# Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Program Overview NOFO: SM-24-011

May 8, 2024

2:00 PM Eastern Standard Time

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

https://www.samhsa.gov/grants/grant-announcements/sm-24-011

SAMHSA
Substance Abuse and Mental Health Services Administration

# Agenda

**Welcome & Brief Remarks**

CDR Nicole Pascua, PIPBHC Program Lead

**Review of Notice of Funding Opportunity (NOFO)**

Jenny Nate Cornelia, PIPBHC Government Project Officer and PIPBHC CoCM NOFO Lead

**Review of Application Evaluation and Program FAQs**

CDR Nicole Pascua

**Overview of Application Process**

Jasmine Magruder, Office of Financial Resources, Division of Grant Review

**Q&A**

CDR Nicole Pascua, Jenny Nate Cornelia, and Jasmine Magruder

# Purpose of the PIPBHC Program

Promote full integration and collaboration in clinical practices between physical and behavioral health care

Support the improvement of integrated care models for physical and behavioral health care to improve overall wellness and physical health status

Promote the implementation and improvement of bidirectional integrated care services, including evidence-based or evidence-informed screening, assessment, diagnosis, prevention, treatment, and recovery services

# Purpose of PIPBHC: Collaborative Care Model

The purpose of this grant is to support implementation of the Collaborative Care Model (CoCM). The CoCM is an evidence-based, integrated care approach that addresses mental and substance use conditions in primary care settings.[1,2]

SAMHSA aims to increase the identification and treatment of mental health conditions for individuals who access care through primary care practices that too often go untreated and cause disability.

State agencies participating in this program will work with at least three primary care practices to develop the staffing and systems necessary to implement the CoCM.

[1] Reist C, Petiwala I, Latimer J, Raffaelli SB, Chiang M, Eisenberg D, Campbell S. Collaborative mental health care: A narrative review. Medicine (Baltimore). 2022 Dec 30;101(52):e32554. doi: 10.1097/MD.0000000000032554. PMID: 36595989; PMCID: PMC9803502.

[2] For a listing of research related to the CoCM see https://aims.uw.edu/collaborative-care/evidence-base-cocm

# Basic NOFO Information (pp. 4-5)

**Funding Opportunity Number:** SM-24-011

**Application Due Date:** May 20, 2024

**Estimated Total Available Funding:** $5,200,000

**Estimated Number of Awards:** Up to 5

**Estimated Award Amount:** Up to $900,000 per year per award

**Anticipated Project Start Date**: September 30, 2024

**Length of Project Period:** Up to 5 Years

# Eligible Applicants (Section III.1)

**Eligibility for this program is statutorily limited to a State or appropriate State agency. Appropriate state agencies include the State Mental Health Authority, the Single State Agency (SSA) for substance abuse services, the State Medicaid agency, or the State Health Department.**

State agencies participating in this program will work with at least three primary care practices to develop the staffing and systems necessary to implement the CoCM.

- Only one application per state will be funded. If more than one state agency applies, SAMHSA will fund the highest scoring application.

- States (and other state agencies in those states) that received funding under the PIPBHC NOFO (SM-23-005) to implement a Track 2 project are not eligible for this funding opportunity. **The states that are not eligible to apply are Arkansas, Florida, Kansas, Maryland, Minnesota, and New York.**

# Evidence of Experience and Credentials (Section III.3)

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide the required services quickly and effectively. Applicants are encouraged to include appropriately credentialed organizations that provide services to underserved, diverse populations.

Applicants must submit evidence that three additional requirements related to the provision of services have been met (in attachment 1):

1. At least three primary care provider/practice organization for direct client services appropriate to the award must be involved in the project. The provider must be an organization committed to the project as demonstrated by a Letter of Intent (LOI).
2. Each primary care provider/practice organization must have at least two years of experience (as of the due date of the application) providing relevant services. Official documents must establish that the organization has provided relevant services for the last two years.
3. Each of the three primary care providers/practices must be in compliance with all applicable local (city, county) and state licensing, accreditation, and certification requirements, as of the due date of the application.

# Evidence of Experience and Credentials (continued)

**(Section III.3)**

The three additional requirements listed on Slide 7 apply to all primary care service provider organizations.

- If the state licensure requirements are not met by the organization, an individual's license cannot be used instead of the state requirement.
- Eligible tribes and tribal organizations primary care providers must be in compliance with all applicable tribal licensing, accreditation, and certification requirements as of the due date of the application.
- In Attachment 1 of the application, applicants must include a statement certifying that the service provider organizations meet these requirements.

# Key Personnel (Section I.2)

The Key Personnel for this program will be the **Project Director** with a minimum level of effort of 0.25 FTE and the **Project Evaluator** with a minimum level of 0.25 FTE.

- The roles of Project Director and Evaluator must not be held by the same individual.
- These positions require prior approval by SAMHSA after review of credentials of staff and job descriptions.

The **Project Director** is responsible for oversight of the entire project. For this program, the Project Director is expected, at a minimum, to:

a) have decision-making authority within the organization for project-related matters;
b) maintain knowledge of/experience with behavioral health services and service delivery;
c) provide overall oversight and leadership for all aspects of the project,
d) ensure all key program, required activities are implemented;
e) report on key program requirements; and
f) meet on a regular basis with the Government Project Officer.

The **Project Evaluator** will be responsible for supporting data collection, analysis, required reporting and participation in any federally required evaluation activities, and coordination of the evaluation and data collection with local participating providers.

# Required Activities-Provider Partners (Section I.3)

States must partner with at least three primary care providers/practices to implement the Collaborative Care Model (CoCM).

> Primary care settings include "those practicing in family medicine, general internal medicine, general pediatrics, geriatrics, and other professions that fulfill general health needs."

The **Collaborative Care Model**[1] serves defined patient populations tracked in a registry, using measurement-based care and treatment that is adjusted when desired outcomes are not achieved.

Grantees should partner with providers in underserved communities or providers with a significant focus on serving populations facing health disparities.

[1]The Collaborative Care Model is an evidence-based, integrated behavioral health service delivery method that includes care directed by the primary care team; structured care management; regular assessments of clinical status using developmentally appropriate, validated tools; and modification of treatment as appropriate.

# Populations to Be Served (Section I.3)

Grantees are expected to serve the general population served through their primary care practices. In addition, each practice must select one or more of these special populations to serve as part of their proposed project:

- Adults with a Severe Mental Illness (SMI) who have co-occurring mental illness and physical health conditions or chronic disease
- Children/adolescents with a Serious Emotional Disturbance (SED) who have a co-occurring physical health condition
- Individuals with a substance use disorder
- Individuals with co-occurring mental illness and substance use disorder

# Required Activities (Section I.3)

- Delivery of services must begin within seven months of award (refer to the Integration Program Plan).
- Applicants are expected to serve the unduplicated number of individuals proposed in the Project Narrative (B.1).
- Applicants must provide a description in B.2. of the Project Narrative of how you plan to implement all the required activities listed in Section I.3.

# Required Activities-Program Readiness (Section I.3)

## 1. Conduct a Program Readiness Review

Within five months of award, grantees shall conduct a **Program Readiness Review** to identify barriers and current or potential facilitators to implementing the CoCM. The Program Readiness Review will inform the required integration program plan and quality improvement program. At a minimum, the Program Readiness Review must address:

- Behavioral health conditions that are commonly experienced by the selected population(s) of focus at the chosen primary care provider(s); and
- Barriers to access, such as cultural sensitivity, language inclusivity, economic status, and health literacy; and
- Policies, practices, barriers, needs, supports, and facilitators that should be addressed within the chosen primary care practices to strengthen implementation of the CoCM, as well as strategies to address those barriers, needs, supports, and facilitators.

# Required Activities-Program Implementation Plan

**(Section I.3)**

## 2. Develop a Program Implementation Plan

Within seven months of the award, grantees shall develop/implement a **Program Implementation Plan** that identifies the project activities. The plan must describe how you and selected primary care providers/practices will implement the CoCM, including:

- Care directed by the primary care team in collaboration and consultation with licensed behavioral health specialists;
- Regular assessments of clinical status using developmentally appropriate, culturally adapted, validated tools, including broad screening for mental and substance use conditions across the population served through the primary care practice;
- Modification of treatment, using measurement-based care and evidence-based protocols, including consultation with a psychiatrist or other behavioral health specialist for individuals who are not showing improvement; and
- Structured care management, including:
  - Use of a patient registry that tracks progress with measurement-based care and engagement; and
  - Warm handoff to or direct delivery of behavioral health supports for individuals identified as experiencing a mental health or substance use condition.

# Required Activities-Statewide Planning Council (Section I.3)

## 3. Develop and/or add to an Existing Statewide Planning Council

Within six months of the award, grantees shall develop and/or maintain an existing **State Planning Council** for integrated care. The Council will:

- Provide guidance to the recipient on barriers that impact the implementation of integrated care;
- Explore opportunities to advance the CoCM across state health programs, including the Medicaid program, and the state plans developed in conjunction with the Community Mental Health Services Block Grant and the Substance Use Prevention, Treatment, and Recovery Services Block Grant application; and
- Collaborate with and get feedback from the state primary care and behavioral health associations, academic partners, other provider associations and stakeholders, such as those that represent individuals being served by the program and community partners that work with *underserved populations* to inform state planning.

# Required Activities-Program Agreements and Sustainability
(Section I.3)

## 4. Develop and Implement Program Agreements

Within seven months of the award, grantees shall develop and implement **program agreements** between the grant recipient and participating primary care practices. The program agreements must outline the formal relationship between the grant recipient and primary care practices to deliver the clinical services and adhere to applicable federal regulations as well as the program requirements indicated in the NOFO.

## 5. Submit and Implement a Sustainability Plan

At the end of Year 1 (and updated annually), grantee shall submit a **Sustainability Plan** that addresses, at the state and provider levels, sustainability for the integrated care program when the funding ends. The sustainability plan must include the identification of financing gaps and administrative and billing challenges, in addition to the identification of sources of support that will be used to sustain the CoCM program.

# Required Activities-Partnerships and TA (Section I.3)

## 6. Support partnerships with local health care providers

Grantees will demonstrate support for partnerships with providers offering services to special populations and, as applicable, in areas with demonstrated need, such as tribal, rural, or other medically underserved communities, such as those with a workforce shortage of mental health and substance use disorder, pediatric mental health, or other related professionals.

## 7. Technical assistance and training

Grantees will actively engage with the Center of Excellence for Integrated Health Solutions (CIHS) to develop and implement strategies that enhance bi-directional integrated care related to clinical practice, workforce development (recruitment and retention), evidence-based and evidence informed treatment, financing, program evaluation, and program sustainability.

# Required Activities-Contracts and Software (Section I.3)

## 8. Identify and formalize contractual relationships

Grantees will support participating provider practices to hire staff and to **identify and formalize contractual relationships** with other health care providers or relevant entities offering care management and behavioral health consultation to facilitate the adoption of integrated care. This can include, as applicable, providers who can function as psychiatric consultants and behavioral health care managers in providing behavioral health integration services through the CoCM.

## 9. Purchase or upgrade software

Grantees will **purchase or upgrade software** and other resources, as needed, to provide behavioral health integration, including resources needed to establish a patient registry and implement measurement-based care.

# Allowable Activities (Section I.4)

This list shows the types of activities that are allowable with these funds. These are examples, not required activities. Applicants may propose to use funds for the following activities:

1. Screening for some medical conditions, such as:
    - HIV and other sexually transmitted infections
    - Viral hepatitis
    - Tobacco/nicotine use
    - Substance use disorders, including opioid and alcohol use disorders
    - Dental health needs
2. Support the delivery of integrated care through cloud-based systems, or remote support of integrated care functions, such as expert consultation on the delivery of integrated primary or behavioral health care, care management, or support for stepped care protocols.
3. Pay for one-time costs that will support the integrated care program (e.g., shared team resources, establishing clinical workflows, policy development, initial engagement to establish relationships across care providers).
4. Support the uptake of telehealth appointments and care coordination.
5. Conduct state-sponsored networking activities and technical assistance to support integrated care providers.

# Allowable Activities (cont.) (Section I.4)

6. Develop the capacity to prescribe buprenorphine and naltrexone in the integrated care settings supported through the award regardless of the population(s) of focus identified in the integration program plan.
7. Facilitate immediate warm handoff to providers of medications for opioid and alcohol use disorders when needed.
8. Provide dental hygiene kits to program clients to aid in oral health disease prevention and treatment.
9. Implement and provide training on the National CLAS Standards to service providers to increase awareness and acknowledgment of differences in language, age, culture, racial and ethnic disparities, socio-economic status, religious beliefs, sexual orientation and gender identity, and life experiences to improve the inclusiveness of the service delivery environment and ultimately improve behavioral health outcomes.
10. Provide activities that address behavioral health disparities and the social determinants of health, including through partnerships with Medicaid providers and agencies and other state, local, tribal, and territorial partners as applicable.
11. Implement efforts aligned to the project that may expand diversity, equity, inclusion, and accessibility.
12. Use data to understand who is served and disproportionately served (e.g., overserved or underserved).
13. Develop and implement outreach and referral pathways that engage/target all demographic groups representative of the community (e.g., veterans, LGBTQ+ persons, and older adults).

# Evidence Based Practices (Section I.5)

- Evidence-based practices are interventions that promote individual-level or population-level outcomes. They are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the people receiving the services. See SAMHSA's Evidence-Based Practices Resource Center and the National Network to Eliminate Disparities in Behavioral Health to identify evidence-informed and culturally appropriate mental illness and substance use prevention, treatment, and recovery practices that can be used in your project.

- See Section I.5 of NOFO for definitions and further discussion around the use of **evidence-based practice** (EBP), **culturally adapted practice**, and **community-defined evidence practice** (CDEP).

- In Section C of the Project Narrative, applicants are required to identify the practice(s) from the above categories that are appropriate or can be adapted to meet the needs of the specific population(s) of focus.

# Data Collection & Performance Measurement (Section I.6)

Recipients 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.

- You must collect and report in SAMHSA's Performance Accountability and Reporting System (SPARS) two types of data using the Mental Health Client/Consumer Outcome Measures tool and the Infrastructure, Prevention and Promotion Indicators tool. Training and technical assistance on SPARS data collection and reporting will be provided after award.

# NOMS Data (Section I.6)

The Mental Health Client/Consumer Outcome Measures (NOMs) tool collects client-level data on a real-time basis as clients are enrolled for services. You must collect these data on each client at baseline (i.e., client entry into the project), at 6-month follow-up, and at client discharge.

Data must be entered in SPARS within 7 days after collection. Data are to be captured for clients who are served by the program.

Data will be collected on:

- Behavioral Health Diagnoses
- Demographic Data
- Functioning
- Services Received

# IPP Data

The Infrastructure Development, Prevention, and Mental Health Promotion (IPP) indicators are project-level data collected and reported in SPARS on a quarterly basis. Recipients must collect data on the following IPP assigned indicators:

- The number of individuals screened for mental health or related interventions;
- The number of individuals referred to mental health or related services; and
- The number and percentage of individuals receiving mental health or related services after referral.

Recipients must periodically review their performance data to assess your progress and use this information to improve the management of the project. The project performance assessment allows you to determine whether your goals, objectives, and outcomes are being achieved and if changes need to be made to the project. This information is included in your Programmatic Progress Report.

In addition, one key part of the performance assessment is determining if your project has or will have the intended impact on behavioral health disparities. You will be expected to collect data to evaluate whether the disparities you identified in your Disparity Impact Statement (DIS) are being effectively addressed.

See Application Guide Section D and E and for more information on responding to this section.

# Other Expectations (Section I.7)

- SAMHSA expects recipients to use funds to implement high quality programs, practices, and policies that are **recovery-oriented**, **trauma-informed**, and **equity-based** to improve behavioral health.

- If funded, you must submit a Disparity Impact Statement (DIS) no later than 60 days after your award. (See Section G of Application Guide).

- Recipients must first use revenue from third-party from providing services to pay for uninsured or underinsured individuals. Recipients must implement policies and procedures that ensure other sources of funding are used first when available for that individual. Program income revenue generated from providing services must first be used to pay for programmatic expenses related to the proposed grant activities. Recipients must also assist eligible uninsured clients with applying for health insurance.

# Other Expectations (cont.)

See I.7. for full details related to other expectations. The following are some examples:

- Recipients are encouraged to address the behavioral health needs of active-duty military service members, National Guard and reserve service members, returning veterans, and military families in designing and implementing their programs. Where appropriate, consider prioritizing this population for services.
- In line with the Executive Order on Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals and the behavioral health disparities that the LGBTQI+ population faces, all recipients are encouraged to address the behavioral health needs of this population in designing and implementing their programs.

SAMHSA will hold virtual recipient meetings and expects grantees to fully participate in these meetings. (Section I.8.)

# Funding Limitations/ Restrictions (Section IV.5)

Be sure to identify these expenses in your proposed budget.

- **No more than 10 percent** of funds for each budget period may support state administrative functions, and the remaining amounts shall be allocated to health facilities that provide integrated care.

- **Not less than 90 percent** of the total award for each budget period shall be allocated to qualified community programs, community mental health centers, rural health clinics, Federally Qualified Health Clinics, and primary care providers/practices that provide integrated care.

- Food can be included as a necessary expense for individuals receiving SAMHSA-funded mental and/or substance use disorder treatment services, not to exceed $10.00 per person per day.

You must also comply with SAMHSA's Standards for Financial Management and Standard Funding Restrictions in Section H of the Application Guide.

# Required Application Components (Section IV)

- SF-424 – Fill out all Sections of the SF-424.

- SF-424A Budget Information Form– Fill out all Sections of the SF-424A. The totals in Sections A, B, and D must match.
  - See Section B of the Application Guide to review common errors in completing the SF-424 and the SF-424A. These errors will prevent your application from being successfully submitted

- Project Narrative– (Maximum 15 pages total)

- Budget Justification and Narrative

# Required Application Components (Continued)

- Attachments 1 Through 7:
  - Attachment 1: Evidence of Experience and Credentials and Letters of Intent
  - Attachment 2: Data Collection Instruments/ Interview Protocols
  - Attachment 3: Sample Consent Forms
  - Attachment 4: Project Timeline
  - Attachment 5: Biographical Sketches and Position Description
  - Attachment 6: ~~Letter to the State Point of Contact~~ (N/A)
  - Attachment 7: Confidentiality and SAMHSA Participant Protection/ Human Subjects Guidelines

# SAMHSA Grants and Confidentiality and Participant Protection

## Attachment 7: Confidentiality and SAMHSA Participant Protection/ Human Subjects Guidelines

- All SAMHSA grantees are required to have safeguards protecting individuals from potential risks associated with their participation in SAMHSA projects, even if those projects are not focused on research
- All organizations that apply for SAMHSA grants must address all seven components of confidentiality and participant protection to ensure there are safeguards for participants and staff
- **If you are working with individuals, there are potential risks to both participants and staff.**

# Seven Components of Participant Protection

1. Protect Clients and Staff from Potential Risks
2. Fair Selection of Participants
3. Absence of Coercion
4. Data Collection
5. Privacy and Confidentiality
6. Adequate Consent Procedures
7. Risk/Benefits Discussion

# Participant Protection - Common Mistakes

- Not submitting a response to the participant protection guidelines with your application
- Stating that participant protection is not applicable since you are not conducting research
- Stating there are no foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project. *If your project involves individuals, there will be some level of risk or potential adverse effects*.
- Only addressing participant protection as it relates to evaluation of the project.
- Not addressing all of the bulleted items within each of the seven components

# Application Evaluation Criteria (Section V)

- The Project Narrative (Sections A-E) together may be no longer than 15 pages.
- SECTION A: Population of Focus and Statement of Need (15 points – approximately 1 page)
- SECTION B: Proposed Implementation Approach (30 points – approximately 8 pages not including Attachment 4 – Project Timeline)
- SECTION C: Proposed Evidence-Based Service/Practice (25 points approximately 3 pages)
- SECTION D: Staff and Organizational Experience (20 points – approximately 2 pages)
- SECTION E: Data Collection and Performance Measurement (10 points – approximately 1 page)

# Section A: Population of Focus and Statement of Need

1. Identify and describe your population(s) of focus and the geographic catchment area where you will deliver services that align with the intended population of focus. Provide a demographic profile of the population of focus to include the following: race, ethnicity, federally recognized tribe (if applicable), language, sex, gender identity, sexual orientation, age, and socioeconomic status. Provide detail to substantiate that the state plans to partner with providers in underserved communities or providers with a significant focus on serving populations facing health disparities.

2. Describe the extent of the problem in the catchment area, including service gaps and disparities experienced by underserved and historically under-resourced populations. Document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus identified in A.1. Identify the source of the data (for example, the National Survey on Drug Use and Health (NSDUH), County Health Rankings and Roadmaps, Social Vulnerability Index, etc.).

# Section B: Proposed Implementation Approach

1. Describe the goals and measurable objectives of your project and align them with the Statement of Need described in A.2.

2. Describe how you will implement all Required Activities in Section I.

3. In Attachment 4, provide no more than a two-page chart or graph depicting a realistic timeline for the entire five years of the project period showing dates, key activities, and responsible staff. The key activities must include the required activities outlined in Section I .

# Section C: Proposed Evidence-Based Service/Practice

1. Identify the EBPs, culturally adapted practices, or CDEPs that you will use. Discuss how each intervention chosen is appropriate for your population(s) of focus and the intended outcomes you will achieve. Describe any modifications (e.g., cultural) you will make to the EBP(s)/CDEP(s) and the reasons the modifications are necessary. If you are not proposing to make any modifications, indicate so in your response.

2. Describe the monitoring process you will use to ensure the fidelity of the EBPs/CDEP(s), evidence-informed and/or promising practices that will be implemented. (See information on fidelity monitoring in Section I.5).

# Section D: Staff and Organizational Experience

1. Demonstrate the experience of your organization with similar projects and/or providing services to the population(s) of focus, including underserved and historically under-resourced populations.

2. Identify at least three the primary care practices/providers that you will partner with in the project. Describe their experience providing services to the population(s) of focus. Describe the diversity of partnerships. Include Letters of Intent from each partner in **Attachment 1.**

3. Provide a complete list of staff positions for the project, including the Key Personnel (Project Director and Project Evaluator) and other significant personnel. For each staff member describe their:
   - Role,
   - Level of Effort (stated as a percentage full-time employment, such as 1.0 (full-time) or 0.5 (half-time) and not number of hours)
   - Qualifications, including their experience providing services to the population of focus, familiarity with the culture(s) and language(s) of this population, and working with underserved and historically under-resourced populations.

# Section E: Data Collection and Performance Measurement

Describe how you will collect the required data for this program and how such data will be used to manage, monitor, and enhance the program.

# Application Submission

You are required to complete three (3) step registration processes:

- System for Award Management (SAM);
- Grants.gov; and
- eRA Commons
  - **This process takes up to six weeks. If you believe you are interested in applying for this opportunity, start the registration process immediately. Do not wait to start this process.**

If you have already completed registrations for SAM, and Grants.gov, you need to ensure that your accounts are still active, and then register in **eRA Commons**.

**See Section A of the Application Guide for detailed instructions**

# FAQs

**Q.** ***We are a state agency and currently have a PIPBHC grant. Can we apply for this NOFO?***

A. States (and other state agencies in those states) that received funding under the PIPBHC NOFO (SM-23-005) to implement a Track 2 project are not eligible for this funding opportunity. The states that are not eligible to apply are **Arkansas, Florida, Kansas, Maryland, Minnesota, and New York.**

***Q. Can more than one state agency apply for this NOFO?***

A. Yes, more than one state agency can apply for NOFO SM-24-011. However, 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.

# FAQs

**Q.** ***We are a contracting agency that works with the State. Can we apply for this grant?***

**A.** 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).

**Q.** ***We are a primary care provider and are interested in applying for SM-24-011. Can we apply for this grant?***

**A.** No. Community organizations that wish to participate in this NOFO should contact their state to discuss how they can be a collaborating provider of services.

# FAQs

***Q. What if our state wants to partner with a primary care provider that is not fully operational? Is this okay?***

**A.** Providers of services must have at least two years of experience providing relevant services. The delivery of services must begin within seven months of the award. Grantees are expected to deliver the Required Activities as listed in the NOFO and in the applicant's project narrative. Additionally, please review the NOFO regarding Letters of Intent from experienced, credentialed primary care providers/practices that will implement the Collaborative Care Model.

# FAQs

**Q.** ***Are indirect costs included in the Funding Limitations / Restrictions for our proposed budget?***

A. Yes, indirect and direct costs are subject to the Funding Limitations/Restrictions. Please see Section IV.5 of the NOFO for additional information.

# Points of Contact

For **program and eligibility questions** contact:

Jenny Nate Cornelia
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
PIPBHC@samhsa.hhs.gov

For **fiscal/budget questions** contact:

Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
(240) 276-1940
FOACMHS@samhsa.hhs.gov

For **review process and application status questions** contact:

Jasmine Magruder
Office of Financial Resources, Division of Grant Review
Substance Abuse and Mental Health Services Administration
(240) 276-1200
Jasmine.Magruder@samhsa.hhs.gov

# Points of Contact

Problems submitting your application on **Grants.gov?** Contact the Grants.gov Service Desk at the following:

By e-mail: support@grants.gov

By phone: (toll-free) 1-800-518-4726 (1-800-518-GRANTS).

Additional support is also available from the **NIH eRA Service desk** at:

To submit a service request ticket:

http://grants.nih.gov/support/index.html

By phone: 301-402-7469 or (toll-free) 1-866-504-9552. (Press menu option 6 for SAMHSA).

If you experience problems **accessing or using ASSIST,** you can:

Access the ASSIST Online Help Site at:

https://era.nih.gov/erahelp/assist/

Or contact the NIH eRA Service Desk