Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Pregnant Women Services

Priority Type: SAP, SAT

Population(s): PWWDC

Goal of the priority area:

Target alcohol and other drug use among women of child-bearing years and women currently pregnant

Objective:

Reduce the prevalence of pregnant women or women with dependent children using illicit drugs or abusing alcohol

Strategies to attain the objective:

i. Educational campaigns on available services and consequences of use
ii. Utilize SBIRT
iii. Proper referrals to agencies that provides services for pregnant women

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Pregnant women and women with dependent children receiving treatment for substance use disorder

Baseline Measurement: 121 Pregnant women received block grant funded services FY 2015-2016 which is approximately 15% of the current 791 women in need

First-year target/outcome measurement: Increase substance using pregnant women receiving treatment services to 20% of the need identified in the most recient NSDUH data

Second-year target/outcome measurement: Increase substance using pregnant women receiving treatment services to 40% of the need identified in the most recient NSDUH data

Data Source:

TEDS

Description of Data:

TEDS provides information on the demographic and substance abuse characteristics of the 1.8 million annual admissions to treatment for abuse of alcohol and drugs in facilities that report to individual State administrative data systems.
TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, for example, an individual admitted to treatment twice within a calendar year would be counted as two admissions.
TEDS does not include all admissions to substance abuse treatment. It includes admissions to facilities that are licensed or certified by the State substance abuse agency to provide substance abuse treatment (or are administratively tracked for other reasons). In general, facilities reporting TEDS data are those that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of alcohol and/or drug treatment services.
Data updated quarterly

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Workforce Development

Priority Type: SAT

Population(s): Other (Rural)

Goal of the priority area:

Increase behavioral health care in Nevada with a specific focus on rural areas.

Objective:

Expand access to professionals in areas of Nevada that currently have shortages

Strategies to attain the objective:

i. Increase incentives to practice in rural areas
ii. utilize telehealth when needed
iii. increase training opportunities for professionals
iv. increase evidence-based practices
v. provide adequate screening at multiple outlets (hospitals,treatment,etc)
vi. utilize mobile units and first responders
vii. increase Naloxone trainings and availability

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Alcohol and Drug Counselors

Baseline Measurement: 140 Licensed Alcohol and Drug Counselors in 2016

First-year target/outcome measurement: increase substance use professionals in rural areas by 5% or 7 new professionals

Second-year target/outcome measurement: increase substance use professionals In rural areas by 10% or 14 new professionals

Data Source:

8th Edition Nevada Rural Data Book 2017

Description of Data:

Data was gathered from the Nevada State Board of Examiners for Alcohol, Drug and Gambling Counselors.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Increase the number of telehealth trainings

Baseline Measurement: 1 face-to-face training and 1 webinar in 2016

First-year target/outcome measurement: Complete 2 face-to-face trainings and 2 webinars

Second-year target/outcome measurement: Complete 4 face-to-face trainings and 4 webinars

Data Source:

Center for the Application of Substance Abuse Technologies (CASAT)

Description of Data:

CASAT is the only agency in Nevada completing trainings for telehealth.

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Recovery Support Services

Priority Type: SAT

Population(s): Other (Adolescents w/SA and/or MH, Students in College, Rural)

Goal of the priority area:

Increase recovery support services offered throughout the state

Objective:

Expand continuum of care with support services after treatment

Strategies to attain the objective:

i. Increase the use of Peer Support Specialists
ii. increase the number of sober living opportunities
iii. open a recovery community organization in Northern Nevada
iv. Utilize holistic health and wellness activities

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Peer Support Specialists

Baseline Measurement: 1,500 Peers certified as of July, 1017 specifically for SUD

First-year target/outcome measurement: Increase number of peers certified by 50, totally 1,550

Second-year target/outcome measurement: Increase the number of peers certified by 50, totally 1,600

Data Source:

Foundations for Recovery (FFR) and the Center for the Application of Substance Abuse Technologies (CASAT)

Description of Data:

FFR is located in Southern Nevada and CASAT in Northern Nevada.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Develop a training for agencies on how to most effectively utilize Peers and the benefits

Baseline Measurement: None

First-year target/outcome measurement: Develop the training

Second-year target/outcome measurement: Complete 3 trainings

Data Source:

Center for the Application of Substance Abuse Technologies

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Behavioral Health Care

Priority Type: SAP, SAT

Population(s): PP

Goal of the priority area:

Integrate behavioral health with health promotion and health care delivery

Objective:

Improve the accessibility and dissemination of prevention, outreach, intervention, treatment, and recovery information and intercommunication throughout the state

Strategies to attain the objective:

i. Create linkages between state systems for access to information
ii. develop culturally and linguistically appropriate services
iii. provide easy access and up-to-date information for providers and consumers
iv. utilize Electronic Health Records
v. Utilize 2-1-1

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Develop a communications plan and engage partners in sharing up-to-date messaging and information.

Baseline Measurement: N/A

First-year target/outcome measurement: establish a baseline of satisfaction of communication between prevention and treatment providers and the state

Second-year target/outcome measurement: show a statistically significant increase in the number of prevention and treatment providers who indicate that they are satisfied.

Data Source:

survey to be developed.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Utilize 2-1-1

Baseline Measurement: number of 211 calls for behavioral health services in state fiscal year 2017

First-year target/outcome measurement: Require SAPTA funded providers to provide up-to-date information to 2-1-1 about access and availability of services

Second-year target/outcome measurement: increase the volume of behavioral health calls to 2-1-1 for behavioral health purposes

Data Source:

211 call volume

Description of Data:

Calls for behavioral health

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Prevention and Early Intervention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Support earlier access to prevention and early intervention services

Objective:

Prevent or delay onset of, and mitigate symptoms and complications from substance use disorders

Strategies to attain the objective:

i. Target high risk populations (adolescents/LGBTQ, pregnant women),
ii. alternative activities
iii. Outreach/education/environmental strategies targeting youth, young adults and adults about how to resist and avoid abuse of alcohol and other drugs
iv. Use of evidence-based practices

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Decrease alcohol use in middle school students
Baseline Measurement:	29.4% of middle school students have used alcohol in 2015 survey
First-year target/outcome measurement:	Decrease alcohol use to 28% of middle school students
Second-year target/outcome measurement:	Decrease alcohol use to 26% in middle school students.

Data Source:

Nevada Youth Risk Behavior Survey

Description of Data:

Nevada Youth Risk Behavior Survey completes it's surveys in the school setting.

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Increase in access to treatment for Illicit Drug Use Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse
Baseline Measurement:	85.6% of individuals who needed treatment do not receive it
First-year target/outcome measurement:	Increase percentage of individuals who needed treatment aged 12 or older for SUD do not receive it to 16%
Second-year target/outcome measurement:	Increase percentage of individuals who needed treatment aged 12 or older for SUD do not receive it to 17.5%

Data Source:

Behavioral Health Barometer 2015

Description of Data:

SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010--2014.

Data issues/caveats that affect outcome measures::

Priority #:	6
Priority Area:	Improve the quality and disorder-relevance of services.
Priority Type:	MHS
Population(s):	SED

Goal of the priority area:

Goal 1–Improve capacity of social institutions within communities (Ex: schools, youth social groups and services organizations, faith-based organizations) to identify, assess, treat and track at-risk and high-risk populations of children and adolescents with the purpose of improving child and adolescent mental health.

Objective:

Objective 1.1: By March 2018, increase the number of youth-serving adults, including but not limited to school professionals, social groups and service organizations, faith-based organizations, etc., who are trained in recognizing the signs and symptoms of substance use and mental health disorders.
Objective 2.1: By March 2018, increase the number of referrals from trained community members to behavioral health services.
Objective 3.1: By October 2019, demonstrate a statistically significant decrease in the proportion of students who report the following mental health symptoms on the YRBS: psychological stress, including self-harm behaviors such as intentional cutting or burning; mood symptoms and decreases in usual activities; and suicide attempts.

Strategies to attain the objective:

Activity 1: By March 2018, through the State process solicit competitive bids from community providers statewide to implement mental health training protocols.
Activity 2: By October 2018, select an evidence-based practice (EBP) to provide training for community members concerning the signs and symptoms of substance use and mental health disorders.
Activity 3: By March 2019, establish database and schedules for long-term tracking of outcomes for each at-risk and high-risk individual who is served in behavioral health protocols.
Activity 4: By October 2019, establish mechanisms for routine (at least annually) programmatic reviews that are outcomes driven.
Activity 5: By March 2018, develop an evaluation plan.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Statistically significant reduction in the proportions of Youth who report the following emotional health conditions on the YRBS: depressed mood and a decrease in usual activities; and suicide attempts.
Baseline Measurement:	In 2015, 33% of respondents reported feeling sad or hopeless almost every day for 2 or more weeks in a row, and stopped engaging in usual activities; and 11% reported one or more suicide attempts during the 12 months prior to the survey.
First-year target/outcome measurement:	Using analysis of variance strategies, determine statistically significantly lower proportions of individuals reporting the following conditions on the emotional health section of the YRBS: depressed mood and a reduction in usual activities; and one or more suicide attempts.
Second-year target/outcome measurement:	Achieve and maintain status of equal to or below the national norms for indicators of compromised emotional health.

Data Source:

2015 Nevada Youth Risk Behavior Survey (YRBS), which is conducted by the Centers for Disease Control (CDC) and Prevention, and local and state education and health agencies.

Description of Data:

Statewide Youth Risk Behavior Survey (YRBS) Data.

Data issues/caveats that affect outcome measures::

The YRBS is only conducted bi-annually, and the methodology is not always consistent across communities. Some communities use an active consent model while other communities use a passive consent model, and this difference across communities likely creates ascertainment bias. Moreover, in small communities it is difficult to ensure anonymity due to the ease of identifying individuals.

Priority #:	7
Priority Area:	Unmet Service Need and Critical Gaps. Improve access to services for First Episode of Psychosis (FEP) and Early Severe Mental Illness (ESMI).
Priority Type:	MHS

Population(s): ESMI

Goal of the priority area:

Ensure early intervention services are available statewide for individuals with First Episode of Psychosis (FEP), and Early Serious Mental Illness (ESMI).

Objective:

Objective 1.1: Expand capacity to address ESMI in the urban areas.
Objective 2.1: Build capacity in the State's Rural and Frontier counties to provide early intervention services for FEP and ESMI.

Strategies to attain the objective:

Activity 1.1: By October 2018, adapt and implement the evidence-based Coordinated Specialty Care (CSC) model in Nevada's Rural and Frontier Counties to treat individuals with First Episode of Psychosis (FEP) and Early Severe Mental Illness (ESMI).
Activity 1.2: By October 2018, through the State process solicit competitive bids from community providers to implement CSC-Rural and Frontier Nevada.
Activity 1.3: By March 2019, roll out CSC-Rural and Frontier Nevada.
Activity 1.4: By March 2018, assist current providers in urban areas to increase the number of individuals receiving early intervention services.
Activity 1.5. By March 2018, provide technical assistance to providers to enhance community outreach strategies for identifying and recruiting individuals with ESMI, including FEP, for potential enrollment in early intervention services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of persons receiving ESMI services.
Baseline Measurement:	Forty (n=40) individuals received FEP services from July 2015 through May 2017 (23 months).
First-year target/outcome measurement:	Increase enrollment in early intervention services for individuals with ESMI, including FEP, to 75 individuals by September 2018.
Second-year target/outcome measurement:	Further increase enrollment in early intervention services for individuals with ESMI, including FEP, to 150 individuals by September 2019.

Data Source:

Department of Child and Family Services report of number of clients served.

Description of Data:

Actual Client counts. Using the incidence rate of 15.2 per 100,000 population (McGrath et al., 2008), it was estimated that 380 new cases per year may be expected for Nevada's population. Over a 2-year period the early intervention program was able to build enrollment and active cases to 40 participants. Therefore, in the next 2 years the State's goal is to continue the trend, and to reach 150 additional individuals, which would reflect 20% of new cases that are anticipated based on the estimated incidence rate and the State's population.

Data issues/caveats that affect outcome measures::

Because of the increase in the State's reliance on private providers, clinical data are fragmented across multiple providers, and there is no current mechanism to integrate the myriad data sources. Therefore, technical assistance is needed to integrate the electronic health records of the different providers. Such integration is necessary to build a reliable, comprehensive database that is easy to use for providers, and that can be accessed to determine program efficacy, and unmet needs and gaps in services.

Indicator #:	2
Indicator:	Outcomes on the Structured Clinical Interview for DSM-5-Clinician Version (SCID-5-CV).
Baseline Measurement:	Primary SCID-5-CV diagnosis at the time of enrollment, and medical diagnoses and health status at the time of enrollment.
First-year target/outcome measurement:	For the individuals enrolled in services in 2018, we aim to achieve clinical stability (i.e., not in an active episode), as measured by the SCID-5-CV, for all enrolled individuals.
Second-year target/outcome measurement:	For the individuals enrolled in services in 2019, we aim to achieve clinical stability (i.e., not in an active episode), as measured by the SCID-5-CV, for all enrolled individuals.

Data Source:

The Structured Clinical Interview for DSM-5-Clinician Version (SCID-5-CV).

Description of Data:

Clinical stability (i.e., not experiencing an active episode of illness) as measured by the Structured Clinical Interview for DSM-5-Clinician Version (SCID-5-CV).

Data issues/caveats that affect outcome measures::

Lack of acceptable level of inter-rater reliability for the Structured Clinical Interview for DSM-5-Clinician Version (SCID-5-CV) between clinicians and across sites.

Indicator #:	3
Indicator:	Medical status at admission and yearly thereafter.
Baseline Measurement:	Medical evaluation by primary care physician.
First-year target/outcome measurement:	Medical status is stable at Year 1.
Second-year target/outcome measurement:	Medical status is stable at Year 2.

Data Source:

Physicians who provide medical exams. Communication is required between the ESMI provider and the primary care physician that is consistent with the RAISE model.

Description of Data:

Data are relevant to medical status. For example, if a patient is diagnosed with diabetes, then the treatment provided is consistent with best practice for that medical condition.

Data issues/caveats that affect outcome measures::

Lack of fidelity to yearly follow up by staff coordinating the care that is necessary.

Priority #:	8
Priority Area:	3-Promote professional competence and development of Nevada's mental health workforce.
Priority Type:	MHS
Population(s):	Other (Rural)

Goal of the priority area:

Strengthen knowledge and skills of workforce through their participation in education and training curricula that are mission-relevant and nationally recognized as evidence-based.

Objective:

Objective 1.1: By March, 2018, increase the number of trainings offered to providers.

Strategies to attain the objective:

Activity 1.1: By March 2018, develop education and training curricula for staff and community providers.
Activity 1.2: By March 2018, through the State process solicit competitive bids from community providers statewide for implementation of education and training for staff and community providers.
Activity 1.3: By October 2018, roll out educational and training curricula for staff and community providers.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of providers who have completed trainings.
Baseline Measurement:	Number of trainings completed by contracted agencies in 2016.
First-year target/outcome measurement:	Increase the number of trainings by 25% from the 2016 baseline.
Second-year target/outcome measurement:	Increase the number of trainings from Year 2018 by an additional 25%.

Data Source:

Contracted trainings completed.

Description of Data:

Frequency counts of participants.

Data issues/caveats that affect outcome measures::

None.

Priority #: 9

Priority Area: Increase the integration of suicide prevention efforts, clinical services and post-mortem reviews within the state's mental health system.

Priority Type: MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Develop a model of suicide prevention services that integrates community education, clinical intervention and treatment, and continual quality assurance and performance improvement.

Objective:

Objective 1.1: Increase participation in training and cross-agency collaboration, learning through case presentation and analysis, and implementing evidence-based suicide prevention practices.

Strategies to attain the objective:

Activity 1.1: By March 2018, identify evidence-based and promising practices for suicide prevention education, clinical interventions and treatment, and post-mortem reviews that support quality assurance and performance improvement initiatives.
Activity 1.2: By March 2018, through the State process solicit competitive bids (RFAs/RFPs) from community providers statewide for implementation of evidence-based and promising practices for suicide prevention education, clinical interventions and treatment, and post-mortem reviews that support quality assurance and performance improvement initiatives.
Activity 1.3: By October 2018, roll out evidence-based and promising practices for suicide prevention education, clinical interventions and treatment, and post-mortem reviews that support quality assurance and performance improvement initiatives.
Activity 1.4: By March 2019, establish database and schedules for long-term tracking of outcomes associated with each component in the integrated model: suicide prevention education, clinical interventions and treatment, and post-mortem reviews that support quality assurance and performance improvement initiatives.
Activity 1.5: By October 2019, establish mechanisms for routine (at least semi-annually, initally) programmatic reviews of the integrated model for suicide prevention driven by clinical outcomes related to suicide.
Activity 1.6: By March 2018, host meetings with a minimum of participants from all three sectors: community education component; clinical interventions and treatment component; and post mortem reviews component.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Numbers of meetings held and participants in attendance.

Baseline Measurement: Anything greater than zero participation.

First-year target/outcome measurement: Hold 2 meetings during Year 1.

Second-year target/outcome measurement: Hold quarterly meetings during Year 2.

Data Source:

State Office of Suicide Prevention will track the number of meetings held, and the number of participants in attendance.

Description of Data:

Frequency counts.

Data issues/caveats that affect outcome measures::

None.

Priority #: 10

Priority Area: Priority 5-Organize clinical data to enable tracking of empirically-based clinical outcomes

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID

Goal of the priority area:

To establish health information technology and measurement methodology that support Nevada's current mental health care system, including its community providers.

Objective:

Improve capacity for monitoring and evaluating programmatic effectiveness through the tracking of empirically-based clinical and medical outcomes.

Strategies to attain the objective:

Activity: 5.1: By March 2018, implement the WITS system, and integrate it with other data tools.
Activity: 5.2: By March 2019, establish an inter-agency planning committee to identify common outcome measurements.
Activity: 5.3: By October 2019, develop a pilot group of participants to roll out database for health information technology and measurement protocol.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Ability to track clinical outcomes for each individual who receives clinical care using a longitudinal, repeated measures design.

Baseline Measurement: The State does not currently have a mechanism to measure multiple clinical outcomes for each individual.

First-year target/outcome measurement: A battery of standardized assessments that has been adopted formally for the purpose of measuring behavioral health and clinical outcomes.

Second-year target/outcome measurement: The standardized assessments have been implemented and data are being collected.

Data Source:

Medicaid behavioral health dashboard reports and claims data; Avatar reports; WITS system reports; and other electronic health record systems that providers are currently using.

Description of Data:

Standardized clinical diagnoses and level of functioning scores.

Data issues/caveats that affect outcome measures::

Issues/caveats will depend on the assessments and tools that are selected. It may be difficult to achieve universal agreement and a collective solution on standardized data assessments and tools.

Footnotes:

We would appreciate technical assistance to address anonymity issues in small and rural communities when collecting data.
We would also appreciate technical assistance on data based systems that can help us to gather the data across various providers, including non block grant funded providers.
The State anticipates a need for technical assistance on training providers to administer and interpret the results from the Structured Clinical Interview for DSM-5-Clinician Version (SCID-5-CV). The need for technical assistance is also anticipated for training providers on methods to demonstrate inter-rater reliability.
Technical assistance may be needed on selecting a standardized evidence-based assessment battery for all providers to use.