

SAMHSA Disparity Impact Statement

Purpose

SAMHSA requires that its grant recipients prepare a Behavioral Health Disparity Impact Statement (DIS) as part of a data-driven, quality improvement approach to advance equity for all, and to identify racial, ethnic, sexual and gender minority populations at highest risk for experiencing behavioral health disparities as part of their grant projects. The purpose of the DIS is for grant recipients to identify, contextualize and address disparities¹ and to develop and implement a disparity reduction action plan with a quality improvement process to address and close the identified gap(s). The aim is to achieve behavioral health equity² for disparate populations and to improve systems addressing the needs of these populations. The DIS requirement aligns with expectations outlined in [Presidential Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government](#), which includes identifying the needs of underserved communities and developing policies to advance (health) equity within those communities.

Background

To address behavioral health disparities, it is important to understand the role that Social Determinants of Health (SDOH)³ can have on the health of individuals and communities. SDOH are the conditions in the environment where people are born, live, work, play, worship, age and thrive that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into 5 domains: 1) Economic Stability; 2) Education Access and Quality; 3) Healthcare Access and Quality; 4) Neighborhood and Built Environment; and 5) Social and Community Context. The SDOH framework recognizes that cross-sectoral systems contribute to advancing equity through a lifespan perspective. Understanding the SDOH community context can help recipients identify the disparity (or problem), population of focus and inform the development of accurate measures to study and improve outcomes.

¹ Healthy People 2030 defines a health disparity as a “particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; disability; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

² Behavioral health equity is the right to access high quality and affordable health care services and supports for all populations regardless of the individual’s race, age, ethnicity, gender (including gender identity), disability, socioeconomic status, sexual orientation, or geographical location. Advancing behavioral health equity involves ensuring that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with quality services, this involves addressing social determinants of health, such as employment and housing stability, insurance status, proximity to services, and culturally responsive care – all of which have an impact on behavioral health outcomes.

³ <https://www.cdc.gov/socialdeterminants/index.htm>

The purpose of this document is to support grant recipients in developing measures associated with DIS. All of SAMHSA's discretionary grants are required to report Government Performance and Results Act (GPRA)⁴ data, which includes the National Outcome Measures (NOMS). Grant programs using the NOMS client-level outcomes tool uses data collected that includes demographics⁵, ICD-10 diagnostic categories, substance use and abuse, mental health and physical health functioning and other variables. There are limitations to the categories regarding certain race, ethnicity, language, and disability. For some grant programs that are collecting Infrastructure, Prevention and Promotion (IPP) indicators, demographic data are collected, but are not housed within SAMHSA's Performance Accountability and Reliability System (SPARS).

Despite these limitations, the DIS can be used to identify and demonstrate the impact of SAMHSA's investments to reduce and eliminate inequities among underserved populations. By developing the DIS, recipients will identify the population experiencing the disparity, share more specific population data that will assist in determining if SAMHSA's grant investments are reducing disparities, use data to more precisely direct resources to improve the SDOH and CLAS while moving towards outcomes that will reduce disparities among the population(s) noted.

For recipients serving distinct populations (i.e., tribes, etc.), disparities within these populations can be identified (e.g., age, gender identity, sexual orientation, disability).

As recipients collaborate within their respective organizations to complete this DIS, we hope that it will inspire and guide an approach to reducing and eliminating behavioral health disparities for the populations being served. In the following pages the modernized SAMHSA Behavioral Health Disparity Impact Statement is included as a worksheet to support completion by the recipient.

Resources, guidance, and training to support recipients in completing the DIS can be found here [<https://www.samhsa.gov/grants/grants-management/disparity-impact-statement>]; see also accompanying Appendices).

⁴ <https://www.samhsa.gov/grants/gpra-measurement-tools>

⁵ <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53>

Disparity Impact Statement Worksheet

Grantee Organization Name: Carson City Community Counseling Center

Grant ID (SM/TI/SP/FG): 1H79SM086908-01

Grant Program: Enhancing Carson City Community Counseling Center's CCBHC to meet the emerging needs of our rural community.

Project Director: Walter Saunders

Grant Project Officer: Gavin Kirkpatrick

SECTION I. Identifying Behavioral Health Disparities

IDENTIFY and DESCRIBE THE SCOPE of the PROBLEM

What is the disparity/problem/gap you are seeking to address as it relates to the grant program?

What is the data to support this (e.g. [SAMHSA National Survey on Drug Use and Health \(NSDUH\)](#), [CDC and OMH Minority Health Social Vulnerability Index \(SVI\)](#), [CDC/ATSDR Social Vulnerability Index \(SVI\)](#), [CDC Behavioral Risk Factor Surveillance System](#), [CDC Youth Risk Behavioral Surveillance System](#), [AHRQ National Healthcare Quality Disparities Report \(NHQRDR\)](#), [U.S. Census Bureau Data](#), [U.S. Census Bureau American Community Survey \(ACS\)](#), [Federal Register Annual Update of the HHS Poverty Guidelines](#), [CMS Informational Bulletin on 2022 Federal Poverty Level Standards](#), other federal, state, or county level data. Note: You may frame the disparity(ies) by looking at the individual/client level, organizational level, and/or systemic level.

- Carson City Community Counseling Center (CCC) is a Certified Community Behavioral Health Clinic (CCBHC) serving the catchment area (CA) of Carson City - an independent city with a population of 58,993 - and Douglas County, population 49,870 (Nevada-demographics.com) in Northern Nevada (NNV). Both Carson City and Douglas County are in rural Nevada with Carson City being the 4th largest (population) in the state.
- 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). CCC's population is overwhelmingly poverty-stricken: 33.4% are homeless with another estimated 30% at risk of homelessness. Carson City and Douglas County's population of this demographic is approximately 24% and 13% respectively. About 7% of CCC clients have SED/SMI and 90% have SUDs; we estimate 70% of these have CODs. Although Hispanics/Latinos or those who speak another language at home develop SED/SMI at equal rates to other ethnicities, this vulnerable group is less likely to engage in seeking out mental health services (35.1% vs. 46.2%, mhanational.org).

- Both Carson City and Douglas County residents face increased risk of health disparities and behavioral health (BH) care access gaps including those who speak a language other than English at home, veterans, and uninsured persons (see table). CCC's current census consists of 12.9% of Hispanic/Latinos & those who speak another language at home.
- Hispanic/Latino populations and those who speak another language at home are more likely to experience language related barriers to access primary and preventive care, lower quality of care, and report worse health outcomes. (Healthy People 2030).
- Only offering primary care services in English can negatively impact access to primary care and screening programs for patients who speak a language other than English.¹⁰ For example, a study found that Hispanic children who do not primarily speak English and immigrant Hispanic children are more likely to lack a usual source of care compared to non-immigrant Hispanic individuals in English-speaking households.¹⁰ Similarly, a study examining health quality of life outcomes in older populations discovered that older immigrants with limited English proficiency had less access to health care than older adults who speak English fluently.²⁰
- While only 8% of all U.S. adolescents report experience with racial/ethnic discrimination, there is significant variation between White (2%) and Hispanic (11.0%) youths.³² Experiencing discrimination may be related to health behaviors that have clear associations with particular disease outcomes, such as smoking^{33,34} or alcohol abuse.³⁵ It may also be related to not participating in health-promoting behaviors, such as cancer screening, diabetes management, and condom use. ^{5,36,37,38}
- Further, the 2019 National Healthcare Disparities Report indicated that White patients receive better quality of care than 34.5 percent of Hispanic patients. Primary and Behavioral Health equity is one of the "Six Domains of Health Care Quality" (ahrq.gov).
- Current barriers for the Hispanic/Latino & those who speak another language at home include not being aware of CCC's Behavioral Health Center's bilingual capability, staff shortages as often the Hispanic/Latino & those who speak another language at home require full family therapy, concerns that undocumented clients could be reported, and being unfamiliar with navigating the behavioral health system. Traditional approximate therapist-to-client ratios to avoid therapist burnout have been listed as 15-20 clients for f/t therapists and half that for p/t. Due to the rural nature of CCC and difficulty in hiring therapists and more specifically, bilingual therapists, family therapy, a desirable approach for the Hispanic/Latino and those who speak another language at home, is currently impossible. Wait times for mental health evaluation and services for the Hispanics/Latinos & those who speak another language at home can be as much as several weeks. Current mental health caseloads currently exceed national averages. These factors will be more evident as we increase our services to the Hispanic/Latino & those who speak another language at home populations.

DISPARATE POPULATION(S) OF FOCUS

Identify the focus population(s) experiencing disparate access, use, and outcomes and that experience adverse SDOH with impact to behavioral health in your geographic/catchment area.

Identify data source(s) that you are using to inform the DIS for the grant program. *Grant recipients must select sound and reliable source(s) of programmatic, county, state, or national indicators the program deems best suited to the needs of this grant. Recipients may consider the same data sources listed above (e.g., ACS, NHQDR, SVI, NSDUH). The data referenced within the DIS should be in alignment with the data provided in your application.*

**Note: For client level data, SDOH Z-codes are available and can be used to collect data on disparities. It is recommended to use SDOH Z-codes more broadly and beyond the billing environment to support data collection on available determinants. For more information on SDOH Z-codes and how they are being used to narrow health disparities, please see <https://www.cms.gov/files/document/zcodes-infographic.pdf>; <https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf>; and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6207437/pdf/18-095.pdf>.*

Demographic Table

Complete a table that includes the disparity (the gap or difference) at the individual/client, organizational, or systemic level as it relates to the grant data collection requirements: NOMs, IPP, or both related to access, use and outcomes. *For examples, including the use of a table, please see Appendix A.*

- White: 66% in Carson City; 80% in Douglas County; 82% of CCC consumers (both sites)
- African American: 2% in Carson City; 1% in Douglas County; 1.8% of CCC consumers (both sites)
- **Hispanic/Latino: 24% in Carson City; 13% in Douglas County; 12.9% of CCC consumers (both sites)**
- Other (Asian American, Alaska Native/American Indian, Mixed race. Etc.): 3% Carson City, 2.1%; in Douglas County; 1.8% of CCC consumers (both sites)
- Veterans: 7% in Carson City; 10.9% in Douglas County; 6% of CCC consumers (both sites)
- Under 18: 20.4% in Carson City; 16% in Douglas County; 9.3% of CCC consumers (both sites)

***Data Source:** Census, CCC EHR demographic report

Carson City Community Counseling Center's CCBHC, historically, serves on average 525 people a year across both locations. For this new CCBHC-IA grant program, we plan to serve 525 unduplicated individuals across both sites over the entire project period per our application. In Carson City, our goal is to serve 498 unduplicated persons at this location. In Douglas County, our goal is to serve 27 unduplicated persons at this location.

- We will increase the number of Hispanic/Latino & those who speak another language at home from 12.9% to 22% across both locations across the entire grant period. We will increase the number of Hispanic/Latino & those who speak another language at home under the age of 18 by 10% and those who are over the age of 65 by 5%.
- CCC will hire additional bilingual staff who will assist in engaging the Hispanic/Latino & those who speak another language at home in their intake process thereby increasing the agency's organizational health literacy.
- Increase OP clinic primary care screening and monitoring of key health indicators and health risk for our Hispanic/Latino & those who speak another language at home
- Increase additional behavioral health services (SUDS, MH, Peer Supportive Services and TCM) that are offered in Spanish.
- CCC will hire additional mental health therapists with a focus on bilingual therapists.

Demographic Table
Total (2 sites together)

	Year 1	Year 2	Year 3	Year 4	Totals
Non-Duplicated	100	125	150	150	525
Active # of Individuals to Be Served Per Year (can include duplicates) – if applicable	300	300	300	300	1200

By Race	Year 1	Year 2	Year 3	Year 4	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%

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%

Sexual Orientation and Gender Identity	Year 1	Year 2	Year 3	Year4	Totals	Breakdown by Percentage
LGBTQ+ (or Choose Not To Disclose)	6	7	8	8	29	6
Heterosexual	94	118	142	142	496	94
Total	100	125	150	150	525	100%

SECTION II. Addressing Disparities Using the Funding Opportunity

SOCIAL DETERMINANTS OF HEALTH⁶

Identify one or more SDOH domain(s) that your organization will work to address and improve for the identified population(s) of focus using the Notice of Award (NOA). Include a brief explanation about how your organization will address the specific domain(s) to support the reduction or elimination of disparities for the identified population.

Social Determinant of Health Domains

(Visit [Healthy People 2030](https://www.ruralhealthinfo.org/toolkits/sdoh) for more information on the five (5) domains.)

1. Education and Quality
2. Economic Stability
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

⁶ <https://www.ruralhealthinfo.org/toolkits/sdoh>

SECTION II. Addressing Disparities Using the Funding Opportunity

SOCIAL DETERMINANTS OF HEALTH⁷

Identify one or more SDOH domain(s) that your organization will work to address and improve for the identified population(s) of focus using the Notice of Award (NOA). Include a brief explanation about how your organization will address the specific domain(s) to support the reduction or elimination of disparities for the identified population.

Social Determinant of Health Domains

(Visit [Healthy People 2030](https://www.hhs.gov/healthypeople/2030) for more information on the five (5) domains.)

1. Education and Quality
2. Economic Stability
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

Our grant activities will address the SDOH domains of Health Care Access and Social and Community Context.

CCC will increase its outreach by engaging Hispanics/Latinos & those who speak another language at home communities through local churches, school settings, and other community-based organizations. CCC will increase bilingual staff levels to appropriately engage Hispanics/Latinos & those who speak another language at home in behavioral health services including primary care, family therapy, and SUDs treatment. CCC will increase Spanish-speaking peers to engage the Hispanic/Latino & those who speak another language at the home population as they can assist this population in connecting to community-based systems of care. CCC will increase outreach to the Hispanic/Latino & those who speak another language at home population through increased targeted case management. CCC will increase its outreach to Hispanics/Latinos & those who speak another language at home during their incarceration in the jail through information sharing regarding services available upon release.

Health Care Access

OP clinic primary care screening and monitoring of key health indicators and health risks are conducted at check-in by a certified medical assistant (MA) who obtains vitals and performs screening and monitoring. Abnormal findings trigger a referral to either the onsite FNP or the clients outside the primary care provider (PCP). However, wait times to see the FNP can be 4+ weeks, and many clients do not have a PCP due to access barriers, especially among people with SMI/SED/COD, SUD, those experiencing *homelessness*, and/or members of health disparity populations. **Proposed grant activities:** Reduce wait times and increase access to regular primary care by hiring at least 2 providers [1 MA and 1 APRN have been hired so far and an additional (FNPs, physician's assistants, or other advanced practice nurses experienced in community health may be hired)]. Providers will offer onsite physicals/wellness exams, with targeted referrals to PCPs.

⁷ <https://www.ruralhealthinfo.org/toolkits/sdoh>

We will include two local federally qualified health centers with whom we will seek care coordination agreements - for advanced diagnostics and care. CMs and the MA coordinate referrals, follow up, and (HIPAA-compliant) information sharing. This may reduce disparities via increased access to regular care, enabling earlier detection and treatment. Basic lab tests and periodic blood work/monitoring for clients taking psychotropic medications will be provided in-house via phlebotomy training for the MA and obtaining lab equipment and licensure. Community outreach and education will include primary care service availability,

Social and Community Context

Psychiatric rehabilitation services will be integrated into treatment and focus on the client in the context of their world and relationships; many will be offered in Spanish. They include group and individual psychoeducation, support groups, Basic Skills Training (BST), a goal-oriented rehabilitative mental health (RMH) service that teaches cognitive, behavioral, and life skills, Psychosocial Rehabilitation (PSR), a strength-based RMH that teaches practical and coping skills for everyday life, community participation and managing serious MH conditions. **Proposed grant activities:** Community outreach/education about stigma reduction and the availability of recovery-oriented services. **Peer Support** is integrated into nearly all programs, and provided to veterans, those with SED/SMI/COD, SUD, criminal justice system involvement, frequent crisis and/or inpatient admissions, and others, with 3 peers being reassigned to the activities specified in our grant. Several Peers, including a bilingual peer, are also parents of people with SED/SMI/COD/SUD and can support family members. **Proposed grant activities:** Staff training for Peers in homelessness, crisis response. Full integration of Peers into crisis teams, with teams educated on their value. Open a Peer-staffed Drop-In Center (DC) to support recovery and increase service access and engagement. The DC will offer recovery-oriented activities, Peer-led groups, socializing, or simply somewhere to be to avoid relapse. Peers will connect with and engage consumers, provide resources and individualized harm reduction education and supplies with MI or SBIRT, and otherwise facilitate rehabilitation, empowerment, and hope.

Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care⁸

Using the Behavioral Health Implementation Guide, identify one or more of the CLAS standards (listed below) that your organization plans to meet, expand, or improve through this grant opportunity. Include an explanation on any activities, policies, and procedures that your organization will undertake to ensure adherence.

(Review the [Behavioral Health Implementation Guide](#) for full explanations of the overarching themes and 15 CLAS Standards with behavioral health related samples, strategies, and examples.)

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

⁸ https://www.minorityhealth.hhs.gov/minority-mental-health/clas/?utm_medium=email&utm_source=govdelivery

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency (LEP) and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all partners, constituents, and the general public.

- 1) Hire clinical staff who are from the communities of the populations being served
- 2) Create treatment plans for non-English proficient individuals in Spanish
- 3) Expand Peer Supportive Services that are reflective of and imbedded in the community
- 4) Proactively engage the community via the community needs assessment process
- 5) Expand PSR (psychosocial rehabilitation) and BST (basic skills training) services to be provided by Spanish-speaking paraprofessionals.
- 6) Utilize outreach coordinators to engage the Hispanic/Latino & those who speak another language at home through community-based venues.

SECTION III. Developing a Disparity Reduction Quality Improvement Plan

This final section of the DIS addresses development and implementation of a disparity reducing quality improvement plan as part of your DIS to address under-served population differences based on the (GPRA) data for access, use and outcomes of activities.

For example:

- Access: number of individuals served, number of outreach contacts, number of screenings, number of referrals.
- Use: number of screenings, number of referrals, retention rate, number of trainings.
- Outcomes: number of completed referrals, number of people trained, number and percentage of individuals who have demonstrated improvement in knowledge/attitudes/beliefs, number of programs/organizations/communities that implemented specific behavioral health practices or evidence-based activities.

Include activities as they relate to both the grant requirements and your application. Also mention the identified gaps, disparate/population(s) of focus, and subpopulations listed above. As part of the programmatic progress reports, an annual update on the disparity reducing quality improvement plan (what worked, what did not work, and what modifications were made) will be required per the NOFO. The DIS should be viewed as a living document.

IMPLEMENTATION OF ACTIVITY

Based on the responses above, identify specifically how you will address these disparities and the populations' needs with the required activities from the NOFO and within your application (using the SMART goals). Using the SMART goals, your application should be aligned with the DIS. Be sure to answer the following: What can your grant program activities do to address the disparity/ies? Address access, use, and outcomes (see Appendix C). How will you implement these activities? Who will be responsible to do so? How will you include client/peer/family/friends' voices in your program activities?

Please describe the activities that you will implement.

In Carson City and Douglas County, we will:

- Increase the number of outreach contacts to the Hispanic/Latino population by 10%
- Increase the number of screenings and intakes for the Hispanic/Latino population by 12% across both locations.
- We will also focus on adding staff training by increasing annual training for cultural competency and sensitivity, trauma-informed, crisis de-escalation, and LGBTQ+
- Build and maintain at least 5 partnerships in each county that will better support the needs of the populations to be serviced across the entire project period. We will offer peer and family support services.
- Review/revise CCC's Policies and Procedures as they relate to improving wait times and providing culturally appropriate services and trauma-informed care on an annual basis.
- Increase SUDS counselors and Mental Health Therapists with an emphasis on bilingual capability.
- 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 by mo 6
- 90% of all crisis contacts responded to within 2 hours by mo 6
- 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) by mo 12.
- Institute additional holistic, patient-centered, and consumer-led community education and psychiatric rehabilitation services
- Creation of a peer-staffed Drop-In Center (DC) offering social and practical support, groups, peer support, and other services by mo 12
- Institute a community harm reduction program with at least every other month Narcan (naloxone) training, supply distributions, and availability of Motivational Interviewing (MI) or Screening, Brief Intervention, Referral to Treatment (SBIRT) by mo 12.
- Increase access to regular primary care among health disparity populations
- Reduce barriers to care by offering onsite physicals/wellness exams via hiring family nurse practitioners (FNPs) or other qualified PCPs by mo 24
- Provide onsite labs/bloodwork for people prescribed psychotropic medication via staff training, lab equipment, licensing by mo 24
- Reduce wait time for primary care appts to 10 days by mo 24.
- 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
- 30% of all clients participating in TCM by mo 18
- 50% reduction in primary case manager (CM) caseloads by mo 18 through hiring additional case manager(s)
- Build capacity for treating clients with complex trauma via clinical staff training in Somatic Experiencing (SE) and Internal Family Systems (IFS), evidence-based practices
- 50% of QMHPs trained by mo 12
- 40 additional treatment hours of SE and/or IFS therapy provided to clients with complex trauma by mo 12.
- 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 by mo 12.

INTENDED OUTCOMES AND IMPACT

How will these activities improve the problem or close the disparity? How will you identify and outreach to the selected population(s) of focus in your catchment area?

(Intended outcomes and impact should be directly related to your goals and objectives.)

Through the implementation of the activities mentioned above, our intended goals and impact are to:

- Increase access to and use of mental health and substance use services in both Carson City and Douglas County to reduce wait times and increase overall behavioral health outcomes
- Increase the number of primary care screenings and behavioral health services including Naloxone training with the goal of decreasing substance misuse and overdoses
- Improve the quality of care by increasing the number of mental health therapists and SUDs counselors with an emphasis on bilingual capability.
- Begin providing appropriate services through ASAM Level of Care (Level 1 Outpatient and Level 2.1 IOP) in Spanish.
- Decrease mental health and SUD counselors' caseloads to increase staff retention.
- Increase capacity and decrease response time to behavioral health emergencies in the community.
- Increase provider capacity to engage in complex and developmental trauma while engaging the families.
- Reduce community wait time for establishing primary care.
- Decrease isolation for those with behavioral health concerns by establishing a drop-in center.
- **Increase services for those who are Hispanic/Latino & those who speak another language at home through increasing bilingual staff and through outreach into the community.**

How will you include client/peer and family voices and other relevant partners in your program's activities based on the identified population of focus?

Per the CCBHC Community Needs Assessment that we will conduct, we will engage consumers and their family members and provide enhanced training on treatment issues relating to complex trauma, SED/SMI, Veterans, and the use of person and family-centered service planning. Clinical supervision and training will be provided to the peer specialist/supporter/(s). The bilingual peers will work with clients and medical staff as a bridge/translator to increase primary care and outreach to our Hispanic/Latino & "those who speak another language at home" populations. CCC will establish a "peer advisory board" which will assist in the community needs assessment process. The advisory board will continue to meet monthly after the needs assessment process has ended. The advisory board will consist of community partners (minimum of 5) who may assist in determining needs or provide constructive feedback. The requirement for this committee's membership is "in active recovery from a behavioral health (mental health, co-occurring, or SUDS) condition or has a family member in active recovery from said condition." CCC will conduct periodic outreach to community-based organizations utilizing a two-person team approach (staff member and community member) while cognizant that outreach will occur through an individual that best represents the demographic we are reaching out to. Outreach activities will happen at a minimum of biweekly.

TIMELINE

When will you implement these activities? How often will they be reviewed and adjusted? (Recipient should follow NOFO specific NOMs data collection timelines with DIS reporting updates.)

Per the NOFO, the implementation of activities will begin no later than 3 months after the grant award start date. We will have hired our full clinical team and will begin providing trainings throughout the year, at time of hire (onboardings) and annually. Enrolling clients will begin in January and providing screenings and referrals will occur regularly in real time, through the project period. NOMS data collection methods will capture needed measures any adjustments will be made quarterly based on evaluator feedback on NOMS performance measures.

MEASUREMENT/ EVALUATION

How will you measure your process, progress, and outcomes to show you were able to improve disparities (i.e., close the gap) within the identified population(s) of focus? How will you measure incremental progress achieved under this award?

You should link measurement⁹ and evaluation to goals and objectives submitted in or with your application and as noted earlier in the DIS. Please refer to Appendix D for additional resources.

Goal	Grant Objectives	Inputs	Outputs	Short-term Outcomes	Long-Term Outcomes
Reduce SUDs for Hispanic/Latino population in Carson City	Increase access to effective, team-based integrative and follow-up care for people experiencing SUD including crises related to SUDs (Obj.1)	Increase the # of outreach contacts to the Hispanic/Latino pop by 10% Hire 1-2 bilingual staff who will assist with the intake process Increase Spanish language screenings made by clinicians for SUDs by 12% Hire and train a mobile crisis team by month 6 Increase the # of trainings in SUD BH interventions delivered to bilingual practitioners Institute a community harm reduction program w >= every other month Narcan trainings, supply distributions, and	90% of all crises contacts responded to within 2 hours by month 6 100% of all crises receive case followup from a case manager within 24 hours of crises contact (or 24 hours of discharge if admitted inpatient) by month 12 # of bilingual clinicians trained Increase # of relevant SUD EBPs (TCM, Harm Reduction techniques, IDDT, CBT, DBT, SS, EMDR, IFS, SE, SBIRT, MI, & Peer Support) received in the appropriate language by	Reduced SUDs for Hispanic/Latinos served by the CCC by Oct. 2023 as measured by the # of clients referred to SUD services and/or diagnosed with a substance use disorder during intake, 6 month, or annual assessment interviews % improvement in social connectedness	The % of SUDs in Carson City sustains a decrease of X% over a 4 year period for the Hispanic/Latino population The number of overdoses in Carson City decreases by X% over a 4 year period

		availability of MI or SBIRT by month 12 # of supplies ordered Integrate the 1-2 Spanish speaking peers into SUD services especially into crisis teams. Train peers in crisis response and harm reduction	Hispanic/Latino consumers # of Hispanic/Latinos referred # of Hispanics/Latinos who received Naloxone, # of fentanyl test strips used?		
Improve the Mental Health (MH) of the Hispanic/Latino population in Carson City	Increase access to effective, team-based integrative and follow-up care for people experiencing MH problems including crises related to MH (Obj.1)	Hire 1-2 bilingual staff who will assist with the intake process Increase Spanish language screenings made by clinicians for diagnosing MH disorders by 12% Hire and train a mobile crisis team by month 6 Increase the # of trainings in mental health services including trauma based training in Spanish delivered to bilingual practitioners Hire 1-2 peers who speak Spanish & train them in crises & peer support	# of Hispanics/Latinos screened 100% of all crises receive case followup from a case manager within 24 hours of crises contact (or 24 hrs of discharge if admitted inpatient) by month 12 50% of QMHPs trained by month 12 Increase # of relevant MH EBPs (TCM, IDDT, CBT, DBT, SS, EMDR, IFS, SE, & Peer Support)	TCM caseloads reduced by 20% by month 12, 50% by month 18 Levels of depression, anxiety, and PTSD decline annually for Hispanic/Latino persons as measured by clinician's diagnoses during assessments % improvement in social connectedness	# of Hispanic/Latinos diagnosed with SMI, or SED, decreases by X% over a 4 year period # of Hispanic/Latinos who attempt or commit suicide decreases by X% over a 4 year period Or # of Hispanic/Latinos experiencing MH crises decreases by X% over 4 years

		Create a peer drop in center (DC) that offers social and practical support & other services by month 12 Psychiatric rehabilitation services (PRS) are offered in Spanish and integrated into treatment	received in the appropriate language by Hispanic/Latino consumers by month 12 # of Hispanic/Latinos that visit the DC annually (months 12-48) # of Hispanic/Latinos who receive PRS		
Improve the physical health of the Hispanic/Latino population in Carson City	Increase access to regular primary care among health disparity populations (Obj. 3) Reduce barriers to primary care Reduce wait time for primary care	Increase OP clinic primary care screening and monitoring of key health indicators and health risk for Hispanic/Latino populations Offer onsite physicals/wellness exams via hiring 1 family nurse practitioner or other qualified PCP by month 24 Provide onsite labs/bloodwork for Hispanic/Latino people prescribed psychotropic medication 2 trainings for staff on lab equipment, licensing by month 24	# of hispanic/latinos screened and vitals monitored # of hispanic/latinos examined # of hispanics/Latinos who have received bloodwork # of staff trained	Wait time for primary care appointments reduced to 10 days by month 24 TCM caseloads reduced by 20% by month 12, 50% by month 18. Blood pressure, BMI, Breath CO for smoking, blood sugar & cholesterol improve between intake, 6 months and 12 month assessments	Key health indicators improved (HIV incidence reduced by X%, hepatitis reduced by X%, # of hospitalizations & emergency room visits reduced by x%) over a 4 year period # of premature deaths decreases over a 4 year period

SUSTAINABILITY

What changes will your organization make to enable sustainability and continue the process to improve disparities? (e.g., policies, financing, budget, training, systems, environmental changes) What external systems exist that can support sustainability efforts? (e.g., Local organizations adopting service priorities to support progress made under this award, partnerships with other community organizations, etc.).

We will implement HIPAA-compliant scheduling software to increase access and convenience and improve clinic efficiency. We will update the EHR to increase portability and compatibility with other care systems, including primary care, to improve care coordination, and facilitate QI by enhancing the capacity for collecting, reporting, and tracking encounters, outcomes, and quality data. The PD and CQM will lead the implementation of a CCBHC-wide, data-driven continuous QI plan that will incorporate real-time aggregated data and "snapshots" from the EHR, anonymous surveys of current clients (rather than those who completed treatment, as is currently done). A data analyst will conduct in-house analyses, including some that are currently done by the state, to make data available sooner, and will prepare state-required and internal reports. Reports will be discussed at monthly leadership team meetings and improvements made.

We will use the new National Outcome Measures – Client Level Tool in SPARS, which is administered at baseline, every 6 months, and at discharge. This is conducted and collected in real-time. In the NOMS questionnaire, demographic information and questions that focus on the SDOH domains are collected and updated every six months until discharge.

We also collect and report on the Infrastructure, Prevention, and Promotion Indicators (IPP) every quarter in SPARS. For the IPPs specific to the DIS, we report on WD2 (workforce development – number of staff trained in mental health or substance use interventions); S1 (number of screenings); AC1 (percent based on the number of referrals made and number of referrals completed where the client is seen).

Our evaluator will present monthly data dashboard reports that track client enrollment by identified subgroups at staff meetings to the integrated care team to provide updates and progress on these activities.

We will also provide an update on our required programmatic progress reports to the GPO.

CCC has strong relationships with local hospital systems in both Carson City and Douglas County and they have supported our activities as they relate to outpatient service referrals post-hospitalization for our clients. We also work with the Carson City Jail (CCJ) to ensure better coordination of care to increase access to and engagement with treatment and improve care coordination and transitions among incarcerated and justice-involved people with MH and SUD need. Our current care coordination agreement enables us to provide in-person assessment, diagnosis, and care navigation to facilitate release from jail into inpatient or intensive outpatient rehabilitation, and some prescribing, with incarcerated people able to request BH services. We collaborate with CCJ to provide Forensic Assertive Community Treatment (FACT) to justice-involved individuals with MH and SUD needs. However, there are administrative and system barriers to consistent care access for incarcerated individuals, and clients often get “lost” between release and rehab.

We will collaborate with the CCJ to identify gaps and update our care coordination agreement to implement processes for improved coordination, access and outcomes. This may include: hiring to expand TCM for incarcerated individuals with a CM to follow the client through the service continuum; expanding FACT program availability; enhancing prescribing services to incarcerated people; and providing transportation to inpatient rehab upon release.

References

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