WEST VIRGINIA Department of Health & Human Resources

Bureau for Behavioral Health and Health Facilities

Announcement of Funding Availability

Youth Service Center: Transitional Housing Program

Proposal Guidance and Instructions

AFA Title: Youth Service Center: Transitional Housing Program
Targeting Regions: 2 and 3
AFA Number: AFA 08-2014-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:	February 25, 2014
TECHNICAL ASSISTANCE MEETING:	March 14, 2014, more details to follow
Letter of Intent Deadline:	March 17, 2014 Close of Business – 5:00PM
EXTENDED Application Deadline:	April 18, 2014 Close of Business–5:00PM
Funding Announcement(s) To Be Made:	May 2, 2014
Funding Amount Available:	Not to exceed $125,000.00 per Region

The following are requirements for the submission of proposals to the Bureau for Behavioral Health and Health Facilities (BBHHF): 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/BHHF/AFA. ✓Responses must be submitted electronically via email to 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/BHHF/AFA. This statement must be signed by the agency's CEO, CFO, and Project Officer. ✓Proposals that fail to comply with the requirements provided within this document, incomplete proposals or proposals submitted after the application deadline *will not* be reviewed.

LETTER OF INTENT

Organizations planning to submit a response to this Announcement of Funding Availability (AFA) must submit a Letter of Intent (LOI) by **March 17, 2014 close of business (5:00pm)** to the email address: **DHHRBHHFAnnouncement@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 (BBHHF) may renew or continue funding beyond the initial fiscal year award for up to one (1) additional fiscal year. Future funding will be contingent on factors including, but not limited to, availability of funds, successful implementation of goals, and documented outcomes.

LEGAL REQUIREMENTS

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

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

FUNDING AVAILABLITY

This funding announcement is part of a statewide plan to expand regionally based substance use and co-occurring services for youth. The funding recommendation in Region 3 was made possible by Governor Earl Ray Tomblin while the Substance Abuse and Mental Health Service Administration (SAMHSA) Block Grant will provide funding for the remaining regions with the availability of a maximum of $125,000.00 per region to support the development of a Youth Service Center: Transitional Housing Program.

Funding for a **Youth Service Center: Transitional Housing Program** 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:

REGION	REGIONAL FUNDING AVAILABILITY Not to exceed:
Two (2) and Three (3)	$125,000.00 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 BBHHF will contact the applicant organization and arrange a meeting to discuss remedial action.

BACKGROUND INFORMATION

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 BBHHF. 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.

REGIONS IN WEST VIRGINIA

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

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

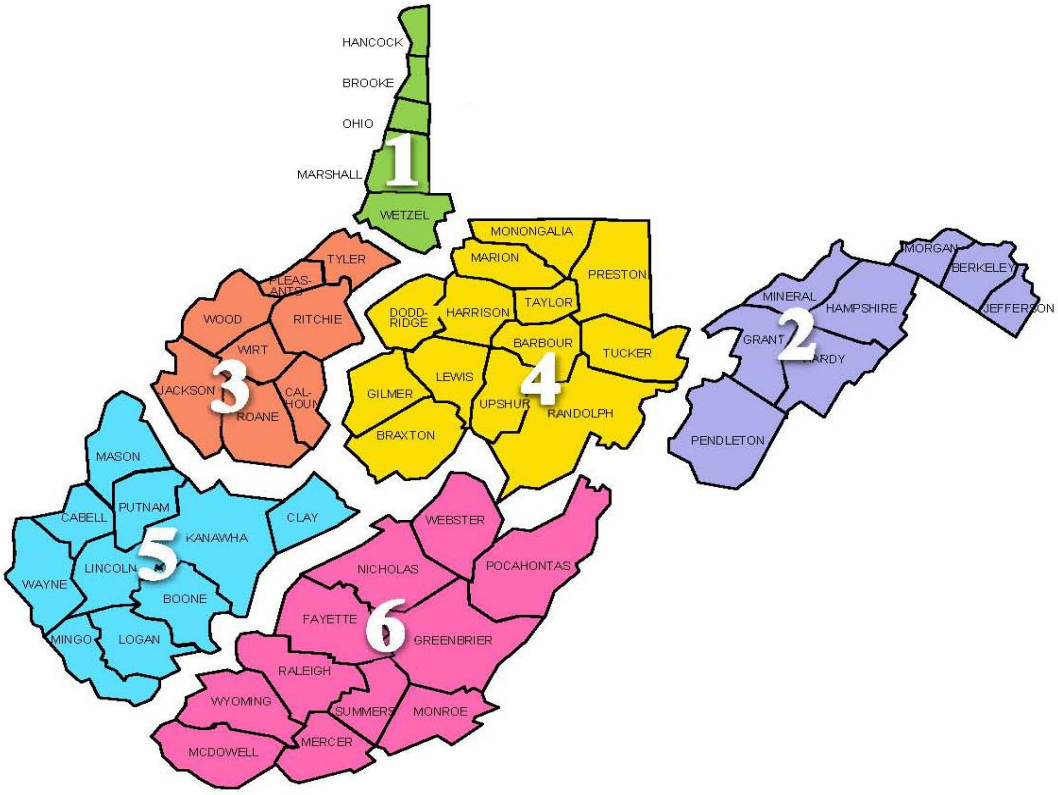
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

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**

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 State behavioral health system of care:

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]

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 out-cry 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, WVSBIRT 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. Technical assistance was also provided by Robert Vincent, SAMHSA Public Health Advisor to further discuss improvements necessary for youth service system reform in WV. 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.

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 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 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: **SERVICE DESCRIPTION**

AFA Title: Youth Service Center: Transitional Housing Program
Service Description: Substance Use Recovery Residence – Level II
Target Population: Transitional Aged Youth (Ages 18-24)

Purpose

Recovery is as a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential. Peer support, mutual aid meetings, such as AA/NA, and safe living environments are effective components of the process.

Community Support Services are meaningful daily activities, such as employment, education, volunteerism, family caretaking, or creative endeavors. These services create social networks, independence, income, and resources to support participation in a safe and stable environment and range from skill building (social, daily living, cognitive) to recovery housing.

The Bureau for Behavioral Health and Health Facilities' (BBHHF) purpose for establishing Substance Use Recovery Residence – Level II facilities for Transitional Aged Youth throughout West Virginia is to:

1. Expand the availability of safe, stable, substance-free, recovery housing;
2. Integrate residents into a community network of recovery and other peer supports;
3. Offer life skill development opportunities that promote personal and professional growth for residents; as well as,
4. Facilitate the resident's transition into the next appropriate level of care.

Service Overview

Substance Use Recovery Residences sometimes referred to as “Transitional Living”, “Oxford Houses” and “Recovery Homes”, provide safe housing for individuals, age eighteen (18) and older who are in recovery from substance use and/or substance use and co-occurring mental health disorders. The service follows and/or is concurrent with substance use treatment and is intended to assist those individuals for a period of months or until it is determined that an individual is able to safely transition into a more integrated environment.

The Youth Service Center: Transitional Housing Program is a 10 bed, short-term recovery unit for transitional aged youth (18-24). Males and females who have a substance abuse and/or co-occurring substance abuse and mental health issue seeking out of home, substance use treatment and/or recovery services are eligible for admission. Those admitted can reside on the unit for 60-90 days depending on the needs of the youth as they transition to the appropriate level of care or a more integrated environment.

A partnership between the Transitional Housing Program and local Regional Youth Service Center (R-YSC) will be established to provide for the treatment and recovery programming of the residents. These services will include but are not restricted to participation in age-specific, intensive outpatient and intensive case management services, in addition to the available R-YSC’s Engagement & Outpatient Clinic programming and Behavioral Health Youth Service Network resources. The Transitional Housing Program will also partner 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.

The Transitional Housing Program will coordinate staff professional development efforts with the Bureau for Behavioral Health and Health Facilities in order to increase the capacity of youth service providers by offering quality, evidence-based programming that will improve clinical and functional outcomes for West Virginia youth. Sites will work

collaboratively with the Bureau for Behavioral Health and Health Facilities (BBHHF), 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.

Key components of a Level II Recovery Residence include but are not restricted to: drug screening, house/resident meetings, mutual aid/self-help meetings, structured house/resident rules, peer-run groups, and clinical treatment services accessed and utilized within the community. Staff positions for a Level II Recovery Residence include but are not restricted to a Certified Peer (Recovery) Coach and other Certified Peer staff.

All applicants for funding to operate a Level II Recovery Residence must provide statements agreeing to meet the BBHHF's Substance Use Recovery Residence Standards for this service and provide comprehensive detail(s) demonstrating their capacity to do so. For details regarding these standards see **Appendix A** of this document. The following assurances must also be included in the proposal narrative:

- Ensure residential services will be provided in the language and cultural context that is most appropriate, and the program will be operated at a location that is readily accessible to the population served.
- Ensure that all recovery facilities are staffed adequately to include a minimum of 16 hours "on-site" supervision/support.
- Ensure that all residents receive a full orientation to program within twenty-four (24) hours of admission.
- Ensure that each resident establishes short and long-term goals and objectives within forty-eight (48) hours of admission.
- Ensure that each individual has a goal review session at least bi-weekly.
- Ensure that each resident has a written record that is current and legible.

- Ensure that each resident being discharged from the program is referred/ linked to a stable and safe environment/living program.
- Ensure that each resident being discharged from the program is referred/ linked to services/supports as needed to enable them to continue their recovery.
- Ensure that residents are assigned a Recovery Coach who will monitor resident mutual aid meeting attendance (such as NA/AA), mental health and substance use services, employment/education, volunteer activity, drug/alcohol abstinence and participation with all conditions of community placement.

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 and Mental Health)
- Primary Health
- Hospitals
- Obstetric/Gynecological, if applicable
- Pediatric, if applicable
- 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 Three: **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 BBHHF 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 BBHHF. 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, and one (1) inch margins. Page numbers must also be included as a footer.

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 be reviewed.

Section Four: **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. <u>Population of Focus and Statement of Need:</u> (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 that could be used are focus groups, news articles, key informant interviews, local epidemiologic data, state data, and/or national data.
- Identify health disparities relating to access, use, and outcomes of the proposed service citing relevant data. Identify the source of all data referenced.
- Document the need for an enhanced infrastructure to increase the capacity to implement, sustain, and improve effective substance use and co-occurring substance use and mental health recovery 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.

B. <u>Proposed Evidence-Based Service/Practice:</u> (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 address the following issues in the target population, while retaining fidelity to the chosen practice: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status), language and literacy, sexual identity (sexual orientation and gender identity) and disability.
- Identify any screening tools that will be used and basis for selection. Screening tools do not include clinical assessment, admission criteria, or intake data collection instruments.
- Describe how identified 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 BBHHF 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. <u>Proposed Implementation Approach</u>: (50 Points)

- Provide a one (1) year/12 month chart or graph depicting a realistic timeline of the service. The timeline must include the key activities and staff(s)/partners responsible for action through all phases including but not restricted to planning/development, implementation, training/consultation, intervention(s) milestones (EBPs), data collection, 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 1**.
- 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 BBHHF 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 BBHHF 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 BBHHF 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.
- Reference **Appendix A** for the 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 Proposal Narrative.

- 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 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 organization 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. Staff and Organization Experience: (20 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 Five: 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. <u>Budget Form and Budget Narrative:</u> *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 Quarterly BBHHF Provider Meetings.
- 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 B**.

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

G. Attachments 1 through 3:

- **Attachment 1:** Letters of Support / Memorandum's of Understanding (MOU)
- **Attachment 2:** Facility/site diagrams (if applicable/available)
- **Attachment 3:** Targeted Funding Budget(s) and Budget Narrative(s)

Section Five: **EXPECTED OUTCOMES / PERFORMANCE MEASURES**

Expected Outcomes:

1. Expand the availability of safe, stable, substance-free, recovery housing;
2. Integrate residents into a community network of recovery and other peer supports;
3. Offer life skill development opportunities that promote personal and professional growth for residents; as well as,
4. Facilitate the resident's transition into the next appropriate level of care.

Performance Measures:

1. Maintain data and documentation of all service activities related to each service area(s) indicated by Number of Persons Served by Age, Gender, Race and Ethnicity at admission and discharge to include:
   a. Target Population Service Activities
   b. Type of Service Activity per Service Area(s)
2. Maintain data and documentation related to the following (baseline at service admission and discharge as applicable):
   a. Number of resident beds provided for, include capacity and utilization totals
   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) for the following service areas, to include specific service activity:
      i. For Recovery Support Services
      ii. For Community Support Services
      iii. For substance use and/or co-occurring substance use and mental health treatment

e. Number of unduplicated transitional aged youth:
    i. Participating in an educational and/or employment program indicated by type and number
    ii. Participating in a volunteering program indicated by type and number
    iii. Participating in a recovery support and/or mutual aid program/network indicated by type and number
    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. Transitioned to clinically appropriate, substance use residential treatment programming
    ix. Transitioned to safe, stable, substance-free long term recovery housing
    x. Transitioned to safe, stable, substance-free independent housing
    xi. Length of stay (in days) at facility
f. Results of target population satisfaction surveys for the service provided
g. Number of Cross Planning (partnering/multi-system collaborative) initiatives, meetings and service activities implemented with other sectors indicating type and number.
h. Number and type of professional development trainings/events attended
    i. Include number/type of project staff in attendance per training/event

3. 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.
4. Submit all programmatic and service data through web-based reporting by the 10th working day of each month as related to the Expected Outcomes/Performance Measures in accordance with applicable BBHHF Data Reporting

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 Abuse and Mental Health issues, includes substance-specific data, suicide trends, etc.: http://www.dhhr.wv.gov/bhhf/resources/Documents/2013_State_Profile.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/DataResearch.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 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 **Level II Recovery Residence** standards:

1. Organizational/Administrative Standards
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;
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 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 3rd party clinical services in accordance to 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 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 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 where street parking is scarce.

Appendix B
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 C
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