Northern Regional Behavioral Health Legislative priorities

January 2018

1. **Change NRS 433A:** Multiple stakeholders in our region, DPBH, Washoe County, and hospitals are interested in this for different reasons.
    1. Transportation: give EMS authority to transport people (Lyon County Manager/ East Fork Fire) Legal 2000 needs to get changed so that we are not limited to police vehicle/ taxi
    2. Stigma: Karen Torrey- Green
    3. Hospital clarity- Rural Nevada Hospital Partners

2. **Support workforce development in rural counties-** bringing providers to area, increasing access
    a. Reciprocity of licenses
    b. Provide funding for workforce development initiatives in rural counties
    c. Provide higher rate to incentivize providers in rural counties
    d. Support access to assistance for use of technology/ telemedicine in rural counties

3. **Develop information sharing mechanism for coordination of vulnerable adults 18-59**
    a. Possibility of ADSD developing Adult Protective Services
        1. ADSD recently met with sister agencies and national elder protection group to review issues and process of developing Adult Protective Services.
        2. Nevada only one of 5 states left to only have APS and not EPS.
    b. Vulnerable person definition found in NRS 200.5092 #8
        "A person 18 years of age or older who:
        (a) Suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or
        (b) Has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living.
        1. Term vulnerable person would have to potentially be added to 200.5098 #2 in consultation with ADSD DAG.
    c. However, there is much research and work to do to be prepared for next legislative session, working to research individuals connected with criminal justice system.

4. **Increase options for non-emergency mental health transportation:**
    a. Engage MTM to understand challenged, address gaps and issues, then identify gaps not covered by MTM/ Medicaid infrastructure
        1. Develop regularly scheduled workgroup (HCGP and Medicaid included)
        2. Increase understanding of system, and educate providers on how system works

1. Historic challenges:
    1. MTM obtained contract during large increase in Medicaid recipient
    2. Required to notify every Medicaid recipient

b. Non-emergency alternative to law enforcement
    1. Medical issue- not a criminal issue
    2. Identify and contract with community provider + MTM reimbursement
    3. Concept: Unmarked law enforcement vehicle/ or vehicle with protection with behavioral health trained driver.

c. Regional Transportation Commission

5. **Continuity of care: Continuation of medication/ service connection**
    a. Work on transition from jails, hospitals, and treatment (higher levels of care) into community to ensure continuity of medication and services.
    b. Community Health Workers:
        1. State is working on plan for more community health workers
            1. Regulations established to create community health worker pools: Working with HCC and Nye Communities Coalition to see if they could bill.
        2. Peers more behavioral health focus: Solutions for Recovery, grant funding for training in the rurals?
    c. Assertive Community Treatment-increasing community capacity
    d. Tele-medicine:
        1. Mallory clinic: assessments via telemedicine.
        2. Tele- medicine trainings
        3. Use of community health worker, peer specialist

6. **Inmate healthcare:**
    a. Explore funding/ reimbursement mechanisms for inmate healthcare in jails
        1. Inmates innocent until being proven guilty but don't have access to insurance
        2. NRS 211: Inmate responsible for healthcare- counties footing the bill for costs.
    b. Medicaid suspension versus termination

7. **Sustaining/ Increasing jail diversion and crisis intervention programs:**
    a. Advocate for pot of money designated for Rural Behavioral Health initiatives, or specifically for jail diversion/ crisis stabilization programs such as FASTT, MOST, and CIT either at rural or regional level (This was successfully achieved for family planning in the last legislative session.

Please see Governor's Behavioral Health and Wellness Council Report from December 2014: http://dpbh.nv.gov/uploadedFiles/December%202014%20Council%20Report.pdf

Speaks to many of the region's current initiatives and priorities, and could be used as rational for funding.

a. Identify how much the programs would cost if running at an optimal level
b. Identify what is not being provided due to lack of funding currently (gaps)…."this is what we can utilize by providing this infusion of money"
c. Example Douglas, Lyon, Carson, and Churchill all want to expand MOST programs, why?

<u>Initial prioritization of top 3 priorities</u>

a. L2K
b. Continuity of care
c. Advocate for designated funding for rural behavioral health initiatives (possibly specific
d. Workforce development

<u>Identified action steps:</u>

1. Observe Interim Health Care Committee for trends and look for opportunities to present
2. Survey Regional Behavioral Health Coalition to better understand priorities