

**Department of Health and Human Services  
Substance Abuse and Mental Health Services  
Administration**

**Promoting Integration of Primary and Behavioral Health Care  
(Short Title: PIPBHC)**

(Initial Announcement)

**Funding Opportunity Announcement (FOA) No. SM-17-008**

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

**PART 1: Programmatic Guidance**

**Note to Applicants:** This document MUST be used in conjunction with SAMHSA’s “Funding Opportunity Announcement (FOA) PART II: Administrative and Application Submission Requirements for Discretionary Grants and Cooperative Agreements.” PART I is individually tailored for each FOA. PART II includes requirements that are common to all SAMHSA FOAs. You MUST use both documents in preparing your application.

**Key Dates:**

<b>Application Deadline</b>	<b>Applications are due by May 17, 2017.</b>
<b>Intergovernmental Review (E.O. 12372)</b>	<b>Applicants must comply with E.O. 12372 if their state(s) participate(s). Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.</b>
<b>Public Health System Impact Statement (PHSIS)/Single State Agency Coordination</b>	<b>Applicants must send the PHSIS to appropriate state and local health agencies by the application deadline. Comments from the Single State Agency are due no later than 60 days after the application deadline.</b>

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## EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2017 Promoting Integration of Primary and Behavioral Health Care (Short Title: PIPBHC) Cooperative Agreements. The purpose of this cooperative agreement is to: (1) promote full integration and collaboration in clinical practice between primary and behavioral healthcare; (2) support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED); and (3) promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases. SAMHSA expects that a continuum of prevention, treatment and recovery support services will be offered to consumers within the PIPBHC grant program.

<b>Funding Opportunity Title:</b>	Promoting Integration of Primary and Behavioral Health Care Integration (PIPBHC)
<b>Funding Opportunity Number:</b>	SM-17-008
<b>Due Date for Applications:</b>	May 17, 2017
<b>Anticipated Total Available Funding:</b>	\$22,612,000
<b>Estimated Number of Awards:</b>	Up to 11
<b>Estimated Award Amount:</b>	Up to \$2,000,000 per year
<b>Cost Sharing/Match Required</b>	No
<b>Length of Project Period:</b>	Up to 5 years

<b>Eligible Applicants:</b>	<p>States, or appropriate state agency, in collaboration with:</p> <ul style="list-style-type: none"><li>• One or more qualified community programs, as described under section 1913(b)(1) of the Public Health Service Act (PHS), as amended; or</li><li>• One or more community health centers as described in section 330 of the PHS Act, as amended.</li></ul> <p>[See <u>Section III-1</u> of this FOA for complete eligibility information.]</p>
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**Be sure to check the SAMHSA website periodically for any updates on this program.**

**IMPORTANT:** SAMHSA is transitioning to the National Institutes of Health (NIH)'s electronic Research Administration (eRA) grants system. Due to this transition, SAMHSA has made changes to the application registration, submission, and formatting requirements for all Funding Opportunity Announcements (FOAs). All applicants must register with NIH's **eRA Commons** in order to submit an application. Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).

Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process **six (6) weeks in advance** of the application due date.

## **I. FUNDING OPPORTUNITY DESCRIPTION**

### **1. PURPOSE**

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2017 Promoting Integration of Primary and Behavioral Health Care (Short Title: PIPBHC) Cooperative Agreements. The purpose of this cooperative agreement is to: (1) promote full integration and collaboration in clinical practice between primary and behavioral healthcare; (2) support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED); and (3) promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases. SAMHSA expects that a continuum of prevention, treatment and recovery support services will be offered to consumers within the PIPBHC grant program.

In addition to the above, these activities will be provided to one or more of the following special populations as specified in the Cures Act, P.L. 114-255:

- Adults with a mental illness who have co-occurring physical health conditions or chronic diseases; or
- Adults with a serious mental illness who have co-occurring physical health conditions or chronic diseases; or

- Children and adolescents with a serious emotional disturbance with co-occurring physical health conditions or chronic diseases; or
- Individuals with a substance use disorder.

In FY 2009, SAMHSA launched the Primary and Behavioral Health Care Integration (PBHCI) program, focused on adults with a serious mental illness who experienced increased morbidity and mortality, in large part due to elevated incidence and prevalence of obesity, diabetes, hypertension, and dyslipidemia. This increased morbidity and mortality can be attributed to a number of factors, including inadequate physical activity and poor nutrition; smoking; side effects from atypical antipsychotic medications; and lack of access to health care services<sup>1</sup>. Untreated, chronic co-morbid health conditions often lead to increased emergency room visits and inpatient admissions, which drives up the costs of health care. The impact of these health conditions can be reduced with health promotion activities; primary care screening and early intervention; monitoring, treatment and care management/coordination strategies; and other outreach programs. Much of the national effort towards achieving the aims of improved health, enhanced care, and reduced costs are associated with developing person-centered systems of care that address an individual's holistic health and wellness.

The PIPBHC grant program supports the goals of the Million Hearts™ Initiative 2.0 for 2017-2022. People with behavioral health disorders are disproportionately impacted by many chronic health conditions, including heart disease and hypertension. The health goals of the PIPBHC program align with the Million Hearts objectives and outcomes, and information will be reported to the Million Hearts™ Initiative.

The PIPBHC grant program supports SAMHSA's Strategic Initiative on Health Care and Health Systems Integration. PIPBHC is one of SAMHSA's services grant programs. SAMHSA intends that its services grants result in the delivery of services as soon as possible after award. Service delivery should begin by the fourth month of the project at the latest.

PIPBHC grants are authorized under section 9003 of the 21<sup>st</sup> Century Cures Act, P.L. 114-255, and section 520K of the Public Health Service Act, as amended. This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-MHMD and Substance Abuse Topic Area HP 2020-SA-8.

## **2. EXPECTATIONS**

SAMHSA expects States or the appropriate State agency, in collaboration with one or more qualified community programs as described in section 1913(b)(1) of the Public

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<sup>1</sup> National Association of State Mental Health Program Directors, Medical Directors Council. (October 2006). *Morbidity and Mortality in People with Serious Mental Illness*. Alexandria, VA.

Health Service (PHS) Act, as amended; or, one or more community health centers as described in section 330 of the PHS Act, as amended, to provide the following three core requirements:

- Promote full integration and collaboration in clinical practices between primary and behavioral health care.
- Support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness or children with a serious emotional disturbance.
- Promote integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases.

Applicants must select qualified community programs or community health centers that serve an area or population(s) of high need. Refer to [Appendix I](#) – SAMHSA’s Guidelines for Selecting Communities of High Need. Applicants must also identify the number of behavioral health or health provider organizations that will be involved and indicate which one or more of the four special populations will receive integrated care services<sup>2</sup>.

The state or appropriate state agency receiving funding under this grant may not allocate more than 10 percent of the total grant award for administrative costs at the state level. The remaining 90 percent of funds must be allocated to a community program(s) or community health center(s) to provide direct integrated care. Of the remaining 90 percent of funding, no more than 10 percent may be allocated for evaluation/performance assessment/data collection (as referenced in [Section I.2.2](#) and [Section I.2.3](#) of this FOA), and no more than 15 percent may be allocated for infrastructure development, (as referenced in [Section I.2.4](#) of this FOA).

If a national evaluation is funded grantees will be expected to participate in the evaluation and may need to reallocate funds in their budget.

The key staff for this program will be the Project Director (PD), who must be a state employee and the principal point of contact responsible for the entirety of the grant.

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<sup>2</sup> These activities will be provided to one or more of the following special populations: adults with a serious mental illness who have co-occurring physical health conditions or chronic diseases; adults with a serious mental illness who have co-occurring physical health conditions or chronic diseases; children and adolescents with a serious emotional disturbance with co-occurring physical health conditions or chronic diseases; or individuals with a substance use disorder.

## Definitions

The following section defines integrated care, primary care services and screenings, and behavioral health care services and screenings.

**Integrated care** is defined as “collaborative models or practices offering mental and physical health services, which may include practices that share the same space in the same facility” (21st Century Cures Act of 2016, P.L. 114-255). There are various effective approaches to co-location of primary and mental health and/or behavioral health care services. Integrated care services should be tailored to meet the health needs of the population served with consideration of other realities such as geographic location (use of tele-health/behavioral health), space availability (including cultural considerations such as family exam rooms), and cost feasibility. Integrated care should be provided in a manner that is coordinated, accessible, and seamless to best suit the needs of the consumer.

There are different levels of primary care and behavioral health services being provided in integrated care settings. For the purpose of this program, **primary care** is defined as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community,” according to *The Milbank Quarterly* (2005) and the Institute of Medicine’s “Defining Primary Care: An Interim Report” (1994).

Within the Health Resources and Services Administration (HRSA) funded health centers, “general **primary medical care services** are comprehensive and address prevention as well as acute and chronic conditions. At a minimum, these services include assessment; diagnosis; screening; education and treatment; referrals; and follow-up of such services.” These definitions will be the required primary care services to be provided through the PIPBHC grant, as stated under section 330(b)(1)(A) of the PHS Act, as amended. General primary care services should also include preventive screenings that are performed based on identified risk factors to evaluate, treat, and educate a PIPBHC client. Self-management approaches (e.g. tobacco cessation, health literacy, etc.) should also be included. For additional information on these primary care services and screenings, refer to Appendix E – General Primary Medical Care and Screenings Service Descriptors.

Every identified provider organization must include routine health screening for cholesterol and blood lead, hypertension, tobacco, communicable disease and cancer for adults 18 years of age and older. Similarly, health screening for children and adolescents must include, at a minimum, a growth chart with Body Mass Index (BMI), age-appropriate immunizations for communicable disease, age-appropriate physical examinations, blood pressure, tobacco use, oral health, and scheduled age-

appropriate wellness visits as recommended by CDC and the American Academy of Pediatrics (AAP)<sup>3</sup>.

**Behavioral health** means preventing or intervening in mental illness such as depression and anxiety as well as preventing or intervening in substance use or other addictions. For this grant, the full spectrum of behavioral health services<sup>4</sup> are strongly encouraged and are defined as: screening for mental and substance use disorders; suicidality and trauma (e.g., interpersonal violence, physical abuse, terrorism) assessment, including risk assessment and diagnosis; assessment (including risk assessment) and diagnosis; patient-centered treatment planning; evidence based outpatient mental and substance use disorder treatment services (including pharmacological and psychosocial services); crisis services; peer support services; and care coordination (which can include targeted case management and referral to adjunct or higher level care). Refer to <http://www.integration.samhsa.gov/clinical-practice/screening-tools> for examples.

### **Required Activities:**

You must use SAMHSA's services grant funds primarily to support direct services, including the following activities:

### **State Grantee Requirements**

- Develop a plan to achieve fully collaborative agreements to provide services to special populations.

This plan must identify the selected provider organizations (i.e., behavioral health or health facilities) that will provide integrated care and a justification for the amount of funding requested for the services provided as related to selected special populations to be served. Differentiating the types of services that will use grant funds must also be indicated. For example, a community health center that already provides primary care services would likely use PIPBHC grant funds for behavioral health services. A community behavioral health center that already provides mental health and substance use services would likely use PIPBHC grant funds to provide primary care services.

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<sup>3</sup> Academy of American Pediatrics. "Bright Futures Guidelines." [https://www.aap.org/en-us/Documents/periodicity\\_schedule\\_oral\\_health.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule_oral_health.pdf)

<sup>4</sup> SAMHSA's National Behavioral Health Quality Framework, <https://www.samhsa.gov/data/national-behavioral-health-quality-framework> and <https://www.samhsa.gov/treatment>

Provider organizations shall be located among communities of high need, including federally recognized tribes; an Urban Indian organization; tribal organizations, tribally operated clinics, urban health clinics, or a HRSA-designated health professional shortage area (HPSA). Refer to [Appendix I](#) – SAMHSA’s Guidelines for Selecting Communities of High Need for more information. It is encouraged that provider organizations be located in geographically diverse regions of the state in order to increase equitable access to treatment and recovery support services for the population(s) of focus. Partnering with non-profit, faith-based, adolescent and/or transitional aged youth, substance use treatment provider agencies, federally qualified health centers, school-based health centers, primary health care, education, or other agencies serving the population of focus is recommended.

- In order to promote full (or bi-directional) integration and collaboration in clinical practices between primary and behavioral health care, please note the following:
  - If the selected provider organization is a qualified, community health program as described in section 1913(b)(1) of the PHS Act, then a formal partnership with a community health center as described in section 330 of the PHS Act will be required to provide the *integration of primary care services into the behavioral health setting*.
  - If the selected provider organization is a community health center as described in section 330 of the PHS Act, then a formal partnership with a qualified, community health program as described in section 1913(b)(1) of the PHS Act will be required to provide *integration of behavioral health services into the primary care setting*.
- Applicants must identify those consumers most in need of integrated services (including those with HIV/AIDS and Hepatitis A, B, and C, as well as those with histories of trauma). Individuals who have or are at risk of developing chronic physical conditions are eligible to participate in the PIPBHC program. In order to support the goals of PIPBHC, it is important these services are long-term in nature and not time-limited.
- Develop a document that summarizes the policies, if any, that serve as barriers to the provision of integrated care, and the specific steps, if applicable, that will be taken to address such barriers;
- Describe the partnerships or other arrangements with local health care providers (e.g., community behavioral health centers, health centers, school-based health centers, substance use treatment facilities) that will provide services to the selected special populations;

- Develop an agreement and plan to report to the Secretary of Health and Human Services (to be referred to as “the Secretary”) performance measures data necessary to evaluate outcomes and facilitate evaluations across participating projects;
- Develop a plan for sustainability beyond the grant or cooperative agreement period. One of the important goals of this cooperative agreement is to develop and implement the policy and financing policy changes required to sustain project activities when the grant ends. Grantees should develop, submit and receive approval of a sustainability plan from their Government Project Officer within 90 days of the beginning of the second and fourth years of the grant.
- Develop a continuous quality improvement (CQI) plan and oversight process. Grantees are required to engage with a coordination team or advisory council (that may already exist at the State level) among mental health, substance use, primary care, and children’s services). This coordination team or advisory council should also include family, youth, peers, and consumer organizations. The purpose is to obtain guidance and feedback for quality improvement, sustainability, and scalability of this grant program. Additionally, the CQI plan will assist in developing, reviewing, and improving required grant activities and evaluating the outcomes.

**Selected Provider Organization Requirements – Note: If you are a qualified community health program, you are required to partner with a community health center (as defined in section 330 of the PHS) to provide integrated primary care services. If you are a community health center (as defined in section 330 of the PHS), you are required to partner with a qualified community health program (under section 1913(b)(1) of the PHS) to provide integrated behavioral health services.**

- Provide outreach and other engagement and retention strategies to increase participation in, and access to primary care and behavioral health treatment and prevention services for diverse populations. NOTE: If only outreach and other strategies to increase access are provided, the provider organization must identify that treatment services are available and that the organization has the ability to connect individuals with those services.
- Provide direct primary care and behavioral health treatment (including screening, assessment, and care management) and prevention services for diverse special populations at risk.
- Screen and assess clients for the presence of co-occurring chronic physical conditions; mental and substance use disorders for adults with serious mental illness; mental illness; children and adolescents with serious emotional

disturbance; and individuals with a substance use disorder. The information obtained from the screening and assessment should be used to develop appropriate treatment approaches with the persons identified as having such co-occurring physical health conditions and chronic diseases.

- Identify the evidence-based or promising practices integrated care model(s) for primary care and behavioral health. This can include tele-health/behavioral health services and culturally appropriate or adapted models for disparate populations, such as rural/frontier communities, Alaskan Native/ American Indians, African Americans, Hispanic/Latino Americans, Asian Americans, and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) populations,
- Develop a plan for the implementation of services for the identified special population. The plan must include descriptions of the integrated services that will be provided, the roles of the integrated care team and how they relate to the service provision, and the expected impact on the physical and behavioral health outcomes of the individuals served by the grant.
- Achieve Modified Stage 2 Program Requirements for Providers and Hospitals, as defined by the Centers for Medicare and Medicaid Services (CMS), by the end of the grant. To that end, organizations must develop and demonstrate the ability to meet the Modified Stage 2 Objectives and Measures for 2017 post award of the grant. Providers and hospitals will be required to attest to a single set of objectives and measures. More information can be found here [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents\\_EP\\_Medicaid\\_ModifiedStage2.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_ModifiedStage2.pdf). Provider organizations should have an electronic health record (EHR) that meets Meaningful Use Stage 2 in order to ensure the capability of meeting the required reporting of the functional outcomes for this grant. Further, service provider organization(s) must demonstrate that they have the appropriate consent regarding the sharing of information as defined by 42 CFR, PART2.
- Provide all of the following components of person-centered, integrated care services:
  - Care coordination including comprehensive care management and comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
  - Shared decision-making<sup>5</sup>

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<sup>5</sup> Refer to the following link for the definition and examples of shared decision-making: <https://www.samhsa.gov/brss-tacs/shared-decision-making>

- Health promotion
- Individual and family support
- Referral to community and social support services, including appropriate follow-up

For guidance on person-centered, integrated care service categories that could inform the proposal, refer to [Appendix F](#) – Components of Person-centered, Integrated Care Services: Sample Definitions and roles.

For information on components of family centered care and peer support, refer to <https://www.samhsa.gov/section-223/carecoordination/person-family-centered>.

- Implement tobacco cessation, nutrition/exercise interventions, recovery and prevention of substance use disorders, in addition to other health and behavioral health promotion programs (e.g., wellness consultation, health education and literacy, independent living skills, sleep hygiene, prevention and recovery, and illness, stress, anger and self-management programs, etc.) for the special populations. These programs and the formulation of the integrated person-centered care plan for each individual receiving PIPBHC services need to include peer support, peer leaders and incorporate recovery principles. SAMHSA expects that grantees involve peers in the development and implementation of these services. For information on relevant service models, see <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>.

### **Allowable Activities:**

Due to the breadth and scope of the project, it may be helpful to consider the following activities:

- Collaborate and partner with the State Community Mental Health and Substance Abuse Block Grant programs, State Medicaid offices, state health departments, and children and health agencies.
- Work with the State Medicaid office on the CMS-recognized Collaborative Care Codes to determine how they may align to support sustainability of integrated care services.
- If the service provider organization is a qualified community health program, then you must partner with a community health center as described in section 330 of the PHS Act. Consider utilizing the HRSA data warehouse and Universal Data System (UDS) on locating health centers and safety-net providers, as well as the health outcomes and requirements already collected in

these programs. Although designated look-alike health centers do not qualify under section 330 of the PHS Act, as amended, they can still be a community partner to expand integration services.

- If serving children with SED, determine the state-level SAMHSA-funded Comprehensive Community Mental Health Services for Children and their Families Program (Children's Mental Health Initiative, or CMHI) grantee and HRSA's Title V Maternal and Child Health Services block grant program to establish a formal collaborative relationship. This will allow for the leverage of federal resources and promote comprehensive, integrated services for adolescents and/or transitional aged youth with SUD and co-occurring substance use and mental disorders.

### **Other Expectations:**

If your application is funded, you will be expected to develop a behavioral health disparities impact statement no later than 60 days after the award. (See PART II: Appendix E, Addressing Behavioral Health Disparities.)

Although people with behavioral health conditions represent about 25 percent of the U.S. adult population, these individuals account for nearly 40 percent<sup>6</sup> of all cigarettes smoked and can experience serious health consequences<sup>7</sup>. A growing body of research shows that quitting smoking can improve mental health and addiction recovery outcomes. Research shows that many smokers with behavioral health conditions want to quit, can quit, and benefit from proven smoking cessation treatments. SAMHSA strongly encourages all grantees to adopt a tobacco-free facility/grounds policy and to promote abstinence from all tobacco products (except in regard to accepted tribal traditions and practices).

PIPBHC funded provider organizations must utilize third party and other revenue realized from provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are not covered by public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an

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<sup>6</sup> Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (March 20, 2013). *The NSDUH Report: Adults with Mental Illness or Substance Use Disorder Account for 40 Percent of All Cigarettes Smoked*. Rockville, MD. <http://media.samhsa.gov/data/spotlight/spot104-cigarettes-mental-illness-substance-use-disorder.pdf>

<sup>7</sup> U.S. Department of Health and Human Services. *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

individual's health insurance plan. PIPBHC funded organizations should also consider other systems from which a potential service recipient may be eligible for services (e.g., the Veterans Health Administration, child/adolescent services, senior services) if appropriate for and desired by that individual to meet his/her needs. In addition, PIPBHC funded provider organizations are required to implement policies and procedures that ensure other sources of funding are utilized first when available for that individual.

Recovery from mental and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Recovery Support Strategic Initiative is leading efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them. Building on research, practice, and the lived experiences of individuals in recovery from mental and/or substance use disorders, SAMHSA has developed the following working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* See <http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF> for further information, including the four dimensions of recovery, and 10 guiding principles. Programs and services that incorporate a recovery approach fully involve people with lived experience (including consumers/peers/people in recovery, youth, and family members) in program/service design, development, implementation, and evaluation.

SAMHSA's standard, unified working definition of recovery is intended to advance recovery opportunities for all Americans, particularly in the context of health reform, and to help clarify these concepts for peers/persons in recovery, families, funders, providers and others. The definition is to be used to assist in the planning, delivery, financing, and evaluation of behavioral health services. SAMHSA grantees are expected to integrate the definition and principles of recovery into their programs to the greatest extent possible.

Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.<sup>8</sup> Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical illnesses. Many of these health and behavioral health conditions can be addressed through routine health/behavioral health promotion activities, primary care and behavioral health screening, monitoring, treatment and care management/coordination strategies and/or other outreach

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<sup>8</sup> Anda, R.F., Brown, D.W., Dube, S.R., Bremner, J.D., Felitti, V.J, & Giles, W.H. (2008). *Adverse childhood experiences and chronic obstructive pulmonary disease in adults.* American Journal of Preventive Medicine.

programs. SAMHSA provides a comprehensive public health approach to addressing trauma and establishing a trauma-informed approach in health, behavioral health, human services and related systems. Organizations can build a trauma-informed approach by implementing the Key Principles of and Guidance for a Trauma-informed Approach as articulated by the SAMHSA Trauma and Justice Strategic Initiative and in SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, which can be downloaded from <http://store.samhsa.gov/product/SMA14-4884>.

SAMHSA encourages all PIPBHC-funded provider organizations to address the health and behavioral health needs of returning veterans and their families in designing and developing their programs and to consider prioritizing this population for services, where appropriate. SAMHSA encourages its PIPBHC-funded provider organizations to utilize and provide technical assistance (TA) regarding locally-customized web portals that assist veterans and their families with finding health and behavioral health treatment and support.

## **2.1 Using Evidence-Based Practices**

SAMHSA's services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population(s) of focus. An evidence-based practice (EBP) refers to approaches to prevention or treatment that are validated by some form of documented research evidence. However, SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. See [Appendix A](#) of this document for additional information about using EBPs.

In [Section C](#) of the Project Narrative, you are required to:

- Identify the evidence-based practice(s) you propose to implement for the specific population(s) of focus. If an EBP does not exist/apply for your program/population(s) of focus, describe the service/practice you plan to implement as an appropriate alternative. The EBPs or promising practices must support the following categories: tobacco cessation, nutrition/exercise, chronic disease self-management, and appropriate mental health and substance use interventions.
- If you are proposing to use more than one evidence-based practice, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support.
- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus. Indicate whether/how the practice(s) will be adapted for a specific population. SAMHSA encourages you to consult with an expert or the program developer to complete any modifications to the chosen EBP. This is especially

important when adapting EBPs for specific underserved populations for whom there are fewer EBPs.

In selecting an EBP, be mindful of how the choice of an EBP or practice may impact disparities in service access, use, and outcomes for your population(s) of focus. While this is important in providing services to all populations, it is especially critical for those working with underserved and minority populations.

**Note: See PART II: Appendix C – Standard Funding Restrictions, regarding allowable costs for EBPs.**

## **2.2 Data Collection and Performance Measurement**

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010 and the 21<sup>st</sup> Century Cures Act of 2016, P.L. 114-255. You must document your ability to collect and report the required data in [Section E: Data Collection and Performance Measurement](#) of your application.

Refer to [Appendix H](#) for information on recommended screenings and protocols for adults, children, and adolescents for behavioral health and health.

All data will be entered into SAMHSA's Performance and Accountability Reporting System (SPARS) except for the PIPBHC specific health outcomes for children and adolescents. These data will be reported in a quarterly report.

Grantees will be required to report performance on performance measures in the following categories:

### **GPRA Consumer National Outcome Measures (NOMs)**

GPRA Consumer National Outcome Measures (NOMs) must be:

- Conducted face-to-face [unless a waiver has been granted by the Government Project Officer (GPO)];
- Collected at baseline (i.e., the client's entry into the project), at six-month intervals post baseline, and at discharge;
- Gathered using a uniform data collection tool(s) provided by SAMHSA; and
- Entered within seven days of data collection.

### **PIPBHC Specific Health Outcomes**

These parameters represent risk factors for chronic conditions that are associated with early mortality. The impact of each these risk factors can be reduced with changes in behavior, involvement in health promotion activities, and effective engagement with primary care. For children and adolescents, refer to the following link for standards for monitoring height, weight, and BMI for children

<https://www.cdc.gov/growthcharts/data/set2clinical/cj411074.pdf>. For adult physical health measures, refer to Appendix G.

PIPBHC specific health outcomes must be:

- Gathered in a section of the uniform data collection tool that is specific to PIPBHC grantees; and
- Collected at baseline (i.e., the client's entry into the project), at six-month intervals post baseline, and at discharge.

For adults 18 years of age and over, data for the following data must be collected:

- Blood pressure: Semi-annually
- Body Mass Index (BMI): Semi-annually
- Waist circumference: Semi-annually
- Breath CO (carbon monoxide): Semi-annually
- Plasma Glucose (fasting) and/or HgbA1c: Annually
- Lipid profile (HDL, LDL, triglycerides): Annually

For children and adolescents, the following data must be collected:

- BMI
- Age-appropriate immunizations for communicable disease
- Blood pressure
- Tobacco use (including second- hand smoke exposure) and oral health
- Scheduled age-appropriate wellness visits (as recommended by the CDC and AAP)
- Age-appropriate physical examinations.

### **Infrastructure, Prevention and Promotion (IPP) performance measures**

Data for the following IPP indicators must be collected and reported:

- The number of policy changes completed as a result of the grant (PD1);
- The number of programs/organizations/communities that have implemented evidence-based practices/activities as a result of the grant (T2);
- The number of individuals screened for mental health or related interventions (S1);
- The number of individuals referred to mental health or related services (R1); and

- The number and percentage of individuals receiving mental health or related services after referral (AC1).

These data must be submitted on a quarterly basis into SPARS within thirty (30) days after the end of each quarter.

Access to SPARS will be provided upon award. An example of the type of data collection tool required can be found at [https://www.cmhs-gpra.samhsa.gov/TracPRD/View/docs/SVCS\\_AdultTool\\_v15\\_07\\_2016.pdf](https://www.cmhs-gpra.samhsa.gov/TracPRD/View/docs/SVCS_AdultTool_v15_07_2016.pdf).

Training, technical assistance (TA), measurement tools, and reporting formats related to data collection and reporting will be provided to all grantees and sub-awardees post award.

The collection of these data will enable SAMHSA to report on key outcome measures relating to this grant program. In addition to these outcomes, data collected will be used to demonstrate how SAMHSA's grant programs are reducing disparities in access, service use, and outcomes nationwide.

Performance data will be reported to the public as part of SAMHSA's Congressional Justification.

**Note:** If a PIPBHC cross-site evaluation is funded, all grantees are expected to participate and meet the requirements of the evaluation.

### **2.3 Local Performance Assessment**

Grantees must periodically review the performance data they report to SAMHSA (as required above), assess their progress, and use this information to improve management of their grant. The local performance assessment should be designed to help determine whether goals, objectives, and outcomes are being achieved and whether adjustments need to be made to the project. Performance assessments also should be used to determine whether the project is having/will have the intended impact on behavioral health disparities.

Quarterly performance assessment reports must address and include:

- PIPBHC specific health outcomes data for children and adolescents;
- An assessment of progress made towards meeting the goals and objectives of the program;
- An assessment of progress made to reduce barriers to integrated care as described in the application;
- An assessment of the effectiveness of the integrated care models being used, how they have contributed to improving the overall wellness and physical health status of the selected special populations, and if the models need to be changed or improved to produce more positive outcomes; and

- A report on the functional outcomes of the special populations being served by the project as follows:
  - Entities serving Adults with SMI must report on participation in supportive housing or independent living programs; attendance in social and rehabilitative programs; participation in job training opportunities; satisfactory performance in work settings; attendance at scheduled medical and mental health appointments; and compliance with prescribed medication regimes.
  - Entities serving Individuals with co-occurring mental illness & physical health conditions & chronic diseases must report on attendance at scheduled medical and mental health appointments; compliance with prescribed medication regimes; and participation in learning opportunities related to improved health and lifestyle practices.
  - Entities serving Children & Adolescents with serious emotional disturbance who have co-occurring physical health and chronic conditions must report on attendance at scheduled medical and mental health appointments, compliance with prescribed medication regimes, and participation in learning opportunities at school and extracurricular activities.
  - Entities serving Individuals with substance use disorders must report on participation in supportive housing or independent living programs, criminal justice involvement, attendance in social & rehabilitative programs, participation in job training opportunities, satisfactory performance in work settings, attendance at scheduled medical and behavioral health appointments, and compliance with prescribed medication regimes.

Training, technical assistance, measurement tools, and reporting formats related to data collection and reporting will be provided to all grantees and sub-awardees post award.

PIPBHC funded provider organizations must use EHR population management tools in order to support a robust continuous quality improvement process, and must regularly generate reports by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. PIPBHC services funded organizations must use these tools to target specific interventions to populations most at risk of or in need of said intervention.

**No more than 10 percent of the community program(s) or community health center(s) funding can be used for data collection, evaluation, and performance assessment.**

## **2.4 Infrastructure Development**

Although services grant funds must be used primarily for direct services, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness.

**No more than 15 percent of the community program(s) or community health center(s) funding may be used for infrastructure development.**

These funds may be used to support the following types of infrastructure development activities:

- Developing partnerships with other service providers for service delivery.
- Adopting and/or enhancing computer systems, management information system (MIS), electronic health records (EHRs), etc., to document and manage client needs, care process, integration with related support services, and outcomes.
- Training/workforce development to help staff or other providers in the community identify primary care (for behavioral health staff only), mental health or substance use disorders (for primary care staff only) such as SBIRT and MAT, or provide effective services consistent with the purpose of the grant program.
- Redesigning processes, as needed, to enhance effectiveness, efficiency and optimal collaboration between primary care and mental health and/or behavioral health provider settings staff.
- Facility modifications and health information technology needed to support bi-directional integration services at the health or behavioral health facility.
- Policy development to support needed service system improvements (e.g., rate-setting activities, establishment of standards of care, adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, development/revision of credentialing, licensure, or accreditation requirements).<sup>9</sup>

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<sup>9</sup> For purposes of this FOA, “policy” refers to programs and guidelines adopted and implemented by institutions, organizations and others to inform and establish practices and decisions and to achieve organizational goals. Policy efforts do not include activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders (“legislation and other orders”) proposed or pending before the Congress or any State government, State legislature or

## 2.5 State Grantee Meetings

Grantees must plan to send a minimum of five people (including the Project Director, and other personnel to be determined by SAMHSA) to a grantee meeting every other year of the grant program. For this grant cohort, grantee meetings will likely be held in years two and four of the grant. A detailed budget and narrative is required for this travel. At these meetings, grantees will present the results of their projects and federal staff will provide TA. Each meeting will be up to 3 days. These meetings are usually held in the Washington, D.C. area and attendance is mandatory.

## II. AWARD INFORMATION

<b>Funding Mechanism:</b>	Cooperative Agreement
<b>Anticipated Total Available Funding:</b>	\$22,612,000
<b>Estimated Number of Awards:</b>	Up to 11
<b>Estimated Award Amount:</b>	Up to \$2,000,000
<b>Length of Project Period:</b>	Up to 5 years
	<b>Proposed Project:</b>
	<b>Start Date: 9/30/2017</b>
	<b>End Date: 9/29/2022</b>

**Proposed budgets cannot exceed \$2,000,000 in total costs (direct and indirect) in any year of the proposed project.** Given the limited funding available, applicants are encouraged to apply only for the grant amount which they can reasonably expend based on the activities proposed in their application.

**Only one application per state will be funded. If more than one entity from a state applies, SAMHSA will only fund the highest scoring application.**

Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

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local legislature or legislative body, and awardees may not use federal funds for such activities. This restriction extends to both grass-roots lobbying efforts and direct lobbying. However, for state, local, and other governmental grantees, certain activities falling within the normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government are not considered impermissible lobbying activities and may be supported by federal funds.

**Funding estimates for this announcement are based on an annualized Continuing Resolution and do not reflect the final FY 2017 appropriation. Applicants should be aware that funding amounts are subject to the availability of funds.**

SAMHSA will not fund proposals that duplicate any other related SAMHSA and/or HHS initiatives. PIPBHC funding will only be used in a coordinated manner to complement and not to duplicate or supplant funding for other grant programs. PIPBHC funding may not supplant existing federal or state funding. States may not use PIPBHC funds as state match nor use funds to substitute for currently funded SAMHSA services or administrative activities. For example, if a selected provider organization already receives a SAMHSA Primary and Behavioral Healthcare Integration grant (PBHCI) or Project LAUNCH grant (where a percentage of grant funds allow for integration services), funds must be used in a complementary manner.

### **Cooperative Agreement**

These awards are being made as cooperative agreements because they require substantial post-award federal programmatic participation in the conduct of the project. Under this cooperative agreement, the roles and responsibilities of grantees and SAMHSA staff are:

#### **Role of Grantee:**

- Comply with all terms and conditions of the award and satisfactorily perform activities to achieve the program goals;
- Consult with and accept guidance and respond to requests for information from the Government Project Officer, the Grants Management Specialist, and other relevant SAMHSA and Federal staff;
- Consult and seek approval from Government Project Officer and Grants Management Specialist prior to any change in key personnel or change in project scope (i.e. numbers served, location, model, EBPs, renovations, etc.);
- Agree to provide SAMHSA with all required data;
- Support and participate in grantee meetings;
- Advise SAMHSA in advance of any future participation in related Federal initiatives, allowing SAMHSA to make adjustments as necessary;
- Produce required SAMHSA reports;
- Keep Federal program staff informed of emerging issues, developments, and problems; and
- Participate in a cross-site evaluation of the PIPBHC program should one be conducted.

#### **Role of SAMHSA Staff:**

- Work cooperatively with the grantees to augment goals upon notification of award to ensure PIPBHC dollars and services are being maximized;
- Work cooperatively with grantees to develop an approved sustainability plan;
- Review and approve annual goals and budget;
- Consult with the PIPBHC grant investigators on all phases of the project development and implementation to ensure accomplishment of the goals;
- Approve key staff (e.g., project director) responsible for the management, leadership, and oversight of the grants;
- Review critical project activities for conformity to the mission of the PIPBHC grant program;
- Provide guidance on project design and components, as needed;
- Approve data collection plans;
- Recommend outside consultants, if needed; and
- Assume overall responsibility for monitoring the conduct and progress of the PIPBHC grant program, review quarterly reports, annual grant continuation reports, conduct site visits, and make recommendations to SAMHSA regarding continuation funding.

### **III. ELIGIBILITY INFORMATION**

#### **1. ELIGIBLE APPLICANTS**

Eligibility for this program is statutorily limited to a State or appropriate State agency (e.g., state mental health authority, the single state agency (SSA) for substance abuse services, the State Medicaid agency, or the state health department) in collaboration with one or more qualified community health programs, as described in section 1913(b)(1) of the PHS Act as amended; or one or more community health centers as described in section 330 of the PHS Act, as amended (e.g., community health centers, health care for the homeless, public housing health centers, and migratory and seasonal agricultural workers health centers).

The statutory authority for this program prohibits grants to for-profit agencies.

#### **2. COST SHARING and MATCH REQUIREMENTS**

Cost sharing/match is not required in this program.

#### **3. EVIDENCE OF EXPERIENCE AND CREDENTIALS**

States must ensure that the capacity of the selected service provider organization(s) exists, is/are experienced, and is/are appropriately credentialed with demonstrated

infrastructure and expertise to provide all required services quickly and effectively. Each selected provider organization must also meet the following two additional requirements related to the provision of services:

- Each mental health/substance use disorder treatment/primary care provider organization must have at least two years' experience (as of the due date of the application) providing relevant services. Official documents must establish that the organization has provided at least two years of relevant services; and
- Each mental health/substance use disorder treatment/primary care provider organization must comply with all applicable local (city, county) and state licensing, accreditation, and certification requirements, as of the due date of the application.

A signed Statement of Assurance from the Authorized Representative of the State or appropriate State agency, assuring that the selected service provider organization(s) meet the above requirements, must be included as Attachment 1 of the application.

**Note: The above requirements apply to all community or community health center provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license or certification. Eligible tribes and tribal organization mental health/substance use disorder treatment/primary care providers must comply with all applicable tribal licensing, accreditation, and certification requirements, as of the due date of the application.**

Following application review, if the application's score is within the fundable range, the government project officer (GPO) may contact the applicant to request that additional documentation be sent by email, or to verify that the documentation submitted is complete. **If the GPO does not receive this documentation within the time specified, the application will not be considered for funding.**

#### **IV. APPLICATION AND SUBMISSION INFORMATION**

**In addition to the application and submission language discussed in PART II: Sections I and II, applicants must include the following in the application:**

##### **1. ADDITIONAL REQUIRED APPLICATION COMPONENTS**

- **Budget Information Form** – Use SF-424A. Fill out all Sections of the SF-424A. Please note the following:
  - **In Line #17 of the SF-424** please input the following information: (Proposed Project: a. Start Date: 9/30/2017; b. End Date: 9/29/2022).
  - **Section A - Budget Information** – Non-Construction Programs: Use the first row only (Line 1) to report the total federal funds and non-federal funds requested for the 1<sup>st</sup> year of your project only.

- **Section B** – Budget Categories: Use the first column only (Column 1) to report the budget category breakouts (Lines 6a through 6h) and indirect charges (Line 6j) for the total funding requested for the 1<sup>st</sup> year of your project only.
- **Section D** – Forecasted Cash Needs: Use the first column “*Total for 1<sup>st</sup> Year*” only to enter the amount requested (federal and non-federal) for Year 1 of the project period
- **Section E** – Budget Estimates of Federal Funds Needed for Balance of the Project is for the amount requested for Year 2, Year 3, Year 4, and Year 5.
- A sample budget and justification is included in [Appendix D](#) of this document. **It is highly recommended that the sample budget format in [Appendix D](#) is used. This will expedite review of the application.**
- **Project Narrative and Supporting Documentation** – The Project Narrative describes the proposed project. It consists of Sections A through E. Sections A-E together may not be longer than forty-five (45) pages. Remember that if the Project Narrative starts on page 5 and ends on page 45, it is 46 pages long, not 45 pages. More detailed instructions for completing each section of the Project Narrative are provided in [Section V](#) – Application Review Information of this document.

The Supporting Documentation section provides additional information necessary for the review of the application. This supporting documentation must be attached to the application using the **Other Attachments Form** from the Grants.gov application package. Additional instructions for completing these sections and page limitations for Biographical Sketches/Position Descriptions are included in PART II: Section II-3.1, Required Application Components, and Appendix D, Biographical Sketches and Position Descriptions. Supporting documentation should be submitted in black and white (no color).

- **Budget Justification and Narrative** – The budget justification and narrative must be submitted as file BNF when submitting the application into Grants.gov. (See PART II: Section II-3.1, Required Application Components.)
- Applicants for this program are required to complete the Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations Form SMA 170. This form is posted on SAMHSA’s website at <http://www.samhsa.gov/grants/applying/forms-resources>.

- **Attachments 1 through 4** – Use only the attachments listed below. If the application includes any attachments not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Attachments 1, 3, 4, and 5 combined. There are no page limitations for Attachment 2. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them. Label the attachments as: Attachment 1, Attachment 2, etc. Use the **Other Attachments Form** from Grants.gov to upload the attachments.
  - **Attachment 1:** (1) Identification of at least one experienced, licensed qualified community programs, as described under section 1913(b)(1) of the Public Health Service Act, as amended or one community health center as described in section 330; of the PHS Act, as amended ; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project; (3) letters of commitment from each direct service provider organization that have agreed to participate in the proposed project; (4) the Statement of Assurance(provided in [Appendix B](#) of this announcement), that has been signed by the authorized representative of the State or appropriate State agency identified on the first page (SF-424) of the application, assuring SAMHSA that all listed service providers meet the two-year experience requirement, are appropriately licensed, accredited and certified, and that if the application is within the funding range for an award, the applicant will send the GPO any additional required documentation within the specified time.
  - **Attachment 2:** Data Collection Instruments/Interview Protocols – if you are using standardized data collection instruments/interview protocols, do not include these in the application. Instead, provide a web link to the appropriate instrument/protocol. If the data collection instrument(s) or interview protocol(s) is/are not standardized, you must include a copy as Attachment 2.
  - **Attachment 3:** Sample Consent Forms. Also include 42 CFR, Part 2 if serving individuals with substance use disorders.
  - **Attachment 4:** Letter to the SSA, if applicable. Refer to PART II: Appendix B – Intergovernmental Review (E.O. 12372) Requirements.

## 2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **May 17, 2017**.

**IMPORTANT:** Due to SAMHSA's transition to NIH's eRA grants system, SAMHSA has made changes to the application registration, submission, and formatting requirements.

**Be sure to read PART II of this FOA very carefully to understand the requirements for SAMHSA's new grant system. Applicants will need to register with NIH'S eRA Commons in order to submit an application.** Applicants also must register with the System for Award Management (SAM) and Grants.gov (see PART II: Section I-1 and Section II-1 for all registration requirements).

Due to the new registration and application requirements, it is strongly recommended that applicants start the registration process **six (6) weeks in advance** of the application due date.

### **3. FUNDING LIMITATIONS/RESTRICTIONS**

- No more than 10 percent of the total grant award may be used for State or other State agency administrative costs.
- The remaining 90 percent of funds must be allocated to a community program(s) or community health center(s) to provide direct integrated care.
- No more than 15 percent of the 90 percent of funding may be used by the community program or community health center for infrastructure development, as referenced in [Section I.2.4](#) of this FOA.
- No more than 10 percent of the 90 percent of funding may be used by the community program or community health center for data collection, performance measurement, and performance assessment, as referenced in [Sections I.2.2](#) and [I.2.3](#) of this FOA.

Expenses related to the above three categories of costs must be clearly identified in the proposed budget.

**SAMHSA grantees must also comply with SAMHSA's standard funding restrictions, which are included in PART II: Appendix C, Standard Funding Restrictions.**

### **4. INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS**

All SAMHSA grant programs are covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100. Under this Order, states may design their own processes for reviewing and commenting on proposed federal assistance under covered programs. See PART II: Appendix B for additional information on these requirements as well as requirements for the Public Health System Impact Statement.

## V. APPLICATION REVIEW INFORMATION

### 1. EVALUATION CRITERIA

The Project Narrative describes what the applicant intends to do with the project and includes the Evaluation Criteria in Sections A-E below. The application will be reviewed and scored according to the quality of the response to the requirements in Sections A-E.

- In developing the Project Narrative section of the application, use these instructions, which have been tailored to this program.
- The Project Narrative (Sections A-E) together may be no longer than 45 pages.
- Applicants must use the five sections/headings listed below in developing the Project Narrative. **Applicant must indicate the Section letter and number in the response, i.e., type “A-1”, “A-2”, etc., before the response to each question.** It is not permitted to combine two or more questions or refer to another section of the Project Narrative in your response, such as indicating that the response for B.2 is in C.7. **Only information included in the appropriate numbered question will be considered by reviewers.** The application will be scored according to how well the requirements for each section of the Project Narrative are addressed.
- The number of points after each heading is the maximum number of points a review committee may assign to that section of the Project Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.

#### **Section A: Population of Focus and Statement of Need (15 points)**

1. Provide a comprehensive demographic profile of people with SMI and SED in your local area in terms of race, ethnicity, federally recognized tribe (if applicable), language, sex, gender identity, sexual orientation, age, and socioeconomic status.
2. Identify your special population(s) of focus. Provide a comprehensive demographic profile in your local area in terms of race, ethnicity, federally recognized tribe (if applicable), language, sex, gender identity, sexual orientation, age, and socioeconomic status.
3. Discuss the differences in access, service use, and outcomes for the selected provider organization’s population of focus in comparison with the general population in the local service area, citing relevant data. Describe how the proposed project will improve these disparities in access, service use, and outcomes.

4. 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 special population(s) identified in the response to question A.1. States or appropriate State agencies are expected to identify those consumers most in need of integrated services (including those with HIV/AIDS and Hepatitis A, B, and C, as well as those with histories of trauma). To the extent available, use local data to describe need and service gaps, supplemented with state and/or national data. Identify the source of the data.

### **Section B: Proposed Implementation Approach (30 points)**

1. Describe the purpose of the proposed project, including its goals and measurable objectives. These must relate to the intent of the FOA and the performance measures identified in [Section E: Data Collection and Performance Measurement](#).
2. Provide a chart or time line for the implementation of services by the selected provider organizations for the identified special population(s) of focus. The implementation plan must depict a realistic time line for the entire five years of the project period, showing dates, key activities, and responsible staff. These key activities should include the requirements outlined in [Section I-2: Expectations](#) of this FOA. **NOTE:** Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than four months after grant award. The time line should be part of the Project Narrative. It should not be placed in an attachment.
3. Describe how the key activities in the project timeline will be implemented. Include descriptions of the integrated services that will be provided to the identified special populations, the roles of the integrated care team and how they relate to the service provision, and the expected impact on the physical and behavioral health outcomes of the individuals served by the grant.
4. Describe how the proposed activities will adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (go to <http://ThinkCulturalHealth.hhs.gov>). Select one element from each of the CLAS Standards: 1) Governance, Leadership and Workforce; 2) Communication and Language Assistance; and 3) Engagement, Continuous Improvement, and Accountability, and specifically describe how these activities will address each element selected.
5. Describe how the selected provider organization(s) will screen and assess clients for the presence of chronic physical health and behavioral health conditions and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having or at risk for chronic health and behavioral health conditions.

6. Describe how people with SMI, SED, and the special population(s) of focus will be identified, recruited, and retained and how this approach will take into consideration the language, beliefs, norms, values, and socioeconomic factors of this/these population(s).
7. State the unduplicated number of individuals you propose to serve, annually and over the entire grant period, with grant funds, including the types and numbers of services to be provided and anticipated outcomes. Explain how you arrive at this number and that it is reasonable given your budget request. You are required to include the numbers to be served by race, ethnicity, gender, and sexual orientation.
8. Describe how the selected provider organization(s) will provide the following six components of person-centered, integrated care services as referenced in [Section I.2.](#) of the FOA and in [Appendix F](#):
  - Care coordination including comprehensive care management and comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
  - Shared decision-making<sup>10</sup>;
  - Health promotion;
  - Individual and family support;
  - Referral to community and social support services, including appropriate follow-up.
9. Identify any other organization(s) that will partner in the proposed project. Describe their specific roles and responsibilities. Demonstrate their commitment to the project by including Letters of Commitment from each partner in **Attachment 1** of the application.
10. Provide a document that summarizes the policies, if any, that serve as barriers to the provision of integrated care, and the specific steps, if applicable, that will be taken to address such barriers.
11. Provide a description of partnerships or other arrangements with local health care providers to provide services to special populations, including how effective consent will be obtained, tracked, and any additional special conditions dictated by State law and 42 CFR, Part 2.

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<sup>10</sup> Refer to the following link for the definition and examples of shared decision-making: <https://www.samhsa.gov/brss-tacs/shared-decision-making>

12. If applicant plans to use grant funds for infrastructure development, describe the proposed infrastructure changes and how they will enhance/improve access, service use, and outcomes for the population of focus. If applicant does not plan to use grant funds for infrastructure development, indicate so in the response.

**Section C: Proposed Evidence-Based Service/Practice (20 points)**

1. Describe the Evidence-Based Practice(s) (EBPs) that will be used for the PIPBHC program. Identify and describe the (EBPs) that will be used for tobacco cessation, nutrition/exercise, chronic disease self-management and appropriate mental health and substance use interventions as well as assessment and treatment of behavioral health and physical health conditions. Document how each selected EBP is appropriate for the outcomes to be achieved and how they also meet SAMHSA's goals for this program. Justify the use of each EBP for the special population(s) of focus. If an EBP does not exist/apply for the program, fully describe the practice planned for implementation, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate existing EBP.
2. Identify the evidence-based or promising practices integrated care model(s) for primary care and behavioral health (this can include culturally appropriate or adapted models for disparate populations). Describe how the funded organizations will use the models to improve overall wellness and physical health status of adults with a mental illness or SMI, children with a SED, and/or individuals with substance use disorders. Describe the evidence and support of the identified integrated care model(s).
3. Explain how your choice of an EBP or practice will help you address disparities in service access, use, and outcomes for your population(s) of focus.
4. Describe any modifications that will be made to the EBP or practice and the reasons the modifications are necessary. If you are not proposing any modifications, indicate so in your response.
5. Explain how you will monitor the delivery of the EBPs to ensure that they are implemented according to the EBP guidelines.

**Section D: Staff and Organizational Experience (10 points)**

1. Discuss the capability and experience of the selected provider organization(s) with similar projects and populations. Demonstrate that the selected provider organization(s) has/have linkages to the special population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the special population(s) of focus.
2. Discuss the capability and experience of other partnering organizations with similar projects and special populations. Demonstrate that other partnering organizations have linkages to the special population(s) of focus and ties to

grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the special population(s) of focus. If the applicant does not plan to partner with any other organizations, indicate so in the response.

3. Provide a complete list of staff positions for the project, including the Project Director, State and provider organization(s) personnel. Explain the role of each and their level of effort and qualifications. Demonstrate successful project implementation for the level of effort budgeted for the Project Director and key staff.
4. Discuss how key staff members have demonstrated experience and are qualified to serve the special population(s) of focus and are familiar with their culture(s) and language(s). If key staff members are to be hired, discuss the credentials and experience the new staff must possess to work effectively with the special population(s) of focus. Describe staff experience and knowledge of integrated care, mental health, substance use, primary care, wellness and resiliency.
5. Describe how applicant will ensure the involvement of family members, youth peers, and consumer organizations in supporting the planning, implementation, and evaluation of PIPBHC activities. In addition, indicate whether applicant plans to engage with a coordination team or advisory council as part of an oversight process. If applicant plans to engage with a coordination team or advisory council, describe the structure of this group, including key stakeholders, and its role in an oversight capacity.

#### **Section E: Data Collection and Performance Measurement (25 points)**

1. Describe the process to be used to achieve Modified Stage 2 Program Requirements for Providers and Hospitals, as specified in [Section I.2](#) of this FOA to ensure the capability of meeting the required reporting of functional outcomes for this grant.
2. Describe the plan for data collection and performance measurement as specified in [Section I.2.2](#) of this FOA to:
  - Collect and enter GPRA Consumer National Outcomes Measures (NOMS) into the SAMHSA SPARS data collection system and maintain an 80 percent follow-up rate on NOMS at six-month intervals post baseline and at discharge.
  - Collect and enter PIPBHC specific health outcomes into the SAMHSA SPARS data collection system and maintain an 80 percent follow-up rate on PIPBHC outcomes at six-month intervals post baseline and at discharge.
  - Collect and enter IPP performance measures data into the SAMHSA SPARS data collection system on a quarterly basis.

- Provide oversight and management to ensure the data is accurate, complete, and entered into the SAMHSA data collection system within the required time frames.
3. Describe the plan for conducting the local performance assessment as specified in I.[2.3 Local Performance Assessment](#) of this FOA and document your ability to address the following:
    - The data (i.e., performance indicators) that will be used for local performance assessment
    - Who will be responsible for collecting and analyzing the data;
    - The plan for reviewing and reporting on progress achieved, barriers encountered, and efforts to overcome these barriers;
    - How a review of the performance data submitted to SAMHSA will be conducted;
    - An assessment of progress made towards meeting the goals and objectives of the program,
    - An assessment of progress made to reduce barriers to integrated care as described in the application.
  4. Describe the plan to report on the following functional outcomes of the special populations being served by the project, as specified in [Section I.2.3](#) of this FOA:
    - Entities serving Adults with SMI must report on participation in supportive housing or independent living programs, attendance in social & rehabilitative programs, participation in job training opportunities, satisfactory performance in work settings, attendance at scheduled medical and mental health appointments, and compliance with prescribed medication regimes.
    - Entities serving Individuals with co-occurring mental illness & physical health conditions & chronic diseases must report on attendance at scheduled medical and mental health appointments, compliance with prescribed medication regimes and participation in learning opportunities related to improved health and lifestyle practices.
    - Entities serving Children & adolescents with serious emotional disturbance who have co-occurring physical health and chronic conditions must report on attendance at scheduled medical and mental health appointments, compliance with prescribed

medication regimes, and participation in learning opportunities at school and extracurricular activities.

- Entities serving Individuals with substance use disorders must report on participation in supportive housing or independent living programs, criminal justice involvement, attendance in social & rehabilitative programs, participation in job training opportunities, satisfactory performance in work settings, attendance at scheduled medical and behavioral health appointments, and compliance with prescribed medication regimes.
5. Describe the quality improvement process that will be used to track whether the performance measures and objectives are being met. Describe how findings of the local performance assessment will be utilized to inform the ongoing implementation of the project. The plan must include timelines, processes, responsible persons, and who will be included in the process and decision making.

**Budget Justification, Existing Resources, Other Support (other federal and non-federal sources)**

Provide a narrative justification of the items included in the proposed budget, as well as a description of existing resources and other support applicant expects to receive for the proposed project. Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions, or non-federal means. (This should correspond to Item #18 on the SF-424, Estimated Funding.) Other sources of funds may be used for unallowable costs, e.g., meals, sporting events, entertainment.

An illustration of a budget and narrative justification is included in [Appendix D – Sample Budget and Justification](#), of this document. **It is highly recommended that the Sample Budget format in [Appendix D](#) is utilized. This will expedite review of the application.**

Be sure the proposed budget reflects the funding limitations/restrictions specified in [Section IV-3](#). **Specifically identify the items associated with these costs in the budget.**

**The budget justification and narrative must be submitted as file BNF when the application is submitted into Grants.gov. (See PART II: Section II-3.1, Required Application Components.)**

## **REQUIRED SUPPORTING DOCUMENTATION**

### **Section F: Biographical Sketches and Position Descriptions.**

See PART II: Appendix D, Biographical Sketches and Job Descriptions, for instructions on completing this section.

### **Section G: Confidentiality and SAMHSA Participant Protection/Human Subjects**

Applicants must describe procedures relating to Confidentiality, Participant Protection, and the Protection of Human Subjects Regulations in Section G of the application. See [Appendix C](#) of this document for guidelines on these requirements.

## **2. REVIEW AND SELECTION PROCESS**

SAMHSA applications are peer-reviewed according to the evaluation criteria listed above.

Decisions to fund a grant are based on:

- The strengths and weaknesses of the application as identified by peer reviewers;
- When the individual award is over \$150,000, approval by the CMHS National Advisory Council;
- Availability of funds;
- Equitable distribution of awards in terms of geography (including urban, rural and remote settings) and balance among populations of focus and program size; and
- In accordance with 45 CFR 75.212, SAMHSA reserves the right not to make an award to an entity if that entity does not meet the minimum qualification standards as described in section 75.205(a)(2). If SAMHSA chooses not to award a fundable application, SAMHSA must report that determination to the designated integrity and performance system accessible through the System for Award Management (SAM) [currently the Federal Awardee Performance and Integrity Information System (FAPIIS)].

## **VI. ADMINISTRATION INFORMATION**

### **1. REPORTING REQUIREMENTS**

In addition to the data reporting requirements listed in [Section I-2.4](#), grantees must comply with the reporting requirements listed on the SAMHSA website at <http://www.samhsa.gov/grants/grants-management/reporting-requirements>. Grantees are expected to submit quarterly reports during the 4 year grant program and a final report at the end of the grant to meet programmatic requirements. A final report is due 90 days after the end of the grant period.

## **VII. AGENCY CONTACTS**

For questions about program issues contact:

Tenly Pau Biggs, MSW, LGSW  
Center for Mental Health Services, Community Support Programs Branch  
Substance Abuse and Mental Health Services Administration  
[PBHCI@samhsa.hhs.gov](mailto:PBHCI@samhsa.hhs.gov)

For questions on grants management and budget issues contact:

Gwendolyn Simpson  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
(240) 276-1408  
[FOACMHS@samhsa.hhs.gov](mailto:FOACMHS@samhsa.hhs.gov)

## **Appendix A – Using Evidence-Based Practices (EBPs)**

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain practices for American Indians/Alaska Natives, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and, therefore, have a limited or nonexistent evidence base. In addition, other practices that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with a practice that has not been formally evaluated with that population are required to provide other forms of evidence that the practice(s) they propose is appropriate for the population(s) of focus. Evidence for these practices may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups with community members, etc. The applicant may describe the experience, either with the population(s) of focus or in managing similar programs. Information in support of the proposed practice needs to be sufficient to demonstrate the appropriateness of the practice to the individuals reviewing the application.

- Document that the EBP(s) chosen is/are appropriate for the outcomes the applicant wants to achieve.
- Explain how the practice the applicant has chosen meets SAMHSA's goals for this grant program.
- Describe any modifications/adaptations needed for the proposed practice(s) to meet the goals of the project and explain why these changes will improve the outcomes. It is expected that the evidence-based service(s)/practice(s) will be implemented in a way that is as close as possible to the original service(s)/practice(s). However, SAMHSA understands that minor changes may be needed to the service(s)/practice(s) to meet the needs of the population(s) of focus or the program, or to allow the use of resources more efficiently. Describe any changes to the proposed service(s)/practice(s) that are necessary for these purposes based on either the applicant's experience with the population(s) of focus or in managing similar programs.
- Explain why this EBP was selected over other evidence-based practices.
- If applicable, justify the use of multiple EBPs. Discuss how the use of multiple EBPs will be integrated into the program. Describe how the effectiveness of each evidence-based practice will be quantified in the performance assessment of the project.
- Discuss training needs or plans for training to successfully implement the proposed evidence-based practice(s).

### **Resources for Evidence-Based Practices (EBPs):**

Information on EBPs can be found at <http://store.samhsa.gov/resources/term/Evidence-Based-Practice-Resource-Library>. SAMHSA has developed this website to provide a simple and direct connection to websites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Resource Library* provides a short description and a link to dozens of websites with relevant EBPs information – either specific interventions or comprehensive reviews of research findings.

In addition to the website noted above, you may provide information on research studies to show that the services/practices planned for implementation are evidence-based. This information is usually published in research journals, including those that focus on minority populations. If this type of information is not available, provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts.

**Note: Refer to PART II: Appendix C – Standard Funding Restrictions, regarding allowable costs for EBPs.**

## Appendix B – Statement of Assurance

As the authorized representative of [*insert State or appropriate State agency*], I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents listed below. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- Official documentation that all mental health/substance use disorder treatment/primary care provider organizations participating in the project have been providing relevant services for a minimum of two years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last two years; and
- Official documentation that all mental health/substance use disorder treatment/primary care provider organizations: 1) comply with all local (city, county) and state requirements for licensing, accreditation and certification; **OR** 2) official documentation from the appropriate agency of the applicable state, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist.<sup>11</sup>
- Official documentation is a copy of each service provider organization's license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation, and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.
- For tribes and tribal organizations only, official documentation that all participating mental health/substance use disorder treatment/primary care provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation, and certification; **OR** 2) documentation from the tribe or other tribal governmental unit that licensing, accreditation, and certification requirements do not exist.

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<sup>11</sup> Tribes and tribal organizations are exempt from these requirements.

- At least one provider organization located among communities of high need, including federally recognized tribes, an Urban Indian organization; a state recognized tribe, or a HRSA-designated health professional shortage area (HPSA).

I assure SAMHSA that the applicant organization meets the eligibility for this program, which is a State, or other appropriate State agency, in collaboration with one or more qualified community programs, as described under section 1913(b)(1) of the Public Health Service Act, as amended or one or more community health centers as described in section 330 of the PHS Act, as amended.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

## Appendix C – Confidentiality and SAMHSA Participant Protection/Human Subjects Guidelines

### Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants (including those who plan to obtain IRB approval) must address the seven elements below. Be sure to discuss these elements as they pertain to on-line counseling (i.e., tele health) if they are applicable to the program. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven elements, read the section that follows entitled “Protection of Human Subjects Regulations” to determine if the regulations may apply to the project. If so, it is required to describe the process to be followed for obtaining Institutional Review Board (IRB) approval. While we encourage brief responses, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

#### 1. Protect Clients and Staff from Potential Risks

- Identify and describe any foreseeable physical, medical, psychological, social and legal risks or potential adverse effects as a result of the project itself or any data collection activity.
- Describe the procedures followed to minimize or protect participants against potential risks, including risks to confidentiality.
- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.
- Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you chooses not to use these other beneficial treatments, provide the reasons for not using them.

#### 2. Fair Selection of Participants

- Describe the population(s) of focus for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women or other targeted groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners and individuals who are likely to be particularly vulnerable to HIV/AIDS.
- Explain the reasons for including or excluding participants.
- Explain how you will be recruited and selected.. Identify who will select participants.

### 3. Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.
- If you plans to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious and conservative and that incentives do not provide an “undue inducement” which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed \$30.
- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

### 4. Data Collection

- Identify from whom data will be collected (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.
- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Attachment 2 of your application** (“Data Collection Instruments/Interview Protocols”) copies of all available data collection instruments and interview protocols that will be used (unless you are providing the web link to the instrument(s)/protocol(s)).

#### 5. Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.
- Describe:
  - How data collection instruments will be utilized.
  - Where data will be stored.
  - Who will or will not have access to information.
  - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

**NOTE:** If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

#### 6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how data will be kept private.
- State:
  - Whether or not their participation is voluntary.
  - Their right to leave the project at any time without problems.
  - Possible risks from participation in the project.
  - Plans to protect clients from these risks.
- Explain how you will obtain consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

**NOTE:** If the project poses potential physical, medical, psychological, legal, social or other risks, written informed consent **must be obtained**.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will provider organization(s) read the consent forms? Will provider organization(s) ask prospective participants questions to be sure they understand the forms? Will provider organization(s) give them copies of what they sign?
- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Attachment 3, “Sample Consent Forms,”** of your application. If needed, give English translations.

**NOTE:** Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?
- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

#### 7. Risk/Benefit Discussion

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

### **Protection of Human Subjects Regulations**

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant’s proposed performance assessment design may meet the regulation’s criteria for research involving human subjects.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling participants in the project. General information about Human Subjects Regulations can be obtained through OHRP at <http://www.hhs.gov/ohrp> or (240) 453-6900. SAMHSA-specific questions should be directed to the program contact listed in Section VII of this announcement.

## Appendix D – Sample Budget and Justification (no match required)

THIS IS AN ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE JUSTIFICATION WITH GUIDANCE FOR COMPLETING SF-424A: SECTION B FOR THE BUDGET PERIOD

**A. Personnel:** Provide employee(s) (including names for each identified position) of the applicant/recipient organization, including in-kind costs for those positions whose work is tied to the grant project.

### FEDERAL REQUEST

Position	Name	Annual Salary/Rate	Level of Effort	Cost
(1) Project Director	John Doe	\$64,890	10%	\$6,489
(2) Grant Coordinator	To be selected	\$46,276	100%	\$46,276
(3) Clinical Director	Jane Doe	In-kind cost	20%	0
			<b>TOTAL</b>	<b>\$52,765</b>

### JUSTIFICATION: Describe the role and responsibilities of each position.

- (1) The Project Director will provide daily oversight of the grant and will be considered key staff.
- (2) The Coordinator will coordinate project services and project activities, including training, communication and information dissemination.
- (3) The Clinical Director will provide necessary medical direction and guidance to staff for 540 clients served under this project.

**Key staff positions require prior approval by SAMHSA after review of credentials of resume and job description.**

**FEDERAL REQUEST** (enter in Section B column 1 line 6a of form S-424A) **\$52,765**

**B. Fringe Benefits:** List all components that make up the fringe benefits rate

**FEDERAL REQUEST**

Component	Rate	Wage	Cost
FICA	7.65%	\$52,765	\$4,037
Workers Compensation	2.5%	\$52,765	\$1,319
Insurance	10.5%	\$52,765	\$5,540
		<b>TOTAL</b>	<b>\$10,896</b>

**JUSTIFICATION:** Fringe reflects current rate for agency.

**FEDERAL REQUEST** (enter in Section B column 1 line 6b of form SF-424A) \$10,896

**C. Travel:** Explain need for all travel other than that required by this application. Applicants must use their own documented travel policies. If an organization does not have documented travel policies, the federal GSA rates must be used.

**FEDERAL REQUEST**

Purpose of Travel	Location	Item	Rate	Cost
(1) Grantee Conference	Washington, DC	Airfare	\$200/flight x 2 persons	\$400
		Hotel	\$180/night x 2 persons x 2 nights	\$720
		Per Diem (meals and incidentals)	\$46/day x 2 persons x 2 days	\$184
(2) Local travel		Mileage	3,000 miles @ .38/mile	\$1,140

Purpose of Travel	Location	Item	Rate	Cost
			<b>TOTAL</b>	<b>\$2,444</b>

**JUSTIFICATION: Describe the purpose of travel and how costs were determined.**

(1) Two staff (Project Director and Evaluator) to attend mandatory grantee meeting in Washington, DC.

(2) Local travel is needed to attend local meetings, project activities, and training events. Local travel rate is based on organization's policies/procedures for privately owned vehicle reimbursement rate. If policy does not have a rate use GSA.

**FEDERAL REQUEST** (enter in Section B column 1 line 6c of form SF-424A) **\$2,444**

**D. Equipment:** An article of tangible, nonexpendable, personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit (federal definition). Organizations should follow their documented capitalization policy thresholds.

**FEDERAL REQUEST** – (enter in Section B column 1 line 6d of form SF-424A) **\$ 0**

**E. Supplies:** Materials costing less than \$5,000 per unit (federal definition) and often having one-time use

**FEDERAL REQUEST**

Item(s)	Rate	Cost
General office supplies	\$50/mo. x 12 mo.	\$600
Postage	\$37/mo. x 8 mo.	\$296
Laptop Computer	\$900	\$900
Printer	\$300	\$300
Projector	\$900	\$900
Copies	8000 copies x .10/copy	\$800
	<b>TOTAL</b>	<b>\$3,796</b>

**JUSTIFICATION: Describe the need and include an adequate justification of how each cost was estimated.**

- (1) Office supplies, copies and postage are needed for general operation of the project.
- (2) The laptop computer and printer are needed for both project work and presentations for Project Director.
- (3) The projector is needed for presentations and workshops. All costs were based on retail values at the time the application was written.

**FEDERAL REQUEST – (enter in Section B column 1 line 6e of form SF-424A) \$ 3,796**

**F. Contract:** A contractual arrangement to carry out a portion of the programmatic effort or for the acquisition of routine goods or services under the grant. Such arrangements may be in the form of consortium agreements or contracts. A consultant is an individual retained to provide professional advice or services for a fee. The applicant/grantee must establish written procurement policies and procedures that are consistently applied. All procurement transactions shall be conducted in a manner to provide to the maximum extent practical, open and free competition.

**COSTS FOR CONTRACTS MUST BE BROKEN DOWN IN DETAIL AND A NARRATIVE JUSTIFICATION PROVIDED. IF APPLICABLE, NUMBERS OF CLIENTS SHOULD BE INCLUDED IN THE COSTS.**

**FEDERAL REQUEST**

Name	Service	Rate	Other	Cost
(1) State Department of Human Services	Training	\$250/individual x 3 staff	5 days	\$750
(2) Treatment Services	1040 Clients	\$27/client per year		\$28,080

Name	Service	Rate	Other	Cost
(3) John Smith (Case Manager)	Treatment Client Services	1FTE @ \$27,000 + Fringe Benefits of \$6,750 = \$33,750	*Travel at 3,124 @ .50 per mile = \$1,562  *Training course \$175  *Supplies @ \$47.54 x 12 months or \$570  *Telephone @ \$60 x 12 months = \$720  *Indirect costs = \$9,390 (negotiated with contractor)	\$46,167
(4) Jane Smith	Evaluator	\$40 per hour x 225 hours	12 month period	\$9,000
(5) To Be Announced	Marketing Coordinator	Annual salary of \$30,000 x 10% level of effort		\$3,000
			<b>TOTAL</b>	<b>\$86,997</b>

**JUSTIFICATION: Explain the need for each contractual agreement and how it relates to the overall project.**

- (1) Certified trainers are necessary to carry out the purpose of the statewide Consumer Network by providing recovery and wellness training, preparing consumer leaders statewide, and educating the public on mental health recovery.

- (2) Treatment services for clients to be served based on organizational history of expenses.
- (3) Case manager is vital to client services related to the program and outcomes.
- (4) Evaluator is provided by an experienced individual (Ph.D. level) with expertise in substance abuse, research and evaluation, is knowledgeable about the population of focus, and will report GPRA data.
- (5) Marketing Coordinator will develop a plan to include public education and outreach efforts to engage clients of the community about grantee activities, and provision of presentations at public meetings and community events to stakeholders, community civic organizations, churches, agencies, family groups and schools.

**\*Represents separate/distinct requested funds by cost category**

**FEDERAL REQUEST** – (enter in Section B column 1 line 6f of form SF-424A) **\$86,997**

**G. Construction: NOT ALLOWED** – Leave Section B columns 1& 2 line 6g on SF-424A blank.

**H. Other:** Expenses not covered in any of the previous budget categories

**FEDERAL REQUEST**

<b>Item</b>	<b>Rate</b>	<b>Cost</b>
(1) Rent*	\$15/sq.ft x 700 sq. feet	\$10,500
(2) Telephone	\$100/mo. x 12 mo.	\$1,200
(3) Client Incentives	\$10/client follow up x 278 clients	\$2,780
(4) Brochures	.89/brochure X 1500 brochures	\$1,335
	<b>TOTAL</b>	<b>\$15,815</b>

**JUSTIFICATION: Break down costs into cost/unit (e.g. cost/square foot). Explain the use of each item requested.**

- (1) Office space is included in the indirect cost rate agreement; however, if other rental costs for service site(s) are necessary for the project, they may be requested as a direct

charge. The rent is calculated by square footage or FTE and reflects SAMHSA's fair share of the space.

**\*If rent is requested (direct or indirect), provide the name of the owner(s) of the space/facility. If anyone related to the project owns the building which is less than an arm's length arrangement, provide cost of ownership/use allowance calculations. Additionally, the lease and floor plan (including common areas) are required for all projects allocating rent costs.**

(2) The monthly telephone costs reflect the percent of effort for the personnel listed in this application for the SAMHSA project only.

(3) The \$10 incentive is provided to encourage attendance to meet program goals for 278 client follow-ups.

(4) Brochures will be used at various community functions (health fairs and exhibits).

**FEDERAL REQUEST – (enter in Section B column 1 line 6h of form SF-424A) \$15,815**

**Indirect Cost Rate:** Indirect costs can be claimed if the organization has a negotiated indirect cost rate agreement. It is applied only to direct costs to the agency as allowed in the agreement. For information on applying for the indirect rate go to: <https://rates.psc.gov/fms/dca/map1.html>. **Effective with 45 CFR 75.414(f), any non-federal entity that has never received a negotiated indirect cost rate, except for those non-federal entities described in Appendix VII part 75 (D)(1)(b), may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. If an organization has a federally approved rate of 10%, the approved rate would prevail.**

**FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF-424A)**

**8% of personnel and fringe (.08 x \$63,661) \$5,093**

=====

TOTAL DIRECT CHARGES:

**FEDERAL REQUEST** – (enter in Section B column 1 line 6i of form SF-424A) \$172,713

INDIRECT CHARGES:

**FEDERAL REQUEST** – (enter in Section B column 1 line 6j of form SF-424A) \$5,093

**TOTAL: (sum of 6i and 6j)**

**FEDERAL REQUEST** – (enter in Section B column 1 line 6k of form SF-424A)  
**\$177,806**

=====  
**Provide the total proposed project period and federal funding as follows:**

**Proposed Project Period**

- a. Start Date: 09/30/2012                      b. End Date: 09/29/2017

**BUDGET SUMMARY** (should include future years and projected total)

<b>Category</b>	<b>Year 1</b>	<b>Year 2*</b>	<b>Year 3*</b>	<b>Year 4*</b>	<b>Year 5*</b>	<b>Total Project Costs</b>
Personnel	\$52,765	\$54,348	\$55,978	\$57,658	\$59,387	\$280,136
Fringe	\$10,896	\$11,223	\$11,559	\$11,906	\$12,263	\$57,847
Travel	\$2,444	\$2,444	\$2,444	\$2,444	\$2,444	\$12,220
Equipment	0	0	0	0	0	0
Supplies	\$3,796	\$3,796	\$3,796	\$3,796	\$3,796	\$18,980
Contractual	\$86,997	\$86,997	\$86,997	\$86,997	\$86,997	\$434,985
Other	\$15,815	\$13,752	\$11,629	\$9,440	\$7,187	\$57,823

Category	Year 1	Year 2*	Year 3*	Year 4*	Year 5*	Total Project Costs
Total Direct Charges	\$172,713	\$172,560	\$172,403	\$172,241	\$172,074	\$861,991
Indirect Charges	\$5,093	\$5,246	\$5,403	\$5,565	\$5,732	\$27,039
<b>Total Project Costs</b>	<b>\$177,806</b>	<b>\$177,806</b>	<b>\$177,806</b>	<b>\$177,806</b>	<b>\$177,806</b>	<b>\$889,030</b>

**TOTAL PROJECT COSTS: Sum of Total Direct Costs and Indirect Costs**

**FEDERAL REQUEST** (enter in Section B column 1 line 6k of form SF-424A) **\$889,030**

**\*FOR REQUESTED FUTURE YEARS:**

1. Justify and explain any changes to the budget that differs from the reflected amounts reported in the 01 Year Budget Summary.
2. If a cost of living adjustment (COLA) is included in future years, provide the organization's personnel policy and procedures that state all employees within the organization will receive a COLA.

**IN THIS SECTION, REFLECT OTHER FEDERAL AND NON-FEDERAL SOURCES OF FUNDING BY DOLLAR AMOUNT AND NAME OF FUNDER e.g., Applicant, State, Local, Other, Program Income, etc.**

Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, in-kind contributions or non-federal means. [Note: Refer to PART II: Appendix C – Standard Funding Restrictions, regarding allowable costs.]

**IN THIS SECTION,** include a narrative and separate budget for each year of the grant that shows the percent of the total grant award that will be used for data collection, performance measurement and performance assessment. **Be sure the budget reflects the funding restrictions in [Section IV-5](#).**

<b>Infrastructure Development</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>	<b>Total Infrastructure Costs</b>
Personnel	\$2,250	\$2,250	\$2,250	\$2,250	\$2,250	\$11,250
Fringe	\$558	\$558	\$558	\$558	\$558	\$2,790
Travel	0	0	0	0	0	0
Equipment	\$15,000	0	0	0	0	\$15,000
Supplies	\$1,575	\$1,575	\$1,575	\$1,575	\$1,575	\$7,875
Contractual	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$25,000
Other	\$1,617	\$2,375	\$2,375	\$2,375	\$2,375	\$11,117
<b>Total Direct Charges</b>	<b>\$6,000</b>	<b>\$11,758</b>	<b>\$11,758</b>	<b>\$11,758</b>	<b>\$11,758</b>	<b>\$53,072</b>
Indirect Charges	\$750	\$750	\$750	\$750	\$750	<b>\$3,750</b>
<b>Total Infrastructure Costs</b>	<b>\$6750</b>	<b>\$12,508</b>	<b>\$12,508</b>	<b>\$12,508</b>	<b>\$12,508</b>	<b>\$56,782</b>

<b>Data Collection &amp; Performance Measurement</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>	<b>Total Data Collection &amp; Performance Measurement Costs</b>
Personnel	\$6,700	\$6,700	\$6,700	\$6,700	\$6,700	\$33,500
Fringe	\$2,400	\$2,400	\$2,400	\$2,400	\$2,400	\$12,000
Travel	\$100	\$100	\$100	\$100	\$100	\$500

<b>Data Collection &amp; Performance Measurement</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>	<b>Total Data Collection &amp; Performance Measurement Costs</b>
Equipment	0	0	0	0	0	0
Supplies	\$750	\$750	\$750	\$750	\$750	\$3,750
Contractual	\$24,950	\$24,950	\$24,950	\$24,950	\$24,950	\$124,750
Other	0	0	0	0	0	0
<b>Total Direct Charges</b>	<b>\$34,300</b>	<b>\$34,300</b>	<b>\$34,300</b>	<b>\$34,300</b>	<b>\$34,300</b>	<b>\$171,500</b>
Indirect Charges	\$698	\$698	\$698	\$698	\$698	\$3,490
<b>Data Collection &amp; Performance Measurement</b>	<b>\$34,900</b>	<b>\$34,900</b>	<b>\$34,900</b>	<b>\$34,900</b>	<b>\$34,900</b>	<b>\$174,500</b>

## Appendix E – General Primary Medical Care and Screenings Service Descriptors

5A Service	Service Descriptor	Statute Reference	Regulation Reference
<b>REQUIRED SERVICES</b>			
<p><b>General Primary Medical Care</b></p>	<p>General primary medical care services are comprehensive and address prevention as well as acute and chronic conditions.</p> <p>At a minimum, these services include assessment, diagnosis, screening, education and treatment; referrals; and follow-up of such services.</p> <p>Any referrals are based on the provider’s documented assessment of the health center patient, indicating the medical necessity for referral(s) to other health-related services (including but not limited to specialty, behavioral health and substance abuse services). Follow-up of services includes the medical coordination of ongoing treatment involved with the transfer or discharge planning of health center patients in various settings.</p>	<p>Section 330(b)(1)(A)</p> <p>“(i)Basic Health Services: (I) Health services related to family medicine, internal medicine, pediatrics, obstetrics or gynecology, that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives; (II) diagnostic laboratory and radiologic services; (III) preventive health services, including- - ...”</p>	<p>42 CFR, Part 51c.102(h)</p> <p>“Primary health services means: (1) Diagnostic treatment, consultative, referral, and other services rendered by physicians, and, where feasible, by physicians' extenders, such as physicians' assistants, nurse clinicians, and nurse practitioners;”</p>

5A Service	Service Descriptor	Statute Reference	Regulation Reference
<b>REQUIRED SERVICES</b>			
<b>Screenings</b>	<p>Screening services are performed based on <b>identified risk factors</b> in the patient population and/or communities to evaluate, treat, and educate a health center patient.</p> <p>At a minimum, these services include all of the following: cancer, communicable disease, cholesterol and blood lead.</p> <p>Cancer screenings at a minimum must include, but are not limited to, screening for breast, cervix, and colorectal cancers (e.g., mammography, Pap testing, fecal occult blood testing, sigmoidoscopy, colonoscopy).</p> <p>Communicable disease screenings at a minimum must include, but are not limited to, testing for tuberculosis, HIV, Hepatitis B and C, and other sexually transmitted diseases/infections based on a patient's identified risk factors.</p> <p>Cholesterol screenings are blood tests used to assess and understand a patient's risk for</p>	<p>Section 330(b)(1)(A)  “(i) Basic Health Services:…  (III) Preventive Health Services, including--(aa) prenatal and perinatal services; (bb) appropriate cancer screening; (cc) well- child services; (dd) immunizations against vaccine-preventable diseases; (ee) screenings for elevated blood lead levels, communicable diseases, and cholesterol”</p>	<p>Not described</p>

## **Appendix F – Components of Person-Centered, Integrated Care Services – Sample Definitions and Roles**

These are sample definitions, pulled from the CMS Approved State Plan Amendment submitted by the State of Missouri.

### ***Care Coordination***

Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkages to long-term services and supports. Specific activities include, but are not limited to: appointment scheduling; conducting referrals and follow-up monitoring; participating in hospital discharge processes; and communicating with other providers and consumers/family members. For children, include parents/caregivers and school staff. Nurse Care Managers, with the assistance of the Health Home Administrative Support staff, will be responsible for conducting care coordination activities across the health team. The primary responsibility of the Nurse Care Manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.

### ***Comprehensive care management***

Comprehensive care management services are conducted by the Nurse Care Manager, Primary Care Physician Consultant, the Health Home Administrative Support staff, and Health Home Director with the participation of other team members. Services include:

- a. Identification of high-risk individuals and use of client information to determine level of participation in care management services;
- b. Assessment of preliminary service needs and treatment plan development, which will include client goals, preferences and optimal clinical outcomes;
- c. Assignment of health team roles and responsibilities;
- d. Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
- e. Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and
- f. Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

### ***Comprehensive transitional care from inpatient to other settings, including appropriate follow-up***

In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing consumers' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management. The Health Home Director, Primary Care Physician Consultant, and Nurse Case Manager will all participate in providing Comprehensive Transitional Care activities including, whenever possible, participating in discharge planning.

### ***Health promotion***

Health promotion services shall minimally consist of: providing health education specific to an individual's chronic conditions; development of self-management plans with the individual, education regarding the importance of immunizations and screenings; and providing support for improving social networks and providing health-promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist consumers with participating in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Health Home Director, Primary Care Physician Consultant, and Nurse Care Manager will each participate in providing Health Promotion activities. The success of health promotion activities is enhanced by support from Peer Wellness Coaches/Peer Recovery Specialists and other models of health navigators.

### ***Individual and family support, which includes authorized representatives***

Individual and family support services activities include, but are not limited to advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning with their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self-manage their care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with developmental disabilities (DD) the health team will refer to and coordinate with the approved DD case management entity for services more directly related to habilitation and coordinate with the approved DD case management entity for services more directly related a particular healthcare condition. Nurse Care Managers will provide this service.

### ***Referral to community and social support services, including appropriate follow-up***

Referral to community and social support services, including long term services and supports, involves providing assistance for consumers to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for this service. The Nurse Care Manager and Administrative support staff will provide this service.

## Appendix G – Adult Physical Health Measures

The following chart depicts the health measurements and ranges collected by current PIPBHC grantees to help determine health outcomes and risk statuses of clients for these physical health conditions. Data for additional health conditions (e.g., HIV/AIDS, Hepatitis A, B, C testing) are to be collected and additional guidance will be provided post award.

<b>Health Measurements</b>	<b>Term</b>	<b>Measurements and Ranges to be Collected</b>
Blood pressure (Systolic / Diastolic)	mmHg	<ul style="list-style-type: none"> <li>•Normal <i>Less than 120 (S) / less than 80 (D)</i></li> <li>•Prehypertension <i>129-139 (S) / 80-89 (D)</i></li> <li>•High hypertension <i>140 or higher (S) / 90 or higher (D)</i></li> </ul>
Body Mass Index	BMI	<ul style="list-style-type: none"> <li>•Normal <i>Under 25</i></li> <li>•Overweight <i>25-29</i></li> <li>•Obese <i>30-39</i></li> <li>•Extreme Obesity <i>40+</i></li> </ul>
Waist circumference	cm/ inches	Men <i>Over 102 cm (40 inches)</i> Women <i>Over 88 cm (35 inches)</i>
Breath CO	Ppm	Normal <i>1-6</i> Light smoker <i>7-10</i> Heavy smoker <i>10+</i> *These numbers are generally shown using the Breathalyzer, which help clients see and track their progress in tobacco cessation and reduction
Plasma glucose (fasting) and/or HgbA1c	mg/dL and/or percent	<ul style="list-style-type: none"> <li>•Normal <i>99 mg/dL or below (FPG) and/or about 5% (HgbA1c)</i></li> <li>•Prediabetes <i>100-125 mg/dL (FPG) and/or 5.7 to 6.4% (HgbA1c)</i></li> <li>•Diabetes <i>126 mg/dL or above (FPG) and/or 6.5% or above (HgbA1c)</i></li> </ul>
HDL cholesterol	mg/dL	At risk for cardiovascular disease <i>Less than 40</i>
LDL cholesterol	mg/dL	At risk for cardiovascular disease <i>Greater than 130</i>
Triglycerides	mg/dL	At risk for cardiovascular disease <i>Greater than 150</i>

## Appendix H: Recommended Screenings and Protocols for Health and Behavioral Health

### Recommended screenings and protocols

It is recommended that an integrated care setting provide substantial screenings and protocols for primary care, mental health, and substance use. Identify the types of screenings and protocols that will be used for each of the categories related to the special population(s) served. The following categories include suggested screenings and protocols:

#### **For Adults:**

*General health* screenings must include: cholesterol and blood, blood pressure/hypertension, BMI, weight, tobacco use, fasting glucose or HgbA1c, diabetes, heart disease, cholesterol, cancer, communicable diseases such as HIV/AIDS, sexually transmitted diseases (STDs), Hepatitis A, B, and C, etc.

*General behavioral health* screenings must include: depression (including suicidal ideation), anxiety, trauma, alcohol and illicit substance use. For a full listing of publically available screening tools, follow <http://www.integration.samhsa.gov/clinical-practice/screening-tools>.

While provider organizations are free to choose which screening tools are suitable for their particular population of focus, for evaluation purposes provider organizations **must** utilize the following screening tools to report outcomes for depression, anxiety and posttraumatic stress disorder (PTSD):

- Patient Health Questionnaire-9 (PHQ-9) - The PHQ-9 is a concise, self-administered tool for assessing depression. It is a free and publically available tool that can be downloaded in 30 different languages at <http://www.phqscreeners.com/>. The manual and scoring guide are available at: <https://phqscreeners.pfizer.edrupalgardens.com/sites/g/files/g10016261/f/201412/instructions.pdf>.

Reference information for the utility of the PHQ-9 for the assessment of depression can be found at

<http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.aspx>.

- Generalized Anxiety Disorder-7 item scale (GAD-7) is a screening tool for generalized anxiety disorder which identifies whether a complete assessment for

anxiety is indicated.<sup>12</sup> It is a free and publically available tool that can be downloaded in 30 different languages at <http://www.phqscreeners.com/>.

- The Primary Care PTSD Screen (PC-PTSD) is a 4-item screen that was designed for use in primary care and other medical settings for the identification of posttraumatic stress disorder. This tool and its instructions are available at <http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp>.

For blood pressure, there are 4 CDC recommended protocols:

1. National Heart, Lung and Blood Institute, National Institutes of Health. *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure - Complete Report*. National Heart, Lung, and Blood Institute, National Institutes of Health. NIH Publication No. 04-5230, 2004.  
(<http://www.nhlbi.nih.gov/health-pro/guidelines/current/hypertension-jnc-7/>)
2. Elements Associated with Effective Adoption and Use of a Protocol  
Insights from Key Stakeholder.  
(<http://millionhearts.hhs.gov/resources/protocols.html>)
3. An Effective Approach to High Blood Pressure Control A Science Advisory From the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and  
(<http://www.sciencedirect.com/science/article/pii/S0735109713060774>)
4. Protocol-Based Treatment of Hypertension : A Critical Step on the Pathway to Progress; *JAMA January 1, 2014 Volume 311, Number 1*  
(<http://jama.jamanetwork.com/journal.aspx>)

For tobacco use, review the Protocol for Identifying and Treating Patients Who Use Tobacco

<https://millionhearts.hhs.gov/files/Tobacco-Cessation-Protocol.pdf>

### **For Children and Adolescents:**

*General health* screenings must include: weight, obesity, body mass index, sleep, asthma, oral health, immunizations, wellness visits, tobacco use (for school-aged children and adolescents, including exposure to second hand smoking), communicable diseases such as HIV/AIDS, sexually transmitted diseases (STDs), Hepatitis A, B, and

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<sup>12</sup> Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

C, etc. Note that not all of the health outcomes are available to be collected in SPARS and will be reported separately. Additional guidance will be provided to grantees.

*General behavioral health* screenings must include: depression (including suicidal ideation), anxiety, trauma, developmental/behavioral and substance use. While provider organizations are free to choose which age-appropriate screening tools are suitable for their particular population of focus, for evaluation purposes provider organizations **must** utilize the following screening tools to report outcomes for depression and psychosocial problems in children/adolescents:

- The Pediatric Symptom Checklist-17 (PSC-17) (parent/caretaker version) is a brief screening questionnaire that is used by pediatricians and other health professionals to improve the recognition and treatment of psychosocial problems in children ages 4 to 18 years old. This tool is available over 12 languages and is publically available at [http://www.massgeneral.org/psychiatry/services/psc\\_home.aspx](http://www.massgeneral.org/psychiatry/services/psc_home.aspx).
- Patient Health Questionnaire-Adolescent (PHQ-A) - The PHQ-A was adapted from the PHQ-9 modified for Adolescents (PHQ-A)<sup>13</sup>, which is in the public domain (<http://www.phqscreener.com/instructions/instructions.pdf>). The PHQ-A is a concise, self-administered tool for assessing depression in children ages 12-18 years old. It is a free and publically available at <http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/upload/PHQ-A-Severity-Measure-for-Depression.pdf>.

The U.S. Preventive Services Task Force recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents (Grade B Recommendation). This recommendation has been adopted by the American Academy of Family Physicians and American Academy of Pediatrics.

<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions>

Below are two recommended protocols to screen for tobacco use in children.

American Academy of Pediatrics' Clinical Practice Policy to Protect Children from Tobacco, Nicotine, and Tobacco Smoke”

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<sup>13</sup> The reference for the original measure is: Johnson JG, Harris ES, Spitzer RL, Williams JBW: The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. *J Adolescent Health* 30:196–204, 2002.

<http://pediatrics.aappublications.org/content/136/5/1008>

Protocol for Identifying and Treating Patients Who Use Tobacco (age 13 and older)

<https://millionhearts.hhs.gov/files/Tobacco-Cessation-Protocol.pdf>

For adults and children, consider using the metabolic protocol when first episode psychosis occurs to monitor and prevent physical health conditions associated with atypical medications for behavioral health.

## **Appendix I – SAMHSA’s Guidelines for Selecting Communities of High Need**

In identifying and selecting communities of high need to be funded with PIPBHC funds, applicants must be able to describe a limited population that is:

1. A specific geographically defined area; or
2. A specifically defined population based on a culture, federally recognized tribe, ethnicity, language, occupation, or gender or other specifically described identity, within a specific geographic area; or
3. A specific population defined by a school, military base, campus or other institutional setting;

Where the population described has or is at risk of having a higher than average prevalence rate of underage drinking and/or prescription drug abuse/misuse; or a higher than average prevalence rate of the substance abuse priority(ies) the applicant is proposing to address;

AND

Where the population or area has limited resources or has had fewer opportunities or less success in identifying and bringing to bear resources to address the identified priority(ies).

**NOTE TO TRIBAL APPLICANTS:** It is up to each eligible applicant tribe, tribal organization or tribal entity to define for themselves, within the framework of the definition and its criteria provided above, what constitutes their particular community or communities of high need—ranging from a single community tribe of high need to multiple communities within a tribe, tribal entity or organization.