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Richard Whitley, MS  
Director



**DEPARTMENT OF  
HEALTH AND HUMAN SERVICES**  
Division of Public and Behavioral Health  
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Lisa Sherych  
Administrator

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

**Request for Applications (RFA) # A2020:  
Coordinated Specialty Care (CSC) for First Episode of Psychosis  
To Serve Nevada Residents in:  
The Washoe Behavioral Health Region  
Washoe County, Nevada**

**Application Release Date: Wednesday, April 15, 2020**

**Deadline for Application Submission: Friday, May 29, 2020 at 5 pm PST**

**Questions submitted on or before: May 4, 2020**

**Questions submitted to: [rcondray@health.nv.gov](mailto:rcondray@health.nv.gov)**

**Email subject line: RFA Coordinated Specialty Care for First-Episode Psychosis**

**Technical Assistance Call In: May 4, 2020 from 9—11am**

**Call in Number: 888-363-4735, Access Code: 381 8294 #**

*For additional information, please contact:*

**Ruth Condray, Ph.D.**

**Bureau, Behavioral Health Wellness & Prevention**

Nevada Department of Health & Human Services

Division of Public & Behavioral Health

4126 Technology Way, Suite 200

Carson City, NV 89706

T: (775) 684-4229 | E: [rcondray@health.nv.gov](mailto:rcondray@health.nv.gov)

Dear Interested Parties and Potential Sub-grantees:

The Nevada Department of Health and Human Services and the Division of Public and Behavioral Health (DPBH) and Bureau of Behavioral Health Wellness and Prevention (BHWP) announce the availability of up to \$1,500,000 in funding to develop an outpatient mental health clinic in the Washoe Behavioral Health Region, which encompasses all of Washoe County. This clinic will provide coordinated specialty care (CSC) for the early treatment of individuals who are experiencing a first episode of psychosis (FEP) and who are living in Washoe County, Nevada. This funding opportunity is provided through a 10% set aside of the 2020-2021 US Substance Abuse and Mental Health Services/Community Mental Health Services Block Grant (SAMHSA/MHBG) and administered by the Nevada Department of Health and Human Services.

The award has a maximum budget of \$1,500,000 to support a Coordinated Specialty Care (CSC) Mental Health Clinic for the duration of 24 months. A completed scope of work, budget, and spending plan must be submitted with the application for funding. All funding is subject to change, based on availability.

Completed applications must be received no later than **Friday, May 29, 2020 at 5:00 PM (PST)**.

Thank you,

**Ruth Condray, Ph.D.**

Ruth Condray, Ph.D.

Psychologist

Bureau, Behavioral Health Wellness & Prevention

Nevada Department of Health & Human Services

Division of Public and Behavioral Health

1426 Technology Way

Carson City, NV 89706

Email: [rcondray@health.nv.gov](mailto:rcondray@health.nv.gov)

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## INTRODUCTION

### **Purpose of Request**

Nevada Department of Health and Human Services recognizes the importance of building a statewide evidence-based program of early interventions to address early-stage first episode of psychosis. The clinical programs outlined in this **Scope of Work** will be physically located in Washoe County, and will serve individuals who are experiencing a first episode of psychosis (FEP).

**Rationale for Program:** The **Substance Abuse and Mental Health Services Administration (SAMHSA)** has prioritized implementation of evidence-based early interventions to address the early stages of serious mental illness (ESMI), including first episodes of psychotic disorders (FEP). Setting this priority follows recognition that, historically, mental health intervention and treatment services have focused on the later stages of illness. Concentrating societal resources on late-stage illness has meant that interventions have often occurred only after things reached a crisis. While acute care is necessary, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity for patients and their families, and the heavy toll on health and quality of life for patients and their family members. The guidance from SAMHSA has also been informed by growing concerns among patients and family members that mental health systems need to do more when people first experience serious mental illness.

**Goals of this Program:** Establish a flagship outpatient clinic for the early treatment of individuals who are experiencing a first episode of psychosis and living in the Washoe Behavioral Health Region in Washoe County, Nevada. This County represents the most populous region within Northern Nevada. An evidence-based treatment program of coordinated specialty care (CSC) for first episode of psychosis has been selected for statewide implementation, including within the Washoe Behavioral Health Region. Coordinated specialty care (CSC) involves the integration of multiple layers of complex interventions that are provided to individuals who are suffering from the early stages of this debilitating illness. For that reason, a health care workforce is needed that is knowledgeable about early-stage psychosis and that possesses the clinical expertise required for implementing and sustaining best practice programs that are tailored for this population. The State of Nevada recognizes the importance of building a professional workforce that is able to implement and sustain evidence-based specialty care for early-stage psychosis and serious mental illness and that can educate and train the next generation of specialty care clinicians.

### **Objectives of this RFA**

The objective of this RFA is to identify an applicant that can meet the criteria for implementing the evidence-based NAVIGATE Program for First Episode of Psychosis. This RFA does not obligate the State to award a contract or complete the project, and the State reserves the right to cancel the solicitation if it is in the State's best interest. All costs incurred in responding to this RFA will be borne by the applicant(s). In the event no qualified applicant is identified in response to this RFA, the State reserves the right to perform alternate measures to identify potential applicants.

### **Funding Availability**

The First Episode of Psychosis (FEP) program that is funded under this RFA will be eligible for up to \$1,500,000 to be expended within a 24-month period, and one application will be selected for the Washoe Behavioral Health Region that comprises all of Washoe County, Nevada. As described above, these funds are provided through the Mental Health Block Grant (MHBG) that is awarded to the Nevada Department of Health and Human Services by the **United States Substance Abuse and Mental Health Services Administration (SAMHSA)**. Funding cannot be guaranteed past the 24

months period covered in the RFA. It will therefore be necessary to build sustainability of future clinical programming through fiscal mechanisms such as Medicaid reimbursement structures and other third party liability entities.

**Prospective Payment System: Nevada DPBH Policy for Requests for Reimbursement (RFR)** Effective January 1, 2018, the Bureau of Behavioral Health Wellness and Prevention (BBHWP) will be implementing a new Request for Reimbursement (RFR) procedure to ensure that sub-recipients are submitting accurate RFRs with appropriate supporting documentation and that the sub-recipient's are paid promptly. It is the policy of the BBHWP to review RFRs submitted by sub-recipients to receive the reimbursement of costs for work performed by the sub-recipient within the terms and conditions of their subgrant and in accordance with to Title 2 of the Code of the Federal Regulations (CFR) Part 200.

**Minimum Requirements for Applicant Organization:** The following information is required for each applicant organization:

- 1. Does the composition of professional staffing within the applicant organization include the availability of the following professionals for staffing of the FEP Clinic Program?**
  - a. FEP Program Medical Director – M.D. psychiatrist (preferred)
  - b. NAVIGATE Clinical Team Director – M.D. board certified psychiatrist (preferred); Ph.D. licensed clinical psychologist (preferred); Licensed Clinical Social Worker (acceptable)
- 2. What is the status of the applicant organization as a Medicaid provider?** If not currently a designated Medicaid provider, does the applicant organization meet eligibility criteria for Medicaid provider status?
- 3. What is the level of commitment of the applicant organization to implement NAVIGATE, the evidence-based program for the early treatment of individuals who are experiencing a first episode of psychosis?** The applicant organization should describe their commitment to participate in the required pre-training assessment, planning, and preparation activities that are provided by the national NAVIGATE Training Team for FEP programming. These activities include assessment of agency capacity for FEP Program implementation, planning for FEP program implementation, and preparation for NAVIGATE FEP Program training. [NOTE: Assessment, planning and preparation activities are required for grant awardees and will be supported financially by the Mental Health Block Grant (MHBG).]
- 4. A statement that the applicant organization and its representatives understand the scope of work (SOW) described in this RFA (pp. 6-18) for the NAVIGATE early treatment program for the first episode of psychosis (FEP) population, and that they are willing to deliver this evidence-based program with fidelity within the designated geographical area of the Washoe Behavioral Health Region located within Washoe County, Nevada.**

**First Episode of Psychosis Population: How many new cases of First Episode of Psychosis (FEP) will occur each year in Nevada?** The *median rate of new cases (or incidence)* each year for schizophrenia, one of the principal psychotic disorders, is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007a; Kessler et al., 2007b). However, approximately 20% of individuals diagnosed with schizophrenia have an onset of their illness after the age of 40 years (Harris and Jeste, 1988; Howard et al., 2000; Maglione et al., 2014). The age range for capturing cases of first episode of psychosis therefore extends from middle

adolescence and early adulthood through middle adulthood. Based on these findings, the **anticipated incidence rate of schizophrenia for Nevada was estimated at approximately 307 new cases during each fiscal year**, as follows:  $(2,022,031) (15.2/100,000) = 307.4$ .

[NOTE: The State does not collect information regarding the rate of new cases of mental disorders per year, so this estimate was determined using the best available information, as follows:

- (1) Population estimates for 2018 (as of July 1) for Nevada residents ages 14 to 64: **2,022,031** (Source: U.S. Census Bureau, Population Division (Release Date: June 2019).
- (2) Selection of the age range for population estimation was informed by age of onset distributions for schizophrenia described above.
- (3) Median incidence of schizophrenia of 15.2/100,000 persons determined with national (U.S) and international samples by McGrath et al. (2008).]

## DESCRIPTION of the COORDINATED SPECIALTY CARE for FIRST EPISODE of PSYCHOSIS PROGRAM INITIATIVE

### What is Coordinated Specialty Care for First Episode of Psychosis?

First Episode of Psychosis (FEP) affects approximately 100,000 adolescents and young adults each year. The primary age of onset is between 15 and 25, and involves psychotic disorders, such as schizophrenia, which can be frightening for the affected individuals and their family members and loved ones. These disorders can cause a derailment in academic and personal life goals and interfere with important relationships and social interactions.

**Coordinated Specialty Care (CSC)** is a team-based, multi-component approach to treating FEP (first episode of psychosis). At its core, CSC is a collaborative, recovery-oriented approach that involves clients, treatment team members and when appropriate relatives. The CSC focuses its method on shared decision making as the primary strategy for addressing the individual needs of patients experiencing FEP.

### COORDINATED SPECIALTY CARE and FIRST EPISODE OF PSYCHOSIS TIMELINE:

**Phase I – Installation and Initial Implementation (Calendar Years 2020 and 2021)**: The First Episode of Psychosis (FEP) provider for the Washoe Behavioral Health Region will be selected and the State will assist the providers in building the workforce and the structures and functions necessary to implement a comprehensive, multidisciplinary, team-based treatment approach for individuals who are experiencing a first episode of psychosis (FEP). NAVIGATE is one of the evidence-based programs (EBPs) of comprehensive, coordinated specialty care (CSC) that was developed as part of the NIMH **RAISE** initiative. **The NAVIGATE Program for First Episode Psychosis has been selected for statewide implementation in Nevada.** An advantage of this evidence-based, manualized treatment protocol is its systematic curriculum and the availability of the national NAVIGATE Training Team to assist in pre-implementation readiness assessment and training and peri- and post-implementation consultation.

**0-5 months (Calendar Year 2020)**: Financial support will be awarded to a clinical services site that is located in Washoe County, and that is determined most ready to develop and implement the national evidence-based NAVIGATE program of early interventions for individuals experiencing a first episode of psychosis (FEP). Demonstration of readiness to implement will include participating in pre-training planning and preparation activities offered by the national NAVIGATE Program training

network and that include analysis of agency capacity, implementation planning, and preparation for training.

**6-24 months (Calendar Years 2020-2021):**

- 1. Establish a physical and operational location for the FEP Team in the Washoe Behavioral Health Region, Washoe County, Nevada**—identify the physical site where the FEP Team-based program will reside and operate; for example: existing and established mental health clinic or hospital.
- 2. Workforce selection and ongoing training and development for the providers of early treatment of early-stage psychosis, which will include but not be limited to the following:**

**NAVIGATE FEP Program Training:** All Coordinated Specialty Care (CSC) Team Members of the NAVIGATE program of services for the early treatment of first episode of psychosis (FEP) must participate in the training provided by the **national NAVIGATE Training Team**, which is coordinated by **Susan Gingerich, MSW**. Training will be organized by Staff members of the Bureau of Behavioral Health Wellness and Prevention, Division of Public and Behavioral Health, Carson City, Nevada.

**Project ECHO, University of Nevada, Reno School of Medicine:** All Coordinated Specialty Care (CSC) team members of the NAVIGATE Program for First Episode Psychosis (FEP) in **Washoe Behavioral Health Region** are expected to participate in ongoing clinical training and professional development activities that specifically address the identification, treatment and management of early-stage psychosis. Ongoing training and professional development activities are required and include case conferences with panels of specialty care experts, which are created and directed by **Erika Ryst, M.D.**, and provided through **Project ECHO, a tele-mentoring platform supported by the University of Nevada, Reno School of Medicine**. By enhancing the knowledge of mental health care providers through tele-mentoring consultations, patients can receive informed specialty care not easily accessible otherwise.

Additional training materials and guidelines for the FEP program are provided in the following manuals:

- ⑩ *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment (Section A. Training and Supervision, pp. 2-3; Appendix 1: Person-Centered Language; pp. 29-31).*
- ⑩ *Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation (pp. 11-16).*

**3. Staffing & Role Responsibilities of CSC Team for FEP program:**

During **Phase 1– First Episode of Psychosis (FEP) Team**, staff will be identified and hired, and the FEP Team role activities will be developed that are specific to the CSC program. In the following, role activities and responsibilities are described for positions comprise the NAVIGATE FEP Team, although not every position will require 1 FTE:

- 1 Team Leader/Program Director (Master’s level clinician) – Roles and responsibilities:

- Oversee start-up of CSC First Episode of Psychosis program in the State's Washoe Behavioral Health Region, Washoe County, Nevada.
  - Develop Outreach plan for educating, advertising and providing lectures/talks to potential referral sources.
  - Oversee Referral process.
  - Oversee development of CSC Team.
  - Leading the CSC Team – Build and maintain the CSC Team functions and cohesion; educate CSC Team members about First Episode of Psychosis (FEP) clients; manage CSC Team meetings; oversee shared-decision making model and collection of outcomes measurement, including fidelity of program to RAISE model; conduct CSC Team meetings; oversee implementation of the clinic setting and ensure suitability for First Episode clients; engage clients' and family members' transition from screening and enrollment to CSC interventions; provide clinical supervision of Family Education clinician, IRT clinician, and Assertive Case Management/SEE specialist.
- 1 Centralized Assessor (Master's level clinician) – primary role is to determine diagnostic eligibility of clients for FEP program and to conduct clinical status evaluations throughout the CSC treatment of each client (See Section 7 & Section 8 (below); specifically: 7. Required Assessments and Schedule of Evaluations; 8. Performance Indicators).
  - 1 Team Psychiatrist/Prescriber
  - 1 Team Nurse – primary role as coordinator of evidence-based pharmacotherapy and primary medical care, including monitoring cardio-metabolic risk factors.
  - 1 Team Outreach & Referral Specialist (Master's level clinician)
  - 1 Individual Resiliency Training (IRT) Clinician (Master's level clinician)
  - 1 Family Education Clinician (Master's level clinician)
  - 1 Assertive Case Management/Supported Employment and Education (SEE) Specialist (Bachelor's level Social Worker)
- 4. Implement the NAVIGATE evidence based, manualized treatment protocol, which involves the coordinated specialty care (CSC) interventions developed for individuals who are experiencing an initial episode of psychosis (NIMH RAISE initiative: Heinssen, Goldstein, & Azrin, 2014). The feasibility and efficacy of the CSC approach have been demonstrated for community mental health settings, as well as within rural areas (Kane et al., 2016). Manuals are available for each of the **four required core interventions of the NAVIGATE program (<https://raiseept.org/>), including: a. Individual Resiliency Training (IRT); b. Evidence-based Pharmacotherapy and Primary Care Coordination; c. Family Education Program; d. Supported Employment and Education (SEE). A fifth component is e. Assertive Case Management. These required core program components are described briefly below:****
- a. **Psychotherapy based on Individual Resiliency Training (IRT)**; an evidence-based, manualized psychosocial treatment program developed for individuals recovering from an initial episode of psychosis. The primary aims of IRT include the promotion of recovery by identifying client strengths and resiliency factors, enhancing illness management, teaching skills to facilitate functional recovery, and achieving and maintaining personal wellness. IRT includes 14 modules, with the first 7 modules considered foundational for individual

treatment of first episode of psychosis, and the remaining 7 modules useful for addressing individualized problem areas that may be creating challenges to recovery and health.

## Standard Modules

- 1) Orientation
- 2) Assessment/Initial Goal Setting
- 3) Education about Psychosis
- 4) Relapse Prevention Planning
- 5) Processing the Psychotic Episode
- 6) Developing Resiliency—Standard Sessions
- 7) Building a Bridge to your Goals

## Individualized Modules

- 8) Dealing with Negative Feelings
- 9) Coping with Symptoms
- 10) Substance Use
- 11) Having Fun and Developing Good Relationships
- 12) Making Choices about Smoking
- 13) Nutrition and Exercise
- 14) Developing Resiliency—Individualized Sessions

After completing the first seven standard modules, progress is evaluated, and based on joint client and clinician decision-making, the direction of the next step in the IRT program is determined. As an example, for a client with a current substance use problem, the first seven standard modules would be completed, and then the individualized Substance Use module would be pursued.

[Source: Lead Authors: Penn DL, Meyer PS, & Gottlieb JD; Contributing Authors: Cather C, Gingerich S, Mueser KT, & Saade S. (April 1, 2014): Individual Resiliency Training (IRT): A Part of the NAVIGATE Program for First Episode of Psychosis, Clinician Manual. <http://raiseetp.org/studymanuals/index.cfm>]

- b. Evidence-based Pharmacotherapy and Primary Care Coordination.** Pharmacotherapy for first episode of psychosis typically begins with a low dose of a single antipsychotic medication, and includes monitoring for psychopathology, side effects and attitudes about medication at each visit. Emphasis is given to cardio-metabolic risk factors (smoking, weight gain, hypertension, dyslipidemia, and pre-diabetes), which are evaluated monthly. Prescribers maintain close contact with primary care providers to assure optimal medical monitoring and intervention for risk related to cardiovascular disease and diabetes.

[Source: NAVIGATE Psychopharmacological Treatment Manual. Developed by the NAVIGATE Psychopharmacological Treatment Committee: Robinson DG (Chair); Correll CU, Kurian B, Miller AL, Pipes R, and Schooler NR (Contributors to Scientific Content of Manual and the COMPASS Computer Decision Support System). <http://raiseetp.org/studymanuals/index.cfm>]

- c. Family Education Program.** Family education teaches relatives and other supporting individuals about psychosis and its treatment, with the aim of strengthening their ability to help in the patient's recovery. If possible, and with the patient's agreement, family members and supporting individuals are included in all phases of the patient's treatment planning and decision making. Participation of a family member or guardian will be required for individuals who are 17 years and younger.

The foundation of this treatment component includes recognition that an initial episode of psychosis can have a devastating effect on the patient's relatives and other close relationships. Moreover, family relationships present complexities that impact treatment outcomes in significant ways. The research literature is clear about the relationship between family conflict and worse clinical outcomes for a patient but is also informative about the association between family members' involvement in care and better patient outcomes. The goals of family education and support efforts include reducing the burden on the patient's relatives; and helping those relatives acquire the needed knowledge and interpersonal skills to adapt to their new circumstances and to support the patient's recovery.

[Source: Lead Author: Glynn SM; Contributing Authors: Cather C, Gingerich S, Gottlieb JD, Meyer PS, Mueser KT, & Penn DL. (April 1, 2014): NAVIGATE Family Education Program: A Part of the NIMH Funded RAISE Program for First Episode Psychosis, Clinician Manual. <http://raiseetp.org/studymanuals/index.cfm>]

- d. **Supported Employment and Education (SEE)** services are also an integral part of the CSC program developed for the NIMH RAISE initiative. SEE specialty staff assist in a recovering person's return or initial entry to work or educational settings and facilitate achievement of expected vocational and educational goals. SEE specialty staff aim to integrate vocational and mental health services, and to function as a CSC Team liaison with educators and employers.

[Source: Lead Author: Lynde DW; Contributing Authors: Gingerich S, McGurk SR, & Mueser KT. (April 1, 2014): NAVIGATE Supported Employment and Education (SEE) Manual: A Part of the NIMH Funded NAVIGATE Program for First Episode Psychosis, Clinician Manual. <http://raiseetp.org/studymanuals/index.cfm>]

- e. **Assertive Case Management** as a fifth component will also be provided to assist clients with problem solving, including but not limited to identifying and facilitating solutions to practical difficulties in living, and coordinating social services for areas of specific needs.

#### 5. **Required features and functions of the Coordinated Specialty Care (CSC) for FEP:**

There are specific aspects of team functioning that are required for coordinated specialty care (CSC) as it was designed for the **RAISE (Recovery After an Initial Schizophrenia Episode)** model. These characteristics are described in the following:

- a. **Small Caseloads.** Small caseloads of 25-30 clients or less are recommended for each CSC Team to ensure that Team members have sufficient time to address fully all areas of the coordinated specialty care interventions.
- b. **Duration of Coordinated Specialty Care (CSC) Services.** Continuous enrollment of clients and access to CSC Services for a minimum of 2 years. Clients will not be placed on a wait list. Clients will not be discontinued from enrollment and services, even after lengthy interruptions (e.g., incarceration or hospitalization).
- c. **Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.** CSC services for the first episode of psychosis population and their family members should be consistent with the principal standard advanced by the Office of Minority Health, U.S. Department of Health and Human Services (<https://www.thinkculturalhealth.hhs.gov/>): ***“Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices,***

**preferred languages, health literacy, and other communication needs.”** The CSC Team will identify potential barriers to clinical care and support services that might arise due to English not being the first language spoken by patients and their family members. Language translation services will be included in the range of CSC services provided to each patient and his or her family members, if appropriate.

- d. Weekly Team Meetings.** The entire CSC Team will meet once weekly to review the status of each client, discuss each Team member’s role in each client’s ongoing care, and review the progress of each client toward his or her treatment goals. CSC Team meetings should include shared decision-making and provide the opportunity for Team members to inform and to be informed by one another. Weekly CSC Team meetings also provide a forum for the CSC Team Leader to check carefully with each CSC Team member about the activities and goals of each CSC treatment specialty. CSC Team meetings are also used to support the principles of CSC through the review of active cases, and to provide ongoing training to enhance clinical knowledge and skills.

The weekly CSC Team meeting should be followed by discussion sessions with clients about treatment planning or updating, and the presence of the entire CSC Team during these discussions is important. CSC Teams have found that an easy way to ensure the attendance of all Team members is by scheduling these treatment planning/updating meetings to occur immediately following the weekly CSC Team meetings.

- e. Central Point of Referral.** As discussed in *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment*, referrals to the CSC Team should come to a staff member dedicated to outreach and referral activities. (See below: e. Establish an Outreach and Referral (O&R) Team.) All advertising about the FEP program should list appropriate contact information for this dedicated staff member. A central referral process that involves a dedicated line (direct telephone number) and named contact person makes calling and contacting the CSC Team a straightforward, easy process for potential clients, current clients, families, community providers, and other potential referral sources.
- f. Coordinating Entry to the Program.** The person who serves as the Central Point of Referral (above) will work with the entire CSC Team to coordinate the initial CSC Team activities for each client, including the intake assessment and preliminary treatment planning. Based on results of the assessment, the CSC Team will engage in shared decision making with the client to create an overall treatment plan to meet the individual’s recovery goals. Developers of the CSC approach have emphasized that clients’ capacities and motivations about active involvement in goal setting and shared decision making can fluctuate throughout the course of treatment. Due to this tendency, it is recommended that each client’s preference and comfort with the decision-making role should be explored regularly.
- g. Working as a Team in a Shared Decision-Making Framework.** While the CSC Team works collaboratively in treating each client, a client may be working with only a few clinicians at any point in time. At minimum, all clients should work with the CSC Team Leader/Program Director and the Team Psychiatrist. Even if a client is not interested in taking medication, he or she should meet with the CSC Team Psychiatrist regularly to learn about medication options, to set goals regarding when a trial of medication may be medically indicated, and to establish a therapeutic relationship with the psychiatrist in the event the client’s feelings about medication change.

- h. Connecting with Community Partners.** The CSC Team helps clients create a social network or reconnect and enhance the functioning of an existing social network within the family and beyond. School and work are additional opportunities to build social supports. Certain clients will need assistance to protect against or intervene in disadvantageous social circumstances, such as homelessness and food insecurity. The CSC Team serves in an advocacy role, as well as supports the development of advocacy skills for clients and family members.

For additional details, see the following manuals developed by National Institute of Mental Health for the RAISE Research Project:

- *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment.*
- *Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation.*

- i. Establish and equip an Outreach and Referral (O&R) Team** that will oversee the outreach and referral process for the FEP program. This Team will also be responsible for the initial assessments of clients' eligibility for the FEP program. The O&R Team should include a dedicated staff member who serves as the central point of referral, and who is a master's level clinician (or higher clinical degree) with the ability to identify primary psychosis, as well as perform differential diagnoses for symptom profiles related to these categories of disorders. All O&R Team members should be knowledgeable about the following general information and key concepts that are related to outreach and referral activities for the FEP program:

- Program Components for the RAISE model: CSC Team roles and functions, services offered, and the general RAISE model.
- Insurance and Financial Matters: O&R Team members should know the program's predetermined payment structure in order to be able to inform providers, potential clients (service seekers), and family members. Examples include: if certain services are provided at no cost; if medications are covered; if any insurance is accepted; and/or if there are options for an income-based sliding scale.
- Psychoeducation: O&R Team members must be familiar with the concepts and general literature regarding schizophrenia, including early warning signs, impact on functioning, and importance of early intervention.
- Presentations: O&R Team members may require training in how to give presentations to various audiences, including physicians, mental health professionals, school counselors, and other community professionals (e.g., law enforcement, religious leaders, etc.).
- Evaluation: O&R Team members should be knowledgeable about the clinical symptoms associated with psychosis, mood disorders, and substance use disorders; know how to diagnose primary psychotic disorders and be familiar with differential diagnoses; be able to identify the onset of prodromal symptoms; and become accustomed to determining the date of onset of psychosis.
- Safety and Emergencies: O&R Team members must know the emergency procedures implemented by the organization that houses the FEP specialty clinic. O&R Team members must also know the emergency procedures that are in place for the CSC Team; for example, contacting the senior clinician during a crisis, etc.

- **Reporting Requirements:** O&R Team members must understand fully the required responses to suspected child abuse and homicidal thoughts as mandated by State law.

j. **Team Meetings:** The Team Leader/Program Director will conduct regular Team Meetings, as follows:

- **Weekly Team Meetings (30-60 Minutes) with All Team Members** to develop preliminary treatment plans for new clients; discuss and review progress towards treatment goals for established clients; identify and address other issues related to clinical management of each client's disorder.
- **Weekly Supervision Meetings** (60 minutes) that include the Team Leader/Program Director and the Individual Resilience Training (IRT) psychotherapy clinician(s). The purpose of these meetings is to provide supervision for implementing the IRT intervention.
- **Collaborative Treatment Planning and Review Meetings for Each Client** (60 minutes) that occur within one month of the client's enrollment in the FEP program, and again every 6 months after the client's initial enrollment.

[Source: Lead Authors: Mueser KT & Gingerich S; Contributing Authors, in alphabetical order: Addington J, Brunette MF, Cather C, Gottlieb JD, Lynde DW & Penn DL (April 1, 2014): The NAVIGATE Team Members' Guide: A Part of the NIMH Funded NAVIGATE Program for First Episode Psychosis, Clinician Manual. <http://raiseetp.org/studymanuals/index.cfm>]

k. **Develop a program of Peer and Family Support** that is involved at multiple levels of the CSC program for First Episode of Psychosis (FEP) within the Behavioral Health Region, such as the framework developed for SAMHSA/CMHS that is organized around the following domains:

- Program development, policy and planning.
- Direct service delivery.
- Public outreach and engagement.
- Clinician education.
- Quality improvement, evaluation and research.

[Source: Peer Involvement and Leadership in Early Intervention in Psychosis Services, Guidance Manual. Author: Nev Jones, Ph.D., Stanford University, Technical Assistance Material Developed for SAMHSA/CMHS.]

l. **Reporting Requirements for Deliverables:** Collect and record all required assessment and clinical outcomes data and services tracking data for all FEP clients beginning at eligibility determination and continuing through to final discharge from the program. Outcomes and services tracking data will be submitted to the State in quarterly reports, and include all data points at each scheduled assessment time point, as detailed in the following sections below:

**7. Required Assessments and Schedule of Evaluations;** and **8. Performance Indicators.**

m. **Develop Tele-health Services** for delivering the NAVIGATE program of coordinated specialty care to individuals who are experiencing a first episode of psychosis (FEP). Tele-health Services may be needed for this population under certain circumstances, such as for

some clients who may live in sectors of the Washoe Behavioral Health Region that are physically distant from the clinical home site. Additional reasons for the importance of Tele-health Services include atypical and ongoing circumstances, such as the **2020 Coronavirus Pandemic** which may require careful social engineering of person-to-person contact to protect the health, safety and well-being of clients, their family members and significant others, and healthcare personnel. Thus, Tele-health Services can improve **Access to Care** for people living in remote areas of Washoe County, as well as ensure **Continuity of Care** for vulnerable individuals and protect healthcare professionals during unusual circumstances like the **COVID-19 Crisis**. Several resources are now available to mental health providers for direction and guidance in developing effective and secure Tele-health Services, including:

- **On-line trainings on how to deliver online behavioral health services safely and effectively:**  
<https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>
  - **Telebehavioral Health Informed Consent Library (includes sample consent forms):**  
[https://www.naadac.org/assets/2416/marlene\\_maheu\\_ac17ho2.pdf](https://www.naadac.org/assets/2416/marlene_maheu_ac17ho2.pdf)
  - **American Telemedicine Association, Practice Guidelines for Videoconferencing-Based Telemental Health :**  
<https://www.americantelemed.org/>
  - **Nevada Division of Health Care Financing and Policy is available to provide informational support and direction for delivering Tele-health Services to Medicaid recipients:**  
<http://dhcfnv.gov>
- n. **Eligible FEP Disorders and Length of CSC Treatment (24 months):** Provide a minimum of 24 months of coordinated specialty care (CSC) treatment for individuals, ages 15–44 years, who meet DSM-5 diagnostic criteria for the following first episode of psychosis (FEP) disorders:
- a. Schizophrenia
  - b. Schizoaffective Disorder
  - c. Schizophreniform Disorder
  - d. Brief Psychotic Disorder
  - e. Psychotic Disorder NOS
- Exclusion Criteria:* The following DSM-5 diagnoses will be excluded: Affective psychosis, substance-induced psychotic disorder, psychosis due to general medical conditions, clinically significant head trauma, or other serious medical conditions.
- o. **Early Stage of Illness:** Commonly, participants will have experienced only one episode of psychosis. Individuals with a psychotic episode followed by full symptom remission and relapse to another episode of psychosis will be excluded from FEP treatment and referred to other program services. Additionally, participants typically will have taken only 6 months or less of lifetime psychiatric medications (antipsychotics, anti-depressants, stimulants, anti-anxiety medications, mood stabilizers). Here, lifetime psychiatric medications refer to

the person ever having received a specific psychiatric medication during his or her entire lifetime.

- p. **Retention in CSC Treatment Program:** Patients will not be discontinued even under circumstances involving lengthy interruptions of care. Assessments will be suspended during periods of hospitalization or incarceration and resumed after discharge or release.

[NOTE: DSM-5 diagnostic criteria are consistent with SAMHSA definitions of SED & SMI: For purposes of block grant planning and reporting, SAMHSA clarified the definitions of SED and SMI, which first appeared in the 1993 Federal Register (May 10, 1993; 58 FR 29422-29425): Children with serious emotional disturbance (SED) refers to persons from birth to age 18 and adults with serious mental illness (SMI) refers to persons age 18 and over; (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.]

6. **How many new cases of First Episode of Psychosis (FEP) will occur each year in Nevada?** The *median rate of new cases (or incidence)* each year for schizophrenia, one of the principal psychotic disorders, is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007a; Kessler et al., 2007b). However, approximately 20% of individuals diagnosed with schizophrenia have an onset of their illness after the age of 40 years (Harris and Jeste, 1988; Howard et al., 2000; Maglione et al., 2014). The age range for capturing cases of first episode of psychosis therefore extends from middle adolescence and early adulthood through middle adulthood. Based on these findings, the anticipated incidence rate of schizophrenia for Nevada was estimated at approximately **307 new cases during each fiscal year, as follows:**

$$(2,022,031) (15.2/100,000) = 307.4$$

NOTE: The State does not collect information regarding the rate of new cases of mental disorders per year, and this estimate was determined using the best available information, as follows:

- Population estimates for 2018 (as of July 1) for Nevada residents ages 14 to 64: **2,022,031** (Source: U.S. Census Bureau, Population Division (Release Date: June 2019).
- Selection of the age range for population estimation was informed by age of onset distributions for schizophrenia described above.
- Median incidence of schizophrenia of 15.2/100,000 persons determined with national (U.S) and international samples by McGrath et al. (2008).

## 7. **Required Assessments and Schedule of Evaluations: Quarterly Reporting Requirements**

The Washoe County First Episode of Psychosis (FEP) Program will be responsible for assessing and reporting clinical status and outcomes data in Quarterly Reports to the Nevada Bureau of Behavioral Health Wellness and Prevention. Reports will include the

results from required assessments and evaluations of all FEP clients enrolled in the NAVIGATE coordinated specialty care program. Data records will begin at eligibility determination and enrollment and continue through to final discharge from the program. Technical assistance will be provided to ensure compliance and reliability of data reports. The following assessments and evaluations are required:

- a. **SCID-5-RV (Structured Clinical Interview for DSM-5 Disorders-Research Version: American Psychiatric Association, 2016). Assessed at baseline and every 12 months. Assessments will be additionally administered, automatically, following any suspension of services**, such as for hospitalization, incarceration or other reason.
- b. **Social and Occupational Functioning Scale (SOFAS) (SCID-5-RV). Assessed at baseline and monthly.**
- c. **WHODAS 2.0 (World Health Organization Disability Assessment Schedule 2.0) (Self-Rating). Assessed at baseline and monthly.**
- d. **Neuropsychological Evaluation**, which is completed at **baseline and 12 months** and includes but is not limited to the following:
  - 1) Wechsler Adult Intelligence Scale.
  - 2) WRAT 5 (2017): Word Reading subtest; Sentence Comprehension subtest
- e. **Patient Self-Rating Form, RAISE Early Treatment Program Subscales: Well Being, MH Recovery, Autonomy Support, Medication Influences/Beliefs, Stigma, Global. Assessed at baseline and monthly.**
- f. **Psychopharmacology Module Ratings: Patient Self-Rating Form; Clinician Rating Form; Nurse Assessment (Vital Signs & Laboratory Tests for Cardio-metabolic Risk Factors; NAVIGATE Medication Tracking. Assessed at baseline, monthly and more frequently, if needed.**

**Appendix, pp. 1-24: NAVIGATE Psychopharmacological Treatment Manual.** Developed by the NAVIGATE Psychopharmacological Treatment Committee: Robinson DG (Chair); Correll CU, Kurian B, Miller AL, Pipes R, and Schooler NR (Contributors to Scientific Content of Manual and the COMPASS Computer Decision Support System).  
<http://raiseetp.org/studymanuals/index.cfm>

- g. **Family Assessment Scale (Reinhard Burden Assessment Scale). Assessed at baseline and monthly, if family members are involved in program.**
  - h. **Primary Care Physician** evaluation and report regarding medical status, management plan and recommendations. **Assessed at baseline and every 12 months.**
  - i. **First Episode Psychosis Services Fidelity Scale (Addington DE, Norman R, Bond GR, et al., 2016), which measures adherence to evidence-based practices for first episode psychosis services. Assessed at baseline and every 12 months.**
8. **Performance Indicators: Quarterly Reporting Requirements**  
**Quarterly Reporting Requirements:** The Washoe County First Episode of Psychosis (FEP) Program will be responsible for tracking the rates of services received by all FEP

clients enrolled in the NAVIGATE coordinated specialty care program, including: numbers of individuals screened for eligibility for enrollment, numbers of individuals enrolled in CSC services, and numbers and types of CSC services received. Data records will begin at eligibility determination and enrollment and continue through to final discharge from the program. Technical assistance will be provided to ensure compliance and reliability of reporting, including the following:

- Number of persons screened for eligibility for enrollment in the coordinated specialty care (CSC) early treatment program for FEP.
- Number of persons enrolled and receiving services based on the coordinated specialty care (CSC) early treatment program for FEP.
- Number of persons who are retained as ongoing and active cases (minimum of 24 months) receiving services as part of the coordinated specialty care (CSC) early treatment program for FEP.
- Number of persons who are active cases receiving pharmacotherapy services once monthly.
- Number of persons who are receive a primary medical care evaluation once yearly.
- Number of persons who are active cases receiving pharmacotherapy services that include the following assessments of cardio-metabolic risk factors: smoking, weight gain, hypertension, dyslipidemia, and pre-diabetes.
- Number of persons who are active cases and for whom contacts between prescribers of psychiatric medications and primary care physicians are tracked concerning medical risk factors related to cardiovascular disease and diabetes, and any necessary medical interventions and management for such conditions.
- Adherence to evidence-based practices for first-episode psychosis services, as measured by the First-Episode Psychosis Services Fidelity Scale (Addington et al., 2016). Assessments will be conducted **at baseline and every 6 months afterward**. The established national benchmark of 86% of the maximum total score on this Scale will be used to evaluate the FEP services in each behavioral health region. This Scale will also be used as the primary tool for programmatic quality assurance and performance improvement.

**9. Additional Information involving Coordinated Specialty Care for First Episode of Psychosis** is available on the following websites:

**NAVIGATE:** <http://navigateconsultants.org/how-it-works/>

**RAISE:**

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml>

**NIMH (National Institute of Mental Health):**

<https://www.nimh.nih.gov/index.shtml>

**CSC (Coordinated Specialty Care):**

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode>

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosis-manual-i-outreach-and-recruitment.shtml>



## **Defined Terms & Conditions**

### **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 to an operational outpatient psychiatric and/or substance use disorder clinic for children/youth and/or adults.

### **General Requirements Acceptance of Conditions Governing the RFA**

Submission of an application constitutes acceptance of all terms and requirements contained in this RFA.

### **Incurring Cost**

Any cost incurred by the Applicant in preparation, transmittal, and/or presentation of any application or material submitted in response to this RFA shall be borne solely by the Applicant. Any cost incurred by the Applicant for set up and demonstration of the proposed equipment and/or system shall be borne solely by the Applicant.

### **Primary Sub-Grantee Responsibility**

Any sub-grant agreement that may result from this RFA shall specify that the primary subgrantee is solely responsible for fulfillment of all requirements of the contractual agreement with the BBHWP which may derive from this RFA. The BBHWP entering into a sub-grant agreement with a sub-grantee will make payments only to the primary sub-grantee.

### **Sub-contractors/Consent**

The use of sub-contractors is allowed and encouraged to enhance services. The primary subgrantee shall be wholly responsible for the entire performance of the contractual agreement whether or not sub-contractors are used. Additionally, an Applicant shall disclose, in its application, plans for using sub-contractors, if applicable. The primary sub-grantee must receive written approval from the BBHWP before awarding any resultant contract during the term of this agreement.

### **Amended Applications**

An Applicant may submit an amended application **before** the deadline for receipt of applications. An amended application must be a complete replacement for a previously submitted application and must be clearly identified as such in the transmittal letter. The BBHWP personnel will not merge, collate, or assemble application materials.

### **Applicant's Rights to Withdraw an Application**

Applicants will be permitted to withdraw their application at any time. The applicant must submit a written withdrawal request signed by the Applicant's duly authorized representative and addressed to the RFA Manager.

### **Application Offer Firm**

Responses to this RFA will be considered firm for one hundred twenty (120) days after the due date for receipt of applications if the Applicant is invited or required to submit one.

## Disclosure of Application Contents

Applications will be kept confidential until negotiations and the award are completed by the BBHWP. At that time, all applications and documents pertaining to the applications will be open to the public, except for material that is clearly marked proprietary or confidential. The RFA Manager will not disclose or make public any pages of an application on which the potential

Applicant has stamped or imprinted “proprietary” or “Confidential” subject to the following requirements:

a. Proprietary or confidential data must be readily separable from the application to facilitate eventual public inspection of the non-confidential portion of the application. b.

Confidential data is restricted to:

- i. Confidential financial information concerning the Applicant’s organization.
- ii. Data that qualifies as a trade secret.
- iii. PLEASE NOTE: The cost of services proposed **shall not be designated** as proprietary or confidential information.

If a request is received for disclosure of data for which an Applicant has made a written request or confidentiality, the BBHWP shall examine the Applicant’s request and make a written determination that specifies which portions of the application may be disclosed. Unless the Applicant takes legal action to prevent the disclosure, the application will be so disclosed. The application shall be open to public inspection subject to any continuing prohibition on the disclosure of confidential data.

## No Obligation

This RFA in no manner obligates the BBHWP to the use of any Applicant’s services until a valid written sub-grant is awarded and approved by appropriate authorities.

## Termination

This RFA may be canceled at any time and all applications may be rejected in whole or in part when the BBHWP determines such action to be in the best interest of the BBHWP.

## Sufficient Appropriation

Any contract awarded because of this RFA process may be terminated if sufficient appropriations or authorizations do not exist. Such terminations will be affected by sending written notice to the Sub-grantee. The BBHWP decision as to whether sufficient appropriations and authorizations are available will be accepted by the Sub-grantee as final.

## Legal Review

The BBHWP requires that all Applicants agree to be bound by the General Requirements contained in this RFA. Any Applicant’s concerns must be promptly submitted in writing to the attention of the RFA Primary Contact, [Primary Contact].

**Applicant Qualification**

The Evaluation Committee may make such investigations as necessary to determine the ability of the potential Applicant to adhere to the requirements specified within the RFA. The Evaluation Committee will reject the application of any potential Applicant who is not a responsible Applicant or fails to submit a responsive offer.

**Right to Waive Minor Irregularities**

The Evaluation Committee reserves the right to waive minor irregularities. The Evaluation Committee also reserves the right to waive mandatory requirements in instances where all responsive applications failed to meet the same mandatory requirements and the failure to do so does not otherwise materially affect the RFA. This right is at the sole discretion of the Evaluation Committee.

**Change in Sub-Grant Representatives**

The BBHWP reserves the right to require a change in sub-grant representative(s) if the assigned representative(s) is/are not, in the opinion of the BBHWP, adequately meeting the needs of the BBHWP.

**BBHWP Rights**

The BBHWP in agreement with the Evaluation Committee reserves the right to accept all or a portion of a potential application.

**Right to Publish**

Throughout the duration of this RFA process and contract term, Applicants and sub-grantees must secure from the BBHWP written approval prior to the release of any information that pertains to the potential work or activities covered by this RFA and/or the BBHWP sub-grants deriving from this RFA. Failure to adhere to this requirement may result in disqualification of the application or removal of the sub-grant.

**Ownership of Application**

All documents submitted in response to the RFA shall become property of the BBHWP.

**Confidentiality**

Any confidential information provided to, or developed by, the sub-grantee in the performance of the sub-grant resulting from this RFA shall be kept confidential and shall not be made available to any individual or organization by the sub-grantee without the prior written approval of the BBHWP.

**Electronic Mail Address Required**

A large part of the communication regarding this RFA will be conducted by electronic mail (email). The Applicant must have a valid e-mail address to receive this correspondence.

**Use of Electronic Versions of this RFA**

This RFA is being made available by electronic means. In the event of conflict between a version of the RFA in the Applicant's possession and the version maintained by the

BBHWP, the Applicant acknowledges that the version maintained by the BBHWP shall govern.

**Conflict of Interest; Governmental Conduct Act**

The Applicant warrants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Agreement.

**Compliance with Bureau of Behavioral Health Wellness and Prevention Program Requirements**

The Applicant must agree to comply with the Bureau of Behavioral Health Wellness and Prevention Program Requirements as detailed in Appendix F.

## RFA – APPLICATION REVIEW PROCEDURES

### Overview

The Department of Health and Human Services and The Division of Public and Behavioral Health will use a multi-level application review process.

- a) The first level of review is **Technical Review**. This internal process identifies those applications that have met the requirements of the RFA and can therefore be passed on to the next review. Applications that do not pass the Technical Review or are turned in late are returned to the applicant along with a letter of explanation.
- b) The second level is the **Objective Review**. Objective reviews are conducted by professionals within the State of Nevada Department of Health and Human Services, who do not have an apparent conflict of interest with the applicant, have some knowledge of the RFA content area.
- c) The third level of review is a **Standardized Interview** conducted by an interview panel comprised of state employees who span across DHHS Divisions of Public and Behavioral Health (DPBH) and Health Care Financing (medical) and Policy (DHCFP). This review determines the final funding recommendations. Key DHHS staff participating in this review include members of the Rates Department and Policy Department at DHCFP, representatives from Health Care Quality and Compliance (HCQC), and key staff from DPBH, including the Project Director and Project Manager.
- d) The fourth level of review is a **Comprehensive Review** of the findings of the evaluators from the Objective Review and the Standardized Interviews. The comprehensive review will allow all reviewers the opportunity to discuss their findings in detail. The group will then make final decisions based on key variables that have been identified including but not limited to geography, known strengths and risks, and providers overall readiness to implement the Coordinated Specialty Care for First Episode of Psychosis model.

### **Coordinated Specialty Care for First Episode of Psychosis: Application and Interview Comprehensive Review**

The following factors are to be considered by the team when making the final Coordinated Specialty Care for First Episode of Psychosis selection decisions:

- Geographic considerations/coverage: The program outlined in this **RFA and Scope of Work** will serve individuals who reside in the Washoe Behavioral Health Region in Washoe County, Nevada.
- Risk: Are there considerable risk factors that could inhibit a provider from successfully accomplishing all required activities, cost reports, data collection and reporting, ability to expand services, and the ability to be certified?
- Strengths: Does the provider have significant demonstrated experience with staffing, scope of services, availability and accessibility, cost reporting, data collection and reporting, billing, etc.

- Population served: Individuals, ages 15–44 years, who meet Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for the following first episode of psychosis (FEP) disorders:
  - o Schizophrenia
  - o Schizoaffective Disorder
  - o Schizophreniform Disorder
  - o Brief Psychotic Disorder
  - o Psychotic Disorder NOS
- Readiness: The applicant organizations that are located within the specified geographical region will be evaluated for the required system characteristics and strengths and ranked according to the greatest overall readiness to implement the Coordinated Specialty Care model for the early treatment of first episode of psychosis. The organization selected to receive the award will next participate in required pre-training assessment, planning, and preparation activities that are provided by the Bureau of Behavioral Health Wellness and Prevention and the national NAVIGATE Training Team for FEP programming. These activities include assessment of agency capacity for FEP Program implementation, planning for FEP program implementation, and preparation for NAVIGATE FEP Program training. [NOTE: Assessment, planning and preparation activities are required and will be supported financially by the Mental Health Block Grant (MHBG).]

## SUBMISSION OF PROPOSALS/APPLICATIONS

Proposals / applications must conform to all instructions, conditions, and requirements included in the RFA. Applicants are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the proposal / application process are at the Applicant's risk and may, at the discretion of the State, result in disqualification of the proposal for non-responsiveness. Emphasis should be on completeness and clarity of content.

### **Submittal Instructions (electronic or hardcopy):**

Send via email to [rcondray@health.nv.gov](mailto:rcondray@health.nv.gov) by the submission deadline. Send Hardcopy submissions to:

### **Ruth Condray, Ph.D.**

Nevada Department of Health and Human Services  
Division of Public and Behavioral Health  
Bureau of Behavioral Health Wellness and Prevention  
4126 Technology Way, Suite 200  
Carson City, NV 89706

**To be reviewed, all applications and supporting documents must be received on or before the deadline of FRIDAY, MAY 29, 2020 at 5 pm PST. Please note that applications that do not meet the technical requirements or the submission deadline will be disqualified and will not be evaluated.**

Responses to this RFA must consist of the following required components. Each of these components must be separate from the others and uniquely identified. Additional detail on each required application section is provided below:

**Cover Page** – Complete template in Appendix A.

### **Description of the Applicant Organization**

A completed Agency Profile Worksheet (see Appendix B) begins this section.

This section also must include information on the programs and activities of the agency, the number of people served, geographic area served, staff experience, and/or programmatic accomplishments. Include reasons why your organization is capable of effectively completing the services outlined in the RFA. Include a brief history of your organization and all strengths that you consider are an asset to your program.

The Applicant should demonstrate the length, depth, and applicability of all prior experience in providing the requested services. The Applicant should also demonstrate the skill and experience of lead staff and designate a project manager with experience in planning and providing the proposed services. Applicants must also include your standard governance, which is defined as processes of governing and processes by which the applicant organization is managed.

Applicants must also list all licenses and certifications which are held by the applicant entity and its contracting organizations (DCOs).

### **Staff Resume of Program Manager/Director**

A resume must be completed for the proposed key individual who is responsible for clinical operations and authority for performance under any contract resulting from this RFA. Additional staff resumes are not required at this time but may be required if selected.

### **Description of Target Population and Geographic Region**

Describe the level of need for services in your service area, how the need was identified, and what group or groups of individuals will be targeted for services by the program. Discuss the geographic area your program will impact and how you will serve low and moderate-income individuals and families. Describe the services provided and outreach methods that will be used to effectively reach the target population. Include description of referral systems, staff experience, and other methodologies to reach the target population. Discuss how your programs and activities will positively impact the target population; you may provide examples, performance measures, and desired outcomes. Applicants should speak to the process to include input from consumers, providers, or community members in program identification and quality improvement.

**Scope of Work** – Prepare using template and instructions in Appendix C.

**Budget and Budget Justification** – Prepare using template and instructions in Appendix D.

**Spending Plan** – Prepare using template and instructions in Appendix E.

## RFA TIMELINE

The following represents the proposed timeline for this project. All times stated are Pacific Standard Time (PST). These dates represent a tentative schedule of events. The State reserves the right to modify these dates at any time.

Task	Date/Time
Release Date of RFA	April 15, 2020
Deadline for submitting questions regarding the RFA process. Questions to be submitted to <a href="mailto:rcondray@health.nv.gov">rcondray@health.nv.gov</a> . <b>You must include RFA [Project Name/Year] in the heading for the questions to be considered.</b>	By May 4, 2020
Technical Assistance Call specific to RFA process. Call in number [Get with AAll for this conference line]. Technical Assistance call may end early, if there are no callers are on the phone.	May 4, 2020, 9am–11am PST
<b>Deadline for RFA submittal</b>	<b>May 29, 2020 at 5 pm [PST]</b>
Evaluation period ( <b>approximate time frame</b> ); <b>which will include interviews with applicant’s leadership team.</b>	On or before June 1–15, 2020
Technical Review	June 1–15, 2020
Applicant response to Technical Review requests, if needed.	June 1–15, 2020
Selection of applicant(s)	June 1–15, 2020

### SUBMISSION CHECKLIST

This checklist is provided for applicant's convenience only and identifies documents that must be submitted with each package in order to be considered responsive. Any RFAs received without these requisite documents may be deemed non-responsive and not considered for an award.

<b>Part I A– Technical RFA Submission Requirements Document should be tabbed with the following section</b>		<b>Completed</b>
	Organization or Non-Profit Information	
	Cover page	
	Description of Applicant Agency (include DCO's if appropriate)	
	Program Manager Resume	
	Description of Target Population	
	Scope of Work	
	Proposed Implementation Plan	
	Budget and Budget Justification	
	Spending Plan	
	Technical Assistance Assessment	
	Attachments: 1)[specific for RFA] 2)[specific for RFA] 3)[specific for RFA] 4)[specific for RFA]	
	State Certification Documents [if applicable]	

APPENDIX A: COVER PAGE  
**Nevada Division of Public and Behavioral Health**  
**Bureau of Behavioral Health Prevention and Wellness**

*In response to:*  
**Request for Applications**  
**Coordinated Specialty Care for First Episode of Psychosis**  
**Release Date: April 15, 2020**  
**Deadline for Submission and Time: May 29, 2020 by 5pm PST**

*Our application is respectfully submitted as follows:*

<b>Company Name:</b>			
<b>Clinic Address:</b>			
<b>Mailing Address: (If different)</b>			
<b>Phone:</b>		<b>Fax:</b>	
<b>Executive Director/CEO:</b>			
<b>Name of Primary Contact for Proposal:</b>			
<b>Proposal Primary Contact Email Address:</b>			

*As a duly authorized representative, I hereby certify that I have read, understand, and agree to all terms and conditions contained within this request for applications and that information included in our organization's application hereby submitted is accurate and complete.*

**Signed:**

**Date:**

---

**Print Name:**

**Title:**

---

APPENDIX B:  
AGENCY/ORGANIZATION PROFILE INSTRUCTIONS

Project Number – Leave blank (Assigned by SAPTA)

Application Number – Leave blank (Assigned by SAPTA)

Project Name – Provide a short descriptive name for the proposed project

Organization Name – Applicant's legal agency name

Organization Website – If applicable, provide the applicant's website address

Organization Address – Street and floor or suite number

Organization City/State – City and State

Organization Zip Code – Five or nine-digit zip code

Employer ID Number – Provide employer identification number (EIN)

DUNS Number – Provide Data Universal Numbering System (DUNS) number

Locations – Service location (i.e. Washoe Behavioral Health Region, Washoe County, Nevada), provide full address, phone number, fax, site contact person and their email (if applicable)

Project Director – This will be the main programmatic contact person for this project

Financial Officer – This will be the main fiscal contact person for this project

Agency Director – This will be the main administrative contact person for this project

[AGENCY/ORGANIZATION NAME] PROFILE

Project HD Number: <i>(Assigned by DPBH)</i>		
Application Number: <i>(Assigned by DPBH)</i>		
Organization Name:		
Organization Website:		
Organization Telephone Number:		
Organization Fax Number:		
Organization Address:		
Organization City, State:		
Organization Zip Code:		
Employer ID Number (EIN):		
DUNS Number:		
SAPTA Certified Residential and/or Transitional Treatment Facility:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date certified?
Project Period: <i>(Month/Day/Year)</i>	Start Date [date]	End Date [date]
Amount Requested:		

ADDITIONAL FACILITY LOCATIONS [if applicable]

1.	Service Location: Address: Phone Number: Site Contact Person/Email:
2.	Service Location: Address: Phone Number: Site Contact Person/Email:
3.	Service Location: Address: Phone Number: Site Contact Person/Email:
4.	Service Location: Address: Phone Number: Site Contact Person/Email:

ORGANIZATION CONTACT INFORMATION

Name of <b>Project Manager/ Director:</b>	
Title:	
Telephone:	
Fax:	
Email:	

Check, If same as Project Director

Name of <b>Financial Officer:</b>	
Title:	
Telephone:	
Fax:	
Email:	

**Signature Authority:**

Check, If same as Project Director

Name of <b>Agency Director:</b>	
Title:	
Telephone:	
Fax:	
Email:	

**Additional Point of Contacts**

Name // Title:	
Title:	
Telephone:	
Email:	

Name // Title:	
Title:	
Telephone:	
Email:	

Name // Title:	
Title:	
Telephone:	
Email:	

[AGENCY/ORGANIZATION NAME] SUMMARY AND EXPERIENCE INSTRUCTIONS

In no more than 500 words, please describe the [ORGANIZATION NAME] history and experience in the community and how it applies to the proposed project(s). Describe the mission and purpose of the [PROJECT COMPANY NAME] including staff members, their expertise, and the structure of the [PROJECT COMPANY NAME] including the Board of Directors, hours of operation, and number of locations.

Provide a statement as to the [PROJECT COMPANY NAME] knowledge and familiarity with the local community's needs and goals. Describe the client population the [PROJECT COMPANY NAME] currently serves, and the level of service provided. If the project is to be accomplished through a subcontractor, please list the name(s) and address(s) of the subcontractor; a signed Memorandum of Understanding or agreement must be provided for each subcontractor, as an addendum.

## APPENDIX C: PROPOSED SCOPE OF WORK INSTRUCTIONS

1. Provider Name: Please fill in the name of your organization.
2. HD #: The 5-digit HD (Health Division number). *Please leave this space blank.* This number will be assigned by Division staff.
3. Purpose/Title: Please fill in the purpose or title (project name) and then a brief description.
4. Brief Description of Program: Please provide a short description of the program/project.
5. Problem Statement: Briefly describe the problem or the gap that is being addressed through this scope of work.
6. Goal (Provide a description of a broad 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.
7. Outcome Objectives: Please enter a description of measurable Outcome Objectives, which are Specific, Measurable, Achievable, Realistic, Time limited (S.M.A.R.T.):  
  
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
8. Percent Funding: Please enter the estimated percent of the budget that will be allocated to this objective. Total sum of the percentages allocated to the following budget categories – Personnel, Travel, Equipment, Operating, Consultant/Contracts, Training and Other – should equal 100%.
9. Activities: List the steps planned to achieve the stated Outcome Objective.
10. Date Due By: Please indicate the expected date by which the activity will be accomplished. The end of the grant period may suffice in some cases but using the end of the grant to complete all activities should be avoided as activities should show progression towards achieving the objective. Please make these realistic dates that show a progression towards achieving the outcome objective.
11. Documentation: Please list any documentation or process evaluation documents that will be produced to track the completion of the activities.

12. Evaluation: Please explain how you will evaluate whether you have met your objectives or not. The evaluation plan should clearly explain what data will be used, where and how you will collect the data, and any analysis, e.g. simple rate comparison, statistical tests of significance, etc. If you are using an evidence-based program, many times the evaluation criteria is provided and should be used to preserve fidelity with the evidence-based methods. (Please note: Bureau/Division can provide technical assistance on this element, if needed, if application is approved for funding.)

## SAMPLE SCOPE OF WORK

*Please provide the following information for the Scope of Work using the provided template below*

**Goal(s)** – List the achievement(s) desired.

**Problem Statement** - Briefly describe the problem or the gap that is being addressed through this scope of work.

**Outcome Objectives** – Describe the program objectives used to obtain the goal. These should be measurable objectives.

**Activities** – Describe the steps or activities that the program will use to accomplish the objectives.

**Due Dates:** The date by which activities will be completed.

**Documentation:**

- Performance Measures – What are the measures by which you will evaluate the progress of achieving your goals and objectives through the activities? These are the items that will be evaluated as a successful realization of the project.
- Evaluation and Outcome for this Objective – This is how your agency will qualify and quantify the selected performance measures. Measure or evaluate the work being done to ensure that the agency is on track to achieve the goals and objectives. What tools will the agency use to evaluate performance?

APPENDIX D:  
PROPOSED BUDGET PLAN – INSTRUCTIONS & BUDGET EXAMPLE

The following budget development instructions and budget example have been prepared to help you develop a complete and clear budget to ensure delays in processing awards are minimized.

Funding Details and Requirements:

The sub-grant period for this application will be for twenty-four months (24) beginning approximately July 1, 2020 and continuing through June 30, 2022.

1. Apply for the full twelve-month project period. Complete an individual scope of work (SOW), budget and budget narrative for each budget cycle of the twelve-month project period.
2. All funding is subject to the availability of funding.

Detailed Budget Building Instructions by Line Item:

Budget building is a critical component of the application process. The budget in the application is going to be the budget used for the sub-grant. The budget must be error free and developed and documented as described in the instructions.

1. Under the “Category” section of the line item; there is nothing to be filled out or completed by the applicant. Please see the Example Budget for reference
2. Under the “Total Cost” section of the line item; the total cost identified should represent the sum of all costs represented in the “Detailed Cost” section associated to the line item. Please see the Example Budget for reference
3. Under the “Detailed Cost” section of the line item; the detailed costs identified should represent the sum of all costs represented in the “Details of expected expenses” section associated to the line item. Please see the Example Budget for reference

Under the “Details of Expected Expenses” section of the line item; the details of expected expenses identified here should represent the fiscal/mathematical representation of all costs that are outlined in the budget narrative. The expenses should represent a projection of the expenses that will be charged to the sub-grant that directly support the work necessary to complete the tasks that are required to meet the goals and objectives as outlined in the scope of work (SOW) for this sub-grant.

[SAMPLE BUDGET]

Example Budget for reference.

<u>Category</u>	<u>Total Cost</u>	<u>Detailed Cost</u>	<u>Details of Expected Expenses</u>
1. Personnel	\$ 77,280	Personnel: The costs that are allowable in this budget line item are personnel costs only. This does not include any form of temporary staff, contract employees and/or volunteers.  The following details must be included in the details of expected expenses sections of the line item.  1. The positions title must be included. NOTE: Do not put an individual name. 2. The number of staff that will be charged to the grant under a specific position title. NOTE: If your organization charges multiple staff that share the same projected allocation of time, then group them together. See Project Coordinators NOTE: If your organization charges multiple staff that do not share the same projected allocation of time, then separate them. See Administrative Assistant 3. The total annual salary of the position per year. 4. The percentage of time they will be contributing to the project. 5. The sum total of 1 through 4. 6. The fringe benefits line must be represented as an average percent of the total salaries being charged to the grant. Example: \$7,000 + \$22,500 + \$35,000 + \$3,000 + \$1,500 = \$69,000. The average cost of fringe benefits for all staff being charged to the grant is 12%. Fringe benefits are calculated as \$69,000 X 12% (0.12) = \$8,280. Salaries: (FTE X Annual Salary X % of Effort = Salary Charged)  Fringe: (Total Salary Charged X Average Fringe Benefit Rate = Fringe Benefit Cost)  NOTE: Please see the example below.	
		\$ year X 10% =  X 50% =  year X 50%	7,000 Executive Director, 1 X \$70,000 per \$7,000 22,500 Project Manager, 1 X \$45,000 per year \$22,500 35,000 Project Coordinators, 2 X 35,000 per = \$35,000

		<p>3,000 Administrative Assist, 1 X \$15,000 per year X 20% = \$3,000</p> <p>1,500 Administrative Assist, 1 X \$15,000 per year X 10% = \$1,500</p> <p>8,280 Fringe Benefits equals 12% of total salaries charged - \$69,000 X 12% = \$8,280</p>
2. Travel	\$ 8,160	<p>Travel: The costs that are allowable in this budget line item are all travel costs.</p> <p>The following details must be included in the details of expected expenses sections of the line item. All rates must be reflective of actual GSA approved rates at the time budget development.</p> <ol style="list-style-type: none"> <li>1. Mileage should reflect GSA approved rate and total projected miles to be driven.</li> <li>2. A brief description of the trip.</li> <li>3. The destination of the trip.</li> </ol>

		<ol style="list-style-type: none"> <li>4. The number of staff that will be traveling.</li> <li>5. An estimated trip cost per staff traveling.</li> <li>6. The projected trip totals.</li> </ol> <p>Mileage: (GSA Rate X Number of Miles = Cost)</p> <p>Trips: (Number of staff X estimated cost per staff X number of trips = Cost)</p> <p>NOTE: Please see the example below</p>
	\$	<p>1,070 Mileage for local meeting and events - \$.535 X 2000 miles = \$1,070</p> <p>3,000 1 SAMHSA Conference, Washington DC, April 2017, 2 Staff, \$1,500 each = \$3,000</p> <p>4,000 4 Quarterly Meetings, Statewide, 2 Staff, \$500 each = \$4,000</p> <p>90 1 "Prevention Training" travel only, Reno, 6 staff, \$15 each = \$90</p>

3. Operating	\$ 7,075	<p>Operating: The costs that are allowable in this budget line item are all operating costs. Operating costs may include but are not limited to; building space, utilities, telephone, postage, printing and copying, publication, desktop/consumable office supplies, drugs, biologicals, certification fees and insurance costs. If applicable, indirect costs are not included in this section. Organizational costs that do not reasonably contribute the accomplishments of project tasks, goals and objectives of the scope of work cannot not be charged to the grant.</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> <li>1. A brief description of the item being charged.</li> <li>2. The monthly average cost of the item.</li> <li>3. The number of months that the budget encompasses.</li> <li>4. If the item of cost is split between funding sources, then include the percentage of split being charged to this grant.</li> </ol> <p>NOTE: if one item of cost is split at 25% then all other items of cost should share the same percent of the split.</p> <p>Supplies: (Per Month Cost X number of months charged X Rate of Allocation = Cost)</p> <p>NOTE: Please see the example below</p>
	<p>\$</p> <p>900</p> <p>4,500</p> <p>300</p> <p>375</p> <p>1,000</p>	<p>Office Supplies (paper, pencils, pens, etc.) - \$75 per month X 12 months = \$900</p> <p>Rent - \$1,500 per month X 12 Months = \$18,000 X 25% allocation.</p> <p>Phone - \$100 per month X 12 months = \$1,200 X 25% allocation.</p> <p>E-mail - \$125 per month X 12 months = \$1,500 X 25% allocation. 1 Computer for the project manager X \$1000 per computer</p>
4. Equipment	\$ 16,500	<p>Equipment: The costs that are allowable in this budget line item are equipment costs. Per federal regulation; §200.33 Equipment. Equipment means 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 per unit</p> <p>The following details must be included in the details of expected</p>

		expenses sections of the line item.
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		<ol style="list-style-type: none"> <li>1. Include a brief description of the item being charged.</li> <li>2. Include the cost of the item, per unit.</li> <li>3. Include the number of units that are being purchased.</li> <li>4. If the item of cost is split between funding sources, then include the percentage of split being charged to this grant.</li> </ol> <p>NOTE: if one item of cost is split at 25% then all other items of cost should share the same percent of the split.</p> <p>Equipment: (Per Unit Cost X Number of Units = Cost)</p> <p>NOTE: Please see the example below</p>
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	\$ 16,500	Examination Table, \$5,500 per unit X 3 units – 16,500 ( <i>this is almost never used; most expenditures will fall under Operating costs</i> )
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5. Contractual Consultant	\$ 99,575	<p>Contractual: The costs that are allowable in this budget line item are contract costs. List all sub-grants, consultants, contract, personnel/temporary employees and/or vendors that will be procured through a competitive process. (Travel and expenses of consultants and contractor should be incorporated into the contracts and included in this section as a part of the estimate contract cost.)</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> <li>1. Include a brief description of the intended future contract that is being considered.</li> <li>2. Include the estimated cost of the contract.</li> <li>3. If applicable, include the cost of and number of deliverables that will be the result of the completed contract.</li> <li>4. If applicable, include the per hour rate of the contract and the number of hours the project is going to take.</li> <li>5. For sub-grant funding; provide a brief description of the</li> </ol>
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		<p>sub-grant project or projects and the total estimated pass-through amount.</p> <p>NOTE: Do not list the actual names of contractors, consultants, vendors or subgrantees in the budget.</p> <p>NOTE: Please see the example below</p>															
		<table border="1"> <tr> <td>\$</td> <td></td> <td></td> </tr> <tr> <td>20,000</td> <td></td> <td>Contract to provide 4 regional prevention training courses; \$5,000 X 4 Courses = \$20,000</td> </tr> <tr> <td>4,375</td> <td></td> <td>Media consultant - \$35 per hour X 125 hours = \$4,375</td> </tr> <tr> <td>15,200</td> <td></td> <td>Contract for the development of a community needs assessment = \$95.00 per hour X 160 hours - \$15,200</td> </tr> <tr> <td>60,000</td> <td></td> <td>Sub-grants for community primary prevention programs = \$60,000</td> </tr> </table>	\$			20,000		Contract to provide 4 regional prevention training courses; \$5,000 X 4 Courses = \$20,000	4,375		Media consultant - \$35 per hour X 125 hours = \$4,375	15,200		Contract for the development of a community needs assessment = \$95.00 per hour X 160 hours - \$15,200	60,000		Sub-grants for community primary prevention programs = \$60,000
\$																	
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15,200		Contract for the development of a community needs assessment = \$95.00 per hour X 160 hours - \$15,200															
60,000		Sub-grants for community primary prevention programs = \$60,000															
6. Training	\$ 1,650	<p>Training: The costs that are allowable in this budget line item are training costs. This line item may include registration fees/conference fees and training costs. This line item can be used to budget for training that will be attended by staff and for the costs of training and educational materials being provided to targeted populations as identified in accordance to the proposed SOW.</p>															
		<p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> <li>1. Include a brief description of the intended training cost being considered.</li> <li>2. Include the estimated cost of the training.</li> <li>3. If developing educational materials for hosting a training.</li> <li>4. Include the "per unit" cost and number of units being developed for the training.</li> </ol>															

		NOTE: Please see the example below	
		\$ staff X  X \$25	500 SAMSHA Conference registration fees, 2 \$250 each=\$500 150 Prevention Training registration fees, 6 staff each = \$150 Printing cost for education books for seminar 1,000 = \$20 per book X 50 books = \$1000
7. Other/Indirect	\$ 27,469	<p>Other/Indirect: The costs that are allowable in this budget line item are indirect costs and if applicable audit costs.</p> <p>The following details must be included in the details of expected expenses sections of the line item.</p> <ol style="list-style-type: none"> <li>1. Include a brief description of the intended cost being considered.</li> <li>2. For audit costs include the total annual of the audit and the rate of allocation. NOTE: the rate of allocation should be the same as the rates of allocation in the operating section. If not, provide a justification as why the rate of allocation is different.</li> <li>3. If applicable, include the total direct costs being charged for indirect.</li> <li>4. If applicable, include the federally approved indirect rate total direct costs being charged for indirect.</li> </ol> <p>Audit Cost: (Annual audit cost X Rate of Allocation = Cost)</p> <p>Indirect Cost: (Total Direct Costs being charged x Federally Approved Indirect Rate = Indirect Cost)</p> <p>NOTE: Please see the example below</p>	
		\$ 2,000  25,469	Annual audit cost: \$8,000 X 25% = \$2,000 Indirect Costs: \$210,228 X 12% = 25,468.80
Total Cost	\$ 237,709		

Develop a line item budget for the project. For each itemized category, specify the total project costs (including subcontracting cost), description of expense, and the amount requested from Nevada Division of Public and Behavioral Health (DPBH) funding. A line item expense under a category must include a description of the line item expense in the detail description.

*See Proposed Budget Template on the next page...*

PROPOSED BUDGET TEMPLATE

<b>Click to insert the Organizations Name</b>			
<b>BUDGET NARRATIVE</b>			
<b>Upon Approval through December 31, 2020</b>			
<b><u>Category</u></b>	<b><u>Total cost</u></b>	<b><u>Detailed cost</u></b>	<b><u>Details of expected expenses</u></b>
1. Personnel	\$		
		\$	# and type (position type; FTE type) of staff to be hired
2. Travel	\$		
		\$	# traveling, positions traveling, location, dates of travel, purpose, reimbursement made in accordance with SAM
3. Operating	\$		
		\$	To include: xxxx
4. Equipment	\$		
		\$	Itemize expenses allowed within this category
5. Contractual	\$		
Consultant			
		\$	Itemize expenses allowed within this category
6. Training	\$		
		\$	Type of training, location, # attending, benefit to Subgrantee and implementation of subgrant
7. Other	\$		
		\$	Itemize expenses allowed within this category
Total Cost	\$		

## APPENDIX E: SPENDING PLAN TEMPLATE

Sub-grant Time Period		To											
Total Budget Requested													
Category	Total Requested Budget	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Personnel	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Travel	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Operating	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Equipment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Contract/Consultant	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Training	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Total:</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Percent of Total</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

**Instructions:**

Please fill out the following spending plan using the budgeted amounts from your subgrant budget. All amounts must match the budget categories in your budget justification. All fields in the template are locked except those requiring your input as follows:

- In cell C3, please enter the name of your organization.
- In cell C4, select the start month and year of your subgrant by using the drop-down box. After you make your month and year selection, the rest of the dates will be filled in automatically for a 12-month time period.
- In cell C5, enter the total amount of your sub-grant award.
- In cells B7 to B 13, put the total amount of the categorical costs in the appropriate section. These amounts must match the amounts in the same categories in your budget justification.
- In cells C7 to N7, enter your expected total personnel costs for each month.
- In Cells C8 to N8, please enter your expected travel costs for each month as appropriate.
- In Cells C9 to N9, please enter operating costs you expect to spend for each month.
- In Cells C10 to N10, please enter any planned equipment purchases and place those costs in the month(s) you expect to incur the costs.
- In Cell C11 to N11, place the total expected costs for Contracts/Consultants in the months you plan on using such services.
- In Cell C12 to N12, please note any expected training costs in the months you expect the training activities to occur.
- In Cell C13 to N13, please specify any other costs that are planned in the months they will occur.

While you are entering this information, you will observe that cells for the "Total" and "Total Percentage" will be auto calculated and will reflect one of three colors. If the cell is yellow, it indicates that the amount is less than the total awarded amount; if the color is green, it indicates the amount is the same as the total awarded amount; and if the cell turns red, it indicates that the amount is above the total awarded amount. All applicable cells must reflect green once you are finished filling in your spending plan for each month.

In the same way, you will notice the end column (O7 thru O15) will also change colors. Once again, yellow indicates that the total amount for the total of all months for the category is under the total budgeted amount (reflected in the "B" column), the green indicates that the monthly total for the category matches the total categorical budget, and red indicates that the monthly total exceeds the categorical budget. All cells must reflect green before submitting the spending plan. At the bottom of each column, a monthly percentage of the total budget is also calculated. The sum of all monthly percentages must equal 100% of the total award.

## APPENDIX F: PROGRAM REQUIREMENTS

In addition to the Division of Public and Behavioral Health Subaward Grant Assurances, the subrecipient and all organizations or individuals to whom the sub-grantee passes through funding must be in compliance with all applicable rules, federal and state laws, regulations, requirements, guidelines, and policies and procedures. The terms and conditions of this State subaward flow down to the subrecipient's pass through entities unless a particular section specifically indicates otherwise.

### PROGRAM REQUIREMENTS

#### Applicability

This section is applicable to all subrecipients who receive funding from the Division of Public and Behavioral Health through the Bureau of Behavioral Health Wellness and Prevention (BBHWP). The subrecipient agrees to abide by and remain in compliance with the following:

1. 2 CFR 200 -Uniform Requirements, Cost Principles and Audit Requirements for Federal Awards
2. 45 CFR 96 - Block Grants as it applies to the subrecipient and per Division policy.
3. 42 CFR 54 and 42 CFR 54A Charitable Choice Regulations Applicable to States Receiving Substance Abuse Prevention & Treatment Block Grants and/or Projects for Assistance in Transition from Homelessness Grants
4. NRS 218G - Legislative Audits
5. NRS 458 - Abuse of Alcohol & Drugs
6. NRS 616 A through D Industrial Insurance
7. GAAP – [Generally Accepted Accounting Principles] and/or GAGAS [Generally Accepted Government Auditing Standards]
8. GSA – [General Services Administration] guidelines for travel
9. The Division of Public and Behavioral Health, BBHWP policies and guidelines.
10. State Licensure and certification
  - a. The subrecipient is required to be in compliance with all State licensure and/or certification requirements.
  - b. The subrecipient's certification must be current and fees paid prior to release of certificate in order to receive funding from the Division. Subawards cannot be issued unless certifications are current.
11. The Sub-grantee shall carry and maintain commercial general liability coverage for bodily injury and property damage as provided for by NRS 41.038 and NRS 334.060. In addition, Sub-grantee shall maintain coverage for its employees in accordance with NRS Chapter 616A. The parties acknowledge that Sub-grantee has adopted a self insurance program with liability coverage up to \$2,000,000 and has excess liability coverage up to \$20,000,000 for bodily injury (automobile and general liability), property damage (automobile and general liability), professional liability, and personal injury liability. The parties further acknowledge that Sub-grantee is self-insured for workers' compensation liability. Sub-grantee warrants that its participation in the plan is in full force and effect and that there have been no material modifications thereof. If, at any time, Sub-grantee is no longer a participant in the

self-insurance program, then Sub-grantee shall immediately become a participant in a comparable self-insurance program or immediately obtain a policy of commercial insurance. The parties acknowledge that any Sub-grantee liability is limited by NRS 41.0305 through NRS 41.035.

12. The subrecipient shall provide proof of workers' compensation insurance as required by Chapters 616A through 616D inclusive Nevada Revised Statutes at the time of their certification.
13. The subrecipient agrees to be a "tobacco, alcohol, and other drug free" environment in which the use of tobacco products, alcohol, and illegal drugs will not be allowed.
14. The subrecipient will report within 24 hours the occurrence of an incident, following Division policy, which may cause imminent danger to the health or safety of the clients, participants, staff of the program, or a visitor to the program, per NAC 458.153 3(e).
15. The subrecipient shall maintain a Central Repository for Nevada Records of Criminal History and FBI background checks every 3 to 5 years conducted on all staff, volunteers, and consultants occupying clinical and supportive roles, if the subrecipient serves minors with funds awarded through this subaward.
16. Application to 2-1-1:
  - As of October 1, 2017, the Sub-grantee will be required to submit an application to register with the Nevada 2-1-1 system.
17. The subrecipient agrees to cooperate fully with all BBHWP sponsored studies including, but not limited to, utilization management reviews, program compliance monitoring, reporting requirements, complaint investigations, and evaluation studies.
18. The subrecipient must be enrolled in System Award Management (SAM) as required by the Federal Funding Accountability and Transparency Act.
19. The subrecipient acknowledges that to better address the needs of Nevada, funds identified in this subaward may be reallocated if ANY terms of the sub-grant are not met, including failure to meet the scope of work. The BBHWP may reallocate funds to other programs to ensure that gaps in service are addressed. [WITS]
20. The subrecipient acknowledges that if the scope of work is NOT being met, the subrecipient will be provided an opportunity to develop an action plan on how the scope of work will be met and technical assistance will be provided by BBHWP staff or specified subcontractor. The subrecipient will have 60 days to improve the scope of work and carry out the approved action plan. If performance has not improved, BBHWP will provide written notice identifying the reduction of funds and the necessary steps.
21. The subrecipient will NOT expend BBHWP funds, including Federal Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Funds for any of the following purposes:
  - a. To purchase or improve land: purchase, construct, or permanently improve, other than minor remodeling, any building or other facility; or purchase major medical equipment.
  - b. To purchase equipment over \$1,000 without approval from the Division.
  - c. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.

- d. To provide in-patient hospital services.
  - e. To make payments to intended recipients of health services.
  - f. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstrated needle exchange program would be effective in reducing drug abuse and there is no substantial risk that the public will become infected with the etiologic agent for AIDS.
  - g. To provide treatment services in penal or correctional institutions of the State.
22. Failure to meet any condition listed within the subaward award may result in withholding reimbursement payments, disqualification of future funding, and/or termination of current funding.

### Audit Requirements

The following program Audit Requirements are for non-federal entities who do not meet the single audit requirement of 2 CFR Part 200, Subpart F-Audit requirements:

- 23. Subrecipients of the program who expend less than \$750,000 during the non-federal entity's fiscal year in federal and state awards are required to report all organizational fiscal activities annually in the form of a Year-End Financial Report.
- 24. Subrecipients of the program who expend \$750,000 or more during the fiscal year in federal and state awards are required to have a Limited Scope Audit conducted for that year. The Limited Scope Audit must be for the same organizational unit and fiscal year that meets the requirements of the Division Audit policy.

### Year-End Financial Report

- 25. The non-federal entity must prepare financial statements that reflect its financial position, results of operations or changes in net assets, and, where appropriate, cash flows for the fiscal year.
- 26. The non-federal entity financial statements may also include departments, agencies, and other organizational units.
- 27. Year-End Financial Report must be signed by the CEO or Chairman of the Board.
- 28. The Year-End Financial Report must identify all organizational revenues and expenditures by funding source and show any balance forward onto the new fiscal year as applicable.
- 29. The Year-End Financial Report must include a schedule of expenditures of federal and State awards. At a minimum, the schedule must:
  - a. List individual federal and State programs by agency and provide the applicable federal agency name.
  - b. Include the name of the pass-through entity (State Program).
  - c. Must identify the CFDA number as applicable to the federal awards or other identifying number when the CFDA information is not available.
  - d. Include the total amount provided to the non-federal entity from each federal and State program.

30. The Year-End Financial Report must be submitted to the Division 90 days after fiscal year end at the following address.

Behavioral Health Wellness and Prevention  
Attn: Management Oversight Team  
4126 Technology Way, Second Floor, Carson City, NV 89706

Limited Scope Audits

31. The auditor must:

- a. Perform an audit of the financial statement(s) for the federal program in accordance with GAGAS;
- b. Obtain an understanding of internal controls and perform tests of internal controls over the federal program consistent with the requirements for a federal program;
- c. Perform procedures to determine whether the auditee has complied with federal and State statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on the federal program consistent with the requirements of federal program;
- d. Follow up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with the requirements of 2 CFR Part 200, §200.511 Audit findings follow-up, and report, as a current year audit finding, when the auditor concludes that the summary schedule of prior audit findings materially misrepresents the status of any prior audit finding;
- e. And, report any audit findings consistent with the requirements of 2 CFR Part 200, §200.516 Audit findings.

32. The auditor's report(s) may be in the form of either combined or separate reports and may be organized differently from the manner presented in this section.

33. The auditor's report(s) must state that the audit was conducted in accordance with this part and include the following:

- a. An opinion as to whether the financial statement(s) of the federal program is presented fairly in all material respects in accordance with the stated accounting policies;
- b. A report on internal control related to the federal program, which must describe the scope of testing of internal control and the results of the tests;
- c. A report on compliance which includes an opinion as to whether the auditee complied with laws, regulations, and the terms and conditions of the awards which could have a direct and material effect on the program; and
- d. A schedule of findings and questioned costs for the federal program that includes a summary of the auditor's results relative to the federal program in a format consistent with 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(1), and findings and questioned costs consistent with the requirements of 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(3).

34. The Limited Scope Audit Report must be submitted to the Division within the earlier of 30 calendar days after receipt of the auditor's report(s), or nine months after the end of the

audit period. If the due date falls on a Saturday, Sunday, or Federal holiday, the reporting package is due the next business day. The Audit Report must be sent to:

Behavioral Health Wellness and Prevention  
Attn: Management Oversight Team  
4126 Technology Way, Second Floor  
Carson City, NV 89706

#### Amendments

35. The Division of Public and Behavioral Health / Bureau of Behavioral Health, Wellness, and Prevention (BBHWP) policy is to allow no more than 10% flexibility within the approved Scope of Work budget line items. Notification of such modifications must be communicated in writing to the BBHWP through the assigned analyst prior to submitting any request for reimbursement for the period in which the modification affects. Notification may be made via email.
36. For any budgetary changes that are in excess of 10 percent of the total award, an official amendment is required. Requests for such amendments must be made to BBHWP in writing.
37. Any expenses that are incurred in relation to a budgetary amendment without prior approval are unallowable.
38. Any significant changes to the scope of work over the course of the budget period will require an amendment. The assigned program analyst can provide guidance and approve all scope of work amendments.
39. The subrecipient acknowledges that requests to revise the approved subaward must be made in writing using the appropriate forms and provide sufficient narrative detail to determine justification.
40. Final changes to the approved subaward that will result in an amendment must be received 60 days prior to the end of the subaward period (no later than April 30 for State funded grants and July 31 for federal funded grants). Amendment requests received after the 60-day deadline will be denied.

#### Remedies for Noncompliance

41. Corrective Action Plan...
42. The Division reserves the right to hold reimbursement under this subaward until any delinquent requests, forms, reports, and expenditure documentation are submitted to and approved by the Division.

#### BILLING THE DIVISION – AS APPLICABLE

##### Fee-for-service only:

1. The subrecipient agrees to submit a monthly billing invoice, along with back-up documentation via the Secure File Transfer Protocol (SFTP) site to the Division; the Subgrantee agrees to notify the treatment analyst once the invoice has been posted to the SFTP site.

2. Upon official written notification from the BBHWP, prior authorizations will be required for all residential and transitional housing services being billed to the Division.
3. The subrecipient agrees to include an explanation of benefits for all charges requested for services that have been denied by Medicaid or any other third-party payer due to non-coverage of that benefit.
4. The subrecipient understands that charges greater than 90 days from the date of service will be considered stale dated and may not be paid.
5. The subrecipient understands that quarterly Medicaid audits will be conducted by Division and recouping of funds may occur.
6. The subrecipient understands that they are required to produce an invoice that breaks out the total number of services provided by level of care and CPT or HCPCS code. The invoice must, at a minimum meet the following conditions.
  - a. The invoice must contain, company information (Name, address, City, State and Zip), Date, unique Invoice #, vendor #, PA or HD#.
  - b. The invoice must contain contact name, phone number, e-mail and identify the invoice period.
  - c. The invoice must contain: Billed To: The Division of Public and Behavioral Health, Bureau of Behavioral Health Wellness and Prevention, 4126 Technology Way, Suite 200, Carson City, NV 89706.
  - d. The invoice must show the total number of services by CPT or HCPCS code, the rate being charged, the total amount charged to that CPT or HCPCS code line and summarize the totals by level of care.
  - e. The invoice must also show the total number of services provided, the total number of unique clients served for the invoice and the total amount charged to the invoice.
  - f. The invoice must be signed and dated by the organizations fiscal officer and include the following certification, "By submitting this invoice, we certify that all billing is correct and no Medicaid or other insurance eligible services have been charged to this invoice."

**REQUESTS FOR REIMBURSEMENTS (All non-fee-for-service subawards):**

1. A Request for Reimbursement is due, at a minimum, on a monthly basis, based on the terms of the sub-grant agreement, no later than the 15th of the month. If there has been no fiscal activity in a given month, a Request for Reimbursement claiming zero dollars is required to be submitted for the month.
2. Reimbursement is based on actual expenditures incurred during the period being reported.
3. Requests for advance of payment will not be considered or allowed by the Division.
4. Reimbursement must be submitted with all Division required supporting back up documentation. The Division has the authority to ask for additional supporting documentation at any time and the information must be provided to Division staff within 10 business days of the request.
5. Payment will not be processed without all programmatic reporting being current.
6. Reimbursement may only be claimed for allowable expenditures approved within the sub-grant award.

7. The subrecipient is required to submit a complete financial accounting of all expenditures to the Division within 30 days of the **CLOSE OF THE SUBAWARD PERIOD**. All remaining balances of a federally funded subgrant revert back to the Division 30 days after the close of the subaward period.
8. The Request for Reimbursement to close the State Fiscal Year (SFY) is due at a minimum of 25 days after the close of the SFY, which occurs on June 30. All remaining balances of the State funded subawards revert back to the State after the close of the SFY.
9. The subrecipient must retain copies of approved travel requests and claims, consultant invoices, payroll register indicating title, receipts for goods purchased, and any other relevant source documentation in support of reimbursement requests for a period of three years from the date of submission of the State's final financial expenditure report submitted to the governing federal agency.

The subrecipient agrees that any failure to meet any of the conditions listed within the above Program Requirements may result in the withholding of reimbursement for payment, termination of current contract and/or the disqualification of future funding.

APPENDIX G: ACRONYMS and DEFINITIONS

	<b>Description</b>
<b>AOR</b>	Authorized Organization Representative -An AOR submits a grant on behalf of a company, organization, institution, or government. Only an AOR has the authority to sign and submit grant applications.
<b>Agreement</b>	As used in the context of care coordination, an agreement is an arrangement between the [Organization name] and external entities with which care is coordinated. Such an agreement is evidenced by a contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU) with the other entity, or by a letter of support, letter of agreement, or letter of commitment from the other entity. The agreement describes the parties' mutual expectations and responsibilities related to care coordination.
<b>Applicant</b>	Organization/individual submitting an RFA in response to this RFA.
<b>Application Package</b>	A group of specific forms and documents for a specific funding opportunity which are used to apply for a grant. Mandatory forms are the forms that are required for the application. Please note that a mandatory form must be completed before the system will allow the applicant to submit the application package. Optional forms are the forms that can be used to provide additional support for an application but are not required to complete the application package.
<b>Assumption</b>	An idea or belief that something will happen or occur without proof. An idea or belief taken for granted without proof of occurrence.
<b>Awarded Applicant</b>	The organization/individual that is awarded and has an approved contract with the State of Nevada for the services identified in this RFA.
<b>BBHWP</b>	Bureau of Behavioral Health, Wellness, and Prevention
<b>BOE</b>	State of Nevada Board of Examiners
<b>Behavioral health</b>	Behavioral health is a general term “used to refer to both mental health and substance use” (SAMHSA-HRSA [2015]).
<b>CFDA</b>	Catalog of Federal Domestic Assistance - An online database of all Federal programs available to state and local governments, Federally-recognized tribes, and nonprofits.
<b>Confidential Information</b>	Any information relating to the amount or source of any income, profits, losses or expenditures of a person, including data relating to cost or price submitted in support of a bid, proposal, or RFA. The term does not include the amount of a bid, proposal, or RFA.
<b>Contract Approval Date</b>	The date the State of Nevada Board of Examiners officially approves and accepts all contract language, terms and conditions as negotiated between the State and the successful applicant.
<b>Contract Award Date</b>	The date when applicants are notified that a contract has been successfully negotiated, executed and is awaiting approval of the Board of Examiners.

<b>Contractor</b>	The company or organization that has an approved contract with the State of Nevada for services identified in this RFA. The contractor has full responsibility for coordinating and controlling all aspects of the contract, including support to be provided by any subcontractor(s). The contractor will be the sole point of contact with the State relative to contract performance.
<b>Cooperative Agreement</b>	An award of financial assistance used to enter into the same kind of relationship as a grant and is distinguished from a grant in that it provides for substantial involvement between the Federal agency and the recipient in carrying out the activity contemplated by the award.

<b>Cost Share/Match</b>	The portion of a project or program costs not borne by the Federal government.
<b>Cross Reference</b>	A reference from one document/section to another document/section containing related material.
<b>CSC</b>	Coordinated Specialty Care
<b>Cultural and linguistic competence</b>	Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers (Office of Minority Health [2014]).
<b>Disallowed Costs</b>	Charges to an award that the awarding agency determines to be unallowable, in accordance with the applicable Federal cost principles or other terms and conditions contained in the award.
<b>Discretionary Grant</b>	A grant (or cooperative agreement) for which the Federal awarding agency generally may select the recipient from among all eligible recipients, may decide to make or not make an award based on the programmatic, technical, or scientific content of an application, and can decide the amount of funding to be awarded.
<b>Desirable</b>	The terms “may”, “can”, “should”, “preferably”, or “prefers” identify a desirable or discretionary item or factor.
<b>Division/Agency</b>	The Division/Agency requesting services as identified in this RFA.
<b>DUNS</b>	Dun and Bradstreet Number.
<b>Engagement</b>	Engagement includes a set of activities connecting consumers with needed services. This involves the process of making sure consumers and families are informed about and initiate access with available services and, once services are offered or received, individuals and families make active decisions to continue receipt of the services provided. Activities such as outreach and education can serve the objective of engagement. Conditions such as accessibility, provider responsiveness, availability of culturally and linguistically competent care, and the provision of quality care, also promote consumer engagement.
<b>Equipment</b>	Tangible, nonexpendable personal property, including exempt property, charged directly to the award and having a useful life of more than one (1) year and an acquisition cost of \$5,000 or more per unit. However, consistent with recipient policy, lower limits may be established.
<b>ESMI</b>	Early Serious Mental Illness

<b>Evaluation Committee</b>	Means a body appointed to conduct the evaluation of the applications, typically an independent committee comprised of a majority of State officers or employees established to evaluate and score applications submitted in response to the RFA.
<b>Exception</b>	A formal objection taken to any statement/requirement identified within the RFA.
<b>Family-centered</b>	The Health Resources and Services Administration defines family-centered care, sometimes referred to as “family-focused care,” as “an approach to the planning, delivery, and evaluation of health care whose cornerstone is active participation between families and professionals. Family-centered care recognizes families are the ultimate decision-makers for their children, with children gradually taking on more and more of this decision-making themselves. When care is family-centered, services not only meet the physical, emotional, developmental, and social needs of children, but also support the family’s relationship with the child’s health care providers and recognize the family’s customs and values” (Health Resources and Services Administration [2004]). More recently, this concept was broadened to explicitly recognize family-centered services are both developmentally appropriate and youth guided (American Academy of Child & Adolescent Psychiatry [2009]). Family-centered care is <i>family-driven</i> and <i>youth-driven</i> .

<b>Federal Register</b>	A daily journal of the U.S. Government containing notices, proposed rules, final rules, and presidential documents.
<b>FEP</b>	First Episode Psychosis
<b>GAGAS</b>	Generally Accepted Government Auditing Standards
<b>Grant</b>	An award of financial assistance, the principal purpose of which is to transfer a thing of value from a Federal agency to a recipient to carry out a public purpose of support or stimulation authorized by a law of the United States [see 31 U.S.C. 6101(3)]. A grant is distinguished from a contract, which is used to acquire property or services for the Federal government's direct benefit or use.
<b>Grants.gov</b>	A storefront web portal for use in electronic collection of data (forms and reports) for Federal grant-making agencies through the <a href="http://www.grants.gov">www.grants.gov</a> site.
<b>IFC</b>	Interim Finance Committee.
<b>Key Personnel</b>	Applicant staff responsible for oversight of work during the life of the project and for deliverables.
<b>LCB</b>	Legislative Counsel Bureau.
<b>LOI</b>	Letter of Intent - notification of the State’s intent to award a contract to an applicant, pending successful negotiations; all information remains confidential until the issuance of the formal notice of award.
<b>Limited English Proficiency (LEP)</b>	LEP includes individuals who do not speak English as their primary language or who have a limited ability to read, write, speak, or understand English and who may be eligible to receive language

	assistance with respect to the particular service, benefit, or encounter.
<b>Mandatory</b>	The terms “must”, “shall”, “will”, and “required” identify a mandatory item or factor. Failure to meet a mandatory item or factor will result in the rejection of an application.
<b>May</b>	Indicates something that is recommended but not mandatory. If the applicant fails to provide recommended information, the State may, at its sole option, ask the applicant to provide the information or evaluate the RFA without the information.
<b>Minor Technical Irregularities</b>	Anything in the application that does not affect the price, quality, and quantity or any mandatory requirement.
<b>Must</b>	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of an RFA as non-responsive.
<b>NAC</b>	Nevada Administrative Code –All applicable NAC documentation may be reviewed via the internet at: <a href="http://www.leg.state.nv.us">www.leg.state.nv.us</a> .
<b>NOA</b>	Notice of Award – Formal notification of the State’s decision to award a contract, pending Board of Examiners’ approval of said contract, any non-confidential information becomes available upon written request.
<b>NRS</b>	Nevada Revised Statutes – All applicable NRS documentation may be reviewed via the internet at: <a href="http://www.leg.state.nv.us">www.leg.state.nv.us</a> .
<b>OMB</b>	Office of Management and Budget.
<b>PAMA</b>	Protecting Access to Medicaid Act
<b>Pacific Standard Time (PST)</b>	Unless otherwise stated, all references to time in this RFA and any subsequent contract are understood to be Pacific Time.
<b>Peer Support Services</b>	Peer support services are services designed and delivered by individuals who have experienced a mental or substance use disorder and are in recovery. This also includes services designed and delivered by family members of those in recovery.
<b>Peer Support Specialist</b>	A peer provider (e.g., peer support specialist, recovery coach) is a person who uses their lived experience of recovery from mental or substance use disorders or as a family member of such a person, plus skills learned in formal training, to deliver services in behavioral health settings to promote recovery and resiliency. In states where Peer Support Services are covered through the state Medicaid Plans, the title of “certified peer specialist” often is used. SAMHSA recognizes states use different terminology for these providers.

<b>Person-centered care</b>	Person-centered care is aligned with the requirements of Section 2402(a) of the Patient Protection and Affordable Care Act, as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs (Department of Health & Human Services [June 6, 2014]). That guidance defines “person-centered planning” as a process directed by the person with service needs which identifies recovery goals, objectives and strategies. If the consumer wishes, this process may include a representative whom the person has freely chosen, or who is otherwise authorized to make personal or health decisions for the person. Person-centered planning also includes family members, legal guardians, friends, caregivers, and others whom the person wishes to include. Person-centered planning involves the consumer to the maximum extent possible. Person-centered planning also involves self-direction, which means the consumer has control over selecting and using services and supports, including control over the amount, duration, and scope of services and supports, as well as choice of providers (Department of Health & Human Services [June 6, 2014]).
<b>Practitioner or Provider</b>	Any individual (practitioner) or entity (provider) engaged in the delivery of health care services and who is legally authorized to do so by the state in which the individual or entity delivers the services (42 CFR § 400.203).
<b>Project Costs</b>	All allowable costs, as set forth in the applicable Federal cost principles (see Sec. 74.27), incurred by a recipient and the value of the contributions made by third parties in accomplishing the objectives of the award during the project period.
<b>Project Period</b>	The period established in the award document during which awarding agency sponsorship begins and ends.
<b>Proprietary Information</b>	Any trade secret or confidential business information that is contained in a bid, proposal, or RFA submitted on a particular contract.
<b>Public Record</b>	All books and public records of a governmental entity, the contents of which are not otherwise declared by law to be confidential, must be open to inspection by any person and may be fully copied or an abstract or memorandum may be prepared from those public books and public records.
<b>RFA</b>	Request for Application - a written statement which sets forth the requirements and qualifications of a contract to be awarded by an open and competitive selection. [Does not automatically mean any subaward funds]

<b>Recovery</b>	Recovery is defined as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” The 10 guiding principles of recovery are: hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect. Recovery includes: Health (abstinence, “making informed healthy choices that support physical and emotional wellbeing”); Home (safe, stable housing); Purpose (“meaningful daily activities ... and the independence, income and resources to participate in society”); and Community (“relationships and social networks that provide support, friendship, love, and hope”) (Substance Abuse and Mental Health Services Administration [2012]).
<b>Recovery-oriented care</b>	Recovery-oriented care is oriented toward promoting and sustaining a person's recovery from a behavioral health condition. Care providers identify and build upon each individual’s assets, strengths, and areas of health and competence to support the person in managing their condition while regaining a meaningful, constructive sense of membership in the broader community (Substance Abuse and Mental Health Services Administration [2015]).

<b>Redacted</b>	The process of removing confidential or proprietary information from a document prior to release of information to others.
<b>SAM</b>	State Administrative Manual. This document outlines the management of all Federal grant awards and provides guidance on sub-awards and sub-recipients.
<b>Shall</b>	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of an RFA as non-responsive.
<b>Shared Decision Making (SDM)</b>	SDM is an approach to care through which providers and consumers of health care come together as collaborators in determining the course of care. Key characteristics include having the health care provider, consumer, and sometimes family members and friends taking steps in sharing a treatment decision, sharing information about treatment options, and arriving at consensus regarding preferred treatment options (Schauer, Everett, delVecchio, & Anderson [2007]).
<b>Should</b>	Indicates something that is recommended but not mandatory. If the applicant fails to provide recommended information, the State may, at its sole option, ask the applicant to provide the information or evaluate the RFA without the information.
<b>Standard Form 424</b>	Standard government-wide grant application forms including: SF-424 (Application for Federal Assistance cover page); SF-424A (Budget Information Non-construction Programs); SF-424B (Assurances Non-construction Programs); SF-424C (Budget Information Construction Programs); and SF-424D (Assurances Construction Programs), plus named attachments including Project Narrative and Budget Narrative.
<b>State</b>	The State of Nevada and any agency identified herein.

<b>Subcontractor</b>	A third party, not directly employed by the contractor, who will provide services identified in this RFA. This does not include third parties who provide support or incidental services to the contractor.
<b>Sub-recipient</b>	The legal entity to which a sub-award is made, and which is accountable to the recipient for the use of the funds provided.
<b>Supplant</b>	Federal funds must be used to supplement existing funds for program activities and must not replace those funds that have been appropriated for the same purpose. Supplanting will be the subject of application review, as well as pre-award review, post-award monitoring, and audit. A written certification may be requested by the awarding agency stating that Federal funds will not be used to supplant State or local funds.
<b>Targeted case management</b>	Targeted case management is case management, as defined above, directed at specific groups, which may vary by state. CMS defines targeted case management as case management furnished without regard to requirements of statewide provision of service or comparability that typically apply for Medicaid reimbursement 42 CFR § 440.169(b). Examples of groups that might be targeted for case management are children with serious emotional disturbance, adults with serious mental and/or substance use disorders, pregnant women who meet risk criteria, individuals with HIV, and such other groups as a state might identify as in need of targeted case management. See also the definition of “case management.”
<b>Trade Secret</b>	Information, including, without limitation, a formula, pattern, compilation, program, device, method, technique, product, system, process, design, prototype, procedure, computer programming instruction or code that: derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by the public or any other person who can obtain commercial or economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
<b>Trauma-informed</b>	<b>Trauma-informed:</b> A trauma-informed approach to care “ <i>realizes</i> the widespread impact of trauma and understands potential paths for recovery; <i>recognizes</i> the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and <i>responds</i> by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively <i>resist re-traumatization</i> .” The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (Substance Abuse and Mental Health Services Administration [2014]).
<b>User</b>	Department, Division, Agency or County of the State of Nevada.
<b>Will</b>	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of an RFA as non-responsive.

## EXHIBIT A: REFERENCES

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- Mueser KT & Gingerich S; Contributing Authors, in alphabetical order: Addington J, Brunette MF, Cather C, Gottlieb JD, Lynde DW & Penn DL (April 1, 2014): The NAVIGATE Team Members' Guide: A Part of the NIMH Funded NAVIGATE Program for First Episode Psychosis, Clinician Manual. <http://raiseetp.org/studymanuals/index.cfm>
- Lead Authors: Penn DL, Meyer PS, & Gottlieb JD; Contributing Authors: Cather C, Gingerich S, Mueser KT, & Saade S. (April 1, 2014): Individual Resiliency Training (IRT): A Part of the NAVIGATE Program for First Episode of Psychosis, Clinician Manual. <http://raiseetp.org/studymanuals/index.cfm>
- NAVIGATE Psychopharmacological Treatment Manual. Developed by the NAVIGATE Psychopharmacological Treatment Committee: Robinson DG (Chair); Correll CU, Kurian B, Miller AL, Pipes R, and Schooler NR (Contributors to Scientific Content of Manual and the COMPASS Computer Decision Support System). <http://raiseetp.org/studymanuals/index.cfm>
- Lead Author: Glynn SM; Contributing Authors: Cather C, Gingerich S, Gottlieb JD, Meyer PS, Mueser KT, & Penn DL. (April 1, 2014): NAVIGATE Family Education Program: A Part of the NIMH Funded RAISE Program for First Episode Psychosis, Clinician Manual. <http://raiseetp.org/studymanuals/index.cfm>
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