Brian Sandoval
Governor

Brooke O'Byrne
Chair

Bryce Shields
Vice-Chair

Rural Regional Behavioral Health Policy Board

August 24, 2018

The Honorable Pat Spearman
Nevada State Senate
Chair, Nevada Legislative Committee on Health Care
Nevada Legislature
401 S. Carson St.
Carson City, Nevada 89701

Dear Senator
Spearman:

The Rural Regional Behavioral Health Policy Board established by the 79th Legislative Session in 2017 represents nearly 60% of the state and is comprised of Elko, Eureka, Humboldt, Lander, Lincoln, Pershing and White Pine Counties. The seven counties encompass over 64,000 square miles of the State of Nevada. The board is composed of 13 board members appointed in compliance with the statutory guidelines AB366 set forth. The board has met regularly since its formation to identify policies and solutions to recognized gaps or break-downs in our current behavioral health system of care.

The Board identified priorities for the region, some of which will be addressed in the Board's bill draft request that will be submitted by August 31, 2018; however, there are many other issues that we believe could help to correct our current system. It is the request of the Board that the Chair of the Legislative Committee on Health Care consider the remaining priorities that we were unable to address as potential pieces of legislation.

Bill Draft Request Concept:

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

1. **Medicaid-** Suggested changes to Medicaid to maximize reimbursement rates in an effort to attract behavioral health providers to the region. This will require a Medicaid State Plan Amendment.
2. **Transportation -** Emergency and non-emergency transportation is a vital need in the region. 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 reinforcing the notion that someone in a mental health crisis is dangerous. In no other medical emergency would law enforcement be responsible for transport. 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.
3. **Crisis Response-** The pilot program will provide services to introduce a crisis response

approach consistent with the nationally supported Sequential Intercept Model. Crisis response components will include Crisis Intervention Team training for all first responders, a shared clinician and case manager positions to respond to the needs of the region. 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. Diversion from unsuitable levels of care results in better treatment outcomes for individuals and stops the unnecessary drain on community services and agencies.

Regional Priorities

Because the BDR only encompasses the region's most urgent needs we have included the other key needs to support the enhancement of behavioral health services within nearly 60% of the state.

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 support from the state. As a result, they [and the region] are passed over for state funding opportunities preventing the region from establishing sustainability. The region needs technical assistance from the State to establish Medicaid billing at a county level, to secure funds that would allow counties to build out social services and develop institutions that can recruit new providers. Requiring infrastructure already be in place to qualify for state awards or grants often completely eliminates our participation to even compete from the start. Without investment and technical assistance from the front end, we are continuously put in a predicament of not being able to apply for monies that would make progress possible. Consideration of extenuating circumstances of our most rural regions is requested when formulating criteria for opportunities. The rural region should be viewed and considered differently from not only our urban counties, but even by our rural counties with larger populations and are less distance from urban hubs. Programming awards and grants awarded to the rurals are disproportionately awarded to counties with significantly more resources than ours. Without investment we will continuously be unable to build and progress.

The region feels increasingly frustrated when funds are distributed to other parts of the state for programming. It is not clear how to access or even apply for some of the programming dollars that other rural counties are receiving. In all transparency, to the public, it looks as if money is distributed erratically or arbitrarily to rural counties. There seems to be no method looking at how and why one county would receive funding for implementation or expansion of a program over another. We have some small counties in significant need, that will continue to be in constant crisis without aid. Rural counties surrounding the Capital seem to benefit from state employees attending their meetings, and with many of them living in the surrounding counties, they are able witness the need. There is very little state interaction with our region. Programming like MOST teams and FASTT teams are being demonstrated in other rural counties, yet when we express interest, we are told that those dollars have already been allocated. We believe that if money was awarded regionally, in contrast to county-by-county, it would lead to more effective use of funds that could build out programming throughout the 7 counties represented in this region. When one county is awarded all or most opportunities the rest of the region's needs

remain unmet. Our region believes that the stakeholders that live and work and experience the gaps in services here are the same stakeholders that should be consulted before money or programming is looked at. We are requesting transparency, equity and regional voice when funding and programming decisions are being made by DPBH.

- *Community Diversion and Crisis Stabilization System of Care*- Best practice for treatment of individuals is to keep them in their community with proper support. Currently we are unable to do that. Individuals in crisis often wait days in our emergency rooms, are then transported by law enforcement (up to 5-hours away) to psychiatric care for a brief time, only to be sent home without follow-up support. We would like to build infrastructure to provide treatment for patients while keeping them in their communities. This may include:
- Funding for regionally managed and operated Mobile Outreach Safety Teams (MOST)
- Funding for regionally 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

Workforce Development: Workforce development is of utmost priority in the rurals. Licensing, supervision, and scope of practice, is a state need that is exacerbated in the region due to our geographic isolation. Nevada ranks 51st in access to mental health providers, yet we are one of most difficult places to be granted licensure. While improvements have been made recently, there are more barriers that can be alleviated. The following recommendations would greatly improve access to licensed mental health providers. Workforce development is of utmost priority in the rurals and special considerations and carve outs should be set forth for our smaller communities, allowing up and coming professionals that need experience to stay in their communities while working towards their professional licensure. The rurals need the ability to "home-grow" their workforce.

The MFT-CPC Board of Examiners has already crafted mock language for a BDR to solve many of these issues and our Board recommends considering these adjustments. Workforce development is of utmost priority in the rural areas, which is why we endorse the proposed changes, listed in concept below:

- Restoring full clinical practice scope for MFTs and CPCs, pulling Nevada into alignment with all other states that outrank us
- Adding new fees to the Board of Examiners to cover increasing costs and to pay a market-competitive wage to its staff; the last fee adjustment was in 1989.
- Addition of a third public member to balance the board's public representation in response to recent legal developments
- Biennial license renewal to expand opportunities to obtain continuing education at conferences, presently deterred by annual renewal
- Language cleanup in reciprocity statute to expedite licensure
- Language cleanup to remove contradictory language that has often stymied clinical care

Support for other regional boards priorities: the four regional boards and coordinators have worked closely together. Despite our unique needs, it has become clear that many of the priorities that came forward were consistent across the state. The BDR concepts put forth by the other three Regional Behavioral Health Boards would positively impact our region. We as a board have felt supported by the other boards and we are prepared to support one another in every capacity. Thank you for your time and consideration.

Sincerely,

Brooke
O'Byrne
Chairwoman
Rural Behavioral Health
Policy Board

CC: