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

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

(Short Title: PIPBHC-States)

(Initial Announcement)

Notice of Funding Opportunity (NOFO) No. SM-24-003

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); 2. 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: States program. The purpose of this program is to (a) promote full integration and collaboration in clinical practices between physical and behavioral health care; (b) support the improvement of integrated care models for physical and behavioral health care to improve overall wellness and physical health status; and (c) promote the implementation and improvement of bidirectional integrated care services, including evidence-based or evidence-informed screening, assessment, diagnosis, prevention, treatment, and recovery services for mental and substance use disorders, and co-occurring physical health conditions and chronic diseases through integrated care. State recipients are expected to partner with qualified community programs, health centers, rural health clinics, or Federally Qualified Health Centers to develop and implement an integration program plan. With this program, SAMHSA aims to improve the health outcomes for persons with behavioral health conditions by supporting the adoption and improvement of integrated care models for behavioral and primary physical health.

Funding Opportunity Title:	Promoting the Integration of Primary and Behavioral Health Care: State (Short Title: PIPBHC-States)
Funding Opportunity Number:	SM-24-003
Due Date for Applications:	May 20, 2024
Estimated Total Available Funding:	$6,000,000
Estimated Number of Awards:	Up to 3
Estimated Award Amount:	Up to $2,000,000 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. 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. [See Section III-1 for complete eligibility information.]
Authorizing Statute:	Section 520K of the Public Health Service Act, as amended.

I. PROGRAM DESCRIPTION

1. PURPOSE

The purpose of this program is to (a) promote full integration and collaboration in clinical practices between physical and behavioral health care; (b) support the improvement of integrated care models for physical and behavioral health care to improve overall wellness and physical health status; and (c) promote the implementation and improvement of bidirectional integrated care services, including evidence-based or evidence-informed screening, assessment, diagnosis, prevention, treatment, and recovery services for mental and substance use disorders, and co-occurring physical health conditions and chronic diseases through integrated care.

Individuals with serious mental illness (SMI) and substance use disorders (SUDs) are at higher risk for increased mortality and illness from chronic physical health conditions, such as cardiovascular disease, obesity, diabetes, hypertension, and dyslipidemia.[1] These physical health conditions are often exacerbated by poor-quality health care services that are fragmented and inadequate to address their complex needs.[2,3,4] To better address these needs, systems must provide integrated care that addresses both physical and behavioral health needs.

Access to behavioral health care is also a persistent problem. According to the 2022 National Survey on Drug Use and Health, of the 59.3 million adults ages 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 ages 12 or older who had a need for SUD treatment (54.6 million people), only 24 percent (13.1 million people) received any substance use treatment.[5] As a result, there is a need to improve

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[1] Forman-Hoffman, L., Muhuri, P. K., Novak, S. P., Pemberton, M. R., Ault, K. L., & Mannix, D. (August 2014). *CBHSQ Data Review: Psychological distress and mortality among adults in the U.S. household population*. https://www.samhsa.gov/data/sites/default/files/CBHSQ-DR-C11-MI-Mortality-2014/CBHSQ-DR-C11-MI-Mortality-2014.htm

[2] Liu, N. H., Daumit, G. L., Dua, T., et al. (2018). Excess mortality in persons with severe mental disorders: A multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry, 16*(1):30–40. https://doi.org/10.1002/wps.20384. https://pubmed.ncbi.nlm.nih.gov/28127922/

[3] Druss, B. G., & Goldman, H. H. (2018). Integrating health and mental health services: a past and future history. *American Journal of Psychiatry, 175*(12):1199–1204. doi:10.1176/appi.ajp.2018.18020169. https://doi.org/10.1176/appi.ajp.2018.18020169

[4] Bruce, M. L., & Sirey J. A. (2018). Integrated care for depression in older primary care patients. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 63*(7):439-446. https://doi.org/10.1177/0706743718760292

[5] 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

access to whole-person health by increasing capacity for primary care settings to identify and connect people to integrated physical and behavioral health care.

SAMHSA aims to improve the health outcomes for persons with behavioral health conditions by supporting the adoption and improvement of integrated care models for behavioral and primary physical health, advancing bidirectional care integration of health care services across systems, and improving the integration of primary and physical health care within specialty behavioral health settings.

SAMHSA encourages grant recipients to address the diverse behavioral health needs of underserved communities[6] 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 pregnancy). Recipients must also agree to comply with federal conscience laws, where applicable.

The Promoting the Integration of Primary and Behavioral Health Care: States program is authorized under section 520K of the Public Health Service (PHS) 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 0.50 FTE and the Project Evaluator with a minimum level of 0.50 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 requirement activities are implemented; (e) report on key program requirements; and (f) meet on a regular basis with the Government Project Officer (GPO).

[6] Underserved populations includes 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.

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 Project Evaluator can be a contracted position with you.

If you receive an award, you will be notified if the individuals 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 one or more qualified community programs, as defined in section 1913(b)(1) of the PHS Act;[7] one or more health centers as defined in section 330(a) of the PHS Act (including community mental health centers, child mental-health programs, psychosocial rehabilitation programs, and mental health peer-support or consumer-directed programs); one or more rural health clinics, as defined in section 1861(aa) of the Social Security Act; or one or more Federally Qualified Health Centers, as defined in section 1861(aa) of the Social Security Act, to develop and implement an integration program plan. You should partner with providers in underserved communities (as defined in E.O. 13895) or providers with a significant focus on serving populations facing health disparities. You are to select one or more of these special populations to serve:

- Adults with SMI;
- Adults who have co-occurring mental illness and physical health conditions;
- Children and adolescents with a serious emotional disturbance (SED) who have a co-occurring physical health condition;
- Individuals with an SUD; or
- Individuals with co-occurring mental illness and substance use disorders (COD).

You are expected to begin the delivery of services within seven months after award. You are also 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 of the following required activities:

[7] https://uscode.house.gov/view.xhtml?req=(title:42%20section:300x-2%20edition:prelim)%20OR%20(granuleid:USC-prelim-title42-section300x-2)&f=treesort&num=0&edition=prelim

1. **Conduct a Program Readiness Review**

   When: Within five months after award

   Conduct a **Program Readiness Review** to identify barriers, current or potential opportunities, and areas that need improvement in providing integrated primary and behavioral health care. The results of the Program Readiness Review shall be used to develop the required Integration Program Plan and quality improvement activities (refer to **Appendix A** for details about systematic measurement and quality improvement). The Program Readiness Review shall address the following areas:

   - **Physical and behavioral health conditions** commonly experienced by the selected population(s) of focus and how those conditions are not currently being addressed by providers participating in the program;
   - The culturally responsive and **evidence-based programs** that currently address the integrated care needs of the selected population(s) of focus and needed adaptations to those programs for chosen care settings and the selected population(s);
   - The extent to which **health information technology** and data-sharing capacity across primary and behavioral health to support integrated care are available or need to be developed;
   - Any needed processes and infrastructure to support **ongoing measurement of population and individual outcomes** for both common and specific physical and behavioral health conditions that will be addressed by this project;
   - The **training needs** for both the state agency and community providers;
   - Activities to ensure continuous engagement between state and provider leadership that promote the successful implementation of the integrated care model; and
   - Any **barriers and facilitators** that may impact the implementation of the integration program.

2. **Develop and Implement an Integration Implementation Plan**

   When: Within seven months of the award

   Develop and implement an **Integration Program Plan** that includes the activities to be conducted. The Integration Program Plan shall include descriptions of the following:

   - The demographics and physical and behavioral health needs of the selected population(s) of focus to be served by participating provider organizations;
   - Common physical and behavioral health conditions, and other specific physical and behavioral health conditions that will be addressed directly through the integrated care program;

- The plans for how the program will address barriers and facilitators identified in the Program Readiness Review;
- Support partnerships or other arrangements with local health care providers that will provide culturally appropriate services to special populations and, as applicable, in areas with demonstrated need, such as tribal, rural, or other medically underserved communities and those with a workforce shortage of mental health and substance use disorder, pediatric mental health, or other related professionals; and
- Integrated care program activities, including the following areas (refer to **Appendix A** for details about what **must** be addressed in each of these areas):[8]
    - Access, screening, referral to care, and follow-up
    - Evidence-supported prevention and intervention
    - Ongoing care coordination and care management
    - Person-centered self-management support
    - Multidisciplinary team and team-based care
    - Systematic measurement and quality improvement
    - Linkages with community and social services
    - Sustainable funding and practice

3. **Develop and implement Program Agreements**
   When: Within five months of project start

   Develop and implement **Program Agreements** between the state and participating qualified community programs, recovery community organizations, community mental health centers, rural health clinics, or Federally Qualified Health Centers, to provide integrated care to chosen special population(s) and community-based organizations serving underserved populations.[9]
4. **Develop and implement a Training and Workforce Development Plan**
   When: Within five months of project start

[8] These domains have been adapted from the Comprehensive Healthcare Integration Framework developed by the Center of Excellence for Integrated Health Solutions with support from SAMHSA.

[9] Underserved populations includes 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.

Develop and implement a **Training and Workforce Development Plan** at both the state and provider levels to support program implementation, including cross-training between primary care and behavioral health providers team members (e.g., training on health information technology, providing culturally responsive services to advance health equity, trauma-informed care, integrated care processes, chosen interventions, social determinants of health).

The plan should also include how state and provider leadership will be educated and engaged about:

- The need for integrated care and the integrated care program at the state and provider levels;
- How providers supported through the award will take active steps to change the culture and practices across physical and behavioral health practitioners to support integrated care; and
- How integrated care can be used to better serve underserved and marginalized populations.

5. **Develop or maintain an existing Provider-level Steering and Implementation Committee**
   When: Within seven months of project start

   Develop or maintain an existing **Steering and Implementation Committee** at each provider site that includes:

   - Individuals with lived experience from the special population(s) being served at the provider site;
   - People from underserved communities who are served by the program;
   - Provider executive and clinical leadership;
   - A state liaison; and
   - Personnel with expertise in electronic medical record (EMR) data management at each provider organization directly collaborating with the state on the award.

   If an existing body, with or without modifications, can fulfill the requirements of this activity, it may be used instead of developing a new committee.

6. **Develop and implement a Health Information Technology and Data Management Systems Plan (HIT Plan)**
   When: Within seven months of project start

   Develop and implement a **Health Information Technology and Data Management Systems Plan (HIT Plan)** to ensure that such tools as electronic health records, registries, dashboards, cloud-based systems, digital therapeutics, and other digital health interventions to support care coordination, integrated care workflows, and data sharing across primary care and behavioral health providers

are being utilized. This plan should also discuss compliance with health privacy statutes and regulations.

7. **Develop and/or Maintain an Existing State Planning Council**

   When: Within seven months of project start

   Develop and/or maintain an existing **State Planning Council** for integrated care, which includes representation across the:

   - State Mental Health Authority,
   - The Single State Agency that leads efforts related to substance use disorder,
   - The State Medicaid Agency to coordinate the financing and development of integrated care, and
   - People with lived experience from the special population(s) served through the program, including underserved populations.

   The planning council shall explore opportunities to advance integrated care and address barriers that impact the implementation of integrated care. States may add other agencies as necessary 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. 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 state planning council may also engage with the state primary care associations, stakeholders representing specialty behavioral health providers participating in the proposed project, academic partners, other provider associations and stakeholders, or organizations representing those being served to inform state planning.

8. **Actively engage in technical assistance and training with the Center of Excellence for Integrated Health Solutions** to develop and implement strategies that enhance bidirectional integrated care as it relates to clinical practice, workforce development, evidence-based and evidence-informed treatment, financing, program evaluation, and program sustainability.

9. **Implement the following activities if they are clinically appropriate** for the selected population of focus being served by the program:
   - Screen and refer individuals with HIV, sexually transmitted infections, and viral hepatitis to appropriate care; and
   - Screen and assess for opioid and alcohol use disorders and immediate warm handoff to prescribers of medications for opioid and alcohol use disorders, including buprenorphine, when needed.

10. **Submit a Sustainability Plan**
    When: Within 12 months of project start and updated annually

    Submit a **Sustainability Plan** that addresses, at the state and provider levels, sustainability for the integrated care program when federal funding ends. The sustainability plan shall 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 support local integration programs.

11. Screen for tobacco/nicotine use and promote interventions for tobacco/nicotine cessation, as appropriate to the population being served.

4. ALLOWABLE ACTIVITIES

Allowable activities are not required. Applicants may propose to use funds for the following activities:

- 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, recovery support services, or support for stepped care protocols.
- Pay for one-time costs that will support the integrated care program (e.g., standing up shared team resources, establishing clinical workflows, policy development, initial engagement to establish relationships across care providers).
- Conduct state-sponsored networking activities and technical assistance to support integrated care providers.
- Support co-location of services to facilitate the delivery of integrated care.
- Develop capacity to prescribe medications for opioid and alcohol use disorders, including buprenorphine, in the integrated care settings supported through the award regardless of the population(s) of focus identified in the integration program plan.
- Provide dental hygiene kits to program clients to aid in oral health disease prevention and treatment.
- Provide naloxone or other U.S. Food and Drug Administration (FDA)-approved opioid overdose reversal medications to program clients to support the prevention of overdose.
- 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 in order to improve the inclusiveness of the service delivery environment and ultimately improve behavioral health outcomes.

- Provide activities that address behavioral health disparities and the social determinants of health, including through partnerships with Medicaid providers and agencies, recovery community organizations, and other state, local, tribal, and territorial partners, as applicable.
- Implement efforts aligned to the award that may expand diversity equity, inclusion, and accessibility.
- Use data to identify groups or communities that are not receiving needed integrated care services (e.g., underserved populations or geographic areas that are not receiving services compared with the general population or experience health disparities that are not being addressed through current approaches).
- Develop and implement outreach and referral pathways that engage underserved populations.
- Screen for suicide risk and connect with supports when needed.
- Connect individuals served through the program with needed oral health supports.
- Support for provision of care via telehealth.

5. USING EVIDENCE-BASED AND EVIDENCE-BASED ADAPTED 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.

Both researchers and practitioners recognize that EBPs and culturally adapted practices 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) exist(s) 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, 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.

1. 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 will be collected on:

   - Behavioral Health Diagnoses
   - Demographic Data
   - Functioning
   - Program-specific Questions

2. The Infrastructure Development, Prevention, and Mental Health Promotion (IPP) indicators are project-level data collected and reported in SPARS on a quarterly basis. You 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, including any sub-recipients, contractors, or staff, must participate in all aspects of the evaluation if you are selected to be a part of the evaluation. You will be provided with details on the evaluation upon award, including the type of evaluation and research questions, and expectations.

Project Performance Assessment

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. (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.[10] 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

[10] "Behavioral health" means the promotion of mental health, resilience and well-being; 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.

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;
- *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 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 first use revenue from third-party payments (such as Medicare or Medicaid) from providing services to pay for uninsured or underinsured individuals. 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: $6,000,000

Estimated Number of Awards: 3

Estimated Award Amount: $2,000,000 per year, inclusive of indirect costs

Length of Project Period: Up to 5 years

Anticipated Start Date September 30, 2024

Your annual budget cannot be more than $2,000,000 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 abuse services, the State Medicaid agency, or the State Health Department. Applicants must collaborate with **one or more qualified community programs,** as described in section 1913(b)(1) of the PHS Act (including community mental health centers, child mental health programs, psychosocial rehabilitation programs, and mental health peer-support or consumer-directed programs); **one or more health centers** [as defined in section 330(a)]; **one or more rural health clinics** (as defined in section 1861(aa) of the Social Security Act); **or one or more Federally Qualified Health Centers (FQHCs)** (as defined section 1861(aa) of the Social Security Act).

- 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 from that state.

- States and territories (and other state agencies in those states) that received an award under the PIPBHC NOFOs (SM-20-003 or SM-23-005) to implement a Track 1 project are not eligible for this funding opportunity.

    - The states, territories, and state/territory agencies that are not eligible to apply are: Alabama, American Samoa, Connecticut, Indiana, Kentucky, Louisiana, Nebraska, New Jersey, Puerto Rico, Rhode Island, Tennessee, Texas, Washington, and West Virginia.

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 one organization for direct client services appropriate to the award must be involved in the project (one or more qualified community programs, one or more health centers, one or more rural health clinics, or one or more FQHCs). The provider(s) must be an organization committed to the project as demonstrated by a Letter of Intent (LOI).

2. Each 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 organizations 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 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 organization mental health/substance use disorder prevention, treatment, and recovery support 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. (Remember that if your Project Narrative starts on page 5 and ends on page 20, it is 16 pages long, not 15 pages.) 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 8**

  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***

    1. LOI must be submitted at the time of application and include:
       - A LOI from at least one experienced, credentialed qualified community program, health center, rural health clinic, or FQHC that will be partnering in the project.
       - Each partner must demonstrate their intent to implement the program and meet other requirements under the award within the timeframes specified in this NOFO. States should prioritize organizations that are serving underserved and historically marginalized areas.
       - A list of all direct service provider organizations that will partner 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:

  - service intervention;
  - 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.

- ***Attachment 9: Form SMA 170 – Assurance of Compliance with SAMHSA Charitable Choice Statutes and Regulations.*** You must complete Form SMA 170 if your project is providing substance use prevention or treatment services.

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 you are not currently registered with the eRA Commons, Grants.gov, and/or SAM.gov, the registration process MUST be started immediately. If you have 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:

- **As required by statute, 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.
- **As required by statute, 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[11] 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.
- **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.

[11] 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.

- 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 and Roadmaps, 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 or Evidence-Based/Adapted Practices (25 points — approximately 3 pages)

1. Identify the EBPs or culturally adapted practices 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) 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, 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 the organization(s) that you will partner with in the project. Describe their experience providing services to the population(s) of focus. Describe the diversity of the 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), when the individual award is over $250,000.
- Availability of funds.
- 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 for substance abuse services, the State Medicaid agency, or the state health department. Applicants must collaborate with one or more qualified community programs, as described in section 1913(b)(1) of the PHS Act (including community mental health centers, child mental health programs, psychosocial rehabilitation programs, and mental health peer-support or

consumer-directed programs); one or more health centers [as defined in section 330(a)]; one or more rural health clinics (as defined in section 1861(aa) of the Social Security Act); one or more Federally Qualified Health Centers (as defined section 1861(aa) of the Social Security Act).

- 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 from that state.
- States and territories (and other state agencies in those states) that received an award under the PIPBHC NOFO (SM-20-003 or SM-23-005) to implement a Track 1 project are not eligible for this funding opportunity.
- **The states, territories, and state/territory agencies that are not eligible to apply are: Alabama, American Samoa, Connecticut, Indiana, Kentucky, Louisiana, Nebraska, New Jersey, Puerto Rico, Rhode Island, Tennessee, Texas, Washington, and West Virginia.**
- 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

You are required to submit annual progress reports due within 90 days of the end of each budget period, along with an annually updated Sustainability Plan. The PPR must be submitted in eRA Common 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
- 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:

Rachel Zahn
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Email: 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:

Hawa Kamara
Office of Financial Resources, Division of Grant Review
Substance Abuse and Mental Health Services Administration
(240) 276-1103
Hawa.Kamara@samhsa.hhs.gov

Appendix A – Requirements for Integrated Care Program Domains

1. **Access, screening, referral to care, and follow-up:** Integrated care programs supported by the award shall:

   - Increase points of access to care (e.g., through mobile clinics, telehealth, and partnerships with other organizations);

   - Collaborate with such entities as CMHCs, federally qualified health centers and look-alikes, substance use disorder treatment centers, opioid treatment programs, Medicaid Health Homes and Certified Community Behavioral Health Clinics; and

   - Include the use of health information technology and development of necessary workflows to ensure the systematic use of screening, closed loop referrals, and follow-up to track engagement in activities included in individual care plans. Screening protocols shall include screening for suicide risk, and appropriate management.

2. **Evidence-supported prevention and intervention** for common primary and/or behavioral health conditions and physical and behavioral health conditions of focus that will be addressed directly through the integrated care program. Integrated care programs supported by the grant shall:

   - Include the use of evidence-based practices, expert consultation on the delivery of integrated primary or behavioral health care, and stepped care protocols to adjust care when ongoing measurement does not demonstrate effective treatment or management of physical and behavioral health conditions. Chosen practices shall be developmentally appropriate and chosen and adapted to address the needs of the population(s) of focus;
   - Develop workflows and processes to ensure that individual physical and behavioral health needs are identified and addressed; and
   - Develop processes to ensure fidelity to selected practices and models of service delivery.

3. **Ongoing care coordination and care management.** Integrated care programs supported by the award shall:

   - Have infrastructure and protocols in place to adjust the intensity of care coordination and management based on the needs of the individual or family being served;

- Include a focus on care transitions and ensuring coordinated access to care when services are being provided by entities outside of the integrated care program supported by this award; and

- Include an explicit focus on family and caregiver engagement and support when working with children and youth or others who depend on caregivers to help manage their care and health conditions, care coordination efforts shall have.

4. **Person-centered self-management support** that is adapted to culture, socioeconomic, and life experiences of the people being served. Integrated care programs supported by the award shall actively support the individuals they serve to manage their physical and behavioral health conditions. The programs shall provide this support to caregivers when working with children and youth or other clients who depend on caregivers to help manage their care and health conditions.

5. **Multidisciplinary team** (including the people being served) with dedicated time to provide integrated primary and behavioral health care. Integrated care programs supported by the award shall define of roles of the providers that comprise the integrated care team and how they support integrated care workflows and processes.

6. **Systematic measurement and quality improvement.** Integrated care programs supported by the award shall:

    - Implement measurement-based care[12] for common physical and behavioral health conditions and specific behavioral health conditions that will addressed directly through the integrated care program and

    - Engage in continuous quality improvement, including identification of process and outcome measures to track improvement and demonstrate improvement in the delivery of integrated care across the course of the five-year project period. Quality improvement programs shall include an explicit focus on the populations identified in the disparity impact statement and disaggregate data to track and improve outcomes for populations facing health disparities. The quality improvement program shall also have an explicit focus on addressing social determinants of health. Quality improvement programs shall also track issues identified in the needs assessment and update the findings of the needs assessment over the course of the award.

[12] Measurement-based care (MBC) is an evidence-based strategy to improve service outcomes that involves the systematic administration of symptom rating scales and use of the results to drive clinical decision-making.

7. **Linkages with community and social services** that improve behavioral and primary health and/or mitigate environmental risk factors and address social drivers of health that support a focus on sustainable funding and practice. Integrated care programs supported by the award shall coordinate care planning and delivery with other systems that provide care or influence social determinants of health (e.g., housing, employment, school-based services for children and youth).

8. **Focus on sustainable funding and practice.** Integrated care programs supported by the award shall, before the end of the first award year, develop a plan that addresses, at the state and provider levels, sustainability for the integrated care program beyond the grant period. The sustainability plan shall include the identification of financing gaps, administrative and billing challenges, in addition to the identification of sources of support that will be used to support local integration programs beyond the project period. This sustainability plan shall be updated before the end of each award year.