Assertive Community Treatment Request for Application

Informational Webinar Session

Timeline

TASK	DUE DATE & TIME
SAPTA distributes the Request for Application Guidance with all submission forms	July 31, 2018
Q&A Written Questions due to SAPTA	August 9, 2018 by 5:00
Informational Webinar to address questions	August 14, 2018 (10:00am – 11:00am)
Deadline for submission of applications	August 21, 2018 by noon
Technical Review of Applications	August 21-22, 2018
SAPTA will notify organizations that have discrepancies within their application.	August 23, 2017
Evaluation Period: Content review of applications	August 23-28, 2018
Interviews with Applicants	August 30, 2018
Funding Decisions Announced – SAPTA will notify organizations via e-mail to the listed Project Director	September 4, 2018
Successful awardees MUST attend the MANDATORY AWARDEE MEETING: Kickoff Meeting	September 14, 2018
Completion of subgrant awards for selected awardees	September 30, 2018
Grant Award Commencement of Project – Pending approved SAMHSA grant award and receipt of Notice of Award	Upon Execution of Award October 2018

Funding Opportunity Title:	Assertive Community Treatment Teams (ACT)
Funding Opportunity Number:	NV ACT - 01
Due Date for Applications:	August 21, 2018 by noon
Anticipated Total Funding Available:	$1,800,000
Estimated Number of Award(s):	Up to 6 awards
Estimated Award Amount:	$350,000 / applicant organization. *(Per page 13 of the RFA – Program Funding – In the event no qualified applicants are identified through the RFA, the State reserves the right to perform alternate measures to identify potential applicants).*
Cost Sharing/Match Required:	None
Project Period:	Upon approval through September 30, 2019
Eligible Applicants:	Indian Health Centers Federally Qualified Health Centers (FQHC) SAPTA Certified Providers Medicaid Enrolled Behavioral Health Providers (Clinical or treatment-based services must be provided by applicants that are existing Medicaid providers)

Successful awardees M ST attend the MANDATORY AWARDEE MEETING:
September 14, 2018 - K ckoff Meeting (specific location TBD)

Assertive Community Treatment (ACT)

- Evidence Based Practice (EBP) designed to assist individuals with Serious Mental Illness (SMI) primarily those who have been diagnosed with major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, borderline personality disorder, who struggle living independently within the community, have been unsuccessful in traditional treatment models, engage emergency services frequently, have housing instability, and/or have legal issues.

ACT cont.

- The ACT model is a team-based, multidisciplinary treatment approach that is capable of being more flexible based upon individual needs than a more traditional model.
- This multidisciplinary treatment program can provide intensive wrap around services within the assembled team rather than referring to external providers.
- Services are available 24 hours a day, 7 days a week and 365 days a year.
- Services are provided primarily within the community and home-based setting.

ACT Implementation Timeline

- Programs are expected to begin to provide services to the intended population 6-12 months after the grant has been awarded.
- Each program will be responsible for establishing and implementing program standards that adhere to the ACT model and address the following:
  - Admission and discharge;
  - Staffing and credentials;
  - Service intensity and capacity;
  - Program organization and communication;
  - Assessment and treatment planning;
  - Required services;
  - Medical records of program participants; and
  - Program participant rights and grievance procedures.
- Programs are responsible for developing sustainability plans ***to ensure program continuation when the funding ends.***

ACT Team Staffing

- Recommended staffing for each proposed team includes the following key personnel:
  - Team leader - Licensed Mental Health or Co-Occurring Disorder (COD) Qualified Professional,
  - Psychiatric Prescriber in an urban setting (1 per 100 patients); Psychiatric Prescriber in a rural setting (1 per 60 patients),
  - Registered Nurse,
  - Supportive Employment Specialist*,
  - Masters Level Substance Use Treatment Specialist,
  - Peer Recovery Support Specialist,
  - Case Manager (BA level position),
  - Program or administrative support staff who work in shifts over a 24-hour period

Staff Training

- ***The Project will provide learning communities in which ACT Teams can participate to develop foundational skills to streamline organizational processes and begin to serve clients within the Assertive Community Treatment model.***
- ACT providers are responsible for ensuring all ACT staff receives appropriate and ongoing professional training.
- Providers are responsible for ensuring all staff are trained in evidence-based practices such as Integrated Dual Disorder Treatment (IDDT), Focus on Integrated Treatment (FIT), Motivational Interviewing (MI), and Trauma Informed Care.
- Ongoing training includes specialty practices, clinical skill development, and culturally competent care as related to providing ACT services.
- Providers will maintain a plan for regular supervision of all staff members, including the team leader.

Services to be provided by an ACT team

- Services that are expected to be provided within the team, as directed within an individualized treatment plan, include:
  - Crisis intervention,
  - Clinical evaluation/assessment for Co-Occurring Care and Substance Use Treatment
  - Psychiatric care,
  - Case management,
  - Medication administration and management,
  - Illness management and recovery skills,
  - Individual supportive therapy,
  - Supportive Employment services such as pursuing education or vocational training,
  - Assistance with activities of daily living such as skill development addressing housing, performing household activities, personal hygiene and grooming tasks, money management, accessing and using transportation resources, accessing medical or dental resources and accessing other applicable benefits,
  - Intervention with family and natural supports,
  - Coordination of care between team members and/or external services,
  - Housing assistance.

Care Coordination with other Agencies

- ACT teams will be expected to build relationships and agreements for assuring service continuity with other systems of care including:
  - Emergency service programs
  - State and local psychiatric hospitals
  - Rehabilitation services
  - Housing agencies
  - Social services
  - Educational institutions
  - Self-help/peer run services
  - Independent living centers
  - Natural community supports, including parenting programs, churches/spiritual centers and local groups/ organizations
  - Local correctional facilities and organizations such as parole and probation
  - Programs will submit formalized care coordination plans in response to this RFA and are expected to fully implement plans during the individual treatment of a client.

Ongoing Program Evaluation

- ACT teams will be evaluated annually based upon the Dartmouth Assertive Community Treatment Fidelity Scale (DACTS) with considerations for rural locations, number of participants, and staffing availability.

Staff to Client Ratio

- Urban- 10 participants to 1 full time staff member (excluding psychiatric prescriber and program assistant)
- Rural/Frontier- 8 participants to 1 full time staff member (excluding psychiatric prescriber and program assistant)
- Psychiatrist/psychiatric prescriber ratio
  - Urban- 1 full time prescriber to 80-100 participants
  - Rural- 1 full time prescriber to 60-80 participants
- Admission into the ACT program should not exceed 6 clients per month as new clients often require intensive services within the first weeks to stabilize in the program.

- The ACT team should meet at minimum of 4 days a week to review each client, to address any concerns as they arise and to assess current treatment plans.
- At least 90% of participants should have face-to-face interaction with at least one member of the ACT team every 2 weeks.
- Seventy five percent (75%) of services provided are expected to be face-to-face within the community.
- It is typically recommended that clients have an average of 4 or more face-to-face contacts per week at 2 or more hours total of direct contact weekly.
- Rural communities, however, often do not share this ability do to geographical challenges. Extended visits at less frequency may be utilized to address the challenges with the same success.

Program Funding – Page 12 of the RFA

- This is a competitive process and as such, sub recipient(s) who receive awards through this RFA are not guaranteed future funding.

Technical Requirements

- Per NRS 439.200, 458.025 a program must be certified by the Division through SAPTA to be eligible for any state or federal money for alcohol and drug abuse programs administered by the Division pursuant to chapter 458 of NRS for the prevention or treatment of substance-related disorders.

Division Certification Process through SAPTA

- The following steps describe the process to submit a Certification Application.
  - Contact Joan Waldock from SAPTA via email at jwaldock@health.nv.gov to obtain the Division Certification Application and checklist.
  - In additional to the application checklist materials requirements, please include the following items with your Certification Application Packet and submit per the instructions on the Certification Application.
    - Health Care Quality & Compliance (HCQC) license, if applicable.

SUBSTANCE ABUSE PREVENTION AND TREATMENT AGENCY

APPLICATION FOR STAT E CERTIF ICATION CHECKLIST

Eletunn com pleted ap plication pa c et and paymen t to:
SAPTA, 4126 Techn o'lo gy Way, Su H:e 200, C_arson City, NV 89706

Prn vide r Nam e: _____
Executive Director : _____
Telephone Number: _____

By initialing lbelu w, please indicate whether these required items are included In yom application packet or not applicable to your program. Separate geogra11M call locations willll require a separate aprilication form and separate check.

_____ Comri leted and siwn ed certificatio n app'li cation

_____ Certifiication fee made payable to, he Substance Abuse Prevention Treatm ent Agency **(SAPT.A)**

_____ Documentation evidencing the aum ority of the pm wra m op erator to do bu.sin ess in the State of Nevada (e.g., *Articles of Incorporation, Articles of Organii ation, business license, etc.)*
State filed Art icles o f Incorporation/ Organiza tio n
Curr ent b u sinesslicense ,or proo f of ekemption
List of all oth er names used by the prngram and any curren t DBA filings

_____ Gove rning Board Bylaws/ Operati ng Agreement and latest meetin g m in 'Liles, **if** applicable

_____ Proof of general **liability** insura n ce

_____ Proof of professional liability insu ran ce for prnv ider staff and contract staff (Tlearmenr ***applicants*** *onl y)*

_____ One ,ellectronic copy ***(flash drive)*** ,o f th e program's current policies and prncedu res manual, incllu d in g a oom pleted Policies and Pro cedures Checkli st

_____ Personne ll list wit h name, date of hire, and a copy of the professiona l! certification/ license for each clinical sta ff member

_____ Accreditat ions, llice nse.s, and regulatory report s from other government agencies, if aprilicable

_____ Quality Assurance Plan *(Pio n for mono gemen t ond improvemen t of the quo h'ty o f service, if seporote from policy ond procedures m onuol; note poge number if included in policy and procedures manua l.)*

_____ Verification of a written state ment signed by the operator of the serv,ioe assu ri n g that he.service riro motes a message io minors not to use alcohol, tobacco or illicit su bstances *(Prevent ion applicants, o n /y)*

Will this program be serving in dividuals 16years of age and younger? Yes O No O

If yes, ha11e fi ng erriri nt-based ba ckgrou nd checks th rou !jh the Nevada Department of Publ ic Safety been completed? YesO NoD

Organizat ions applyIn for State Certifl c-atlon are encouraged to review and be In compliance with the regulatlons In NAC Chapter 458. S• paral l! g• ograp lcal locall o•• will r• quIN! a ... paratl applicall on form and ... parat• ch•clc. Re t urn oomplet<!d ap llca!lon, payment, aad) porti ng documeatat lon to PTA lo r processing. Incomplete ap plicati ons and/or payment, WM b e returned to the applicant. All l...,el of vice adhere 10 t he treatment crlt<>r l a for addlcU e. substance-r elat ed, and co-occurr1n g condit lo as as d,;flned by the Division teria/ American Society of Addiction Morlldne (ASAM).

Medicaid Enrollment Requirements and Division Funding Eligible Requirements

Organizations must be enrolled or in the process of becoming enrolled in both Fee for Service (FFS) Medicaid and with each Managed Care Organization to the extent they have open networks in order to maximize all Medicaid billing opportunities.

Submission of Proposals

- Applications must be completed on the forms included in this application packet provided by SAPTA. The application packet must be emailed to dhumphrey@health.nv.gov in original files (Word, Excel) and must be received **on or before the deadline of August 21, 2018, by noon**.

  Dennis Humphrey, Program Manager
  Must be submitted to: dhumphrey@health.nv.gov
  with **RFA Assertive Community Treatment** in the subject line of the email.

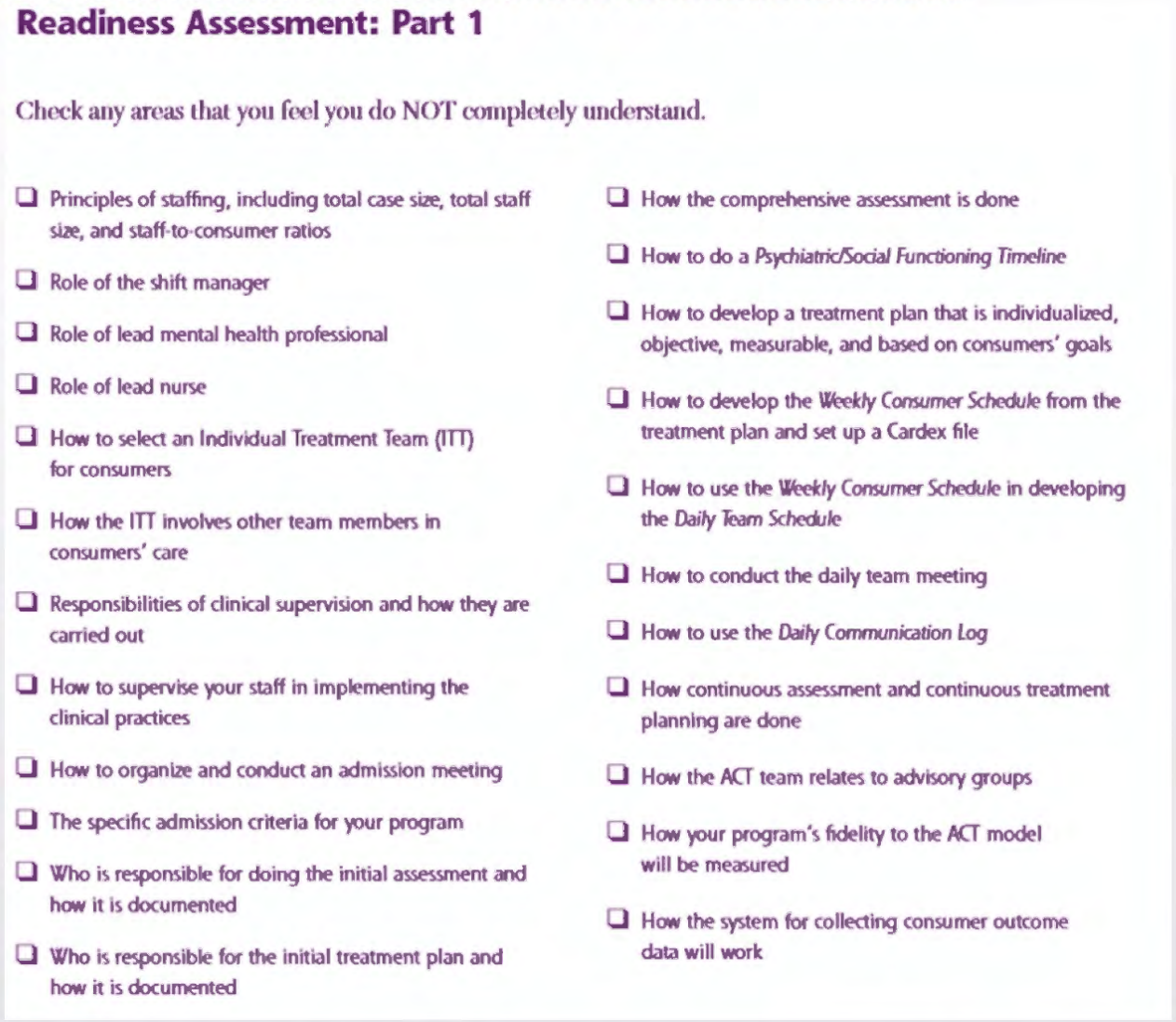
- Attachments are required to be in Microsoft Word or Excel format.

Section / Page Limit	**Narrative to Consist of the following:** **Organizational Strength and Description (no more than 2 pages)** **Collaborative Partnerships (no more than 2 pages)** **Service Delivery (no more than 3 pages)** **Cost Effectiveness and Leveraging of Funds (no more than 1 page)** **Outcomes and Sustainability (no more than 3 pages)** **The following do not have page limitations:** **Scope of Work (See Appendix C)** **Outcome Objectives (See Outcome Objectives worksheet)** **Budget (See Appendix D)** **Attachments** **Certification/License Documents**
Submission Format	Emailed, Microsoft word or excel format, no-color
Font Size	11 pt., Times New Roman
Margins	1 inch on all sides
Spacing	Single Spaced
Headers and Page Numbers	Mandatory and Identical to RFA Request
Attachments	Attachments other than those defined below, are not permitted. These appendices are not intended to extend or replace any required section of the Application.

Technical RFA Submission Requirements Checklist Document should be tabbed with the following sections		Completed
Electronic Submission		
Tab I	Technical RFA Submission Requirements Checklist & Cover Page with all requested information (Appendix A)	
Tab II	Agency Profile and contact information with all requested information (Appendix B)	
Tab III	Narrative to Consist of the following: (Appendix C)	

Readiness Assessment

- Taken from SAMSHA
- Needs to be completed and submitted with proposal



Readiness Assessment: Part 1

Check any areas that you feel you do NOT completely understand.

- ❑ Principles of staffing, including total case size, total staff size, and staff-to-consumer ratios
- ❑ Role of the shift manager
- ❑ Role of lead mental health professional
- ❑ Role of lead nurse
- ❑ How to select an Individual Treatment Team (ITT) for consumers
- ❑ How the ITT involves other team members in consumers' care
- ❑ Responsibilities of clinical supervision and how they are carried out
- ❑ How to supervise your staff in implementing the clinical practices
- ❑ How to organize and conduct an admission meeting
- ❑ The specific admission criteria for your program
- ❑ Who is responsible for doing the initial assessment and how it is documented
- ❑ Who is responsible for the initial treatment plan and how it is documented
- ❑ How the comprehensive assessment is done
- ❑ How to do a *Psychiatric/Social Functioning Timeline*
- ❑ How to develop a treatment plan that is individualized, objective, measurable, and based on consumers' goals
- ❑ How to develop the *Weekly Consumer Schedule* from the treatment plan and set up a Cardex file
- ❑ How to use the *Weekly Consumer Schedule* in developing the *Daily Team Schedule*
- ❑ How to conduct the daily team meeting
- ❑ How to use the *Daily Communication Log*
- ❑ How continuous assessment and continuous treatment planning are done
- ❑ How the ACT team relates to advisory groups
- ❑ How your program's fidelity to the ACT model will be measured
- ❑ How the system for collecting consumer outcome data will work

Question & Answer

- Is it mandatory that we have SAPTA certification to address the COD issues of the clients we serve?
    - Yes. You will need to be Certified for Level 1 Outpatient at a minimum, with a Co-Occurring Disorder endorsement

- We are not totally clear relative to being eligible to apply for the grant due to not currently being SAPTA certified but is a Medicaid Behavioral Health Provider.
  - *Per Page 14 of the RFA-Division Certification Process through SAPTA-if an agency is not currently Certified, a Certification application should be submitted along with the grant application. See Certification Application, Application Checklist and Certification P&P Checklist for specific requirements.*

- Can the appendix A, B, C, D, G and I be converted to a word document file and E & F to an excel document file?
  - *Yes.*
  - *http://dpbh.nv.gov/Programs/ClinicalSAPTA/dta/Grants/SAPTAGrants/*

- In the readiness assessment it spoke of the consumer records being done manually, can they also be accepted via electronic file in lieu of manual file.
  - *Yes, an acceptable EHR is appropriate*

- Cost Reimbursement or FFS Grant?
  - The grant is not designed to support client care within the first 6-12 months due to program development.
  - Once program is able to begin seeing participants, Medicaid will become primary payer source

- Grant Specifies $1.8 M, $350K per provider, will grant be selecting 6 different providers throughout the state?
  - *The State seeks to fund up to 6 awards within Nevada. Per Page 13 of the RFA- Program Funding-In the event no qualified applicants are identified through the RFA, the State reserves the right to perform alternate measures to identify potential applicants.*

- What type of services make up a service hour?
  - *Services that are expected to be provided within the team, as directed within an individualized treatment plan, include this list below. Definitions for each can be found beginning on Page 9 of the RFA.*

- *Crisis Intervention*
- *Clinical evaluation/assessment for Co-Occurring Care and Substance Use Treatment*
- *Psychiatric Care*
- *Case Management*
- *Medication Administration and Management*
- *Illness management and recovery skills,*
- *Individual supportive therapy,*
- *Supportive Employment services such as pursuing education or vocational training,*
- *Assistance with activities of daily living such as skill development addressing housing, performing household activities, personal hygiene and grooming tasks, money management, accessing and using transportation resources, accessing medical or dental resources and accessing other applicable benefits,*
- *Intervention with family and natural supports,*
- *Coordination of care between team members and/or external services,*
- *Housing assistance.*

- (Rural) Ratio 1-8 for staffing per FTE? Are we to assume 1-FTE cannot exceed a case load of 8 at any time?
  - *Correct, due to the intensity of services client to staff ratios are limited. Full time staff member to client ratio is limited to 1 to 8 in a rural setting (excluding team psychiatric prescriber and program assistant).*

- Staffing – Can the Team Leader also so hold the Psychiatric Prescriber position?
  - *No, these positions must be separate. The Team Leader manages the ACT Team and also serves the ACT participants as well. The Team Leader is a full time position and a Psychiatric Prescriber can work a minimum of 16 hours per week per 50 clients.*

- Transportation – Can we contract alternative transportation with these funds, IE Uber / Lyft?
  - *No, transportation costs will be covered under Medicaid. ACT Team client services will not commence until the end of this funding period.*

- Telehealth – can these services be provided via telehealth?
  - *The initial assessment must be conducted in person with the client and when needed psychiatric follow ups using Telehealth (especially in the rural areas), are acceptable. The intent of the ACT model is to provide in-person services to clients in the community and home settings.*

- Can we subcontract for per diem work?
  - *Per Page 7 of the RFA-Staffing Definitions-Supportive Employment Specialist services may be conducted through referral or subcontracting; Psychiatric Prescriber may work full or part time for a minimum of 16 hours per week for every 50 consumers. The Provider may subcontract for this position. The remaining positions identified in the RFA (Page 7 Staffing) are intended to be full time staff members.*

- Would the grant be payer of last resort if clients are Medicaid eligible? Would we be required to bill Medicaid first for any services eligible through Medicaid and charge back any payments to the grant in the reporting period?
  - *The first year of this funding is intended to build out your ACT Teams and increase capacity to provide the intensity of services required within the ACT Model. Once the Teams are active Provider are expected to first bill Medicaid for services.*

- MCO – would we need to be enrolled with all current MCO providers including Anthem, Silversummit and HPN as well as FFS?
  - *Yes, it is recommended to be enrolled with all current MCOs available within your service area.*

- Crisis Intervention – please define services available 24 hours a day for those in crisis.
  - *Any services offered by the ACT Team is to be available 24 hours a day, 7 days a week, 365 days a year for participants of the ACT Program who are at risk of or experiencing a behavioral health or life crisis.*