



Bureau for Behavioral Health

Announcement of Funding Availability (AFA)

American Rescue Plan Act of 2021
Psychiatric Urgent Care



Proposal Guidance and Instructions

AFA Title: Adult Crisis Response

Targeting Regions: Statewide

AFA Number: AFA 4-2022-ARPA

West Virginia Department of Health and Human Resources
Bureau for Behavioral Health (BBH)

*For Technical Assistance please include the AFA # in the
subject line and forward all inquiries in writing to:*

DHHRBBHAnnouncements@wv.gov

Key Dates:	
Date of Release:	November 22, 2021
Technical Assistance:	Submit written requests to dhhrbbhannouncements@wv.gov
Application Deadline:	January 10, 2022 5:00 PM
Funding Announcement(s) To Be Made:	To be posted on BBH Website
Funding Amount Available:	Up to \$1,600,000
Target Area to be Served	Statewide

The following are requirements for the submission of proposals to BBH:

- ✿ Responses must be submitted using the required Proposal Template available at <https://dhhr.wv.gov/BBH/funding/Pages/Applying-for-Funding.aspx>
- ✿ Responses must be submitted electronically via email to DHHRBBHAnnouncements@wv.gov with “Proposal for Funding” and the corresponding AFA number in the subject line. Paper copies of the proposal will not be accepted. Notification that the proposal was received will follow via email from the Announcement mailbox.
- ✿ A Statement of Assurance agreeing to these terms is required of all proposal submissions available at <https://dhhr.wv.gov/BBH/funding/Pages/Applying-for-Funding.aspx>. This statement must be signed by the agency’s CEO, CFO, and Project Officer and attached to the Proposal Template.
- ✿ To request additional Technical Assistance, forward all inquiries via email to DHHRBBHAnnouncements@wv.gov and include “Proposal Technical Assistance” in the subject line. Proposal related questions should be submitted by **January 5, 2022** in order to guarantee a response in advance of the application deadline.

FUNDING AVAILABILITY

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Behavioral Health (BBH) is seeking proposals for the implementation of a statewide system of Adult Crisis Response services.

Funding for this announcement was released to West Virginia through the Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Services Block Grant (MHBG) as part the American Rescue Plan Act of 2021 (ARPA). This additional funding is intended to address the effects of the COVID -19 pandemic for Americans with mental illness and substance use disorders. The COVID-19 pandemic has exposed and exacerbated severe and pervasive health and social inequities in America, including the importance of supporting people with mental illness and substance use disorders.

BBH is seeking proposals from public or private, not-for-profit organizations with experience serving adults experiencing mental health conditions for the following services:

Psychiatric Urgent Care Centers

Funding Availability: A maximum of **four** awards will be made, with up to **\$400,000** per project.

Psychiatric Urgent Care Centers (PUCC) provide rapid access to mental health assessment and evaluation, medication support, peer support, case management and crisis intervention 24 hours a day, 7 days a week for individuals currently experiencing emotional distress or mental health crisis. Individuals presenting to the PUCC have characteristics including, but not limited to, high utilization of psychiatric emergency and inpatient services, at-risk of suicide, inability to acquire timely access to mental health care, legal involvement for low-level offenses resulting from or associated with mental illness and co-occurring substance use disorder. PUCCs mitigate inpatient hospitalization, commitment proceedings, avoidable incarcerations and emergency department visits by providing immediate access to mental health treatment, short-term observation (less than 24 hours), peer support, and linkage and referral to continuing community services and supports.

Total Funding Available: \$1,600,000

One-time funding: The Coronavirus Response and Relief Supplement Appropriations Act, 2021 and the American Rescue Plan Act of 2021 (ARPA) funding is issued as one time funding.

Allowable Expenses: Because this funding is being provided via the Community Mental Health Block Grant, property acquisition, construction and/or renovation costs **are not** allowable expenses. It is anticipated that most proposed expenses will be for personnel, rent, equipment and supplies necessary to start and maintain the project.

Grantee Eligibility: To be considered, applicants must:

- Possess a valid West Virginia business license and must provide proof of 501(c)3 status, if applicable.
- Have or be eligible to obtain a behavioral health license in the State of West Virginia
- Be able to meet the requirements for enrollment as a West Virginia Medicaid provider.
- Be able to demonstrate experience in the provision of behavioral health services.

Sustainability: Due to the one-time nature of the funding, applicants must be able to demonstrate the ability to work towards billing Medicaid and other third-party insurers for services (if appropriate).

Applicants should submit proposals with specified timeframes for project development and implementation. Proposals will be selected that meet the required criteria contained within this Announcement of Funding Availability. If a project is selected for award, the proposed timeframes will serve as the basis for developing the period of performance for the grant agreement.

Section One: INTRODUCTION

The West Virginia Department of Health and Human Resources, Bureau for Behavioral Health envisions healthy communities where integrated resources are accessible for everyone to achieve wellness, personal goals, and a self-directed future. The mission of BBH is to ensure that West Virginians with mental health and/or substance use disorders and intellectual/developmental disabilities experience quality services that are comprehensive, readily accessible and tailored to meet individual, family, and community needs.

Partnerships and collaboration *among* public and private systems, as well as with individuals, families, agencies, and communities, are important components of the systems of care surrounding each person. The role of the Bureau is to provide leadership in the administration, integration, and coordination of the public behavioral health system. The work is informed by results of a multi-year strategic planning process that includes critical partners in planning, funding, and delivering services and supports.

The following Strategic Priorities guide services and service continuum development:

Behavioral Health System Goals	
<i>Priority 1 Assessment and Planning</i>	<i>Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the WV behavioral health service delivery system.</i>
<i>Priority 2 Capacity</i>	<i>Build the capacity and competency of WV's behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.</i>
<i>Priority 3 Implementation</i>	<i>Increase access to effective behavioral health prevention, early identification, treatment and recovery management that is high quality and person-centered.</i>
<i>Priority 4 Sustainability</i>	<i>Manage resources effectively by promoting good stewardship and further development of the WV behavioral health service delivery system.</i>

BBH REGIONS IN WEST VIRGINIA

BBH utilizes a six region approach:

Region 1: Brooke, Hancock, Marshall, Ohio, and Wetzel counties

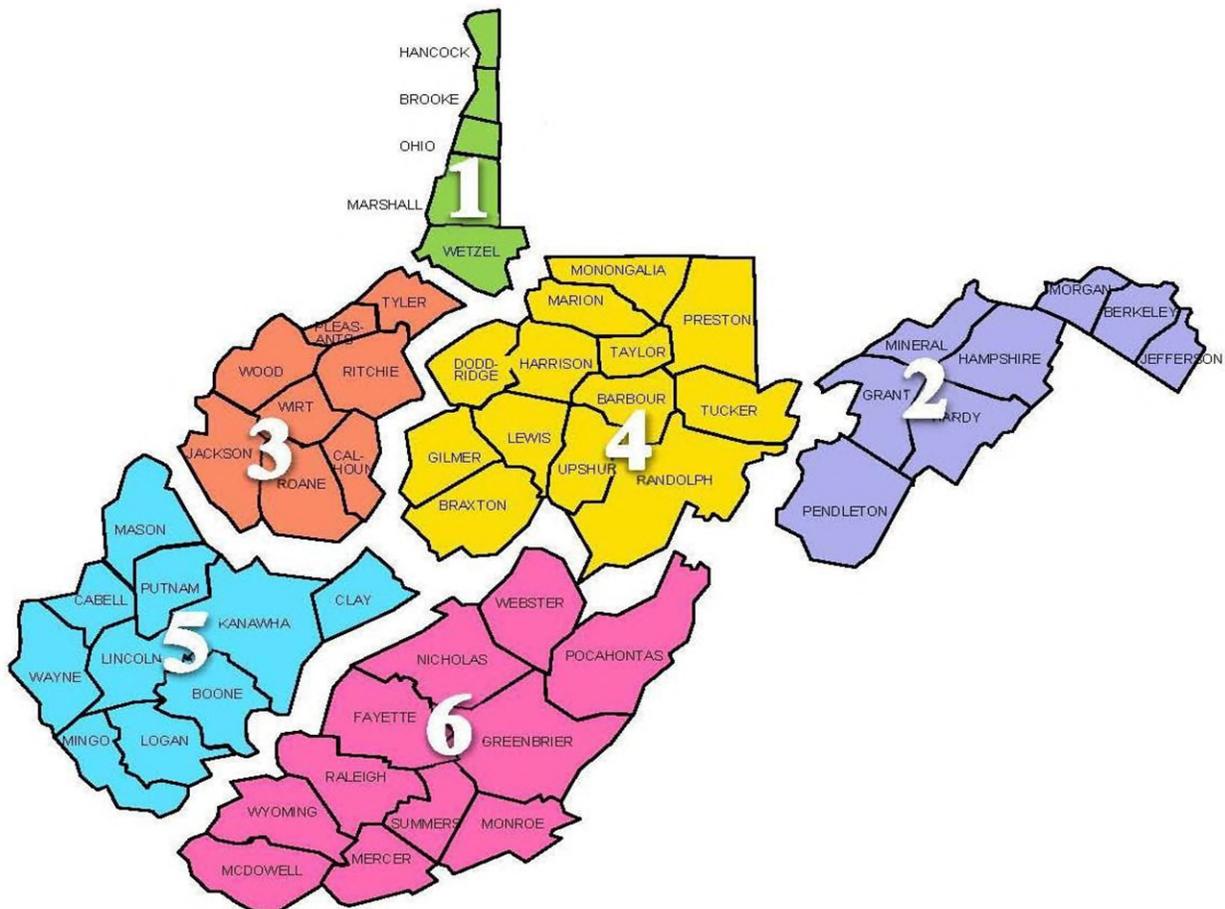
Region 2: Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, and Pendleton counties

Region 3: Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, and Wood counties

Region 4: Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur counties

Region 5: Boone, Cabell, Clay, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam and Wayne counties

Region 6: Fayette, Greenbrier, McDowell, Mercer, Monroe, Nicholas, Pocahontas, Raleigh, Summers, Webster, and Wyoming counties



Section Two: SERVICE DESCRIPTION

Target Population

Adults over age 18 experiencing serious mental health crisis or emotional distress.

Background

The COVID-19 pandemic has significantly and disproportionately impacted people with mental illness. Public health recommendations, such as social distancing, are necessary to reduce the spread of COVID-19; however, these public health recommendations can at the same time negatively impact those with Serious Mental Illness – Serious Emotional Disturbance (SMI/SED). The COVID-19 pandemic can increase stress, anxiety, feelings of isolation and loneliness, the use of alcohol or illicit substances, and other symptoms of underlying mental illness and co-occurring substance use disorder (SUD). Too many people with SMI and SED cannot access the treatment and support that they need, and the pandemic has further disrupted access and care for even greater numbers.

A fully developed crisis response system is responsive any time and any place. What does a person in crisis need? Someone to talk to, or someone to respond, or a safe place to go for evaluation, stabilization and follow up.

Crisis services are a continuum of services that are provided to individuals experiencing a psychiatric emergency. The primary goal of these services is to stabilize and improve psychological symptoms of distress and to engage individuals in an appropriate treatment service to address the problem that led to the crisis. Core crisis services include: 23-hour crisis stabilization/observation beds, short term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, psychiatric advance directive statements, and peer crisis services.

The research base on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes.

Historically, individuals who experienced acute psychiatric or substance use symptoms, such as an acute disturbance in thought, mood, behavior, or social relations that required immediate attention, would be treated in a general hospital emergency department or admitted to a hospital. Subsequently, they would receive less intensive outpatient treatment. It has become increasingly apparent that this service mix is frequently inadequate and expensive. Emergency rooms often lack staff with specialized psychiatric training as well as the time and infrastructure to appropriately address the

needs of individuals experiencing psychiatric or substance use crises. Furthermore, an emphasis on delivering the most appropriate care in the most appropriate setting has led to greater care provided in the community, thereby lessening the reliance on admitting individuals to hospitals. While the move to community-based treatment has led to a reduction in the number of psychiatric beds, in some instances, it has led to an unintended resource shortage.

This situation has led to the development of a continuum of alternative psychiatric emergency services, or “crisis services” (Allen, M. H., Forster, P., Silver, J., & Currier, G, 2002). The primary goals of these services are to stabilize and improve psychological symptoms of distress and to engage individuals in the most appropriate course of treatment. In contrast to the traditional hospital inpatient-based care settings available to people in need of immediate attention for psychiatric or substance use symptoms, crisis services include an array of services that are designed to reach individuals in their communities through telephone “hotlines” or “warm lines,” and mobile outreach, and to provide alternatives to costly hospitalizations—such as short-term crisis stabilization units and 23-hour observation beds.

Like emergency medical services, crisis services are intended to be available to the entire community. Those receiving services may include individuals with a history of serious and persistent mental illness and/or SUD or those who have never before used behavioral health services. They may be children, adults, or the elderly. Although not everyone with a mental health or substance use disorder will experience a need for crisis services, some factors may increase the risk of crisis and the need for individuals to access essential services and supports. These factors include poverty, unstable housing, coexisting substance use, and other physical health problems associated with mental illness (SAMHSA, 2009b).

BBH recognizes that the development of fully accessible and responsive crisis services involves complex problem solving with multiple entities and systems. The Bureau also recognizes that strategic crisis services implementation can result in better care and cost savings through the reduction in avoidable emergency department visits, psychiatric admissions, police engagement, arrests, incarcerations and 911 calls.¹

Service Overview

The State of West Virginia is committed to finding solutions to improve behavioral health crisis services by expanding opportunities across West Virginia. With the upcoming implementation of 988 as the national crisis hotline, it is imperative that the State

¹ Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

simultaneously increase and improve the provision and availability of community-based behavioral health crisis services.

Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for anyone, anywhere and anytime.²

Psychiatric Urgent Care Centers

Psychiatric Urgent Care Centers (PUCC) provide rapid access to mental health assessment and evaluation, medication support, peer support, case management and crisis intervention, 24 hours a day, 7 days a week, for individuals currently experiencing emotional distress or mental health crisis. Individuals presenting to the PUCC may have characteristics including, but not limited to, high utilization of psychiatric emergency and inpatient services, suicide risk, an inability to acquire timely access to outpatient mental health care, or legal involvement for low-level offenses resulting from or associated with mental illness. PUCC mitigate inpatient hospitalization, commitment proceedings, avoidable incarcerations and emergency department visits by providing immediate access to mental health treatment, short-term observation (less than 24 hours), peer support, and linkage and referral to continuing community-based services and supports.

Psychiatric Urgent Care Centers, or psychiatric walk-ins, offer both urgent care, such as immediate access to a psychiatrist or physician extender for medication evaluation, pharmacy services and medical screening, and 23-hour observation beds that provide a safe, secure place for ongoing evaluation, observation, and intervention. These facilities are staffed by psychiatric care providers, nursing staff, crisis intervention specialists and/or peers. Psychiatric urgent care centers offer an affordable alternative to utilizing emergency rooms for mental health crisis situations and provide a safety net in the event of a needed medication adjustment or refill, as well as adequate, timely care both pre- and post-crisis. Ideally these facilities are located outside of the hospital setting to divert people more effectively from hospital admissions.

Mobile crisis services and Psychiatric Urgent Care Centers can be used in conjunction with a full array of crisis services to people experiencing psychiatric signs and symptoms. Mobile crisis services can be deployed to provide immediate crisis intervention and assessment. If a situation is unable to be resolved in the community setting, psychiatric urgent care centers can allow for more intensive services such as medication evaluation, peer support and a safe place for the individual in crisis.

² *Practice Guidelines: Core Elements for Responding to Mental Health Crises*. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

Section Three: PROPOSAL INSTRUCTIONS/REQUIREMENTS

All proposals for funding will be reviewed by BBH staff for minimum submission requirements and must comply with the requirements specified in this AFA to be eligible for evaluation: (1) be received on or before the due date and time; (2) meet the Proposal Format requirements; (3) follow the required Proposal Outline; and (4) be complete. Proposals that fail to follow instructions or satisfy these minimum submission requirements will not be reviewed further.

A review team independent of BBH will review the full proposals. Proposals must contain the following components:

- ✓ A completed Proposal for Funding Application, available at <https://dhhr.wv.gov/BBH/funding/Pages/Applying-for-Funding.aspx>.
- ✓ A Project Abstract (one page, does not count toward the 15 total pages) detailing the proposed program noting the funding option being pursued
- ✓ A Proposal Narrative consisting of the following sections: Statement of Need, Proposed Implementation Approach, Staff and Organization Experience, Data Collection and Performance Measurement.
- ✓ Together these sections may not exceed **15 total pages**. Applicants must use 12-point Arial or Times New Roman font, single line spacing, and one-inch margins. Page numbers must also be included in the footer.

The following is an outline of the Proposal Narrative content:

1. Statement of Need and Population of Focus: Describes the need for the proposed initiative, to include:
 - A description of the target population and relevant data.
 - Describe the nature of the problem, including service gaps, and document the extent of the need for the population(s) of focus
 - Identification of the geographic area to be served, to include specific region/county(ies).
2. Proposed Evidence-Based Practice (EBP)/Service:
 - Describes the program/service being proposed and sets forth the goals and objectives for the proposed service(s) during Year One.
 - Describe the EBP(s) proposed for program
 - Explain how your choice of an EBP or practice will help you address disparities in service access, use, and outcomes for your population(s) of focus.

3. Proposed Implementation Approach: Describes how the Applicant intends to **implement the proposed program/service(s)** to include:
 - Describe how the key activities in your timeline will be implemented.
 - Describe how you will ensure that service providers will identify, recruit, and retain the population(s) of focus.
 - Describe how you will screen and assess consumers. Demonstrate an understanding of the Level of Care Utilization System (LOCUS) tool. See: <https://www.communitypsychiatry.org/resources/locus>
 - Identify any organization(s) that will participate in and collaborate on the proposed project and the geographic areas/jurisdictions in which they will provide behavioral health services. Describe their roles and responsibilities and demonstrate their commitment to the project (Attachment 3: Letters of Support).
 - Provide a chart or graph depicting a realistic timeline for the project period, showing dates, key activities, and responsible staff.
 - State the unduplicated number of individuals you propose to serve (annually and over the entire project period), including the types and numbers of services to be provided and anticipated outcomes. Explain how you arrived at this number and that it is reasonable given your budget request.
 - Describe how your staff will ensure the input of consumers (representing the population(s) of focus) is utilized in assessing, planning, and implementing your project.
4. Staff and Organization Experience: This section should describe the Applicant's expertise with the population(s) of focus and with Recovery Housing services, to include:
 - Describes the Applicant's existing and planned qualifications to carry out the proposed initiative/service(s).
 - A description of the Applicant's and their partners' current involvement with the population(s) of focus.
 - Provide a complete list of staff positions for the project.
5. Data Collection and Performance Measurement: Describes the Applicant's capability for collecting information/data required by funders, which may include client specific demographics, sources/types of referrals, length of stay, reasons/destinations for discharge, post-discharge status. Describes the Applicant's process for using data to manage and improve quality of the service, to ensure each goal is met and to assess outcomes within the target population. Plan must also include how data will be shared, bi-directionally, with DHHR.
6. Sustainability Plan: Describes how the Applicant will maintain the proposed program/facility operations beyond the one-time funding provided through this AFA, including establishing or maintaining eligibility for reimbursement through third party payors.
7. References/Works Cited: All sources referenced or used to develop this proposal must be included on this page. This list does **not** count towards the **15-page** limit.

- ✓ Attachment 1: Targeted Funding Budget(s) and Budget Narrative(s).
 - Targeted Funding Budget (TFB) form includes sources of other funds where indicated on the TFB form. A separate TFB form is required for any capital or start-up expenses. This form and instructions are located at <https://dhhr.wv.gov/BBH/funding/Pages/Applying-for-Funding.aspx>.
 - Budget Narrative for each Targeted Funding Budget (TFB) form, with specific details on how funds are to be expended. The narrative should clearly specify the intent of and justify each line item in the TFB. The narrative should also describe any potential for other funds or in-kind support. The Budget Narrative is a document created by the Applicant and not a BBH Fiscal form.
- ✓ Attachment 2: Applicant Organization's Valid WV Business License (if applicable).
- ✓ Attachment 3: Letters of Support (as opposed to Memoranda of Understanding) must be submitted with the application to demonstrate that a coordinated and integrated service system is in place to meet the complex needs of the target population.

The attachments **do not** count toward the **15-page** limit.

Section Four: EXPECTED OUTCOMES / PERFORMANCE MEASURES

Individuals receiving this service should demonstrate the following generally accepted outcomes:

Expected Outcomes:

1. Reduce utilization of hospital emergency departments, psychiatric inpatient units, and incarcerations.
2. Reduce utilization of the civil commitment process.
3. Decrease law enforcement involvement with individuals experiencing psychiatric signs and symptoms.
4. Increase access to all medically appropriate mental health service options (medication support, crisis intervention, therapy, peer support).
5. Increase participation rates in outpatient mental health services.

Performance Measures

- a. Client data:
 - Systems involvement (e.g., Behavioral Health, Legal Involvement, Probation/Parole)
 - Number of individuals referred for outpatient services
 - Number of individuals who required hospitalization
 - Number of crisis alternative placements accessed, by type of placement
 - Number of individuals requiring initiation of civil commitment procedure
- b. Service data:
 - Number of total walk-ins
 - Number of individuals dropped off by first responders
 - Number of Individualized Crisis Plans (ICP) developed
 - Number of individuals receiving Medicaid
 - Number of individuals/families who used the resources and services that were recommended to them
- c. Outcome data:
 - Percent discharged in 23 hours or less to home or current living situation
 - Percent referred to acute care hospital
 - Percent referred to Crisis Stabilization Units
 - Percent requiring placement from civil commitment process
 - Percent requiring 72 hour hold for evaluation by physician

Section Five: CONSIDERATIONS

LEGAL REQUIREMENTS

Eligible applicants are public organizations (e.g., units of local government) or private nonprofit organizations with a valid West Virginia Business License. If the applicant is not already registered as a vendor in the State of West Virginia, registration must either be completed prior to award or the vendor must demonstrate proof of such application. Applicants must have or be eligible to obtain a behavioral health license and, if applicable, an office-based medication-assisted treatment registration in the State of West Virginia, and the Applicant must be able to meet requirements for enrollment as a West Virginia Medicaid provider.

The Grantee is solely responsible for all work performed under the agreement and shall assume all responsibility for services offered and products to be delivered under the terms of the award. The State shall consider the designated Grantee applicant to be the sole point of contact about all contractual matters. The Grantee may, with the prior written consent of the State, enter written sub-agreements for performance of work; however, the Grantee shall be responsible for payment of all sub-awards.

All capital expenditures for property and equipment shall be subject to written prior approval of DHHR and must be included as a separate budgetary line item in the proposal. Upon award, regulations regarding the acquisition, disposition and overall accounting for property and equipment will follow those delineated in federal administrative requirements and cost principles. Additionally, the Grantee may be bound by special terms, conditions, or restrictions regarding capital expenditures for property and equipment determined by the Department as to best protect the State's investment.

FUNDING METHODOLOGY

After receipt of the fully executed Grant Agreement, the Grantee will submit invoices pursuant to the Schedule of Payments. Requests by the Grantee for payment shall be limited to the minimum amount needed and be timed to be in accordance with the actual, immediate cash requirements of the Grantee in carrying out the purpose of the approved program. The timing and amount of the cash payment shall be as close as is administratively feasible to the actual disbursements by the Grantee for direct program costs and the proportionate share of any allowable indirect costs. Reports reconciling payments received and actual expenditures incurred will be submitted in accordance with reporting requirements.

ALLOWABLE COSTS

Please note that Departmental policies are predicated on requirements and authoritative guidance related to federal grants management and administrative rules and regulations, Grantees shall be required to adhere to those same requirements when administering other DHHR grants or assistance programs, the source of which is non-federal funds (e.g., state-appropriated general revenue and appropriated or non-appropriated special revenue funds) unless specifically provided direction to the contrary.

COST PRINCIPLES

Subpart E of 2 CFR 200 establishes principles for determining the allowable costs incurred by non-federal entities under federal awards. The Grantee agrees to comply with the cost principles set forth within 2 CFR 200 Subpart E, regardless of whether the Department is funding this grant award with federal pass-through dollars, state-appropriated dollars or a combination of both.

GRANTEE UNIFORM ADMINISTRATIVE REGULATIONS (COST PRINCIPLES AND AUDIT REQUIREMENTS FOR FEDERAL AWARDS)

Title 2, Part 200 of the Code of Federal Regulations (2 CFR 200) establishes uniform administrative requirements, cost principles and audit requirements for federal awards to non-federal entities. Subparts B through D of 2 CFR 200 set forth the uniform administrative requirements for grant agreements and for managing federal grant programs. The Grantee agrees to comply with the uniform administrative requirements set forth within 2 CFR 200 Subparts B through D, regardless of whether the Department is funding this grant award with federal pass-through dollars, state-appropriated dollars or a combination of both.