.
- Although community providers expected waiver funds to flow to them, this has yet to happen after one year.

Timeline for DSRIP Implementation



CURRENT OUTLOOK

Converging federal and state health reforms place New York in a unique position to improve the health care delivery system. It is moving to a value-based payment system to reward higher quality care and health outcomes, rather than numbers of visits or procedures. Success relies on a number of new institutional arrangements, including:

- Community providers can adequately integrate information technology, clinical, and administrative systems into the PPSs.
- A system to ensure the smooth flow of reimbursements to all providers is developed quickly.
- A robust network of hospitals, primary care, behavioral health, and social service providers coordinate services effectively.
- Gains made in covering the uninsured don't backslide because coverage becomes unaffordable even with subsidies.
- There is adequate assistance available for chronically ill and high-risk individuals to navigate the new system, particularly for the homeless, frail elderly, and the mentally ill who may be confused by new system requirements.
- There is a well-trained and competent workforce to provide care delivered in the community.

Under the ACA, health coverage is far more accessible to low-income New Yorkers, but there are emerging trouble spots.

- About 347,000 New York City residents are undocumented and therefore ineligible for any form of insurance.
- Another 580,000 residents have jobs without insurance, or are freelancers or unemployed, so subsidies are insufficient.
- Many are dissatisfied with coverage networks that lack enough providers, or find costs difficult to bear even with subsidies.
- New pharmaceutical products, which can cure diseases and allow patients to avoid hospitalizations, have staggering costs that threaten overall affordability of health insurance.

NEW YORK CITY HEALTH AND BEHAVIORAL HEALTH STATUS AND SYSTEMS

New York is the nation's largest and most diverse City. It is home to more than 8.5 million people.

- Close to 1.8 million are children under the age of 18.
- About 37 percent of the population is foreign-born, and nearly half of the City births are to foreign-born parents.

New Yorkers are far healthier than before.

- In the past decade, life expectancy increased by 2.2 years to 81.1 years, more than two years higher than the national average.
- There were citywide reductions in age-adjusted premature deaths, infant mortality, and teen births, with the greatest improvements among black and Hispanic residents, leading to a small narrowing of racial gaps in these indicators.
- Heart disease, cancer, and influenza remain the leading causes of death in the City, despite rates that declined by 29 percent, 6 percent, and 21 percent respectively over the past decade. Deaths from diabetes, fourth-ranked, increased slightly.

But some risk factors, such as obesity, remain distressingly common, and there are significant racial, economic, and neighborhood disparities in many health indicators.

- Forty percent of mothers who gave birth were overweight or obese before pregnancy, including 59 percent of black and 42 percent of Hispanic women.
- Infant mortality rates reached a historic low of 4.6 percent citywide, but were nearly twice as high in very high-poverty neighborhoods as in low-poverty ones.
- Teen births were four and a half times higher in high-poverty neighborhoods than in low-poverty neighborhoods.

New York City has the largest and most sophisticated health care system in the country, including:

- seven medical schools that educate one of every six physicians in the United States;
- 59 hospitals with 24,300 beds and 172 nursing homes with 45,100 beds; and
- 350,000 health care jobs, representing 12 percent of all employment.

But care is delivered through two parallel systems.

- Wealthy and middle-class New Yorkers with employer-sponsored or private insurance get health care through private-practice physicians or voluntary hospitals and academic medical centers.
- New Yorkers on Medicaid, insured through the state exchanges, and the un- and under-insured rely on safety-net providers—the City public hospitals and community health clinics.
- This bifurcated system of care, combined with social determinants of health, produces dramatic health disparities—especially alarming are the differences in life expectancy between poor and rich neighborhoods.

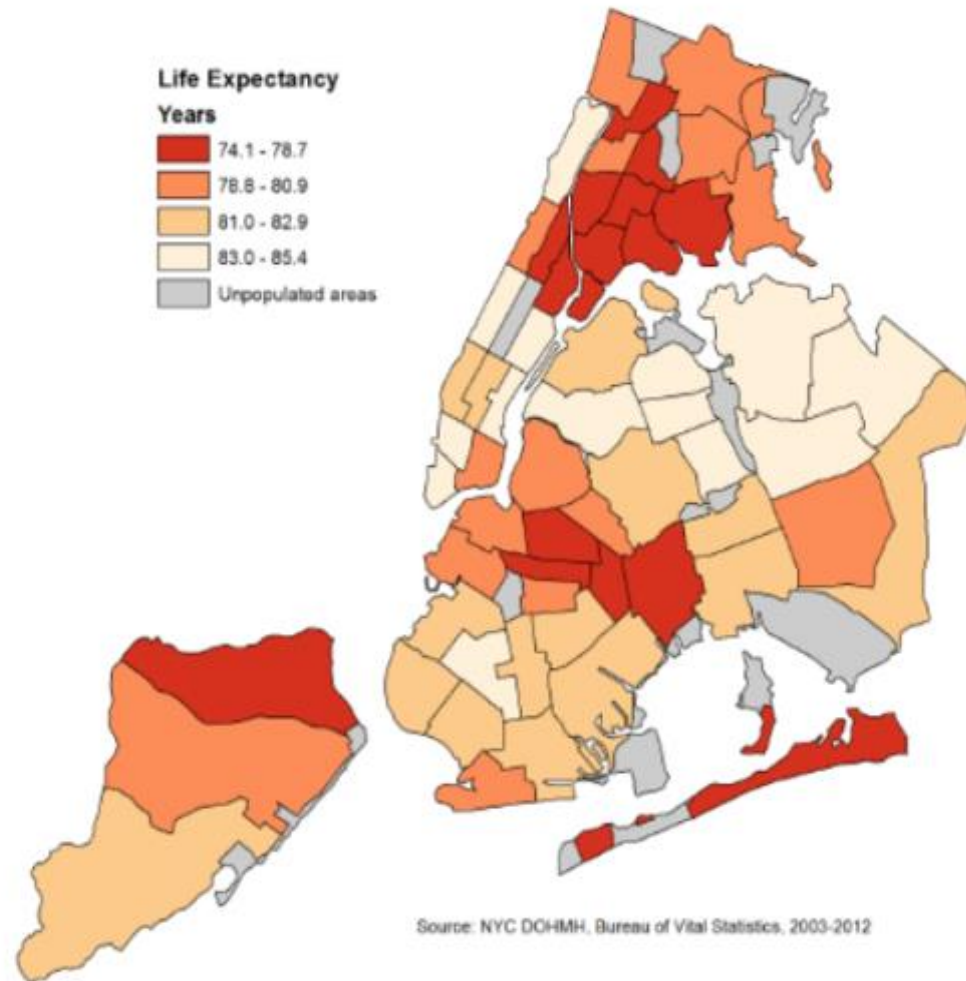
(See chart on the following page).

Residents in Poor Neighborhoods Have a Lower Life Expectancy

Life expectancy at birth

Highest		Years
1	Financial District	84.5
2	Stuyvesant Town and Turtle Bay	85.3
3	Upper East Side	85.0
4	Greenwich Village and Soho	84.3
5	Elmhurst and Corona	84.1

Lowest		Years
59	Brownsville	74.1
58	Bedford Stuyvesant	75.1
57	Central Harlem	75.1
56	Morrisania and Crotona	75.3
55	Rockaway and Broad Channel	75.9



New York City's safety net system includes a combination of its public hospital system and community health centers.

- NYC Health + Hospitals is the nation's largest and most complex public hospital system.
- With a budget of \$6.7 billion, it cares for 1.4 million New Yorkers annually, including 475,000 uninsured New Yorkers, through 11 acute care hospitals, 5 long-term care facilities, 72 community clinics, and a home health agency.
- It also operates Metro-Plus, a managed care plan with nearly 500,000 members, and offers its health and behavioral health services in community locations such as family courts, jails, shelters, and schools.
- More than 40 percent of its patients are foreign-born, of which approximately 250,000 are undocumented and uninsured.
- Health + Hospitals has operated at a deficit for years: \$645 million in 2014, projected to increase to \$1.7 billion by 2018. Short-term government cash infusions have helped, but a systemic overhaul is needed to ensure long-term viability.

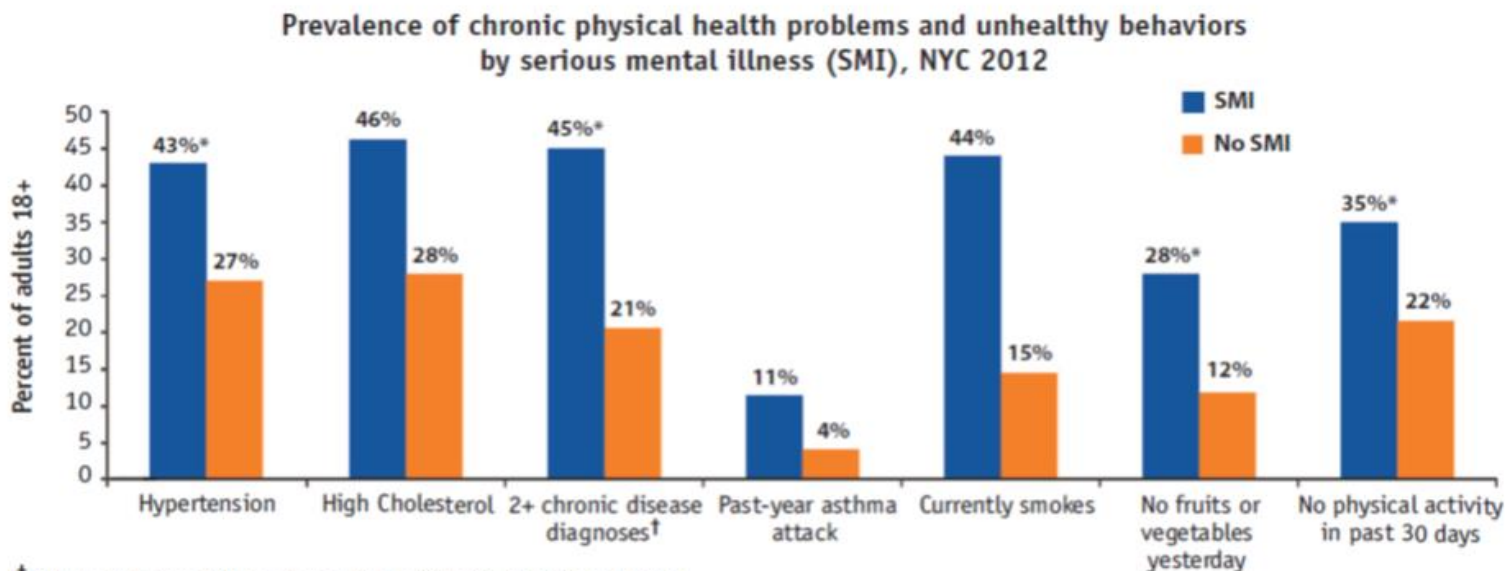
Federally qualified community health centers are the second main safety net provider in New York City.

- There are 370 community health center sites operated by about 50 agencies, serving almost a million New Yorkers a year.
- Almost 80 percent of community health center patients are black or Hispanic.
- Close to 86 percent of patients live below 200 percent of the federal poverty level.
- These centers have a mandate to serve the uninsured (including the undocumented) and receive modest federal funds to do so; about 19 percent of community health center patients are uninsured.

The ACA provides insurance coverage to many previously uninsured people. Federal funds historically allocated to cover care for the uninsured, such as Medicaid's Disproportionate Share Hospital (DSH) payments, are being reduced.

New Yorkers' mental health mirrors national figures: close to 239,000 New Yorkers have a serious mental illness diagnosis.

- About one in five New Yorkers experience a mental health disorder in any given year, with 500,000 thought to have depression; fewer than 40 percent receive treatment.
- Approximately eight percent of public high school students report attempting suicide.
- Close to a third of individuals in both the homeless system and the City jails have a serious mental illness.
- People with chronic mental health problems are far more likely to have chronic physical health problems; about half also have a substance use disorder.



†Includes diagnoses of high cholesterol, hypertension, diabetes and asthma.

*Estimate should be interpreted with caution due to small numbers. Data are age-adjusted to the US 2000 Standard Population.

Source: 2012 NYC Community Mental Health Survey and 2012 NYC Community Health Survey

Substance use disorder is the excessive use of any addictive substance, such as prescription or illicit drugs, alcohol, or tobacco. The amount and frequency of use, and effects on functioning, characterizes a person as using, abusing, or being addicted.

- Use means infrequent, experimental, or recreational usage, with few, if any, short or long-term impairments.
- Abuse implies enough consumption regularly to impair at least one aspect of health or social functioning.
- Addiction denotes chronic, relapsing, brain disease characterized by craving and substantial functioning impairments.

Approximately 575,000 New York City residents have a substance use disorder; 70 percent of them also have a mental health disorder.

- There is a high prevalence of co-morbidity between people with substance use and mental health disorders, although one does not cause the other. The overlap adds a level of complexity to treatment as service systems are not fully aligned.
- Treatment includes a combination of residential and out-patient services; but recovery is a long-term process and can require multiple treatment episodes, a disconnect in the redesigned outcome-based system.

Deaths from drug overdoses have jumped in nearly every county across the United States, driven largely by an explosion in addiction to prescription painkillers and heroin. In every borough of New York City the opioid epidemic is reflected in a steadily increasing number of deaths from drug overdose over the past five years.

- Opioid death rates increased by 65 percent between 2005 and 2011; rates increased by 261 percent on Staten Island. Opioid prescriptions increased by 31 percent, while oxycodone prescriptions increased by 73 percent.
- New Yorkers under the age of 30 typically start misusing opioids recreationally and mostly obtain pills through street sources.
- Those who are 30 or older start using through medical treatment and mostly obtain pills through prescriptions.
- A third group includes entrenched heroin users who inject substances and obtain pills from street and medical sources.

Consequences of substance use disorders are a leading cause of premature death in every New York City neighborhood with about 1,000 New Yorkers dying every year due to unintentional drug use overdose.

- Approximately 104,000 emergency room visits are attributed to substance use disorders; about 80,000 were for illicit drugs while 23,000 were for prescription drug use.
- Cocaine was the reason for 12 percent of New York City’s unintentional poisoning deaths.
- Opioids made up close to three-quarters of New York City’s unintentional drug poisoning deaths.

Most people start using illicit drugs at an early age, with close to 90 percent of all users starting before age 30. The majority of heroin and cocaine users start between 15 and 30 years of age, while marijuana users start as teens, as shown below:

	Cocaine	Heroin	Marijuana
Age of first use	Percentage	Percentage	Percentage
14 and younger	7	11	51
15 to 19	31	34	41
20 to 29	43	38	6
30 and older	19	17	1

FUNDING FOR HEALTH AND BEHAVIORAL HEALTH CARE IN NEW YORK CITY

National foundations provide \$220 million in health care funding to New York City nonprofits, which includes major contributions for capital expenditures such as buildings.

Top 10 foundations awarding grants for health to NYC organizations	Amount (\$)
Susan Thompson Buffett Foundation	43,028,000
Open Society Institute	13,200,000
Harry and Jeanette Weinberg Foundation	10,870,000
Leona M. and Harry B. Helmsley Charitable Trust	10,232,000
JPB Foundation	8,550,000
Robertson Foundation	7,725,000
Foundation to Promote Open Society	6,474,000
Steven A. and Alexandra M. Cohen Foundation	5,118,000
W. K. Kellogg Foundation	4,972,000
New York State Health Foundation	4,762,000
The New York Community Trust	2,677,000

We have worked closely for decades with a small group of local foundations on shared programmatic priorities. Within this group The Trust is second largest health funder.

Top 5 foundations closely aligned with The Trust's grantmaking focus	Amount (\$)
New York State Health Foundation	4,762,000
The New York Community Trust	2,677,000
Doris Duke Charitable Foundation	2,636,000
United Hospital Fund	1,740,000
Altman Foundation	1,115,000
Peter and Carmen Lucia Buck Foundation	425,000

Note: Figures come from the Foundation Center's 2012 data (the most recent available at the time of the report). It does not include biomedical research or HIV/AIDS-related grantmaking at The Trust or other funders.

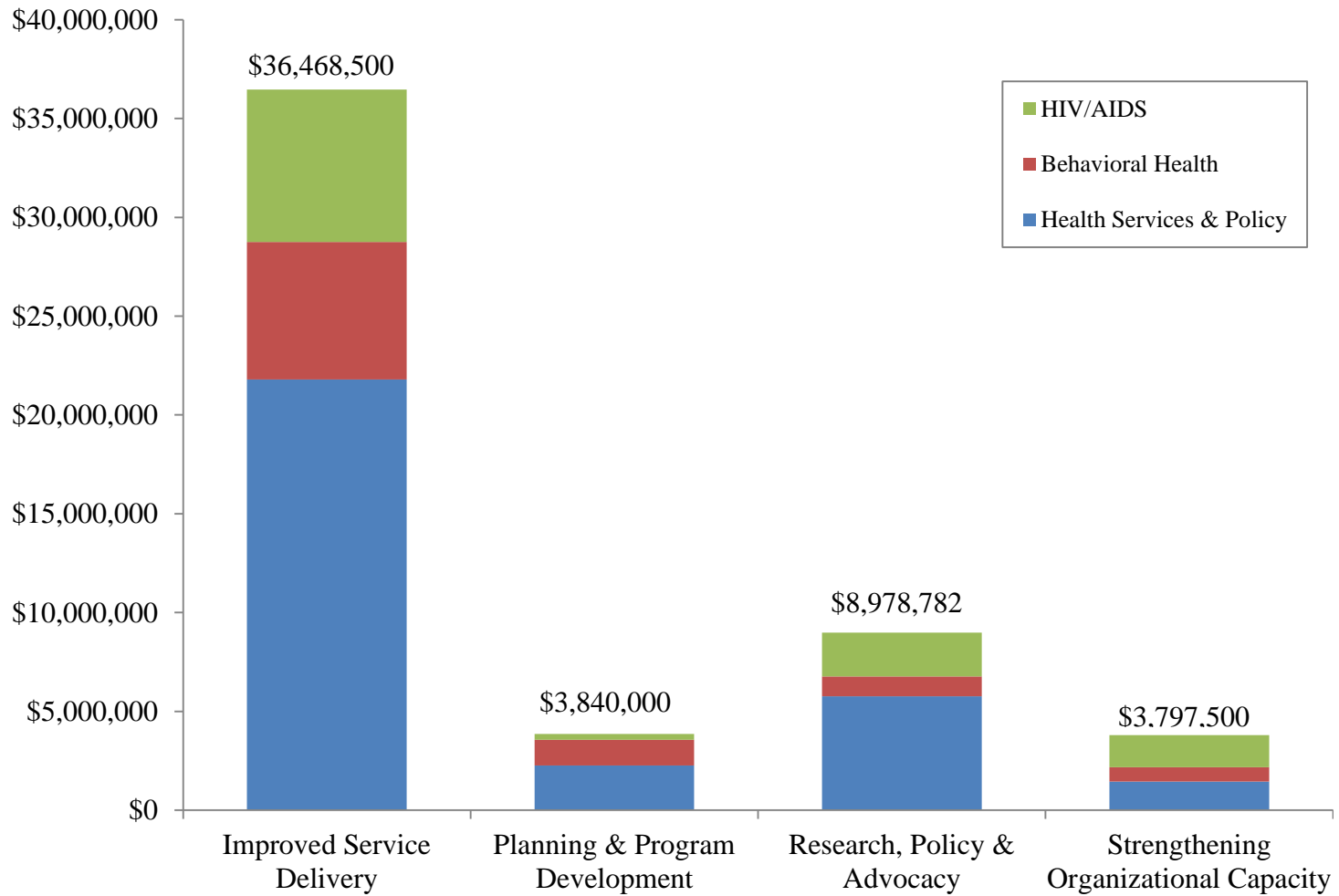
Nearly \$22 million is provided for New York City behavioral health issues by more than 50 national and local funders.

Top 10 foundations awarding grants for behavioral health to NYC organizations	Amount (\$)
Foundation to Promote Open Society	5,910,000
Van Ameringen Foundation	3,400,000
Oak Foundation U.S.A.	1,609,000
Harry and Jeanette Weinberg Foundation	875,000
Ford Foundation	860,000
New York State Health Foundation	756,000
M.A.C. AIDS Fund	738,000
The New York Community Trust	537,000
Tisch Foundation	500,000
Fan Fox and Leslie R. Samuels Foundation	442,000
Tiger Foundation	400,000

Within the group of foundations with which we work closely on behavioral health, The Trust is the third largest behavioral health funder.

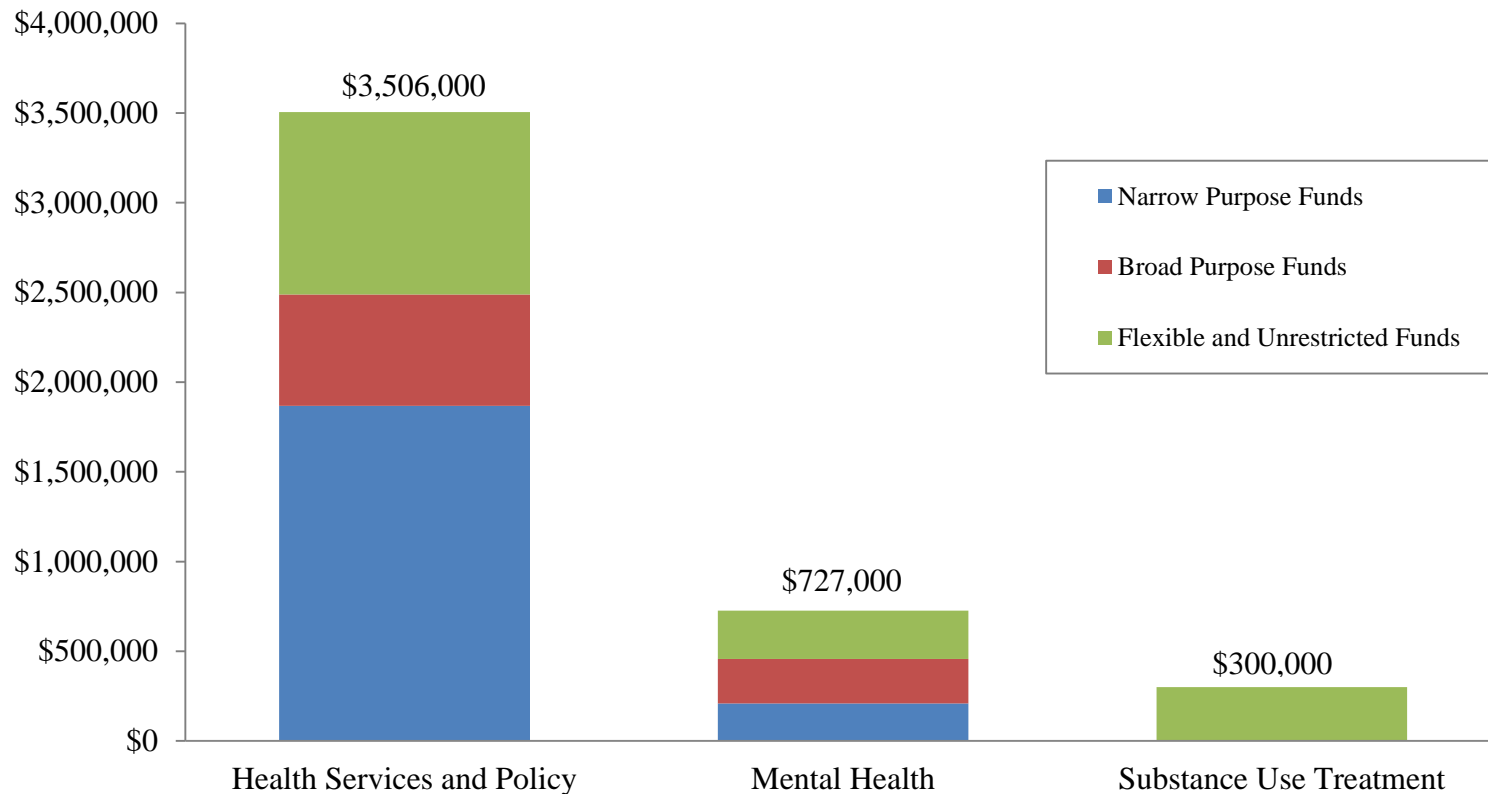
Top 5 foundations closely aligned with The Trust's grantmaking focus	Amount (\$)
Van Ameringen Foundation	3,400,000
New York State Health Foundation	756,000
The New York Community Trust	537,000
Tisch Foundation	500,000
Tiger Foundation	400,000
Staten Island Foundation	345,000

Since 2005, 68 percent of The Trust’s grants totaling just over \$53 million for health policy and services, behavioral health, and HIV/AIDS were focused on improving service delivery.



Almost half of The Trust’s current 2016 health and behavioral health grants budget of \$4,533,000 is from funds with a narrow purpose, such as a particular population (e.g., children), disease (e.g., cancer), or geography (e.g., Queens).

- Only 35 percent of the budget is from flexible or unrestricted funds.
- Almost \$1 million of the health services and policy budget is dedicated to cancer treatment through the large Greene Fund.
- Substance use treatment is an area made up entirely of unrestricted funds.



ACCOMPLISHMENTS OF THE TRUST'S GRANTMAKING

The Trust awarded about \$53 million in health and behavioral health grants over the past 10 years. Most of the work in the past five years has been guided by the triple aim framework and has supported federal and state-level health reform.

Our grants helped government design and implement health care reform. The grants:

- analyzed and evaluated potential changes to Medicaid and long-term care services;
- assisted in development and roll-out of the State health insurance exchanges;
- advocated for the needs of special populations affected by health care reform, such as the elderly and the disabled; and
- ensured that the push for coordinated and comprehensive care equally addressed both fiscal interests to manage health care costs and clinical mandates to improve health outcomes.

We helped nonprofits adapt to federal and state health reform. We supported initiatives that:

- helped social service agencies meet managed care mandates, including hosting a Trust-developed learning lab series;
- expanded community health center capacity and reimbursements by adding quality and outcome measures;
- piloted and assessed new models of primary care, including ones that seamlessly integrated behavioral health care;
- developed systems to align health care delivery systems with rehabilitation, housing, and holistic care services;
- educated consumers, especially low-income and eligible immigrants, about the new State insurance exchanges;
- harnessed technology to explain to consumers and providers how to transition successfully to the new systems; and
- advocated for health care access for undocumented immigrants who remain uninsured.

And we made grants that incorporated strategies to address the social determinants of health, not just the narrower clinical and medical issues. We:

- developed a multi-year, “place-based” grantmaking effort that targeted the South Bronx to help community agencies develop programs to improve residents’ health and wellness; and
- improved linkages to community care options for people with chronic illnesses.

Behavioral health grants complemented our health grants, with particular emphasis on building the capacity of community providers to operate under new reimbursement systems. Our grants:

- improved operations of clinics licensed to provide both mental health and substance abuse treatment;
- advocated for better conditions for mentally ill individuals living in illegal boarding homes and adult homes;
- developed early intervention models using peers for people with severe mental illness hospitalized for the first time; and
- strengthened integrated models of healthcare delivery and financing for high cost Medicaid users.

And under our separate substance use disorder grantmaking guidelines, we used a strategy that combined improved service delivery and policy advocacy. Our grants:

- strengthened the capacity of organizations to treat people with addictions, particularly vulnerable individuals such as elders, court-involved youth, gay and lesbian youth, veterans, and formerly incarcerated women;
- advocated for improved policies for substance use disorder treatment, including expansion of treatment options for substance abusers with criminal records; and
- developed targeted education, outreach, and treatment for the burgeoning heroin and opioid epidemic in Staten Island.

FINDINGS AND CONCLUSIONS

- Decades of scientific advances in understanding disease transmission, prevention, and treatment—from germ theory to vaccines—means once common and often deadly infectious diseases are now far rarer in the United States.
Even AIDS, the most severe epidemic experienced by New Yorkers over age 30, is now largely a chronic condition. And in general, better treatment of acute diseases has resulted in longer life expectancy.
- As challenges of coping with acute diseases have decreased, there has been a growth in chronic diseases, such as diabetes. These conditions now have a far greater impact on population health and take a larger share of treatment costs.
Without a sustained focus on treating poorly managed chronic conditions, gains made in the past decades to advance health outcomes could easily be overshadowed.
- Health care reform recognizes there is value in prevention and provision of coordinated and comprehensive care.
But addressing only medical concerns through these interventions is insufficient when the real challenges often stem from issues related to the more intractable problems associated with the social determinants of health.
- The ACA mandate requiring all Americans to carry health insurance triggered Medicaid expansion and establishment of state health insurance exchanges that now provide insurance coverage to thousands of previously uninsured New Yorkers.
But there are groups that remain ineligible for coverage (such as undocumented immigrants) and subsidies for those who are eligible and enrolled are often insufficient to make coverage affordable.

- A core tenet of health reform is the shift away from fee-for-service to managed care, coupled with a greater reliance on community clinics and social service agencies to offer comprehensive outpatient services that keep people out of hospitals. **But health and human service agencies need lots of help to adapt clinical, information technology, and financing systems to the new requirements. And inconsistent reimbursements for services have hampered a smooth transition.**
- There is growing evidence that integrated primary and behavioral health care is good clinical practice and an essential ingredient to achieving the improved health outcomes that are central to the goals of health reform. **But there are significant systemic barriers that hinder provision of seamless and comprehensive care, e.g., licensing, reimbursement silos, and workforce accreditation.**
- The health care safety net in New York City—the public hospitals and community health clinics—remains under great financial and programmatic stress as funds to support the uninsured dwindle. **But those who still remain uninsured or unable to pay for care increasingly rely on these facilities, putting more pressure on an already stressed system. Efforts to streamline public hospitals will most likely mean job losses, a political minefield.**

PROPOSED GUIDELINES

We recommend a single health and behavioral health grant strategy to promote an equitable, patient-focused, and cost-effective health and behavioral health care delivery system in four ways.

1. Monitor—through research and advocacy—health care reform implementation to ensure:

- maintenance of a strong and viable health and behavioral health care safety net system;
- access to comprehensive and coordinated care for those who remain un-or under-insured; and
- availability of screening, early intervention, and referral for effective treatment of disease.

2. Build the capacity of New York City’s health, behavioral health, and human service sectors to succeed in a reformed health care system by:

- developing effective skills training for the professional and paraprofessional health care workforce; and
- strengthening financial and information technology systems to allow transition to value-based payments.

3. Reduce health disparities between low- and higher-income neighborhoods through investments in disadvantaged communities that:

- improve indoor and outdoor air quality;
- provide safe and inviting parks and open space;
- promote access to affordable and healthy food; and
- engage residents in efforts to encourage physical activity and healthy diets.

4. Foster the independence of people with mental illness and substance use histories by:

- expanding innovative programs that offer clinical care as well as practical services, such as housing, employment, and education; and
- advocating for expansion of participant-led or informed service models that are sustainable and effective.

For the revised strategy:

- Preference will be given to projects that offer sector-wide, systemic, and multi-agency solutions.
- Whenever possible, health and behavioral health grants will be made in partnership with the People with Special Needs and other Trust program areas to encourage cross-sector collaboration and ensure the greatest impact of our dollars.