

MAI CoC RFA 2014 FAQs

1. What is the purpose of the grant?

The purpose of this jointly funded program is to integrate care (behavioral health treatment, prevention, and HIV medical care services) for racial/ethnic minority populations at high risk for behavioral health disorders and high risk for or living with HIV. The grant will fund programs that provide coordinated and integrated services through the co-location of behavioral health treatment and HIV medical care. This program is primarily intended for substance abuse treatment programs and community mental health programs that can co-locate and fully integrate HIV prevention and medical care services within them (page 7)

2. Who is eligible to apply for the grant?

Eligible applicants are domestic public and private nonprofit entities. This includes behavioral, health programs, community and faith based organizations, federally recognized American Indian/Alaska Native tribes or tribal organizations, urban Indian organizations, hospitals, public or private universities and colleges. Eligible entities include behavioral health programs (e.g., substance abuse treatment and mental health providers) that are currently or can be co-located/integrated with HIV prevention and HIV medical care within four months of grant award. These behavioral healthcare providers may also partner with other organizations that will provide HIV prevention and HIV medical care (page 20).

3. My organization is a federally qualified health center or AIDS Service Organization, are we eligible to apply?

Yes, the Federally Qualified Health Centers and AIDS Service Organizations can apply either as the lead or a partner organization along with a certified and experienced (two year minimum) substance abuse treatment provider as long as the Evidence of Experience and Credentials requirements are met as described in section 3.2 (page 21).

4. Are State government agencies eligible to apply?

Yes, please refer to Eligibility (page 20).

5. What are the target populations (minority populations and sub-populations) of focus for this grant?

The target populations for this RFA are racial/ethnic minority populations at high risk for or have a mental and/or substance abuse disorder and who are most at risk for or living with HIV, including African American and Latino women and men, gay and bisexual men, transgendered persons, and substance users. Other high priority populations, such as American Indian/Alaskan Natives, Asian Americans, and other Pacific Islanders may be included based on the grantee's local HIV/AIDS epidemiological profile (page 7).

6. May our organization focus only on a sub-population that is not part of the primary population of focus (e.g. anyone who is gay, bisexual, or transgendered)?

No, sub-populations must be part of the primary population of focus, racial/ethnic minorities.

7. What are the goals of the grant?

As a result of this program SAMHSA expects the following outcomes: 1) increased HIV testing to identify behavioral health clients who are unaware of their HIV status; 2) increased diagnosis of HIV among behavioral health clients; 3) increased number of clients who are linked to HIV

medical care; 4) increased number of behavioral health clients who are retained in HIV medical care; 5) increased number of behavioral health clients who are receiving antiretroviral therapy (ART); 6) improved adherence to behavioral treatment and ART; 7) increased number of behavioral health clients who have sustained viral suppression; and 8) increased adherence and retention in behavioral health (both substance use and mental disorders) treatment. It is expected that effective person-centered treatment will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections. SAMHSA also expects an increase in behavioral health screenings, and a decrease in burden of behavioral health disorders in the surrounding community through partnering with community based organizations to provide substance abuse and HIV primary prevention services (pages 7-8).

8. What are SAMHSA's expectations for the awarded grantees?

SAMHSA expects the integration of projects (e.g., substance abuse, mental health, and co-occurring treatment) and HIV medical services through either the co-location of services or other means that demonstrate full service integration.

Regardless of the model chosen, applicants are expected to partner with a community based organization (CBO) to provide substance abuse and HIV primary prevention services. The CBO is expected to provide prevention education in the community served by the behavioral healthcare provider in addition to providing the appropriate primary prevention services within the behavioral health program.

Applicants must screen and assess clients for the presence of co-occurring mental and substance use disorders as well as HIV and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.

All clients within the behavioral health program should be screened for HIV and hepatitis in accord with existing CDC and USPSTF guidelines. It is expected that the grantee will increase enrollment in HIV medical services and necessary primary care services for racial/ethnic minorities by 10 percent in year two and 10 percent in each subsequent year of the grant award. (pages 9-10)

9. How does SAMHSA define co-location and full integration?

Co-location is defined as providing the HIV services within the physical space of the behavioral health program. Full Integration is defined as clients receiving the entire spectrum of HIV medical care in coordination and conjunction with the behavioral health services being received (pages 9-10).

10. If my organization already provides prevention education in the community we serve in addition to providing the appropriate primary prevention services within the behavioral health program, do we need to partner with another community based organization?

No, if these services are being provided, your organization would be considered the community based organization.

11. My organization currently has a SAMHSA grant. Can we apply to this RFA?

Yes

12. Are there any expectations for clinical research to be undertaken in this grant?

No, MAI CoC Pilot-Integration of HIV Medical Care into Behavioral Health Programs 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 4th month of the project at the latest (page 8).

13. Can SAMHSA grant funds be used to support medical provider salaries?

SAMHSA funds can be utilized when the medical provider is overseeing care or case management, but for any billable medical services, that part of the salary can't be paid for with SAMHSA funds. In your budget narrative/justification you would need to detail the Level of Effort for the medical provider's time that can be covered by SAMHSA's funding.

14. Can we use less or more than 5% of funding for supported viral hepatitis activities?

No, it must be exactly 5% of grant funding (page 13).

15. What viral hepatitis activities can be support with SAMHSA funds?

Hepatitis testing (antibody and confirmatory) and vaccinations.

16. Can any center's funds be utilized for the supported viral hepatitis services?

Yes (page 13).

17. What HIV activities can be directly supported with SAMHSA funds?

SAMHSA funds can directly support HIV risk assessments, antibody, and confirmatory testing. SAMHSA funds can also be used to establish the necessary partnerships with the HIV service organization to provide the above and medical services or primary care needed as part of complete HIV related medical care (page 13).

18. Can my organization request less than \$500,000? Yes.

19. Can my organization only provide the behavioral services we currently offer (e.g. can we only provide mental health services, and not substance abuse treatment or prevention)?

No. Regardless of the award amount requested, grantees will receive 39.23 percent of the total grant from CSAT (up to \$196,150), 45.86 percent of the total grant from CMHS (up to \$229,300), and 14.91 percent of the total grant from CSAP (up to \$74,550) for a total of \$500,000 per year (page 11 and 19).