

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



**Minority AIDS Initiative Continuum of Care Pilot-
Integration of HIV Prevention and Medical Care
into Mental Health and Substance Abuse
Treatment Programs for Racial/Ethnic Minorities at
High Risk for Behavioral Health Disorders and HIV
*Request for Applications Webinar***

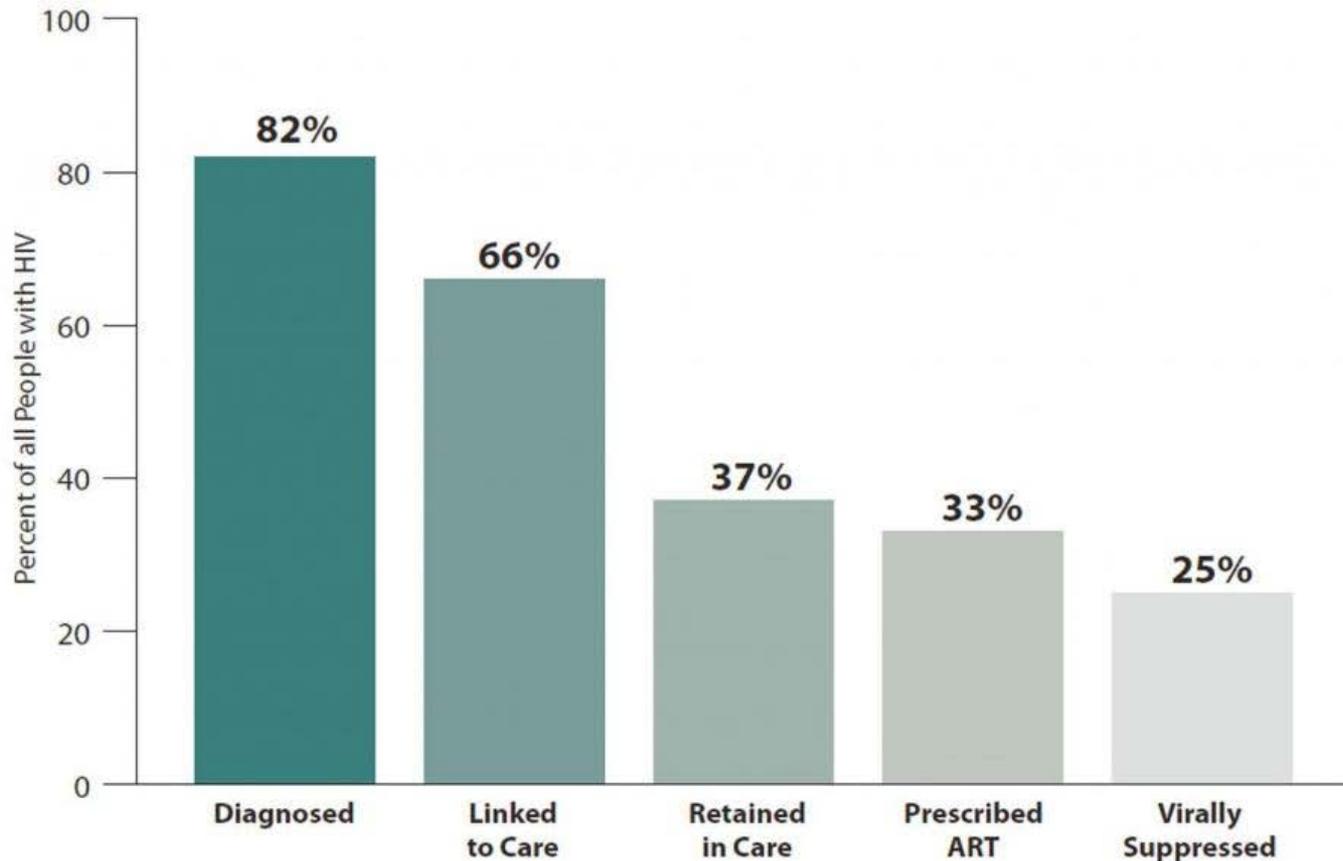
**Chana Rabiner, PhD, Office of Policy, Planning, and Innovation, Division of Policy
Innovation**



Overview

- Background and Purpose of the RFA
- Minority AIDS Initiative (MAI) Continuum of Care (CoC) Pilot Details
 - Definitions
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HIV Care Continuum



<http://www.aids.gov/federal-resources/national-hiv-aids-strategy/hiv-care-continuum-initiative-fact-sheet.pdf>

Background

- About one in six (16.6%) with HIV/AIDS have used an illicit drug intravenously in their lifetime
- Nearly two thirds had used an illicit drug but not intravenously (64.4%)
- Nearly one quarter of persons with HIV/AIDS were in need of treatment for alcohol use or illicit drug use in the past year (23.9%)
- Untreated mental health (MH) and substance use disorders (SUDs) are among top 5 predictors of poor ART adherence
- Depression is the most commonly observed MH disorder in HIV, affecting up to 22% of patients; prevalence is even greater in people with an SUD
- Depression among HIV-infected persons is common and is associated with increased high-risk behavior, non-adherence to ART, and progression of immunodeficiency

Background (continued)

- Injection drug users (IDUs) have high rates of viral hepatitis infection with an estimated 64% chronically infected with Hepatitis C Virus (HCV) and up to 11% chronically infected with HBV.
- Between 14% and 36% of people who abuse alcohol are infected with HCV.
- 19.6% of the population with a serious mental illness is infected with HCV.
- Approximately 20% of those with behavioral health (substance abuse (SA), MH, or co-occurring SA/MH disorders) are infected with hepatitis
- One-third of HIV-infected persons are co-infected with HBV or HCV

MAI CoC Pilot: Purpose

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

MAI CoC Pilot Details

- Details about MAI CoC Pilot grant awards (page 11):
 - Funded by the Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services (CMHS), and the Center for Substance Abuse Preventions (CSAP)
 - Estimated Award Amount – up to \$500,000
 - Maximum CSAT Award- \$196,150 (39.23%)
 - Maximum CMHS Award- \$229,300 (45.86%)
 - Maximum CSAP Award- \$74,550 (14.91%)
 - Estimated Number of Awards - Up to 33 awards
 - Length of Project Period – up to 4 years

MAI CoC Pilot Details- Populations of Focus

- Grant funds must be used to serve the populations of focus for this program (page 7):
 - Racial/ethnic minority populations at high risk for or having a mental and/or substance use disorder and who are most at risk for, or living with HIV, including African American and Latino women and men, gay and bisexual men, and transgender persons
 - Other high priority populations, such as American Indian/Alaskan Natives, Asian Americans, and other Pacific Islanders may be included based on the grantee's local HIV/AIDS epidemiological profile

MAI CoC Pilot Details-Eligibility

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

MAI CoC Pilot - Major Goals

As a result of this program SAMHSA expects the following outcomes (pages 7-8):

- Increased HIV testing to identify BH clients who are unaware of their HIV status;
- Increased diagnosis of HIV among BH clients;
- Increased number of BH clients who are linked to HIV medical care;
- Increased number of BH clients who are retained in HIV medical care;
- Increased number of BH clients who are receiving antiretroviral therapy (ART);
- Improved adherence to BH treatment and ART;
- Increased number of BH clients who have sustained viral suppression; and
- Increased adherence and retention in BH treatment.

MAI CoC Pilot Major Goals (cont'd)

As a result of this program SAMHSA expects the following outcomes (pages 7-8):

- It is expected that effective person-centered treatment will reduce the risk of HIV transmission, improve outcomes for those living with HIV, and ultimately reduce new infections.
- SAMHSA also expects an increase in behavioral health screenings, and a decrease in burden of behavioral health disorders in the surrounding community through partnering with community based organizations to provide substance abuse and HIV primary prevention services.

Definitions

- The RFA provides definitions for key terms, including (pages 9-10):
 - Co-location-providing the HIV services within the physical space of the BH program
 - Full Integration-clients receiving the entire spectrum of HIV medical care in coordination and conjunction with the BH services being received.

Expectations

- Co-location (page 9): providing the HIV services within the physical space of the BH program . Applicants are expected to co-locate and integrate services within four months of the award.
 - If you meet the requirements for co-location you must complete the Co-location Assurance (see Appendix O) and include this as part of Attachment 1 of the application. See Section V of this RFA for additional information.
- Full Integration (page 10): If co-location is not possible, the applicant must provide a plan for fully integrating behavioral health and HIV prevention and HIV primary care services.
- Applicants must include letters of commitment from all participating service providers as part of Attachment 1 of the application. Grantees will be required to submit Memorandums of Understanding (MOU) for all service providers within 30 days of grant award. For more information on the requirements for MOU's see Appendix N.

Expectations (continued)

- Screen and assess clients for the presence of co-occurring mental and substance use disorders as well as HIV (page 10)
- Use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.
- All clients within the BH program should be screened for HIV and hepatitis in accord with existing CDC and USPSTF guidelines.
- It is expected that the grantee will increase enrollment in HIV medical services and necessary primary care services for racial/ethnic minorities by 10 percent in year two and 10 percent in each subsequent year of the grant award.
- Develop a health disparities impact statement upon award
- Utilize evidence-based practices (page 15)

Funding Allocation

- Although CSAT, CMHS, and CSAP funds are jointly funding a spectrum of infrastructure, treatment, prevention, and recovery support services, **applicants must track and report the use of funds separately** (page 11)
- Regardless of the total amount of grant funding requested by the applicant, the total project costs in the proposed budget must reflect a split of 39.23 percent CSAT funds and 45.86 percent CMHS funds, and 14.91 percent CSAP funds.
- CSAT, CMHS, and CSAP funds may be used for infrastructure development, evaluation, screening, assessment, and HIV and hepatitis screening, testing, and vaccination.
- CSAT and CMHS funds may be used for treatment and recovery support of individuals diagnosed with co-occurring substance use and mental disorders.

Funding Allocation (continued)

- Please refer to page 11
- Only CMHS funds can be used to pay for treatment and recovery support services for individuals with a mental illness. CMHS funds cannot be used to pay for treatment and recovery support services for individuals with only a substance use disorder
- Only CSAT funds can be used to pay for treatment and recovery support services for individuals with a substance use disorder. CSAT funds cannot be used to pay for treatment and recovery support service for individuals with only a mental disorder.
- Only CSAP funds can be used to pay for prevention services and prevention education focusing on substance abuse prevention and HIV prevention.
- **Grant funds may not be used for primary HIV medical care.**

Restricted Funding Allocation

- Up to 15 percent (i.e., \$75,000) of the total grant award for the following types of infrastructure development (page 19)
 - Developing partnerships, adopting and/or enhancing your computer system and training/workforce development
- Up to 15 percent (i.e., \$75,000) for data collection, performance measurement, and performance assessment (page 19)
 - Activities required in Sections I-2.2 and 2.3 of the RFA (pages 15-19)
- **Exactly** 5 percent (i.e., \$25,000) **must** be used for hepatitis screening, testing, vaccination and referrals (page 13).

MAI CoC Pilot Required Activities

You must use SAMHSA's services grant funds to support allowable direct services. Grant funds cannot be used to supplant current funding of existing activities*. The following activities are required (pages 12-13):

- Providing direct BH treatment (including screening, assessment, and care/case management). Treatment must be provided in outpatient, day treatment (including outreach-based services) or intensive outpatient, or residential programs
- Providing “wrap-around”/recovery support services (e.g., child care, vocational, educational and transportation services) designed to improve access and retention.
- Mechanisms to ensure client retention in BH and HIV care (e.g. peer support workers, health coaches, technology assisted approaches).

*Supplant is defined as replacing funding of a recipient's existing program with funds from a federal grant.

MAI CoC Pilot Required Activities (cont'd)

- Integration of substance abuse primary prevention services into the broader spectrum of BH and other services.
- Partnership with Community Based Organization(s) to provide primary SA prevention education and messaging. These prevention services can be provided to the children of adult clients receiving BH and HIV medical care.
- Providing outreach and other engagement strategies to increase participation in, and access to treatment or prevention services for minority populations identified in the National HIV/AIDS Strategy.
- It is encouraged that funds be utilized to provide for a dedicated medical case manager (e.g. a nurse, physician assistant, or other qualified health professional) to ensure all appropriate care is received and documented in the medical records.

MAI CoC Pilot Required Activities (cont'd)

- HIV risk assessments, antibody testing, and confirmatory testing.
- Partnership with HIV service organizations that can provide HIV risk assessments, HIV antibody testing and confirmatory testing as well as direct HIV medical services and any other primary care services needed as part of complete HIV-related medical care (see utilization and third party payment, page 11-12).
- Pre and post-test counseling for HIV and Viral Hepatitis.
- **Exactly** five percent (i.e., \$25,000) of grant funds **must** be used for the following hepatitis testing and services (based on risk and United States Preventive Services Task Force guidelines – page 13):
 - Hepatitis testing (B, C [antibody and confirmatory]), and Hepatitis A and B vaccination (Twinrix).
 - Any center's funds can be utilized for these services as long as the total amount allocated is exactly five percent of the total funding request.

Data Collection & Performance Measurement

All SAMHSA grantees are required to (page 15):

- Collect and report certain data through the Government Performance and Results Modernization Act of 2010 (GPRA).
- Provide documentation of the ability to collect and report the required data.
- Report performance on a number of the following client level and infrastructure performance measures including: mental health, substance use, HIV testing, HIV positivity, viral hepatitis status, linkage to HIV/hepatitis medical care, retention in behavioral health and HIV medical care, viral load/suppression among persons in HIV medical care, housing status, and demographics (please refer to Appendix M, page 82)

Data Collection & Performance Measurement

- The TRAC reporting system will migrate to the Common Data Platform (CDP) during the life of the grant.
- Changes may occur in the measures for reporting over time and grantees will be expected to comply with changes in these requirements when implemented.
- Required to complete the ‘SAMHSA/MAI Rapid HIV/Hepatitis Testing Clinical Information Form’ (access to this form will be provided post grant award).
- Expected to collect/report the following data on an annual basis: HIV risk, incidence, and prevalence; reduction of the impact of behavioral health problems; and the reduction of HIV related health disparities in the area of service.
- Technical assistance related to data collection and reporting will be offered.

Data Collection & Performance Measurement

- Please refer to pages 16-18.
- Grantees must periodically review the performance data they report
- Performance assessments also should be used to determine whether projects have the intended impact on behavioral health disparities.
- Report on progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.
- SAMHSA will implement a cross-site evaluation of this program through a contract and the contractor will manage data collection, analysis, and evaluation products. Grantees will be required to participate in any evaluation by sharing in information, participating in phone calls/or in person meetings.

Evaluation Criteria

- The Project Narrative describes what you intend to do with your project and includes the Criteria in Sections A-G. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-G (pages 28-33);
- Section A: Population of Focus and Statement of Need (10 points)
- Section B: Proposed Evidence-Based Service/Practice (25 points)
- Section C: Proposed Implementation Approach (25 points)
- Section D: Staff and Organizational Experience (10 points)
- Section E: Data Collection and Performance Measurement (20 points)
- Section F: Electronic Health Record (EHR) Technology (5 points)
- Section G: Co-Location Assurance (5 points)

Budget

- Provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project (pages 33-34).
- Funds must be split precisely: 39.23 percent CSAT funds, 45.86 percent CMHS funds, and 14.91 percent CSAP funds.
 - Applicants must submit one budget that includes a column for CSAT requested funds, a column for CMHS requested funds, and a column for CSAP requested funds.
- Specifically identify the costs for the following items in your budget:
 - No more 15 percent (i.e., \$75,000) of the total grant award will be used for infrastructure development;
 - no more than 15 percent (i.e., \$75,000) of the total grant award will be used for data collection, performance measurement, and performance assessment; and
 - exactly 5 percent (i.e., \$25,000) will be used for hepatitis testing and services

Corrections/Clarifications

- If you downloaded the RFA prior to May 1, 2014. Page 11- the total funding amount for CMHS is incorrect. It isn't \$222,650. It is \$229,300 and it is correct on the website and page 19 of the RFA.
- Pages 33 and 34- There are two section Gs. The first section G (co-location assurance) should be in the project narrative if applicable (sections A-G, page 25). The second G (literature citations) goes in the supporting documentation.

MAI CoC Pilot- How to Apply

Please refer to RFA Section IV. Application and Submission Information (page 22)

- You must go to both Grants.gov (<http://www.Grants.gov>) and the SAMHSA website (<http://beta.samhsa.gov/grants/applying>) to download the documents required to apply for a SAMHSA grant.
- You are **required** to have a Dun and Bradstreet (DUNS) number
- You are **required** to be registered in the new System for Award Management (SAM) – page 24 of the RFA.
 - May take 48-72 hours so **DO NOT DELAY**
- Applications are due by **11:59 PM** (Eastern Time) on **June 4, 2014**.
- **Your application must be submitted through** <http://www.Grants.gov>



Questions???

MAI Coc Pilot- Agency Contacts

For program-related questions contact:

Chana Rabiner, PhD

Office of Policy, Planning and Innovation, Division of Policy Innovation
Substance Abuse and Mental Health Services Administration

1 Choke Cherry Road

Room 8-1012

Rockville, Maryland 20857

(240) 276-1875

chana.rabiner@samhsa.hhs.gov

MAI Coc Pilot- Agency Contacts (con't)

For grants management and budget-related questions contact:

Eileen Bermudez

Office of Financial Resources, Division of Grants Management

Substance Abuse and Mental Health Services Administration

1 Choke Cherry Road

Room 7-1091

Rockville, Maryland 20857

(240) 276-1412

eileen.bermudez@samhsa.hhs.gov