

Carson City Certified Community Behavioral Health (CCBHC) Project Evaluation Plan

Purpose

Carson City Community Counseling Center (CCC) is a Certified Community Behavioral Health Clinic (CCBHC) that provides comprehensive, culturally sensitive behavioral health treatment and recovery services for adults, children and families. CCC's catchment area (CA) consists of Carson City - an independent city - and Douglas County, located in Northern Nevada (NNV). The populations of focus, which includes veterans, are children, youth and adults with serious emotional disturbance (SED), serious mental illness (SMI), substance use disorder (SUD), co-occurring disorders (COD), and those experiencing a mental health (MH) or substance use related crisis, without regard to insurance status, ability to pay or residence.

The population of both catchment areas is 107,509 (Carson City has a population of 58,639 and Douglas County has a population of 48, 870) (Census). About 48.5% and 49.8% of Carson City and Douglas County residents, respectively, are female (Census), and 5.5% of the NV population are LGBTQ (Williams Institute). While the CA's poverty rates for are slightly below NV averages (10% in Carson City and 8% in Douglas County, Census), CCC's population is overwhelmingly poverty-stricken: 33.4% are homeless with an another estimated 30% at risk of homelessness, reflecting NV's homelessness rate, 8th highest in the nation (USICH). Other populations at increased risk of health disparities and behavioral health (BH) care access gaps include those who speak a language other than English at home, veterans, uninsured persons (see demographic table). About 7% of CCC clients have serious emotional disturbance (SED) or serious mental illness (SMI) and 90% have substance use disorders (SUDs) and an estimated 70% of these have co-occurring disorders (COD)s. Carson City and Douglas County are HRSA-designated health professional shortage areas in MH/BH and primary care (HRSA, 2021), with rates of substance use and suicide above both state and national averages (Douglas County Community Prevention Plan/ DCCPP).

The project's **overall goal** is to:

Goal: Increase availability of and access to comprehensive, coordinated, community-based BH services

The project has proposed to accomplish these goals through providing the following activities:

1. Crisis mental health services
2. Screening, assessment, and diagnosis, including risk assessment
3. Patient-centered treatment planning
4. Screening for HIV and viral hepatitis (A, B, and C) and HIV Support
5. Primary care coordination/ screening and monitoring of key health indicators and health risk on site
6. Targeted case management
7. Psychiatric rehabilitation services
8. Peer and community recovery and harm reduction supports
9. Intensive community-based mental health care
10. Training in and provision of evidenced-based practices

11. Cooperative relationships with Court systems, jails, hospitals, law enforcement and other stakeholders
12. Consumer-led community education

CCC aims to serve 525 unduplicated clients of all ages across both locations over the four years of the project: 100 in Year 1 of the project, 125 unduplicated in year 2, 150 in year 3, and 150 in year 4.

Specific Project Goals and Objectives

Goal 1: Increase availability of and access to comprehensive, coordinated, community-based BH services

Objective 1.0: By 06/01/2023, Increase access to effective, team-based intervention and follow up care for people experiencing MH/ SUD related crises via mobile crisis team hiring and training

Data source: EHR & SPARS (NOMs), training spreadsheet, personnel files, front desk logbook/excel spreadsheet

Objective 1.1: By 06/31/2022, 90% of all crisis contacts responded to within 2 hours

Data source: EHR currently tracks days between initial phone call and receipt of services; front office logbook → excel spreadsheet on a shared drive;

Objective 1.2: By 12/31/2023, 100% of crisis contacts receive case follow up from a case manager (CM) within 24 hours of crisis contact (or 24 hours of discharge if admitted inpatient) .

Data source: EHR & SPARS (NOMs), front office logbook/excel spreadsheet

Objective 2.0: By 12/31/2023, Institute additional holistic, patient-centered and consumer-led community education and psychiatric rehabilitation services

Data source: EHR progress notes, SPARS (NOMs), CQI Plan or QA Plan/staff report

Objective 2.1: By 12/31/2023, create a peer-staffed Drop-In Center (DC) offering social and practical support, groups, peer support and other services

Data source: Sign in sheet and peer tracking list; PD report

Objective 2.2: By 12/31/2026 Institute a community harm reduction program with at least every other month Narcan (naloxone) trainings, supply distributions and availability of Motivational Interviewing (MI) or Screening, Brief Intervention, Referral to Treatment (SBIRT)

Data source: Staff report in excel spreadsheet, EHR client notes

Objective 3.0: By 12/31/2026 Increase access to regular primary care among health disparity populations

Data source: EHR & SPARs (NOMs)
<u>Objective 3.1:</u> By 12/01/2024, Reduce barriers to care by offering onsite physicals/wellness exams via hiring family nurse practitioners or other qualified PCPs
Data source: EHR & SPARs (p.20, section G3 of NOMs); personnel files
<u>Objective 3.2:</u> By 12/01/2024, Provide onsite labs/bloodwork for people prescribed psychotropic medication via staff training, lab equipment, licensing
Data Source: EHR & SPARs (NOMs; training spreadsheet)
<u>Objective 3.3:</u> By 12/01/2024, Reduce wait time for primary care appointments to 10 days
Data Source: EHR or a new dedicated spreadsheet or the scheduler or staff report (Erika)
<u>Objective 4.0:</u> By 12/31/2026, Increase access to, quality of targeted case management (TCM) for members of vulnerable disparity populations including veterans, incarcerated and justice involved persons, people experiencing or at risk for homelessness and frequent users of crisis services, via hiring, retention & training
Data Source: training spreadsheet; SPARs (NOMs)
<u>Objective 4.1:</u> By 06/01/2024, 30% of all clients participating in TCM
Data Source: SPARs (NOMs)
<u>Objective 4.2:</u> By 06/01/2024, 50% reduction in case manager (CM) caseloads
Data Source: EHR
<u>Objective 5.0:</u> By 12/31/2026, Build capacity for treating clients with complex trauma via clinical staff training in Somatic Experiencing (SE) and Internal Family Systems (IFS), evidence-based practices
Data Source: training spreadsheet; progress note in Awards
<u>Objective 5.1:</u> By 12/01/2023, 50% of QMHPs trained
Data Source: training spreadsheet
<u>Objective 5.2:</u> By 12/31/2026, 40 additional treatment hours of SE and/or IFS therapy provided to clients with complex trauma
Data Source: Progress note in Awards

Objective 5.2: By 12/31/2026, Further develop relationships, care agreements with jails, hospitals, law enforcement, other stakeholders to raise awareness of services & facilitate coordination, with a 20% increase in referrals/crisis calls

Data Source: Collaborative Agreements Binder; EHR; Crises billing codes; Crises binder

The Evaluation Team

Evaluation of the project will be conducted by the evaluator, Tara Batista, PhD, MSc, an academically trained program evaluator and researcher with more than 20 years' experience in evaluating social service programs. She will work closely with Cara Renzelli, PhD, MBA, another academically trained program evaluator with more than 25 years of experience in the field.

To enhance project sustainability after grant funding, it is important that performance assessment and ongoing quality monitoring become institutionalized within CCC. This process will provide the project an opportunity to assess its strengths, milestones and opportunities in serving adults, children, and families in Nevada. This process will focus on documenting and describing the operation of the project through all stages of service delivery over the project's funding period, and will examine and carefully document key aspects of the project's outcomes and implementation including the selection of program participants, retention and attrition of participants, and performance. The measurement of outcomes delineated by the stated grant objectives will provide the organization and the project's collaborative partners involved in this project with a true representation of the effect these proposed project services are having on the population of focus and community. Such information will be used not only by CCC to demonstrate to policy makers and top level agency administrators that funds are being used efficiently while providing services that are accomplishing desired outcomes, but will also inform the CCC the impact the project is having within the system.

Performance Measures Data Collection and Reporting

Primary responsibility for the actual collection and preparation of the data will rest with CCC project staff. Analysis of the data collected to address the project's performance questions will be accomplished using statistical procedures in SPSS including descriptive statistics to identify patterns and organize data for reporting and presentation purposes. Planned univariate and bi-variate analyses will track and quantify trends in key outcomes. Evaluation reports will be provided to the project's leadership via monthly dashboards and reports submitted to SAMHSA. Reports are due to SAMHSA after six months after the award start date (by March 30th 2023), at 12-months of operation, and at the end of the project's second, third, and fourth year to facilitate quality improvement efforts and to assist with sustainability efforts for the project.

Process Evaluation of CCC

The process evaluation of CCC will serve as a means of discovering the extent, fidelity, and quality of the components of the project. This evaluation will assist project leadership in determining if the stated goals, objectives, and outcomes are being achieved, and will identify any modifications to the project's plan that may be necessary. The evaluation will also include an assessment of CCC's impact on behavioral health disparities.

Additionally, evaluation reports will describe the project's progress, barriers, and continuous quality improvement efforts: evaluation activities will help to identify gaps in service delivery, system redundancies in funding and/or services, and health disparities.

A projected total of 525 participants will be enrolled in the evaluation. Participants will be children, youth, and adults with SED, SMI, COD and/or a mental health (MH) crisis and youth and adults with SUD or experiencing a substance use related crisis in Carson City and Douglas County Nevada. Individuals receiving services from the project will be screened for appropriate diagnoses by clinical staff and will undergo an intake session where the baseline NOMs will be collected by peers. Eligible adults, youth, and children will then work with CCC staff to develop a treatment plan formulated to address their most salient assessed needs. This plan may include (but is not limited to) crisis intervention, substance use counseling, case management, and primary care coordination. CCC staff will complete all data collection interviews and forms and enter them into their electronic health record management system (EHR). All data will be entered into SPARS within seven days of the intake date. CCC's project coordinator will be responsible for quality assurance, including accuracy and completeness of the assessment forms.

Assessments will also be administered at the six-month window, and again at one year or program discharge (whichever comes first). The data management will follow the same process as described above.

The lead evaluator (Batista) will provide CCC with a monthly report on progress toward the stated admission objectives, including enrollment rates, demographics to reflect alignment with the health disparities impact statement, reassessment rates, discharge/retention rates. CCC will work closely with the evaluators on a routine basis to ensure timely high-quality data; one cannot gauge the progress of a program with incomplete, inaccurate, or untimely information.

The lead evaluator will also write summary reports of the program at six months, one year, two years, three years, four years, and a cumulative report for review by program leadership and for submission to the SAMHSA Program Officer. The reports will assess the project's performance as related to the stated outcome objectives of the project.

At each step, the lead evaluator will work with program staff on data-driven analyses that identify barriers and bottlenecks as they may arise—and, to provide positive feedback to program staff as goals are approached and met. The evaluators (Batista and Renzelli) will meet with program leadership regularly to update and problem-solve issues that become apparent and will assist in developing plans of action to address these issues.

When implementing a new treatment initiative, it is important to ensure that the target population for the initiative is representative of the overall population of the community. Disparities found in access to care, treatment and support services can lead to negative health outcomes for subpopulations of individuals with cultural and linguistic needs not found within the system of care. Assessing health disparities provides an overview of current disparities and helps inform a plan of action to reduce barriers relating to disparate access and utilization of project services. The table below shows the proposed number of individuals to be served during the grant period and identified subpopulations in the project's catchment area. As you will see, the goal is to ensure that the racial, ethnic, gender, and sexual orientation groups reflect the communities the CCC serves. These percentages in the breakdown by percentage column were chosen so that parity for each group was reached (the number the CCC serves in each group is at least 80% of the % of that group that the community comprises. For example, Hispanic/Latinos have been historically underserved by the CCC in Carson City. Carson City's population is 24% Hispanic/Latino, but only 12.9% of the people the CCC serves are Hispanic/Latino. Parity would be reached if 19.2% or more of the CCC's service recipients were Hispanic/Latino in Carson City). Progress toward parity targets will be tracked and reported during the grant period for all racial, ethnic, gender, and sexual orientation groups. For more information about how the CCC will address disparities, please see the disparities impact statement.

Proposed number of individuals to be served by CCC by subpopulations

# to receive direct services By Race	Year 1	Year 2	Year 3	Year4	Totals	Breakdown by Percentage
White or Caucasian	80	94	110	110	394	75
Black or African American	2	3	4	4	13	2.5
Native American/Alaska Native	3	4	5	5	17	3.2
Asian or Pacific Islander	2	2	3	3	10	1.7
Other or Refused	13	22	28	28	91	17.6
Total	100	125	150	150	525	100%

# to receive direct services by ethnicity	Year 1	Year 2	Year 3	Year4	Totals	Breakdown by Percentage
Hispanic	22	27	33	33	115	22%
Non-Hispanic	78	98	117	117	410	78%
Total	100	125	150	150	525	100%

Gender	Year 1	Year 2	Year 3	Year4	Totals	Breakdown by Percentage
Female	48	60	72	72	252	48.5
Male	52	65	78	78	273	51.5
Total	100	125	150	150	525	100%

Assessment of Project Implementation

The extent to which the project components are implemented as intended will be analyzed by comparing project timelines, targeted vs. actual number of services provided, and targeted vs. actual number of participants served (both aggregate for the whole sample and by demographic group). The process component of this evaluation will address these questions:

- 1) Was the project implemented as intended? (Data sources: FOA, grant application, project reports, NOMs, personnel files, staff report in excel spreadsheet from logbook in front office and other documentation such as shared training spreadsheet and stakeholder binder);
- 2) What types of deviations from the plan occurred? (Data sources: evaluation team meeting minutes, project meeting minutes, project-related correspondence such as timelines, and other documentation);
- 3) What led to the deviations? (Data sources: evaluation minutes, project meeting minutes, project-related correspondence and other documentation);
- 4) What effect did the deviations have on the planned intervention and evaluation? (Data sources: evaluation minutes, project meeting minutes, project-related correspondence and other documentation);
- 5) What types of services were provided and what gaps remain in the delivery of services? (Data sources: NOMS Reassessment Interview and Discharge Services Received Form & Section G8. CCBHC Q1 (a-j) asked at baseline, reassessment & discharge, DIS & CNA)
- 6) How long did participants stay in program services? (Data sources: NOMS Section H. Q1 Reassessment Interview and Discharge Assessments)

- 7) How satisfied were participants with services received? (Data sources: NOMS Section E. Perception of Care & Clinic Level Quality Measures MHSIP surveys that include Patient experience of care surveys and Family experience of care surveys).
- 8) What was the demographic profile of the individuals receiving services? (Data sources: NOMS Intake Assessment)

Data Management Procedures for Process Evaluation

The project will utilize a Microsoft Excel workbook containing worksheets for data tracking in addition to the NOMS data that are entered into the CMHS SPARS database. The project coordinator will be responsible for entering these project data into the Excel workbook within 7 days of collection. The evaluation team will use this workbook for tracking and prompting follow-up activities and producing monthly project reports.

Outcome Evaluation of CCC

The outcome evaluation will examine changes in the participants' life functioning in a number of domains frequently used to assess program effectiveness, using a single-group, repeated measures design. The outcome evaluation will primarily assess the project's effectiveness over time through a pre/post-test design. Repeated measures on individuals will be used to study the short-term outcomes at six months post-baseline and at discharge on key program indicators (see Goals and Objectives). The following questions will frame the outcome evaluation:

1. What was the effect of interventions on key outcomes?
2. What program/contextual/cultural/linguistic factors were associated with outcomes?
3. What demographic and other individual factors were associated with outcomes?
4. How durable are the effects over 6 or more months?

Key Outcomes	Measure	Data Source
Suicide Risk	NOMs Q2, BH diagnoses section The Columbia-Suicide Severity Rating Scale (C-SSRS) DSM-5 Cross Cutting Measure: Domain 5, Suicidal Ideation Consumer suicide deaths or suicide attempts	EHR State portal
Substance Use	• <u>Drug Use</u>: Initiation & engagement of alcohol & other drug dependence treatment. NOMs Substance use Diagnoses (opioid related disorders, cannabis related disorders, sedative	EHR, EHR,

	hypnotic, or anxiolytic related disorders, cocaine related disorders, other stimulant related disorders, hallucinogen related disorders, inhalant related disorders, other psychoactive substance related disorders) • Preventative Care & Screening: Unhealthy <u>Alcohol Use</u> - Screening & Brief Counseling. NOMs Substance Use Disorders Section on Alcohol Related Disorders (F10.10-F10.9) • Preventive Care & Screening: <u>Tobacco use</u> Screening & Cessation Intervention. NOMs Nicotine dependence section (F17.20-21). DSM Cross Cutting Measure: Domain 8, Substance Use. Q 21 Alcohol, Q22 Tobacco Q23 Drugs NOMs Section B. 1c	EHR EHR
Social Connectedness	NOMs Section F 6 items	EHR
Education & Employment Status	NOMs Section C. Education & Employment Q1-4	
Housing Stability	NOMs z codes: Z59 problems related to housing & economic circumstances & section B. Stability in Housing (Q1= items 1a & 1f + Q2). Q 2g. on NOMs under Section A. Functioning “I have a safe place to live”	EHR
Quality of Life	Screening Question: GPRA Section F Q1: “How would you rate your quality of life over the past 30 days?” WHODAS	EHR
Mental Health	<u>Depression</u> Depression Scale PHQ-9 BH Diagnoses Section of NOMs: items F32 & F33 under Mood disorders. Section A. Functioning: Q3d DSM Cross Cutting Measure: Domain I <u>PTSD</u> PCL-Civilian or Veteran?	EHR

	NOMs Mental Health Diagnosis F43.10 - Post traumatic stress disorder, unspecified <u>Anxiety</u> DSM - 5 cross cutting measure domain II anxiety NOMs Section A. Functioning 3a Nervous? 3c Restless or fidgety? <u>MH Functioning</u> Section A on NOMs including self rated mental health Q1, and Q2 MH functioning more broadly. Q3 (emotional states). DSM Cross Cutting Measure: Domain XII Personality Functioning NOM Sect. B 1b & 1e	
Physical health	NOMs Section G8 Q2a-d physical measures of systolic and diastolic blood pressure, Height, Weight Diabetes screening for people w schizophrenia or bipolar disorder who are using antipsychotic medications & Medication adherence for those w schizophrenia	EHR, patient records EHR, Encounter data Claims Data/ encounter data
Crime & Criminal Justice Involvement	NOMs Section D. Crime & Criminal Justice Status Q1 a & 1b Section B. 1d	EHR & SPARS

Data Collection Plan:

Program staff will collect the baseline, 6-month reassessment, and discharge from all individuals participating in this project. All data will be entered into the CCC's EHR within seven days of collection. To fulfill the requirements of a national study, a random sample of 10% of the previous month's data from the EHR will be selected to be entered into SPARS within 30 days of its original collection date. Appendix A contains details about the probability sampling for the national study.

Data Reporting Plan for Project Management

The lead evaluator will provide preliminary analyses to check the case flow, degree of project and evaluation implementation, trends, and/or to answer questions and concerns raised in project meetings. When problems arise, the evaluation team will use both qualitative and quantitative data to understand the problem, develop a plan to address the problem, and evaluate whether the plan is working. Monthly management reports will track the cumulative rate of several leading indicators including:

- enrollment rate;
- reassessment rate;
- racial and gender demographics of enrolled participants

The goal is to reach enrollment and reassessment rates of 80%. Evaluation reports will provide more detailed information regarding a) the number and characteristics of the clients served; b) the amount and type of services provided; and c) the services received (measured at discharge) by the services recommended at intake. Reports will examine change from intake to 6 months in: substance use (overall and by substance); housing/employment status; involvement in the criminal justice system; and experiencing other life problems. The lead evaluator and project staff will meet regularly to review project reports, to incorporate adjustments necessary to achieve and maintain the project goals, and to monitor the impact of any modifications to the planned interventions and implementation plan.

Outcome data will be analyzed by racial and ethnic groups and gender to assure that appropriate populations are being served and that disparity in services and outcomes is minimized. The evaluation team will report on any identified health disparity quarterly and will notify program staff if follow-up responses indicate that services provided were not culturally appropriate or relevant.

Appendix A - Sample for a National Evaluation

Sampling Methodology Plan**CCBHC-IA (SM-22-012)****CCBHC-PDI (SM-22-002)**

Date:	Jan 25, 2023
Grantee Name:	Carson City Community Counseling Center (CCC)
Grant Award Number:	
GPO:	Gavin Kirkpatrick
GMS:	

1. Expected Annual Active CCBHC Client Population		
Year 1:	174	(232 x .75 to prorate)
Year 2:	290	(232 x 1.25% increase)
Year 3:	348	(232 x 1.5% increase)
Year 4:	348	(232 x 1.5% increase)
Year 5:	Total = 1,160 over 4 years (174+290+348+348)	

GPO Comments:

2. Sample rate required for NOMS data collection (**10%**, 8%, 6%, 4%, 2%, or 1%)

Year 1:	18
Year 2:	29
Year 3:	35
Year 4:	35
Year 5:	Total = 117

GPO Comments:

3. Clinic process/procedures outlining steps of random selection and NOMs baseline data collection/enrollment.

The CCC will administer NOMs to all clients who contact the CCC seeking services after March 1st within 7 days of admission/appointment. Their NOMs and participant IDs will be entered into the EHR by a peer support specialist. The CCC generates unique participant IDs that are 8 digits long and enters those IDs along with the corresponding participant data into rows in their EHR (1 row per participant). The first 5 digits are the same for each client, however the last 3 digits vary. The last digit of participant IDs are in chronological order (0-9) and start over each time after 9 is reached. The Lead Evaluator has selected the random number of 10480 from the Random Number table in one of her statistics textbooks (column 1, row 1 Appendix E, pg. 611, Research Methods for Social Work, 3rd Edition, Rubin & Babbie 1997, Brooks/Cole Publishing Company). After a month has passed, the CCC's Compliance

& Quality Manager Deanna Torres will select a random 10% sample of the participants by selecting participants with IDs ending in 1 (starting from top to bottom of the last month's rows in the EHR) until 10% of that month's sample is reached. She will upload the selected client's data into SPARs. Ex - If 10 clients receive NOMs in March, in April the client whose ID ends in 1 is uploaded to SPARs. If 20 more new clients are administered NOMs in April, 2 clients who have unique IDs ending in 1 will be selected and uploaded to SPARs.

GPO Comments:

4. Clinic process/procedures outlining means for ensuring the same clients assessed at baseline are assessed at reassessment and discharge.

Starting July 1st, the lead evaluator, Tara Batista, will log into SPARs and note the client IDs that completed baselines in March and notify Deanna to flag those IDs for reassessments in August. SPARs has a built-in notification mechanism as well that helps notify grantees when reassessments are due. The CCC is also examining ways to build a notification mechanism into their EHR.

GPO Comments:

5. Clinic process/procedures outlining the regular review or checks to ensure the implementation is resulting in a random sample and that certain populations are not being excluded.

GPO Comments:

GPO Response	
☐	Approved.
☐	Not approved. Please resubmit by:
Additional Comments	