Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Primary and Behavioral Health Care Integration

(Short Title: PBHCI)

(Initial Announcement)

Request for Applications (RFA) No. SM-15-005

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

PART 1: Programmatic Guidance

[Note to Applicants: This document must be used in conjunction with SAMHSA's "Request for Applications (RFA): PART II – General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements". PART I is individually tailored for each RFA. PART II includes requirements that are common to all SAMHSA RFAs. You must use both documents in preparing your application.]

Key Dates:

Application Deadline	**Applications are due by February 27, 2015.**
Intergovernmental Review (E.O. 12372)	**Applicants must comply with E.O. 12372 if their state(s) participates. Review process recommendations from the State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	**Applicants must send the PHSIS to appropriate state and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.**

Table of Contents

EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, is accepting applications for fiscal year (FY) 2015 Primary and Behavioral Health Care Integration (Short Title: PBHCI) grants. The purpose of this program is to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care medical services in community-based behavioral health settings. The goal is to improve the physical health status of adults with serious mental illnesses (SMI) and those with co-occurring substance use disorders who have or are at risk for co-morbid primary care conditions and chronic diseases. The program's objective is to support the triple aim of improving the health of individuals with SMI; enhancing the consumer experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care.

Funding Opportunity Title:	Primary and Behavioral Health Care Integration (PBHCI)
Funding Opportunity Number:	SM-15-005
Due Date for Applications:	February 27, 2015
Anticipated Total Available Funding:	$40,897,330
Estimated Number of Awards:	102
Estimated Award Amount:	Up to $400,000 per year
Cost Sharing/Match Required	No
Length of Project Period:	Up to 4 years
Eligible Applicants:	Qualified community mental health programs, as defined under section 1913(b)(1) of the Public Health Service Act, as amended. [See Section III-1 of this RFA for complete eligibility information.]

Be sure to check the SAMHSA website periodically for any updates on this program.

I. FUNDING OPPORTUNITY DESCRIPTION

1. PURPOSE

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, is accepting applications for fiscal year (FY) 2015 Primary and Behavioral Health Care Integration (Short Title: PBHCI) grants. The purpose of this program is to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care medical services in community-based behavioral health settings. The goal is to improve the physical health status of adults with serious mental illnesses (SMI) [1]and those with co-occurring substance use disorders who have or are at risk for co-morbid primary care conditions and chronic diseases. The program's objective is to support the triple aim of improving the health of individuals with SMI; enhancing the consumer experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care.

SAMHSA launched the PBHCI program in FY 2009 with the knowledge that adults with serious mental illness experience heightened morbidity and mortality, in large part due to elevated incidence and prevalence of obesity, diabetes, hypertension, and dyslipidemia. This increased morbidity and mortality can be attributed to a number of issues, including inadequate physical activity and poor nutrition; smoking; side effects from atypical antipsychotic medications; and lack of access to health care services. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.[2] Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical illnesses. Many of these health conditions are preventable through routine health promotion activities, primary care screening, monitoring, treatment and care management /coordination strategies and/or other

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[1] Adults with a serious mental illness (SMI) are defined by SAMHSA as persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the [DSM-IV], resulting in functional impairment which substantially interferes with or limits one or more major life activities. SAMHSA will defer to state definitions of SMI and/or serious and persistent mental illness (SPMI).

[2] Anda, R.F., Brown, D.W., Dube, S.R., Bremner, J.D., Felitti, V.J, & Giles, W.H. (2008). Adverse childhood experiences and chronic obstructive pulmonary disease in adults. *American Journal of Preventive Medicine, 34*(5), 396-403.

outreach programs. Much of the national effort towards achieving the triple aim of improved health, enhanced care, and reduced costs are associated with developing person-centered systems of care that address an individual's holistic health and wellness.

The PBHCI grant program supports the goals of the Million Hearts™ Initiative in that people with behavioral health disorders are disproportionally impacted by many chronic primary care health conditions, including heart disease and hypertension.

The Million Hearts™ initiative supports cardiovascular disease prevention activities across the public and private sectors in an unprecedented effort to prevent 1 million heart attacks and strokes over five years and demonstrate to the American people that improving the health system can save lives. Million Hearts™ will scale-up proven clinical and community strategies to prevent heart disease and stroke across the nation by empowering people to make healthy choices such as preventing tobacco use and reducing sodium and trans fat consumption and by improving care for people who do need treatment by encouraging a targeted focus on the "ABCS" - aspirin for people at risk, blood pressure control, cholesterol management and smoking cessation.

Million Hearts™ brings together existing efforts and new programs to improve health across communities and help Americans live longer, healthier, more productive lives. The Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services are the co-leaders of Million Hearts within the U.S. Department of Health and Human Services, working alongside other federal agencies including the Administration on Aging, National Institutes of Health, the Agency for Healthcare Research and Quality, and the Food and Drug Administration, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration, the Office of the National Coordinator, and the Veterans Administration. Key private-sector partners include the American Heart Association, and YMCA, among many others.

In FY2015, SAMHSA builds on previous PBHCI funding opportunities by capitalizing on lessons learned from previous PBHCI grantees and the field at large, in order to further develop the coordination and integration of primary care and behavioral health care services. Grantees will be expected to achieve this by strengthening their focus on integrated treatment teams, evidence-based and promising wellness interventions, program structures (e.g., primary care access, information sharing, and treatment planning, etc.), performance monitoring and continuous quality improvement, and sustainability.

SAMHSA has demonstrated that behavioral health is essential to health, prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce health care and other costs to society. Continued improvement in the delivery and financing of

prevention, treatment and recovery provides a cost savings. SAMHSA has identified six Strategic Initiatives to focus the Agency's work on people and emerging opportunities. More information is available at the SAMHSA website: www.samhsa.gov/about-us.

The PBHCI grant program supports SAMHSA's Strategic Initiative on Health Care and Health Systems Integration, as well as aligns with Prevention of Substance Abuse and Mental Illness; Recovery Support; and Health Information Technology. The PBHCI grant program seeks to address behavioral health disparities among racial and ethnic minorities by encouraging the implementation of strategies to decrease the differences in access, service use and outcomes among the racial and ethnic minority populations served. (See PART II: Appendix G – Addressing Behavioral Health Disparities.)

PBHCI is one of SAMHSA's services grant programs. SAMHSA intends that its services grants result in the delivery of services as soon as possible after award. Service delivery should begin by the 4th month of the project at the latest.

PBHCI grants are authorized under 520K of the Public Health Service Act, as amended. This announcement addresses Healthy People Mental Health and Mental Disorders Topic Area HP 2020-MHMD and/or Substance Abuse Topic Area HP 2020-SA.

2. EXPECTATIONS

SAMHSA expects grantees to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care medical services in community-based behavioral health settings, with the following core requirements:

- Provide, by qualified primary care professionals, on site primary care services and
- Provide, by qualified specialty care professionals or other coordinators of care, medically necessary referrals and linkages to primary care services

There are various effective approaches to co-location of primary and behavioral health care services. The most important aspect of co-location is the integration of behavioral health and primary care services. Integrated services should be tailored to meet the needs of the population served with consideration of other realities such as geographic location, space availability, and cost feasibility. Integrated services should be provided in a manner that is coordinated, accessible and seamless to best suit the needs of the client.

As mentioned earlier under Section I-1: Funding Opportunity Description – Purpose, HHS' Million Hearts™ initiative is to prevent 1 million heart attacks and strokes by 2017. CDC has issued several treatment protocols for the Million Hearts initiative. Grantees will be expected to use the CDC's Treatment Protocols for Improving Blood Pressure Control (See Section I-2.3: Data Collection and Performance Measurement). New

guidelines for HDL and LDL cholesterol, and triglycerides have been issued by the American College of Cardiology, the American Heart Association, and the National Heart, Lung, and Blood Institute. Please refer to Section I-2.3: Data Collection and Performance Management for more detail.

Per the SAMHSA/HRSA Center for Integrated Health Solutions' *Standard Framework for Levels of Integrated Healthcare*, SAMHSA expects grantees to (at minimum) have basic collaboration onsite (Level 3) with the goal of full collaboration in a transformed/merged integrated practice (Level 6) by the fourth year of the grant program.

Grantees are expected to serve as a consumer centered health home where grantees must provide the following categories of service (see Appendix IV, in this document, for sample definitions of these services):

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support, which includes authorized representatives
- Referral to community and social support services, including appropriate follow-up

For guidance on health home service categories that could inform your proposal, see www.samhsa.gov/sites/default/files/healthhomesconsultationprocess.pdf

Health Information Technology

The Health Information Technology for Economic and Clinical Health (HITECH) Act places strong emphasis on the widespread adoption and implementation of electronic health record (EHR) technology. Successful tracking and coordination of care is enhanced by the ability to exchange health information; this and the documenting and tracking of preventive health efforts across settings helps improve the overall health of consumers. SAMHSA expects PBHCI grantees to achieve Meaningful Use Standards, as defined by CMS, by the end of the grant period; to that end, applicants must propose how they will develop and demonstrate the ability to:

- Submit at least 40% of prescriptions electronically (as allowable given state-specific laws regarding the use of e-prescriptions for controlled substances);

- Receive structured lab results electronically;

- Share a standard continuity of care record between behavioral health providers and physical health providers; and

- Participate in the regional extension center program.

For more information on Meaningful Use Standards, visit https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp.

When considering the integration of primary care into community behavioral health settings, services may be provided by the applicant, purchased through a contract with community primary care providers, or made available through a memorandum of agreement (MOA)/letter of commitment (LOC) with community primary care providers. Applicants must demonstrate cooperation/collaboration with community primary care providers, as well as other community resources (e.g., hospitals, specialists, long term care providers, social support agencies, etc.). Specifically, applicants should provide evidence of collaborative agreements with primary care agencies, settings, and/or entities when appropriate. Partnerships between primary care and behavioral health organizations are deemed crucial to this grant. It is important for applicants expecting to partner with a HRSA-funded safety net provider to consider HRSA's policy for an approved scope of project for health centers funded under section 330 of the Public Health Service Act, as amended.

Grantees will have 60 days from the date of award to conduct a PBHCI needs assessment, under direction from the training and technical assistance contractor and with final GPO approval. A needs assessment tool will be distributed to grantees upon award, with the goal of identifying gaps and strengths for integrating physical and behavioral health care. The results of the needs assessment will support the grantee in understanding both programmatic and client needs regarding PBHCI implementation, and will support development of the grantee's training and technical assistance plan. The needs assessment must be conducted annually thereafter, in order to determine progress to date and ongoing needs.

Grantees are expected to identify those consumers most in need of on-site primary care services and specialty referrals (including those with HIV/AIDS and Hepatitis A, B, & C, as well as those with histories of trauma), and must make PBHCI services available as long as a client is willing and able to make use of them. In order to support the health-home aspect of PBHCI, it is important these services are long-term in nature and not time-limited.

If your application is funded, you will be expected to develop a behavioral health disparities impact statement no later than 60 days after your award. In this statement you must propose: (1) the number of individuals to be served during the grant period and identify subpopulations (i.e., racial, ethnic, sexual and gender minority groups) vulnerable to behavioral health disparities; (2) a quality improvement plan for the use of

program data on access, use and outcomes to support efforts to decrease the differences in access to, use and outcomes of service activities; and (3) methods for the development of policies and procedures to ensure adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care**.** (See PART II: Appendix G – Addressing Behavioral Health Disparities.)

Over 2 million men and women have been deployed to serve in support of overseas contingency operations, including Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn. Individuals returning from Iraq and Afghanistan are at increased risk for suffering post-traumatic stress and other related disorders. Experts estimate that up to one-third of returning veterans will need mental health and/or substance abuse treatment and related services. In addition, the family members of returning veterans have an increased need for related support services. To address these concerns, SAMHSA strongly encourages all applicants to consider the unique needs of returning veterans and their families in developing their proposed project and consider prioritizing this population for services where appropriate.

2.1 Required Activities

Grantees are required to establish PBHCI Coordination Teams, which at minimum includes the grantee's Chief Executive Officer, Chief Financial Officer, Chief Medical Director, primary care lead, PBHCI Project Director, and PBHCI consumer (comprising more than half of the entity). A letter detailing the members, scope of oversight and involvement must be included in **Attachment 5** of your application, inclusive of member signatures. The coordinating entity must convene upon award and at least quarterly to support the following tasks:

- Providing leadership and guidance to the grantee in accomplishing the goals of the PBHCI program
- Serving as a link between the program and the community
- Ensuring compliance with State and Federal laws
- Developing and implementing PBHCI sustainability efforts
- Reviewing data on program effectiveness with associated development of continuous quality improvement efforts

Grantees will be expected to prioritize enrolling consumers into the PBHCI program who are not currently receiving primary care services. In order to support the overall coordination of care between PBHCI grantees and community primary care providers, you must include in **Attachment 6** of your application at least three Memorandums of Understanding (MOU)/Letters of Commitment (LOC) with distinct primary care providers delivering services to the applicant's service population. This is to support ongoing communication and coordination for PBHCI consumers who choose to retain external primary care services, but want to avail themselves of the grantee's care coordination services and health and wellness programming. (For applicants in a HRSA-designated

health professional shortage area (HPSA), evidence of the inability to secure MOUs/LOCs from three providers must be submitted). Applicants must address the following in the MOU/LOC:

- Data sharing protocols
- Connection with care coordination activities
- Relation to the integrated treatment team and associated planning, including the providers' operations (e.g., location, services provided, business hours, etc.)

Grantees are required to implement program structures designed to minimize barriers to primary care access for PBHCI consumers across the following core domains: integrated treatment teams; team meetings; treatment planning; and information sharing.

When developing an integrated treatment team, grantees must include the following members at minimum:

- Primary care provider (e.g., doctor, nurse practitioner, physician assistant, medical assistant, etc.)
- Nurse care coordinator
- Integrated care manager
- Peer wellness coach
- Co-occurring substance use disorder counselor
- Other: pharmacist, nutritionist/dietician, dentist, occupational therapist, etc.

The integrated treatment teams must meet at minimum weekly to:

- Discuss cases and oversee, and monitor a single integrated person-centered treatment plan per client, inclusive of procedures for effective transitions of care procedures. Grantees must ensure these plans are inclusive of behavioral health, primary care, and health/wellness elements for PBHCI consumers.
- Conduct gap-in-care analysis to ensure that client strategies to address the above mentioned areas (behavioral health, primary care, and health/wellness elements) are implemented
- Establish effective practices for medication management and medication adherence.
- Problem-solve issues affecting access to primary care services (e.g. transportation to appointments, capacity to obtain prescribed medications, medical testing and labs, etc.).

In order to further minimize barriers to care for consumers with serious mental illness, by the beginning of Year 2, grantees must provide access to primary care services five (5) days per week during routine operating hours. In addition, grantees may provide primary care services

- During evenings
- On weekends
- By telephone or email (during regular office hours and after hours)

Given the importance of sharing information across primary care and behavioral health providers, grantees are expected to implement mechanisms that support routine information collection and sharing regarding the behavioral health and primary care needs of PBHCI consumers, and therefore must:

- Use electronic health record (EHR), including population management tools in order to support a robust continuous quality improvement process, and must regularly generate reports by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. Grantees must use these tools to target specific interventions to populations most at risk of or in need of said intervention.
- Implement protocols for sharing client-level data across behavioral health and primary care systems.

Preventive and Health Promotion Services (**minimum 10% of total grant award**)

SAMHSA expects that a continuum of preventive and health promotion services will be offered to consumers within the PBHCI health home program. Grantees must use results of their needs assessments (baseline, annual) to inform what services are offered to consumers according to the severity of the condition and/or risk factors. Similarly, grantees are expected to continually use reporting tools available in their EMR to target specific interventions to populations most at risk of or in need of said intervention.

According to the National Survey on Drug Use and Health, individuals who experience mental illness or who use illegal drugs have higher rates of tobacco use than the total population. Data from the National Health Interview Survey, the National Death Index, and other sources indicate earlier mortality among individuals who have mental and substance use disorders than among other individuals. Due to the high prevalence rates of tobacco use and the early mortality of the target population for this grant program, grantees are encouraged to promote abstinence from tobacco products (except with regard to accepted tribal traditional practices) and to integrate tobacco cessation strategies and services in the grant program. Applicants are encouraged to set annual targets for the reduction of past 30-day tobacco use among individuals receiving direct client services under the grant.

Grantees must implement tobacco cessation and nutrition/exercise interventions, in addition to other health promotion programs (e.g., wellness consultation, health education and literacy, self-help/management programs). These programs should

incorporate recovery principles and peer leadership and support, and must be included in the formulation of the integrated person-centered care plan for each individual receiving PBHCI services. SAMHSA expects that grantees involve peers in the development and implementation of these services. For information on relevant service models, see http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper.

Applicants must screen and assess consumers for the presence of co-occurring mental and substance use disorders and use the information obtained to develop appropriate treatment approaches for those identified as having such co-occurring disorders.

SAMHSA strongly encourages all grantees to provide a tobacco-free workplace and to promote abstinence from all tobacco products (except in regard to accepted tribal traditions and practices).

Sustainability

Applicants are expected to serve as person-centered health homes for PBHCI consumers beyond the four year grant period. In order to encourage sustainability of this effort, grantees must utilize third party and other revenue realized from provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are ineligible for public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. Grantees are also expected to facilitate the health insurance application and enrollment process for eligible uninsured consumers. Grantees must implement policies and procedures that ensure other sources of funding are secured first when available for that individual, and should consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Administration or senior services) if appropriate for and desired by that individual. Grantees are expected to serve at minimum (relative to their census of individuals with SMI)

- Year 1: >10% enrolled (PBHCI services must begin within six (6) months of award.)
- Year 2: >25% enrolled
- Year 3: >40% enrolled
- Year 4: >50% enrolled

For example, if a grantee has 1000 consumers enrolled in services for their serious mental illness, then the grantee must at minimum enroll 100 consumers in Year 1, 250 consumers in Year 2 (150 more than in Year 1), 400 consumers in Year 3 (150 consumers more than in Year 2), and 500 consumers in Year 4 (100 more than in Year 3).

Grantees will be required to submit a comprehensive sustainability plan in the beginning of Year 2 of the grant (See Appendix V, in this document, for the Sustainability Plan Template).

Recovery from mental disorders and/or substance use disorders has been identified as a primary goal for behavioral health care. SAMHSA's Recovery Support Strategic Initiative is leading efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them. Building on research, practice, and the lived experiences of individuals in recovery from mental and/or substance use disorders, SAMHSA has developed the following working definition of recovery: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.* See http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF for further information, including the four dimensions of recovery, and 10 guiding principles. Programs and services that incorporate a recovery approach fully involve people with lived experience (including consumers/peers/people in recovery, youth, and family members) in program/service design, development, implementation, and evaluation.

SAMHSA's standard, unified working definition is intended to advance recovery opportunities for all Americans, particularly in the context of health reform implementation, and to help clarify these concepts for peers/persons in recovery, families, funders, providers and others. The definition is to be used to assist in the planning, delivery, financing, and evaluation of behavioral health services. SAMHSA grantees are expected to integrate the definition and principles of recovery into their programs to the greatest extent possible.

PBHCI grantees are expected to incorporate SAMHSA's working definition of recovery as an underlying theme for all PBHCI efforts, where recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Recovery has four major dimensions that support a life in recovery:

- *Health*: overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- *Home*: a stable and safe place to live;
- *Purpose*: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- *Community*: relationships and social networks that provide support, friendship, love, and hope.

While the explicit focus of PBHCI is to bridge the divide between traditional health care and behavioral health care (*health*), the recovery dimensions of *home, purpose, and community* should be embraced and embedded in all components of PBHCI when able and appropriate.

2.2 Using Evidence-Based Practices

SAMHSA's services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population(s) of focus. An evidence-based practice (EBP) refers to approaches to prevention or treatment that are validated by some form of documented research evidence. In Section B of your project narrative, you will need to:

- Identify the evidence-based practice(s) you propose to implement for the specific population(s) of focus.
- Identify and discuss the evidence that shows that the practice(s) is (are) effective for the specific population(s) of focus.
- If you are proposing to use more than one evidence-based practice, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support.
- Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus.

[Note: See PART II: Appendix D – Funding Restrictions, regarding allowable costs for EBPs.]

Information on EBPs specific to the integration of primary and behavioral health care integration can be found at HHS/Agency for Healthcare Research and Quality (AHRQ)'s Integration Academy, http://integrationacademy.ahrq.gov/literature. For the required PBHCI activities related to Preventive and Health Promotion Services, applicants must select and implement amongst the following evidence-based and promising interventions. Information on the implementation of the selected EBPs will be expected by grantees to collect and report in their quarterly reports (see Section VI-1: reporting requirements). In addition, EBPs can be found at SAMHSA's National Registry of Evidence Based Programs and Practices (NREPP) at www.nrepp.samahs.gov. SAMHSA recognizes that some EBPs have not been developed for all populations and/or service settings, and applicants may provide justification for other interventions. See Appendix I for additional information about using EBPs.

1. Tobacco Cessation (*required*)

a. Peer-to-Peer Tobacco Dependence Recovery Program
b. Learning About Healthy Living
c. Intensive Tobacco Dependence Intervention for Persons Challenged by Mental Illness: Manual for Nurses

2. Nutrition/Exercise (*required*)
    a. Nutrition and Exercise for Wellness and Recovery (*NEW-R)*
    b. Diabetes Awareness and Rehabilitation Training (DART)
    c. Solutions for Wellness
    d. Weight Watchers
    e. In SHAPE
    f. Stoplight Diet
    g. Achieving Healthy Lifestyles in Psychiatric Rehabilitation (ACHIEVE)
3. *Chronic Disease Self-Management*
    a. Whole Health Action Management (WHAM)
    b. Health and Recovery Peer (HARP) Program

2.3 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your ability to collect and report the required data in Section E: Data Collection and Performance Measurement of your application. Grantees will be required to report performance on the following performance measures: Adult Consumer Outcome Measures for Discretionary Programs National Outcome Measures (NOMs), Infrastructure, Prevention and Promotion performance measures, and PBHCI specific health outcomes. See below for more details. This information will be gathered using a uniform data collection tool provided by SAMHSA. The current tool is being updated and will be provided upon award. An example of the type of data collection tool required can be found at https://www.cmhs-gpra.samhsa.gov/index.htm. Data will be collected at baseline (i.e., the consumer entry into the project), discharge, and at 6 month intervals post baseline. Data are to be reported into the uniform data collection tool every quarter, along with a narrative written quarterly report to be submitted to the government project officer. This written quarterly report will include grantees' analysis of the data collected and the outcomes. Technical assistance related to data collection and report will be offered.

The collection of these data will enable CMHS to report on key outcome measures relating to mental health. In addition to these outcomes, data collected by grantees will be used to demonstrate how SAMHSA's grant programs are reducing disparities in access, service use and outcomes nationwide.

Grantees will be required to report on the following Infrastructure, Prevention, and Promotion performance measures on a quarterly basis: Policy Development; Workforce

Development, Financing, Organizational Change, Partnership/collaborations, Accountability, Types/Targets of Practices, Awareness, Training, Knowledge/Attitudes/Beliefs, Screening, Outreach, Referral, and Access.

In addition to these measures, grantees will be expected to collect and report the following health outcomes data at baseline (i.e., the consumer entry into the project), discharge, and at intervals as detailed below. (Note: This does not prevent grantees from collecting health indicator data more frequently, as clinically indicated.)

i. Blood pressure—semiyearly
ii. Body Mass Index (BMI)—semiyearly
iii. Waist circumference— semiyearly
iv. Breath CO (carbon monoxide)— semiyearly
v. Plasma Glucose (fasting) and/or HgbA1c—annually
vi. Lipid profile (HDL, LDL, triglycerides)—annually

Measuring blood pressure, cholesterol and BMI are indicators for the risk of cardiovascular disease. Plasma glucose, Hemoglobin A1c and the lipid profile are predictors of diabetes. The risk of having respiratory disease is also determined by Breath CO. The following chart depicts the health measurements and ranges collected by current PBHCI grantees to help determine health outcomes and risk statuses of clients for these physical health conditions.

Health Measurements	**Term**	**Ranges**
Blood pressure (Systolic / Diastolic)	mmHg	•Normal *Less than120 (S) / less than 80 (D)* •Prehypertension *129-139 (S) / 80-89 (D)* •High hypertension *140 or higher (S) / 90 or higher (D)*
Body Mass Index	BMI	•Normal *Under 25* •Overweight *25-29* •Obese *30-39* •Extreme Obesity *40+*
Waist circumference	cm/ inches	Men *Over 102 cm (40 inches)* Women *Over 88 cm (35 inches)*
Breath CO	ppm	Normal *1-6* Light smoker *7-10* Heavy smoker *10+* *These numbers are generally shown using the Breathalyzer, which help clients see and track their progress in tobacco cessation and reduction
Plasma glucose (fasting) and/or HgbA1c	mg/dL and/or percent	•Normal *99 mg/dL or below (FPG) and/or about 5% (HgbA1c)* •Prediabetes *100-125 mg/dL (FPG) and/or 5.7 to 6.4% (HgbA1c)*

		•Diabetes *126 mg/dL or above (FPG) and/or 6.5% or above (HgbA1c)*
HDL cholesterol	mg/dL	At risk for cardiovascular disease *Less than 40*
LDL cholesterol	mg/dL	At risk for cardiovascular disease *Greater than 130*
Triglycerides	mg/dL	At risk for cardiovascular disease *Greater than 150*

As part of the HHS' initiative to prevent 1 million heart attacks and strokes by 2017, the Million Hearts Campaign has issued treatment protocols. Grantees will be expected to use one of the four protocols recommended by the CDC, which are listed below:

a. National Heart, Lung and Blood Institute, National Institutes of Health. *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure - Complete Report*. National Heart, Lung, and Blood Institute, National Institutes of Health. NIH Publication No. 04-5230, 2004. (http://www.nhlbi.nih.gov/health-pro/guidelines/current/hypertension-jnc-7/)
b. Elements Associated with Effective Adoption and Use of a Protocol Insights from Key Stakeholder. (http://millionhearts.hhs.gov/resources/protocols.html)
c. An Effective Approach to High Blood Pressure Control A Science Advisory From the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and (http://www.sciencedirect.com/science/article/pii/S0735109713060774)
d. Protocol-Based Treatment of Hypertension : A Critical Step on the Pathway to Progress; *JAMA January 1, 2014 Volume 311, Number 1* (http://jama.jamanetwork.com/journal.aspx)

The HDL and LDL cholesterol and triglycerides ranges listed above illustrate the ballpark readings for cardiovascular disease. There are additional guidelines developed by the American College of Cardiology (ACC) and American Heart Association (AHH) in conjunction with the National Heart, Lung, and Blood Institute (NHLBI) that can be found online in both the *Journal of American College of Cardiology* and *Circulation*. These guidelines identify four groups of primary and secondary prevention patients in whom primary care providers should focus their efforts to reduce cardiovascular disease events. These guidelines no longer use the recommended LDL and non-HDL cholesterol targets. For more information please visit https://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf+html for the *2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults*.

Performance data will be reported to the public, the Office of Management and Budget (OMB) and Congress as part of SAMHSA's budget request.

Please also note that should a PBHCI cross-site evaluation be funded, all grantees are expected to participate and meet the requirements of this evaluation.

2.4 Local Performance Assessment

Consistent with 520K(e) of the Public Health Service Act, as amended, grantees will be required to evaluate and report on the effectiveness of their grant activities, no later than 90 days after the grant award expires.

Grantees must periodically review the performance data they report to SAMHSA (as required above) and assess their progress and use this information to improve management of their grant projects. The assessment should be designed to help you determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project. Performance assessments also should be used to determine whether your project is having/will have the intended impact on behavioral health disparities. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.

At a minimum, your performance assessment should include the required performance measures identified above. You may also consider outcome and process questions, such as the following:

Outcome Questions:

- What was the effect of the intervention on key outcome goals?
- What program/contextual/cultural/linguistic factors were associated with outcomes?
- What individual factors were associated with outcomes, including race/ethnicity/ sexual identity (sexual orientation/gender identity)?
- How durable were the effects?
- Was the intervention effective in maintaining the project outcomes at 6-month follow-up?

As appropriate, describe how the data, including outcome data, will be analyzed by racial/ethnic group or other demographic factors to assure that appropriate populations are being served and that disparities in services and outcomes are minimized.

Process Questions:

- How closely did implementation match the plan?

- What types of changes were made to the originally proposed plan?

- What types of changes were made to address disparities in access, service use, and outcomes across subpopulations, including the use of the National CLAS Standards?

- What led to the changes in the original plan?

- What effect did the changes have on the planned intervention and performance assessment?

- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

- What strategies were used to maintain fidelity to the evidence-based practice or intervention across providers over time?

- How many individuals were reached through the program?

Grantees must use EHR population management tools in order to support a robust continuous quality improvement process, and must regularly generate reports by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. Grantees must use these tools to target specific interventions to populations most at risk of or in need of said intervention.

No more than 20 percent of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-2.3 and 2.4 above.

2.5 Infrastructure Development (maximum 25 percent of total grant award)

Although services grant funds must be used primarily for direct services and supports, SAMHSA recognizes that infrastructure changes may be needed to implement the services or improve their effectiveness. You may use no more than **25%** (this includes no more than 15% for facility modifications and health information technology) of the total services grant award for the following types of infrastructure development, if necessary to support the direct service expansion of the grant project, such as:

- Development of interagency coordination mechanisms and partnerships with other service providers for service delivery (e.g., building provider networks, building functional and sustainable linkages among services partners)
- Policy development to support needed collaborative service systems improvement (e.g., change in standards of practice, data sharing)

- Workforce development to assist staff or other providers in identifying primary care, mental health and/or substance abuse service issues including training on coordinating access to and enrollment in public and private insurance
- Redesigning processes, as needed, to enhance effectiveness, efficiency and optimal collaboration between primary care and behavioral health provider settings staff
- Facility modifications and Health Information Technology (applicants may use no more than **15%** of their grant award for facility modifications and health information technology needed to support primary care service provision at the community behavioral health center.)

2.6 Grantee Meetings

Grantees must plan to send a minimum of three people (including the Project Director and the grantee organization's CEO or designee) to at grantee meeting every other year of the grant program. You must include a detailed budget and narrative for this travel in your budget. At these meetings, grantees will present the results of their projects and federal staff will provide technical assistance. Each meeting will be 3 days. These meetings are usually held in the Washington, D.C., area and attendance is mandatory.

II. AWARD INFORMATION

Funding Mechanism: Cooperative Agreements
Anticipated Total Available Funding: $40,897,330

Estimated Number of Awards: 102
Estimated Award Amount: Up to $400,000 per year
Length of Project Period: Up to 4 years

Proposed budgets cannot exceed $400,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

Cooperative Agreement

These awards are being made as cooperative agreements because they require substantial post-award federal programmatic participation in the conduct of the project. Under this cooperative agreement, the roles and responsibilities of grantees and SAMHSA staff are:

<u>Role of Grantee:</u>

- Comply with all terms and conditions of the award and satisfactorily perform activities to achieve the program goals;
- Consult with and accept guidance and respond to requests for information from the Government Project Officer, the Grants Management Specialist, and other relevant SAMHSA and Federal staff;
- Agree to provide SAMHSA with all required data;
- Respond to requests for information from SAMHSA and other Federal partners;
- Support and participate in grant meetings;
- Advise SAMHSA in advance of any future participation in related Federal initiatives, allowing SAMHSA to make adjustments as necessary;
- Produce required SAMHSA reports;
- Keep Federal program staff informed of emerging issues, developments, and problems; and
- Participate in a cross-site evaluation of the PBHCI program should one be conducted.

Role of SAMHSA Staff:

- Review and approve sub-recipient contracts;
- Work cooperatively with the grantees to augment goals upon notification of award to ensure PBHCI dollars and services are being maximized;
- Work cooperatively with grantees to ensure that the project continues after the funding period ends;
- Review and approve annual Needs Assessment Plans.
- Consult with the PBHCI grant investigators on all phases of the project development and implementation to ensure accomplishment of the goals;
- Approve key staff (e.g., project director, supervisors) responsible for the management, leadership, and oversight of the grants;
- Review critical project activities for conformity to the mission of the PBHCI grant program;
- Provide guidance on project design and components, as needed;
- Participate in policy and steering groups or related work groups;
- Approve data collection plans;
- Recommend outside consultants, if needed; and
- Assume overall responsibility for monitoring the conduct and progress of the PBHCI grant program, review quarterly reports, annual grant continuation reports, conduct site visits, and make recommendations to SAMHSA regarding continuation funding.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligibility for this program is statutorily limited to qualified community mental health programs, as defined under section 1913(b)(1) of the Public Health Service Act, as amended.

The statutory authority for this program prohibits grants to for-profit agencies.

2. COST SHARING and MATCH REQUIREMENTS

Cost sharing/match is not required in this program.

3. EVIDENCE OF EXPERIENCE AND CREDENTIALS

SAMHSA believes that only existing, experienced, and appropriately credentialed organizations with demonstrated infrastructure and expertise will be able to provide required services quickly and effectively. You must meet three additional requirements related to the provision of services.

The three requirements are:

- A provider organization for direct client mental health services appropriate to the grant must be involved in the proposed project. The provider may be the applicant or another organization committed to the project. More than one provider organization may be involved;

- Each treatment provider (including partnering primary care) organization must have at least 2 years' experience (as of the due date of the application) providing relevant services in the geographic area(s) in which services are to be provided (official documents must establish that the organization has provided relevant services for the last 2 years); and

- Each treatment provider (including partnering primary care) organization must comply with all applicable local (city, county) and state licensing, accreditation and certification requirements, as of the due date of the application.

[Note: The above requirements apply to all service provider organizations. A license from an individual clinician will not be accepted in lieu of a provider organization's license. Eligible tribes and tribal organization mental health/substance abuse treatment providers must comply with all applicable tribal licensing, accreditation, and certification requirements, as of the due date of the application. See Appendix II, Statement of Assurance, in this document.]

Following application review, if your application's score is within the funding range, the government project officer (GPO) may contact you to request that the following documentation be sent by overnight mail, or to verify that the documentation you submitted is complete:

- a letter of commitment from every mental health/substance abuse treatment provider organization that has agreed to participate in the project that specifies the nature of the participation and the service(s) that will be provided;

- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which the services are to be provided;

- official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county or other governmental unit that licensing, accreditation and certification requirements do not exist; and

- for tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation and certification; OR 2) documentation from the tribe or other tribal governmental unit that licensing, accreditation and certification requirements do not exist.

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

In addition to the application and submission language discussed in PART II: Section I, you must include the following in your application:

1. ADDITIONAL REQUIRED APPLICATION COMPONENTS

- **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through G. Sections A-G together may not be longer than 30 pages. (Remember that if your Project Narrative starts on page 5 and ends on page 35, it is 31 pages long, not 30 pages.) More detailed instructions for completing each section of the Project Narrative are provided in Section V – Application Review Information of this document.

The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be provided immediately following your Project Narrative in PART II-V. There are no page limits for these sections except for PART II: Appendix E, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in PART II-V: Supporting Documentation. Supporting documentation should be submitted in black and white (no color).

- **Attachments 1 through 8** – Use only the attachments listed below. If your application includes any attachments not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Attachments 1, 3 and 4 combined. There are no page limitations for Attachments 2, 5, 6, 7, and 8 combined. Do not use attachments to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do. Please label the attachments as: Attachment 1, Attachment 2, etc.

  - **Attachment 1**: Identification of at least one experienced, licensed mental health/substance abuse treatment provider organization; (2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment or prevention service provider organization; (3) letters of commitment from these direct service provider organizations; **(Do not include any letters of support – it will jeopardize the review of your application if you do.)** (4) the Statement of Assurance (provided in Appendix II of this announcement) signed by the authorized representative of the applicant organization identified on the first page (SF-424) of the application, that assures SAMHSA that all listed providers meet the 2-year experience requirement, are appropriately licensed, accredited and certified, and that if the application is within the funding range for an award, the applicant will send the GPO the required documentation within the specified time.

  - **Attachment 2**: Data Collection Instruments/Interview Protocols – if you are using standardized data collection instruments/interview protocols, you do not need to include these in your application. Instead, provide a web link to the appropriate instrument/protocol. If the data collection instrument(s) or interview protocol(s) is/are not standardized, you must include a copy in Attachment 2.

  - **Attachment 3**: Sample Consent Forms

  - **Attachment 4**: Letter to the SSA (if applicable; see PART II: Appendix C – Intergovernmental Review (E.O. 12372) Requirements).

  - **Attachment 5**: A letter detailing the PBHCI Coordination Entity members and scope of oversight and involvement, inclusive of member signatures.

- **Attachment 6**: At least three Memoranda of Understanding (MOU)/Letters of Commitment (LOC) with separate area primary care providers delivering services to the applicant's service population. (For applicants in a HRSA-designated health professional shortage area (HPSA), evidence of the inability to secure MOUs/LOCs from three providers must be submitted).

- **Attachment 7**: A copy of the signed, executed EHR vendor contract.

- **Attachment 8**: Health Home Flow Chart (the flow chart is a visual or narrative description of how consumers will move in, though, and out of your health home program).

2. APPLICATION SUBMISSION REQUIREMENTS

Applications are due by **11:59 PM** (Eastern Time) on **February 27, 2015**.

3. FUNDING LIMITATIONS/RESTRICTIONS

- No more than 25 percent of the total grant award may be used for developing the infrastructure necessary for expansion of services (No more than 15% of the total grant award may be used for facility modifications and health information technology necessary for expansion of services).

- No more than 20 percent of the total grant award may be used for data collection, performance measurement and performance assessment, including incentives for participating in the required data collection follow-up.

- No less than 10 percent of the total grant award may be used for preventive and health promotion services.

Be sure to identify these expenses in your proposed budget.

SAMHSA grantees also must comply with SAMHSA's standard funding restrictions, which are included in PART II: Appendix D – Funding Restrictions.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-G below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-G.

- In developing the Project Narrative section of your application, use these instructions, which have been tailored to this program.

- The Project Narrative (Sections A-G) together may be no longer than 30 pages.

- You must use the seven sections/headings listed below in developing your Project Narrative. **You must indicate the Section letter and number in your response or it will not be considered, i.e., type "A-1", "A-2", etc., before your response to each question.** Your application will be scored according to how well you address the requirements for each section of the Project Narrative.

- Although the budget and supporting documentation for the proposed project are not scored review criteria, the Review Group will consider their appropriateness after the merits of the application have been considered. (See PART II: Section V and Appendix F).

- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Although scoring weights are not assigned to individual bullets, each bullet is assessed in deriving the overall Section score.

Section A: Population of Focus and Statement of Need (10 points)

1. Provide a comprehensive demographic profile of your population of focus in terms of race, ethnicity, federally recognized tribe, language, gender, age, socioeconomic characteristics and sexual identity (sexual orientation, gender identity).

2. Discuss the relationship of your population of focus to the overall population in your geographic catchment area and identify sub-population disparities, if any, relating to access/use/outcomes of your provided services, citing relevant data. Demonstrate an understanding of these populations consistent with the purpose of your program and intent of the RFA.

3. Describe the nature of the problem, including service gaps, and document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus based on data. Provide detail on the chronic health conditions experienced by your population; quantify the problem with information on current diagnosis and related hospital admissions, readmissions, etc., when data is available. Identify the source of the data. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for the quantitative data that could be used are local epidemiologic data, state data (e.g., from state needs assessments, SAMHSA's National Survey on Drug Use and Health), and/or national data [e.g., from SAMHSA's National Survey on Drug Use and Health or from National Center for Health Statistics/Centers for Disease Control and Prevention (CDC) reports, and Census data]. This list is not exhaustive; applicants may submit other valid data, as appropriate for your program.

4. Describe how, if at all, you are currently involved in funding/providing primary care and other health home related services to individuals with serious mental illness. If applicable, explain how PBHCI can enhance the financing/provider systems currently in place. Include a discussion of the existing collaborations and/or agreements with primary care agencies as well as with consumer/peer/family driven organizations.

5. If you plan to use grant funds for infrastructure development, describe the infrastructure changes you plan to implement and how they will enhance/improve service effectiveness. If you do not plan to use grant funds for infrastructure changes, indicate so in your response.

Section B: Proposed Evidence-Based Service/Practice (10 points)

1. Describe the purpose of the proposed project, including its goals and objectives. These must relate to the intent of the RFA and performance measures you identify in Section E: Data Collection and Performance Measurement.

2. Describe the Evidence-Based Practice (EBP) that will be used and justify its use for your population of focus, your proposed program, and the intent of this RFA. Describe how the proposed practice will address the following issues in the population(s) of focus: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual orientation, gender identity); and disability. [See Appendix I: Using Evidence-Based Practices (EBPs).]

3. If an EBP does not exist/apply for your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate existing EBP. Describe how the proposed practice will address the following issues in the population(s) of focus: demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status); language and literacy; sexual identity (sexual orientation, gender identity); and disability.

4. Explain how your choice of an EBP or practice will help you address disparities in service access, use and outcomes for subpopulations.

5. If applicable, describe any modifications that will be made to the EBP or practice and the reasons the modifications are necessary.

Section C: Proposed Implementation Approach (30 points)

1. Provide a chart or graph depicting a realistic time line for the entire project period showing key activities, milestones, and responsible staff. These key activities should include the requirements outlined in Section I-2: Expectations. Be sure to

show that the project can be implemented and service delivery can begin as soon as possible and no later than 4 months after grant award. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]

2. Describe how you will identify, recruit and retain those consumers most in need of on-site primary care services and specialty referrals (including those with HIV/AIDS and Hepatitis A, B, & C, as well as those with histories of trauma). Using your knowledge of the language, beliefs, norms, values and socioeconomic factors of the population(s) of focus, discuss how the proposed approach addresses these issues when conducting outreach, engagement and delivery of services to this population. In addition, describe how you will prioritize enrolling consumers into the program who do not currently receive primary care services.

3. Describe how you will screen and assess clients for the presence of co-occurring mental and substance use disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders.

4. Describe the flow (visually or by narrative) depicting how consumers will move in, though, and out of your health home program. Please provide a flow chart. This should be included in **Attachment 8** of your application.

5. Describe your proposal to implement the core services outlined in Section 2. Expectations, including provision of on-site primary care services, specialty referrals, and person-centered health home services. Include activities that will lead to the achievement of the goals and objectives.

6. Describe your plan to establish a PBHCI Coordination Team, including how the Entity will provide leadership and guidance in accomplishing the goals of the PBHCI program; serve as a link between the program and the community; ensure compliance with state and federal laws; develop and implement PBHCI sustainability efforts; and review data on program effectiveness with associated development of continuous quality improvement efforts. A letter detailing the members and scope of oversight and involvement must be included in **Attachment 5** of your application, inclusive of member signatures.

7. Describe how you will use the information obtained from the annual needs assessment to implement programmatic and client's needs. Please see Section I-2: Expectations for details about the annual needs assessment.

8. Describe how you plan to implement program structures are designed to minimize barriers to primary care access for PBHCI consumers across the

following core domains: integrated treatment teams; team meetings; treatment planning; and information sharing.

9. Describe how a continuum of preventive and health promotion services will be offered to consumers within your PBHCI health home program.

10. Describe how the recovery dimensions of *home, purpose, and community* will be embraced and embedded in all components of your PBHCI program, when able and appropriate.

11. Describe how the proposed activities will be implemented and how they will adhere to the National Standards for Culturally and Linguistic Appropriate Services (CLAS) in Health and Health Care. For additional information go to http://ThinkCulturalHealth.hhs.gov.

12. Describe your plan to support overall coordination of care with separate area primary care providers delivering services to consumers in your service population. Include how you will address data sharing protocols; connection with care coordination activities; and relation to the integrated treatment team and associated planning. Evidence of this support must be provided in **Attachment 6** (can be a letter from primary care providers)**.**

13. Identify any organizations (e.g., primary care providers, hospitals, social support agencies, etc.) with whom you have collaborations and/or formal agreements that support your proposed PBHCI activities. Describe their roles and responsibilities and demonstrate their commitment to the project. Include at least three MOUs/LOCs from organizations connected to and supporting the project in **Attachment 6.**

14. State the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and anticipated outcomes. Explain how you arrived at this number. You are required to include the numbers to be served by race, ethnicity, gender, and sexual orientation.

15. Provide a per-unit cost for this program. Justify that this per-unit cost is providing high quality services that are cost effective. Describe your plan for maintaining and/or improving the provision of high quality services that are cost effective throughout the life of the grant.

    [NOTE: One approach might be to provide a per-person or unit cost of the project to be implemented. You can calculate this figure by: 1) taking the total cost of the project over the lifetime of the grant and subtracting 20 percent for data and performance assessment; 2) dividing this number by the total unduplicated number of persons to be served. Another approach might be to

calculate a per-person or unit cost based upon your organization's history of providing a particular service(s). This might entail dividing the organization's annual expenditures on a particular service(s) by the total number of persons/families who received that service during the year. Another approach might be to deliver a cost per outcome achieved.]

Section D: Staff and Organizational Experience (10 points)

1. Discuss the capability and experience of the applicant organization and other participating organizations with similar projects and populations. Demonstrate that the applicant organization and other participating organizations have linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the population(s) of focus.

2. Provide a complete list of staff positions for the project, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications. Note the minimum requirements for your integrated treatment team as outlined in Section 2. You may use Part 2 (Staffing Profile) of the Sustainability Checklist provided in Appendix V.

3. Discuss how key staff has demonstrated experience and are qualified to serve the population(s) of focus and are familiar with their culture(s) and language(s).

4. Describe how your staff will ensure the input of consumers, clients, families, and people in recovery in assessing, planning and implementing your project.

Section E: Data Collection and Performance Measurement (20 points)

1. Document your ability to collect and report on the required performance measures as specified in Section I-2.3 of this RFA. Describe your plan for data collection, management, analysis and reporting. If applicable, specify and justify any additional measures or instruments you plan to use for your grant project. Include how you will use reporting tools available in your EHR to support population health management.

2. Describe the data-driven quality improvement process by which sub-population disparities in access/use/outcomes will be tracked, assessed and reduced.

3. Describe your plan for conducting the local performance assessment as specified in Section I-2.4 of this RFA and document your ability to conduct the assessment.

4. Describe how you will use data to monitor overall population care planning implementation, conduct gap analysis of care provided, and ensure timely changes to care plan to best meet needs of consumers.

5. Explain how you will track avoidable hospital readmissions and calculate cost savings that result from improved coordination of care and chronic disease management. Include how you will track emergency room visits and skilled nursing facility admissions.

Section F: Sustainability (15 points)

1. Describe anticipated program, policy and reimbursement barriers regarding the establishment of your PBHCI health home project.

2. Based upon your response to bullet #3 of Section A, clearly state the unduplicated number of individuals you propose to serve with grant funds in each year of the grant. Note the requirements outlined in Section 2 Expectations—Sustainability regarding the minimum goals for consumers served, relative to your census of individuals with SMI. Also include the number of individuals to be served by race, ethnicity, and sexual/gender minority.

3. Describe how this PBHCI grant will transform your organization with the intention of expanding the service model to all service recipients in your organization upon completion of the grant.

4. Describe your plan to continue the project after the funding period ends. Also describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership, etc.) to ensure stability over time.

5. Describe your plan to connect with opportunities available at the state, federal, and other levels that support continuation of PBHCI activities.

6. Describe your PBHCI business model and strategies for revenue maximization. The business model should include how your program is fundamentally structured with detail on key partners; key activities; key customers including engagement and needs; cost; and revenue streams. Business strategies for how to develop the key areas and maximize revenue should be addressed.

Section G: Electronic Health Record (EHR) Technology (5 points)

1. Describe your plan to meet Meaningful Use Standards. This plan should include staffing, training, budget requirements and a timeline for complete implementation by the end of the grant period. Be sure to add information on

electronic prescriptions, electronic lab results, the shared standard continuity of care record, and the regional extension center program, as mentioned in the Health Information Technology (HIT) section under 2. Expectations.

2. Explain how you will use reporting tools available in your EHR to target specific interventions to populations most in need of said interventions.

3. Identify the EHR system that you, or the primary provider of clinical services associated with the grant (i.e., the grantee, sub-awardee or sub-contractor that is expected to deliver clinical services to the most patients during the term of the grant), have adopted to manage client-level clinical information for your proposed project. Provide a copy of the signed executed EHR vendor contract in **Attachment 7** of your application.

4. If your EHR system does not have the capacity or capability to use population management tools, reporting tools or meet the Meaningful Use Standards, please submit a plan that can describe how you will fulfill these requirements. It is expected that grantees have an EHR system that can manage and track client data and outcomes and provide reports by the end of the grant period.

SUPPORTING DOCUMENTATION

Section H: Biographical Sketches and Job Descriptions

See PART II: Appendix E – Biographical Sketches and Job Descriptions, for instructions on completing this section.

Section I: Confidentiality and SAMHSA Participant Protection/Human Subjects

You must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section I of your application. See Appendix III of this document for guidelines on these requirements.

VI. ADMINISTRATION INFORMATION

1. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.3, grantees must comply with the reporting requirements listed on the SAMHSA website at http://www.samhsa.gov/grants/applying/reporting-requirements. Grantees are expected to submit quarterly reports during the 4 year grant program and a final report at the end of the grant. Final reports are due 90 days after the end of the grant period.

VII. AGENCY CONTACTS

For questions about program issues contact:

Tenly Pau Biggs, MSW, LGSW
Center for Mental Health Services, Community Support Programs Branch
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 6-1008
Rockville, Maryland 20857
(240) 276-2411
Tenly.Biggs@samhsa.hhs.gov

For questions on grants management and budget issues contact:

Gwendolyn Simpson
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) 276-1408
gwendolyn.simpson@samhsa.hhs.gov

Appendix I – Using Evidence-Based Practices (EBPs)

SAMHSA recognizes that EBPs have not been developed for all populations and/or service settings. For example, certain practices for American Indians/Alaska Natives, rural or isolated communities, or recent immigrant communities may not have been formally evaluated and, therefore, have a limited or nonexistent evidence base. In addition, other practices that have an established evidence base for certain populations or in certain settings may not have been formally evaluated with other subpopulations or within other settings. Applicants proposing to serve a population with a practice that has not been formally evaluated with that population are required to provide other forms of evidence that the practice(s) they propose is appropriate for the population(s) of focus. Evidence for these practices may include unpublished studies, preliminary evaluation results, clinical (or other professional association) guidelines, findings from focus groups with community members, etc. You may describe your experience either with the population(s) of focus or in managing similar programs. Information in support of your proposed practice needs to be sufficient to demonstrate the appropriateness of your practice to the individuals reviewing your application.

- Document the evidence that the practice(s) you have chosen is appropriate for the outcomes you want to achieve.

- Explain how the practice you have chosen meets SAMHSA's goals for this grant program.

- Describe any modifications/adaptations you will need to make to your proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes. We expect that you will implement your evidence-based service(s)/practice(s) in a way that is as close as possible to the original service(s)/practice(s). However, SAMHSA understands that you may need to make minor changes to the service(s)/practice(s) to meet the needs of your population(s) of focus or your program, or to allow you to use resources more efficiently. You must describe any changes to the proposed service(s)/practice(s) that you believe are necessary for these purposes. You may describe your own experience either with the population(s) of focus or in managing similar programs. However, you will need to convince the people reviewing your application that the changes you propose are justified.

- Explain why you chose this evidence-based practice over other evidence-based practices.

- If applicable, justify the use of multiple evidence-based practices. Discuss how the use of multiple evidence-based practices will be integrated into the program.

Describe how the effectiveness of each evidence-based practice will be quantified in the performance assessment of the project.

- Discuss training needs or plans for training to successfully implement the proposed evidence-based practice(s).

Resources for Evidence-Based Practices:

You will find information on evidence-based practices at http://store.samhsa.gov/resources/term/Evidence-Based-Practice-Resource-Library. SAMHSA has developed this website to provide a simple and direct connection to websites with information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Resource Library* provides a short description and a link to dozens of websites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings.

In addition to the website noted above, you may provide information on research studies to show that the services/practices you plan to implement are evidence-based. This information is usually published in research journals, including those that focus on minority populations. If this type of information is not available, you may provide information from other sources, such as unpublished studies or documents describing formal consensus among recognized experts.

[Note: Please see PART II: Appendix D – Funding Restrictions, regarding allowable costs for EBPs.]

Appendix II – Statement of Assurance

As the authorized representative of [*insert name of applicant organization*] _____, I assure SAMHSA that all participating service provider organizations listed in this application meet the two-year experience requirement and applicable licensing, accreditation, and certification requirements. If this application is within the funding range for a grant award, we will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

- a letter of commitment from every mental health/substance abuse treatment service provider organization listed in **Attachment 1** of the application that specifies the nature of the participation and the service(s) that will be provided;

- official documentation that all mental health/substance abuse treatment provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and

- official documentation that all mental health/substance abuse treatment provider organizations: 1) comply with all local (city, county) and state requirements for licensing, accreditation and certification; OR 2) official documentation from the appropriate agency of the applicable state, county or other governmental unit that licensing, accreditation and certification requirements do not exist.[3] (Official documentation is a copy of each service provider organization's license, accreditation and certification. Documentation of accreditation will not be accepted in lieu of an organization's license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

- for tribes and tribal organizations only, official documentation that all participating mental health/substance abuse treatment provider organizations: 1) comply with all applicable tribal requirements for licensing, accreditation and certification; OR

[3] Tribes and tribal organizations are exempt from these requirements.

2) documentation from the tribe or other tribal governmental unit that licensing, accreditation and certification requirements do not exist.

_____ _____

Signature of Authorized Representative Date

Appendix III – Confidentiality and SAMHSA Participant Protection/Human Subjects Guidelines

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants (including those who plan to obtain IRB approval) must address the seven elements below. Be sure to discuss these elements as they pertain to on-line counseling (i.e., telehealth) if they are applicable to your program. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these seven elements, read the section that follows entitled "Protection of Human Subjects Regulations" to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application must be resolved prior to funding.

1. Protect Clients and Staff from Potential Risks

   - Identify and describe any foreseeable physical, medical, psychological, social and legal risks or potential adverse effects as a result of the project itself or any data collection activity.

   - Describe the procedures you will follow to minimize or protect participants against potential risks, including risks to confidentiality.

   - Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

   - Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. Fair Selection of Participants

   - Describe the population(s) of focus for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women or other targeted groups.

- Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners and individuals who are likely to be particularly vulnerable to HIV/AIDS.

- Explain the reasons for including or excluding participants.

- Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

- Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

- If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.). Provide justification that the use of incentives is appropriate, judicious and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven effective by consulting with existing local programs and reviewing the relevant literature. In no case may the value if an incentive paid for with SAMHSA discretionary grant funds exceed $30.

- State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. Data Collection

- Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

- Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

- Provide in **Attachment 2**, "Data Collection Instruments/Interview Protocols," copies of all available data collection instruments and interview protocols that you plan to use (unless you are providing the web link to the instrument(s)/protocol(s)).

5. Privacy and Confidentiality

- Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

- Describe:

    - How you will use data collection instruments.

    - Where data will be stored.

    - Who will or will not have access to information.

    - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

6. Adequate Consent Procedures

- List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.

- State:

    - Whether or not their participation is voluntary.

    - Their right to leave the project at any time without problems.

    - Possible risks from participation in the project.

    - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Attachment 3, "Sample Consent Forms"**, of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

- Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

SAMHSA expects that most grantees funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria for research involving human subjects.

In addition to the elements above, applicants whose projects must comply with the Human Subjects Regulations must fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, these grantees will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling participants in the project.

General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

Appendix IV – Health Homes Services, Sample Definitions, and Roles

These are sample definitions, pulled from the CMS Approved State Plan Amendment submitted by the State of Missouri, in response to the Affordable Care Act 2703.

Comprehensive care management

Comprehensive care management services are conducted by the Nurse Care Manager, Primary Care Physician Consultant, the Health Home Administrative Support staff and Health Home Director with the participation of other team members and involve:

a. Identification of high-risk individuals and use of client information to determine level of participation in care management services;

b. Assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes;

c. Assignment of health team roles and responsibilities;

d. Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;

e. Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;

f. Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Care coordination

Care Coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and consumers/family members. Nurse Care Managers with the assistance of the Health Home Administrative Support staff will be responsible for conducting care coordination activities across the health team. The primary responsibility of the Nurse Care Manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.

Health promotion

Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, providing support for improving social networks and providing health- promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist consumers to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Health Home Director, Primary Care Physician Consultant, and Nurse Care Manager will each participate in providing Health Promotion activities. The success of health promotion activities is enhanced by support from Peer Wellness Coaches/Peer Recovery Specialists and other models of health navigators.

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing consumers' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management. The Health Home Director, Primary Care Physician Consultant, and Nurse Case Manager will all participate in providing Comprehensive Transitional Care activities, including, whenever possible, participating in discharge planning.

Individual and family support, which includes authorized representatives

Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self-manage their care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with DD the health team will refer to and coordinate with the approved DD case management entity for services more directly related to Habilitation and coordinate with the approved DD case management entity for services more directly related a particular healthcare condition. Nurse Care Managers will provide this service.

Referral to community and social support services, including appropriate follow-up

Referral to community and social support services, including long term services and supports, involves providing assistance for consumers to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for this service. The Nurse Care Manager and Administrative support staff will provide this service.

Appendix V – PBHCI Sustainability Plan

Part One: Checklist

What Is This?

The PBHCI Sustainability Checklist outlines many of the elements most important to your organization as you continue supporting integrated care for your consumers.

Grantees should use this to identify the factors most important to sustaining your integration efforts through PBHCI. This is the "what," in "what are we trying to accomplish?"

How Do I Use It?

Review and discuss each domain with your executive leadership and integrated care team members. Your CEO, COO and CFO should be involved in all or parts of your sustainability discussion and plan development.

1. Rank each factor 1-5 (1 being highest priority, 5 being least high priority) regarding the factor's importance to your efforts at sustaining PBHCI services.
2. For each item ranked "1," mark this as a "Key Item."
3. For each Key Item,
   a. Provide an explanation of its importance to sustaining your PBHCI services
   b. List 1-2 action steps for addressing this key factor (include expected dates of completion)
   c. Note responsible parties and vital partners to achieving each action step (e.g., PBHCI Project Director, CEO, Managed Care Organization, etc.)

<u>Domain 1: Environment</u> - What does our external environment require of us?

Key Item	Rank Importance 1-5	Sustainability Factors
		Do you know the implications of Medicaid expansion in 2014 on your agency?
		Are you participating in your state's health home discussions?
		Are you in contact with likely Accountable Care Organizations in your area?
Key Item(s) Action		

Plan	

Domain 2: Strategy - What gives us direction?

Key Item	Rank Importance 1-5	Sustainability Factors
		Is integration embedded in your strategic plan?
		What is your agency's vision & mission? Does it need to change to include integration elements?
		Do you have a business plan for growing your integration business? Have you quantified the impact of Medicaid expansion on your business plan in 2015?
		Do you know how much money your organization needs to make in order to support your integrated care vision?
		Is integration part of the service every client receives? Are wellness programs parts of your service array? Are consumers trained in peer support and wellness coaching programs??
		Does your organization support the health and wellness of your employees?
Key Item(s) Action Plan		

Domain 3: Leadership Practices, Culture and Communication

Key Item	Rank Importance 1-5	Sustainability Factors
		Have you formed a change team that is empowered to influence integration in your clinic?

Key Item	Rank Importance 1-5	Sustainability Factors
		Is your governing board engaged and knowledgeable about integration?
		Are supervisors supporting staff during integration, including reviewing client health goals during supervision?
Key Item(s) Action Plan		

<u>Domain 4: Administrative and Policy</u> - Are we capable?

Key Item	Rank Importance 1-5	Sustainability Factors
		Do your administrative policies support integration? (Confidentiality policies, Billing and Reimbursement policy, Ethics policy)
		Do your clinical policies regarding care coordination, annual lab work, prescribing, smoking, treatment planning, etc.; require elements related to integrated services?
		Does your annual lab assessment include metabolic syndrome indicators?
		Are blood pressure and BMI measurements completed at each medical visit?
		Are health and wellness goals in your treatment plans?
		Do you have organization-wide policies regarding tobacco use?
		For services you will be unable to sustain, how will you assist consumers to find other providers of those services?
Key Item(s) Action Plan		

Domain 5: Billing (Are we maximizing our billing potential?)

Key Item	Rank Importance 1-5	Sustainability Factors
		Are you billing for all possible behavioral health services provided? Primary care visits?
		Are your Medicaid and Medicare numbers appropriately linked to the service provided?
		If partnering with an FQHC, do you understand FQHC billing rules and regulations?
		If partnering with an FQHC, do they understand your billing rules and regulations?
		If partnering with an FQHC, do you have a contract outlining payment for clinical services, and operations expectations?
		Have you walked through your workflow and identified who can pay for each step of your process - with your clinical and billing staff at the same time?
		Do you know what existing billing codes for integrated health are billable in your state and to which third party source?
Key Item(s) Action Plan		

Domain 6: Technology (Do we have the technology in place necessary to support integrated services?

Key Item	Rank Importance 1-5	Sustainability Factors

		Are you using a certified EHR?
		Can your system generate registries for staff to use to support integration?
		Can you generate a Coordination of Care Document (CCD)?
		Does your clinical record support documentation of physical health related services?
		Are you connected to the State HIE?
		Can your system generate an electronic bill after the completion of a documented event?
Key Item(s) Action Plan		

Domain 7: Quality Improvement (Do we have a structured approach for engaging in integration-related quality improvement efforts?)

Key Item	Rank Importance 1-5	Sustainability Factors
		Do you have automated methods for understanding the health and wellness of the people you serve at a population-level?
		Do you routinely use clinical and client-level data to make policy and practice decisions?
		Does your quality improvement program include benchmarks for integration activities?
		Does your quality improvement data drive change processes?
Key Item(s) Action Plan		

<u>Domain 8: Structure</u> - Are roles and responsibilities clear? Are we organized so we can meet strategy?

Key Item	Rank Importance 1-5	Sustainability Factors
		Do your job descriptions for case managers, therapists, nurses and doctors include key tasks associated with integration?
		Are your integrated teams meeting routinely and often (daily, weekly, etc.) to discuss integration efforts and client issues?
		Have nurses transitioned from “behavioral health nurses” to “integrated health nurses”?
		Is the treatment team required to monitor BOTH physical health and behavioral health issues?
		Have you identified the baseline caseloads for both primary care and behavioral health clinicians?
		Are your clinicians seeing enough consumers to meet the financial need?
Key Item(s) Action Plan		

<u>Domain 9: Skills</u> - Are staff able to do the desired work?

Key Item	Rank Importance 1-5	Sustainability Factors
		Does your staff development program include iterative integration trainings?
		Are staff trained on evidence based programs and tracked regarding fidelity to those approaches?
		Have case managers and therapists been trained on health navigation/care coordination?
		Is your billing staff trained on correct billing procedures such as the proper CPT code, linked with the proper diagnostic code and the proper credential?
		Are you as an agency and your providers empanelled with all of the appropriate managed care plans?
Key Item(s) Action Plan		

<u>Domain 10: People</u> - How do we attract and develop our talent?

Key Item	Rank Importance 1-5	Sustainability Factors
		Do your performance evaluations include integration tasks?
		Does your new staff orientation include information on integrated care?
		How do you ensure that new staff has an integration “mindset?”
Key Item(s) Action		

Key Item	Rank Importance 1-5	Sustainability Factors
Plan		

<u>Domain 11: Rewards</u> – How do we recognize people for supporting the change towards an integrated system?

Key Item	Rank Importance 1-5	Sustainability Factors
		How engaged are staff in your transition to integrated services?
		How well designed and aligned are incentives and informal rewards to drive needed behaviors necessary for achieving the strategy?
Please describe your efforts on this factor		

<u>Domain 12: Marketing</u> – How do we tell the story of both the need for integrated care and the success of our efforts?

Key Item	Rank Importance 1-5	Sustainability Factors
		Are you capturing client stories that demonstrate complex needs and successes?
		Are you able to generate clear short reports for varied audiences (board, staff, elected officials, health and community partners, additional funders) with your data and stories?
Please describe your efforts on this factor		

Part 2: Staffing Profile

What Is This?

The PBHCI Sustainability Staffing Profile allows you to, under "Current Staffing," list all staff currently involved with the PBHCI project, including the role, primary duties, level of effort, % funded through the PBHCI grant, and the employer. Under "Projected Staffing Post-Grant" list all staff you anticipate will stay involved in your integration efforts, including the role, primary duties, level of effort, projected funding source, and employer.

Current Staffing					
Clinical Discipline	**Role**	**Primary Duties**	**Level of Effort**	**PBHCI Funding**	**Employer**
e.g. Nurse Care Manager	Registered Nurse	Assess a consumer physical, mental, and social needs; develop an individualized plan of care to meet them, be they small or large, medical or practical (includes making referrals to appropriate services, and coordinating, evaluating, and adjusting them as needed); and ongoing monitoring, advocacy and assistance	0.50 FTE	25%	FQHC Partner
e.g. Peer Support	Wellness Coach	Help consumers identify personal reasons for pursuing greater wellness, and to enhance motivation for behavior change using evidence-based strategies; establishes relationships and practices core coaching skills that assist the	1.0 FTE (increased from 0.50 FTE)	100%	CMHC

Current Staffing					
Clinical Discipline	**Role**	**Primary Duties**	**Level of Effort**	**PBHCI Funding**	**Employer**
		client in identifying values and desires, transforming them into action, and maintaining lasting change over time			
Projected Staffing Post-Grant					
Clinical Discipline	**Role**	**Primary Duties**	**Level of Effort**	**Projected Funding**	**Employer**