Executive Committee

Beaufort County, SC

This meeting will be held both in person in Council Chambers at 100 Ribaut Road, Beaufort, and virtually through Zoom. Please be aware that there is limited seating available for the in-person meeting and attendees must practice social distancing

Monday, November 01, 2021
2:30 PM

AGENDA

1. CALL TO ORDER
2. PLEDGE OF ALLEGIANCE
3. PUBLIC NOTIFICATION OF THIS MEETING HAS BEEN PUBLISHED, POSTED, AND DISTRIBUTED IN COMPLIANCE WITH THE SOUTH CAROLINA FREEDOM OF INFORMATION ACT
4. APPROVAL OF AGENDA
5. APPROVAL OF MINUTES - SEPTEMBER 7, 2021
6. **CITIZEN COMMENTS - (ANYONE who wishes to speak during the Citizen Comment portion of the meeting will limit their comments to no longer than three (3) minutes (a total of 15 minutes) and will address Council in a respectful manner appropriate to the decorum of the meeting, refraining from the use of profane, abusive, or obscene language)**

AGENDA ITEMS

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7. CONSIDERATION OF THE APPROVAL OF MONDAY, DECEMBER 27, 2021, AS AN ADDITIONAL CHRISTMAS HOLIDAY FOR THE BEAUFORT COUNTY EMPLOYEES.
8. AUTHORIZATION FOR THE COUNTY ADMINISTRATOR TO OFFER A BUYBACK OF EMPLOYEE PERSONAL TIME OFF FOR 2021. FISCAL IMPACT: ESTIMATE IS AROUND $820K.
9. DISCUSSION OF BEAUFORT COUNTY REDISTRICTING BENCHMARK REPORT TO DETERMINE THE DATA SETS, TIMELINE, SCHEDULES TO BE USED FOR REDRAWING THE COUNTY COUNCIL DISTRICT BOUNDARIES.
10. RESOLUTION TO ACCEPT OPERATION MARIPOSA GRANT IN THE AMOUNT OF $260,311
11. AUTHORIZATION FOR THE ALCOHOL AND DRUG DEPARTMENT TO APPLY FOR THE RURAL OPIOID IMPLEMENTATION.

12. A RESOLUTION ESTABLISHING THE CRITERIA TO BE USED FOR THE REAPPORTIONMENT OF ALL COUNTY COUNCIL DISTRICTS AS TO POPULATION FOLLOWING THE ADOPTION BY THE STATE OF THE FEDERAL DECENNIAL CENSUS AS REQUIRED BY S.C. CODE ANN. SEC. 4-9-90

13. DEFERMENT OF AN ORDINANCE PROPOSING AMENDMENTS TO BEAUFORT COUNTY CODE OF ORDINANCES: CHAPTER 46, ARTICLE II, SECTIONS 46.26 THROUGH 46.33 WHICH WAS REFERRED TO THE EXECUTIVE COMMITTEE

14. DISCUSSION REGARDING THE ELEMENTS OF THE RULES AND PROCEDURES HANDBOOK

EXECUTIVE SESSION

15. PURSUANT TO S.C. CODE SEC. 30-4-70(A)(2): RECEIPT OF LEGAL ADVICE WHERE THE LEGAL ADVICE RELATES TO A PENDING, THREATENED, OR POTENTIAL CLAIM OR OTHER MATTERS COVERED BY THE ATTORNEY-CLIENT PRIVILEGE

16. MATTERS ARISING OUT OF EXECUTIVE SESSION

17. ADJOURNMENT

Executive Committee

Beaufort County, SC

Council Chambers, Administration Building Beaufort County Government Robert Smalls Complex 100 Ribaut Road, Beaufort

Tuesday, September 07, 2021
1:00 PM

MINUTES

1. **CALL TO ORDER**

Committee Chairman Sommerville called the meeting to order at 1:00 PM

PRESENT
Committee Chairman D. Paul Sommerville
Council Member Joseph F. Passiment
Council Member Gerald Dawson
Council Member Stu Rodman
Council Member Alice Howard
Council Member Lawrence McElynn
Council Member Logan Cunningham

ABSENT
Council Member Brian Flewelling
Council Member York Glover
Council Member Chris Hervochon
Council Member Mark Lawson

2. **PLEDGE OF ALLEGIANCE**

Committee Chairman Sommerville led the Pledge of Allegiance

3. **FOIA**

Committee Chairman Sommerville stated public notice of this meeting had been published, posted, and distributed in compliance with the SC FOIA Act.

4. **APPROVAL OF AGENDA**

Motion: It is moved by Council Member Howard, seconded by Council Member Dawson to approve the agenda. The motion was approved without objection.

5. **APPROVAL OF MINUTES**

Motion: It is moved by Council Member Howard, seconded by Council Member Dawson to approve the June 7, 2021 minutes. The motion was approved without objection.

6. **CITIZEN COMMENTS**

No Citizen Comments

7. **DISCUSSION OF COVID-19 AD HOC COMMITTEE RECOMMENDATIONS.**

Status: For Informational Purposes Only

Discussion: To see the full discussion click the link below.

https://beaufortcountysc.new.swagit.com/videos/136464

AGENDA ITEMS

8. **FIRST READING OF AN ORDINANCE PROPOSING AMENDMENTS TO BEAUFORT COUNTY CODE OF ORDINANCES: CHAPTER 46, ARTICLE II, SECTIONS 46.26 THROUGH 46.33**

Vote at First Reading on June 14, 2021 was to postpone the ordinance until July 26, 2021.

July 26, 2021: voted without objection to defer to September Executive Committee Meeting

Status: It was moved to the next Executive Committee Meeting

Discussion: To see the full discussion click the link below.

https://beaufortcountysc.new.swagit.com/videos/136464

9. **A DISCUSSION REGARDING THE ELEMENTS OF THE RULES AND PROCEDURES HANDBOOK-**

Status: For Informational Purposes Only

Discussion: To see the full discussion click the link below.

https://beaufortcountysc.new.swagit.com/videos/136464

10. **LOWCOUNTRY WORKFORCE BOARD RE-APPOINTMENT OF SARAH MARSHALL, DIRECTOR OF COMMUNITY SERVICES BEAUFORT, JASPER EOC**

Motion: It was moved by Council Member Passiment, seconded by Council Member Howard to approve Re-Appointment of Sarah Marshall, Director of Community Services Beaufort, Jasper EOC, to Lowcountry Workforce Board. The motion was approved without objection.

Discussion: To see the full discussion click the link below.

https://beaufortcountysc.new.swagit.com/videos/136464

The Voting Yea: Committee Chairman Sommerville, Council Member Passiment, Council Member Dawson, Council Member Rodman, Council Member Howard, Council Member McElynn, Council Member Cunningham. The vote 7:0

11. **REAPPOINTMENT OF STEPHEN MURRAY TO BEAUFORT COUNTY ECONOMIC DEVELOPMENT WITH AN EXPIRATION OF 2024**

Motion: It was moved by Council Member Dawson, seconded by Council Member Howard to approve reappointment of Stephen Murray to Beaufort County Economic Development with an expiration of 2024. The motion was approved without objection.

Discussion: To see the full discussion click the link below.

https://beaufortcountysc.new.swagit.com/videos/136464

The Voting Yea Committee Chairman Sommerville, Council Member Passiment, Council Member Dawson, Council Member Rodman, Council Member Howard, Council Member McElynn, Council Member Cunningham. The vote 7:0

12. **REAPPOINTMENT OF RICHARD GOUGH TO BEAUFORT COUNTY ECONOMIC DEVELOPMENT CORPORATION EXPIRES 2024**

Motion: It was moved by Council Member Howard, seconded by Council Member Dawson to approve reappointment of Richard Gough to Beaufort County Economic Development Corporation expires 2024. The motion is approved without objection.

Discussion: To see the full discussion click the link below.

https://beaufortcountysc.new.swagit.com/videos/136464

The Voting Yea Committee Chairman Sommerville, Council Member Passiment, Council Member Dawson, Council Member Rodman, Council Member Howard, Council Member McElynn, Council Member Cunningham. The vote 7:0.

13. **ADJOURNMENT**

The meeting adjourned at 1:48 PM.

BEAUFORT COUNTY COUNCIL
AGENDA ITEM SUMMARY

ITEM TITLE:
Consideration of approval of Monday, December 27, 2021, as an additional Christmas Holiday for the Beaufort County Employees.
MEETING NAME AND DATE:
Executive Committee November 1, 2021
PRESENTER INFORMATION:
Eric Greenway, County Administrator 5-10 minutes
ITEM BACKGROUND:
N/A
PROJECT / ITEM NARRATIVE:
County Administration recommends that Council consider approving Monday, December 27, 2021, as a 3rd paid Christmas holiday for the employees.
FISCAL IMPACT:
Any fiscal impact is negligible.
STAFF RECOMMENDATIONS TO COUNCIL:
Staff recommends that Council approve Monday, December 27, 2021, as a 3rd paid Christmas holiday for the employees.
OPTIONS FOR COUNCIL MOTION:
Motion to approve Monday, December 27, 2021, as an additional Christmas Holiday for the Beaufort County Employees. Motion to deny Monday, December 27, 2021, as an additional Christmas Holiday for the Beaufort County Employees.

BEAUFORT COUNTY COUNCIL
AGENDA ITEM SUMMARY

ITEM TITLE:

Approval authorizing the County Administrator to offer a buyback of employee Personal Time Off for 2021.

MEETING NAME AND DATE:

Executive Committee, November 1, 2021

PRESENTER INFORMATION:

Eric Greenway, County Administrator 5-10 minutes

ITEM BACKGROUND:

This program as been offered as a 4 out of the last 5 years. There is some question if Council approval is necessary, but the Administrator is bringing it forward for Council input.

PROJECT / ITEM NARRATIVE:

FISCAL IMPACT:

The fiscal impact already exists since this fiscal liability must be carried on our books.

Estimate is around $820K and it is based on three assumptions:

1) the average salary increase of 14.70%
2) the same number of employees participate;
3) they cash out the same number of hours.

Could be as much as $850-900K just to be on the conservative side.

The original budget for each fund was projected to cover the PLT Cash Out.

STAFF RECOMMENDATIONS TO COUNCIL:

Staff recommends approval if Council action is necessary

OPTIONS FOR COUNCIL MOTION:

Motion to approve the authorization for the County Administrator to offer a buyback of employee Personal Time Off for 2021.

Motion to deny the authorization for the County Administrator to offer a buyback of employee Personal Time Off for 2021.

BEAUFORT COUNTY COUNCIL
AGENDA ITEM SUMMARY

ITEM TITLE:
Resolution to accept Operation Mariposa Grant in the amount of $260,311
MEETING NAME AND DATE:
Executive Committee Meeting November 1, 2021
PRESENTER INFORMATION:
Steve Donaldson *5-10 minutes*
ITEM BACKGROUND:
The department wrote a three-year Prevention Capacity Expansion Grant in August 2021.
PROJECT / ITEM NARRATIVE:
Given the Hispanic population in Beaufort County, and the higher per capita arrest and car crashes within that demographic, the BCADAD wrote a Prevention grant to target the #1, #4, and #5 per capita cities in SC (All in Beaufort) to work within the schools and the community and with police departments to raise awareness of the risks to them, SC Code of Laws, and to the services available through BCADAD.
FISCAL IMPACT:
The grant is 100% funded with no county match for $260,311.
STAFF RECOMMENDATIONS TO COUNCIL:
Approve acceptance of Operation Mariposa Grant.
OPTIONS FOR COUNCIL MOTION:
Motion to approve acceptance of Operation Mariposa Grant or Motion to disapprove the acceptance of Operation Mariposa Grant.

BEAUFORT COUNTY BCADAD
ALCOHOL & DRUG ABUSE DEPARTMENT

Application Package for Submission

Beaufort County Alcohol and Drug abuse Department

Primary Prevention Enhancement for County Alcohol and Drug Abuse Authorities

Operation Mariposa

Steve Donaldson
Beaufort Alcohol and Drug Abuse Director
PO Drawer 1228. Beaufort, SC 29901
sdonaldson@bcgov.net
843-255-6008

August 25, 2021

To: DAODAS

It is the Intent of Beaufort County Alcohol and Drug Abuse Department (BCADAD) to apply and compete for funding made available through the American Rescue Plan Act of 2021 (ARPA) and the Coronavirus Response and Relief Supplement Appropriations Act of 2021 via the Substance Abuse Block Grant COVID (SABG COVID) Supplement. It is the understanding of BCADAD that DAODAS is administering these funds through the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) under the CFDA number 93.788.

The intent of the department is to positively impact the Hispanic community in Beaufort County by:

- Recruiting and Hiring a Spanish Speaking Preventionist or someone to become In-Process;
- Obtain training in PRI and the South Carolina Code of Laws related to driving under the influence;
- Provide community-based education to Hispanic parishioners at local mission churches;
- Whereupon increasing knowledge of laws, alcohol and drug misuse, and alternatives to drinking and driving;
- Publicize DUI Checkpoints in Spanish to potentially curb driving under the influence;
- Evaluate impact of the intervention.

Should you have any questions or concerns, please contact me. I would be happy to discuss further.

Sincerely,

Steven Donaldson, CS, MAC, LAC, AADC
Executive Director
Beaufort County Alcohol and Drug Abuse Department

Applicant Information Form

	Primary Prevention Enhancement for County Authorities RFP		
1.	**Organization Information**	Organization Name	Beaufort Alcohol and Drug Abuse Department
		Mailing Address	PO Drawer 1228 Beaufort, SC 29901-1228
2.	**Substance Selected & Special Population of Focus**	Substance(s)	Alcohol
		Special Population(s)	Hispanics
3.	**Point of Contact**	Contact Name	Steve Donaldson
		E-mail Address	sdonaldson@bcgov.net
		Phone Number	843-255-6008
4.	**Grant Award Requested**		$260,311

Technical Proposal

1. Statement of Need

Beaufort County is the third in the overall census of Latinos by population in South Carolina, the first by percentage (16.84% or 20,799 people) in the state for Bluffton (16.4%), Port Royal (12.55% or 12,770) with the fourth highest, and Hilton head Island ranks fifth in Hispanic population with 11.8%. According to www.homesnacks.com/most-hispanic-cities-in-south-carolina and the U.S. Census Bureau Quick Facts site confirms this data.

2020 Beaufort County Population		%
Total	187117	100%
Male	91687	49%
Female	95429	51%
White	145951	78.20%
African American	33681	17.90%
American Indian	748	0.40%
Asian	2807	1.50%
Native Hawiian/ Pacific Islander	187	0.01%
2+ Races	3555	1.90%
Hispanic	20770	11.10%
Non-Hispanic	166347	88.90%

Table 1

Evidence suggests that Hispanic and non-Hispanic White men (NHW) have comparable prevalence rates of alcohol use. However, Hispanic men consistently have higher prevalence rates of alcohol misuse compared with NHW men. Consequently, Hispanic men experience disproportionate levels of adverse consequences of alcohol misuse when compared with NHW men, according to Valdez, Carvajal, and Garcia (2019) in Health Education & Behavior (Source: https://pubmed.ncbi.nlm.nih.gov/30755045/) Relatedly, Latinos are disproportionally higher in the incidence of driving under the influence (DUI) related arrest and fatal crashes nationally (42% vs. 29% Hispanic vs. NHW men).

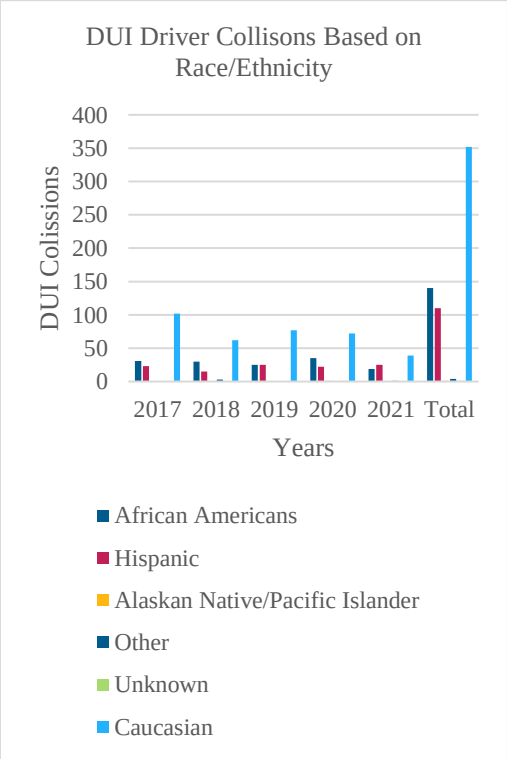

Chart 1

According to Valdez, Carvajal, Ruiz, Oren, and Garcia from the Journal Health Education & Behavior, 2019 Aug;46(4):648-655. doi: 10.1177/1090198119826212. Epub 2019 Feb 12, nearly 21% of Hispanic men report having a DUI. It is speculated some of this is related to a misunderstanding of DUI. In a publication by Sanchez, Romano, Dawson, et al. in 2016, it was reported that drinking and driving among recent Hispanic immigrants was high, and men typically reported drinking seven beers on average with a propensity for still driving, and www.ncbi.nim.nih.gov also points to research that describes the differences in Hispanic drinking pattens that of non-Hispanic whites and the propensity to higher volumes of alcohol. In Beaufort County, 512 Hispanics (37.10% illegal citizen status) were arrested with some type of DUI between 2017 and August 2021, per the demographic analysis of persons booked at the Beaufort County Detention Center. Gender differences found support the literature than a greater frequency of Hispanic men is arrested for DUIs. In Beaufort County, the data analyzed indicates that 74.68% of the DUI arrests among Hispanics between 2019 and 2021 were men. The gender differences could not be easily found in

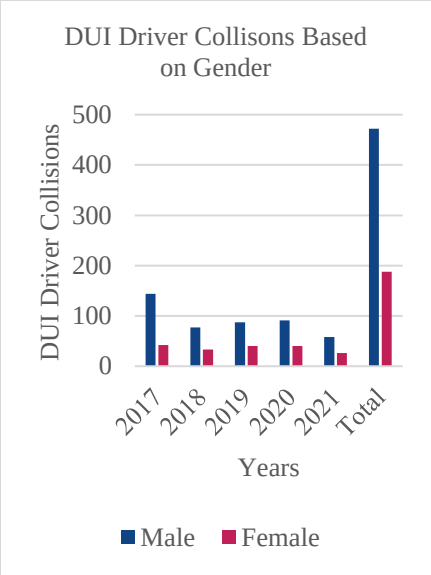

Chart 2

the data sets kept by race type before 2019. However, more men are arrested for DUIs and are involved in DUI crashes. Data from the South Carolina Office of Public Safety indicates that 16.41% of the drivers from Beaufort County contributing to alcohol involved collisions between 2017 and August 2021 were Hispanic with 71% being men (See chart 2). Furthermore, 82% of Hispanics seeking ADSAP services were men. Also, at BCADAD, 445 or 12.73% of the overall admissions to ADSAP were Hispanic with a ratio of nearly 4 to 1 men to women. Those Hispanics attending ADSAP Services at BCADAD and those Hispanics involved in alcohol involved car crashes may or may not be correlated. It's also not clear how many of those of an "illegal" status are involved ian car crashes, but it is clear none of them are accessing services at BCADAD. To that end, there is a segment of our community who drinks and drives. They may not understand the laws related to drinking and driving and may not understand the dangers to drinking and driving until adverse consequences occur.

As such, Beaufort Alcohol and Drug Abuse Department (BCADAD) is compelled to enhance prevention and early intervention services to the Bluffton, Hilton Head, and Port Royal Hispanic Communities, given the high concentration of Hispanics living in those parts of Beaufort. Providing information to high school students in densely populated Hispanics is deemed essential, as well in the communities and neighborhoods where they live, especially given the high percentage of Hispanic men arrested for DUI, receiving services for ADSAP, and for their high incidence for involvement in alcohol-related fatal and non-fatal car crashes.

It seems prudent to work in the schools, given that in parts of Beaufort County, first-generation or children of migrant workers make up a majority of the public schools. Hispanics have become the face of Hilton Head Island, per "The story of 'La Isla': How Hispanic students became the face of Hilton Head" (Island Packet, Aug 26, Lucas Larson, Chiara Eisner), Latino & Hispanic student population grows in Hilton Head SC | Hilton Head Island Packet. The article also indicates that many of these students are first generation or the children of migrant workers with acculturation issues. On Sunday, August 29, 2021 the same demographics in school were reported as Hilton Head Island. Given those circumstances, the BCADAD intends to target 9th through 12th graders with Class Action, which is part of the Project Northland alcohol prevention curriculum series, a multilevel, multiyear program proven to delay the age at which young people begin drinking, reduce alcohol use among those who have already tried drinking, and limit the number of alcohol related problems of young drinkers. To that end, intervene early. However, adults with a lack of clear understanding of SC DUI Laws and to the dangers of alcohol and drug misuse, community outreach is deemed warranted to create safer roads in Beaufort County.

Accompanying the school age intervention, the BCADAD Prevention Department will present the South Carolina Code of Laws related to DUI, and educational materials from the Prime for

Life curriculum in a secular environment in Hispanic neighborhoods, to provide information to assist with preparing families to do culturally appropriate interventions. The thinking behind using Prime for Life came from https://primeforlife.org/sites/default/files/2020 article, which indicates that data from a five state study, including South Carolina, showed positive changes in beliefs and intentions. As such, with the potential that the family and neighborhoods can influence behaviors in the Hispanic communities, providing the PRI curriculum to these groups seems beneficial.

Finally, the BCADAD will widely disseminate information to the Hispanic Community through various media related to various strategies. One strategy relates to creating a wider visibility of Prevention programs available to the Hispanic population by Spanish speaking facilitators. Another relates to advertising community forums where DUI and alcohol prevention, abuse and misuse information is provided, and lastly, publish and broadcast DUI Checkpoint information in Spanish, to deter drinking and driving.

The BCADAD does not have a Spanish speaking Preventionist nor the manpower to commit to the Spanish population at this time, much less the capacity of staff who speak Spanish. During the COVID era, revenues have been reduced, and it is not justifiable to add expenditures through the creation of new positions, especially to a Prevention department that always runs a deficit. However, if the project can boast a lower incidence of DUI arrests and fatalities, measured by crash data and Beaufort County Detention Center arrest data, an argument may be leveraged to have Beaufort County Council to continue to fund a new position after the end of the funding period or else risk widening a visible service gap.

Plan to Implement Selected Strategies:
The strategies to be used are both evidence and non-evidenced base strategies. The BCADAD Blueprint for Healthy Youth Strategy selected is from the SAMSHA Model Program, Project Northland's "Class Action". The selection of participants in Class Action is based upon Hispanic density of a community and a memorandum of agreement with the Beaufort County School District. The curriculum will be taught to fidelity by the bilingual Preventionist in grades 9 through 12 only. At minimum, in selected classes in Port Royal, Bluffton, and Hilton Head where Hispanics are densely populated. The intended benefit is to raise awareness and to influence healthier choices, as it relates to alcohol use. Benefit will be measured by self-report in surveys to be distributed and collected at each session for monthly reporting purposes (during the school year). All data collected will also be imported into the department's continuous quality improvement (CQI) outcome matrix by the Prevention Director and reported to all stakeholders, as well as changes made to enhance service delivery.

Another strategy is for the bilingual Preventionist to be trained in Prime for Life and to learn the South Carolina Code of Laws as they relate to driving under the influence (DUI). That information will be used in the community forums via information dissemination. According to Valdez, Carvajal, and Garcia (2019), its hypostasized that Hispanics do not know the laws related to DUI, and nearly 21% of the men interviewed reported getting a DUI. As such, understanding the laws may be helpful to comply with the law, especially those undocumented. Satisfaction data will also be collected by the bilingual Preventionist at each of these sessions

and incorporated into the CQI processes of BCADAD and shared with the churches hosting the events for other dissemination.

Information dissemination is a key component to the project. Advertising in digital television, radio, print ads, and social media in Spanish is intended. Furthermore, law enforcement in densely populated Hispanic areas have committed to providing DUI checkpoint days and times for the BCADAD to publish in Spanish, to reduce the number of DUIs and crashes by Hispanics. Crash and DUI data will be collected, reviewed, and analyzed quarterly for trends. It should be noted that the quasi-experimental design selected requires monthly collection of data. However, the South Carolina Department of Public Safety (SCDPS) indicates data collection at minimum should only be sought quarterly, in view of the lack of data integrity sought monthly. It should also be noted that although a memorandum of agreement was sought, the SCPDS indicated the request may not be approved and probably not within the time sought for application submission. Ross Hatfield indicated to avoid FOIA and fees, obtaining the information from SC-DAODAS is suggested.

Lastly, through relationship building with Hispanic Community partners, the BCADAD can become more visible and a resource to those in need of services beyond ADSAP and part of more prevention coalitions through this endeavor.

Month	**Key Activities November 2021- September 2022**
November	**A.** Develop Protocols & Resource Manual/**B**. Purchase Technology for grant staff./ **C.** Deliverable.
December	A. Hire & Onboard grant staff/ B. Deliverable.
January	A. Seek & Schedule PRI Training./ B. Get "In-Process" with SCAPPA. C. Research SC Code of Laws related to DUI, Review Grant Goals./ D. Deliverable.
February	A. Develop Presentation Materials./ B. Hold Community Stakeholders Meeting (individually or as a group)./ C. Complete PRI Training./ D. Deliverable.
March	A. Attend Prevention Quarterly. B. Attend AET Monthly./C. Schedule Forum Presentations for the rest of the year./D. Print literature in Spanish./ E. Deliverable.
April	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Design and start Quantitative and Qualitative Satisfaction Data./E. deliverable
May	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
June	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
July	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
August	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
September	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F.School Presentations.
Annual Report	This will be shared with stakeholders

Month	**Key Activities October 2022- September 2023**
October	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable. /F. Annual Report./G. School Presentations.
November	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
December	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.

January	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
February	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
March	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
April	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
May	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
June	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
July	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
August	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable/ F. School Presentations.
September	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
Annual Report	This will be shared with stakeholders

Month	**Key Activities October 2023- September 2024**
October	A. Forum Presentation. /B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable. /F. Annual Report./G. School Presentations.
November	A. Forum Presentation. /B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
December	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
January	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
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May	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable./F. School Presentations.
June	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
July	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
August	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
September	A. Forum Presentation./B. AET Meeting./C. Aggregate Monthly Crash Data./D. Quantitative and Qualitative Satisfaction Data./E. Deliverable.
Annual Report:	This will be shared with all stakeholders.

It is worth noting that through the data collection, it has become increasingly clear that the Cultural Diversity Plan of the department needs to change from “contracting with interpreters” to

hiring staff who are bilingual, and provide existing staff with the resources needed to learn to understand and speak Spanish. Not to do so will lead to widening service gaps in the future.

Potential Barriers:

There are many potential barriers. To start, recruiting a bilingual Preventionist or a qualified person to be certified as a Preventionist may be difficult. The Behavioral Health Services Association (BHSA), Executive Director, Laura Aldinger sent out a recent salary study conducted on 29 of the public alcohol and drug agencies in South Carolina. As of August 1, 2021, there are 105 vacancies. Similarly, the Coronavirus era experience has demonstrated that filling vacant positions is difficult. Therefore, recruitment may be challenging. However, BCADAD plans to utilize grant partners to help disseminate the word into the Hispanic Community as part of BCADAD's recruitment efforts.

A secondary anticipated barrier relates to trust. PASOs and other community outreach organizations indicate that developing trust will be key to having participation in the community forums. As evidence by the high number of DUIs by undocumented Hispanics, community partners with established trust will be key to having a wide turnout. The BCADAD is relying on advertisements in and by trusted and utilized media sources by the Hispanic population in Beaufort County.

Sustainability:

The BCADAD intends to treat this project as a demonstration project. If there is documented and sustained improvement that can be captured through data collection, the data will be used in future grants and or request for continued funding in the BCADAD County Plan, through Beaufort County Council, or participating churches.

Attachment 1 – SMART Goals and Objectives

Goals:

Goal #1: Decrease youth substance use in the community by implementing evidence-based programs within the school district that address behaviors that may lead to the initiation of use.

Objectives:

a. The BCADAD Prevention Department will purchase the Class Action curriculum and review all lessons by July 2022.
b. By the start of August, 2022m the Prevention Department will have at least one school scheduled in Port Royal, Bluffton, and Hilton Head Island with students ranging from grades 9 through 12 scheduled to participate in the Class Action curriculum.
c. By the end of the 2022-2023 school year, district BCADAD's Prevention Department will have conducted at least classes on the dangers underage drinking in youth in grades 9 through 12 in densely populated Hispanic areas receiving the Class Action curriculum (2 school years).

Goal #2: Increase the knowledge of Hispanic Communities of South Carolina Driving Under the Influence Laws and Healthy Choices that may lead to socially and culturally appropriate family interventions and education.

Objectives:

a. The BCADAD Bilingual Staff will be trained in Prime for Life by March 2022 and select meaningful materials for dissemination at monthly community forums to start in April 2022.
b. The BCADAD Bilingual Prevention Staff will review and learn the South Carolina Laws and translate those laws into culturally meaningful language for dissemination by the end of March 2022.
c. The BCADAD Bilingual Prevention Staff will provide at least one presentation on Prime for Life and South Carolina Code of DUI Laws to Hispanic attendees in Port Royal, Bluffton, or Hilton Head by the end of each month, starting in April 2022 through September 2023.

Goal #3: Through Community presentations and information to the Hispanic Community, including broadcasting DUI checkpoint information, Hispanic drivers will make healthier choices and reduce their risk for DUIs and Alcohol related crashes.

Objectives:

a. * The BCADAD will broadcast DUI Checkpoint information in Spanish within 72 hours of teach event in the Bluffton, and Port Royal communities, starting in January 2022 until September 2023.
b. The BCADAD will obtain DUI arrest and crash data quarterly, starting in April 2022 and track the changing values until Sept 2023 as part of a Quasi-Experimental design study.
c. By self-report, attendees at Community Forums and in schools will complete targeted surveys after each presentation to obtain both qualitative and quantitative data to guide program delivery and quality to ensure benefit.

*Hilton Head Island does not have their own police. The county sheriff polices the island. Per Captain Robert Bromage, The Beaufort County Sheriff's Department does not do DUI or Safety Checkpoints on Hilton Head. The department will urge the 14th Curcuit AET Team to lobby for such activites.

Qualifications and Experience

Capacity and Competencies

Organizational Structure and Staffing Plan:
The BCADAD is a department of Beaufort County Government. There are two service locations serving the citizens of Beaufort County. One location is South of the Broad River in Bluffton and the other is North of the Broad in Beaufort. The department provides Prevention, Intervention, Treatment, and Recovery services in both locations, virtually, and or in the community.
The department's Prevention Department has a director, Wade Bishop, and two prevention staff. One preventionist is in each service location. This department will serve as the teammates of a new full-time bilingual employee who is eligible for Prevention certification. This staff will be supervised by Wade Bishop (see below for resume) who is a senior certified preventionist through IC&RC. Wade would be the supervisor for this initiative and grant personnel.
The grant funded Preventionist would work primarily out of the Bluffton service location, given the density of Hispanic speaking citizens South of the Broad River. However, traveling North of the Broad River will be required to provide services in the Port Royal community.

Key Personnel:

Steven Donaldson, M.Ed. LAC, CS, MAC, AADC
Steven Donaldson is the Executive Director of The Beaufort County Alcohol and Drug Abuse Department, designated as the local authority on alcohol and drug abuse services. Mr. Donaldson has over thirty years' experience in the alcohol and other drug and mental health services field. He has worked and supervised in the areas of intervention and treatment both on an Inpatient and an Outpatient basis and maintains a working knowledge of all programs and services from Prevention to Recovery. Steve is responsible for approving and monitoring budgetary expenditures, planning comprehensive annual strategic plans and goals, determining program priorities, and revising and updating policies and procedures through planning, establishing, and administering business functions. He ensures the department meets the standards for the international accreditation process with The Center of Accreditation for Rehabilitative Facilities (CARF). Mr. Donaldson received his bachelor's degree in Political Science, Master of Education degree and Alcohol and Drug Studies degree from the University of South Carolina. He is also a CARF Surveyor and served as the chair and a member of the Addiction Professionals of South Carolina (APSC- formerly known as SCAADAC) and assisted in the transition from NAADAC to IC&RC in South Carolina and bringing a Peer Recovery Support Services credential under the umbrella of APSC.

Wade E. Bishop, CSPS
Wade Bishop is the Director of Prevention Services and Supervisor of Peer Support Services at Beaufort County Alcohol and Drug Abuse Department, designated as the local authority on alcohol and drug abuse services. Mr. Bishop has over thirty-five years of experience in the alcohol and other drug abuse services field. He has worked and supervised in the areas of prevention, intervention and treatment and maintains a working knowledge of all programs and services. Mr. Bishop is responsible for planning comprehensive annual strategic plans and goals, focusing on prevention service within the department. He ensures the agency meets the standards for the international accreditation process with The Center of Accreditation for

Rehabilitative Facilities (CARF), specific to Health and Safety and Prevention Program standards. Mr. Bishop received his bachelor's degree in Individual and Family Studies from The Pennsylvania State University. He is a certified Senior Prevention Specialist and has held certification as a CACI, School Intervention Program (ScIP) group facilitator and Alcohol Drug Safety Action Program (ADSAP) Level 1 group facilitator, during his employment with Beaufort County Alcohol and Drug Abuse Department (BCADAD). Mr. Bishop currently serves on the South Carolina Association of Prevention Professionals and Advocates (SCAPPA) Certification Commission and has served on the Peer Review Committee of over 25 years (serving as the chairman for over 20 years). He also serves as a member of the SCAPPA Professional Development Committee.

The Bilingual Preventionist to be hired to work on this project must have the following qualifications:

- Bachelor's degree in a human service degree field from an accredited institution.
- Bilingual in Spanish and English, ideally of Hispanic descent.
- A Valid South Carolina Driver's License.
- Eligible to work in the United States.
- Prevention certified by IC&RC, SCAPPA, or must have the ability to become SCAPPA certified.

The BCADAD has been in operation for 47 years. Although Prevention has not worked primarily with a Hispanic Speaking population, the department has been contracting with Spanish speaking personnel for many years, given the change to the demographics in the Beaufort Community. To that end, literature of the department and the agency newsletter are in Spanish. There have been other enhancements through the direction of the BCADAD Cultural Diversity Plan. Incrementally, progress is being made with diversity and inclusivity.

The department will be working with several churches in Port Royal, Bluffton, and Hilton Head, the Beaufort County School Department (See MOAs) to provide evidence-based curriculum and other information, as well as the South Carolina Department of Public Safety for data collection.

Organizational Experience:

The BCADAD has had collaborations with the school system, but no formal relationships with the community churches. The BCADAD collaborates with the schools to provide ScIP and the Bridge Program, in addition to serving on many committees and coalitions in Beaufort for several years.

St Gregory the Great in Bluffton has been a constant source of support to BCADAD. The Spanish Outreach Coordinator has routinely advertised BCADAD personnel vacancies, in the department's effort to diversify staff. Nevertheless, the department is no stranger to collaborations. The BCADAD Prevention division is involved in several coalitions. For example, Low County Alliance for Healthy Youth (LACHY), a local Opioid Consortium, the Human Services Alliance of the Low county, Collaborative of Organization of Services for Youth (COSY), Collaborative of Service for Adults (CODA) and Citizens Opposed to Domestic Abuse (CODA), and Together for Beaufort County.

Training:

The Class Action manualized curriculum to be used in the schools does not require training. Following the guidance in the manual without deviation is the methodology to maintain fidelity to the program. However, the BCADAD will seek a Trainer of Trainers training from Hazelden on the entire Northland curriculum to benefit other community providers, including teachers.
It should be noted that the regions lead on the Alcohol Enforcement Team and senior preventionist from Jasper County has offered to be a resource for using the Class Action curriculum, in view of her experience and use of it. To that end, relationships exist through coalition involvement to ensure fidelity to evidence-based curriculums.

Additionally, staff for this project will be trained in the Prime for Life curriculum by the PRI Institute, since it is proprietary. Becoming PRI certified will be a requirement before using the educational materials at any church forums. Learning the DUI Code if Laws in South Carolina will not require training.

Privileging will be conducted to ensure the bilingual Preventionist is prepared to provide community services. The to be hired Preventionist will provide all services under Supervision until demonstrating the ability to provide those services independently and or certified by both SCAPPA, The PRI Institute, and has gone through the Hazeldon training on Class Action.

Partnerships:

Organization	Contact	Contact Info	Location	Signed MOU
Port Royal Police Department	Chief Alan Beach	abeach@portroyal.org	Port Royal	*Not unless awarded
Pasos	Yajaira Benet-Uzcategui	(843) 379-7837	Beaufort County	*Not unless awarded
Saint Gregory the Great Catholic Church	Nora Araujo	Naraujo@sgg.cc	Bluffton	*Not unless awarded
AET	Nicole Smith	nsmith@nlcbhsa.org	Jasper County	*Not unless awarded
Beaufort County School District	Lakinsha R. Swinton	lakinsha.swinton@beaufort.k12.sc.us	Beaufort County	*Not unless awarded
South Carolina Department	Ross Hatfield	RossHartfield@scdps.gov	Richland County, SC	*Not unless awarded

of Public Safety				
Bluffton Police Department	Chief Stephanie Price	sprice@townofbluffton.com 843-706-4550	Bluffton	*Not unless awarded
Saint Peters Catholic Church	Father Andrew	(843) 522-9555	Lady's Island	*Not unless awarded

Informal arrangements with the Beaufort County Sheriff's Department who polices Hilton Head Island for DUI Checkpoint Studies have been discussed. Currently, the South Carolina State Highway Patrol is the only law enforcement entity doing any sort of safety checkpoints on the island. Customarily those checkpoints have related to saturation checkpoints and not DUI checkpoints. Therefore, more discussions in the community will need to occur to encourage DUI checkpoints before data the BCADAD can alert any such event.

* Committing through an MOA without first having the resources to keep to any commitment was not done. Drafts of all MOAs are attached to be fully executed, if awarded, are attached.

Attachment 2 –Evaluation Plan

The BCADAD is planning to collect in report on data in a couple of ways.
First, the department plans to use the pre-grant data on crashes and DUIs and alcohol related crashes in Beaufort County as a baseline and track both of those data points quarterly to measure change, starting after the first quarter of community interventions.

Grant Year 1	Oct1-Dec 31, 2021	Jan 1-Mar 31, 2022	Apr 1-June 30, 2022	July 1-Sept 30, 2022	Data source	Responsible Staff	Analysis Method (% of change per quarterly)
Reduce Hispanics Arrested for DUI by 10% each quarter.					Beaufort County Detention Center	To be Hired Preventionist	q.1 q.2 q.3 q.4
Hispanics involved in alcohol related crashes					South Carolina Department of Public Safety	To be Hired Preventionist	q.1 q.2 q.3 q.4
Hispanics attending ADSAP Services at BCADAD					Carelogic Reports	Quality Assurance Director	q.1 q.2 q.3 q.4

Repeat for Grant Year 2 & 3

Secondly, a survey for students and for adults will be developed to assess benefit and satisfaction with materials presented and aggregated for report and quality improvement purposes. Data will be collected in English and Spanish for both qualitative and quantitative information. The goal will be for 90% satisfaction and to establish benefit.

Finally, each quarter a report will be created to look at the values of arrests, crashes, and satisfaction. This data will be shared with all stakeholders. Other data reporting required by the grant body will occur monthly.

Attachment 3- Community Survey

Survey Questions for Students:

On a scale of 1-10 (one not good, and 10 the best), please circle number that best meets your satisfaction of learning needs:

School: _____ Grade: _____ Gender: _____ Race: _____

1. The information presented was helpful to my learning about the dangers to alcohol and drugs:
   1 2 3 4 5 6 7 8 9 10
2. What is the most important thing you got out of today's class:

_____

_____

_____

Survey Questions for Community Forums:

On a scale of 1-10 (one not good, and 10 the best), please circle number that best meets your satisfaction of learning needs:

Gender: _____ Race: _____

1. The information presented was helpful to my learning about the dangers to alcohol and drugs:
   1 2 3 4 5 6 7 8 9 10
2. What is the most important thing you got out of today's class:

_____

_____

_____

3. What other things related to DUI Laws or Alcohol and Drug Issues do you need to learn more about?

Information from both the satisfaction and data collection from the Beaufort County Detention Center and the South Carolina Office of Public Safety will be forward to the CQI for outcome matrix entry no later than the 23rd day of the new month following a quarters end. The Preventionist will also aggregate data and share in their grant report as part of their deliverable reporting (quarterly, in this case). An annual report will also be prepared, and an overarching report to compare data values related to DUI arrests and alcohol related crashes among Hispanics. Throughout the project the data input into the CQI outcome matrix will be monitored and utilized for continued funding opportunities for program sustainability.

Attachment 4
BCADAD Budget/Budget Narrative

A total of **$260,311**is requested by the Beaufort County Alcohol and Drug Abuse Department.

Personnel:

	Year1	Year 2	Year 3	Total
# Personnel = 1 To be hired	Effort =100%	Effort =100%	Effort =100%	**100%**
Salary	47,694	47,694	49,124	**144,512**
Cola	0	1,430	1,474	**2,904**
Fringe (32.5%)	15,501	15,963	16,444	**51,890**
Total Personnel	63,195	64,817	67,042	**$195,054**

Justification:

Preventionist (Bilingual) $47,694k +32.5% fringe (Identified with the project and not claimed as Indirect Cost)

This position is the sole personnel for the project. The proposed salary is the department minimum, plus the identified fringe rate of 32.5%, based upon Beaufort County Human Resource department allocations. It should be noted that personnel cost is the higher expense, and those rates are established by Beaufort County Government. An entry level salary is all that is going to be offered, despite the value in recruiting a bilingual staff that is key for this project. The salary typically gets a 3% Cost of Living is allocated by the Beaufort County Council Annually. As such, the grant personnel will be budgeted for such an increase.

This person will be working primarily with a Hispanic audience by doing services within the Beaufort County School District in cities with a high density of Hispanics living. Similarly, adult audiences will be targeted to do community forums by presenting information related to SC DUI Laws, information from the Prime for Life curriculum, and serving as a resource for other needed alcohol and drug information. The person would also work with local law enforcement and Hispanic media sources by providing DUI Checkpoint information. Further, this person will be coordinating information gathering from law enforcement and the South Carolina Office of Public Safety and then disseminating it to digital television, radio, print ads, and reports, as appropriate. All grant deliverables will be the responsibility of this position.

Operating Costs:

Training and Travel:

Hazeldon Class Action Training	495	0	0	**495**
PRI Training	0	0	0	**0**
Hotel and Per Diem for PRI	484	0	0	**484**
SCAPPA/Prevention Training Bucket	500	500	500	**1,500**
Conference and Community Forum, and Health Fair Display Materials in	1,750	500	500	**2,750**

Spanish, and vender fees				
Other Destination Mileage (Local travel @.56)	4,480	6,720	6,720	**17,920**
Total Training and Travel Expenses:	7,709	7,720	7,720	**$23,149**

Justification:

Training and Travel- The cost of the training is largest in year one when the new Preventionist. Fees for PRI Institute, Hazeldon, and SCAPPA In-process fees, hotel, per diems, and milage are budgeted. In years two and three, the bilingual Preventionist will be allocated a training budget of $500, which includes any hotel, mileage, or per diem (County rates, per established policy), in view of the lost cost and ongoing trainings offered through both SC DAODAS, the region, and BHSA.

Conference and Community Forum, and Health Fair expenses are budgeted Spanish table linen, a highboy signage display through DisplaystoGo are priced just below $1,000 plus taxes. Pens with the agency logo written in Spanish for $250, and a $500 vender fee for an annual Latin Festival are budgeted in year one. Years two and three will use the same items used at health fairs, community forums, and the Latin Festival. The only anticipated additional expenses for years two and three are for vender fees. Other opportunities to display at health fairs are usually free. Therefore, once the foundation for displays and set-up spend in year one is paid, other than the Latin Festival, no other expenses will be budgeted.

Other Destination Mileage – The Preventionist working in Beaufort will be traveling from Bluffton to Port Royal and Hilton Head on a regular basis. Year one has been prorated to 8 months, in view of the time it will take to recruit, train, and be ready for traveling to provide interventions. Both years two and three are budgeted at a full year @.56 cents per mile, which is the 2021 IRS rate https://www.gsa.gov/portal/category/26429 @1,000 miles per month or 250 miles per week. This seems reasonable, given the 871 square mile radius of Beaufort County.

The expenses for training seem justifiable, in view of the intention to provide evidence-based curriculums in schools. To keep the cost low, the 14th Circuit AET Director is providing no cost consolation on the "Class Action" curriculum, and the BCADAD will have ADSAP staff monitor and provide feedback when presenting PRI information and the SC DUI Code of Laws at community forums. Other Prevention supervision will be provided by Wade Bishop. No supervision fees are budgeted.

Supplies and Materials:

Supplies and Materials				
Office Supplies				
Computer	780	0	0	**780**
Computer Bag	50	0	0	**50**
Business Cards	185	0	0	**185**
Hand Sanitizer	72	72	0	**144**
Brochures and Flyers	250	250	250	**750**

Pens, paper, staples, stickems	296	75	75	**225**
Total Supplies and Materials:	1,633	397	325	**$2,355**

Justification:

Supplies and Materials- Startup cost for a computer, Surface Pro, at county rate ($780), computer bag ($50) given employees ability to carry computer while working in the community. The office supplies, such as paper, pens, Post-Its ($296/75 are needed to take notes, for organization, and to use during presentations. Anticipated expenses:

- Year one:

Office supplies from ULINE for startup:

S-21131 Memo 5 x 8" x 12 per pack x $13
S-21132 Letter 8 1/2 x 11 3/4" 12 per pack x $16
Stapler: H-2029 $21
Desk Top Staples: S-14138 $3
Pens S-21758 BIC® Gel-ocity™ Fine @ $1.40 $17
S-19661 3M Post-It® Pad 25 x 30" 30 2 $63 (For presentations)
S-17272 Desk Post-Its $150
H-255 Sharpie® King Size $2.10 x6 $13
$296

- Hand sanitizer will be purchased in bulk during year one and two @ 12 pack of 8-ounce hand sanitizer $35.83 x 2 cases= $71.66. If more is needed in year three, slippage from this line item will be used if necessary. The sanitizer will aid in the safety of staff working with the public at all community forum events.
- Year two/ Year three- Only necessary replenishment. The grant will not be charged for printer or toner allocations. Office supplies are only having $75 allocated for years two and three, given replenishment cost is deemed less and some leftover supplies are anticipated.
- The department also is providing low-cost business cards to the bilingual Preventionist, which is deemed essential when making connections to the Hispanic community. Five hundred cards will cost $185.
- Brochures and Flyers are estimated, given the departments history of using both Staples and Broad Street printing. Brochures and flyers will also be developed, printed, and distributed to alert Hispanic citizens about scheduled community forums and BCADAD. These materials will be distributed on community partner community information boards and for dissemination at health fairs, and like venues.

Technology Services:

Technology Services				
Relias	50	50	50	**50**
Total Technology Services:	50	50	50	**$150**

Justification: Technology Services- All personnel must have a Relias training account. This is for onboarding and accreditation, beyond the learning experience.

Contractual Services:

Contractual Services:				
TV, Radio, and Print Ads	6,133 (&8 months)	9,200	9,200	**24,533**
Palmetto Breeze Bus Advertising @ set up fee $250 + $25 per month on inside of bus 7% sales tax, x3 buses=	749	963	963	**2,675**
Contractual Services Total:	6,882	10,163	10,163	**$27,208**

Justification:

Advertising- Advertising is deemed critical. The department intends to run ads in Vaqueva Magazine, do radio spots, and place ads on Spanish social networks and digital television on Monday, Wednesday, and Friday. This service will also assist the project by pushing out alerts to planned DUI checkpoints. The owner, Alberto Ortega has quoted BCADAD cost at 50%, in view of the plans for making a multi-year commitment and to do a public service. Year one has been prorated to eight months.

The BCADAD plans to place the Preventionist business card in a "Michelangelo" format inside of the Palmetto Breeze buses on three routes in the more densely populated Hispanic areas. The captions on the advertising have not been developed. However, they will be alerting citizens to learn more about community forums that will alert them to the SC DUI Code of Laws and to more information about alcohol and drug misuse.

Administrative Costs:

Total Administrative Costs (5%)	3,949	4,154	4,265	**$12,368**

Justification:

Administrative Cost-A 5% Administrative fee will be included for operations activities related to the additional position for administrative support, payroll processing, fees for physicals and TB test, and time to develop and upload deliverable reports.

GRAND TOTAL	Year 1	Year 2	Year 3	**$Totals**
Total Personnel	63,195	64,817	67,042	**$195,054**
Total Operating Expenses	16,274	18,330	18,258	**$52,558**
Subtotal	79,469	83,147	85,300	**$247,916**
Administrative Fee	3,973	4,157	4,265	**$12,395**
Grand Total	**83,442**	**87,304**	**89,565**	**$260,311**

Attachment 5 – Health Disparities Impact Statement

The BCADAD will work with DAODAS to refine and submit a Health Disparity Impact Statement (HDIS) within the first six months of the sub-award, which will be a data-driven quality-improvement effort to ensure underserved subpopulations are addressed in the grant. The HDIS will consists of three components:

(1) identify the number of Hispanics individuals to be served during the grant period and identify subpopulation.

(2) implement a quality-improvement plan to address subpopulation differences based on the data on access, use, and outcomes of service activities.

(3) and identification of methods in the development of the BCADAD's Cultural Diversity Plan to ensure adherence to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.

RESOLUTION 2021/_____

A RESOLUTION AUTHORIZING THE COUNTY ADMINISTRATOR TO ACCEPT A GRANT OFFERED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES

Whereas, there has been made available certain grant funds to be administered by the Department of Alcohol and Other Drug Abuse Services, to be awarded to Beaufort County Alcohol and Drug Abuse Department; and

Whereas, Beaufort County has submitted to the Department of Alcohol and Other Drug Abuse Services and the Department of Alcohol and Other Drug Abuse Services has awarded Beaufort County, the following:

1. Operation Mariposa Grant CFDA number 93.788 in the amount of $260,311

NOW THEREFORE, IT IS HEREBY RESOLVED, at a duly called meeting of Beaufort County Council, that the County Administrator is hereby provided the authority necessary to execute the aforementioned grant from the Untied States Department of Health and Human Services.

Adopted this _____ day of _____, 2021

COUNTY COUNCIL OF BEAUFORT COUNTY

_____

Joseph Passiment, Chairman

Clerk to Council

_____

Sarah Brock

BEAUFORT COUNTY COUNCIL
AGENDA ITEM SUMMARY

ITEM TITLE:
Rural Opioid Implementation RFP- 2022
MEETING NAME AND DATE:
Community Services Committee November 1, 2021
PRESENTER INFORMATION:
Steve Donaldson, Director of the Alcohol and Drug Abuse Department 10 minutes.
ITEM BACKGROUND:
Grant is completely written from the last funding cycle, although was not accepted for submission due to a clerical error. Therefore, the plan is simply to change a few dates and budget items and resubmit.
PROJECT / ITEM NARRATIVE:
Increase local capacity & Infrastructure necessary to reduce opiate misuse
FISCAL IMPACT:
No matching fees or financial outlay by Beaufort County. This grant would pay 5% towards the director's salary and enhance revenue streams.
STAFF RECOMMENDATIONS TO COUNCIL:
Approve the Alcohol and Drug Department in applying for the Rural Opioid Implementation.
OPTIONS FOR COUNCIL MOTION:
Motion to approve submittal of grant application for Rural Opioid Implementation RFP- 2022 or motion to disapprove submittal of grant application for Rural Opioid Implementation RFP – 2022.

BUDGET JUSTIFICATION

LINE ITEM	JUSTIFICATION	YEAR 1	YEAR 2	YEAR 3	TOTAL
PERSONNEL					
Director	5% of Director salary for ultimate oversight, county reporting, Project Director supervision, and contract developments and oversight.	$4,400	$4,400	$4,400	$13,200
Project Director	One full time oversee all aspects of project implementation and operation of the project including scheduling, staff hiring, supervision, consultant management, execution of deliverables, coordination of all program elements, budgeting, and reporting.	$63,500	$63,500	$63,500	$190,500
Clinical Social Worker	One full time clinical social worker to project clinical supports, case management, and patient monitoring.	$43,500	$58,000	$58,000	$159,500
Peer Recovery Support Specialist	One Full time individual to manage peer recover support services, and insurance enrollment as outlined in proposal narrative. To be hired Q2 of Y1.	$25,500	$34,000	$34,000	$93,500
	TOTAL PERSONNEL:	**$136,900**	**$159,900**	**$159,900**	**$456,700**
FRINGE	Includes: FICA – 6.20%, health insurance (full time positions only) 10.56%, state retirement 15.56% provided as mandated by board policy, Employer Tort Liability .013 or 32.33% **TOTAL FRINGE:**	**$45,359**	**$51,405**	**$51,405**	**$148,169**
TRAVEL					
Travel to required meetings.	Two staff to travel to Washington D.C annually plus attend regional Meetings plus Regional meetings (location unknown). Travel and per diem annually for these purposes is $3,000.	$4,125	$4,125	$4,125	$12,375
Local mileage reimbursement	Estimated 501 miles @57.5 cents per mile.	$288	$288	$288	$864
	TOTAL TRAVEL:	**$4,413**	**$4,413**	**$4,413**	**$13,239**

Voice–Vision-Leadership

LINE ITEM	JUSTIFICATION	YEAR 1	YEAR 2	YEAR 3	TOTAL
SUPPLIES	Three Palmetto Breeze buses in target zip codes @$250/$25 per month; Art Set-up fee, 7% sales				
Advertising & Printing	tax, $8,961; Rack cards for hospitals, the FQHC, United Way, pharmacies, and consortium members. Set-up & card stock approx.. $1,000 annually	$9,961	$9,961	$9,961	$29,883
Environmental Prevention Supplies	InfoUSA phone data $1,000/yr x 3 years ($3,000), Robo Calls $150 x 3 per year x 3 years ($1,350) & RX drug drop boxes 5 @ $120/box ($600)	$1,650	$1,650	$1,650	$4,950
Narcan	62 doses @ 2 for $50 per state contract x 3 years	$1,550	$1,550	$1,550	$4,650
Phone	Cell phone purchase for new staff. Agency procurement rate.	$800	$0	$0	$800
Computer	Surface Pros for new project staff will cost $800 each or @3,200.	$3,200	$0	$0	$3,200
Ballistic Jackets	Ballistic Jacket @ $800x5 or $4,000 is for consortium members assigned to do post overdose follow-up, as recommended by the fire rescue and emergency medicine consortium members.	$4,000	$0	$0	$4,000
Office Equipment & Supplies	Office supplies and minor office equipment will include a computer bag, pencils, pens, paperclips, staplers, scratch pads, legal pads, and file folders, and associate labels for record-keeping. Costs are estimated to be higher in year one and titrate down after that. Year one budget is $250/$750 or $1,000.	$1,000	$1,000	$1,000	$3,000
	TOTAL SUPPLIES:	**$22,161**	**$14,161**	**$14,161**	**$50,483**

BEAUFORT COUNTY CADAD
ALCOHOL & DRUG ABUSE DEPARTMENT

Voice–Vision-Leadership

LINE ITEM	JUSTIFICATION	YEAR 1	YEAR 2	YEAR 3	TOTAL
CONTRACTUAL					
APRN	Subcontract staffing for provision of MAT expansion and treatment services in county detention facility.	$55,120	$55,120	$55,120	$165,360
CLINICAL SUPERVISOR	Subcontract staffing for clinical supervision of expanded caseloads and staffing.	$20,000	$20,000	$20,000	$60,000
EVALUATION SUPPORT	Project evaluation support to monitor process and outcome objectives, data dashboard, assist with Continual Quality Improvement Monitoring and reporting. $4,000 per quarter, incudes travel	$12,000	$12,000	$12,000	$36,000
FAVOR TRAINING	Lowcountry FAVOR training tailored for law enforcement, hospital personnel, emergency medicine, and the community. The fees include speaker fees (preparation and training time), mileage, and printed materials @$6,532 annually.	$6,532	$6,532	$6,532	$19,596
	TOTAL CONTRACTUAL:	**$93,652**	**$93,652**	**$93,652**	**$280,956**
OTHER					
Phone/Internet	$64 per phone for new project staff @30 months. $1,920 plus $269 taxes or $2,189 for year 1 and @ 36 months in year 2 and 3 or $2,304 plus taxes $323	$2,189	$2,627	$2,627	$7,443
Insurance	Malpractice protection for project staff	$2,475	$2,475	$2,475	$7,425
County Fees	Facility Maintenance allocation= $2,166; phone, x4= $400; Carelogic x5= $ 2,660; Relias LMS x5= $750; Fleet PM = $775 Vehicle Insurance $833; Professional Liability $2,286; Fuels & Lubricants $ 950; Onboarding physicals /TB $1,375 ($275 per personx5); Agency License/Membership $150	$12,345	$11,245	$11,245	$34,835
		$17,009	**$16,347**	**$16,347**	**$49,703**
	GRAND TOTAL:	**$319,494**	**$339,878**	**$339,878**	**$999,250**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HRSA
Health Resources & Services Administration

Federal Office of Rural Health Policy
Rural Strategic Initiatives Division

Rural Communities Opioid Response Program-Implementation

Funding Opportunity Number: HRSA-22-057
Funding Opportunity Types: New and Competing Continuation
Assistance Listings (CFDA) Number: 93.912

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2022

Application Due Date: January 13, 2022

Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!
HRSA will not approve deadline extensions for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to 1 month to complete.

Issuance Date: October 15, 2021

Sabrina Hope Frost
Public Health Analyst, Federal Office of Rural Health Policy
Telephone: (301) 945-5131
Email: ruralopioidresponse@hrsa.gov for program-specific questions

Please contact the Grants Management Specialist on page 38 of the NOFO for budget-related questions (e.g., allowable costs, SF-424 A form, etc.).

Authority: 42 U.S.C. 912(b)(5) (§ 711(b)(5) of the Social Security Act)

508 COMPLIANCE DISCLAIMER

Note: Persons using assistive technology may not be able to fully access information in this file. For assistance, please email or call one of the HRSA staff listed in Section VII. Agency Contacts.

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2022 Rural Communities Opioid Response Program-Implementation (RCORP-Implementation). RCORP is a multi-year initiative by HRSA aimed at reducing the morbidity and mortality of substance use disorder (SUD), including opioid use disorder (OUD), in high-risk rural communities. This funding opportunity, RCORP-Implementation, will advance RCORP's overall goal by strengthening and expanding SUD/OUD prevention, treatment, and recovery services to enhance rural residents' ability to access treatment and move towards recovery.

Funding Opportunity Title:	Rural Communities Opioid Response Program-Implementation
Funding Opportunity Number:	HRSA-22-057
Due Date for Applications:	January 13, 2022
Anticipated Total Annual Available FY 2022 Funding:	Approximately $50,000,000, subject to the availability of appropriated funds.
Estimated Number and Type of Awards:	Approximately 50 grants
Estimated Award Amount:	Up to $1,000,000 for the three-year period of performance. Award recipients will receive the full award amount in the first year of the period of performance and are required to allocate it across all three years.
Cost Sharing/Match Required:	No
Period of Performance:	September 1, 2022 through August 31, 2025 (3 years)
Eligible Applicants:	All domestic public and private entities, nonprofit and for-profit, are eligible to apply. Domestic faith-based and community-based organizations, tribes, and tribal organizations and organizations based in the territories and freely associated states are also eligible to apply. See Section III.1 of this notice of funding opportunity (NOFO) for complete eligibility information.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this NOFO to do otherwise.

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Wednesday, November 10, 2021
Time: 12:30 – 2:00 p.m. ET
Call-In Number: 1-833-568-8864
Meeting ID: 160 852 4742
Passcode: 23233962
Weblink: https://hrsa-gov.zoomgov.com/j/1608524742?pwd=UFJvcGs5bHFiYXRkcGRleFd6REpnZz09

The webinar will be recorded. Please email ruralopioidresponse@hrsa.gov for a link to the recording.

Table of Contents

I. Program Funding Opportunity Description

1. Purpose

The Rural Communities Opioid Response Program (RCORP) is a multi-year initiative by the Health Resources and Services Administration (HRSA) aimed at reducing the morbidity and mortality of substance use disorder (SUD), including opioid use disorder (OUD), in high risk rural communities. This notice announces the opportunity to apply for funding under RCORP-Implementation. This funding opportunity, RCORP-Implementation, will advance RCORP's overall goal by strengthening and expanding SUD/OUD prevention, treatment, and recovery services to enhance rural residents' ability to access treatment and move towards recovery.

Given the complex and multifaceted nature of SUD/OUD, as well as the need to secure community buy-in and generate adequate patient volume to sustain services, HRSA requires that applicants be part of broad, multi-sectoral consortia. HRSA expects that consortia funded by RCORP-Implementation will sustain the SUD/OUD-related services in rural areas made possible by this funding opportunity both during and beyond the period of performance.

The target population for the award is: 1) individuals who are at risk for, have been diagnosed with, and/or are in treatment and/or recovery for OUD; 2) their families and/or caregivers; and 3) other community members[1] who reside in HRSA-designated rural areas, as defined by the Rural Health Grants Eligibility Analyzer. In addition to this target population, applicants are encouraged to give special consideration to rural populations that have historically suffered from poorer health outcomes or health disparities, as compared to the rest of the rural population.

The primary focus of the RCORP-Implementation award program is OUD. However, recognizing that many individuals with OUD use multiple substance and/or have other co-occurring conditions, consortia may also use RCORP-Implementation support to help address other SUD-related needs of the target population of individuals and families affected by OUD. Applicants should link any additional activities they propose to the needs of their target population and service area. Please note that no competitive advantage, funding priority, or preference is associated with proposing activities beyond the core/required activities outlined in the Program-Specific Instructions section of this NOFO.

2. Background

RCORP-Implementation is authorized by Section 711(b)(5) of the Social Security Act (42 U.S.C. 912(b)(5)).

The Rural Communities Opioid Response Program is administered through HRSA's Federal Office of Rural Health Policy, which is charged with supporting activities related to improving health care in rural areas.

[1]Applicants are encouraged to include individuals in the community who are involved in improving health care in rural areas.

In 2017, HHS declared the opioid crisis a nationwide public health emergency. Rural providers and communities in particular face a number of challenges in providing and accessing SUD/OUD services. In July 2020, nearly two-thirds of all rural counties (63.1%) had at least one clinician with a Drug Enforcement Administration (DEA) waiver but more than half of small and remote rural counties lacked one.[2] In addition to workforce shortages, rural communities face barriers such as stigma, transportation, and costs associated with setting up MAT and other SUD/OUD services.[3]

Rural residents who use opioids are more likely than their urban counterparts to have socioeconomic vulnerabilities, including limited educational attainment, poor health status, lack of health insurance, and low income,[4] which may further limit their abilities to access treatment. The opioid epidemic has also led to an increase in people who inject drugs (PWID), which in turn has increased the risk of transmission of viruses such as human immunodeficiency virus (HIV) and hepatitis B and C viruses (HBV and HCV) through shared equipment. Rural communities are particularly vulnerable to outbreaks of HIV and HCV among uninfected PWID.[5]

Recent Centers for Disease Control and Prevention data suggest that synthetic opioids are increasingly playing a role in psychostimulant-involved deaths. Drug overdose deaths involving psychostimulants with abuse potential, including methamphetamine, increased by over a third in rural communities between 2016 and 2017.[6]

The COVID-19 pandemic forced rural communities to adapt and stretch limited resources and exacerbated the opioid crisis. Over 81,000 drug overdose deaths occurred in the United States in the 12 months ending in May 2020, the highest number of overdose deaths ever recorded in a 12-month period, according to recent provisional data from CDC.[7] From 1999 through 2019, the rate of drug overdose deaths increased from 4.0 per 100,000 to 19.6 in rural counties.[8]

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[2] Andrilla CHA, Patterson DG. Tracking the geographic distribution and growth of clinicians with a DEA waiver to prescribe buprenorphine to treat opioid use disorder. *J Rural Health.* 2021; 1-6. https://doi.org/10.1111/jrh.12569

[3] See, e.g., *Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care: Environmental Scan Volume 1,* AHRQ, https://integrationacademy.ahrq.gov/sites/default/files/mat_for_oud_environmental_scan_volume_1_1.pdf

[4] Lenardson, Jennifer et al (2016), "Rural Opioid Abuse: Prevalence and User Characteristics," Maine Rural Health Research Center, http://muskie.usm.maine.edu/Publications/rural/Rural-Opioid-Abuse.pdf

[5] Van Handel MM et al, "County-level vulnerability assessment for rapid dissemination of HIV or HCV infections among persons who inject drugs, United States," J Acquir Immune Defic Syndr (2016): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5479631/; See also Centers for Disease Control and Prevention, "Managing HIV and Hepatitis C Outbreaks Among People Who Inject Drugs," March 2018, https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-guide.pdf.

[6] See, e.g., Kariisa et al (2019), "Drug Overdose Deaths Involving Cocaine and Psychostimulants with Abuse Potential—United States, 2003-2017," CDC Morbidity and Mortality Weekly Report, https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6817a3-H.pdf.

[7] Center for Disease Control. (December 2020) *Expanded prevention efforts needed* [Press release]. Retrieved from https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html

[8] Hedegaard H, Spencer MR. Urban–rural differences in drug overdose death rates, 1999–2019. NCHS Data Brief, no 403. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: https://dx.doi. org/10.15620/cdc:102891.

RCORP supports and encourages projects that address the needs of a wide range of population groups, including, but not limited to, low-income populations, the elderly, pregnant women, youth, adolescents, ethnic and racial minorities, people/persons experiencing homelessness, and individuals with special health care needs.

Addressing issues of equity should include an understanding of intersectionality and how multiple forms of discrimination impact individuals' lived experiences. Individuals and communities often belong to more than one group that has been historically underserved, marginalized, or adversely affected by persistent poverty and inequality. Individuals at the nexus of multiple identities often experience unique forms of discrimination or systemic disadvantages, including in their access to needed services.

As part of HRSA's overall strategy for addressing SUD/OUD in rural communities, in FY 2022, HRSA will provide funds for the National Health Service Corps (NHSC) Rural Community Loan Repayment Program (LRP) under separate funding opportunity to award eligible providers (Allopathic/Osteopathic Physicians, Physician Assistants, Psychiatrists, Nurse Practitioners, Certified Nurse-Midwives, Psychiatric Nurse Specialists, Health Service Psychologists, Licensed Clinical Social Workers, Marriage and Family Therapists, Licensed Professional Counselors, SUD counselors, Clinical Pharmacists, Registered Nurses and Nurse Anesthetists) who are working at a rural NHSC-approved SUD treatment facility. Clinicians working at NHSC-approved RCORP consortium member site will receive funding priority. RCORP-Implementation applicants are encouraged to leverage the NHSC Rural Community LRP to support the recruitment and retention of eligible providers from the SUD workforce.

- For additional information on the Rural Community LRP and Sites, see Appendix A. For a list of current rural NHSC-approved SUD facilities, visit HRSA's Health Workforce Connector.
- To learn how to become an NHSC site, visit the NHSC website.

In 2019, the U.S. Department of Health and Human Services (HHS) Rural Health Task Force developed the "Healthy Rural Hometown Initiative" (HRHI). The HRHI is an effort that seeks to address the underlying factors that are driving growing rural health disparities related to the five leading causes of avoidable death (heart disease, cancer, unintentional injury/substance use, chronic lower respiratory disease, and stroke). RCORP-Implementation supports the HRHI initiative by aiming to reduce mortality from unintentional injury resulting from drug overdose. While applicants and award recipients to RCORP-Implementation do not need to explicitly link their activities to the HRHI, HRSA may plan to use the performance data submitted by RCORP-Implementation award recipients to demonstrate how RCORP-Implementation supports the overall goal of the HRHI. For more information on the Healthy Rural Hometown Initiative, see page 29 of the HHS Rural Action Plan.

For information on other HRSA-supported SUD/OUD funding opportunities, resources, technical assistance, and training, visit https://www.hrsa.gov/opioids. For information on other federal SUD/OUD resources, please see **Appendix B**.

II. Award Information

1. Type of Application and Award

Types of applications sought: New and Competing Continuation

HRSA will provide funding in the form of a grant.

2. Summary of Funding

HRSA estimates approximately $50,000,000 to be available to fund approximately 50 recipients over a three-year period of performance. The actual amount available will not be determined until the enactment of the final FY 2022 federal appropriation. You may apply for a ceiling amount of up to $1,000,000 total cost (includes both direct and indirect, facilities and administrative costs). This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds appropriately.

The period of performance is September 1, 2022 through August 31, 2025 (three years). Award recipients will receive the full award amount in the first year of the three-year period of performance, and must allocate the funding across each of the three years. Additionally, recipients must submit a budget and budget narrative for each of the three years of the period of performance. While you must distribute the funding across each of the three years, the budget does not need to be evenly split across the three-year period of performance, and can vary based on your community's needs.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at 45 CFR part 75.

III. Eligibility Information

1. Eligible Applicants

Applicant Organization Specifications

Eligible applicants include all domestic public or private, non-profit or for-profit entities, including faith-based and community-based organizations, tribes, and tribal organizations. In addition to the 50 U.S. states, organizations in the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated State of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau may apply.

The applicant organization may be located in an urban or rural area and should have the staffing and infrastructure necessary to oversee program activities, serve as the fiscal agent for the award, and ensure that local control for the award is vested in the targeted rural communities.

Service Delivery Specifications

All planned activities supported by this program **must exclusively target and be located in HRSA-designated rural counties and rural census tracts, as defined by the HRSA Rural Health Grants Eligibility Analyzer.** Within partially rural counties, **only** HRSA-designated rural census tracts are eligible to receive activities and services supported by this award.

NOTE: Beginning with FY 2022 grants, FORHP has modified its list of areas eligible for Rural Health funding. No areas were removed from the prior listing but 295 outlying Metro counties are now considered fully rural. Applicants can check the Rural Health Grants Eligibility Analyzer or the List of Rural Census Tracts document to determine eligibility status of an address or county.

While all service delivery sites supporting RCORP-Implementation projects must be exclusively located in HRSA-designated rural areas, given the shortage of service delivery sites in HRSA-designated rural areas, some exceptions apply in the specific instances listed below. In order to qualify for one of these exceptions, the applicant must establish that the non-rural service delivery site is a primary service provider for the target rural service area and that the delivery site will directly contribute to building health service delivery infrastructure within the target rural service area (see Attachment 9 for additional instructions on submitting required documentation for these exceptions).

- Critical Access Hospitals (CAHs) that are not located in HRSA-designated rural areas.
- Entities eligible to receive Small Rural Hospital Improvement (SHIP) funding and that are not located in HRSA-designated rural areas. Eligible entities under this exception include hospitals that are non-federal, short-term general acute care and that: (i) are located in a rural area as defined in 42 U.S.C. 1395ww(d) and (ii) have 49 available beds or less, as reported on the hospital's most recently filed Medicare Cost Report.
- Entities that are located in urban areas of partially rural counties in their target service area if the service delivery site is located in an incorporated city, town, or village, or unincorporated census-designated place (CDP), with 49,999 or fewer people.
- Telehealth service delivery sites located in an urban facility, but exclusively serving patients in HRSA-designated rural areas

Consortium Specifications

HRSA requires that applicants be part of broad, multi-sectoral consortia comprised of the following:

- At least four or more separately owned entities, including the applicant organization. The entities should all have different EINs and have established working relationships. Tribal applicants may be eligible for an exception to the EIN requirement, as described in the Eligibility section.
- At least 50 percent, of members in each consortium must be located within HRSA-designated rural areas or census tracts, as defined by the **HRSA Rural Eligibility Analyzer.** Applicants must provide a single letter of commitment signed by **all consortium members reflected in the proposed work plan.** See Attachment 3 for additional information.
- Members from multiple sectors and/or disciplines that have a demonstrated history of collaborating to address SUD/OUD in a rural area. Applicants are encouraged to incorporate individuals and community sectors particularly affected by SUD/OUD, including health and social service organizations, employers, individuals in recovery, law enforcement and first responders, teachers and school systems, child welfare agencies, etc.
    - Note while individuals may be included as consortium members, there must also be at least four separately owned **entities/organizations** to meet HRSA's required consortium specifications. See **Appendix C** for a non-exhaustive list of potential consortium partners.

If awarded, recipients must notify consortium members who will be serving as subcontractors/subrecipients that they must be registered in SAM.

NOTE: HRSA is aware that tribes and tribal governments may have an established infrastructure without separation of services recognized by filing for EINs. In the case of tribes and tribal governments, only a single EIN located in a HRSA designated rural area is necessary for eligibility as long as the EIN is associated with an entity located in a HRSA-designated rural area. **Tribes and tribal entities under the same tribal governance must still meet the consortium criteria of four or more entities committed to the proposed approach**

FY 2020 and FY 2021 RCORP-Implementation Award Recipients and Consortium Members:

Applicants that are FY 2020 or FY 2021 RCORP-Implementation award recipients and/or Consortium Members are ONLY eligible to apply for this funding opportunity if they meet the following conditions:

1. **Target Geographic Rural Service Area:** The target geographic rural service area proposed in this application does not overlap **at all** with the one currently served by the consortium for the FY 20 or FY 21 RCORP-Implementation award and all proposed services are delivered in the new target rural service area. FY

2020 and FY 2021 RCORP-Implementation award recipients and/or consortium members should demonstrate they meet these conditions in **Attachment 7**; **and**

2. **Consortium Membership:** At least 50 percent of the consortium members proposed in this application are physically located in the new service area and are signatories to the letter of commitment (**Attachment 3**).

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

HRSA may not consider an application for funding if it contains any of the non-responsive criteria below:

- Exceeds the ceiling amount;
- Fails to satisfy the deadline requirements referenced in Section IV.4; and/or
- Exceeds the page limit (80 pages).

HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, before the Grants.gov application due date as the final and only acceptable application.

NOTE: Organizations may not serve as the applicant organization on more than one FY 2022 RCORP-Implementation application. Only one application can be associated with an EIN.

- **Exception to Multiple Submissions Policy:** In general, multiple applications associated with the same EIN are not allowable. However, HRSA recognizes a growing trend towards greater consolidation within the rural health care industry and the possibility that multiple organizations with the same EIN could be located in **different** rural service areas that have a need for SUD/OUD services. **Therefore, at HRSA's discretion, separate applications associated with a single EIN may be considered for this funding opportunity if the applicants provide HRSA with the following information in Attachment 8**:

    1. Names, street addresses, and EINs of the applicant organizations;
    2. Name, street address, and EIN of the parent organization;
    3. Names, titles, email addresses, and phone numbers for points of contact at each of the applicant organizations and the parent organization;
    4. Proposed RCORP-Implementation service areas for each applicant organization (these should not overlap);

5. Justification for why each applicant organization must apply to this funding opportunity separately as the applicant organization, as opposed to serving as consortium members on other applications;
6. Assurance that the applicant organizations will each be responsible for the planning, program management, financial management, and decision making of their respective programs, independent of each other and/or the parent organization; and
7. Signatures from the points of contact at each applicant organization and the parent organization.

Applications associated with the same EIN must be independently developed and written. HRSA reserves the right to deem applications that provide insufficient information in **Attachment 8** to be ineligible. In this instance, assuming all other eligibility criteria are met, HRSA will only accept the last validated electronic submission associated with the EIN.

Note that this exception does not apply to a single organization (e.g., a parent organization/headquarters) that wants to apply more than once for this funding opportunity on behalf of its satellite offices or clinics.

If multiple entities that share an EIN apply for this funding opportunity, the applicant organization names (as reflected in Box 8A of the SF-424 Application Page) should be different and reflect the names of the satellite offices/clinics. If HRSA receives multiple FY 2022 RCORP-Implementation applications with the same applicant organization name (as reflected in Box 8A of the SF-424 Application Page), only the last submitted and validated application will be reviewed.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** you to apply electronically. HRSA encourages you to apply through Grants.gov using the SF-424 workspace application package associated with this notice of funding opportunity (NOFO) following the directions provided at http://www.grants.gov/applicants/apply-for-grants.html.

The NOFO is also known as "Instructions" on Grants.gov. You must select "Subscribe" and provide your email address for HRSA-22-057 in order to receive notifications including modifications, clarifications, and/or republications of the NOFO on Grants.gov. You will also receive notifications of documents placed in the RELATED DOCUMENTS tab on Grants.gov that may affect the NOFO and your application. *You are ultimately responsible for reviewing the For Applicants page for all information relevant to this NOFO.*

2. Content and Form of Application Submission

Application Format Requirements
Section 4 of HRSA's *SF-424 Application Guide* provides general instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, etc. You must submit the information outlined in the HRSA *SF-424* Application Guide in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide* except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the *HRSA SF-424 Application Guide* for the Application Completeness Checklist.

Application Page Limitation
The total size of all uploaded files included in the page limit may not exceed the equivalent of **80 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. Please note: If you use an OMB-approved form that is not included in the workspace application package for HRSA-22-057, it may count against the page limit. Therefore, we strongly recommend you only use Grants.gov workspace forms associated with this NOFO to avoid exceeding the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit.

It is the responsibility of the applicant to take appropriate measures to ensure your application does not exceed the specified page limit.

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1) You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3321).
3) If you are unable to attest to the statements in this certification, you must include an explanation in *Attachments 10-15: Other Relevant Documents*.

See Section 4.1 viii of HRSA's *SF-424 Application Guide* for additional information on all certifications.

Program Requirements and Expectations

HRSA requires that applicants be part of a broad, multi-sectoral consortia. For the purposes of RCORP-Implementation, a consortium is an organizational arrangement among four or more separately owned domestic public or private entities, including the applicant organization, with established working relationships. The entities, including the applicant organization, must all have different Employment Identification Numbers (EINs).[9]

HRSA expects that consortia funded by RCORP-Implementation will sustain the SUD/OUD-related services in rural areas made possible by this funding opportunity both during and beyond the period of performance. Over the course of the three-year period of performance, RCORP-Implementation award recipients will complete detailed plans for sustaining their consortia and SUD/OUD services beyond the RCORP-Implementation period of performance.

Finally, RCORP-Implementation award recipients are expected to work closely with a HRSA-funded technical assistance (TA) provider throughout the three-year period of performance. Targeted TA is provided to each award recipient at no additional cost, and is intended to help recipients achieve desired project outcomes, sustain services, align their performance reporting/evaluative activities, implement quality improvement efforts, and overcome challenges to project implementation. HRSA will provide more information about TA support upon receipt of award.

Program-Specific Instructions

In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 Application Guide* (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), include the following:

Core Activities

Over the course of the three-year period of performance, consortia must implement **all core activities** described below, which are aimed at improving health care in HRSA-designated rural areas. If a consortium is already implementing one or more of the core activities within the service area, applicants may propose to expand or enhance those activities.

Note: Applicants must make progress on each core activity in every year of the grant. Consortium members do not have to complete all required core activities individually, nor do all core activities have to be implemented in every part of the target rural service area. Implementation of the core activities should reflect the demonstrated needs and capacity of the target rural service area.

Foundational Core Activities

[9]Tribal entities may be exempt from this requirement. Please reference Eligible Applicants for more information.

- Track and collect aggregate data and other information from consortium members to fulfill HRSA reporting requirements, and use this data to support continuous improvement of services and activities.
- Develop processes for achieving financial and programmatic sustainability beyond the period of performance, including (but not limited to) training providers, administrative staff, and other relevant stakeholders to optimize reimbursement for clinical encounters through proper coding and billing across insurance types.
- Address the SUD-related needs of populations that have historically suffered from poorer health outcomes or health disparities, as compared to the rest of the target rural population. Examples of these populations include, but are not limited to, persons/people experiencing homelessness, racial and ethnic minorities, people who are pregnant, adolescents and youth, LGBTQ individuals, the elderly, individuals with disabilities, etc.
- Leverage partnerships at the local/community, state, and regional levels, including with rural counties and municipalities, health plans, law enforcement, community recovery organizations, faith-based organizations, and others to secure buy-in for the proposed project and ensure that it complements (versus duplicates) existing SUD/OUD resources.

Prevention Core Activities

- Support culturally and linguistically appropriate substance use prevention activities and evidence-based programs, delivered in diverse environments (e.g., schools, community centers) and to diverse participants.
- Increase access to naloxone within the target rural service area and provide training on overdose prevention and naloxone administration for community members likely to respond to an overdose.
- Train community members and other stakeholders on safe storage and disposal of prescription drugs with potential for misuse.
- Identify and screen individuals at risk for SUD/OUD and co-occurring disorders disorders/infectious complications (including HIV, viral hepatitis, mental illness, etc.), and provide, or make referrals to, prevention, harm reduction, early intervention, treatment, and other support services.
- Train and strengthen collaboration with and between law enforcement and first responders to enhance their capability of responding and/or providing emergency treatment to those with SUD/OUD.

Treatment and Recovery Core Activities

- Recruit, train, mentor, and retain interdisciplinary teams of clinical and social service providers, to support an integrated approach to SUD/OUD treatment, including evidence-based behavioral therapy (e.g., cognitive behavioral therapy, community reinforcement approach, etc.), U.S Food and Drug Administration-approved pharmacotherapy (e.g., buprenorphine, naltrexone), and any other necessary supportive services. This activity must include providing support to providers who are seeking DATA 2000 waivers.
- Create community linkages and referral systems for a seamless entry into MAT/SUD treatment from primary care, emergency departments, law enforcement/first responders, community-based organizations, social service organizations, etc.
- Ensure linkages to and coordination with home and community-based social services (such as case management, housing, employment, food assistance, transportation, etc.) to support individuals in recovery, including those discharged from inpatient treatment facilities and/or the criminal justice system.
- Expand the peer workforce to provide support in various settings, including hospitals, emergency departments, law enforcement departments, jails, SUD/OUD treatment programs, and in the community.
- Support the development of recovery support services such as recovery community organizations, recovery homes, mutual aid groups, and other recovery resources and infrastructure to expand the availability of and access to recovery support services.

Additional Activities

If capacity exists, award recipients may use funding to implement additional activities that strengthen the consortium's ability to deliver prevention, treatment, and/or recovery services for SUD/OUD that improve health care in their service area. Applicants must provide detailed descriptions of all additional activities in the Project Narrative, as well as justifications for how those activities will advance RCORP-Implementation's goal and fulfill the needs of the target population. No funding priority or preference is associated with proposing additional activities. Please see **Appendix D** for a non-exhaustive list of allowable additional activities

Requirements for Service Provision

All activities funded by this award must exclusively occur in HRSA-designated rural areas, as defined by the Rural Health Grants Eligibility Analyzer. Please note the exceptions under Eligible Applicants. Additionally, RCORP-Implementation is a payer of last resort, and award recipients should bill for all services covered by a reimbursement plan and make every reasonable effort to obtain payments. At the same time, award recipients may not deny services to any individual because of an inability to pay.

Services should aim to eliminate pre-requisites to entering MAT, be individualized to the needs and circumstances of the patient, promote retention in treatment, recognize the need to manage recurrence of substance use and address ambivalence in patient motivation.

Target Population

The target population for this award are: 1) individuals who are at risk for, have been diagnosed with, and/or are in treatment and/or recovery for OUD; 2) their families and/or caregivers; and 3) other community members[10] who reside in HRSA-designated rural areas, as defined by the Rural Health Grants Eligibility Analyzer.

Applicants are encouraged to focus on rural populations that have historically suffered from poorer health outcomes, health disparities, and other inequities, as compared to the rest of the target population, when addressing SUD in the proposed service area. Examples of these populations include, but are not limited to, racial and ethnic minorities, people/persons experiencing homelessness, pregnant women, youth and adolescents, etc.

i. Project Abstract

Use the Standard OMB-approved Project Abstract Summary Form 2.0 that is included in the workspace application package. Do not upload the abstract as an attachment or it will count toward the page limitation. For information required in the Project Abstract Summary Form, see Section 4.1.ix of HRSA's *SF-424 Application Guide.*

Please include the following information in your abstract:

1. Project Title
2. Requested Award Amount
3. Applicant Organization Name
4. Applicant Organization Address
5. Applicant Organization Facility Type (e.g., Rural Health Clinic, Critical Access Hospital, Tribe/Tribal Organization, Health System, Institute of Higher Learning, Community-based Organization, Foundation, Rural Health Network, etc.)
6. Project Director Name and Title
7. Project Director Contact Information (phone and email)
8. Are you a current FY20 or FY21 RCORP-Implementation award recipient?
9. EIN Exception Request in **Attachment 8**? (Y/N) - Note: HRSA reserves the right to deem applications that provide insufficient information in **Attachment 8**, or are nearly identical in content, to be ineligible. In this instance, assuming all other eligibility criteria are met, HRSA will only accept the last submitted application associated with the EIN.
10. How the Applicant **First** Learned About the Funding Opportunity (**select one**: State Office of Rural Health, HRSA News Release, Grants.gov, HRSA Project

[10] Applicants are encouraged to include individuals in the community who are involved in improving health care in rural areas.

Officer, HRSA Website, Technical Assistance Provider, State/Local Health Department)

11. Number of Consortium Members & List of Consortium Members
12. Previous or Current RCORP Award Recipient? (**specify:** FY18 RCORP-Planning Applicant Organization; FY18 RCORP-Planning Consortium Member; FY19 RCORP-Planning Applicant Organization; FY19 RCORP-Planning Consortium Member; FY20 RCORP-Planning Application Organization; FY20 RCORP-Planning Consortium Member; FY19 RCORP-MAT Expansion; FY19 RCORP- Implementation Applicant Organization; FY19 RCORP-Implementation Consortium Member, FY20 RCORP-Implementation Applicant Organization; FY20 RCORP-Implementation Consortium Member; FY 21 RCORP- Implementation Applicant Organization; FY21 RCORP-Implementation Consortium Member; FY20 RCORP-NAS Applicant Organization; FY20 RCORP-NAS Consortium Member; FY21 RCORP-Psychostimulant Support Applicant Organization; FY21 RCORP-Psychostimulant Support consortium member)
13. Brief Description of the Target Population
    - Indicate approximately what percentage (if any) of the target population is American Indian/Alaskan Native;
    - If applicable, provide 2-3 sentences regarding how this project specifically targets tribal populations;
    - If applicable, provide 2-3 sentences regarding how this project will target populations who have historically suffered from poorer health outcomes or health disparities, as compared to the rest of the target rural population (e.g., racial/ethnic minorities; persons/people experiencing homelessness; veterans; etc.).
14. Target Service Area (**must be exclusively rural, as defined by the Rural Health Grants Eligibility Analyzer**)
    - Fully Rural Counties: Provide the county name and state
    - Partially-Rural Counties: Provide county name, state, **and** the rural census tract (**list of rural census tracts**)
15. Does target service area overlap with an existing FY 19 or FY 20 RCORP-Implementation award recipient's service area? (Y/N)

NARRATIVE GUIDANCE

To ensure that you fully address the review criteria, the table below provides a crosswalk between the narrative language and where each section falls within the review criteria. Any forms or attachments referenced in a narrative section may be considered during the objective review.

Narrative Section	Review Criteria
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response
Work Plan	(2) Response
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures and (4) Impact
Organizational Information	(3) Evaluative Measures and (5) Resources/Capabilities
Budget Narrative	(6) Support Requested - the budget narrative section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

ii. Project Narrative

This section provides a comprehensive description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments, and organized in alignment with the sections and format below so that reviewers can understand the proposed project.

Use the following section headers for the narrative:

- *INTRODUCTION -- Corresponds to Section V's Review Criterion #1 – "Need"*

  This section should clearly and succinctly summarize the overarching goals of the proposed project. In particular, you should provide a description of the target rural service area counties and/or rural census tracts; the characteristics and needs of the target population and service area; the consortium's proposed approach to meeting those needs; and the consortium's history of collaborating to address SUD/OUD in rural areas and capacity to implement the proposed project.

- *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion #1 – "Need"*

  Describe, in detail, the needs of the target rural population as they relate to the core activities and any additional proposed activities. Provide supporting data and statistics from appropriate sources (e.g., local, state, tribal, and federal) that reflects the most recent timeframe available. Where possible, compare the data for the target rural population to regional, statewide, and/or national data to

demonstrate need. Please cite the data sources (including year) you use to provide this data.

Applicants encountering difficulty obtaining data are encouraged to contact their state or local health departments and/or refer to data and information provided by the Rural Health Information Hub and the Opioid Misuse Community Assessment Tool developed by NORC at the University of Chicago. If you are still unable to locate appropriate and accurate data, please provide an explanation for why the data could not be found and how you will leverage the RCORP-Implementation award to strengthen the quality and availability of OUD/SUD data in your target rural service area.

Specifically, the Needs Assessment section should include detailed, quantitative descriptions of the following:

- The target rural population, including demographic and social determinants of health indicators;
    - Describe the extent to which the population you propose to serve includes subpopulations that have historically suffered from poorer health outcomes, health disparities, and other inequities compared to the rest of the target population. Examples of these populations include, but are not limited to, persons/people experiencing homelessness, racial and ethnic minorities, people who are pregnant, adolescents and youth, LGBTQ individuals, the elderly, individuals with disabilities, etc.
    - Describe which segments of the target rural population are most at risk for, and/or are most likely to be diagnosed with, OUD. This may include certain age groups, racial/ethnic groups, persons/people experiencing homelessness, etc.
- The prevalence and impact of SUD/OUD in the target rural service area. Examples can include, but are not limited to, the number/ percentage of children in the foster care system as a result of their caregivers' OUD; number of individuals with infectious complications as a result of OUD; the number of SUD/OUD hospitalizations and/or emergency room visits; etc.
- Overview of existing SUD/OUD-related prevention, treatment, and recovery support services in the target rural service area, including any federal, state, or locally funded SUD/OUD initiatives such as other RCORP projects.
    - Please reference the RCORP website for a list of RCORP award recipients in each program—Planning, Implementation, Neonatal Abstinence Syndrome, and MAT Expansion—as well as this table of RCORP award recipient service areas for more information.
- SUD/OUD-related health care needs and gaps in prevention, treatment, and recovery services in the **target rural service area**.

- *METHODOLOGY -- Corresponds to Section V's Review Criterion #2 – "Response"*

The Methodology Section should provide clear, actionable strategies for how you will achieve each of the core activities. Your methodology should directly link to and reflect the data and information provided in the "Needs Assessment" section of the Project Narrative.

The methodology should include a thorough, detailed explanation of how you will achieve each core activity and how you will collaborate, and not duplicate, existing OUD/SUD programming in the target rural service area, including other RCORP awards. In addition, the methodology should also address the following for each set of core activities:

Foundational Core Activities

Explain in detail how your proposed approach to achieving the foundational core activities will improve health care in the target rural area and:

- Support consortium members to ensure that they are able to collect and report accurate, reliable data to fulfill HRSA reporting requirements. Examples can include, but are not limited to, providing financial support to consortium members to strengthen their capacity to track and report data, and/or designating an individual at each consortium member organization who will be responsible for reporting that organization's data to the applicant organization (in addition to the required Data Coordinator described in the Staffing Plan);
- Ensure that all activities and services complement, and do not duplicate, any existing initiatives and efforts in the target rural service area.
- Utilize the data collected as part of HRSA's reporting requirements to inform and improve the project's activities and service delivery;
- Ensure that activities and services are sustainable beyond the period of performance, particularly for underinsured/uninsured populations, and for those populations that have historically suffered from poorer health outcomes or health disparities, as compared to the rest of the target rural population (examples of these populations include, but are not limited to, persons/people experiencing homelessness, racial and ethnic minorities, people who are pregnant, adolescents and youth, LGBTQ individuals, the elderly, individuals with disabilities, etc.);
- Sustain consortium membership beyond the period of performance;
- Secure target population support and engagement; and
- Ensure that proper coding and billing across insurance types is implemented across the consortium and that billing/coding information/education is available to other key service providers in the target rural service area, as needed.

Prevention Core Activities

Explain in detail how your proposed approach to achieving the prevention core activities will improve health care in the target rural area and will:

- Directly address the demonstrated need of the target rural service area;
- Improve family members', caregivers', and the public's understanding of evidence-based prevention, treatment, and recovery strategies for SUD/OUD,
- Reduce stigma associated with SUD/OUD;
- Reach populations that have historically suffered from poorer health outcomes or health disparities, as compared to the rest of the rural population. Examples of these populations include, but are not limited to, persons/people experiencing homelessness, racial and ethnic minorities, people who are pregnant, adolescents and youth, LGBTQ individuals, the elderly, individuals with disabilities, etc.
- Ensure that those who are most likely to witness an overdose are prepared to respond;
- Minimize the potential for the development of SUD/OUD; and,
- Minimize the potential for those with SUD/OUD to develop infectious complications or other co-occurring disorders.

Treatment and Recovery Core Activities

Explain in detail how your proposed approach to achieving the treatment and recovery core activities will improve health care in the target rural area and will:

- Reduce stigma and other barriers to care;
- Enable individuals, families, and caregivers to find, access, and navigate evidence-based, affordable treatments for SUD/OUD;
- Support integration of health care delivery and social service entities for seamless, coordinated, whole-person-oriented care;
- Ensure access to care and supportive services for populations that have historically suffered from poorer health outcomes or health disparities, as compared to the rest of the rural population. Examples of these populations include, but are not limited to, persons/people experiencing homelessness, racial and ethnic minorities, people who are pregnant, adolescents and youth, LGBTQ individuals, the elderly, individuals with disabilities, etc.

Additional Activities (if applicable)

- If proposing additional activities, you must provide a detailed description of the activities, clearly justify why they are needed, and explain how they will improve health care in the target rural area and benefit the target population.

- *WORK PLAN -- Corresponds to Section V's Review Criterion #2 – "Response"*

This section describes the processes that you will use to achieve the strategies in the "Methodology" section. Note that while the "Methodology" section of the Project Narrative centers on the overall strategy for fulfilling the core/additional activities, the work plan is more detailed and focuses on the tasks, activities, and timelines by which you will execute your strategy.

The work plan activities should align with your methodology section, and should include the following:

- Specific tasks/sub-activities that you will undertake to achieve all core activities and, if applicable, any additional activities, (as outlined in the "Program-Specific Instructions" section of this NOFO);
- Responsible individual(s) and/or consortium member(s) for each task/sub-activity;
- Timeframes to accomplish all tasks/sub-activities;
- How the proposed task/sub-activity will improve the health care delivery system in the target rural service area;
- Any products/deliverables associated with each task/required core activity/ additional activity.

The work plan must reflect a three-year period of performance. Each task/activity in the work plan should have beginning and completion dates. It is not acceptable to list "ongoing" as a timeframe. Note that while award recipients should make progress towards completing each core activity during each year of the award, activities do not need to be **completed** until the end of the three-year period of performance.

Please provide your work plan in **Attachment 1.** (It is appropriate to refer reviewers to **Attachment 1** in this section instead of including the work plan twice in the application.)

It is strongly encouraged that you provide your work plan in a table format and that you clearly delineate which tasks/deliverables/sub-activities correspond to which core and/or additional activities.

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion #2 – "Response"*

  Describe challenges that your consortium is likely to encounter in implementing the proposed work plan and the approaches you will use to resolve each challenge. You should highlight both internal challenges (e.g., maintaining cohesiveness among consortium members) and external challenges (e.g., stigma around SUD/OUD in the target rural service area, securing patient engagement in treatment, geographical limitations, policy barriers, etc.). **You must detail potential challenges to sustaining services after the period of performance ends and how your consortium intends to overcome them.**

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion(a) #s 3 and 4 – "Evaluative Measures" and "Impact"*

  Describe the process (including staffing and workflow) for how you will track, collect, aggregate, and report data and information from all consortium members to fulfill HRSA reporting requirements. **You must clearly demonstrate how the applicant organization will support and enable consortium members to collect accurate data in response to HRSA reporting requirements.** Examples include, but are not limited to, allocating a portion of award funding to each consortium member to support data collection, and/or designating an individual at each member organization who will be responsible for collecting and reporting the HRSA-required data to the application organization.

  Applicants should also demonstrate that the consortium has the capacity and is committed to working with a HRSA-funded evaluator to take part in a larger, RCORP-wide evaluation. Finally, applicants should clearly describe their plan for updating participating entities, the target rural service area, and the broader public on the program's activities, lessons learned, and success stories. You should provide examples of mediums and platforms for disseminating this information.

  It is the applicant organization's responsibility to ensure compliance with HRSA reporting requirements. Applicants should make every reasonable effort to track, collect, aggregate, and report data and information from all consortium members throughout the period of performance. Finally, consortium members should commit to sharing aggregate (**not** patient-level or other personally identifiable information) performance data and information with the applicant organization to fulfill HRSA reporting requirements in the signed Letter of Commitment (**Attachment 3)**.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion #s 3 and 5 – "Evaluative Measures" and "Resources and Capabilities"*

  This section provides insight into the organizational structure of the consortium and the consortium's ability to implement the activities outlined in the work plan. See the Program-Specific Instructions and the Eligibility sections for additional information on consortium requirements and specifications.

NOTE: It is appropriate to refer reviewers to the relevant attachment(s) in this section instead of including the information twice in the application.

Applicants should include the following information:

Consortium Membership (Attachment 2)

For each member of the consortium reflected on the proposed work plan, including the applicant organization, include the following information. It is **highly encouraged** that you provide this information in a table format.

- Organization (or individual) name;
- Street address;
- Contact information (Consortium member representative's name, title, email);
- EIN (tribal entities may be exempt from this requirement; for individuals, indicate N/A);
- Service delivery sites (street address, including county) where services supported by the RCORP-Implementation award will be administered;
- Sector represented (e.g., health care, public health, education, law enforcement, tribal entity, etc.);
- Current and/or previous RCORP awards received (list award name, year, and whether the entity served as the applicant organization or consortium member);
- Specify (yes/no) whether consortium member is a National Health Service Corps (NHSC) site or NHSC–eligible site (see https://nhsc.hrsa.gov/sites/eligibility-requirements.html for more details);
- Specify (yes/no) whether consortium member is located in a HRSA-designated rural county or rural census tract of an urban county, as defined by the Rural Health Grants Eligibility Analyzer; and
- Specify (yes/no) whether consortium member has signed the Letter of Commitment (**Attachment 3**).

Consortium Letter of Commitment (Attachment 3)

All consortium members reflected in the proposed work plan, including the applicant organization, must sign and date a **single** letter of commitment (**Attachment 3**) that delineates the expertise, roles, responsibilities, and commitments of each consortium member. At least 50 percent of signatories must be physically located in HRSA-designated rural areas, as defined by the Rural Health Grants Eligibility Analyzer. Consortium members must represent diverse sectors and disciplines. Electronic signatures are acceptable. If you are unable to obtain a given signature, please provide a brief explanation why.

The letter of commitment must identify each consortium member organization's roles and responsibilities in the project, the activities in which they will be included, how the organization's expertise is pertinent to the project, and the length of commitment to the project. The letter must also include statements indicating that:

- Consortium members understand that the RCORP-Implementation award is to be used for the activities proposed in the work plan;

- That the activities must exclusively benefit populations in the target rural service area and that the award is not to be used for the exclusive benefit of any one consortium member; and
- A commitment to sharing accurate, aggregate (**not** patient-level or other personally identifiable information) performance data and information with the applicant organization to fulfill HRSA reporting requirements.

Stock or form letters are not recommended.

Letters of Commitment should be submitted as part of the electronic application package through Grants.gov. HRSA will not accept or consider Letters of Commitment or Support received through other means, including through the mail, e-mail, etc.

Organizational Chart (Attachment 4)

Provide a one-page organizational chart that clearly depicts the relationships and/or hierarchy among all consortium members participating in the project.

Staffing Plan (Attachment 5)

Provide a detailed and clear staffing plan that includes the following information for each proposed project staff member reflected in the proposed work plan. It is recommended that you provide this information in a table format:

- Name;
- Title;
- Organizational affiliation;
- Full-time equivalent (FTE) devoted to the project;
- Roles/responsibilities on the project; and
- Timeline and process for hiring/onboarding, if applicable.

The staffing plan should directly link to the activities proposed in the work plan. If a staff member has yet to be hired (TBH), please put "TBH" in lieu of a name and detail the process and timeline for hiring and onboarding the new staff, as well as the qualifications and expertise required by the position. All key staff associated with the project should be hired within 60 days of the project start date.

All staffing plans must include a Project Director and a Data Coordinator (although not recommended, the same individual can serve both roles):

- **Project Director:** The Project Director is the point person on the award and makes staffing, financial, and other decisions to align project activities with project outcomes. You should detail how the Project Director will facilitate collaborative input and engagement across consortium members to complete the proposed work plan during the period of performance**. The Project Director is a key staff member and an FTE of at least 0.25 is required for this position. If awarded, the Project Director is expected to attend monthly calls with HRSA/Technical Assistance team.** If the Project Director serves as a Project Director for other federal awards, please list the federal awards as well as the percent FTE for that respective federal award. Any given staff member, including the Project Director, may not bill

for more than 1.0 FTE across federal awards. **More than one Project Director is allowable in the staffing plan. However, only one Project Director can be designated in Box 8f of the SF-424 A Application Page. If awarded, this is the Project Director who will be officially reflected in the Notice of Award. If there is more than one Project Director, a total FTE of at least 0.25 between the two Project Directors is allowable.**

- **Data Coordinator:** Applicants must designate at least one individual in the staffing plan to serve as a "Data Coordinator." The Data Coordinator is responsible for tracking, collecting, aggregating, and reporting quantitative and qualitative data and information from consortium members to fulfill HRSA's quarterly and biannual reporting requirements. Though not required, this position may include analyzing the data or utilizing the data to inform process or quality improvement. There is no minimum FTE for this position.

Finally, applicants should designate staff to attend regular meetings of the FY22 RCORP-Implementation Learning Collaborative. Further details will be available upon award.

Staff Biographical Sketches (Attachment 6)

All proposed staff members should have the appropriate qualifications and expertise to fulfill their roles and responsibilities on the award. For each staff member reflected in the staffing plan, provide a brief biographical sketch (not to exceed one page per staff member) that directly links their qualifications and experience to their designated RCORP-Implementation project activities. The names reflected in the staffing plan must align with the names identified in the biographical sketches

If a staff member will serve two separate and distinct roles on the award that do not overlap, please submit two separate biosketches for that individual. Please note that the individual must not exceed 1.0 FTE.

iii. Budget

The directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions in Section 4.1.iv of HRSA's *SF-424 Application Guide* and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if HRSA selects your application for funding, you will have a well-organized plan and, by carefully following the approved plan, may avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) you incur to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by you to satisfy a matching or cost-sharing requirement, as applicable.

The Consolidated Appropriations Act, 2021 (P.L. 116-260), Division H, § 202 states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." See Section 4.1.iv Budget – Salary Limitation of HRSA's SF-424 Application Guide for additional information. Note that these or other salary limitations may apply in the following fiscal years, as required by law.

Indirect costs are those costs incurred for common or joint objectives, which cannot be readily and specifically identified with a particular project or program but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For some institutions, the term "facilities and administration" (F&A) is used to denote indirect costs. If your organization does not have an indirect cost rate, you may wish to obtain one through HHS's Cost Allocation Services (CAS) (formerly the Division of Cost Allocation (DCA)). Visit CAS's website to learn more about rate agreements, the process for applying for them, and the regional offices, which negotiate them. If indirect costs are included in the budget, attach a copy of the indirect cost rate agreement. If the indirect cost rate agreement is required per the NOFO, it will not count toward the page limit. Any non-federal entity that has never received a negotiated indirect cost rate, (except a governmental department or agency unit that receives more than $35 million in direct federal funding) may elect to charge a de minimis rate of 10 percent of modified total direct costs (MTDC) which may be used indefinitely. If chosen, this methodology once elected must be used consistently for all federal awards until such time as a non-federal entity chooses to negotiate for a rate, which the non-federal entity may apply to do at any time.

In addition, RCORP-Implementation requires the following:

1. **Technical Assistance Workshop:** Applicants should budget for two individuals to travel **annually** to a workshop. The workshop will likely be located in the Washington, DC area. If funded, more information will be provided upon receipt of award. Project officers will work with award recipients to make any budget adjustments if necessary once the details of these meetings are finalized.

iv. Budget Narrative

See Section 4.1.v. of HRSA's *SF-424 Application Guide*.

In addition, the RCORP Implementation program requires the following:

RCORP-Implementation award recipients will receive the full award amount in the first year, but must allocate the award funding across each year of the three-year period of performance. Applicants are required to submit a budget and budget narrative for each of the three years of the grant.

Reminder: The Budget, SF-424A, and Budget Narrative amounts must align and cannot exceed the budget ceiling amount.

v. Attachments

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limitation.** Your indirect cost rate agreement and proof of non-profit status (if applicable) will not count toward the page limitation. **Clearly label each attachment**. You must upload attachments into the application. Any *hyperlinked* attachments will *not* be reviewed/opened by HRSA.

Attachment 1: Work Plan

Attach the work plan for the project that includes all information detailed in Section IV.2.ii. Project Narrative

Attachment 2: Consortium Membership

Attach the information for each consortium member detailed in the work plan (see Section IV.2.ii. Project Narrative). As a reminder, the consortium must consist of at least four separately owned entities (i.e., different EINs), including the applicant organization, and a majority (or at least 50 percent) must be located in a HRSA-designated rural area, as defined by the Rural Health Grants Eligibility Analyzer.

Attachment 3: Letter of Commitment

Attach a **single** letter of commitment signed by **all consortium members reflected in the proposed work plan**, including the applicant organization that delineates the expertise, roles, responsibilities, and commitments of each consortium member. At least 50 percent of signatories must be physically located in HRSA-designated rural areas, as defined by the Rural Health Grants Eligibility Analyzer. Electronic signatures are acceptable. If you are unable to obtain a given signature, please provide a brief explanation why.

The letter of commitment must identify each consortium member organization's roles and responsibilities in the project, the activities in which they will be included, how the organization's expertise is pertinent to the project, and the length of commitment to the project. The letter must also include a statement indicating that consortium members understand that the RCORP-Implementation award is to be used for the activities proposed in the work plan; that the activities must exclusively benefit populations in the target rural service area; and that the award is not to be used for the exclusive benefit of any one consortium member. Finally, consortium members should commit to sharing aggregate (**not** patient-level or other personally identifiable information) performance data and information with the applicant organization to fulfill HRSA reporting requirements. Stock or form letters are not recommended.

Attachment 4: Organizational Chart

Attach the one-page organizational chart in accordance with the instructions provided in Section IV.2.ii. Project Narrative.

Attachment 5: Staffing Plan

Attach the staffing plan that includes all of the information detailed in Section IV.2.ii. Project Narrative. As a reminder, all staffing plans should include a Project Director and a Data Coordinator position (the same individual may serve both roles).

Attachment 6: Staff Biographical Sketches

Attach brief biographical sketches (not to exceed one page per staff member) for each of the staff members listed on the staffing plan in accordance with the instructions provided in Section IV.2.ii. Project Narrative.

Attachment 7: Other RCORP Awards (if applicable)

Provide the following information for each additional past or current RCORP award the applicant organization has received (it is recommended you provide this information in a table format):

- Name of RCORP award (e.g., RCORP-Planning)
- Dates of award (e.g., September 30, 2018 to September 29, 2019)
- Indicate whether you serve/d as the applicant organization or consortium member
- Target rural service area for past or current RCORP award
    - For fully rural counties, list the county and state
    - For partially rural counties, list the county, state, and eligible rural census tract(s)
- Target rural service area for proposed FY 22 RCORP-Implementation award
    - For fully rural counties, list the county and state
    - For partially rural counties, list the county, state, and eligible rural census tract(s)
- List of consortium members for past or current RCORP award
- List of consortium members for proposed FY 22RCORP-Implementation award
- Detail how, if funded, activities performed under the RCORP-Implementation award will complement—and not duplicate—activities performed under current or previous RCORP awards.

Note that an applicant organization who is a current recipient of an FY20 or FY 21 RCORP-Implementation award, as either the applicant organization or consortium member, is not eligible to apply for this funding opportunity unless certain criteria are met, as detailed in the Eligibility Section of this NOFO.

Attachment 8: EIN Exception Request (if applicable)

In general, multiple applications associated with the same EIN are not allowable. However, HRSA recognizes a growing trend towards greater consolidation within the rural health care industry and the possibility that multiple organizations with the same EIN could be located in different rural service areas that have a need for SUD/OUD services. **Therefore, at HRSA discretion, separate applications associated with a single EIN may be considered for this funding opportunity if the applicants provide HRSA with the following information in Attachment 8**:

1. Names, street addresses, or EINs of the applicant organizations;
2. Name, street address, or EIN of the parent organization;
3. Names, titles, email addresses, and phone numbers for points of contact at each of the applicant organizations and the parent organization;
4. Proposed RCORP-Implementation service areas for each applicant organization (these should not overlap);
5. Justification for why each applicant organization must apply to this funding opportunity separately as the applicant organization, as opposed to serving as consortium members on other applications;
6. Assurance that the applicant organizations will each be responsible for the planning, program management, financial management, and decision making of their respective projects, independent of each other and/or the parent organization; and
7. Signatures from the points of contact at each applicant organization and the parent organization.

Applications associated with the same EIN should be independently developed and written. HRSA reserves the right to deem applications that provide insufficient information in **Attachment 8**, or are nearly identical in content, to be ineligible. In this instance, assuming all other eligibility criteria are met, HRSA will only accept the last submitted application associated with the EIN.

If multiple entities that share an EIN apply for this funding opportunity, the applicant organization names (as reflected in Box 8A of the SF-424 Application Page) should be different and reflect the names of the satellite offices/clinics. If HRSA receives multiple FY 2021 RCORP-Implementation applications with the same applicant organization name (as reflected in Box 8A of the SF-424 Application Page), only the last submitted and validated application will be reviewed.

Attachment 9: Exceptions to Service Delivery Sites

All exception requests must include a statement attesting that either the non-rural service delivery site is a primary service provider for the target rural service area and that the delivery site will directly contribute to building health service delivery infrastructure within the target rural service area (e.g., by providing mentorship/training opportunities for rural providers).

a) **Critical Access Hospitals (CAHs) that are not located in HRSA-designated rural areas** must provide the six-digit CMS Certification Number/Medicare Provider Number for the relevant service delivery site(s) in **Attachment 9**. If the service delivery site has been recently designated a CAH (less than a year ago), please submit the CAH approval letter from CMS in **Attachment 9.**

b) **Entities eligible to receive Small Rural Hospital Improvement (SHIP) funding and that are not located in HRSA-designated rural areas** must provide their six-digit CMS Certification Number/Medicare Provider Number for the relevant service delivery site(s) in **Attachment 9**. Eligible entities under this exception include hospitals that are non-federal, short-term general acute care and that: (i) are located in a rural area as defined in 42 U.S.C. 1395ww(d) and (ii) have 49 available beds or less, as reported on the hospital's most recently filed Medicare Cost Report.

c) **Entities that are located in urban areas of partially rural counties in their target service area** must provide a screenshot from the census website (2010 Census) documenting that service delivery sites are located in an incorporated city, town, or village, or unincorporated census-designated place (CDP), with 49,999 or fewer people. If the applicant searches a place and it does not appear in the Quick Facts dropdown list, this means that the place has less than 5,000 residents, and therefore, the site would be eligible. In this instance, please include screenshot documentation.

Attachments 10-15: Other Documents (if applicable)

If applicable, include other relevant documents including indirect cost rate agreements, letters of support from non-consortium members, etc.

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number Transition to the Unique Entity Identifier (UEI) and System for Award Management (SAM)

You must obtain a valid DUNS number, also known as the Unique Entity Identifier (UEI), and provide that number in the application. In April 2022, the *DUNS number will be replaced by the UEI, a "new, non-proprietary identifier" requested in, and assigned by, the System for Award Management (SAM.gov). For more details, visit the following webpages: Planned UEI Updates in Grant Application Forms and General Service Administration's UEI Update.

You must register with SAM and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless you are an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or you have an exception approved by the agency under 2 CFR § 25.110(d)). For your SAM.gov registration, you must submit a notarized letter appointing the authorized Entity Administrator.

If you are chosen as a recipient, HRSA will not make an award until you have complied with all applicable SAM requirements. If you have not fully complied with the requirements by the time HRSA is ready to make an award, you may be deemed not qualified to receive an award, and HRSA may use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

Currently, the Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (https://www.dnb.com/duns-number.html)
- System for Award Management (SAM) (https://sam.gov/content/home | SAM.gov Knowledge Base)
- Grants.gov (https://www.grants.gov/)

For more details, see Section 3.1 of HRSA's *SF-424 Application Guide*.

In accordance with the Federal Government's efforts to reduce reporting burden for recipients of federal financial assistance, the general certification and representation requirements contained in the Standard Form 424B (SF-424B) – Assurances – Non-Construction Programs, and the Standard Form 424D (SF-424D) – Assurances – Construction Programs, have been standardized. Effective January 1, 2020, the forms themselves are no longer part of HRSA's application packages; instead the updated common certification and representation requirements will be stored and maintained within SAM. Organizations or individuals applying for federal financial assistance as of January 1, 2020, must validate the federally required common certifications and representations annually through SAM.gov.

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date

The due date for applications under this NOFO is *January 13, 2022 at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **3 calendar days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's *SF-424 Application Guide* for additional information.

5. Intergovernmental Review

RCORP-Implementation is subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

See Section 4.1 ii of HRSA's *SF-424 Application Guide* for additional information.

6. Funding Restrictions

You may request funding for a three-year period of performance for a ceiling amount of $1,000,000 (inclusive of direct **and** indirect costs). This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds appropriately.

The General Provisions in Division H of the Consolidated Appropriations Act, 2021 (P.L. 116-260) and Division A of the FY 2022 Extending Funding and Emergency Assistance Act (P.L. 117-43) are in effect at the time this NOFO is posted. Please see Section 4.1 of HRSA's SF-424 Application Guide for additional information. Awards will be made subsequent to enactment of the FY 2022 appropriation. The NOA will reference the FY 2022 appropriation act and any restrictions that may apply. Note that these or other restrictions will apply in the next fiscal year, as required by law.

You cannot use funds under this notice for the following purposes:

- To acquire real property;
- To purchase syringes;
- To supplant any services that already exist in the service area;
- For construction; and
- To pay for any equipment costs not directly related to the purposes of this award.

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

Be aware of the requirements for HRSA recipients and subrecipients at 2 CFR § 200.216 regarding prohibition on certain telecommunications and video surveillance services or equipment. For details, see the HRSA Grants Policy Bulletin Number: 2021-01E.

All program income generated as a result of awarded funds must be used for approved project-related activities. Any program income earned by the recipient must be used under the addition/additive alternative. You can find post-award requirements for program income at 45 CFR § 75.307.

Minor Alteration and Renovation (A/R) Costs

Minor alteration and renovation (A/R) costs to enhance the ability of the consortium to deliver SUD/OUD services are allowable, but must not exceed $200,000 total over the three-year period of performance (or 20 percent of the total award amount). Additional post-award submission and review requirements apply if you propose to use RCORP-Implementation funding toward minor A/R costs**. You may not begin any minor A/R activities or purchases until you receive HRSA approval.** You should develop appropriate contingencies to ensure delays in receiving HRSA approval of your minor

A/R plans do not affect your ability to execute work plan activities and HRSA deliverables on time.
Examples of minor A/R include, but are not limited to:

- Reconfiguring space to facilitate co-location of SUD, mental health, and primary care services teams;
- Creating space to deliver virtual care that supports accurate clinical interviewing and assessment, clear visual and audio transmission, and ensures patient confidentiality;
- Creating or improving spaces for patients to participate in counseling and group visit services, and to access and receive training in self-management tools; and
- Modifying examination rooms to increase access to pain management options, such as chiropractic, physical therapy, acupuncture, and group therapy services.

The following activities are not categorized as minor A/R:

- Construction of a new building;
- Installation of a modular building;
- Building expansions;
- Work that increases the building footprint; and
- Significant new ground disturbance.

RCORP-Implementation award funds for minor renovations may not be used to supplement or supplant existing renovation funding; funds must be used for a new project. Pre-renovation costs (Architectural & Engineering costs prior to 90 days before the budget period start date) are unallowable.

Telehealth Infrastructure

If a service delivery site is located in an urban setting, the applicant organization may use RCORP-Implementation funds to purchase telehealth infrastructure for that site if the infrastructure will exclusively be used to provide services to rurally-located facilities within the target HRSA-designated rural service area.

Mobile Units or Vehicles

Mobile units or vehicles purchased with RCORP-Implementation award funds must be reasonably priced and used exclusively to carry out award activities. Additional post-award submission and review requirements apply if you propose to use RCORP-Implementation funding toward mobile units or vehicles. You may not begin any purchases until you receive HRSA approval. You should develop appropriate contingencies to ensure delays in receiving HRSA approval of your mobile unit or vehicle purchase do not affect your ability to execute work plan activities and HRSA deliverables on time.

Participant Support Costs

Participant support costs—i.e., direct costs for items such as stipends or subsistence allowances, travel allowances, and registration fees paid to or on behalf of participants or trainees (but not employees) in connection with conferences, or training projects—are allowable costs, subject to HRSA review and approval upon receipt of award.

NOTE: For the purposes of participant support costs, “employees” refer to individuals directly employed on an hourly, salaried or employment contract basis by the applicant

organization/award recipient. Individuals employed by subcontractors, consortium members and subrecipients are not included in this definition.

Medication

Food and Drug Administration (FDA)-approved opioid agonist medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination and buprenorphine mono-product formulations) for the maintenance treatment of OUD, opioid antagonist medication (e.g., naltrexone products) to prevent relapse to opioid use, and naloxone to treat opioid overdose are all allowable costs under RCORP-Implementation.

Payer of Last Resort

If awarded, recipients may use RCORP-Implementation funding as a payer of last resort -- i.e., all services covered by reimbursement should be billed and every effort should be made to obtain payment from third-party payers. Only after award recipients receive a final determination from the insurer regarding lack of full reimbursement can the RCORP-Implementation award be used to cover the cost of services for underinsured individuals. RCORP-Implementation award funds can also be used to cover the cost of services for uninsured patients.

*RCORP-Implementation funds **cannot** be used for the following purposes:*

- To supplant existing funding sources;
- To pay down bad debt. Bad debt is debt that has been determined to be uncollectable, including losses (whether actual or estimated) arising from uncollectable accounts and other claims. Related collection and legal costs arising from such debts after they have been determined to be uncollectable are also unallowable.
- To pay the difference between the costs to a provider for performing a service and the provider's negotiated rate with third-party payers (i.e., anticipated shortfall).

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review and to assist you in understanding the standards against which your application will be reviewed. HRSA has critical indicators for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation.

These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. The entire proposal will be considered during objective review.

Six review criteria are used to review and rank RCORP-Implementation applications. Below are descriptions of the review criteria and their scoring points.

Criterion 1: NEED (20 points) – Corresponds to Section IV's "Introduction" and "Needs Assessment" sections

- The extent to which the applicant clearly outlines the project goals and anticipated outcomes of the project.
- The extent to which the applicant clearly defines and describes the target rural service area.
- The quality and relevance of the data that the applicant provides to demonstrate the target rural service area's need in the "Needs Assessment" section of the Project Narrative.
- The quality and appropriateness of the sources used to provide the data/information in the "Needs Assessment" section of the Project Narrative, **or** if the applicant is unable to locate appropriate and accurate data, the extent to which they provide an explanation for why the data could not be found and how they will leverage the RCORP-Implementation award to strengthen the quality and availability of OUD/SUD data in their target rural service area;
- The extent to which the applicant demonstrates that the target population's need for SUD/OUD prevention, treatment, and recovery services is high compared to the rest of the state, region, and/or country.
- The level of detail and clarity with which the applicant describes the target rural population, including the subpopulations most at risk for and/or most likely to be diagnosed with OUD and those who have historically suffered from poorer health outcomes, health disparities, and other inequities compared to the rest of the target population.
- The thoroughness with which the applicant details the existing SUD/OUD services in the target rural service area, including the anticipated impact the RCORP-Implementation project will have on those services.
- The thoroughness with which the applicant details the SUD/OUD needs and gaps within the target rural service area.

Criterion 2: RESPONSE (30 points) – Corresponds to Section IV's "Methodology," "Work Plan," and "Resolution of Challenges" sections

Methodology (10 points):

- The clarity and comprehensiveness of the applicant's proposed methods for fulfilling all core activities, as outlined in Section IV.2 of the NOFO.
    - If applicable, the extent to which the applicant details methods for fulfilling any additional activities and provides compelling justification for how those activities will advance RCORP's goal and fulfill the needs of the target population.
- The extent to which the proposed methods improve health care in the target rural area and:
    - Reduce stigma associated with SUD/OUD and other barriers to care;
    - Minimize the potential for developing SUD/OUD
    - Minimize the potential for individuals with SUD/OUD to develop infectious complications and other co-occurring disorders;
    - Support integration of health care delivery and social services;

  - Improve health access and reduce outcome disparities experienced by vulnerable populations within the target rural service area;
  - Secure target populations support and engagement;
  - Support the consortium's ability to report accurate, reliable data to fulfill HRSA's reporting requirements; and
  - Improve family, caregivers, and community members' understanding of SUD/OUD services and their ability to navigate SUD/OUD treatment options.
- The appropriateness of the methods proposed for fulfilling all core and additional activities given the needs and characteristics of the target population.
- The clarity and comprehensiveness of the applicant's proposed methods to ensure programmatic and financial sustainability of the proposed activities beyond the period of performance.

Work Plan (15 points):

- The clarity and completeness of the proposed work plan, including its inclusion of:
  - Responsible individuals and/or consortium members;
  - Feasible timeframes for achieving tasks/sub-activities ("ongoing" is not an acceptable timeframe);
  - Description of how each proposed task will improve health care delivery in rural areas;
  - Specific tasks/sub-activities to achieve all core activities and the deliverables associated with each core activity and, if applicable, additional activity(ies).
- The clarity with which the work plan reflects a three-year period of performance;
- The comprehensiveness and feasibility of the processes detailed for decreasing health access and outcome disparities within the target rural service area as identified by the applicant in the needs assessment;
- The extent to which the work plan details processes for achieving financial and programmatic sustainability beyond the period of performance, including the deliverables, responsible individuals and/or consortium members, and timelines associated with these processes; and
- The extent to which the work plan includes specific activities related to the tracking and collection of aggregate data and other information from consortium members to fulfill reporting requirements.

Resolution of Challenges (5 points):

- The clarity with which the applicant describes both internal and external challenges they are likely to face in implementing their proposed work plan, and the quality and feasibility of the solutions proposed to address them; and
- The extent to which the applicant details potential challenges and solutions to sustaining services after the period of performance ends.

Criterion 3: EVALUATIVE MEASURES (10 points) – Corresponds to Section IV's "Evaluation and Technical Support Capacity" and "Organizational Information" sections

- The clarity and comprehensiveness of the applicant's proposed processes (including staffing and workflow) for tracking, collecting, aggregating, and reporting data and information from all consortium members to fulfill HRSA reporting requirements;
- The clarity with which the applicant designates at least one qualified individual in the staffing plan (**Attachment 5**) to serve as a "Data Coordinator"; and
- The extent to which the Letter of Commitment (**Attachment 3**) contains an explicit commitment by consortium members to sharing aggregate (**not** patient-level or other personally identifiable information) performance data and information with the applicant organization to fulfill HRSA reporting requirements.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's "Evaluation and Technical Support Capacity" section

- The clarity and comprehensiveness of the applicant's proposed plan for updating participating entities, the target rural service area, and the broader public on the program's activities, lessons learned, and success stories; and
- The extent to which the applicant provides examples of mediums and platforms for disseminating this information.

Criterion 5: RESOURCES/CAPABILITIES (20 points) – Corresponds to Section IV's "Organizational Information" section

- The clarity with which the applicant demonstrates that the consortium is comprised of at least four separately owned (i.e., different EINs) entities, including the applicant organization (**see Attachment 2**);
    - **Note: Tribal applicants are exempt from this requirement (applicant organizations will indicate whether they are a tribal entity in the Project Abstract). Applicants who meet this exception should not be penalized for not meeting this criteria during the review process**
- The clarity with which the applicant demonstrates that at least 50 percent of the consortium members are physically located in HRSA-designated rural areas, as defined by Rural Health Grants Eligibility Analyzer (**see Attachment 2**);
- The clarity with which the applicant details consortium members representation of diverse sectors and disciplines;
- The clarity with which the applicant demonstrates that all services will be provided exclusively in HRSA-designated rural areas, as defined by Rural Health Grants Eligibility Analyzer or meets the exception requirements **(Attachments 9, 10,12);**
- The extent to which all consortium members reflected in the proposed work plan, including the applicant organization, have signed and dated a **single** letter of commitment (**Attachment 3**) that contains, at a minimum, the following elements:
    - Description of each consortium member organization's roles and responsibilities in the project, the activities in which they will be included, how the organization's expertise is pertinent to the project, and the length of commitment to the project;

  - A statement indicating that consortium members understand that the RCORP-Implementation award is to be used for the activities proposed in the work plan; that the activities must exclusively benefit populations in the target rural service area; and that the award is not to be used for the exclusive benefit of any one consortium member; and
  - An explicit commitment by consortium members to sharing aggregate (**not** patient-level or other personally identifiable information) performance data and information with the applicant organization to fulfill HRSA reporting requirements.
  - **Note: Tribal applicants are exempt from the four separate EINs requirement.**
- The clarity of the Organizational Chart (**Attachment 4**) and extent to which it depicts the relationships and/or hierarchy among all consortium members participating in the project.

Criterion 6: SUPPORT REQUESTED (10 points) – Corresponds to Section IV's "Budget and Budget Narrative" section

- The degree to which the estimated cost to the government for proposed award-funded activities is reasonable given the scope of work;
- The extent to which the applicant includes a budget and budget narrative for each of the three years of the award;
- The extent to which the applicant allocates the award across a three-year period of performance (i.e., the applicant should not plan to spend the entire award in the first two years); and
- The clarity and comprehensiveness of the budget narrative, including the extent to which the applicant logically documents how and why each line item request (such as personnel, travel, equipment, supplies, and contractual services) supports the goals and activities of the proposed work plan and project.

2. Review and Selection Process

The objective review process provides an objective evaluation of applications to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below. See Section 5.3 of HRSA's *SF-424 Application Guide* for more details.

3. Assessment of Risk

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory, or other requirements (45 CFR § 75.205).

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable; cost analysis of the project/program budget; assessment of your management systems, ensuring continued applicant eligibility; and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all applicable information, HRSA's approving and business management officials will determine whether HRSA can make an award, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

HRSA is required to review and consider any information about your organization that is in the Federal Awardee Performance and Integrity Information System (FAPIIS). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider your comments, in addition to other information in FAPIIS in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

HRSA will report to FAPIIS a determination that an applicant is not qualified (45 CFR § 75.212).

VI. Award Administration Information

1. Award Notices

HRSA will release the Notice of Award (NOA) on or around the start date of September 1, 2022. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's *SF-424 Application Guide*.

If you are successful and receive a NOA, in accepting the award, you agree that the award and any activities thereunder are subject to:

- all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award,
- other federal regulations and HHS policies in effect at the time of the award or implemented during the period of award, and
- applicable statutory provisions.

Accessibility Provisions and Non-Discrimination Requirements
Federal funding recipients must comply with applicable federal civil rights laws. HRSA supports its recipients in preventing discrimination, reducing barriers to care, and promoting health equity. Non-discrimination legal requirements for recipients of HRSA federal financial assistance are available at the following address: https://www.hrsa.gov/about/organization/bureaus/ocrdi#non-discrimination. For more information on recipient civil rights obligations, visit the HRSA Office of Civil Rights, Diversity, and Inclusion website.

Executive Order on Worker Organizing and Empowerment
Pursuant to the Executive Order on Worker Organizing and Empowerment, HRSA strongly encourages applicants to support worker organizing and collective bargaining and to promote equality of bargaining power between employers and employees. This may include the development of policies and practices that could be used to promote worker power. Applicants can describe their plans and specific activities to promote this activity in the application narrative.

Requirements of Subawards
The terms and conditions in the NOA apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NOA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards, and it is the recipient's responsibility to monitor the compliance of all funded subrecipients. See 45 CFR § 75.101 Applicability for more details.

Data Rights
All publications developed or purchased with funds awarded under this notice must be consistent with the requirements of the program. Pursuant to 45 CFR § 75.322(b), the recipient owns the copyright for materials that it develops under an award issued pursuant to this notice, and HHS reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use those materials for federal purposes, and to authorize others to do so. In addition, pursuant to 45 CFR § 75.322(d), the Federal Government has the right to obtain, reproduce, publish, or otherwise use data produced under this award and has the right to authorize others to receive, reproduce, publish, or otherwise use such data for federal purposes, e.g., to make it available in government-sponsored databases for use by others. If applicable, the specific scope of HRSA rights with respect to a particular grant-supported effort will be addressed in the NOA. Data and copyright-protected works developed by a subrecipient also are subject to the Federal Government's copyright license and data rights.

3. Reporting

Award recipients must comply with Section 6 of HRSA's *SF-424 Application Guide* **and** the following reporting and review activities:

a) **Progress Report**. The recipient must submit a progress report to HRSA on a **biannual** basis. These progress reports should reflect data and information from across consortium members, not just the applicant organization. These

reports should reflect award recipients' progress towards completing the core/required activities as outlined in this NOFO to ensure that continuation of the award is in the best interests of the Federal government. More information will be provided upon receipt of award.

b) **Performance Improvement Measurement System (PIMS) Reports.** The recipient must submit quantitative performance reports on a **biannual basis** to demonstrate that their project is advancing the overall goal of RCORP of strengthening and expanding prevention, treatment, and recovery services for rural individuals who misuse opioids to enhance their ability to access treatment and move towards recovery. These data should reflect the performance of all consortium members, not just the applicant organization. Performance indicators have been developed and approved for RCORP-Implementation and focus on service provision, workforce, sustainability, and demographics. As a reminder, RCORP-Implementation award recipients are expected to work with a HRSA-funded evaluator to take part in a larger, RCORP-wide evaluation. Further information will be provided upon receipt of award.

c) **Sustainability Plan.** Building off the sustainability strategies outlined in your application, award recipients will submit a sustainability plan that identifies strategies for achieving programmatic and financial sustainability beyond the period of performance and ensuring that services remain accessible and affordable to individuals who need them most, including the uninsured and the underinsured. HRSA will provide further information during the period of performance.

d) **Mental/Behavioral Health Disparities Impact Statement.** The award recipient will submit an "Impact Statement" within the first nine months of the award that describes how the consortium will reduce mental/behavioral health disparities in the target rural service area and continuously monitor and measure the project's impact on health disparities to inform process and outcome improvements. This deliverable will be modeled from the Substance Abuse and Mental Health Services Administration (SAMHSA) Disparities Impact Statement (DIS), and will entail developing a plan to improve access to care, use of service and outcomes related to behavioral health disparities of the identified subpopulation(s) within the target rural service area. The plan should identify subpopulation(s) within the target rural service area experiencing disparities, current access/use of care, capacity building needs, quality of care, prevalence of SUD and psychostimulant use. In this statement, you may be asked to include elements, including, but not limited to: (1) the number of individuals to be reached during the award 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 care, use of services, and outcomes of award activities; and (3) methods for the development of policies and procedures to ensure adherence to the National Culturally and

Linguistically Appropriate Services Standards. Further information will be provided during the period of performance.

e) **Federal Financial Report (FFR).** The FFR (SF-425) is required no later than January 30 for each budget period. The report is an accounting of expenditures under the project that year. The recipient must submit financial reports electronically. HRSA will provide more detailed information in the NOA.

f) **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in FAPIIS, as required in 45 CFR part 75 Appendix XII.

Note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at 2 CFR § 200.340 - Termination apply to all federal awards effective August 13, 2020. No additional termination provisions apply unless otherwise noted.

VII. Agency Contacts

You may request additional information and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Benoit Mirindi, PhD, MPH.
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 443-6606
Email: bmirindi@hrsa.gov

You may request additional information regarding the overall program issues and/or technical assistance related to this NOFO by contacting:

Sabrina Frost
Public Health Analyst
Attn: RCORP-Implementation
Federal Office of Rural Health Policy
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 945-5131
Email: sfrost@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International callers, please dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). Always obtain a case number when calling for support. For assistance with submitting information in the EHBs, contact the HRSA Contact Center, Monday–Friday, 7 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772 / (877) Go4-HRSA
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

VIII. Other Information

Technical Assistance

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Wednesday, November 10, 2021
Time: 12:30 – 2:00 p.m. ET
Call-In Number: 1-833-568-8864
Meeting ID: 160 852 4742
Passcode: 23233962
Weblink: https://hrsa-gov.zoomgov.com/j/1608524742?pwd=UFJvcGs5bHFiYXRkcGRleFd6REpnZz09

The webinar will be recorded. Please email ruralopioidresponse@hrsa.gov for a link to the recording.

Tips for Writing a Strong Application

See Section 4.7 of HRSA's *SF-424 Application Guide*.

Appendix A: Rural Communities Opioid Response Program (RCORP) and the National Health Service Corps (NHSC)

HRSA encourages award recipients to leverage National Health Service Corps funding to strengthen the SUD workforce in rural communities. The Further Consolidated Appropriations Act, 2021 (P.L.116-260) appropriated funding to the NHSC for the purpose of expanding and improving access to quality Opioid Use Disorder (OUD) and other SUD treatment in underserved areas nationwide. A portion of the NHSC's funding will be used for rural workforce expansion to combat the opioid epidemic, which has had a particularly significant impact on rural communities. Accordingly, the NHSC Rural Community LRP will make loan repayment awards in coordination with the Rural Communities Opioid Response Program (RCORP) initiative within the Federal Office of Rural Health Policy (FORHP).

A part of this initiative, the NHSC Rural Community Loan Repayment Program (LRP) will recruit and retain medical, nursing, and behavioral/mental health clinicians with specific training and credentials, and are part of an integrated care team, providing evidence-based SUD treatment and counselling in eligible communities of need, designated as Health Professional Shortage Areas (HPSAs). The NHSC will make awards of up to $100,000 for three years to eligible providers under the NHSC Rural Community LRP. HRSA seeks providers with Drug Addiction Treatment Act of 2000 (DATA) waivers and SUD-licensed or SUD-certified professionals to provide quality evidence-based SUD treatment health care services at SUD treatment facilities located in Health Professional Shortage Areas (HPSAs). For this initiative, the NHSC Rural Community LRP has expanded the list of eligible disciplines to include pharmacists, registered nurses, SUD counselors and nurse anesthetists. NHSC Rural Community LRP will provide a funding preference for applicants serving at rural NHSC-approved SUD treatment facilities that are RCORP Consortium member sites.

Eligibility

To be eligible for NHSC service, a provider must:

- Be a U.S. citizen or national;
- Currently work, or have accepted employment , at a rural-NHSC-approved site;
- Have unpaid government or commercial loans for school tuition, reasonable educational expenses, and reasonable living expenses, segregated from all other debts; and
- Be licensed to practice in state where the employer site is located.

Eligible Occupations

Members of the SUD integrated treatment team who qualify for NHSC SUD expansion include:

Primary Care:
Physician (MD or DO)
Nurse Practitioner
Certified Nurse-Midwife
Physician Assistant

New Program Disciplines:
Substance Use Disorder Counselors
Pharmacists
Registered Nurses
Nurse Anesthetists (RCORP NHSC LRP only)

Mental Health:
Physicians (MD or DO)
Health Service Psychologist
Licensed Clinical Social Worker
Psychiatric Nurse Specialist
Marriage and Family Therapist
Professional Counselor
Physician Assistant
Nurse Practitioners

Eligible Site Criteria
NHSC-approved sites must:

- Be located in and serve a federally designated HPSA;
- Be an outpatient facility providing SUD services;
- Utilize and prominently advertise a qualified discounted/sliding fee schedule (SFS) for individuals at or below 200 percent of the federal poverty level;
- Not deny services based on inability to pay or enrollment in Medicare, Medicaid, and Children's Health Insurance Program (CHIP);
- Ensure access to ancillary, inpatient, and specialty care;
- Have a credentialing process that includes a query of the National Practitioner Data Bank; and
- Meet all requirements listed in the NHSC Site Agreement.

For more complete information about site eligibility and the site application process, please see the NHSC Site webpage and the NHSC Site Reference Guide. For a list of current NHSC-approved sites, please see HRSA's Health Workforce Connector.

Eligible Site Types
Regular Application Process:
1. Certified Rural Health Clinics;
2. State or Local Health Departments;
3. State Prisons;
4. Community Mental Health Centers;
5. School-Based Clinics;
6. Mobile Units/Clinics;
7. Free Clinics;
8. Critical Access Hospitals (CAH);
9. Community Outpatient Facilities; and
10. Private Practices.

Newly-eligible SUD Site Types:
1. Opioid Treatment Program (OTP);
2. Office-based Opioid Agonist Treatment (OBOT); and
3. Non-Opioid SUD treatment sites.

Auto-Approval Process:
1. Federally-Qualified Health Centers (FQHC);
2. FQHC Look-Alikes;
3. American Indian Health Facilities: Indian Health Service (IHS) Facilities, Tribally Operated 638 Health Programs, and Urban Indian Health Programs);
4. Federal Prisons; and
5. Immigration and Customs Enforcement.

Please note that all NHSC sites must deliver comprehensive mental/behavioral health on an outpatient basis, with the exception of CAHs and IHS hospitals. NHSC-approved sites must provide services for free or on a SFS to low-income individuals, and:
1. Offer a full (100 percent) discount to those at or below 100 percent of the federal poverty level;
2. Offer discounts on a sliding scale up to 200 percent of the federal poverty level;
3. Use the most recent HHS Poverty Guidelines;
4. Utilize family size and income to calculate discounts (not assets or other factors); and
5. Have this process in place for a minimum of 6 months.

Note:
• A health care organization of a consortium must receive NHSC site approval prior to members of their workforce applying for NHSC Rural Community Loan Repayment Program.
• Consortium members do not receive auto-approval based on their RCORP status.

Consortium members must meet all NHSC site eligibility criteria. All NHSC sites, except SUD treatment facilities, Critical Access Hospitals and Indian Health Service Hospitals, are required to provide an appropriate set of services for the community and population they serve. NHSC-approved sites must provide services for free or on a sliding fee schedule to low-income individuals. More information can be found here.

Additional information on the SFS can be found in the recently updated SFS Information Package.

Appendix B: Resources for Applicants

Several sources offer data and information that may help you in preparing the application. Please note HRSA is not affiliated with all of the resources provided, however, you are especially encouraged to review the reference materials available at the following websites:

HRSA Resources:

- **HRSA Rural Communities Opioid Response Program (RCORP) Website**
  Provides information regarding HRSA's RCORP initiative.
  Website: https://www.hrsa.gov/rural-health/rcorp
  RCORP Technical Assistance website: https://www.rcorp-ta.org/
  RCORP-Rural Centers of Excellence on Substance Use Disorder: https://www.hrsa.gov/rural-health/rcorp/rcoe

- **HRSA Opioids Website**
  Offers information regarding HRSA-supported opioid resources, technical assistance and training.
  Website: https://www.hrsa.gov/opioids

- **HRSA Data Warehouse**
  Provides maps, data, reports and dashboard to the public. The data integrate with external sources, such as the U.S. Census Bureau, providing information about HRSA's grants, loan and scholarship programs, health centers and other public health programs and services.
  Website: https://datawarehouse.hrsa.gov/

- **Ending the HIV Epidemic: A Plan for America**
  Learn how HRSA—in conjunction with other key HHS agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA)—is supporting the President's new initiative to reduce new HIV infections by 75 percent in the next five years and by 90 percent in the next 10 years.
  Website: https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

- **UDS Mapper**
  The UDS Mapper is a mapping and decision-support tool driven primarily from data within the Uniform Data System. It is designed to help inform users about the current geographic extent of U.S. federal (Section 330) Health Center Program award recipients and look-alikes. Applicants can use this resource to locate other collaborative partners.
  Website: https://www.udsmapper.org/index.cfm

- **National Health Service Corps (NHSC)**
  HRSA's Bureau of Health Workforce administers the NHSC Loan Repayment Program, which is authorized to provide loan repayment to primary health care professionals in exchange for a commitment to serve in a Health Professional Shortage Area.

- For general information about NHSC, please visit: https://nhsc.hrsa.gov/
- For state point of contacts, please visit here: https://nhsc.hrsa.gov/sites/helpfullcontacts/drocontactlist.pdf

- **Primary Care Offices (PCOs)**
  The PCOs are state-based offices that provide assistance to communities seeking health professional shortage area designations and recruitment assistance as NHSC-approved sites. To locate contact information for all of the PCOs, visit here: https://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices

Other Resources:

- **American Society of Addiction Medicine (ASAM)**
  Offers a wide variety of resources on addiction for physicians and the public.
  Website: https://www.asam.org/resources/the-asam-criteria/about

- **Case Study: Medication Assisted Treatment Program for Opioid Addiction**
  Learn about Vermont's Hub & Spoke Model for treating opioid addiction here: http://www.astho.org/Health-Systems-Transformation/Medicaid-and-Public-Health-Partnerships/Case-Studies/Vermont-MAT-Program-for-Opioid-Addiction/

- **Centers for Disease Control and Prevention (CDC)**
  Offers a wide variety of opioid-related resources, including nationwide data, state-specific information, prescription drug monitoring programs, and other useful resources, such as the *Guideline for Prescribing Opioids for Chronic Pain*.
  Website: https://www.cdc.gov/drugoverdose/opioids/index.html

  - ***Managing HIV and Hepatitis C Outbreaks Among People Who Inject Drugs: A Guide for State and Local Health Departments (March 2018):*** https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-guide.pdf

  - **National Center for Health Statistics**
    Provides health statistics for various populations.
    Website: http://www.cdc.gov/nchs/

  - **Syringe Services Programs**
    For more information on these programs and how to submit a Determination of Need request visit here: https://www.cdc.gov/hiv/risk/ssps.html

- **Community Health Systems Development Team at the Georgia Health Policy Center**
  Offers a library of resources on topics such as collaboration, network infrastructure, and strategic planning.
  Website: http://ruralhealthlink.org/Resources/ResourceLibrary.aspx

- **Legal Services Corporation**
  Legal Services Corporation (LSC) is an independent nonprofit established by Congress in 1974 to provide financial support for civil legal aid to low-income Americans.
  Website: https://www.lsc.gov/

- **National Area Health Education Center (AHEC) Organization**
  The National AHEC Organization supports and advances the AHEC Network to improve health by leading the nation in recruitment, training and retention of a diverse health work force for underserved communities.
  Website: http://www.nationalahec.org/

- **National Association of County and City Health Officials (NACCHO)** NACCHO created a framework that demonstrates how building consortiums among local health departments, community health centers, health care organizations, offices of rural health, hospitals, nonprofit organizations, and the private sector is essential to meet the needs of rural communities.
  Website: http://archived.naccho.org/topics/infrastructure/mapp/

- **National Institutes of Health (NIH)**
  - **HEALing Communities Study:** Learn about the multi-site implementation research study launched by NIH and SAMHSA to test the impact of an integrated set of evidence-based practices across health care, behavioral health, justice, and other community-based settings.
    Website: https://heal.nih.gov/research/research-to-practice/healing-communities
  - **National Institute on Drug Abuse (NIDA):** NIDA advances science on the causes and consequences of drug use and addiction and applies that knowledge to improve individual and public health.
    Website: https://www.drugabuse.gov/about-nida

- **National Opinion Research Center (NORC) at the University of Chicago—Overdose Mapping Tool**
  NORC and the Appalachian Regional Commission have created the Overdose Mapping Tool to allow users to map overdose hotspots in Appalachia and overlay them with data that provide additional context to opioid addiction and death.
  Website: http://overdosemappingtool.norc.org/

- **National Organization of State Offices of Rural Health (NOSORH)—Toolkit**
  NOSORH published a report on lessons learned from HRSA's Rural Opioid Overdose Reversal Grant Program and compiled a number of tools and resources communities can use to provide education and outreach to various stakeholders.
  Website: https://nosorh.org/rural-opioid-overdose-reversal-program/

- **Providers Clinical Support System**
  PCSS is a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) created in response to the opioid overdose epidemic to train primary care providers in the evidence-based prevention and treatment of opioid use disorders (OUD) and treatment of chronic pain.
  Website: https://pcssnow.org/

- **Primary Care Associations (PCAs)**
  To locate contact information for all of the PCAs, visit here:
  http://www.nachc.org/about-nachc/state-affiliates/state-regional-pca-listing/

- **Rural Health Information Hub – Community Health Gateway**
  Offers evidence-based toolkits for rural community health, including systematic guides, rural health models and innovations, and examples of rural health projects other communities have undertaken.
  Website: https://www.ruralhealthinfo.org/community-health

    - **Rural Health Information Hub – Rural Response to Opioid Crisis**
      Provides activities underway to address the opioid crisis in rural communities at the national, state, and local levels across the country.
      Website: https://www.ruralhealthinfo.org/topics/opioids

    - **Rural Health Information Hub - Rural Prevention and Treatment of Substance Abuse Toolkit**
      Provides best practices and resources that organizations can use to implement substance abuse prevention and treatment programs.
      Website: https://www.ruralhealthinfo.org/toolkits/substance-abuse

- **Rural Health Research Gateway**
  Provides access to projects and publications of the HRSA-funded Rural Health Research Centers, 1997-present, including projects pertaining to substance use disorder.
  Website: http://www.ruralhealthresearch.org/

- **Substance Abuse and Mental Health Services Administration (SAMHSA)** Offers a wide variety of resources on the opioid epidemic, including data sources, teaching curriculums, evidence-based and best practices, and information on national strategies and initiatives.
  Website: https://www.samhsa.gov/

    - **SAMHSA Evidence-Based Practices Resource Center**
      Contains a collection of scientifically based resources for a broad range of audiences, including Treatment Improvement Protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources.
      Website: https://www.samhsa.gov/ebp-resource-center

    - **SAMHSA State Targeted Response to the Opioid Crisis Grants**
      This program awards grants to states and territories and aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for OUD.
      List of individual grant award activities:
      https://www.samhsa.gov/sites/default/files/grants/pdf/other/ti-17-014-opioid-str-abstracts.pdf

    - **SAMHSA State Opioid Response Grants**
      The program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs).

Website: https://www.samhsa.gov/grants/grant-announcements/ti-18-015
List of awarded states: https://www.hhs.gov/about/news/2019/09/04/state-opioid-response-grants-by-state.html

- **SAMHSA Peer Recovery Resources**
  - https://www.samhsa.gov/brss-tacs
  - https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers

- **Other Opioid Use Disorder Resources**
  - "TIP 63: Medications for Opioid Use Disorder" https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006
  - "The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder – 2020 Focused Update" https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline

- **State Offices of Rural Health (SORHs)**
  All 50 states have a SORH. These offices vary in size, scope, organization, and in services and resources, they provide. The general purpose of each SORH is to help their individual rural communities build health care delivery systems.
  List of and contact information for each SORH: https://nosorh.org/nosorh-members/nosorh-members-browse-by-state/

- **State Rural Health Associations (SRHAs)**
  To locate contact information for all of the SRHAs, visit here: https://www.ruralhealthweb.org/programs/state-rural-health-associations

- **U.S. Department of Agriculture (USDA)**
  Provides information and resources—including relevant USDA funding opportunities such as the Community Facilities Loan and Grant Program—for rural communities that want to address the opioid epidemic. Visitors can also share feedback on what prevention, treatment and recovery actions have been effective in addressing the opioid epidemic in their rural communities.
  Website: https://www.usda.gov/topics/opioids

- **U.S. Department of Labor**
  - **Federal Bonding Program:** The U.S. Department of Labor established The Federal Bonding Program in 1966 to provide Fidelity Bonds for "at-risk," hard-to-place job seekers. The bonds cover the first six months of employment at no cost to the job applicant or the employer.
    Website: https://nicic.gov/federal-bonding-program-us-department-labor-initiative

  - **Work Opportunity Tax Credit:** The Work Opportunity Tax Credit (WOTC) is a federal tax credit available to employers for hiring individuals from certain target groups who have consistently faced significant barriers to employment.
    Website: https://www.doleta.gov/business/incentives/opptax/

- **U.S. Department of Health and Human Services (HHS)**
  Provides resources and information about the opioid epidemic, including HHS' 5-point strategy to combat the opioid crisis.
  https://www.hhs.gov/opioids/
  https://www.outreach.usda.gov/USDALocalOffices.htm

Appendix C: Potential Consortium Members

Examples of potential partner organizations include, but are not limited to:

- Community Members, such as:
  - Individuals in Recovery;
  - Youth;
  - Parents;
  - Grandparents;
  - Individuals who have historically suffered from poorer health outcomes, health disparities, and other inequities, as compared to the rest of the target population;

- Health care providers, such as:
  - Critical access hospitals or other hospitals;
  - Rural health clinics
  - Local or state health departments;
  - Federally qualified health centers;
  - Ryan White HIV/AIDS clinics and community-based organizations;
  - Substance abuse treatment providers;
  - Mental and behavioral health organizations or providers;
  - Opioid Treatment Programs;
- HIV and HCV prevention organizations;
- Entities that are owned or managed by people from minority groups;
- Single State Agencies (SSAs);
- Prisons;
- Primary Care Offices;
- State Offices of Rural Health;
- Law enforcement;
- Cooperative Extension System Offices;
- Emergency Medical Services entities;
- School systems;
- Primary Care Associations;
- Poison control centers;
- Maternal, Infant, and Early Childhood Home Visiting Program local implementing agencies;
- Universities;
- Healthy Start sites; and
- Other social service agencies and organizations.

Appendix D: Allowable Additional Activities (Optional)

While RCORP-Implementation award recipients are required to implement all core/required activities outlined in the Program-Specific Instructions section of this NOFO, HRSA recognizes that some applicants may have the capacity (e.g., staffing, infrastructure, resources, etc.) to pursue additional activities beyond the core/required activities. Under these circumstances, award recipients may propose additional activities that aim to improve health care and reduce SUD/OUD morbidity and mortality in high-risk rural communities.[11] Proposals for additional activities will be evaluated on a case-by-case basis by HRSA Program Staff. Examples include, but are not limited to, the following:

1. Advance telehealth direct care and consultation approaches to MAT. Note that the Drug Enforcement Agency (DEA) has issued a clarification of current law allowing the prescribing of MAT via telehealth under certain circumstances.

2. Create space to deliver virtual care that supports accurate clinical interviewing and assessment, clear visual and audio transmission, and ensures patient confidentiality.

3. Purchase Food and Drug Administration (FDA)-approved opioid agonist medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination and buprenorphine mono-product formulations) for the maintenance treatment of OUD, opioid antagonist medication (e.g., naltrexone products) to prevent relapse to opioid use, and naloxone to treat opioid overdose.

4. Perform minor renovations to facilitate co-location of SUD, mental health, and primary care services teams. Please reference the Funding Restrictions section of the NOFO for more information on minor renovations.

5. Provide training and education to patients, families, and communities on SUD prevention and treatment, mental health, neo-natal abstinence syndrome, trauma-informed care, suicide prevention, and opioid overdose.

6. Test and implement new payment models that facilitate and incentivize coordinated care.

7. Implement or expand access to evidence-based and/or promising practices that enhance better pain management through implementing opioid prescribing guidelines and other evidence-based methods of pain management.

8. Identify at least one individual within the consortium who has the capacity and ability to manage HIV care and treatment; understands the HIV care continuum to better identify gaps in HIV services; and can develop strategies to improve engagement in care and outcomes for people with HIV.

[11] Applicants will demonstrate the level of need and risk in their communities in the Project Narrative section of this NOFO.

9. Provide support for pregnant and postpartum women to enter and adhere to family centered OUD treatment, reduce the risk of relapse, and prevent, and reduce and manage medical complications in the newborn and other children, using approaches that minimize stigma and other barriers to care, and to support the long-term recovery of the women.

10. Recruit, train, and mentor interdisciplinary teams, including clinical and social service providers, who can engage with, and provide evidence-based psychosocial treatment to, the target population and address underlying social determinants of health.

11. Address other SUD-related needs of the target population, given that many individuals with OUD are polysubstance users or have co-occurring conditions.

Appendix E: Application Completeness Checklist

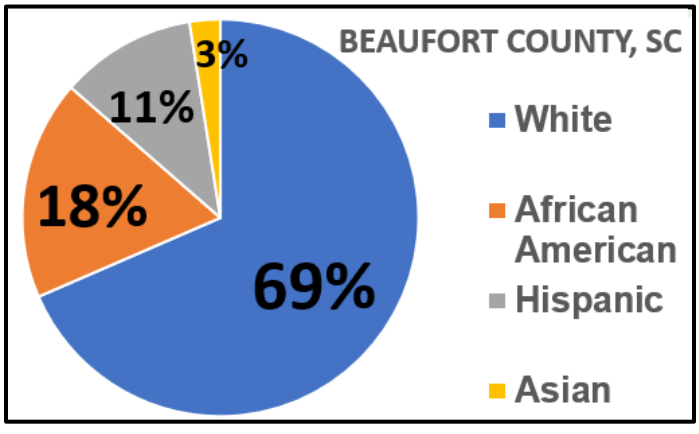
- ✓ Have I read this NOFO thoroughly and referred to the SF-424 Application Guide where indicated?
- ✓ Is my organization part of a multi-sector consortium comprised of at least four separately owned entities, at least fifty percent of whom are located in HRSA-designated rural areas?
- ✓ Are all of my proposed service delivery sites physically located in HRSA-designated rural areas?
    - If not, have I included an exception request in Attachment 9 and attested that the non-rural service delivery site is a primary service provider for the target rural service area and that the delivery site will directly contribute to building health service delivery infrastructure within the target rural service area?
- ✓ If I share an EIN with another applicant, have I submitted the information requested in Attachment 8?
- ✓ Does my budget total $1,000,000 (or less), inclusive of direct and indirect costs?
- ✓ Have I submitted a budget and budget narrative for each of the three years of the period of performance?
- ✓ Does my proposed project reduce the morbidity and mortality of SUD/OUD within an exclusively rural service area, including among subpopulations that have historically faced health disparities, outcomes, and other inequities?
- ✓ Do my "Work Plan" and "Methodology" sections reflect all core activities outlined in the Program-Specific Instructions section of the NOFO?
- ✓ Does my work plan reflect a three-year period of performance?
- ✓ Have all consortium members reflected in the work plan signed and dated a single Letter of Commitment and are at least 50 percent of the signatories located in HRSA-designated rural areas?
- ✓ Have I designated a Project Director who will serve at least 0.25 FTE on the grant and a Data Coordinator?
- ✓ Have I completed all forms and attachments as requested in Section IV of this
- ✓ NOFO and in the SF-424 Application Guide?
- ✓ Will I apply at least 3 calendar days before the deadline to accommodate any unforeseen circumstances?
- ✓ Have I confirmed that my application does not exceed the 80-page limit?

BEAUFORT COUNTY CADAD
ALCOHOL & DRUG ABUSE DEPARTMENT

Voice–Vision-Leadership

CRITERION I: NEED (INTRODUCTION & NEEDS ASSESSMENT)

A. Extent to Which Applicant Clearly States Service Area and Characteristics and Needs of Target Rural Population

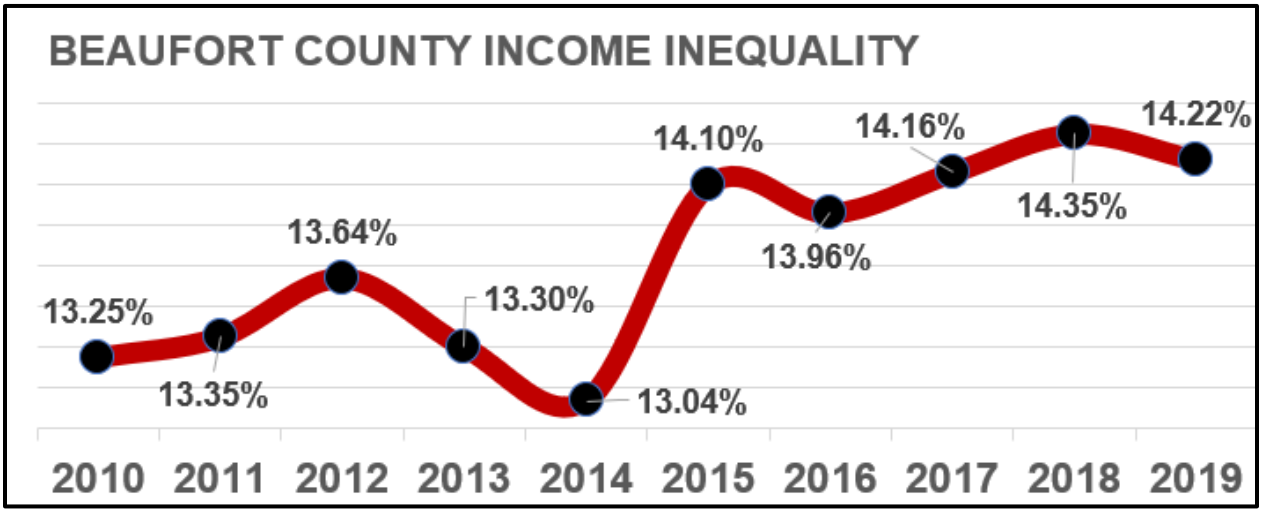


The focus of the proposed project lies in **Beaufort County, South Carolina**—one of the **south's fastest growing counties**, although with this growth has come staggering levels of **community distress**, **social and economic division**, and upheaval.

Perhaps one of the most significant changes in the community is its growing transformation from a cluster of **small rural towns**, **slow and southern**, into a national destination for **tourists, retirees, college students**, and **commerce**. The entire population of Beaufort County is 186,095 spanning **42 census tracts**. Of those tracts, **17 are rural** (40.5%), with a total census of 72,895, or **39.2% of the total county**.

Beaufort County Eligible Census Tracts		
45013000100	45013000400	45013000503
45013000200	45013000501	45013000600
45013000300	45013000502	45013000700
45013000800	45013000902	45013000903
45013000901	45013001101	45013001000

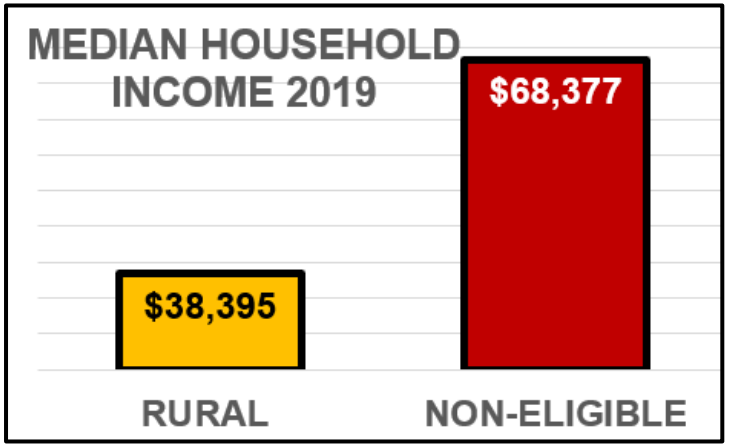
The problems to be addressed with the proposed project can best be understood within context of these demographic population changes. With an estimated **3 million**[1] **tourists each year,** the county has become a proverbial "**Tale of Two Cities**" -- **comfortable and affluent**, predominantly white, and others: **poor, undereducated**,

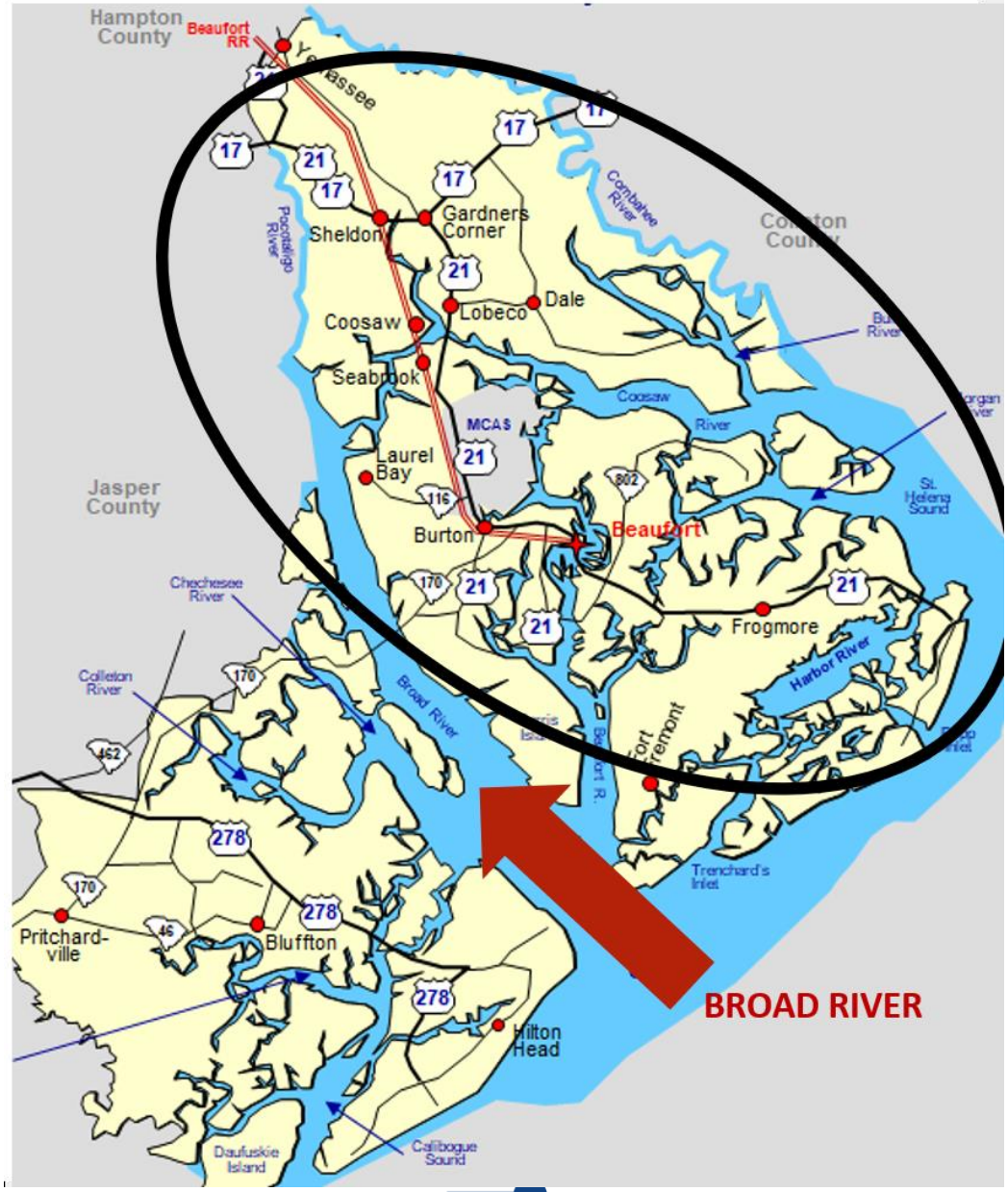


[1] Economic and Fiscal Impact Analysis, Regional Transactions Concepts, 2016.

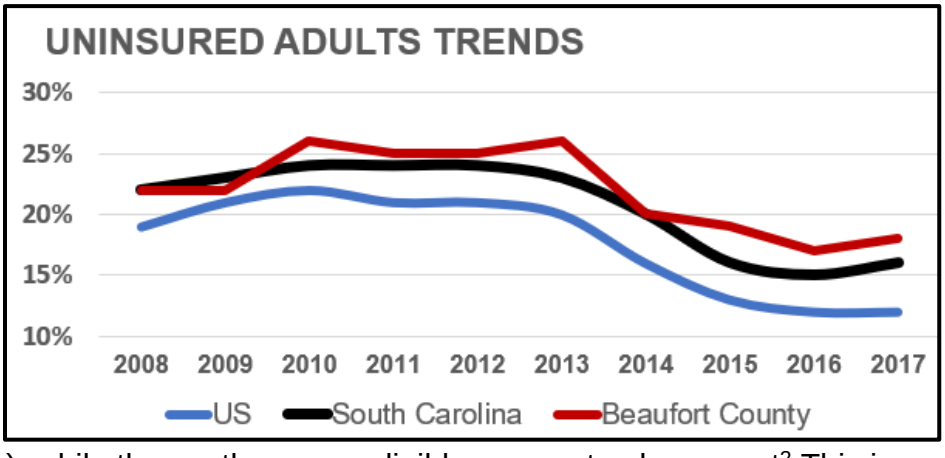
employed in **tourism service jobs**, but increasingly **unable to keep pace with growing housing costs** as many new tourists make the transition to **permanent residents**.

This growing income inequality portends a wide range of social distress—from **crime, poverty**, and **educational failure** to **addiction and violence**. The map to the right depicts the central geographic structure of the county, **divided by the broad river**. The encircled area includes all eligible census tracts, all rural. Everything south of the river is non-rural. While the median **household income** for the southern portion is **surpassed the U.S. average in 2018**, residents in the **target area earn 46% less**, and a staggering 14% of these households report **less than $15,000 a year in income.** This division between north and south will be returned to **repeatedly throughout the narrative** to better understand the unique risk factors at work in the target service area.





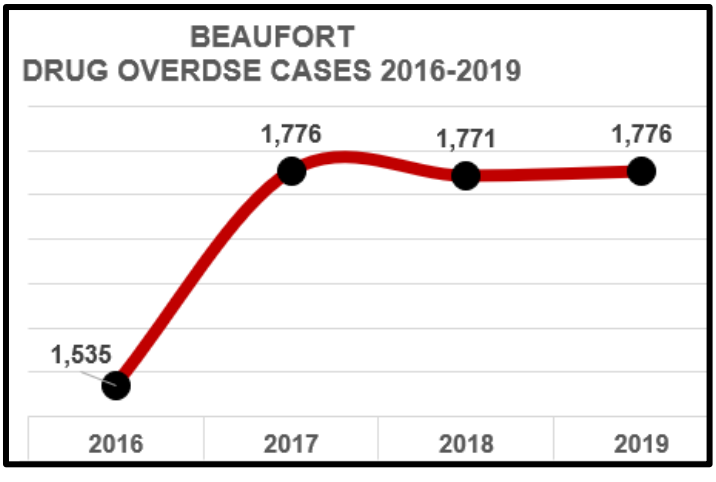
The health status of individuals residing in many rural communities is dire, a condition that unfortunately is mirrored within the proposed target census tracts. The US Census Bureau's Small Area Health Insurance Estimates (SAHIE) program produces estimates of **health insurance coverage** for all states and counties. Although the rate uninsured individuals have dropped dramatically over the past decade, South Carolina ranks **42nd in the nation on individuals lacking health insurance**, with Beaufort County **consistently exceeding state average.**



To further illustrate the bifurcated structure of the county, the entire eligible rural census tracts have all been designated **Medically Underserved Areas** by the Federal Health Resources and Services Administration (HRSA), while the southern non-eligible census tracks are not[2].This is especially problematic with regards to **accessing treatment services**, with only one **behavioral health provider** for every 660 residents, **13% higher than the state average**[3]. The county also falls behind state average for access to primary care physicians, with **one for every 1,430 individuals, 7% higher than the US average**.

AREA	SCORE
PRIMARY CARE	
Sheldon	**51.5**
Helena / Port Royal	**59.9**
BEHAVIORIAL HEALTH	
Beaufort County	**14**

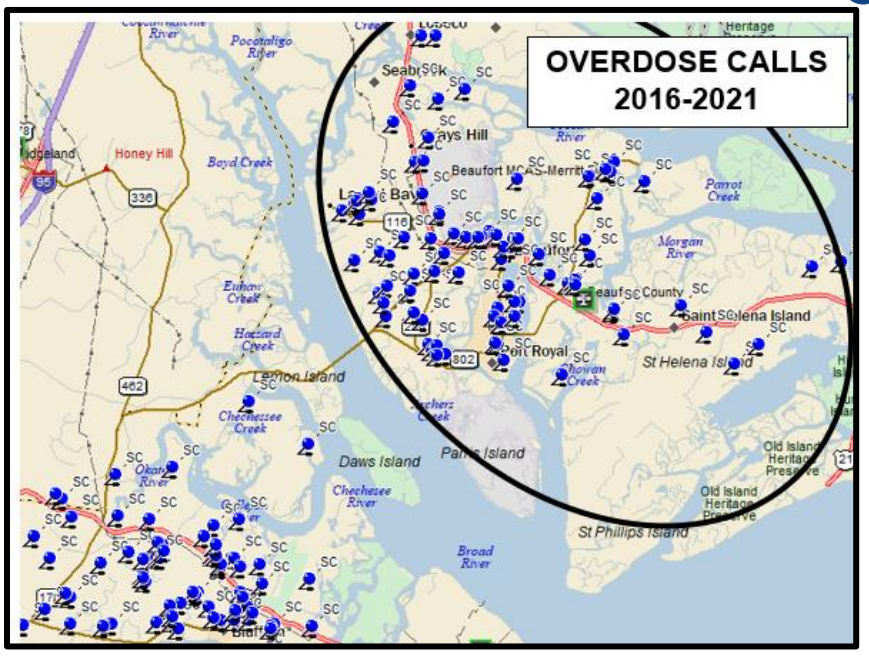
It is no surprise that over the past five years, national attention to **opioid misuse,** especially **overdose**, has occupied the national discourse, overshadowed with the onset of Covid-19. While every state has seen massive rises in the abuse of opioids, **South Carolina is currently grappling with the largest heroin death rate in the country** at a **57% increase** between 2014 and 2015.



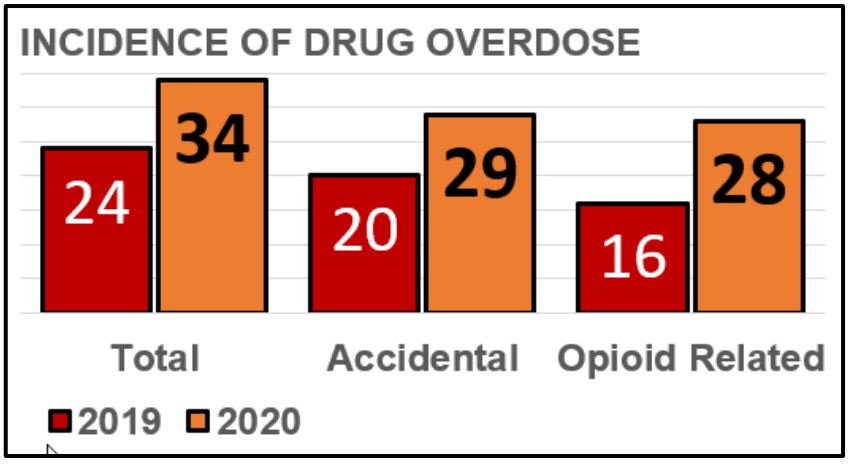
While opioid misuse and overdose is **not confined to the target rural census tracts,** it is nonetheless most

[2] South Carolina Department of Health and Environmental Control, 2014
[3] County Health Rankings, Robert Wood Johnson, 2020

prominently and disproportionately located in the southern region, again, as evidenced in the map.



During the execution of a rigorous community **needs assessment** comprised of **local, state, and federal** archival sources, **service provider data**, **law enforcement** scan, **emergency room** statistics, and overall service delivery **utilization patterns**, an interesting pattern emerged, best explained as an artifact of **Covid restrictions**, while not officially a shelter in place order, places significant limitations on residents in all counties.



While the number of drug overdoses has steadily increased beginning in 2019 and continuing through the next year, the overall **rate of increases appears to decline somewhat**. For example, a review of emergency room data reveals **412 opioid related visits in 2019**, but with **only 208 the next year.** While policy leaders predicted that shelter-im-place orders could cause an increase in what is known as "**deaths of despair**," while increases in psychiatric stressors have been reported, it is presently **unknown whether suicide ratees similarly changed** during stay-at-home periods[4].

reveals what appears to be a decreased in drug related suicide but increase for homicides.

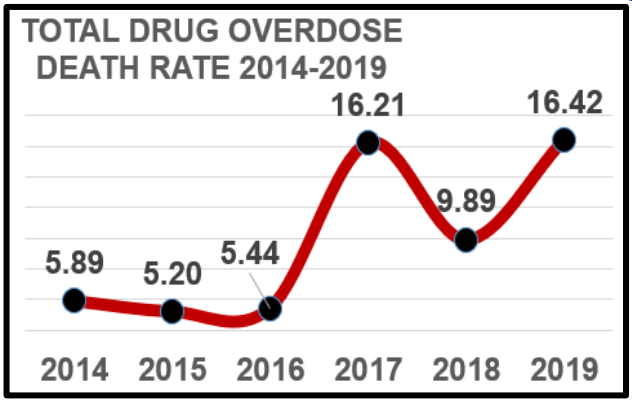
Suicides:	**2020**	12 of 32 suicides involved drugs or alcohol **(37.5%)**
	2019	14 of 27 suicides involved drugs or alcohol **(52%)**
Homicides:	**2020**	11 of 13 homicides were drugs or alcohol related **(84.6%)**
	2019	11 of 17 homicides were drugs or alcohol related **(64.7%)**

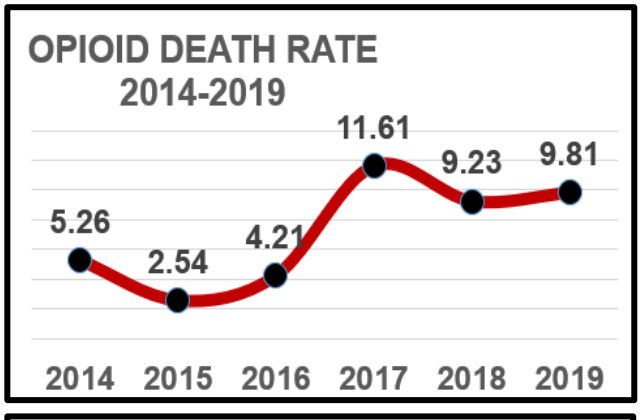
[4] Suicide Deaths During COVID 19 Home Advisory, Journal of American Medical Assoc.. Faust, 2021.

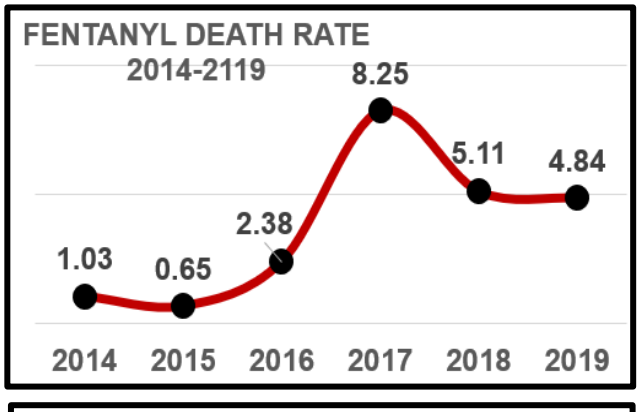
It is especially important to note that the incidence and prevalence of **opioid misuse and overdoes does not occur in isolation,** but as part of a broader clinical picture that often involves abuse of many different substances including **psychostimulants, heroin**, and increasingly, **synthetic opioids** in the form of **fentanyl.**

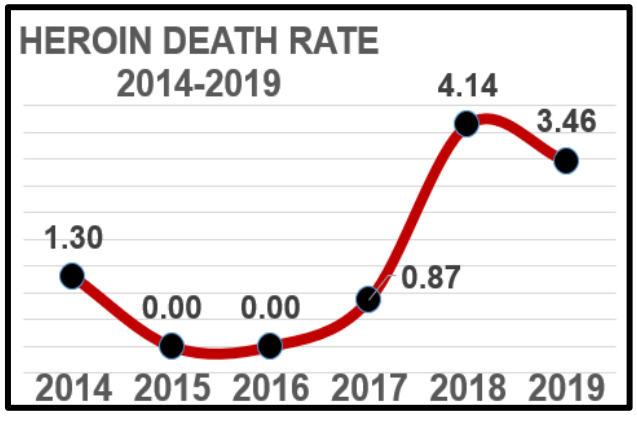
A longitudinal review of drug related deaths for the community reveals quite similar patterns, with a **linear increase** in **total deaths, opioid deaths**, **fentanyl deaths**, and **heroin.** While the linear increase is comparable across substance, the sheer scope of **opioid deaths in most cases overshadows that of fentanyl or heroin**, in some cases, **double or even trip the rate.**

A **segmentation analysis** for the target community suggests that the problem has a **differential impact based on several domains**. First, a study published by the Journal of Health Justice documents that drug overdose is the **leading cause of death after release from prison**[5]. Given restricted access to substances while incarcerated, **personal tolerance is likely lowered.** Upon release, many individuals resort to using at their previous dosage and greatly increases the risk of overdose or death. Local detention center data reveals an **average of 50 inmates with drug related histories enrolled each month,** with 30-40% incarcerated well over two or more days. In addition, medical staff report an average of **20 inmates a month that are assessed for**



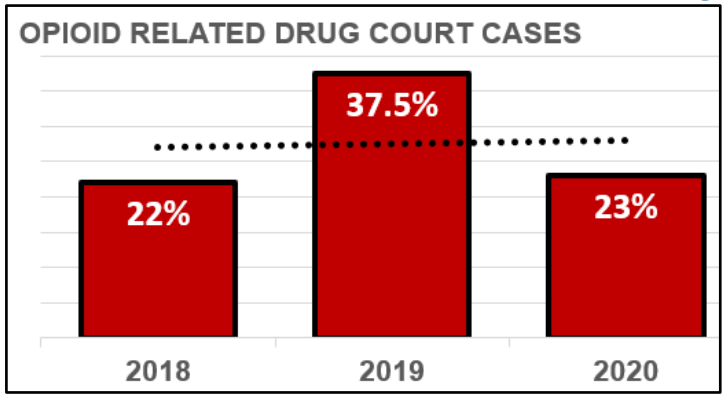






[5] Reducing overdose after release from incarceration; Waddell, Health Justice, Dec. 8, 2020.

withdrawal. This pattern has remained stable, with **6% of inmates screened from 2014 through 2019 included opioid use.** Drug misuse in criminal justice populations is also evidenced in local **Adult Drug Court** docket where opioid related cases have surged over the past three years, although the Covid suppression is evident within this data as well.



Next, another **differential target population** includes those with **blood related infections**. The prevalence of **Hepatitis-C-Virus** (HCV) infections is high among opioid-dependent individuals. Prior research on the simultaneous treatment of both conditions has primarily assessed success as it pertains to HCV[6]; although, it has been noted that favorable substance-use-therapy outcomes may improve the likelihood of HCV-treatment initiation and success Local data shows a **40% increase since 2014 in the Hep C rate** in Beaufort. Likewise, **HIV**-infected persons are more likely to have chronic pain, receive **opioid** analgesic treatment, receive higher doses of opioids, and to have substance **use** disorders and mental illness compared with the general population, putting them at increased risk for **opioid use disorder**. Again, the HIV incidence rate in the county went up 50% since 2018.

While much of the data appears to differentiate based on target population, and not location, there is much evidence that problems related to opioid use disorder also have a place-related impact within the targeted rural census tracts. Therefore, in addition to archival data collection and review, the needs assessment also included an analysis on **where and when activities are most acute within the rural target tracts**. Using **Geographic Information System (GIS) Mapping** to geo-code the database onto **census bureau shapefiles** most relevant to the potential risk for opioid use and misuse. National trend data related to the incidence and prevalence of opioid misuse and overdoses has spotlighted several high-risk target populations:

- Homes with **senior citizens** (most likely to suffer falls or illness requiring painkillers)
- Imputation of **Health Insurance Coverage**, by Age and Educational Attainment
- **Veteran Status** (often linked in literature as a risk factor)
- **Disability Status** (likewise a potential risk factor associated with misuse[7])

In each case, the maps on the next page reveal the **highest density of at-risk individuals reside in the target rural census tracts**.

[6] Association between Hepatitis C Virus and Opioid Use while In Buprenorphine treatment: preliminary findings. Murphy, Dweik, McPherson, & Roll; Am Journal of Drug Abuse, 2025, 41 (1) 88-92.
[7] When Addictions, Opioid and Disability Meet; Wilson, National Center on Disability and Journalism

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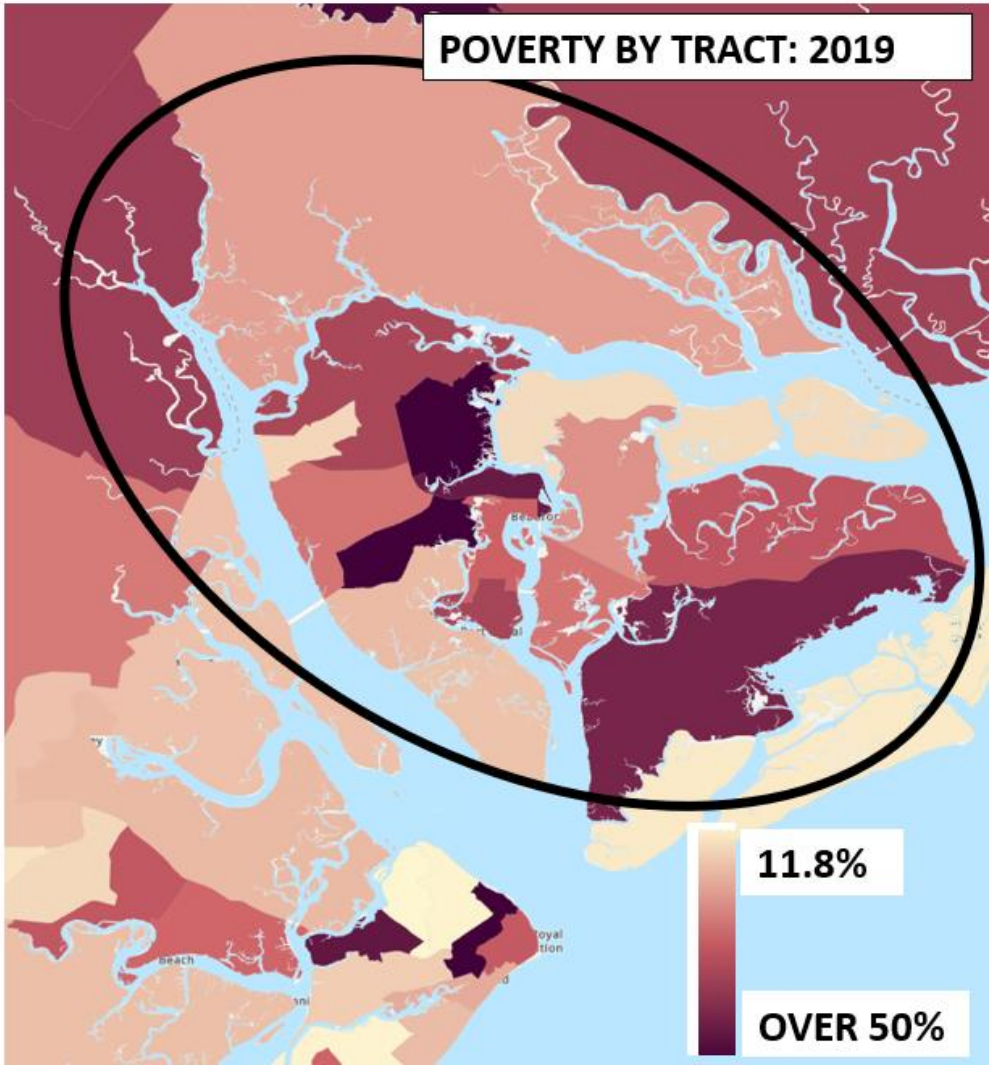

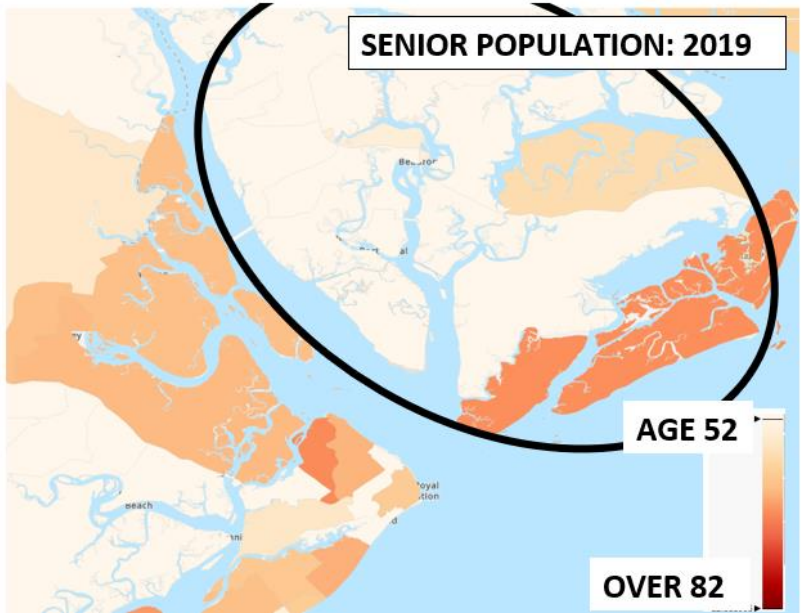

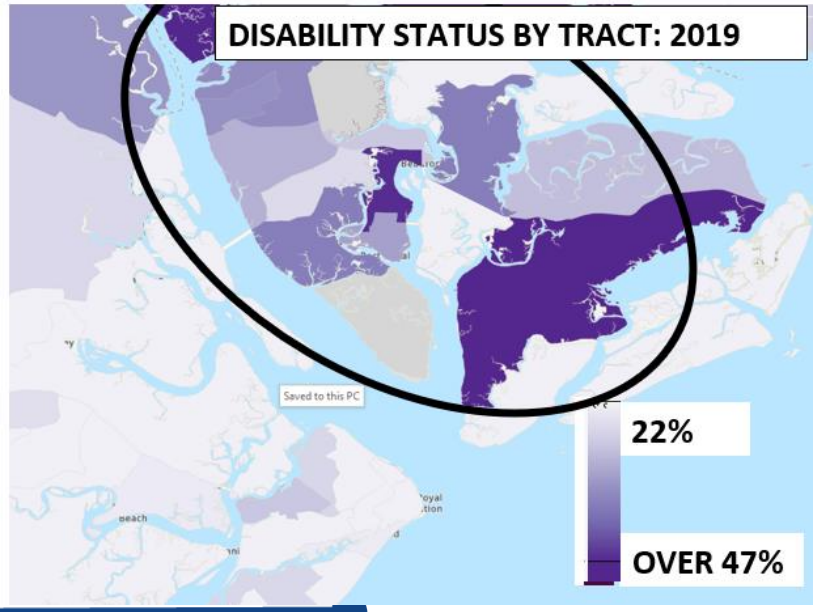

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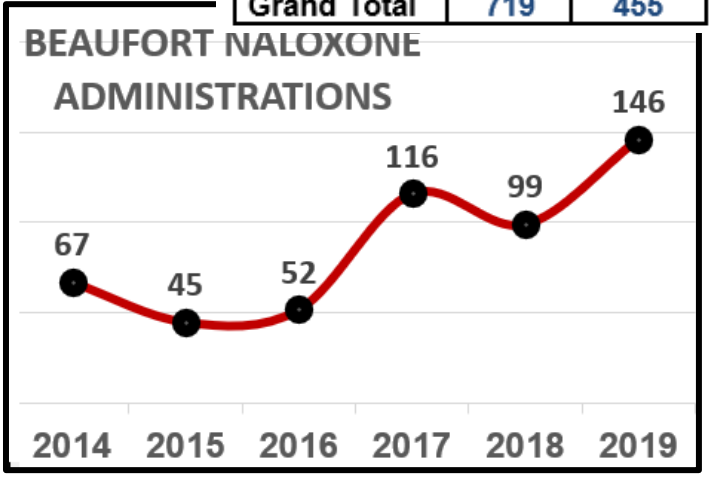
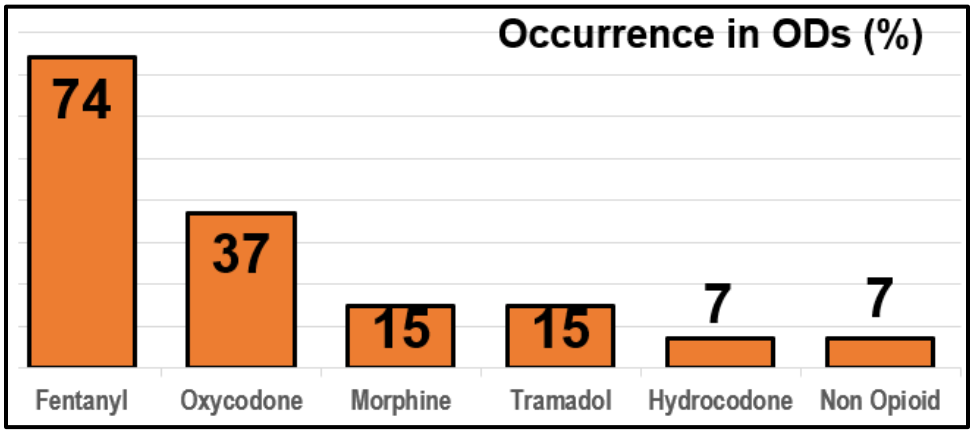
Finally, data from the applicant agency (Beaufort County Alcohol and Drug Abuse Department) documents the incidence of individuals seeking treatment and perceived covid suppression. Over the past five years, opioids and psychostimulants represents a disturbing trend. One result, an explosion in the administration of **opioid antagonists**, such as **Naloxone.**

	2019	2020
Alcohol	424	260
Opioid	41	50
Cannabis	185	108
Sedative	4	3
Cocaine	43	27
Amphetamine	14	2
Tobacco	8	5
Grand Total	**719**	**455**

The data in this narrative, which represents but a **small portion collected**, was employed to assess the overall efficacy and capacity of current resources related to **prevention, treatment, and recovery** of substance use disorders, especially opioid. **Critical service gaps** were then prioritized and formulated into a **three-year work plan**, with careful attention on strategies to **sustain the overall effort once federal grant funding has lapsed.**





B. Applicant Clearly and Succinctly Summarizes Goals of Project, Approach and Capacity, Including History of Collaborating to Address SUD/OUD

The proposed project brings to culmination, over one-year of data collection, planning, discussion with consortium members and staff, gap analysis, identification of evidence-based intervention strategies, and devise a detailed workplan. The following provides a brief summary of the project goals and objectives:

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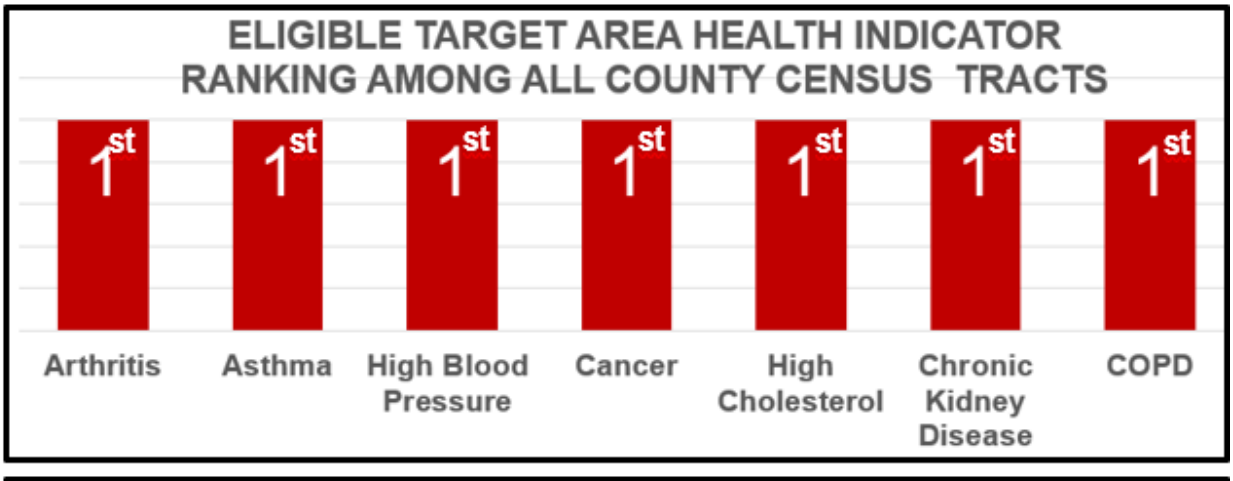
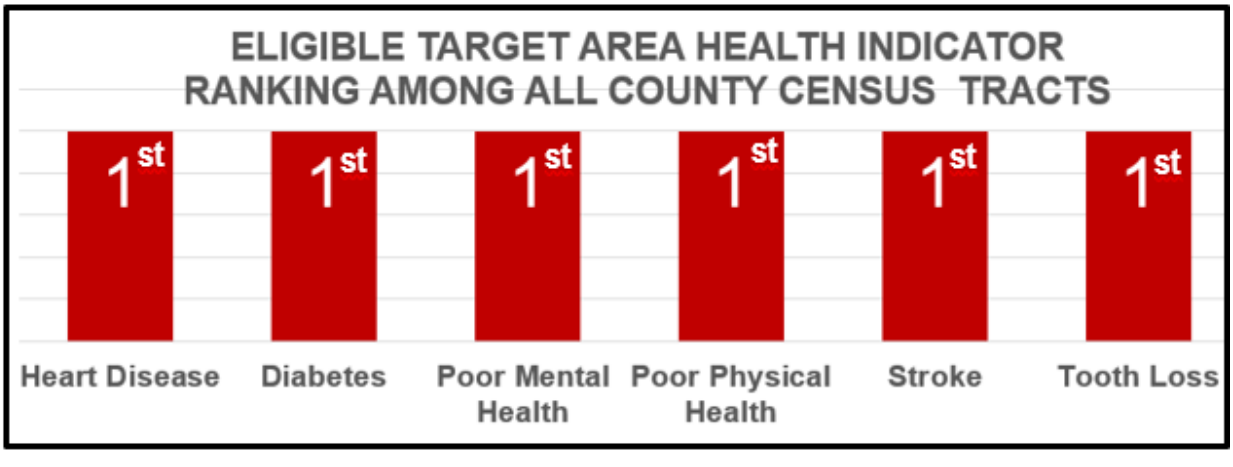
GOAL 1: Increase Local Capacity & Infrastructure Necessary to Reduce Opioid Misuse By 20% by 2023 Through Enhanced Service Delivery Network of Prevention, Treatment & Recovery Conducted by a Consortium of Key Members.
OBJECTIVE 1: Within four months of grant award, the proposed staffing expansion plan will be fully complete, as outlined in project narrative and budget as measured by signed and executed employment contracts.
OBJECTIVE 2: All new and existing direct service staff will complete all proposed professional development (1. electronic health record training; 2. Clinical Assessment; 3. Treatment Planning; and 4. Mental Health First Aid) within the first month of employment, as measured by attendance logs collected at the beginning of each training session.
OBJECTIVE 3: Execute subcontract .40 FTE Advanced Practice Registered Nurse (APRN) provider to increase the current service delivery capacity to prescribe/administer MAT
OBJECTIVE 4: The APRN will complete Buprenorphine Waiver Management Training within 30 days of employment and submit commensurate application to prescribe MAT through SAMHSA and the DEA, as required under Drug Addiction Treatment Act of 2000 (DATA 2000), as measured by approved waiver status award notice.
OBJECTIVE 5: Recruit 1.0 FTE Peer Support Specialist to work with law enforcement and EMS to transition individuals into treatment in a timely and efficacious manner.
OBJECTIVE 6: Recruit 1.0 FTE Social Worker to provide case management and clinical supports from treatment through recovery and including support to the county detention facility.
OBJECTIVE 7: Execute .25 FTE Clinical Supervisor to oversee expanded service delivery and staffing as per licensure standards, including support to the county detention center
OBJECTIVE 8: A range of community awareness and engagement resources will be developed for distribution and include traditional and social media, public transport advertising, flyers, brochures, and town hall meetings.
OBJECTIVE 9: The number of individuals served through Medically Assisted Treatment and commensurate individual, group, and/or family counseling sessions will be 50 unduplicated cases in a calendar year, including both regular and intensive outpatient treatment, as measured by the DAODAS Clinical Services Log.
OBJECTIVE 10: Project staff will conduct a clinical screening and assessment of clients within 48 hours of referral, using state mandated tools (psychosocial history, addiction severity index, client strengths analysis, interview) for presence of SUD and occurring disorders, use the information in treatment planning, as measured by completed intake battery.
OBJECTIVE 11: Participant clients will devise a recovery support plan that details adjunct services required to improve access and retention in clinical services, including vocational, education, transportation, childcare, and enrollment in the affordable care act program, within 48 hours of enrollment, as measured by completed case management plan.

C. Extent to Which Applicant Demonstrates Population has Historically Suffered from Poorer Health Outcomes, Disparities, and Other Inequities.

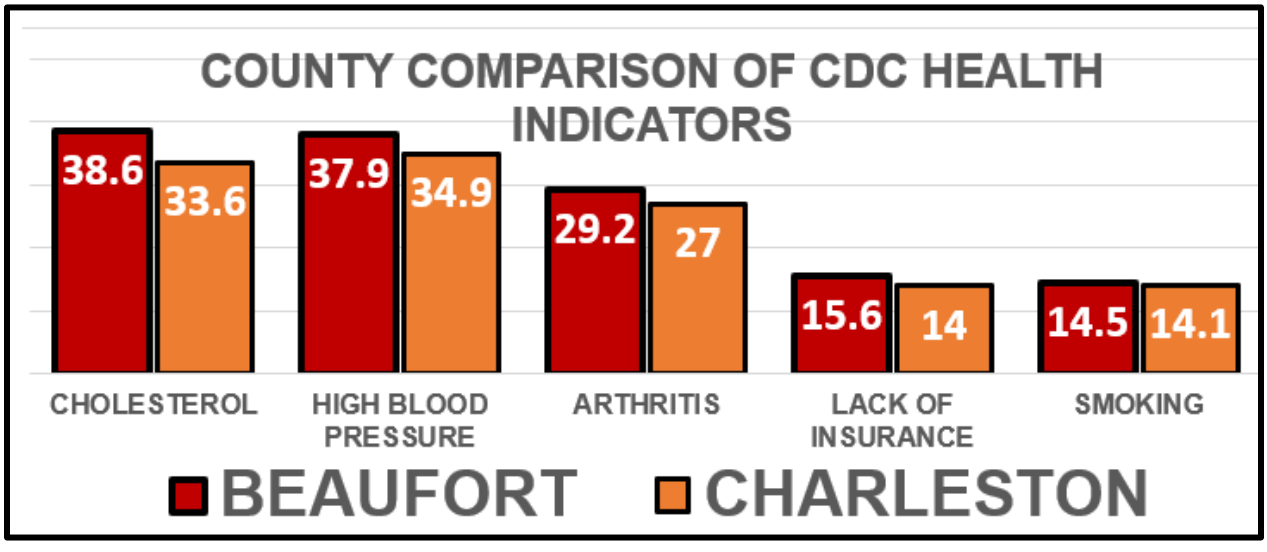
During the needs assessment process data was collected with regards to a wide range of **health disparities throughout the entire county**. Using the **Centers for Disease Control archival database**, the top thirteen health outcomes were **analyzed for each census tract** wiithn Beaufort County. The conclusion was **nothing short of staggering**. The geographic area eligible for the proposed project **ranked number one in all thirteen of the CDC Health Outcomes.** The range of these health concerns reflet some of the most serious conditions and include **cancer, high blood pressure**, and **diabetes** to **poor mental health** and **stroke.**

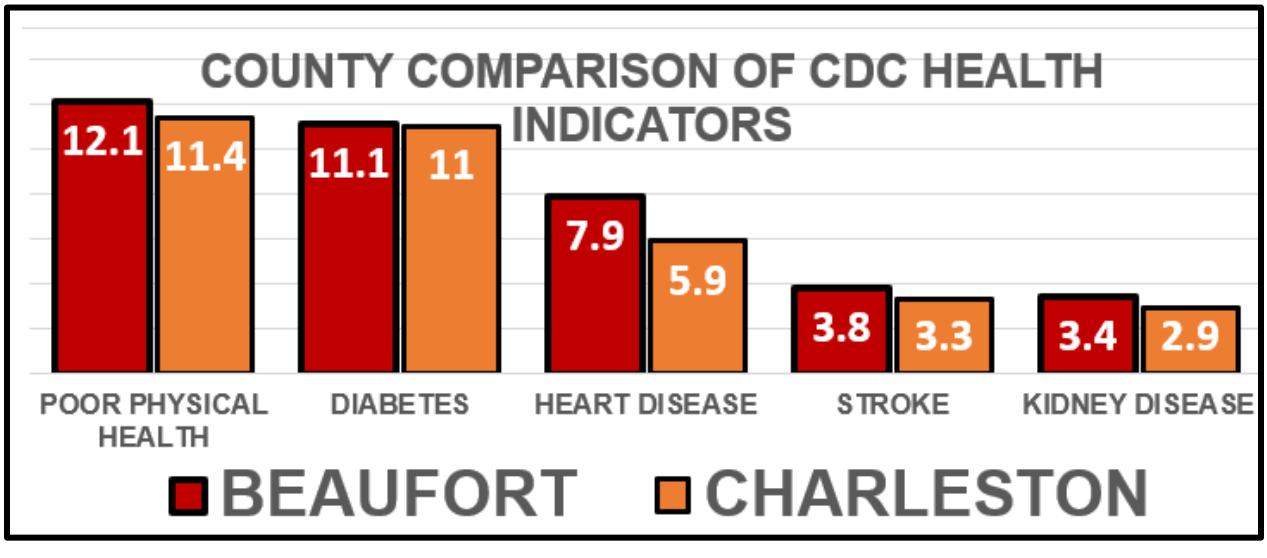




To further explore the data, a **comparison county** (Charleston) was selected to better understand if the level of problems within the target community were consonant with a **similar coastal tourist area in the state** often viewed as a “sister county.” Using the CDC archive, the same analysis was conducted for each of the aforementioned health indicators. Not surprising to health officials in Beaufort, but the level of health disparities **exceeded that of the comparison county in all but two categories**. In most cases, the problems facing residents of the proposed target community **exceed the non-**

eligible census tracts as well as Charleston County. While such a comparison lacks empirical rigor, it does further the argument that the proposed target population has historically **suffered from poorer health outcomes, disparities, and other inequities**





D. Extent to Which Applications Provides Requested Data and Information

From the outset, the proposed project was designed to be **data driven**—beginning with **identification of those populations most vulnerable** to substance use disorders, especially opioid related to ensuring that any proposed continuum of services will **track efficacy over time and budget.** That said, careful attention was taken in the collection of all required baseline data, aligned specifically to the eligible census tracts targeted by the proposed project. The pages summarize the required **Core Measures Table, Population Demographics**, and **Substance Use Disorder Prevalence**.

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REQUIRED CORE MEASURES TABLE

MEASURE	DEFINITION	BASELINE	DATA SOURCE
Core #1: Total population in the project's service area	Please report the total number of individuals in your project's service area.	The entire population of Beaufort County is 186,095 spanning 42 census tracts. Of those tracts, 17 are rural (40.5%), with a total census of 72,895, or 39.2% of the total county.	U.S. Census, 2019. Table B01003
Core #2: Number of individuals screened for SUD	Total number of individuals screened for SUD, including OUD, in the past 6-months. Include tools such as the CAGE, Michigan Alcohol Screening Test, Drug Abuse Screening Test, or screening methods such as SBIRT, or provider-developed screening questions.	299 in past six months at the Beaufort County Alcohol and Drug Abuse Services.	CSL Care Logic Database;
Core #3: Number of non-fatal opioid overdoses in the project service area	Total number of non-fatal overdoses from opioid poisoning in your project's service area in the past 6-months. Include all types (e.g., accidental, intentional, undetermined).	112, 21 involving Heroin	SC Dept of Health, February 2021.
Core #4: Number of fatal opioid overdoses in the project service area	Total number fatal overdoses from opioid poisoning in your service area in the past 6-months. Include cases where opioids are the underlying **or** contributing cause of death and include all types (e.g., accidental, intentional, undetermined).	*2020= 29 opioid deaths 2019= 16 2018= 14 2017= 17	*Beaufort County Coroner's Office, Just Plain Killers
Core #5: Number healthcare providers in the project service area with DATA waiver	Total number of healthcare providers **in the service area** who have a Data Treatment Act 2000 waiver to prescribe buprenorphine products for MAT. Total number providers **in consortium** who have a DATA Waiver.	Three practitioner levels: Family Nurse Practitioner (2) Nurse Practitioner (1) MD's (10)	SAMHSA Buprenorphine Practitioner Locater

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REQUIRED POPULATION DEMOGRAPHICS TABLE

MEASURE	TARGET RURAL POPULATION	COMPARATIVE DATA		DATA SOURCE
MEASURE 1: Percentage target rural population with health insurance	67,778 individuals **(86%)**	**South Carolina** 89.5%	**US** 91.1%	U.S Census Table PL 94-171
MEASURE 2: Breakdown of target rural population by race/ethnicity	White: 59.7% African Amer: 33.3% Hispanic: 7%	**South Carolina** White: 68.5% African Amer: 27.1% Hispanic: 5.8%	**US** White 76.5% African Amer: 13.4% Hispanic: 18.3%	2018 Census Vintage Population Estimates
MEASURE 3: Breakdown of target rural population by sex	Male (**51%**) Female (**49%**)	**South Carolina** Male 48% Female 51.4%	**US** Male 49.2% Female 50.8%	U.S. Census Table DP05
MEASURE 4: Breakdown of target rural population by age:				
Children (Ages 0-14)	15,789 individuals **(19%)**	**South Carolina** (18.5%)	**US** (18.9%)	U.S. Census Table SO101
Adolescents (Ages 15-19	6,595 Individuals **(7.9%)**	**South Carolina** (5.2%)	**US** (6.6%)	U.S. Census Table SO101
Adults (Ages 20-64)	46,626 Individuals **(56.1%)**	**South Carolina** (56.2%)	**US** (59.3%)	U.S. Census Table SO101
Elderly (Age 65 and over)	13,962 individuals **(16.8%)**	**South Carolina** (20.1%)	**US** (15.2%)	U.S. Census Table SO101
MEASURE 5: Percentage target rural population unemployed	**Target (4%) County (3.9%)**	**South Carolina** 3.5%	**US** 3.9%	Federal Reserve Dec 2020
MEASURE 6: Percentage of target rural population living below the federal poverty line	**Target (13.3%) County (10.2%)**	**South Carolina** 15.3%	**US** 11.8%	U.S. Census Table SI701 2018

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REQUIRED SUD/OUD PREVALENCE TABLE

<table>
<tr><th>MEASURE</th><th>TARGET RURAL POPULATION</th><th>COMPARATIVE DATA</th><th>DATA SOURCE</th></tr>
<tr><td>Number of SUD/OUD emergency room visits in the target rural service area(s).</td><td>Data for key service points show a decline for 2020, due mostly to the impact of covid on admissions. The rate is trending to previous historical growth patters thus far in 2021
<table>
<tr><th></th><th>2019</th><th>2020</th></tr>
<tr><td>Alcohol</td><td>424</td><td>260</td></tr>
<tr><td>Opioid</td><td>41</td><td>50</td></tr>
<tr><td>Cannabis</td><td>185</td><td>108</td></tr>
<tr><td>Sedative</td><td>4</td><td>3</td></tr>
<tr><td>Cocaine</td><td>43</td><td>27</td></tr>
<tr><td>Amphetamine</td><td>14</td><td>2</td></tr>
<tr><td>Tobacco</td><td>8</td><td>5</td></tr>
<tr><td>Grand Total</td><td>719</td><td>455</td></tr>
</table></td><td>South Carolina documented an Opioid Related Hospital rate of 161.2 compared to 291.5 for the U.S. National Rate (per 100,000). Comparative data is for 2018, local target data is 2019.</td><td>Beaufort Memorial Hospital Epic Patient Software System.</td></tr>
<tr><td>Prevalence of SUD in target rural population, by type:</td><td>
<table>
<tr><th>Diagnosis</th><th>Unduplicated Count</th></tr>
<tr><td>Alcohol abuse</td><td>218</td></tr>
<tr><td>Opioid abuse</td><td>33</td></tr>
<tr><td>Other psychoactive abuse</td><td>127</td></tr>
<tr><td>Other psychoactive dependence</td><td>22</td></tr>
<tr><td>Grand Total</td><td>400</td></tr>
</table></td><td>Of 2019 patients served and 2020 data comparison. Admissions were significantly impacted, due to Covid-19.</td><td>Beaufort County Alcohol and Drug Abuse Department Care Logic Database</td></tr>
<tr><td>Prescription Volume</td><td>A total of thirteen prescription drop box collections are maintained with in the target footprint.
<table>
<tr><th>DATE</th><th>POUNDS</th></tr>
<tr><td>July 2020</td><td>3,618</td></tr>
<tr><td>Oct. 2020</td><td>253.6</td></tr>
<tr><td>Jan. 2021</td><td>135.8</td></tr>
</table></td><td>No comparative data is available for state. The project has reached out to state authorities with plans to collect and report this data for other counties engaged in take back strategies with state funds.</td><td>Monthly intake reports from agency and project partners.</td></tr>
</table>

E. Extent to Which Applicant Demonstrates How Funding will Increase Scope and Magnitude of Service Delivery, Beyond Baseline

A detailed project work plan has been devised that will address **every single service gap** identified during the segmentation analysis, that will allow the agency to reach and **exceed full staffing capacity**, with **all required clinical supervision** and **monitoring**, removal of barriers to providing **Medically Assisted Treatment**, and provide more individualized clinical supports complicated due to state policy limiting the use of virtual sessions for treatment. The estimated increase in service delivery capacity for this funding is between **35% and 50% increase client enrollment and care**. Most important, the project will involve new phase in relationship with county law enforcement with rigorous training related to the **efficacy of harm reduction strategies**, **Medically Assisted Treatment**, and first steps in bringing substance abuse treatment services with adults in **detention**. This last element has the potential to significantly **reduce repeat episodic treatment** for the same client in and out of detention.

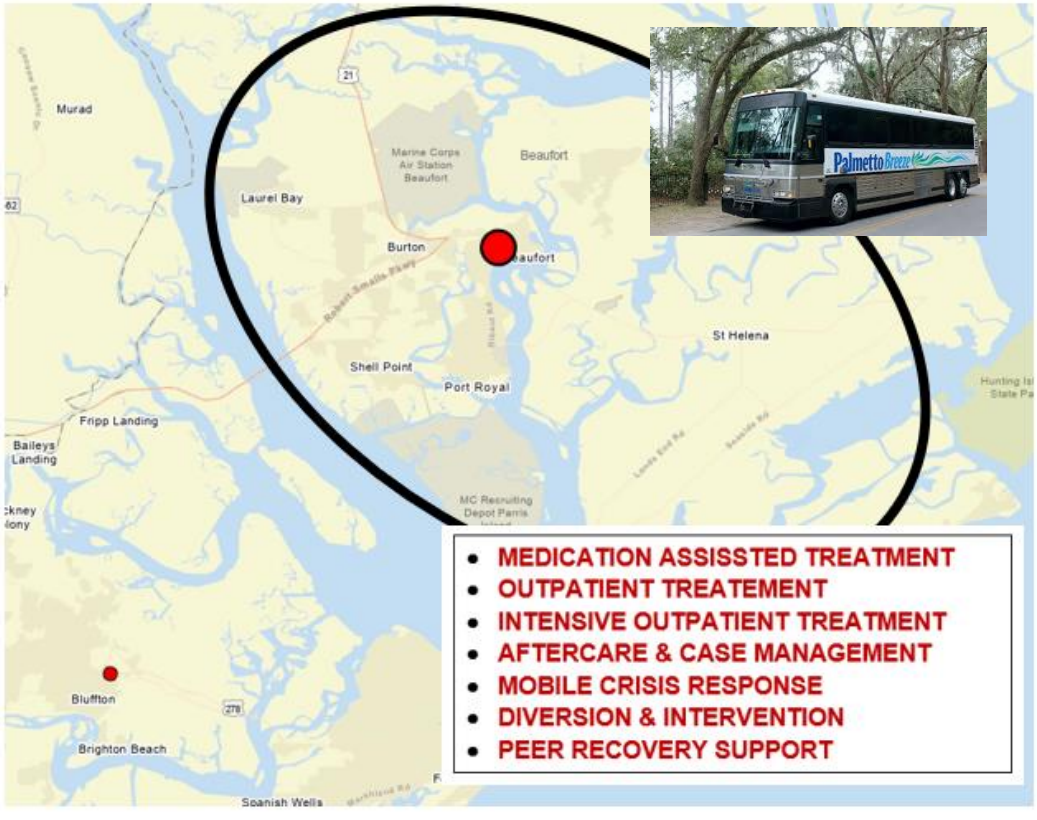
F. Quality and Appropriateness of Sources Used to Provide Data

The proposed project is based on an enormous level of local, state, and federal data collected over the past twelve six months. Key elements in the selection of data sources highlighted the **importance of recency** (data that is no older than two years, if possible), sources that will allow **disaggregation by census tract**, safeguarding of **protected information** while still allowing meaning analysis, and the use of sources that could be **employed in the future to monitor progress** towards Core Indicators. That said, the following sources were vetted and determined most accurate and dependable, and were then used in the needs assessment and segmentation analysis:

U.S. Census Bureau Data Manager
U.S. Centers for Disease Control
Robert Wood Johnson Foundation – Community Health Indicators
Anna Casey Foundation Kids Count Data Center
Environmental Systems Research Institute (ESRI) mapping shapefiles
Beaufort County Alcohol and Drug Abuse Department
Beaufort County Detention Center
Beaufort County Coroner Office Toxicology Report
South Carolina Department of Alcohol and Other Drug Addiction Services
South Carolina Revenue and Fiscal Affairs Office
SC Department of Health and Environmental Controls – SCRIPTS database
South Carolina Office of Mental Health
South Carolina Law Enforcement Division of Statistics (SLED)
Just Plain Killers Opioid Campaign: https://justplainskillers.com/data/
Law Enforcement Records Management Software (LERMS) by Municipality

G. Extent to Which Data Demonstrates Relatively High Need for RCORP Funded Prevention, Treatment and Recovery Services

EXISTING TREATMENT SERVICES / CRITICAL GAPS



The Beaufort County Alcohol and Drug Abuse Services Department (BCADAD) has been in existence since 1974 as the sole public treatment entity in the county. **The main service site,** located in the target census tracts, provides a **full continuum of evidence-based treatment services** as depicted in the map. Although 871 square miles and rural, this area is served by an affordable **public transportation system**, that significantly facilitates target client access.

The core of essential treatment services determined most relevant to the proposed project include the following:

Screening and Diagnostic Assessment (full spectrum of instrumentation)

Cognitive Behavioral Therapy

Medical Assisted Treatment **MAT**

Motivational Interviewing

Peer Recovery Support Services

The table on the next page summarizes current details with regards to these services followed by an identification of **critical gaps** that form the basis of the proposed project:

COMPONENT	SCOPE	NOTES
Outpatient	9 Hours per week; Day or Evening; M-F	A total of six master's level clinical therapists provide coverage for all levels of outpatient care.
Intensive Outpatient	20 Hours per week or more; Day or Evening; M-F	Gender specific (i.e., women) available.
Crisis and Case Management	Emergency mobile crisis response available;	
Diversion / Intervention Services	offered to patients convicted of driving or boating under the influence of alcohol or drugs.	
Aftercare	Step down services for clients in intensive outpatient.	Individual counseling sessions, peer supports, drug screening.
Clinical and Diagnostic Screening	Full range of assessments including DAST 10, AUDIT, GAIN II, Trauma and Suicide, Drug Screening, Breathalyzer, TB, HIV, Psychosocial.	Currently provided through virtual model due to Covid restrictions

The department is working to maximize services to as many patients as possible in a timely manner. The current staff in both locations collectively have a 67% productivity rate and the show rate for **patients attending services is 82%**. However, several barriers exist in the enrollment of patients into services within 6 days of the assessment:

- The COVID-19 impact on services has **reduced the group size to 5 patients** so safe social distancing can occur, resulting in a census reduction of more than 50%
- The South Carolina Department of Health and Human Service is **not allowing for virtual services for therapy** or education groups. This barrier prevents the department's ability to serve more patients efficiently. This significantly impacts both client access as well as treatment dosage.

A key concern raised during the planning involve the need for training and support among **law enforcement partners**. While the department has a good relationship with these departments, issues related to stigma persist. The Sheriff's department views Naloxone training and distribution as "**enabling**", and chronic disease language is not used. As such a comprehensive training and support plan (FAVOR model) will prioritize these partners, with assistance from other municipalities across the state that have made the **transition into a harm reduction model** in a law enforcement context.

SUMMARY OF TREATMENT SYSTEM CONCERNS

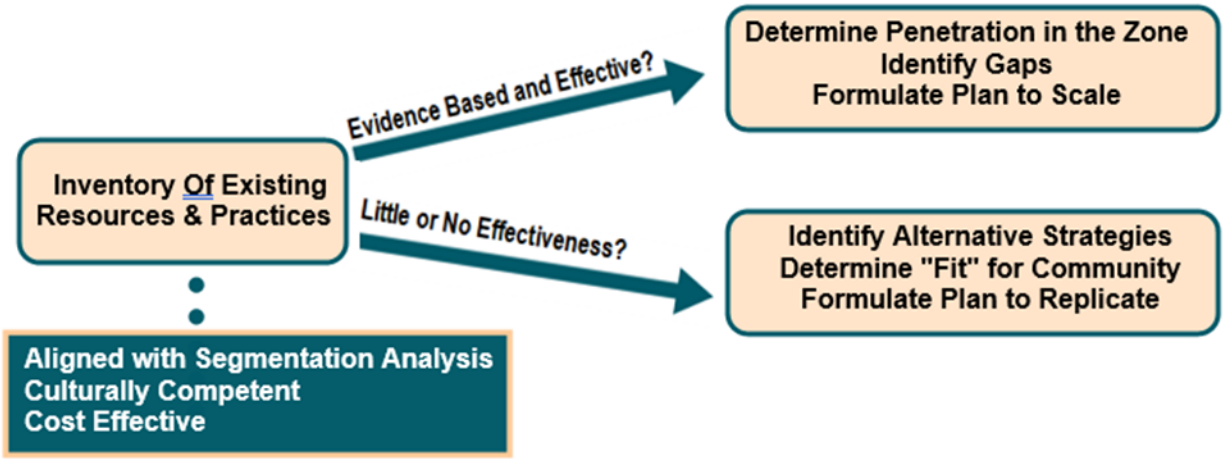
KEY SERVICE DELIVERY SYSTEM CONCERNS:

- There is only **one public treatment facility** operating in the county, providing outpatient, intensive outpatient, Medically Assisted Treatment, and recover support. The agency accepts private insurance, self-pay and sliding fee scale.
- **Current clinical capacity** is limited and represents critical concerns. With Covid, the agency has gone from serving 1,100 patients a year to less than 500. Despite the reduction in persons served, clinical staff are performing at **a 67% productivity** rate over the past the quarters.
- **Clinical Supervision** required for **licensure and accreditation** represents the greatest challenge to the expansion of new treatment staff. Current funding is available for treatment counselors, but without clinical supervision, the action would be futile.
- The explosion of **Medical Assisted Treatment (MAT)** has exhausted the current agency capacity to **meet standard**s, **issue prescriptions**, and **monitor clients**. This obstacle operates as a **bottleneck**, limiting the capacity of the agency to employ what is now known as one of the gold standards of opioid misuse treatment.
- Like many **detention centers**, the local facility can function as a "**revolving door**" to clients incarcerated with substance use disorders and receive little or no treatment to prepare for transition back into the community. The risk of overdose also represents the **leading cause of death** following detention release.

CRITERION 2: RESPONSE (METHODOLOGY/WORK PLAN CHALLENGE)

A. The Clarity and Comprehensiveness of The Applicant's Proposed Methods for Fulfilling All Core Activities, As Outlined in Section IV.2 Of The NOFO

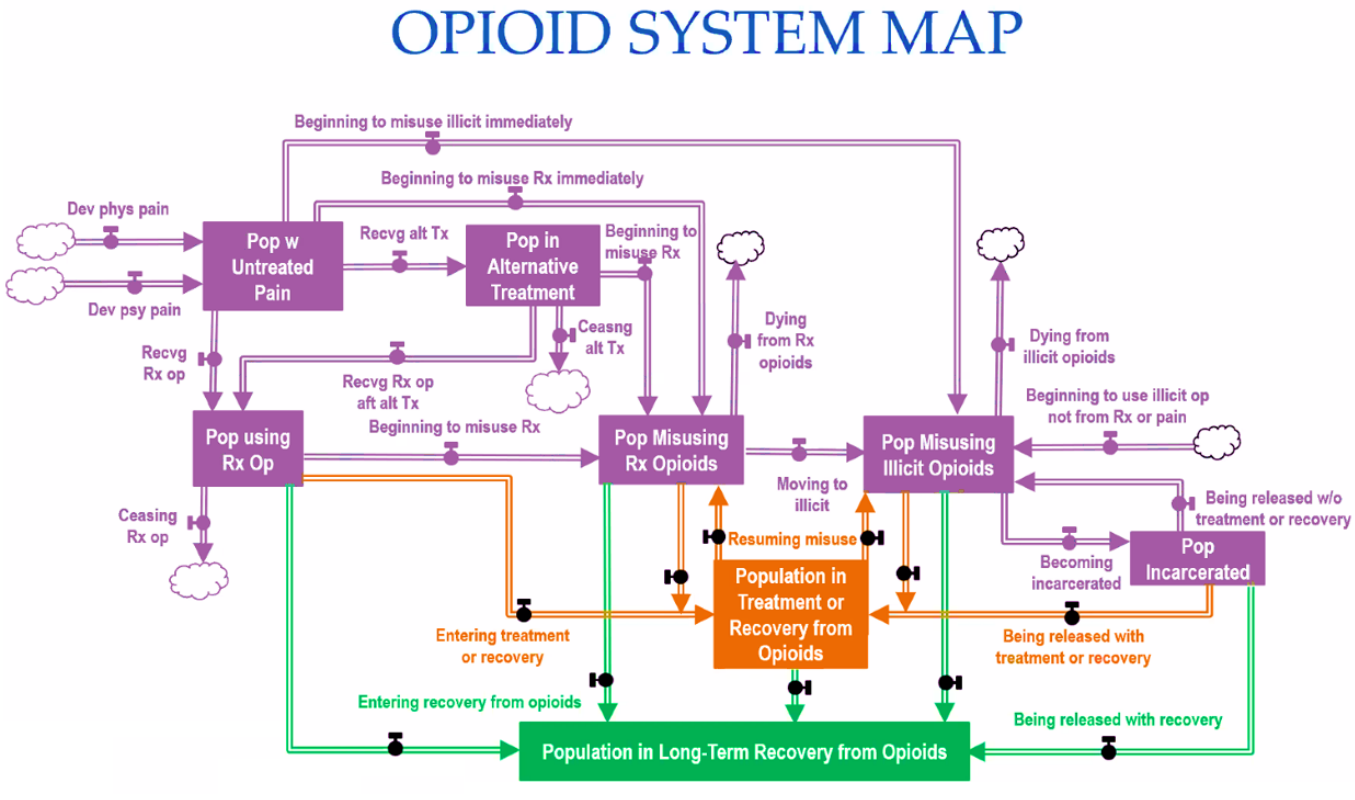
The development of the project work plan was not completed in a cavalier or adventitious manner, but based on a **rigorous community needs assessment**, input from **consortium members**, and extensive **review of empirical literature**. Project leaders reviewed the work of other states or municipalities that have been successful in reversing misuse, especially Ohio and West Virginia. As such, the proposed project has been designed to address local **service gaps** through a **coordinated network** of **evidence-based solutions**, proven effective in **communities with similar demographics** as in Beaufort. One of the first steps was a careful examination of currently available resources in **three domains: Prevention, Treatment and Recovery**. The scope and capacity of local resources were assessed to determine **alignment with research** and consonant with critical gaps identified in the needs assessment. This process is summarized in the schematic below and resulted in several key strategies that form the foundation of the work plan.



Next, the overall work was guided by several **action theories gaining prominence**, especially within South Carolina. First, there has been much discussion towards understanding health in a broader definition structured around **social determinants of health**[8], such as poverty, unemployment, and educational attainment. In this framework, individuals seeking treatment for substance use disorders are better understood when other affiliated and causal conditions related to addiction are addressed, such as family functioning, education, and employment, all of which call for a more individualized approach to service delivery and importance of high-quality case

[8] Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity; Atiga & Hinton, Disparities Policy, May, 2018

management. Next, recent additions to the Criminal Justice literature employ a **public health model** for understanding problems such as **substance use** and **violence**[9]. This work is grounded in **general systems theory,** which emphasizes the interconnectivity of varying elements in the development, maintenance and amelioration of a behavior such as substance misuse. The system map below summarizes the complex nature of the problem with attention to **access to opioids**, the transition **from use to misuse**, **treatment and recovery process**, and interface with **public safety and enforcement**.

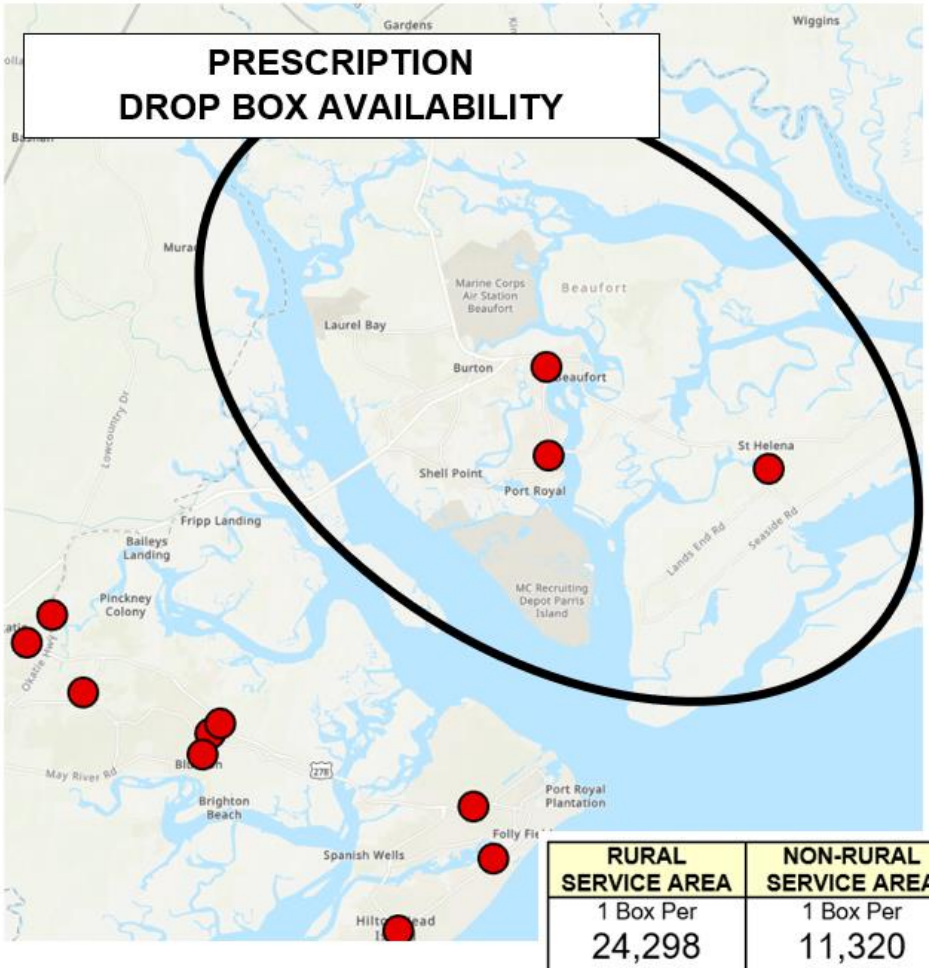


With the assistance from a consultant trained in system theory, consortium members engaged in extensive analysis of **local conditions and elements** that have helped drive the problem in Beaufort along with existing dynamics already in place to combat the problem. This process, **less static than a typical logic model**, was employed to ensure that proposed interventions **did not operate in isolation** but part of a more **complementary and collaborative** network of solutions. Specifically, to address such a complex problem, strategies must **address multiple systems levels**, with careful attention to **prevention, treatment, and recovery**. Based on these theoretical paradigms, the following summarizes proposed methods to address critical concerns identified during assessment.

[9] Centers for Disease Control, Public Health Approach to Violence Prevention, 2019

PREVENTION – MOVING UPSTEAM

While the field of prevention has evidenced an explosion in terms of both **theory and research**, specific studies that f**ocus exclusively on the prevention of opioid misuse are few.** A casual internet search for the term "Opioid Prevention" is likely to return information related to the **prevention of overdose**, **Naloxone**, or school-based curricula but **do not explicitly focus on the unique conditions** surrounding the abuse of prescription painkillers. The most common strategy supported within the field involves an attempt to remove unused medications through "**drug take back days**" or **prescription drop boxes**. Unfortunately, while the collection boxes are widely used within Beaufort County, amassing hundreds of pounds of discarded medications, the availability of these tools in the target census tracts are somewhat limited. The GIS map below illustrates the **relative scarcity of drop boxes in the eligible service area.** Given earlier data with regards to the density of **senior citizens, disabled, and veterans,** supports in this region are especially needed.

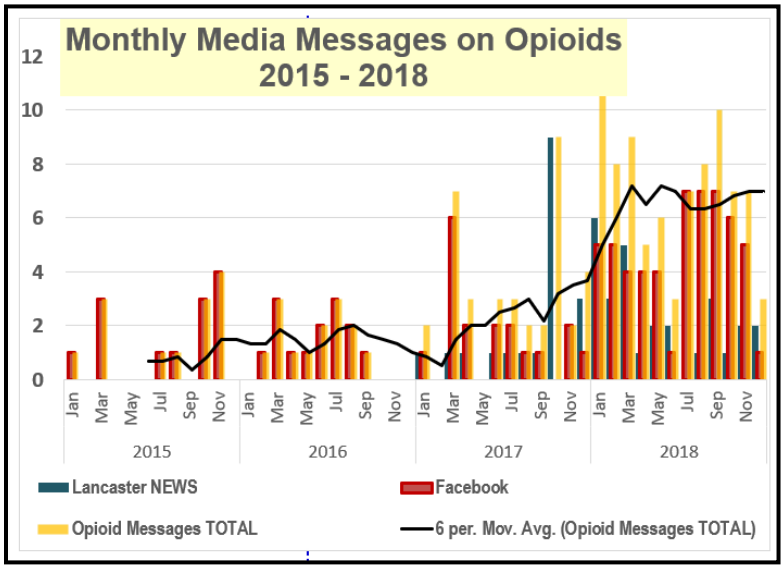


GIS mapping suggests the need for at least **four more boxes**, which will be secured through the Implementation Grant. Likewise, the plan calls for a rigorous **awareness campaign to promote use** of these tools as well as other important environmental prevention elements.

During planning of the project, a **media analysis** was conducted to determine the most **common message domains** related to substance misuse, especially opioids. The results suggest a disproportionate level of attention on what is best described as "**Ain't it Awful**." With all respect and not to minimize the tragic impact that this epidemic has had across the state and nation, but news stories that decry the problem but do little to promote measurable **changes in knowledge, attitude or behavior** are unlikely to ameliorate the problem. However, within the state, there has been a shift towards solution focused media attention designed to articulate specific skills or behaviors, that if practiced, are likely to reduce the incidence of prescription drug-abuse. Key elements of this framework include:

- ✓ Safe **Handling and Storage** of Prescription Medications, Especially Painkillers
- ✓ The **Dangers of Sharing** (Or Selling) Prescription Medications with Family or Friends
- ✓ **How and Why to Dispose of Unused Prescription** Medications
- ✓ The **Purpose and Proper Administration of Naloxone**
- ✓ Availability and Efficacy of **Local Community Treatment Resources**
- ✓ The **Role of Peer Recovery Supports** and How to Access Them

The Beaufort County Opioid Action Network (consortium) will design and implement a targeted **community awareness and media campaign** structured around these message domains, employing a range of tools including **social media, traditional media** sources such as **newspaper, television**, and **radio**, flyers, and bus advertising. The evaluation consultant has significant experience in the tracking of public awareness campaigns to determine saturation, message domain, and whether such attempts produce changes in public norms and behaviors. The chart to the right is from a **comparable project in the state** that has tracked media messages for **five years.** Examples of this new focus on solution focused public awareness are detailed on the next page.



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ALCOHOL & DRUG ABUSE DEPARTMENT

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Opioid epidemic hits Beaufort County

Published on August 24, 2017 — in News

By Amy Rigard

The number of opioid-involved overdoses and deaths continues to increase throughout much of the country, and Beaufort County is no exception.

According to the Centers for Disease Control and Prevention (CDC), the number of overdose deaths involving opioids – including prescription opioids and heroin – has quadrupled since 1999.

Ninety-one Americans die every day from an opioid overdose, according to the CDC.

According to Capt. Bob Bromage, the Beaufort County Sheriff's Office has seen a surge in


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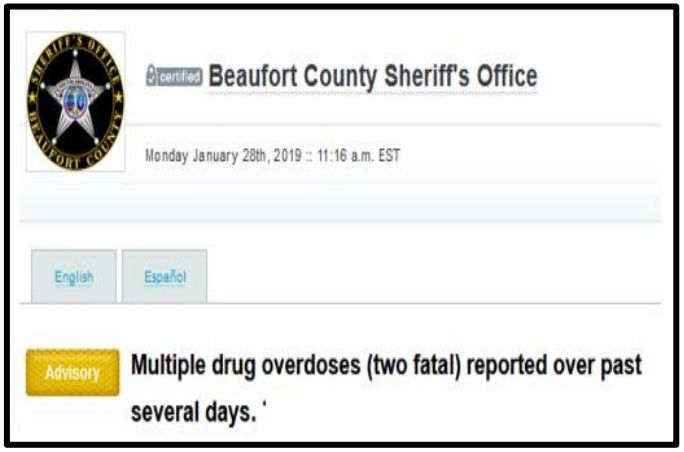
HOME NEWS TRACKING THE VACCINE FIRST ALERT WEATHER SPORTS

Drug overdoses rising in Beaufort County. Here's how you can lower those numbers

The Beaufort County Sheriff's Office says drug overdoses, including those involving opioids, are rising in the Lowcountry. And two lives have recently been lost as a result.


certified Beaufort County Sheriff's Office

Monday January 28th, 2019 :: 11:16 a.m. EST

English Español

Advisory Multiple drug overdoses (two fatal) reported over past several days. '

PROBLEM FOCUSED

SOLUTION FOCUSED

To further expand the saturation and reach of the campaign, **electronic Robo-calls** will be employed to create and broadcast messages in a more exact and targeted manner. A **consumer database of every household** in the county will be secured from a national marketing firm (e.g., Hoovers, InfoUSA, etc.) that provides a range of publicly available demographic data (e.g., **age, race, ethnicity, gender, family composition**, **socioeconomic indicators**, etc.) along with name, address, and phone number. This database will enable the consortium to develop and disseminate messages based on these criteria and provide a more individualized awareness campaign. For example, the marketing list could be employed to identify every household likely to include a **grandparent.** A **60 second Robo-Call** could then be directed to these households to take steps to safely secure medications from teen grandchildren that may visit.

Likewise, unique targeted messages can be directed to households with calls recorded by a range of stakeholders (e.g., **county council representative** to his or her constituents, the **police chiefs in different municipalities**, **sheriff, school principal**, or clergy. By individualizing message, messenger, and target recipient, community awareness strategies can have a more focused and deliberate impact. All aspects of these environmental prevention strategies have likewise been included in the evaluation methodology to track both process and outcome.

It is important to note that Beaufort County Alcohol and Drug Abuse Department has made a significant shift towards the use of environmental strategies, under guidance from state authorities. While there are numerous evidence-based prevention curricula available, the **ongoing cost of delivery** to cohorts of youth, year after year, becomes an obstacle. Environmental prevention works to alter the **physical, cultural, or governmental variables** that will lead to long-standing changes in behavior. For example, one of the most effective environmental changes has been **raising the legal drinking age to 21**. After states adopted a 21 minimum drinking age, saw a **decline of 19% in underage drinking**[10]. Other environmental strategies with demonstrated capacity to deter misuse include **high**

[10] Serdula MK, Brewer RD, Gillespie C, Denny CH, Mokdad A. Trends in alcohol use and binge drinking, 1985-1999: results of a multi-state survey. AM J PREV MED. 2004;26(4):294-298

visibility enforcement[11], **ignition interlocks** installed in cars[12], and **lowering the blood alcohol level** required for citation for DUI[13]. The consortium is especially interested in the utilization of more environmentally informed frameworks in addressing opioid misuse in the targeted census tracts.

TREATMENT – MEETING DEMAND AND HARD TO REACH

The proposed project represents an expansion of services that the applicant organization is well experienced in which significantly enhances the overall implementation process. While a number of **high-quality services are available,** data presented earlier highlight **critical shortages facing the community**. The applicant is also well experienced in each of the proposed evidenced based services, licensure and reporting requirements, assessment protocols, and the importance of fidelity reviews. The overall implementation process for this element will be defined by five distinct steps, as outlined below, and further outlined in the **Work Plan)**:

STEP I: Clinical Supervision Capacity Expansion- Current limitations on clinical supervision necessary for licensure and monitoring will allow the agency to fill current vacant counselor positions and significantly increase treatment population base. One position will be secured. **Job descriptions** have been devised and if funded, positions will be advertised, interviewed, and selections made with careful attention to **education, experience, and understanding of local culture, language, and conditions.**

STEP II: Medically Assisted Treatment Capacity Expansion- The second obstacle involves access to an Advanced Practice Registered Nurse (APRN) able to manage new MAT patients, with special supports for the detention partnership.

STEP III: Case Management and Peer Support Capacity Expansion- Covid restrictions have resulted in a service delivery model that requires additional client supports, case management, and client monitoring. Based on the gap analysis, **two new positions** will be hired to meet the growing demands of targeted subpopulations: 1) **Clinical Social Worker**; and 2) **Peer Recovery Support Specialists**

STEP IV: Professional Development – In addition to the standard training and orientation provided for **all agency staff** and accordance with state licensure and **accreditation standards,** two key areas for additional training were identified during the assessment: 1) **Assessment and Treatment Planning**; and 2) Electronic **Health Records**.

[11] Elder et al. 2002; Shults et al. 2001
[12] Evaluation of State Ignition Interlock Programs :Interlock Use Analyses From 28 States, 2006–2011Centers for Disease Control.
[13] James C. Fell, University of Chicago; Michael Scherer, Pacific Institute for Research and Evaluation

STEP V: Full Scale Clinical Implementation - Treatment will begin the process with a full assessment and screening comprised of **psychosocial inventory**, **social history**, **addiction severity index**, **strengths-based analysis**, standardized for state funded treatment providers. An **individualized care plan** is then formulated to outline the most appropriate continuum of care that may include one or more of the following: **Individual Counseling, Group Counseling, Family Counseling, Support Groups** and **After-Care Services**. If suitable, MAT will be prescribed as part of the treatment regime and may include **Naltrexone or Buprenorphine**.

STEP VI: Ongoing Assessment and Quality Improvement- A **Project Advisory Team** will meet weekly during the first six months of the grant to conduct an **implementation review** and monitor objectives. This will then continue monthly over the tenure of the grant as part of the **CQI process**. In addition, given the importance of ongoing professional development, funds are also allocated to allow staff to participate in **two required training events**

In addition to these activities, the applicant agency also provides a range of **client support services and case management** to monitor client participation, coordinate referrals, collect and analyze program data, oversee drug testing, and track compliance. Client monitoring may include home or workplace visits, phone-checks, and collateral contacts with employers or others involved with the client. All case management activities will be logged in the client chart and reviewed weekly by the lead clinician. A key element of this component will be to assist eligible individuals with **enrollment in the Affordable Care Act** delivery system to facilitate access to health services.

B. The Appropriateness of Methods Proposed for Fulfilling All Core and Additional Activities Given Needs and Characteristics of Target Population

It is important to note the extensive care and planning that went into the development of the proposed project. The focus throughout was **consortium driven**, with attention to the entire service continuum of **prevention, treatment** and **recovery.** Likewise, it does little good to secure needed resources, only to lose these supports once **federal grant funds have lapsed.** In addition to the rigorous community needs assessment, extensive planning effort, and aforementioned systems mapping, much time was spent in **reviewing empirical literature** related to the Opioid epidemic. Project leaders reviewed the work of other states or municipalities that have been successful in reversing misuse, especially Ohio and West Virginia. As such, the proposed project has been designed to address local **service gaps** through a **coordinated network** of **evidence-based solutions**, proven effective in **communities with similar demographics** as in Beaufort. Each prioritized intervention was selected to produce the largest contribution to programmatic capacity, especially as the impact of Covid is projected to impact local conditions for at least a year or more. The inclusion of **Clinical Supervision** and an **Advanced Practice Registered Nurse** will facilitate an expansion of caseloads, with the **current therapeutic staffing levels** available under **current local and state funding levels.** The addition of **Clinical Social Worker** and **Peer Recovery** Support position will position the consortium to provide community supports

to clientele experiencing even greater economic, familial, and health related distress exacerbated by Covid. Finally, although less costly, resources directed toward **environmental prevention** activities will assist the consortium in eventually **moving upstream of the problem** and **ultimately reduce treatment demand.**

C. The Clarity and Comprehensiveness of Proposed Methods to Ensure Sustainability of Activities Beyond Period of Performance, Including:

1. Sustain Consortium Membership and Support

The Beaufort County Alcohol & Drug Abuse Department (applicant) staff have long standing relationships with community problems concerning substance abuse and misuse, as evidence by the recruitment of ten organizations recruited for the Beaufort County Opioid Consortium. The organizations represent government and the non-profit sectors. The proposed consortium membership involves local, regional, and state organizations engaged in public amenities provided in Beaufort County such as **law enforcement, emergency medical services, legal**, and **prevention, intervention**, **treatment,** and **recovery substance use services**. Since a focus of the RCORP funding is data collection and sharing, capacity for data-driven decisions will extend to other community stakeholders also addressing community issues in Beaufort County.

Specific strategies exist to ensure consortium membership and support. The strategies include:

1. Outreach to new members avoiding perceptions the group is "**closed or exclusive**"
2. Scheduling meetings at a **convenient time as determined** by membership
3. **Continuous evaluation of consortium operations** annually through an anonymous survey
4. Ensuring monthly **meetings are pertinent, deliberate, and organized** so that the meeting is mindful of the schedules of the membership
5. Ensure all consortium activities includes a rigorous evaluation methodology that allows members to **celebrate accomplishments and problem-solve when obstacles occur,** and
6. Allowing time at the meetings for members to **socialize and share both professional and personal information.**

2. Secure Target Population Support and Engagement

The Beaufort County Alcohol & Drug Abuse Department recently was awarded a small amount funding through the State Opioid Response (SOR) grant administered through the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS). The funding establishes a collaborative prevention effort among seven Beaufort County partners called Project Stigma. Project Stigma is working to address the stigma of substance use, misuse, and treatment in Beaufort County that leads individuals to believe that their substance use concerns are a moral failing.

3. Leverage Local/Community, State, and Regional Partnerships

If the RCORP funding is awarded to the Beaufort County Opioid Consortium, **opportunities for additional membership** will exist and new potential community partners will join in the effort to reduce opioid-related issues in Beaufort County. Aside from the proposed consortium membership, the proposed Beaufort County Opioid Consortium member organizations have other community relationships, such as with the **Beaufort County School District**, Beaufort County **municipal police agencies**, **University of South Carolina Beaufort**, **Coastal Empire Mental Health** and other community **non-profits and governmental agencies**.

Other funding streams for the overall work of the Consortium will be leveraged. For instance, the Beaufort County Alcohol & Drug Abuse Department recently was awarded a small amount funding through the State Opioid Response (SOR) grant administered through the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS). The funding establishes a collaborative prevention effort among seven Beaufort County partners called Project Stigma. Project Stigma is working to address the stigma of substance use, misuse, and treatment in Beaufort County that leads individuals to believe that their substance use concerns are a moral failing. If the RCORP funding is awarded to the Beaufort County Opioid Consortium, Project Stigma will not be supplanted by the new funding, but the goals and objectives of both projects will be combined strategically.

4. Optimize Reimbursement for Services Across Insurance Types and Facilitate the Health Insurance Process for Eligible Uninsured Patients

It is important to note that Beaufort County Alcohol & Drug Abuse Department is a county affiliate of the state addictions agency (SC Department of Alcohol and Other Drug Addiction Services) and as such, provides services throughout the county as a public entity. The agency currently accepts private insurance as well as Medicaid.

5. Leverage Other Funding Streams to Cover the Cost of Services

South Carolina currently provides funding to cover the cost of Buprenorphine to indigent individuals, such that Beaufort Alcohol & Drug Abuse Department regularly submits reimbursement claims to the state to cover these prescriptions. Likewise, the agency provides a sliding scale, in addition to the public and private pay funding streams.

6. Ensure Services Are Accessible and Affordable to Individuals Most in Need, Including the Uninsured and Underinsured.

Project leaders understand that the RCORP-Implementation Grant is **payer of last resort**. As such, service providers will bill for all services covered by reimbursement and **exhaust all possible efforts to obtain payment for services**. Likewise, agency policy also provides support to all clients without insurance coverage to **seek out and apply for any eligible reimbursement streams** (e.g., Medicaid, Affordable Care Act). At the same time, as a branch of the state treatment system, agency policy **will not deny any individual service due to inability to pay**. It is important to note that the Beaufort

County Alcohol & Drug Abuse Department is a well-established public treatment agency with an extensive record of services, especially to individuals who are either **uninsured or underinsured**.

WORK PLAN

A. Clarity and Completeness of Work Plan, Including Inclusion of Responsible Individuals And /Or Consortium Members, Timeframes, And Deliverables Associated with Each Core Activity And, If Applicable, Additional Activity

As indicated in the RFP, the complete **Work Plan** is provided as an attachment in the appendix to avoid repetition within the narrative. This lengthy document aligns project **goals and objectives**, with target strategies with includes specific tasks, **starting and end dates**, **responsible parties**, any **external partners** to be involved, the process for **tracking progress**. This document is further clarified within the narrative section, especially with regards to **tracking completion of each programmatic task on time** and in **budget.** The applicant agency furthermore commits to participate in all required **data tracking requirements**, regular **reporting as requested**, and travel related to **grantee orientation** outlined in the RFP. Work plan details, coupled with narrative supports articulate the involvement of each consortium member, especially as it relates to service on the **Project Advisory Team**, over the **three-year grant tenure** to monitor each aspects of **program implementation, management,** and **evaluation.**

B. Extent to Which the Work Plan Reflects A Three-Year Period of Performance / Timeframes are at Minimum Broken into Quarters

As per instructions detailed in the RPF, the project Work Plan summarizes tasks associated with the **entire three-year grant tenure**. Instead of projected dates, the plan is structured around specific **quarterly time segments**. This approach (As abbreviated in the Work Plan: **Y1: Q1, Q2, Q3, Q4, Y2: Q1, Q2, Q3**…) obviously involves greater actions during the onboarding of the project but provides consistent attention from project beginning to final reporting submitted to grantor.

C. Extent to Which the Plan Incorporated Processes for Reducing Health Access and Outcome Disparities in Target Population

A key element of the aforementioned **systems model,** and informed by the **social determinants of health framework**, is an emphasis on addressing a wider spectrum of **concerns beyond substance misuse disorder issues**. This is especially significant given the staggering level of poor health among the target census tracts described during the segmentation analysis of **CDC indicator data**. This was a key decision in the prioritization of **client support services and case management** to monitor client participation, coordinate referrals, collect and analyze program data, oversee drug

testing, and track compliance. Client monitoring may include home or workplace visitation, phone-checks, and collateral contacts with employers or others involved with the client. All case management activities will be logged in the client chart and reviewed weekly by the lead clinician. A key element of this component will be to assist eligible

individuals with **enrollment in the Affordable Care Act** delivery system to facilitate access to health services. These strategies are likewise outlined as required in the work plan.

D. Extent Work Plan Details Process for Financial & Programmatic Sustainability Beyond Period of Performance, Including Deliverables, Responsible Parties, And /Or Consortium Members, And Timelines Associated with Processes

As indicated earlier, the work plan includes details related to the **minimization of long-term cost centers** for proposed activities and emphasizes expenditures that will **maximize currently available resources** (expanded Clinical Supervision and MAT). Likewise, elements related to sustainability are also included in the plan, and discussed in even greater detail later in the narrative.

E. Extent to Which the Work Plan Includes Activities Related to Tracking and Collection of Aggregate Data to Fulfill Reporting Requirements

Consortium members have taken significant effort during planning to ensure that systems were created to facilitate ongoing **collection, aggregation, analysis** and **reporting** of all data, **required by the RFP** as well as **part of the overall evaluation** effort. For this reason, **baseline data has already been secured** and reported in a series of tables (Section I). Likewise, a network of **local, state, and national archival databases** has been identified that will further be employed over the course of the three- year grant tenure. Discussions have taken place with regards to a series of targeted **surveys** to be employed with treatment clients (in full compliance with **participant protections including HPPA**), as well as an ongoing **community household survey** to **monitor changes in local norms** associated with the planned awareness campaign.

Assisting in the effort will be a **consultant team** to support **ongoing tracking and evaluation of the project.** This team has conducted evaluations of **over 60 state and federal projects**, with an emphasis on **substance misuse, community health**, and **public safety**. Much of the planning and discussion of each element related to tracking and collection of aggregate data has **already been positioned within the system**, which will greatly **enhance the speed in which the project can be onboarded**, if funded.

RESOLUTION OF CHALLENGES

A. Extent Applicant Describes Internal and External Challenges in Implementing Proposed Work Plan, & Quality of The Solutions Proposed to Address Them

While much planning and discussion were focused on development of the project, there are however several key challenges that present significant opportunities for the growth and effectiveness of the consortium. Throughout the state, **the adoption of a harm reduction model** related to the opioid epidemic has evolved significantly. Three years ago, **few municipalities actively encouraged law enforcement officers to carry and administer naloxone.** Concerns regarding liability, training, security, and cost were often raised. The governor then created a **state tracking system** to monitor naloxone distribution by each law enforcement agency in South Carolina, **still voluntarily** at the local level. Likewise, as **adult treatment courts** expanded across the state, local authorities often questioned the wisdom and efficacy of **Medically Assisted Treatment.** Most common objectives suggest that such actions merely **substitute one drug for another** or lead to long lines of methadone patients in blighted neighborhoods.

The grant applicant has an excellent relationship with law enforcement and first responders in the county, as these entities play a major role on the consortium, they are open to additional training and discussion surround harm risk reduction. Despite their participation, there is a **great deal of stigma** that exists with regards to understanding the **dynamics of addiction**, **treatment efficacy**, and **brain structure** as it relates to **long term participation in MAT**. The Sheriff's department views Naloxone training and distribution as "enabling", and chronic disease language is not used. The lack of using recovery-oriented language is also true for the fire rescue departments. These critical partners struggle to understand the scientific advances of the benefit for providing medication assisted treatment to offender populations. To that end, law enforcement and a variety of first responders could benefit from anti-stigma and medication assisted treatment education and training.

This challenge, why not unique, presents a promising opportunity for the consortium. Law enforcement members have agreed to work together on making the **transition to a harm reduction framework** and participate in a **series of training activities** and consultations to review the science and **best practice protocols.** To assist is **Face and Voices of Recovery**, one of the most prolific and effective recovery advocacy groups in the entire state. This organization well aware of stigma and especially adept at helping communities **understand current science** and discussion of **myths and misperceptions**

Next, since law enforcement credibility is enhanced when the message itself comes from other law enforcement officers, the plan calls for a series of consults to be provided by the sheriff in the upstate are who has successfully made the transition to the harm reduction framework, after much consideration and initial objection. In fact, this municipality is the **first rural sheriff's office in South Carolina** to implement the nationally recognized Law Enforcement Assisted Diversion (LEAD) model. LEAD is a **pre-booking diversion** program developed to address low-level drug and prostitution crime. The program allows law enforcement officers to **redirect low-level offenders** engaged in drug or prostitution activity to community-based services, instead of jail and prosecution. The model has been named a best practice model by the **National Institute of Corrections**, **Bureau of Justice Assistance, Ford Foundation, CrimeSolutions.Org**,, and **DrugPolicy.Org.** Numerous national evaluations of LEAD have demonstrated its capacity, with the largest study showing the model **reduced short-term recidivism by 23%, and long-term by 56%.**

LEAD
LAW ENFORCEMENT ASSISTED DIVERSION

It is probably no coincidence that the upstate sheriff was named **Sheriff of the Year** last year, due in part to his aggressive work in addressing opioid misuse within a public safety system, strongly grounded in harm reduction. He has generously agreed to assist with consultations and conduct community tour of local programs in the upstate. In addition, a member of the evaluation team (**Dr. Michael George**, of the Pacific Institute for Research and Evaluation, at Berkley) is a retired officer with **over 20 years law enforcement experience** in South Carolina. With an expertise in **enforcement, public health, and harm reduction**, Dr. George will play a key role in helping build local capacity and address perceived challenges related to stigma.

B. The Extent Which Applicant Details Potential Challenges and Solutions to Sustaining Services After the Period of Performance Ends

As indicated earlier, much of the organizational infrastructure and critical gaps identified during planning are **directly related to or exacerbated by the onset of Covid.** As **businesses closed, tax base decreased**, and **public funding suffered**. Given the strong tourism sector in the county, permanent business closures are unlikely, and as the Governor is easing restrictions in the near future, it is likely that previous revenue streams can be restored. In addition, the acquisition of **clinical supervision** and **Advanced Practice RN** with **MAT waiver**, will result in an immediate expansion of service delivery in the target census tracts. These priorities will greatly enhance sustainability potential to ensure continuation of efforts once federal grant funds have lapsed.

Next, project leaders understand that the RCORP-Implementation Grant is **payer of last resort**. As such, service providers will bill for all services covered by reimbursement and **exhaust all possible efforts to obtain payment** for services. Likewise, agency policy also provides support to all clients without insurance coverage to **seek out and apply for any eligible reimbursement streams** (e.g., Medicaid, Affordable Care Act). At the same time, as a branch of the state treatment system, agency policy will **not deny any individual service due to inability to pay**. It is important to note that the agency is a well-established public treatment agency with an extensive record of services, especially to individuals who are either **uninsured or underinsured**. This emphasis on existing reimbursement streams is also a key element in the sustainability plan.

Finally, importance of the consortium cannot be overstated. The process of data collection and analysis, planning, discussion, and formulation of intervention strategies has stimulated the group to **explore other potential venues for partnership**. During the next meeting the group will discuss **Adult Drug Treatment Court**, **MAT Expansion Psychostimulant Program Resources**, and the aforementioned **Law Enforcement Assisted Diversion** initiative. Similar planning efforts are likely to be adopted to strengthen overall resources for community, both **federal and state**. Project leaders that strong assessment data, combined with a prolific partnership, and high-quality service models are essential to securing highly competitive state grants, as well as federal.

EVALUATIVE MEAURES (EVALUATION& TECHNICAL SUPPORT

A. Clarity & Comprehensiveness of Processes (Staffing/Workflow) For Tracking, Collecting, Aggregating, Reporting Data from Consortium Members

The proposed project will employ the data, in addition to the required **Core Measures** outlined with **baseline data in the required chart presented earlier (Section 1D)**, to track progress towards stated goals and objectives. Partners envision the current problem with short term, mid-range, and long-term outcomes, as outlined in the graphic below, with the ultimate outcome of reducing Opioid misuse, overdose, and morbidity. To that end, all consortium activities employ a rigorous evaluation methodology to track activities throughout planning and implementation.

A significant strength of the Beaufort County Alcohol & Drug Abuse Department (BCADAD) is that over the last several years, BCADAD has adhered to data driven decision making. With support from the **Data Coordinator**, extensive data will be collected to monitor the overall incidence and prevalence of substance use disorders, especially Opioid related, changes to community norms, and progress towards implementation of all elements of the work plan. The following table describes each data element, and how and when this data will be collected.

Voice–Vision-Leadership

Data Element	Foci	Frequency & Methodology
Outcomes and Associated Harms		
Youth 30 Day Non-Medical Use of Prescription Drugs	Survey of middle and high school students on incidence of non-medical use of prescription drugs and other drugs; Perceived risk of use; Perceived parental and peer disapproval	Twice a year, based on Communities that Care Survey.
Adult 30 Day Non-Medical Use of Prescription Drugs	Community Survey of the incidence and prevalence of non-medical use of prescription drugs, perceived norms, and attitudes	Stratified random sample of 1,000 residents, Bi-annual: Monthly from treatment and recovery clients.
Overdose Deaths	Deaths from Prescription Drugs by drug class including prescription opioids Total, Fentanyl, and Heroin	Collected monthly from coroner, public health records
Hospital Admissions	Admissions for drug poisoning, overdose, etc. by drug class including Opioids Total, Fentanyl, Heroin (Not for dependency)	Collected monthly, SC Dept. of Health and Human Services
ER discharges	Discharges related to opioid overdose	Collected monthly, SC Dept. of Health and Human Services
Prescription Validity	% of Opioid overdose cases with valid prescriptions.	Monthly; Coroner and SCRIPTS records
Outcomes Related to Treatment Access		
Timeliness of Treatment	Mean length of time to enter treatment from overdose event or crises which lead to requesting or entering treatment	Patient survey conducted in inpatient and programs
Treatment Access	# of treatment admissions for prescription drug misuse recovery/dependency both outpatient and inpatient	Monthly; aggregate records from treatment partners
Treatment Duration	Average length of time for patients in opioid treatment	Monthly; aggregate records from treatment partners
Access to MAT	# of Medically Assisted Treatment (MAT) cases are active	Monthly; aggregate records from treatment partners

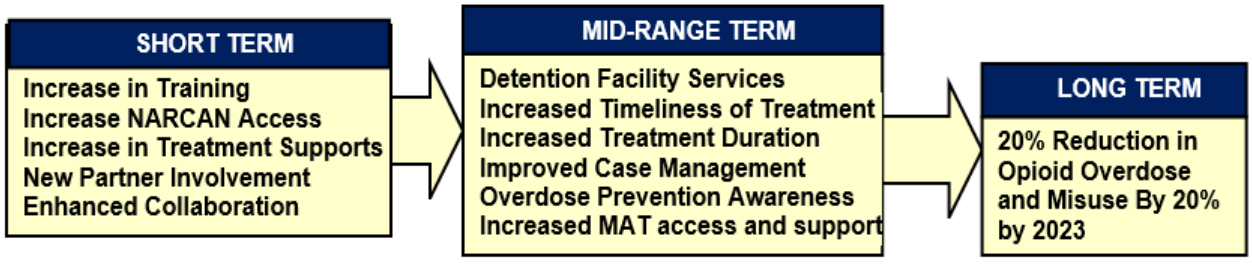
Voice–Vision-Leadership

Data Element	Foci	Frequency & Methodology
Naloxone Leve of Use to Prevent Opioid Overdoes		
NARCAN Training	Accumulative % of Police, Fire, and ER personnel Trained for proper administration of Naloxone for overdose cases	Annual; Training records from consortium partners
NARCAN Use	Number of Naloxone Administrations	Monthly: Collected by consortium partners
Social Availability		
Social Sources	% of Opioid users citing various social sources	Annually, Community survey; Patient surveys from treatment
Source by Treatment	% of Opioid users admitted for treatment citing various social sources	Monthly; ER Admissions, Treatment Admissions
Access to Disposal Tools	Number of Prescription Drop Boxes, Location, Hours of Operation	Monitored monthly
Disposal Box Content	Weight of prescription drugs in each drop box by class	Conducted by law enforcement; monthly
Retail Availability		
Source	# of Non-Medical Prescription Drug Users obtaining from retail sources including from local providers	Annual; As part of Community Survey
Source by Treatment	# of Opioid users Admitted for Treatment citing various retail sources	Monthly; ER Admissions, Treatment Admissions
Pharmacist Training	# of pharmacists trained and accumulative # registered with SCRIPTS	Monthly; Pharmacy Board; SCRIPTS
Provider Training	# of local health providers trained and accumulative # registered with SCRIPTS	Monthly; County Medical Association; SCRIPTS
Opioid Distribution	# of Opioid Prescriptions issued by local providers	Monthly; SC SCRIPT Monitoring System

Voice–Vision-Leadership

Data Element	Foci	Frequency & Methodology
Community Awareness and Environmental Prevention		
Prescription Drop Box Site Location	GIS Mapping of Drop Box Locations, aligned with Awareness Data and Utilization	Quarterly, Data from Drop Box Sites
Prescription Drop Box Promotion	Number of traditional and social media messages targeting drop box locations or events.	Quarterly, Media Analysis
Prescription Drop Box Utilization	Content by weight of each drop box by location and date.	Quarterly, Data from Drop Box Sites
Prescription Drug Storage Promotion	Number of traditional and social media messages targeting safe storage procedures or promotions	Quarterly, Media Analysis
Prescription Drug Storage Practices	Percentage of respondents reporting awareness of, and effective practice of recommended storage practices	Household survey, annual
Prescription Drug Sharing Awareness	Number of traditional and social media messages focused on reduced sharing of prescription medications	Quarterly, Media Analysis
Prescription Drug Sharing Practices	Percentages of respondents reporting awareness of dangers of, and effective practices to reduce prescription drug sharing.	Household survey, annual.
General Community Awareness	Number of traditional and social media messages content categorized around 1) general awareness and concern of the problem; 2) general awareness of local entities working toward a solution; 3) general awareness of availability of local resources; 4) general awareness of purpose and protocol for administration of Naloxone, and 5) impressions regarding efficacy of existing resources and promotions.	Household survey mirrored by community partner survey administration of within-reach populations.

Partners envision the current problem with short term, mid-range and long-term outcomes, as outlined in the graphic below, with the ultimate outcome of reducing Opioid misuse, overdose, and morbidity. To that end, all coalition activities employ a rigorous evaluation methodology to track activities throughout planning and implementation. In addition to these outcome indicators, the data monitoring plan will also address overall implementation, with the following **process indicators** employed:



PROCESS INDICATOR	PLAN FOR TRACKING
General Assessment, Analysis, and Planning Indicators	
Number of Consortium Meetings / Attendance Level	Meeting Sign-in Sheets / Documentation of Minutes
Number of new Consortium Members Engaged in Initiative.	Consortium Memorandum updated annually.
Number of GIS Maps Developed	Map Count by Project Director
Electronic Robo Calls	Number of calls made, percentage of households that listen to full message, saturation based on zip code.
Compliance with Project Timeline	Target tasks, planned dates, compared to completed tasks and dates.
Budget management over grant tenure	Monthly expenditures to date, compared to year to date, proportionate to 36 full months of funding.
Continuous Quality Improvement	Monthly meetings, documented minutes, data reviewed, and scheduled follow-up; Number of obstacles identified, addressed and timeframe.

As indicated earlier, the project will employ strategic use of **Geographic Information System (GIS) Mapping** to analyze specific target populations including **senior citizens** (most likely to suffer falls or illness requiring painkillers)**,** Imputation of **Health Insurance Coverage**, by Age and Educational Attainment**, Veteran Status** (often

linked in literature as a risk factor), and **Disability Status** (likewise a potential risk factor associated with misuse. This data will be employed to monitor population changes, but no patient identifiers or protected information will be accessed, employed or mapped.

In addition to alignment with census data, the database will also be employed for **electronic telephone calls**, recorded by the Sheriff, Police Chief, Mayor, or County Administrator to inform the public of ongoing activities such as **enforcement patrols**, **community forums,** household **community surveys**, or other awareness strategies. Electronic calls will be coupled with a network of existing **digital mobile signs** that law enforcement can be **relocated throughout the county**, **strategically aligned** with any of the aforementioned shapefiles or mapping results. In this way, data collection, analysis, and awareness activities can all be more systematically conducted as opposed to a 'shotgun' approach and hoping that the most relevant target populations will be reached.

The Program Coordinator, with support from the Data Coordinators, will be responsible for collection of all process and outcome data, to be submitted quarterly to members of the consortium, as well as incorporated into a project **data dashboard** for use in monitoring performance over time. As indicated earlier, the Data Coordinators will meet bi-weekly during the first year to monitor implementation and outcome data. In cases where programmatic benchmarks or timelines are at risk, the team will devise corrective action strategies.

B. Extent Which Applicant Designates Individual in Staffing Plan (Attachment 5) To Serve as A "Data Coordinator"

The plan calls for the current Office Manager at the agency to serve in this capacity, at .25 FTE. He currently manages data systems for reporting state and fiscal reports and was involved in the planning of the effort, including support in collection of baseline data.

C. Extent Letter of Commitment Contains Explicit Commitment by Consortium Members to Sharing Aggregate Data to Fulfill Reporting Requirements.

Each member of the consortium assisted in development of a data collection plan, with strong emphasis on ensuring participant protections and to **comply with HIPAA** and other local, state and national regulations. As such, any potential concerns or obstacles have been discussed and data has been forthcoming throughout the planning process. The signed **Letter of Commitment** explicitly indicates the **willingness to share aggregate** (not patient-level or other personally identifiable information) **performance data and information with the applicant organization** to fulfill HRSA reporting requirements.

CRITERION 4: IMPACT EVALUATION & TECHNICAL SUPPORT

A. Clarity & Comprehensiveness of Plan for Updating Participating Entities, Target Area, & Public on Activities, Lessons Learned, & Success Stories

Members of the consortium have extensive experience in information dissemination. Potential platforms will include venues such as **social media**, **newspapers**, **state law enforcement networks,** and the South Carolina **Department of Alcohol and Other Drug Addiction Services** network. The consortium has also learned the importance of interfacing with local, state, and federal **legislative delegates**; and often hosts delegate tours to spotlight local issues or success stories to elected officials. This is especially important given the extensive plans involving the development of a community awareness campaign to address key norms and behaviors. Previous strategies described with regards to **tracking media message domain** and **saturation over time**, coupled with an **annual community household survey** provides an excellent opportunity for articulating **lessons learned, success stories**, and ongoing **awareness.**

Another significant resource for dissemination is the **National Rural Substance Abuse Prevention Conference**, hosted at the University of South Carolina-Lancaster. Founded through a SAMHSA grant, this conference is **now in the 13th year,** and highlights the **unique challenges of conducting prevention in a rural context.** This **three-day conference** brings national speakers to South Carolina and averages 200 in attendance, with participants from **26 states and Canada**. Project leaders have contacted conference organizers for future **Calls for Presentation**, with the hopes of participating as presenters. The plan is to theme next year's conference around Opioid misuse, with tracks for **law enforcement, physicians, pharmacists**, and **prevention specialists.** If accepted, this presents an excellent opportunity for stakeholders from Beaufort to spotlight their work and engage in discussions with other leaders from throughout the state and nation.

B. Extent Which Applicant Provides Examples of Mediums and Platforms for Disseminating This Information.

As indicated earlier, a key element of sustainability is dissemination of information to promote greater knowledge and understanding about the value of research informed practices. Consortium members are positioned to conduct a series of formal **presentations** and **town hall meetings** as a mechanism for information exchange. As such, in addition to planned presentations at **city and county council, school board**, **civic groups**, and meetings with **medical providers and hospital staff**, project leaders have prioritized **local newspaper, radio,** and **television outlets.** However, one of the most important dissemination platforms is publication in **peer reviewed journals**. The evaluation team has extensive publication experience and are most interested in exploring possible work, especially with regards to the impact of community awareness activities.

CRITERION 5: RESOURCES / CAPABILITIES

A. Extent Which Applicant Demonstrates Consortium Is Comprised Of At Least Four Separately Owned Entities, Including the Applicant Organization

As required within the RFP, **Attachment Two** provides a detailed chart listing all consortium members participating in the proposed project. This information provides all required information, including the following elements:

Consortium Member Name	Member Street Address / County
Point of Contact at Organization	Employer Identification Number (EIN)
DUNS / EIN	Service Delivery Site
Sector Represented	RCCORP Award History
NHSA Site or Eligible	Located in HRSA Rural County or Tract
Signature on Letter of Commitment	

B. Extent Which Applicant Demonstrates At Least 50% of Consortium Members Are Physically Located In HRSA-Designated Rural Area (Rural Eligibility Analyzer)

On February15, 2021 a query was conducted of the HRSA Eligibility Analyzer, for each address of every consortium member participating in the project. Every single member is **located and operates in an eligible rural tract.** Attachment Two summarizes the rural eligibility analyzer data.

C. Extent Which Consortium Members Represent Diverse Sectors & Disciplines

As indicated earlier, the proposed project is the work of consortium of local stakeholders, well familiar with each other, and comprised of the following:

Beaufort County Alcohol and Drug Abuse Department	
Beaufort County Sheriff's Office	14th Circuit Solicitor's Office
Beaufort County Detention Center	Lady's Island Internal Medicine
Lady's Island /St Helena Fire District	Burton Fire District /EMS
South Carolina Office of Rural Health	Lowcountry FAVOR
SE Center for Strategic Community Development	SC DAODAS

This group represents expertise in law enforcement, healthcare, behavioral health, community development, recovery, first responders, and community mobilization.

D. Extent Which Applicant Demonstrates All Services Provided Exclusively In HRSA-Designated Rural Areas, (Rural Health Grants Eligibility Analyzer)

As indicated earlier, the targeted census tracks are bifurcated within the county, **separated by a large body of water** (Broad River), with **all required services situated within the population center of the area.** The applicant agency and all project partners have agreed to ensure that **only eligible rural residents will be served** with grant funded resources. Since the major service providers for the partner are all located in the eligible rural area and have longstanding history of service, the ability to limit provision of grant funded strategies to only eligible residents is greatly enhanced. In fact, during project planning, the process for establishing a "**geo-fence**" around service delivery and data collection was devised. This is important, as the coalition widely employs **Geographic Information Systems (GIS) mapping** as a project planning, management and evaluation tool.

E. Extent Which Consortium Members, Including Applicant, Have Signed and Dated A Single Letter of Commitment

A Copy of a scanned, **signed and dated Letter of Commitment** have been included in the attachments. This letter identifies each organization's **roles and responsibilities** in the project, the activities in which they will be included, how the organization's **expertise is pertinent to the project**, and **length of commitment** to the project. Likewise, the letters detail each entity's understanding of the benefits that the consortium will bring to the member and to the target rural service area. Finally, **all required statements are embedded within each letter.**

F. Extent to Which 50% of Signatories are Physically Located in the Rural Area

On February15, 2021 a query was conducted of the HRSA Eligibility Analyzer, for each address of every consortium member participating in the project. Every single member is **located and operates in an eligible rural tract.** Attachment Two summarizes the rural eligibility analyzer data

G. Clarity of Organizational Chart and Extent Which It Depicts Relationships And /Or Hierarchy Among Consortium Members Participating in The Project

A detailed Organizational Chart has been included in the attachment. This chart references the proposed project in **relationship to existing services and initiatives**. It delineates new proposed staff positions and **hierarchical relationship** to designated consortium members.

H. Clarity and Completeness of Proposed Staffing Plan Including Extent to Which the Plan Includes All Elements Outlined In "Project Narrative" Section

As required within the RFP, a staffing plan table has been included (Attachment 5) that provides all elements: **Member Name, Title, Organizational Affiliation, FTE**, and **Roles and Responsibilities**. In the case of positions to be hired, the table includes a **timeline, process, and qualifications**.

I. If Staff Member Has to Be Hired, Extent Which the Applicant Details Process & Timeline for Hiring/ Onboarding Staff, Qualifications & Expertise Required

The aforementioned Staffing Plan also (**Attachment 5**) provides the required information for all positions to be hired: Advanced Practice Registered Nurse, Clinical Supervisor, Clinical Caser Manager, and Peer Recovery Support. Likewise, the plan includes a general timeline and hiring process, in additional to basic qualifications for each position. Counseling Services of Beaufort generally advertises for new or vacant positions through LinkedIn, local and regional newspapers, social media, and at universities within the state that provide clinical training in substance use disorders.

J. Extent Which Staffing Plan Directly Links to Activities Proposed in Work Plan

Following the planning process preceded development of the proposed grant, significant work was done to review service delivery trends and gap analysis. As such, five positions were prioritized within the Work Plan (**Attachment 1) and** listed within the Staffing Plan (**Attachment 5**). Likewise, the entire project follows closely to the aforementioned Opioid System Mapping and SOCI recommendations (Section 1) to ensure a comprehensive and logical approach to addressing the problem.

K. Extent to Which Applicant Demonstrates that the Project Director will devote at least 25% FTE to project

The project staffing plan calls for a 100% FTE Project Director to coordinate all aspects of program implementation, management, evaluation, and reporting. In addition, the individual will Co-Chair the Project Advisory Team and provide leadership with regards to the Community Awareness Campaign.

L. Clarity & Comprehensiveness Which Applicant Describes Project Director Will Serve as Point Person & Facilitate Collaborative Input & Engagement Among Members to Complete Work Plan During Period of Performance

It is important to note that the applicant agency (Beaufort County Alcohol and Drug Abuse Department and consortium members are well established partners that interface

regularly for years. As such, the **agency Executive Director is both comfortable and experienced** in serving as point person for the proposed project. Because the process of community mobilization often involves individuals with competing agendas, the process employed by the Coalition has greatly facilitated positive **participation, communication, and buy-in**. At onset, the consortium has adopted the **Consensus Decision-Making Framework,** a process that seeks the agreement of participants, but also mitigates the objections of the minority to achieve the most agreeable decision. Once an agenda has been set and ground rules for the meeting have been agreed upon, each item is addressed in turn. The process employed in the framework is outlined on the chart below.

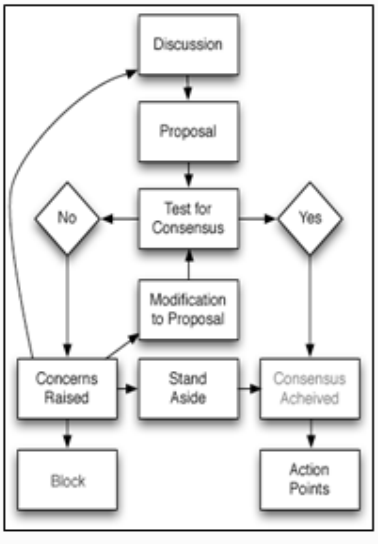
Discussion of the Item: The item is discussed with the goal of identifying opinions and information. Potential proposals for action are often identified during at this time.

Formation of a Proposal: Based on discussion, a decision proposal is presented to the group.

Call for Consensus: The facilitator calls for consensus on the proposal. Each member usually must actively state their agreement with the proposal, often by using a hand gesture or raising a colored card, to avoid the group interpreting silence or inaction as agreement.

Identification and Addressing of Concerns: If consensus is not achieved, the dissenter presents the concern, potentially starting another round of discussion to address or clarify the concern.

Modification of the Proposal: The proposal is amended to address the concerns. The process returns to the call for consensus and the cycle is repeated until a satisfactory decision is made.



M. Extent Which Applicant Describes How Data Coordinator Will Track, Collect, Aggregate, & Report Data from Members to Fulfill HRSA Data Requirements

As indicated earlier in the narrative (Section: Evaluation and Technical Support: A), a team of individuals will assist the Data Coordinator with data collection, aggregation, analysis and reporting. Much of the **planning and inter-agency cooperation** needed to collect Core HRSA Indicators and other measures was completed during the one-year planning tenure. A **Memorandum of Understanding** was devised, and still in operation, that provided access to all data points listed earlier in the narrative. A **data dashboard** was devised and is still being tracked, in most cases on a **monthly basis** to facilitate a **time series analysis**.

N. Extent Which All Proposed Staff Members Have the Appropriate Qualifications and Expertise to Fulfill Their Roles and Responsibilities

The applicant and lead investigator for the project is The Beaufort County Alcohol and Drug Abuse Services Department (BCADAD), the **sole public substance abuse treatment provider in the county.** Established in 1974, the agency functions as a department under the County Council of Beaufort County, South Carolina, established under South Carolina law (Act 301 of 1973) to help individuals and families troubled by alcohol, tobacco or other drug-related problems. The department liaises with the Beaufort County Alcohol and Drug Abuse Board, which is comprised of seven members appointed by the Beaufort County Council. The Board's role is to advise County Council, staff, and other agencies in matters concerning the provisions of ongoing programs in prevention, treatment, and recovery for alcohol and drug abuse problems.

The organization is accredited by the **Commission on Accreditation of Rehabilitation Facilities** (CARF), **licensed** by the SC Department of Health and Environmental Control, and certified by the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS). The BCADAD employs staff (and secures professional services when necessary) who are highly trained in their areas of expertise, including **person-centered care** and **evidence-based practices.** The BCADAD Treatment section is led by an experienced **Treatment Director** who has worked in the section for almost **25 years.** The BCADAD Prevention section is led by an experienced **Prevention Director** who has worked in the section for **more than 30 years**.

Key positions from the agency and consortium include:

Steve Donaldson is the Executive Director of BCADAD and will oversee the Project Director and all contracted positions in the grant during the funding period. With over 25 years of experience in roles as a Director over treatment services, Mr. Donaldson has a wealth of knowledge and expertise in running and managing treatment programs similar to the ones proposed in the grant narrative. Steve has held positions in the lowcountry area since 1998 which has bolstered his connections and vast knowledge of services available in the area and the team members running them. With his extensive experience and deep ties to the community, Steve will play a critical role in management and oversight of the proposed grant programs.

Brian Wagner - Chief Wagner is the district's Medical Training Officer overseeing the district's Basic and Advanced Life Support programs. Chief Wagner was noted for upgrading the district's medical program for both firefighters and the public. Specifically, with more than 65 percent of the emergency calls involving a medical emergency, Chief Wagner initiated the district's new Advanced Emergency Medical Technician (EMT) Program, increasing the skills of district EMTs and enabling them to deliver more advanced medical treatment to citizens. His peers universally applaud him for taking the Burton Fire District "to the next level" and he was awarded Officer of the Year in 2018.

Sara Goldsby – Sara Goldsby was confirmed as Director of DAODAS by the South Carolina Senate on February 8, 2018, after being appointed Acting Director by Governor Nikki Haley in August 2016, then nominated as Director by Governor Henry McMaster in May 2017. As Director, she has led the states response to the opioid crisis and currently serves as co-chair of the State Opioid Emergency Response Team. Under her leadership, DAODAS has been instrumental in helping local law enforcement agencies employ the use of the emergency overdose antidote naloxone. With passion around social determinants of health and access to care, Director Goldsby has worked in legal and dental practices, and hospital case management. She earned her Master of Social Work and Master of Public Health degrees – with an emphasis on health services, policy, and management – from the University of South Carolina in 2015.

Duffie Stone - Duffie Stone became the 14th Circuit Solicitor in 2006, after nearly two decades split between private practice and his work as a prosecutor in South Carolina's 14th and 5th judicial circuits. He was appointed by then Governor Mark Sanford. Stone's time as Solicitor has been marked by several innovations. Among them is intelligence-led prosecution, which uses technology and information-sharing to better understand and more effectively combat criminal elements that operate within the 14th Circuit's various communities. In 2015, he was appointed to Gov. Nikki Haley's Domestic Violence Task Force, and he currently serves as chair of the S.C. Domestic Violence Advisory Committee. Applying the lessons of those endeavors, his office launched a Special Victims Unit to prosecute rapists, domestic batterers and child abusers; and it opened the 14th Circuit Victims Center, a partnership of various nonprofit agencies that assist victims of those crimes.

Isaac Waters – Isaac Waters has made it his life's mission to support others as they build a life in recovery. He believes that the power of recovery has given him a unique opportunity to help individuals attempting to recover from substance use disorder. He has worked in many different capacities with many of the recovery organizations in the lowcountry. From founding the Collegiate Recovery Program at CofC to volunteering with WakeUp Carolina. Today, his work as Executive Director with FAVOR Lowcountry provides a platform for him to support other individuals in learning how to advocate for policy change, how to stand up and speak publicly and proudly about their recovery, and to put a face on what recovery looks like.

Col. Quandara Grant - Quandara Grant was named Director of the Beaufort County Detention Center, taking over responsibility for the jail in 2014. Prior to being named Director, Quandara served as the detention center's Security Lieutenant since 2009 and has had a tenure at the jail spanning over 25 years.

Captain Kyle Blackmon - In 2000, Captain Blackmon began his law enforcement career with the South Carolina Highway Patrol and was assigned to Beaufort County. In 2002, he transferred to the State Transport Police and worked in seven counties encompassing the low country of South Carolina. Captain Blackmon began his career with the Beaufort County Sheriff's office in March of 2004. Blackmon has attended many specialized schools and has acquired multiple instructor certifications to give him a well-rounded approach to leadership at the sheriff's office.

Captain Bruce Kline – Captain Kline has dedicated career to firefighting in Beaufort County. His tenure started in 1984 with the City of Beaufort as a firefighter and now Captain Kline has served as Lady's Island / St. Helena Fire Chief since 2005. Due to his dedication to his craft and Beaufort County, Captain Kline has extensive knowledge and connections within the county and the lowcountry.

Dr. Graham Adams - Dr. Graham Adams serves as the CEO of the South Carolina Office of Rural Health, a statewide non-profit organization striving to improve access to care, quality of life and health outcomes in rural and under-served communities. Since joining SCORH in 1995 and his appointment as CEO in 2002, Dr. Adams continues to provide technical assistance regarding strategic planning, grant development, funding opportunities, infrastructure development and resource allocation. He holds adjunct faculty positions at several universities, as well as serving on the board of trustees for numerous national and statewide organizations.

Dr. Michael D George holds a Ph.D. in Public Policy & Administration and a Master's in Justice & Public Safety with a Bachelor's in Political Science. He is employed full-time with the Pacific Institute for Research & Evaluation (PIRE) in the South Carolina office. He coordinates the evaluation of several state and county-level projects that involve collaboration among stakeholders to improve public health and public safety problems. His research and expertise areas are in high visibility enforcement, law enforcement, traffic safety, media campaigns related to traffic safety issues, underage drinking enforcement and education, qualitative research, community assessment, data collection related to substance abuse and traffic safety issues, community policing, trend analysis, community, and state collaboration, and occupant protection issues.

Dr. Paul N. McKenzie is a social scientist and proposed evaluator with 30 years of experience. He is the founder of the Institute for Adolescent Addictions, selected as a model program by the Texas Commission on Alcohol Abuse, and Euphrasia Center, named a promising program by Office of Juvenile Justice and Delinquency Prevention. He is the author of two books and numerous journal articles, and has served as evaluator for 30 federal grant projects.

O. Extent Which Applicant Clearly Links Staff Qualifications and Experience to Their Designated RCORP-Implementation Project Activities (Attachment 6).

As required within the RFP, a detailed staffing plan (Attachment 6), outlines the biographical summaries for each key position in the proposed project. This includes professional and educational backgrounds, any relevant licensure or certification, and other important qualifications for serving in the proposed project.

CRITERION 6: SUPPORT REQUESTED

A. Degree Which Estimated Cost to The Government for Proposed Grant-Funded Activities Is Reasonable Given the Scope of Work

Although an actual estimate of clients to be served within the proposed project was not required within the RFP, a general and conservative projection of direct service clients is 300 per year, or 900 over the course of the grant. This amounts to approximately $1,110 per client. Likewise, funding allocated to prevention is positioned to significantly reduce the incidence of substance misuse within the rural target area and could represent a substantial savings to the community.

B. Extent to Which Applicant Includes A Budget and Budget Narrative for Each of The Three Years of The Grant

The budget and budget narrative in the attachments includes three full years of detailed budget allocations, broken out by year.

C. Extent Which Applicant Allocates Award Across Three-Year Period of Performance

Due to the nature of the grant funding period, the awarded grant funds in the budget are split across three 12-month periods. This aligns with the project Work Plan (Attachment 1), which details three full years of activities.

D. Clarity and Comprehensiveness of The Budget Narrative, Including The Extent To Which The Applicant Logically Documents How And Why Each Line Item Request (Such As Personnel, Travel, Equipment, Supplies, And Contractual Services) Supports The Goals And Activities Of The Proposed Work Plan And Project.

Each line item and cost center within the budget narrative has been carefully justified as to its use, and the calculations behind each expenditure have been broken out. Beaufort County Alcohol and Drug Abuse Department is well experienced with grants management, especially with regards to fiscal oversight. As such, the agency **Operations Manager** will conduct **quarterly budget reviews** with project leadership to ensure that the proposed line items will **cover the entire three year project tenure.**

BEAUFORT COUNTY RESOLUTION No. 21-____

A RESOLUTION ESTABLISHING THE CRITERIA TO BE USED FOR THE REAPPORTIONMENT OF ALL COUNTY COUNCIL DISTRICTS AS TO POPULATION FOLLOWING THE ADOPTION BY THE STATE OF THE FEDERAL DECENNIAL CENSUS AS REQUIRED BY S.C. CODE ANN. SEC. 4-9-90

WHEREAS, S.C. Code Ann. Sec. 4-9-90 requires that all County Council districts be reapportioned as to population by County Council within a reasonable time prior to the next scheduled general election which follows the adoption by the State of each federal decennial census; and,

WHEREAS, the State has adopted the federal decennial census conducted in 2020; and,

WHEREAS, Beaufort County Council is desirous of establishing the criteria which should be used during the process of reapportionment to ensure that each County Council district be of equal population, or as nearly as practical, to comply with the constitutional principles and requirements of “one person, one vote”.

NOW, THEREFORE, BE IT RESOLVED by Beaufort County Council, duly assembled, that the following criteria are hereby established to be used during the process of reapportionment of all County Council districts as required by S.C. Code Ann. Sec. 4-9-90:

1. County Council districts shall be of equal population, or as nearly as practical, to comply and adhere to the Constitutional requirement of one person, one vote.
2. The population variance between County Council districts shall not exceed 10% as required by S.C. Code Ann. Sec. 4-9-90.
3. County Council districts must comply with the Federal Voting Rights Act to ensure that minorities have an equal opportunity to elect representatives of their choice.
4. County Council districts must be contiguous.
5. County Council districts should be drawn to minimize the division of voting precincts, and, when feasible, with respect to existing districts and communities of interest.

6. County Council districts should be geographically compact to the extent practicable, so that nearby areas of population are not bypassed for a more distant population.
7. County Council districts must comply with all other applicable court decisions and federal and state laws.
8. Public input should be solicited throughout the process.

Adopted this _____ day of _____, 2021.

BEAUFORT COUNTY COUNCIL

_____
Joseph Passiment, Jr. Chairman

_____
Attest: Sarah Brock, Clerk to Council