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

FY 2024 Promoting the Integration of Primary and Behavioral Health Care: Collaborative Care Model

(Short Title: PIPBHC-CoCM)

(Initial Announcement)

Notice of Funding Opportunity (NOFO) No. SM-24-011

Assistance Listing Number: 93.243

Key Information:

Application Deadline	**Applications are due by May 20, 2024.**
FY 2024 NOFO Application Guide	Throughout the NOFO there will be references to the FY 2024 NOFO Application Guide (Application Guide). The Application Guide provides detailed instructions on preparing and submitting your application. Please review each section of the Application Guide for important information on the grant application process, including the registration requirements, required attachments, and budget.
Electronic Grant Application Submission Requirements	**You must complete three (3) registration processes**: 1. System for Award Management (SAM); 1. Grants.gov; and 3. eRA Commons. See ***Section A of the Application Guide*** *(Registration and Application Submission Requirements)* to begin this process.

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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 the fiscal year (FY) 2024 Promoting the Integration of Primary and Behavioral Health Care: Collaborative Care Model program. The purpose of this program 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] Care is provided by a primary care team and includes a case manager, consulting psychiatrist, and other mental health professionals. Recipients will be expected to work with at least three primary care practices to develop the staffing and systems necessary to implement the CoCM. With this program, 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.

Funding Opportunity Title:	Promoting the Integration of Primary and Behavioral Health Care: Collaborative Care Model (Short Title: PIPBHC-CoCM)
Funding Opportunity Number:	SM-24-011
Due Date for Applications:	May 20, 2024
Estimated Total Available Funding:	$5,200,000
Estimated Number of Awards:	5
Estimated Award Amount:	Up to $900,000 per year
Cost Sharing/Match Required:	No
Anticipated Project Start Date:	September 30, 2024
Anticipated Award Date:	No later than September 29, 2024
Length of Project Period:	Up to 5 years

Eligible Applicants:	Eligibility for this program is statutorily limited to a state or appropriate state agency. [See Section III-1 for complete eligibility information.]
Authorizing Statute:	PIPBHC grants are authorized under section 520K of the Public Health Service Act, as amended.

I. PROGRAM DESCRIPTION

1. PURPOSE

The purpose of the Promoting the Integration of Primary and Behavioral Health Care: Collaborative Care Model is to support implementation of the Collaborative Care Model (CoCM). The CoCM improves care for mental and substance use conditions in primary care settings.[1,2] Care is provided by a primary care team and includes a case manager, consulting psychiatrist, and other mental health professionals. This integrated care approach is patient-centered and evidence-based.

Access to behavioral health care is a persistent problem. According to the 2022 National Survey on Drug Use and Health, of the 59.3 million adults aged 18 or older who had a mental illness in the past year, about half (29.3 million people) did not receive mental health treatment. Of the 19.4 percent of people aged 12 or older who had a need for substance use disorder (SUD) treatment (54.6 million people), only 24 percent (13.1 million people) received any substance use treatment.[3] As a result, there is a need to improve access to whole-person health by increasing capacity for primary care settings to identify and connect people to integrated physical and behavioral health care. A range of research has shown the CoCM to be effective in improving outcomes for individuals with mental health needs by providing treatment through primary care settings.[4]

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.

SAMHSA encourages grant recipients to address the diverse behavioral health needs of underserved communities as defined by Executive Order 13985. Recipients must also serve all individuals equitably and administer their programs in compliance with federal civil rights laws that prohibit discrimination based on race, color, national origin, disability, age, religion, and sex (including gender identity, sexual orientation, and

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[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.

[3] Substance Abuse and Mental Health Services Administration. (2023). *Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health* (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

[4] https://aims.uw.edu/wordpress/wp-content/uploads/2023/11/1-Evidence-Base_Foundational.pdf

pregnancy). Recipients must also agree to comply with federal conscience laws, where applicable.

The Promoting the Integration of Primary and Behavioral Health Care: Collaborative Care Model is authorized under section 520K of the Public Health Service Act, as amended.

2. KEY PERSONNEL

Key personnel are staff members who must be part of the project, even if they do not receive a salary from the project. Key personnel must make a major contribution to the project. Key personnel and staff selected for the project should reflect the diversity in the geographic catchment area.

Key personnel for this program are 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 Project Director is responsible for oversight of the 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 and 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 is 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.

The roles of Project Director and Evaluator may not be held by the same individual. The role of the Evaluator can be a contracted position with the state.

If you receive an award, you will be notified if the individual(s) designated for these positions have been approved. If you need to replace Key Personnel during the project period, SAMHSA will review the credentials and job description before approving the replacement.

3. REQUIRED ACTIVITIES

You (the state) 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**[5] serves defined patient populations tracked in a registry, using measurement-based care and treatment that is adjusted when desired outcomes are not achieved. You should partner with providers in underserved communities or providers with a significant focus on serving populations facing health disparities. You 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 Serious Mental Illness (SMI) who have co-occurring mental illness and physical health conditions or chronic disease;
- Children and adolescents with a Serious Emotional Disturbance (SED) who have a co-occurring physical health conditions;
- Individuals with a substance use disorder (SUD); or
- Individuals with co-occurring mental illness and substance use disorder (COD).

Delivery of services must begin within seven months of award (refer to the Integration Program Plan).

You are expected to serve the unduplicated number of individuals proposed in the Project Narrative (B.1).

You must provide a description in B.2. of the Project Narrative of how you plan to implement all the required activities listed below.

1. **Conduct a Program Readiness Review**

When: Within five months of award

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

[5] 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.

implementation of the CoCM, as well as strategies to address those barriers, needs, supports, and facilitators.

2. **Develop a Program Implementation Plan**

   When: Within seven months of award

   Develop 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.

3. **Develop and/or add to an Existing State-wide Planning Council**

   When: Within six months of award

   Develop and/or maintain an existing **State Planning Council** for integrated care, which includes representation from the State Mental Health Authority, the Single State Agency that leads efforts related to substance use disorders (if SUD is a primary focus of the CoCM model being implemented at any of the chosen providers), the section of the state health department focused on primary care, and the State Medicaid Agency. The State Planning Council should also include relevant agencies to the CoCM programs being implemented under the award, such as agencies that work on the intersection of integration and social determinants of health or support services to children, youth, and families. If an existing body, with or without modifications, can fulfill the requirements of this activity, it may be used instead of developing a new planning council. 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[6] to inform state planning.

4. **Develop and Implement Program Agreements**

   When: Within seven months of award

   Develop and implement **program agreements** between you and participating primary care practices. The program agreements must outline the formal relationship between you and primary care practices to deliver the clinical services and adhere to applicable federal regulations as well as the program requirements indicated in this NOFO.

5. **Submit and Implement a Sustainability Plan**

   When: At the end of Year 1, and updated annually

   Submit and implement 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.

6. **Support partnerships with local health care providers** providing 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. Actively engage in **technical assistance and training** 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.

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[6] Underserved populations include populations such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; older adults; and persons otherwise adversely affected by persistent poverty or inequality.

8. 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** and other resources, as needed, to provide behavioral health integration, including resources needed to establish a patient registry and implement measurement-based care.

4. ALLOWABLE ACTIVITIES

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.
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 Behavioral Health Guide for Implementing 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).

5. USING EVIDENCE-BASED PRACTICES, ADAPTED, AND COMMUNITY-DEFINED EVIDENCE PRACTICES

You should use SAMHSA's funds to provide services or practices that have a proven evidence base and are appropriate for the population(s) of focus. 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.

An ***evidence-based practice*** (EBP) is a practice that has been documented with research data to show its effectiveness. A ***culturally adapted practice*** refers to the systematic modification of an EBP that considers language, culture, and context in a way that is compatible with the clients' cultural patterns, meaning, and values. ***Community-defined evidence practices*** (CDEPs) are practices that communities have shown to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically but have reached a level of acceptance by the community.

Both researchers and practitioners recognize that EBPs, culturally adapted practices, and CDEPs are essential to improving the effectiveness of treatment and prevention services. While SAMHSA realizes that EBPs have not been developed for all populations and/or service settings, application reviewers will closely examine proposed interventions for evidence base and appropriateness for the population of focus. If an

EBP(s) exists for the population(s) of focus and types of problems or disorders being addressed, it is expected you will use that/those EBP(s). If one does not exist but there are culturally adapted practices, CDEPs, and/or culturally promising practices that are appropriate, you may implement these interventions.

In Section C of your Project Narrative, identify the practice(s) from the above categories that are appropriate or can be adapted to meet the needs of your specific population(s) of focus. You must discuss the population(s) for which the practice(s) has (have) been shown to be effective and document that it is (they are) appropriate for your population(s) of focus. You must also address how these interventions will improve outcomes and how you will monitor and ensure fidelity to the practice. For information about monitoring fidelity, see the Fidelity Monitoring Checklist. In situations where an EBP is appropriate but requires additional culturally-informed practices, discuss this in C.1.

6. DATA COLLECTION/PERFORMANCE MEASUREMENT AND PROJECT PERFORMANCE ASSESSMENT

Data Collection/Performance Measurement

You must collect and report data for SAMHSA to meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your plan for data collection and reporting in Section E of the Project Narrative.

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.

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

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.

A cross-site evaluation may be required to build the evidence base for this program. This may include collecting additional supporting data by the evaluation team, staff and client participation in focus groups, site visits, and/or submission of documents for review. You, and your sub-recipients, staff, or contractors, as applicable, must participate in all aspects of the evaluation if selected as part of the evaluation design. You will be provided with details on the evaluation upon award, including the type of evaluation and research questions, and expectations for selected grant recipients.

Project Performance Assessment

Recipients must periodically review their performance data to assess their progress and use this information to improve the management of the project. The project performance assessment allows recipients to determine whether their 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 (See Section VI.3 for a description of reporting requirements).

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.

For more information, see the *Application Guide, Section D - Developing Goals and Measurable Objectives and Section E - Developing the Plan for Data Collection and Performance Measurement.*

7. OTHER EXPECTATIONS

SAMHSA Values That Promote Positive Behavioral Health

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.[7] These are part of SAMHSA's core principles, as documented in our strategic plan.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recipients promote partnerships with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster:

- *Health*—managing one's illnesses or symptoms and making informed, healthy choices that support physical and emotional well-being;
- *Home*—having a stable and safe place to live;
- *Purpose*—conducting meaningful daily activities, such as a job or school; and
- *Community*—having supportive relationships with families, friends, and peers.

Recovery-oriented systems of care embrace recovery as:

- emerging from hope;
- person-driven, occurring via many pathways;
- holistic, supported by peers and allies;
- culturally-based and informed;
- supported through relationship and social networks;
- involving individual, family, and community strengths and responsibility;
- supported by addressing trauma; and based on respect.

Trauma-informed approaches recognize and intentionally respond to the lasting adverse effects of experiencing traumatic events. SAMHSA defines a trauma-informed approach through six key principles:

- *Safety*: participants and staff feel physically and psychologically safe;
- *Peer Support:* peer support and mutual self-help are vehicles for establishing safety and hope, building trust, enhancing collaboration, and using lived experience to promote recovery and healing;
- *Trustworthiness and Transparency*: organizational decisions are conducted to build and maintain trust with participants and staff;
- C*ollaboration and Mutuality:* importance is placed on partnering and leveling power differences between staff and service participants;
- *Cultural, Historical, and Gender Issues*: culture- and gender-responsive services are offered while moving beyond stereotypes/biases;

[7] "Behavioral health" means the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

- *Empowerment, Voice, and Choice*: organizations foster a belief in the primacy of the people who are served to heal and promote recovery from trauma.

It is critical for recipients to promote the linkage to recovery and resilience for individuals and families affected by trauma.

Behavioral health equity is the right to access high-quality and affordable health care services and supports for all populations, regardless of the individual's race, age, ethnicity, gender (including gender identity), disability, socioeconomic status, sexual orientation, or geographical location. By improving access to behavioral health care, promoting quality behavioral health programs and practices, and reducing persistent disparities in mental health and substance use services for underserved populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further reduced by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity.

Behavioral Health Disparities

If your application is funded, you must submit a Behavioral Health Disparity Impact Statement (DIS) no later than 60 days after award. *See Section G of the Application Guide*. Progress and evaluation of DIS activities must be reported in annual progress reports (see Section VI.3 Reporting Requirements).

The DIS is a data-driven, quality improvement approach to advance equity for all. It is used to identify underserved and historically under-resourced populations at the highest risk for experiencing behavioral health disparities. The purpose of the DIS is to create greater inclusion of underserved populations in SAMHSA's grants.

The DIS aligns with the expectations related to Executive Order 13985.

Language Access Provision

Per Title VI of the Civil Rights Act of 1964, recipients of federal financial assistance must take reasonable steps to make their programs, services, and activities accessible to eligible persons with limited English proficiency. Recipients must administer their programs in compliance with federal civil rights laws that prohibit discrimination based on race, color, national origin, disability, age, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). (See the Application Guide *Section J - Administrative and National Policy Requirements.*)

Tobacco and Nicotine-free Policy

You are encouraged to adopt a tobacco/nicotine inhalation (vaping) product-free facility/grounds policy and to promote abstinence from all tobacco products (except accepted tribal traditions and practices).

Reimbursements for the Provision of Services

Recipients must implement policies and procedures that ensure other sources of funding (such as Medicare, Medicaid, private insurance, etc.) are used first when available for that individual. Grant award funds for payment of services may be used for individuals who are not covered by public or other health insurance programs. Each recipient must have policies and procedures in place to determine affordability and insurance coverage for individuals seeking services. 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. If appropriate, consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Health Administration or senior services).

Inclusion of People with Lived Experience Policy

SAMHSA recognizes that people with lived experience are fundamental to improving mental health and substance use services and should be meaningfully involved in the planning, delivery, administration, evaluation, and policy development of services and supports to improve processes and outcomes.

Behavioral Health for Military Service Members and Veterans

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.

Behavioral Health for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex (LGBTQI+) Individuals

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.

Behavioral Health Crisis and Suicide Prevention

Recipients are encouraged to develop policies and procedures that identify individuals at risk of suicide/crisis; and utilize or promote SAMHSA national resources, such as the 988 Suicide & Crisis Lifeline, SAMHSA Helpline/Treatment Locator, and FindSupport.gov.

8. RECIPIENT MEETINGS

SAMHSA will hold virtual recipient meetings and expects you to fully participate in these meetings.

II. FEDERAL AWARD INFORMATION

1. GENERAL INFORMATION

Funding Mechanism:	Grant Award
Estimated Total Available Funding:	$5,200,000
Estimated Number of Awards:	5
Estimated Award Amount:	$900,000 per year, inclusive of indirect costs
Length of Project Period:	Up to 5 years
Anticipated Start Date	09/30/2024

Your annual budget cannot be more than $900,000 in total costs (direct and indirect) in any year of the project. Annual continuation awards will depend on the availability of funds, progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

Funding estimates for this announcement are based on an annualized Continuing Resolution and do not reflect the final FY 2024 appropriation. Funding amounts are subject to the availability of funds.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

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 use 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.**

For general information on eligibility for federal awards, see https://www.grants.gov/applicants/applicant-eligibility.html.

2. COST SHARING AND MATCHING REQUIREMENTS

Cost sharing/match is not required in this program.

3. OTHER REQUIREMENTS

Evidence of Experience and Credentials

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with an established record of service delivery and expertise will be able to provide the required services quickly and effectively. You are encouraged to include appropriately credentialed organizations that provide services to underserved, diverse populations.

In **Attachment 1**, you must submit evidence that three additional requirements related to the provision of services have been met.

The three requirements are:

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.

The above requirements 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, you must include a statement certifying that the service provider organizations meet these requirements.

Following the review of your application, if the score is in the fundable range, the GPO may request that you submit additional documentation or verify that the documentation submitted is complete. **If the GPO does not receive this documentation within the time specified, your application will not be considered for an award.**

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

The application forms package can be found at Grants.gov Workspace or eRA ASSIST. Due to potential difficulties with internet access, SAMHSA understands that applicants may need to request paper copies of materials, including forms and required documents. See *Section A of the Application Guide* for more information on obtaining an application package.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

REQUIRED APPLICATION COMPONENTS:

You must submit the standard and supporting documents outlined below and in *Section A - 2.2 of the Application Guide (Required Application Components).* All files uploaded must be in Adobe PDF file format. See *Section B of the Application Guide* for formatting and validation requirements.

SAMHSA will not accept paper applications except under special circumstances. If you need special consideration, the waiver of this requirement must be approved in advance. See *Section A - 3.2 of the Application Guide (Waiver of Electronic Submission)*.

- **SF-424** – Fill out all Sections of the SF-424.
  - In **Line 4** (Applicant Identifier), enter the eRA Commons Username of the PD/PI.
  - In **Line 8f**, enter the name and contact information of the Project Director identified in the budget and in Line 4 (eRA Commons Username).
  - In **Line 17** (Proposed Project Date) enter: a. Start Date: 9/30/2024; b. End Date: 9/29/2029.
  - **In Line 18** (Estimated Funding), enter the amount requested or to be contributed for the first budget/funding period only by each contributor.

- **Line 21** is the authorized official and should not be the same individual as the Project Director in Line 8f.

  It is recommended new applicants review the sample of a completed SF-424.

- **SF-424A BUDGET INFORMATION FORM –** Fill out all Sections of the SF-424A using the instructions below. **The totals in Sections A, B, and D must match.**

  - **Section A –** Budget Summary: If cost sharing/match is **not required,** use the first row only (Line 1) to report the total federal funds (e) and non-federal funds (f) requested for the **first year** of your project only. If cost sharing/match **is required,** use the **second row** (Line 2) to report the total non-federal funds (f) for the **first year** of your project only.

  - **Section B –** Budget Categories: If cost sharing/match is **not required**, 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 **first year** of your project only. If cost sharing/match is required, use the second column (Column 2) to report the budget category breakouts for the **first year** of your project only.

  - **Section C –** If cost sharing/match is **not required** leave this section blank. If cost sharing/match **is required** use the second row (line 9) to report non-federal match for the **first year** only.

  - **Section D –** Forecasted Cash Needs: Enter the total funds requested, broken down by quarter, only for **Year 1** of the project period. Use the first row for federal funds and the second row (Line 14) for **non-federal** funds.

  - **Section E –** Budget Estimates of Federal Funds Needed for the Balance of the Project: Enter the total funds requested for the out years (e.g., Year 2, Year 3, Year 4, and Year 5). For example, if funds are being requested for five years total, enter the requested budget amount for each budget period in columns b, c, d, and e (i.e., 4 out years) — (b) First column is the budget for the second budget period; (c) Second column is the budget for the third budget period; (d) Third column is the budget for the fourth budget period; (e) Fourth column is the budget for the fifth budget period. Use Line 16 for federal funds and Line 17 for non-federal funds.

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.

See instructions on completing the SF-424A form at Sample SF-424A (No Match Required).

It is highly recommended you use the Budget Template on the SAMHSA website.

- **PROJECT NARRATIVE – (Maximum 15 pages total)**

  The Project Narrative describes your project. It consists of Sections A through E. Instructions for completing each section of the Project Narrative are provided in Section V.1 – Application Review Information.

- **BUDGET JUSTIFICATION AND NARRATIVE**

  You must submit the budget justification and narrative as a file entitled "BNF" (Budget Narrative Form). (*See Section A - 2.2 of the Application Guide - Required Application Components*).

- **ATTACHMENTS 1 THROUGH 7**

  Except for Attachment 4 (Project Timeline), do not include any attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider these attachments.

  To upload the attachments, use the:

    - Other Attachment Form if applying with Grants.gov Workspace.
    - Other Narrative Attachments if applying with eRA ASSIST.

  - ***Attachment 1: Evidence of Experience and Credentials and Letters of Intent (LOI)***

    1. LOI must be submitted at the time of application and include:

       - Identification of at least three experienced, credentialed primary care providers/practices that will implement the Collaborative Care Model.
       - Each participating practice must demonstrate their intent to implement a CoCM program and meet other requirements under the award within the timeframes specified in this NOFO. States should prioritize primary care practices that are serving underserved and historically marginalized areas.
       - A list of all direct service provider organizations that will partner in the project.

       Do not include any letters of *support*. Reviewers will not consider them. A letter of support describes general support of the project while a LOI outlines the specific contributions an organization will make in the project.

    2. Statement of Certification — You must provide a written statement certifying that all partnering service provider organizations listed in this

application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements.

- ***Attachment 2: Data Collection Instruments/Interview Protocols***
  You do not need to include standardized data collection instruments/interview protocols in your application. If the data collection instrument(s) or interview protocol(s) is/are not standardized, submit a copy. Provide a publicly available web link to the appropriate instrument/protocol.

- ***Attachment 3: Sample Consent Forms***
  Include, as appropriate, informed consent forms for:
  1. service intervention;
  2. exchange of information, such as for releasing or requesting confidential information

- ***Attachment 4: Project Timeline***
  Reviewers will assess this attachment when scoring Section B of your Project Narrative. The timeline cannot be more than two pages. See instructions in Section V, B.3.

- ***Attachment 5: Biographical Sketches and Position Descriptions***
  See *Section F of the Application Guide - Biographical Sketches and Position Descriptions* for information on completing biographical sketches and position descriptions. Position descriptions should be no longer than one page each and biographical sketches should be two pages in total.

- ***Attachment 6: Letter to the State Point of Contact***
  Not applicable for this NOFO.

- ***Attachment 7: Confidentiality and SAMHSA Participant Protection/ Human Subjects Guidelines***
  This **required** attachment is in response to *Section C of the Application Guide* and reviewers will assess the response.

3. UNIQUE ENTITY IDENTIFIER AND SYSTEM FOR AWARD MANAGEMENT

Section A of the Application Guide has information about the three registration processes you must complete including obtaining a Unique Entity Identifier and registering with the System for Award Management (SAM). You must maintain an active SAM registration throughout the time your organization has an active federal award or an application under consideration by an agency. This does not apply if you are an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110.

4. APPLICATION SUBMISSION REQUIREMENTS

Submit your application no later than 11:59 PM (Eastern Time) on May 20, 2024.

If you have been granted permission to submit a paper copy, the application must be received by the above date and time. Refer to *Section A of the Application Guide* for information on how to apply.

All applicants MUST be registered with NIH's eRA Commons, Grants.gov , and the System for Award Management (**SAM.gov**) **in order to submit this application.** The process could take up to six weeks**.** (See *Section A of the Application Guide* for all registration requirements).

If an applicant is not currently registered with the eRA Commons, Grants.gov, and/or SAM.gov, the registration process MUST be started immediately. If an applicant is already registered in these systems, confirm the SAM registration is still active and the Grants.gov and eRA Commons accounts can be accessed.

WARNING: BY THE DEADLINE FOR THIS NOFO THE FOLLOWING TASKS MUST BE COMPLETED TO SUBMIT AN APPLICATION:

- **The applicant organization MUST be registered in NIH's eRA Commons;**

  AND

- **The Project Director MUST have an active eRA Commons account (with the PI role) affiliated with the organization in eRA Commons.**

No exceptions will be made.

DO NOT WAIT UNTIL THE LAST MINUTE TO SUBMIT THE APPLICATION. Waiting until the last minute, may result in the application not being received without errors by the deadline.

5. FUNDING LIMITATIONS/RESTRICTIONS

The funding restrictions for this project must be identified in your budget for the following:

- **No more than 10 percent** of funds for each budget period may support state administrative functions.
- **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[8] 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.*

6. INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS

All SAMHSA programs are covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (HHS) 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 the Application Guide, *Section I* – *Intergovernmental Review* for additional information on these requirements as well as requirements for the Public Health System Impact Statement (PHSIS).

7. OTHER SUBMISSION REQUIREMENTS

See *Section A* *of the Application Guide* for specific information about submitting the application.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes your plan for implementing the project. It includes the Evaluation Criteria in Sections A–E below. The application will be reviewed and scored according to your response to the evaluation criteria.

In developing the Project Narrative, use these instructions:

- The Project Narrative (Sections A–E) may be no longer than **15 pages**.

- You must use the five sections/headings listed below in developing your Project Narrative.

[8] Appropriated funds can be used for an expenditure that bears a logical relationship to the specific program, makes a direct contribution, and be reasonably necessary to accomplish specific program outcomes established in the grant award or cooperative agreement. The expenditure cannot be justified merely because of some social purpose and must be more than merely desirable or even important. The expenditure must neither be prohibited by law nor provided for through other appropriated funding.

- **Before the response to each criterion, you must indicate the section letter and number**, **i.e.**, **"A.1," "A.2," etc.** You do not need to type the full criterion in each section.

- Do not combine two or more criteria or refer to another section of the Project Narrative in your response, such as indicating that the response for B.2 is in C.1. **Reviewers will only consider information included in the appropriate numbered criterion.**

- Your application will be scored based on how well you address the criteria in each section.

- The number of points after each heading is the maximum number of points a review committee may assign to that section. Although scoring weights are not assigned to individual criterion, each criterion is assessed in determining the overall section score.

- Any cost-sharing in your application will not be a factor in the evaluation of your response to the Evaluation Criteria.

SECTION A: Population of Focus and Statement of Need (15 points – approximately 1 page)

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, Social Vulnerability Index, etc.).

SECTION B: Proposed Implementation Approach (30 points – approximately 8 pages, not including Attachment 4 – Project Timeline)

1. Describe the goals and measurable objectives of your project and align them with the Statement of Need described in A.2. (See the Application Guide, *Section D – Developing Goals and Measurable Objectives*) for information of how to write

SMART objectives – Specific, Measurable, Achievable, Relevant, and Time-bound). Provide the following table:

Number of Unduplicated Individuals to be Served with Award Funds					
Year 1	Year 2	Year 3	Year 4	Year 5	Total

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. **NOTE**: Be sure to show that the project can be implemented, and service delivery can begin as soon as possible and no later than seven months after the award. **The timeline does not count towards the page limit for the Program Narrative.**

SECTION C: Proposed Evidence-based, Adapted, or Community defined Evidence Service/Practices (25 points – approximately 3 pages)

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 (20 points – approximately 2 pages)

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); and
    - 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 (10 points – approximately 1 page)

1. 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 (See the *Application Guide, Section E - Developing the Plan for Data Collection and Performance Measurement*).

2. BUDGET JUSTIFICATION, EXISTING RESOURCES, OTHER SUPPORT (Other federal and non-federal sources)

You must provide a narrative justification of the items included in your budget. In addition, if applicable, you must provide a description of existing resources and other support you expect to receive for the project as a result of cost matching. Other support is defined as funds or resources, 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 your SF-424, Estimated Funding). Other sources of funds may be used for unallowable costs, e.g., sporting events, entertainment.

See the *Application Guide, Section K - Budget and Justification* for information on the SAMHSA Budget Template. **It is highly recommended that you use the template.** Your budget must reflect the funding limitations/restrictions noted in Section IV-5. **Identify the items associated with these costs in your budget**.

3. REVIEW AND SELECTION PROCESS

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

Award decisions are based on the strengths and weaknesses of your application as identified by peer reviewers. Note the peer review results are advisory and there are other factors SAMHSA might consider when making awards.

The program office and approving official make the final decision for funding based on the following:

- Approval by the Center for Mental Health Services National Advisory Council (NAC).
- Availability of funds.
- 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.**
- Submission of any required documentation that must be received prior to making an award.
- SAMHSA is required to review and consider any Responsibility/Qualification (R/Q) information about your organization in SAM.gov. 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). You may include in your proposal any comments on any information entered into the R/Q section in SAM.gov about your organization that a federal awarding agency previously entered. SAMHSA will consider your comments, in addition to other information in R/Q, in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

VI. FEDERAL AWARD ADMINISTRATION INFORMATION

1. FEDERAL AWARD NOTICES

You will receive an email from eRA Commons that will describe how you can access the results of the review of your application, including the score that your application received.

If your application is approved for funding, a Notice of Award (NoA) will be emailed to the following: 1) the Signing Official identified on page 3 of the SF-424 (Authorized Representative section); and 2) the Project Director identified on page 1 of the SF-424 (8f). The NoA is the sole obligating document that allows recipients to receive federal funding for the project.

If your application is not funded, an email will be sent from eRA Commons.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

If your application is funded, you must comply with all terms and conditions of the NoA. See information on standard terms and conditions. See the Application Guide, *Section J - Administrative and National Policy Requirements* for specific information about these requirements. You must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS 690). To learn more, see the HHS Office for Civil Rights website.

In addition, if you receive an award, HHS may terminate it if any of the conditions in CFR § 200.340 (a)(1)-(4) are met. No other termination conditions apply.

3. REPORTING REQUIREMENTS

Recipients are required to submit an annual progress report, due within 90 days of the end of each budget period along with an annually updated Sustainability Plan. The Performance Progress Report (PPR) must be submitted in eRA Commons using a standardized template (OMB Control Number 0930-0395).

The report must discuss:

- Updates on key personnel, budget, or project changes (as applicable).
- Progress achieving goals and objectives and implementing evaluation activities, especially as it relates to reducing barriers to integrated care.
- Progress implementing required activities, including accomplishments, challenges and barriers, and adjustments made to address these challenges.
- Problems encountered serving the populations of focus and efforts to overcome them.
- Progress and efforts made to achieve the goal(s) of the DIS, including qualitative and quantitative data and any updates, changes, or adjustments as part of a quality improvement plan.

You must submit a final performance report within 120 days after the end of the project period. This report must be cumulative and include all activities during the entire project period.

Management of Award:

Recipients must also comply with standard award management reporting requirements, unless otherwise noted in the NOFO or NoA.

VII. AGENCY CONTACTS

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