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| **Request for Applications (RFA)** |
| For |
| State Opioid Response (SOR): Services Expansion |
| **Release Date: April 4, 2019**  **Questions to be Submitted: On or before April 10, 2019, 12:00 p.m. PST**  Must be submitted to: opr@casat.org  with **RFA State Opioid Response: Service Expansion Questions** in the subject line of the email.  **Informational Webinar: April 11, 2019, 10:00 a.m. PST**  <https://zoom.us/s/818776410>  **Letter of Intent due: April 15, 2019, 5:00 p.m. PST** | |
| **Deadline for Application Submission: May 6, 2019 by noon** | |
| *For additional information, please send email correspondence to:*  *OPR@casat.org* | |
| *Funding for this solicitation is made possible through the Nevada State Opioid Response Grant (Grant Number 3 H79 TI081732-01S1) awarded to the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Behavioral Health Prevention and Treatment Program by the Substance Abuse and Mental Health Services Administration (SAMSHA).*  Dear Interested Parties and Potential Subgrantees:  The University of Nevada, Reno’s Center for the Application of Substance Abuse Technologies (CASAT) solicits applications from entities that will expand availability of MAT services and/or provide supportive services in collaboration with SAPTA Certified Behavioral Health Providers, CCBHCs and the IOTRCs (when geographically able) in an effort to provide integrated primary and behavioral health care for adults and adolescents with opioid use disorder. Funding for this solicitation is made possible through the Nevada State Opioid Response Grant (Grant Number 3 H79 TI081732-01S1) funded by Substance Abuse and Mental Health Services Administration (SAMSHA) and awarded to the Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Behavioral Health Prevention and Treatment Program.  As a State Opioid Response (SOR) Grantee, the State of Nevada is required to expand access to overdose prevention, treatment and recovery support services. Nevada expects to meet the goals of the SOR Grant through the following activities:   * Implement system design models that will most rapidly address the gaps in their systems of care to deliver evidence-based treatment interventions, including induction and maintenance of medication assisted treatment services (MAT) medication and psychosocial interventions; * Implement or expand access to clinically appropriate evidence-based practices (EBPs) for Opioid Use Disorder (OUD) treatment, particularly, the use of medication assisted treatment (MAT), i.e., the use of FDA-approved medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine) in combination with psychosocial interventions. (For more relevant resources: https://www.samhsa.gov/medication-assisted-treatment.) * Provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings. * Report progress toward increasing availability of treatment for OUD and reducing opioid-related overdose deaths based on measures developed in collaboration with the Department of Health and Human Services (DHHS); and * Ensure individuals have opportunities for engagement in treatment and recovery supports throughout the continuum of care and increase retention in care. * Enhance or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.   For the period of July 1, 2019 - June 30, 2020 (with execution of the prime award) the goal of this Request for Application (RFA) is to promote MAT Expansion services across the state by increasing Nevada’s service and referral network. Activities and services will build upon the work accomplished during the 2017-2018 funding cycle that established three Integrated Opioid Treatment and Recovery Centers (IOTRC) across the State of Nevada. The Integrated Opioid Treatment and Recovery Center’s (IOTRC) serve as the regional consultants and subject matter experts on opioid use disorder treatment; provide Medication Assisted Treatment (MAT), clinically appropriate evidence-based interventions for the treatment of OUD, and Recovery services for adult and adolescent populations.  Completed applications must be received no later than Wednesday, May 6, 2019 at 12:00 PM (PST). | |

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| Funding Opportunity Title: | State of Nevada Opioid Response Services Expansion |
| Funding Opportunity Number: | NV SOR-02 |
| Due Date for Applications: | May 6, 2019 by noon |
| Anticipated Total Funding Available: | $3,600,000.00 |
| Estimated Number of Award(s): | Varies by category |
| Estimated Award Amount:  Categories 1, 2, 3, 4, 5, 7, & 8  Category 6 | Award ceiling per organization will be $150,000.  Award ceiling per organization will be $10,000  \*University of Nevada, Reno reserves the right to reapply funds to any given category based on the applications received |
| Cost Sharing/Match Required: | None |
| Project Period: | July 1, 2019 – June 30, 2020 |
| Eligible Applicants: | Certified Community Behavioral Health Clinic (CCBHC)  Community-Based Organizations  EMS – First Responder Organizations  Federally Qualified Health Centers (FQHC)  Indian Health Centers  Licensed Medical Facilities  Licensed Medical Providers  Opioid Treatment Providers (OTP)  Peer Recovery Organizations  SAPTA Certified Providers  Specialty Courts, Jails, Prisons, Law Enforcement  Other Organizations meeting the additional eligibility requirements |
| Additional Information on Eligibility: | If providing direct treatment services (e.g. SUD), the applicant organization must have an established service delivery system in place for a minimum of two years.  Program locations must be providing services in at least one of the required geographical areas (counties) with priority given to Rural/Frontier counties: Carson, Churchill, Clark, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, Washoe, or White Pine |

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| **Task** | **Due Date & Time** |
| UNR/CASAT distributes the Request for Application Guidance with all submission forms | April 4, 2019 |
| Q&A Written Questions due to CASAT | April 10, 2019 by 12:00 pm |
| Informational Webinar to address questions | April 11, 2019 (10:00am – 11:00am) |
| **Letter of Intent Due**  **Deadline for submission of applications** | April 15, 2019 by 5:00 pm  May 6, 2019 by noon |
| Technical Review of Applications | May 6-7, 2019 |
| UNR/CASAT will notify organizations that have discrepancies within their application. | May 7, 2019 |
| Evaluation Period: Content review of applications | May 8-15, 2019 |
| Interviews with Applicants | May 16-17, 2019 |
| Funding Decisions Announced – UNR/CASAT will notify organizations via e-mail to the listed Project Director | May 21, 2019 |
| Completion of subgrant awards for selected awardees | on or before June 30, 2019 |
| Grant Award Commencement of Project – Pending approved SAMHSA grant award and receipt of Notice of Award | July 1, 2019 |

# Request for Application (RFA) Timeline

*NOTE: These dates represent a tentative schedule of events. UNR reserves the right to modify these dates at any time, with appropriate notice to prospective applicants.*

# Introduction

In 2018, the State of Nevada Department of Health and Human Services Office of Analytics reported over 6,434 emergency room visits and 9,526 inpatient admissions for opioid related diagnoses. These figures have more than doubled since 2010. The burden of opioid related disorders, opioid use disorders and opioid overdose have increased exponentially over the past 8 years. From 2010-2018, 3,644 individuals have died from opioid related overdoses, with approximately 30% of the deaths also involving benzodiazepines. Opioid use disorder and opioid related overdoses has impacted individuals, families, communities, healthcare systems, and the criminal justice system in Nevada. The goal of this RFA is to continue to expand access and enhance the quality of care for individuals with Opioid Use Disorder and prevent opioid overdoses through increased access to naloxone. For additional data reference the [Nevada Opioid Surveillance site](http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Resources/opioids/NevadaOpioidSurveillance10-17(4-2018).pdf).

Individuals with an opioid use disorder (OUD) must have access to clinically appropriate evidence-based practices (EBPs) for OUD treatment, particularly, the use of medication assisted treatment (MAT), i.e., the use of FDA-approved medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine) in combination with psychosocial interventions. Individuals with OUD must also have access to specialty care for co-occurring medical and psychiatric complications. Left untreated, these complications are associated with significant morbidity and mortality, resulting in increased healthcare costs and threatening public health. Effective care coordination that addresses the complexity and variability of OUDs should be multifaceted and not a “one size fits all” model. Persons with an OUD often have complex treatment needs that require concurrent and coordinated attention to addiction, medical, psychiatric, and social problems. OUD patients do best when they have access to a full range of medication assisted treatment (MAT) options in a variety of settings. They can also benefit from assistance in locating and navigating an array of social and recovery support services (Stoller et al., 2016).

The 2017-2018 funding cycle established three Integrated Opioid Treatment and Recovery Center’s (IOTRC). These centers serve as the regional consultants and subject matter experts on opioid use disorder treatment; and provide Medication Assisted Treatment (MAT) and Recovery services for adult and adolescent populations. IOTRCs will work in collaboration with applicant organizations to continue to foster a network to treat individuals with an OUD within the State of Nevada through concurrent provision of medication assisted treatments, behavioral health therapies, collaborative stepped-care, wrap-around services, and expert consultation. The IOTRC can provide the initial comprehensive SUD/Co-Occurring screening and assessment, and when MAT maintenance is recommended, induct and stabilize the patient through its medication clinic. The IOTRC will also provide at a minimum Level 1 Outpatient counseling services and meet the criteria for co-occurring capable and can refer out to a substance use/co-occurring program that has been certified by the Division through the Substance Abuse Prevention and Treatment Agency (SAPTA) or other applicable Medicaid approved network of behavioral health providers. Once a patient is stabilized, the MAT provision can shift to an FDA Waiver approved prescriber through formal care coordination agreement if, and when the IOTRC and patient determine it is clinically appropriate to step-down care.

This treatment system, organized through the IOTRCs, will be structured to ensure that service-recipients receive the appropriate service for their assessed level of care based on American Society of Addiction Medicine (ASAM) Criteria coupled with wraparound services (e.g. peer recovery support, housing, supportive employment, etc.). The System will feature an adaptive stepped care model that adjusts counseling intensity and medication prescribing and dispensing based on ongoing indicators of treatment response (e.g., toxicology screen results and counseling adherence). If there are indications of clinical destabilization (e.g., positive toxicology screen or decline in counseling adherence), treatment plans should be revised, and counseling interventions should be intensified based on ASAM Criteria. When necessary, if a patient’s needs become too acute or intense for an office-based opioid treatment provider, medication dispensing can be shifted from an office-based MAT provider to the IOTRC site. Conversely, as the patient stabilizes, counseling intensity is decreased and medication prescribing in the office-based setting resumed.

The objective of this RFA is to identify qualified applicants who meet the eligible organization criteria to fulfill the Nevada SOR MAT Service Expansion as outlined below. This RFA does not obligate the University of Nevada, Reno’s CASAT to award a subgrant. The University retains the right to cancel solicitation if it is in its best interest.

# Nevada SOR MAT Services Expansion

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

Using the needs assessment and strategic plan developed through the State Targeted Response to the Opioid Crisis Grant, the following service expansion areas have been identified: *Note: Service expansion for the Nevada SOR project is comprised of services directed to clients with* ***opioid use disorders*** *within the following categories:*

1. Outpatient Clinical Treatment and Recovery Services
2. Medication Assisted Treatment Expansion for SAPTA-Certified Providers
3. Tribal Treatment and Recovery Services
4. Criminal Justice Treatment and Recovery Services
5. Peer Recovery Support Services
6. Community Preparedness Planning for Tribal Communities
7. Mobile Opioid Recovery Outreach Teams
8. Neonatal Abstinence Syndrome (NAS) prevention and wrap around treatment and recovery support services (pre-natal and post-partum up to one year)

Grantees will be required to do the following: use epidemiological data to demonstrate the critical gaps in availability of treatment for OUDs in geographic, demographic, and service level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly and adequately address the gaps in their systems of care; deliver evidence-based treatment interventions that include medication(s) FDA-approved specifically for the treatment of OUD, and psychosocial interventions; report progress toward increasing availability of medication-assisted treatment for OUD and reducing opioid-related overdose deaths.

The program supplements activities pertaining to opioids currently undertaken by the Division of Public and Behavioral Health (DPBH), Substance Abuse Prevention and Treatment Agency (SAPTA) and will support a comprehensive response to the opioid epidemic. The results of the assessments will identify gaps and resources from which to build upon existing substance use overdose prevention activities, treatment activities as well as community-based recovery support services. Grantees will be required to describe how they will expand access to overdose prevention, treatment and recovery support services. Grantees will also be required to describe how they will advance substance misuse prevention in coordination with other efforts occurring throughout the State of Nevada. Grantees must use funding to **supplement and not supplant** existing opioid prevention, treatment, and recovery activities in their service area. Grantees are required to describe how they will improve retention in care, using a chronic care model or other innovative model that has been shown to improve retention in care.

*SOR is authorized under Title II Division H of the Consolidated Appropriations Act, 2018. This announcement addresses Healthy People 2020, Substance Abuse Topic Area HP 2020-SA. All grants and sub-awards made under this announcement are governed by 45 CFR Part 75.*

**Expectations**

Grantees will develop and provide opioid misuse prevention, treatment, and recovery support services for the purposes of addressing the opioid abuse and overdose crisis within Nevada. This service array should be based on needs identified in the State’s State Targeted Response (STR) strategic plan. See State of Nevada STR Strategic Plan here: [www.nevadasor.org](http://www.nevadasor.org).

The use of these funds requires that only evidence-based treatments, practices and interventions for OUD be used by grantees and subgrantees. SAMHSA requires that FDA-approved medication-assisted treatment (MAT) be made available to those diagnosed with OUD. FDA-approved MAT for OUD includes methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, buprenorphine implants, and injectable extended-release naltrexone. Medical withdrawal (detoxification) is not the standard of care for OUD, is associated with a very high relapse rate, and significantly increases an individual’s risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it **must be accompanied by injectable extended-release naltrexone** to protect such individuals from opioid overdose in relapse and improve treatment outcomes. In addition to these treatment services, grantees will be required to employ effective prevention and recovery support services to ensure that individuals are receiving a comprehensive array of services across the spectrum of overdose prevention, treatment, and recovery.

**Required Activities:**

Organizations must use SAMHSA’s SOR grant funds primarily to support evidence-based overdose prevention, treatment, and recovery support activities as described above. This includes the following required activities:

* Implement service delivery models that enable the full spectrum of treatment and recovery support services that facilitate positive treatment outcomes and long-term recovery. Models for evidence-based treatment include, but are not limited to:
  + Hub and spoke models in which patients with OUD are stabilized in a specialized treatment setting focused on the care and treatment of OUD and associated conditions such as mental illness, physical illness, including infectious diseases, and other substance use disorders and then transferred to community-based providers once stabilization has occurred.
  + Other evidence-based models to treat OUD include treatment in federally and state-regulated Opioid Treatment Programs, addiction specialty care programs that either directly provide or support use of MAT for OUD in addition to psychosocial services such as drug counseling, psychoeducation, toxicology screening, individual, group, or family therapy, vocational/educational resources, and recovery support services.
  + Specialty programs such as emergency departments, urgent care centers, in some cases, pharmacies, and intensive outpatient, partial hospital, or outpatient substance use disorder treatment programs that also support appropriate MAT and recovery support services may also qualify as programs utilizing evidence-based practices.
  + Inpatient/residential programs that provide intensive services to those meeting medical necessity criteria and which offer MAT may also be programs engaging in evidence-based practices if the care continuum includes a connection to MAT in the community once discharged from the inpatient/residential program.
  + Primary care or other clinical practice settings where MAT is provided and linkages to psychosocial services and recovery services in support of patient needs related to the provision of comprehensive treatment of OUD may also qualify as evidence-based programs/practices.

More detailed information on treatment models may be found at [AHRQ](https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioid-use-disorder_technical-brief.pdf).

* Implement community recovery support services such as peer supports, recovery coaches, and recovery housing. Grantees must ensure that recovery housing supported under this grant is in an appropriate and legitimate facility. Individuals in recovery should have a meaningful role in developing the service array used in the program.
* Implement prevention and education services including training of healthcare professionals on the assessment and treatment of OUD, training of peers and first responders on recognition of opioid overdose and appropriate use of the opioid overdose antidote naloxone, develop evidence-based community prevention efforts including evidence-based strategic messaging on the consequence of opioid misuse, and distribute naloxone and train on its use.
* Overdose education and naloxone distribution (naloxone will be provided by the project through the State of Nevada Virtual Dispensary, do not include this in your budget)
* Ensure that all applicable practitioners (physicians, NPs, PAs) associated with your program obtain a DATA waiver.
* Provide assistance to patients with treatment costs and develop other strategies to eliminate or reduce treatment costs for uninsured or underinsured patients.
* Provide treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings.

**Allowable Activities:**

* Address barriers to receiving MAT by reducing the cost of treatment, developing innovative systems of care to expand access to treatment, engage and retain patients in treatment, address discrimination associated with accessing treatment, including discrimination that limits access to MAT, and support long-term recovery.
* Support innovative telehealth strategies in rural and underserved areas to increase the capacity of communities to support OUD prevention, treatment and recovery.
* Develop and implement tobacco cessation programs, activities and/or strategies.
* Provision of HIV/AIDS care and treatment services, including Hepatitis screening, testing and vaccination for people living with HIV. HIV prevention is a priority service and populations for this intervention should include individuals who inject drugs. Activities funded under this RFA must be coordinated with Ryan White funded programs. For a list of funded programs please reference the Nevada [Resource Guide](http://endhivnevada.org/wp-content/uploads/2019/03/Resource-Guide_2019-Final.pdf)

**Other Requirements**

* Recipients must utilize third party and other revenue realized from the provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are not covered by public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual’s health insurance plan. Recipients are also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients. Recipients should also consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Health Administration or senior services), if appropriate for and desired by that individual to meet his/her needs. In addition, recipients are required to implement policies and procedures that ensure other sources of funding are utilized first when available for that individual.
* SAMHSA encourages all recipients to address the behavioral health needs of returning service members and veterans and their families in designing and developing their programs and to consider prioritizing this population for services, where appropriate. SAMHSA will encourage its recipients to utilize and provide technical assistance for service members, veterans and their families. This includes efforts to engage staff in cultural competency training courses and to collaborate with key organizations in local communities that are focused on serving this population.

**Using Evidence-Based Practices**

SAMHSA’s services grants are intended to fund services or practices that have a demonstrated evidence base and that are appropriate for the population(s) of focus. An evidence-based practice (EBP) refers to approaches to prevention, treatment, or recovery that are validated by some form of documented research evidence. Both researchers and practitioners recognize that EBPs are essential to improving the effectiveness of services in the behavioral health field. While SAMHSA realizes that EBPs have not been developed for all populations and/or service settings, application reviewers will closely examine proposed interventions for their evidence base and appropriateness for the population to be served. If an EBP(s) exists for the types of problems or disorders being addressed, the expectation is that EBP(s) will be utilized and that grantees are competent in implementing them.

In your Project Narrative you must include:

* PDMP and epidemiological data. State specific information can be found at [the Office of Analytics](http://dhhs.nv.gov/Programs/Office_of_Analytics/OFFICE_OF_ANALYTICS_-_DATA___REPORTS/)
* Identify the EBPs you propose to implement for the specific population(s) of focus. If an EBP does not exist/apply for your program/population(s) of focus, describe the service/practice you plan to implement as an appropriate alternative.
* If you are proposing to use more than one EBP, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support.
* Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus. Indicate whether/how the practice(s) will be adapted for a specific population. SAMHSA encourages you to consult with an expert to complete any modifications to the chosen EBP. This is especially important when adapting EBPs for specific underserved populations for whom there are fewer EBPs.

All grantees are required to use evidence-based MAT with patients diagnosed with OUD. Grantees will also utilize other EBPs in conjunction with the required EBP for this RFA. Applicants are encouraged to visit the [SAMHSA Evidence-Based Resource Center](http://www.samhsa.gov/ebp-resource-center) and the National Institute of Health, [National Institute on Drug Abuse website](https://www.drugabuse.gov/) for more information on EBPs.

* In selecting an EBP, be mindful of how your choice of an EBP or practice may impact disparities in service access, use, and outcomes for your population(s) of focus. While this is important in providing services to all populations, it is especially critical for those working with underserved and minority populations.

**Data Collection and Performance Measurement**

All SAMHSA recipients and subsequent sub-awardees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. You must document your plan for data collection and reporting using the Data Collection and Performance Measurement tools.

Grantees will be required to report a series of data elements that will enable both the State of Nevada and SAMHSA to determine the impact of the program on opioid use, and opioid-related morbidity and mortality. Grantees will be required to report client-level data on elements including but not limited to diagnosis, demographic characteristics, substance use, services received, types of MAT received; length of stay in treatment; employment status, criminal justice involvement, and housing. Additional data elements will also be required and will be provided upon award.

Examples of the type of data collection tools required can be found at [here](https://www.google.com/url?q=https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services&sa=D&source=hangouts&ust=1554337293751000&usg=AFQjCNFc4T7goiCQbbgV9Ku5e0v4LysPZA). Data will be collected via a face-to-face interview using this tool at four data collection points: intake to services, three months post intake, six months post intake, and at discharge. Recipients will be expected to do a GPRA interview on all clients in their specified unduplicated target number and are also expected to achieve a three-month follow-up rate of 80 percent and a six-month follow-up rate of 80 percent. GPRA training and technical assistance will be offered to recipients.

The collection of these data enables SAMHSA to report on key outcome measures relating to the grant program. Performance data will be reported to the public via SAMHSA’s Congressional Justification posted on the SAMHSA website.

Subawardees will be required to submit monthly progress reports.

# Focus Areas for Funding

Applicant organizations may apply for one or more than one category within the application. Each category must be specified, and applicants must provide separate narratives and budgets for each category applied for.

**Note: All organizations providing opioid use disorder treatment will need to complete the SOR Client-Level Data Collection Tool at baseline, three-month follow-up, six-month follow-up, and discharge for all clients served with funding and report data in SAMHSA’s Performance and Accountability Reporting System (SPARS). The Tool is estimated to take 45 minutes to complete. To see the types of questions included in the tool, visit https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services.**

## Category 1: Outpatient Clinical Treatment and Recovery Services

The purpose of this programing is to expand/enhance access to medication-assisted treatment (MAT) services for persons with an opioid use disorder (OUD) seeking or receiving MAT within a Patient-Centered Opioid Addiction Treatment Model (P-COAT). For additional information regarding the P-COAT model visit [here](https://www.asam.org/docs/default-source/advocacy/asam-ama-p-coat-final.pdf?sfvrsn=447041c2_2).

The Patient-Centered Opioid Addiction Treatment Model is designed to:

* to provide appropriate financial support to enable physicians and other clinicians to provide successful MAT services for individuals with opioid use disorders;
* to encourage more primary care practices to provide MAT;
* to encourage coordinated delivery of three types of services needed for effective outpatient care of patients with opioid addiction – medication therapy, psychological and counseling therapies, and social services support;
* to reduce or eliminate spending on outpatient treatments that are ineffective or unnecessarily expensive;
* to reduce use of inpatient/residential addiction treatment for patients who could be treated successfully through office-based or outpatient treatment;
* to improve access to evidence-based outpatient care for patients being discharged from more intensive levels of care;
* to reduce spending on potentially avoidable emergency department visits and hospitalizations related to opioid addiction;
* to increase the proportion of individuals with an opioid addiction who are successfully treated; and
* to reduce deaths caused by opioid overdose and complications of opioid use.

Services can be delivered through the following means[[1]](#footnote-1):

Option A: Medical Management by a Data 2000 Practitioner

Under Option A, the Opioid Addiction Team would consist of:

* A physician, or other qualified healthcare professional with a waiver to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000. This practitioner could bill for Initiation of Medication-Assisted Treatment / Maintenance of Medication-Assisted Treatment (IMAT/MMAT) payments to support medication-assisted treatment (using buprenorphine or naltrexone) and care management services for the patient.
* A physician who specializes in addiction medicine who would be available for consultative support, including telephonic/electronic support to the waivered practitioner via telephonic or electronic communication links. This Addiction Specialist could bill for payments to support consultations with the DATA 2000 practitioner. An Addiction Specialist would need to be board certified in addiction medicine by the American Board of Addiction Medicine (ABAM), the American Board of Preventive Medicine (ABPM), American Osteopathic Association (AOA), or ASAM or be board certified in addiction psychiatry by the American Board of Psychiatry and Neurology.
* One or more physicians, psychologists, counselors, nurses, social workers, or other qualified healthcare professionals, who are licensed and certified to provide appropriate psychiatric, psychological, or counseling services to individuals with an opioid use disorder, and who have contracts or collaboration agreements with the practitioner prescribing buprenorphine or naltrexone to deliver services to patients in a coordinated way. Under Option A, these providers would be paid using existing billing codes or other payment methods that support their services.
* One or more nurses, social workers, pharmacists, or other healthcare or social services professionals, who have the training and skills necessary to help individuals with an opioid use disorder to address non-medical needs, and who have a contract or collaboration agreement with the practitioner prescribing buprenorphine or naltrexone to deliver services to patients in a coordinated way. Under Option A, these providers would be paid using existing billing codes or other payment methods that support their services.

Option B: Medical Management by an Addiction Specialist

Under Option B, the Opioid Addiction Team would consist of:

* A physician who specializes in addiction medicine. This Addiction Specialist could bill for IMAT/MMAT payments to support medication-assisted treatment and care management services for the patient. An Addiction Specialist would need to be board certified in addiction medicine by the American Board of Addiction Medicine (ABAM), the American Board of Preventive Medicine (ABPM), American Osteopathic Association (AOA), or ASAM or be board certified in addiction psychiatry by the American Board of Psychiatry and Neurology.
* One or more physicians, psychologists, counselors, nurses, social workers, or other qualified healthcare professionals, who are licensed and certified to provide appropriate psychiatric, psychological, or counseling services to individuals with an opioid use disorder, and who have contracts or collaboration agreements with the Addiction Specialist to deliver services to patients in a coordinated way. Under Option B, these providers would be paid using existing billing codes or other payment methods.
* One or more nurses, social workers, pharmacists, or other healthcare or social services professionals, who have the training and skills necessary to help individuals with an opioid use disorder to address non-medical needs, and who have contracts or collaboration agreements with the Addiction Specialist to deliver services to patients in a coordinated way. Under Option B, these providers would be paid using existing billing codes or other payment methods that support their services.

Option C: Comprehensive Services from an Opioid Addiction Team Under

Under Option C, a single organization would serve as the Opioid Addiction Team, and it would employ or contract with the necessary personnel to prescribe medications, deliver psychiatric, psychological, or counseling services, address non-medical needs, and provide care management services for individuals with an opioid use disorder.

Applicant organizations are encouraged work to provide treatment for individuals with an OUD through concurrent provision of medication assisted treatments, behavioral health therapies, collaborative stepped-care, wrap-around services, and expert consultation. SOR will award funds to SAPTA Certified Organizations[[2]](#footnote-2), Federally Qualified Health Centers (FQHC), Opioid Treatment Programs, or practitioners who have a waiver to prescribe buprenorphine in an effort to expand access to Food and Drug Administration (FDA)-approved drugs or devices for emergency treatment of known or suspected opioid overdose. The recipients must partner with the Integrated Opioid Treatment and Recovery Centers (as geographically able) in addition to other prescribers at the community level and SAPTA Certified Community-Based Organizations to implement best practices for prescribing and co-prescribing FDA-approved overdose reversal drugs.

## Category 2: Medication Assisted Treatment Expansion for SAPTA-Certified Providers\*\*

The purpose of this programing is to expand/enhance access to medication-assisted treatment (MAT) services for persons with an opioid use disorder (OUD) seeking or receiving ASAM/Division Criteria Levels of Service; *Technical assistance and/or mentoring will be offered to awarded sub recipients to assist with the onboarding of MAT services.*

Medication Assisted Treatment Expansion for SAPTA-Certified Provideris designed to:

* Provide appropriate financial support to enable physicians and other clinicians to provide successful MAT services for individuals with opioid use disorders within ASAM/Division Criteria Levels of Service;
* Encourage more of these settings to provide MAT;
* Encourage coordinated delivery of three types of services needed for effective care of patients with opioid addiction – medication therapy, psychological and counseling therapies, and social services support;
* Reduce or eliminate spending on services that are ineffective or unnecessarily expensive;
* Reduce use risk for patients who could be treated successfully through MAT;
* Improve access to evidence-based care for patients being discharged from more intensive levels of care;
* Reduce spending on potentially avoidable emergency department visits and hospitalizations related to opioid addiction;
* Increase the proportion of individuals with an opioid addiction who are successfully treated; and
* Reduce deaths caused by opioid overdose and complications of opioid use.

\*\*Provider organizations applying under this category must already have services in place for the appropriate level of care under SAPTA certification and actively bill third party payers, including Medicaid, where applicable. Programs must also be at a minimum co-occurring capable.

All programs must use ASAM criteria/Division criteria and NAC458 to design and develop their programming under this announcement to include the required staffing, support systems, therapies, assessment and treatment plan review, documentation, and follow ASAM admission, continued service, transfer, and discharge criteria. More information regarding ASAM criteria/division criteria and NAC458 can be found at:

* [ASAM Criteria](https://www.asam.org/resources/the-asam-criteria)
* [Division Criteria](http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/dta/Partners/Certification/Division%20Criteria-SAPTA%2012.2017_FINAL.pdf)
* [NAC458](https://www.leg.state.nv.us/NAC/NAC-458.html)

Programs currently certified to provide Level 3.2WM Clinically Managed Residential Withdrawal Management may apply for this funding to enhance services in order to meet criteria for Level 3.7WM Medically Monitored Inpatient Withdrawal Management, at a minimum. It is expected that providers enhancing services at all levels through this funding announcement will successfully meet all requirements for SAPTA certification and licensing through Health Care Quality and Compliance, when applicable, by the completion of the sub-award.

## Category 3: Tribal Treatment and Recovery Services

Services targeting tribal populations utilizing culturally appropriate treatment services to address the needs of the community including prevention, treatment and recovery. Services will be focusing on improving MAT access for tribal communities, both urban and rural. Applicants should ensure the following services are addressed:

* Increase MAT access utilizing FDA approved medication for OUD treatment
* Toxicology screening
* Wrap-around services including peer recovery supports
* Behavioral Health Screening/Assessment
* ASAM Level 1 Outpatient (substance use and mental health) counseling
* Organization prescriber of record checks Prescription Drug Monitoring Program (PDMP) for new patient admission under prescriber care for MAT services
* Establish and implement a plan to mitigate the risk of diversion of methadone or buprenorphine and ensure the appropriate use/dose of medication by patients
* Culturally relevant prevention activities targeting OUD and overdose including naloxone distribution
* Ensure all applicable practitioners working on the grant-funded project obtain a DATA waiver
* Use telehealth services, or other innovative interventions, to reach, engage and retain clients in treatment
* Care Coordination with an IOTRC or CCBHC, when appropriate and available in the service area

Programs that are unable to provide one or more services may develop them through formal coordinated care agreements with organizations in the community.

All programs must use [ASAM criteria](https://www.asam.org/resources/the-asam-criteria)/[Division criteria](http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/dta/Partners/Certification/Division%20Criteria-SAPTA%2012.2017_FINAL.pdf) to design and develop their programming under this announcement to include the required staffing, support systems, EBP therapies, assessment and treatment plan review, documentation, and follow ASAM admission, continued service, transfer, and discharge criteria. See previous category for links regarding more information.

## Category 4: Criminal Justice Treatment and Recovery Services

Eligible entities can be linked to programming along the Sequential Intercept Model addressing individuals with OUD. Recipients can refer to the [Sequential Intercept Model](https://www.prainc.com/sim/) for more detailed information about the model. The Intercept points of the model include:

1. Intercept 1: Law Enforcement
2. Intercept 2: Initial Detention/Initial Court Hearings
3. Intercept 3: Jails/Courts
4. Intercept 4: Reentry
5. Intercept 5: Community Corrections

These programs are intended for the development of services targeted towards individuals in contact with the criminal justice system who meet criteria for an OUD. Programs will develop interventions within the field, prison mental/behavioral health, and re-entry.

## Category 5: Peer Recovery Support Services

All Recovery Support Services funded under this announcement must provide services in accordance with principles that support stage of change, harm reduction, patient engagement, and the use of Medication Assisted Recovery Services (MARS). MARS is a specialized peer program targeting individuals who are participating in medication-assisted recovery services. MARS peers facilitate MAT recovery group meetings, greet and engage MAT participants, and spend one on one time with those struggling with an OUD. MARS provides peer support and information about medication, addiction, and recovery. More information about the MARS project may be found at <http://marsproject.org/>.

Recovery Support Services are intended to complement, supplement, and extend formal behavioral health services throughout the continuum of care. When working in conjunction with other behavioral and primary health services, peer support has been found to promote sustained behavior change for people at risk. These programs do not replace the role of formal treatment.

Note: Organizations that are Medicaid eligible (e.g. qualify for provider type 14, 17, 82) providing peer recovery support services under this award must be capable to provide services as outlined within Medicaid Chapter 400.

## Category 6: Community Preparedness Planning for Tribal Communities

The goal of implementing community preparedness planning measures is to reduce injury or death related to overdose by facilitating the development and implementation of coordinated response strategies using existing resources. Public Health/Emergency Awareness in response to the opioid crisis is designed to occur in communities to address local needs regarding substance use misuse and abuse trends, community access to resources, and facilitate interaction between programs including but not limited to Opioid Use Disorder (OUD) treatment centers, health care centers, community centers, social service programs, and law enforcement.

A template has been made available and can be accessed at [NevadaSOR](https://www.google.com/url?q=https://www.nevadasor.org/community-preparedness-plan-template/&sa=D&source=hangouts&ust=1554330588960000&usg=AFQjCNFbT7WbDVnXbUebzt6584iG0l07dQ.).

## Category 7: Mobile Opioid Recovery Outreach Teams

The vision of the mobile outreach teams is to connect with every opioid related incident or overdose patient in Nevada’s emergency departments and provide a linkage to care utilizing an innovative hub and spoke model as designed by the Nevada State Targeted Response to the opioid epidemic. As well as, to develop a model of mobile recovery that easily fits into preexisting emergency department policies and procedures while providing a resource that was previously not easily accessible. Teams must be accessible 24 hours a day year-round and be capable of responding to an emergency department within 2 hours after receiving a request from medical personnel.

Mobile recovery will expand recovery support services for individuals with an opioid use disorder, who are receiving services through OTPs, OBOTs, FQHCs, CCBHCs, Behavioral Health Clinics or Hospitals for MAT. The mobile recovery team includes a licensed or certified alcohol and drug counselor and peer recovery support specialists who are properly trained to provide evidence-based peer recovery services and have two or more years living in long-term recovery without relapse. There is a substantial body of research confirming the role of recovery-specific peer support for all populations, including William White’s paper on Peer Based Addiction Recovery Support. Peer Recovery Support Specialists can enhance long-term recovery outcomes, including increased physical, emotional, and relational health and functioning, as well as reduced mortality rates. The mobile recovery team will provide all interested emergency departments within their service area educational materials, contact information, and naloxone kits. Further, teams will coordinate support linkages with other agencies to assist with housing, life skills, employment, and legal issues for the goal of sustained recovery, as well as links to social and recreational activities to encourage a sober, healthy lifestyle. Additionally, the mobile recovery team will provide linkages to support the many pathways to recovery, including SMART Recovery, Life RING, twelve-step support groups, etc.

Recognizing there are various entities that can house mobile teams the following has been provided to help establish what is needed:

*Mobile Opioid Recovery Outreach Team within a Hospital System:*

Hospital staff:

* Screen patients to determine type of substance use disorder
* Ask patients if they would like to be referred to the team within the hospital system
* Refer patients to the recovery mobile outreach team if patients give permission
* Offer naloxone kit to patient or family members if patient declines meeting the mobile treatment team

The Mobile Treatment Provider:

* Meets with patients at their bedside or within a clinic
* Screens and assesses patients to determine type of treatment needed
* Discusses treatment options with patients and completes referral to treatment
* Coordinates with treatment agency as applicable
* Connects patients to community resources
* Educates hospital staff on substance use disorders and the recovery process
* Provides Overdose education and naloxone distribution when appropriate

The Peer Recovery Support Specialist (PRSS):

* Has lived experience of substance use disorder and the recovery process either personally or through family members
* Can meet first with patients on request
* Educates patients' families on the recovery process
* Connects patients to natural community supports
* Attends support group meetings with recoverees, as needed

*Community-Based Organization leading a Mobile Opioid Recovery Outreach Team*

Organization Staff:

* Screen patients to determine type of substance use disorder
* Ask patients if they would like to be referred to the mobile team program
* Refer patients to the recovery mobile outreach team if patients give permission
* Offer naloxone kit to patient or family members if patient declines meeting the mobile treatment team

The Mobile Treatment Provider:

* Meets with patients
* Screens and assesses patients to determine type of treatment needed
* Discusses treatment options with patients and completes referral to treatment
* Coordinates with treatment agency to determine pickup time or arrival for patients
* Connects patients to community resources
* Educates hospital staff on substance use disorders and the recovery process

The Peer Recovery Support Specialist (PRSS):

* Has lived experience of substance use disorder and the recovery process either personally or through family members
* Can meet first with patients on request
* Educates patients' families on the recovery process
* Connects patients to natural community supports
* Attends support group meetings with recoverees, as needed

The organization and mobile team must have relationship with an ER/ED if no existing program exists for that population. The organization must coordinate services with a community-based Medication Assisted Treatment provider, including but not limited to Integrated Opioid Treatment and Recovery Centers.

## Category 8: Neonatal Abstinence Syndrome (NAS) prevention and wrap around treatment and recovery support services (pre-natal and post-partum up to one year)

Home visitation services for NAS prevention and recovery support services provide support consistent, caring relationships, parenting guidance, and connections to the services that many pregnant women and families with newborns need. They also may help educate women about the effects of substance use during pregnancy, support pregnant women, mothers, and other members of the household with OUD in entering MAT programs, and support mothers in caring for babies who may be experiencing NAS. Applicants should ensure the following services are addressed, at a minimum:

* Share information about the program with professional associations, healthcare providers, substance use treatment providers, etc.
* Partner with agencies that encounter at-risk families, pregnant and post-partum women, and infants born with NAS
* Provide training to home visit workers including, but not limited to: Substance Use Disorders (SUDs), risks of use during pregnancy, NAS, pre-natal and maternal health, positive parenting, child abuse prevention (including mandated reporting requirements), local resources, SUD and Co-Occurring Disorder (COD) treatment options, Screening, Brief Intervention, and Referral to Treatment (SBRIT), safety measures for home visits, ethics, confidentiality, professional boundaries, and non-stigmatizing language
* Provide screenings in homes, hospitals, clinics, physician’s offices, and or community organizations to identify needs of mothers and child(ren) and when applicable refer to a nurse/social worker/counselor/maternal-infant educator for further assessment and support
* Provide services to the women based on identified needs of mother/baby
* Provide the families with information and educational materials on SUDs, risk of use during pregnancy, NAS, pre-natal and material health, positive parenting, child abuse prevention, local resources, SUD and COD treatment options
* Provide naloxone kit and train mother and family, if applicable
* Continue to check in with families to offer further support or referrals

# Program Funding

This is a competitive process and as such, sub recipient(s) who receive awards through this RFA are not guaranteed future funding. All costs incurred in responding to this RFA will be borne by the applicant(s). In the event no qualified applicants are identified through this RFA, in partnership with the Division of Public and Behavioral Health, CASAT reserves the right to perform alternate measures to identify potential applicants.

The Applicant, its employees and agents, must comply with all Federal, State and local statutes, regulations, codes, ordinances, certifications and/or licensures applicable to an eligible organization.

Program funds may support staff salaries, training opportunities, technical assistance, and MAT expansion within outpatient and residential/transitional housing services. The Division of Public and Behavioral Health in partnership with the University of Nevada, Reno CASAT will make the final determination of an applicant’s abilities and intent to comply with the required program expectations. Funds are intended to establish infrastructure, support program implementation, and promote sustainability. See Appendix D for additional instructions.

***Please note that funds requested cannot be used to supplant existing positions. The expectation is that staff supported by these funds cannot bill 3rd party payers for services rendered by grant funded positions. By no later than the end of the grant cycle (June 30, 2020), all grant funded positions must be converted to 3rd party billing options (e.g. Medicaid, SAPTA).***

### Allowable Activities

* *Salary Support* 
  + Allowable funds for the onboarding of new staff positions:
    - Nevada Licensed Healthcare Professionals
    - Nevada Licensed Medical Provider
    - Nevada Licensed / Certified Behavioral Health Professionals
    - Nevada Licensed EMT I or EMT II
    - Peer Recovery Support Specialists
* *Training and Technical Assistance (No more than 10% of your budgeted costs)*
  + Allowable funds for:
    - Training and technical assistance to increase provider competencies specifically related to the treatment and recovery support of individuals with OUD.
    - Travel required to obtain requested training.
* *Residential/Transitional Housing MAT Expansion Services*

This category does NOT include room and board rates of reimbursement as this is ONLY for the expansion and onboarding of MAT services within an established SAPTA Certified Residential or Transitional Housing program. Programs must demonstrate all applicable licenses through Health Care Quality and Compliance for the level of care provided. ***All ASAM residential/transitional housing services that can be reimbursable under Medicaid or 3rd party payers (e.g. SAPTA block grant, private insurance, etc.) must be billed to those payers. To promote sustainability of services designed under this RFA, a sustainability plan for uninterrupted continuation of services must be included in this submission and be in place no later than the end of the grant cycle (June 30, 2020).***

* + Allowable funds for:
    - Level 3.7WM Medically Monitored Inpatient Withdrawal Management services based on ASAM Criteria and Division Criteria.
    - Level 3.1 or Level 3.5 Residential treatment services for MAT clients based on ASAM Criteria and Division Criteria.
    - Transitional Housing services for MAT clients based on Division Criteria.

### Non-Allowable Activities

Non-allowable budget items:

* Supplanting of funding for existing positions.
* Individual provider purchase of naloxone.
* Individual provider purchase of MAT (i.e. Buprenorphine, Suboxone, Methadone, Naltrexone, Vivitrol).
* The purchasing of property, the construction of new structures, and the addition of a permanent structure, capital improvements of existing properties or structures.
* The purchasing of vehicles or lease of a vehicle.
* Bus passes / transportation.
* Participant or staff incentives.

# Technical Requirements

**Registration of your business with the Nevada System of Higher Education (NSHE) Supplier Registration System**

You **must** register your business with the Nevada System of Higher Education (NSHE) Supplier Registration system. It is strongly encouraged that you register as part of this application process.

Registering is a two-step process. You will first need to go to the NSHE Supplier Registration website at <https://suppliers.nevada.edu/> and create an account. After you have created an account, you will receive an email with a verification link. Click the verification link and follow the steps to finish registration. More detailed instructions for each step are available at the following links.

Step 1:

<https://suppliers.nevada.edu/Files/NSHE%20Supplier%20Registration_Step%201_Create%20an%20Account.pdf>.

Step 2:

<https://suppliers.nevada.edu/Files/NSHE%20Supplier%20Registration_Step%202_Complete%20Registration.pdf>.

**Fiscal and Audit Forms**

In addition to registering as a vendor with the University of Nevada, Reno you will need to complete and Audit Assessment Questionnaire. This form can be found in Appendix G.

# Division Certification Process through SAPTA

**Certification is required to receive funding from the Division of Public and Behavioral Health, hereafter referred to as the Division. (**NRS 439.200**,**458.025**)** A program must be certified by the Division through SAPTA to be eligible for any state or federal money for alcohol and drug abuse programs administered by the Division pursuant to chapter 458 of NRS for the prevention or treatment of substance-related disorders. For currently non-certified applicants refer to the Certification Process below.

* + Organizations must be enrolled as a Medicaid Provider, and actively billing Medicaid for approved services within 30 days of application submission.
  + **Excluded Parties –** DPBH requires that no sub-recipients of federal funding are to be found on the Lists of Parties Excluded from Federal Procurement or Non-procurement Programs accessible at https://www.sam.gov.

(Added to NAC by Bd. of Health by R120-04, eff. 10-5-2004)

The following steps describe the process to submit a Certification Application along with the funding application:

1. Contact Raul Martinez from SAPTA via email at rmartinez@health.nv.gov to obtain the Division Certification Application and checklist.
2. In addition to the application checklist materials requirements, please include the following items with your Certification Application Packet and submit per the instructions on the Certification Application.
   1. A copy of the manual containing the policies and procedures of the program per NAC 458/ Division Criteria https://www.leg.state.nv.us/NAC/NAC-458.html;
   2. Health Care Quality & Compliance (HCQC) license if applicable, this would include a Narcotic Treatment Program in which Methadone maintenance is provided, if applicable.
   3. Copies of FDA Waiver for Physicians, Physician Assistants and Nurse Practitioners approved to prescribe medications for OUD treatment.

# Medicaid Enrollment Requirements and Division Funding Eligible Requirements

1. Organizations must be enrolled in both Fee for Service (FFS) Medicaid and with each Managed Care Organization to the extent they have open networks in order to maximize all Medicaid billing opportunities. Additionally, the applicant organization must be actively billing Medicaid for services at time of application submission.
2. Organizations must be a Division Certified Provider through SAPTA or obtain a Certification application packet from SAPTA at the time of application submission. For currently non-certified applicants refer to the Certification Process above.

# Submission of Proposals

Applications must be completed on the forms included in the application packet provided by CASAT. The application packet must be emailed to CASAT in original files (Word, Excel) and must be received **on or before the deadline of May 6, 2019, by 12:00 p.m**.

Must be submitted to: opr@casat.org   
with **RFA State Opioid Response: Service Expansion** in the subject line of the email.

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

The Question and Answer (Q&A) period will be provided from April 4 – April 10, 2019. Questions must be submitted to: opr@casat.org by 12:00 pm on April 10, 2019. Responses will be provided via informational webinar on April 11, 2019 from 10:00am. to 11:00am [<https://zoom.us/s/818776410>]. In addition, a follow-up Frequently Asked Questions (FAQ) document will be provided capturing all questions asked and will be distributed on the [www.nevadasor.org](http://www.nevadasor.org) website.

Submissions should be in Times New Roman font using only 11-point with 1-inch margins. Submissions must abide by the maximum page limitations and exceeding identified limits may be cause for disqualification for review. Any documents or questions that are not applicable, identify the question and reflect NA.

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

### ***Required Format****:* Each proposal submitted **must** contain the following sections:

|  |  |  |
| --- | --- | --- |
| **Technical RFA Submission Requirements**  **Document should be tabbed with the following section** | | **Completed** |
| Submission will be completed electronically through [opr@casat.org](mailto:opr@casat.org) | |  |
| Tab I | Submission Checklist & Cover Page with all requested information |  |
| Tab II | Agency Profile and contact information with all requested information (Appendix B) |  |
| Tab III | Narrative to Consist of the following: (Appendix C)   * Organizational Strength and Description * Collaborative Partnerships * Service Delivery * Cost Effectiveness and Leveraging of Funds * Sustainability |  |
| Tab IV | Scope of Work with all requested information (Appendix D) |  |
| Tab V | Budget and Budget Justification with all requested information (Appendix E) |  |
| Tab VI | Fiscal & Audit to Consist of the following: (Appendix G)   * Audit Assessment Questionnaire |  |
| Tab VII | Attachments   * Assurances * Signed Conflict of Interest Policy Acknowledgement * Proposed Staff Resume(s) * Formal Care Coordination Agreements / MOUs currently in place * 501 (c) 3 tax exempt where applicable * Latest Audit Letter |  |
| Tab VIII | National, State, HCQC and Division Certification through SAPTA Documents, if applicable |  |
| **Email completed application in native (not PDF) Microsoft Word or Excel format to: opr@casat.org** | |  |

# Application Evaluation Criteria

Applicants must provide evidence of their capacity to successfully execute all proposed strategies and activities to meet the objectives outlined in this RFA. Applications will be scored using the following criteria:

**1. ORGANIZATION STRENGTH AND DESCRIPTION (Up to 25 Points)**

Elements to be evaluated: (1) Service area applying for and P-COAT Option, if applicable (2) Agency history, client population and levels of service, and experience in the community to include knowledge of local needs; (3) Project alignment with agency mission and goals; (4) Geographic Service Area; (5) Qualifications and tenure of staff providing proposed services; (6) The structure of the agency including Board of Directors (if applicable), hours of operation, and number of locations (7) Location(s) where service that you are applying for will be provided.

**2. COLLABORATIVE PARTNERSHIPS (Up to 15 Points)**

Elements to be evaluated: (1) Collaboration with external community resources; (2) Roles of collaborating partners including sub-awardees (if any); (3) Plan to monitor sub-awardees to ensure adherence to award agreements and terms; and (4) Formalized care coordination agreements that are in place.

**3. SERVICE DELIVERY (Up to 25 Points)**

Elements to be evaluated: 1) Proposed Project Service System; (2) Scope of Work Deliverables; (3) Proposed plan to expand evidenced based overdose prevention, SUD treatment and recovery services to include number of new, unduplicated patients to be serviced; (4) Evidence-Based Practice to be utilized in OUD overdose education, treatment and recovery supports, if applicable; (5) Plan to align with Nevada Plan of Safe Care, if applicable (6) Patient engagement activities, if applicable; and (7) Description of MAT Services to be provided and FDA Waiver Approved Providers (if-applicable).

**4. COST-EFFECTIVENESS AND LEVERAGING OF FUNDS (Up to 15 Points)**

Elements to be evaluated: (1) Existing Grants and Projects dedicated to addressing OUD, overdose prevention overdose and recovery activities and (2) Sources of reimbursement (e.g. Medicaid, Contracted MCOs, Sliding Fee Scale, Private Pay) (3) If a new program describe how this funding will expand your service delivery.

**5. SUSTAINABILITY (Up to 20 Points)**

Elements to be evaluated: (1) Sustainability Plan to include transition from grant funds to 3rd party payers (2) Impact of services to patients (3) Data Collection (GPRA, TEDS and SOR specific data) and Management Plan to include submission of required reports in a timely manner.

# APPENDICES

# APPENDIX A

## COVER PAGE

**University of Nevada, Reno**

**Center for the Application of Substance Abuse Technologies**

*In response to:*

**Request for Applications**

**SOR MAT Service Expansion**

**Release Date: 04/04/19**

**Deadline for Submission and Time: 05/06/19 at 12:00 PM (PST)**

*Our application is respectfully submitted as follows:*

|  |  |  |  |
| --- | --- | --- | --- |
| **Company Name:** |  | | |
| **Clinic Address:** |  | | |
| **Mailing Address: (If different)** |  | | |
| **Phone:** |  | **Fax:** |  |
| **Executive Director/CEO:** |  | | |
| **Name of Primary Contact for Proposal:** |  | | |
| **Proposal Primary Contact Email Address:** |  | | |

*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 PROFILE INSTRUCTIONS

Project Number – Leave blank (Assigned by UNR Office of Sponsored Projects)

Application Number – Leave blank (Assigned by UNR Office of Sponsored Projects)

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

Agency Name – Applicant’s legal agency name

Agency Website – If applicable, provide the applicant’s website address

Agency Address – Street and floor or suite number

Agency City/State – City and State

Agency 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. Fallon, Clark, Elko, or Carson City), 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 PROFILE | | | | |
| Project HD Number: *(Assigned by UNR OSPA)* |  | | | | |
| Application Number: *(Assigned by UNR OSPA)* |  | | | | |
| Agency Name: |  | | | | |
| Agency Website: |  | | | | |
| Agency Telephone Number: |  | | | | |
| Agency Fax Number: |  | | | | |
| Agency Address: |  | | | | |
| Agency City, State: |  | | | | |
| Agency Zip Code: |  | | | | |
| Employer ID Number (EIN): |  | | | | |
| DUNS Number: |  | | | | |
| SAPTA Certified: | 🞎 Yes 🞎 No | Date certified? | | Level certified for? | |
| Project Period: *(Month/Day/Year)* | Start Date  07/01/19 | | End Date  6/30/20 | | |
| Amount Requested: |  | | | | |

|  |  |
| --- | --- |
| ADDITIONAL FACILITY LOCATIONS | |
|  | Service Location:  Address:  Phone Number:  Site Contact Person/Email: |
|  | Service Location:  Address:  Phone Number:  Site Contact Person/Email: |
|  | Service Location:  Address:  Phone Number:  Site Contact Person/Email: |
|  | Service Location:  Address:  Phone Number:  Site Contact Person/Email: |

SUBRECIPIENT CONTACT (Double click to access PDF)

# APPENDIX C

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| Narrative |
| Applicants must provide evidence of their capacity to successfully execute all proposed strategies and activities to meet the objectives as outlined in this RFA. Outline category area(s) in which you are submitting for.  In your Project Narrative you must include:   * PDMP and epidemiological data. State specific information can be found at the following link: [Office of Analytics](file:///C:\Users\morgang\Downloads\•%09http:\dhhs.nv.gov\Programs\Office_of_Analytics\OFFICE_OF_ANALYTICS_-_DATA___REPORTS\) * Identify the EBPs you propose to implement for the specific population(s) of focus. If an EBP does not exist/apply for your program/population(s) of focus, describe the service/practice you plan to implement as an appropriate alternative. * If you are proposing to use more than one EBP, provide a justification for doing so and clearly identify which service modality and population of focus each practice will support. * Discuss the population(s) for which the practice(s) has (have) been shown to be effective and show that it (they) is (are) appropriate for your population(s) of focus. Indicate whether/how the practice(s) will be adapted for a specific population. SAMHSA encourages you to consult with an expert to complete any modifications to the chosen EBP. This is especially important when adapting EBPs for specific underserved populations for whom there are fewer EBPs. |
| Organizational Strength and Description (up to 25 points) |

In no more than three pages, single spaced, please describe:

* Service area applying for and P-COAT Option, if applicable
* Agency history, client population and levels of service, and experience in the community to include knowledge of local needs;
* Project alignment with agency mission and goals;
* Geographic Service Area;
* Qualifications and tenure of staff providing proposed services;
* The structure of the agency including Board of Directors (if applicable), hours of operation, and number of locations
* Location(s) where service that you are applying for will be provided.

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| Collaborative Partnerships (up to 15 points) |

In no more than two pages, single spaced, please describe:

* Collaboration with external community resources;
* Roles of collaborating partners including sub-awardees (if any);
* Plan to monitor sub-awardees to ensure adherence to award agreements and terms; and
* Formalized care coordination agreements that are in place.

*\*Please note that any sub-awardees must be certified or eligible to become certified by SAPTA and an approved vendor of the University of Nevada, Reno.*

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| Service Delivery (up to 25 points) |

In no more than three pages, single spaced, please describe:

* Proposed Project Service System;
* Scope of Work Deliverables;
* Proposed plan to expand access to treatment and recovery services to include number of new, unduplicated patients to be served;
* Evidence-Based Practice to be utilized in OUD overdose education, treatment and recovery supports, if applicable;
* Plan to align with Nevada Plan of Safe Care, if applicable
* Patient engagement activities, if applicable; and
* Description of MAT Services to be provided and FDA Waiver Approved Providers (if-applicable).

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| Cost Effectiveness and Leveraging of Funds (up to 15 points) |

For existing projects or organizations, in no more than one page, single spaced, please describe:

* Existing Grants and Projects dedicated to addressing OUD, overdose prevention overdose and recovery activities and
* Sources of reimbursement (e.g. Medicaid, Contracted MCOs, Sliding Fee Scale, Private Pay).

If you are a new project or organization, please describe how this funding will expand your service delivery.

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| Sustainability (up to 20 points) |

In no more than three pages, single spaced, please describe:

* Sustainability Plan to include transition from grant funds to 3rd party payers
* Impact of services to patients
* Data Collection (TEDS, GPRA, and SOR specific data) and Management Plan to include submission of required monthly progress reports in a timely manner.

# APPENDIX D

## PROPOSED SCOPE OF WORK

*(Please use the attached Scope of Work Template (not the example template))*

1. **Provider Name:** Please fill in the name of your organization.
2. **Purpose/Title:** Please fill in the purpose or title (project name) and then a brief description. *Example: Women’s Housing; to increase the number of beds available for treatment in Nevada for women.*
3. **Problem Statement:** Briefly describe the problem or the gap that is being addressed through this scope of work.

*Example: Our facility continually carries a waitlist on average of 5 women.*

1. **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.

*Example: To add beds to a stable residential care facility providing therapy for substance abuse, mental illness, other behavioral problems and other wrap around services.*

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

Who: Target population?

What: Strategies and Evidence based programs utilized to effect change

Where: Area

When: When will the change occur

How much: Measurable quantity of change

*Example: will increase the number of women’s beds from 6 to 12.*

***Outcome Objectives can be Qualitative or Quantifiable:***

*Example – Qualitative: At least 95% of 2018-2019 program graduates will report an understanding of the increased risk of negative birth outcomes when women consume alcohol during pregnancy.*

*Example – Quantifiable: By June 2019, the waitlist for residential substance abuse treatment beds will be reduced from sixty days to no more than fourteen days.*

1. **Activities:** List the steps planned to achieve the stated Outcome Objective.

*Example:*

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

*Identify and implement advertising, outreach, fundraising, and other financial support mechanisms to support future sustainability.*

1. **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.

*Example****:*** *September 30, 2019*

1. **Documentation:** Pease list any documentation or process evaluation documents that will be produced to track the completion of the activities.

*Example:*

1. *Informational brochures, copies of flyers, ads and newspaper articles, social media and TV ads used in this effort.*
2. *Contracts related to leasing, employment, supplies, maintenance agreements, operations, etc.*
3. *Meeting minutes, Memorandum of Understanding, records of efforts to influence public opinion.*
4. *Records of interviews, surveys, reports, focus groups, local law enforcement data, etc.*
5. **Evaluation:** All organizations providing opioid use disorder treatment will need to complete the SOR Client-Level Data Collection Tool at baseline, three-month follow-up, six-month follow-up, and discharge for all clients served with funding and report data in SAMHSA’s Performance and Accountability Reporting System (SPARS). The Tool is estimated to take 45 minutes to complete. To see the types of questions included in the tool, visit https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services.

Evaluation continued: 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 are provided and should be used to preserve fidelity with the evidence-based methods. (Please note: SOR Team can provide technical assistance on this element, if needed, if application is approved for funding.)

***Example:*** *Bi-weekly monitoring of the county residential treatment waitlist will be conducted. Changes in wait times will be analyzed to ensure that evidence supports the desired wait reduction. If analysis shows that wait times remain stagnant, increase, or do not decrease at a rate significant to meet stated reduction objective, a root cause analysis will be conducted to determine reasons.*

## SCOPE OF WORK - TEMPLATE

**2019 SOR Expansion Services**

**Provider**: Click here to name.

**Purpose/Time and Brief Description of the proposed Program/Project**: Click here to enter text.

**Problem Statement:** Click here to enter the problem being addressed

**Goal 1:** Click here to enter a goal

|  |  |  |
| --- | --- | --- |
| **Outcome Objective 1a:** Click here to enter text. | | |
| **Activities including Evidence-based Programs** | **Date due by** | **Documentation** |
| 1. [List specific activities to be achieved to meet the outcome objective] | Enter date. | [Documentation and or evidence that the activity was completed, e.g. clinical records, meeting minutes, written policy, etc.] |
| 1. [List specific activities to be achieved to meet the outcome objective] | Enter date. | Click here to enter documentation. |
| **Evaluation: Note: All subawardee organizations will be required to submit monthly progress reports. Additionally, all organizations providing opioid use disorder treatment will need to complete the SOR Client-Level Data Collection Tool at baseline, three-month follow-up, six-month follow-up, and discharge for all clients served with funding and report data in SAMHSA’s Performance and Accountability Reporting System (SPARS). The Tool is estimated to take 45 minutes to complete. To see the types of questions included in the tool, visit https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services.** | | |

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| --- | --- | --- |
| **Outcome Objective 1b:** Click here to enter text. | | |
| **Activities including Evidence-based Programs** | **Date due by** | **Documentation** |
| 1. [List specific activities to be achieved to meet the outcome objective] | Enter date. | [Documentation and or evidence that the activity was completed, e.g. clinical records, meeting minutes, written policy, etc.] |
| 1. [List specific activities to be achieved to meet the outcome objective] | Enter date. | Click here to enter documentation. |
| **Evaluation: Note: All subawardee organizations will be required to submit monthly progress reports. Additionally, all organizations providing opioid use disorder treatment will need to complete the SOR Client-Level Data Collection Tool at baseline, three-month follow-up, six-month follow-up, and discharge for all clients served with funding and report data in SAMHSA’s Performance and Accountability Reporting System (SPARS). The Tool is estimated to take 45 minutes to complete. To see the types of questions included in the tool, visit https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services.** | | |

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| **Outcome Objective 1c:** Click here to enter text. | | |
| **Activities including Evidence-based Programs** | **Date due by** | **Documentation** |
| 1. [List specific activities to be achieved to meet the outcome objective] | Enter date. | [Documentation and or evidence that the activity was completed, e.g. clinical records, meeting minutes, written policy, etc.] |
| 1. [List specific activities to be achieved to meet the outcome objective] | Enter date. | Click here to enter documentation. |
| **Evaluation: Note: All subawardee organizations will be required to submit monthly progress reports. Additionally, all organizations providing opioid use disorder treatment will need to complete the SOR Client-Level Data Collection Tool at baseline, three-month follow-up, six-month follow-up, and discharge for all clients served with funding and report data in SAMHSA’s Performance and Accountability Reporting System (SPARS). The Tool is estimated to take 45 minutes to complete. To see the types of questions included in the tool, visit https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services.** | | |

**Goal 2:** Click here to enter a goal

**Problem Statement:** Click here to enter the problem being addressed

|  |  |  |
| --- | --- | --- |
| **Outcome Objective 2a:** Click here to enter text. | | |
| **Activities including Evidence-based Programs** | **Date due by** | **Documentation** |
| 1. [List specific activities to be achieved to meet the outcome objective] | Enter date. | [Documentation and or evidence that the activity was completed, e.g. clinical records, meeting minutes, written policy, etc.] |
| 1. [List specific activities to be achieved to meet the outcome objective] | Enter date. | Click here to enter documentation. |
| **Evaluation: Note: All subawardee organizations will be required to submit monthly progress reports. Additionally, all organizations providing opioid use disorder treatment will need to complete the SOR Client-Level Data Collection Tool at baseline, three-month follow-up, six-month follow-up, and discharge for all clients served with funding and report data in SAMHSA’s Performance and Accountability Reporting System (SPARS). The Tool is estimated to take 45 minutes to complete. To see the types of questions included in the tool, visit https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra/csat-gpra-discretionary-services.** | | |

*NOTE: Please add or delete table rows as necessary. You may also add additional charts if needed to detail additional objectives under each goal and/or to add additional goals.*

# 

# APPENDIX E

## 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:**

This funding announcement is for the STR Service Expansion. The subgrant period for this application will be for **the project period of 12 months** and will start **July 1, 2019** and continue through **June 30, 2020 (with execution of the prime award).**

1. Apply for the project period. Complete an individual scope of work (SOW), budget and budget narrative for each budget cycle of the twelve-month project period.
2. Unspent funding will be returned to the state. **No exceptions**.
3. 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 subgrant. 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 subgrant 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 subgrant.

### Budget Example for Reference

|  |  |  |  |
| --- | --- | --- | --- |
| ***Example Budget for Reference*** | | | |
| **Category** | **Details of Expected Expenses** | **Detailed Cost** | **Total Category Cost** |
| **1. Salaries** | **Salaries: 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 position's 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 in the example. **NOTE:** If your organization charges multiple staff that do not share the same projected allocation of time, then separate them. See Administrative Assistant in the example. 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. | | |
|  | Executive Director, 1 X $70,000 per year X 10% = $7,000 | $7,000.00 |  |
|  | Project Manager, 1 X $45,000 per year X 50% = $22,500 | $22,500.00 |  |
|  | Project Coordinators, 2 X 35,000 per year X 50% = $35,000 | $35,000.00 |  |
|  | Administrative Assist, 1 X $15,000 per year X 20% = $3,000 | $3,000.00 |  |
|  | Administrative Assist, 1 X $15,000 per year X 10% = $1,500 | $1,500.00 |  |
|  | Fringe Benefits equals 12% of total salaries charged - $69,000 X 12% = $8,280 | $8,280.00 |  |
| Salaries Subtotal |  |  | $77,280.00 |
| **2. Fringe** | **Fringe: 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 fringe benefits line must be represented as a~~n average~~ percent of the total salaries being charged to the grant.  **Note:** The following components are generally included in fringe rates: worker's compensation, Medicare, Social Security, Unemployment, retirement, health insurance, and social security.  **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. | | |
|  | Fringe Benefits equals 12% of total salaries charged - $77,280 X 12% = $9,273.60 | $9,273.60 |  |
| Fringe Subtotal |  |  | $9,273.60 |
| **2. Travel** | **Travel: The costs that are allowable in this budget line item are all travel costs. Please note that travel reimbursement must be supported by receipts.** 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 of budget development. GSA approved rates can be found at https://www.gsa.gov/travel/plan-book/per-diem-rates 1. Mileage should reflect GSA approved rate and total projected miles to be driven.  2. A description of the trip and its purpose. 3. The destination of the trip. 4. The number of staff that will be traveling. 5. An estimated trip cost per staff traveling with breakdown of airfare, lodgings, meals, ground transportation, baggage and airport parking fees. 6. The projected trip total. **Mileage:** (GSA Rate X Number of Miles = Cost) **Trips:** (Number of staff X estimated cost per staff X number of trips = Cost) **NOTE:** Please see the example below | | |
|  | Mileage for local meeting and events - $.55 X 2000 miles =$1,070 | $1,100.00 |  |
|  | 1 SAMHSA Conference, Washington DC, April 3, 2017 - April 6, 2017, 2 Staff, $1,500 each ($400 roundtrip airfare, $600 lodgings, $200 meals, $200 ground transportation, $50 airport parking, $50 baggage fees) = $3,000 | $3,000.00 |  |
|  | 4 Quarterly Meetings (1 day each), Statewide, 2 Staff, $500 each ($400 roundtrip airfare, $100 meals) = $4,000 | $4,000.00 |  |
|  | 1 “Prevention Training” May 3, 2017, Reno, 6 staff, $15 each ($15 ground transportation) = $90 | $90.00 |  |
| Travel Subtotal |  |  | $8,190.00 |
| **3. Supplies** | **Supplies: 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.** The following details must be included in the details of expected expenses sections of the line item.  1. A description and purpose of the item being charged. 2. If a cost is recurring, use average monthly cost and number of months costs recurs and allocation if less than 100%. **Supplies:** (Per Month Cost X number of months charged X Rate of Allocation = Cost) **NOTE:** Please see the example below | | |
|  | Office Supplies (paper, pencils, pens, etc.) - $75 per month X 12 months = $900 | $900.00 |  |
|  | Rent - $1,500 per month X 12 Months = $18,000 X 25% allocation. | $4,500.00 |  |
|  | Phone - $100 per month X 12 months = $1,200 X 25% allocation. | $300.00 |  |
|  | Internet - $125 per month X 12 months = $1,500 X 25% allocation. | $375.00 |  |
|  | 1 Computer for the project manager X $1000 per computer | $1,000.00 |  |
| Supplies Subtotal |  |  | $7,075.00 |
| **5. Contractual** | **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. (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.)**  The following details must be included in the details of expected expenses sections of the line item.  1. Include a description and purpose of the intended future contract that is being considered. 2. Include a justification of the use of the specific contractor and/or the contractor qualifications. 3. Include breakdown of the cost, including the estimated total cost of the contract, number of deliverables that will be the result of the completed contract, and the per hour rate of the contract and the number of hours the project is going to take. **NOTE:** Do not list the actual names of contractors, consultants, or vendors in the budget.  **NOTE:** Please see the example below | | |
|  | Contract to provide 4 regional prevention training courses; $5,000 X 4 Courses = $20,000 | $20,000.00 |  |
|  | Media consultant - $35 per hour X 125 hours = $4,375 | $4,375.00 |  |
|  | Contract for the development of a community needs assessment = $95.00 per hour X 160 hours - $15,200 | $15,200.00 |  |
| Contractual Subtotal |  |  | $39,575.00 |
| **4. Equipment** | **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.** The following details must be included in the details of expected expenses sections of the line item.  1. Include a description and purpose of the item being charged. 2. Include the cost of the item, per unit. 3. Include the number of units that are being purchased. **Equipment:** (Per Unit Cost X Number of Units = Cost) **NOTE:** Please see the example below | | |
|  | Examination Table to complete participant physicals, $5,500 per unit X 3 units – 16,500 *(this is almost never used; most expenditures will fall under Operating costs)* | $16,500.00 |  |
| Equipment Subtotal |  |  | $16,500.00 |
| **7. Indirect** | **Indirect: The costs that are allowable in this budget line item are indirect costs and if applicable audit costs.** For Indirect Costs, provide documentation of federally negotiated indirect cost rate agreement, if available. If subrecipient does not have this, it will receive the de minimus indirect cost rate of 10% of total cost pursuant to the Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance), §200.414. Note that if the federal award has a lesser rate than the subrecipient's federally negotiated rate, the rate on the award will be followed. Insert a new row for each item. The following details must be included in the details of expected expenses sections of the line item.  1. Include a description of the intended cost being considered. 2. For audit costs include the total annual cost 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. 3. If applicable, include the total direct costs being charged for indirect. 4. If applicable, include the federally approved indirect rate total direct costs being charged for indirect. **Audit Cost:** (Annual audit cost X Rate of Allocation = Cost) **Indirect Cost:** (Total Direct Costs being charged x Federally Approved Indirect Rate = Indirect Cost) **NOTE:** Please see the example below | | |
|  | Annual audit cost: $8,000 X 25% = $2,000 | $2,000.00 |  |
|  | Indirect Costs: $210,228 X 12% = 25,468.80 | $25,468.80 |  |
| Indirect Subtotal |  |  | $27,468.80 |
| **Total Cost** |  |  | $185,362.40 |
| Note #1: Totals listed must match totals on Cover Page. | | | |

*Please use the Excel template provided with the announcement package to complete and submit.*

Review and complete the included Excel budget form. Please refer to the Instructions for Proposed Budget Plan(s) and/or Subcontracting Budget Plan provided in Appendix B.   
  
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 for the project. 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…***

|  |
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| PROPOSED BUDGET TEMPLATE  Double Click on the table to open |

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| APPENDIX FLETTER OF INTENT |

Request for Letters of Intent (LOI): Interested applicants are invited to submit a letter of intent, not more than two (2) pages in length. due on Monday, April 15, 2019 at 5:00 pm. Submissions must be made electronically to: [opr@casat.org](mailto:opr@casat.org) and must reference State Opioid Response Service Expansion.

Applicants must address the following questions in the letter of intent:

1. Proposed category of application
2. Intended service area(s)
3. Intended target population(s) to serve

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| --- |
| APPENDIX GAUDIT AND FISCAL FORMSAUDIT QUESTIONNAIRE AND RISK ASSESSMENT (Double Click to Access)  APPENDIX HBUREAU OF BEHAVIORAL HEALTH WELLNESS AND PREVENTION PROGRAM REQUIREMENTS As a subawardee of the Division of Public and Behavioral Health Bureau of Wellness and Prevention, the University of Nevada, Reno complies with all assurances ass specified by the Bureau. |

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.

## GENERAL REQUIREMENTS

Applicability

This section is applicable to all subrecipients who receive finding from the Board of Regents, Nevada System of Higher Education, obo University of Nevada, Reno and 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
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
    1. The subrecipient is required to be in compliance with all State licensure and/or certification requirements.
    2. 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 Subgrantee 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, Subgrantee shall maintain coverage for its employees in accordance with NRS Chapter 616A.
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 were 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.

1. The subrecipient agrees to cooperate fully with all UNR/BBHWP sponsored studies including, but not limited to, utilization management reviews, program compliance monitoring, reporting requirements, complaint investigations, and evaluation studies.
2. The subrecipient must be enrolled in System Award Management (SAM) as required by the Federal Funding Accountability and Transparency Act.
3. 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. UNR may reallocate funds to other programs to ensure that gaps in service are addressed.
4. 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 UNR staff or specified contact. The subrecipient will have 60 days to improve the scope of work and carry out the approved action plan. If performance has not improved, UNR will provide written notice identifying the reduction of funds and the necessary steps.
5. 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:
   1. To purchase or improve land: purchase, construct, or permanently improve, other than minor remodeling, any building or other facility; or purchase major medical equipment.
   2. To purchase equipment over $1,000 without approval from the Division.
   3. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
   4. To provide in-patient hospital services.
   5. To make payments to intended recipients of health services.
   6. 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.
   7. To provide treatment services in penal or correctional institutions of the State.
6. 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:

1. 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.
2. 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

1. 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.
2. The non-federal entity financial statements may also include departments, agencies, and other organizational units.
3. Year-End Financial Report must be signed by the CEO or Chairman of the Board.
4. 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.
5. The Year-End Financial Report must include a schedule of expenditures of federal and State awards. At a minimum, the schedule must:
   1. List individual federal and State programs by agency and provide the applicable federal agency name.
   2. Include the name of the pass-through entity (State Program).
   3. Must identify the CFDA number as applicable to the federal awards or other identifying number when the CFDA information is not available.
   4. Include the total amount provided to the non-federal entity from each federal and State program.
6. The Year-End Financial Report must be submitted to UNR 60 days after fiscal year end at the following email: ospadmin@unr.edu and must contain the subaward number.

Limited Scope Audits

1. The auditor must:
   1. Perform an audit of the financial statement(s) for the federal program in accordance with GAGAS;
   2. Obtain an understanding of internal controls and perform tests of internal controls over the federal program consistent with the requirements for a federal program;
   3. 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;
   4. 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;
   5. And, report any audit findings consistent with the requirements of 2 CFR Part 200,

§200.516 Audit findings.

1. 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.
2. The auditor's report(s) must state that the audit was conducted in accordance with this part and include the following:
   1. 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;
   2. 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;
   3. 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
   4. 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).
3. The Limited Scope Audit Report must be submitted to UNR 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.

Amendments

1. Subrecipient is allowed no more than 10% flexibility within the approved Scope of Work budget line items. Notification of such modifications must be communicated in writing to UNR through the assigned contact via the specified email opr@casat.org prior to submitting any request for reimbursement for the period in which the modification affects. Notification may be made via email.
2. 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 UNR in writing.
3. Any expenses that are incurred in relation to a budgetary amendment without prior approval are unallowable.
4. 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.
5. 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.
6. 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 July 31 for federal funded grants). Amendment requests received after the 60-day deadline may be denied.

Remedies for Noncompliance

1. UNR reserves the right to hold reimbursement under this subaward until any delinquent requests, forms, reports, and expenditure documentation are submitted to and approved by UNR.

# SUBSTANCE USE TREATMENT SERVICES

### Applicability

This section applies to all sub-grants that support direct services to persons being treated for substance use.

1. The subrecipient, as applicable, if identifying as Faith-Based Organizations must comply with 42 USC

§ 300x-65 and 42 CFR part 54 (42 CFR §§ 54.8(c) (4) and 54.8(b)), Charitable Choice provisions and regulations.

* 1. The subrecipient must post a notice to advise all clients and potential clients that if the client objects to the religious character of the Sub-grantee’s organization as applicable.
  2. The client has the right to be referred to another Division-funded provider that is not faith-based or that has a different religious orientation.

1. Priority Groups – The subrecipient agrees to prioritize and expedite access to appropriate treatment, except for Civil Protective Custody Services, for priority populations in the following order:
   1. Pregnant injecting drug users;
   2. Pregnant substance abusers;
   3. Injection drug users;
   4. Substance using females with dependent children and their families, including females who are attempting to regain custody of their children; and
   5. All others.
2. The subrecipient agrees to report within 24 hours to the Bureau of Behavioral Health Wellness and Prevention when any level of service reaches 90 percent capacity or greater in accord with the Division’s Wait List and Capacity Management policy.
3. A subrecipient who provides residential services agrees to report bed capacity in the HavBed system or a successor system for residential services daily in accord with the Division’s Wait List and Capacity Management policy.
4. Programs will make continuing education in alcohol and other drug treatment available to all employees who provide services.
5. The subrecipient must post a notice, where clients, visitors, and persons requesting services may easily view it, that no persons may be denied services due to inability to pay. This notice may stipulate that the organization is authorized to deny services to those who are able to pay but refuse to do so.
6. The subrecipient is required to implement the National Institute of Drug Abuse (NIDA) 13 principles of treatment.
7. The subrecipient is required to participate, if selected to be reviewed by the Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services (AADAPTS) annual peer review process.

### Capacity of Treatment for Intravenous Substance Abusers

1. A subrecipient must admit an individual who requests and needs treatment for intravenous drug use to a treatment program. If unable to provide services, the subrecipient must contact the BBHWP according to the Division’s Capacity Management and Wait List policy.
2. The subrecipient who treats persons who inject drugs agrees to carry out activities to encourage individuals in need of treatment for injection drug use to undergo such treatment. The subrecipient must use outreach models that are scientifically sound or an alternate outreach method that is reasonably expected to be effective and has been approved by the BBHWP. All outreach activities will be reported to UNR quarterly. The model shall require that outreach efforts include the following at a minimum:
   1. Selecting, training and supervising outreach workers;
   2. Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR part 2;
   3. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;
   4. Recommend steps that can be taken to ensure that HIV transmission does not occur; and
   5. Encouraging entry into treatment.

### Treatment services for pregnant women (45 CFR § 96.131)

1. All subrecipient who treat women agree to provide immediate comprehensive treatment services to pregnant women, or if the sub-grantee is unable to do so, the sub-grantee must immediately contact the Bureau of Behavioral Health Wellness and Prevention in accord to the Divisions Capacity Management and Wait List policy.
2. Subrecipients who do not treat women and who receive a request for treatment services from a pregnant woman must provide a referral to an appropriate treatment provider within 48 hours of the request for services and must immediately notify the Bureau of Behavioral Health Wellness and Prevention of the need for such services.
3. Subrecipients who provide services to women agree to publicize the availability of services to women in priority populations and the admission priority granted to pregnant women. The publication of services for women in priority populations may be achieved by means of street outreach programs, ongoing public service announcements, regular advertisements, posters placed in target areas, and frequent notification of availability of such treatment services distributed to the network of community-based organizations, health care providers, and social services agencies.

### Records

1. All subrecipients will have in effect a system to protect from inappropriate disclosure of client records, compliant with all applicable State and federal laws and regulations, including 42 CFR, Part 2.
2. The system to protect confidentiality shall include, but not be limited to, the following provisions:
   1. Employee education about the confidentiality requirements, to be provided annually;
   2. Informing employees of the fact that disciplinary action may occur upon inappropriate disclosure.

### Reporting

1. The subrecipient is required to submit monthly Treatment Episode Data Set (TEDS) admissions files and TEDS discharges files in accordance with current block grant requirements. The subrecipient is also required to submit any other reporting as defined and requested by the BBHWP.
2. The subrecipient agrees to participate in reporting all required data and information through the authorized BBHWP data reporting system and to the evaluation team as required; or, if applicable, another qualified Electronic Health Record (EHR) reporting system.

# REQUESTS FOR REIMBURSEMENTS

1. 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 UNR.
4. Reimbursement must be submitted with UNR required supporting back up documentation. UNR has the authority to ask for additional supporting documentation at any time and the information must be provided to UNR 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.

1. The subrecipient is required to submit a complete financial accounting of all expenditures to UNR within 30 days of the **CLOSE OF THE SUBAWARD PERIOD**. All remaining balances of a federally funded sub-grant revert back to UNR 30 days after the close of the subaward period.
2. The Request for Reimbursement to close the State Fiscal Year (SFY) is due at a minimum of 10 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.
3. 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.

# Acronyms & Definitions

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| **Acronym** | **Definition** |
| ***Agreement*** | As used in the context of care coordination, an agreement is an arrangement between the applicant organization 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. |
| ***AOR*** | 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. |
| ***Applicant*** | Organization/individual submitting an RFA in response to this RFA. |
| ***Application Package*** | 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. |
| ***ASAM*** | American Society of Addiction Medicine, 3rd Edition |
| ***Assumption*** | An idea or belief that something will happen or occur without proof. An idea or belief taken for granted without proof of occurrence. |
| ***AWARD*** | An award between the DPBH and an outside agency or sub-awardee to perform tasks identified in the RFA. |
| ***Awarded Applicant*** | The organization/individual that is awarded and has an approved contract with the State of Nevada for the services identified in this RFA. |
| ***BBHWP*** | Bureau of Behavioral Health, Wellness and Prevention |
| ***Behavioral health*** | Behavioral health is a general term “used to refer to both mental health and substance use” (SAMHSA-HRSA [2015]). |
| ***BOE*** | State of Nevada Board of Examiners |
| ***Care Coordination*** | The deliberate coordination of patient care activities between two agencies involved in a patient’s care to facilitate the appropriate delivery of services identified on the treatment or care management plan. The Agency for Healthcare Research and Quality (2014) defines care coordination as “deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer’s care to achieve safer and more effective care. This means the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.” |
| ***CCBHC*** | CCBHCs refer to Certified Community Behavioral Health Clinics as certified by states in accordance with these criteria and with the requirements of PAMA. A CCBHC may offer services in different locations. For multi-site organizations, however, only clinics eligible pursuant to these criteria and PAMA may be certified as CCBHCs. |
| ***CDC*** | Centers for Disease Control and Prevention |
| ***Certification*** | Division Certification through SAPTA |
| ***CLIA*** | The Clinical Laboratory Improvement Amendments |
| ***Confidential Information*** | 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. |
| ***Consumer*** | Within this document, the term “consumer” refers to clients, persons being treated for or in recovery from mental and/or substance use disorders, persons with lived experience, service recipients and patients, all used interchangeably to refer to persons of all ages (i.e., children, adolescents, transition aged youth, adults, and geriatric populations) for whom health care services, including behavioral health services. Use of the term “patient” is restricted to areas where the statutory or other language is being quoted. Elsewhere, the word “consumer” is used. |
| ***Contract Approval Date*** | 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. |
| ***Contract Award Date*** | The date when applicants are notified that a contract has been successfully negotiated, executed and is awaiting approval of the Board of Examiners. |
| ***Contractor*** | 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. |
| ***Cooperative Agreement*** | An award of financial assistance that is 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. |
| ***Cross Reference*** | A reference from one document/section to another document/section containing related material. |
| ***Cost Share/Match*** | The portion of a project or program costs not borne by the Federal government. |
| ***Cultural and linguistic competence*** | 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]). |
| ***Disallowed Costs*** | 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. |
| ***Discretionary Grant*** | 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. |
| ***Desirable*** | The terms “may, “can”, “should”, “preferably”, or “prefers” identify a desirable or discretionary item or factor. |
| ***Division/Agency*** | The Division/Agency requesting services as identified in this RFA. |
| ***DUNS*** | Dun and Bradstreet Number. |
| ***Engagement*** | 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. |
| ***Equipment*** | 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. |
| ***Evaluation***  ***Committee*** | 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. |
| ***Exception*** | A formal objection taken to any statement/requirement identified within the RFA. |
| ***Family*** | Families of both adult and child consumers are important components of treatment planning, treatment and recovery. Families come in different forms and, to the extent possible, applicant organizations should respect the individual consumer’s view of what constitutes their family. Families can be organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, care givers, friends, and others as defined by the family. |
| ***Family-centered*** | 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 *family-driven* and *youth-driven*. |
| ***Federal Register*** | A daily journal of the U.S. Government containing notices, proposed rules, final rules, and presidential documents. |
| ***Formal Care Coordination Agreement*** | A formal, written agreement between an IOTRC and partner agency specifying the services to be provided for clients through a coordinated effort. |
| ***Grant*** | 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. |
| ***Grants.gov*** | A storefront web portal for use in electronic collection of data (forms and reports) for Federal grant-making agencies through the www.grants.gov site. |
| ***FQHC*** | Federally Qualified Health Center |
| ***HCQC*** | Bureau of Health Care Quality and Compliance |
| ***Hub and Spoke System*** | Hub and Spoke system means a model comprised of OTPs that serve as the hubs and Data 2000 waivered prescribers who prescribe buprenorphine in office-based settings who serve as the spokes. |
| ***IFC*** | Interim Finance Committee. |
| ***IMAT*** | Initiation of Medication-Assisted Treatment |
| ***MAT*** | Medication Assisted Treatment (MAT) means a combination of medications utilized to treat an opioid use disorder (OUD) in conjunction with counseling services. |
| ***MMAT*** | Maintenance of Medication-Assisted Treatment |
| ***Medical Evaluation*** | A comprehensive assessment, conducted by Nevada Licensed medical professional, of a patient’s overall medical history and current condition for the purpose of identifying health problems and planning treatment. |
| ***Mobile Recovery Unit*** | An outreach team staffed to provide linkage and referral to the local Integrated Opioid Treatment and Recovery Center’s for engagement, treatment, and/or recovery support for treatment transition. |
| ***OBOT*** | Office Based Opioid Treatment |
| ***OSPA*** | Office of Sponsored Projects and Awards with the University of Nevada, Reno |
| ***OTP*** | Opioid Treatment Program |
| ***OUD*** | Opioid Use Disorder |
| ***RFA*** | Request for Application |
| ***SAMHSA*** | Substance Abuse and Mental Health Services Administration |
| ***SAPTA*** | Substance Abuse Prevention & Treatment Agency |
| ***SUD*** | Substance Use Disorder |
| ***Wellness Promotion*** | The promotion of healthy ideas and concepts to motivate individuals to adopt healthy behaviors. |
| ***Key Personnel*** | Applicant staff responsible for oversight of work during the life of the project and for deliverables. |
| ***LCB*** | Legislative Counsel Bureau. |
| ***LOI*** | 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. |
| ***Limited English Proficiency (LEP)*** | 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. |
| ***Mandatory*** | 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. |
| ***May*** | 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. |
| ***Minor Technical Irregularities*** | Anything in the application that does not affect the price, quality, and quantity or any mandatory requirement. |
| ***Must*** | Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of an RFA as non-responsive. |
| ***NAC*** | Nevada Administrative Code –All applicable NAC documentation may be reviewed via the internet at: **www.leg.state.nv.us.** |
| ***NOA*** | 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. |
| ***NRS*** | Nevada Revised Statutes – All applicable NRS documentation may be reviewed via the internet at: **www.leg.state.nv.us**. |
| ***OMB*** | Office of Management and Budget. |
| ***PAMA*** | Protecting Access to Medicaid Act |
| ***Pacific Standard Time (PST)*** | Unless otherwise stated, all references to time in this RFA and any subsequent contract are understood to be Pacific Time. |
| ***Peer Support Services*** | 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. Peer Recovery Support Service include any service designed to initiate, support and enhance recovery. |
| ***Peer Support Specialist*** | 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. |
| ***Person-centered care*** | 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]). |
| ***Practitioner or Provider*** | 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). |
| ***Prescriber*** | An FDA Waiver approved prescriber for FDA approved medications for the treatment of OUDs. |
| ***Project Costs*** | 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. |
| ***Project Period*** | The period established in the award document during which awarding agency sponsorship begins and ends. |
| ***Proprietary Information*** | Any trade secret or confidential business information that is contained in a bid, proposal, or RFA submitted on a particular contract. |
| ***Public Record*** | 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. |
| ***RFA*** | 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. |
| ***Recovery*** | 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]). |
| ***Recovery-oriented care*** | 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]). |
| ***Redacted*** | The process of removing confidential or proprietary information from a document prior to release of information to others. |
| ***SAM*** | State Administrative Manual. This document outlines the management of all Federal grant awards and provides guidance on sub-awards and sub-recipients. |
| ***Shall*** | Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of an RFA as non-responsive. |
| ***Shared Decision-Making (SDM)*** | 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]). |
| ***Should*** | 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. |
| ***Standard Form 424*** | 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. |
| ***State*** | The State of Nevada and any agency identified herein. |
| ***Subcontractor*** | 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. |
| ***Sub-recipient*** | The legal entity to which a sub-award is made, and which is accountable to the recipient for the use of the funds provided. |
| ***Supplant*** | 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. |
| ***Trade Secret*** | 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. |
| ***Trauma-informed*** | **Trauma-informed:** A trauma-informed approach to care “*realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization.*” 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]). |
| ***User*** | Department, Division, Agency or County of the State of Nevada. |
| ***Will*** | Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of an RFA as non-responsive. |

# Resources

* Integrated Service Delivery Models for Opioid Treatment Programs in an Era of Increasing Opioid Addiction, Health Reform, and Parity (Stoller et. al., 2016)

http://www.aatod.org/wp-content/uploads/2016/07/2nd-Whitepaper-.pdf

* Vermont Hub and Spoke Model: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5537005/
* The Division of Public and Behavioral Health certifies substance abuse facilities and programs through its Bureau of Behavioral Health Wellness and Prevention.  Per Nevada Revised Statute 458.024(d) and Nevada Administrative Code 458.103 programs and facilities that are not certified are ineligible to receive state and federal funding for alcohol and drug abuse programs.  Applicable regulations on certification can be found at: https://www.leg.state.nv.us/NAC/NAC-458.html#NAC458Sec103
* SAPTA Strategic Plan

<http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/SAPTA%20Strategic%20Plan_2017-2020.pdf>

1. Following criteria taken from ASAM (2018) *Patient-Centered Opioid Addiction Treatment (P-COAT): Alternative Payment Model (APM)*. Developed in collaboration with the AMA. [↑](#footnote-ref-1)
2. Certification process can be found on page 19 [↑](#footnote-ref-2)