



Bureau for Behavioral Health and Health Facilities

## Announcement of Funding Availability

Regional Youth Service Center



# **Proposal Guidance and Instructions**

**AFA Title: Regional Youth Service Center (R-YSC)**  
**Targeting Region: Four (4)**  
**AFA Number: AFA 04C-2014-SA**

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:	July 15, 2014
Technical Assistance Requests:	Email to <a href="mailto:DHHRBHHFAnnouncement@wv.gov">DHHRBHHFAnnouncement@wv.gov</a>
Application Deadline:	Continuous Application, see Page 2 for details
Funding Amount Available:	Not to exceed \$280,000.00 per Region

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) 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.

### CONTINUOUS APPLICATION

Applications received will be scored using the standard grant review process on the following continuous schedule (see below) until all available services described in this AFA have been awarded. Applications must be received to [DHHRBHFAnnouncement@wv.gov](mailto:DHHRBHFAnnouncement@wv.gov) on or before close of business (5:00pm) on the dates listed below.

Cycle	Continuous Posting Release	Application Period Closes for Review and Award Consideration	Award Notification
1	Tuesday, 07-15-2014	Thursday, 08-14-2014	Thursday, 08-28-2014
2	Thursday, 08-28-2014	Monday, 09-29-2014	Monday, 10-13-2014
3	Monday, 10-13-2014	Wednesday, 11-12-2014	Wednesday, 11-26-2014
4	Wednesday, 11-26-2014	Friday, 12-26-2014	Friday, 01-09-2015
5	Friday, 01-09-2015	Monday, 02-09-2015	Monday, 02-23-2015
6	Monday, 02-23-2015	Wednesday, 03-25-2015	Wednesday, 04-08-2015
7	Wednesday, 04-08-2015	Friday, 05-08-2015	Friday, 05-22-2015

## FUNDING AVAILABILITY

This funding announcement is part of a statewide plan to expand regionally based substance use and co-occurring services for youth. This funding recommendation was made possible by the Substance Abuse Mental Health Service Administration (SAMHSA) Block Grant with the availability of a maximum of \$280,000.00 per Region.

Funding for a **Regional Youth Service Center (R-YSC)** will be awarded based on accepted proposals that meet all of the required criteria contained within this document. Funding availability for this AFA is as follows:

<b>REGION</b>	<b>REGIONAL FUNDING AVAILABILITY</b> <b>Not to exceed:</b>
<b>Four (4)</b>	\$280,000.00 per Region

### 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

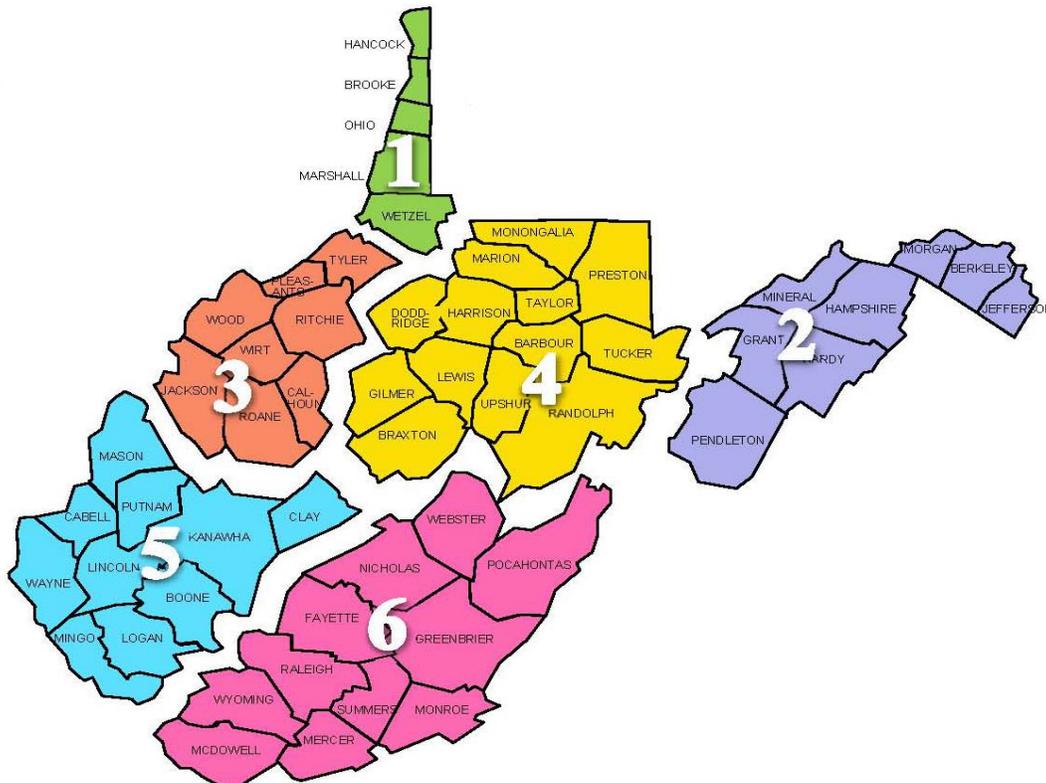
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

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 June 2010 the needs assessment process to support the development of the strategic plan for Substance Abuse Prevention, Treatment and Recovery services was initiated in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) with a series of meetings of key stakeholders and representatives of the BBHMF. A total of 14 key stake holder, focus groups and community forums engaging more than 400 participants were conducted to assess current public perception about substance misuse, use, and abuse, treatment availability, prevention efforts and what is currently absent from and working effectively in communities across the state. In addition, various topic or agency specific work sessions (youth, law enforcement and others) were convened to support a full understanding of and development of action strategies needed.

On September 6, 2011, Governor Earl Ray Tomblin issued Executive Order 5-11, establishing the Governor's Advisory Council on Substance Abuse (GACSA) and six (6) Regional Task Forces (RTF's). These newly formed entities meet regularly and share a collective charge to provide guidance regarding implementation of the approved *Statewide Substance Abuse Strategic Action Plan*, recommend priorities for the improvement of the statewide substance abuse continuum of care, identify planning opportunities with interrelated systems and provide recommendations to the Governor emphasizing the enhancement of: substance abuse education; collecting, sharing and utilizing data; and supporting policy and legislative action. Significant legislation was passed during the regular 2012 Legislative Session to improve conditions regarding substance abuse, including but not limited to \$7.5 Million in additional State revenue supporting the Substance Abuse Continuum of care. After completing a thorough review of the service delivery system and considering community identified need, the Governor is pleased to announce, in coordination with the Bureau for Behavioral Health and Health Facilities, the availability of these funds.

### **Services for Youth in WV**

The Governor's Advisory Council on Substance Abuse (GACSA) recommended that an Adolescent Facility be developed to support the growing need for out-of-home residential services for young people as indicated by out of state placements, lack of a full continuum of community based services and public outcry for assistance in accessing and navigating youth services statewide. This recommendation was approved by Governor Earl Ray Tomblin with funding support in Region 3. As Bureau staff began to prepare for the development of the

Announcement for Funding Availability (AFA), it appeared that several new residential facilities had opened across West Virginia (WV) increasing bed capacity for youth primarily aged 12-17. In order to fully inform the GACSA and to meet the needs of WV youth and their families a more thorough and up-to-date assessment was necessary.

According to the Bureau for Children and Families, there has been an overall reduction in the number of youth out-of-state. The **total** number of youth in State's custody for a 6 month period through December 2012 was 411 unduplicated youth. A technical assistance and evaluation report on the *WV System of Care Youth in Out-of-Home/State Placement* stated that over twice as many youth in parental custody were placed in out-of-state residential treatment facilities due to the limited services in the State for youth in the custody of their parents. In March 2013, a point-in-time review determined that there were approximately 100 empty in-state beds available for youth in State's custody. Upon further discussion with key agency and community-based youth service providers, it was determined that while there do seem to be "empty beds," that those beds are not always the "correct" fit for the youth needing services. A survey was completed and additional stakeholder meetings were conducted to assess the increased capacity of WV to serve youth with primary substance use and use disorders, gaps in the service continuum, and to make informed recommendations for the provision of services.

### ***Capacity to Serve Youth***

The Bureau for Children and Families' (BCF) residential facilities and child placing agencies offer 1053 beds in 61 sites throughout WV. WV placement levels of care include Division of Juvenile Services, Transitional Living, Group Residential Level(s) I, II, III and Psychiatric Residential Treatment Facility (PRTF). Currently, the largest number of facilities and bed capacity are reserved for Level II placement, totaling 24 of the 61 sites and 404 beds. Transitional Living has the lowest number of beds totaling 32. Only nine 9 of the 61 sites report having a substance use treatment focus, and only 12 of the 61 sites serve youth with co-occurring substance use and mental health disorders. Using SAMHSA service definitions, the facilities were able to identify service types provided. The majority of the facilities provide primary prevention, engagement and medication management. None of the facilities provide intensive support, peer/recovery support, acute intensive, in-patient detoxification or peer-based crisis services. Region 3 continues to have the fewest number of beds and residential facilities and Region 4 continues to maintain the most.

Within the last year, six facilities have added additional residential support for youth and transitioning youth in West Virginia. The majority of the added capacity is geared to serve 12-17 year olds in State custody with an acute psychiatric diagnosis. Additionally, WWSBIRT has screened 10,700 adolescents 10-17 years of age since 2008, with 1,278 adolescents screening

positive for substance use; about 12% of those screened. The WV Juvenile Drug Courts have also expanded to 20 counties. While the goal of these services is to identify and provide interventions early, often young people are identified that require additional out-patient and intensive out-patient services, resulting in an increased need for “close to home,” community-based services where families can participate in treatment.

### ***Collaborative Planning & Recommendations***

In addition to focus groups, Substance Abuse Taskforce meetings and coordinated statewide adolescent key stakeholder meetings over the past year, agencies and provider organizations met and/or participated in survey administration during the past month. System-wide transformation is necessary to improve access to care and service navigation for West Virginia adolescents, transitional youth and their families/primary caregivers. The overall system recommendation will be to build a solid foundation for sustaining an effective, integrated adolescent and transitional aged youth treatment and recovery support services network. The State will need to explore programmatic infrastructures as they work toward supporting local systems of care that will offer the right services, at the right place and at the right time for WV Youth.

- ✓ A Single Point of Entry will improve access and referral to appropriate levels of care
- ✓ Every region will provide a full continuum of services for youth and families in-state regardless of payer source.
- ✓ Consistent Assessment / Diagnostic Tools utilizing electronic records will enhance service delivery and sharing of information between multiple systems
- ✓ Training and Technical Assistance for Youth Serving Organizations will improve clinical capacity and ensure quality services.
- ✓ State and regional collaborative partnerships will increase engagement, improve referral mechanisms and access needed and appropriate community supports.
- ✓ An increase in the capacity to serve transitioning youth (adolescents and young adults 17-24) will offer a “last best change” to decrease unemployment, homelessness, and improve behavioral health and health outcomes for this population.
- ✓ Youth Service Centers will be developed in an inviting location that will decrease stigma and meet the needs of youth and their families through increased hours of operation.
- ✓ An increase in the number of peer/recovery support groups for youth will assist in maintaining sobriety and community and social connectedness.

### ***West Virginia Behavioral Health Youth Service System Reform***

The West Virginian Behavioral Health Youth Service System will provide individualized strength based services, in a more integrated environment incorporating evidence based practices and effective cross-system collaboration including integrated management of service delivery and cost. This approach is comprised of a spectrum of effective community based services and supports that are organized in a coordinated network that provides meaningful partnerships with families and youth improving the youth's functioning in the home, school and community promoting recovery and resilience.

The system will be comprised of six (6) regional Youth Service Centers that will implement a cross-system, collaborative approach to youth service delivery, both at a regional and state level, creating the statewide Behavioral Health Youth Service Network. The Substance Abuse Mental Health Service Administration (SAMHSA) Block Grant will provide funding for regional coordinated programming offered to the communities through an Announcement of Funding Availability (AFA) process. State revenue funds designated by the GACSA will be used to fund programming in Region 3 and will also utilize the same AFA process.

## Section Three: **SERVICE DESCRIPTION**

### **Regional Youth Service Center (R-YSC)**

**Target Population(s): Youth (Ages 12-17), Transitional Aged Youth (Ages 18-24) experiencing substance use and/or co-occurring substance use and mental health issues; family/primary caregivers of the youth/transitional aged youth are a targeted sub-population.**

#### **Purpose**

The Bureau for Behavioral Health and Health Facilities' (BBHFF) purpose for establishing six (6) regional Youth Service Centers throughout West Virginia is to:

1. Create a centralized information and referral network to serve the target population;
2. Conduct local needs assessments to identify behavioral health resources for the target population; and
3. Develop, provide for, and coordinate a full continuum of care (prevention, early intervention, treatment and recovery services) for the target population utilizing a data-driven decision model to include the needs assessment information.

#### **Service Overview**

The project design for the **Regional Youth Service Center (R-YSC)** is a single facility or coordinated partnering of multiple facilities to provide a variety of treatment and non-treatment options for youth with substance use and co-occurring substance use and mental health disorders. Programming offered, as defined by the Substance Abuse and Mental Health Service Administration (SAMHSA) service area definitions, will include: Primary Prevention, Promotion & Wellness, Engagement Service, Outpatient Services, Medication Services, Community Support Services, Recovery Support Services, and Intensive Support Services. For the specific service area definitions see **Appendix A**. In order to provide for such a wide array of programming the R-YSC is required to offer distinct service settings. The following are details regarding each of those components:

The **Referral & Outreach Center (ROC)** is a 24-hour call center for individuals seeking behavioral health assistance for WV youth. The Regional Youth Service Center (R-YSC) will maintain a "live" data base containing statewide service options and will be updated daily to reflect up-to-date residential bed capacity. Anyone that contacts the R-YSC ROC will be offered education on behavioral health issues and information on service options in their region, as well as a facilitated referral to an appropriate level of care based on the individuals need in coordination

with regional centers. ROC staff will track and follow-up on all calls made to their R-SYC to ensure quality assurance and successful outcomes. Each Regional Youth Service Center (6 total) will operate in conjunction with one another in order to create the statewide Behavioral Health Youth Services Network. This network will create a single access point for all youth behavioral health needs in West Virginia; a resource that addresses the top two identified barriers for families seeking services: access and navigation.

The **Engagement (Diagnostic) & Outpatient Clinic** is a separate unit within the R-SYC that will act as a centralized screening, diagnostic, outpatient, intensive outpatient and recovery service center for youth, transitional aged youth and their families/primary caregivers. Youth served at the clinic are eligible to receive a variety of services as determined by the needs of the individual regardless of payer source. All youth served at the clinic will be screened for the presence of co-occurring substance use and mental health issues; information gained from this screening will be used to develop an appropriate referral to treatment. After initial screening and referral, youth will have access to services that include clinical and specialized assessments, service planning, individual and group therapy, medication services, case management, and recovery support services, all of which will be offered during both traditional and non-traditional business hours. In addition, family/primary caregivers of these youth will have access to consumer/family education, family therapy, multi-family counseling, and parent/caregiver support. Programming provided for by the R-YSC must be age appropriate, evidence-based, trauma-informed care, including assessments and interventions that consider the individual's adverse life experiences within the context of their culture, history, and exposure to traumatic events. Youth who require additional assessment services not currently available in their region will receive a facilitated referral through the Behavioral Health Youth Service Network to arrange for such services, as available. Upon completion of this service, youth requiring additional programming will be referred back to the region where the youth resides in order to complete treatment and/or recovery programming as recommended. Telehealth service options will also be available and utilized by the R-YSC, in addition to the development and implementation of an Electronic Health Record (EHR) system.

The Regional Youth Service Center (R-YSC) will provide facilitated referrals to the Youth Service Center: Transitional Housing Program, a short-term recovery unit for transitional aged youth (18-24). Males and females who have a substance use and/or co-occurring substance use and mental health issues seeking out-of-home treatment and/or recovery programming are eligible for admission. Those admitted can reside on the unit for 60-90 days, depending on the needs of the youth. Residents of the Transitional Housing Program will participate in intensive outpatient programming and intensive case management, in addition to the available Engagement & Outpatient Clinic programming. The Transitional Housing Program will also

collaborate with external community resources in offering the residents supported education (GED) and employment opportunities, recovery housing, and facilitated residential treatment or aftercare referrals as needed. Regional Youth Service Center's (R-YSC) may include a Transitional Housing Program however this is not a requirement of the project. Such programming must abide by the Recovery Residency guidelines outlined in **Appendix B**.

The Regional Youth Service Center (R-YSC) will coordinate with the Bureau for Behavioral Health and Health Facilities in professional development efforts in order to increase the capacity of youth service providers by participating and offering quality, evidence-based programming that will improve clinical and functional outcomes for West Virginia youth. Sites will also work in collaboration with the BBHBF, the Behavioral Health Youth Service Network, and other youth service providers to identify work force needs and pursue state of the art training and technical assistance to meet those needs. Youth service workers will learn current, effective practice and promote idea exchanges so that they can help to strengthen the network of service providers, decrease turnover, and implement consistent service delivery. Advanced technology will be a pillar of the Youth Services Network, wherein a significant commitment is made to explore, pursue, and provide the most modern, efficient, and effective service instruments and training tools available.

### **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 restricted to:

- Local Public Housing Authorities
- Behavioral Health (Substance Use, Mental Health, I/DD)
- Primary Health
- Hospitals
- Obstetric/Gynecological, Pediatric, Childcare if applicable
- Medication Assisted Treatment (MAT) Providers
- 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 BBHF 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 BBHF. 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 (10 points)
- B. Proposed Evidence-Based Service/Practice (20 points)
- C. Proposed Implementation Approach (50 points)
- D. Staff and Organizational Experience (10 points)
- E. Data Collection and Performance Measurement (10 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, one (1) inch margins, and include page numbers.

**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 submit 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 pass the initial administrative review.

## 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: (10 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 among the target population 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 substance use and co-occurring substance use and mental health 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: (20 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 retain fidelity to the chosen practice, while addressing the following issues in the target population: 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 assessments, admission criteria, or intake data collection instruments. For more information visit SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) ‘Screening Tools’ website: <http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs>
  - Describe how previously identified 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 BBHFF 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: (50 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, staff(s)/partners responsible for action and timeframe for each activity 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. Include the projections for sub-population (family/primary supports) served separate from projections for the targeted population.
- 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 and/or assess clients for the presence of co-occurring mental health and substance use disorders and use the information obtained from the screening and/or assessment to facilitate appropriate referral to treatment for the persons identified as having such co-occurring 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 BBHFF 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 substance use treatment and recovery services to the fullest extent possible, using BBHFF 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.
- Discuss the applicant organization's current level of participation in the Governor's Regional Substance Abuse Task Force Meetings in the proposed region and document your ability to attend future meetings.

**E. Data Collection and Performance Measurement: (10 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 BBHMF-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 C**

All forms referenced in Section F: Budget Form and Budget Narrative can be accessed through the BBHMF 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%20BBHMF%20TFB%20Instructions.pdf>

#### **G. Attachments 1 through 3:**

- **Attachment 1:** Reference/Work Cited Page (to include all proposal data citations); Facility/site diagrams (if applicable/available)
- **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. Create a centralized information and referral network to serve the target population;
2. Conduct local needs assessments to identify behavioral health resources for the target population; as well as,
3. Develop, provide for, and coordinate a full continuum of care (prevention, early intervention, treatment and recovery services) for the target population utilizing a data-driven decision model to include the needs assessment information.

**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, 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
  - 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 service information to include:
  - a. Number and type of evidence-based practices utilized for provision of the service
  - b. Number of referrals received by referral source, funding source, with disposition (accepted, unable to accept with reason).
  - c. Number of and disposition of discharges and transfers (completed service, transferred to a higher level of care).
  - d. Number of referrals made with disposition (accepted, unable to accept with reason):
    - i. Other Regional Youth Service Center, indicate Region
    - ii. Youth Service Center: Transitional Housing Program(s)
  - e. Number of unduplicated individuals at admission and discharge:

- i. Participating in an educational and/or employment program indicated by type and number
  - ii. Participating in a recovery support and/or mutual aid program/network indicated by type and number
  - iii. Residing in safe, stable, substance-free housing
  - iv. Having no legal involvement/charges in the last 30 days; If legal involvement/charges within 30 days, indicated by type and number
  - v. Reporting no alcohol use in the last 30 days
  - vi. Reporting no drug use in the last 30 days
  - vii. Screened for the presence of co-occurring substance use and mental health issues and referred for appropriate services
  - viii. Involuntarily committed while participating in services
4. Participate in a peer-review process to assess the quality and appropriateness of substance use services that will foster the increased availability and sustainability of evidence based practices, programs and policies.
5. 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: [DHHRBHHFAnnouncement@wv.gov](mailto:DHHRBHHFAnnouncement@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. Additional data resources are available at the BBHFF website. Explore 'Links' to all Division Teams, including 'Prevention' with a sample of Substance-Specific Presentations:  
<http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Pages/default.aspx>
2. **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)
3. **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**

### **SAMHSA Service Areas and Definitions**

**Primary Prevention:** Prevention is defined by the Substance use Mental Health Services Administration (SAMHSA) as creating communities where individuals, families, schools, faith-based organizations and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance use including tobacco and suicide. Prevention services are divided into three population categories based on the Institute of Medicine (IOM) model of care: universal, selective and indicated.

**Health Promotion & Wellness:** The support needed to address the complex needs of individuals; families and communities impacted by mental disorders, substance use disorders and associated problems by obtaining a physically and emotionally healthy lifestyle.

**Engagement Service:** Engagement Services include the evaluation and service planning support needed to address the complex needs of individuals and their families impacted by mental disorders, substance use disorders and associated problems.

**Outpatient Services:** Out-Patient Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual with mental, substance and other disorders.

**Medication Services:** To use medicine in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of mental, substance use and other disorders.

**Community Support Services:** Community supports are meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors.

**Intensive Support Services:** Intensive Support Services is the use of structured and well planned intentional interventions in the health, behavior, personal and/or family life of an individual suffering from substance use and mental health disorders that require the same daily level of care as residential treatment but the individual has a safe environment to reside during treatment.

**Recovery Support Services:** Recovery support services provide opportunities of change whereby individuals work to improve their own health and wellness.

**Appendix B**  
**Required Level II Recovery Residence Standards**

The West Virginia Bureau for Behavioral Health and Health Facilities (BBHFF), in order to better assure that recovering individuals have safe, recovery-oriented, habitual housing requires adherence to the following Substance Use Recovery Residence Standards for its grantees. All Recovery Residences must be managed in an ethical, honest, and reasonable fashion.

The process of establishing and monitoring minimum standards is an evolving one, intended to elevate the quality of WV Recovery Residences. There are six major components of the standards which broadly include (1) Organizational/Administrative, (2) Fiscal Management, (3) Operational, (4) Recovery Support, (5) Property and (6) Good Neighbor Standards.

The following are Recovery Residence Level II standards:

<b>1. Organizational/Administrative Standards</b>
1.1 The Recovery Residence is a legal business entity, as evidence by business license or incorporation documents;
1.2 The Recovery Residence has a written mission statement and vision statement;
1.3 The Recovery Residence has a written code of ethics;
1.4 The Recovery Residence property owners/operators carry general liability insurance;
1.5 The Recovery Residence complies with State and Federal requirements, including licensure or certification
1.6 The Recovery Residence clearly identifies the responsible person(s) in charge of the Recovery Residence to all residents;
1.7 The Recovery Residence clearly states the minimum qualifications, duties, and responsibilities of the responsible person(s) in a written job description and/or contract;
1.8 The Recovery Residence provides a drug and alcohol free environment;
1.9 The Recovery Residence collects and reports accurate process and outcome data for continuous quality improvement
1.10 The Recovery Residence have written permission from the owner of record to operate a Recovery Residence on their property;
<b>2. Fiscal Management Standards</b>
2.1 The Recovery Residence maintains an accounting system that fully documents all resident financial transactions such as fees, payments and deposits;
<b>3. Operation Standards</b>
3.1 The Recovery Residence posts emergency procedures (including evacuation maps, emergency numbers) and staff emergency contact information in conspicuous locations;
<b>4. Recovery Support Standards</b>
4.1 The Recovery Residence maintains a staffing plan;
4.2 The Recovery Residence use an applicant screening process that helps maintain a safe and supportive environment for a specific group of persons in recovery;
4.3 The Recovery Residence adheres to applicable confidentiality laws;

4.4 The Recovery Residence keeps resident records secure with access limited to authorized staff only;
4.5 The Recovery Residence has a grievance policy and procedure for residents;
4.6 The Recovery Residence creates a safe, structured, and recovery supportive environment through written and enforced residents' rights and requirements;
4.7 The Recovery Residence has an orientation process that clearly communicates residents' rights and requirements prior to them signing any agreements; collects demographic and emergency contact information and provides a new resident with written instructions on emergency procedures and staff contact information;
4.8 The Recovery Residence fosters mutual supportive and recovery-oriented relationships between residents and/or staff through peer-based interactions, events, and/or other social activities;
4.9 The Recovery Residence fosters recovery-supportive, alcohol and drug-free environments through written and enforced policies and procedures that address: residents who return to alcohol and/or drug use; hazardous item searches; drug-screening and/or toxicology protocols; and prescription and non-prescription medication usage and storage;
4.10 The Recovery Residence encourages each resident to develop and participate in their own personalized recovery plan;
4.11 The Recovery Residence informs residents on the wide range of local treatment and recovery support services available to them including: 12-step or other mutual support groups, recovery community centers, recovery ministries, recovery-focused leisure activities and recovery advocacy opportunities;
4.12 The Recovery Residence provides nonclinical, recovery support and related services;
4.13 The Recovery Residence encourages residents to attend mutual supportive, self-help groups and/or outside professional services;
4.14 The Recovery Residence provides access to scheduled and structured peer-based services such as didactic presentations;
4.15 The Recovery Residence provides access to 3 <sup>rd</sup> party clinical services in accordance to State laws;
<b>5. Property Standards</b>
5.1 The Recovery Residence abides by all local building and fire safety codes;
5.2 The Recovery Residence provides each resident with food and personal item storage;
5.3 The Recovery Residence places functioning fire extinguishers in plain sight and/or in clearly marked locations;
5.4 The Recovery Residence has functioning smoke detectors installed. If the residence has gas appliances, functioning carbon monoxide detectors are installed;
5.5 The Recovery Residence provides a non-smoking living environment;
5.6 The Recovery Residence has a community room large enough to accommodate house meetings and sleeping rooms that adhere to Local and State square footage requirements;
5.7 The Recovery Residence has one sink, toilet, and shower per six residents or adhere to Local and State requirements;
5.8 The Recovery Residence has laundry services that are accessible to all residents;
5.9 The Recovery Residence maintains the interior and exterior of the property in a functional, safe and clean manor that is compatible with the neighborhood;
5.10 The Recovery Residence has a meeting space that accommodates all residents;
5.11 The Recovery Residence has appliances that are in working order and furniture that is in good condition;
5.12 The Recovery Residence addresses routine and emergency repairs in a timely fashion;
<b>6. Good Neighbor Standards</b>
6.1 The Recovery Residence provides neighbors with the responsible person(s) contact information upon

request. The responsible person(s) responds to neighbor's complaints, even if it is not possible to resolve the issue. All neighbor complaints and responsible person(s) response and actions must be documented;

6.2 The Recovery Residence has rules regarding noise, smoking, loitering, and parking that are responsive to neighbor's reasonable complaints;

6.3 The Recovery Residence has and enforces a parking courtesy rule where street parking is scarce.

**Appendix C**  
**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> .