Nevada Department of Health and Human Services

Office of Community Partnerships and Grants

Problem Gambling Services

DHHS Problem Gambling Services

2017 – 2019 Strategic Plan

DRAFT Version May 13, 2016

Department of Health and Human Services

Helping people. It's who we are and what we do.

DHHS Problem Gambling Services
2017 – 2019 Strategic Plan

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Mission & Vision

In 2008, the DHHS Advisory Committee on Problem Gambling drafted the following Mission and Vision statements to guide their decisions:

Mission:

To support effective problem gambling prevention, education, treatment, and research programs throughout Nevada.

Vision:

Improve the public health of Nevadans through a sustainable and comprehensive system of programs and services that reduce the impact of problem gambling.

These Mission and Vision statements have become the cornerstone of the Department of Health and Human Services strategy to reduce the impact of problem gambling on Nevadans.

Acknowledgements

Project Participants

The Department of Health and Human Services (DHHS) would like to extend its gratitude to all those involved in this project, including the DHHS Advisory Committee on Problem Gambling; DHHS Office of Community Partnerships and Grants staff Laurie Olson, Pat Petrie, and Gloria Sulhoff; key-informant stakeholder interview participants; participants of the Problem Gambling Services Strategic Planning Think Tank held in Reno, Nevada; and the participants of the Problem Gambling Strategic Planning Workgroup Meeting held in Las Vegas, Nevada.

Special recognition is provided to Pat Petrie, DHHS Problem Gambling Program Coordinator, for his leadership and support of this project; Carol O'Hare, of the Nevada Council on Problem Gambling, for her guidance and logistical support in organizing planning meetings; and members of the UNLV Problem Gambling Services Information Management team, Sarah St. John, Andrea Dassopoulos, and Bo Bernhard, for their efforts and support in helping us make data driven program and policy decisions.

All of you who participated in this projected were instrumental in identifying needs, generating ideas on how to meet those needs, and discussing how to best align problem gambling services within Nevada's larger health and human service system. Your dedication to improving problem gambling services and supporting the health of individuals, families, and communities has been demonstrated by all the effort you put forth. Our effort has produced a strategic plan that builds upon our accomplishments and steers us to ever improving outcomes.

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Work that Informed the Plan

Understanding DHHS Problem Gambling Services exists within the context of broader public health systems, as well as within the larger problem gambling field, efforts were made to incorporate knowledge, structure, and strategies from authoritative works. The following documents most notably informed this Strategic Plan:

Dassopoulos, A., St. John, S. & Bernhard, B. (2015). *The Nevada Problem Gambling Project: Follow-Up Research*. UNLV International Gaming Institute: Las Vegas, NV;

Marotta, J. J. (2014). *Problem Gambling Services Meeting Proceedings: Strategic Planning Think Tank April 9, 2014*. Carson City, NV: Department for Health and Human Services;

Oregon Health Authority (2015). *Problem Gambling Services in Oregon: 2016 to 2020 System Improvement Plan*. Salem, OR: Author.;

Substance Abuse and Mental Health Services Administration, *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015 – 2018*. HHS Publication No. (PEP) 14-LEADCHANGE2. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

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DHHS Problem Gambling Services

2017 – 2019 Strategic Plan

Pat Petrie, Problem Gambling Program Coordinator, DHHS OCPG
Prepared by Problem Gambling Solutions, Inc.

May 2016

Introduction to the DHHS Problem Gambling Services Plan

Nevada is viewed throughout the world as a leader in the casino and gaming sector with regard to regulation, technology, business strategies, and sophistication of its gaming companies. In 2005, Nevada introduced legislation to expand its approach to legalized gambling by investing in the development of problem gambling treatment and prevention systems. The legislation resulted in the creation of a Revolving Account for the Prevention and Treatment of Problem Gambling and an Advisory Committee on Problem Gambling (ACPG) to advise the Department of Health and Human Services (DHHS) in its administration of this account. Program funding was linked to the number of slot machines operating in the state ($2 per slot machine per quarter) which approximates $1.5 million dollars in annual funding, an amount sufficient to build the infrastructure for a statewide gambling treatment system and the groundwork for a problem gambling prevention system. Over one decade has passed since problem gambling service funding was established and over that time services for problem gamblers have evolved and now support five problem gambling treatment centers, two prevention grantees, a workforce development grantee, and a strong program evaluation system. While the problem gambling service system has developed over the years, along with gambling treatment demand, funding for that system has not increased.

During the process of developing this strategic plan and engaging stakeholders in exercises to identify system strengths, limitations, and opportunities, it became clear that without additional funding the system would not be able to achieve its stated vision to "improve the public health of Nevadans through a sustainable and comprehensive system of programs and services that reduce the impact of problem gambling." However, a strategic plan is needed to guide services beginning in fiscal year 2017 as the lifespan of the last strategic plan was reaching its defined end date (June 30, 2016).

In the spring of 2016, the ACPG decided to take action to update legislated language that met the needs of the State over a decade ago with language to meet today's needs. That is, develop legislation providing for a new funding strategy and ACPG governance approach that will allow for innovation, program evolution, and sustainability to meet tomorrow's challenges.

In light of the ACPG's actions in the spring of 2016 and intentions moving forward, the present

strategic plan was re-conceptualized from a 5-year plan to a 3-year plan that is designed to make system improvements based on a relatively stable program budget. This plan may serve as a bridge between the system of DHHS Problem Gambling Services largely based off of the 2005 enabling legislation and possible new legislation ushering in a new era in system development. Though this plan's time horizon is shorter than the last, its implementation will be of critical importance in filling select service gaps, refining and advancing services, and guiding ongoing system improvement efforts.

The present strategic plan is the first DHHS Problem Gambling Services strategic plan that combined all program elements into a unified and integrated plan. As the plan goes into effect midway through a two-year DHHS grant cycle for the problem gambling program grants, it is not expected to significantly impact the State Fiscal Year (SFY) 2016 and 2017 program grants. Rather, this plan seeks to inform future decisions, provide strategic direction, and build off of program successes to offer a comprehensive approach to service development.

The DHHS Problem Gambling Services strategic plan summarizes what has been learned from a number of resources: consumers, treatment providers, prevention providers, gaming industry collaborators, program administrators, a review of DHHS supported program evaluation research, and a review of state and federal policy and identified best practices.
The DHHS Problem Gambling Services Strategic Plan includes:

Section I: Capacity of the Problem Gambling Service Delivery System

Section II: Needs Assessment Findings

Section III: Stakeholder Identified Priorities

Section IV: Framework and Guiding Principles for DHHS Problem Gambling Services

Section V: Goals, Activities, Enhancements, & Phases

Some elements of this Plan, such as the DHHS Problem Gambling Treatment Providers Guide in Appendix A, provide specific and detailed changes that will go into effect on July 1, 2016, while other elements of this Plan were developed to provide a high level summary of improvement efforts that will be explored over the plan's three year period, with some being launched and others not. This Plan will be used as a roadmap for DHHS and the ACPG to develop a work plan that will detail the action steps to be taken to achieve the goals and guide initiative development from one point to another.

I. Capacity of the Problem Gambling Service Delivery System

A. Funding[1]

In 2005, the Nevada State Legislature passed Senate Bill 357 to create the Revolving Account for the Prevention and Treatment of Problem Gambling and an Advisory Committee on Problem

[1] Note: All budget figures presented in this section are rounded to the nearest $1,000.

Gambling (ACPG) to advise the Department of Health and Human Services (DHHS) in its administration of this account. The 2007 Legislature amended NRS 463.320(e) to remove a sunset provision and left the 2007 funding in place for 2008. The program budget for 2008 was $1,700,000. As Nevada entered a state fiscal crisis, the program budget received a series of reductions beginning in 2009 with a $200,000 reduction, and another $100,000 reduction in 2010. As the state fiscal crisis worsened, the 2011 Nevada State Legislature passed budget bill AB500, which temporarily reduced from $2 to $1 the slot tax revenue directed to DHHS problem gambling services. This reduction remained in effect through SFY 2013. During these lean budget years, the gambling treatment grantees agreed to take a reduction in service reimbursement rates in order to serve more problem gamblers, and all DHHS funded problem gambling prevention activities were discontinued. In SFY 2014, as the state emerged from the impact of the Great Recession, funding was restored to the $2 per slot machine revenue calculation. Today, Nevada Revised Statute (NRS) 458A provides the program structure and NRS 463.320(e) authorizes the revenue ($2 per slot machine per quarter). The annual DHHS problem gambling services budget for SFY 2016 and 2017 is approximately $1,315,000. These funds support multiple components of a comprehensive problem gambling service system including program administration, treatment, prevention, workforce development, program supports, and program evaluation.

The most recent survey of all U.S. states' problem gambling services took place in 2013.[2] At that time, Nevada ranked 13th out of the 50 U.S. states in terms of per-capita public funds plus unduplicated National Council on Problem Gambling affiliate funds invested in problem gambling services. The average per-capita allocation for problem gambling services in the 39 states with publicly funded services was 32 cents; Nevada's per capita public investment was 28 cents. Nevada's per capita problem gambling services budget has since increased to 46 cents in SFY 2016 and 2017. Investing 46 cents per Nevadan to mitigate gambling related problems is less than half the per-person problem gambling service budget of several other states with a much smaller gaming presence such as Oregon, Massachusetts, Iowa, and Delaware, each with a per-person problem gambling service budget of more than $1.00.

B. The Advisory Committee on Problem Gambling (ACPG)

The Advisory Committee on Problem Gambling consists of nine Governor appointed members that by statute (NRS 458A.060) represent a broad stakeholder group including three members from the gaming industry, two members who work in the area of mental health, one member each representing higher education and veterans, and two members who represent organizations that provide assistance to problem gamblers. When the ACPG was created in 2005, most of the duties, as defined in statute and in subsequent bylaws, were directly related to developing, reviewing, recommending, and monitoring the grant award system within DHHS for programs funded by the Revolving Account for the Prevention and Treatment of Problem Gambling. Over the years, as the information management system became more sophisticated and procurement methods relied more on data and experienced reviewers, the reliance on the ACPG

[2] Marotta, J., Bahan, M., Reynolds, A., Vander Linden, M., & Whyte, K. (2014). 2013 National Survey of Problem Gambling Services. Washington DC: National Council on Problem Gambling.

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to advise DHHS on specific grant awards diminished. More recently, the ACPG refocused its efforts in order to more effectively reach its mission "to support effective problem gambling prevention, education, treatment, and research programs throughout Nevada." Because the majority of the traditional ACPG functions were being carried out by DHHS staff and consultants, this allowed the ACPG to focus more on advancing the system, rather than implementing and monitoring it. In the spring of 2016, the ACPG created a workgroup to explore possible revisions to NRS 458A.060-080 in order to refocus the efforts of the ACPG to be more engaged in external policy discussions and workgroups that can impact the broader efforts of the state in addressing problem gambling issues.

C. Nevada Problem Gambling Treatment System

The DHHS supported problem gambling treatment system was launched in 2005 with several of the original grantees continuing to provide services throughout the program's existence. The system design was based on supporting problem gambling treatment "centers of excellence" as opposed to creating a wide distribution network of providers. Characteristics of a "center of excellence" model include (a) a limited number of treatment programs, typically only one or two in population centers; (b) programs that offer a variety of services including group, family, and individual treatment modalities; (c) larger grant amounts by virtue of program size and small number of total treatment grants; and (d) high standards and funder expectations inclusive of provider qualifications, documentation practices, and performance in a number of defined areas. Another distinguishing characteristic of Nevada's publicly funded gambling treatment system is its variety of providers. DHHS does not restrict what type of entity may apply for problem gambling treatment grants and this has resulted in some providers being accredited substance abuse treatment agencies, some being exclusive problem gambling treatment centers, some holding non-profit status, and others not. The grant selection process has emphasized qualifications and experience in treating problem gamblers.

In SFY2016, the year this plan was written, there were five DHHS funded problem gambling treatment grantees. The largest program, in terms of number of enrollments each year, is The Problem Gambling Center (PGC) located in Las Vegas. Each year the PGC treats approximately 280 individuals with majority participating in its Intensive Outpatient Program (IOP). The only other Southern Nevada treatment program is Pathways, located in Henderson. Pathways' primary treatment modality is also an intensive outpatient model and like the PGC offers one to one counseling and family counseling. The other three gambling treatment grantees are in Northern Nevada, including two in Reno and one in Fallon. The Reno Problem Gambling Center provides mainly outpatient treatment services with the option of participating in an IOP program while the other Reno grantee, Bristlecone Family Resources' Gambling Addiction Treatment and Education (GATE) program, primarily provides residential gambling treatment services and offers less intensive levels of care. The remaining gambling treatment grantee, New Frontier Treatment Center, has a catchment area that serves the vast majority of rural Nevada. New Frontier has offices located in Lovelock, Battle Mountain, Elko, West Wendover, Ely, Caliente, and Fallon; however, only two of those locations (Fallon and Battle Mountain) are served by a Certified Problem Gambling Counselor (CPGC) or Certified Problem Gambling Counselor Intern (CPGC-I). Gambling treatment services outside of those areas are provided via "V-SEE", a secure web-based video conference technology that links a CPGC to a client in a remote location; typically the

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client's personal home computer. In concept, persons interested in participating in remote counseling would be sent a structured change guide, participate in regularly scheduled video conference sessions with a CPGC, and encouraged to participate in online problem gambling recovery support sites. Unfortunately, this distance treatment option is seldom utilized.

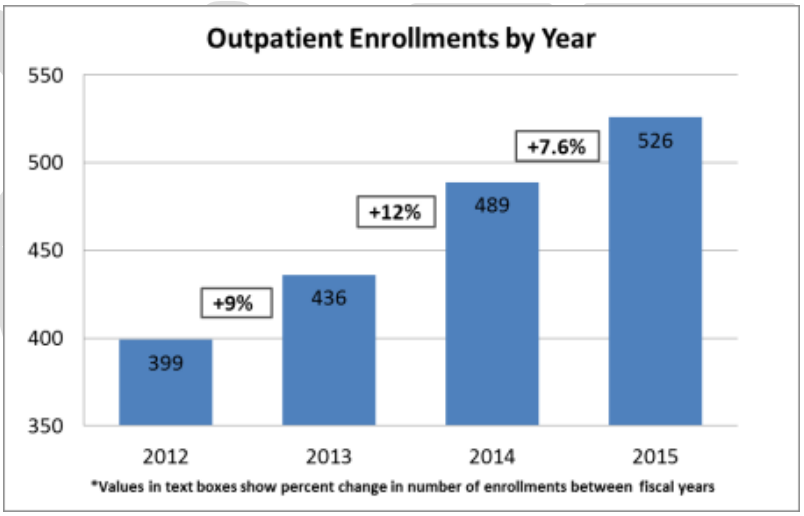
The two residential gambling treatment programs, Bristlecone Family Resources and New Frontier Treatment Center, are charged with serving the residential gambling treatment needs for the entire state. Persons living in Southern Nevada are eligible to receive fully subsidized treatment at one of the Northern Nevada residential gambling treatment programs, inclusive of transportation costs. However, very few persons living outside of the residential treatment centers' geographic areas utilize this level of service. Both residential gambling treatment programs are embedded in larger addiction treatment agencies. These agencies provide problem gambling screens to clients from all their services and those needing gambling treatment are referred into their gambling treatment program.

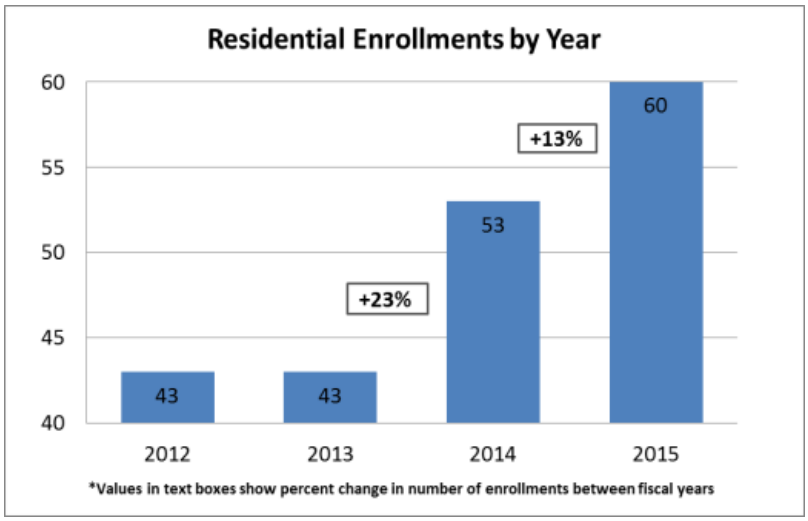
Over the period that the last problem gambling treatment strategic plan was in place, fiscal years 2012 to 2016, enrollments into DHHS supported problem gambling treatment programs have increased year to year (see Figures 1 & 2). About half of all clients entering treatment endorsed 9 or 10 of the 10 characteristics of Pathological Gambling defined in the DSM-IV, with an average score of 7.8.[3]

Almost 71% of clients were in problem gambling treatment for the first time, with about 22% attending one program in the past.[3] Together these statistics demonstrate that persons are not seeking help for their gambling problem until it becomes very severe.

Programs receiving treatment funding are required to be staffed by Certified Problem Gambling

Figures 1 [3] & 2 [3]



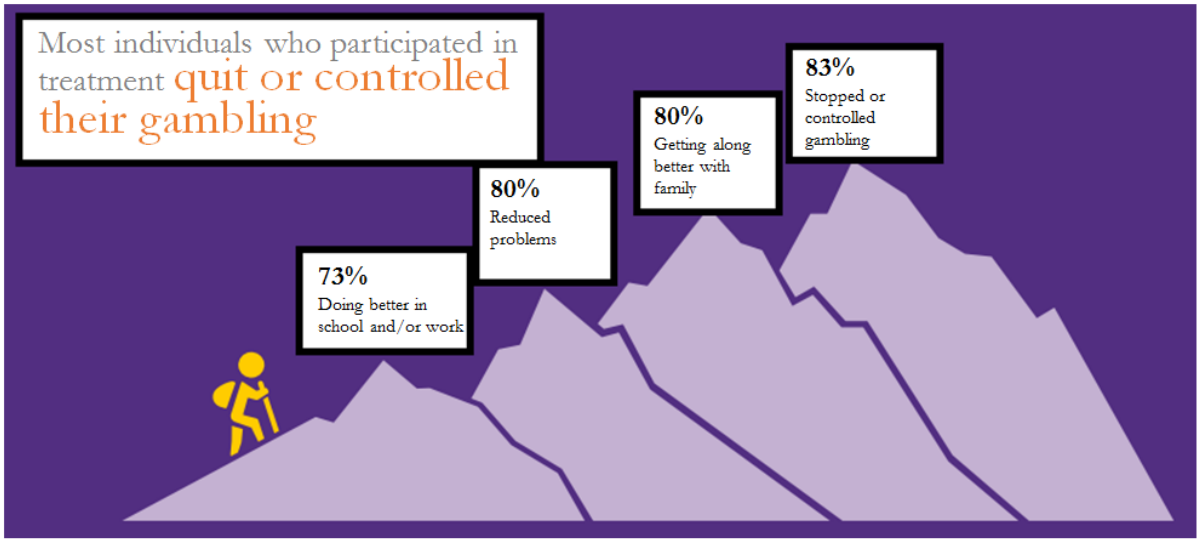


[3] St. John, S. A., Dassopoulos, A., & Bernhard, B., 2015. "The Nevada Problem Gambling Project: Evaluating Treatment and Identifying Underserved Communities." Presented at the 9th Annual Nevada State Conference on Problem Gambling. Las Vegas, NV.

Counselors (CPGC) or Certified Problem Gambling Counselor Interns (CPGC-I). Counselor certification is funded and administered through the State of Nevada's Board of Examiners for Alcohol, Drug and Gambling Counselors.

Problem gambling treatment services in Nevada have provided help to thousands of individuals and in the process saved lives, preserved families, and strengthened communities. The system of services has been evolving from its 2005 inception and will continue to evolve in its quest to meet DHHS Advisory Committee on Problem Gambling's vision statement to "improve the public health of Nevadans through a sustainable and comprehensive system of programs and services that reduce the impact of problem gambling".

Treatment Works*



80% of individuals with problem gambling reported reduction in symptoms and improved quality of life with treatments and supports (at 12-months post enrollment).

** Based on surveys conducted 12-months post enrollment with individuals who obtained DHHS supported problem gambling treatment.* St. John, S. A., Dassopoulos, A., & Bernhard, B., 2015. *"The Nevada Problem Gambling Project: Evaluating Treatment and Identifying Underserved Communities."* Presented at the 9th Annual Nevada State Conference on Problem Gambling. Las Vegas, NV.

D. Prevention Efforts

The efforts to establish a problem gambling prevention system have not been as successful as the development of the gambling treatment system. Within the first two years of DHHS supported problem gambling services, the ACPG identified the need to bring in a consultant to assist the organization with problem gambling prevention efforts. By 2009, DHHS had an ACPG endorsed Problem Gambling Prevention Five-Year Strategic Plan. Two years into that plan, the budget for DHHS supported problem gambling services was dramatically reduced, resulting in the discontinuation of funding for all problem gambling prevention grants. In SFY 2014, investments in problem gambling prevention services returned, although they did not pick-up where they left off. Much of the problem gambling prevention infrastructure that had been in place was lost when programs ceased to be funded. Further, funding for prevention programs did not return at the same level as demand for treatment services were on the rise, leaving fewer dollars available for prevention programs (approximately $200,000 a year). When prevention funding was restored, problem gambling prevention grants were awarded to two entities, the Nevada Council on Problem Gambling (NCPG) and the Center for the Application of Substance Abuse Technologies (CASAT) at the University of Nevada, Reno. The CASAT program sought to develop a problem gambling prevention program for Nevada colleges and universities and pilot that program on the University of Nevada, Reno campus. This left the NCPG with being the primary provider of problem gambling prevention activities for the rest of the state. The NCPG applied a dual approach to its problem gambling prevention efforts through utilizing its existing infrastructure to expand core education, awareness and advocacy programs, and develop an outreach and strategic partnership program by administering a problem gambling prevention mini-grant program.

Although grants are funding problem gambling prevention efforts and those efforts are reaching important populations, the limited investment in problem gambling prevention is insufficient to provide problem gambling prevention activities throughout the state in scope and intensity to realistically expect significant statewide impacts in reducing gambling related harm.

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II. Needs Assessment Findings

To ascertain the needs for system improvement, DHHS conducted a problem gambling services needs assessment, with assistance from Problem Gambling Solutions, Inc. partnering with the Nevada Council on Problem Gambling. Information from stakeholders was gathered utilizing in-person and telephone semi-structured interviews, reviewing reports and program documents, and holding two five-hour workshops designed to solicit input and ideas to consider when drafting a strategic plan for DHHS Problem Gambling Services. The first workshop was held in Reno in 2014 with eighteen participants representing various organizations and stakeholder groups including higher education, social service agencies, treatment agencies, advocacy groups, and consumers. The second workshop took place in Las Vegas, in May of 2016, with ACPG members and DHHS problem gambling program grantees to review a complete draft of the new 3-year strategic plan and seek input into revisions and discuss other possible improvement initiatives.

> *"Including providers in the development of the strategic plan has been very helpful and beneficial. Each provider serves different client populations and so far the system has made allowances for differences between clinics."*
>
> *Anonymous interview participant*

The 48 persons who participated in the semi-structured interviews and/or workshop events represented a wide range of stakeholder groups including treatment consumers, representatives from various service agencies, gambling treatment and problem gambling prevention providers, and others involved in the DHHS problem gambling service system. The workshops, interviews, and review of reports and program documents detailed a set of strengths and a set of limitations of the existing system.

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System Strengths: Everyone involved in the assessment expressed a number of positives about the DHHS problem gambling system including several who expressed gratitude to either be involved within the system or served by the system. The following includes a list of other commonly expressed system strengths:

- Dedicated funding for problem gambling services.
- A strong treatment system with very good providers, programs, payment methods, and evaluation data.
- Good DHHS program administration including prompt responses to questions and prompt payments.
- Lots of problem gamblers are getting help.
- Like use of the strategic plan; find it extremely helpful and appreciate being able to know what to expect.
- With what few problem gambling prevention projects are taking

> *"The state does the best job with treatment grantees. Impressed with the way the treatment side is being handled. Getting good bang for the buck on the treatment side."*
>
> *ACPG interview participant*

place the quality has been good. Appreciate focus on college populations.

- Appreciate the workforce development with broader mental health and addiction community.
- Having the UNLV International Gaming Institute as a local resource is a system strength both for its gambling treatment evaluation program and contribution to other efforts.
- The gambling treatment provider standards work well at creating accountability, assuring quality, and providing adequate reimbursement.
- The treatment programs are well known and respected.
- The ACPG is a strength as it enables input from a broad range of stakeholders.
- Doing a lot with not a lot of funding.

> *"Like the new structure where ACPG is not making funding decision and exploring ways to serve the larger system by taking on roles that DHHS cannot."*
>
> *Anonymous interviewee*

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System Limitations: A number of gaps were found as a result of the needs assessment. Limitations to system effectiveness included:

- The system is under-funded to the point the treatment providers are not adequately resourced to meet demand and the grantees are stretched too thin to expand services without increased allocations.
- The UNLV data system needs to be refined to better align with differences between family member clients and problem gambling clients and to increase user efficiency with data entry.
- Grantees are not optimally learning from one another; need to find more ways to share information between grantees.
- Very little effort and resources are devoted to raising public awareness of programs to address problem gambling; need more funds devoted to raising public awareness.
- Too little is being done to target and work with diverse populations such as Spanish only speakers, veterans, and rural populations.
- Need to develop programs or approaches to encourage more professionals and students to get involved with problem gambling services; difficult to meet certification requirements, find internship placements, and to find interns when and where they are most needed.
- High risk populations need problem gambling prevention programing and little such activity is taking place; there is a need to infuse problem gambling prevention efforts into other addiction prevention efforts.
- The statutes describing the ACPG's activities and purpose need to be revised to give the committee purpose that is needed within today's system; the ACPG is underutilized as a body that can bring needed attention to current issues relating to problem gambling.
- More can be done with data that is collected from programs to better inform clinics, policy, and

> *"The area needing most attention is raising problem gambling awareness. Need more resources to expand system. Need to expand the number of organizations addressing problem gambling."*
>
> *Anonymous interviewee*

inform the larger field.

- DHHS and the ACPG can't do it all; there is a need to develop positions or job duties within other organizations such as developing a responsible gambling position with Gaming Control or a Responsible Gambling Fellowship at the International Gaming Institute.
- There is a lack of effort in primary prevention of gambling problems; need to start educating people earlier, get into schools and educate youth.
- Existing community coalitions and other prevention entities are not routinely engaging with the issue of problem gambling or understanding how problem gambling is related to their work.
- Large scale community assessment efforts to monitor problem gambling impacts are missing in Nevada. Need an updated prevalence study, gambling questions on health surveillance surveys, and a body to analyze and make sense out of what information is gathered.
- Lack of residential gambling treatment services in Southern Nevada.
- Need more attention and resources directed at recovery support services including engaging the recovery community to take on a larger role as change agents and educators.

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III. Stakeholder Identified Priorities

The needs assessment identified several critical issues challenging the performance of Nevada's Problem Gambling Services system. The next step in the planning process was to solicit possible solutions for DHHS to consider when addressing identified problem gambling prevention and treatment system needs. Possible solutions were solicited during the key stakeholder interviews and during the workshops. As a final question during the key stakeholder interviews and as an exercise within the workshops, participants were tasked with prioritizing items. By far the top priority identified was the need for increased funding within the system. It was expressed that without increased funding none of the other priority areas could be adequately addressed and the current funding formula was not keeping up with the times. That is, current funding is based on the number of slot machines licensed in the state; however, gaming has changed., There are fewer machines and the future of gaming is handheld internet gambling where no funding for problem gambling services are attached. One stakeholder summed up what many expressed as a priority by stating, "We need a plan that brings more of everything".

IV. Framework & Guiding Principles

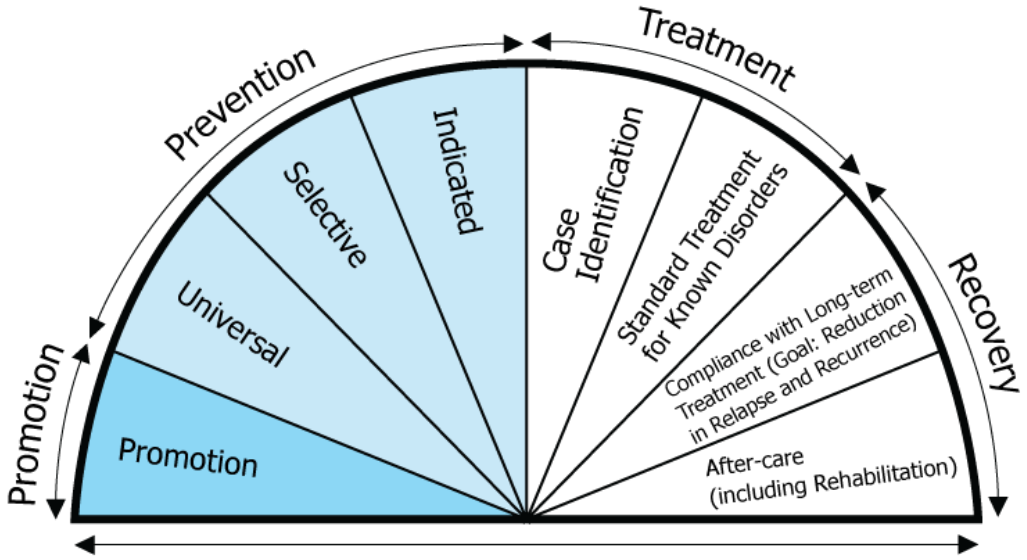
This section introduces a framework and principles that have guided the development of this plan and that will serve as signposts for Nevada's journey in developing services to reduce gambling related harm. The Behavioral Health Continuum of Care Model serves as the framework used to describe Nevada's vision for a comprehensive service approach for addressing problem gambling. This framework is woven into a set of principles to guide the implementation of the plan by DHHS grantees and others who will participate in its implementation.

Continuum of Care

Programs and services to prevent and address problem gambling in Nevada can be defined within a Continuum of Care: a scope of services for individuals, groups, and communities before, during, and after they experience a behavioral health problem such as problem gambling. These services include:

- Health Promotion: These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- Prevention: Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem.
- Treatment: These services are for people diagnosed with a behavioral health disorder.
- Recovery Support: These services support individuals' recovery while in treatment and after.

Figure 3: Behavioral Health Continuum of Care



Ideally, the Continuum of Care will offer assistance to people at all levels of need, from prevention and health promotion for those who do not gamble or who gamble only recreationally to efforts that include screening and referral for at-risk individuals and brief interventions for those in the early stages of problem development as well as treatment services for disordered gamblers, and, finally, recovery support and rehabilitation. The infrastructure and resources in the current DHHS problem gambling system are not sufficient to ideally support this continuum of service at a statewide level; however, this model can be applied in limited scope and serve as a vision for longer term system development if or when additional resources are made available. For this continuum of services to most effectively function it must be supported by an appropriate infrastructure addressing workforce development, system administration, technical assistance, and information management, and requires ongoing evaluation and adjustment to meet changing needs.

To learn more about the Behavioral Health Continuum of Care Model including prevention strategies, principles of cultural awareness and competency, and other approaches used to implement this model, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) website (http://www.samhsa.gov/prevention). SAMHSA is the federal agency that leads public health efforts to advance the behavioral health of the nation. Nevada's publicly funded behavioral health services, including problem gambling services, support approaches advocated by SAMHSA.

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Guiding Principles

The following principles guided the development of this strategic plan and will guide the implementation of the plan by DHHS grantees and others who will participate in its implementation:

- Work to reduce gambling related harm while maintaining a neutral position in neither being for or against legalized gambling.
- Support the mission and vision of the DHHS Advisory Committee on Problem Gambling.
- Enhance existing infrastructure whenever possible, rather than creating something new.
- Engage populations of highest need in designing programs and interventions for problem gambling and related issues.
- Work collaboratively across agency boundaries to make interventions more impactful.
- Address gambling through a public health lens, working at a community level to create norms and environments that support healthy behavior.
- Base priorities on data.
- Choose interventions based on evidence of efficacy and proven methods to increase success.
- Provide interventions along the entire Continuum of Services, with a priority on making treatment accessible, recovery supported, and increasing the focus on prevention as resources grow.
- Evaluate and adjust as the work progresses; make data driven decisions.

- Messaging to the public about responsible gambling and problem gambling awareness is provided in a manner that is non-blaming, hopeful, and supports the normalization of help seeking for persons with gambling related problems.
- When developing programs and materials, work collaboratively with consumer and provider communities.
- Strive to bring prevention efforts to the local level and create community empowerment.
- Don't develop and implement projects in isolation; utilize available resources, nurture existing partnerships and develop new ones.
- Cultural and linguistic competency will be the expectation and the rule.
- Prevention programs should enhance protective factors, reverse or reduce risk factors, and strategically take place when targeted populations are at key transition points.

V. Goals, Activities, Enhancements, & Phases

Improving DHHS Funded Problem Gambling Services

This strategic plan follows the problem gambling system needs assessment that was completed in 2016. Information gathered during the needs assessment and solution finding phases were categorized into five domains that correspond with the DHHS Problem Gambling Services system's historical conceptualization of program components, funding designation categories, and service procurement categories. These domains are:

A. Administrative Operations

B. Information Management

C. Prevention and Health Promotion

D. Treatment

E. Workforce Development

Each of the above problem gambling service components is accompanied with a goal followed by a list of enhancement activities intended to achieve the stated goal. The goals and enhancement activities outlined below conform to the ACPG's vision and mission, and the Plan's framework and guiding principles previously described.

In addition to compartmentalizing enhancement activities by service component, they are divided into two phases, reflecting the sequence in which they will begin:

Phase 1 enhancement activities are those to take place during SFY 2017, the second year of a two-year grant award cycle where service providers and work plans are largely in place. As one of the guiding principles of this strategic plan is to "enhance existing infrastructure whenever possible, rather than creating something new", many of these activities will continue and expand into Phase 2.

Phase 2 enhancement activities are those designated to take place during the SFY 2018 and 2019 grant cycle. Many of these enhancement activities are contingent on funding availability with some possible if funding remains relatively stable and others only being possible with additional dollars invested in DHHS Problem Gambling Services.

A: Administrative Operations

Goal:

Maintain the highest standards of stewardship over essential services supported by the Revolving Account for the Prevention and Treatment of Problem Gambling including establishing strategic directions and program policies, developing needed infrastructure, and operating effective procurement, funding, and reimbursement systems.

Ongoing Delivery:

The DHHS Office of Community Partnerships and Grants is the administrative body that oversees programs funded by the Revolving Account for the Prevention and Treatment of Problem Gambling and the Advisory Committee on Problem Gambling (ACPG) advises DHHS on the administration of these programs. Over the years, an infrastructure was developed to support a problem gambling service system including (a) DHHS staffing dedicated to problem gambling program coordination; (b) the formation and maintenance of the ACPG; (b) contracting for the development and operation of an information management and evaluation system; (c) contracting technical assistance services to help support program operations, the ACPG, and grantees; and (d) utilizing internal DHHS business processes and supports to drive critical functions such as service procurement, service payments, and program leadership.

Enhancement Activities:

Phase I:

- Maintain and enhance human and programmatic capacity to implement this strategic plan.
    - Explore with the Advisory Committee on Problem Gambling (ACPG) measures DHHS Office of Community Partnerships and Grants can take to support ACPG initiatives and ACPG functions.
    - Examine existing funding structures, allocations, and outputs to determine necessary funding reallocations and make changes based on identified needs and resources.
    - Consider developing and/or supporting legislation necessary to increase funding for the problem gambling service system.
- Seek opportunities to improve upon policies and procedures that will support the successful enhancement and implementation of services.
    - Implement revised standards for problem gambling treatment providers and gambling treatment services as recommended in Appendix A.
    - Solicit input from grantees on recommended changes to the grant application process, develop methods to revise service procurement practices, and implement to procure SFY2018 and SFY2019 service grants.

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- Explore methods and policies enabling DHHS to leverage funds from the Revolving Account for the Prevention and Treatment of Problem Gambling with other funding sources.
- Explore policies enabling and encouraging providers to braid funds from multiple funding streams, such as Medicaid, the Revolving Account for the Prevention and Treatment of Problem Gambling, charitable donations, and private insurance so that funds are combined, with careful accounting for how dollars from each funding source are spent.

- Enhance grant oversight activities to increase system performance including quality of care and/or services across all grantees.
  - For treatment grantees, develop and implement new program review procedures to monitor compliance with gambling treatment standards, including newly developed performance benchmarks, and develop corrective action procedures and conditions upon which funding may be reduced, revoked, or redirected.
  - Revise treatment grantee performance benchmarks to update goals for treatment utilization, timely access to treatment, treatment engagement, treatment retention, and treatment outcomes, and add a new benchmark for data reporting accuracy.
  - Conduct program reviews of service grants to support and monitor grantee progress in meeting grant conditions.

Phase II:

- Foster integration of problem gambling interventions into core elements of other DHHS administered programs.
  - Request the ACPG to advise on strategies and methods that DHHS can take to increase the integration of problem gambling interventions into other DHHS service programs.
  - Explore opportunities and implement when feasible Gambling Screening, Brief Intervention, and Referral to Treatment (SBIRT/GBIRT) model programs to identify, reduce, and prevent problematic gambling behaviors.
  - Where determined feasible, add problem gambling into standardized reporting systems and revise DHHS rules and contracts to encourage agencies to integrate problem gambling interventions into service programs.
  - Explore opportunities and implement when feasible contract conditions to require state funded programs to add education about problem gambling into appropriate educational curricula (e.g. DUII diversion programs).
  - Explore the development of a Problem Gambling Informed endorsement for mental health and addiction programs and develop technical assistance programs and other incentives for programs to obtain the endorsement.

- Continually assess the performance of the problem gambling service system; seek input from partners, collaborators, and other stakeholders; and engage in efforts to

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continually improve the effectiveness and efficiency of efforts to address problem gambling.

- Conduct program reviews to monitor compliance with treatment standards and develop corrective action procedures and conditions upon which funding may be reduced, revoked, or redirected.
- Conduct an assessment of SFY2017 grant process and recommend changes to address identified issues or areas in need of improvement.
- Award funds based on performance including service encounter claims, ability to meet performance benchmarks, and program review findings.
- Review and adjust service reimbursement rates to correspond with rate changes in Nevada's other publicly funded behavioral health systems.
- At least annually review the DHHS Problem Gambling Services Strategic Plan and update as needed.

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B: Information Management

Goal:

To have access to valid and reliable data on the population being served, utilization of services, program performance, and the outcomes produced. The information management system will support and enhance data-driven program and policy decisions.

Ongoing Delivery:

The information management of DHHS supported problem gambling services has been tasked to three entities. The hub of the information is the DHHS Office of Community Partnerships and Grants and its staff assigned to the problem gambling program. DHHS obtains progress reports directly from grantees that include information on progress toward stated goals and fiscal reports. Two other entities serve as business associates in the administration of the problem gambling system; an Information Management contractor, currently UNLV International Gaming Institute, and a Technical Assistance contractor, currently Problem Gambling Solutions, Inc. The Information Management contractor is responsible for developing, operating, and reporting on a data management and evaluation system for the problem gambling treatment system. This comprehensive system provides information needed to process claims, determine if treatment grantees are achieving defined performance benchmarks, track trends in enrollments and client outcomes, and provide DHHS with requested data to inform policy and program decisions. The Technical Assistance contractor is tasked with, among other duties, designing, coordinating, and reporting on problem gambling treatment program reviews and collecting needs assessment data from the field.

Enhancement Activities:

Phase I:

- Embark on efforts to improve the type and quality of data collected by DHHS OCPG from grantees and provided to grantees.
  - Explore revisions to quarterly reporting forms.
  - Seek opportunities to reduce information request redundancy by better utilizing existing information.
  - Seek methods to increase information feedback loops to assist grantees to make data informed program changes.
- Improve the functionality of the UNLV problem gambling treatment information management system.
  - Clarify and update the Encounter Data Reporting Requirements (see Exhibit 3).
  - Develop new user interface for clinics to enter data into the UNLV problem gambling treatment data system.
  - Create training manual and frequently asked questions document for the new user interface.
  - Create new forms for clinics to enter updated client contact information as it becomes available to them, in order to increase participation in follow-up evaluation.
  - Improve database architecture to link intake, encounter, and follow-up data.
  - Survey grantees and produce preliminary report on function of new data collection system with recommended adjustments to improve system to more accurately monitor program performance on defined benchmarks.
- Revise gambling treatment program review protocols to increase effectiveness and transparency, and fit with other system changes.
  - Revise protocols and instruments to fit with revisions to the Problem Gambling Treatment Provider Guide (Appendix A).
  - Provide training sessions on how to use new user interface at each clinic for all staff who complete data entry.
  - Systematically review encounter claims data for each grantee and match sample of claims with client file documentation and other supporting documentation.
  - Implement methods to assist grantees with meeting performance benchmarks and provider standards upon request and in response to program review findings.
- Develop "Problem Gambling Treatment Program Quality Improvement Report" based on data collected and report findings according to defined performance benchmarks.

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Phase II:

- Based on information collected during Phase I, implement improvements on the type and quality of data collected by DHHS OCPG from grantees and data reported to grantees.
  - Explore development of family client specific forms and information tracking.
  - Explore methods to seamlessly transfer data between clinics' electronic records management systems and the UNLV problem gambling treatment information management system.
- Annually evaluate and improve on the functionality of the UNLV problem gambling treatment information management system.
  - Evaluate new user interface; update and revise as necessary.
  - Create master training manuals for the positions of Project Manager and Follow-Up Coordinator for ease of staff transitions.
  - Find and train a replacement graduate assistant for the follow-up evaluations.
- Provide annual problem gambling treatment system performance and evaluation reports and as requested reports to enable data driven program and policy decisions.
- Annually evaluate and revise as needed gambling treatment program review protocols to increase effectiveness and transparency, and fit with other system changes.

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C: Prevention & Health Promotion

Goal:

Support effective problem gambling prevention and health promotion programs to reduce the occurrence and impact of problem gambling on individuals, families, and communities.

Ongoing Delivery:

In SFY 2016 and 2017 problem gambling prevention grants were awarded to two entities, the Nevada Council on Problem Gambling (NCPG) and the Center for the Application of Substance Abuse Technologies (CASAT) at the University of Nevada, Reno. The CASAT program involves implementing problem gambling prevention initiatives on the University of Nevada, Reno campus. The problem gambling prevention grantee with the largest grant, NCPG, provides a number of services including: Development, production and statewide dissemination of problem gambling awareness and education materials; Integration of problem gambling messaging, materials, and referral resources into community awareness and health promotion activities and events; Promotion and coordination of activities in support of Problem Gambling Awareness Month; Maintenance and use of the NCPG website and social media to provide and promote problem gambling awareness, information and resources for help; Development of a program to mobilize the recovery community to

raise problem gambling awareness; and Administration of a mini-grant program to encourage a limited number of community entities to integrate problem gambling into their existing prevention efforts.

Enhancement Activities:

Phase I:

- Increase the capacity of prevention efforts to address problem gambling.
  - Explore opportunities to add funding to the DHHS administered problem gambling service system in order to increase the financial investment in problem gambling prevention efforts.
  - Explore the possibility of requiring state funded addiction prevention programs to integrate the topic of gambling addiction into their materials and efforts.
  - Focus the use of limited prevention funding to prepare the system for a more robust prevention effort when more funds materialize.
- Expand upon current problem gambling prevention efforts.
  - Increase the number of NCPG administered mini-grants designed to develop partnerships and collaborative projects with organizations where addressing problem gambling is consistent with meeting their mission.
  - Expand upon past efforts to coordinate statewide activities during Problem Gambling Awareness Month.
  - Further develop the NCPG website as a resource for entities interested in or actively providing problem gambling prevention messaging or other forms of problem gambling awareness activities.
  - Seek opportunities to expand problem gambling prevention efforts piloted on the University of Nevada, Reno campus to other Nevada institutes of higher education.

Phase II:

- Develop the infrastructure of problem gambling prevention efforts in Nevada. Explore and implement if feasible the following actions:
  - Add a Problem Gambling Prevention Coordinator position within DHHS.
  - Develop and implement a data system to monitor and track problem gambling prevention activities.
  - Provide training opportunities and technical assistance on SAMHSA endorsed practices for effective prevention service development and implementation.
  - Collect and track a greater number of health indicators related to problem gambling behavior.
  - Identify state-level changes and improvements that will impact the problem gambling prevention system.

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- Increase the readiness and capacity of prevention professionals in related fields (substance abuse, violence, suicide) to address problem gambling. Explore and implement if feasible the following actions:
  - Incorporate problem gambling into DHHS funded substance abuse prevention coalitions' scopes of work.
  - Provide technical assistance and written guides to support the incorporation of problem gambling content into coalitions' work.
  - Educate the prevention workforce about comorbidities, overlapping risk, and protective factors between substance misuse, suicide, and problem gambling.
- Design and disseminate messaging and campaigns specifically for high-risk populations. Explore and implement if feasible:
  - The use of social media and new technologies to promote problem gambling prevention and treatment.
  - Develop and expand peer delivered services through the creation of a speaker's bureau.
  - Enhance prevention activities and client finding outreach to underserved populations (e.g. older adults, culturally specific, veterans).
- Increase collaborative partnerships to help increase efficiency and efforts to address problem gambling.
  - Support and participate in workgroups tasked with further developing problem gambling prevention services.
  - Support meeting and webinar opportunities for providers to network, to form partnerships, and to share successes.
  - Reach out to representatives of state agencies and explore opportunities to partner on common ground initiatives where addressing problem gambling supports fellow state agencies' goals.

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D: Treatment System

Goals:

(a) Support effective and efficient problem gambling treatment programs to reduce the occurrence and impact of problem gambling on individuals, families, and communities.

(b) Increase problem gambling treatment enrollments by no less than 10% each year.

(c) 100% of gambling treatment grantees meet defined performance standards.

Ongoing Delivery:

Continue to support a problem gambling treatment system composed of elements that offer a continuum of care from health promotion, screening and referral, brief interventions, distance treatment, outpatient treatment, residential treatment, and longer-term recovery support.

Enhancement Activities:

Phase I:

- Implement revisions made to the Gambling Treatment Provider Guide (see Appendix A).
  - Add new performance standard to establish benchmarks for documentation accuracy.
  - Incentivize providers to increase enrollments and provide high quality intake assessments by revising intake assessment reimbursement schedule.
  - Reduce residential stay length and increase recovery support by adding a procedure code for Transitional Housing and reducing the client benefit cap to $3,000 for Residential Treatment, and increasing the client benefit cap to $2,200 for Outpatient Services inclusive of Transitional Housing.
  - Increase support for clients with co-morbid psychiatric disorders by adding procedure code for Mental Health Professional Case Consultation.
  - Support workforce development by increasing reimbursement rates of problem gambling treatment counselor interns.
  - Clarify and simplify procedures for requesting prior authorization and exception requests.
  - Create provisions for behavioral health professionals who are not certified problem gambling counselors to provide reimbursable services to gambling treatment clients when certified problem gambling counselors are temporarily unavailable.
- Explore methods to expand treatment access, and for those enhancements determined feasible, include in the procurement process for SFY 2018 and 2019 service grants. Possible new service components may include:
  - Development of a program designed to fill service gaps within the existing gambling treatment system where persons seeking specialized assistance are provided vouchers to exchange for services among certified providers.
  - Development of a centralized distance treatment program and/or promotion of existing internet based help programs.
  - Inclusion within the gambling treatment requests for proposals the option to apply for funds to support demonstration projects to fill existing gambling treatment system gaps.
  - Development of peer support service programs either within existing grantee programs or as stand-alone programs.

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Phase II:

- Implement new grants with targeted technical assistance services provided to new gambling treatment grantees resulting from the SFY 2017 procurement process.
- Explore development of a residential problem gambling treatment program located in Southern Nevada that follows mainstream models for providing residential gambling treatment.
- Monitor encounter claim data and based on utilization, adjust allocations to gambling treatment grantees as indicated.
- Utilize the ACPG to inform the development and implementation of innovative interventions targeting high risk populations/groups.
- Annually conduct a review of the gambling treatment program standards and revise as needed.
- Conduct a problem gambling treatment needs assessment. Utilizing data collected, develop a procurement strategy that will result in the purchasing of services for SFY 2020 and 2021 to meet identified needs and objectives.
- Each year assess strengths and gaps in the provision of these services and make adjustments as needed.
- Approximately every six months, based on encounter claims, adjust allocations to gambling treatment grantees.

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F. Workforce Development

Goal:

Offer training, education programs, and networking opportunities designed to develop provider competencies and foster a supportive and collegial workforce made up of sufficient numbers.

Ongoing Delivery:

Continue to offer a workforce development grant to support an annual state conference on problem gambling and continually update the community with opportunities for problem gambling education. Continue to offer grantees the ability to utilize a portion of their grant monies to support the professional development of their problem gambling service staff including supervision services.

Enhancement Activities:

Phase I:

- Support the costs of grantees to provide Certified Problem Gambling Counselors (CPGC) and Interns (CPGC-I) with case consultation services from Mental Health Professionals.
- Encourage problem gambling treatment grantees to offer internships to CPGC-I by increasing reimbursement rates for CPGC-Is.
- Develop and provide educational opportunities for qualified mental health professionals, as defined by NRS 458A.057, to meet the educational requirements to become back-up problem gambling counselors per Exhibit 2: Problem Gambling Treatment Provider Standards (10 hours of gambling specific education including at least 2 hours specific to gambling treatment).
- Explore strategies to increase information exchanges between providers.
- Explore strategies to effectively and efficiently offer core problem gambling treatment counselor education for individuals seeking to become a CPGC-I.
- Survey workforce to assess training needs and satisfaction with training offered.
- Utilize workforce survey results to inform objectives and activities to be included in the SFY2018 – 2019 Problem Gambling Workforce Development Request for Proposals.

Phase II:

- Devise training and education programs to develop provider competencies. Explore the following initiatives and implement if and when feasible:
  - Develop technical assistance services to offer support and training to new problem gambling treatment and prevention staff working within DHHS funded problem gambling treatment and prevention programs.
  - Establish standards for student placements and internships focused on developing competence in problem gambling prevention, early intervention and treatment services.
  - Utilize training models that emphasize coaching and on-site implementation support.
  - Offer regional problem gambling training opportunities.
  - Sponsor an annual problem gambling conference.
- Assess workforce development needs and implement programmatic changes based on needs.
  - Survey workforce to assess training needs and satisfaction with training offered.
  - Utilize workforce survey results to continue to improve workforce development efforts.
- Expand efforts to educate the broader mental health and addictions community about problem gambling including links between problem gambling and other

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behavioral health issues, problem gambling treatment availability and evaluation outcomes, and problem gambling screening and referral. Explore the following strategies and implement if feasible:

- Partner with colleges and institutions to offer specialty education and training in the knowledge, skills and attitudes essential to provide effective gambling disorder prevention and treatment services.
- Expand web accessible resources for problem gambling service providers through the creation of a new provider specific website for problem gambling service providers.
- Improve and make available continuing education events on a regular basis throughout the state that enhance the knowledge and skills of problem gambling service providers at all levels, including allied providers in the fields of behavioral health, physical health, and public health.
- Maintain an ongoing annual schedule of continuing education events for a variety of professionals.
- Actively seek out and arrange for presentation opportunities at conferences within Nevada attended largely by health care service providers including behavioral health, physical health, and public health.
- Collaborate with professional credentialing/licensing bodies to require a minimum number of problem gambling education hours for certification and licensing of behavioral health professionals.
- Meet with behavioral health and education associations to explore where and how the topic of problem gambling can be incorporated into trainings, curricula, testing, and certifications.

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"I could not have done it without this program, and I hope that it never stops because there are always going to be people with addictions out there. I could have never been to this point—ever. That program saved my life."

— Anonymous Client

Quote taked from: Dassopoulos, A., St.John, S. & Bernhard, B. (2015). The Nevada Problem Gambling Project: Follow-Up Research. UNLV International Gaming Institute. Las Vegas, NV.

APPENDIX A

NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES PROBLEM GAMBLING TREATMENT PROVIDER GUIDE

Working Draft: Version 5/2/16

INTRODUCTION: This Agreement/Provider Guide (hereinafter referred to as "Agreement") describes requirements that must be met by agencies and individual providers who wish to provide problem gambling treatment services funded by the Revolving Account for the Prevention and Treatment of Problem Gambling through NRS 463.320(2)(e). Providers must meet the requirements contained in this Agreement in order to receive funds for services provided under grant or agreement with the Nevada Department of Health and Human Service (DHHS).

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I. Definitions

Throughout this Agreement, the following words and terms are used as defined in this section unless (a) the context in which they are used clearly requires a different meaning or (b) a different definition is prescribed for a particular part or portion of a part.

"**Abuse**" is defined as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary harm or cost to DHHS or clients, or in reimbursement for services that are not medically necessary or fail to meet Agreement standards.

"**Aftercare**" shall mean the stage following discharge, when the client no longer requires services at the intensity required during primary treatment.

"Board" shall mean the Nevada State Board of Examiners for Alcohol, Drug, and Gambling Counselors.

"**Certified Problem Gambling Counselor"** or "**CPGC**" means a person who is certified as a problem gambling counselor pursuant to NRS 641C.050

"Certified Problem Gambling Counselor Intern" or "CPGC-I" means a person who is certified as a problem gambling counselor intern pursuant to the provisions of NRS 641C.060.

"**DHHS**" shall mean The Nevada Department of Health and Human Services, and its employees, agents and representatives.

"**Distance Treatment**" shall mean professionally delivered treatment where the majority of time spent between a counselor and client are non face-to-face encounters. The primary forms that distance treatment take are phone, web-based or video counseling.

"Eligible Client" or **"Client"** shall mean, for purposes of this Agreement, an individual with a gambling related problem is an individual with (a) a primary diagnosis of Gambling Disorder (DSM-5 code 312.31), (b) a primary diagnosis of sub-clinical Gambling Disorder (meets two to three DSM-5 diagnostic criteria for Gambling Disorder), or (c) a primary diagnosis of Relational Problem Related to Gambling Disorder (a variant of DSM-5 code V61.9).

"**Fraud**" is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

"**May**" denotes the permissive.

"Outpatient Gambling Treatment Program" shall mean to provide problem gambling assessment, treatment and rehabilitation services delivered on an outpatient basis or intensive outpatient basis to individuals with gambling related problems who are not in need of 24-hour supervision for effective treatment. Outpatient Gambling Treatment Services must include regularly scheduled face-to-face or non-face to face therapeutic sessions or services in response to crisis for the individual and may include individual, group, couple, and family counseling.

"**Primary Diagnosis**" shall mean the main condition treated or investigated during the relevant episode of healthcare. The reason for admission in and of itself does not constitute the primary diagnosis. A primary diagnosis for Gambling Disorder, or other eligible client diagnoses, may only be made by CPGCs and mental health professionals qualified to make DSM-5 diagnoses as specified in their license or certification scope of practice.

"**Provider**" shall mean an institution, facility, program, agency, group or individual practitioner who has agreed to a written arrangement of cooperation with DHHS as an independent contractor or grantee to provide Problem Gambling Services. Provider is not an agent of DHHS, and shall not represent itself as an agent of DHHS.

"**Psycho-educational Group**" shall mean a specific type of group therapy that focuses on educating clients about their disorders and developing competencies in members through such structured groups as social skills, coping skills, relapse prevention skills, and life skills training.

"Residential Gambling Treatment Program" shall mean to provide problem gambling assessment, treatment, rehabilitation and twenty-four hour monitoring for pathological and problem gamblers consistent with Level III of ASAM PCC-2R. Residential Gambling Treatment Programs must be within a licensed inpatient mental health facility or residential alcohol and drug treatment facility that is in good standing and certified by a DHHS recognized accreditation board.

"Shall" denotes the imperative.

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"**Self-refer**" shall mean a referral to a program without a prior assessment/treatment recommendation.

"**Service appointment**" shall mean a scheduled time for Client to meet with CPGC or CPGC-I for treatment session or assessment session.

"Session" or "treatment session" means services delivered in individual, couple, family, or group formats.

"**Treatment Episode**" shall mean the period beginning with the service date reported on the first encounter claim to the submission date of the discharge form.

II. Performance Standards

Providers funded through this Agreement must comply with the requirements set forth on Exhibits 1, 2, 3 and 4 attached hereto and incorporated herein by this reference.

Providers funded through this Agreement must meet the performance standards below. These performance standards are imposed and assessed on individual Providers and based ~~exclusively~~ on required data submitted by Providers to the UNLV International Gaming Institute, the current Information Management Contractor for DHHS gambling treatment services, **and through program reviews and fiscal audits**. If DHHS determines that a Provider funded through this Agreement fails to meet the specified performance standards, Provider will be required to submit a corrective action plan to DHHS's satisfaction. Repeated inability to meet the performance standards below may result in discontinuation of grantee funding. Providers are also subject to requirements imposed by DHHS in other documents attached to the Notice of Grant Award.

Access: The amount of time between a problem gambling affected individual's request for outpatient services and the first offered service appointment must be five business days or less for at least 90% of all individuals receiving services funded through this Agreement.

Retention: The percent of problem gambling affected individuals receiving services funded through this Agreement who actively engage in problem gambling treatment for at least 10 clinical contact sessions must not be less than ~~40~~**50**%.

Successful Completion: The percent of all individuals receiving services funded through this Agreement who successfully complete treatment must not be less than ~~35~~**50**%. A successful problem gambling treatment completion is defined as the individual's: (a) achievement of at least 75% of short-term treatment goals, (b) completion of a continued wellness plan (i.e., relapse prevention plan), and (c) lack of engagement in problem gambling behaviors for at least 30 days prior to discharge from services.

Client Satisfaction: The percent of problem gambling affected individuals receiving services funded through this Agreement who complete a problem gambling client satisfaction survey would positively recommend the Provider to others must not be less than 85%.

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Long-term Outcome: The percent of problem gambling affected individuals receiving services funded through this Agreement who successfully complete treatment whose responses to a problem gambling follow-up survey suggest maintained improvement at twelve months after ~~discharge~~ **intake** must not be less than 50%.

Consent for Follow-Up Evaluation: percentage of problem gambling affected individuals receiving services funded through this Agreement at each clinic consenting for follow-up evaluation should be no less than 80% of the average percentage of clients consenting system-wide.

Case Cost: The average outpatient treatment cost per case must not be more than 120% of the average cost per case across all DHHS funded outpatient gambling treatment grantees.

Service Cost Share: The percentage of total reported services not claimed for DHHS reimbursement should be no less than 75% of the average percentage of total reported services not claimed for DHHS reimbursement across all DHHS treatment grantees.

Documentation Accuracy: A comparison of documented clinical services provided within client files and client sign-in sheets with encounters entered into the UNLV Problem Gambling Treatment Data Management System must have a correspondence rate of 95% or greater for any period of 28 consecutive calendar days or longer.

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III. Special Reporting Requirements

Providers funded through this Agreement must submit the following information to Department (or to DHHS's designee), with respect to the individuals receiving services funded through this Agreement, as well as any other information related to the delivery of Services funded through this Agreement that DHHS reasonably requests from time to time:

A. Intake Data: The data form must be collected and submitted within 14 days of the first face-to-face treatment contact with an individual.

B. Client Consent Form: A completed client consent form for use in follow-up efforts must be collected and submitted ~~prior to discharge~~ **as part of the Intake data.** Client refusal to participate in the follow-up survey must be documented in the client file **and when filling out the consent portion of the Intake form.**

C. Encounter Data: Encounter data for billing must be collected and submitted as described in Exhibit 3 attached hereto and incorporated herein by this reference. Prior to submitting an encounter claim each claimed encounter must be documented in the clinical record. Encounter claim documentation placed in the clinical record must include the date of the encounter service; the type of service delivered, the length of service, a clinical note describing data from the session, the clinician's signature and date the note was completed.

D. Discharge Data: ~~Discharge data must be collected and submitted within 90 days after the last date of service to an individual.~~ **Clients must be discharged 60 days after last date of service or after a change in level of service to or from residential treatment. The discharge must be documented in the client file, and discharge data must be**

collected and submitted within 30 days of discharge. Discharge data must be collected and submitted as described in Exhibit 3 attached hereto and incorporated herein by this reference. Prior to submitting discharge data, a treatment summary must be completed stating the reason for discharge, progress toward treatment plan objectives, and recommendations.

IV. Grant Award Calculation and Disbursement Procedures

A. Grant Award Calculation. DHHS grant awards are based on the following services and claim rates:

Services and Rates*

Types of Providers	Assessment \ Diagnostic Workups	PRIMARY TREATMENT			
		Individual Session	Psycho-therapy Group Session	Psycho-educational Group Session	Residential Bed-day
CPGC	**$82.50/hr**	$66/hr	$24/hr	$18/hr	**$140**
CPGC-I	**$62/hr**	**$49.5/hr**	**$18/hr**	**$13.5/hr**	**$140**

**See Exhibit 4 for service and unit definitions.*

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The above services and rates are subject to the following:

1. These rates are based on maximum allowable claims for the DHHS Office of Community Partnerships and Grants' Gambling Treatment Program, applicable only to granted DHHS Problem Gambling Treatment vendors.

2. Rates are on an hourly per person basis except for ~~(a) assessment where 1 unit is for the complete activity including administrative time needed for documentation and enrollment and (b)~~ residential bed-day where 1 unit is an overnight stay.

3. Psychotherapy Group size is not to exceed 12 participants.

4. Rates for individual counseling include family and marital counseling which are based on **time** per session not the number of persons attending.

5. Residential Treatment Assessments / Diagnostic Workups must include the administration of the Gambling Patient Placement Criteria (GPPC) instrument. Outpatient Treatment Assessment / Diagnostic Workups must include the

administration of the GPPC or other DHHS approved assessment tool(s) and protocol.

6. Only one assessment claim per client is allowable except in situations where a client was discharged then later re-enrolled.

7. If the person enters treatment, reimbursement eligibility begins after successful submission of client enrollment information to DHHS designated information management entity.

8. The types of services and number of sessions rests with the clinical judgment of the provider as reflected in the treatment contract between the provider and the client.

9. If provider does an assessment/diagnostic workup and the client enters treatment, those costs are considered part of the maximum allowed reimbursement per treatment episode of $2,200 for outpatient treatment and $3,000~~500~~ residential treatment.

10. No state reimbursement payment will be made for a missed scheduled session. All services reimbursed by DHHS must be documented in the client chart.

11. The rate to be billed must be based on the educational and training level of the direct provider, not of the person supervising the provider.

12. Persons eligible to enroll into DHHS reimbursed gambling treatment must have a gambling related problem as defined by (a) a primary diagnosis of Gambling Disorder (DSM-5 code 312.31), (b) a primary diagnosis or sub-clinical Gambling Disorder (meets two to four DSM-5 diagnostic criteria for Gambling Disorder), or (c) a primary diagnosis of Relational Problem Related to Gambling Disorder (a variant of DSM-5 code V61.9).

13. Persons eligible to enroll into DHHS reimbursed residential gambling treatment must have special needs as defined by all of the following: (a) a primary diagnosis of Gambling Disorder (DSM-5 code 312.31); (b) referral from a certified problem gambling counselor or inpatient psychiatric facility; (c) must meet residential gambling treatment program admission criteria as defined in Exhibit 1.

14. Services that receive reimbursement must be face-to-face therapeutic sessions unless a specific distance treatment plan is documented in the client record and conforms to DHHS conditions to provide distance treatment.

15. Providers of services funded through this Agreement may charge client co-pays. The maximum client co-pay in a residential program is $10.00 per bed day. The maximum client co-pay in an outpatient program is $10.00 per session. No client shall be refused services due to inability to pay.

16. Total DHHS payment for all services delivered under this Agreement shall not exceed the total funds awarded for services as specified in the Notice of Grant Award.

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17. DHHS is not obligated to provide payment for any Services that are not properly reported **or documented** as described or referenced in this Agreement by the date 45 days after the termination of this Agreement.

18. ~~If at the end of any six month period during the term of this Agreement,~~ DHHS may unilaterally reduce or increase the amount of funds awarded based on one or a combination of factors including the underutilization or overutilization of the current grant budget, the efficiency of funds used as determined by average cost-per-treatment episode and performance in meeting standards as defined above in Section II, changes in grantee program capacity, changes in available funds from the DHHS Revolving Account for the Prevention and Treatment of Problem Gambling, **and/or discovery of grantee being out of compliance with grant conditions** . Provider shall execute and deliver to DHHS an appropriate amendment, as written by DHHS, to reflect budget change. In addition to the six month utilization review and allocation adjustment, additional funding adjustments may be made at the request of the provider or DHHS.

B. Provider Audits. Providers and sub-contracted Providers receiving payments from DHHS are subject to fiscal review and/or audit for all payments applicable to services rendered. **DHHS may require Providers to payback funds for services paid for and not appropriately documented or for services claimed that are not allowable or claimed incorrectly.** Refer to Grant Instructions and Requirements for further details.

C. Prior Authorization **and Exception Requests**. DHHS may grant the following exceptions with prior authorization.

1. The maximum allowed reimbursement per treatment episode may be exceeded. Treatment providers may request up to 10% of the grant award, for the current grant cycle, to be used for extensions of client benefit caps. Only the actual amount expended on behalf of each client (rather than the requested amount) will apply toward the overall 10% extension limit.

2. Other exceptions to conditions or clauses of Agreement, as mutually agreed upon in writing by DHHS and Provider.

D. Procedure for requesting prior authorization **and exception requests**.

1. For submitting benefit extension requests, providers must complete the most recent version of the "Nevada Department of Health and Human Services Problem Gambling Treatment Benefit Extension Request Form" in its entirety (Exhibit 5) then email the DHHS Problem Gambling Program Coordinator, Pat Petrie

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(pdpetrie@dhhs.nv.gov) a scanned copy of PART C or within body of email include all information from PART C along with a statement that a completed Benefit Extension Request Form has been placed in the client's file.

2. The procedure for requesting exceptions to conditions or clauses of Agreement, other than benefit extension requests, consist of emailing the DHHS Problem Gambling Program Coordinator the exception request along with an explanation of why the request is needed.

   a. In situations where a program's CPGC or CPGC-I are temporarily unavailable due to vacancies of 30 or less days, vacation time, sick leave, or job related travel, then other qualified mental health professionals (QMHP), as defined by NRS 458A.057 may provide gambling treatment services if they had completed at least 10 hours of gambling specific education within the past two years including at least 2 hours specific to gambling treatment. Submission of an exception request to enact this provision is required and must include the name of the QMHP, documentation that the education requirements have been met, and description of the intended use and duration of QMHP gambling treatment services.

~~3.~~

~~4. Provider requests for prior authorization exceptions may be submitted via email to Pat Petrie (pdpetrie@dhhs.nv.gov) or other agent as designated by DHHS. Providers' prior authorization requests should not contain the name of the client or clinical information relating to the client as the DHHS management role in this process is solely related to fiscal and contract considerations and not clinical case management. Prior to submitting a request for a client's benefit limit to be increased, the provider must complete the "Nevada Department of Health and Human Services Problem Gambling Treatment Benefit Extension Request Form". Prior authorization requests must include either the scanned copy of PART B from the "Nevada Department of Health and Human Services Problem Gambling Treatment Benefit Extension Request Form" or within body of email all information from PART B of this form along with a statement that a completed Benefit Extension Request Form has been placed in the client's file. Information requested on this form includes:~~

~~a) Name of agency requesting the exception;~~

~~b) Client identification code (please do not include client name);~~

~~c) Description of the exception request (if requesting funds in excess of benefit limit, must provide the specific dollar amount);~~

~~d) Statement indicating that the exception request was reviewed and approved by the agency's gambling treatment clinical team or clinical supervisor.~~

~~e) Statements indicating what other resources the client might have to pay for the additional service. Requesting State funds to pay for additional services should~~

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~~only occur if the client and/or agency have no other means to pay for continued services. Clients who have insurance but refuse to allow the provider to contact their insurance company are not eligible for benefit limit extensions.~~

~~2. Documentation must be placed in the client's clinical record describing the clinical review of the exception request including the clinical justification for requesting the exception. When requesting funds in excess of benefit limit, Part A of the "Nevada Department of Health and Human Services Problem Gambling Treatment Benefit Extension Request Form" needs to be signed by client and Part B must be signed by clinic director and placed in client's clinical record documenting:~~

~~a) The client does not have third-party payer to cover the costs of continued care;~~

~~b) The client is experiencing financial hardship and is therefore unable to afford out-of-pocket payment for the full costs of continued services, and~~

~~c) The treatment agency is not in possession of charitable contributions or other funds earmarked for covering the costs of care for those without treatment payment means.~~

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Exhibit 1

Residential Gambling Treatment Admission Criteria

The following criteria shall be met before an individual is admitted to the residential care program.

A. Primary DSM-5 diagnosis by a qualified care provider as a disordered gambler; and

B. At time of admission, manifestation of at least one the following liabilities, as documented and supported by client responses to the Gambling Patient Placement Criteria (GPPC):

1. Severe Gambling Disorder symptom intensity to the extent symptom control can only be expected within a structured residential setting;
2. Depression and/or other emotional behavioral symptoms are sufficiently interfering with recovery efforts requiring residential care including endangerment to self or others; inability to function outside a controlled environment;
3. Even though faced with serious consequences, the individual does not accept them and requires intensive motivational strategies and efforts only available in a structured residential setting;
4. Failed attempts to achieve abstinence from gambling through formalized outpatient treatment or other residential treatment episodes;
5. Living in an environment where efforts to obtain even short-term abstinence in outpatient treatment are, or likely to be, thwarted, or living in a location where outpatient treatment is not available on a regular basis.

CONTRAINDICATIONS

A. Individual is physically, mentally, or behaviorally inappropriate for a residential setting and requires supervised medical attention, potential seclusion, or restraint.

B. Individual has a moderate to severe substance use disorder that is not in remission (less than 1 month of cessation of dependence)

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Exhibit 2

Gambling Treatment Provider Standards

Providers of Services funded through this Agreement must comply with the conditions stated in the main body of this document and the standards set forth below. These standards were developed based on principles where (a) the safety and dignity of problem gambling treatment individuals should be maintained at all times and (b) treatment services should be designed to enhance the strengths of each client.

I. Accessibility – Providers of problem gambling treatment shall:

A. Deliver treatment at a physical location that conforms to the requirements of the Americans with Disabilities Act (ADA), to the extent reasonably practical.

B. The hours of operation and service availability shall reflect the needs of the clients served.

1. A client with emergency needs shall have immediate access to a clinician or a referral to emergency services.
2. Individuals not yet enrolled into service and requesting an appointment should be seen within twenty-four (24) hours, to the extent reasonably practical.
3. Make treatment available during both daytime and evening hours, to the extent reasonably practicable.
4. A client requesting services shall be seen for a routine office visit within ten (10) business days.

C. Develop and implement a policy of delivering treatment in a non-discriminatory and culturally sensitive manner. Recognize and respond appropriately to the unique needs of special populations (e.g., language, illiteracy, disability, culture, race, gender, sexual orientation, age-related differences, etc.) which could include but is not limited to: Making reasonable modifications in policies, practices, and procedures to avoid discrimination (unless the program can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity) such as:

1. Providing individuals capable of assisting the program in minimizing barriers (such as interpreters);
2. Translation of written materials to appropriate language or method of communication;

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3. To the degree possible, providing assistive devices which minimize the impact of the barrier and;

4. To the degree possible, acknowledge cultural and other values which are important to the client including supporting the use of traditional healers and traditional healing methods, when advocated by the client and appropriate.

D. No person should be denied services or be discriminated against on the basis of age or diagnostic or disability category unless predetermined clinical or program criteria for service restrict the service to specific age or diagnostic groups or disability category. The provider should have written criteria for accepting or refusing admission requests, including steps for making referrals for individuals not admitted to the program. For those clients refused admission based on assessment, the provider should document the reasons for refusal and subsequent referrals within seven days following the refusal decision.

E. In the treatment of clients under the age of fourteen the service plan must conform to State laws.

II. Eligibility – Persons acceptable to receive problem gambling treatment services funded by the Revolving Account for the Prevention and Treatment of Problem Gambling through NRS 463.320(2)(e) shall:

A. Demonstrate residency within the State of Nevada, AND either

B. Present with a primary diagnosis of Gambling Disorder or sub-clinical Gambling Disorder, OR

C. Be a family member or significant other that is impacted by another's gambling behavior (even if the gambler does not seek counseling).

III. Eligible Providers – Persons administering gambling treatment clinical services, reimbursed through funds from by the Revolving Account for the Prevention and Treatment of Problem Gambling through NRS 463.320(2)(e), shall hold current certification, in good standing, as a Certified Problem Gambling Counselor (CPGC) pursuant to NRS 641C.~~050~~ or Certified Problem Gambling Counselor Intern (CPGC-I) pursuant to the provisions of NRS 641C.~~060~~. Providers must be in compliance with Alcohol, Drug, and Gambling Counselor Standards of Practice as defined in NRS 641.C. ~~ethical codes of conduct commonly used by a CPGC or CPGC-I.~~

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A. CLINICAL SUPERVISION: Problem gambling treatment providers who are not trained to diagnose or treat mental illness other than substance use disorders and gambling disorders, as determined by the scope of practice provided by their professional license, are required to make provisions for a minimum of two (2) hours per month of clinical supervision or consultation by a clinical supervisor with at least two years of postgraduate experience providing mental health services to adults. Supervisory staff who oversee the treatment of individuals with diagnoses other than substance use disorders and gambling disorders shall hold a license allowing them to diagnosis and treat a range of mental health disorders. Supervisors shall complete at least 10 hours of gambling specific education within the past two years including 2 hours on supervising gambling treatment counselors and maintain documentation evidencing each supervisor's compliance with this education standard.

Certified Problem Gambling Counselor Interns are required to make provisions for a minimum of two (2) hours per month of clinical supervision by a CPGC that is Board approved to supervise certified problem gambling interns.

B. COMPETENCY: Providers shall refer individuals to other professionals if an individual's clinical presentation is beyond the scope of the Provider staff's competency as determined by their certification restrictions, or license restrictions, or supervisor evaluation, or self-evaluation.

C. AVAILABILITY: Persons administering gambling treatment clinical services have an obligation to their clients to provide services to their client on a schedule therapeutically appropriate to their needs or refer the client to services matched to their needs. In situations where a program's CPGC or CPGC-I are temporarily unavailable due to vacancies of 30 or less days, vacation time, sick leave, or job related travel, then other qualified mental health professionals, as defined by NRS 458A.057 may provide gambling treatment services if they had completed at least 10 hours of gambling specific education within the past two years including at least 2 hours specific to gambling treatment and maintain documentation evidencing compliance with this education standard.

IV. Accountability – Providers shall deliver the services in accordance with the following standards:

A. GUIDELINES FOR TREATMENT SERVICES – Providers shall provide a variety of diagnostic and treatment service alternatives to each individual receiving problem gambling treatment. Treatment plans shall be designed to meet the particular

individual's needs and resources as identified in the comprehensive assessment. Providers shall offer, at minimum, the following types of problem gambling treatment services:

1. Assessment – The assessment involves a face-to-face interview with the individual completed within the fifth client contact following enrollment into the treatment program. The purpose of the interview is to collect and assess pertinent information regarding the individual's past history and current situation that results in a clinical diagnosis and a recommendation regarding the need for treatment. The Provider shall have the ability to perform a structured interview process to assess the existence of problem gambling and co-existence with other disorders including, but not limited to, substance abuse, mental disorders, and significant health problems. Suicide potential and potential to harm others must be assessed and clinical records must contain follow-up actions and/or referrals when a client reports symptoms indicating risk of harm to self or others.

2. Orientation: The provider shall give to the client, document the receipt of by the client, and make available to others, written program orientation information which includes:

   a) The program or provider's philosophical approach to treatment;

   b) A description of treatment services;

   c) Information on client's rights and responsibilities, including confidentiality, while receiving services and following discharge.

   d) Information on the rules governing client's behavior and those infractions that may result in discharge or other actions. At a minimum, the rules shall state the consequence of substance use and gambling while in treatment, absences from appointments and failure to participate in the planned treatment activities; and

   e) Information on emergency services.

3. Individual, Family, and Group Treatment – Treatment sessions must address the problems of the individual(s) as they relate, directly or indirectly, to the problem gambling behavior.

   a) CRISIS INTERVENTION – Providers shall accommodate after-hour crisis intervention as necessary. This may be accomplished through agreement with other crisis services or on-call staff.

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b) FAMILY & COUPLES COUNSELING – To the extent reasonably practicable, providers should make efforts to accommodate the therapeutic needs of family members, partners, and concerned others of problem gamblers. This may be accomplished, in part, by forming working relationships with other problem gambling counselors and referring to colleagues the partner and/or family members of a problem gambler when either such requests are made or it is in the best interest of the gambler and family member(s) to work with different counselors.

c) DISCHARGE PLANNING – A recovery/wellness plan or relapse prevention plan shall be developed by the Provider in collaboration with the individual and placed in the individual's file. A wellness plan shall be initiated early in treatment and finalized prior to discharge. The client's signature and date is proof of participation in the discharge planning. If the client was not involved in discharge planning, the file must show documentation that the client was notified of file closure. The discharge plan/relapse plan must document the therapeutic closure of formal treatment for the identified individual as well as recommendations and community resources for ongoing recovery.

4. Continuity of Care (community resources) – Providers shall have the capacity to coordinate services and make appropriate referrals to other formal and informal service systems, such as: mental health, Gamblers Anonymous, Gam-Anon, financial consultants, legal advice, medical, crisis management, cultural issues, housing, vocational, etc. The referral and follow-up action needs to be documented in the client's file.

B. DOCUMENTATION

Providers shall create and maintain the following documentation with respect to each individual receiving problem gambling treatment.

1. Identifying and demographic information for the individual including, at a minimum: Client ID, name, address, telephone number, date of birth, gender, marital status, and emergency contact. Any additional identifying and demographic data reasonably required by funding body.

2. Intake assessment documentation for the individual, including all of the following.

- Referral source.
- Presenting problem.
- Gambling history.
- Current financial status assessment.

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- History of substance use and substance use disorders, including past treatment episodes, assessment of risk of possible withdrawal, and history of other behavioral addictions.
- Health status (e.g., last physical, diet, exercise), current medical problems including medication use.
- Mental health history and current mental health status (e.g., treatment history, psychiatric medications).
- Profile of family of origin and marital/relationship history which describes family composition and dynamics.
- Recovery environment.
- Strength and recovery assets.
- Education and vocational history.
- Legal history (including arrest and conviction history).
- Risk of harm to self or others (e.g., assess for suicide risk, intimate partner violence, child neglect and abuse, elder abuse).

The information gathered shall include an intake assessment summary containing a DSM 5 diagnosis with supporting documentation, level of risk of harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider.

An individualized treatment plan shall be developed in accordance with general professional standards for either substance abuse or mental health outpatient services. The treatment plan shall be completed within 30 days of intake or the third session following the commencement of treatment to the individual. The treatment plan shall adhere to the following standards.

a) Address client-centered issues identified from the assessment and modified as appropriate.
b) Be written with clear and measurable objectives that are consistent with the client's abilities and strengths and that the individual agrees to as the foundation of treatment.
c) Include an adequate range of services.
d) Include a plan to address financial issues, if applicable.
e) Include regularly scheduled sessions.

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f) Document that participation of the family members was encouraged.

g) Reflect the theoretical treatment approach taken by the program in clinical sessions.

The treatment plan shall be reviewed and modified continuously as needed and as clinically appropriate, and documentation of a treatment plan review shall be no less frequent than once every 90 days.

The individual's signature and signature date will signify participation in the development and review of the plan. The treatment plan shall also be signed and dated by the clinician.

The individual's progress and current status in meeting the goals set in the treatment plan shall be documented within ~~72~~ 96 hours of all clinical contacts. All progress notes shall ~~be~~ include service date~~d~~, indicate type and length of service, ~~location of service,~~ contain data from the session, clinical assessment, a clinical plan, and be signed by the person providing the service, and dated for when the documentation was written. Within a residential treatment setting, the use of weekly summary notes is sufficient to document clients' progress. Additionally, providers of residential gambling treatment services must document each per-diem treatment claim by asking clients to sign and date a residential gambling treatment log.

5. The following additional information shall be documented in the client file (as applicable).

- Documentation that the individual has been informed of client rights and responsibilities, including the Health Insurance Portability and Accountability Act (HIPAA) privacy rule and other confidentiality protections and exceptions.
- Results of all examinations, tests, intake, and assessment information.
- Reports from referring sources.
- Correspondence related to the individual, including letters and dated notations of telephone conversations relevant to the individual's treatment.
- Information release forms, signed and dated with client and clinician's signatures.
- Gamblers Anonymous or other community support network participation.
- Consent to treat form signed by the individual (see Section VIII).

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6. Within 30 days of the client leaving treatment, a treatment summary shall be completed stating the reason for discharge, progress toward treatment plan objectives, and recommendations.

7. Clients not provided services for 60 continuous days should be notified by letter of their case file closure, and invited back to treatment if appropriate. A treatment summary should be completed within 90 days of last service.

V. Financial - Providers of problem gambling treatment should implement a structured process for assessing client financial circumstances and needs of individual. Treatment strategies should be developed to address the individual's financial circumstances and needs that may include, but are not limited to the following.

- Developing a financial management plan for the individual that includes a restitution plan, if appropriate.
- Connection with relevant financial assistance services.
- Development of a plan with the individual to cope and manage with loan/debt collectors, if appropriate.

VI. Effectiveness – Providers should use appropriate treatment techniques and be able to document the effectiveness of treatment using measurable criteria.

A. Providers shall have a system for measurement of progress and outcomes as stated in treatment objectives on the treatment plan.

B. Providers shall clearly define the process for internal program review and self-correction (e.g., Continuous Quality Improvement Protocols). A program shall develop and implement written policies and procedures that describe program operations. Policies and procedures shall include a records retention policy per GIR-16-20, quality assurance plan for ensuring that clients receive appropriate treatment services and that the program is in compliance with relevant administrative rules, and other reporting requirements.

C. If two or more staff provides services, the program shall have and implement the following written personnel policies and procedures, which are applicable to program staff and interns/students.

1. Rules of conduct and standards for ethical practices of treatment program practitioners.

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2. Standards for use and abuse of alcohol and other drugs with procedures for managing incidents of use and abuse that, at a minimum, comply with Drug Free Workplace Standards.
3. Compliance with regulations related to employment practices.

D. Providers shall implement a written treatment approach that is defined and supported in current literature.

VII. Efficiency – Providers shall provide services in the least restrictive setting and in the most cost-effective manner based on the individual's needs, resources, and strengths as determined by the problem gambling assessment.

VIII. Client Protections and Rights – Providers shall:

A. Maintain the confidentiality of all client records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws and regulations.

B. Develop and implement policies and procedures to safeguard and protect the case record of individuals against loss, tampering, or unauthorized disclosure of information. Maintenance of such records shall include adequate physical facilities for the storage, processing, and handling of the records. These facilities shall include suitably locked, secured rooms for file cabinets.

C. Retain the records of individuals as specified under HIPAA.

D. The client shall have the right of access to records. Access includes the right to obtain a copy of the record within 30 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:

1. When the clinical supervisor determines that disclosure of records would be detrimental to the client's treatment; or
2. If confidential information has been provided to the program on the basis that the information not be re-disclosed or may be obtained directly from originating source.

E. Require each individual to sign consent to treatment statements which includes conditions under which confidentiality can (or must) be broken.

F. Document, and inform each individual of the individual's rights and responsibilities in treatment. Each client shall be assured the same civil and human rights as other persons. Each program or private-practice provider shall develop and implement and inform clients of written policies and procedures which protect clients' rights including:

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1. Protecting client privacy and dignity;
2. Prohibiting physical punishment or physical abuse;
3. Protecting clients from sexual abuse or sexual contact and
4. Providing adequate treatment or care.

D. Documentation must include a formal grievance procedure with provision for appeals. The program or private practice provider shall develop, implement, and fully inform clients of policies and procedures regarding grievances that provide for:

1. Receipt of written grievances from clients or persons acting on their behalf;
2. Investigation of the facts supporting or disproving the written grievance;
3. Initiating action on substantiated grievances within five working days, and
4. Documentation in the client's record of the receipt, investigation, and any action taken regarding the written grievance.

E. The client shall have the right to refuse service, including any specific procedure. If consequences may result from refusing the service, those consequences must be explained verbally and in writing to the client.

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Exhibit 3

Encounter Data Reporting Requirements

INTRODUCTION:

In order to efficiently implement the disbursement of financial assistance it is necessary for all Providers of Services funded through this Agreement to submit individual-level service delivery activity (encounter data) each month.

OVERVIEW:

The encounter data collection process is intended to create as minimal a burden on Providers as possible, while creating a sound documentation trail for necessary fiscal auditing that will occur at least once each year for all Providers. The system is designed to provide optimal flexibility for Providers to facilitate minimum changes to local procedures. A standardized electronic transfer of detail service data is required monthly for Providers that currently have automated accounting and billing systems in place. All Providers will be required to comply with DHHS procedures for HIPAA compliance.

At the time the Treatment Strategic Plan was implemented (July 2016), the UNLV International Gaming Institute was the DHHS designee to manage the encounter data collection process. Should a different entity be designated in the future, DHHS will amend the Treatment Strategic Plan and communicate the change to Providers.

The UNLV International Gaming Institute has created an online encounter data reporting form, to be completed and transmitted electronically, for use by small Providers that do not have automated accounting systems in place. Completed reporting forms must be transmitted monthly to the UNLV Nevada Problem Gambling Project.

Client eligibility data will be required to be submitted online via the UNLV International Gaming Institute web site (http://www.nvpgdata.com/index.php prior to the authorization of reimbursement for encounter claims. This eligibility data will consist of the current intake/enrollment online forms as promulgated in the gambling program evaluation data collection protocol.

<u>Required Encounter Data:</u>

The following fields must be collected, with respect to each individual receiving Services funded through this Agreement, for the grants management disbursement system:

> Individual Identification Code: Local code utilized to identify individuals for the Provider evaluation effort. The client identification code (called the "client id") consists of the month and day of the client's birthdate, the last 5 digits of the client's social security number, and ends with the number "1" for a final format of MMDDsocsc1. If two clients have the same month and day of birth, and same last 5 digits of their social security numbers, UNLV International Gaming

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Institute will alter one client's identification number to end in a "2" to distinguish between the two clients.

Individual's Date of Birth: This field is utilized for individual identity verification in the event of incorrect or duplicate individual identification codes. Data is to be provided in MMDDYYYY format.

Provider Identification: The identification of the agency or organization providing the service.

Type of Service Session: Appropriate HIPAA compliant codes for eligible services must be used. See Exhibit 4.

Date of Service: Date the service was provided in American format - MMDDYYYY.

Units of Service: Service units are reported in a manner that is consistent with current DHHS standards, with 1 unit = 15 minutes of service.

Counselor/Therapist: The identification of the counselor, or therapist, conducting the session. This is a discrete identification that can be utilized during audits to enable verification of services performed from the clinical charting. The treating professional identification must be included in the appropriate field, in the format of first initial and last name, ex. JDoe.

Other Payments: This field is used to report any amount clinics were reimbursed from any other parties for providing this service, including insurance carriers and the clients themselves, but not including the co-pay amount collected from clients at each session (typically $10).

Service Type: This field is utilized for designating whether the service was provided to a concerned other, a gambler receiving outpatient services, or a gambler receiving residential services.

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Operational Reporting Schedule:

1. Encounter data must be submitted online via the UNLV International Gaming Institute web site (http://www.nvpgdata.com/index.php), until or unless notified otherwise by DHHS.

2. Encounter data for the previous month must be entered on the UNLV International Gaming Institute web site no later than 4 p.m. on the 10th day after the period being reported (e.g., July 2012 encounter data is due on August 10, 2012).

3. The UNLV International Gaming Institute will assemble data and prepare draft summary reports to be submitted to individual treatment Providers by the 20th of each month. The reports will include (at minimum) the total number of units of service claimed for the billing period under each billing code.

4. Each Provider is required to respond to the draft summary report via an e-mail to the UNLV International Gaming Institute.

a. The Provider must either:
   (1) Verify that the summary report is an accurate record of services provided, or
   (2) Report discrepancies, including apparent cause and remedy.

b. The timeframe for response is within 4 days from notification.

5. The UNLV International Gaming Institute will work with Providers to resolve any discrepancies and submit a final summary report and Request for Funds (RFF) to individual treatment Providers within 4 days of notification of the discrepancies.

6. Each Provider will return a signed Request for Funds (RFF) in pdf format to the UNLV International Gaming Institute.

7. The UNLV International Gaming Institute will submit the final summary report and a signed Request for Funds (RFF) to DHHS for each individual Provider by the last day of each month.

8. DHHS will reimburse Providers within 15 days following receipt of the final summary report from the UNLV International Gaming Institute. Any additional discrepancies that are identified after payment is made will be addressed as adjustments (credits or debits) on the next payment processed. After August 15th, no further adjustments will be made for service claims for the preceding grant year (July 1st through June 30th).

9. Encounter data for July 1 through December 31 of each grant year may be used to determine mid-year grant award adjustments. If such adjustments are made, they will likely occur 45 days after the closing of the mid-year utilization period to allow any discrepancies identified for December to be resolved and to allow sufficient time for DHHS to evaluate the encounter data and prepare the necessary paperwork to execute grant amendments.

10. In even-numbered years when grants are renewed, encounter data for July 1 through April will be used to determine initial grant awards for the following grant year.

11. In odd-numbered years when a competitive grant process is conducted, encounter data from the preceding grant year may be used to help determine grant awards for any repeat grantees.

12. Required Discharge Data. Clients must be discharged either:

    a. 60 days after last date of service, or
    b. Following a change in the level of care the client is receiving (e.g. when a client completes residential treatment, then starts outpatient treatment at the same or a different clinic).

    Client discharges must be documented in the client file, and discharge data must be collected and submitted online within 30 days of discharge via the UNLV International Gaming Institute web site (http://www.nvpgdata.com/index.php). This discharge data will consist of the client id, client date of birth, date of discharge, and a discharge code selected from the online discharge form specifying the reason the client was discharged.

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Exhibit 4

Nevada DHHS Problem Gambling Services
Procedure Codes and Reimbursement Rates

Code	Description	Upper Payment Amount*	Service Criteria
H0004	Gambling Treatment counseling and therapy, per 15 min	$16.50	Service provided by a CPGC. The treatment of a gambling disorder by psychological means.
H0004i	Gambling Treatment counseling and therapy, per 15 min	$12.38	Service provided by a CPGI. The treatment of a gambling disorder by psychological means.
H0005	Gambling Treatment counseling, group per 15 min	$6	Service provided by a CPGC. The practitioner seeks to help individual group members to understand and remediate their significant emotional and psychological problems, focusing on intrapersonal and interpersonal dynamics. Maximum group size of 12 clients.
H0005i	Gambling Treatment counseling, group per 15 min	$4.50	Service provided by a CPGI. The practitioner seeks to help individual group members to understand and remediate their significant emotional and psychological problems, focusing on intrapersonal and interpersonal dynamics. Maximum group size of 12 clients.
G2013	Residential gambling treatment service, per diem	$140	Services provided within a licensed inpatient mental health facility or residential alcohol and drug treatment facility designated as a residential gambling treatment program and intensively staffed 24-hour for which treatment includes an appropriate mix and intensity of assessment, medication management, individual and group therapies and skills development to reduce or eliminate the acute symptoms of the disorder and restore the client's ability to function in a home or the community to the best possible level. A claim for residential gambling treatment services can only be made for those days where the client is occupying a bed during sleeping hours or a client has been provided a therapeutic pass for up to 48 hours. With pre-authorization, exceptions to the 48 hour rule may be made with reasonable justification.
G2100	Problem Gambling Psychoeducational Group Services, per 15 min for gambler and/or family member	$4.50	Service provided by a CPGC. Service to clients with a specific type of group therapy that focuses on educating clients about their disorders and ways of coping.
G2100i	Problem Gambling Psychoeducational Group Services, per 15 min for gambler and/or family member	$3.38	Service provided by a CPGI. Service to clients with a specific type of group therapy that focuses on educating clients about their disorders and ways of coping.

G2200	Intake Assessment, per 15 minutes (12 unit claim maximum; allowable per administration and documentation of intake assessment)	$20.63	Service provided by a CPGC. Biopsychosocial clinical assessment containing a DSM 5 diagnosis with supporting documentation, level of risk of harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider. Eligibility based on Provider's reasonable cause to believe the person requesting the intake assessment may be eligible for DHHS-funded gambling treatment services.
G2200i	Intake Assessment per 15 minutes (12 unit claim maximum; allowable per administration and documentation of intake assessment)	$15.50	Service provided by a CPGCI. Biopsychosocial clinical assessment containing a DSM 5 diagnosis with supporting documentation, level of risk of harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider. Eligibility based on Provider's reasonable cause to believe the person requesting the intake assessment may be eligible for DHHS-funded gambling treatment services.
S9484	Crisis Services, per 15 min	$16.50	Crisis Intervention Mental Health Services for Eligible Clients. Code for pre-enrollment use. For enrolled clients, use code H004. Use of this code is limited to no more than 10% of the total claims for any calendar month.
G3000	Clinical Supervision of CPGC-I, per 15 minutes	$16.50	Clinical supervision, by Board approved supervisor, provided to CPGC-I needed to meet minimum Board supervision requirement (60 hours total) or (2 hrs per month). For use only by Providers with CPGC-I staff that are employed or contracted to provide an average of 8 hours per week or more within the Provider's gambling treatment program. Every claim using this code must be documented in the CPGC-I staff file.
G3100	Mental Health Professional Case Consultation , per 15 minutes	$16.50	Case consultation, by Mental Health Professional, provided to CPGC or CPGC-I or with their client, to assess and assist in treatment planning and case management for clients with psychiatric comorbidity. Every claim using this code must be documented in the client file.
G2300	Continuing Care Group Services, per activity	$10.00	CC Group Services are provided by CPGC or CPGI to clients who have completed problem gambling treatment within the past 12 months and are utilized to facilitate continued recovery. Services can be provided within an existing therapy or psycho-educational group being provided to current clients or to a group of previous clients meeting on a regular basis for aftercare. To be entered as an encounter, the continuing care group must be at least 60 minutes in duration and the same participant may not be claimed more than once per week.
G2500	Transitional Housing, per week	$155	Transitional housing refers to a supportive type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, problem gambling recovery support, life skills, education and training.

Exhibit 5

Nevada Department of Health and Human Services
Problem Gambling Treatment Benefit Extension Request Form 2016-2017

PART A: Client Information & Certification of Need

Name: _____ Identification code: _____

- You have or are close to exhausting your Nevada State Resident benefit level for problem gambling treatment.
- You do not have private insurance or the financial means to pay for problem gambling treatment without continued support from the Nevada Department of Health and Human Services.
- You believe you are making progress toward your goals and desire to continue in treatment with your current problem gambling treatment provider.
- Are all of the above statements true? Yes ☐ No ☐

I hereby certify that I desire to continue problem gambling treatment, do not have insurance or other resources to pay for the continuation of treatment, and seek long term recovery from problem gambling.

Client Signature: _____ Date: _____

PART B: Treatment Team Clinical Review

Primary Counselor: _____ Clinical Supervisor:_____

Others Present During Clinical Review: _____

Client Admission Date: _____ Date of Clinical Review: _____

Date Last Gambled: _____ ☐ In early remission ☐ In sustained remission

Gambling Disorder Severity (past 3 months): ☐ Mild: 4-5 ☐ Moderate: 6-7 ☐ Severe: 8-9 criteria met.

Summary of Progress:

Clinical Justification for Requesting Benefit Exception:

Schedule of Services (*how will benefit extension be used*):

Signature of Clinical Director: _____ Date: _____

Signature of Primary Counselor: _____ Date: _____

Place this complete form in the client's clinical file.

PART C: Gambling Treatment Provider Information & Certification of Compliance to Rule

Name of Agency Providing Problem Gambling Treatment: _____

Client identification code: _____

Amount of benefit requested in excess of the consumer's benefit limit: $_____

- The exception request was reviewed and approved by the agency's gambling treatment clinical team or clinical supervisor.
- **Documentation** has been placed in the client's clinical record **describing the clinical review** of the exception request including the **clinical justification** for requesting the exception *(PART B)*.
- The client does not have third-party payor to cover the costs of continued care.
  - *Note: Clients who have insurance but refuse to allow the provider to contact their insurance company are not eligible for benefit limit extensions.*
- The client is experiencing financial hardship and is therefore unable to afford out-of-pocket payment for the full costs of continued services.
- The treatment agency is not in possession of charitable contributions or other funds earmarked for covering the costs of care for those without treatment payment means.

I hereby certify that all of the above statements are true.

Clinic Director Signature: _____ Date: _____

Place this complete form in the client's clinical file. Do not send copy of PART A or PART B to DHHS.

For submitting benefit extension requests, email Pat Petrie (pdpetrie@dhhs.nv.gov) and include scanned copy of PART C or within body of email include all information from PART C along with a statement that a completed Benefit Extension Request Form has been placed in the client's file.