WEST VIRGINIA
Department of
Health & Human Resources

Bureau for Behavioral Health and Health Facilities

Announcement of Funding Availability

Prevention works! Treatment is effective! And Recovery happens!

Proposal Guidance and Instructions

AFA Title: State Youth Service Center Targeting Region 3

AFA Number: AFA 12B-2013-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:	September 11, 2013
TECHNICAL ASSISTANCE MEETING:	TBD, details to follow
Letter of Intent Deadline:	Sept. 25, 2013 Close of Business – 5:00PM
Application Deadline:	October 30, 2013 Close of Business–5:00PM
Funding Announcement(s) To Be Made:	November 15, 2013
Funding Amount Available:	Not to exceed $900,000

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

LETTER OF INTENT

All organizations planning to submit an application for an Announcement of Funding Availability (AFA) must submit a Letter of Intent (LOI) by **September 25, 2013 close of business (5:00pm)** to the email address: **DHHRBHHFAnnouncement@wv.gov** prior to submission of the AFA.

Please list the AFA Title and Number found on Page 1 of this document in the email subject line.

These letters of intent shall serve to document the applicant's interest in providing each type of service (AFA) and will not be considered binding until documented receipt of the application.

RENEWAL OF AWARD

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

LEGAL REQUIREMENTS

All applicants must be able to provide proof of 501(c) 3 status and possess a valid West Virginia business license. If the applicant is not already registered as a vendor in the State of West Virginia, this must either be completed by the award notification date or the vendor must demonstrate proof of such application. It is also required that the applicants have a System for Award Management (SAM) registration and have a Dun & Bradstreet or DUNS number. For more information visit: https://www.sam.gov

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

FUNDING AVAILABLITY

This funding announcement is part of a statewide plan to expand regionally based substance abuse and co-occurring services for youth that have been identified as a priority for Region 3. This funding recommendation was made possible by Governor Earl Ray Tomblin on August 23, 2012, with the availability of a maximum of $900,000 per region to support the development of the Youth Service Center.

Funding for a **Youth Service Center** 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:
3	$900,000

Start Up Costs

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

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

For the purposes of proposal review, all startup costs requests submitted by the applicant will be considered to be necessary for the development of the service and/or program outlined in the applicant proposal. As such, where/if capital/start-up costs exceed funding availability the proposal may not be funded. The maximum amount available for the **Youth Service Center** is **$900,000.00.**

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

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

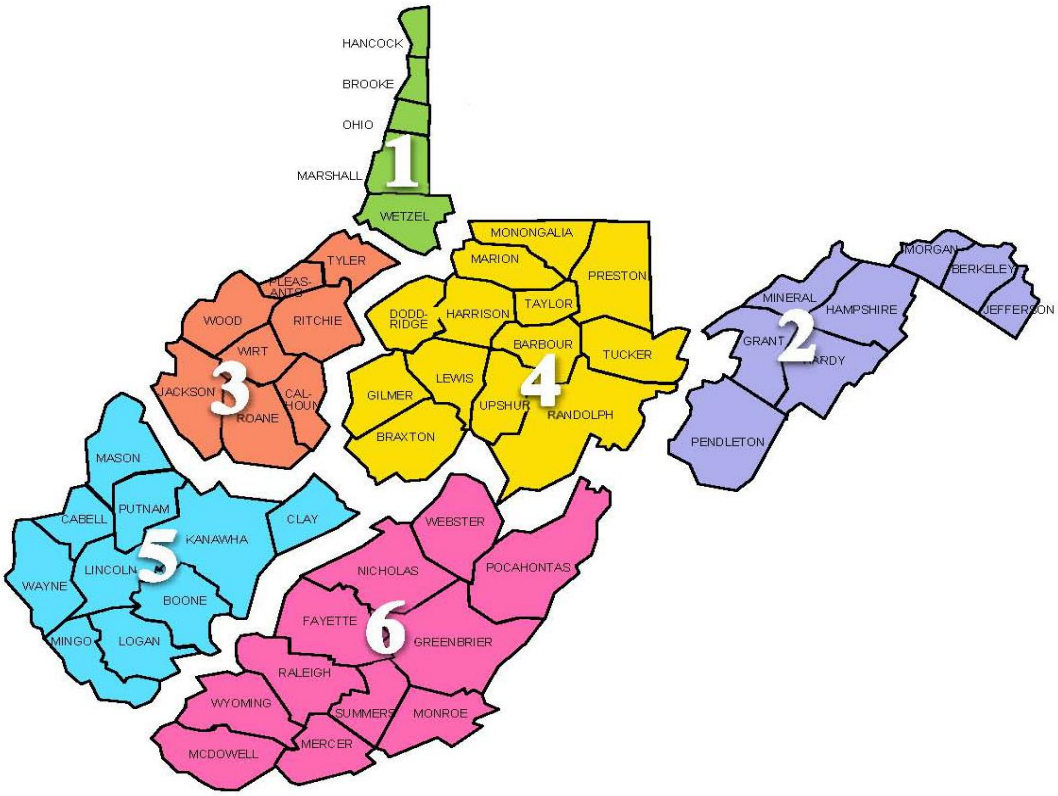
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

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

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

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

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



Section One: **INTRODUCTION**

Individuals and families cannot be healthy without positive mental health and freedom from addictions and abuse 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 abuse, 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 abuse 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 with only 34.7 percent of these adolescents suffering from 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 receive 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 abuse 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 abuse and mental health related services.

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 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 and through the careful collections and review of key indicators and prevalence data. Included below are indicators considered in the development and evolution of the behavioral health system of care in WV:

Substance Abuse 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 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 abuse.*[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 abuse 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 of $900,000.00. 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 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 seems 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 abuse 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 abuse treatment focus, and only 12 reported co-occurring service provision and twelve (12) of the 61 sites serve youth with co-occurring substance abuse 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 past 6 months, 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 abuse; 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 Advisory 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 the least restrictive 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 include a State Funded Youth Service Center located in Region 3 that will serve as a model for the implementation of the cross-system collaborative approach. This State-funded Facility will operate in conjunction with five (5) other Regional Youth Service Centers to create the statewide Behavioral Health Youth Services Network. The Substance Abuse Mental Health Administration (SAMHSA) Block Grant will provide funding for regional coordinated programming offered to the communities through an Announcement of Funding Availability (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 2012 SAMHSA Integrated Block Grant Application and will be updated annually to insure continued consistency. Both documents can be located as follows for reference:

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

Behavioral Health Prevention, Treatment and Recovery System Goals	
Priority 1 Assessment and Planning	Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the WV behavioral health service delivery system.
Priority 2 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: **SERVICES DESCRIPTION**

State Youth Service Center (S-YSC)

The project design for the **State Youth Service Center (S-YSC)** is a single facility that provides a variety of treatment and non-treatment options for youth with substance abuse and co-occurring substance abuse and mental health disorders. Programming, defined by SAMHSA service definitions, offered by the S-YSC will include: Primary Prevention, Promotion & Wellness, Engagement Service, Outpatient Services, Medication Services, Community Support Services, Recovery Support Services, Intensive Support Services and Out of Home, Transitioning Young Adult Residential. In order to provide such a wide array of programming the S-YSC is required to provide three distinct service settings and a statewide learning laboratory for professional development. The following provides details regarding those components:

The **Referral & Outreach Center (ROC)** is a 24-hour call center for individuals seeking behavioral health assistance for WV youth. The State Youth Service Center (S-YSC) will maintain a "live" data base with all service options which will be updated daily for residential bed capacity and regional service options. Anyone that contacts the S-YSC ROC will be offered education on behavioral health issues and information on service options in their region, as well as a facilitated referral to an appropriate level of care based on the individuals need in coordination with regional centers. ROC staff will track and follow-up with all calls made to the center to ensure quality assurance and successful outcomes. The State Youth Service Center will operate in conjunction with other Regional Youth Service Centers (6 total) to create the statewide Behavioral Health Youth Services Network. This network will create a single access point for all behavioral health needs in West Virginia; a resource that addresses the top two identified barriers for families seeking services: access and navigation.

The **Engagement (Diagnostic) & Outpatient Clinic** is a separate unit within the facility that will act as a centralized screening, diagnostic and outpatient service center for children, adolescents, transitional aged youth and their families/primary caregivers.

Youth served at the clinic are eligible to receive a variety of services as determined by the needs of the individual regardless of payer source. All youth served at the clinic will be screened for the presence of co-occurring substance abuse and mental health issues; information gained from this screening will be used to develop an appropriate referral to treatment. After initial screening and referral, youth who reside in proximity to the State Youth Service Center (S-YSC) will have access to services that include clinical and specialized assessments, service planning, individual and group therapy, medication services, case management, and recovery support services offered at traditional and non-traditional business hours. Family/primary caregivers of these youth will have access to consumer/family education, family therapy, multi-family counseling, and parent/caregiver support. Programming provided for by the S-YSC will be age appropriate, evidence-based, trauma-informed care including assessments and interventions that consider the individual's adverse life experiences within the context of their culture, history, and exposure to traumatic events. The S-YSC will also provide clinical and specialized assessment services for out-of-region youth. Upon completion of this service, youth requiring additional programming will receive a facilitated referral from the S-YSC to the region where the youth resides in order to complete such treatment and/or recovery programming. Tele-health service options will also be available for youth, in addition to the development and implementation of an Electronic Health Record (EHR) system.

The **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 co-occurring substance abuse and mental health issue seeking out of home treatment and/or recovery are eligible for admission. Those admitted can reside on the unit for 60-90 days depending on the needs of the youth. Residents of the Transitional Housing Program will participate in an intensive outpatient program and intensive case management, in addition to the Engagement & Outpatient Clinic programming. The Transitional Housing Program will also collaborate with external community resources in offering the residents supported education (GED) and employment opportunities, recovery housing, and facilitated residential treatment or aftercare referrals as needed.

The **Statewide Learning Laboratory for Professional Development** will increase the capacity of youth service providers by offering quality, evidence-based programming that will improve clinical and functional outcomes for West Virginia youth. Staff will work in coordination with the Bureau for Behavioral Health and Health Facilities (BBHHF), Bureau for Children and Families (BCF), and other youth service providers to identify work force needs and provide state of the art training and technical assistance to meet those needs. Bringing youth service workers together from across the State to learn current, effective practice and promote idea exchanges will strengthen the network of service providers, decrease turnover, and implement consistent service delivery. Advanced technology will be a pillar of the S-YSC Learning Laboratory, wherein a significant commitment is made to explore, pursue, and provide the most modern, efficient, and effective service instruments and training tools available.

Collaborations and Memorandums of Understanding

Applicants must demonstrate that a coordinated and integrated service system is in place to meet the complex needs of youth and their families/primary caregivers. 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 Abuse and Mental Health)
- Primary Health
- Hospitals
- Obstetric/Gynecological
- Pediatric
- Childcare
- MAT Facilities
- Family Assistance Programs
- Early Intervention and Home Visiting Programs
- Family and/or Drug Courts (Adult or Juvenile)
- Criminal Justice
- Employment, Education and/or Vocational programs

Section Three: **PROPOSAL INSTRUCTIONS / REQUIREMENTS**

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

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

All applications will be reviewed by the BBHHF staff for administrative compliance with all required guidelines. All applications passing the administrative review will be subsequently forwarded to an independent grant review team which will score the proposal narrative consisting of five areas:

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

A. Population of Focus and Statement of Need (20 points)
B. Proposed Evidence-Based Service/Practice (25 points)
C. Proposed Implementation Approach (35 points)
D. Staff and Organizational Experience (10 points)
E. Data Collection and Performance Measurement (10 points)

Section Four: **PROPOSAL OUTLINE**

All proposal submissions must include the following components without exception.

Abstract:

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

Project Narrative and Supporting Documentation:

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

- Provide a comprehensive demographic profile of your population of focus in terms of race, ethnicity, language, gender, age, socioeconomic characteristics, and other relevant factors, such as literacy.
- Describe the stakeholders and resources in the geographic catchment area of the proposed project that can help implement the needed infrastructure development and intent of this AFA
- Discuss the relationship of your population of focus (youth), including sub-populations (families/primary caregivers), to the overall population in your geographic catchment area and identify sub-population disparities, if any, relating to access/use/outcomes of your provided services citing relevant data. Demonstrate an understanding of these populations consistent with the purpose of your project and intent of the AFA
- Describe the nature of the problem, including service gaps, and document the extent of the need (i.e. current prevalence rates or incidence data) for the population(s) of focus based on data. Identify the source of the data. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for quantitative data that could be used are local epidemiologic data, state data, and/or national data.
- Document the need for an enhanced infrastructure to increase the capacity to implement, sustain, and improve effective substance abuse and co-occurring substance abuse and mental disorder treatment services in the proposed

catchment area that is consistent with the purpose of the program and intent of the AFA

- Document the need for the proposed project in West Virginia and more specifically in the identified catchment area of Region 3. Clearly indicate which region and county(ies) that will be served by the proposed project
- Discuss your agencies current level of participation in the Governor's Regional Task Force Meetings in the proposed region and ability to attend future meetings

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

- Describe the purpose of the proposed project
- Clearly state project goals, objectives and strategies. These must relate to the intent of the AFA and performance measures identified in Section E: Data Collection and Performance Measurement
- Describe evidence-based practice(s) (EBP) that will be used and justify use for your population(s) of focus, your proposed program, and the intent of this AFA
- If an EBP does not exist/apply for your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate, existing EBP
- Describe how the proposed practice(s) will address the following issues in the population(s) of focus, while retaining fidelity to the chosen practice: in demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status), language and literacy, sexual identity (sexual orientation and gender identity) and disability
- Discuss any screening tools that will be used and basis for selection
- Describe how health disparities will be addressed including information related to sub-populations identified in the proposed region and suggested strategies to decrease the differences in access, service use, and outcomes among those sub-populations. A strategy for addressing health disparities is use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care which can be found at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

- Describe how the organization will address cultural competence in proposal implementation. All BBHHF sub-grantees are required to receive cultural competence training and to ensure that no one will be discriminated against due to race, ethnicity, religion, gender, age, geography or socioeconomic status. All project materials associated with awarded funding should be developed at low literacy levels for further understanding and comprehension in WV communities
- Briefly describe how privacy and confidentiality will be ensured, including an explanation of what data will be collected and how it will be used

C. <u>Proposed Implementation Approach:</u>

- Reference **Appendix A** for the Non-Treatment Recovery Program Standards. Reviewers will look for applicants documented awareness/knowledge of and commitment to upholding these standards within this section of the Project Narrative
- Describe how achievement of the goals will produce meaningful and relevant results in your community (e.g. increase access, availability, prevention, outreach, pre-services, treatment and/or intervention) and support BBHHF's goals for the program
- Describe the proposed program activities, how they meet your infrastructure needs, how they fit within or support the development of the statewide continuum of care and how they relate to your goals and objectives
- Provide a chart or graph depicting a realistic time line for the entire project period showing key activities, milestones of the intervention(s) (EBPs), and staff(s) responsible for action. Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than six (6) months after award. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]
- Describe how you will screen and assess clients for the presence of co-occurring mental and substance abuse disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders

- Describe how you will ensure the input of clients (i.e. adolescents and transitional aged youth and their families/primary supports) in assessing, planning, and implementing your project. Describe the feedback loop between the clients, your organization, project partners/key stakeholders, and the BBHHF in all implementation stages of the project.
- Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project. Include letters of support from community organizations supporting the project in **Attachment 1**
- Clearly state the unduplicated numbers of individuals you expect to serve (annually) with grant funds, including the types and numbers of services to be provided. Include projections for sub-populations (family/primary caregivers) served separate from projections for the targeted population
- Describe briefly how all required program components will be developed, which how the required program components will be coordinated with one another to provide for a full continuum of care for adolescents, transitional aged youth, and their families/primary care givers
- Describe additional training to be sought and utilized in the development of the project, identifying key training components (by title) and their relevance
- Describe how you will ensure the utilization of other revenue realized from the provision of substance abuse treatment and recovery services to the extent possible and use BBHHF grant funds only for services to individuals for whom coverage has been formally determined to be unaffordable; or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of BBHHF grant funds). Also describe how you will facilitate the health insurance application and enrollment process for eligible uninsured clients
- Describe how you will work across systems to ensure that services provided to these target populations are coordinated and considered by multiple levels and systems

- Describe the potential barriers to successful conduct of the proposed project and how you will overcome them
- Describe your plan to continue the project after the funding period ends. Also, describe how program contiguity 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 and may describe an existing facility already owned and operated by the applicant agency, or a facility for which the applicant agency has a detailed business plan for acquisition, leasing, or other manner of habitation. The BBHHF is available to discuss what options may exist for securing a building or other location in the event that a location is not readily available. If the applicant agency chooses to speak to the BBHHF regarding what options may exist, the discussions must occur prior to submission of the proposal. Any diagrams that may exist may be included as **Attachment 2**

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

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

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

- Document your ability to collect and report on the required performance measures as specified in Section Five: Expected Outcomes / Products of this AFA. Describe your plan for data collection, management, analysis, and reporting. Specify and justify any additional measures or instruments you plan to

use for your project

- Describe the data-driven quality improvement process by which population and sub-population disparities in access/use/outcomes will be tracked, assessed, and reduced
- Describe how data will be used to manage the project and assure that the goals and objectives at a systems level will be tracked and achieved.
- Describe how information related to process and outcomes will be routinely communicated to program staff, governing and advisory bodies, and stakeholders

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

- Include a proposed Target Funding Budget (TFB) with details by line item including sources of other funds where indicated on the TFB form
    - Include expenses for attending Quarterly BBHHF Provider Meetings
- Include a Budget Narrative document with specific details on how funds are to be expended
    - The budget narrative clarifies and supports the budget (TFB). The narrative should clearly/specify the intent of and justify each line item in the budget (TFB)
- Describe any potential for other funds or in kind support. Please include a description of such funds as a supplement to the Budget Narrative document.
- Prepare and submit a separate TFB for any capital or start-up expenses and accompany this separate TFB with a coordinating Budget Narrative 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.wvdhhr.org/bhhf/resources.asp

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

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

Section Five: **EXPECTED OUTCOMES / PRODUCTS**

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

Treatment Performance Measures

Performance Measure	Admission Clients	Discharge Clients
Number of admission by level of care and number of persons served	☑	
Number of persons served (unduplicated count) for alcohol and other drug use by age, sex, race, and ethnicity	☑	
Number of clients employed or students (full-time or part-time) prior 30 days	☑	☑
Number of clients living in a stable living condition prior 30 days	☑	☑
Number of clients without arrests prior 30 days	☑	☑
Number of clients with no alcohol use in the last 30 days	☑	☑
Number of clients with no drug use in the last 30 days	☑	☑
Number of clients participating in self-help groups prior 30 days	☑	☑
Length of stay (in days) of clients completing treatment		☑

Peer Review Process

All grantees must discuss their willingness to participate in a peer-review process to assess the quality and appropriateness of substance services that will foster the increased availability and sustainability of evidence based practices, programs and policies.

Section Six: **TECHNICAL ASSISTANCE**

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

Technical assistance needs may also be submitted via email to: **DHHRBHHFAnnouncement@wv.gov.** All emailed technical assistance inquiries will be addressed by the BBHHF and posted to a Frequently Asked Questions (FAQ) document on the BBHHF website available at **DHHR.WV.GOV/BHHF/AFA.**

1. Additional data resources are available at the BBHHF website. Explore 'Links' to all Division Teams, including 'Prevention' with a sample of Substance-Specific Presentations: http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Pages/default.aspx

2. **WV Behavioral Health Profile** (also accessible by clicking 'Resources' on DADA webpage): Contains Statewide data pertaining to Substance Abuse and Mental Health issues, includes substance-specific data, suicide trends, etc.: http://www.dhhr.wv.gov/bhhf/resources/Documents/WV%202012%20Behavioral%20Health%20Profile.pdf

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

Appendix A
Required Level IV 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 Abuse Recovery Residence Standards for its grantees. All Recovery Residences must be managed in an ethical, honest, and reasonable fashion.

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

The following are **Level IV 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 pattern;
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;
4.16 The Recovery Residence offers life skills development services;
4.17 The Recovery Residence offers 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
References

1. National Drug Intelligence Center (2011). The Economic Impact of Illicit Drug Use on American Society. Washington D.C.: United States Department of Justice. Available at: http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf
2. Centers for Disease Control and Prevention. (2005). Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004. Morbidity and Mortality Weekly Report. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm
3. Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon Y., Patra, J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet, 373(9682):2223–2233, 2009.
4. Thomas R. Insel, Assessing the Economic Costs of Serious Mental Illness, Am J Psychiatry, Jun 2008;165: 663 - 665.
5. World Health Organization (WHO). (2004). Promoting mental health: Concepts, emerging
evidence, practice. Summary report. Geneva, Switzerland: WHO. Retrieved March 25, 2011, from http://www. who. inti mental health/ evi dence/ en/promoting mhh. pdf
6. Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.
7. – 9. Ibid.
10. WV Health Statistics Center (2013). Prescription drug overdose deaths. Unpublished data.
11. National Highway Traffic Safety Administration (NHSTA). (2013). Fatality Analysis Reporting System. www-fars.nhtsa.dot.gov
12. Kaiser Family Foundation. (2012). State health facts. Available at kff.org/statedata/?state=WV
13. WV Health Statistics Center. (2013). Prescription drug overdose deaths. Unpublished data.
14. WV Poison Control Center. (2012). Bath salt exposure calls. Unpublished data.
15. HCUP Home. Healthcare Cost and Utilization Project (HCUP). May 2013. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/home.jsp
16. Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.
17. WV Coalition to End Homelessness. (2012). Unpublished data. Weston, WV.
18. Centers for Disease Control and Prevention. (2012). Youth Risk Behavior Surveillance System, 2011 Results. Atlanta, GA: Centers for Disease Control and Prevention.
19. -20. Ibid.
21. WV Coalition Against Domestic Violence. (2012). Unpublished data.