Prevention of Substance Abuse (SA) and HIV for At-Risk Racial/Ethnic Minority Subpopulations

(Request for Applications (RFA) No. SP-08-001)

FREQUENTLY ASKED QUESTIONS

QUESTIONS	ANSWERS
1. I am currently a recipient of SAMHSA's RFA # SP-05-001 (*Substance Abuse (SA), HIV, & Hepatitis Prevention for Minority Reentry Populations in Communities of Color*). **Am I eligible to apply for funding under this new RFA?**	Yes, you are eligible to apply if you meet the requirements outlined in Section III, *Eligibility Information*, and Section III-1 of the RFA.
2. Are State government agencies and national organizations eligible to apply?	No. Please refer to Section III-1, *Eligible Applicants*, of the RFA.
3. My State has a high HIV/AIDS rate, but my MSA is NOT listed in Appendix I. Can I apply for this cooperative agreement?	Only community-level domestic public and private nonprofit entities (e.g., non-profit community-based organizations, faith-based organizations, colleges and universities, local health care delivery organizations, local governments, tribal governments, tribal organizations and tribal urban Indian entities) are eligible to apply if they are located in and proposing to provide services in either an eligible State, Virgin Islands, Puerto Rico, District of Columbia, **OR** an MSA listed in Appendix I. Please refer to Section III of the RFA for detailed information on eligibility.
4. Our organization is located in Baltimore City and currently works with post-incarcerated minority women. Can our agency partner with Hopkins or some other place to conduct the Epi work?	If you are located in and proposing to serve an eligible MSA listed in Appendix I of the RFA, and your agency is funded for this program, you may partner under a subcontract with a University or any other organization to assist you with the epidemiology work. **NOTE:** If you are a current award recipient of SAMHSA's RFA # SP-05-001 (*Substance Abuse (SA), HIV, & Hepatitis Prevention for Minority Reentry Populations in Communities of Color*), please refer to Section I-2.1 (*Required Activities*) of the RFA to review the program requirements.
5. Can you send me or e-mail me the RFA?	You may download the RFA and required documents from the SAMHSA Web site at: www.samhsa.gov/grants/apply.aspx. www.grants.gov

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	You may also request a complete application kit from the SAMHSA Clearinghouse by calling: 1-877-SAMHSA-7 [TDD: 1-800-487-4889].
6. What is the definition of "reentry?"	For the purposes of this RFA, CSAP defines *reentry* populations as racial/ethnic minorities who have been released from prisons and jails within the past 2 years.
7. What is the definition of "minority?" Are "minority populations" limited to only racial and ethnic minorities? Or could "men who engage in same-sex sexual activity, regardless of race, ethnicity or self-identified sexual identity" be considered a "minority population?"	As defined by the Department of Health and Human Services, *minorities* are a subset of the U.S. population distinguished by racial, ethnic, or cultural heritage. The Office of Management and Budget (OMB) Directive No. 15 defines racial and ethnic categories as: American Indian or Alaskan Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian and other Pacific Islander. Men who engage in same-sex sexual activity are not considered a minority as defined above. However, data has indicated they are one of the groups at highest risk for substance abuse and HIV transmission. As a result, this group has been listed as a target subpopulation of the RFA IF they meet racial and ethnic definitions. Refer to Section I-2.2 of the RFA (*Data Supporting Target Racial/Ethnic Minority Subpopulations*) to review the list of target subpopulations at highest risk for substance abuse and HIV transmission.
8. In my State, there is an AIDS rate lower than 10 per 100,000 population. Can my agency still apply for this grant?	Eligible applicants MUST be located in and proposing to provide services in a State (including the Virgin Islands, Puerto Rico and the District of Columbia) with an annual AIDS rate of 10 or greater per 100,000 population **OR** eligible applicants MUST be located in and proposing to provide services in a Metropolitan Statistical Area (MSA) with an annual AIDS rate of 10 or greater per 100,000 population. If your proposed State is NOT listed in Appendix I, you are not eligible to apply, unless you reside in and serve an MSA that is listed in Appendix I.

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9. Can our agency provide HIV testing off-site with a partner organization?	Yes. However, your agency is required to submit signed Memoranda of Understanding (MOUs) or Agreement (MOAs) in Appendix 1 of your application demonstrating established referral networks for clients needing HIV testing, appropriate counseling, treatment, and support services. **Award recipients with MOUs in place with local providers for HIV testing or rapid HIV testing for participants enrolled in this program may use up to five percent (5%) of the total direct costs of the award to purchase rapid HIV antibody test kits, control kits, confirmatory kits, and/or confirmation laboratory services for providers to conduct on- and off-site HIV testing services.** (Note: Partner organizations providing on or off-site rapid HIV testing must meet SAMHSA's guidelines and reporting requirements delineated in Appendix J of this RFA.)
Could we partner with another organization to provide it on-site?	Yes. See response above.
If we did provide rapid HIV testing on-site, would we have to meet SAMHSA's guidelines and reporting requirements BEFORE we submit our application? Or could we undertake those activities upon notification of award, such as various training opportunities (State-certified HIV Counseling, Testing, and Reporting [CTR] services and specific OraQuick training) and the CLIA waiver?	No, you would not have to meet SAMHSA's guidelines and reporting requirements BEFORE you submit your application. SAMHSA's guidelines and reporting requirements listed in Appendix J of the RFA can be assumed following notification of your award.
10. How do you define rural vs. metropolitan areas?	For the purposes of this RFA, SAMHSA uses the Census Bureau's classification of rural. *Rural* is defined as all territory, population, and housing units located outside of urbanized areas and urban clusters. *Urbanized areas* include populations of at least 50,000, and *urban clusters* include populations between 2,500 and 50,000. The core areas of both urbanized areas and urban clusters are defined based on population density of 1,000 per square mile. Certain blocks adjacent to them are added that have at least 500 persons per square mile. (Reference: http://www.rupri.org/Forms/RuralDefinitionsBrief.pdf) For the purposes of this RFA, a Metropolitan Statistical

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	Areas (MSAs) are whole counties (or equivalent entities) that have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. (Reference: http://www.whitehouse.gov/omb/bulletins/fy2007/b07-01.pdf)
11. Where can I find resources about Evidence-Based Practices?	You will find information on evidence-based practices in SAMHSA's *Guide to Evidence-Based Practices on the Web* at www.samhsa.gov/ebpwebguide. SAMHSA developed this Web site to provide a simple and direct connection to information about evidence-based interventions to prevent and/or treat mental and substance use disorders. The *Guide* provides a short description and a link to dozens of Web sites with relevant evidence-based practices information – either specific interventions or comprehensive reviews of research findings. Please note that SAMHSA's Guide to Evidence-Based Practices also refers to another SAMHSA Web site, the ***National Registry of Evidence-Based Programs and Practices (NREPP)***. NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. NREPP is intended to serve as a decision support tool rather than an authoritative list of effective interventions. (**Note**: Inclusion in NREPP, or in any other resource listed in the Guide, does not mean an intervention is "recommended" or that it has been demonstrated to achieve positive results in all circumstances.)
12. A needs assessment is finished and in the printing stage for our area through Ryan White Titles I and II. Would we need to complete another needs assessment (the RFA states that the first year would require this)?	Applicants who have completed a comprehensive community needs assessment within the last two years on your selected target subpopulation listed in Section I-2.2 of the RFA should submit a copy of their needs assessment in Appendix 5 of their application. If documentation is insufficient after you have received the award, you will be notified to begin with Step 1, *Community Needs Assessment*, of SAMHSA's Strategic Prevention Framework. Award recipients with an approved needs assessment may carry out Steps 2-5 of the SPF. (See Section I-2.1 of the RFA for more details on required activities.)

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13. If we are planning to provide HIV testing, should we budget for it?	Yes, you will need to budget for HIV testing. You may use up to 5% of the total direct cost of the award to purchase HIV testing supplies and related services for participants enrolled in this program. Those who meet SAMHSA's Rapid HIV Testing guidelines and reporting requirements delineated in Appendix J of this RFA may use funds (not to exceed 5% of the total direct cost of the award) for purchasing rapid HIV antibody test kits, control kits, confirmatory kits, and/or confirmation laboratory services to test participants enrolled in this program. If you have not met SAMHSA's guidelines and reporting requirements for rapid HIV testing prior to submission of your application, but plan to meet them post-award, you should still budget for the above items.
14. Since the requirements for Section G ("Biographical Sketches and Job Descriptions") and for Section C of the narrative request very similar information, would you prefer that applicants include the job/position descriptions in BOTH Section 'C' and Section 'G'? Or would you prefer that we summarize in Section 'C' the descriptions that we will include in Section 'G' (and refer reviewers to Section 'G' for the full descriptions)?	You are required in Section C of your narrative to submit a complete list (preferably, in a table format) of all staff positions (including key staff—e.g., Project Director, Project Coordinator, Evaluator) for the project, showing the role of each, and their level of effort and qualifications. You are required in **Section G** to submit detailed biographical sketches and job descriptions for key positions—e.g., Project Director, Project Coordinator, Evaluator. Please refer to Section VII of the RFA for SAMHSA's contact information should you need further clarification.
15. When can I expect that this grant will be awarded and when do you expect us to implement our plans?	SAMHSA expects to make grant awards by September 2008. Following the award and approval of Steps 1-3 of the SPF, implementation is expected to begin in the latter part of Year 1 or at the beginning of Year 2.
16. How much of the total direct cost can I use for evaluation?	No more than 20% of the total direct cost of the award may be used for data collection, performance measurement or performance assessment activities (as specified in **Section I-2.3, *Data Collection and Performance Measurement*** and **Section I-2.4, *Performance Assessment,*** of this RFA).
17. I have additional questions about the RFA. Whom should I contact?	For questions about program issues, please contact: Helpline: (240) 276-2409 Email inquiries to: fy08mairfa@samhsa.hhs.gov For questions on grants management issues, contact: Edna Frazier, Grants Management Specialist (240) 276-1405

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	edna.frazier@samhsa.hhs.gov
18. What are the National Outcome Measures (NOMs)?	NOMs are a set of domains and measures that the Substance Abuse and Mental Health Services Administration (SAMHSA) will use to accomplish its vision and to meet all of its Federal reporting requirements, thus reducing burden and redundancy for grantees. SAMHSA's vision is "A Life in the Community for Everyone: Building Resilience and Facilitating Recovery." Within this vision are three goals: accountability, capacity, and effectiveness for all agency initiatives. NOMs are SAMHSA's means to address its accountability goal and performance-monitoring approach. Given the differing components of SAMHSA, the actual measures are slightly different across its three Centers— Center for Substance Abuse Prevention (CSAP), Center for Mental Health Services (CMHS), and Center for Substance Abuse Treatment (CSAT). The actual measures for each Center are posted on the SAMHSA website (http://www.nationaloutcomemeasures.samhsa.gov). The NOMs measures will be used for the GPRA and PART reporting.
19. Can a grantee conduct both group and individual interventions?	Yes, a grantee can conduct both group and individual interventions as long as the intervention is entered on the appropriate form (Group Dosage form or Individual Dosage form). In addition, if one client receives an individual intervention and participates in a group intervention, that client should be recorded on both forms.
20. For which clients should we collect baseline, exit, and follow-up data?	You should collect data for all clients for whom you are providing SA and HIV prevention services or related referrals (e.g., HIV treatment, hepatitis services, substance abuse treatment) and for whom you will provide services for at least 30-days. The only situation where you would not collect the baseline, exit, and follow-up data is where you have limited contact with the client(s) (e.g., a school assembly, health fair or public awareness campaign).
21. When should the baseline questionnaire be administered?	The baseline questionnaire should be administered within 30 days of intake or before core program services begin and is considered to be the first data collection point.
22. When should the exit questionnaire be administered?	The timing for the exit questionnaire with specific clients must be determined by each grantee. The exit questionnaire should be conducted when the interventions provided to an individual or group have ended. The exit questionnaire is considered to be the second data collection point. As a rule of thumb, the exit interview should be

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	conducted: (a) More than 30 days after the baseline survey (b) Within 30 days after the last intervention
23. When should the follow-up questionnaire be administered?	The follow-up questionnaire should be administered approximately 3 to 6 months after the exit questionnaire is administered. The exit questionnaire is considered to be the third data collection point.
24. Am I required to maintain a control or comparison group, and if I do, when should the surveys be administered?	You are not required to conduct a control or comparison group. If you do, comparison/control group participants must follow the same assessment schedule as their intervention counterparts. Comparison group instruments should be administered within 2 weeks before or after the administration of the intervention group instruments.
25. What type of service should be entered as an intervention?	Core services that last at least 30-days should be considered an intervention. A core intervention may consist of participation in several activities or services. Drop-in services where a client is rarely seen or participation in a single activity or event, such as a community health fair or school assembly are not considered core service interventions.
26. If someone comes to the agency and receives a "rapid" HIV test and then comes back for a confirmatory test, is that one or two interventions?	That is two interventions.
27. Follow-up is from 3 to 6 months, which seems like quite a range. What is the best timeframe for follow-up?	It is up to each grantee, in consultation with the Project Officer, to decide the best timeframe for follow-up. It depends on what works for your client base. A 6-month timeframe is the optimum.