RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

2022 Annual Report

April 2023

PREPARED BY
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RURAL REGIONAL BEHAVIORAL HEALTH COORDINATOR

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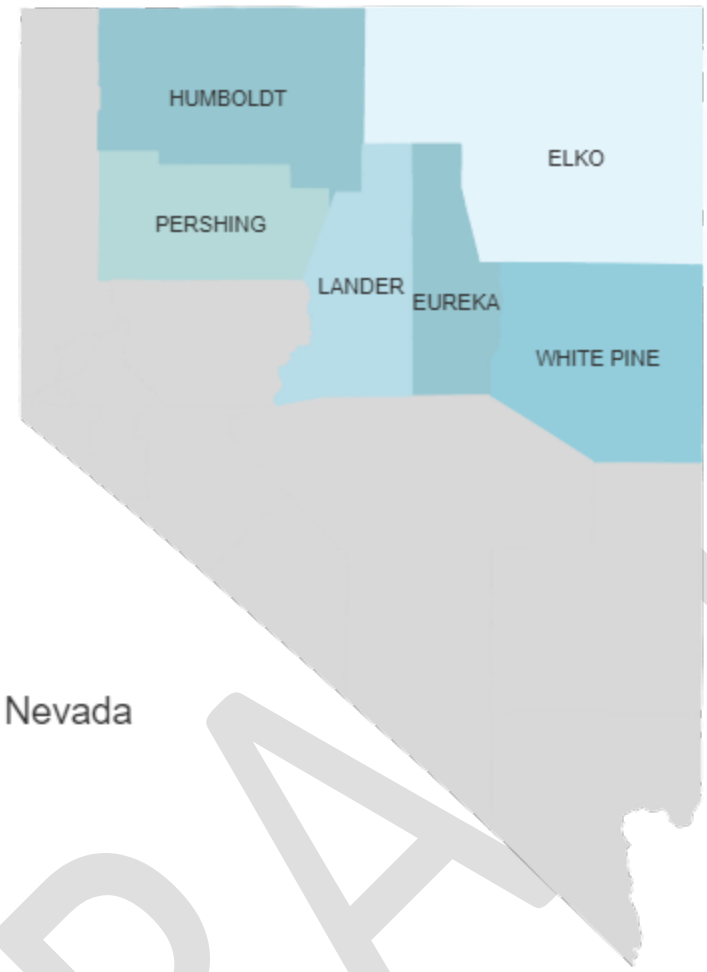


The Counties Included in the Rural Region

served by the Rural Regional Behavioral Health Policy Board:

Elko

Eureka

Humboldt

Lander

Pershing

White Pine

Board Members

2022 Board Members

As of December 2022

Fergus Laughridge
Board Chair
Health Officer Representative
(Health Director/Health Officer, Ft. McDermitt Tribal Wellness Center)
Humboldt County

Amy Adams
Drug and Alcohol Counselor Representative
(Certified Substance Abuse Counselor)
White Pine County

Senator Pete Goicoechea
Appointed Legislator
(Senate District 19)
Elko, Eureka, White Pine Counties

Matt Walker
Hospital Representative
(CEO, William Bee Ririe Hospital)
White Pine County

Bryce Shields
Criminal Justice System Representative
(Pershing County District Attorney)
Pershing County

Jeri Sanders
Law Enforcement Representative
(Peace Officer, Eureka County District Court)
Eureka County

Dr. Erika Ryst
Psychiatry Representative
(University of Nevada, Reno School of Medicine)
Remote

Amanda Osborne
Human Services Representative
(Elko County Manager; past Director of Human Services/Resources)
Elko County

Brooke O'Byrne
Family Member Representative
Remote

Sara Dearborn
Public Insurer Representative
(Nevada Medicaid – Behavioral Health Unit)
Remote

Chris McHan
EMS Representative
(Director, Elko County EMS)
Elko County

Patrick Rogers
Community-Based Service Provider Representative
(Behavioral Health Clinical Services Director, Nevada Health Centers)
Remote

Rural Regional Behavioral Health Coordinator:

Valerie Haskin, MA, MPH
vcauhape@thefamilysupportcenter.org

Executive Summary

The Rural Regional Behavioral Health Policy Board (Rural RBHPB, or "the Board") focused much of its efforts during 2022 towards learning from the process of building and implementing SB 44 during the 2021 legislative session, and towards building a meaningful and potentent bill for the 2023 legislative session.

The Board's priorities for 2023 are included in Appendix A. Along with these priorities are proposed solutions and strategies to address pressing issues. This section was initially developed as a stand-alone document and was submitted to the Commission on Behavioral Health in early 2023.

Unfortunately, there are still issues related to effective data collection and reporting, which would be used to advise this report and the overall focus of the Board itself. These issues are outlined in the sections below.

The Board will continue to learn how to best address its priority issues and will be working throughout 2023 to advocate for programs and services to fill gaps, build upon successful strategies, and improve the overall functioning and quality of the regional and statewide behavioral health system.

Data Highlights

In previous annual reports of the Board, the DHHS Division of Public and Behavioral Health (DPBH), Substance Abuse Prevention and Technical Assistance (SAPTA) and Office of Analytics branches provided each region with a comprehensive epidemiological report. While these reports are now to be developed on a bi-annual basis, with early 2023 being a publication target for data to be used in this report, the Rural Regional Behavioral Health Coordinator (Rural RBHC) **had not yet received the epidemiological report profile before the due date of this publication to the Commission on Behavioral Health (April 28, 2023).**

Because it was understood that the Rural RBHC would have access to this data report before the penning of Rural RBHPB's Annual Report, no further data was collected and prepared.

Because of the lack of comparable, region-wide data, the information provided below is largely based off of anecdotal information collected through meetings with stakeholders across the Rural Region. While this does not provide information as to the volume or trends of behavioral health issues across the region, or even by county, it does provide insight as to the major challenges and context of those issues within the local, regional, and statewide behavioral health region. These concerns and challenges voiced by stakeholders and community members across the region and at the state-level include the following:

- Increased awareness of overdoses and contact with fentanyl in rural communities causing overdoses or other poisoning, particularly among youth. The emerging threat of Xylazine is also causing alarm among stakeholders across the region, as I-80 and Highway 50 run through their communities and may be primary routes for narcotics to be transported.
- Many stakeholders noted the increased need for treatment providers who are skilled at trauma-informed therapies and have experience working with post-traumatic stress disorder (PTSD). As per stakeholders, the increase in trauma experienced by stakeholders includes the following experiences:
    - Increased sexual assault cases (noted specifically by law enforcement leadership in two counties);
    - Increased exposure to loss of community members due to suicide or overdose;
    - Real or perceived increases in community violence, contributed largely to increased substance abuse;
    - And exposure to loss of community members, coworkers, or loved ones to violence or accidents. This is most pertinent in first responders, law enforcement, and mining vocations.
- Inability to get inmates of local detention facilities into either forensic psychiatric facilities or getting them access to other intensive care. Frequently, inmates who are in need of intensive psychiatric care cannot access that care within the jail due to the lack of available providers. Additionally, with Lakes Crossing at capacity with little ability to bring in inmates who have been referred, many of these inmates are languishing in jails for several months, sometimes further psychiatrically deteriorating.

Continuing Issues from the 2021 Annual Report:

- Inability to find placement for patients needing crisis stabilization or inpatient care in a timely manner. After discussing this problem with facility administrators, it becomes clear that high staff attrition has limited the state-run facilities, as well as many private facilities, to offer services at their full potential capacity. Continuing challenges affecting this attrition and difficulty hiring new staff for open positions includes comparatively uncompetitive wages at state facilities, particularly while there is high demand for private practice clinicians who may have more flexibility and better pay.
- Transportation to both crisis and outpatient services continues to be a challenge in all of the communities in the region.
- Lack of mid-level services is another persistent issue. Communities are working towards improved access to crisis care, but the availability of treatment services that fit between crisis and weekly outpatient treatment is virtually non-existent within the region at the time of this report. This gap in treatment for both mental illness and substance use disorder is felt to contribute the rising incidence of persons presenting to hospitals and encountered by law enforcement needing crisis or other inpatient care.
    - **Please note:** while some virtual programs may be available to persons within the Rural Region, there are none known at this time that accept Medicaid Fee-for-Services coverage. Additionally, while virtual programs can be effective if done successfully, they may not be an appropriate fit for all patients; this is particularly poignant in rural communities where internet and Wi-Fi access is much more expensive and less reliable than the internet provided in Nevada's urban centers.
- Increased concerns for the mental health of youth and young adults, including concerns over increased suicidality and intentional overdoses among youth as young as those who are junior high/middle school aged.
- Law enforcement has reported concerns regarding the misuse and trafficking of suboxone among high-risk populations. This has led to a lack of trust in medication assisted treatment (MAT) modalities among law enforcement and elected officials. However, the best practice is to have MAT interwoven with substance abuse counseling, which is often not feasible in most programs due to the lack of counselors available.

Data-Specific Issues:

When the Regional Behavioral Health Coordinators across the state were notified of the due date for their respective Boards' Annual Reports, there was communication regarding if the data to be collected and reported upon by the Boards that is delineated in statute is yet available. As outlined in NRS 433.4295, this information includes:

NRS 433.4295

1. (Number of) persons placed on a mental health crisis hold pursuant to NRS 433A.160,
2. (Number of) persons admitted to mental health facilities and hospitals under an emergency admission pursuant to NRS 433A.162,
3. (Number of) persons admitted to mental health facilities under an involuntary court-ordered admission pursuant to NRS 433A.200 to 433A.330, inclusive, and

4. (Number of) persons ordered to receive assisted outpatient treatment pursuant to NRS 433A.335 to 433A.345, inclusive, in the behavioral health region, including, without limitation:

    (1) The outcomes of treatment provided to such persons; and

    (2) Measures taken upon and after the release of such persons to address behavioral health issues and prevent future mental health crisis holds and admissions.

After investigation of various data outlets and potential resources, it appears that **this data is not collected consistently across the state. In fact, most hospitals of all types do not have this data readily available and may not be necessarily consistently coding the data in a way that would make it comparable across communities and facilities even if it was available**. After bringing this to the attention of the fairly new leadership team at the Division of Public and Behavioral Health (DPBH) with which the RBHCs work, great interest among these professionals was taken in fixing this problem.

While this data is included in statute as to be collected and reported by the boards “as feasible”, this data is key to fully understanding the current and past status of the crisis mental health system across the state, to which DPBH and other DHHS Divisions are focusing quite a bit of resources and energy. Furthermore, this information is vital to evaluating the outcomes of these programmatic and policy efforts across DHHS, and identifying best practices in Nevada, fixing chronic problems, identifying unintended consequences, and ultimately, having a true idea of both the return on investment in these programs and any improvements in the quality of care experienced by persons experiencing mental health crises.

2022 Rural Regional Behavioral Health Policy Board Activities

The following sections cover the activities of the Rural RBHPB and the Rural RBHC throughout 2022.

Development of Assembly Bill 37 for the 82nd Session of the Nevada Legislature

During its regular meeting in May 2022, the Rural Regional Behavioral Health Policy Board heard a presentation on the Behavioral Health Education Center of Nebraska from Dr. Sara Hunt, the Assistant Dean of Behavioral Health Sciences, within the Kirk Kerkorian School of Medicine at UNLV. The model used by Nebraska affected aspects of the behavioral health workforce pipeline that were either not functioning as well as they could be in Nevada or were missing altogether. As addressing the lack of behavioral health providers across the region, and indeed, across the state had been a priority of the Board since its inception, the Board voted to move forward with the concept for its bill draft request (BDR) for the 2023 session of the Nevada Legislature in July 2022.

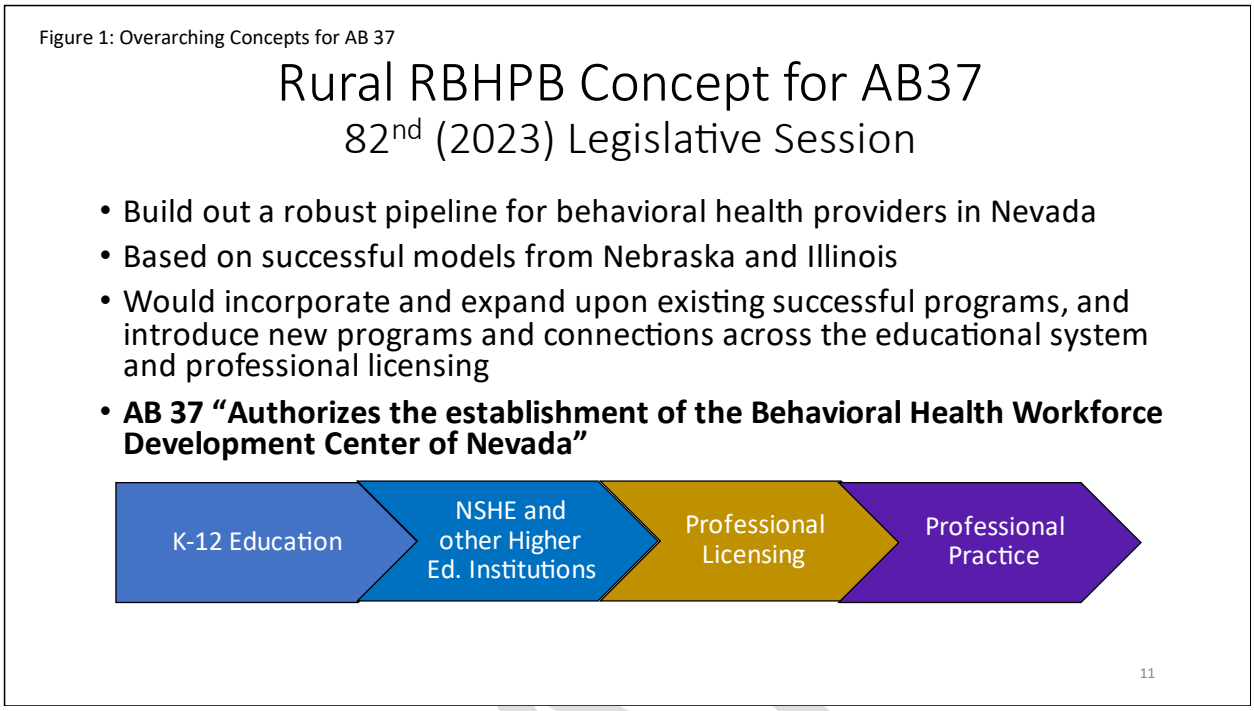
To ensure the bill proposed by the Board would include meaningful strategies and feedback from stakeholders statewide, and from all aspects of the behavioral health system, a BDR Development Subcommittee was launched to formally collect this information and to advise the formation of the BDR concepts. After two meetings were held with great stakeholder engagement, the Board Chair, Rural Regional Behavioral Health Coordinator, and Dr. Hunt worked collaboratively to develop the BDR Concept Language, which was reviewed and approved by the full board at its regular meeting in August 2022.

Stakeholder groups invited to participate in this collaborative process included:

- The occupational licensing boards overseeing behavioral health providers
- The Nevada Department of Education
- Local School District contacts
- Law Enforcement
- Criminal Justice System and Special Courts staff
- DHHS staff
- Faculty and staff from UNR and UNLV
- Prevention Coalitions
- Mental health and substance use recovery advocacy organizations and individual advocates
- Health care systems
- Behavioral health providers
- Other nonprofit and educational stakeholders engaged in provider workforce development

Figure 1 below gives and overview of the overarching basic concepts to be affected by the Center proposed by the Board's bill.

Figure 1: Overarching Concepts for AB 37



The overall goals of the "Behavioral Health Workforce Development Center of Nevada include the following, as outlined within the bill language:

- Increase the number of graduates of high schools in this State who pursue higher education in fields related to behavioral health;
- Increase the number of graduates from programs for the education of providers of behavioral health care within the System who intern and practice in this State;
- Increase the number of providers of behavioral health care who have the specialized training necessary to address the most critical shortages of such providers in this State;
- Increase the number of supervisors and sites for internships for students and graduates of programs for the education of providers of behavioral health care;
- Decrease the amount of time between graduation from a program for the education of providers of behavioral health care and licensure, certification, or registration and, if applicable, endorsement as such a provider; and
- Address other needs relating to the number and distribution of providers of behavioral health care in this State, as determined by the Center.

Early presentations of the bill's concept and goals towards the end of 2022 were met with careful enthusiasm by stakeholders, partners, and other Regional Behavioral Health Policy Boards. While the concept and framework proposed by the bill was lauded as badly needed, there was concern over how successful the bill might be through the legislative process, given it would likely incur a large fiscal note.

Board Meetings and Presentations

The Rural RBHPB was able to build momentum and meet several times throughout 2022. The table below outlines the meeting dates, type of meeting, and topics agenized.

Date	Meeting Type	Topics
February 23, 2022	Regular Board Meeting	Reappointment of previous members, appointment of new members, scheduling of future meetings, and approval of the Board's 2022 priorities.
March 23, 2022	Regular Board Meeting	Program presentation by Nevada Health Service Corps, Behavioral health occupational licensing boards' presentations of progress towards meeting the requirements of SB44, and Rural RBHC update.
April 27, 2022	Regular Board Meeting	Letters tabled, addition of May meeting to the board's schedule, presentation of current Nevada Medicaid reimbursements and programming by Sarah Dearborn, DHHS Division of Financing and Policy, Social Services Chief II (and member of the Rural RBHPB), presentations by local behavioral health service providers regarding services and challenges, and Rural RBHC update.
May 17, 2022	Regular Board Meeting	Discussion and approval of letter regarding workforce concerns to the 2022 Joint Interim Legislative Standing Committee on Health and Human Services, Discussion and approval of letter to the behavioral health occupational licensing boards regarding concerns arising from their previous presentations, Presentation of the Nebraska Workforce Development Model by Dr. Sara Hunt of UNLV, Presentation regarding the extended use of peer services throughout the Nevada behavioral health system from Laura Yanez (ED at NAMI Western Nevada), and Rural RBHC announcements.
June 22, 2022	Regular Board Meeting	Discussion and approval of the Board's proposed bylaws, Discussion and approval of the Board's proposed topic for it's BDR for the 2023 Legislative Session and creation of a subcommittee to form the BDR concept, Presentation regarding supportive housing opportunities for Nevada (Ariana Saunders from the Corporation for Supportive Housing), and Presentation of potential opportunities to support statewide supportive housing programs (Sara Adler, representing NAMI Nevada).

July 22, 2023	BDR Development Subcommittee	Presentation on Nebraska and Illinois models for behavioral health workforce development centers (Dr. Sara Hunt from UNLV), presentation regarding work completed by the Statewide Health Care Workforce Pipeline Workgroup (Megan Comlossy, UNR Center for Public Health Excellence), open discussion regarding gaps and potential legislative fixes to address workforce shortages in behavioral health, initial review and prioritization of solutions, and approval of proposed subcommittee meeting schedule.
August 12, 2022	BDR Development Subcommittee	Review of last meeting's outcomes and setting goals for this meeting, discussion of potential solutions related to program funding and infrastructure, and identify and approve next steps for the following subcommittee meeting.
August 24, 2022	Regular Board Meeting	Overview of BDR Development Subcommittee's work to date, approval of draft language for the Rural RBHPB's BDR, approval of bylaw amendments to reflect feedback from the Office of the Attorney General, and determination of future subcommittee work.
November 16, 2022	Regular Board Meeting	Introduction of new EMS representative member of the Board (Chris McHan), Nomination of Patrick Rogers to replace Steven Brotman on the Board (Mr. Brotman was moving out of state), brief overview of bill progress, review and approval of draft language from the Legislative Counsel Bureau for BDR 34-361 for inclusion in the final bill proposed by the Board, Rural RBHC updates, approval of a letter to DHHS leadership regarding long-term funding sustainability for the Boards and their respective RBHCs, and creation of the Legislative Subcommittee to involve the Board in legislative action during session.
December 21, 2022	Regular Board Meeting	Initial development of the Board's 2023 priorities and recommendations, scheduling and membership of the Board's Legislative Subcommittee, scheduling of the Board's regular meetings through June 2023, and RBHC updates.

Rural Regional Behavioral Health Coordinator (Rural RBHC) Activities

As the ability to meet with stakeholders in-person across the state and attend conferences out of state increased with the lifting of COVID restrictions, the Rural RBHC was better able to create meaningful connections with stakeholders across the state and learn about best practices in overcoming the behavioral health challenges faced in our Nation's "new normal".

The following sections outline some of the major projects and activities engaged in by the Rural RBHC throughout 2022

Development of Assembly Bill 37

The Rural RBHC worked diligently during 2022 to ensure that the Board had the information and resources it needed to identify an appropriate subject area for its bill for the 82nd session of the Nevada Legislature. Luckily, through attendance of other meetings, the Rural RBHC made contact with Dr. Sara Hunt, who was looking for any interested partner to bring the concept of a coordinated, statewide behavioral health provider pipeline center forward to the legislative session. As previously mentioned, this subject area has been of high interest to the Board for several years, and the Board voted to move forward with the concept for the upcoming legislative session.

The role of the Rural RBHC in this work was not only the administrative functions of setting up meetings and presentations but went further into having individual and group discussions with stakeholders to identify concerns, potential challenges, and wishes for the proposed concept. The RBHC also ensured that all pertinent stakeholders were invited to the table for the development of the concept, to increase the breadth of feedback received, and to also garner improved buy-in. The Rural RBHC worked closely with Dr. Hunt and the Board Chair to hammer out the details and ensure the Board was presented with concepts for the bill that would be meaningful to their respective communities and professions, while having the greatest positive impact. This approach also helped the Board move forward with concepts that are hoped to avoid unintended negative consequences to the greatest extent that could be known at that time.

At the end of 2022, the BDR was assigned the number Assembly Bill 37, in preparation for the start of the legislative session in February of 2023.

Changes in Funding

Towards the close of 2022 Fiscal Year (October 1, 2021 through September 30, 2023), all RBHCs across the state were notified that there would be changes in how their funding would be managed. The results of recent audits and unrelated staffing changes pressed program oversight at DPBH to revise the activities, reporting processes, and grant processes for all three of the funding streams used for RBHCs: the State Opioid Response Grant, the Mental Health Block Grant, and the Substance Abuse Block Grant. Unfortunately, as the necessity for these changes became clear at the end of the grant cycle, and with a largely new program and fiscal staff, the timelines and processes for grant development became uncertain, and were pushed back several months. At the time of the penning of this draft, the grant funding, and the activities for the Rural RBHC has only been formally finalized within the last several days.

On a positive note, staff at DPBH are well-aware of this program and are actively moving forward with efforts to fix the problematic issues. Furthermore, DPBH staff are working more collaboratively with the RBHCs to identify more sustainable and appropriate funding streams to keep the positions (and the Regional Behavioral Health Policy Boards) supported.

Crisis Intervention Team (CIT) Training Development Efforts

At the onset of 2022, the Rural RBHC reached out to the law enforcement Sheriffs and Chiefs across the region to identify the appetite to re-visit the implementation of Crisis Intervention Team (CIT) training opportunities. While the answer was largely an overwhelming "yes", it became clear that the crux in the re-launch of these trainings at the local level was the lack of staff available at these agencies to attend the necessary training to implement the training program itself with any kind of fidelity, and beyond that, to enable officers to have the time to attend the 40-hour CIT training as prescribed.

In collaboration with Southern and Northern counterparts, the Rural RBHC offered to attend the training to help jump-start the training within the region, thus taking some pressure off of overburdened law enforcement. The Northern, Southern, and Rural RBHCs attended the CIT International Conference and the associated 8-hour CIT Coordinator training in August of 2022. The opportunity for all three RBHCs to attend together became an natural opportunity for planning and strategy development. It also became clear that while the CIT Coordinator training was helpful, it would be required to attend an additional Curriculum Training for Trainers to gain access to best practices in training delivery, which was the primary need across rural and frontier Nevada at that time.

Towards the end of 2022, a Curriculum Training for Trainers became available in Salt Lake City in February of 2023, for which the Rural RBHC registered to attend.

Overdose Data to Action (OD2A) Program – Substance Misuse Specialists (SMS)

In 2022, the Rural OD2A program lost one of its Substance Misuse Specialists (SMSs), due to needing to partake in family caretaking.

By fall, it became clear that the close of the OD2A funding in its current iteration was coming to a close after FY23 (ending June 30, 2023). As such, the Rural RBHC, the remaining SMS, and the PACE Coalition Director worked to identify strategies that could improve the long-term sustainability of the SMS program in the region. From that, the program's efforts refocused towards identifying means to implement free-of-cost SMART Recovery Facilitator training opportunities, to bolster the number of these evidence-based, non-religion-based, peer support groups available to community members. That work continues into 2023.

Collaboration with Other Regional Behavioral Health Coordinators

The Rural RBHC continued to work collaboratively with the other RBHCs across the state, but specifically focused on building a partnership with the new Northern and Southern RBHCs. Projects worked on collaboratively include the CIT training work discussed above, the continuing work on the previously-launched all-board website (nvbh.org), communication regarding bills during the legislative session, and many others.

Engagement with Prevention Coalitions

The Rural RBHC continued to work with and strengthen relationships with the two prevention coalitions within the region, PACE and Frontier Community Coalition (FCC) in 2022. While the grant application (mentioned in the 2021 Annual Report) that was built in conjunction with both coalitions and other stakeholders was ultimately not funded by DPBH, the process build further trust and collaboration among these partners.

Task Forces and Multi-Disciplinary Teams

The Rural RBHC's work with the Humboldt County Behavioral Health Task Force continued, in conjunction with the county's Pre-trail Services Coordinator/Human Services Director. Additionally, in the fall of 2022, it became clear that there was renewed appetite to create a Task Force in Elko County to address rising concerns regarding suicide and substance abuse.

County	Task Force and MDT Status
Humboldt County	Humboldt County Task Force – Continuing strategic planning. Had focused on improving referral processes and communication through the use of readily available and currently cost-free platforms such as OpenBeds.
Elko County	Elko County Behavioral Health Task Force formally launched in October 2022, with broad stakeholder representation.
Eureka County	Interest in a task force of sorts; very few potential participants. Existing coalition meetings fill role of a Task Force.
White Pine County	
Pershing County	Pershing FCC meeting designated as Task Force.
Lander County	Outreach difficult; efforts to renewed in 2023 to possibly focus on the use of opioid litigation funding.

Closing

The sections above highlight the larger projects undertaken by the Rural RBHC during 2022. However, for the sake of brevity, this description is not completely exhaustive and there were many smaller projects and activities undertaken to support the improvement of the behavioral health system in the Rural Region not listed here.

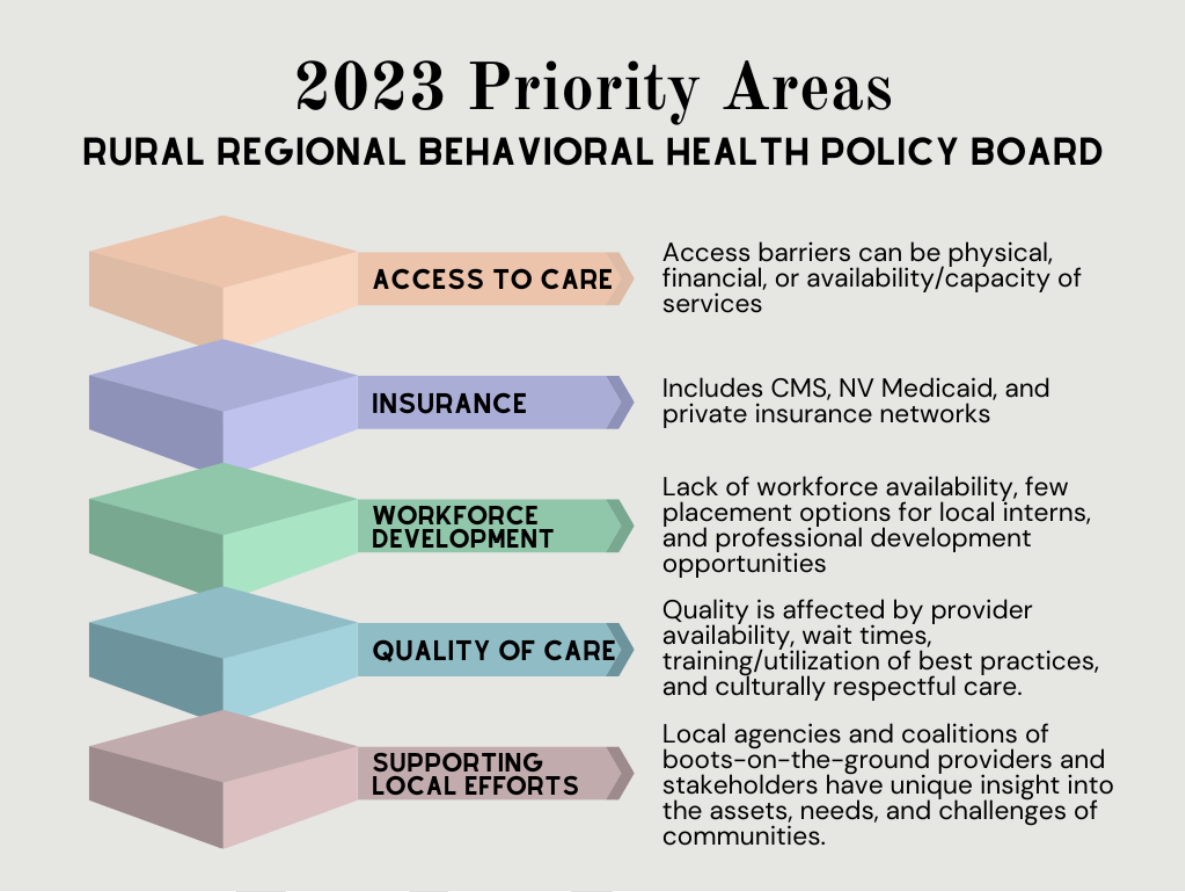
Appendix A: Rural Regional Behavioral Health Policy Board 2023 Priorities

RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

2023 PRIORITIES

JANUARY 2023

Prepared by:
Valerie Haskin, MA, MPH
Rural Regional Behavioral Health Coordinator

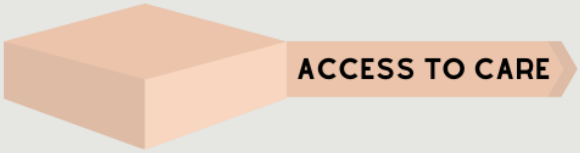


For 2023, the issues pertinent to the Rural Regional Behavioral Health Policy Board (Rural RBHPB) were organized into a group of broad priority areas, all tending to overlap and compound each other, but outlining the underlaying issues for the most critical behavioral health challenges faced by communities located within the "Rural Region". These broad priority areas include: Access to Care, Insurance, Workforce Development, Quality of Care, and Supporting Local Efforts.

In the following pages, details regarding the specific issues and challenges within each of these areas are outlined, as well as possible solutions to these challenges that are supported by the Rural RBHPB. These solutions may be evidence-based or best practices from other states or regions, recommendations from trusted state or national agencies, or even novel ideas that may be planned, implemented, and evaluated for effectiveness at the local level. As the Rural RBHPB itself does not have the capacity to implement programming, the solutions proposed may be carried out by local or state agencies, and some may fit within the scope of work of the Rural Regional Behavioral Health Coordinator.

For more information about the Rural RBHPB or its priorities, feel free to contact the Rural Regional Behavioral Health Coordinator (Valerie Haskin, vcauhape@thefamilysupportcenter.org).

PRIORITY AREA: ACCESSS TO CARE



Access barriers can be physical, financial, or availability and/or capacity of services

PHYSICAL ACCESS

Physical barriers to accessing care may come in many forms, including lack of transportation to local or regional services, particularly for intensive and/or inpatient programs that are not deemed appropriate for tele-behavioral health. Other barriers to physical access could be proximity (being hours away from care), or scheduling issues related to work shifts or child care.

FINANCIAL ACCESS

Even if physical access is not a problem, financial aspects such as insurance coverage, insurance type, ability to meet co-pays, or even being able to purchase fuel to access services may be a hindrance for some community members. Additionally, some people may have to choose between going to work and accessing services (similar to the above), which can cause additional finacial hardships.

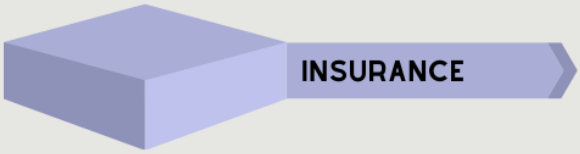
AVAILABILITY AND CAPACITY OF SERVICES

It has been broadly acknowledged that a lack of licensed providers of all types across Nevada has limited the capacity of many organizations to treat current and potential clients. This is particularly poignant for providers of intensive or specialty care. Additionally, many private insurance companies are claiming networks are full and not accepting new providers, further limiting access to services for many community members.

Possible Solutions:

- Focus on meaningful and useful transportation solutions. This may include piloting models from other states, or supporting novel or innovative approaches the keep the client's needs for scheduling, safety, and payment as the central focus. All new programs should undergo program evaluation and quality assurance controls.
- Identify means of ensuring no patient is discharged from inpatient care without safe and expedient transportation to their home community with the resources they need at hand.
- Identify ways to hold private insurers accountable for coverage for behavioral health services (please see "Insurance" on page 4 for more information).
- Increase capacity of services through sustainable funding streams for public behavioral health programming, increased availability of providers (see "Workforce Development" on page 6), advocate for the raising of public provider compensation to better compete with private practice, and remove barriers for providers applying to join new insurance networks (see "Insurance" on page 4).

PRIORITY AREA: INSURANCE



Includes CMS, NV Medicaid, and private insurance networks

LIMITED COVERAGE

Many insurance types may have limitations to the type of care or services that are reimbursed for, including transportation to critical inpatient care. While the patient is in "crisis" and is not able to provide safe care for themselves, insurance companies frequently deny claims for transportation as the patient is not deemed to be in a medical emergency. Additionally, many provider facilities for inpatient and intensive outpatient services do not accept Medicaid "Fee For Service" (FFS), thus limiting the ability of rural residents without private insurance to access services at most facilities in Nevada that are critical to regaining stabilization and safety. This puts additional strain on public inpatient resources, such as NNAMHS and SNAMHS.

LIMITED REIMBURSEMENT FOR PROVIDERS

Many insurers do not provide adequate reimbursement for behavioral health services, but most critically, Nevada Medicaid and CMS do not currently reimburse at rates that enable providers to serve the needs of the Nevadans they cover and cover standard overhead costs.

BARRIERS TO IN-NETWORK CARE

It has come to the attention of the Rural Regional Behavioral Health Policy Board that providers interested in practicing in rural Nevada are being turned down when applying to enter the insurer networks, as the insurers state that the "network is full", all while there are long waiting lists to meet the needs of rural (and urban) community members.

Possible Solutions:

- Advocate for increased reimbursement for behavioral health services from federal payors (CMS).
- Work with Nevada Medicaid to identify key behavioral health services and provider types for which reimbursement should be examined and increased.
- Collaborate with Nevada Medicaid to promote the completion of quadrennial reimbursement surveys by behavioral health providers to ensure a larger group of providers is sampled.
- Work with Nevada Medicaid to identify ways to sample current non-Medicaid providers to identify ways to make the acceptance of Nevada Medicaid patients more feasible for their businesses.
- Remove unnecessary barriers for providers who are applying to new insurance networks.
- Work with private and public insurers to ensure parity of coverage for behavioral health care in line with Assembly Bill 181(http://search.leg.state.nv.us/isysquery/5c6d7ade-d095-4717-b5b1-dc17d0df9786/3/doc/AB181_EN.PDF#xml=http://WebApp/isysquery/5c6d7ade-d095-4717-b5b1-dc17d0df9786/3/hilite/), passed during the 2021 legislative session and the Mental Health Parity and Addiction Equity Act, updated and passed at the federal level in

2022 (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet).

- Support efforts to ensure para-professionals, such as Community Health Workers (CHWs) and Peer Recovery Support Specialists (PRSSs), can provide behavioral health system navigation and other appropriate services under the supervision of licensed behavioral health providers.
- Support efforts to ensure that appropriate behavioral health services provided by CHWs and PRSSs are reimbursable by Nevada Medicaid, and eventually CMS.
- Support efforts by any DHHS division to explore the development of a Managed Care Organization (MCO) coverage type for persons with complex behavioral health challenges to increase access to a broader type and number of care providers, specialty care programs, and facilities across the state.

PRIORITY AREA: WORKFORCE DEVELOPMENT

Lack of workforce availability, few placement options for local interns, and professional development opportunities

NUMBER AND TYPE OF PROVIDERS AVAILABLE
The chronic behavioral health provider shortage across Nevada has been well-documented for years but has reached a critical status since 2020. Proper resources must be allocated to support statewide efforts to educate and place providers in shortage areas across the state.

TRAINING IN BEST PRACTICES IN TELE-BEHAVIORAL HEALTH
While long-term solutions to fill in-person provider shortage gaps are underway, tele-behavioral health can be leveraged in many cases to connect community members with services. However, it is integral to the implementation of these services that providers are well-trained on how properly use tele-behavioral health to produce the best outcomes for the client.

CULTURALLY COMPETENT, RESPECTFUL, AND AGE-APPROPRIATE PRACTICES
Many providers who serve rural communities are providing services for clients from a variety of different backgrounds, ethnicities, religions, and age groups. It is vital to the quality and safety of patient care that providers have adequate training regarding practices that are culturally respectful and age-appropriate.

Possible Solutions:

- Development and implementation of a Behavioral Health Workforce Development Center, set within the Nevada System of Higher Education (NSHE), as proposed by Assembly Bill 37.
- Expanded student loan repayment and forgiveness programs for behavioral health providers serving communities documented as provider shortage areas.
- Expand options for professional development in best practices for tele-behavioral health.
- Expand options for foundational training and ongoing professional development that includes cultural competency, cultural respectfulness, and enable providers to appropriately serve clients from a broad spectrum of backgrounds, generations, and beliefs.
- Through training and technical assistance (TA), expand the number of clinical internship sites approved by the behavioral health licensing boards within rural, frontier, and underserved urban communities.
- Through training and technical assistance (TA), expand the number of graduate and clinical supervisors or preceptors approved by the behavioral health licensing boards within rural, frontier, and underserved urban communities. Special focus should be made

to include supervisors or preceptors with experience in high-need specialty areas, such as children's services.

- Continue to directly work with or support the work of other organizations who are working with behavioral health provider's occupational licensing boards to ensure consistency and expediency of licensure processes.
- Expand opportunities for professional development for existing professionals on the use of evidence-based and best practices for the provision of care.
- Expand opportunities for professional development in the areas of leadership, management, business planning, insurance billing, human resources, grant management, and other administrative skills for existing behavioral health providers in Nevada, in order to facilitate the ease of practice and maintaining a business in Nevada.

PRIORITY AREA: QUALITY OF CARE

Quality is affected by provider availability, wait times, training/utilization of best practices, and culturally respectful care.

IMPROVED CARE TRANSITIONS

Historically, care transitions among providers within and outside of the Rural Region have been "hit-and-miss", the quality and communication through which have been largely dependent on who is staffed at each organization, rather than being consistent across the staff. However, the most prominent problems with care transitions have been seen by persons leaving inpatient and/or high-intensity care in urban Nevada, and any attempts made to return to their home communities. Often, these patients are discharged from care in unfamiliar cities, with no access to food, water, medications, or other resources, other than some minimal transportation home (if that). In order to keep community members safe and in proper care, transitions between providers must be ameliorated and conducted in a way that keeps the patient's needs as the central focus.

IMPROVED COMMUNICATION AMONG PROVIDERS

In order to improve care transitions and case management, there must be tools or mechanisms in place that allow provider agencies to communicate with one another to ensure high-quality care of the client. This may include the use of MOUs, psychiatric advanced directives, ACT, AOT, or multi-disciplinary teams.

INCREASED SAFEGUARDS TO CARE QUALITY

In Nevada, there are few ways to meaningfully evaluate the quality of care received by behavioral health clients, and less can be done to protect these patients if the quality of care they are receiving is not appropriate. The Board will entertain supporting programs to evaluate and improve the quality of service provision across the state, but most pointedly, in the Rural Region.

Possible Solutions:

- Exploration, evaluation, and promotion of existing solutions to improving communications and case management without violating HIPAA and other confidentiality laws, including:
    - Use of MOUs among provider organizations to hold “closed door” meetings for specific case coordination.
    - Use of psychiatric advanced directives (PADs) to ensure the client’s wishes for care are being met when they are unable to make informed health decisions for themselves.
      Note: Use of PADs also allows the patient to agree to having pertinent information shared with outside agencies for care coordination purposes.
    - Use of shared referral platforms to standardize the coordination of care. Once proper training and standardization occurs, it’s theorized this will reduce the instance of missed opportunities for care, reduce miscommunication, and improve patient outcomes.
    - Expansion of Assertive Community Treatment (ACT) programs across the state.
    - Expansion of Assisted Outpatient Treatment (AOT) programs and jurisdictions across the state.
- Exploration, evaluation, and promotion of solutions that are new to Nevada for improving communication and care coordination, including:

    - Launch of an MCO through Nevada Medicaid for patients with complex behavioral health challenges, which would improve care coordination, coverage, and access to specialty or inpatient care.
    - Exploration and possible establishment of a statutory mechanism for multi-disciplinary team (MDT) care coordination for persons who have complex behavioral health challenges, and who don't meet the inclusion criteria for MDTs currently held through Nevada Aging and Disability Services (ADSD) or the Division of Child and Family Services (DCFS).
- Exploration, implementation, and evaluation of expanded programming to evaluate the quality of care experienced by behavioral health service utilizers. This may include patient satisfaction surveys, "secret shopper"-type programs, and other means to ensure patients are given appropriate care and the appropriate time.
- Improved communication of the availability of current mechanisms through which complaints regarding the quality of care can be made, and evaluation of how those reports or claims are investigated. This includes complaint mechanisms through Nevada DHHS divisions and provider licensing boards.
- Exploration of programs to reward providers for track records of excellent service provision, based on both quantitative and qualitative data, including patient experience and satisfaction outcomes.
- Ensure SAPTA-funded providers are evaluated for the use of evidence-based and best practices in patient care.

PRIORITY AREA: SUPPORTING LOCAL EFFORTS

Local agencies and coalitions of boots-on-the-ground providers and stakeholders have unique insight into the assets, needs, and challenges of communities.

COLLABORATION AND SUPPORT FOR ALIGNING EFFORTS OF LOCAL COALITIONS AND AGENCIES

There are several groups of highly experienced and passionate professionals, volunteers, and advocates across the Rural Region who are undertaking work to improve community behavioral health outcomes. The efforts and insight of these groups are valuable, and the Rural Regional Behavioral Health Policy Board will work to support and elevate the efforts of these groups that are aligned with both the needs of the community and evidence-based or best practices.

SUPPORT BEST USE OF OPIOID SETTLEMENT FUNDS

As all counties in Nevada are receiving some funding from the One Nevada Agreement opioid settlement, the Rural Regional Behavioral Health Policy Board will support local government efforts to use those funds in a way that both meets their intended purpose of addressing the opioid epidemic, as well as meeting the needs of the community. The Board and/or its Coordinator will provide technical assistance to local planning groups as able and appropriate.

EXPANSION OF LOCAL BEHAVIORAL HEALTH TASK FORCES

In collaboration with local stakeholders, coalitions, and other grass-roots efforts, the Board is directing its Coordinator to expand the establishment of county-level behavioral health task forces across the Rural Region, as communities are willing.

Possible Solutions:

- Implement local-level programs to reduce recidivism and/or chronic crisis, thus improving outcomes for patients or clients, and reducing unnecessary use of local emergency and CJS resources. Examples of programs to explore that have been launched successfully in Nevada that are not currently implemented in every community across the Rural Region include:
    - Mobile Outreach Safety Teams (MOST): co-response model including a law enforcement or other first response professional and a behavioral health provider. This model is really only feasible within smaller jurisdictions.
    - Virtual Crisis Care (VCC) or similar model: law enforcement and/or first responders have access to a behavioral health professional via telehealth in the field (using tablet or similar) to assess community members in crisis and advise courses of action.
    - Forensic Assessment Services Triage Team (FASTT): Mobile team response similar to MOST, but focuses on persons who are or are likely to be involved in the criminal justice system (CJS), but whose primary concerns center around their behavioral health challenges. For more information on FASTT, visit: https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/5826

    - Expansion of Mental Health Courts to all court systems in the Rural Region.
    - Expansion of Assertive Community Treatment (ACT) programming to provide coverage to all or most of the communities in the Rural Region (as of right now, only the City of Elko has coverage). ACT is a comprehensive program that includes wrap-around services for adults with mental illness and/or co-occurring disorders with substance misuse or abuse. These programs are housed within one parent agency, thus alleviating many concerns regarding case coordination and communications without violating HIPPA. Providers and support staff will meet the clients wherever they are, as they are, regardless of the situation. Currently, all Certified Community Behavioral Health Clinics (CCBHCs) in Nevada are required to provide ACT services within specified and limited areas. Patient participation in ACT programming is completely voluntary.
    - Expansion of Assisted Outpatient Treatment (AOT) programs across local court jurisdictions. AOT is nearly identical to ACT, but participation is court-mandated (non-voluntary). Currently, Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS) are the only two agencies providing AOT, and those services are limited to persons within the local court systems' respective jurisdictions (Washoe and Clark Counties).
- Support and provide technical assistance (TA) to local elected officials and governmental teams as they identify the best use of county or city funds appropriated to them through the One Nevada Agreement (opioid settlement dollars), including only evidence-based, best, or emerging practices. Programming with evidence speaking to lack of effectiveness will not be supported by the Rural Regional Behavioral Health Policy Board or its Coordinator.
- Support and provide technical assistance (TA) as necessary and able for local jurisdictions to complete assessments that enable them to apply for additional opioid settlement dollars from the State's portion of the Fund for Resilient Nevada.
- Provide support and TA, including program planning and evaluation support, for local jurisdictions who apply for additional funds from the Fund for Resilient Nevada.
- Support local coalitions and other nonprofit groups who undertake work to provide behavioral health programming to address stigma, awareness, behavioral health education, support for persons with behavioral health challenges, support for family members of those with behavioral health challenges, and other evidence-based practices.
- Where there is need and interest, expand the number of county-level behavioral health task forces across the region to bring together efforts to improve mental health and substance use outcomes.