

## Southwestern Behavioral Health Disparity Impact Statement

**Grantee Organization Name:** Southwestern Behavioral Healthcare, Inc.

**Grant ID (SM/TI/SP/FG):** 1H79SM086408-01

**Grant Program:** Certified Community Behavioral Health Clinics-IA

**Project Director:** Lisa Withrow

**Grant Project Officer:** Stephanie Kersheskey

### **SECTION I. Identified Behavioral Health Disparities & Problem Scope**

#### **1. Identify and describe the behavioral health disparity aligns with the grant program and the population(s) of focus**

Southwestern Behavioral Health (SBH) has 14 sites of care located in four counties in Southwest Indiana. The city of Evansville, population 180,000, is in Vanderburgh County. The bulk of specialized SUD (Substance Use Disorder), SMI (Severe Mental Illness), and SED (Serious Emotional Disturbance) programs are in Vanderburgh County. Satellite offices located in Warrick, Gibson, and Posey Counties provide centralized services to the county in which they are located. For the purposes of this grant, we will be focused on Vanderburgh County.

Vanderburgh county located in Southwest Indiana, has a population of 181,548, and is 85% White, 9.5% Black/African American, 4.8% Hispanic/Latino and 6.8% LGBTQI+. <sup>1</sup> Vanderburgh County has a high prevalence and risk of SMI, SUD, SED, and co-occurring SMI/SUD among adults, youth, and children. Vanderburgh County is designated a Health Professional Shortage Area (HIPSA) by Health Resources and Services Administration (HRSA) for primary care and mental health care and has the highest alcohol abuse rate in the state. <sup>2</sup>

The CCBHC-E grant was focused on providing services to Vanderburgh County adult and child client population with an exclusion of our SUD department. With the award of the CCBHC-IA grant the focus of year 1 will explicitly focus on expanding CCBHC-IA to include the SUD population. A significant aspect of this expansion will be providing grant services and launching NOMS collection for individuals with a primary or secondary diagnosis of SUD.

The comparative demographic profile indicates the largest demographic disparities includes two groups, Black/African Americans and the LGBTQIA+ community. Demographics for Black/African Americans indicate SBH SUD services = 9.9% vs, 12.7% in the Evansville metropolitan area. (The broader Vanderburgh County Black/African American demographic population is 9.5%). <sup>3</sup> Given these findings, year 1 target population will be the former with year 2 expanding to include the latter client group.

Under the CCBHC-E grant, SBH established a crisis services department that is actively providing 24/7/365 integrated, coordinated service provision, including a 24-hour crisis line, mobile crisis response and a crisis stabilization unit. Care gaps for the community population include a lack of same-day access, which is being addressed via the SBH continuous quality improvement (CQI)

<sup>1</sup> ACS 2016 to 2020 5 year estimates, March Release, 2022

<sup>2</sup> Indiana Primary Care Needs Assessment. IU School of Medicine, Bowen Center for Health Workforce Research and Policy. Retrieved May 3, 2021 from <https://scholarworks.iupui.edu/bitstream/handle/1805/17192/PCNA%20Report%2008-21-2018%20FINAL.pdf?sequence=2&isAllowed=y>

<sup>3</sup> Data Commons 2022, *Data Commons*, viewed 19 Dec 2022, <https://datacommons.org>

committee and multi-disciplinary workgroups across internal service departments. Access to services at SBH is inversely impacted by a staffing shortage of licensed social workers and the need to re-engineer the role of Bachelor level staff and Peer Support Specialists to maximize clinical availability by reducing the administrative burden of Federal, State, and Joint Commission data collection, estimated to require 4 hours per completion, per client.

According to the Greater Evansville Health Survey, one out of four residents drinks to excess, nearly twice the state and national rates. One in five residents report having a depressive disorder, and almost one in four has anxiety. Around a third of binge drinkers report comorbid depression (30%) and/or anxiety (28%). Children in the region have a reported 18% incidence of ADD/ADHD, 15% anxiety, 7% depression, 6% behavioral or conduct disorders, and 3% autism.<sup>4</sup> The rate of deaths from intentional self-harm in Vanderburgh County is 21 per 100,000 population,<sup>5</sup> exceeding the state rate of 15.9 per 100,000. (cite)9 There were 66 accidental overdose deaths in Vanderburgh County in 2020, with 35 deaths involving opioids; 27 of these deaths resulted from an accidental overdose of Fentanyl.<sup>6</sup> Evansville, located in Vanderburgh County, is the third largest city in the state having a population of 116,486, and is 77.6% White, 12.7% Black, and 3.15% Hispanic/Latino.<sup>7</sup>

In 2021 per the requirements of the CCBHC-E NOFO, we completed a CCBHC Needs Assessment (CCBHC Certification Criteria 1.A). Findings from that assessment showed that accessibility of services presented a significant barrier to services such as psychotherapy. Factors impeding access included lack of transportation and lack of mental health/substance use community-based crisis services being offered in Vanderburgh County. While CCBHC-E enabled us to establish crises services in Vanderburgh County, there remains no mobile crisis services in the other 3 counties in our catchment area. In addition, the Vanderburgh County Needs Assessment, and the city of Evansville identified the barriers related to staffing and the lack of diversity representing the Black/African American population being served. Feedback indicated that community outreach and engagement, clinical and recovery support services were not always viewed as culturally responsive as our mission intends.<sup>8</sup>

<sup>4</sup> Greater Evansville Health Survey, 2021 ed.: A Survey of Health-Related Community Indicators in the Greater Evansville, IN Region. Welborn Baptist Foundation. Retrieved on May 3, 2021 from <https://www.welbornfdn.org/app/uploads/2021/03/2021-Welborn-GEHS-Book-Web.pdf>

<sup>5</sup> Deaths from Intentional Self-Harm (Suicide): Vanderburgh County. Indiana Prevention Resource Center. Retrieved on May 3, 2021 from [https://iprc.iu.edu/epidemiological-data/epi\\_table.php?table\\_id=t802&county=82](https://iprc.iu.edu/epidemiological-data/epi_table.php?table_id=t802&county=82)

<sup>6</sup> 2020 Vanderburgh County Overdoses Data Report. Vanderburgh County Health Department.

<sup>7</sup> Data Commons 2022, *Data Commons*, viewed 19 Dec 2022, <https://datacommons.org>

<sup>8</sup> Community Health Needs Assessment Vanderburgh County, Indiana 2019-2021. Deaconess Health System, Retrieved 19 Dec 2022 [www.deaconess.com/CHNA](http://www.deaconess.com/CHNA)

### SBH SUD SERVICES DISPARATE POPULATION(S) OF FOCUS

| <b>Race</b>   | <b>Baseline</b> | <b>FY1</b>  | <b>FY2</b>  | <b>FY3</b>  | <b>FY4</b>  |        |
|---|-----------------|-------------|-------------|-------------|-------------|--------|
| <b>Unknown</b>  | 27              | 28          | 29          | 30          | 32          | 2.13%  |
| <b>American Indian and Alaska Native alone</b>                                | 1               | 1           | 1           | 1           | 1           | 0.08%  |
| <b>Two or More Races</b>  | 185             | 192         | 200         | 208         | 216         | 14.60% |
| <b>Asian alone</b>  | 2               | 2           | 2           | 2           | 2           | 0.16%  |
| <b>Black or African American alone</b>  | 125             | 134         | 147         | 166         | 193         | 13.01% |
| <b>Native Hawaiian or Other Pacific Islander</b>                              | 1               | 1           | 1           | 1           | 1           | 0.08%  |
| <b>Other single race</b>  | 23              | 24          | 25          | 26          | 27          | 1.82%  |
| <b>White alone</b>  | 903             | 939         | 977         | 1016        | 1056        | 71.27% |
| <b>Grand Total</b>  | <b>1267</b>     | <b>1318</b> | <b>1370</b> | <b>1425</b> | <b>1482</b> |        |
| <b>Ethnicity</b>  | <b>Baseline</b> | <b>FY1</b>  | <b>FY2</b>  | <b>FY3</b>  | <b>FY4</b>  |        |
| <b>Unknown Ethnicity: Client preferred not to share ethnicity information</b> | 16              | 17          | 17          | 18          | 19          | 1.26%  |
| <b>Hispanic or Latino</b>   | 39              | 41          | 42          | 44          | 46          | 3.08%  |
| <b>Not Hispanic or Latino</b>   | 1212            | 1260        | 1311        | 1363        | 1418        | 95.66% |
| <b>Grand Total</b>  | <b>1267</b>     | <b>1318</b> | <b>1370</b> | <b>1425</b> | <b>1482</b> |        |
| <b>Sex</b>  | <b>Baseline</b> | <b>FY1</b>  | <b>FY2</b>  | <b>FY3</b>  | <b>FY4</b>  |        |
| <b>Female</b>   | 519             | 540         | 561         | 584         | 607         | 40.96% |
| <b>Male</b>   | 736             | 765         | 796         | 828         | 861         | 58.09% |
| <b>Unknown</b>  | 12              | 12          | 13          | 13          | 14          | 0.95%  |
| <b>Grand Total</b>  | <b>1267</b>     | <b>1318</b> | <b>1370</b> | <b>1425</b> | <b>1482</b> |        |
| <b>Orientation</b>  | <b>Baseline</b> | <b>FY1</b>  | <b>FY2</b>  | <b>FY3</b>  | <b>FY4</b>  |        |
| <b>Unknown</b>  | 730             | 759         | 790         | 821         | 854         | 57.62% |
| <b>Bisexual</b>   | 27              | 28          | 29          | 30          | 32          | 2.13%  |
| <b>Don't know</b>   | 8               | 8           | 9           | 9           | 9           | 0.63%  |
| <b>Lesbian, gay or homosexual</b>   | 5               | 5           | 5           | 6           | 6           | 0.39%  |
| <b>Other</b>  | 5               | 5           | 5           | 6           | 6           | 0.39%  |
| <b>Straight or heterosexual</b>   | 492             | 512         | 532         | 553         | 576         | 38.83% |
| <b>Grand Total</b>  | <b>1267</b>     | <b>1318</b> | <b>1370</b> | <b>1425</b> | <b>1482</b> |        |

The demographics for Vanderburgh County and the city of Evansville are as follows:

- White 85% Vanderburgh County, City of Evansville is 85% White
- **Black/African American:** 9.5% Black/African American in Vanderburgh County, 12.7% in the City of Evansville
- Hispanic/Latino: 4.8% in Vanderburgh County, 3.15% in the City of Evansville (cite)<sup>9</sup>

SBH's SUD program, serves on average 1250 people a year. SUD services include outpatient, social detox, residential, and transitional residential services for men and women. For the CCBHC-IA grant program, we plan to serve 1710 unduplicated individuals over the four-year project period. Our goal is to increase the number of Black/African Americans served from 9.87% to 13.01% (125 to 193) over the course of the grant period.

Currently in SUD services, 9.9% of our clients are Black/African Americans, which is less than the Evansville metropolitan area of 12.7%. Given the disparity between the city, agency and SUD services representation of Black/African American clients, we need to increase access to mental health and substance use services to this population. SBH will use the CCBHC-IA grant to expand outreach and services, utilizing SBH's Diversity Equity and Engagement Committee (DEE Committee) and SUD services as primary outreach hubs. Using grant activities, we will increase the number of screenings for mental health, substance use, and suicide risk for Black/African Americans ages 18-65 by 3.1%. This % will be adjusted for a projected 4% increase in need across the life of the grant. As part of this initiative, we will provide training to our staff on crisis services, suicide risk, and expand evidence-based practices to reduce opioid overdose risk.

The other client subpopulation that is likely underrepresented in our client reporting base is the LGBTQIA+ community. There is no ready availability of Vanderburgh County Census data for baseline goal setting. SBH began collecting gender identity and sexual orientation demographics in August 2021, when the new electronic health record was implemented, as it came packaged with the core EHR system install.

Under SAMHSA CCBHC grant funding, the EHR and Data Analytics departments have been working at a sustained pace to engineer a foundational data management and reporting system, using the Plan -> Do -> Study-> Act (PDSA) model of continuous quality improvement. This has involved a strenuous effort and debugging and programming our new EHR data warehouse with Crystal Reports, Excel and an abacus. We have worked diligently with the clinical subject matter experts in multi-departmental workgroups to establish NOMS collection via paper instrument, SPARS entry and extraction. We have developed internal EHR documents to track health integration measures, inpatient admission/discharge/follow-up care pathways, and document crisis phone and live contacts, mobile law enforcement and hospital co-response, and crisis stabilization unit stay. Communication process pathways have been established between crisis services and both internal and external partners. We have been very busy.

<sup>9</sup>Data Commons 2022, *Data Commons*, viewed 19 Dec 2022, <https://datacommons.org>

### 2022 Sexual Orientation Demographics

| Sexual Orientation         | SWB System  | %     | Vanderburgh County | %     | SWB SUD     | %     |
|----------------------------|-------------|-------|--------------------|-------|-------------|-------|
| Uncollected                | 4573        | 54.3% | 3873               | 58.3% | 607         | 55.5% |
| Bisexual                   | 176         | 2.1%  | 150                | 2.3%  | 24          | 2.1%  |
| Don't know                 | 414         | 4.9%  | 225                | 3.4%  | 6           | 0.6%  |
| Lesbian, gay or homosexual | 83          | 1.0%  | 69                 | 1.0%  | 5           | 0.4%  |
| Other                      | 67          | 0.8%  | 58                 | 0.9%  | 5           | 0.4%  |
| Straight or heterosexual   | 3107        | 36.9% | 2264               | 34.1% | 446         | 38.8% |
| <b>Total</b>               | <b>8420</b> |       | <b>6639</b>        |       | <b>1093</b> |       |

| Gender Identity | SWB System  | %     | Vanderburgh County | %     | SWB SUD     | %     |
|-----------------|-------------|-------|--------------------|-------|-------------|-------|
| Uncollected     | 3866        | 45.9% | 2474               | 47.0% | 492         | 45.0% |
| Female          | 2416        | 28.7% | 1429               | 27.1% | 237         | 21.7% |
| Transgender     | 42          | 0.5%  | 34                 | 0.6%  | 0           | 0.0%  |
| Male            | 2060        | 24.5% | 1296               | 24.6% | 362         | 33.1% |
| Other           | 36          | 0.4%  | 33                 | 0.6%  | 2           | 0.2%  |
| <b>Total</b>    | <b>8420</b> |       | <b>5266</b>        |       | <b>1093</b> |       |

For year 2 DIS reporting, SBH will have established a baseline demographic profile of all four agency counties that includes reporting on gender orientation and sexual orientation including 'Unsure/Questioning.' Here is where our internal limitations are on reporting currently. With a denominator of 8420 active clients, 58% of our Vanderburgh County clients have no orientation data noted in their medical record demographics. Much of the base demographic data was migrated from our previous EHR system; no orientation data was collected at the time of its use. Newer clients are anecdotally more likely to have orientation information in their records.

Conversely, the level of comfort felt by our administrative support staff in asking these questions may also inadvertently be an issue. We live on the buckle of the Bible belt a factor complicating all diversity initiatives. Ongoing agency cultural humility training will continue, work process development and workflow quick guides will be developed/provided, and ongoing efforts to recruit staff with diverse lives and lived experience will continue.

We compared the internal demographic breakdown of identified sexual orientation internally, comparing SUD services to the broader agency. 39% of the SUD clients included in the sample self-identified as heterosexual/straight, a +/- 2% points above the agency norm. A combined 3.5% identified as bisexual, 4% identified as gay/lesbian, and 1% identified as don't know or other. Again, the missing data impacts validity. Complications currently impacting this data set include an EHR bug that interrupts the transfer of updated demographic data into the database. Our EHR vendor is working to fix this issue. Correcting this will allow us to verify if attempts by staff to update these data points have been successful. We will revisit this issue in the FY 2024 DIS report.

Currently social determinants of health are being captured across ANSA, CANS and two separate

NOMS tools. As part of an internal and Statewide CQI process we are working to consolidate the administrative burden of data collection. Currently we must complete two versions of the NOMS, one State and one Federal. However, due to collective lobbying among the Indiana community mental health centers and the Indiana Council, Indiana will be adopting the Federal NOMS instrument as part of its own CCBHC certification process. An SDOH measure now included in our EHR will be used as a more specific measure of SDOH. As such a new screening tool will be collected on a standardized basis, at six-month intervals, to coincide with our existing NOMS collection protocols.

The CQI plan and the methods for the development and implementation of policies and procedures to enhance adherence to the Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards and the provision of effective care and services that are responsive to: a) Diverse cultural health beliefs and practices; b) Preferred languages; and c) Health literacy and other communication needs of all sub-populations within the proposed geographic region.

**CLAS Training by Domain**

| Domain   | Jan 1 - June 30 |
|--|-----------------|
| Cultural/Linguistic Competence                         | 86              |
| Evidence-Based and Trauma-Informed Care                | 328             |
| Healthcare Integration                                 | 92              |
| HIPAA & Compliance                                     | 968             |
| LGBTQ+   | 125             |
| Peer Support   | 64              |
| Person-Centered and Family-Centered Treatment Planning | 314             |
| Recovery Care  | 130             |
| State or Accrediting Agency Annual Training            | 18              |
| Substance Use  | 228             |
| Suicide Risk Assessment: Clinical                      | 188             |
| Suicide Risk Assessment: Non-Clinical                  | 36              |
| Veterans/Military                                      | 195             |
| <b>Total Trainings:</b>                                | <b>2772</b>     |

As part of the CCBHC-E grant, SBH hired a corporate trainer to develop, track and implement a comprehensive program to train our workforce on the following CLAS domains: Cultural/Linguistic Competence, Evidence-Based and Trauma-Informed Care, Healthcare Integration, HIPAA & Compliance, LGBTQ+, Peer Support, Person-Centered and Family-Centered Treatment Planning, Recovery Care, State or Accrediting Agency Annual Training, Substance Use, Suicide Risk Assessment: Clinical, Suicide Risk Assessment: Non-Clinical, and Veterans/Military. Each of these training domains contain specific courses that are designed to meet the underlying CLAS standard requirements. SBH has offered training to 279 unique learners through our catalog of 91 courses each chosen to meet some aspect of each of these domains. As part of the CCBHC-E grant, training priority



was given to training staff on the CLAS Standards, per IPP Goal WD-2. SBH utilizes the HHS Office of Minority Health trainings, Star Behavioral Health Veteran-specific training modules, and monthly internal diversity panels sponsored by our Diversity, Equity, and Engagement (DEE) Committee.

SBH's DEE Committee predates both our SAMHSA grants and is active both inside and outside the agency. Cedalia Ellis and our DEE Committee have just been nominated for the 2022 Celebration of Leadership Award by Leadership Evansville. Agency culture has been the focus in 2022 including completion of an agency climate survey followed by a series of cultural humility trainings on microaggressions, code switching, neurodiversity, privilege, and with the LGBTQIA+ community.



**A message from Katy Adams**  
CEO, Southwestern Behavioral Healthcare



A sense of belonging is a basic need all of us have. A place where you can be your authentic self, where your perspective is valued and respected, where your story is heard, where you are not only included, but engaged. A place where being brave and vulnerable is an asset. It is my desire that Southwestern Behavioral Healthcare, Inc. (Southwestern) would grow to be an employer, treatment provider, and community partner that has a culture that allows our staff, clients, and community at large to be brave and truly belong. We want healthy, respectful, diverse, inclusive teams that partner well with our community, and provide a place for people to heal.

Because we value the ideas and experiences of our staff, we invest our time and resources towards the activities of the Diversity, Equity, and Engagement Committee (D.E.E.) within Southwestern. As an organization, we will continue this journey together through our R.I.S.E. (Respect, Inclusion, Social Justice, Equity) Company Challenge. This journey is inclusive and it will take all of Southwestern to move it forward!

## Our Goals

- Understand and Improve the current climate of the company
- Assist in the creation of an inclusive work environment
- Assist with recruitment efforts
- Assist with fostering a culture that encourages collaboration, flexibility, and fairness
- Assist with identification of systemic barriers to full inclusion
- Maintain and enhance cultural competence and humility trainings



## Our Committees

### Celebration of Diversity & Heritage

Promote and celebrate diversity within Southwestern Behavioral.

### Climate Assessment

Provide a data-driven understanding of Southwestern Behavioral's current state and tone around diversity and inclusion using a climate assessment.

### Cultural Humility Trainings

Provide live trainings to increase personal and organizational knowledge and self-awareness of biases by challenging preconceived notions through real human experiences and connection.

Fifty-eight SBH staff marched as a group in the Evansville Gay Pride march this year. Our goal as an agency is to increase client and staff diversity by increasing our reputation in the community as a culturally safe place to work and receive treatment. Here is a link to our PSA, "I am SBH," the DEE monthly newsletter, and diversity resources: [inclusion](#)

SBH's activities are geared to advance health equity, improve quality, and help eliminate health care disparities by adhering to the National Culturally and Linguistically Appropriate Standards (CLAS). All services strive to be effective, equitable, understandable, and respectful as well as responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Evaluation staff regularly assess SBH's CLAS-related activities, integrate CLAS-related measures into quality improvement activities, and evaluate the impact of CLAS on equity and outcomes to inform service delivery. The CCBHC project team creates culturally and linguistically appropriate processes and updates stakeholders about CLAS implementation progress. Under the IA grant we will seek to continue and expand this program and further transform our service provision through these training initiatives.

## **SECTION II. Addressing Disparities Using the Funding Opportunity**

### **SOCIAL DETERMINANTS OF HEALTH (SDOH)**

**SDOH as defined in the DIS guidance: (1) education access and quality, (2) economic stability, (3) neighborhood and built environment, (4) health care access and quality, and (5) social and community context.**

SBH has identified social and community context as the SDOH measure that will be examined throughout year 1 of the grant cycle. This SDOH domain was chosen in consultation with our external evaluator as a proxy measure for recovery progress, prior to this assigned report. As a service provider we have recognized that when individuals reconnect with their community and reestablish meaningful interpersonal connections their ability to create and sustain SUD treatment progress is anecdotally improved.

#### **Section B: Proposed Implementation Approach**

##### ***B1. Goals and measurable objectives, aligned to A2.***

| <b>Table 2 - Goals, Process and Outcomes Measures</b>  |   |  |
|--|---|--|
| <b>Goal 1. Southwestern will increase treatment and improve outcomes for individuals with substance-use disorders.</b> |   |  |
| <b>Activity</b>  | <b>Process Measures</b>   | <b>Outcome Measures</b>  |
| <b>1. Expand treatment for substance-use disorders (Year one)</b>  | 1.a. Number of clients served with a SUD diagnosis                  | 1.1. 75% of clients with a SUD diagnosis will <b>improve mental health functioning</b> from the initial NOMS assessment to the 6-month NOMS reassessment.          |
|  | 1.b. 30-day substance use (at initial assessment) among SUD clients | 1.2. 75% of clients with a SUD diagnosis will <b>decrease substance use</b> from the initial NOMS assessment to the 6-month NOMS reassessment.                     |
|  | 1.c. Number of SUD clients that have a 6-month reassessment         | 1.3. 75% of clients with a SUD diagnosis will <b>improve social connectedness</b> from the initial NOMS assessment to the 6-month NOMS reassessment.               |
|  | 1.d. Number of SUD clients that receive a physical evaluation (H&P) | 1.4 75% of clients with SUD diagnosis will improve overall health from initial NOMS assessment to the six-month NOMS reassessment (as measured by responses to B1) |

SBH's SDOH focus for our year 1 goal is to increase clients social and community connectedness across all service populations, but specifically in SUD service population, we will measure the



lifestyle change (social environment, friends, contacts, sites of socialization, early recovery support) by utilizing our NOMS data. Our measure for social context is outlined in our logic model above.

## **Behavioral Health Implementation for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care**

SBH has chosen to focus on CLAS standards 10 and 11 for year 1 DIS reporting as identified in the HHS Office of Minority Health, Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.

### **Standard 10: Conduct ongoing assessments of an organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.**

#### **Purpose:**

#### **1. To accurately identify population groups within a service area**

Under the mandates and funding of the CCBHC-E and IA grants, SBH has expanded data collection processes and grants management. SBH has created EHR documentation as part of our data foundation build. Cross validation of demographic and SDOH indicators will continue to evolve and be completed by the FY2 reporting.

#### **2. To monitor individual needs, access, utilization, quality of care, and outcome patterns**

SBH is engaged in state-level workgroups for operationalizing, financing, and developing statewide standards for data collection and reporting, for Indiana to become a CCBHC certification state. State plans include application to become a demonstration state or pass legislation that will bring Indiana to CCBHC status by 2026. Indiana has funded a centralized state data repository to be completed prior to CCBHC certification go-live.

#### **3. To ensure equitable allocation of organizational resources**

Overrepresentation of diverse populations, increased awareness of, and service provision to those with high-risk SDOH profiles is our overarching goal. Year 1 goals are based on matching our agency and SUD services demographic breakdown to meet or exceed local census norms., establishing validated demographic profiles of service outcomes based on racial, ethnic, and identity status once validated baseline benchmarks are identified.

#### **4. To improve service planning to enhance access and coordination of care**

By the end of the grant period, the State of Indiana intends to reengineer the current payment and level of need assessment to reimburse peer support services, BS-level care coordination, and crisis services. None of these services are currently reimbursed or may be under reimbursed under our current MRO Medicaid system. We are pivoting our current work processes to increase access and reduce the administrative/client burden of completing a lengthy initial assessment.

SBH partners with Purdue University Healthcare Advisors on lean process improvement events when our workflows need an intensive reboot. Our most recent Rapid Improvement Event (RIE) dealt with

reducing access barriers experienced by those who may have higher SDOH risk profiles. We have worked to meet CCBHC access goals with a deficit of staffing. The workflow, documentation process, and data extraction plans are being refined. The goal is to meet CCBHC access standards by the next DIS report.

#### **5. To assess and improve to what extent health care services are provided equitably**

SBH has been active over the past 20 months working to establish the foundation of CCBHC attestation in the agency, departments, and programs. We have an active DEE Committee, have completed a preliminary DEE Committee Climate Assessment Survey by contract with Diehl Group and Associates, and launched an agency-wide corporate training program on CLAS standards. The focus on these standards will expand existing CQI development and reporting. By year 2 we will have the capacity to report on SDOH measures on agency client

### **SBH Implementation Strategies**

#### **1. To accurately identify population groups within our service catchment areas**

SBH will complete an ongoing community needs assessment, via contract with Diehl Group and Associates within the revised timetable of the CCBHC-IA guidance.

1. Transition from paper Federal NOMS collection to integrated EHR NOMS collection, including validated data extraction protocols and eliminate the duplicative State NOMS by July 2023.
2. Begin collecting Federal NOMS data by January 2023 via the EHR system with all workflows in place.
3. Identify community partnerships to identify the racial, ethnic, gender, language, sexual orientation, gender identity and disability status categories most relevant to the community. Report on progress at the end of year 1.
4. Identify and develop data-sharing mechanisms that adhere to confidentiality requirements, including the utilization of health information technology, quality assurance and accountability measures. Complete Indiana IHIE synchronization with our internal EHR by March 2023.
5. Develop and implement training of all administrative support staff on collecting full demographic information, including sexual and gender orientation information by July 2023
6. Develop Memoranda of Agreements related to data collection and sharing with IHIE, IN DMHA, and our non-IHIE hospital partners for information sharing by September 2023.
7. Develop a plan to use demographic and SDOH in concert with service and quality care data for evaluation and continuous quality improvement activities by September 2023.
8. Increasing depression and suicide risk screening by 4% and improve efficacy of suicide risk assessment and clinical pathways. Report on progress at the end of year
9. Align current CPI to the Evaluation of the National CLAS Standards toolkit, explicitly add CLAS Standard 10 & Standard 11 definitions to the SBH CQI plan and implement

targeted workgroups as indicated.

**Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery**

**Purpose**

- 2. To monitor individual needs, access, utilization, quality of care, and outcome patterns**  
SBH will monitor access through collected NOMS data. We will work with our external evaluators, Diehl Group and Associates to complete logic modeling.
- 3. To ensure equitable allocation of organizational resources**  
SBH will increase visibility and linkages with local community agencies to increase collaboration and awareness of SBH services and those of our community partners. This will be tracked and reported at the end of grant year 1.
- 4. To improve service planning to enhance access and coordination of care**  
By hiring and utilizing BS level and Peer Support Specialists as part of our assessment processes, we can reduce administrative burden and maximize LCSW clinicians to work at the top of their scope.
- 5. To assess and improve to what extent health care services are provided equitably** In order to address equity, we will need to identify our baseline SDOH assessment results. To accomplish this, we will launch the SDOH instrument into the assessment and reassessment processes. We will use CQI mechanisms to refine and address equity.

**SBH Implementation Strategies**

1. Create and utilizing multi-departmental (EHR, IPT, Clinical Director, end users) workgroups to rapidly identify improvement opportunities in workflows between the clinical, EHR, and data analytics teams within the first year. Begin Create a CPI plan using the Plan-Do-Study-Act model for identifying and rectifying EHR system bugs in data collection, data warehousing, and data extraction processes by end of year one.
2. SBH will standardize data collection process and workflows at an agency, department, location, and program level implementation to ensure data integrity and validity SBH will have created a implementation logic model for beginning this process by July 2023. Bi-weekly EHR/IPT team meetings will continue throughout year 1 of the CCBHC-IA grant.
3. Indiana uses a State NOMS which differs from SAMHSA's; currently clients must complete both. Due to CMHS and Indiana Council lobbying to reduce redundancy and delay of services, IN DMHA recently announced that IN will be transitioning to using the current version of the Federal NOMS by July 2023.
4. Streamline by SmartCare, our current EHR vendor, is launching EHR-based NOMS, with an expected go-live date in December 2022.

5. Modify current standardized demographic data collection instrument to align with the [HHS https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53](https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53) SBH will have a detailed plan for implementation by the end of year one.
6. We will have \_\_\_ number of new partnerships by the end of year one as tracked by IPP PC2. Work with community members via documented inter-agency and community coalition meetings/trainings/collaborations to identify the racial, ethnic, gender, language, sexual orientation, gender identity and disability status categories most relevant to the community. We will continue to track IPP PC2 as a mechanism for reporting expanded partnerships in the year 2 DIS report.
7. All SBH staff engaged in data collection will complete CLAS training as part of annual agency training, this will be tracked by collecting information under the IPP WD2.
8. Develop a process that facilitates client self-identification by end of year 1. Known issues include staff relying on personal observation and visual determinations of gender identity and sexual orientation. We will develop and deploy interactive training by end of year 2. Standardization of collecting demographic data at registration, focusing on trauma-informed processes, and asking clients questions about their pronouns, gender identity and sexual orientation will be a priority in this goal. (Agency advocacy for utilizing person-centered language in standardized demographic reporting tools will be ongoing.)
9. Indiana as of November 2022 has launched the Indiana Health Information Exchange (IHIE). SBH will have workflows in place by September 2023 for accessing IHIE via our EHR system, per our EHR vendor.
10. SBH will standardize data reports on quality care using NOMS and SDOH tools focusing on the demographic breakdown and distribution. The timeline is to be completed by the end of reporting year 1. We will use the EHR to facilitate this process.
11. SBH's CQI and QAI Committees will complete an internal self-assessment utilizing the *Evaluation of the National CLAS Standards* toolkit from the HHS Office of Minority Health by the end of Year 1.

### **SECTION III. Developing a Disparity Reduction Quality Improvement Plan**

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

- **Access: number of individuals served, number of outreach contacts, number of screenings, number of referrals.**

SBH will utilize NOMS data internally to identify the number of individuals served. While SAMHSA may use a sampling method of 10%, DMHA will require the NOMS on all clients.

The number of outreach contacts, number of screenings, and number of referrals will be measured via the EHR data warehouse. This will require a full PDSA design: from administrative process to clinical process, to internal EHR document design, to EHR data extraction and validation plan.

Demographic data models will be refined to maximize the accurate picture of who we serve, who

we do not yet serve, and where to place our outreach and engagement efforts at increasing access across our communities.

- **Use: number of screenings, number of referrals, retention rate, number of trainings.**

SBH will utilize IPP indicators to report the number of screenings, and number of staff trainings. The workflow on reporting referrals and effectively closing the referral loop will be added to the CQI for a PDSA project.

The retention rate of minority clients in SUD residential services has not previously been examined. A PDSA on differentiating discharge status from retained through to service completion vs. behavioral or self-initiated discharge will require a full workflow process. We will explore the current discharge documentation process and refine it through iteration.

- **Outcomes: number of completed referrals, number of people trained, number and percentage of individuals who have demonstrated improvement in knowledge/attitudes/beliefs, number of programs/organizations/communities that implemented specific behavioral health practices or evidence-based activities.**

The project management team will meet to review findings using our CQI PDSA model. Throughout the CQI process the project management team will monitor initial NOMS and follow up. Based on this review, the project management team will determine the need for any changes to the intake and treatment process.

## IMPLEMENTATION OF ACTIVITY

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

The SMART goals identified in the following tables will be added to the CQI committee agenda in January 2023. As part of an ongoing Continuous Process Improvement plan, the below measures will be reviewed monthly and revised as goals are preliminarily met. Goals will be revised annually per our current SAMHSA guidance.



### SMART GOAL 1: CQI Implementation Plan and Timeline

|                   |   |
|-------------------|---|
| <b>Specific</b>   | <ul style="list-style-type: none"> <li>SBH's CQI and QAI Committees will complete an internal self-assessment utilizing the <i>Evaluation of the National CLAS Standards</i> toolkit from the HHS Office of Minority Health by the end of Year 1. <b>Project Director (IPT), EHR</b></li> </ul>   |
| <b>Measurable</b> | <ul style="list-style-type: none"> <li>CQI workgroup to be established by end of 1<sup>st</sup> quarter</li> <li>Create and use multi-departmental (EHR, IPT, Clinical Director, end users) workgroups to identify and streamline workflow processes linking the clinical, EHR, and data analytics teams by April 2023</li> <li>Incorporate identified CLAS Standard 10 &amp; Standard 11 to the SBH CQI Plan, by April 2023</li> <li>Self-Assessment will be completed by end of year 1</li> </ul> |
| <b>Attainable</b> | <ul style="list-style-type: none"> <li>CQI committee exists with work group and PDSA format for workgroups</li> <li>CEO supports improvement goals</li> <li>Potential of expanding CQI staffing by February 2023</li> </ul>   |
| <b>Relevant</b>   | <ul style="list-style-type: none"> <li>Establishes foundation for Indianan CCBHC certification by demonstrating adherence to CLAS standards</li> </ul>  |
| <b>Time bound</b> | <ul style="list-style-type: none"> <li>CQI workgroup to be established by end of 1<sup>st</sup> quarter</li> <li>Self-Assessment will be completed by end of year 1</li> <li>Results of self-assessment will be reported in October 2023</li> </ul>   |

### SMART GOAL 2: SDOH/Total Served:

|                   |  |
|-------------------|--|
| <b>Specific</b>   | <ul style="list-style-type: none"> <li>SUD programming will see 1250 clients in year 1. <b>Grants Evaluator</b></li> <li>SBH will increase mental health, substance use, and suicide risk screening for Black/African Americans ages 18-65 by 3.1% adjusted for a projected 4% increase in need: this will be completed by the end of grant year 4. <b>Project Director (IPT)</b></li> <li>SUD programming will increase Black/African Americans served from 9.87% to 13.01% (125 to 193) by the end of the grant year 4. <b>Grants Evaluator</b></li> </ul> |
| <b>Measurable</b> | <ul style="list-style-type: none"> <li>Comparative baseline demographic reporting will be finalized by April 2023.</li> <li>Demographic breakdown will show increase in number of Black/African American clients served by April 2023.</li> <li>SDOH will be collected with NOMS at admission and reassessment comparison will show increase in Black/African demographics goal in SUD services.</li> </ul>  |
| <b>Attainable</b> | <ul style="list-style-type: none"> <li>NOMS collection process expands to SUD services on January 1, 2023.</li> <li>Increased data analytics capacity will allow for enhanced demographic and SDOH specificity for reporting demographic information specific to sub-populations.</li> </ul>   |
| <b>Relevant</b>   | <ul style="list-style-type: none"> <li>Expanded data reporting is key for CCBHC-IA and IN CCBHC certification requirements.</li> </ul>   |

|                   |  |
|-------------------|--|
|                   | <ul style="list-style-type: none"> <li>Increased under-represented population in SUD services will be reportable and this information will be used to set future outreach and CQI goals.</li> </ul>  |
| <b>Time bound</b> | <ul style="list-style-type: none"> <li>SUD programming will see 1250 clients in year 1.</li> <li>SBH will increase mental health, substance use, and suicide risk screening for Black/African Americans ages 18-65 by 3.1% adjusted for a projected 4% increase in need: this will be completed by the end of grant year 4.</li> <li>SUD programing will increase the number of Black/African American clients served from 9.87% to 13.01% (125 to 193) by the end of the grant year 4.</li> </ul> |

### SMART GOAL 3: Training/Staff Development:

|                   |   |
|-------------------|---|
| <b>Specific</b>   | <ul style="list-style-type: none"> <li>SBH staff will complete at least five trainings per year on CLAS standards to be reported on in October 2023. <b>Corporate Trainer</b></li> <li>The SBH DEE Committee will present four internal trainings as part of the ongoing cultural humility series by October 2023.</li> </ul> |
| <b>Measurable</b> | <ul style="list-style-type: none"> <li>Corporate Trainer will report on information consistent with IPP WD-2.</li> <li>DEE trainings will be presented and tracked by internal documentation.</li> </ul>  |
| <b>Attainable</b> | <ul style="list-style-type: none"> <li>A full Relias new-hire and annual trainings on CLAS Standards is in place from CCBHC-E.</li> <li>SBH DEE Committee presented quarterly trainings on cultural humility during 2022.</li> </ul>  |
| <b>Relevant</b>   | <ul style="list-style-type: none"> <li>Cultural humility, crisis services, suicide risk, and opioid treatment evidence-based practices are essential elements of CLAS standards.</li> <li>All staff will be trained on CLAS standards as part of the CCBHC attestation standards.</li> </ul>                                  |
| <b>Time bound</b> | <ul style="list-style-type: none"> <li>Annual CLAS training requirements will continue to be tracked by the Corporate Trainer and reported via an internal tracking document, consistent with IPP WD-2; this data will be presented in the mid-year report by April 2023.</li> </ul>  |

#### SMART GOAL 4: Partnership Development

|                   |   |
|-------------------|---|
| <b>Specific</b>   | <ul style="list-style-type: none"> <li>Identify agencies who serve our targeted outreach communities and meet with a minimum of 5 agencies per month to discuss crisis services, SUD services, and mental health services. Identify agency liaisons with these agencies. - <b>Services Supervisors &amp; Outreach team (expansion of existing outreach process)</b></li> <li>Establish MOUs with at least 2 new agency partnerships by October 2023. <b>Project Director</b></li> </ul>   |
| <b>Measurable</b> | <ul style="list-style-type: none"> <li>2 MOUs will negotiated, drafted, and signed with community based partners</li> <li>We will record the documented outreach activities each month and will determine if we have reached the 5 required community interactions.</li> <li>We will record the name and contact information of agency liaisons upon contact, and we will review this information Monthly to confirm the current validity, In the case of a shift in contact information the records will be updated to meet the most current information we can obtain.</li> </ul> |
| <b>Attainable</b> | <ul style="list-style-type: none"> <li>Community outreach specialists work to establish foundational contacts with local agencies. These contacts are then used to foster higher-level discussions among managing stakeholders, leading to more formal communication and cooperation.</li> </ul>  |
| <b>Relevant</b>   | <ul style="list-style-type: none"> <li>MOUs are a foundational component of CCBHC interagency cooperation for regulating interagency agreements.</li> </ul>   |
| <b>Time bound</b> | <ul style="list-style-type: none"> <li>Identify and meet with at least 5 agencies per month and identify agency liaisons with these agencies. Contacts and their liaisons will be reviewed monthly progress will be discussed at Mid-year report by April 2023 and Year-end report by. <b>Crisis Services Supervisors &amp; Outreach team (expansion of existing outreach process)</b></li> <li>MOUs with 2 agencies will be signed by year-end report Specify when the objective should be completed.</li> </ul>   |

## SMART GOAL 5: NOMS

|                   |   |
|-------------------|---|
| <b>Specific</b>   | <ul style="list-style-type: none"> <li>• Begin collecting Federal NOMS by March 2023<br/><b>Grants Evaluator, SBH Directors</b></li> <li>• Transition from paper Federal NOMS to EHR NOMS April 2023. <b>Grants Evaluator, SBH Directors</b></li> <li>• Establish data extraction protocols for EHR NOMS April 2023. <b>Grants Evaluator, SBH Directors</b></li> <li>• Eliminate State NOMS from SBH workflow by April 2023. <b>Streamline, EHR Team, Grants Evaluator, Project Director</b></li> </ul> |
| <b>Measurable</b> | <ul style="list-style-type: none"> <li>• NOMS collection workflows and trainings in SUD program will be complete and deployed</li> <li>• NOMS reporting will be based out of Crystal Reports</li> <li>• State NOMS will no longer be collected</li> </ul>   |
| <b>Attainable</b> | <ul style="list-style-type: none"> <li>• Established CCBHC-E processes can be built upon to make this process attainable</li> <li>• NOMS tools are in EHR and ready to be operationalized.</li> </ul>   |
| <b>Relevant</b>   | <ul style="list-style-type: none"> <li>• Streamlining NOMs collection is a essential component of successfully meeting CCBHC requirements for both SAMHSA and Indiana DMHA</li> </ul>   |
| <b>Time bound</b> | <ul style="list-style-type: none"> <li>• Federal NOMs will be collected starting when grant guidance directs, current beginning date is March 1 2023</li> <li>• Conversion to EHR collection will be completed by April 2023</li> </ul>   |

## SMART GOAL 6: Data Collection, Validation and Reporting

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|-------------------|--|
| <b>Specific</b>   | <ul style="list-style-type: none"> <li>• Create a detailed CPI plan to align and standardize demographic collection instruments across the agency with the HHS standards, available at <a href="https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&amp;lvlid=53">https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&amp;lvlid=53</a> by April 2023 <b>Project Director</b></li> <li>• Hold 26 Bi-weekly EHR/IPT team meetings by October 2023 <b>Project Director (IPT)</b></li> </ul> |
| <b>Measurable</b> | <ul style="list-style-type: none"> <li>• SBH will produce a logic model for demographic collection and standardization</li> <li>• 26 meetings will be held between EHR and IPT teams by October 2023</li> </ul>  |
| <b>Attainable</b> | <ul style="list-style-type: none"> <li>• The team has developed a CPI process utilizing a PDSA Model</li> <li>• Finding a meeting time may pose some coordination difficulties, but finding a time is within our scope.</li> </ul>   |
| <b>Relevant</b>   | <ul style="list-style-type: none"> <li>• It is crucial to the work of the grant to be able to track and report on validated and reliable measures.</li> <li>• Regular meetings are crucial to coordination and creating an environment of change.</li> </ul>   |

|                   |  |
|-------------------|--|
| <b>Time bound</b> | <ul style="list-style-type: none"> <li>• CPI plan completed by April 2023 so that progress on improvement can be seen by October 2023.</li> <li>• Meetings will be held approximately every other week to ensure regular contact and foster ease and regularity of communication.</li> </ul> |
|-------------------|--|

## INTENDED OUTCOMES AND IMPACT

*How will these activities improve the problem or close the disparity? How will you identify and outreach to the selected population(s) of focus in your catchment area?  
(Intended outcomes and impact should be directly related to your goals and objectives.)*

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

- Increase access to and use of mental health and substance use services with a year 1 focus on client who identify as Black or African American
- Create better overall behavioral health outcomes
- Increase the number of suicide screenings
- Increase access to and use of crisis interventions services and the mobile crisis team
- Expand certified Peer Support Specialists and BS level care coordinators into programs with high demand and low supply LCSWs
- Utilize the outreach plan established by Crisis Services to initiate meetings with existing community agencies, networks, councils, churches, soup kitchens, homeless shelters, and hospitals. Track MOUs and continue to offer mental health navigation for the community.
- Expand mobile crisis response to local community agencies and build relationships based on mutual need for services provided by the other

Through the implementation of the activities mentioned above the unintended consequences may be:

- Increased community participation and collaboration with existing community and social supports and resources for outreach to demographic areas that demonstrate need based on socioeconomic status, county crime indicators, and SDOH.
- Increased visibility of SBH's diverse and glamorous staff with the purpose of increasing recruitment of diverse staff and clients.
- Increased staff satisfaction in getting clients into services the same day
- Refined workflow processes with our central dispatch, law enforcement and hospital partners
- Increased awareness of the array of services available at SBH and improved linkages across community systems

The population of focus for the CCBHC-IA grant, year 1, are the clients that identify themselves as Black/African American seeking and receiving substance use disorder services at Southwestern Behavioral Healthcare, Inc. A demographic profile across the agency programs may assist in identifying communities who may be experiencing a service gap or lack of crisis services.



## CLIENT/PEER/PARTNER INVOLVEMENT

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

Southwestern has a long history of employing persons with lived experience. In 2021 we hosted certification training for Peer Support Specialists (PSS), resulting in 21 additional certifications of existing staff. Peer Support staff are primarily being utilized in substance use disorder and Crisis Services, both of which offer 24/7/365 services; peer support specialists work all shifts. Many of our staff have lived experience in their own lives or family systems.

SBH has a consumer advisory board working with the broader board of directors. on person-/family-centered treatment planning (per the CCBHC Certification criteria requirements). Clinical staff will be working with peer specialist and recovery support specialist and be educated about the roles peer staff can fill and the importance of their role in the expansion of services to our clients. We will also ensure that appropriate Board representation and decision-making will involve peers and family members. Peers and recovery support specialists will also be part of community engagement and outreach.

## TIMELINE

*When will you implement these activities? How often will they be reviewed and adjusted?*

Note: Please refer to the timeline of activities in the SMART Goals as elaborated above.

Per the NOFO, the implementation of activities will begin no later than 4 months of the grant award date. We will continue providing training on CLAS standards and DEE panel training throughout the year; and use our current reporting capacity to report at the end of year 1.

Enrollment of clients and provision of screenings and referrals will occur regularly in real time, throughout the project period, with an internal go-live date in SUD services of 12/10/2022. A CQI workgroup will be formed to review the requirements and commitments of this report and to incorporate the additional measures into our current demographic reporting process by 1/31/23.

Optimized demographic reporting capacity through the EHR data warehouse is key to moving forward in monitoring changes in demographics and SDOH factors. While our agency demographics reporting has been validated, missing data is a primary issue with measuring and addressing service disparities with LGBTQIA+ communities. Workflow design will include training for administrative support staff on asking demographic questions they may not feel comfortable with. Workflow will include updating orientation demographics for existing clients. By the end of year 1 reporting, demographic data on gender and sexual orientation will increase to 70%.

A validated SDOH measurement exists in our EHR system. The requirement to complete this document on intake and reassessment will be built into the administrative process across departments. SAS (Substance Abuse Services) will beta test the processes developed to rapidly establish baseline for our

year 1 population of focus. The data analytics and EHR teams will collaborate on designing extraction models for demographic reporting on a macro and mezzo level of descriptive analysis. A standardized logic model will be used to drill down into our demographic data to present on by the end of year 1.

As part of an ongoing Continuous Process Improvement plan, the measures will be reviewed monthly and revised as preliminary goals are met. With the PDSA model, goals will be revised as data indicates. The DIS and the associated SMART goals will be revised annually per our current SAMHSA guidance.

## **MEASUREMENT/ EVALUATION**

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

We will use the CMHS National Outcome Measures – Client Level Tool (NOMS), which will be administered at baseline, every 6 months (as proscribed by Indiana State and their CCBHC standards as of July 2023), and discharge. This tool will be administered and collected in real time.

Through a comparative analysis of the NOMS and their reassessments SBH will demonstrate how the desired improvements are being observed for our identified target populations. Outcome measures will be tracked against the targets described in Section II. To the extent that improvement rates fail to meet these targets, the project management team will engage relevant stakeholders in discussions about what is working, what is not. We will address what changes to the implementation plan may be necessary with appropriate stakeholders. Because key demographic information (e.g., gender, race, ethnicity, age) is collected through the NOMS assessments, part of the CQI process will involve exploring how outcomes vary by the previously identified sub-populations. Importantly, SBH will emphasize the necessity of learning throughout this project.

A project management team (key leaders, partners, evaluators) will meet monthly to review findings using our CQI PDSA model. Throughout the CQI process the project management team will monitor initial NOMS assessments to determine a) the extent to which initial assessments are being conducted and recorded as planned, b) the prevalence of services to target populations (i.e., the number of children, individuals with SUD, and other identified target populations reflected in the initial NOMS assessments), and c) any additional needs that emerge on a wide scale (e.g., insecure housing), d) monitor the change in social connectedness between initial collection and follow-up to help evaluate treatment outcomes and to inform treatment practice in accordance with the observed data. Based on this review, the project management team will determine (with input from organizational leadership and/or the Advisory Board, as appropriate) the need for any changes to the intake and treatment process. The first post-DIS action will be to move all deadlines, goals, commitments and requirements into a DIS logic model.

## SUSTAINABILITY

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

The SBH sustainability plan centers on collaborations between SAMHSA, the Indiana Department of Mental Health and Addiction Services, as Indiana transitions into becoming a CCBHC certification state. We are working actively with the National Council for Mental Wellbeing to optimize opportunities for training, mentorship, and guidance from other expanding CCBHC sites. We are re-engineering administrative and clinical workflows to increase access. We now respond to crisis calls, providing mobile crisis co-response with law enforcement and emergency rooms. We established a crisis stabilization unit. We implemented a new EHR and founded a data analytics team. We have learned to design and implement EHR templates to collect crisis services data after tracking months of crisis data on an Excel spreadsheet.

Policies are being reviewed, revised, and written to assure that we are positioned to have a working foundation for CCBHC certification, when available. The state has established workgroups for financing; our CFO is a participant. We are mapping from provider to billing code, to EHR documentation as a means to establish cost-basis for services. The funding from the CCBHC-IA grant allows us to continue running our crisis services and data analytics team. Additional funding is being sought via DMHA and the Indiana Council of Mental Health Centers to assist us in expanding services that are otherwise not paid for (crisis, care coordination, peer support).

SBH has strong relationships with our local hospital systems, they have supported our activities as they relate to outpatient service referrals post hospitalization for our clients. We also work with other community health providers and law enforcement agencies and have created better coordination of care across our partners for sustainability of services. We will work with community colleges and local universities to begin recruitment of the workforce by offering field placements, internships, and rotations at Southwestern Behavioral Health. We will also explore additional options as opportunities arise.