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NOTICE OF FUNDING OPPORTUNITY (NOFO) FOR COMMUNITY MENTAL HEALTH, SUBSTANCE USE, PREVENTION, AND CRISIS SERVICES

Release Date: Thursday, October 14, 2021

Questions to be Submitted via email: On or before October 21, 2021, 3:00 p.m. PST
Must be submitted to SLambert@DHHS.NV.GOV
with **SAPTA/MH NOFO** in the subject line of the email.

Response to Questions will be posted **On or before October 28, 2021, 6:00 p.m. PST**
At: SAPTAGrants (nv.gov)

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.

APPLICATIONS WILL NOT BE ACCEPTED AFTER DECEMBER 23, 2021

For additional information, please contact:

Sheila D. Lambert
Project Manager | Southern Nevada Coordinator
Department of Health and Human Services
Director's Office, Grants Management Unit
Email: SLambert@DHHS.nv.gov

The application and budget form can be located at the link above

DEPARTMENT OF PUBLIC AND BEHAVIORAL HEALTH
NOTICE OF FUNDING OPPORTUNITY SUMMARY

Notice of Funding Type: New Award

Any Applicant who wants to be considered for funding under this Notice of Funding Opportunity (NOFO) must submit a completed and signed application in compliance with the instructions within this NOFO, pursuant to Code of Federal Regulations (CFR 200.318) and the federal funding source. **This includes any Applicant that is currently receiving any federal or state grant funds**. This NOFO may also be used for future state or federal subgrant awards should additional money become available, for a period not to exceed four years, for substance abuse, crisis and/or mental health programs. The geographic target area is limited to Nevada. This funding is not for the continuation of existing programs which are currently funded under other program dollars.

Funding Opportunity Award Type: Subgrant Agreement (Grant)

Project Period Varies on Program and Funding Source. Projects should be written not to exceed a two-year program period. Project dates are subject to change but are anticipated to begin on or after January 1, 2022. *The State retains the option to extend program periods depending on the needs of the state and availability of funding through September 2025.* Project periods are anticipated to be:

- *January 1, 2022 – September 30, 2022 (nine-months)*
- *October 1, 2022 – September 30, 2023 (twelve-months)*

Reporting Periods: Monthly, as defined in Notice of Grant Award (NOGA).

Estimated Number of Awards: 20-35 Awards

Estimated Dollars Available: $32,000,000 - $38,000,000

Award Restrictions: *Grant Funds cannot be carried over.* All funding is subject to change, based on the availability of funds, federal awards, and the state needs. **By submitting an application in response to this NOFO, there is no guarantee of funding or funding at the level requested. The state reserves the right to fund any, all, or any variation of services requested in this application.**

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

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SECTION 1.0 INTRODUCTION

1.1 Notice of Funding Opportunity Overview

This Notice of Funding Opportunity (NOFO) is intended to solicit applications for the Community Mental Health Block Grant and the Community Substance Abuse Prevention and Treatment Agency (SAPTA) Block Grant as authorized by Section 1921 of Title XIX, Part B, Subpart I, Subpart II and Subpart III of the Public Health Service Act Title 42, Chapter 6A, Subchapter XVII of the United States Code. **This includes FY 2021 block grant dollars added through the COVID-19 Supplemental and the American Rescue Plan (ARPA).** The Department of Health and Human Services, Division of Public and Behavioral Health (DPBH), Bureau of Health Prevention and Wellness (BHWP) reserves the right to utilize this NOFO for other state or federal subgrant funding that may come available for mental health, substance use or crisis services for a period not to exceed four (4) years, in compliance with both federal and state procurement limitations.

The United States Department of Health and Human Services (USDHHS), Substance Abuse and Mental Health Services Administration (SAMHSA) oversees the Mental Health and SAPTA Block Grants, the State Opioid Response, and COVID grant dollars. The State of Nevada provides legislative authority for grants set aside for specific uses to specific Departments and/or agencies. The DPBH serves as the Single State Authority (SSA) and State Mental Health Authority (SMHA).

Behavioral Health grants reflect the health care system's strong emphasis on coordinated and integrated care along with the need to improve services for persons in crisis or with behavioral health disorders. These funding sources provide Nevada the opportunity to focus on the specific needs of our State to address gaps in the behavioral health delivery system and crisis services focusing on services. As required by Code of Federal Regulations (CFR) Title 45 Chapter 96 governing the allowable uses for the Community Mental Health and Substance Abuse Prevention and Treatment Services Block Grants, funding allocated must be used for programs and services for adults with Serious Mental Illness (SMI) and children with Severe Emotional Disturbance (SED); adults or youth with SUD, and/or those with co-occurring behavioral health conditions, depending on the source of the funding.

1.2 Impact of COVID-19 on Behavioral Health in Nevada

Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) is part of Nevada's Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the DPBH. SAPTA plans, funds, and coordinates statewide substance abuse service delivery and prevention programming. The BBHWP also serves as the mental health authority for Nevada which enable coordinated and comprehensive behavioral health planning. While SAPTA is not responsible for direct service delivery, it is responsible for the distribution of state and federal grant funding, creation, and implementation of statewide plans for substance abuse services, development of statewide behavioral health policy, supporting the growth of workforce, and the oversight and assurances of standards through the certification of programs and services.

The 2021 estimated population for Nevada is 3,185,786, a 15.2% increase from the 2010 estimated population. Nevada is expected to increase another 1.7% over the next year. The population is made up of approximately equal percentages of females and males. The median household income is $63,276. Nevada's land area is approximately 110,567 square miles (US Census Data). This area would include up to seven northeastern states within Nevada's

geographic borders. Nevada's poverty level by county ranges from 12% to 18.9%. The median home level has increased significantly with Clark County's (Las Vegas) median home price at $324,738 and Washoe County's (Reno) median home price at $406,905. This has increased the level of anxiety and stressors in the community due to the higher cost of living. Nevada's unemployment rate continues to fluctuate from 29.5% in June 2020 to 7.8% above the current national unemployment rate at 5.9%. This also impacts access to care issues with many families required to work two jobs or who are out of work with minimal health insurance. In addition, Nevada is projected to be a minority-majority state by the year 2023, which requires approaches that are culturally and linguistically appropriate to improve access of care to all populations.

Nevada has biennial legislative sessions are every two years. This elevates the importance of planning for behavioral health services. During the 2017 legislative session, Nevada established the regional behavioral health policy boards to address behavioral health in Nevada by geographic catchment areas. This includes a Regional Behavioral Health Coordinator (RBHC) who works directly within the region to support behavioral health needs, gaps, assessments, coordination, and communications. In the 2021 legislative session, Nevada worked with the Senate Committee on Health and Human Services for provisions relating to crisis stabilization center and crisis care to ensure that Medicaid was a viable option for continuity of care. Nevada submitted a competitive grant application and was awarded a Mobile Crisis Planning Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a plan to provide for sustainable funding mobile crisis within the state Medicaid program.

Nevada is working to implement legislation to develop regulations to support the maintenance of the 988 behavioral health line (beyond implementation) and to be part of the braided funding for crisis care systems as part of Senate Bill (SB) 390. The legislation will result in the development of the Crisis Response Account with funding derived from a 988 surcharge on all eligible telecommunication lines. Planning for 988 and the entire crisis continuum of care continues has been primary behavioral health priority for Nevada for the past few years and the impact of COVID has prompted even greater focus on designing and implementing the system of crisis care.

With 73.6% of Nevada's population living in Clark County, it is the most populous area in the state, with an estimated 2,251,175 persons. Esmeralda County is the least populous county, with less than a percent of Nevada's population, an estimated 969 persons. Each of these counties have representation as part of the Regional Behavioral Health Policy Boards. Nevada has seventeen counties with only three being identified as urban. The remaining counties are defined as rural and frontier counties, which further challenges the behavioral health system with the large geographic areas and limited services and lack of public transportation. The coordination through the RBHC's provide a linkage and support strategizing with other counties on access of care issues and county specific priorities based on population, especially with limited resources.

Nevada's behavioral health plans are evidence-based, data driven, and geographically focused. Substance use and co-occurring data is collected by numerous data sources in Nevada, including YRBS, BRFSS, hospital billing, state-funded behavioral health facilities, and vital records. These also include utilizing GPRA and the Department of Health and Human Services (DHHS) Data Analytics to trend and identify high need areas or changes in needs over time. Nevada also works with other Divisions to identify services, needs or populations who are underinsured, uninsured or have limited abilities to access behavioral health care, and populations that have been disproportionately impacted by behavioral health issues including

overdose and suicide. As part of the efforts, Nevada has also been working to improve overdose and suicide analytics for non-fatal overdoses, suicide attempts and needed access to care. Nevada has been focused on reducing the number of emergency room visits with plans for stabilization units, Assertive Community Treatment (ACT) teams, mobile crisis, and structured crisis support system.

Nevada also completed a statewide assets and gaps assessment comprised of Nevada's current Crisis Now Care Response System. This work included collaboration with partners across the state in health, behavioral health, law enforcement, courts, hospitals, elected officials, people with lived experience, family members, advocates, stakeholders, and direct service providers. This provided the groundwork for needed development of a strategic plan for complete crisis system with a direct, targeted response to all individuals in crisis in the state of Nevada. The planned crisis system is based upon the ideal crisis system to ensure that Nevada is focused on high-risk, diverse populations emphasizing health equity, health literacy, specialized planning for targeted populations such as those engaged with the justice system as well as individuals with disabilities, language barriers, and tribal populations.

According to Mental Health America's (MHA) 2020 State of Mental Health in America report, Nevada currently ranks 47th (includes U.S. Territories) in the nation overall for Adults with Substance Use Disorder in the Past Year, a ranking that indicates a high prevalence of substance use disorder or co-occurring and low levels of access to behavioral health care. With recent public health challenges brought on by COVID-19, there is a magnified need for a unified approach and organized system for managing crisis. COVID-19 and the restrictions put in place throughout the state and country has had an impact on behavioral health, especially substance use. At a national level, a recent survey indicated that an increasing number of individuals reported experiencing nervousness, depression, loneliness, and hopelessness. The economic impacts of COVID have resulted in lost wages, revenues, lay-off, and economic uncertainty for many and have led to housing insecurity statewide for individuals and families. These impacts of COVID on the population continue to contribute to greater vulnerability to risk factors for behavioral health issues such as depression, anxiety, trauma, addiction and, unfortunately, suicide.

In Nevada, there is a noticeable increase in mental health symptoms related to COVID-19. According to the Centers for Disease Control and Prevention, Household Pulse Survey, during the last reporting period from September 15-27th, 2021, 32% of the adult population surveyed endorsed symptoms consistent with anxiety or depression compared to 37% of Nevada adults surveyed. Nationally, almost half of younger adults aged 18-29 surveyed identified symptoms consistent with anxiety or depression. There are also disproportionately higher rates of depressive and anxiety symptoms identified among adults with disabilities (62%), who identify as transgender (67.4%), gay/lesbian (51%) or bisexual (65%), and individuals who identify as non-Hispanic/Latino of mixed or other races (47%). During the same time-period, 11% of Nevada's surveyed who needed counseling or therapy did not access care.

Throughout the pandemic, many individuals delayed or denied needed care for any number of health conditions, including critical conditions that typically require emergency intervention. Despite the numbers of emergency room visits in Nevada having decreased since March of 2020 for all admissions, the rate of admissions for behavioral health emergencies has remained relatively stable. On any given day in Nevada, over 90 adults are waiting in emergency rooms for admissions to inpatient behavioral healthcare. However, not all individuals waiting for a transfer to an inpatient bed require that level of care. Because there are relatively few community-based options to identify individuals experiencing a behavioral health crisis and provide them the appropriate care, hospital emergency departments are the primary means by

which people in Nevada gain access to necessary behavioral health services. Hospital emergency rooms can become a bottleneck to appropriate treatment, cause unnecessary psychiatric hospitalizations, and contribute to poor follow-up for individuals experiencing suicidal ideation. In addition, individuals with acute suicide risk may not be adequately screened, assessed, or offered evidence-based treatment for suicidality, leading to increased risk of suicide attempt, death by suicide, or chronic untreated suicidal ideation.

With an increased demand being placed on our health care providers due to COVID-19, an individual experiencing a mental health crisis in Nevada may be subjected to significant delay in accessing services, awaiting care in an emergency department instead of receiving services in an appropriate mental health setting. Inability to access appropriate, timely care can have serious consequences, resulting in unnecessary decompensation and decline in well-being. This scenario is even more likely for those in crisis due to many social and economic actions that have been taken as a result of COVID-19. The impacts of COVID on the population contribute to greater vulnerability to risk factors for behavioral health issues such as depression, anxiety, trauma, addiction, and, unfortunately, suicide. With recent public health challenges brought on by COVID-19, there is a magnified need for a unified approach and organized system for managing crises.

The number of youth and adolescents seeking help for anxiety or depression during COVID has been rising. A recent CDC study found that the percentage of children ages 5-11 seeking mental health care in emergency departments in 2020 increased by 24% over 2019. For children ages 12-17, mental health related emergency room visits increased 31% over the previous year. (Mental Health–Related Emergency Department Visits Among Children Aged 18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020, | MMWR (cdc.gov))

An Adverse Childhood Experience (ACES) can be any traumatic experience in a child's life from the ages of 0-17, ranging from neglect, abuse, the death of a family member, transition away from school and support systems. COVID has magnified the challenges of identifying youth with ACES with many of the traditional support and reporting systems fractured over the past 18 months. This has negatively impacted children's mental health with higher prevalence of youth presenting for care at later stages with acute levels of mental health needs. Children are absorbing stressors of parental distress, fluctuations in school-based supports, and family illness and loss. The extent of the impacts on youth cannot be determined simply by current hospitalization and death statistics, but must also identify the signs and symptoms of depression, suicidal thoughts and behavior, as well as general anxiety. The impact of ACE's both short and longer term can have a cumulative and profound impact on the initiation of substance use, the development of problematic substance use, increased risk of suicidality, higher rates of depression or anxiety, and the development of chronic health conditions.

1.3 Nevada's System Goals and Gaps in Services

In compliance with SAMHSA, the Singe State Authority (SSA) and Single Mental Health Authority (SMHA) are responsible to administer the funds in response to an integrated and strategic plan that includes the use of available data to identify strengths, needs, and services for specific populations. By identifying needs and gaps, BHWP has prioritized and established Nevada specific goals, objectives, strategies, and performance indicators. Gaps and needs within Nevada's behavioral health continuum existed well before the COVID-19 pandemic however, those gaps and needs have been exacerbated by the impact of COVID over the past year and a half. The goals of Nevada in addressing these gaps and needs with the

supplemental funding is to help stabilize our communities and support resiliency and recovery across the state.

In 2019, as part of an effort to understand current statewide and regional capacity for Substance Use Disorder (SUD) prevention and treatment services and establish priorities to build future capacity, SAPTA conducted a system-wide assessment using the Calculating an Adequate System Tool (CAST). Critical issues and gaps were identified including availability and access to licit and illicit substances including extremely harmful and addictive substances, including methamphetamine and opioids; cultural norms that support excessive drinking, smoking, and cannabis/marijuana; increased pressure on systems through a growing population of older adults with complex needs; increased pressure on systems from adolescents and young adults with mental health concerns; stigma associated with behavioral health that impacts access and connection to treatment; lack of in-state residential care, especially for adolescents for both substance use and mental health; severe shortages in the workforce in nearly all needed behavioral health professions; limited number of providers that have cultural competence to serve the community; emerging system of care that is fragile; aspects that have the potential to expand availability of care are in the process of development, and not firmly established; competition rather than collaboration among service providers in some of the most populated areas of the state; challenges in addressing questions of unmet need; data systems are emerging to better answer these questions but currently much of the information available is qualitative; populations (geographies and specific subgroups) that are underserved, including but not limited to incarcerated (and recently released people), homeless people, and adolescents; progress slow to spread use of trauma-informed care; and limited adoption of evidence-based practices (EBP). Following a facilitated review and discussion of each region's CAST results, including an analysis of the region's social characteristics, risk score, and unmet need analysis in the context of planning efforts already underway, up to five priorities were identified for each region by their respective RBH Coordinators in consultation with the region's Behavioral Health Policy Board and stakeholders. The most frequently identified needs and priorities for action across all regions fell into the treatment category.

Treatment:
- *Increase availability of short- and long-term residential inpatient treatment*
- *Increase number of psychiatrists and psychologists listed as specializing in substance abuse and addition issues*
- *Increase outpatient treatment by leveraging technology and offering more options for treating co-occurring disorders*
- *Increase availability of crisis stabilization and outpatient detoxification services*

Promotion
- *Increase advocacy events to promote substance misuse education*
- *Increase marketing advertisements placed across all media*

Recovery
- *Increase the availability of transportation vouchers and services for people seeking treatment*
- *Increase the number of housing assistance supports available*

Referral
- *Increase the number of case managers available to assist with care coordination*

Other
- *Increase mental health training for law enforcement, in conjunction w/ administering Naloxone*

According to the Nevada Epidemiological report the following highlights for substance use, including youth are as follows:

- Nevada is comparable to the nation with marijuana use among youth (YRBS).
- Drug use among teens is higher in Nevada than the nation (YRBS).
- There was no significantly higher coalition county region with reported higher marijuana/hashish use, but reported use has continued to rise since to 2017 (BRFSS).
- Emergency department and inpatient admissions due to drugs or alcohol continue to increase in both count and rate (Emergency).
- Males had significantly higher emergency department encounters than females for cocaine, methamphetamines, marijuana/cannabis, and hallucinogens use for 2019 (Emergency).
- Clark County had significantly lower rate of drug and alcohol deaths then the remainder of the state (Deaths).
- In roughly 33% of the unintentional or undetermined overdose deaths in 2019, the deceased had been identified as currently having a mental health problem (Deaths).
- The most common substance listed in cause of death is opioid (type not specified, 57.5%), followed by methamphetamine (51.4%) [Deaths].
- Since marijuana has been legalized in 2017, reported marijuana use during pregnancy has more than doubled and has surpassed all other substances (MCH).
- Tobacco use during pregnancy has decrease for all mothers ages since 2016 (MCH).
- The adult LGBTQI+ community have significantly higher percent of current marijuana use (LGBTQI+).

SAPTA certifies all substance abuse treatment providers in the state using the Dual Diagnosis Capability in Addiction Treatment (DDCAT) along with ASAM Criteria. The DDCAT is a benchmark instrument for measuring addiction treatment program services for persons with co-occurring mental health and substance use disorder. Certification is required by the Division of Health Care Financing and Policy (DHCFP), also known as Nevada Medicaid, for substance use disorder treatment programs to enroll and participate in the Medicaid program. Nevada's substance abuse prevention, intervention, treatment, and recovery system also incorporates Nevada Medicaid, including Medicaid covered services within the Medicaid eligible population in combination with federal and state funded services and supports administered by the BBHWP. SAPTA partners closely with DHCFP to ensure a comprehensive continuum of care is available within the state.

Currently, all ASAM levels of care are available within Nevada however, not all levels of care are available within each of the five regions of the state nor does adequate access exist across all levels of care statewide. Limitations in access to residential treatment services and withdrawal management levels of care are, in part, attributed to low provider participation in block grant funding due to low reimbursement rates, insufficient state and federal funding to meet the growing demand for higher levels of substances use disorder treatment, and inability for agencies to receive reimbursement through the Medicaid program due to the IMD exclusion. SAPTA has been working closely with Nevada Medicaid to design the 1115a Substance Use Disorder IMD Exclusion Waiver to expand access to residential levels of care and withdrawal management within community-based settings which is scheduled to begin implementation January of 2023. While these issues existed well before COVID-19, bed shortages have become a chronic concern in Nevada since March 2020 due to providers limiting admissions, employing needed mitigation efforts, and limited staffing availability.

Transitional living and recovery housing have also been identified as areas of need within Nevada. While SAPTA certifies and funds transitional living across the state, increased pressures on affordable housing and growing unemployment/under-employment have contributed to housing instability and homelessness across the state. Capacity for transitional living is not sufficient to meet the growing demands for individuals with substance use disorders. Grant funding will be allocated to expand access to transitional living program capacity to help individuals with substance use disorders achieve and maintain safe and supportive housing options while they engage in care. Nevada has recently begun to plan for the implementation of recovery housing in collaboration with Foundation for Recovery, a statewide recovery organization, the National Alliance for Recovery Residences (NARR), and the Center for Applied Substance Use Technologies (CASAT). This project will require the development of a certification/licensing standard, technical assistance, training for providers, and the funding to launch recovery housing. Grant funds are planned to be used for the development and implementation of Nevada's recovery housing program.

Specialty services for pregnant persons and parents with dependent children (PPW) have also been identified as needs within Nevada. Through State Opioid Response grant funding and the Nevada Perinatal Collaborative, Nevada has developed a provide toolkit to support the implementation of Screening, Brief Intervention, and Referral to Treatment within OB/GYN settings as well as Labor and Delivery. As we work to fully develop the women's substance abuse treatment network, several gaps have emerged including a need for increased capacity for PPW treatment options across the continuum of care, access to therapeutic/specialty childcare for children whose parents are impacted by substance use, treatment navigation to and collaborative care with providers who offer specialty services, care coordination, case management, transportation, and other needed women's set-aside programming. In addition, home-based care for pregnant and post-partum women is noted as a successful evidence-based treatment modality that is lacking in Nevada. While the state has evidence-based home-visiting programs, none of them are designed to provide primary substance use disorder and co-occurring treatment. Funding from this grant will be used to identify providers to expand access to specialty care and support for pregnant persons and parents with dependent children who are impacted by substance use.

According to the BBHWP Epidemiological Profile Mental Health Key findings are as follows:

- Both female high school and middle school students have significantly higher percent of feeling sad/hopeless, and suicide thoughts including considering, planning, and attempting suicide (YRBS).
- For emergency department encounters, anxiety is the leading mental health-related diagnosis. Females have significantly higher visits for anxiety, depression, bipolar disorder, and PTSD, whereas males are significantly higher encounters for schizophrenia and suicide ideation. The Churchill Community Coalition (CCC) region, and Partners Allied for Community Excellence (PACE) region had significantly higher visits for anxiety, and depression (Emergency). Clark County hard significantly higher emergency department encounters for schizophrenia, anxiety, depression, bipolar disorder, and suicide ideation.
- For inpatient admissions unlike emergency department encounters, depression is the leading diagnosis for mental health-related inpatient admissions. The Clark County has significantly higher admissions for schizophrenia and suicide ideation, whereas CCC and Nye Community Coalition (NCC) county regions have significantly higher admissions from anxiety (Inpatient).
- Unduplicated clients served at state-funded mental health clinics have declined significantly since 2011. The Affordable Care Act (ACA) went into effect in 2014.

Therefore, many Nevada residents are now able to access non-state-funded facilities through the expansion of Medicaid (AVATAR).
- When asked “Have you seriously considered attempting suicide during the past 12 months,” 4.8% of Nevada residents responded yes in 2019, and increase from 3.5% in 2018. (Suicides)
- The PACE county regions have a significantly higher age-adjusted rate for suicide in 2019 (Suicides).
- The Partnership Carson City coalition (PCC) and Join Together Northern Nevada (JTNN), Healthy Communities Coalition (HCC), and CCC coalition county regions have significantly higher rates for mental health related deaths (Deaths).
- The LGBTQI+ community have significantly higher percent of depressive disorder diagnoses and more days of poor mental health (LGBTQI+).

In 2018, Nevada elected to combine community integration efforts into the updated State Olmstead Plan to serve as the DHHS Strategic Framework for Community Integration. The mission of the DHHS Strategic Framework is to ensure that Nevadans have the opportunity to achieve optimal quality of life in the community of their choice. The vision is that Nevadans, regardless of age or ability will enjoy a meaningful life led with dignity and self-determination. The following Priority Areas pertain to the unmet behavioral and mental health needs that were identified for the Target Populations and have been adopted for development and implementation during the next biennium:

- Building out the intensive community-based service array including intensive in-home services, crisis stabilization services, intensive outpatient/PHP, respite care with appropriate certification and oversight built into programming. This will reduce reliance on residential/inpatient level of care and out of state placement.
- Increasing access to high-fidelity wraparound by expanding into community providers with state oversight.
- School-based behavioral health including prevention and skills for resilience.
- Reforming the statewide residential treatment system (public/private) to embrace no eject/no reject policies with individualized levels of care offered at every facility, so that youth do not have to experience placement disruption from facility to facility to get the appropriate level of care and complete a full course of treatment; treatment models emphasizing trauma-informed care and non-coercive milieu (working to eliminate seclusion/restraint with state incentives, TTA and oversight).
- Statewide expansion of early intervention services for individuals with early-stage serious mental illness (ESMI), including first episode of psychosis (FEP).
- Specific Priorities to Address the Behavioral Health Needs of Children and Youth
- Juvenile justice diversion.
- Residential treatment facility treatment capacity, discharges, and linkages to services
- Transitional Age Youth (TAY) services (children to adult).
- Access to Services: Crisis Services, Mobile Crisis Teams, Partial Hospitalization Programs (PHP), Intensive Outpatient Program (IOP), day treatment, wraparound, respite, family peer support, and habilitation services.
- Specific Priorities to Address the Behavioral Health Needs of Adults.
- Criminal justice diversion.
- Supported housing.
- Assertive Community Treatment Services.
- Access to providers for crisis and community-based treatment.
- Expand uncompensated care in Nevada to provide for individuals who have barriers to accessing mental health and substance abuse treatment.
- Development of workforce of mental health professionals.

The need for specialty services for individuals involved in the criminal and juvenile justice systems continues to be a key priority for behavioral health in Nevada Opportunities for deflection and diversion from the criminal justice system and incarceration into treatment continue to be expanded through available funding. Often, individuals with substance use disorder who interface with the criminal justice system have complex needs including serious and persistent mental illness, chronic medical conditions, unemployment, underemployment, and homelessness. Successful deflection and diversion programs are actively identifying individuals who would benefit from treatment and supports to address social determinants of health and connecting them to care. Full implementation of a continuum of care, including Assertive Community Treatment teams and Forensic Assertive Community Treatment teams is needed across Nevada to support individuals is maintaining stability in their communities with a focus on self-determination and recovery. Additionally, Nevada's Juvenile Justice system is undergoing a transformation, including implementing screening and assessment for youth to identify those presenting with a substance use disorder, co-occurring mental health conditions, trauma, and trafficking. Additional funding has been identified as needed to provide the youth with comprehensive behavioral health care that is trauma informed and meets National CLAS standards. Funding from this grant will be allocated to criminal justice/juvenile justice deflection and diversion programs as well as treatment expansion for individuals involved in both systems.

As stated previously, Nevada is moving toward building a Crisis Care Response System that is both supportive of local communities, families, and individuals by fostering resilience, and responsive to the needs of individuals in crisis. The development of a Crisis Care Response System in Nevada is possible and existing infrastructure is in place to support, at least in part, each of the core elements of the Crisis Care Response Model.

A summary of some of these current assets, gaps and goals are as follows:

Crisis Call Center Hub

Assets: Nevada currently has one of only six (6) National Suicide Prevention Hotlines in the US that serves as a Crisis Call Center Hub in Nevada. It is available to individuals and professional organizations throughout the entire state 24/7 365 days a year. The Crisis Call Center Hub provides immediate crisis support via numerous technological platforms and can coordinate referrals to other resources and establish connections to other crisis response services, such as Mobile Crisis Teams or Crisis Stabilization Program. In addition to this statewide service, there are also several local crisis lines available in certain regions. In addition, Nevada has other lines operating in rural Nevada. Having these lines operating at a local level has proven to be beneficial in being able to bring individuals into other services offered by the agencies operating these local crisis lines. The crisis line is experiencing great success deploying resources when necessary and otherwise deescalating people in crisis.

Gaps: The main challenge with Crisis Call Center Hubs is the lack of connectedness to other services outside of the crisis call line. For example, crisis call line agencies in Nevada are unable to independently dispatch Mobile Crisis Teams to individuals in crisis without routing calls through 911. There are also inconsistencies throughout the state in providing referrals to facility-based programs for crisis stabilization and utilizing bed registry technology platforms. These issues are often compounded with a lack of resources, staff, and transportation throughout the state, particularly as evidenced in the Southern Region. While the current Crisis Call Center Hub can provide some referrals to individuals in crisis, all calls made to the call center are routed through 911. It does not serve as a dedicated behavioral health crisis line.

This presents challenges to not only those contacting the Crisis Call Center Hub, but it also has implications for those in need of mobile outreach, as detailed below. Mobile Crisis Teams are often dispatched with law enforcement from 911, not a behavioral health crisis line. This further demonstrates the challenges in communication and barriers to a cohesive response between Crisis Call Center Hubs and Mobile Crisis Teams.

Mobile Crisis

Assets: Similar to the implementation of different crisis call lines, several regions and counties in Nevada have been resourceful in developing different types of mobile outreach units. Various configurations of mobile crisis teams have already been established throughout the state and include law enforcement deflection and diversion programs. There are several examples of units that are connected to hospitals or law enforcement agencies, such as MOST. These connections between Mobile Crisis Teams and agencies that have the capacity to offer other targeted services can be invaluable to an individual experiencing a crisis. These programs are also facilitating diversion from hospitals and meeting patients where they are at in the community. Children's mobile crisis response is currently being expanded in both northern and southern areas of Nevada using the SAMHSA COVID-19 Emergency Behavioral Health Grant. The close relationship between Mobile Crisis Teams and law enforcement is known to be very effective in de-escalating crisis situations and diverting individuals from held in a jail or emergency department. For the Mobile Crisis Teams that are in place in Nevada, many are utilizing evidence-based assessment tools and suicide safety plans, prioritizing safety and security, and providing connections to other resources for the individuals they serve. These resources are implemented by licensed mental health professionals that are staffed as part of the Mobile Crisis Teams that are in place. The clinical understanding and training that these professionals bring to these teams can be very effective in ensuring the safety and security of everyone involved in responding to a crisis.

Gaps**:** There are major gaps in the services provided by Mobile Crisis Teams throughout Nevada. First, none of the regions have a mobile team that is designated or equipped to respond to crisis calls throughout the entire region and one region completely lacks mobile services. Mobile Crisis Teams are often targeted to the most populated areas, leaving unincorporated and rural areas of the state without mobile outreach. Even more populated or metro areas do not always have full access to mobile teams in their areas. There is not enough Mobile Crisis Teams to cover Nevada. The second major gap related to this is the response time for some Mobile Crisis Teams. Some rural regions cited issues with Mobile Crisis Teams responding within the best practice timeframes due to being dispatched from metropolitan areas like Reno or Las Vegas. This can result in individuals not being seen by a Mobile Crisis Team for hours, if not days. In other areas, like the Southern Region, there are no Mobile Crisis services. In addition, most mobile teams do not utilize peers as a resource on their teams. This eliminates an important tool for connecting to a person in crisis and is more costly than teams that include peers in a meaningful way. Finally, as discussed above when looking at the gaps in Crisis Call Center Hubs in Nevada, there is also a lack of formal MOUs and protocols between Crisis Call Center Hubs and Mobile Crisis Teams. This could lead to individuals slipping through the cracks and not receiving the services or support they need following a crisis.

Crisis Stabilization Programs

Assets*:* In more populated areas, there are several options for acute and sub-acute care. In the areas where crisis stabilization programs are easily accessible, there are psychiatric and clinical mental health staff on site to support individuals beyond a crisis. Staff is also provided with adequate training on suicide prevention, trauma-informed care, and safety and security

practices for crisis stabilization. These regions also have the infrastructure to support the recommended ratio for the number of beds per 100,000 residents in each area. Community Triage Centers were defined in Nevada Revised Statute in 2005 and provide a different pathway for accessing mental health services, ensuring stabilization within a community setting without first accessing a hospital. These centers were funded creatively, including resources from both state and local sources. Currently, there are three Triage Centers operating in Nevada (two in Las Vegas, and one in Reno). With the additional funding obtained through the SAMHSA COVID-19 Emergency Behavioral Health Grant, two hospitals are expanding to provide this crisis stabilization as an alternative to an emergency department for individuals in crisis. Crisis Stabilization Programs are intended to provide more than just a bed to individuals, and instead offer a welcoming environment to provide compassionate care that supports an individual both during a crisis and after they return to their community.

Gaps: While the facilities meet almost all best practices listed for Crisis Stabilization Programs, Nevada faces a lack of facilities dedicated to serving less populated regions in accordance with these best practice guidelines. The options for individuals experiencing a crisis and in need of crisis stabilization services are minimal, and typically involve major transportation needs. For example, the Rural Region provided specific information regarding the frequency and costs associated with having to transport individuals either via flight evacuation or ambulance to an area where crisis stabilization services are accessible. This creates a public safety concern, as well as an undue burden on healthcare, public health, and substance use resources. Best practices cannot be upheld when there is no reasonable access to these services in the majority of the state. According to the Crisis Calculator, Nevada requires 123 crisis beds to respond to the demand for services throughout the state. There is an insufficient number of facilities with enough beds or crisis chairs to serve persons in crisis. This results in persons being transported to emergency departments at a much greater cost. Nevadans also lack access to Crisis Residential services as a step down in the continuum from inpatient or crisis stabilization services.

Crisis Response Evidence Based Practices

Assets: Across the state, there is reference to various staff in different programs being trained in practices such as Zero Suicide, evidence-based assessment tools, and suicide prevention. There is also a consistent reference to prioritizing safety and security in crisis response services. It appears in all five regions that there is significant buy-in for a Crisis Care Response System. This benefits not only those in crisis, but also those providing crisis support services. Several regions also referenced the use of trauma-informed care among staff within crisis response agencies such as the crisis call center hubs that are used, the mobile team clinicians, and the staff in crisis stabilization facilities. There are four elements include prioritizing focus on safety and security, implementing suicide care best practices, including screening, planning, and follow-up, utilization of a trauma-informed recovery model, and having peer support in crisis response services. In Nevada, the Office of Suicide Prevention has committed to these essential principles as part of their suicide prevention efforts. Since their inception they have worked to implement evidence-based practices for suicide screenings, such as Signs of Suicide in Nevada schools, training, and outreach for professionals in numerous disciplines across the state, and they have worked to establish partnerships with other agencies to collaborate and coordinate their work to prevent suicide. Two positions were established as part of Zero Suicide and works with hospital systems throughout the state to commit to implementing Zero Suicide. The coordinators provide ongoing TA to the nine of the 12 hospital systems that participating hospitals from the first learning series from April to August 2020. The monthly meetings allow for sharing Electronic Health Record (EHR) questions or concerns, changes in hospital leadership, data collection and evaluation, and policy and procedure updates.

Gaps: There are several themes found in the gaps in essential principles and practices identified by the regions. First, there is an overarching lack of uniformity and consistency with the trainings for suicide prevention, trauma-informed care, and safety and security. Different agencies in each region receive different trainings, or trainings are not offered to all involved in crisis response within the region. These differences can result in discrepancies in care and service delivery during a crisis. Second, the role of peers, while present in some regions, is largely missing in most components throughout the state. Peer support and the role that they play in crisis stabilization and support is extremely valuable to those experiencing a crisis. They provide lived experience and an empathic understanding of being in crisis that not all professionals have. Finally, as with the gaps in the other components listed, implementing these core principles is challenging due to a lack of resources and infrastructure. In regions where services are not available, there is no opportunity to utilize the best practices.

Nevada has been working to identify the needs and gaps for prevention activities for substance use, behavioral health crisis, and resilience including suicide prevention.
Nevada's certified prevention coalitions use the Strategic Prevention Framework to design and deliver primary prevention strategies within their communities. Since the beginning of COVID-19, Nevada's prevention coalitions have been working diligently in their communities to innovate the delivery of primary prevention activities to address the needs of youth and families as schooling was provided virtually and families struggled to cope and manage with the stressors of the pandemic. As students and families plan for in-school learning to resume this fall, school districts, parents, students, teachers, and school administrators have identified an imperative need to support the transition to in-person learning. Prevention services focused on successful transitions to the classroom as well as programming focused on health coping, reducing stressors, suicide prevention, and skills for resilience will be provided to students, parents, and staff.

For additional information and reference, the following links have been provided.

A. Nevada's Behavioral Health Community Integration Strategic Plan (July 2018) serves as Nevada's guiding document for mental health services. For more information, this document can be found at: https:// http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/DHHS%20BHCI%20Strategic%20Plan.pdf.

B. For SAPTA services, Nevada's SAPTA, Bureau of Behavioral Health, Wellness and Prevention, Strategic Plan (2017-2020) serves as Nevada's guiding document. For more information, this document can be found at: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/SAPTA%20Strategic%20Plan_2017-2020.pdf.

C. BHWP has developed the SAPTA Capacity Assessment Report for Nevada, which identifies priorities and a capacity analysis, which can be viewed at: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/Nevada%20Capacity%20Assessment%20Final%207%2015%2019.pdf.

D. Nevada Crisis Response System Virtual Summit – Updated 3-19-21 – Social Entrepreneurs, Inc.

SECTION 2.0 FUNDING OPPORTUNITY INTRODUCTON

2.1 Purpose

The impact of COVID-19 on increased rates of individuals, youth and families experiencing emotional distress, crisis, and unmet behavioral health needs continues to increase as the pandemic continues. The funding available within this NOFO is specifically geared toward increasing access to screening, assessment, intervention, prevention, treatment, and recovery supports across the state with urgency.

Applications expanding access to existing services with the ability to provide services and supports within two (2) months of receiving funding will be prioritized. Projects that include new lines of services or programming are expected to begin services no later than three (3) months after receiving funding. Project proposals requiring longer periods of time for implementation may be considered, however extended time required to implement activities will require additional documentation, oversight, and accountability. This will include the development of an actionable work plan with targeted deliverables to be developed in conjunction with DPBH.

The MHBG provides Nevada's mental health service agencies with a degree of flexibility to design and implement mental health related services and activities to address the complex needs of individuals, families, and communities with SMI and children with SED, co-occurring related services, and services for individuals with dual diagnosis, specific to our population. The purpose of the block grant program is to support these services within the community.

The SAPTA administers programs and activities that provide community-based prevention and treatment. The SAPTA grant(s), including the SABG, provide Nevada service agencies with a degree of flexibility to design and implement substance use and co-occurring related services and activities to address the complex needs of individuals, families, and communities SUD specific to our population as defined by the SAPTA Strategic Plan.

The additional funds available through the block grant allow Nevada to develop infrastructure, expand, and enhance crisis services for behavioral health. Projects funded through this NOFO may be specifically designed to address needs within specific populations and may be restricted due to the federal funds used to support the project. It is imperative that projects proposed within applications pay careful attention to requirements for funding.

The State of Nevada DHHS, DPBH has identified an overall state strategy for the Substance Abuse Block Grant ARPA and COVID Supplemental funds to serve Nevadans. The DPBH will be utilizing both the MHBG and SABG individual awards through block grant to braid funding to support the development of a comprehensive crisis continuum of care and the provision of essential behavioral health and substance use disorders prevention, intervention, treatment, and recovery supports and services in Nevada. Nevada will also be utilizing other fiscal mechanisms to maximize the ability of third- party liability billing through the management care organizations or fee for service Medicaid, as well as state general fund and other federal grants to address the known needs and gaps within the state. This includes 1115 waivers and expansions to Certified Community Behavioral Health Centers (CCBHC) to increase access to care that is community-based, recovery-oriented, trauma-informed, with CLAS standards.

2.2 Target Populations

For this NOFO application, Nevada is utilizing the following definitions for priority populations as set forth by the federal regulations and SAMHSA guidance governing the use of this funding. Additional subpopulations may be identified for specific programs, such as programs serving individuals within Black Indigenous People of Color (BIPOC) Communities, programs providing intensive in-home family support and stabilization for children who are dual diagnosed with SED and ID/DD, or recovery housing programs specifically designed for individuals within the LGBTQA+ population. **Applications that do not clearly define the target population and, as applicable, subpopulations will be ineligible for funding.**

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/or co-occurring and their families (Age 0-17); may include defined subpopulations including ID/DD, ESMI, or FEP
- Adults with SMI, SUD, and/or Co-occurring (Age 18 and older); may include defined subpopulations including ID/DD, ESMI, or FEP
- 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 standardized and validated identified assessment and evaluations tools are utilized and align with the Medicaid State Manual.

A. Serious Mental Illness (SMI)

To meet criteria for serious mental illness (SMI) individuals must be 18 years of age and older, who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder that meets the defining criteria specified in the American Psychiatric Association (APA) Diagnostic and Statistical Manual 5 (DSM 5) that has resulted in serious functional impairment. Serious functional impairment is defined as difficulties that substantially interfere with or limit one or more major life activities, such as basic living (eating, dressing), instrumental living (taking prescribed medications or getting around the community, participating in family school or workplace). Other impacts on life may include maintaining housing, employment, education, relationships, or safety. Conditions that are excluded from the diagnosis of SMI are substance abuse or addictive disorders, irreversible dementias, as well as intellectual disabilities, unless they co-occur with another SMI that meets current diagnostic criteria. **Adults receiving services under specific projects related to the Community Mental Health Services Block Grant (MHBG) within this NOFO must have sufficient documentation, including a SMI determination, to receive services.**

B. Early serious mental illness (ESMI)

As noted above in Section 1.2, Serious Mental Illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI. ESMI includes a broad range of diagnostic categories (e.g., schizophrenia spectrum disorders; affective disorders with and without psychoses; anxiety disorders) that present during the early stages of clinical course (e.g., first episodes). The earlier that an individual is diagnosed with a serious mental illness and appropriate treatment is received, the less likely that individual is to experience significant functional impairment

during the initial episodes of mental illness as well as in the future. Since ESMI can begin as early as late adolescents (age 15-16 years of age) and begin as late as the early to mid-30's, ESMI programs may admit individuals within these age ranges as long as they meet the admissions criteria. Programming must be tailored to the developmental needs of individuals within the program. **Adults or youth receiving services under specific projects related to the Community Mental Health Services Block Grant (MHBG) within this NOFO must have sufficient documentation, including a SMI or SED determination, to receive services.**

C. First Episode Psychosis (FEP)

First episode psychosis simply refers to the first time someone experiences psychotic symptoms or a psychotic episode. Psychosis is a term used to describe symptoms of the onset of a SMI (such as bipolar disorder, post-traumatic stress disorder or schizophrenia). People experiencing a first episode may not understand what is happening. The symptoms can be highly disturbing and unfamiliar, leaving the person confused and distressed. Psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions. Someone who develops psychosis will have their own unique set of symptoms and experiences, according to their particular circumstances. In general, four main symptoms are associated with a psychotic episode: hallucinations, delusions, confused and disturbed thoughts. Someone with psychosis has a short-term (acute) condition that, if treated, can often lead to a full recovery. Similar to ESMI programs, FEP programs are evidence based and designed to ensure early, accurate diagnosis and treatment are available and individuals within these programs received intensive, individualized care. **Adults or youth receiving services under specific projects related to the Community Mental Health Services Block Grant (MHBG) within this NOFO must have sufficient documentation, including a SMI or SED determination, to receive services.**

D. Severe Emotional Disturbance (SED)

Criteria for severe emotional disturbance (SED) includes children and youth up to but not including age 18 who have had a diagnosable mental, behavioral, or emotional disorder (as defined by the DSM 5) in the past year that resulted in functional impairment that substantially interfered with or limited the child's or youth's role or functioning in family, school, or community activities. Conditions that are excluded from the diagnosis of SED are substance abuse or addictive disorders, irreversible dementias, as well as intellectual disabilities and other related conditions, unless they co-occur with another SED that meets current diagnostic criteria and that results in functional impairment. **Youth receiving services under specific projects related to the Community Mental Health Services Block Grant (MHBG) within this NOFO must have sufficient documentation, including a SED determination, to receive services.**

E. Substance Use Disorder (SUD)

Substance use disorders occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), a diagnosis of a substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Substance use disorder treatment should clearly delineate if services are designed for adolescence or adults. Programs offering

substance use disorder treatment must indicate how priority populations will access care. Federal regulations define priority populations for substance use disorder treatment. All priority populations must be addressed within the application to be eligible for funding. Priority populations include pregnant women with Intravenous Drug Use (PIVDU), Pregnant women and women with dependent children (PWD), individuals with Intravenous Drug Use (IVDU), and all other individuals with substance use disorders. **Adults or youth receiving services under specific projects related to the Substance Use Prevention and Treatment Block Grant (SABG) within this NOFO must have sufficient documentation, including a diagnosis of a substance use disorder, to receive services.**

F. Co-Occurring Disorders (COD)

COD or Dual Diagnosis are defined as individuals with the coexistence of both a mental health and substance use disorder who are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated. Nationally, nearly one in four adults with serious mental illness also experienced a substance use disorder in the previous year. All treatment programs funded under this NOFO must be at a minimum co-occurring capable and evidence-based, with the ability to screen, diagnose and treat both mental health and substance use disorders in an integrated setting. This requirement does not apply to recovery programming.

For youth, COD are complex and is often difficult to diagnose correctly. COD refers to the co-existence of both a substance use and serious emotional disturbance (SED). Youth or Adolescents who experience a major depressive episode are twice as likely to begin using alcohol or illicit drugs. For some youth and young adults, the SED/SMI may precede the SUD; for other individuals the reverse can occur. These disorders may also develop during the same time period. It is expected that proposed services will utilize the SAMHSA best practice manual that highlights evidence-based treatment considerations for youth and young adults with SED/SMI and SUD be utilized. **Programs that propose simultaneous services that are not integrated will be deemed ineligible for funding. Adults or youth receiving services under specific projects related to the Substance Use Prevention and Treatment Block Grant (SABG) within this NOFO must have sufficient documentation, including a diagnosis of a substance use disorder, to receive services.**

G. Dual Diagnosis

An adult or child who meets criteria for both and mental health condition and an intellectual disability and/or a developmental disability. For the purposes of this NOFO, programs specifically developed to serve individuals with dual conditions must meet criteria for SMI or SED. Projects that identify SMI or SED as target populations may also specialize in Dual Diagnosis. **Adults or youth receiving services under specific projects related to the Community Mental Health Services Block Grant (MHBG) within this NOFO must have sufficient documentation, including a SMI or SED determination, to receive services.**

H. Individuals in Crisis

Individuals in crisis may include adults, children, youth, and/or families. Individuals in crisis may be experiencing significant distress from an exacerbated existing behavioral health crisis, such as a psychotic episode in an individual with a known psychotic disorder, exposure to an acute internal or environmental stressor in need of support for stabilization, risk of harm or self or others, inability to care for oneself which could lead to harm, or in need of withdrawal management services. Individual may, but are not required to, meet criteria for civil commitment/legal hold, to access crisis services. There is a presumptive eligibility for those being served by a mobile crisis team or crisis stabilization unit, that the individual is in crisis for the first visit and is eligible for services. **Adults or youth receiving services under specific projects related to Crisis Services must receive timely access to care.**

In addition to identifying a primary target population as defined above, applications may also speak to any potential targeted, special populations in the program approach to include, but not be limited to those listed below.

- Transitional youth population (TAY)
- Individuals involved or at risk for being involved with the criminal justice or juvenile justice system
- Rural/Frontier communities
- Black, Indigenous, People of Color (BIPOC) communities
- Individuals in the LQBTQIA+ communities
- Individuals experiencing homelessness

2.3 Allowability of Funds

To ensure that the block grant programs continue to support the needed and necessary services for the identified target population(s), SAMHSA has indicated that Nevada may use block grants:

a) To fund priority treatment and support services for individuals without insurance, underinsured, or for whom coverage is terminated for short periods of time;

b) To fund those priority treatment and support services **not** covered by Children's Health Insurance Program (CHIP), Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;

c) To collect performance and outcome data for mental health and substance use, determine the ongoing effectiveness of promotion, treatment, and supportive services and to plan the implementation of new services;

d) To expand and enhance the infrastructure for crisis response; and,

e) To address the enhanced behavioral health needs to serve disproportionately impacted populations due to the COVID-19 pandemic.

2.4 Eligible Entities

All prospective applicants are advised to review Nevada's ethical standards requirements, including but not limit to Nevada Revised Statute (NRS) 281A, NRS 333.800, and Nevada Administrative Code (NAC) 333.155. All applicable NRS and NAC documentation can be found at www.leg.state.nv.us/law1.cfm.

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

1) Are registered with the Nevada Secretary of State and have the appropriate business license as defined by law in the county/city of geographic location for service delivery. The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS 76. Information regarding the Nevada Business License can be located at http://nvsos.gov. *(Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015)*

2) Do not have any provider or board member of organization identified as subject to the Office of Inspector General (OIG) exclusion from participation in federal health care programs (42 CFR 1001.1901).
3) Can comply with the Third-Party Liability (TPL) for any or all the expenditure(s) that would be payable by another private or public insurance for any application that provides direct service. (This includes Medicaid, Medicare, etc.)
4) Are registered as a Nevada vendor by time of application – Registration can be submitted to: http://purchasing.nv.gov/Vendors/Registration/ and https://controller.nv.gov/Buttons/ElectronicVendorReg/ This is in addition to the state business license.
5) Have an active DUNS/UEI (unique entity identifier) number, which can be applied for at sam.gov. This is a federally required number.
6) Specific to SAPTA or braided services, have not less than one (1) year as a DPBH, SAPTA Certified Provider (http://dpbh.nv.gov/Programs/ClinicalSAPTA/dta/Providers/SAPTAProviders). Pursuant to NRS 458 and NAC 458, a program must be certified by DPBH to be eligible for any state or federal money for alcohol or drug abuse programs administered for the prevention or treatment of substance-related disorders **OR** have not less than two (2) years of providing direct services to at-risk populations and the ability and willingness to become SAPTA Certified within six (6) months.
7) Can provide direct services within 60-days of Notice of Subgrant Award (NOSA), if providing direct services.
8) Can demonstrate significant completion and start of project within 60-days of subgrant or contract within 90-days of awards.

Pursuant to NRS 333.3354, the State of Nevada awards a five percent (5%) preference to a vendor certifying that its principal place of business is in Nevada. The term 'principal place of business' has the meaning outlined by the United States Supreme Court in Hertz Corp v. Friend, 559 U.S. 77 (2010), typically meaning a company's corporate headquarters. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. On the application, please identify if Nevada is the "headquarters" or primary location of the organization.

2.5 Ineligibility Criteria

DPBH will consider the following criteria as potential reasons for Applicant Disqualification for consideration of award.

1) **Incomplete application**. 1) Failure to meet application requirements as described; and/or 2) Omission of required application elements as described. All sections of the grant application require a response. If the response is Not Applicable (N/A) needs to be written in the application.
2) **Insufficient supporting detail provided in the application.** DPBH will not review applications that merely restate the text within the NOFO. Applicants must detail their approach to achieving program goals and milestones. Reviewers will note evidence of how effectively the Applicant includes these elements in its application.
3) **Inability or unwillingness to collect and share monitoring and evaluation data** with DPBH or its contractors.
4) **Program Integrity concerns**. DPBH may deny selection to an otherwise qualified applicant based on information found during a program integrity review regarding the organization, community partners, or any other relevant individuals or entities.
5) **Disregard of instructions for maximum word limits.**
6) **Late submission** of an application, regardless of reason.
7) **Supplanting Funds**. Grant dollars must be used to supplement (expand or enhance) program activities and must not replace those funds that have been appropriated for the same purpose.
8) **Vendors** are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal.

Proposals that do not contain the requisite licensure may be deemed non-responsive

Certified Community Behavioral Health Centers (CCBHC's) may not be able to apply for services under the nine mandatory core areas, as those are incorporated in each prospective payment services model that considers the services areas and the total number of individuals, with and without TPL and are required to meet certification criteria. If a CCBHC applies for funding, sufficient documentation must be provided for the need and rationale for the additional funding to expand services beyond current capacity. This will include the need for critical infrastructure to provide additional services, expand catchment areas, or to expand to specialized populations. Only CCBHC's in good standing, without substantial plans of corrections, who have complete and timely submission of data, are eligible for consideration of funding.

2.6 Matching Fund Requirements

This application does not require a partner match.

SECTION 3.0 PRIORITY FUNDING AREAS

To further the missions of the BHWP, this NOFO seeks partners whose proposals are focused on **achieving positive outcomes**. The overarching objective is to improve the health and well-being of adults, children and families served while influencing positive change in Nevada communities. To reach this objective, collaborations with school-related settings, health care agencies, and/or community organizations are highly desired to address the clients and/or family's needs holistically. A holistic approach recognizes the connection of health care to social services as equal partners in planning, developing programs, and monitoring patients to ensure

their needs are met. Social determinates of health (SDOH) include factors like socio-economic status, education, the physical environment, and access to services. Underserved, low-income, and disparate populations have been identified as being impacted many SDOH, including inadequate access to care. Access to services for this population is strained and requires innovative approaches on behalf of agencies to address these issues. Access barriers may include transportation limitations, cultural and linguistic differences, disabilities, locations of services, lack of access to technology or broadband, policies that structurally promote inequities, and many other factors that may impede patients from accessing services. Applicants are encouraged to be creative to meet the needs of Nevada's citizens, families, and communities, especially for those for whom are disproportionately impacted by COVID-19 either directly through increased risk, burden of infection, or loss and grief, or indirectly through isolation, anxiety, stress, loss of employment, disconnection from education, unstable housing, or those lacking sufficient access to resources to foster resiliency.

The Applicant will receive Technical Assistance during the project period. **Mandatory components** of applicant funding are attendance at regularly scheduled and compliance meetings, data reporting, ad hoc reports as requested, timely and complete program reports, and corrective actions to address deficiencies of program fidelity or quality.

3.1 Sustainability

The COVID and ARPA dollars are "one-shot" dollars and programs with sustainability built in for continued care will receive the highest priority. For infrastructure programs such as hospital/crisis stabilization units, Nevada will work with the providers to identify potentials for continued funding for programs that successfully meet the terms of the subaward.

3.2 Identifying Priority Projects and Populations

Applicants must define ***one*** priority area per application. There is no limit on the number of applications any entity submits for consideration. The application must have a primary focus area but may include various levels of program services for the targeted populations. Applicants may submit more than one application. Each application must stand on its own and may not refer to any outside documents, links to other documents, websites, or other applications. The same criteria applies for all applications.

For SUD focused projects, Applicants must demonstrate current SAPTA certification or have a minimum of two years of experience providing direct services with the ability to become SAPTA certified within six (6) months. Pursuant to NRS 458 and NAC 458, no funding shall be provided for any services for any provider that is not SAPTA certified. The BHWP operates a Fee-For-Service (FFS) model based on provider capacity and the appropriateness of such a fee schedule for the proposed project. Those FFS direct service rates are included in Attachment A.

3.3 Evidence-Based and Best Practices for Crisis Care

Best practices within crisis care incorporate a set of core, essential principles that must be systematically included across the crisis system. These essential principles and practices are: 1) Addressing Recovery Needs, 2) Significant Role for Peers, 3) Trauma-Informed Care, 4) Zero Suicide/Suicide Safer Care, 5) Safety/Security for Staff and People in Crisis and 6) Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services. 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. Implementation program guidance includes:

1. Committing to a no-force-first approach to quality improvement in care that is characterized by engagement and collaboration.
2. Creating engaging and supportive environments that are as free of barriers as possible. This should include eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served to support stronger connections.
3. Ensuring team members engage individuals in the care process during a crisis. Communicating clearly regarding all options clearly and offer materials regarding the process in writing in the individual's preferred language whenever possible.
4. Asking the individual served about their preferences and do what can be done to align actions to those preferences.
5. Helping to ensure natural supports and personal attendants are included in the planning team, such as with youth and persons with intellectual and developmental disabilities.
6. Working to convert those with an involuntary commitment to voluntary so they are invested in their own recovery.

For more information on standards of care and best practices for crisis care please reference 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

3.4 Priority Services for Funding Consideration

Proposals must provide essential services and **address gaps in services** that may prevent individuals from accessing and/or participating in behavioral health programs. This funding announcement is not to pay for existing programs under the primary block grant applications, but is seeking to develop infrastructure, expand or enhance programs to serve Nevada. The programs in this funding announcement are limited in time and funding is not available for long term program support. The goal is to identify and fund programs that can be sustainable.
Each priority area must meet the eligible population(s) identified.

A. Adult Mobile Crisis Teams or Crisis Response Teams

Mobile crisis interventions provide individuals with less restrictive care in a more comfortable, community-based environment that is likely to produce more effective results than hospitalization or Emergency Department (ED) utilization. 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. Mobile crisis team services offer community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. Best practices within crisis care incorporate a set of core, essential principles that must be systematically included across the crisis system. These essential principles and practices are: 1) Addressing Recovery Needs, 2) Significant Role for Peers, 3) Trauma-Informed Care, 4) Zero Suicide/Suicide Safer Care, 5) Safety/Security for Staff and People in Crisis and 6) Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services. 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. 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 an adult 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 Adult Mobile Crisis Teams

- Mobile crisis teams must be designed to be dispatched by the National Suicide Prevention Lifeline, or its successor, as part of the 988 design and implementation, and may not dispatched through 911 as the primary mode of dispatch;
- 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.
- 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, and social service organizations for linkage and referral.
- All mobile crisis teams must have the ability to safely transport an individual to the hospital, should transport be needed.
- 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.
- 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.

Projects proposing services for children, youth, and families, as well as those offering interventions primarily in the emergency room will not be funded.
It is expected that the state will be funding a total of eight to 12 new adult mobile crisis statewide through this NOFO.

Target Population: Adults in Crisis

B. Assertive Community Treatment (ACT) or Forensic Assertive Community Treatment (FACT)

The goal of ACT is to provide individualized, person-centered, team-based care for individuals to achieve and maintain stabilization in the community. Applicants must propose a combination of specialized, mobile, multidisciplinary, integrated and community-based behavioral health services in accordance with the evidence-based practices and work toward fidelity of the ACT model. For rural and frontier areas, the South Dakota ACT model is encouraged. ACT and/or Forensic Assertive Community Treatment (FACT) services support individuals with behavioral health issues who tend to have a high rate of interaction with law enforcement and/or multiple systems including inpatient hospitalizations. FACT builds on the evidence-based ACT model by making adaptations based on criminal justice issues—in particular, addressing criminogenic risks and needs. In this sense, FACT is an intervention that bridges the behavioral health and criminal justice systems FACT is designed to do the following: improve clients' mental health outcomes and daily functioning; reduce recidivism by addressing criminogenic risks and needs; divert individuals in need of treatment away from the criminal justice system; manage costs by reducing reoccurring arrest, incarceration, and hospitalization; and increase public safety. Proposals should demonstrate the partnerships and utilize evidence-based and best practices to support the proposal.

Minimum Criteria for Assertive Community Treatment teams (including FACT):

- Teams must provide a team-based treatment model that provides multidisciplinary, flexible treatment and support to individuals with behavioral health issues with 24/7 access to team members to address crisis and reduce interaction with law enforcement and emergency services.
- Teams must include psychiatry, nursing, behavioral health treatment, case management, and individuals with lived experience (peer recovery support specialists).
- Teams are required to meet all criteria for the evidence based practice as defined within ACT Evidence-Based Practices Toolkit at Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT | SAMHSA Publications and Digital Products. CLAS standards must also be met.
- Teams will be expected to engage in training and technical assistance to build the programs to fidelity and achieve certification for ACT/FACT.
- Teams must have formal agreements in place with law enforcement, emergency services, regional hospitals, housing providers, and social service agencies for care coordination, linkage, and referral.

- Teams may choose to specialize in specific populations of focus including but not limited to ESMI, serious and persistent mental illness, or Assisted Outpatient Treatment.
- 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.
- 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.

Targeted Population: ACT will be utilized with braided funding from both the Mental Health and Substance Abuse Treatment and Prevention Block Grant. This includes with SMI, SED, COD.

C. Hospital-based Crisis Stabilization Units (Crisis Stabilization Centers; CSC)

Crisis stabilization centers offer the community a no-wrong-door access to behavioral health crisis care including screening, assessment, stabilization, withdrawal management, peer recovery support services, care coordination, linkage, and referral to appropriate levels of care, and suicide safety planning in a living room like setting within a licensed hospital facility. CSCs operate much like a hospital emergency department that accepts all walk-ins, ambulance, fire, and police drop-offs. To be eligible to apply for funding for CSC, applicants must be eligible to be endorsed as a Crisis Stabilization Center as defined within NRS 449.0915, including amendments as set forth in Senate Bill (SB) 156 in 2021. The Amendment allows the Nevada Health Care Quality and Compliance (HCQC) to issue an endorsement as a crisis stabilization center to the holder of a license to operate a hospital (free standing psychiatric or medical hospital). For more information on SB 156, please see SB156_EN.pdf (state.nv.us). The funding for CSC includes infrastructure costs but does not support capital expenditures for new buildings. The infrastructure costs for the equipment, chairs, or other such items is an allowable expenditure. This crisis model works with the free-standing hospital or hospital(s) selected to provide infrastructure support to move towards sustainability.

Minimum Criteria for CSCs:

- CSC must accept all behavioral health crisis referrals, including working with persons of varying ages (as allowed by facility license) and clinical conditions (such as serious emotional disturbance, serious mental illness, intellectual and developmental disabilities), regardless of acuity, including individuals on civil commitments and those needing withdrawal management services. This includes all walk-in requests for services, EMS and law enforcement drop-offs, and community referrals.
- CSCs must offer program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. The environment must be warm and welcoming for all individuals admitted within the milieu.
- CSCs must also prioritize safety and meet all necessary safety requirements including anti ligature fixtures.
- CSCs must offer 24/7/365 intensive, sub-acute stabilization for a person experiencing a behavioral health crisis. This requires staffing by a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis

including psychiatrists or psychiatric nurse practitioners (telehealth may be used); Nurses; Licensed and/or credentialed clinicians capable of completing assessments; and Peers with lived experience similar to the experience of the population served.

- If an individual's condition is assessed to require medical attention in a hospital or referral to a dedicated withdrawal management (i.e., referred to more commonly and historically as detoxification) program, it is the responsibility of the CSC to make those arrangements and not shift that responsibility to the initial referral source (family, first responder or mobile team).
- CSCs must tailor the milieu and services provided for children, youth, and families to meet their unique needs. Applications for CSCs to provide services to both adult and child/adolescent populations must clearly define how the milieu and services provided will be tailored for each population and aligned with best practices.
- CSCs cannot require medical clearance prior to admission but rather assessment and support for medical stability while in the program
- CSCs must employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway to transfer the individual to more medically staffed services if needed.
- CSCs are required to screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated and must screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.
- CSC's must establish a formulary of available medications and therapeutics needed to manage a wide range of behavioral health conditions, including buprenorphine and IM antipsychotics.
- CSCs are expected deliver on National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation. The toolkit can be reviewed at: national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov). CLAS standards must also be met.
- Referrals for medication assisted treatment must be offered for individuals requesting such services, when clinically indicated.
- 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.
- 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.

Targeted Population: Individuals in Crisis

D. Expansion Peer Recovery Support Services and Workforce Development:

Individuals with lived experience certified as peer recovery support specialists (PRSS) are integral to many harm-reduction, treatment and recovery programs throughout the state including crisis services. As Nevada works to expand access to crisis services and community-based services, it is a priority to recruit, train, retain, and build a PRSS workforce ready to fulfill the roles of peers. A primary, transformative element of recovery-oriented care is to fully engage the experience, capabilities and compassion of people who have experienced behavioral health crises. Including individuals with lived mental health and substance use disorder experience on the crisis care team supports engagement efforts through the unique power of bonding over common experiences

while adding the benefits of the peer modeling that recovery is possible. These funds may be used to design programs that will provide the necessary training, education, and experience for individuals to achieve IC&RC peer certification and specialize in working in crisis programs. Roles for peers are available throughout the crisis continuum and include opportunities for integrating peers within available crisis line and warm line operations, having peers serve as one of two mobile team members, ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility, and offering continued peer support during follow-up, navigation to services and supports, and engagement in recovery.

Minimum Criteria for Expansion PRSS and Workforce Development:

- Programs must support the education, training, and experience necessary to achieve IC&RC certification in Nevada with a specialization in crisis support to include suicide prevention and crisis intervention. This may include PRSS Supervisors as well.
- Programs must provide services in accordance with principles that support harm reduction, patient engagement, and the use of evidence-based practices.
- Programs must demonstrate an existing commitment to growing and developing the PRSS workforce including supervised training, work experience, and educational opportunities.
- Programs must promote the diversity of the peer experience and diversity within the workforce. This must be reflected in the program design, implementation, and program evaluation.
- Organizations that are Medicaid eligible (e.g., qualify for provider type 14, 17, 82) providing peer recovery support services under this award must be capable of providing services as outlined within Medicaid Chapter 400.
- 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.

Targeted Population: Peer Supports/Workforce Expansion will utilize braided funding from both the MHBG and SABG. This may include those with SMI, SED, COD.

E. Adult or Juvenile Criminal Justice Deflection and Diversion

Agencies should identify programs focused on reducing the costs and consequences of repeated arrests and incarceration for people with mental health and substance use issues. Specific focus should be to improve access to behavioral health treatment and supportive services to individuals to prevent or lessen the impact of involvement within the criminal justice system or juvenile justice system (CJ/JJS). The approaches should maintain a balance between public safety and providing a pathway for individuals prior to involvement with or resulting from the CJ/JJS toward harm reduction, treatment and/or recovery supports. The programs are led by law enforcement agencies with strategic partnerships with community providers for harm reduction, behavioral health treatment, recovery supports, housing programs, and social service agencies.

Minimum Criteria for Adult Criminal Justice Deflection and Diversion

- Must identify individuals at-risk of involvement with the law enforcement that have behavioral health treatment needs.

- Use evidence-based screenings and assessment to individuals with mental health and substance use disorders. It is expected that organizations will utilize evidence-based screening assessments and tools including the Nevada Risk Assessment Screening (NRAS), including the use of the Risk, Needs, and Responsivity Model (RNR) to determine level of treatment needs, strengths, and barriers for responding to programming, and risk for recidivism.
- Provide pre/post-adjudication or alternative options for adjudication using evidence-based screening and assessment to ensure comprehensive treatment, supports, and services.
- Demonstrate policies and procedures that promote deflection and diversion of individuals from the justice system into home- and/or community-based treatment.
- Assure of equity of opportunities for deflection or diversion and linkage to community services and supports for all populations to decrease disproportionate contact with the justice system in underserved and minority populations.
- All programs are expected to use person-centered, trauma informed practices, and facilitate access to necessary levels of care. Participant's preferences must be taken into account.
- Referrals for medication assisted treatment must be offered for individuals requesting such services, when clinically indicated.
- Services may also coordinate care and supports for those releasing from prison or jail as part of a reentry program as ancillary.
- Peers must be included in the structure of the program and offer primary support to those in the program.
- Programs geared toward juvenile justice programs must also work with families, caregivers, and/or advocates and collaborate with care coordination across systems, including schools.
- Utilize SAPTA certified providers for the provision of substance use disorder services. If programs are not currently SAPTA certified, providers must be certified within the first 6 months of the project. Failure to achieve certification timely will result in loss of funding. Similarly, providers who fall under the requirements for licensure under HCQC must be licensed accordingly.
- 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.
- 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.

This funding will not be allowed to pay for additional medical or licensed behavioral health staff located within jails or correctional facilities.

Targeted Population: Adults and youth with SMI, SED, COD. CJ/JJ Deflection and Diversion programs will utilize braided funding from both the MHBG and SABG.

F. Assisted Outpatient Treatment

Assisted Outpatient Treatment (AOT) involves petitioning local courts to order individuals with SMI to enter and remain in treatment within the community for a specified period of time. AOT is currently defined with Senate Bill 70. AOT is intended to facilitate the

delivery of community-based outpatient mental health treatment services to individuals with SMI that are under court order as authorized by state mental health statute.

Minimum Criteria for AOT Programs:

- Demonstrate and utilize existing relationships with local participants in the civil commitment process including law enforcement, families, judges and/or administrative law judges/magistrates and special justices that preside over civil commitment processes on AOT, hospitals, inpatient settings, housing services and peer recovery support services. Build a coalition of local stakeholders in the civil commitment process so that local issues and barriers regarding the implementation of AOT can be addressed. Evaluate the psychiatric, social, and medical needs of individuals participating in the program.
- Develop and implement a treatment plan that includes evidence-based mental and, when indicated, substance use disorder services to those living with SMI including the delivery of outpatient and intensive outpatient services with a multidisciplinary team of clinical experts.
- AOT treatment teams must provide a team-based treatment model that provides multidisciplinary, flexible treatment and support to individuals with behavioral health issues with 24/7 access to team members to address crisis and reduce interaction with law enforcement and emergency services.
- Provide case management services that support the treatment plan, including ensuring that appropriate referrals are made to medical and home- and community-based social service and recovery support service providers.
- Form partnerships between the behavioral health entities that provide an array of evidence-based treatment and the criminal justice system, including the courts.
- Evaluate the process for implementing AOT to ensure consistency with the individual's needs and state law.
- Address issues of equity and diversity, ensuring populations disproportionately impacted by COVID are prioritized.
- Provide community recovery support services, including educational/training programs aimed at assisting with employment, other employment services, housing linkages, peer recovery support, and other related services. Teams must have formal agreements in place with law enforcement, emergency services, regional hospitals, housing providers, and social service agencies for care coordination, linkage, and referral.
- Utilize SAPTA certified providers for the provision of substance use disorder services. If programs are not currently SAPTA certified, providers must be certified within the first 6 months of the project. Failure to achieve certification timely will result in loss of funding. Similarly, providers who fall under the requirements for licensure under HCQC must be licensed accordingly.
- 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.
- 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.

Targeted Population: AOT will utilize braided funding from both the MHBG and SABG. This includes with SMI, SED, COD.

G. Community-Based Treatment for Children, Youth, and Families

Children, youth, and families need access to community-based treatment options that promote healthy development, preserving the child, youth, and family/caregiver relationships, continued engagement in education, and to maintain the highest levels of functioning across all domains. Services and supports eligible for funding under this NOFO include offering increased screening and assessments in school-based or community-based settings for children and families experiencing crisis, outpatient behavioral health services across the continuum including outpatient, intensive outpatient, and partial hospitalization programs (PHP) services, day treatment, and support for youth transitioning back home after discharge from inpatient or residential treatment. Intensive in-home treatment, wrap around care coordination, family peer support and/or in-home habilitation services for children with SED to reduce imminent risk for out of home placement are also eligible for funding.

Minimum Criteria for Children, Youth, and Family Programs:

- Provide evidence-based and culturally appropriate behavioral health services to children with SED, SUD, or Co-Occurring disorders.
- Conduct diagnostic and evaluation services using standardized and validated screening and assessment tools and measures.
- Ensure 24/7 emergency services are available to reduce unnecessary for emergency room utilization. This may be available telephonically or through telehealth.
- Provide support and services consistent with the System of Care philosophy and ensure family/caregiver engagement is prioritized.
- Programming must coordinate across systems as appropriate to include but not limited to school, child welfare, family court, and juvenile justice.
- Ensure trauma informed treatment and practices are embedded in every aspect of the program.
- Screen for adverse childhood experiences and reduce risk.
- Address issues of equity and diversity, ensuring populations disproportionately impacted by COVID are prioritized.
- Referrals for medication assisted treatment must be offered for individuals requesting such services, when clinically indicated.
- Utilize SAPTA certified providers for the provision of substance use disorder services. If programs are not currently SAPTA certified, providers must be certified within the first 6 months of the project. Failure to achieve certification timely will result in loss of funding. Similarly, providers who fall under the requirements for licensure under HCQC must be licensed accordingly.
- 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.
- 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.

Targeted Population: Youth/Adolescents may be utilized with braided funding from both the Mental Health and SAPTA Block Grant. This may include those with SMI, SED, COD.

H. Prevention Programming

Nevada has been working to identify the needs and gaps for prevention activities for substance use, behavioral health crisis, and resilience including suicide prevention. Nevada's certified prevention coalitions use the Strategic Prevention Framework to design and deliver primary prevention strategies within their communities. Since the beginning of COVID-19, Nevada's prevention coalitions have been working diligently in their communities to innovate the delivery of primary prevention activities to address the needs of youth and families as schooling was provided virtually and families struggled to cope and manage with the stressors of the pandemic.

As students and families transition back to in-school learning school districts, parents, students, teachers, and school administrators have identified an imperative need to support the transition to in-person learning. Prevention services focused on successful transitions to the classroom as well as programming focused on healthy coping, reducing stressors, suicide prevention, and skills for resilience will be provided to students, parents, and staff.

Additional prevention activities will focus on expanding existing or creating new activities related to the increased access to marijuana for the underage population, to reduce alcohol accessibility and use as well as incorporate data gathered from the ACEs. Nevada recently collaborated with the University of Nevada Reno to develop a comprehensive report with the focus on ACE's data to drive prevention activities in communities across the state. These reports can be accessed at the links below and should be referred to when developing the proposal for funding.
Middle School YRBS Special ACE's Report:

https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/Meetings/5a%20-%202019%20Middle%20School%20YRBS%20ACEs%20Special%20Report%20FINAL.pdf
High School YRBS Special ACE's Report:
https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/Meetings/5b%20%202019%20High%20School%20YRBS%20ACEs%20Special%20Report%20FINAL.pdf
BRFSS ACE's Special Report:
https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/Meetings/5c%20-%20BRFSS%2018%2020%20ACEs%20report_8-17-21.pdf

Proposals must clearly identify projects that meet any of the areas below and meet the Minimum Criteria.

1) Prevention activities that expand existing or create new activities related to the increased access to address to marijuana for the underage population, to reduce alcohol accessibility and use as well as incorporate data gathered from the ACEs special reports. Activities should address both reducing risk factors as well as increasing protective factors for youth and families.
2) Work with school and youth-based organizations to identify youth and family programs to direct towards resources and suicide prevention efforts, family and school-based capacity building trainings, and lethal means information. Collaboration between agencies and organizations is strongly encouraged including,

but not limited to the Nevada Department of Education, community youth organizations, prevention coalitions, and/or school districts.

3) Program activities may also include healthy coping strategies, stress management, social-emotional learning, peer support, education for parents on helping their student successfully transition back to school, and/or support for school staff to reduce the impact of stressors. The primary focus will be to support students, parents, and school administration/teachers in transitioning back to person learning or alternative learning during COVID and post COVID.
4) Activities may include school, youth-based organizations, or prevention coalitions to develop effective strategies which may include screening and assessment, suicide prevention efforts, strategic messaging, risk messaging, web or technical enhancements or interventions, programs to identify youth and family who need services, provide direct resources, education, training, and support suicide prevention efforts.

Based on the Capacity Assessment Report for Nevada, higher consideration will be given to applications who have existing school and/or community-based prevention programs for youth and adolescents.

Minimum Criteria for Prevention Programming

- All proposed prevention strategies must be evidence-based and applied with fidelity to the model.
- Address issues of equity and diversity, ensuring populations disproportionately impacted by COVID are prioritized.
- Design evaluation procedures, participate in on-going program evaluation, and gather and report data on impact of programming beyond pre/post assessments.
- Clearly articulate the use of the funds and ensure no supplanting with other funds including but not limited to other prevention grants, American Rescue Plan Act (ARPA) funding, and Elementary and Secondary School Emergency Relief (ESSER) funding.
- Programs receiving funding must be SAPTA certified or be able to obtain SAPTA prevention certification within six-months of the award.
- Programs must select activities within the six strategies.

1. **Information Dissemination**: This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.
2. **Education:** This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis of media messages, for example, and systematic judgment abilities.
3. **Alternatives:** This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and would, therefore, minimize or obviate resort to the latter.

4. **Environmental:** This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.
5. **Community-Based Process:** This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking.
6. **Problem Identification and Referral:** This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education.

Targeted Population: Youth/Adolescents are the primary focus of these funds and work may include addition targeting of families/caregivers and school personnel. Depending on application, funding may also be braided between Mental Health and SAPTA programming for crisis related proposals.

For more information:

- https://www.samhsa.gov/about-us/who-we-are/offices-centers/csap
- Evidence-Based Interventions for Preventing Substance Use Disorders in Adolescents (nih.gov)
- Preventing Suicide: A Technical Package of Policy, Programs, and Practices (cdc.gov)
- Zero Suicide Toolkit | SAMHSA

I. Set-Aside Services for Pregnant Women and Women with Dependent Children

Specialty services for pregnant persons and parents with dependent children (PPW) have been identified as priority needs within Nevada. Many women who develop substance use disorders have an underlying co-occurring mental health disorder and/or a history of trauma which must be addressed along with SUD treatment and recovery. PPW are a priority to receive treatment services to prevent prenatal substance exposure and developmental disabilities as children grow, break the intergenerational cycle of substance use, and provide healthy and safe living environments for women, children, and their families. While it is common for most women to face stigma for their substance use, PPW often experience especially harsh stigma from their families, communities, health care and other service providers which can impede their path to recovery. PPW have complex behavioral health needs and require a coordinated, comprehensive, and compassionate approach to treatment services.

As SAPTA/DBPH has worked to fully develop a statewide women's perinatal substance use treatment network during the past few years, several service and care coordination gaps have emerged, indicating a clear need for increased capacity to serve PPW across the continuum of treatment and supportive services. This includes:

- Access to therapeutic/specialty childcare for children whose parents are impacted by substance use,

- Treatment navigation to and collaborative care with providers who offer specialty services, including MAT, reproductive health care, prenatal care, and postpartum support,
- Care coordination,
- Case management,
- Transportation, and
- Other needed women's set-aside programming.

In addition, home-based care and home visiting services for PPW have been demonstrated as a successful evidence-based intervention modality for delivering and helping to connect individuals to critical social, health, and educational services; however, this is an under-resourced service option in Nevada. While the State has evidence-based home-visiting programs available in select communities, there is a need to expand capacity to integrate home visiting services into SUD treatment programming for PPW and their families.

Funding from this grant will be used to identify providers that will expand access to treatment and supportive services for PPW who are impacted by substance use that incorporates the array of specialty services identified above

Minimum Criteria for Set-Aside Services

- Treat all families as a unit and admit both women and children into treatment services, as appropriate. Treating the family as a unit reduces barriers to treatment, improves outcomes for each family member, and has been found to reduce cost burden in non-behavioral health service areas such as criminal justice and foster care.
- Provide evidence-based and culturally competent behavioral health services for PPW and women with dependent children in need of substance use and/or co-occurring disorders treatment. Effective family-centered SUD treatment uses a strengths-based model, promotes culturally competent services specific to women and incorporates an integrated, multidisciplinary approach.
- Ensure policies, procedures, and practices are in place for priority admissions in accordance with federal regulations and state standards.
- Provide directly or through formal referring relationships: primary medical care, including prenatal care and reproductive health care, for women who are receiving substance abuse services, childcare, primary pediatric care including immunizations, gender-sensitive, trauma-informed substance use treatment and other therapeutic interventions for women which may address issues of relationships, ascribed roles and gender expectations, sexual abuse, physical abuse, and parenting, therapeutic services for children accompanying women in treatment that are age-appropriate and address their developmental and psychosocial needs, including developmental screening, Sufficient recovery supports, including case management and transportation, to ensure that women and their children have access to needed services. Effective case management is client-driven and responsive to client needs, mobilizes formal and informal resources and services, and services, and is pragmatic, anticipatory, flexible, and culturally sensitive.
- Participate in Nevada's Perinatal Health Network.
- Accept referrals from community behavioral health and medical providers, social service agencies, child welfare, courts, and law enforcement, and through CARA Plans of Care.
- Programming must coordinate across systems as appropriate to include but not limited to health care, child welfare, family court, and criminal justice.
- Ensure trauma informed treatment and practices are embedded in every aspect of the program.

- Screen for adverse childhood experiences and employ strategies to reduce risk and build resiliency. This includes supporting family preservation and/or work toward reunification.
- Utilize SAPTA certified providers for the provision of substance use disorder services. If programs are not currently SAPTA certified, providers must be certified within the first 6 months of the project. Failure to achieve certification timely will result in loss of funding. Similarly, providers who fall under the requirements for licensure under HCQC must be licensed accordingly.
- 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.
- 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.

Targeted Population: Women's Services are funded out of the SAPTA Block Grant and focus on those with SUD or COD.

J. Early Serious Mental Health (ESMI)

Early-stage SMI or ESMI refers to a recent onset of SMI, and "recent onset" commonly means that diagnostic threshold was reached within the previous one or two years. Thus, the population of individuals with ESMI includes a broad range of diagnostic categories (e.g., schizophrenia spectrum disorders; affective disorders with and without psychoses; anxiety disorders) that present during the early stages of an individual's clinical course (e.g., first episodes; multiple-episode illnesses with an onset during the past 1-2 years; etc.).

The *Nevada NAVIGATE Early Treatment Program of Coordinated Specialty Care (CSC) for First Episode of Psychosis (FEP)* represents the State's strongest evidence-based program for the early treatment of ESMI. Data from the Outcomes-driven Quality Control and Continuous Performance Improvement Methodology that was developed and implemented for the State of Nevada NAVIGATE Early Treatment Program for FEP suggests that the Coordinated Specialty Care (CSC) paradigm is an effective model for advancing the recovery process of individuals who have experienced a recent episode of SMI of the schizophrenia spectrum type. This purpose of this priority area is to extend the CSP paradigm to additional diagnostic types within the SMI domain; specifically, DSM-5 Bipolar and Related Disorders, with and without psychosis.

For more information on the evidence-based practice, please see:
Substance Abuse and Mental Health Services Administration: *Routine Administration of Cognitive Behavioral Therapy for Psychosis as the Standard of Care for Individuals Seeking Treatment for Psychosis | SAMHSA Publications and Digital Products*
NAVIGATE Early Treatment Program of Coordinated Specialty Care (CSC) for First Episode of Psychosis, Manualized. *https://navigateconsultants.org/manuals/*

Nevada has unmet service needs and critical gaps exist within the State's current system of care for ESMI. Implementation of evidence-based CSC services within community mental health settings is needed for the broader population of ESMI Disorders, especially for affective disorders with and without psychosis.

The goal of program activities should be focused on closing the following gaps:

A. To delay and mitigate the deleterious clinical and social outcomes associated with the broad range of ESMI disorders, including psychological deterioration, medical co-morbidity, suicide risk and undesirable social circumstances such as unemployment, homelessness, and poverty.
B. To reduce the societal and economic burdens produced by lengthy durations of untreated serious mental illness, including early-stage schizophrenia spectrum and other psychotic disorders, as well as early-stage affective disorders with and without psychosis.

Minimum Criteria for Early Serious Mental Illness Programs:

- The activities should work to support increased access to evidence-based and best-practice treatments and coordinated recovery support services by two groups: individuals who are diagnosed with ESMI disorders that meet DSM-5 criteria for Bipolar and Related Disorders (1) with Psychosis and (2) without Psychosis. The optimal age range for capturing cases of ESMI of the Bipolar and Related Disorders type extends from mid-adolescence through early adulthood.
- Development and implementation of evidence-based protocols for ESMI disorders that utilize the same or similar CSC framework as the one that was developed for the evidence-based NAVIGATE Early Treatment Program for FEP. These parallel protocols will include CSC services that are relevant for diagnostic categories that fall within the broad range of ESMI disorders not currently being served by the FEP (Bipolar and Related Disorders with Psychosis and without Psychosis).
- CSC services must be delivered by multi-disciplinary teams of mental health professionals whose expertise span biological, psychological, and social domains.
- Utilize recovery-oriented interventions involving clients, CSC Team members and, when appropriate, family members and significant others.
- Protocols should be manualized and include, at minimum, four core interventions: Individual Psychotherapy; Pharmacotherapy & Primary (Medical) Care Coordination; Family Education Program; and Supported Employment & Education.
- Case Management and Peer Support Services must also be considered when proposing to serve the ESMI population.
- Programs must provide outreach, education, training, and TA to community providers and social services agencies on the program and actively engage the community to promote screening, assessment, and referral to specialty care.
- Focus on reducing barriers to access to services which may include structural disadvantages (e.g., socioeconomic) and cultural inequalities (e.g., racial-ethnic group membership) along with a focus on reducing stigma, improving understanding about ESMI, and accepting treatment. CLAS standards must also be met.
- 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.
- 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.

Targeted Population: Individuals who meet criteria for ESMI or Co-Occurring.

SECTION 4.0 EXCLUDED ACTIVITIES

- Prevention activities except for those identified in Section "H."
- Activities that are not evidence-based or best practices for behavioral health.
- Activities that are funded through other program grants or activities.
- Activities not identified as a priority within this NOFO.

SECTION 5.0 CULTURAL COMPETENCE

Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (Behavioral Health Guide) must be referenced when completing applications to inform approaches that support CLAS that are aligned with current practice and standards. Throughout this NOFO, this is referenced as CLAS standards.

https://www.minorityhealth.hhs.gov/Assets/PDF/clas%20standards%20doc_v06.28.21.pdf?utm_source=SAMHSA&utm_campaign=bba9d8b55e-SAMHSA_ANNOUNCEMENT_2021_07_28_1600170&utm_medium=email&utm_term=0_ee1c4b138c-bba9d8b55e-168845297

DPBH expects all applicants to gather and utilize knowledge, information, and data about individuals, families, communities, and groups and integrate that information into clinical practices, standards and skills, service approaches, techniques, and evidenced-based initiatives to best address each client's treatment needs. Culturally competent care is a core value.

For more information, the Office of Analytics created the 2021 Minority Health Report. The purpose of this report is to highlight existing health disparities by race/ethnicity in Nevada, with a focus upon the most current data available. The race/ethnic groups represented in this report are White-non-Hispanic, Black-non-Hispanic, American Indian/Alaskan Native (AI/AN) -non-Hispanic, Asian/Pacific Islander (API) -non-Hispanic, and Hispanic. Racial and ethnic minorities are disproportionately affected by health problems and disease in Nevada and throughout the nation. This report is intended to present current and available data, from the state of Nevada, broken down by race/ethnicity and region, to inform health professionals, policy makers, community members, and researchers about existing disparities among Nevada's population. https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Minority Health Report 2021(2).pdf

All Applicants are required to participate in training made available by the state to improve access, information and improving the system for racial, ethnic, rural, and other underserved communities.

SECTION 6.0 GRANTEE RESPONSIBILITIES

6.1 Grant Program Implementation

All Applicants identified for funding must comply with the Grant Instruction and Requirements (GIRS). Link: Grant Instructions and Requirements revised October 2020 (nv.gov)

Failure to comply with corrective action within sixty days may result in termination of funding.

6.2 Modernization Act of 2010 - Data Collection and Reporting

SAMHSA collects data on key output and outcome measures to monitor and manage grantee performance, improve the quality of services provided, and inform evaluation reports. Client-level data is mandated to be collected including demographics, ICD10 diagnostic categories, substance use and abuse, mental health and physical health functioning, and other key variables. The system includes data entry, data validation and verification, data management, data utilization, data analysis support, and automated reporting.

6.3 Data Collection and Reporting

By submitting a response to this NOFO, all Applicants are agreeing to be compliant with the data reporting and recognizes that funding is contingent on compliance. Applicants must provide details in the grant that document the plan for data collection and reporting using the Data Collection and Performance Measurement tools. Depending on the funding source, Applicant may be required to utilize specific data collection systems or have specific reporting requirements, which may include:

1. Collect data, including data collected using SAMHSA approved measurement instruments, at a minimum of pre and post service on each individual client served;
2. Document and track the amount of service received per client;
3. Collect standard demographic information for each client, such as gender, race, ethnicity, income, education, age;
4. Collect information on adverse events (including but not limited to hospitalization, justice involvement, suicide) avoided for program participants; and,
5. Comply with submitting data and information as part of the National Outcome Measurement System (NOMS), Client Level Data (CLD) and/or Treatment Episode Data Set (TEDS) to DPBH's Central Data Repository (CDR). All Applicants must be able to extract data from each respective EHR systems to comply with the data collection measures.

6.4 Performance Reports

Grantee will submit a Performance Report as required by the subgrant. Performance reports must show progress towards goals and services through defined data collection processes and measures. Specific outputs will be negotiated during the contract award process. DPBH anticipates negotiating performance measures using a standardized menu of outputs and outcomes, depending on the type of work funded. With the importance of the COVID/ARPA funding and getting services into the community, these funds will require monthly meetings to look at output measures to meet the needs of the community. Note: If an infrastructure development grant is approved, such as hospitalization, there will be additional measures that will frame the development of the program that will flow into the direct service deliverables through an agreed upon timeline.

6.4.1 Examples of Output Measures (not limited to)

- The number of unduplicated individuals served annually (by state fiscal year).
- The number of encounters, treatment/services provided, activities occurring per month.
- The percentage of service slots that are filled per month.

- The percentage of individuals that receive the intended number of service encounters.
- The percentage of individuals that receive the required screenings/assessments.
- The percentage of individuals who complete required survey instruments (e.g., satisfaction surveys).
- Increase in utilization of services, including behavioral health services by each sub population;
- Criminal Justice System involvement;
- School Attendance;
- Demographics to include Number, age, and gender of unduplicated patients seen each year; Workforce/Employment status; Housing status; Identified as part of a targeted population (homeless, veterans, LGBTQ, etc.); Number and percentage of clients screened for substance abuse disorders; Number and percentage of patients screened for behavioral health disorders.

6.4.2 Examples of Performance Measures (not limited to)

- Individuals will show improvements in client functioning after program participation (e.g., an ability to complete activities of daily living and basic functions with symptoms and/or does not disrupt activities or social interactions).
- Individuals will show improvements in autonomy after program participation (e.g., requiring less intervention and/or less-restrictive care, an ability to complete instrumental activities of daily living, and/or an ability to earn wages, maintain housing in the community, or access resources when needed).
- Individuals will show improved quality of life after program participation (e.g., self-reported satisfaction with life, fulfillment, and positive emotions and mood. The individual has positive social connections, is engaged with the community, and can achieve self-directed goals)
- Mental health programs will show a decrease in occurrence of adverse events (including but not limited to hospitalization, justice involvement, and suicide)
- Participants will report satisfaction with services and self-perceived improvement after program participation.
- Other outcome areas may include: 30-day use; stable housing; stable employment; percent of clients who complete treatment.

6.4.3 Compliance of Application

Applicant agrees to the following requirements of compliance with submission of an application.

1) If the Applicant has not met performance measures of previous DHHS contracts/subgrants, DHHS reserves the right to not award additional contracts.
2) Funds are awarded for the purposes specifically defined in this document and shall not be used for any other purpose.
3) DHHS may conduct on-site subrecipient reviews annually, or as deemed necessary.
4) DHHS reserves the right during the contract period to renegotiate or change deliverables to expand services or reduce funding when deliverables are not satisfactorily attained.
5) The Applicant, its employees and agents must comply with all Federal, State, and local statutes, regulations, codes, ordinances, certifications and/or licensures applicable to an operational organization as defined under Eligible Organizations.

6.4.4 Program Income

Under Section 2 CFR §200.80, program income is defined as gross income earned by an organization that is directly generated by a supported activity or earned as result of the federal or state award during a specific period of performance. For programs receiving federal or state funds, program income shall be added or deducted from grant funds, depending on federal authority. For added funds, they must be committed to the project and used to further eligible project or program objectives. Program income must be identified monthly on the Request for Reimbursement (RFR). All program funds must be expended prior to requested federal grant funds. Examples of where program funds have been used to augment program activities include, but are not limited to, outreach activities specific to program, bilingual telephone, or program staff, improving Electronic Health Records (EHR), and/or telehealth equipment. Expanding program income is one measure for sustainability to replace grant funds. Grant funds are the payor of last resort. (Please refer to GIRS for more information).

6.4.5 Licenses and Certifications

The Applicant, employees and agents must comply with all Federal, State, and local statutes, regulations, codes, ordinances, certifications and/or licensures applicable for defined mental health direct services for children/youth and/or adults. Prior to award issuance, if selected, DPBH reserves the right to request that agencies provide documentation of all licenses and certifications which may include, but are not limited to licensing board requirements, SAPTA service endorsements, facility licensing requirements HCQC, county business license, proof of non-profit status, etc.

6.4.6 Disclosures

Applicant must disclose any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

6.4.7 Payment & Billing

Upon review and acceptance by the State, payments for invoices are normally made within 30 - 45 days of receipt, after all required information, documents and/or attachments have been received. The State does not issue payment prior to receipt of goods or services. The vendor shall bill the State as outlined in the approved subgrant/contract and/or payment schedule. The State is on a fiscal year calendar. All billings for dates of service prior to July 1 shall be submitted to the State no later than the first Friday in August of the same year. A billing submitted after the first Friday in August that forces the State to process the billing as a stale claim pursuant to NRS 353.097, shall subject the contractor to an administrative fee not to exceed $100.00. This is the estimate of the additional costs to the State for processing the billing as a stale claim and this amount shall be deducted from the stale claim payment due the contractor.

SECTION 7.0 APPLICATION AND SUBMISSION INFORMATION

7.1 Technical Requirements

Pursuant to NRS, Applicants may not call to discuss applications or processes with any staff person. The only contact is Sheila Lambert at SLambert@dhhs.nv.gov. Any violation of this is subject to immediate disqualification of funding. The evaluation committees remain confidential to ensure an open and transparent application process with no appearance of impropriety by any one applicant receiving information that is not available to all applicants. Employees who violate this policy may be subject to disciplinary action.

Applications will be reviewed and evaluated on a rolling basis and will be considered for award based on the merits of the proposal. Completed applications must be submitted via email to the DHHS-DBPH no later than Thursday**, December 23, 2021, at 5:00 p.m. Pacific Standard Time (PST).** Please note that the application has been condensed to reduce the burden on applicants. Additionally, applications may remain on file for consideration of funding for future funds as they may come available for a period not to exceed four years.

The documents required to be submitted include 1) The completed application and 2) The attached excel budget submitted to SLambert@DHHS.NV.Gov. If you do not receive an email acknowledgement of application receipt within 48 business hours, please send an email to with **Notification Status** in the subject line SLambert@DHHS.NV.GOV.

7.1.1 **The DPBH is not responsible for issues or delays in e-mail service**. Any applications received after the deadline may be disqualified from review. Therefore, the DPBH encourages organizations to submit their applications well before the deadline. No acknowledgements will be made for any submittal that arrives after the deadline has passed.

7.1.2 **Formatting:** Applicants must follow the requirements identified in the application including limitations on Word Count.

7.1.3 **Do not submit unsolicited materials** as part of your application. Any unsolicited materials mailed, delivered, or e-mailed to DPBH will **not** be accepted. This includes support letters, cover pages, cover letters, brochures, newspaper clippings, photographs, media materials, etc. **The submission of additional materials is subject to disqualification.**

7.1.4 Once the application is submitted, no corrections or adjustments may be made. DPBH will consider corrections or adjusted prior to the issuance of a subgrant, should both the DPBH and the applicant agree on such changes or adjustments. Corrections or adjustments shall not be considered on any item that was considered critical to the consideration for the award.

7.2 Written Questions and Answers

In lieu of a pre-proposal conference, DBPH will have provide one opportunity for Applicants to provide questions in writing, received by email regarding this NOFO on or before Thursday**, October 21, 2021, at 3:00 p.m.** All questions and/or comments shall be addressed in writing and responses posted to the BHWP website at https://dpbh.nv.gov/Programs/ClinicalSapta/dta/Grants/Saptagrants on or before **Thursday, October 28, 2021, at 6:00 p.m. PST**. Applicants shall provide their company name, phone number, contact name and email address when submitting questions.

7.3 Application Requirements

The Project Application Form must be submitted via PDF, with the excel budget document, to be considered compliant with this NOFO. All sections are required to be complete. **Failure to complete any section may disqualify the applicant.** BHWP will work with the applicant on the performance measures based on the data and information provided if selected for an award. Data collection is not a performance measure, but supports the identification and success of performance measures.

A. Baseline Data

Applicants are required to provide baseline measures of current capacity and clients served, when identifying the enhancement or expansion of programs in the Scope of Work.

B. Identification of Goal

The goal does not need to be measurable (e.g., improve the health of women, reduce IVDU, etc.). The goal is the broadly stated purpose of the program. A goal may be stated as reducing a specific behavioral health problem or as improving health and thriving in some specific way. It should be a very broad result that you are looking to achieve. Goals can be one or many; however, each goal must have its own Outcome Objectives and Activities and may include the target population to be served. *Example: To add beds to a stable residential care facility providing therapy for substance abuse, mental illness, other behavioral problems, and other wrap around services.*

C. Outcome Objectives

Please enter a description of measurable Outcome Objectives which are Specific, Measurable, Achievable, Realistic, Time limited (S.M.A.R.T.). Outcome objectives are specific statements describing the strategies you will employ, the evidence-based programs you plan to utilize to accomplish your objectives, which must be measurable should include:

Who: Target population?
What: Strategies and Evidence based programs utilized to effect change
Where: Area
When: When will the change occur
How much: Measurable quantity of change
Example: will increase the number of women's beds from 6 to 12.

Outcome Objectives can be Qualitative or Quantifiable:

Example – Qualitative: At least 95% of 2018-2019 program graduates will report an understanding of the increased risk of negative birth outcomes when women consume alcohol during pregnancy.
Example – Quantifiable: By June 2019, the waitlist for residential substance abuse treatment beds will be reduced from sixty days to no more than fourteen days.

D. Activities

List the steps planned to achieve the stated Outcome Objective.

Example:

1. *Secure residential location, licensing, inspections, and certifications*
2. *Hire support staff for the program, therapy, maintenance, etc.*
3. *Work with law enforcement, prosecutors, and the judiciary system to identify potential clients.*

E. Documentation

Please list any documentation or process evaluation documents that will be produced to track the completion of the activities.
Example:

1. *Informational brochures, copies of flyers, ads and newspaper articles, social media and TV ads used in this effort.*
2. *Contracts related to leasing, employment, supplies, maintenance agreements, operations, audit, etc.*
3. *Meeting minutes, Memorandum of Understanding, records of efforts to influence public opinion.*
4. *Records of interviews, surveys, reports, focus groups, local law enforcement data, etc.*

F. Budget Instructions

All proposals must include a detailed project budget for each project period requesting grant funding. The BHWP will work with applicants to adjust budgets in compliance with federal and state regulations if any adjustments are required. Please provide a budget that is complete, cost effective, and allowable (e.g., reasonable, allocable, and necessary for program activities) to the best of your ability.

Budget proposals that provide direct services must have a minimum of 75% of the budget for direct services; not more than 15% for administration and 10% for data collection (not including indirect). The initial budget funding limitations do not apply to infrastructure development or hospital stabilization units. Fee For Service may be appropriate based on services provided.

Executive Directors that provide direct service are limited to “up to 25% maximum” and time must be justified and documented and must provide direct services. Not all requests for Executive Directors will be allowed depending on project descriptions, the overall agency and existing funding for those positions. Administrative staff, electronic medical records, human resources, office managers, insurance, are considered part of the indirect and non-allowable as a direct line item. ***Grant funds do not pay for general auditing or the completion of the 990 forms for non-profits.*** Grant funding may contribute to comply with the Single State Audit requirement (separate form) as a percentage basis of the number of federal grant awards.

Applicants **must** use the budget template form (Excel spreadsheet) provided as a link along with this NOFO. This spreadsheet contains formulas to automatically calculate totals and links to the budget summary spreadsheet (tab labeled Budget Summary) to automatically complete budget totals in Column B. **Do not override formulas.**

Ensure that all figures add up correctly and that totals match within and between all forms and sections. The budget application must comply with 2 CFR 200.68 for

Modified Total Direct Cost (MTDC) for determining if any indirect cost is permissible. Indirect cost may not be taken on direct services. The budget narrative should be complete, cost effective, and allowable (e.g., reasonable, allocable, and necessary for program activities). The budget must align with the Project Scope of Work and must not supplant any existing funding.

1. **Personnel:** Employees who provide direct services are provided here. The Personnel section is for staff who are responsible, who work as part of the applicant organization, for whom the applicant organization provides a furnished workspace, tools, and the organization determines the means and the method of service delivery. Contractors include those staff who provide products or services independently, and provide their own workspace, tools, means and methods for completion.

   For example:

Intake Specialist | $20/hour X 40 hours/week X 52 weeks	$ 41,600
Fringe = $41,600 X 15% (e.g., health insurance, FICA, workmen's)	$ 6,240
Personnel Total	$ 47,840

   Only those staff whose time can be traced directly back to the grant project should be included in this budget category. This includes those who spend only part of their time on grant activities. All others should be considered part of the applicant's indirect costs (explained later). If an employee is currently 100% funded by another program and will continue that work, they are not allowed to have activities supplanted by these dollars. For example, moving a staff from .50 to 1.0 FTE, the .50 FTE would be appropriate if directed to expand and enhance for the proposed project. Having a staff member that is 1.0 FTE and currently funded, and requesting additional funds for that staff person may not be allowable, without clear justification. Identify which staff are currently employed and which staff will be new.

2. **Travel:** Travel costs must provide direct benefit to this project. Identify staff that will travel, the purpose, frequency, and projected costs. U.S. General Services Administration (GSA) rates for per diem and lodging, and the state rate for mileage (currently .56 cents), should be used **unless** the organization's policies specify lower rates for these expenses. Local travel (i.e., within the program's service area) should be listed separately from out-of-area travel. Out-of-state travel and nonstandard fares/rates require special justification. GSA rates can be found online at https://www.gsa.gov/portal/category/26429. This funding is not for conference attendance.

3. **Operating/Supplies*:*** List and justify tangible and expendable property, such as office supplies, printing, program supplies, etc., that are purchased specifically for this project. Generally, supplies do not need to be priced individually, but a list of typical program supplies is necessary. Note: Rent is not an allowable expense under occupancy for administrative services. That should be paid through indirect. The only consideration for rent is for expansion of space for new projects, and not space within an existing facility.

4. **Equipment:** Equipment is defined as tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-federal entity for financial statement purposes, or $5,000. A

computer that is valued at $1,200 is not considered equipment and should be requested in Operating. An X-Ray machine that costs $5,001 dollars, would be listed as equipment.

5. **Contractual/Consultant Services:** Project workers who are not employees of the applicant organization should be identified here. Any costs associated with these workers, such as travel or per diem, should also be identified here. Explain the need and/or purpose for the contractual/consultant service. Identify and justify these costs.

   For collaborative projects involving multiple sites and partners, separate from the applicant organization, all costs incurred by the separate partners should be included in this category, with subcategories for Personnel, Fringe, Contract, etc. Written sub-agreements or contracts must be maintained with each partner, and the applicant is responsible for administering these sub-agreements in accordance with all requirements identified for grants administered under the DPBH. A copy must be provided to the state upon request.

6. **Other Expenses:** Identify and justify these expenditures, which can include virtually any relevant, and allowable, expenditure associated with the project, such as client transportation, or other key program expenses required for your program to be a success.

7. **Indirect Costs:** Indirect costs represent the expenses of doing business that are not readily identified with or allocable to a specific grant, contract, project function or activity, but are necessary for the general operation of the organization and the conduct of activities it performs. Indirect costs include but are not limited to: depreciation and use allowances, facility operation and maintenance, memberships, and general administrative expenses such as management/administration staff, human resources, accounting, payroll, legal and data processing expenses that cannot be traced directly back to the grant project. If agencies have a federally approved indirect cost rate, they may use that rate. All other allowable organizations may use the Modified Total Direct Cost Base and Exclusions, currently at 10%.

SECTION 8.0 PROCUREMENT PROCESS

DHHS reserves the right to accept or reject any or all applications. This NOFO does not obligate the State to award a contract, and the State reserves the right to cancel solicitation if it is in its best interest.

8.1 This procurement is being conducted in accordance with NRS Chapter 333 and NAC Chapter 333.

8.2 The State reserves the right to alter, amend, or modify any provisions of this NOFO, or to withdraw this NOFO, at any time prior to the award of a contract pursuant hereto, if it is in the best interest of the State to do so.

8.3 The State reserves the right to waive informalities and minor irregularities in proposals received.

8.4 Pursuant to NRS 333.350, the State reserves the right to limit the scope of work prior to award, if deemed in the best interest of the State.

8.5 Proposals which appear unrealistic in the terms of technical commitments, lack of technical competence, or are indicative of failure to comprehend the complexity and risk of the project/contract, may be rejected.

8.6 The State is not liable for any costs incurred by vendors prior to entering a formal contract or subgrant agreement. Costs of developing the proposals or any other such expenses incurred by the vendor in responding to the NOFO, are entirely the responsibility of the vendor, and shall not be reimbursed in any manner by the State.

8.7 Proposals submitted per proposal submission requirements become the property of the State, selection or rejection does not affect this right; proposals shall be returned only at the State's option and at the vendor's request and expense.

8.8 Pursuant to NRS 333.338, the State of Nevada cannot enter a contract with a company unless that company agrees for the duration of the contract not to engage in a boycott of Israel. By submitting a proposal or bid, vendor agrees that if it is awarded a contract, it will not engage in a boycott of Israel as defined in NRS 333.338(3)(a).

SECTION 9.0 NOFO REVIEW PROCESS

DPBH has selected to use the Notice of Funding Opportunity (NOFO) process which describes the needs and existing goals under the state plans.

- The application must request funding within programmatic funding constraints.
- The application must be responsive to the scope of the solicitation.
- The application must include all items designated as basic minimum requirements.

9.1 Technical Review

DHHS staff will perform a technical review of each proposal to ensure that minimum standards are met. Applications must be completed and submitted on time. All technical criteria are a Pass/Fail (P/F). Financial stability shall be scored on a pass/fail basis. This may include experience with previous DHHS grants in terms of ability to meet deadlines, expectations and submit financial information timely.

9.2 Evaluation

Applications that meet minimum standards will be forwarded to the evaluation team. Reviewers will score each application, using the Scoring Matrix. In accordance with prevailing grant evaluation procedures, discussion between applicants and reviewers will not be allowed during the scoring process. Requests must stand on their own merit. The State reserves the right to identify different evaluation committees for each area of focus (i.e., adolescents/youth services, etc.). The evaluation committee may solicit information from any available source concerning any aspect of a proposal and seek and review any other information deemed pertinent to the evaluation process.

9.3 Program Priorities

Projects applications will also consider priority populations and shall be reviewed under funding priorities. Each proposed area of service will be reviewed separately. BHWP will make awards based on a combination of the grant proposals able to meet the needs of the target population and funding priorities in each section. Grant applications must meet a minimum score of 70 to be considered for funding. Applications with scores above 85 will be considered for funding as part of the rolling evaluation. Those applications with scores between 70 and 85 will be considered after the close of the funding period if funding is available.

9.4 Final Review

After reviewing and scoring the applications based on priority areas, the DPBH will submit funding recommendations to the Bureau Chief and Single State Mental Health Authority who will make the final funding decisions. Final decisions will be made based on the following factors:

a. Scores on the scoring matrix;
b. Geographic distribution between Clark County and the rest of the state;
c. Conflicts or redundancy with other federal, state or locally funded programs, or supplanting (substitution) of existing funding;
d. Availability of funding; and
e. Ensuring underserved populations are addressed.

9.5 Notification Process

Applicants will be notified of their status with a Letter of Intent **on or before January 14, 2022.** DHHS/DPBH staff will conduct negotiations with the applicants regarding the recommendation for funding to address any specific issues identified by the DHHS/DPBH. These issues may include, but are not limited to:

- Revisions to the project budget;
- Revisions to the Scope of Work and/or Performance Indicators; and/or
- Enactment of Special Conditions (e.g., certain fiscal controls, more stringent performance requirements or more frequent reviews, etc.).

9.6 Final Negotiations

Not all applicants who are contacted for final negotiations will necessarily receive an award. All related issues must be resolved before a grant will be awarded. All funding is contingent upon availability of funds. Upon successful conclusion of negotiations, DHHS/DPBH staff will complete a written grant agreement in the form of a Notice of Subaward (NOSA). The NOSA and any supporting documents will be distributed to the subrecipient upon approval of the Subaward.

9.7 Project Scoring Matrix

Application	*Scoring*	*Description and/or Application Section*
Project Application Complete	P/F	Technical Review
Budget Narrative Complete	P/F	Technical Review (Separate Excel Document)
Capacity & Sustainability	5	Section J
Abstract	5	Section M
Organizational Capacity	15	Section N
Project Design & Implementation	25	Section O (Program details)
Capabilities & Competencies	20	Section P (specific to proposed scope)
Data Collection	10	Section Q (ability of agency to collect data)
Scope of Work	15	Section R
Resume for Project Manager	5	Section S
All assurances signed	P/F	Technical Review
Risk Management	P/F	Technical Review
Total	100	
State Headquarters	5 Bonus	

Any section deemed as a "Fail" will result in the Applicants submittal being disqualified.

SECTION 10 GRANTEE MONITORING

10.1 Monthly Financial Status and Request for Reimbursement Reports

DHHS (including all agencies under the umbrella of the Division) requires the use of a standardized Excel spreadsheet reimbursement request form that self-populates certain financial information. This form must be used for all reimbursement requests. Monthly reports are required even if no reimbursement is requested for a month. Instructions and technical assistance will be provided upon award of funds. The monthly reports will be due by the 15th of the following month.

10.2 Performance Reporting

Applicants who receive an award must collaborate with the DHHS in reporting monthly on progress in meeting goals. Additional performance reports may be requested as instructed by the DHHS. Monthly progress reports will be due by the 15th of the month following the end of the reporting quarter.

10.3 Subrecipient Monitoring

Successful applicants must participate in subrecipient monitoring. Subrecipient monitoring is intended to provide ongoing technical support to subrecipients and gather information reportable by DPBH to the state oversight entities. To facilitate the review process, materials referred to in the review documents should be gathered prior to the review. The subrecipient's primary contact person and appropriate staff should make themselves available to answer questions and assist the reviewer(s) throughout the process. At least one (1) board or executive level team member must also be available during the exit discussion. The subrecipient monitoring reports or action items will be sent to the subrecipient within 30 working days following the conclusion of the monitoring.

10.4 Compliance with changes to Federal and State Laws

As federal and state laws change and affect either the DHHS process or the requirements of recipients, successful applicants will be required to respond to and adhere to all new regulations and requirements.

10.5 Applicant Risk

Pursuant to the 2 CFR 200 Uniform Requirements, before award decisions are made, DPBH also reviews information related to the degree of risk posed by the applicant. Among other things to help assess whether an applicant that has one or more prior federal awards has a satisfactory record with respect to performance, integrity, and business ethics, DPBH checks whether the applicant is listed as excluded from receiving a federal award. In addition, if DPBH anticipates that an award will exceed $250,000 in federal funds, DPBH also must review and consider any information about the applicant that appears in the nonpublic segment of the integrity and performance system accessible through the Federal Awardee Performance and Integrity Information System, FAPIIS.

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

MEMORANDUM 21-001

DATE: April 26, 2021
TO: Subrecipients, Contractors, County Officials, and State Agencies

FROM: Brook Adie, Bureau Chief
Bureau of Behavioral Health Wellness and Prevention

RE: Fee-For-Service Rate Schedule Update

The Bureau of Behavioral Health Wellness and Prevention (BBHWP) has recently made the following changes to the approved fee-for-service rates list:

- 31R will increase to $124.92
- 35R will increase to $184.98
- TRNS will increase to $102.76
- 37D will now be included at a rate of $294.01

Please use the attached Fee-For-Service Rate Schedule for any Fee-For-Service BBHWP reimbursements. The attached rate schedule is effective as of April 1, 2021. Please review the attached rate schedule and compare it to your agency's FFY 2020 (October 1, 2020 through September 30, 2021) reimbursements to ensure that accurate rate schedule is being utilized. Reimbursement requests should not be submitted to the Bureau until an executed amendment has been received by the Provider.

If you have any questions or concerns, please do not hesitate to contact the Health Bureau Chief,

Brook Adie at 775-684-4077, or e-mail at badie@health.nv.gov.

BBHWP Fee-For-Service Rate Schedule

Effective April 1, 2021

This exhibit contains agreed upon rates per service for this grant period. Services are only allowable in services levels marked with an "X"

Code	Service Code Description	SAPTA Rate	Level 1: Outpatient Services	Level 2.1: Intensive Outpatient Services	Level 2.5: Partial Hospitalization Services	Level 3.1: CM Low-I Residential Services	Level 3.2-WM: CM Residential WM & 3.7-WM	Level 3.5: CM Med-I Residential	Transitional Housing*
99401	Preventive med counseling	$38.27	X						
99406	Smoking and tobacco cessation counseling (3-10 Minutes)	$13.59	X						
99407	Smoking and tobacco cessation counseling (>10 Minutes)	$26.53	X						
99408	Alcohol and/or substance abuse screening (15-30 Minutes)	$33.95	X						
99409	Alcohol and/or substance abuse screening (>30 Minutes)	$66.14	X						
H0001	Alcohol and/or drug assessment (1 unit per assessment at least 30 minutes) * If a CADC-I completes the assessment, it will not be counted completed until it has been reviewed and approved by the clinical supervisor.	$152.15	X	X	X				
H0002	Behavioral health screening to determine eligibility for admission to treatment program (1 unit per assessment at least 30 minutes)	$33.57	X	X	X				
H0005	Alcohol and/or drug services; group counseling by a	$32.57	X		X				

	clinician (1 unit per group at least 30 minutes)								
H0007	Alcohol and/or drug services; crisis intervention (outpatient)	$23.69	X		X				
H0015	Alcohol and/or drug services; intensive outpatient program (3 hours per day at least 3 days per week) (1 unit equals 1 day/visit)	$153.23		X	X				
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	$4.30	X		X				
H0034	Medication training and support; per 15 minutes	$18.53	X		X				
H0035	Mental health partial hospitalization, treatment less than 24 hours (1 unit equals 60 minutes)	$59.76	X		X				
H0038	Self-help/peer service; per 15 minutes	$8.60	X		X				
H0038	Self-help/peer service; per 15 minutes; Use modifier HQ when requesting/billing for a group setting	$1.72	X		X				
H0047	Alcohol and/or drug services; (State defined: individual counseling by a clinician). (1 unit per session at least 30 minutes)	$63.04	X		X				
H0049	Alcohol/drug screening (1 unit per screening)	$10.64	X		X				
90785	Interactive Complexity	$4.80	X		X				
90791	Psychiatric diagnostic evaluation	$152.15	X		X				

90792	Psychiatric diagnostic evaluation with medical services	$124.11	X		X				
90832	Psychotherapy, 30 mins, with pt and/or family member	$63.04	X		X				
90834	Psychotherapy, 45 mins, with pt and/or family member	$80.65	X		X				
90837	Psychotherapy, 60 mins, with pt and/or family member	$117.99	X		X				
90846	Family psychotherapy (without the patient present)	$88.83	X		X				
90847	Family psychotherapy (conjoint therapy) (with patient present)	$106.75	X		X				
90849	Multiple-family group psychotherapy	$31.13	X		X				
90853	Group psychotherapy (other than of a multiple-family group)	$32.57	X		X				
90839	Psychotherapy for Crisis first 60 mins	$122.80	X		X				
90840	Psychotherapy for Crisis each additional 30 mins	$61.39	X		X				
90833	Psychotherapy, 30 mins, with pt and/or family member when performed with an E/M service.	$41.52	X		X				
90836	Psychotherapy, 45 mins, with pt and/or family member when performed with an E/M service.	$67.34	X		X				
90838	Psychotherapy, 60 mins, with pt and/or family member when performed with an E/M service.	$108.54	X		X				
99201	Office or other outpatient visit for the E/M of a NEW PT, which requires 3 components: a problem	$32.23	X		X				

	focused history, a problem focused exam, and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. 10 mins face-to-face.								
99202	Office or other outpatient visit for the E/M of a NEW PT, which requires 3 components: a problem focused history, a problem focused exam, and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. 20 mins face-to-face.	$58.41	X		X				
99203	Office or other outpatient visit for the E/M of a NEW PT, which requires 3 components: a problem focused history, a problem focused exam, and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s)	$87.62	X		X				

	and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. 30 mins face-to-face.								
99204	Office or other outpatient visit for the E/M of a NEW PT, which requires 3 components: a problem focused history, a problem focused exam, and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. 45 mins face-to-face.	$124.21	X		X				
99205	Office or other outpatient visit for the E/M of a NEW PT, which requires 3 components: a problem focused history, a problem focused examination, and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. 60 mins face-to-face.	$125.05	X		X				
99211	Office or other outpatient visit for the E/M of an	$19.47	X		X				

	ESTABLISHED patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.								
99212	Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least 2 of these 3 key components: a problem focused history, a problem focused examination, and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are self limited or minor. Typically, 10 minutes face-to-face.	$34.57	X		X				
99213	Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least 2 of these 3 key components: a problem focused history, a problem focused examination, and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s)	$48.00	X		X				

	are low to moderate severity. Typically, 15 minutes face-to-face.								
99214	Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least 2 of these 3 key components: a problem focused history, a problem focused examination, and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are of moderate to high severity. Typically, 25 minutes face-to-face.	$74.86	X		X				
99215	Office or other outpatient visit for the E/M of an ESTABLISHED patient, which requires at least 2 of these 3 key components: a problem focused history, a problem focused examination, and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the patient's problem(s) and/or family's needs. Usually, problem(s) are of moderate to high severity. Typically, 40 minutes face-to-face.	$110.11	X		X				

99218	Initial Observation Care, per day, for the E/M of a patient which requires these 3 key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	$60.76	X		X				
99219	Initial Observation Care, per day, for the E/M of a patient which requires these 3 key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Typically, 50	$101.71	X		X				

	minutes are spent at the bedside and on the patient's hospital floor or unit.								
99220	Initial Observation Care, per day, for the E/M of a patient which requires these 3 key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	$142.33	X		X				
31R	Residential Treatment (Level 3.1)	$124.92			X	X			
32D	Detoxification (Level 3.2-D)	$152.74			X		X		
35R	Residential Treatment (Level 3.5)	$184.98			X			X	
37D	Withdrawal Management (Level 3.7-WM)	$294.01			X		X		
TRNS	Transitional Housing	$102.76			X				X

Compliance with this section is acknowledged by signing the subaward cover page of this packet.

ATTACHMENT B – FEDERAL LAWS AND AUTHORITIES

Note to RFP Preparer: This attachment is included only if the project is federally funded. Agency shall review to delete those laws and authorities that are not necessary to their project/contract.
The information in this section does not need to be returned with the vendor's proposal. Following is a list of Federal Laws and Authorities with which the awarded vendor shall be required to comply.

1. Archeological and Historic Preservation Act of 1974, PL 93-291
2. Clean Air Act, 42 U.S.C. 7506(c)
3. Endangered Species Act 16 U.S.C. 1531, ET seq.
4. Executive Order 11593, Protection and Enhancement of the Cultural Environment
5. Executive Order 11988, Floodplain Management
6. Executive Order 11990, Protection of Wetlands
7. Farmland Protection Policy Act, 7 U.S.C. 4201 ET seq.
8. Fish and Wildlife Coordination Act, PL 85-624, as amended
9. National Historic Preservation Act of 1966, PL 89-665, as amended
10. Safe Drinking Water Act, Section 1424(e), PL 92-523, as amended
11. Demonstration Cities and Metropolitan Development Act of 1966, PL 89-754, as amended
12. Section 306 of the Clean Air Act and Section 508 of the Clean Water Act, including Executive Order 11738, Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants or Loans
13. Age Discrimination Act, PL 94-135
14. Civil Rights Act of 1964, PL 88-352
15. Section 13 of PL 92-500; Prohibition against sex discrimination under the Federal Water Pollution Control Act
16. Executive Order 11246, Equal Employment Opportunity
17. Executive Orders 11625 and 12138, Women's and Minority Business Enterprise
18. Rehabilitation Act of 1973, PL 93, 112
19. Uniform Relocation and Real Property Acquisition Policies Act of 1970, PL 91-646
20. Executive Order 12549 – Debarment and Suspension
21. Davis-Bacon Act 40 U.S.C. 3141-3148
22. Contract Work Hours and Safety Standards Act 40 U.S.C. 3701-3708
23. Rights to Inventions Made Under a Contract or Agreement 37 CFR §401.2(a)
24. Byrd Anti-Lobbying Amendment 31 U.S.C. 1352