



Bureau for Behavioral Health and Health Facilities

## Announcement of Funding Availability

Community Engagement



# Proposal Guidance and Instructions

**AFA Title: Community Engagement**  
**Targeting Region: All Regions**  
**AFA Number: AFA13-2014-AMH**

West Virginia Department of Health and Human Resources  
Bureau for Behavioral Health and Health Facilities  
350 Capital Street, Room 350  
Charleston, WV 25301-3702

*For Technical Assistance please include the AFA # in the  
subject line and forward all inquiries in writing to:*

[DHHRBHHFAnnouncement@wv.gov](mailto:DHHRBHHFAnnouncement@wv.gov)

Key Dates:	
Date of Release:	April 14, 2014
TECHNICAL ASSISTANCE MEETING:	April 25, 2014
Letter of Intent Deadline:	April 30, 2014 Close of Business – 5:00PM
<b>EXTENDED Application Deadline:</b>	<b>June 9, 2014 Close of Business–5:00PM</b>
Funding Announcement(s) To Be Made:	June 23, 2014
Funding Amount Available:	Not to exceed \$5,250,000.00 statewide

The following are requirements for the submission of proposals to the Bureau for Behavioral Health and Health Facilities (BBHFF): The document includes general contact information, program information, administrative responsibilities, and fiscal requirements. ✓ Responses must be submitted using the required AFA Application Template available at [DHHR.WV.GOV/BHFF/AFA](http://DHHR.WV.GOV/BHFF/AFA). ✓ Responses must be submitted electronically via email to [DHHRBHHFAnnouncement@wv.gov](mailto:DHHRBHHFAnnouncement@wv.gov) with the AFA Title and Number in the subject line. Paper copies of the proposal *will not* be accepted. ✓ All submissions must be received no later than 5:00 PM on the application deadline. It is the sole responsibility of applicant to ensure that all required documents are received by the application deadline. Notification that the proposal was received will follow. ✓ A Statement of Assurance agreeing to these terms is required of all proposal submissions available at [DHHR.WV.GOV/BHFF/AFA](http://DHHR.WV.GOV/BHFF/AFA). This statement must be signed by the agency's CEO, CFO, and Project Officer. ✓ Proposals that fail to comply with the requirements provided within this document, incomplete proposals or proposals submitted after the application deadline *will not* be reviewed.

### **LETTER OF INTENT**

Organizations planning to submit a response to this Announcement of Funding Availability (AFA) must submit a Letter of Intent (LOI) by **April 30<sup>th</sup> 2014 close of business (5:00pm)** to the email address: [DHHRBHFAnnouncement@wv.gov](mailto:DHHRBHFAnnouncement@wv.gov) prior to submission of the proposal. List the AFA Title and Number found on Page 1 of this document in the email subject line. These letters of intent shall serve to document the organization's interest in providing the type of service(s) described within this AFA and will not be considered binding until documented receipt of the proposal.

### **RENEWAL OF AWARD**

The Bureau for Behavioral Health and Health Facilities (BBHF) may renew or continue funding beyond the initial fiscal year award for up to one (1) additional fiscal year. Future funding will be contingent on factors including, but not limited to, availability of funds, successful implementation of goals, and documented outcomes.

### **LEGAL REQUIREMENTS**

Eligible applicants are public or private organizations with a valid West Virginia Business License and/or units of local government. If the applicant is not already registered as a vendor in the State of West Virginia, registration must either be completed by the award notification date or the vendor must demonstrate proof of such application. It is also required that the applicants have a System for Award Management (SAM) registration and have a Dun & Bradstreet or DUNS number. For more information visit: <https://www.sam.gov>

The grantee is solely responsible for all work performed under the agreement and shall assume all responsibility for services offered and products to be delivered under the terms of the award. The State shall consider the designated Grantee applicant to be the sole point of contact with regard to all contractual matters. The grantee may, with the prior written consent of the State, enter into written sub agreements for performance of work; however, the grantee shall be responsible for payment of all sub awards.

## **FUNDING AVAILABILITY**

This funding announcement is part of a statewide plan to provide community based support capacity to identify individuals with a history of or those at risk of involuntary hospitalization, to provide services to expedite hospital discharge, to support ready access to psychiatric intervention and other supports needed to promote community based (least restrictive) living, and to reduce and/or eliminate the need for psychiatric hospitalization. A total of **\$5,250,000.00 is available statewide** to support the hiring of Community Engagement Specialists (CES) who will provide, promote, and broker access for the above referenced services/supports. Funding is not to exceed **\$35,000 per CES position** proposed.

Funding for **Community Engagement** will be awarded based on accepted proposals that meet all of the required criteria contained within this document. There may be more than one grant awarded in any region. Statewide (55 county) coverage is required with emphasis being placed on meeting the needs in those areas experiencing higher commitment rates as outlined in the Hartley Agreed Order of 2009.

### **Start Up Costs**

Applicants who wish to request reasonable startup funds for their programs must submit a separate “startup” target funded budget (TFB) and budget narrative along with their proposals. For the purposes of this funding, startup costs are defined as non-recurring costs associated with the initiation of a program. These include costs such as fees, registrations, training, equipment purchases, renovations and/or capital expenditures.

For the purposes of proposal review, all startup cost requests submitted by the applicant will be considered to be necessary for the development of the proposed program. If, when taken together, the startup costs and program costs exceed funding availability, BBHFF will contact the applicant organization and arrange a meeting to discuss remedial action.

### **Funding Reimbursement**

All grant funds are awarded and invoiced on a reimbursement basis. Grant invoices are to be prepared monthly and submitted with and supported by the Financial Report and Progress Report to receive grant funds. The grant total invoice should agree with amounts listed on the Financial Report and reflect actual expenses incurred during the preceding service period. All expenditures must be incurred within the approved grant project period in order to be reimbursed. Providers must maintain timesheets for grant funded personnel and activities performed should be consistent with stated program objectives.

## REGIONS IN WEST VIRGINIA

The WV Bureau for Behavioral Health and Facilities utilizes a six (6) Region approach:

Region 1: Hancock, Brooke, Ohio, Marshall, and Wetzel Counties

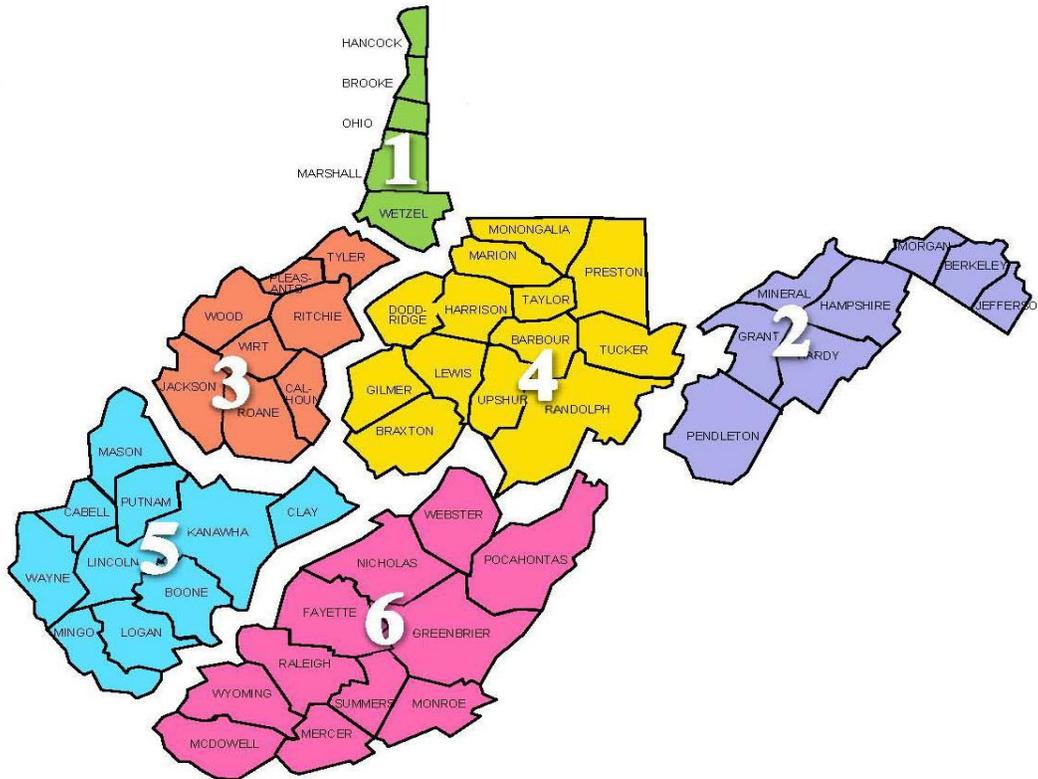
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

Region 3: Tyler, Pleasants, Wood, Ritchie, Wirt, Jackson, Roane, and Calhoun Counties

Region 4: Monongalia, Marion, Preston, Doddridge, Harrison, Taylor, Barbour, Tucker, Gilmer, Lewis, Upshur, Randolph, and Braxton Counties

Region 5: Mason, Cabell, Putnam, Kanawha, Clay, Wayne, Lincoln, Boone, Mingo, and Logan Counties

Region 6: Webster, Nicholas, Pocahontas, Fayette, Greenbrier, Raleigh, Summers, Monroe, Wyoming, McDowell, and Mercer Counties



## Section One: INTRODUCTION

The West Virginia Department of Health and Human Resources' Bureau for Behavioral Health and Health Facilities (BBHFF) envisions healthy communities where integrated resources are accessible for everyone to achieve wellness, personal goals and a self-directed future. The mission of the Bureau is to ensure that West Virginians with mental health and/or substance use disorders, intellectual/developmental disabilities, chronic health conditions or long term care needs experience quality services that are comprehensive, readily accessible and tailored to meet individual, family and community needs.

Within the Bureau, the Programs and Policy Section provides oversight and coordination of policy, planning, development, funding and monitoring of statewide community behavioral health services and supports. Emphasis is placed on function rather than disability, and improving planning and cooperation between facility and community-based services. Programs and Policy includes the Division on Alcoholism and Drug Abuse, Division of Adult Mental Health, Division of Child and Adolescent Mental Health, Division of Intellectual and Developmental Disabilities, and the Office of Consumer Affairs and Community Outreach.

Partnerships and collaboration among public and private systems, as well as with individuals, families, agencies and communities, are important components of the systems of care surrounding each person. The role of the Bureau is to provide leadership in the administration, integration and coordination of the public behavioral health system. The work is informed by results of a multi-year strategic planning process that includes critical partners in planning, funding and delivering services and supports.

The following Strategic Priorities guide services and service continuum development:

<b>Behavioral Health Prevention, Treatment and Recovery System Goals</b>	
Priority 1 Assessment and Planning	Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the WV behavioral health service delivery system.
Priority 2 Capacity	Build the capacity and competency of WV's behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.

Priority 3 Implementation	Increase access to effective behavioral health prevention, early identification, treatment and recovery management that is high quality and person-centered.
Priority 4 Sustainability	Manage resources effectively by promoting good stewardship and further development of the WV behavioral health service delivery system.

## Section Two: **FINANCIAL, LEGAL, & PROGRAMMATIC DESCRIPTION**

In 1981, the West Virginia Supreme Court held that it was contrary to law for the WV Department of Health (now Department of Health and Human Resources “DHHR”) to “warehouse” an individual in a state mental institution. The matter was remanded to the Kanawha County Circuit Court. The Parties entered into a consent order that dealt with virtually every aspect of the mental health system with a Judge and Court Monitor overseeing the process.

In 2005, BBHFF developed Care Coordination Services to strengthen the service system in West Virginia and reduce commitments to inpatient psychiatric hospitals. As referenced above, in 2009, as part of the Hartley Agreed Order, the Care Coordination capacity was expanded through the addition of 35 additional positions targeting high commitment areas of the state. According to the Order, “these care coordinators should be placed in areas with greatest numbers of commitments to state hospitals and diversionary placements with appropriate distribution of care coordinators between independent care coordinators and Comprehensive Behavioral Health Centers and shall be utilized for prevention of inpatient commitment for individuals in crisis and/or for individuals who are being or have been discharged from inpatient psychiatric facilities and to prevent recommitment” (WVDHHR - BBHFF Hartley Funded Services Progress Report, 2013).

To bring focus to the key and essential components of the program, to distinguish BBHFF funded Care Coordination from Care Coordination referenced in various current day federal programming (such as health homes), and to promote consistent implementation of the model of community based supports in all regions of WV, the Care Coordination program has been streamlined to focus on very specific and otherwise unfunded services and supports. Further, the program has been re-titled **Community Engagement** supporting continued and re-focused funding to support the work provided by individuals (Community Engagement Specialist (CES)), who make available this essential community based and person-centered service.

## Section Three: **SERVICE DESCRIPTION**

### **Community Engagement**

**Target Population(s):** Individuals with serious mental illness, substance use, co-occurring or co-existing disorder(s) that are at risk of psychiatric hospitalization or are committed

### **Purpose**

The Bureau for Behavioral Health and Health Facilities (BBHFF) supports evidence-based practices that promote social and emotional wellbeing, prevention approaches, person-centered interventions and self-directed and/or recovery driven support services.

**Engagement** and integrated **community supports** are necessary for individuals to achieve and sustain recovery in the community. By establishing social networks, income, integrated resources, and navigational support individuals can live a meaningful life in a community of their choice.

The Bureau for Behavioral Health and Health Facilities' (BBHFF) purpose for creating Community Engagement throughout West Virginia is to:

1. Develop a network of community resources with key stakeholders in order to share and gain knowledge of available resources, identify gaps, and promote development of resources
2. Ensure, through supportive and preventative services, that at-risk individuals can live securely in the community of their choice
3. Facilitate successful transitions for individuals between psychiatric hospitals and communities
4. Ensure, through intensive follow up and support, that individuals discharged from inpatient psychiatric hospitals are surrounded by community resources that will strengthen their recovery and resilience in the community

## **Service Overview**

The Community Engagement program is intended to support all individuals who have a history of and/or are at risk of involuntary commitment such that they can live in local communities of their choosing. This program's work is supported through the hire and deployment of Community Engagement Specialists (CES) who serve as the stewards of the programs implementation efforts. The CES are the brokers and facilitators of a wide range of community based and collaborative efforts and strategies designed and intended to support the varying needs of those served. The CES can be characterized as someone who understands mental health and co-occurring/co-existing disorders; the varying manifestations associated with such disorders; appreciates the unique needs of individuals and therefore can create the synergy necessary to support successful community based living.

The Community Engagement Specialist (CES) will work in the community to assist individuals with serious mental illness, substance use, co-occurring or co-existing disorder(s) that are at risk of psychiatric hospitalization or are currently committed. Any individual at risk who resides in or is from the grantee's area will be eligible for assistance from the CES; individuals do not have to be an active consumer of the grantee to be eligible for this service as a significant focus is placed on identification and engagement. The CES will engage and collaborate with all available community resources to prevent the need for involuntary commitment, improve community integration, and promote recovery by addressing the often complex needs of eligible individuals.

The CES has a separate and distinct role from crisis services, targeted case management, outpatient therapy, Assertive Community Treatment (ACT), supportive intervention, and peer/recovery supports. The CES will not be performing billable activities nor will he/she provide staff coverage in other programs such as those listed. The CES is a support to the services and positions referenced above and may actively refer individuals served to one or more such service in the course of working with individuals. The CES is expected to carry a caseload of 20-30 individuals.

### **Key activities include:**

1. Engagement of individuals who have a history of and/or are at risk of involuntary commitment to provide services essential to support community based living.
2. Identification and cultivation of a myriad of community wide services and supports key to meeting the varying needs of those served.
3. Provide after-hours and non-traditional hours of availability to meet individual needs of those served.
4. Provide outreach in local communities served to promote the Community Engagement program.

5. Facilitate quarterly stakeholder meetings that may include but are not restricted to representatives from the following areas: housing, shelters, hospitals, primary health care, behavioral health care, employment, education, justice system and other resources that are connected to the promotion of successful living in local communities.
6. Assure there is a written process for accepting referrals from the community and that this process is promoted within communities served.
7. See referred or identified individuals within 24 hours of referral.
8. Assist eligible individuals for a sustained period through at least monthly face-to-face contact in home and community based settings to ensure stability of behavioral health and community resources keeping in mind that the intensity of service may begin at a higher level and reduced gradually with some individuals requiring a level of on-going support and/or referral to a more intensive services such as ACT.
9. Connect individuals to personal and community supports necessary to live independently in the community such as assistance with obtaining medications, housing, employment, applying for benefits, shopping, paying bills, securing official documents, and other services as may be identified and/or needed.
10. Assure there is a written methodology for identifying all admissions to and discharges from psychiatric hospitals serving the service or catchment area.
11. Participate actively in all admission and discharge meetings to ensure seamless transitions for those engaged who are inpatient but preparing for return to local communities.
12. Provide face-to-face contact within 3 days of discharge from psychiatric hospitalization in order to assure that basic and personal needs are available or met.
13. Verify that adequate amounts of medication have been made available to last the individual until their first scheduled follow up appointment.
14. Coordinate with Family and Community Support Grantees to access, monitor and disperse supplemental funds for emergent needs on a case-by-case basis to meet identified emergent needs and to lessen the risk of psychiatric hospitalization.
15. Involve consumers and family members in the development and implementation of services thus developing and engaging the individual's support system.
16. Attend BBHCF CES technical assistance trainings as offered.
17. Support staff to receive training in cultural competency, motivational interviewing, suicide prevention, trauma-informed care and person-centered care.
18. Assess and provide referral information to high risk consumers for Human Immunodeficiency Virus (HIV), Tuberculosis (TB), and Hepatitis.
19. Participate in peer reviews as selected.
20. Pursue West Virginia Peer and Community Certification as applicable.
21. Maintain a caseload of 20-30 individuals.

Supplemental Funds for the CES to use for eligible individuals will be available and accessed through the Family and Community Support Grantees that are established in all six regions. Funds are available on a first come/first served basis with allocations made to support needs that arise during the course of working with an individual. Funds may be used for emergent needs such as medication, housing (security deposits, rent, utilities, and temporary housing including hotel/motel rooms), food, clothing, personal care items (soap, shampoo, combs/brushes, etc.), transportation, and other essential commodities that individuals need to maintain their community stability.

### **Collaborations and Memorandums of Understanding**

Applicants must demonstrate that a coordinated and integrated service system is in place to meet the complex needs of the target population. In doing so, Memoranda of Understanding (MOUs) must be completed with key partnering agencies and organizations which may include but is not limited to:

- Behavioral Health (Substance Use, Mental Health, I/DD)
- Family Support Network entities in region of service
- Local Public Housing Authorities
- Primary Health
- Hospitals
- Medication Assisted Treatment (MAT) Providers, if applicable
- Family Assistance Programs
- Early Intervention and Home Visiting Programs
- Family and/or Drug Courts
- Criminal Justice Systems
- Employment, Education and/or Vocational programs
- Recovery Support Network/Community/Services

## Section Four: **PROPOSAL INSTRUCTIONS / REQUIREMENTS**

**Eligible applicants** must provide proof of a valid West Virginia business license and comply with all requirements provided within this AFA. All proposals will be reviewed by the BBHMF staff for administrative compliance. Proposals that fail to comply with the requirements provided within this document, incomplete proposals or proposals submitted after the application deadline will not be reviewed. A Statement of Assurance agreeing to these terms is required of all proposal submissions to BBHMF. This statement must be signed by the applicant organization's CEO, CFO, and Project Officer. All applications passing the administrative review will be subsequently forwarded to an independent grant review team which will score the proposal narrative consisting of five areas:

- A. Population of Focus and Statement of Need (20 points)**
- B. Proposed Evidence-Based Service/Practice (15 points)**
- C. Proposed Implementation Approach (40 points)**
- D. Staff and Organizational Experience (10 points)**
- E. Data Collection and Performance Measurement (15 points)**

**Proposal Abstract** – All proposals must include a one-page proposal abstract. The abstract should include the project name, description of the population to be served, planned strategies/interventions, and a general overview of service goals and measurable objectives, including the number of people projected to be served annually. Proposal abstracts may be used for governmental reports and public release. As such, all applicants are encouraged to provide a well-developed abstract document not exceeding 35 lines in length.

**Proposal Narrative** – The Proposal Narrative describes your project. It consists of Sections A through E. Sections A-E together may not be more than 15 pages; applicants **must utilize** 12pt. Arial or Times New Roman font, single line spacing, and one (1) inch margins. Page numbers must also be included.

**Supporting Documentation** – The Supporting Documentation provides additional information necessary for the review of your proposal. It consists of Sections F and G. These documents and/or attachments **will not** be counted towards the Proposal Narrative page limit; however, **Section F and G together may not be more than 20 pages.**

**Maximum number of pages permitted for proposal submission is 35 total pages;** limits for the Proposal Narrative and Supporting Documentation must also be upheld. All pages submitted as

part of the proposal submission will count toward this maximum limit. Materials not requested within this AFA such as cover/heading pages, additional supporting documentation, etc. will be counted. Proposals that exceed this maximum limit and/or the limits established for the Proposal Narrative and Supporting Documentation will not be reviewed.

## Section Five: **PROPOSAL OUTLINE**

*All proposal submissions must include the following components without exception to be reviewed.*

### **Abstract:**

Provide a brief description of the proposed service as earlier set forth in this document.

### **Proposal Narrative:**

#### **A. Population of Focus and Statement of Need: (20 Points)**

- Provide a comprehensive demographic profile of the target population in terms of race, ethnicity, language, gender, age, socioeconomic characteristics, and other relevant factors, such as literacy, citing relevant data. Identify the source of all data referenced.
- Clearly indicate the proposed geographic area to be served, by Region and County(ies).
- Discuss the relationship of the target population to the overall population in the proposed geographic area to be served citing relevant data. Identify the source of all data referenced.
- Describe the nature of the problem, including service gaps, and document the extent of the need (i.e. current prevalence rates or incidence data) for the target population based on data. Identify the source of all data referenced. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for data that could be used are key informant interviews, newspaper article, focus groups, local epidemiologic data, state data, and/or national data.
- Identify health disparities relating to access, use, and outcomes of the proposed service citing relevant data. Identify the source of all data referenced.
- Document the need for an enhanced infrastructure to increase the capacity to implement, sustain, and improve effective mental illness, substance use, co-occurring or co-existing services in the proposed geographic area to be served that is consistent with purpose of the AFA.
- Describe the existing stakeholders and resources in the proposed geographic area to be served which can help implement the needed infrastructure development.
- Include a Reference/Work Cited page for all data referenced within proposal in Attachment 1.

#### **B. Proposed Evidence-Based Service/Practice: (15 Points)**

- Describe the purpose of the proposed service.
- Clearly state the goals, objectives and strategies for the service. These must relate to the purpose of the AFA and each of the performance measures identified in Section E:

Data Collection and Performance Measurement.

- Describe all evidence-based practice(s) (EBP) that will be used and justify use for the target population, the proposed service, and the purpose of this AFA. To verify/review EBPs visit SAMHSA's National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov/>
- If an EBP does not exist/apply for the target population and/or service, fully describe practice(s) to be implemented, explain why it is appropriate for the target population, and justify its use compared to an appropriate, existing EBP.
- Describe how the proposed practice(s) will address the following issues in the target population, while retaining fidelity to the chosen practice: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status), language and literacy, sexual identity (sexual orientation and gender identity) and disability.
- Identify any screening tools that will be used and basis for selection. Screening tools do not include clinical assessment, admission criteria, or intake data collection instruments.
- Describe how identified behavioral health disparities will be addressed and suggested strategies to decrease the differences in access, service use, and outcomes among the target population. One strategy for addressing health disparities is use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care which can be found at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>.
- Describe how the applicant organization will ensure cultural competence in service implementation. All BBHMF grantees are required to receive cultural competence training and to ensure that no one will be discriminated against due to race, ethnicity, religion, gender, age, geography or socioeconomic status. All materials associated with awarded funding must be developed at low literacy levels for further understanding and comprehension in WV communities.
- Describe how privacy and confidentiality will be ensured throughout the entirety of the service, including collection and dissemination of data, consumer feedback, etc.

**C. Proposed Implementation Approach: (40 Points)**

- Provide a one (1) year/twelve (12) month chart or graph depicting a realistic timeline of the service. The timeline must include the key activities and staff(s)/partners responsible for action through all phases including but not restricted to planning/development, implementation, training/consultation, intervention(s) milestones (EBPs), data collection/reporting, quality assurance, etc. Be sure to show that the project can be implemented and delivery of the service can begin as soon as possible, and no later than six (6) months post award. Note: The timeline should be part of the Proposal Narrative. It should not be placed in an attachment.

- Describe how achievement of the proposed goals, objectives, and strategies identified for the service will produce meaningful and relevant results in the community (e.g. increase access, availability, prevention, outreach, pre-services, treatment and/or recovery) and demonstrate the purpose of the AFA.
- Describe the proposed service activities and how they relate to the goals, objectives and strategies, how they meet the identified infrastructure needs, how they fit within or support the development of the statewide continuum of care.
- Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project with a letter of support and/or Memorandum of Understanding (MOU). Include letters of support and MOUs from community organizations and/or partners supporting the project in **Attachment 2**.
- Describe how you will work across systems to ensure that services provided to the target population are coordinated and considered by multiple levels and systems.
- Clearly state the unduplicated number of individuals to be served (annually) with grant funds, including the types and numbers of services to be provided.
- Describe additional training to be sought and utilized in the development of the service, identifying key training components (by title) and their relevance.
- Describe how you will screen clients for the presence of serious mental illness, substance use, co-occurring or co-existing disorder(s) and use the information obtained from the screening to facilitate appropriate referral to treatment for the persons identified as having such disorders.
- Describe how you will ensure the input of the target population in planning, implementing, and assessing the proposed service. Describe the feedback loop between the target population, the applicant organization, partners/key stakeholders, and the BBHMF in all implementation stages of the project.
- Describe how you will facilitate the health insurance application and enrollment process for eligible uninsured individuals receiving the proposed service. Also describe how you will ensure the utilization of other revenue realized from the provision of mental health, substance use, co-occurring or co-existing disorder(s) services to the fullest extent possible, using BBHMF grant funds only to serve individuals for whom coverage has been formally determined to be unaffordable; or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of the BBHMF grant funds).
- Identify the potential barriers to successful conduct of the proposed service and describe strategies to overcome them.
- Describe your plan to continue the proposed service after the funding period ends. Also, describe how service continuity will be maintained when there is a change in the

operational environment (e.g. staff turnover, change in project leadership) to ensure stability over time.

- Describe the facility(ies) to be utilized, if any, for the service. This includes an existing facility already owned and operated by the applicant organization, or a facility for which the applicant organization has a detailed business plan for acquisition, leasing, or other manner of habitation. The BBHMF is available to discuss what options may exist for securing a building or other location in the event that a location is not readily available. If the applicant organization chooses to speak to the BBHMF regarding what options may exist, the discussions must occur prior to submission of the proposal. Any architectural plans or diagrams that may exist may be included in **Attachment 1**

**D. Staff and Organization Experience: (10 Points)**

- Discuss the capability and experience of the applicant organization. Demonstrate that the applicant organization has linkages to the target population and ties to grassroots/community-based organizations that are rooted in the culture of the target population.
- Provide a complete list of staff positions for the service, including the Project Officer and other key personnel, showing the role of each, their level of effort/involvement and qualifications.
- Discuss how the key personnel have demonstrated experience, are qualified to serve the target population and are familiar with the applicable culture.

**E. Data Collection and Performance Measurement: (15 Points)**

- Describe the plan for data collection, management, analysis, and reporting on the required performance measures, as specified in Section Six: Expected Outcomes / Products of this AFA. Specify and justify any additional measures or instruments to be used.
- Describe the data-driven, quality improvement process by which target population disparities in access, use, and outcomes will be tracked, assessed, and reduced.
- Describe how data will be used to manage the service at a systems level to ensure that the goals, objectives, and strategies are tracked and achieved.
- Describe how information related to process and outcomes will be routinely communicated to the target population, staff, governing and advisory bodies, and stakeholders.

**Supporting Documentation:**

- F. Budget Form and Budget Narrative:***All requirements set forth in Section F must be included in **Attachment 3***

- Include a proposed Target Funding Budget (TFB) with details by line item, including sources of other funds where indicated on the TFB form.
  - Include expenses for attending BBHFF-required meetings and trainings.
- Include a Budget Narrative word document with specific details on how funds are to be expended.
  - The Budget Narrative clarifies and supports the TFB. The Budget Narrative should clearly/specify the intent of and justify each line item in the TFB.
- Describe any potential for other funds or in kind support. Please include a description of such funds as a supplement to the Budget Narrative word document.
- Prepare and submit a separate TFB form for any capital or start-up expenses and attach this separate TFB form to the coordinating Budget Narrative word document.
- Additional financial information and requirements are located in **Appendix A.**

All forms referenced in Section F: Budget Form and Budget Narrative can be accessed through the BBHFF web-site at: <http://www.dhhr.wv.gov/bhhf/forms/Pages/FinancialForms.aspx>  
 Targeted Funding Budget (TFB) Instructions available at:  
<http://www.dhhr.wv.gov/bhhf/forms/Documents/FY%202014%20BBHFF%20TFB%20Instructions.pdf>

**G. Attachments 1 through 3:**

- **Attachment 1:** Facility/site diagrams (if applicable/available); Reference/Work Cited Page (to include all proposal citations)
- **Attachment 2:** Letters of Support / Memorandum's of Understanding (MOU)
- **Attachment 3:** Targeted Funding Budget(s) and Budget Narrative(s)

## Section Six: **EXPECTED OUTCOMES / PERFORMANCE MEASURES**

### **Expected Outcomes:**

1. Develop a network of community resources with key stakeholders in order to share and gain knowledge of available resources, identify gaps, and promote development of resources
2. Ensure, through supportive and preventative services, that at-risk individuals can live securely in the community of their choice
3. Facilitate successful transitions for individuals between psychiatric hospitals and communities
4. Ensure, through intensive follow up and support, that individuals discharged from inpatient psychiatric hospitals are surrounded by community resources that will strengthen their recovery and resilience in the community

### **Performance Measures:**

1. Maintain and provide documentation of ALL activities related to service area(s) indicated by:
  - a. Number of Unduplicated Persons Served by Type of Activity
  - b. Number of Unduplicated Persons Served by Age, Gender, Race and Ethnicity, and Diagnosis(-es)
2. Maintain and provide documentation related to the following:
  - a. Number of Cross Planning (partnering/multi-system collaborative) initiatives, service activities implemented with other sectors indicating type and number. Provide minutes of quarterly stakeholder meetings to include the date and time of the meeting, stakeholders present, meeting agenda, and a summary of action taken.
  - b. Number and type of professional development trainings attended and provided
  - c. Number, type (focus groups, surveys, or key-informant interviews), and aggregate results of consumer feedback activities conducted
3. Provide additional program information to include:
  - a. Collect:
    - i. Number of referrals received from the community
    - ii. Number of referrals received from a psychiatric hospital
    - iii. Number of referred individuals who accepted service
    - iv. Number of unduplicated individuals served per month and year to date

- v. Number of unduplicated individuals served who were admitted to a psychiatric hospital
  - vi. Number of unduplicated individuals served who were readmitted (prior hospitalization during the past 12 months) to a psychiatric hospital
  - vii. Number of unduplicated individuals who were discharged from CES service and the reason for discharge
- b. Collect number of home visits completed
  - c. Collect number of community outreach activities
  - d. Collect number of admission and discharge planning meetings attended
4. Provide copies of all Memorandums of Understanding (MOU)
5. Provide data for all supplemental funds dispersed to include the following:
- a. Medication
  - b. Housing (security deposits, rent, utilities, and temporary housing including hotel/motel rooms)
  - c. Food
  - d. Clothing
  - e. Personal care items (soap, shampoo, combs/brushes, etc.)
  - f. Transportation
  - g. Other commodities needed in order to maintain the individual within the community in his or her most integrated setting
6. Submit all service data reporting by the 10<sup>th</sup> working day of each month as related to the Expected Outcomes/Performance Measures.

## Section Seven: **TECHNICAL ASSISTANCE**

The **Bureau for Behavioral Health and Health Facilities (BBHFF)** will provide technical assistance to all applicants through a scheduled technical assistance meeting and/or conference call as indicated on Page 1 of this document.

Technical assistance needs may also be submitted via email to: [DHHRBHFFAnnouncement@wv.gov](mailto:DHHRBHFFAnnouncement@wv.gov). All emailed technical assistance inquiries will be addressed by the BBHFF and posted to a Frequently Asked Questions (FAQ) document on the BBHFF website available at <http://www.dhhr.wv.gov/bhhf/AFA/Pages/default.aspx>.

1. **WV Behavioral Health Profile** (also accessible by clicking 'Resources' on DADA webpage):  
Contains Statewide data pertaining to behavioral health issues:  
[http://www.dhhr.wv.gov/bhhf/resources/Documents/2013\\_State\\_Profile.pdf](http://www.dhhr.wv.gov/bhhf/resources/Documents/2013_State_Profile.pdf)
2. **WV County Profiles:** Contains county-level data pertaining to behavioral health issues, uses convenient 'at a glance' format:  
<http://www.dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Research/Pages/2014-County-Profiles.aspx>

**Appendix A**  
**Other Financial Information**

**Allowable Costs:**

*Please note that Departmental Policies are predicated on requirements and authoritative guidance related to Federal grants management and administrative rules and regulations, Grantees shall be required to adhere to those same requirements when administering other DHHR grants or assistance programs, the source of which is non-Federal funds (e.g. state-appropriated general revenue and appropriated or non-appropriated special revenue funds) unless specifically provided direction to the contrary.*

**Cost Principles:**

For each kind of grantee organization, there is a set of Federal cost principles for determining allowable costs. Allowable costs are determined in accordance with the cost principles applicable to the organization incurring the costs. The following chart lists the kinds of organizations and the applicable cost principles. The Grantee agrees to comply with the applicable cost principles as set forth below.

<b>If the Grantee is a:</b>	<b>OMB Circulars Codified at:</b>
State, local or Indian tribal government use the cost principles in <b>OMB Circular A-87.</b>	DHS codified at <b>45 C.F.R. § 92</b> and <b>45 C.F.R. § 95</b> USDA codified at <b>7 C.F.R. § 3016</b> ; EDUC codified at <b>34 C.F.R. § 80</b> ; EPA codified at <b>40 C.F.R. § 31.</b>
Private nonprofit organization other than an (1) institution of higher education, (2) hospital, or (3) organization named in <b>OMB Circular A-122</b> as not subject to that circular use the cost principles in <b>OMB Circular A-122.</b>	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30.</b>
Educational Institution use the cost principles in <b>OMB Circular A-21.</b>	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30.</b>
Hospital use the cost principles in <b>Appendix E of 45 C.F.R. § 74.</b>	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30.</b>

For-profit organization other than a hospital and an organization named in <b>OMB Circular A-122</b> as not subject to that circular use the cost principles in <b>48 C.F.R. pt. 31</b> Contract Cost Principles and Procedures.	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30</b> .
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**Grantee Uniform Administrative Regulations:**

For each kind of grantee organization, there is a set of Federal uniform administrative regulations. The following chart lists the kinds of organizations and the applicable uniform administrative regulations for each listed type of grantee.

<b>If the Grantee is a:</b>	<b>OMB Circulars Codified at:</b>
State, local or Indian tribal government use the uniform administrative requirements in <b>OMB Circular A-102</b> .	Department of Health and Human Services (DHS) codified at <b>45 C.F.R. § 92</b> and <b>45 C.F.R. § 95</b> ; Department of Agriculture (USDA) codified at <b>7 C.F.R. § 3016</b> ; Department of Education (EDUC) codified at <b>34 C.F.R. § 80</b> ; Environmental Protection Agency (EPA) codified at <b>40 C.F.R. § 31</b> .
Private nonprofit organization, institutions of higher education, or a hospital use the uniform administrative requirements in <b>OMB Circular A-110</b> .	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30</b> .
For-profit organization use the uniform administrative requirements in <b>OMB Circular A-110</b> .	DHS codified at <b>45 C.F.R. § 74</b> ; USDA codified at <b>7 C.F.R. § 3019</b> ; EDUC codified at <b>34 C.F.R. § 74</b> ; EPA codified at <b>40 C.F.R. § 30</b> .