AMENDMENT #2

COMMUNITY MENTAL HEALTH, SUBSTANCE USE, PREVENTION, AND CRISIS SERVICES

The following amendments are specific to the Notice of Funding Opportunity for Community Mental Health, Substance Use, Prevention, and Crisis Services released on Thursday, October 14, 2021.

1. Extension of Time

Page 1, Cover Page

Original:

This Notice of Funding Opportunity (NOFO) will be on a rolling-deadline and will remain open until all existing funds are depleted or ~~December 23, 2021~~, at 5:00 p.m. PST.

Amended:

This Notice of Funding Opportunity (NOFO) will be on a rolling-deadline and will remain open until all existing funds are depleted or **January 31, 2022,** at 5:00 p.m. PST.

2. Last Date Application will be Received

Page 1, Cover Page

Original:

APPLICATIONS WILL NOT BE ACCEPTED AFTER ~~DECEMBER 23, 2021~~

Amended:

APPLICATIONS WILL NOT BE ACCEPTED AFTER **January 31, 2022**

3. TIMELINE CHANGES

Page 2, RFA Timeline

Original

RFA Timeline	
Task	**Due Date/Time**
Notice of Funding Opportunity Released	10/14/2021
Deadline for submission of written questions	10/21/2021, 3:00 PST
Deadline for written response to submitted written questions	10/28/2021, 6:00 PST
Final Deadline	**12/23/2021, 5:00 PM PST**
Evaluation Period (Estimated)	11/12/2021 - 01/15/2022
Funding Decisions, Applicants Notified (Estimated)	11/19/2021 - 01/30/2022
Completion of contract/subgrant awards, on or before (variable)	2/30/2022
Notice to Proceed (NTP)/Project Start Date, on or after (variable)	12/01/2021 – 03/01/2022

Amended:

RFA Timeline	
Task	**Due Date/Time**
Notice of Funding Opportunity Released	10/14/2021
Deadline for submission of written questions	10/21/2021, 3:00 PST
Deadline for written response to submitted written questions	10/28/2021, 6:00 PST
Webinar for questions and answers on NOFO changes via Zoom	January 6, 2022 10:00 a.m. – 12:00 p.m.
When: Jan 6, 2022 10:00 AM Pacific Time (US and Canada) Topic: NOFO Amendment Webinar, Q & A Please click the link below to join the webinar: Passcode: 748048 https://us02web.zoom.us/j/83197784766?pwd=dWZmbGdZcGZUWFhCd1B4UDJDOXBoQT09 Or One tap mobile: US:+12532158782,,83197784766#,,,,*748048# Or Telephone: US: +1 253 215 8782 or +1 346 248 7799 Webinar ID: 831 9778 4766 Passcode: 748048	
Deadline for submission of application	**01/31/2022, 5:00 PM PST**
Evaluation Period, on or before	11/12/2021- 02/15/2022
Funding Decisions, Applicants Notified on or before	11/19/2021 – 02/30/2022
Completion of contract/subgrant awards, on or before	3/30/2022
Notice to Proceed (NTP)/Project Start Date, on or after	01/01/2022 – 04/30/2022

4. TARGET POPULATION

Page 7, Section 1.8

Original:

Nevada's NOFO focuses on the following target populations. All Applicants must identify at least one of the following target populations.

- Children with SED, SUD, and their families (Age 0-17)
- Adults with SMI, SUD, and/or Co-occurring (Age 18-64)
- Both. Please note that if selecting both you must write to the evidence-based and best practices for each population and ensure that the appropriate SAMHSA and Medicaid State Manual identified assessment and evaluations tools are utilized

Amended:

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- Both. Please note that if selecting both you must write to the evidence-based and best practices for each population and ensure that the appropriate SAMHSA and Medicaid State Manual identified assessment and evaluations tools are utilized, such as the ASAM, LOCUS, and CASII.

5. ELIGIBLE ENTITIES

Page 22, Section 2.4

Original:

Nevada is seeking applications from ~~public, private, tribal, or non-profit organizations who:~~

Amended:

Nevada is seeking application from partner organizations or providers to include public or governmental agencies, private practices or associations, tribal organizations, limited liability partnerships, sole-providers, or non-profit providers. This may also include any collaboration between any of the above.

Section 3.4, Priority Services for Funding Consideration

K.   Children's Mobile Crisis Teams

Children's Mobile Crisis Teams provide community-based crisis interventions for children, youth, and families wherever the intervention is needed using a family-centered, trauma-informed approach. The Children's Mobile Crisis Model in Nevada was developed by the Division of Child and Family Services (DCFS) to meet the needs of children, youth, and families in the communities using the System of Care Principles. This NOFO offers an opportunity for community-based providers to expand upon the work accomplished by DCFS to increase access to this essential community service, in partnership with DCFS. Successful applicants will be required to work directly with DCFS to design and develop their implementation and training plans, align policies and procedures with established best practices, and actively participate in the DCFS Mobile Crisis system. This system utilizes a centralized call center for initial assessment and deployment of the Children's Mobile Crisis teams. Teams must be staffed to be able to deploy to crises, support in-home stabilization services, and communicate with care providers to ensure continuity of care. Teams must be available 24 hours a day, 7 days and week with acceptable time frames for community response. Data collection and reporting will be required for specific metrics to ensure the care provided maintains fidelity to the Children's Mobile Crisis Model.   When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving behavioral health crisis and preventing future crisis situations.

Crisis providers must address the recovery needs of individuals, children, youth, and families to move beyond their mental health and substance use challenges to regain functioning and stabilization, while supporting self-determination, in the least restrictive environment. Applicants should refer to standards of care and best practices for crisis care within *The Roadmap to an Ideal Crisis System on the National Council on Wellbeing Website:* https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56

Applicants must design a Children/Youth mobile crisis that meet the minimum criteria as established in Senate Bill 390 (SB390). A mobile crisis team established pursuant to SB390 must be:

(a) A team based in the jurisdiction that it serves which includes persons professionally qualified in the field of behavioral health and providers of peer recovery support services;
(b) A team established by a provider of emergency medical services that include persons professionally qualified in the field of behavioral health and providers of peer recovery support services; or
(c) A team established by a law enforcement agency that includes law enforcement officers, persons professionally qualified in the field of psychiatric mental health and providers of peer recovery support services.

Minimum Criteria for Children's Mobile Crisis Teams

- Children's Mobile Crisis Teams must engage with DCFS to design and implement the Children's Mobile Crisis model.
- Children's Mobile Crisis Teams must work with the centralized call center and be available to be deployed as needed, within required response times.

- Teams must be staffed to be able to deploy to crises, support in-home stabilization services, and communicate with care providers to ensure continuity of care.
- Children's Mobile Crisis Teams must be available 24 hours a day, 7 days a week and 365 days a year within their defined catchment area;
- Project leadership must participate in the design and implementation of regional and statewide crisis systems of care, including the development of regulations. Once regulations have been established, all mobile crisis teams will be expected to meet and/or exceed minimum standards as defined by regulations.
- Children's Mobile Crisis Teams must have formal agreements in place with law enforcement, emergency services, and dispatch to ensure coordination and safety are prioritized. In addition, mobile crisis teams will be required to have formal agreements with community providers, hospitals, schools and social service organizations for linkage and referral.
- All Children's Mobile Crisis Teams must have the ability to safely transport an individual to the hospital, should transport be needed, or work with primary caregivers to ensure safe transport.
- Children's Mobile Crisis Teams will work with the State to determine a catchment area for the team to be deployed.
- All mobile crisis teams must use identified evidence-based programs and practices as prescribed by the State and demonstrate proficiency in delivering services for such practices. These include triage/screening, including explicit screening for suicidality; assessment; de-escalation/resolution; Peer support; Coordination with medical and behavioral health services; evidence-based and best practices; and crisis planning and follow-up. CLAS standards must also be met. Teams must use System of Care Principles.
- Provision of crisis services via telehealth may be considered for rural and frontier communities only if the telehealth option is mobile and there is at least one member of the mobile crisis team at the same physical location of the individual in crisis.
- Data collection and reporting as well as continuous quality improvement processes must be undertaken with reporting to local and regional stakeholders on a minimum dataset to be collected.
- Programs must include the use of a standardized level of care determination tool to include the CASII, LOCUS, and/or ASAM. All staff conducting such assessments must demonstrate competency to complete the assessments, including completion of training on the use of the assessment.

Target Population: Children, youth, and families in Crisis

L.   24/7 Telehealth Services for Rural and Frontier Law Enforcement Crisis Services/Virtual Crisis Care

Nationally, approximately 10-15% of all 911 dispatch calls are behavioral health related. Law enforcement in rural and frontier communities are often the primary contacts for individuals needing a behavioral health response. Law enforcement trained in Crisis Intervention may be available to intervene in some behavioral health crises however, most law enforcement are not equipped to provide a crisis behavioral health assessment, de-escalation, safety planning, and follow-up for individuals in crisis. Co-responder models that pair behavioral health professionals and law enforcement officers in the field have been shown to be effective however, these models require behavioral health professionals and costly financing making the model unsustainable for most rural and frontier communities to staff enough teams to have jurisdictional reach 24/7. Oklahoma and South Dakota, among other states, have recently launched programs to provide law enforcement with HIPAA

complaint i-Pads or tablets to connect individuals in crisis to a telehealth behavioral health provider 24/7. These programs have expanded to include schools and other community organizations where law enforcement often respond to behavioral health crisis. These programs also offer support directly to law enforcement experiencing crisis as well as a workforce support tool. On average, approximately 80% of individuals in crisis who receive telehealth-based crisis intervention do not require transport and can be stabilized in the community. Based on the success of these programs, Nevada is planning to collaborate with a national organization to launch a 3-year project in the Spring of 2022 and is seeking a provider organization to provide 24/7 telehealth crisis care to law enforcement statewide.

Additional information on the South Dakota project may be found here:
https://vimeo.com/554872475/5b93176c92

Bill passed last session for telehealth protections.

Minimum Criteria for 24/7 Telehealth Services for Rural and Frontier Law Enforcement Crisis Services/Virtual Crisis Care

- Licensed behavioral health staff must be available via HIPAA compliant, video-enabled telehealth services 24 hours a day/7-days a week.
- Provider must engage with DPBH and law enforcement agencies to design and implement the Virtual Crisis Care model.
- Provider must have formal agreements, including confidentiality statements, in place with law enforcement, emergency services, and dispatch to ensure coordination and safety are prioritized. Additionally, they will be required to have formal agreements with community providers, hospitals, schools and social service organizations for linkage and referral.
- Purchase and deploy iPads/tablets with cellular connectivity to perform the two-way audio and video assessment, de-escalation, and safety planning. App-based video platforms must have encrypted traffic both ways.
- Ability to obtain consent from individuals or legal guardians and transmit records to responsible care providers to ensure continuity of care.
- All providers must use identified evidence-based programs and practices as prescribed by the State and demonstrate proficiency in delivering services for such practices. These include triage/screening, including explicit screening for suicidality; assessment; de-escalation/resolution; coordination with medical and behavioral health services; and crisis planning and follow-up. CLAS standards must also be met.
- Data collection and reporting as well as continuous quality improvement processes must be undertaken with reporting to local and regional stakeholders on a minimum dataset to be collected.
- Programs must include the use of a standardized level of care determination tool to include the CASII, LOCUS, and/or ASAM. All staff conducting such assessments must demonstrate competency to complete the assessments, including completion of training on the use of the assessment.

Target Population: Individuals in crisis

M.   Workforce Development

The State of Nevada is accepting applications to develop and implement training programs to teach students, direct service providers and health professionals (physicians, physician assistants, dentists, psychologists,

pharmacists, nurses, social workers, counselors, medical students, community health worker, peer counselors or residents) the skills and necessary to provide evidence-based screening, assessment, intervention, risk determination through an evidence based program for crisis based programs such as mobile crisis, crisis stabilization, and specialized community treatment programs from early intervention and referral activities to implementation and monitoring of direct treatment services.

Activities may include learning communities on topics that focus on specific populations to include adults and/or children. The workforce development would provide direct training and technical assistance related to mental health and substance use disorder recovery in compliance with SAMHSA evidence-based practices and state regulations. Specific strategies may include clinical integration, building and strengthening capacity of providers, developing and training on evidence-based and practice-based toolkits as well as resource information for diverse stakeholders and various types of organizations. Additional examples include programs to provide education and training to providers on the diagnosis, treatment, and behavioral support for individuals with dual diagnosis, training programs for early childhood mental health specialists, curriculum development for behavioral health training programs to expand course work for evidence-based practices for the treatment of early serious mental illness, or training opportunities for pre-licensed providers to gain the necessary experience working in community based behavioral health or integrated care settings.

An application for workforce development must include 1) a letter of interest, 2) define the target population, 3) define the evidence-based training program, 4) the number of individuals anticipated to be trained annually, 5) how the organization and systems will work together to advance the successful implementation of evidence based practices in an array of settings, 6) what activities will be included, 7) a timeline for implementation, and 8) a one page resume of the lead project manager. This should include identifying what training and for what population of focus you are proposing (i.e. if you are looking at providing training for the entire system or a single program type). A formal application is not required. Please send the letter of interest with the information requested to SLambert@dhhs.nv.gov. Please note that this should not exceed ten pages total.

Eligible Providers: Public and private universities, colleges, and medical residency programs that have or are affiliated with programs for medical students, psychologists, pharmacists, dentists, physician assistants, nursing, social work, and/or counseling.

N.   Community Collective Impact Leadership

The State of Nevada is accepting applications to develop formalized community collective practice initiatives by state, region or geographical area. Collective impact initiatives are focused on a multi-sector/multi-agency collaborative leadership approach to large scale change in communities that is focused on crisis care and delivering substance use/mental health services in a specific area of focus. The collective impact aims to get the community, local organizations and external agencies (e.g., government departments) to work together to address an agreed priority. This approach works to identify critical needs in a specific area of focus and utilizes needs data and information from the community partners so that they define the priorities of service.

The five conditions of collective impact must include:

- **Common Agenda**: All participants have a shared vision for change that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions.
- **Shared Measurement**: Agreement on the ways success will be measured and reported, with a short list of common indicators identified and used across all participating organizations for learning and improvement.

- **Mutually Reinforcing Activities**: Engagement of a diverse set of stakeholders, typically across sectors, coordinating a set of differentiated activities through a mutually reinforcing plan of action.
- **Continuous Communication**: Frequent and structured open communication across the many players to build trust, assure mutual objectives, and create common motivation.
- **Backbone Support**: Ongoing support by independent, funded staff dedicated to the initiative, including guiding the initiative's vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing funding. Backbone staff can all sit within a single organization, or they can have different roles housed in multiple organizations.

It is expected that collective impacts would design and implement the crisis care mental health/substance use delivery for any identified region including the following criteria:

1) **Design and Implement a crisis care mental health/substance use delivery with a priority based on equity**: For collective impact initiatives to achieve sustainable improvements in communities, it is critical that these initiatives address the systemic structures and practices that create barriers to equitable outcomes for all populations, particularly along the lines of race and class. To that end, collective impact initiatives must be intentional in their design from the very outset to ensure that an equity lens is prominent throughout their governance, planning, implementation, and evaluation. In designing and implementing collective impact with a focus on equity, practitioners must disaggregate data and develop strategies that focus on improving outcomes for affected populations. Identify and include community members in the collaborative.

2) **Include community members in the collaborative**. Members of the community—those whose lives are most directly and deeply affected by the problem addressed by the initiative—must be meaningfully engaged in the initiative's governance, planning, implementation, and evaluation. Community members can bring crucial (and sometimes overlooked) perspectives to governance bodies and decision-making tables, can contribute to refining the collective impact initiative's evolving goals, strategies, and indicators, can help co-create and implement solutions that are rooted in lived experience and have the potential for significant uptake, can participate in building communities' capacity to lead and sustain change, and can participate in data interpretation and continuous learning processes. Sometimes, decision-makers or other stakeholders may inadvertently face power dynamics or other structural barriers that can hinder particular partners from participating candidly and fully; true inclusion requires intentional examination of group needs and processes to ensure that all stakeholders have full opportunity to contribute to the process. Engaging community in these ways helps collective impact efforts address the issues most important to those most directly affected, builds capacity and enables community participation in and ownership of solutions, and helps embed the work in the community so that it will be more effective and sustainable.

3) **Recruit and co-create with cross-sector partners.** Collective impact collaboratives are created by and composed of actors from across sectors and parts of the community, including nonprofits, government, private sector, philanthropy, and residents. While not all initiatives will engage all sectors actively at the same time, collaboratives made up of only one or two types of actors (e.g., all nonprofits, all funders) do not have the diversity of actors required to create the systems-level view that contributes to a robust collective impact initiative. These cross-sector partners, who all have a role to play in the solution, share in co-creating the common agenda, identifying shared measures, and implementing the work required to achieve the effort's goals.

4) **Use data to continuously learn, adapt, and improve.** Collective impact is not a solution, but rather a collaborative problem-solving process. This process requires partners to remain aware of changes in context, to collect and learn from data, to openly share information and observations with others, and to adapt their strategies quickly in response to an evolving environment. To accomplish this, initiatives should have clear learning priorities, build strong structures and processes for learning, and create a

learning culture that enables the group to use meaningful, credible, and useful qualitative and quantitative data for continuous learning and strategic refinement. Many initiatives find it valuable to use a disciplined and formalized process to guide their use of data.

5) **Cultivate leaders with unique system leadership skills**. For collective impact initiatives to achieve transformational change, leaders must possess strong facilitation, management, and convening skills. They must be able to create a holding space for people to come together and work out their disparate viewpoints, they must possess the capacity to foster shared meaning and shared aspirations among participants, they must be able to help participants understand the complexity and non-linearity of system-level change, they must be dedicated to the health of the whole and willing to change their own organizations in service of the group's agenda, and they must be adept at building relationships and trust among collaborators. These system leadership skills are essential for the backbone, and also other leaders in the collaborative such as steering committee members, community leaders, and action team leaders.

6) **Focus on program and system strategies.** The mutually reinforcing activities that the initiative takes on to achieve its goals should focus on collective program and system change strategies rather than individual programs or organizations. System strategies include strategies that increase communication and coordination across organizations, change the practices and behavior of professionals and beneficiaries, shift social and cultural norms, improve services system wide (by spreading techniques that already work within the community across organizations, or by bringing a new evidence-based practice into the community), and change policies.

7) **Build a culture that fosters relationships, trust, and respect across participants.** Collective impact partnerships require participants to come to a common understanding of the problem and shared goals, to work together and align work in new ways, and to learn from each other. Authentic interpersonal relationships, trust, respect, and inclusion are key elements of the culture that is required for this difficult work to occur. The backbone and other initiative leaders must be proactive in their efforts to create this culture.

8) **Customize for local context.** While the five conditions are consistent across collective impact initiatives, and initiatives benefit a great deal by learning from each other, customizing the initiative for the local context is essential. Initiatives can do their best work when they deeply understand the problem they are trying to solve locally—both from the data and input from the community and from understanding the existing work and coalitions that may be working on similar issues. Customizing the work to fit the local community context enables the coalition to honor, build on, and/or align with existing work and pursue system and program strategies that are most relevant to local needs.

An application to develop a community collective impact leadership must include 1) a letter of interest, 2) define the target region or community of focus, 3) address the approach and partners to be included under the eight criteria, 4) provide a recommendation of leadership and key partners; 5) define how the organization and systems will work together to advance the successful implementation of a crisis based system in an array of settings and through what type of agreement, 6) a timeline for implementation, and 8) a one page resume of the lead facilitator. A formal application is not required. Please send the letter of interest with the information requested to SLambert@dhhs.nv.gov. Please note that this should not exceed fifteen pages total. It is anticipated that this community collective would be the lead organization to define the needs and services required for the community of focus.

Note: Any applicant who believes the above information would change their original application, may request the application be pulled from early consideration, and may resubmit. This may be done by contacting Sheila Lambert at SLambert@dhhs.nv.gov.