2018 Rural Regional Behavioral Health Report

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Executive Summary

This report is intended to provide an overview of the work done throughout ten months by the Rural Regional Behavioral Health Policy Board (RRBHPB) as well as highlight the Region's priorities and recommendations. Finally, the report will provide a review of the Bill Draft Request that the RRBHPB submitted on September 1, 2018.

The Regional Behavioral Health Policy Boards have been charged with the responsibility to advise The Department of Health and Human Services, Division of Public and Behavioral Health and the Behavioral Health Commission regarding: the behavioral health needs in the region, progress or proposed plans to behavioral health services and methods to improve services in the region, identified gaps in behavioral health services, any recommendations or service enhancements to address those gaps, and priorities for allocating money to support and develop behavioral health services in the region.

The Rural Region, comprised of Elko, Eureka, Humboldt, Lander, Lincoln, Pershing and White Pine Counties spans approximately 64,681 square miles, the size of the state of Florida and well over 58% of Nevada's landmass. The region is home to roughly 100,000 people or 3.4% of the state's population. The closest city in the region is 90 miles (Lovelock) from the nearest urban setting; while the furthest is over 320 miles (Ely). With mountain ranges going as high as 13,065ft, frontier Nevada has stunning views of snow-capped mountains along the US 50; affectionately called "The loneliest highway in America." The Rural Region is rich with rugged beauty, natural resources, and fierce independence, but devastatingly lacking in behavioral health services.

According to Mental Health America, Nevada has an overall Mental Health Ranking of 51st in the U.S. 66% of adults with mental illness in Nevada did not receive any mental health treatment in the last year. Nevada has the fifth highest rate of suicide nationally. Lack of mental health resources and workforce shortages are only exacerbated in areas outside of urban hubs. In the entire region, there is not one practicing psychiatrist or psychologist. As of today, there is one psychiatric advanced practice registered nurse (APRN) in Elko County. Law enforcement agencies are small and understaffed, emergency medical services and fire services are split between paid and volunteer staff, hospitals are limited, some with as little as two-bed emergency departments. State managed Rural Mental Health Clinics are understaffed, have long wait lists, and fail to offer adequate services in all seven counties.

Currently, when an individual is in a mental health crisis, the only option is the nearest emergency department. If law enforcement is are involved with someone in a mental health crisis, they have two choices: the emergency department, or the county jail, both of which could be more than two hours away from many of the region's communities. Neither the emergency department or jail are adequate mental health providers and cannot offer a therapeutic setting. Individuals transported to an emergency room can wait days at a time until a bed opens at either of the (two) state facilitated in-patient psychiatric hospitals that could be as far as a five-hour drive one way. Because law

enforcement is responsible for the transport of individuals in crisis, a 10-hour drive roundtrip can take the one and only deputy on duty in the county out of service, creating a public safety concern. A Mental health crisis of one individual can put an entire community at risk in the Rural Region. Transporting individuals in a marked police vehicle while they are suffering from a mental health crisis can be traumatic and stigmatizing. Taking officers out of service for a mental health transport is ineffective for the individual in need of care, a drain of community resources, and a public safety concern.

This summary is intended to offer a glimpse of how mental health emergencies are handled for those not familiar with the unique challenges of living in frontier Nevada. Mental health emergencies are only a part of our problem. However, they are critical enough to illuminate to any audience with the power to make change until they are adequately addressed.

We would be amiss not to note the significant progress the region has made this year. With the installation of telehealth equipment in all seven county jails, a licensed mental health professional is now available to an inmate within hours. Prior to the telehealth resource, an inmate with suicidal ideation required a trip to the emergency department, a safety concern for the hospital and a staffing burden for a Sheriff's Office. Additionally, the Rural Region launched its first Elko Crisis Intervention Team (CIT) training program in May. Over thirty first responders from five counties in the region are now equipped with skills to help identify behavioral health symptoms, deescalate individuals in crises, and possibly offer a diversion from jail or emergency department if available. In December, Humboldt County will launch their first CIT program, training another 34 individuals from four counties within the region.

In comparison to the other regions, the Rural Region is in its initial stages of collaborating as a region and board, assessing data and truly learning about the entirety of behavioral health. In less than a year, we feel as if we made a great deal of progress, however we are keenly aware that we have a long journey ahead.

The RRBHPB has detailed their list of priorities and recommendations that will aid their communities. Many of the recommendations have been successfully implemented in other regions, and although the solutions will need to be adjusted to fit the needs of such an expansive area, the region's stakeholders are willing to do the work necessary to make improvements for all Rural Nevadans. It is the sentiment of the region as a whole that the needs and recommendations are all too often unheard and the Board hopes The Commission on Behavioral Health will be a partner and advocate. We appreciate your dedication to this critical issue for Nevada.

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Rural Regional Behavioral Health Profile

Significant findings from the 2017 Epidemiologic Profile provided by the Office of Analytics, Department of Health and Human Services, on behalf of the Division of Public and Behavioral Health. **The entire 2017 Epidemiologic Profile, Rural Region can be accessed here.**

- The Rural Region's population has grown by 6% (101,399) since 2010 (95,577)
- 9.5% of Rural Region residents have utilized state-funded mental health resources while comprising only 3.4% of the State's population.
- Mental Health hospital visits to the emergency department and inpatient admissions have increased since 2009
- 9.5% of Rural Region residents have utilized state-funded mental health resources while comprising only 3.4% of the State's population.
- There were 6,090 visits to the emergency department related to mental health in 2017
- There were 1,518 inpatient admissions related to mental health the Rural Region in 2017
- Depression is the leading diagnosis for mental health related admissions
- Ely Outpatient Counseling has served the most patients despite being the 3rd largest population in the Rural Region
- The most common method for attempted suicide is substance or drug overdose attempt
- There were 155 suicide attempt encounters in 2017, 92 encounters (59%) were substance/drug overdose-related
- From 2009-2017 there have been 229 deaths by suicides according to the Nevada Electronic Death Registry System
- On average there are 25 suicides per year
- There were 9 suicides in the 25-34 age group in 2017
- 19.1% of Rural Region high students report that they are currently using tobacco in contrast to 12% of Nevada high school students as a whole
- Rural Region high school students reported a higher prevalence of binge drinking before 13, currently drinking alcohol and ever drank alcohol than the Nevada average
- Rural Regional high school students report lower uses of marijuana than Nevada as a whole
- Rural Region high school students have a higher rate of ever using heroin, methamphetamines, cocaine, inhalants, and synthetic marijuana
- In 2017 there were 2,064 alcohol and drug-related emergency department encounters (432 alcohol, 247 drug-related)
- In 2017 there were 168 alcohol and substance abuse related deaths in the Rural Region.
- 87 alcohol or substance abuse related deaths in 2017 were between the ages 65-84 (52%)
- In 2017 19% of Rural Region high school students have considered suicide

- Rural Regional high school students have a higher graduation rate than Nevada's average (White Pine County excluded)

Although the data provided was comprehensive, many of the collected measures led to further questions. The board hopes to work with the Office of Analytics in the coming year to get a better grasp of the data. Below is a growing list of questions that remain for the Board.

- What age-groups have increased in population in the Rural Region?
- Is the data conclusive about the suicide attempts, or are the suicide attempts collected solely from hospital admission collection?
- In 2017, data reflects that no one in the region reported suicidal ideation? How is that information collected?
- Mental health related admissions: is this self-reported or has a physician diagnosed the patient? It is important to note that out of 7 counties in the Rural Region, no psychiatric specialists are working in the Emergency Departments, so who is doing the diagnosing. How is the fidelity of the diagnosis (primary and secondary) being determined?
- How many licensed mental health professionals are working in the Rural Mental Health Clinics? (How many clerical staff, case managers?)
- What are the current waiting lists for each Rural Clinic?
- How many hours is a licensed clinician is available at the Rural Clinics in Pershing, Lander, Eureka, and Lincoln Counties?
- What are the wait times in a Rural Regional hospital emergency department for patients who need a bed at Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS)?
- What are the rankings of the Rural Region suicides in comparison to national statistics?
- What are the state-wide county rankings of deaths by suicide?
- Request for accurate data of the number of mental health providers in the region
- Request for survey questions to include what residents identify as their greatest need for behavioral health
- Request for survey questions to include what community they utilize for their mental health and substance abuse services

Rural Regional Behavioral Health Policy Board Presentations

The Rural Regional Behavioral Health Policy listened to a wide array of presentations in every meeting. The purpose was to give the board members a solid overview of behavioral health issues, efforts, and programs throughout the state as well as regionally that communities throughout the state are working on. In the far reaches of the state, there is less interaction with state agencies such as the Division of Public and Behavioral Health.

In contrast to the three other regions, the inception of this board was truly the start of conversations centered around behavioral health. The other regions had previously formed task forces or forums to discuss the topic and address issues. The Rural Region spent a significant portion of time in their meetings formulating an idea of the broad scope of the problem, from the perspectives of various stakeholders.

The Regional Behavioral Health Coordinator provided updates regarding efforts made throughout the region at each meeting. **Rural Regional Meetings**

All meeting materials, including minutes, presentation materials are available on the Board's website.

Date	Topic	Presenter(s)
2/27/2018	Overview of AB366 Authorizing Legislation for Regional Behavioral Health Policy Boards	Joelle Gutman, Rural Regional Behavioral Health Coordinator
	NRS Chapter 241- Open Meeting Law- Meetings of State and Local Agencies	Sarah Bradley, Senior Deputy Attorney General
	Regional Behavioral Health Data Report	Kyra Morgan, Division of Public and Behavioral Health
	Rural Suicide Data	Misty Vaughn-Allen, Office of Suicide Prevention
4/3/2018	Medicaid 101	Chuck Duarte, Executive Director of Community Health Alliance
	State of Nevada Perspective on Legal 2000s, and Current Behavioral Health Issues and Initiatives	DuAne Young, Deputy Administrator, Division of Public and Behavioral Health
	State Funding of Mental Health Services in Rural Region	Julia Peek, Deputy Administrator, Community Services, Division of Public and Behavioral Health
	Rural Children's Mental Health Consortium Strategic Plan	Michelle Sandoval, Nevada Children's Mobile Response Team, Elko Counseling and Supportive Services

6/14/2018	Legislative Counsel Bureau- Bill Draft Request and Legislative Process	Marsheilah Lyons, Policy Analyst: Legislative Committee on Health and Human Services, Chief Principal Research Analyst
	Rural Health Workforce Planning and Development in Nevada	John Packham, Ph.D, Associate Dean, UNR School of Medicine Office of Statewide Initiatives
	Presentation from Frontier Community Coalition and PACE Coalition	Jeff Munk, Director, Laura Osland, Director
	MFT- CPC Board of Examiners regarding workforce development efforts	Jake Wiskerschen, President, Nevada MFT-CPC Board of Examiners
7/17/2018	Crisis Intervention Team (CIT) Training	Bekah Bock, Carson City Sheriff's Office MOST
8/21/2018	Bill Draft Request final decision	

Regional Needs, Priorities, and Recommendations

Development in rural infrastructure is vital in every regional priority. The Rural Regions needs a behavioral health crisis triage system that diverts individuals from inappropriate and costly institutions (hospitals, inpatient psychiatric facilities, jails, and prisons), and enables them to be able to live a meaningful life in their communities of choice.

Lack of investment: Investment from the State to allow local agencies to develop sustainable infrastructure is needed. On numerous occasions, local agencies have expressed frustration to this board over their inability to garner any financial support from the State. As a result, agencies are consistently passed over for funding opportunities preventing the region from the ability to establish sustainable community resources. Often, agencies don't meet the arduous criteria set forth from the state to even apply for the funding. From a regional perspective, funding opportunities appear to be a paradoxical dilemma. The funding opportunities seem to be only available to agencies that already have the infrastructure in place needed to meet the application criteria, eliminating agencies that need funding to grow into sustainable institutions.

> ***Recommendation***: Set aside dollars for each region. Grant requests for approval specially designed to aide rural agencies attempting to build infrastructure. Grant request for approval (RFA) with a reasonable amount of time to apply. RFA's are currently going out with an unrealistic turn-around time.

Lack of technical assistance: The region needs technical support from the State to establish Medicaid billing at a county level. Doing so would allow counties to build out their social services and develop institutions that are self-funded.

> ***Recommendation:*** Division of Health Care Finance and Policy personnel available to travel to rural communities and offer personal training. Medicaid reimbursement could help to sustain locally employed case managers. Medicaid providers could help to ease long waits for services at Rural Clinics. Or a Community- Based Medicaid Reimbursement Technical Coordinator to assist communities in increasing capacity to maximize reimbursement for case management and other services offered.

***Lack of consideration of regional characteristics*:** Consideration of extenuating circumstances and an understanding that the rural region needs to be considered separately, even in comparison to the Northern Region. Programming awards and grants are awarded disproportionately awarded to rural counties with significantly more resources.

Erratic funding distribution: State funding is distributed in an unorganized fashion. There have been many innovative programs that have been aided by the State in other counties; however, when communities from the Rural Region have approached the State to ask for funding for programs such as MOST or FASTT teams, we are told that all of the

money has been allocated. Rural counties surrounding Nevada's Capital appear to benefit from state employees attending their meetings. Resources are significantly disproportionate even to our most populous region, Las Vegas.

> ***Recommendation:*** Regional investment in contrast to a county by county approach. Hardships of multi-county applications coupled with the incredibly short turnaround times for RFA makes it nearly impossible for the region to come together and be able to apply for programming. Stakeholders that live, work and experience gaps in services here are the same stakeholders that should be consulted before money or programming decided upon. **Transparency, equity and a regional voice when decisions are made by DPBH is sorely lacking, despite our best efforts of providing recommendations, priorities, and feedback since the inception of this board.**

Lack of community diversion and crisis stabilization system of care: Best practice for treatment of individuals in crisis is to keep them in their community with proper support. Currently, we are unable to provide that for our residents. Individuals in crisis often wait days in our emergency rooms and then transported by law enforcement to psychiatric care for a brief time, only to be sent home without follow-up support.

> ***Recommendations:*** Using the sequential intercept model for a system of care. Community Diversion and crisis stabilization system of care including:
>
> - Funding for non-state managed and operated Mobile Outreach Safety Teams (MOST)
> - Funding for non-state managed and operated Forensic Assessment Services Triage Teams (FASTT)
> - Funding for Crisis Intervention Team (CIT) coordination and training for first responders
> - Crisis Stabilization Units
> - Maintaining representation through Regional Behavioral Health Coordinator role

Transportation Emergency and non-emergency transportation is a vital need in the region: Transporting individuals in a marked police vehicle while they are suffering from a mental health crisis can be traumatic and stigmatizing. Taking officers out of service for a mental health transport is ineffective for the individual in need of care, a drain of community resources, and a public safety concern.

> ***Recommendation:*** Means to reimburse a system of transport by working with the Division of Health Care Finance and Policy to develop a system of sustainable, timely and reliable transportation.

Priority/Need	
Supporting Development of rural infrastructure	1. Regional infrastructure for funding 2. Specific rural grant opportunities for each region 3. Specialized funding or formulas for funding to build out infrastructure in areas that need it most 4. Regional "space" to house grant dollars/regional initiatives 5. Regional Behavioral Health Authority for funding of behavioral health
Workforce Development	1. Psychiatry residency rotation to our most frontier areas of the state 2. Further discussion/collaboration/improvement with professional licensing boards that could incentivize and streamline the process for a rural behavioral health professional 3. Higher Medicaid reimbursement rates for behavioral health services
Program Development	1. Community behavioral health crisis triage system 2. Expansion of CCBHCs in the Rural Region 3. Funding for Crisis Intervention Team (CIT) training for first responders 4. Funding for Mobile Outreach Crisis Teams (MOST) or similar models in the Rural Region 5. Funding for Forensic Assessment Service Triage Teams (FASTT) 6. Direct funding to the Rural Region to implement community-based behavioral health solutions 7. Support development of information sharing mechanism for vulnerable adults 18-59
Transportation	1. Support development for non-law enforcement behavioral health transportation options 2. Support permissible language in NRS 433A allowing secure non-emergency medical transportation

Regional Behavioral Health Coordinator	1. Continuation of funding for the Regional Behavioral Health Coordinator position

Bill Draft Request

The Board would like to pilot a program to addresses the behavioral health crisis response needs within the region. This pilot program will include the following components:

Currently the Rural Region is struggling to provide appropriate behavioral health care to individuals in crisis. The system of care is multifaceted, and cannot be solved with one bill draft request, however, the board feels that a pilot program addressing the most urgent needs is necessary place to start. The pilot program addresses three urgent needs: the need for providers, the need for appropriate, safe, dignified, and timely transportation to behavioral health facilities outside of the region, and the need for a mental health professional and case managers to be able to support first responders' encounters with individuals in crisis, providing therapeutic care and on-going support, allowing individuals to stabilize and remain in their communities and keep them out on-going crises.

1. **Medicaid**- Suggested changes to Medicaid to maximize reimbursement rates to attract providers to the region. Through provider type codes including Psychiatrists, Psychologists, Advanced Practice Registered Nurses, Licensed Clinical Social Workers, Marriage and Family Therapists, Licensed Professional Counselors and Certified Alcohol and Drug Counselors we would like to provide an accelerated rate of reimbursement as well as gas mileage reimbursement for services rendered. This will require a Medicaid State Plan Amendment. With an increased rate for services, we hope to attract providers to work in the area. Currently, in all seven counties, there is not a single practicing Psychiatrist or Psychologist.
2. **Transportation**- Emergency and non-emergency transportation is a vital need in the region (and in every rural county in Nevada). Currently the burden of transportation to a psychiatric hospital (up to 320 miles away) for an individual in a mental health crisis falls to county sheriffs' offices. When a deputy is tasked with the transportation of an individual in crisis, it can leave an entire county without a law enforcement officer; creating a public safety concern. Law enforcement transport is stigmatizing, further enforcing the notion that someone in a mental health crisis is dangerous. In no other medical emergency would law enforcement be responsible for an emergency. The pilot program will create a means to reimburse a system of transport that is safe, dignified and within a reasonable response time that allows for a therapeutic approach for an individual to get the care they need.

   Mandate that DHHS/DPBH implement a Legal Hold Transportation system on or before the start of the next legislative session in 2021. DPBH shall offer regular updates on their progress to the Interim Legislative Committee on Health Care.

3. **Crisis Response**- The pilot program will provide services to introduce a crisis response approach consistent with the nationally supported Sequential Intercept Model. An effective approach involves (1) first responders that have received specialized training, so they can identify signs and symptoms of mental illness, de-

escalate an individual in crisis and help to determine if there is appropriate resource or agency that the individual can receive help from. (2) a Co-responder, a mental health professional that works in partnership with law enforcement and can respond to a scene of a person in a mental health crisis, offering a skilled therapeutic approach. (3) Follow-up case managers that first responders can refer super-utilizers to. Case managers can offer follow-up support to individuals *after* the crisis to address on-going needs in order to keep an individual out of crisis and stable. The program will ensure that individuals will receive the care and follow-up care they need while remaining in their own communities. A robust crisis response will alleviate inappropriate placement in institutions such as emergency rooms, psychiatric hospitals and county jails. The pilot program will require the following state infrastructure investment:

- **$150,000** devoted to training first responders in the Crisis Intervention Team (CIT) model. CIT is a nationally recognized model that offered to law enforcement officers nationwide. Currently Washoe and Clark Counties offer CIT training to all their officers. The Rural Region has launched a CIT training program in Elko and has another planned in Winnemucca (December 2018), however without offering training dollars to our small rural agencies it is very difficult for them to send an officer to a 40-hour training. The burden of overtime and back-fill staffing eliminates agencies from sending officers. Without financial assistance, it is unrealistic that the region will have a sufficient percentage of officers trained. We have a goal of having a CIT-trained officers that is accessible in every county 24-hours a day.
- **$150,000** to support a regional licensed mental health professional to serve as the training coordinator for CIT training. The mental health provider will also partner with law enforcement and serve as the mental health provider devoted to the region. This individual would split time throughout the area and be accessible via telehealth technology.
- **$200,000** to provide four case managers spread throughout the region that would respond to referrals made to them by law enforcement, first responders and emergency rooms.
- **$75,000** for travel costs and supplies, which will be required to serve 58% of the state adequately