



Bureau for Behavioral Health and Health Facilities

## Announcement of Funding Availability

Screening, Brief Intervention and Referral to Treatment (SBIRT)



# **Proposal Guidance and Instructions**

**AFA Title: Screening, Brief Intervention and Referral to Treatment (SBIRT)**  
**Targeting Regions: 2 and 5**  
**AFA Number: AFA 11-2014-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:*  
[DHHRBHFAnnouncement@wv.gov](mailto:DHHRBHFAnnouncement@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
<b>EXTENDED Application Deadline:</b>	<b>April 18, 2014 Close of Business–5:00PM</b>
Funding Announcement(s) To Be Made:	May 2, 2014
Funding Amount Available:	Not to exceed \$50,000.00 per site

The following are requirements for the submission of proposals to the Bureau for Behavioral Health and Health Facilities (BBHF): 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](http://DHHR.WV.GOV/BHHF/AFA). ✓Responses must be submitted electronically via email to [DHHRBHFAnnouncement@wv.gov](mailto:DHHRBHFAnnouncement@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](http://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](mailto: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 AVAILABILITY

This funding announcement is part of a statewide plan to expand regionally based substance use recovery services for adults. This funding recommendation was made possible by Governor Earl Ray Tomblin with the availability of a maximum of \$50,000.00 per site to support the development of Screening, Brief Intervention and Referral to Treatment (SBIRT) services.

Funding for a **Screening, Brief Intervention and Referral to Treatment (SBIRT)** 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:
<b>Two (2), one site authorized</b>	\$50,000.00
<b>Five (5), one site authorized</b>	\$50,000.00

### **Start Up Costs**

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

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

## **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 BBHMF. A total of 14 key stake holder, focus groups and community forums engaging more than 400 participants were conducted to assess current public perception about substance misuse, use, and abuse, treatment availability, prevention efforts and what is currently absent from and working effectively in communities across the state. In addition, various topic or agency specific work sessions (youth, law enforcement and others) were convened to support a full understanding of and development of action strategies needed.

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

## 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

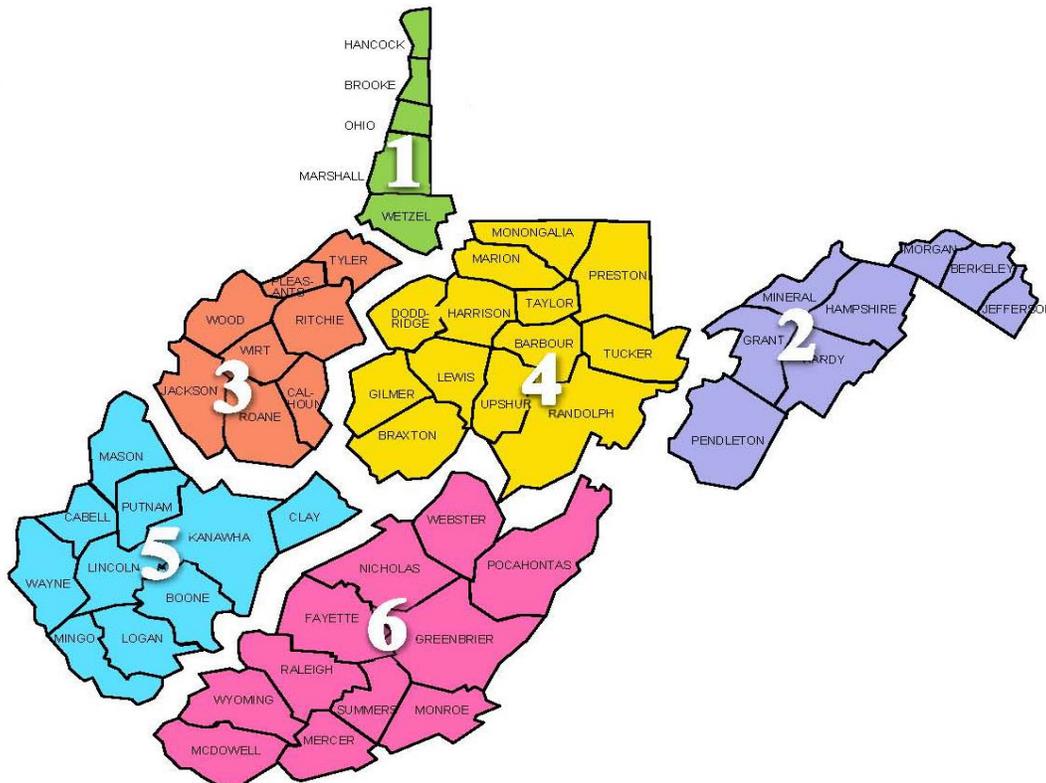
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

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<sup>1</sup>*
  - *193 billion for tobacco<sup>2</sup>*
  - *235 billion for alcohol<sup>3</sup>*
- *Serious mental illnesses cost society \$193.2 billion in lost earnings per year.<sup>4</sup>*
- *By 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide.<sup>5</sup> 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.<sup>6</sup>*
- *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.<sup>7</sup>*

- *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*<sup>8</sup>
- *Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.*<sup>9</sup>

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 (BBHFF) 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.*<sup>10</sup>
- *In 2010, Alcohol was a factor in 31% of fatal motor vehicle accidents in WV.*<sup>11</sup>
- *In 2011, WV had the highest annual number of retail prescription drugs filled at pharmacies nationwide at 19.3 per capita.*<sup>12</sup>
- *Opiates are the number one cause of death associated with drug overdoses in WV.*<sup>13</sup>
- *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.*<sup>14</sup>
- *Hospitalization admissions with an alcohol abuse/dependence related diagnosis at discharge rose 11% from 2005 to 2009.*<sup>15</sup>

### **Mental Illness in WV**

- *Almost 8% of West Virginians experienced at least one major depressive episode within the past year.*<sup>16</sup>

- *In 2010, approximately 25.1% of the people experiencing homelessness staying in shelters in WV reported mental illness and/or substance use.*<sup>17</sup>
- *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*<sup>18</sup>
- *In 2011, over 10% of WV's youth reported making a suicide plan in the past year.*<sup>19</sup>
- *Over 5% of students in grades 9 through 12 reported a suicide attempt within the past 12 months.*<sup>20</sup>
- *In 2010, almost 30% of domestic violence survivors identified that substance use was a contributing factor to their abuse.*<sup>21</sup>

**Strategic Direction**

The WV Bureau for Behavioral Health and Health Facilities (BBHFF), 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/bhff/resources/Pages/FinancialResources.aspx>

The WV Comprehensive Substance Abuse Strategic Action Plan may be found at:  
<http://governorssubstanceabusetaskforceswv.com/images/Resources/strategicactionplan-info.pdf>

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

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

## Section Two: **SERVICE DESCRIPTION**

### **Screening, Brief Intervention and Referral to Treatment (SBIRT)**

**Target Population: To be determined and identified by the applicant**

#### **Purpose**

Early intervention aims to reduce the risk of harm and decrease problem behaviors that result from continued use of substances. The intent of the intervention is to take action that decreases risk factors related to substance use, abuse or dependency; enhance protective factors; and, provide ongoing services, as appropriate.

Health Promotion and Wellness encompasses the support needed to address the complex needs of individuals, families and communities impacted by mental health disorders, substance use disorders and associated problems by obtaining a physically and emotionally healthy lifestyle. Typical services include General Health Screens, Brief Motivational Interviewing, Screening and Brief Intervention for Tobacco Cessation, Facilitated Community Referrals, Relapse Prevention, Physical Health Promotion, Wellness Recovery Support and Warm Lines. The Goal of Health Promotion and Wellness is overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.

The Bureau for Behavioral Health and Health Facilities' (BBHFF) purpose for creating Screening, Brief Intervention and Referral to Treatment (SBIRT) sites throughout West Virginia is to:

1. Increase the number of individuals who are pre-screened for substance use and/or co-occurring substance use and mental health issues annually.
2. Of the individuals who screen positive for substance use issues, increase access to and provision of interventions (Brief Intervention, Brief Treatment, or Referral to Treatment) to reduce their use to a less risky level or abstinence.

3. Increase the number of individuals who report a reduction in their level of substance misuse after receiving an SBIRT intervention for risky substance use.
4. Increase the number of individuals who report improvement in mental health functioning after receiving an SBIRT intervention.

### **Service Overview**

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, population-based, integrated, public health approach to the delivery of early intervention for individuals with risky alcohol and drug use, as well as the timely referral to more intensive substance use treatment for those who have substance use disorders. Primary care centers, hospital emergency rooms, trauma centers, and community health settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

The Substance Abuse and Mental Health Services Administration (SAMHSA) supports a research based, comprehensive behavioral health SBIRT model which reflects the six following characteristics:

1. It is brief. The initial screening is accomplished quickly (modal time about 5-10 minutes) and the intervention and treatment components indicated by the screening results are completed in significantly less time than traditional substance use specialty care.
2. The screening is universal. Patients, clients, students, or other target populations are all screened as part of the standard intake process. In West Virginia (WV) SBIRT sites, individuals are screened annually for substance use/mental health issues.
3. One or more specific behaviors are targeted. The screening tool addresses a specific behavioral characteristic deemed to be problematic, or pre-conditional to substance dependence or other diagnoses.

4. The services occur in a public health, or other non-substance use treatment setting. This may be an emergency department, primary care physician's office, school, etc.
5. It is comprehensive. The program includes a seamless transition between brief universal screening, a brief intervention and/or brief treatment, and referral to specialty substance use care.
6. Strong research or substantial experiential evidence supports the model. At a minimum, programmatic outcomes demonstrate a successful approach.

All applicants for funding must provide statements agreeing to meet the BBHMF's 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** of this document. In addition to the standards, the following assurances must also be included within the proposal narrative.

5. Ensure that 100% of patients receiving services at the screening site will be pre-screened annually.
6. Ensure that 70% of those screening positive will receive an intervention (Brief Intervention, Brief Treatment, or Referral to Treatment) to reduce their use to a less risky level or abstinence.
7. Ensure that 50% of those receiving an intervention for risky substance use will report a reduction in level of substance misuse as determined by outcome interviews done at 3 and 6 months.
8. Ensure that 50% of those receiving an intervention will report improvement in mental health functioning at both 3 and 6 months after SBIRT interventions.

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

- A. Population of Focus and Statement of Need (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. Population of Focus and Statement of Need: (10 Points)**

- Identify the target population for this service.
- Provide a comprehensive demographic profile of the target population in terms of race, ethnicity, language, gender, age, socioeconomic characteristics, and other relevant factors, such as literacy, citing relevant data. Identify the source of all data referenced.
- Clearly indicate the proposed geographic area to be served, by Region and County(ies).
- Discuss the relationship of the target population to the overall population in the proposed geographic area to be served citing relevant data. Identify the source of all data referenced.
- Describe the nature of the problem, including service gaps, and document the extent of the need (i.e. current prevalence rates or incidence data) for the target population based on data. Identify the source of all data referenced. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for data that could be used are key informant interviews, newspaper article, focus groups, local epidemiologic data, state data, and/or national data.
- Identify health disparities relating to access, use, and outcomes of the proposed service citing relevant data. Identify the source of all data referenced.
- Document the need for an enhanced infrastructure to increase the capacity to implement, sustain, and improve effective substance use early intervention

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. Proposed Evidence-Based Service/Practice: (20 Points)**

- Describe the purpose of the proposed service.
- Clearly state the goals, objectives and strategies for the service. These must relate to the purpose of the AFA and each of the performance measures identified in Section E: Data Collection and Performance Measurement.
- Describe all evidence-based practice(s) (EBP) that will be used and justify use for the target population, the proposed service, and the purpose of this AFA. To verify/review EBPs visit SAMHSA's National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov/>
- If an EBP does not exist/apply for the target population and/or service, fully describe practice(s) to be implemented, explain why it is appropriate for the target population, and justify its use compared to an appropriate, existing EBP.
- Describe how the proposed practice(s) will 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.](http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15)

- Describe how the applicant organization will ensure cultural competence in service implementation. All BBHFF grantees are required to receive cultural competence training and to ensure that no one will be discriminated against due to race, ethnicity, religion, gender, age, geography or socioeconomic status. All materials associated with awarded funding must be developed at low literacy levels for further understanding and comprehension in WV communities.
- Describe how privacy and confidentiality will be ensured throughout the entirety of the service, including collection and dissemination of data, consumer feedback, etc.

**C. Proposed Implementation Approach: (50 Points)**

- Provide a one (1) year/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 BBHMF in all implementation stages of the project.
- Describe how you will facilitate the health insurance application and enrollment process for eligible uninsured individuals receiving the proposed service. Also describe how you will ensure the utilization of other revenue realized from the provision of substance use treatment and recovery services to the fullest extent possible, using BBHMF grant funds only to serve individuals for whom coverage has been formally determined to be unaffordable; or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of the BBHMF grant funds).
- Identify the potential barriers to successful conduct of the proposed service and describe strategies to overcome them.
- Describe your plan to continue the proposed service after the funding period ends. Also, describe how service continuity will be maintained when there is a change in the operational environment (e.g. staff turnover, change in project

leadership) to ensure stability over time.

- Describe the facility(ies) to be utilized, if any, for the service. This includes an existing facility already owned and operated by the applicant organization, or a facility for which the applicant organization has a detailed business plan for acquisition, leasing, or other manner of habitation. The BBHMF is available to discuss what options may exist for securing a building or other location in the event that a location is not readily available. If the applicant organization chooses to speak to the BBHMF regarding what options may exist, the discussions must occur prior to submission of the proposal. Any architectural plans or diagrams that may exist may be included 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. Budget Form and Budget Narrative:** *All requirements set forth in Section F must be included in **Attachment 3***

- Include a proposed Target Funding Budget (TFB) with details by line item, including sources of other funds where indicated on the TFB form.
  - Include expenses for attending Quarterly BBHMF 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 A**.

**All forms referenced in Section F: Budget Form and Budget Narrative can be accessed through the BBHMF web-site at:**

<http://www.dhhr.wv.gov/bhmf/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. Increase the number of individuals who are pre-screened for substance use and/or co-occurring substance use and mental health issues annually.
2. Of the individuals who screen positive for substance use issues, increase access to and provision of interventions (Brief Intervention, Brief Treatment, or Referral to Treatment) to reduce their use to a less risky level or abstinence.
3. Increase the number of individuals who report a reduction in their level of substance misuse after receiving an SBIRT intervention for risky substance use.
4. Increase the number of individuals who report improvement in mental health functioning after receiving an SBIRT intervention.

### **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), to include: Screened for the presence of co-occurring substance use and mental health issues, Brief Intervention (BI), Brief Treatment (BT), and Referral to Treatment (RT)
2. Maintain data and documentation related to the following (baseline at service admission and discharge as applicable):
  - a. Number of referrals received by referral source, funding source, with disposition (accepted, unable to accept with reason).
  - b. Number of and disposition of discharges and transfers (completed service, transferred to a higher level of care).
  - c. Number of referrals made with disposition (accepted, unable to accept with reason) for the following service areas, to include specific service activity:

- i. For substance use and/or co-occurring substance use and mental health treatment
  - ii. For Recovery Support Services
  - iii. For Community Support Services
- d. Number of unduplicated individuals (targeted population):
  - 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. Residing in clinically appropriate, substance use residential treatment
  - viii. Residing in safe, stable, substance-free recovery or independent housing
  - ix. Service encounters/visits (in days)
- e. Results of target population satisfaction surveys for service provided
- f. Number of Cross Planning (partnering/multi-system collaborative) initiatives, meetings and service activities implemented with other sectors indicating type and number.
- g. 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 10<sup>th</sup> working day of each month as related to the Expected Outcomes/Performance Measures in accordance with applicable BBHMF Data Reporting

## Section Six: TECHNICAL ASSISTANCE

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

Technical assistance needs may also be submitted via email to: [DHHRBHFFAnnouncement@wv.gov](mailto:DHHRBHFFAnnouncement@wv.gov). All emailed technical assistance inquiries will be addressed by the BBHFF and posted to a Frequently Asked Questions (FAQ) document on the BBHFF website available at [DHHR.WV.GOV/BHFF/AFA](http://DHHR.WV.GOV/BHFF/AFA).

1. Additional data resources are available at the BBHFF website. Explore 'Links' to all Division Teams, including 'Prevention' with a sample of Substance-Specific Presentations:  
<http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Pages/default.aspx>
2. **WV Behavioral Health Profile** (also accessible by clicking 'Resources' on DADA webpage): Contains Statewide data pertaining to 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](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**

### **Screening, Brief Intervention and Referral to Treatment (SBIRT) Standards**

Proposals will include a sample Memorandum of Understanding (MOU) to be used to support the referral process to specialty mental health or substance use 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 use, 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 use 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 use 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](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 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.

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

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

**Grantee Uniform Administrative Regulations:**

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

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

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

## **Appendix C**

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