WEST VIRGINIA
Department of
Health & Human Resources

Bureau for Behavioral Health and Health Facilities

Announcement of Funding Availability

Prevention works! Treatment is effective! And Recovery happens!

Proposal Guidance and Instructions

AFA Title: Substance Use Promotion, Wellness, & Recovery Programming

AFA Number: AFA 06-2014-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

Key Dates:	
Date of Release:	August 5, 2013
TECHNICAL ASSISTANCE:	August 21, 2013, more details to follow
Letter of Intent Deadline:	August 30, 2013 Close of Business – 5:00PM
Application Deadline:	September 23, 2013 Close of Business–5:00PM
Funding Announcement(s) To Be Made:	October 1, 2013
Funding Amount Available:	$650,000 Statewide

The following is a guide and instructions for submitting a proposal to the Bureau for Behavioral Health and Health Facilities (BBHHF). The document includes general contact information, program information, administrative, and fiscal requirements. Responses must be submitted using the required AFA Application Template available at DHHR.WV.GOV/BHHF/AFA. Responses must be submitted electronically via email to DHHRBHHFAnnouncement@wv.gov with the AFA Title and Number in the subject line. All submissions must be received no later than 5:00 PM on the application deadline date. Notification that the proposal was received will follow. Paper copies of proposals *will not* be accepted. It is the sole responsibility of applicants to insure that all documents are received by deadline dates. Incomplete proposals or proposals submitted after the application deadline will not be reviewed.

LETTER OF INTENT

All organizations planning to submit an application for an Announcement of Funding Availability (AFA) must submit a Letter of Intent (LOI) by **August 30, 2013 close of business (5:00pm)** to the email address: **DHHRBHHFAnnouncement@wv.gov** prior to submission of the AFA.

Please 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 applicant's interest in providing each type of service (AFA) and will not be considered binding until documented receipt of the application.

RENEWAL OF AWARD

The BBHHF may renew or continue funding beyond the initial fiscal year award for a period not to exceed one additional fiscal year period beyond the stated AFA period (October 1, 2013 through September 30, 2014). As such, at the discretion of the BBHHF funding may be renewed for a period no later than September 30, 2015. Future funding will be contingent on availability of funds and successful implementation of goals and documented outcomes.

LEGAL REQUIREMENTS

All applicants must be able to provide proof of 501(c) 3 status and possess a valid West Virginia business license. If the applicant is not already registered as a vendor in the State of West Virginia, this 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 AVAILABLITY

This funding announcement is part of a statewide plan to expand regionally based substance use recovery services. There is a maximum availability of $650,000 statewide and not to exceed $100,000 regionally to support the development of Promotion, Wellness, & Recovery programming.

Funding for **Promotion, Wellness, & Recovery Programming** 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:

Start Up Costs

Applicants who wish to request reasonable startup funds for their programs must submit a separate "Startup" target funded budget and budget narrative along with their proposals.

For the purposes of this funding startup costs are defined as non-recurring costs associated with the setting up and opening of a program, such as fees, registrations, training, equipment purchases, renovations and/or capital expenditures.

For the purposes of proposal review, all startup costs requests submitted by the applicant will be considered to be necessary for the development of the service and/or program outlined in the applicant proposal. As such, where/if capital/start-up costs exceed funding availability BBHHF staff will contact the applicant agency and arrange a time to meet and discuss the specifics.

REGIONS IN WEST VIRGINIA

The BBHHF is currently utilizing the six region approach designated by the Governor's Advisory Council on Substance Abuse (GACSA).

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

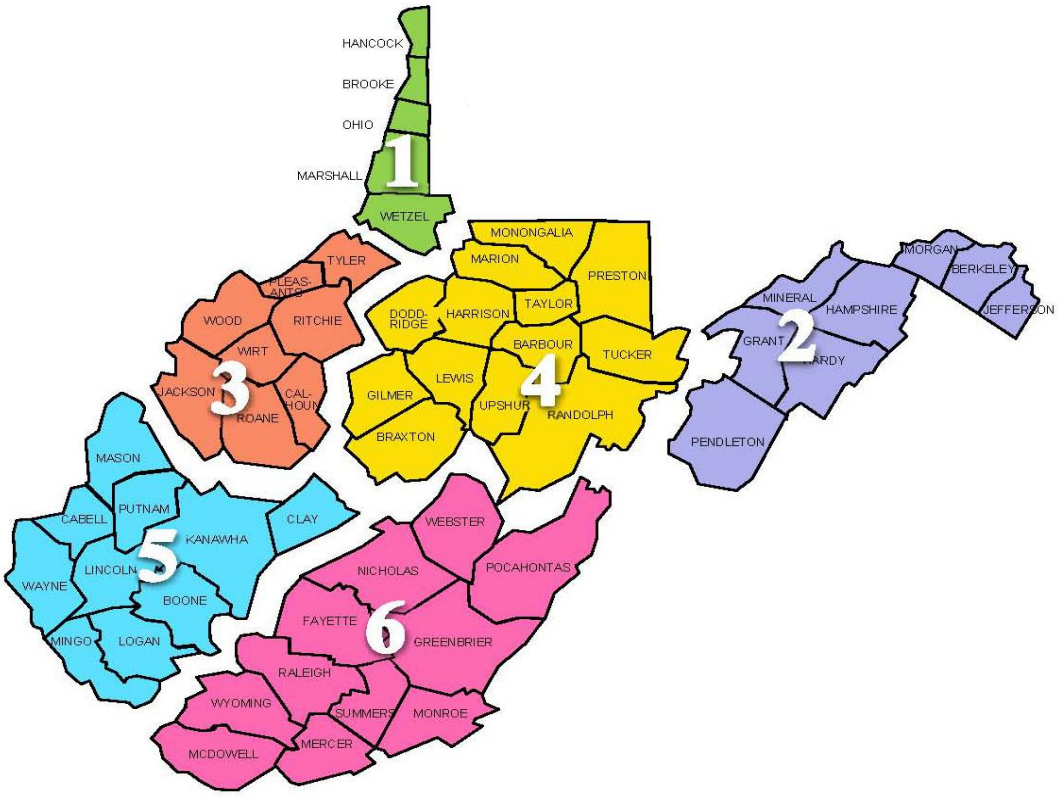
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

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**

Individuals and families cannot be healthy without positive mental health and freedom from addictions and use of substances. Prevention, treatment, and recovery support services for behavioral health are important parts of health service systems and communitywide strategies that work to improve health status and lower costs for individuals, families, businesses, and governments.

Substance use, addictions, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. They cost money, and they cost lives, in the same way that physical illnesses that are not prevented, are left untreated, or are poorly managed. Their presence exacerbates the cost of treating co-morbid physical diseases and results in some of the highest disability burdens in the world compared with other causes of disability. The impact on American's children, adults, and communities is enormous:

- *The annual total estimated societal cost of substance use in the United States exceeds $600 billion annually and includes:*
    - *193 billion for illicit drugs*[1]
    - *193 billion for tobacco*[2]
    - *235 billion for alcohol*[3]
- *Serious mental illnesses cost society $193.2 billion in lost earnings per year.*[4]
- *By 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide.*[5] *In 2009, there were an estimated 45.1 million adults aged 18 or older in the United States with any mental illness in the past year. This represents 19.9 percent of all adults in the U.S.*[6]
- *Two million (8.1%) youth aged 12 to 17 had a major depressive episode during the past year, while only 34.7 percent of these adolescents experiencing major depressive episodes received treatment during this period.*[7]

- *In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use but only 11.2 percent of those people actually received treatment*[8]
- *Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.*[9]

West Virginia, in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), is working to improve understanding about mental and substance use disorders, promote emotional health and the prevention of substance use and mental illness, increase access to effective treatment, and support recovery.

Leading by Change: A Plan for SAMHSA's Roles and Actions

West Virginia is committed to creating communities wherein collaboration is central to the planning and development of community based services. Collaboration may include individuals, families, schools, faith-based organizations, coalitions, agencies, associations and workplaces supporting our statewide capacity to take action to focus on behavioral health prevention and promotion efforts supporting improved emotional and physical health of WV citizens.

West Virginia Behavioral Health System

The Division on Alcoholism and Drug Abuse and the Divisions of Child, Adolescent and Adult Behavioral Health, operating divisions of the Bureau for Behavioral Health and Health Facilities (BBHHF) within the West Virginia Department of Health and Human Resources (WV DHHR), are charged in code with being the Single State Authority (SSA) primarily responsible for prevention, control, treatment, rehabilitation, education research and planning for substance use and mental health related services.

Behavioral Health is Essential to Health: Prevention works! Treatment is effective! And Recovery happens!

The principles that guide the work of the Bureau for Behavioral Health and Health Facilities are aligned with SAMHSA in understanding that the evidence base behind behavioral health prevention, treatment and recovery services continues to grow and promises better outcomes for people with and at risk for mental health and substance use disorders.

Behavioral Health Integration

As health reform efforts are being enacted and SAMHSA is promoting the importance of integrated behavioral health, it is necessary for WV to align its thinking and planning processes within these parameters. In so doing we must continually review, assess and acquaint ourselves with the climate of our state through the careful collection and review of key indicators and prevalence data. Included below are indicators considered in the development and evolution of the behavioral health system of care in WV:

Substance Use in WV

- *Prescription drug overdoses in WV rose 300% from 164 deaths in 2001 to 656 deaths in 2011.*[10]
- *In 2010, Alcohol was a factor in 31% of fatal motor vehicle accidents in WV.*[11]
- *In 2011, WV had the highest annual number of retail prescription drugs filled at pharmacies nationwide at 19.3 per capita.*[12]
- *Opiates are the number one cause of death associated with drug overdoses in WV.*[13]
- *In 2010 the WV Poison Control Center received 4 calls related to bath salt exposures; in 2011 the number increased to 253 exposure calls – a 6200% increase in one year's time.*[14]
- *Hospitalization admissions with an alcohol abuse/dependence related diagnosis at discharge rose 11% from 2005 to 2009.*[15]

Mental Illness in WV

- *Almost 8% of West Virginians experienced at least one major depressive episode within the past year.*[16]

- *In 2010, approximately 25.1% of the people experiencing homelessness staying in shelters in WV reported mental illness and/or substance use.*[17]
- *The WV age-adjusted suicide rate in 2010, 14.1 per 100,000 population, was above the national average at 12.1 per 100,000 population* [18]
- *In 2011, over 10% of WV's youth reported making a suicide plan in the past year.* [19]
- *Over 5% of students in grades 9 through 12 reported a suicide attempt within the past 12 months.*[20]
- *In 2010, almost 30% of domestic violence survivors identified that substance use was a contributing factor to their abuse.*[21]

Strategic Direction

The WV Bureau for Behavioral Health and Health Facilities (BBHHF), Division on Alcoholism and Drug Abuse has developed and published a Comprehensive Substance Abuse Strategic Action Plan to guide services and service continuum development over the next 3-5 years. The Plan sets forth four priority areas to guide system oversight and evolution (see below). In addition, the Plan has been acknowledged by Governor Tomblin with its implementation being overseen by the Governor's Advisory Council on Substance Abuse (GACSA). The Plan is aligned with the WV's 2012 SAMHSA Integrated Block Grant Application and will be updated annually to insure continued consistency. Both documents can be located as follows for reference:

The SAMHSA Integrated Block Grant Application can be found at the following link: http://www.dhhr.wv.gov/bhhf/resources/Pages/FinancialResources.aspx The WV Comprehensive Substance Abuse Strategic Action Plan may be found at: http://governorssubstanceabusetaskforceswv.com/images/Resources/strategicactionplan-info.pdf

Behavioral Health Prevention, Treatment and Recovery System Goals	
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	Build the capacity and competency of WV's behavioral health

Capacity	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.

Rational and Proposed Approach

The Bureau for Behavioral Health and Health Facilities (BBHHF) allocates over $750,000 yearly to support ten public inebriate shelter sites across West Virginia (WV). Between the months of November 2012 and June 2013 approximately 1,443 individuals were served without further interventions using the current model.

Of the public inebriates served, a portion presented with physical health issues as well as co-occurring mental health and substance use issues. The medical needs for this population cannot be met in correctional settings or through a traditional “holding tank” facility. In order to understand and manage both their physical and behavioral health problems appropriately a different level of support and programming is needed and should be made available to serve this population.

A safe, protective and supportive environment is necessary for Law Enforcement to connect persons who appear to be using drugs/alcohol. The current WV shelter model doesn’t offer screening to evaluate the severity and scope of an individual’s involvement with alcohol and/or other drugs. Nor does it provide brief intervention or referral to treatment services if needed.

An information request was placed with the National Association of State Alcohol/Drug Abuse Directors (NASADAD) in 2012 to determine best practice with regard to serving the safety and treatment needs of intoxicated individuals. The majority of the States

responded to the fact that they do not provide funding support for “PI Shelters”, but support Sober Housing and Recovery Support Models that offer screening and education. Over the past year Shelter providers have expressed issues of safety and the historical programming has shown little impact on the population resulting in repeat admissions and the inability to facilitate referrals.

The proposed approach is to establish Level - 2 Recovery Residences offering Promotion, Wellness, and Recovery programming in each of the six regions. These sites will be peer-operated by SBIRT-trained Peer Specialists and Coaches with training and technical provided by the BBHHF. Shelters, faith-based organizations, existing Recovery Residences, and traditional providers would all be eligible to apply for funding with demonstrated partnerships with Law Enforcement, Community Behavioral Health, Hospital Emergency Rooms and Primary/Urgent Care Centers due to the potential health risks associated with intoxication or other poly-substance use.

Section Two: **SERVICES DESCRIPTION**

Substance Use Promotion, Wellness and Recovery Programming

For purposes of this project Promotion, Wellness, and Recovery programming will be provided as a 24 hour, safe, structured, and recovery-oriented environment offering screening services for individuals to determine their level of incapacitation as well as their intervention and/or referral needs due to alcohol and/or other drugs. Programs will be peer-operated with technical assistance and provided by the Bureau for Behavioral Health and Health Facilities (BBHHF).

Program staffing should include SBIRT-trained, peer support specialists and a peer coach as the site supervisor. Each program should be able to describe their experience with the population and their ability to assess and appropriately address the medical risks associated with intoxication.

Allowable program services include general physical and behavioral health screens, brief motivational interviewing, facilitated community referrals, relapse prevention, physical health promotion, wellness recovery support, warm lines (help lines), peer support, recovery support coaching, recovery support center services, support for self-directed care and recovery planning.

The project goal is peers helping peers to create opportunities for change whereby individuals work to improve their own physical and emotional health by engaging in supportive recovery communities. Applicants will accomplish this by reducing the number of emergency room visits by intoxicated individuals, supporting law enforcement in providing a safe location for intoxicated individuals to receive 24-hour screening, intervention, and referral services, promote the use of physical and behavioral health screening, brief intervention, and referral to treatment and recovery support services.

All applicants for funding must provide statements agreeing to meet the BBHHF's Substance Use Recovery Residence Standards and SBIRT Model Standards for this program and provide comprehensive detail(s) demonstrating their capacity to do so. For details regarding these standards see **Appendix A** and **Appendix B** of this document.

Collaborations and Memorandums of Understanding

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

- Law Enforcement
- Behavioral Health (Substance Use and Mental Health) providers
- Physical Health
- Hospitals and other Emergent Care providers
- Medication Assisted Treatment (MAT) providers
- Family Assistance programs
- Family and/or Drug Courts
- Criminal Justice
- Employment, Education and/or Vocational programs

Section Three: **PROPOSAL INSTRUCTIONS / REQUIREMENTS**

Eligible applicants must provide proof of 501(c) 3 status and possess a valid West Virginia business license.

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 project goals and measurable objectives, including the number of people projected to be served annually. Project 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.

All applications will be reviewed by the BBHHF staff for administrative compliance with all required guidelines. 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:

Proposal Narrative and Supporting Documentation – The Proposal Narrative describes your project. It consists of Sections A through E. Sections A-E together may not be longer than **30** pages; applicants must utilize 12pt. Arial or Times New Roman font and single line spacing. Supporting Documentation provides additional information necessary for the review of your application. It consists of Sections F and G. These documents and/or attachments will not be counted towards the Project Narrative page limit; However, Section F and G together may not exceed **20** additional pages.

A. Population of Focus and Statement of Need (20 points)
B. Proposed Evidence-Based Service/Practice (25 points)
C. Proposed Implementation Approach (35 points)

D. Staff and Organizational Experience (10 points)

E. Data Collection and Performance Measurement (10 points)

Section Four: **PROPOSAL OUTLINE**

All proposal submissions must include the following components without exception.

Abstract:

Provide a brief description of the project proposed as earlier set forth in this announcement and as provided for on the proposal template

Project Narrative and Supporting Documentation:

A. <u>Population of Focus and Statement of Need:</u>

- Provide a comprehensive demographic profile of your population of focus in terms of race, ethnicity, language, gender, age, socioeconomic characteristics, and other relevant factors, such as literacy.
- Describe the organization's relationship with key stakeholders and resources in the geographic catchment area of the proposed project which can help implement the needed infrastructure development and intent of this AFA.
- Discuss the relationship of your population of focus, including sub-populations (families/primary supports), to the overall population in your geographic catchment area and identify sub-population disparities, if any, relating to access/use/outcomes of your provided services citing relevant data. Demonstrate an understanding of these populations consistent with the purpose of your project and intent of the AFA.
- 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 population(s) of focus 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 quantitative data that could be used are local epidemiologic data, state data, and/or national data.
- 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 disorder treatment services in the proposed catchment area that is consistent with the purpose of the program and intent of the AFA.

- Document the need for the proposed project in West Virginia and, more specifically, in the identified catchment area/region. Clearly indicate which region and county(ies) that will be served by the proposed project.
- Discuss your agencies current level of participation in the Governor's Regional Task Force Meetings in the proposed region and document your ability to attend future meetings.

B. <u>Proposed Evidence-Based Service/Practice:</u>

- Describe the purpose of the proposed project.
- Clearly state project goals, objectives and strategies. These must relate to the intent 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 your population(s) of focus, your proposed program, and the intent 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 your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate, existing EBP.
- Describe how the proposed practice(s) will address the following issues in the population(s) of focus, while retaining fidelity to the chosen practice: in demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status), language and literacy, sexual identity (sexual orientation and gender identity) and disability.
- Discuss any screening tools that will be used and basis for selection.
- Describe how health disparities will be addressed including information related to sub-populations identified in the proposed region and suggested strategies to

decrease the differences in access, service use, and outcomes among those sub-populations. 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 organization will address cultural competence in proposal implementation. All BBHHF sub-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 project materials associated with awarded funding should be developed at low literacy levels for further understanding and comprehension in WV communities.
- Briefly describe how privacy and confidentiality will be ensured, including an explanation of what data will be collected and how it will be used.

C. Proposed Implementation Approach:

- Reference **Appendix A** for the BBHHF Substance Use Recovery Residence Standards. Reviewers will look for applicants documented awareness/ knowledge of and commitment to upholding these standards within this section of the Project Narrative.
- Reference **Appendix B** for the SBIRT Model Standards. Reviewers will look for applicants documented awareness/ knowledge of and commitment to upholding these standards within this section of the Project Narrative.
- Describe how achievement of the goals will produce meaningful and relevant results in your community (e.g. increase access, availability, prevention, outreach, pre-services, treatment and/or intervention) and support BBHHF's goals for the program.
- Describe the proposed program activities, how they meet your infrastructure needs, how they fit within or support the development of the statewide continuum of care and how they relate to your goals and objectives.
- Provide a chart or graph depicting a realistic time line for the entire project period, showing key activities, milestones of the intervention(s) (EBPs), and

staff(s) responsible for action. Be sure to show that the project can be implemented and service delivery can begin as soon as possible, and no later than six (6) months after award. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]

- Describe how you will screen and assess clients for the presence of co-occurring mental health and substance use disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.
- Describe how you will ensure the input of clients (i.e. SUD adults and their families/primary supports) in assessing, planning, and implementing your project. Describe the feedback loop between the clients, your organization, project partners/key stakeholders, and the BBHHF in all implementation stages of the project.
- Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project. Include letters of support from community organizations supporting the project in **Attachment 1**.
- Clearly state the unduplicated numbers of individuals you expect to serve (annually) with grant funds, including the types and numbers of services to be provided. Include projections for sub-populations (family/primary caregivers) served separate from projections for the targeted population.
- Describe briefly how all required program components will be developed, and how the required program components will be coordinated with one another to provide for a full continuum of care for the target population.
- Describe additional training to be sought and utilized in the development of the project, identifying key training components (by title) and their relevance.
- Describe how you will ensure the utilization of other revenue realized from the provision of substance use treatment and recovery services to the extent possible and use BBHHF grant funds only for services to 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 BBHHF grant funds). Also describe how you will facilitate the health insurance application and enrollment process for eligible uninsured clients.

- Describe how you will work across systems to ensure that services provided to these target populations are coordinated and considered by multiple levels and systems.
- Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.
- Describe your plan to continue the project after the funding period ends. Also, describe how program 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 including an existing facility already owned and operated by the applicant agency, or a facility for which the applicant agency has a detailed business plan for acquisition, leasing, or other manner of habitation. The BBHHF 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 agency chooses to speak to the BBHHF 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 as **Attachment 2**

D. <u>Staff and Organization Experience:</u>

- Discuss the capability and experience of the applicant organization. Demonstrate that the applicant organization has linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) of the population(s) of focus.
- Provide a complete list of staff positions for the project, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications.
- Discuss how key staff have demonstrated experience and are qualified to serve

the population(s) of focus and are familiar with the applicable culture(s).

E. <u>Data Collection and Performance Measurement:</u>

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

F. <u>Budget Form and Budget Narrative:</u> *All requirements set forth in Section F must be included in* ***Attachment 3*** *and will not count toward the Project Narrative page limit*

- 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 Quarterly BBHHF Provider Meetings.
- Include a Budget Narrative document with specific details on how funds are to be expended.
    - The budget narrative clarifies and supports the budget (TFB). The narrative should clearly/specify the intent of and justify each line item in the budget (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 document.
- Prepare and submit a separate TFB for any capital or start-up expenses and attach this separate TFB to the coordinating Budget Narrative 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 BBHHF web-site at:

http://www.wvdhhr.org/bhhf/resources.asp

G. <u>Attachments 1 through 3:</u> *Will not count toward the Project Narrative page limit*

- **Attachment 1:** Letters of Support
- **Attachment 2:** Facility/site diagrams (if applicable/available)
- **Attachment 3:** Budget Form(s) and Budget Narrative(s)

Section Five: **EXPECTED OUTCOMES / PRODUCTS**

All grantees must discuss their ability to report the data collected through web-based reporting by the 5th of each month, in accordance with National Outcome Measures (NOMS), state guidelines and timeframes established by US Center for Substance Abuse Treatment (CSAT), The Substance Abuse and Mental Health Services Administration (SAMHSA), and all other regulatory bodies. Specific outcome measures will include at least the following:

Early Intervention Performance Measures

Performance Measure	Admission	Discharge
Number of **individuals screened** (unduplicated count) for alcohol and other drug use by age, sex, race, and ethnicity	☑	☑
Number of individuals **receiving brief intervention** services (unduplicated count) for alcohol and other drug use by age, sex, race, and ethnicity	☑	☑
Number of individuals referred to **treatment**	☑	☑
Number of individuals referred **for promotion, wellness, and recovery services** and type of referral made	☑	☑
Number of individuals **employed or students** (full-time or part-time) prior 30 days	☑	☑
Number of individuals **living in a stable living condition** prior 30 days	☑	☑
Number of individuals **without arrests** prior 30 days	☑	☑
Number of individuals with **no alcohol use in the last 30 days**	☑	☑
Number of individuals with **no drug use in the last 30 days**	☑	☑
Number of individuals **participating in mutual aid groups** prior 30 days	☑	☑
Number of **lifetime admissions**	☑	
Number (unduplicated count) of **pregnant women** served	☑	
Number (unduplicated count) of **intravenous drug users (IV)** served	☑	
Admitting substance (Primary, Secondary, and Tertiary)	☑	

Peer Review Process

All grantees must discuss their willingness to 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.

Section Six: **TECHNICAL ASSISTANCE**

The **Bureau for Behavioral Health and Health Facilities (BBHHF)** 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.** All emailed technical assistance inquiries will be addressed by the BBHHF and posted to a Frequently Asked Questions (FAQ) document on the BBHHF website available at **DHHR.WV.GOV/BHHF/AFA.**

1. Additional data resources are available at the BBHHF 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 Substance Use and Mental Health issues, includes substance-specific data, suicide trends, etc.: http://www.dhhr.wv.gov/bhhf/resources/Documents/WV%202012%20Behavioral%20Health%20Profile.pdf

3. **WV County Profiles:** Contains county-level data pertaining to SA/MH issues, uses convenient 'at a glance' format: http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Research/Pages/CountyProfiles.aspx

Appendix A
Required Level II Recovery Residence Standards

The West Virginia Bureau for Behavioral Health and Health Facilities (BBHHF), 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 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 the **Level II Recovery Residence** standards:

1. Organizational/Administrative Standards
1.1 The Recovery Residence is a legal business entity, as evidenced by a 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 has written permission from the owner of record to operate a Recovery Residence on their property;
2. Fiscal Management Standards
2.1 The Recovery Residence maintains an accounting system that fully documents all resident financial transactions such as fees, payments and deposits;
3. Operation Standards
3.1 The Recovery Residence posts emergency procedures (including evacuation maps, emergency numbers) and staff emergency contact information in conspicuous locations;
4. Recovery Support Standards
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 all 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 posted 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 of 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 3rd party clinical services in accordance with State laws;
5. Property Standards
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 also 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 at least 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 or 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;
6. Good Neighbor Standards

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 in areas where street parking is scarce.

Appendix B
Screening, Brief Intervention and Referral to Treatment Standards

The application will include a sample Memorandum of Understanding (MOU) to be used to support the referral process to specialty mental health or substance abuse treatment services. Said MOU shall include reference to the following standards:

I. Universal Screening

Universal screening helps identify the appropriate level of services needed based on the patient's risk level.

- Patients who indicate little or no risky behavior and have a low screening score may not need an intervention.
- Those who have moderate risky behaviors and/or reach a moderate threshold on the screening instrument may be referred to brief intervention.
- Patients who score high may need either a brief treatment or further diagnostic assessment and more intensive, long term specialty treatment.

Screening typically takes 5-10 minutes and can be repeated at various intervals as needed to determine changes in patients' progress over time.

Pre-screening, is a required component of the West Virginia SBIRT Model. The justification for this is that it reduces the time needed by staff to identify patients with risky behavior. The funded program will use the prescreening instruments for Adults (Adult Health History Questionnaire) and Youth (CRAFFT) that were used by the West Virginia SBIRT Project. If a patient scores high on any domain in the pre-screen, a full screen is then conducted using the ASSIST and PHQ-9 Depression Inventory (The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire).

Patients are provided with Brief Intervention, brief treatment, or referral to intensive specialty treatment depending on their level of risk using a validated pre-screen and screening tool (Babor & Higgins-Biddle, 2001). With respect to substance abuse, in general only a small proportion of patients screen positive for some level of substance

misuse, abuse or dependency. This is usually 5%-20%, but may be as high as 40% in some settings. The majority of patients report minimal or no problems with alcohol or drugs and as such may be an ideal group for primary or universal prevention activities for maintenance of non-risky use or abstinence.

II. Brief Intervention and/or Brief Treatment

The goal of a Brief Intervention (which usually involves 1-5 sessions lasting about 5 -20 minutes) is to educate patients and increase their motivation to reduce risky behavior (see http://www.ncbi.nlm.nih.gov/pubmed/22514840). The Brief Intervention will be followed by assessment of the patient's level of motivation using readiness/confidence rulers and a plan to engage the patient to address their use.

The goal of brief treatment (which usually involves 5-12 sessions) is to change not only the immediate behavior or thoughts about a risky behavior but also to address long-standing problems with harmful drinking and drug misuse and help patients with higher levels of disorder obtain more long term care. Based on performance data from state SBIRT grantees funded by SAMHSA, only about 3% of patients receive a score that indicates a brief treatment. Patients referred to a brief treatment often have higher risk factors than those referred to a Brief Intervention or may have co-occurring mental health issues. Brief treatment may also require a course of (advanced) motivational enhancement and cognitive behavioral approaches to help patients address unhealthy cognitions and behaviors associated with current use patterns and adopt change strategies. If patients report greater risk factors than what brief treatment can address, they are referred to specialty substance abuse care. In some cases, a patient may receive a Brief Intervention first and then move on to a brief treatment or specialty care.

III. Referral to Treatment

Referral to treatment can be a complex process involving coordination across different types of services. As such, the absence of linkage to treatment referrals can be a significant barrier to the adoption of SBIRT. Referral is recommended when patients meet the diagnostic criteria for substance dependence or other mental illnesses, as

defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). In these cases, a referral to a specialized treatment provider is often made. Referral requires the system to establish new and complex linkages with the traditional specialty care system to connect clients who score in the problematic range to recognized, evidence based treatment in a timely manner. On average, 3% to 4% of screened patients typically need to be referred. The absence of a proper treatment referral will prevent the patient from accessing appropriate and timely care that can impact other psychosocial and medical issues. Research findings suggest that motivational-based Brief Interventions can increase patient participation and retention in substance abuse treatment (Hillman et al., 2001; Dunn and Ries, 1997). Strong referral linkages are critical, as well as tracking patient referrals.

IV. Co-Occurring Disorders and other behavioral health issues: The SBIRT model addressed in this AFA will address Co-Occurring Substance Abuse/Mental Health issues as outlined at:
http://www.kap.samhsa.gov/products/brochures/text/saib_0402.htm

Also, the recipient of these funds will address other behavioral health disorders that are identified at the screening site and, therefore, are highly encouraged to hire or partner with a Licensed Mental Health Professional (i.e. Licensed Psychologist or Licensed Independent Clinical Social Worker) who has experience in working with a wide variety of mental health conditions.

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.

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

Circular A-122.	EPA codified at **40 C.F.R. § 30**.
Educational Institution use the cost principles in **OMB Circular A-21.**	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.
Hospital use the cost principles in **Appendix E of 45 C.F.R. § 74**.	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.
For-profit organization other than a hospital and an organization named in **OMB Circular A-122** as not subject to that circular use the cost principles in **48 C.F.R. pt. 31** Contract Cost Principles and Procedures.	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.

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.

If the Grantee is a:	**OMB Circulars Codified at:**
State, local or Indian tribal government use the uniform administrative requirements in **OMB Circular A-102.**	Department of Health and Human Services (DHS) codified at **45 C.F.R. § 92** and **45 C.F.R. § 95**; Department of Agriculture (USDA) codified at **7 C.F.R. § 3016**; Department of Education (EDUC) codified at **34 C.F.R. § 80**;

	Environmental Protection Agency (EPA) codified at **40 C.F.R. § 31**.
Private nonprofit organization, institutions of higher education, or a hospital use the uniform administrative requirements in **OMB Circular A-110**.	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.
For-profit organization use the uniform administrative requirements in **OMB Circular A-110**.	DHS codified at **45 C.F.R. § 74** USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.

Appendix D
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