Recommended Revisions

Five Year Strategic Plan for Problem Gambling Treatment Services Within the State of Nevada: Fiscal Years 2012 – 2016

The *Five Year Strategic Plan for Problem Gambling Treatment Services Within the State of Nevada: Fiscal Years 2012 – 2016* was conceived as a living document and tool to accomplish the DHHS Advisory Committee on Problem Gambling's (ACPG) mission "to support effective problem gambling prevention, education, treatment, and research programs throughout Nevada." Each grant cycle the treatment system it assessed to identify emergent issues and review the prior years' experience in implementing the Plan. During the current SFY, the ACPG formed a Problem Gambling Treatment Workgroup to assist in this review process. One of the resulting activities was a series of semi-structured interviews with all DHHS funded problem gambling treatment grantees and workforce development grantees. A byproduct of these activities are the following set of identified issues, possible solutions, and staff recommendations.

Discussed Revisions to the Problem Gambling Treatment Strategic Plan: Issues, Solutions, & Recommendations

Identified Issue	Solutions	Staff Recommendation
Supervision		
Clinical supervision limitations are too restrictive.	Consider either expanding supervision limitations or assist grantees program some of their workforce development budget toward supervision costs that are beyond those that can be claimed under Exhibit 4 Procedure codes.	Keep Procedure Codes the same for supervision (they are indexed to certification requirements) and work with grantees in developing their WD budget. *Est. Budget Impact:* ***$0*** *Revise Appendix A, Exhibit 4 (p.33)*
Insurance		
Payer of last resort condition has been an issue. Lots of time has been going into tracking down insurance and when third-party insurance pays there is often a considerable time lapse between billing and payment. Look at how to resolve insurance issue.	Utilize DHHS funds as payer of first resort and set additional conditions.	Revise to recognize DHHS as the entity providing primary gambling treatment coverage up to defined client benefit caps. For any services beyond benefit caps, requests for additional funds will only be made after due diligence is made to obtain resources for services from entity other than DHHS (must submit an insurance verification form). *Est. Budget Impact:* ***$5000*** *No revision to GTSP needed. Revise treatment grantee review tools.*

Identified Issue	Solutions	Staff Recommendation
Perceived Inequity		
Find ways to create better equity in system so that cost-per-client is relatively equal among like programs (all outpatient treatment centers and all residential treatment centers).	Revise client benefit caps to better align with standard course of outpatient and residential treatment.	Revise gambling treatment episode benefit limit to $2000 for outpatient and $3500 for residential. *Est. Budget impact: $33,000 increase for residential treatment; $33,000 reduction for outpatient treatment. Net est. budget impact:* ***$0*** *Revise Appendix A, IV,9 (p.16)*
	Currently using projected client enrollments to formulate future allocations. Look to using performance indicators; add a new one, efficiency.	Develop a new formula to make treatment allocations. For example: (A x B) x (p1 + p2 + p3) Where A = average cost of treatment, B= Estimated enrollment number, p1= efficiency coefficient, p1= success coefficient, p3 = access coefficient). *Est. Budget Impact:* ***$0*** *Revise Appendix A, IV,18 (p.17)*
Residential Treatment		
The 30 day clean and sober rule prior to residential treatment entry is problematic as it delays entry of some in need of residential gambling treatment.	Allow clients with dual diagnosis with low substance abuse severity not have to have 30 days clean and sober. Under this proposal, need to add language to the residential treatment criteria regarding diagnostic specifiers.	Can change criteria to include 30 day rule only for those with moderate to severe substance use disorder. Continue discussion to possibly reduce or eliminate 30 day rule. *Est. Budget Impact:* ***$0*** *Revise Appendix A, Exhibit 1 (p.20)*
No means to assist clients with transportation needs. There have been a small number of cases were transportation costs from Southern Nevada to a residential treatment facility in Northern Nevada has been a significant barrier to treatment.	Subsidize transportation for residential clients.	Enable residential gambling treatment grantees to utilize a portion of "Program Enhancement" funds to pay client transportation costs when needed. *Est. Budget Impact:* ***$0*** *No revision to GTSP needed. Revise treatment grantees' WD grants.*
The current client benefit cap provides only enough funds to support a 30 day residential stay. Some clients would benefit from a much longer stay as many are homeless and unemployed with nowhere to go following residential treatment.	Increase the benefit cap from $3,000 to $6,000 to allow for a 60 day stay.	No change, cost prohibitive. If accepted then projected to increase the cost of residential treatment by approximately $200,000 (assuming 2/3 clients utilize max. benefit)
	Develop a transitional living program.	Defer to SFY15 planning efforts.

Identified Issue	Solutions	Staff Recommendation
Treatment Outreach		
We need more community outreach and advertising. Very few gamblers without co-occurring disorders are coming in. Most of those that come in are from word of mouth referrals from the formal and informal addict community.	Provide outreach budget to providers. Create flexible agreements for workforce development and outreach.	Create "Program Enhancement" grant for each treatment grantee to replace current "workforce development" treatment provider grant. Increase amount from $5,000 to $10,000 and create budget categories (workforce development, outreach, client wrap-around services, other). *Est. Budget Impact:* ***$25,000*** *No revision to GTSP needed. Revise treatment grantees' WD grants.*
Interns		
Need a better system to bring interns into gambling treatment system. As a secondary issue, for some treatment grantees there is a current dependency on a single CPGC without back-up staff in place to keep the program operational if the key staff person was no longer available.	This could be worked into the Workforce Development grant (one the Council currently has or the one the treatment grantees have). In concept, they would cut a check to new intern at hire (to cover costs to get certified) and at one year (to incentivize one year retention).	Discuss with Workforce Development grantee to assess feasibility of revising grant for SFY14 implementation. *Est. Budget Impact:* ***$0*** *No revision to GTSP needed. Possible revision to WD grantee work plan, not budget.*
Quality Assurance		
There have been reports that persons contacting treatment grantees are not receiving call-backs in a timely manner.	Implement "secret shopper" type program.	DHHS staff to periodically call treatment grantees posing as persons seeking assistance and record call-back times; develop correction action plans as necessary. *Est. Budget Impact:* ***$0*** *No revision to GTSP needed.*
Promotion of Program Growth		
As future allocations are based on past performance (numbers served), funding is provided in a manner that hampers program growth.	Revise allocation formula to be more need based. Estimate treatment demand (prevalence x population x treatment seeking prevalence) then compare to numbers served in area. For those greatest underserved areas provide opportunity to offer growth plan and fund those that demonstrate merit.	Defer to longer range planning.

Identified Issue	Solutions	Staff Recommendation
Details within Treatment Standards		
Some details with the treatment standards are not align to CARF standards: "The client shall have the right of access to records. Access includes the right to obtain a copy of the record within 15 days of requesting it and making payment for the cost of duplication. The client shall have the right of access to the client's own records except:"	Change requirement for provider to provide records from 15 days to 30 days.	Change requirement for provider to provide records from 15 days to 30 days. *Est. Budget Impact:* ***$0*** *Revise Appendix A, Exhibit 2, VIII, D (p. 28)*
Plan makes references to DSM-IV, need to update to reflect most recent version of the DSM, the DSM-5	Find and replace references to DSM-IV with DSM-5.	Find and replace references to DSM-IV with DSM-5. *Est. Budget Impact:* ***$0*** *12 references to DSM-IV to be updated*
Continued Recovery Groups		
Programs are not utilizing the "Continued Recovery" encounter code.	Revise claim procedures to that a client ID is not required. • Change reimbursement to a grantee activity code rather than client activity code; e.g., 90 - 120 min gp = $150; 5 groups per week; 50 wks = $37,500 • Change units of service so that one unit = one attendee and set rate per attendee; e.g., $10/unit=person; 100 clients wk = $1000/wk; 50 wks = $50,000 • Keep current reimbursement structure but solve encounter entry problem; e.g., units/per person; 90 min group = $27/pp; 100 clients - $2,700; 50 wks = $135,000	Revise Exhibit 4, "Continued Recovery" to reimburse based on $10/unit where 1 unit = participant. Set minimum group time for 60 minutes and limit per-participant claim to once per week. *Estimated budget impact:* *$10/unit=person* *100 clients wk = $1000/wk* *50 wks =* ***$50,000*** *Revise Appendix A, Exhibit 4 (p.33)*

Estimated Budget Impact Summary

- Insurance: DHHS as primary payee $5,000
- Replace Tx grantee WD grant with "program enhancement grant" $25,000
- Revise claims procedures for "Continuing Recovery Group" $50,000

Total: $80,000