Regional Behavioral Health Policy Boards Current Bill Drafts and/or Annual Report Overviews

February, 2023

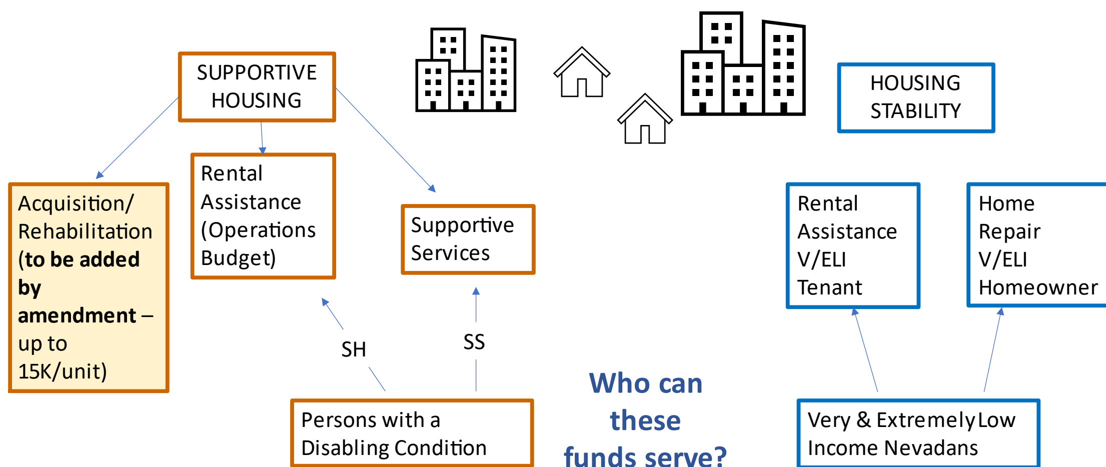
Clark Regional Behavioral Health Policy Board

Clark Regional Behavioral Health Policy Board – SB68 - Summary

Background information and Intent: It is recognized that multiple agencies, systems, and sources of federal, state, local, and philanthropic funding currently exist that seek to address mental health, substance abuse, homelessness, disabilities of all types, and unaffordability of housing. Creating a revenue stream to establish a Critical Needs fund will leverage these resources, while filling gaps where individuals and families may not meet other programs' eligibility criteria, always moving individuals receiving assistance toward other permanent sources of funding and toward greater self-sufficiency.

Proposal: Increase Real Property Transfer Tax by .20/$500 of sales value. Revenues – the Critical Needs Fund - shall be used to leverage existing federal, state, and philanthropic sources of funding for supportive housing, supportive services, and housing assistance for persons of very low and extremely low income (VL/ELI). This proposal is affordable at the residential and commercial & industrial levels. The tax on a $400,000 home sale would be $160; a recent $16.5M property sale to a leading technology company for a data warehouse would have added just $6,600 to the cost.

How can these funds be used?



Supportive housing combines affordability and supportive services, including intensive case management, appropriate to the population for which the housing was established – for example as permanent housing for persons with Severe Mental Illness, as supportive housing for persons in recovery from addiction, as transitional housing for unhoused persons who require supports while re-establishing their ability to participate in the workforce. In addition, Critical Needs funds not needed to create financial stability for supportive housing projects may be allocated to providing services for VL/ELI individuals and households with a disabling

Questions? Contact Char Frost, Chair, CRBHPB, charfrostnv@gmail.com
Or Sarah Adler, NAMI Policy Specialist, sarah@ssgr.us

condition. When these families have the supports they need, their participation in the workforce is not threatened, thus they retain housing stability and reduce family stress.

Thousands of individuals and families in Nevada are at risk of suffering behavioral health and addiction challenges due to the extreme stress of **housing instability**. Nevada has the largest gap between the number of affordable (subsidized) units available to Extremely Low Income households and the size of our ELI population. For this reason, and given that in many areas of Nevada providers of supportive housing are not yet established, a minimum of 25% of the Critical Needs Fund for each Behavioral Health Policy Board region will be allocated to Housing Stability and Affordability; it can be used as rental assistance or in rural areas for home repair.

Process and Allocation of Funds:
Annually, the amount of funds that accrue to the Critical Needs Fund of the Nevada Account for Affordable Housing will be certified by the Nevada Housing Division and reported to the Regional Behavioral Health Policy Boards.

No more than 10% of the fund annually can be used for administrative purposes by the Nevada Housing Division and the Department of Health and Human Services.

Funds will be allocated commensurate with the population served by the Regional Behavioral Health Policy Board, with a minimum of $500,000 per region.

Boards will, within 30 days of receipt of the information, make a decision on the percent of funds to be utilized as assistance to persons of VL/ELI (rental/home repair assistance) and the percent of funds to be allocated to supportive housing and supportive services. A minimum of 25% of the funds available shall be allocated to each of the two categories.

Funds allocated as assistance to persons of VL/ELI will be retained by the Nevada Housing Division, which will distribute the funds to the public housing authority that is aligned with each of the Regional Behavioral Health Policy Boards, to be utilized to create housing affordability with priority given to persons of lowest income.

For supportive housing developers and owners to obtain commitments of financing for construction of such projects, 10 to 15-year commitments of rental assistance, to assure operational feasibility, and of funding for supportive services, to provide essential tenancy supports, are necessary. Therefore, the Critical Needs funds may be awarded as three-year grants, committed for a 12 year period, with the condition that proper utilization of the funds and effective service delivery is reviewed annually. An amendment will be proposed upon bill introduction to allow for acquisition and rehabilitation of existing buildings (e.g. disused motels), with a cap of $15,000/unit. This will have the double benefit of revitalizing existing properties and creating supportive housing at a lower cost than through new construction. It is anticipated that Critical Needs grants will fill funding gaps and leverage substantial other sources of rental assistance (e.g. Housing Choice Vouchers) and supportive services.

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Funds allocated to supportive housing will be used in the following priority order: 1) as a commitment of rental assistance to supportive housing projects in an amount necessary to make the operations of that housing financially sustainable, 2) for services provided in conjunction with supportive housing projects, and 3) for services provided to individuals and families eligible to receive supportive services but who are not residents of supportive housing developments.

Funds identified in 1) above will be retained by the Nevada Housing Division, which will distribute the funds to the owner of the supportive housing development as rental assistance. Funds may be committed for a 12-year period, and allocated as three year grants, subject to annual performance review. Funds identified in 2) and 3) above will be transferred to the Department of Health and Human Services to be allocated through an annual competitive grants process. Funds for the purpose of 2) above may be committed for a 12-year period, and allocated as three-year grants, subject to annual performance review. Funds for the purpose of 3) above may be allocated in up to three-year grants, subject to annual performance review. To maximize the leverage of other sources of funds, it shall be a requirement for any person or household receiving this assistance that that they apply for other sources of assistance for which they are eligible, such as Veterans Administration housing assistance, federal HUD Housing Choice Vouchers, and Aging and Disability Service Division assistance.

Definitions

Supportive housing: Housing for which residents pay no more than 30% of their monthly income and which offers supportive services to assist at least one member, adult or child, with a disabling condition to achieve housing stability. (see NRS 278.01902 for how to define in connection to HUD income limits)

Disabling condition: A diagnosable substance use disorder, serious mental illness, serious emotional disturbance, developmental disability, intellectual disability or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.

Supportive services: Including but not limited to case management, and intensive services delivered at home or through care coordination related to physical and behavioral health, addiction treatment and recovery, trauma recovery, chronic disease management, treatment of intellectual, developmental, and/or physical disabilities, and other tenancy supports.

Persons eligible to receive supportive services: Immediate family members of, and individuals with, a disabling condition.

Very low income: Persons eligible to receive rental assistance or home repair are those below 50% of median monthly gross household income (see NRS 278.01902 for how to define in connection to HUD income limits). **Extremely low income:** Persons whose household income is 30% or less of median monthly gross household income.

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Washoe Regional Behavioral Health Policy Board

Washoe Regional Behavioral Health Policy Board (WRBHPB)

I. Annual Report Summary*

The WRBHPB membership, comprised of thirteen individuals who meet the professional criteria outlined in NRS 433.429 strive to increase awareness and understanding of mental health and substance use disorders, promote emotional health and wellness, address prevention of substance abuse disorders and mental illness, including those with serious mental illness and increase access to effective treatment and support recovery. The WRBHPB meets monthly, with the intent to hear from regional and statewide partners and stakeholders around issues, best practices, developments within the behavioral health community, program updates, fiscal concerns, and recommendations/requests for legislative concept(s) for the biennial Bill Draft Request. Below is a summary of the key behavioral health priorities on which the WRBHPB continues to focus. **** Priorities and board activities are also presented, pursuant to statutory mandate in an annual report which not only presents the work the board has done regionally in support of behavioral health but also provides recommendations and requests to the State for support, funding, legislation, etc. Expanded information regarding the board priorities, actions taken, and supportive behavioral health data can be found in the WRBHPB's annual report and the Washoe regional behavioral health profile. Both of these documents will be made available in February 2023***.

- **Crisis Response System**
  - Since its inception and in response to research and calls from the behavioral health community as a whole, the WRBHPB has focused on the need for a Crisis Response System within the region. Following the National Guidelines for Behavioral Health Crisis Care developed by SAMHSA, the board has supported crisis response system development efforts in Washoe County through the submission and ultimate passage of 2 different pieces of legislation in 2019 and 2021.
  - In June 2021, in support of the behavioral health focus area contained in the Washoe County Health District (WCHD) Community Health Improvement Plan (CHIP), the WCHD convened a planning project to support the implementation of a behavioral health crisis response system in the Washoe County region including the City of Reno, the City of Sparks, and Washoe County. With active involvement from key community members, including those with lived experience, members of the policy board as well as the Regional Behavioral Health Coordinator, Washoe County began to design the State of Nevada's first comprehensive Crisis Response System Implementation Plan (CRSIP) to address critical behavioral health crisis needs of the residents of the Washoe County region.
  - As Washoe region moves into the second and third year (implementation), the impact of and information gathered through several regional and statewide efforts is considered to help the WRBHPB inform the identification of other critical issues and priorities as well as the subject for the 2023 Bill Draft Request (described below).

- **Behavioral Workforce Development**
  - While the Crisis Response System Implementation effort is continuing to move forward, boosted by the passage of certain legislation and the availability of funding through State issued RFPs, the shortage of behavioral health workforce continued to impact decision making**.** Limited funding streams for behavioral health contribute to non-competitive salaries for the nation's behavioral health workforce. This forms the foundation of the workforce shortages that have developed over time and are now at a crisis point, including and especially in Washoe County and Nevada as a state. The board

acknowledged that we can stand up the most beautiful, well researched crisis facility but if we do not have staff (at all levels) to provide the required services, then we are looking at an effort in futility. The Behavioral Health Workforce continues to be a priority area for the WRBHPB.

- 3 million Nevadans reside in a Mental Health Professional Shortage Area (HPSA) or 94.5% of the state's population; 1.9 million Nevadans reside in a Primary Care HPSA or 67.3% of the state's population; 335,222 Washoe County residents live in a Primary Care HPSA (70.9%); and 297,118 Washoe County residents live in a Mental HPSA (62.9%). Having discussed and researched several important behavioral health concepts at great length, the WRBHPB voted on Behavioral Health Workforce Development for their BDR concept and will continue to view this issue as a priority. BDR 34-399 was ultimately assigned a bill number: **AB69**

- **Other Related Priorities:**
  - Workforce Diversity and Inclusion
  - Behavioral Health Needs of Children (Including Crisis Response system)
  - Accurate/Reliable Behavioral Health Data Collection and Resource Availability
  - Housing and Services for Homeless Individuals with Behavioral Health Needs

II. WRBHPB 2023 Legislation Summary: AB 69

- Main purpose to create a state level reimbursement program for behavioral health professionals to complement the existing state program run out of the Nevada Health Service Corps.
- Approves additional settings/criteria (not currently covered) for behavioral health professionals to qualify for tuition reimbursement. These include the crisis response system; faculty reimbursement (as we know one of the barriers to success is having available faculty to teach future professionals); and K12 where we know there is a shortage of behavioral health professionals.
- Participants in the program must commit to practice on a full-time basis for a minimum two years in In a hospital or other inpatient or outpatient setting; as a full-time faculty member with teaching responsibilities in a program of education or training for practitioners or providers of behavioral health care at an institution within the Nevada System of Higher Education; or provide behavioral health care to pupils in kindergarten through 12th grade in public schools in Nevada.
- Provider of behavioral health care who practices in a hospital, other inpatient setting or outpatient setting or provides crisis management services must accept certain forms of payment commonly used by elderly or economically disadvantaged patients; and provide services to all patients, regardless of their ability to pay.

Rural Regional Behavioral Health Policy Board

Cover Slide for Rural Regional Behavioral Health Policy Board Bill Presentation

RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

ELKO, EUREKA, HUMBOLDT, LANDER, PERSHING, AND WHITE PINE COUNTIES

Valerie Haskin, MA, MPH

Rural Regional Behavioral Health Coordinator

AB 37 Summary Presentation to the Nevada Governor's Commission on Behavioral Health

February 9, 2023

Rural RBHPB Concept for AB37
82nd (2023) Legislative Session

- Build out a robust pipeline for behavioral health providers in Nevada
- Based on successful models from Nebraska and Illinois
- Would incorporate and expand upon existing successful programs, and introduce new programs and connections across the educational system and professional licensing
- **AB 37 "Authorizes the establishment of the Behavioral Health Workforce Development Center of Nevada"**

Summary of AB 37

- Collaborate with School Districts to support and expand Career and Technical Education (CTE) Programming related to behavioral health professions in schools
- Collaborate with Area Health Education Centers (AHECs) to include focus on behavioral health professions
- Bolster efforts to support minority and disadvantaged youth in considering careers in behavioral health
- Look for ways to weave SEL and Mental Health support programs with students as leaders or peer supports to increase interest

Summary of AB 37

- Professional programs at NSHE focused upon:
  - Marriage and Family Therapy, Clinical Professional Counseling, Psychology, Psychiatry, Clinical Social Work, Behavior Analysts, all Drug and Alcohol Counselor types, and specialty medical tracks (psychiatric Nurse Practitioners, PAs, etc.)

Summary of AB 37

- Ensure undergraduate students are prepared for rigors of graduate school
- Ensure clear pathways for undergraduate education to graduate school are created (courses needed, application and test deadlines, testing preparation, etc.)
- Create easily-accessible opportunities for high-quality graduate and clinical internships/practicum, with an emphasis on creating opportunities to work with communities with least access to appropriate care (Rural, BIPOC, LGTBQ+, etc.) to ensure competent workforce with these experiences

Summary of AB 37

- Expand the number of approved internship sites and supervisors through targeted training and approval efforts.
- Work with licensing boards (not already doing so) to create processes to improve efficiency related to licensing for Nevadans, and those coming from out of state

Summary of AB 37

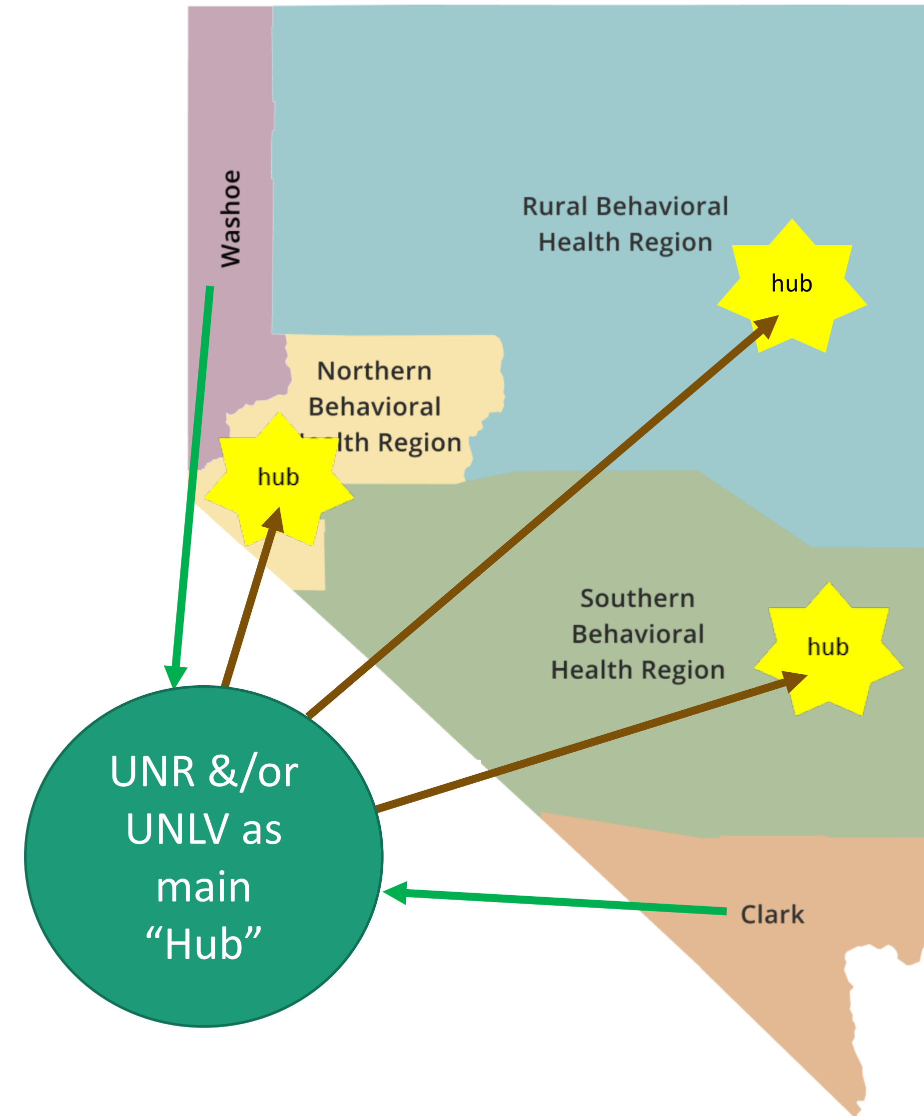
- Work with Nevada Health Corps and federal programs to help place providers in rural and underserved communities for longer-term practice for tuition assistance/forgiveness (existing programs)
- Identify opportunities to educate new providers on the "business" of practice in Nevada, including setting up insurance reimbursement, liability insurance, business licensing, etc.
- Recruit eligible providers as approved supervisors and/or sites for undergraduate, graduate, and clinical internships.

Intention for Infrastructure

- Not a brick-and-mortar “center”
- Fiscal note should be focused on programming and staffing, not on new buildings
- Remote work may promote collaboration across all NSHE institutions providing education for future behavioral health providers
- Allows for participation of staff representing multiple communities and may ease recruitment

"Hub-and-Spoke" Model for Infrastructure

- Main "Hub" within University of Nevada Institutions
- Spokes to regional "hubs" in each Behavioral Health Region where the Center is not otherwise represented
- Regional hubs will have specialty training or experiences to enrich both clinical training programs and to support local recruitment efforts



Advisory Consortium

- The work of the Center would be directed by an Advisory Consortium
- Make-up of the consortium would include:

(1) Institutions within the System;

(2) Providers of behavioral health care;

(3) The Department of Education and school districts;

(4) State and local law enforcement agencies;

(5) Consumers of behavioral health care;

(6) Family members of consumers of behavioral health care;

(7) Hospitals and other facilities that provide behavioral health care;

(8) The Department of Health and Human Services, the Department of Veterans Services, the Department of Employment, Training and Rehabilitation and other relevant agencies of this State selected by the Center;

(9) Sites that provide internships for providers of behavioral health care;

(10) Representatives of members of the Armed Forces of the United States and the National Guard who are on active duty, veterans and families of such members and veterans;

(11) Representatives of historically marginalized communities, including, without limitation:

(I) Lesbian, gay, bisexual, transgender and questioning persons; and

(II) Persons of color;

(12) Representatives of persons with disabilities; and

(13) Other relevant persons and entities, as selected by the Center.

Projected Fiscal Note

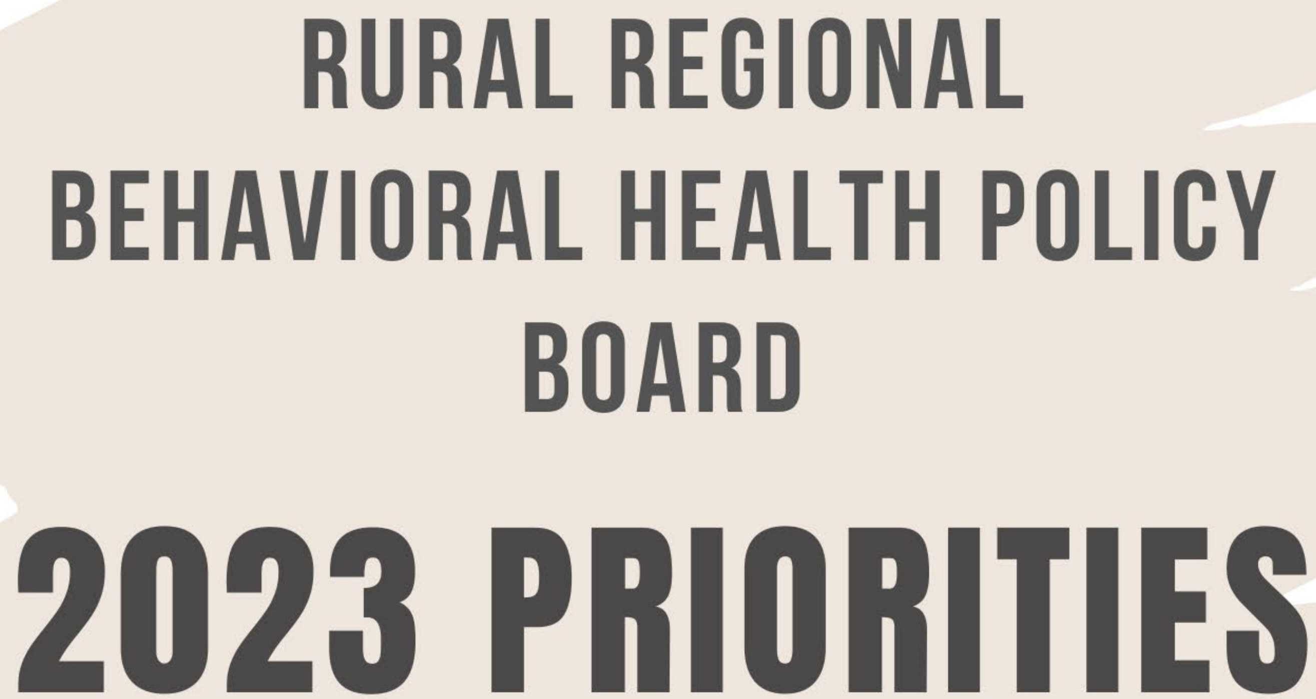
- ***Caution: final numbers have not yet been explored; will be working with NSHE to calculate actual fiscal note.***
- Initial estimates sit at approximately $2M/yr. through the Biennium ($4M total)
- Nebraska model worked with $1.3M - $1.6M, but focused only on psychology and psychiatry
- Argument: we are at a point where bolstering the workforce and enabling the expansion of treatment options to support persons is at crisis levels. We must address staffing shortages before we can fill gaps in services and meet the growing needs of Nevadans.

Contact Information

Valerie Haskin, MA, MPH

Rural Regional Behavioral Health Coordinator

vcauhape@thefamilysupportcenter.org

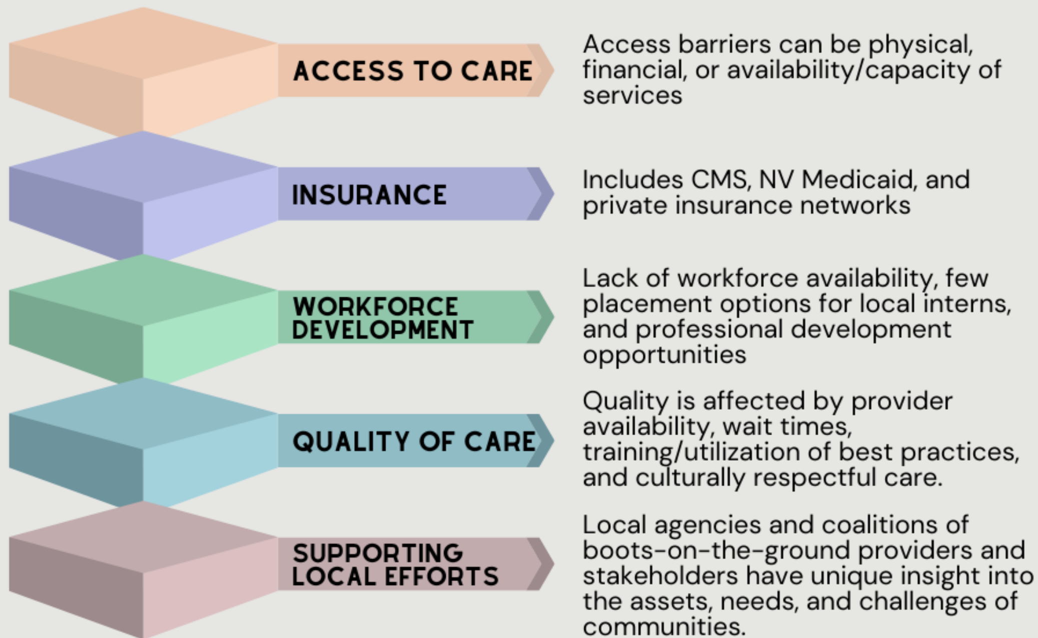


RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

2023 PRIORITIES

JANUARY 2023

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

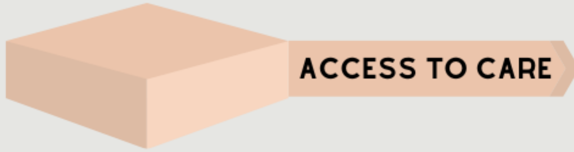


For 2023, the issues pertinent to the Rural Regional Behavioral Health Policy Board (Rural RBHPB) were organized into a group of broad priority areas, all tending to overlap and compound each other, but outlining the underlaying issues for the most critical behavioral health challenges faced by communities 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.

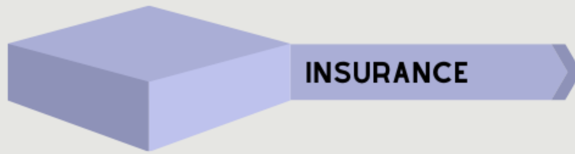
AVAILABILITY AND CAPACITY OF SERVICES

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.

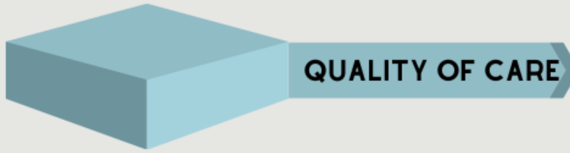
Possible Solutions:

- 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.

Overview of Assembly Bill 37

Developed by the Rural Regional Behavioral Health Policy Board

Background:

Nearly all of Nevada is considered a health care provider shortage area, with even more critical needs for more behavioral health providers across the state, as has been the case for many years (University of Nevada, Reno, School of Medicine, Office of Statewide Initiatives, 2023). While there are ideas to fill immediate gaps in service provision, ultimately, a long-term solution to improve the number of high-quality behavioral health providers licensed in Nevada is necessary to meet the ever-growing need.

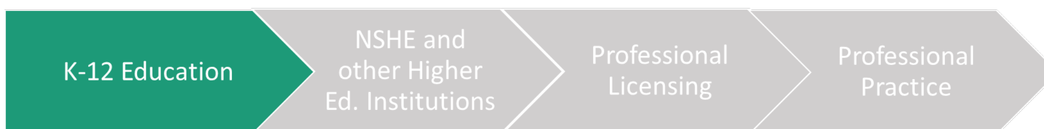
Purpose: To build out a robust pipeline for behavioral health providers in Nevada.

The behavioral health professional pipeline would be housed by a "center" within the Nevada System of Higher Education (NSHE), that would incorporate and expand upon existing successful programs, and introduce new programs and connections across the educational system and professional licensing.

Partner agencies would include: the Nevada Department of Education, local school districts, Area Health Education Centers (AHECs), educational nonprofits, all schools within the NSHE system, occupational licensing boards for behavioral health professionals, and economic development and professional development organizations.

The model proposed by Assembly Bill 37 is based on a successful model from Nebraska, and an emerging model from Illinois. Kentucky is also considering launching a similar center. Over the last ten years since its inception, the Behavioral Health Education Center of Nebraska (BHECN) saw a 32% increase in psychiatric prescribers and 39% increase among psychologists and mental health therapists.

How It Would Work



At the K-12 level, the Center would collaborate with school districts to support and expand Career and Technical Education (CTE) Programming related to behavioral health professions in schools. The Center would also collaborate with Area Health Education Centers (AHECs) to include focus on behavioral health professions. A special focus on bolstering efforts to support minority and disadvantaged youth in considering careers in behavioral health would be made. Finally, staff of the Center would look for ways to weave Social Emotional Learning (SEL) and Mental Health support programs with students as leaders or peer supports to increase interest in pursuing careers in these fields.

Professional programs at NSHE focused upon would include: Marriage and Family Therapy, Clinical Professional Counseling, Psychology, Psychiatry, Clinical Social Work, Behavior Analysts, all Drug and Alcohol Counselor types, and specialty medical tracks.

At the NSHE level, there are two main focuses of the Center. First, to ensure clear pathways for undergraduate education to graduate school are created (courses needed, application and test deadlines, testing preparation, etc.) and ensuring undergraduate students are prepared for rigors of graduate school. Second, the center would seek to partner with licensing boards and NSHE programs to create easily-accessible opportunities for high-quality graduate and clinical internships/practicum, with an emphasis on creating opportunities to work with communities with least access to appropriate care (Rural, BIPOC, LGTBQ+, etc.) to ensure competent workforce with these experiences.

Finding post-graduate professional education that's required for professional licensure is a challenge for many, if not all, emerging behavioral health providers in Nevada. As done at the NSHE level, the Center would work to expand the number of approved internship sites and supervisors by the appropriate licensing boards through targeted training and approval efforts.

Additionally, the Center would work with the licensing boards to create processes to improve efficiency related to licensing for Nevadans, and those coming from out of state. This has been the previous focus of the Rural Regional Behavioral Health Policy Board, but takes enough effort that it's not feasible for the Board or its Coordinator to maintain these functions on an ongoing basis.

Finally, the Center would work with Nevada Health Corps and federal programs to help place providers in rural and underserved communities for longer-term practice for tuition assistance or forgiveness programs, both those that already exist and to assist with the coordination of those that may come to be.

As most provider training programs do not include this information, the Center would identify opportunities to educate new providers on the "business" of practice in Nevada, including setting up insurance reimbursement, liability insurance, business licensing, and others as appropriate.

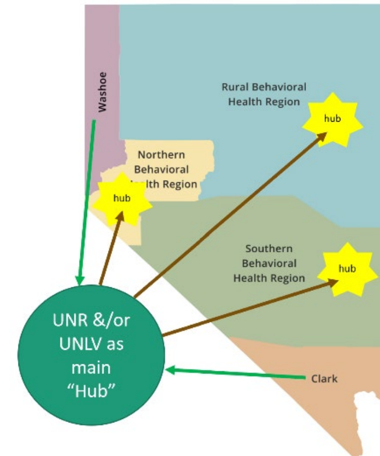
Lastly, the Center would seek to "close the circle" for providers by recruiting eligible providers as approved supervisors and/or sites for undergraduate, graduate, and clinical internships, particularly those who participated in the programs and services related to the Center.

Intention for Infrastructure

It is the belief of the Rural Regional Behavioral Health Policy Board and its stakeholders that this should not a brick-and-mortar “center”; rather the monies allotted to the center through the fiscal note should be focused on programming and staffing, not on new buildings. Remote work for staff may promote collaboration across all NSHE institutions providing education for future behavioral health providers, and also allows for recruitment of staff representing multiple communities.

“Hub and Spoke” Model

The structure of the Center will employ a “hub and spoke” model, with the main “Hub” sitting within University of Nevada Institutions (likely University of Nevada, Las Vegas, and/or Reno), with spokes to regional “hubs” in each Behavioral Health Region where the Center is not otherwise represented. These regional hubs will have specialty training or experiences to enrich both clinical training programs and to support local recruitment efforts, and will also provide an access point for persons within the rural and frontier communities to participate and access training or professional development opportunities.



Advisory Consortium

The work of the Center would be directed by an Advisory Consortium. Make-up of the consortium would include: Institutions within NSHE; providers of behavioral health care; the Department of Education and school districts; state and local law enforcement agencies; consumers of behavioral health care; family members of consumers of behavioral health care; hospitals and other facilities that provide behavioral health care; the Department of Health and Human Services, the Department of Veterans Services, the Department of Employment, Training and Rehabilitation and other relevant agencies of this State selected by the Center; sites that provide internships for providers of behavioral health care; representatives of members of the Armed Forces of the United States and the National Guard who are on active duty, veterans and families of such members and veterans; representatives of historically marginalized communities, including, without limitation, lesbian, gay, bisexual, transgender and questioning persons and persons of color; representatives of persons with disabilities; and other relevant persons and entities, as selected by the Center.

Fiscal Note

Caution: at the time this summary was submitted, the final fiscal note has not been completed. However, initial estimates sit at approximately $2M/yr. through the Biennium ($4M total). The Nebraska model worked with $1.3M - $1.6M, but focused only on psychology and psychiatry, so it is expected that more funding would bee needed. However, there are also already some organizations providing programs related to the Nevada Center, which would not be duplicated, thus the fiscal note is not expected to be larger in proportion to the greater number of provider types addressed.

It is the observation of the Rural Regional Behavioral Health Policy Board that Nevada is at a point where bolstering the workforce and enabling the expansion of treatment options to support persons is at crisis levels. We must address staffing shortages before we can fill gaps in services and meet the growing needs of Nevadans, which takes a coordinated, long-term approach.

For questions, comments, or concerns regarding AB 37, please contact:

Valerie Haskin, MA, MPH
Rural Regional Behavioral Health Coordinator
vcauhape@thefamilysupportcenter.org
(775) 300-3245

Fergus Laughridge,
Chair, Rural Regional Behavioral Health Policy Board
Health Director/Health Officer, Ft. McDermitt Tribal Wellness Center
Fergus.laughridge@fmcdwc.org

Sara Hunt, PhD
Assistant Dean of Behavioral Health Sciences
Director, UNLV Mental/Behavioral Health Training Coalition
Associate Professor
Psychiatry and Behavioral Health
University of Nevada, Las Vegas
sara.hunt@unlv.edu
Office: 702-929-3460

Northern Regional Behavioral Health Policy Board

AB9

Revises Provisions Governing Regional Behavioral Health Policy Boards

Northern Region Behavioral Health Policy Board

Taylor Allison, MBA, Chair of the Northern Regional Behavioral Health Policy Board

Cherylyn Rahr-Wood, MSW, Northern Regional Behavioral Health Coordinator

Board Members

Taylor Allison, MBA (Chair)
Ali Banister, PhD (Vice Chair)
Amy Hyne-Sutherland, PhD
Assemblywoman Robin Titus, MD
Erik Schoen
Lana Robards
Laura Yanez
Nicki Aaker, MSN, MPH, RN
Sandy Wartgow
Shayla Holmes
Sheriff Ken Furlong

**2 Vacant Position – Member representing private/public insurers: psychiatrist/psychologist*

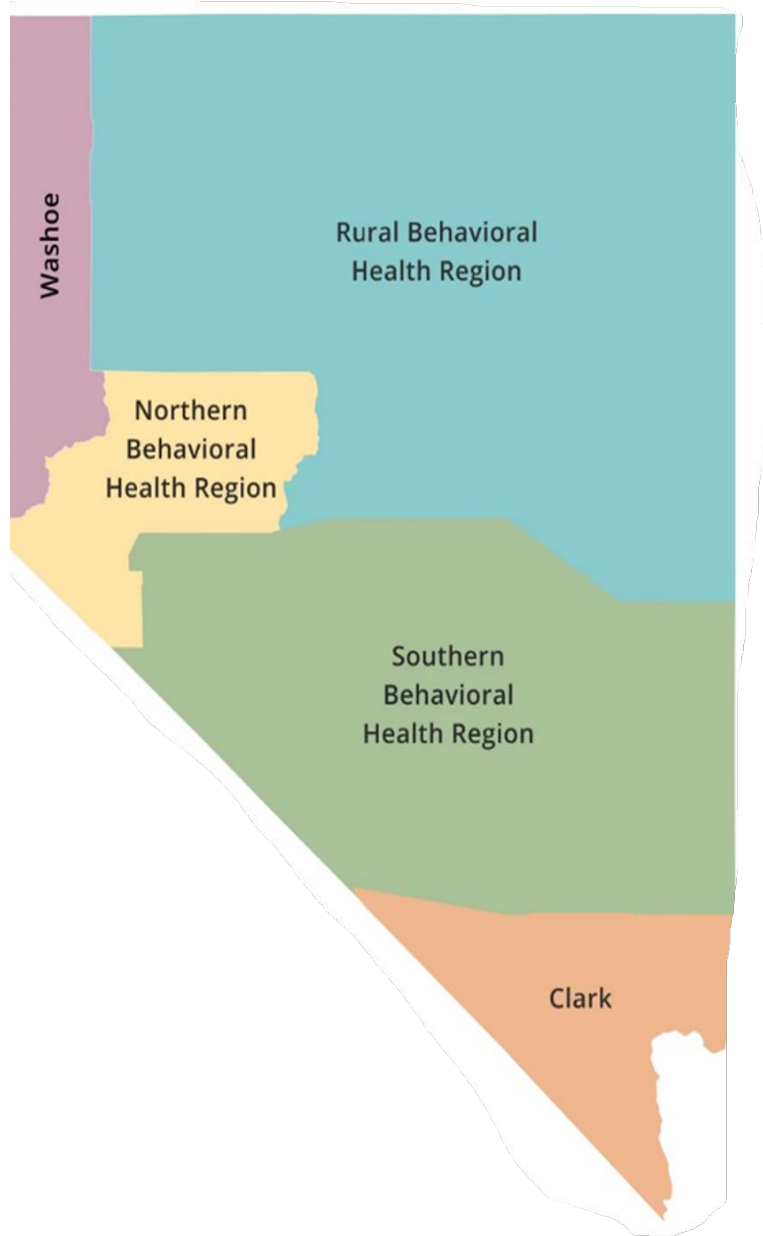
Northern Region Behavioral Health Policy Board

Established in 2017 Legislature (AB 366) and codified into NRS 433.

Updated in 2019 (AB 76) to develop five regions.

Each region is allocated 1 bill draft request to the Nevada Legislature.

Map of the regions



Nevada's Regional Behavioral Health Board Regions

Five regions:

Clark

Washoe

Rural

Northern Rural

Southern Rural

Board Duties

– as outlined in NRS 433.4295

"We must go back to the legislative intent of these boards. When they were being created. The idea was for the board of each region to get an overview of what the mental health needs were across the state of Nevada. Realizing that although there is crossover in the counties each region has its own distinct mental health issues. We are more of an advisory body to report back to the state, with our letters, reports, and recommendations. We share with the state." - Dr. Titus

Each Policy Board shall:

(1) Advise the Department, the Division of Public and Behavioral Health, and the Commission regarding

- *Behavioral Health needs of adults & children*
- *Any progress, problems, or proposed plans to improve regional behavioral health services*
- *Identify Gaps in region and make recommendations or service enhancements to improve or address gaps*
- *Priorities for allocating money to support and develop services*

(2) Promote improvements in the delivery of behavioral health

(3) Review the collection and reporting of behavioral health data to determine standards

(4) Coordinate and exchange information with other policy boards

(5) Establish an electronic data repository

(6) Track and compile data concerning persons placed on a Mental health crisis hold review

(7) Coordinate with other behavioral health entities in the state to avoid duplication of efforts

(8) submit an annual report to the Commission which includes the priorities and needs of the policy board's behavioral health region.

2022 Board Priorities

1. **Regional Board infrastructure***
2. Affordable and supportive housing and other social determinates of health
3. Behavioral health workforce with capability to treat youth and adults
4. Development of a sustainable regional crisis response system that integrates existing local crisis stabilization, jail diversion, and reentry resources (i.e., MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center)
5. Increase access to treatment at all levels of care
6. Develop services to support continuity of care (i.e., continuation of medication/ community health worker model)

2022 Regional Infrastructure Strategies

Explore Regional Behavioral Health Authority models

Sustain Regional Behavioral Health Coordinator and other support positions (i.e., Data Analyst, Grant Analyst, AA) necessary to fulfill Board duties described in NRS 433.4295

Research During the Interim

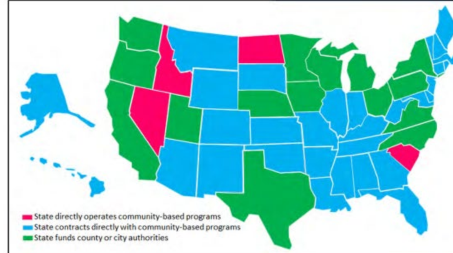
Nevada Department of
Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

2013

Comprehensive Gaps Analysis of
Behavioral Health Services

Prepared by Social Entrepreneurs, Inc.
Lisa Watson, MA
Kelly Marschall, MSW

Mental Health Governance:
A Review of State Models &
Guide for Nevada Decision Makers

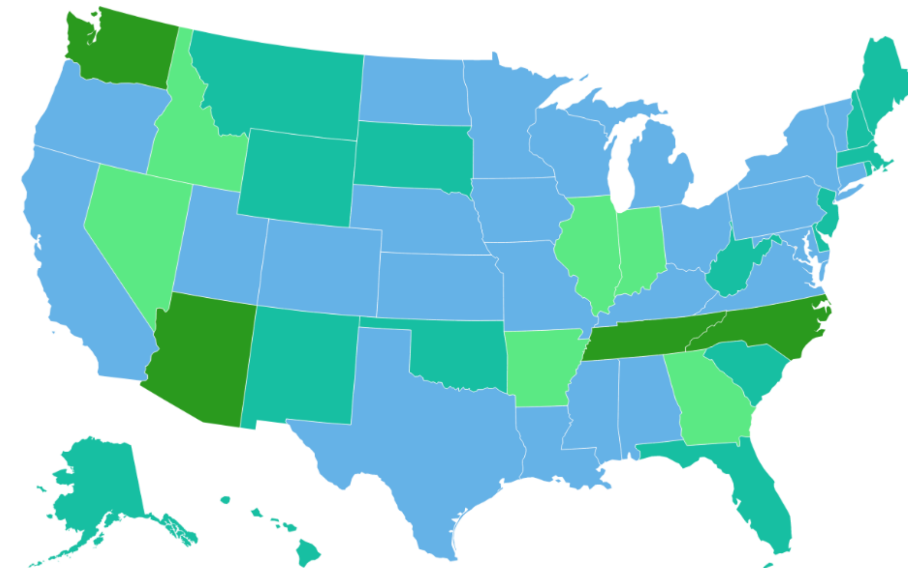


December 2014

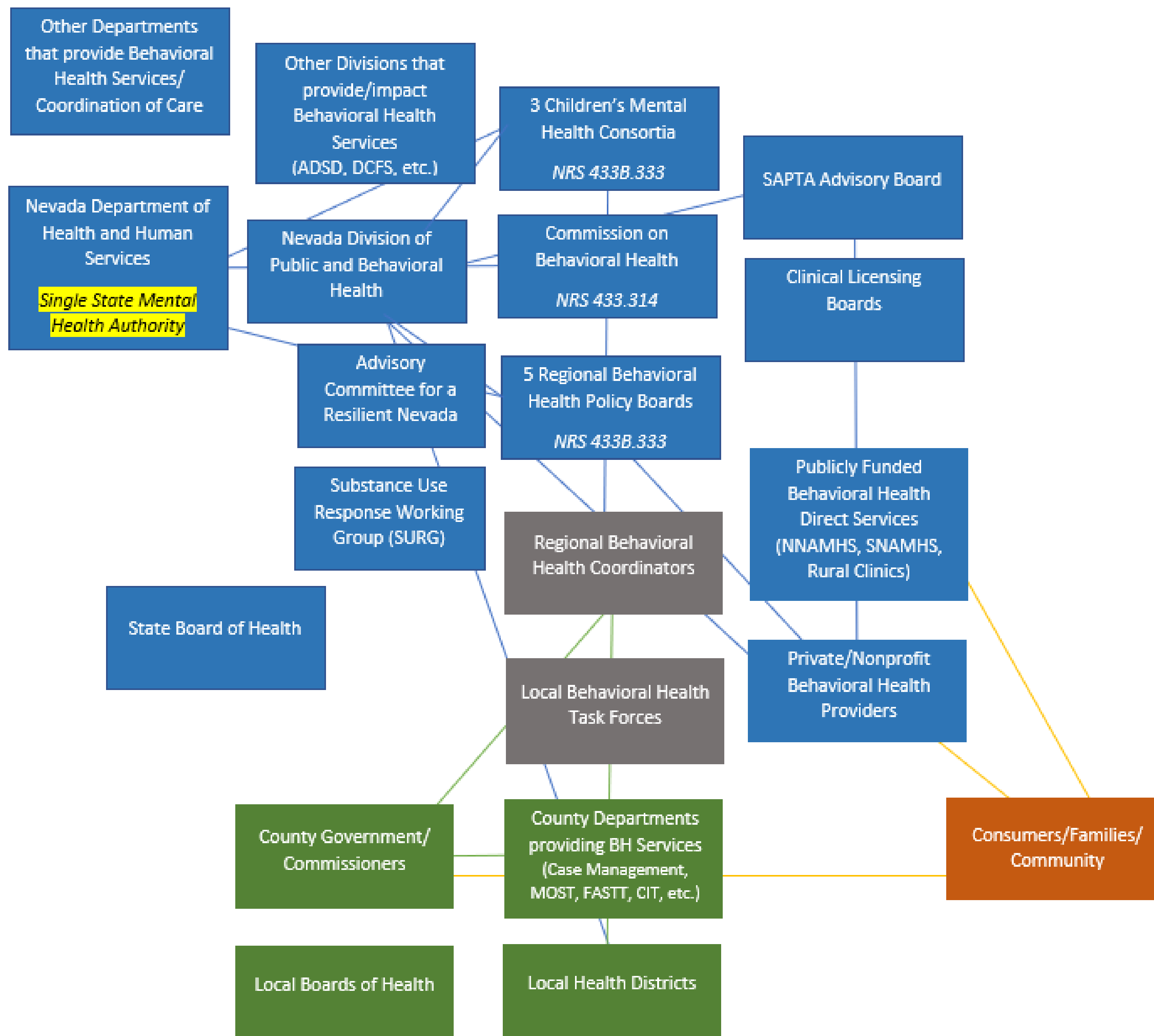
50 State/Regional/Local Behavioral Health Authorities

2022 Northern Nevada Regional Behavioral Health Policy Board conducted a review of state, regional, and local behavioral health authority models in all 50 states.

- Centralized State Behavioral Health Authority
- Hybrid State Authority/Community Board Coordination
- Local/Regional Behavioral Health Authorities
- Primarily Managed Care Models



Map: Nevada Northern Region Behavioral Health Policy Board • Created with Datawrapper



Enhancing Regional Behavioral Health Policy Boards is the first step towards infrastructure solutions.

The COVID-19 pandemic and increasing demand for behavioral health services have exacerbated gaps and inefficiencies in Nevada's behavioral health system, including over all limited capacity.

Proposed Solution

Expand Board duties to include:

- Employ such staff as is necessary to carry out the provisions of NRS 433.425 to .4295
- Encourage cooperation between entities that provide behavioral health in said region
- Identify behavioral health needs of communities – evaluate, resolve, develop plans and objectives relating to such needs
- Meet with behavioral health providers, participate in the development and implementation of long-range plans
- Develop cooperative working relationships with agencies and providers of Behavioral health services and or programs
- Perform such other duties as assigned by board

Sec. 2. ***1. A policy board may employ such staff as is necessary to carry out the provisions of NRS 433.425 to 433.4295, inclusive, and sections 2 of this act.***

Regional Board Staffing Needs:

- Five Regional Behavioral Health Coordinator (5.0 FTEs)
- 1.0 FTE administrative support position to assist 5 regional boards in complying with Open Meeting Law
- 1.0 FTE Data Analyst to the support the 5 regional boards

Allow Policy Boards to Appoint Staff necessary to Fulfill Duties

Working Together – Regional Coordination

(b) Encourage cooperation between state, local and tribal governmental entities and other persons and entities that provide behavioral health services in the behavioral health region;

(c) Identify the behavioral health needs of the community within the behavioral health region, evaluate the quality of behavioral health services in the behavioral health region, resolve problems relating to such needs and services and develop plans and objectives relating to such needs and services;

Identifying Behavioral Health need of region

d) Meet with providers of behavioral health services within the behavioral health region and participate in the development and implementation of long-range plans for the provision of behavioral health services in the behavioral health region;

Assisting in County Behavioral Health long-term Plans

(e) Develop cooperative working relationships with law enforcement agencies, providers of social services, advocacy agencies, providers of behavioral health services and other relevant persons and entities within the behavioral health region; and

Focus on Jail Diversion Programs - Collaboratively

Duties Assigned by Board

(f) Perform such other duties as are assigned by the policy board.

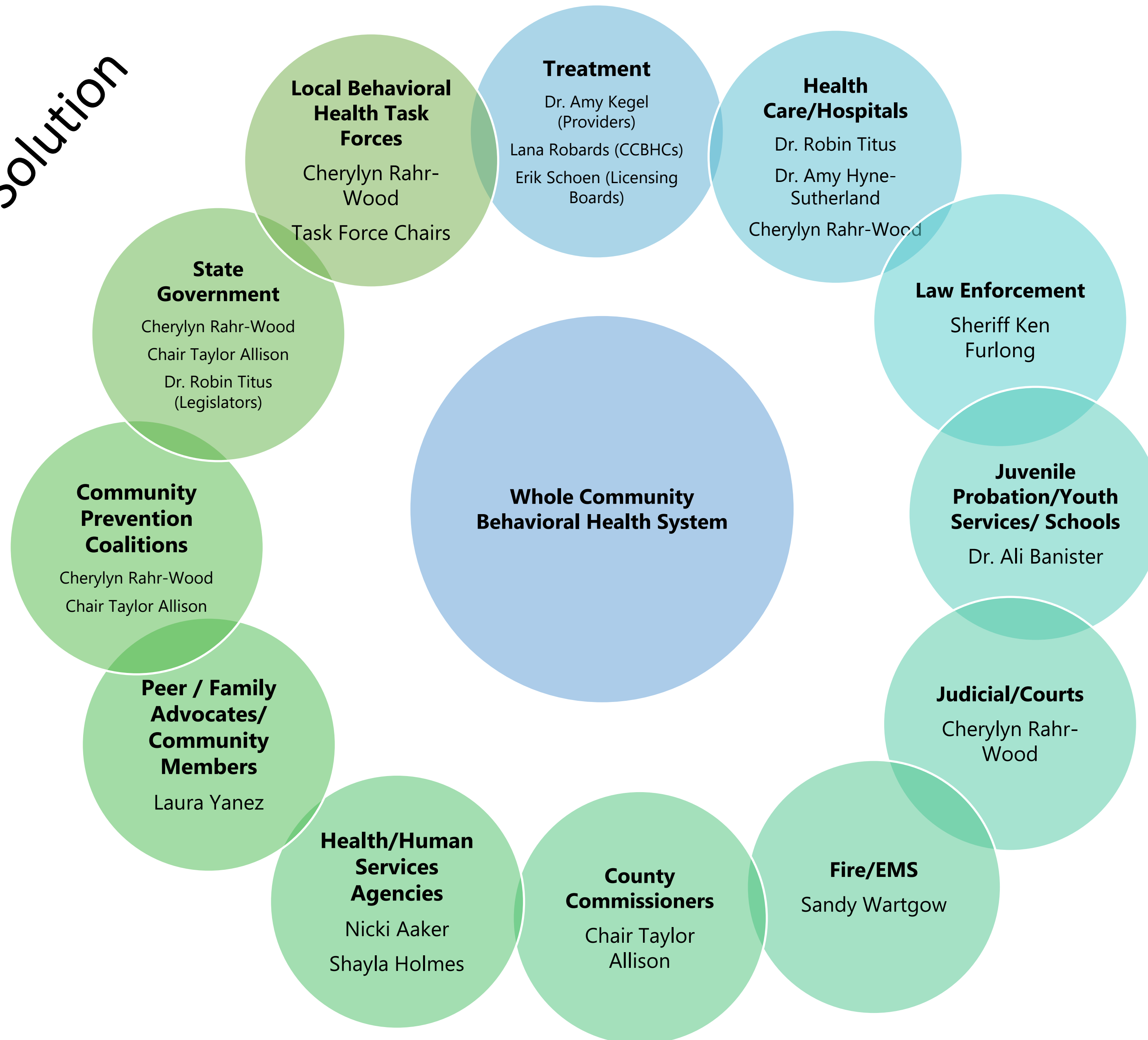
In summary

Following intensive community outreach and research on community-based local behavioral health authority models, the Northern Board identified a drastic change to the governance of our system was premature at this time.

There are infrastructure and capacity challenges that can be addressed now prior to a potential change in governance.

The proposed language is the first step towards formalizing community and statewide behavioral health systems and sustaining the essential Regional Behavioral Health Coordinators.

Whole Community Solution



Regional Policy Board Regions - BDRs

Clark: SB68 Supportive Housing through real property Transfer Tax

Rural: AB37 Authorizes the establishment of the Behavioral Health Workforce Development Center of Nevada

Washoe: AB69 Expands the loan repayment program administered by the Nevada Health Service Corps to include certain providers of behavioral health care.

Southern Rural: BDR 400 - withdrawn

Contact Information

Cherylyn Rahr-Wood

Northern Regional Behavioral Health Coordinator

Nevada Rural Hospital Partners

Cherylyn@nrhp.org

Northern Regional Behavioral Health Policy Board Bill AB 9

Although the Northern Regional Behavioral Health Policy Board focused on multiple priorities in 2022 writing their 82nd legislative session BDR was one of their main focuses. The original bill priority was the language change of NRS 433C enabling the development of a Regional Behavioral Health Authority. The Northern Regional Behavioral Health Policy Board spent the past two years researching other states who utilized a regional behavioral health authority plus researching local Nevada documents and reports such as the 2014 Guinn Center Report - Mental Health Governance: A Review of State Models & Guide for Nevada Decision Makers. As well as the 2013 DHHS DPBH - Comprehensive Gaps Analysis of Behavioral Health Services, we also looked at the newest report the Investigation of Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities - DOJ October 4th, 2022. Unfortunately, these are still relevant in that they read true to the issues Nevada is still facing when it comes to our overall behavioral health services.

Those documents and more aided in the discovery of behavioral health authorities in other states and helped the Board to see why Nevada needs to establish a behavioral health authority. The Coordinator and Board spent more time researching enabling language on how Nevada could stand up a regional behavioral health authority in statute or even if a regional behavioral health authority could work in Nevada. The Board and Coordinator even researched the already established 1975 language already scripted into statute as a possibility to work from.

Following the broader research, the board did intensive community outreach and research on community-based local behavioral health authority models. With that, the Northern Board identified a drastic change to the governance of our behavioral health system was premature. With advice from DHHS, DPBH, and local community stakeholders more modern language was needed as well as more county buy-in. It was noted that there are infrastructure and capacity challenges that need to be addressed now prior to a potential change in governance. This proposed language is the first step towards formalizing community and statewide behavioral health systems and sustaining the essential Regional Behavioral Health Coordinator.

During this time, the Northern Regional Board also heard several other proposed Bill Draft requests from professional groups, providers, and key stakeholders related to the behavioral health workforce shortage, community health worker models, as well as affordable and supportive housing solutions. Bu this Board ultimately voted to take the lead on exploring infrastructure solutions and has put forth a bill draft that does just that builds infrastructure first within the Board and provides enabling language to move forward in the future with the potential for a behavioral health authority model. It also helps to provide staffing for the board to fulfill their duties in accordance with NRS 433.

As the Board and Coordinator began working with the LCB, holes began to emerge in the original BDR385 language. The Board and Coordinator worked on developing more enabling language for the Behavioral Health Authority bill, but it still was not solid. This new endeavor would require more concise language to be researched and scripted.

Fast forward to January 5th, 2023, the Northern Regional Behavioral Health Policy Board voted to accept newly re-edited language added to NRS Chapter 433. This new language increases the Board's duties to be executed by the Regional Behavioral Health Policy Boards with a higher level of collaboration and cohesion between the Boards the Coordinators and the Behavioral Health Regions each board represents and solidifying their relationship in the statute. (AB9 is attached for the full version)

Here are the tentative changes to expand the Boards duties within NRS 433.425 to .4295:

- Employ such staff as is necessary to carry out the provisions of NRS 433.425 to .4295
- Encourage cooperation between entities that provide behavioral health in said region

- Identify behavioral health needs of communities – evaluate, resolve, and develop plans and objectives relating to such needs
- Meet with behavioral health providers, and participate in the development and implementation of long-range plans
- Develop cooperative working relationships with agencies and providers of Behavioral Health services and or programs
- Perform such other duties as assigned by Board

These proposed solutions for building infrastructure will aid in moving closer to a regional authority model as well as sustain the relationship between the Regional Policy Boards, their Coordinators, and the regions they serve.

SUMMARY—Revises provisions governing regional behavioral health policy boards. (BDR 39-385)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.

Effect on the State: Yes.

AN ACT relating to behavioral health; authorizing a regional behavioral health policy board to employ certain staff; requiring the Division of Public and Behavioral Health of the Department of Health and Human Services to provide certain assistance to a regional behavioral health policy board; authorizing a regional behavioral health policy board to engage in certain activities; prescribing certain duties of a regional behavioral health policy board~~; requiring each mental health consortium to submit a long-term strategic plan to the respective regional behavioral health policy boards;~~ and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law divides this State into five behavioral health regions and creates a regional behavioral health policy board for each region. (NRS 433.428, 433.429) Existing law requires each policy board to perform certain duties related to the oversight of behavioral health services in the behavioral health region and make certain recommendations concerning such services. (NRS 433.4295) **Section 2** of this bill authorizes a policy board to employ such staff as is necessary to

carry out the responsibilities of the policy board. **Section 2** requires the Division of Public and Behavioral Health of the Department of Health and Human Services to provide any additional personnel, facilities, equipment and supplies required by the policy board to perform its duties.

~~**Section 3** of this bill authorizes a policy board to: (1) enter into certain contracts and agreements; (2) apply for and accept gifts, grants, donations and bequests; and (3) award competitive grants to governmental entities and nonprofit organizations for the provision of behavioral health services. **Section 3** also authorizes a policy board to participate in other activities as necessary to address the behavioral health needs of the behavioral health region, carry out its duties or improve behavioral health services in the behavioral health region. **Section 3** additionally prescribes requirements governing the accounting of gifts, grants, donations and bequests accepted by a policy board.~~ **Section 4** of this bill makes a conforming change to indicate the proper placement of **sections 2** ~~**and 3**~~ in the Nevada Revised Statutes. **Section 5** of this bill requires a policy board to: (1) coordinate with the Department to increase awareness of issues relating to behavioral health and avoid duplication of efforts; ~~and (2) evaluate and monitor behavioral health services provided to recipients of Medicaid and recipients of insurance provided pursuant to the Children's Health Insurance Program by managed care organizations in the behavioral health region.~~

~~Existing law establishes certain mental health consortiums within this State to develop and carry out a long-term strategic plan for the provision of mental health services to children with emotional disturbance in the jurisdiction of the consortium. (NRS 433B.333-433B.339) Under existing law, each mental health consortium is required to submit its long-term strategic plan to the Director of~~

~~the Department of Health and Human Services. (NRS 433B.335) **Section 6** of this bill requires each consortium to also submit its long-term strategic plan to each policy board whose behavioral health region is within the jurisdiction of the respective consortium. **Section 3** authorizes a policy board to perform certain activities to carry out such a long-term strategic plan~~.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 433 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. ***1. A policy board may employ such staff as is necessary to carry out the provisions of NRS 433.425 to 433.4295, inclusive, and sections 2 and 3 of this act.***

2. The staff of a policy board may:

~~***(a) Coordinate and maximize the integration of services and programs for mental health and substance use disorder, including, without limitation, opioid use disorder, within the behavioral health region;***~~

(b) Encourage cooperation between state, local and tribal governmental entities and other persons and entities that provide behavioral health services in the behavioral health region;

(c) Identify the behavioral health needs of the community within the behavioral health region, evaluate the quality of behavioral health services in the behavioral health region, resolve

problems relating to such needs and services and develop plans and objectives relating to such needs and services;

(d) Meet with providers of behavioral health services within the behavioral health region and participate in the development and implementation of long-range plans for the provision of behavioral health services in the behavioral health region;

(e) Develop cooperative working relationships with law enforcement agencies, providers of social services, advocacy agencies, providers of behavioral health services and other relevant persons and entities within the behavioral health region; and

(f) Perform such other duties as are assigned by the policy board.

3. The Division shall provide any additional personnel, facilities, equipment and supplies required by the policy board to carry out the provisions of NRS 433.425 to 433.4295, inclusive, and sections 2 and 3 of this act.

~~**Sec. 3.** ***1. A policy board may:***~~

~~***(a) Enter into contracts and agreements for the purpose of carrying out the provisions of NRS 433.425 to 433.4295, inclusive, and sections 2 and 3 of this act or the long-term strategic plan prepared pursuant to NRS 433B.335 by the mental health consortium that has jurisdiction over the behavioral health region.***~~

~~***(b) Apply for and accept gifts, grants, donations and bequests from any source for the purpose of carrying out the provisions of NRS 433.425 to 433.4295, inclusive, and sections 2 and 3 of this act or the long-term strategic plan prepared pursuant to NRS 433B.335 by the mental health consortium that has jurisdiction over the behavioral health region.***~~

~~(c) Award competitive grants to regional, local or tribal governmental entities and nonprofit organizations that provide behavioral health services within the behavioral health region. The policy board shall:~~

~~(1) Ensure that each governmental entity or nonprofit organization that receives a grant pursuant to this paragraph funds and provides behavioral health services in an equitable manner;~~

~~(2) Ensure that each provider of behavioral health services funded pursuant to this paragraph holds any required license, certificate or registration and is otherwise properly qualified to provide such services under Nevada law; and~~

~~(3) Require each governmental entity or nonprofit organization that receives a grant pursuant to this paragraph to submit to the policy board an annual report describing all behavioral health services funded by the grant and all expenditures of money from the grant.~~

~~(d) Participate in other activities as necessary to:~~

~~(1) Address the needs identified in the annual report submitted to the Commission pursuant to NRS 433.4295 or the long-term strategic plan prepared pursuant to NRS 433B.335 by the mental health consortium that has jurisdiction over the behavioral health region;~~

~~(2) Carry out the provisions of NRS 433.425 to 433.4295, inclusive, and sections 2 and 3 of this act or the long-term strategic plan prepared pursuant to NRS 433B.335 by the mental health consortium that has jurisdiction over the behavioral health region; or~~

~~(3) Improve the provision of behavioral health services in the behavioral health region or otherwise address the needs of the behavioral health region with regard to such services.~~

~~***2. Any money accepted pursuant to subsection 1:***~~

~~***(a) Must be deposited in the State Treasury and accounted for separately in the State General Fund; and***~~

~~***(b) Except as otherwise provided by the terms of a specific gift, grant, donation or bequest, must only be expended under the direction of the policy board that accepted the money to carry out the provisions of NRS 433.425 to 433.4295, inclusive, and sections 2 and 3 of this act.***~~

~~***3. The Administrator shall administer the account maintained pursuant to subsection 2 for each policy board.***~~

~~***4. The interest and income earned on the money in an account maintained pursuant to subsection 2, after deducting any applicable charges, must be credited to the account. Any money remaining in the account at the end of the fiscal year does not revert to the State General Fund, and the balance in the account must be carried forward to the next fiscal year. All claims against the account must be paid as other claims against the State are paid.***~~

Sec. 4. NRS 433.425 is hereby amended to read as follows:

433.425 As used in NRS 433.425 to 433.4295, inclusive, ***and sections 2*** ~~***and 3***~~ ***of this act,*** unless the context otherwise requires, the words and terms defined in NRS 433.426 and 433.427 have the meanings ascribed to them in those sections.

Sec. 5. NRS 433.4295 is hereby amended to read as follows:

433.4295 1. Each policy board shall:

(a) Advise the Department, Division and Commission regarding:

(1) The behavioral health needs of adults and children in the behavioral health region;

(2) Any progress, problems or proposed plans relating to the provision of behavioral health services and methods to improve the provision of behavioral health services in the behavioral health region;

(3) Identified gaps in the behavioral health services which are available in the behavioral health region and any recommendations or service enhancements to address those gaps;

(4) Any federal, state or local law or regulation that relates to behavioral health which it determines is redundant, conflicts with other laws or is obsolete and any recommendation to address any such redundant, conflicting or obsolete law or regulation; and

(5) Priorities for allocating money to support and develop behavioral health services in the behavioral health region.

(b) Promote improvements in the delivery of behavioral health services in the behavioral health region.

(c) Coordinate and exchange information with the other policy boards to provide unified and coordinated recommendations to the Department, Division and Commission regarding behavioral health services in the behavioral health region.

(d) Review the collection and reporting standards of behavioral health data to determine standards for such data collection and reporting processes.

(e) To the extent feasible, establish an organized, sustainable and accurate electronic repository of data and information concerning behavioral health and behavioral health services in the behavioral health region that is accessible to members of the public on an Internet website

maintained by the policy board. A policy board may collaborate with an existing community-based organization to establish the repository.

(f) To the extent feasible, track and compile data concerning persons placed on a mental health crisis hold pursuant to NRS 433A.160, persons admitted to mental health facilities and hospitals under an emergency admission pursuant to NRS 433A.162, persons admitted to mental health facilities under an involuntary court-ordered admission pursuant to NRS 433A.200 to 433A.330, inclusive, and 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.

(g) If a data dashboard is established pursuant to NRS 439.245, use the data dashboard to review access by different groups and populations in this State to behavioral health services provided through telehealth, as defined in NRS 629.515, and evaluate policies to make such access more equitable.

(h) Identify and coordinate with other entities in the behavioral health region and this State that address issues relating to behavioral health, ***including, without limitation, the Department,*** to increase awareness of such issues and avoid duplication of efforts.

~~(i)~~ ~~***Evaluate and monitor behavioral health services provided to recipients of Medicaid and recipients of insurance provided pursuant to the Children's Health Insurance Program by***~~

~~***managed care organizations in the behavioral health region and identify gaps in such services and barriers to the effective provision of such services.***~~

(j) In coordination with existing entities in this State that address issues relating to behavioral health services, submit an annual report to the Commission which includes, without limitation:

(1) The specific behavioral health needs of the behavioral health region;

(2) A description of the methods used by the policy board to collect and analyze data concerning the behavioral health needs and problems of the behavioral health region and gaps in behavioral health services which are available in the behavioral health region, including, without limitation, a list of all sources of such data used by the policy board;

(3) A description of the manner in which the policy board has carried out the requirements of paragraphs (c) and (h) and the results of those activities; and

(4) The data compiled pursuant to paragraph (f) and any conclusions that the policy board has derived from such data.

2. A report described in paragraph ~~[(i)]~~ ***(j)*** of subsection 1 may be submitted more often than annually if the policy board determines that a specific behavioral health issue requires an additional report to the Commission.

~~***3. As used in this section, "managed care organization" has the meaning ascribed to it in NRS 695G.050.***~~

~~**Sec. 6.** NRS 433B.335 is hereby amended to read as follows:~~

~~433B.335 1. Each mental health consortium established pursuant to NRS 433B.333 shall prepare and submit to the Director of the Department~~ ~~***and each regional behavioral health policy***~~

~~***board created pursuant to NRS 433.429 for a behavioral health region that is within the jurisdiction of the consortium***~~ ~~a long-term strategic plan for the provision of mental health services to children with emotional disturbance in the jurisdiction of the consortium. A plan submitted pursuant to this section is valid for 10 years after the date of submission, and each consortium shall submit a new plan upon its expiration.~~

~~2. In preparing the long-term strategic plan pursuant to subsection 1, each mental health consortium must be guided by the following principles:~~

~~(a) The system of mental health services set forth in the plan should be centered on children with emotional disturbance and their families, with the needs and strengths of those children and their families dictating the types and mix of services provided.~~

~~(b) The families of children with emotional disturbance, including, without limitation, foster parents, should be active participants in all aspects of planning, selecting and delivering mental health services at the local level.~~

~~(c) The system of mental health services should be community-based and flexible, with accountability and the focus of the services at the local level.~~

~~(d) The system of mental health services should provide timely access to a comprehensive array of cost-effective mental health services.~~

~~(e) Children and their families who are in need of mental health services should be identified as early as possible through screening, assessment processes, treatment and systems of support.~~

~~(f) Comprehensive mental health services should be made available in the least restrictive but clinically appropriate environment.~~

~~(g) The family of a child with an emotional disturbance should be eligible to receive mental health services from the system.~~

~~(h) Mental health services should be provided to children with emotional disturbance in a sensitive manner that is responsive to cultural and gender-based differences and the special needs of the children.~~

~~3. The long-term strategic plan prepared pursuant to subsection 1 must include:~~

~~(a) An assessment of the need for mental health services in the jurisdiction of the consortium;~~

~~(b) The long-term strategies and goals of the consortium for providing mental health services to children with emotional disturbance within the jurisdiction of the consortium;~~

~~(c) A description of the types of services to be offered to children with emotional disturbance within the jurisdiction of the consortium;~~

~~(d) Criteria for eligibility for those services;~~

~~(e) A description of the manner in which those services may be obtained by eligible children;~~

~~(f) The manner in which the costs for those services will be allocated;~~

~~(g) The mechanisms to manage the money provided for those services;~~

~~(h) Documentation of the number of children with emotional disturbance who are not currently being provided services, the costs to provide services to those children, the obstacles to providing services to those children and recommendations for removing those obstacles;~~

~~(i) Methods for obtaining additional money and services for children with emotional disturbance from private and public entities; and~~

~~(j) The manner in which family members of eligible children and other persons may be involved in the treatment of the children.~~

~~4. On or before January 31 of each even-numbered year, each mental health consortium shall submit to the Director of the Department and the Commission:~~

~~(a) A list of the priorities of services necessary to implement the long-term strategic plan submitted pursuant to subsection 1 and an itemized list of the costs to provide those services;~~

~~(b) A description of any revisions to the long-term strategic plan adopted by the consortium during the immediately preceding year; and~~

~~(c) Any request for an allocation for administrative expenses of the consortium.~~

~~5. In preparing the biennial budget request for the Department, the Director of the Department shall consider the list of priorities and any request for an allocation submitted pursuant to subsection 4 by each mental health consortium. On or before September 30 of each even-numbered year, the Director of the Department shall submit to each mental health consortium a report which includes a description of:~~

~~(a) Each item on the list of priorities of the consortium that was included in the biennial budget request for the Department;~~

~~(b) Each item on the list of priorities of the consortium that was not included in the biennial budget request for the Department and an explanation for the exclusion; and~~

~~(c) Any request for an allocation for administrative expenses of the consortium that was included in the biennial budget request for the Department.~~

~~6. On or before January 31 of each odd-numbered year, each consortium shall submit to the Director of the Department and the Commission:~~

~~(a) A report regarding the status of the long-term strategic plan submitted pursuant to subsection 1, including, without limitation, the status of the strategies, goals and services included in the plan;~~

~~(b) A description of any revisions to the long-term strategic plan adopted by the consortium during the immediately preceding year; and~~

~~(c) A report of all expenditures made from an account maintained pursuant to NRS 433B.339, if any.~~

Sec. 7. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 6, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On July 1, 2023, for all other purposes.

Northern Regional Behavioral Health Policy Board (NRBHPB)

Board Introduction and Overview

Current Board Members and Point of Contact (NRS 433.429)*

Taylor Allison (Board Chair) Emergency Manager - Lyon County	**Dr. Ali Banister** (Board Vice-Chair) Juvenile Probation Chief First Judicial District
Dr. Robin Titus Senator, Legislative Member	**Dr. Amy Hynes- Sutherland** Public Health Coordinator, Nevada Association of Counties
Nicki Aaker RN, Director, Carson City Health and Human Services	**Ken Furlong** Sheriff Carson City
Erik Schoen Executive Director, Community Chest	**Sandy Wartgow** Carson City Fire Department
Lana Robards Director, New Frontier Treatment Center, Fallon, Nevada	**Laura Yanez** Executive Director, NAMI Western Nevada
Shayla Holmes Executive Director, Lyon County Health and Human Services	*Currently the Northern Board is down two members, recruitment is ongoing

Point of Contact:
Cherylyn Rahr-Wood, MSW
Northern Regional Behavioral Health Coordinator
cherylyn@nhrp.org

Northern Region Demographics and Characteristics

- *Current Population: Estimated to be reaching 200,000 (197,825actual)*
- *Counties Included: Carson, Churchill, Douglas, Lyon, and Storey.*
- *Total Area: Approximately 11,976.95 square miles of rural and frontier*
  Population breakdown by county: InstantAtlas™ Report (unr.edu)-2022
  Carson:57,446
  Churchill:26,793
  Douglas:50,076
  Lyon:59,035
  Storey:4,475
- *Racial/Ethnic Groups: 74.1% of the residents in the Northern Region are White not of Hispanic origin, 16.6% of residents are Hispanic, 3.2% of the population are Native American, 2.4% Asian, and 1.9% of the population are Black or African American.*

- *Veteran population:19,400*

(U.S. Census Bureau, 2020)

Health Care Availability:

- 3 Rural Hospitals: Carson Valley Medical (Gardnerville), Carson-Tahoe (Carson City), South Lyon Medical (Yerington), Banner Churchill Community Hospital (Fallon) Note all these hospitals now have some type of behavioral health professional(s) on staff and have focused on increasing access to these services.
- 3 Tribal Health Clinics: Fallon Paiute-Shoshone (Churchill), Yerington/Campbell (Lyon), Washoe Ranches/Dresslerville/Stewart (Douglas)
- 6 Mental Health Clinics: Rural Clinics Carson/Carson Tahoe Behavioral Health Services/Counseling Center & Supportive Services (Carson), Rural Clinics Fernley (Churchill), Rural Clinics Dayton/Rural Clinics Silver Springs (Lyon)
- 4 CCBHCs: Rural Nevada Counseling (Lyon), Vitality Unlimited/Community Counseling Center (Carson), New Frontier (Churchill)
- 2 Community Health Centers: Virginia City Community Health Center (Storey), Sierra Nevada Health Center (Carson)

2022 Board Priorities

In 2022 this board went through some dramatic changes such as Board member reassignments, the loss of members, and the retirement of their long-time Coordinator. The following priorities are presented to include underlying needs and gaps, strategies utilized by the Northern Board, and recommendations from the Northern Board for forward progress.

1. **Regional Board infrastructure development -** Several areas have been identified where additional infrastructure could lead to greater efficiency as the Northern region works to develop a more sophisticated behavioral health system.

   Strategies: Explore Regional Behavioral Health Authorities – In May 2022, the Northern Board established a formal multidisciplinary subcommittee to explore concepts for regional behavioral health authorities and models to increase system efficiency/ The Northern Board developed and submitted a concept paper for Regional Behavioral Health Authorities to DHHS to express their intent. (Please see the Northern Region's white paper of Behavioral Health Authorities at https://nvbh.org/northern-behavioral-health-region/). Sustain Board Support Positions – advocate for sustainable funding for Regional Behavioral Health Coordinator and regional data analyst positions. These positions provide the support necessary for the Board to fulfill duties described in NRS 433.4295. Implement Northern Region Behavioral Health Emergency Operations Plan (BHEOP) – Support local emergency management agencies in formally adopting the regional BHEOP approved by the Board in early 2021. Implement after-actions identified in the 2022 regional BHEOP tabletop exercise, including expanding awareness of psychological first aid training across all regions.

2. **Affordable and supportive housing and other social determinants of health -** The region's communities are experiencing many individuals who have behavioral health issues and are homeless. These individuals with complex needs deteriorate on the street or become stuck in hospitals or jails for prolonged periods of time with no safe discharge plan available. In addition, the board sees a gap in resources to address social determinants of health. There is no supportive housing aligned with best practices for residents with mental health issues in the region.

   Strategies: The Board established a formal subcommittee to address affordable and supportive housing solutions in January 2022. The Northern Region Behavioral Health Housing Subcommittee established the following recommendations that were adopted formally by the Northern Regional Behavioral Health Policy Board on May 5, 2022: Advocate for the State to fund regional housing assessments and systems modeling by organizations such as Corporation for Supportive Housing, recommend the Nevada Division of Housing consider an equitable distribution of the $500 million Home Means Nevada Housing initiative dedicated to supportive housing to create opportunities for all five behavioral health regions, advocate for sustainable supportive housing, support State and local agencies in the development of 1915i and other applicable home and community-based programs to encourage people-centered services.

3. **Behavioral health workforce with the capability to treat adults and youth (all ages) -** The Northern Region faces significant barriers caused by a lack of behavioral health workforce and difficulties that behavioral health professionals encounter in becoming in-network providers for insurance reimbursement. This gap impedes timely access to treatment and prevents providers from expanding quality services. In addition, the Northern Board recognizes that the community health worker (CHW) and peer recovery support specialists (PRSS) are underutilized in the behavioral health workforce pipeline.

   Strategies: The Northern Board supports a tiered approach for a calibrated mental health system that includes a robust relationship between clinicians, CHWs, and PRSSs. Following this model, the Northern Board has been exploring strategies to increase the clinical workforce and expand the use of CHWs and PRSSs to bridge the gaps caused by the lack of clinical providers. Recommendations: Support local agencies facilitating CHW and PRSS workforce development, expand Medicaid reimbursement amounts to include all behavioral health clinicians as community health worker supervisors, provide incentives for providers in rural areas, evaluate network adequacy and efficiency for insurance company credentialing, support family caregivers through access to reimbursement, respite services, and training across the lifespan. Work with NSHE and DOE on developing workforce tracks for the early development of professionals in these demanding fields.

4. **Development of a sustainable regional crisis response system that integrates existing local crisis stabilization, jail diversion, and reentry resources (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center, CCBHC's) -** The Northern Region has made significant progress in addressing gaps in crisis response services through the following community-based crisis stabilization, jail diversion, and reentry programs: Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), Crisis Intervention Team (CIT) Training, and Carson Tahoe's Mallory Crisis Center. (Please see https://nvbh.org/education/ for more information on these programs.) In addition, there is a need to coordinate local infrastructure into the state crisis response system with the implementation of the 988 system.

   Strategies: While progress is being made in obtaining sustainable funding for these programs, the Northern Board continues to hold this as a priority until long-term program sustainability is achieved. The Board wrote a position statement on behalf of the region's crisis response system which can be found here on the Statewide Regional Behavioral Health Policy Board's website: https://nvbh.org/northern-behavioral-health-region/. In addition, the Northern Board recommends developing sustainable Medicaid reimbursement rates and other funding sources to sustain Assertive Community Treatment (ACT) and First Episode Psychosis (FEP) programs and develop 988 infrastructures in coordination with local agencies. Further, the Board supports Certified Community Behavioral Health Centers (CCBHCs) in providing a full range of services in coordination with communities. In October of 2022, the AG's office was awarded a 5-million-dollar COSSAP grant focused on the sustainability of these programs MOST, FASTT, and CIT. The coordinator of the Northern Board was written into the grant narrative to help support these initiatives as they have already been supporting these implementations and initiatives for the past 6 years and have helped establish these programs and models in four of the five counties in the Northern Region. This is a big focus of the 2023 year as we establish the last counties' diversion programs and beef up those counties that already have solidly established teams. One big part of the FASTT model is the Coordinator is working with UNR in continuation of the FASTT program evaluation as well as currently writing the Statewide Nevada FAST handbook.

5. **Increase access to treatment in all levels of care -** Stakeholders in the region identified a lack of insurance as a barrier to accessing behavioral health care. Furthermore, there is significant concern about access to care for youth and adults who have insurance. While there is no quantitative data on this, there are many stakeholder reports of struggling to obtain outpatient appointments for youth and adults. They also report not having adequate access to intensive outpatient treatment for youth and inpatient treatment for youth as many youths are waiting in hospitals for acute psychiatric treatment. Notable gaps in the region are the lack of intensive in-home services, crisis stabilization centers, and respite care for youth. This goes back to the lack of providers to deliver these services.

   Strategies: In exploring access to care issues for individuals who are under-insured or lack insurance, the Northern Board identified some opportunities to connect uninsured individuals

with care, including the youth trauma recovery grant and the region's Certified Community Behavioral Health Centers (CCBHCs). The Northern Board is planning to continue to learn more about the topic including solutions for underinsured individuals and increasing the use of CCBHCs. The Northern Board is also interested in exploring other models of care including peer drop-in centers, living room models, respite care, and community support centers.

6. **Develop services to support continuity of care (i.e., continuation of medication/ service connection with community health workers) -** For years, stakeholders in the Northern Region have identified issues with continuity of care across the continuum. There are barriers in linkages to care that include a lack of formalized referral systems, a lack of coordination and communication, and limited provider capacity.

   Strategies: The Northern Board is very interested in utilizing community health workers to address challenges in the continuity of care for individuals with behavioral health issues. The Board recommends formal agreements between CHWs and various existing programs such as Nevada Healthlink, OpenBeds, and hospitals. The Northern Board also plans to identify other strategies, such as peers, to support discharge planning and continuity of care in the region and investigate structural solutions to strengthen warm handoffs.

Current Bill Draft Request for 2023, 82nd Legislative Session:

Regional Behavioral Health Authority:(*See attached AB9 for updated language)

- **Aligns with national *Roadmap to the Ideal Crisis System* framework** – establishes an accountable entity for a community/catchment area with responsibility for designing, financing, and operating best practice crisis system, with the goal of ensuring people-centered services.
- **Braided funding model** – Allows for accountability and oversight of all funding streams braided under one umbrella with the goal of providing greater system efficiency to individuals and families in need of behavioral health care across the continuum. Further, a Regional Behavioral Health Authority will increase community oversight and use of federal block grants to deliver community-based services to individuals with serious mental illness and substance use disorders.
- **Allows for increased community oversight and participation in Medicaid-managed care** –Senate Bill 420, which passed in the 2021 Nevada Legislature, will allow for a managed public insurance option for rural areas in 2026. Enabling Regional Behavioral Health Authorities provides for community-based participation in the approval of the competitive bid process with managed care organizations in the regional behavioral health service area.
- **Allows for opportunities to develop additional services** through an intentional transparent democratic process with diverse leadership and community representatives.
- **Potential for quality assurance system and cost savings through system oversight –** establishes a safety net so consumers' needs don't fall through the cracks.
- **Offers communities access to necessary data** - to provide evidence-informed decision-making and to address and mitigate spikes in behavioral health needs in the communities.
- Increases access to care

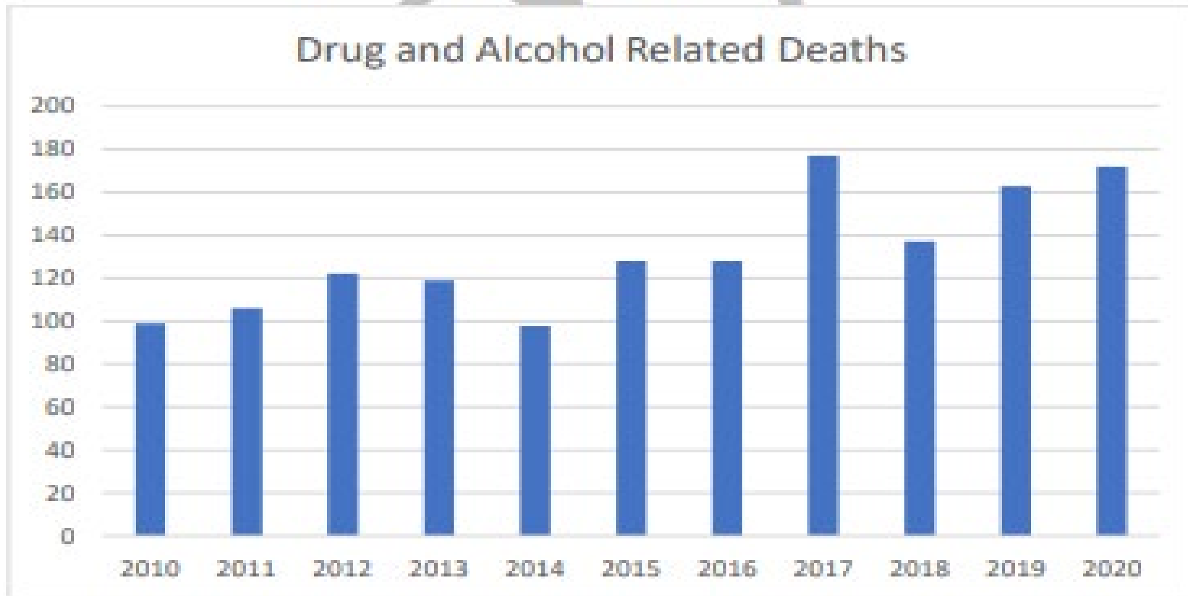
- **Supports state behavioral health authority** - with additional value-based infrastructure to address program capacity, contract management, funding coordination, data collection, quality improvement, etc.
- **Allows for cross-jurisdictional sharing efforts** to obtain grant funding for regional projects.

*As noted, the language of this BDR385 has shifted and is now focused on Board duties and the relationship between the board and coordinator as well as a closer relationship between the Behavioral Health Region.

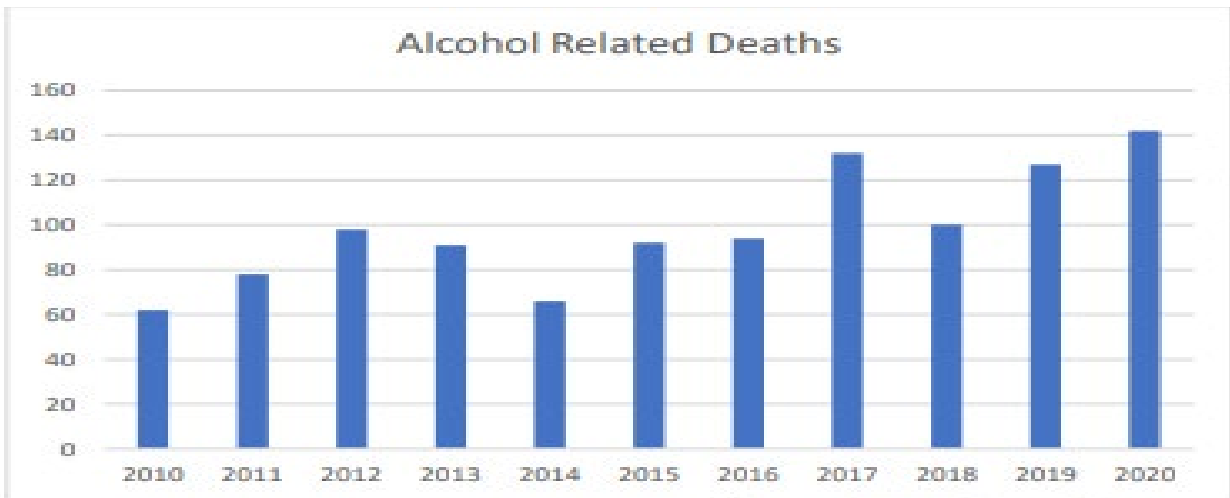
Epidemiological Updates for the Northern Region:

Alcohol, Opioid, and Substance use and misuse:

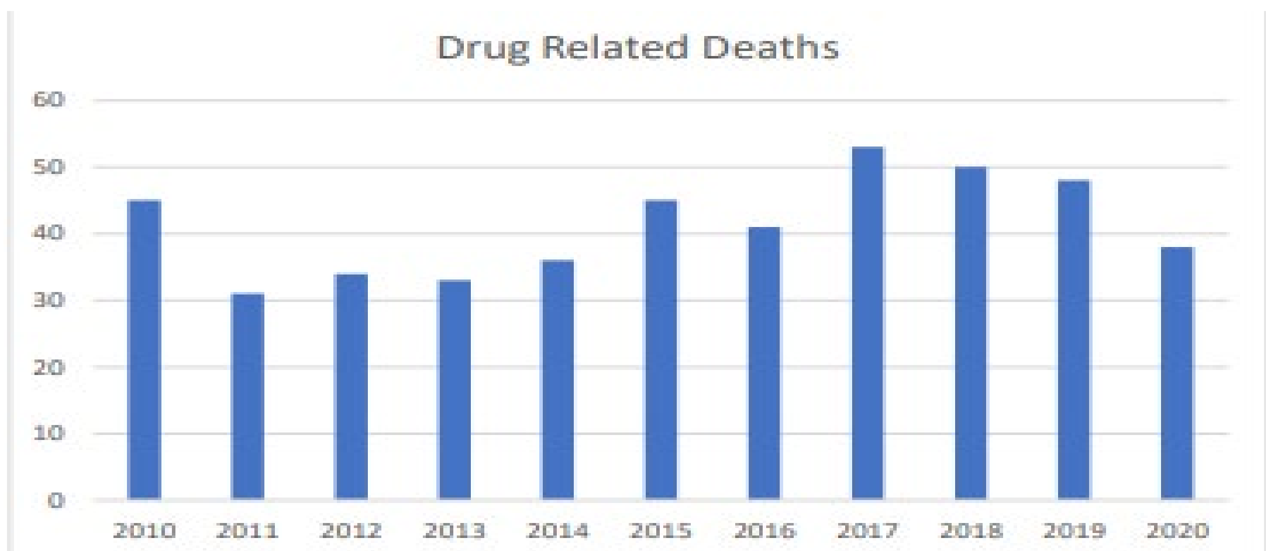
Since 2019, Marijuana/hashish has been the most common drug associated with emergency department visits, followed by methamphetamines, and opioids. In 2019, there were 594.4* visits related to marijuana, and 280.3* visits related to methamphetamine. (*visits per 100,000 population)



Northern Nevada has seen an increase in drug and alcohol-related deaths. Drug and alcohol-related deaths have sharply increased by 25.5% from 2018 to 2020.



From 2010 to 2020 Northern Nevada had 1,081 deaths associated with Alcohol consumption, with each year having an average of 98 deaths.

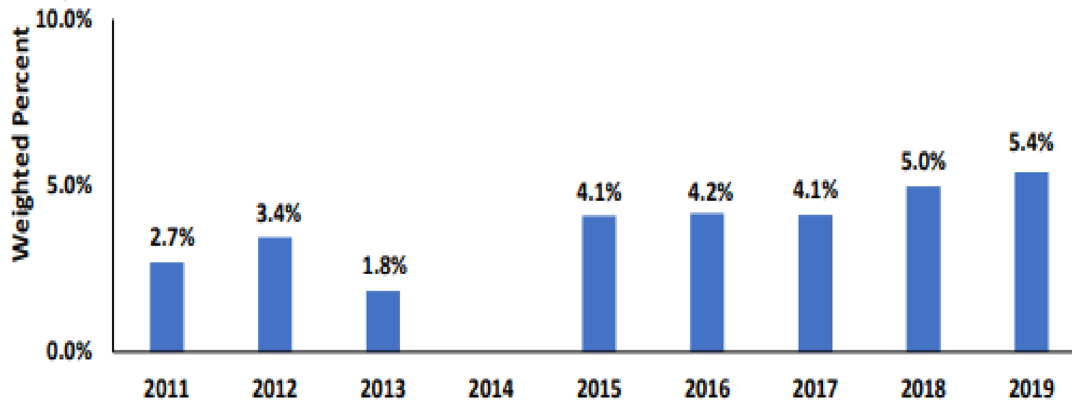


Drug related deaths in Northern Nevada have steadily decreased by 28% from 2017 to 2020.

Suicide:

While suicide is not a mental illness, one of the most common causes of suicide is mental illness. Risk factors for suicide include depression, bipolar disorder, and personality disorders. Of those who attempt or die from suicide, many have a diagnosed mental illness.

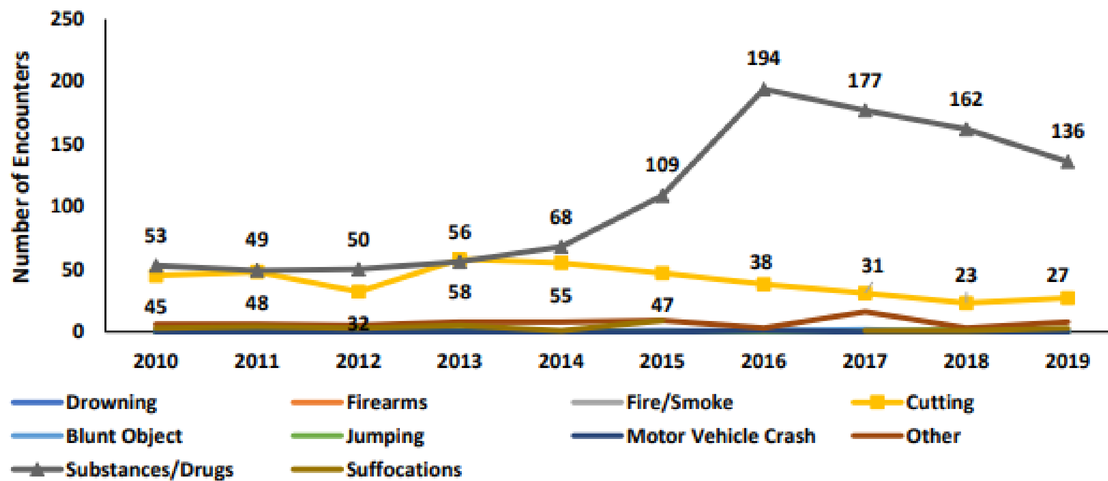
Figure 19. Percentage of Adult Northern Region Residents Who Have Seriously Considered Attempting Suicide, 2011-2019.



Source: Behavioral Risk Factor Surveillance System (BRFSS).
Chart scaled to 10% to display differences among groups.
Indicator was not measured in 2014.
Specific question asked in survey: "During the past 12 months have you ever seriously considered attempting suicide?"

When asked "have you seriously considered attempting suicide during the past 12 months," 5.4% of Northern Region residents responded "yes" in 2019. Between 2011 and 2019, the average prevalence for suicide consideration in the Northern Region is 3.8%.

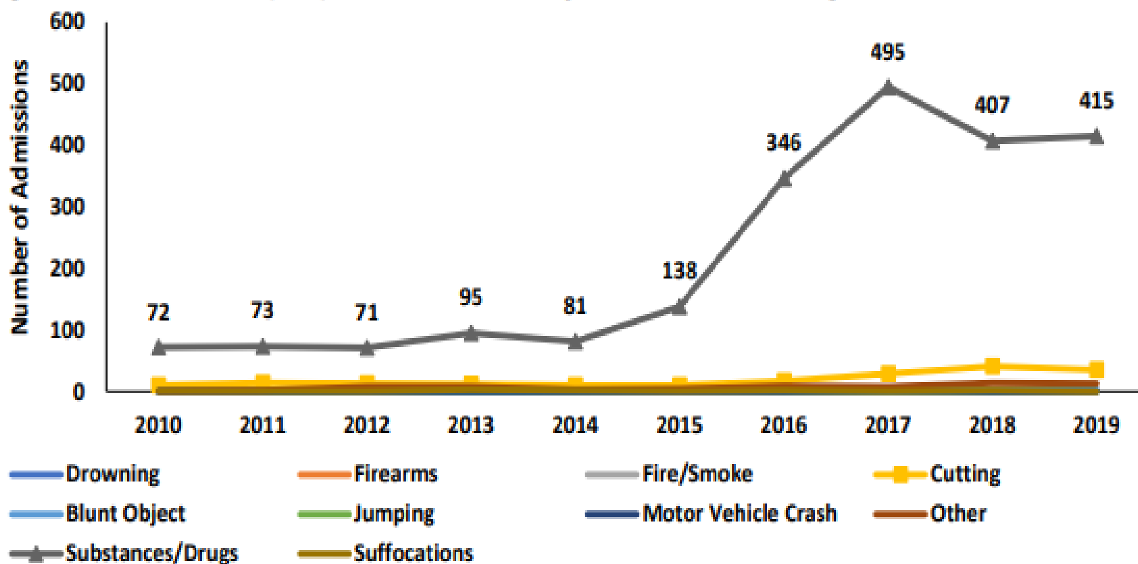
Figure 20. Suicide Attempt Emergency Department Encounters by Method, Northern Region, 2010-2019.



Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
A person can be included in more than category and therefore the counts above are not mutually exclusive.

Emergency department encounters related to suicide attempt, where the patient did not expire at the hospital, have remained steady for all methods except substances/drugs from 2010 to 2019. The most common method for attempted suicide is a substance or drug overdose attempt, with 136 emergency department encounters. The substance or drug overdose attempts have been decreasing since 2016.

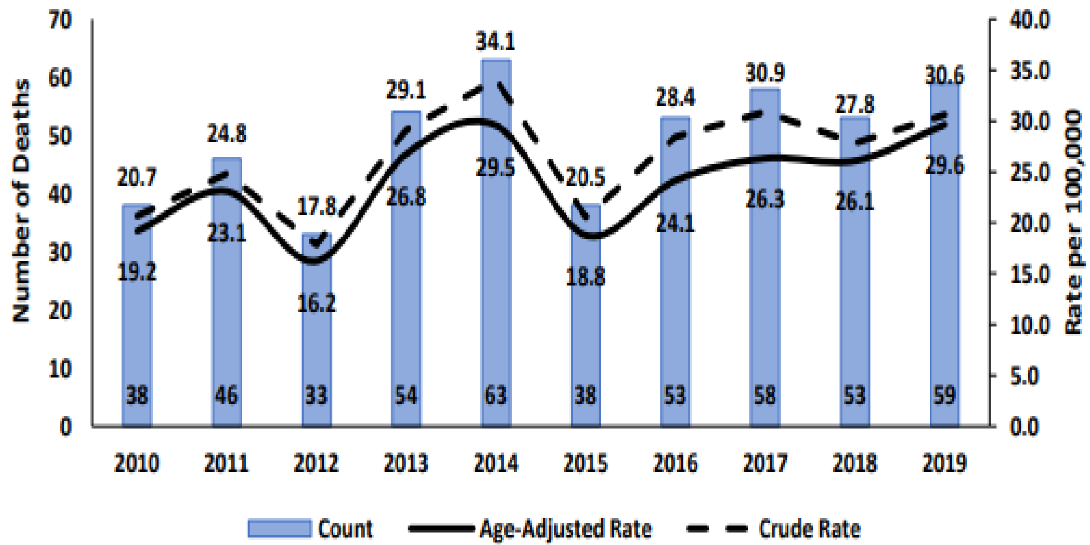
Figure 21. Suicide Attempt Inpatient Admissions by Method, Northern Region, 2011-2019.



Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
A person can be included in more than category and therefore the counts above are not mutually exclusive.

Inpatient admissions for attempted suicide where the patient was admitted and did not expire at the hospital have increased slightly from the previous year but have decreased significantly since 2017.

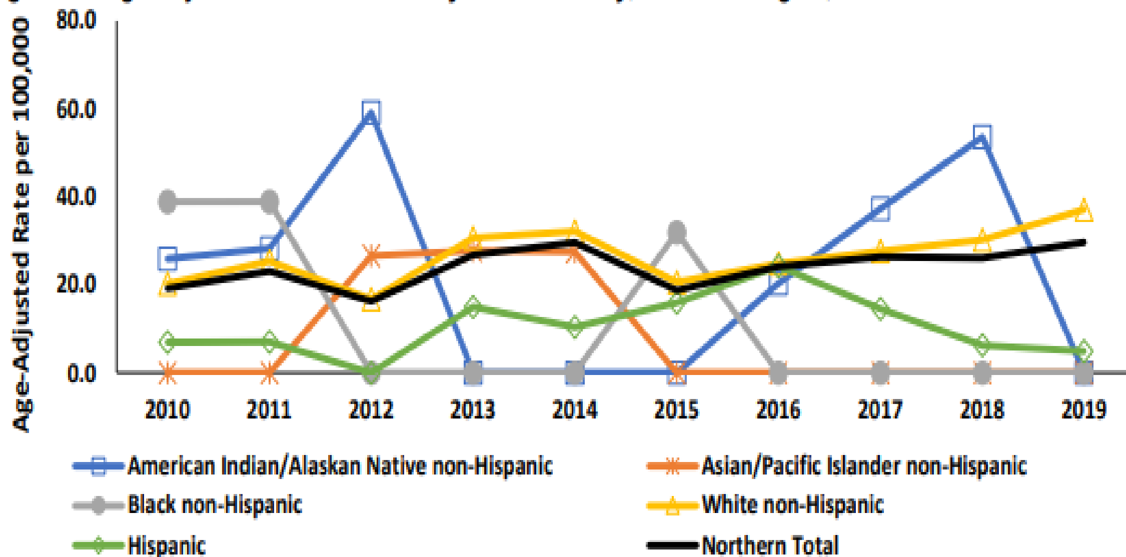
Figure 22. Number and Rate of Suicides, Northern Region, 2010-2019.



Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rate for 2019 in Northern Region was 29.6 per 100,000 population. There were 59 suicides in 2019.

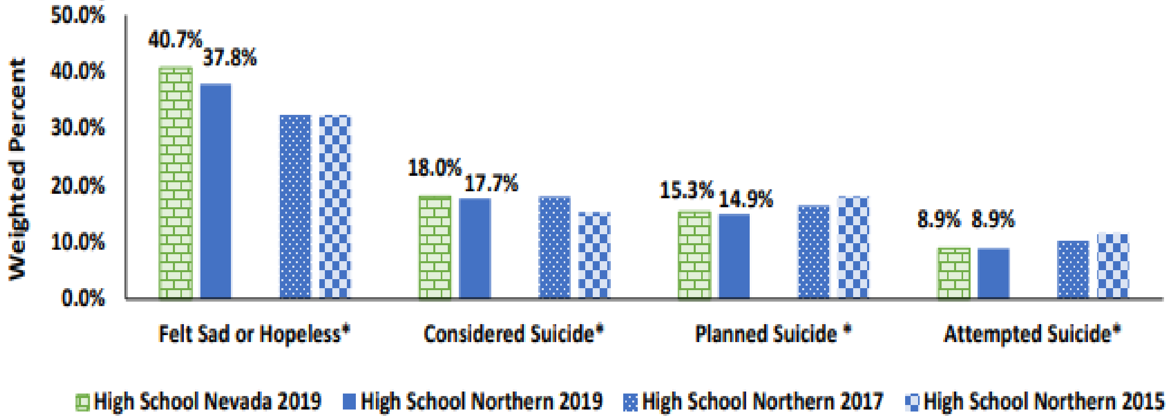
Figure 23. Age-Adjusted Suicides Rates by Race/Ethnicity, Northern Region, 2010-2019.



Source: Nevada Electronic Death Registry System.

Rates among Hispanics are significantly lower than overall Northern Regions rates from 2017 to 2019.

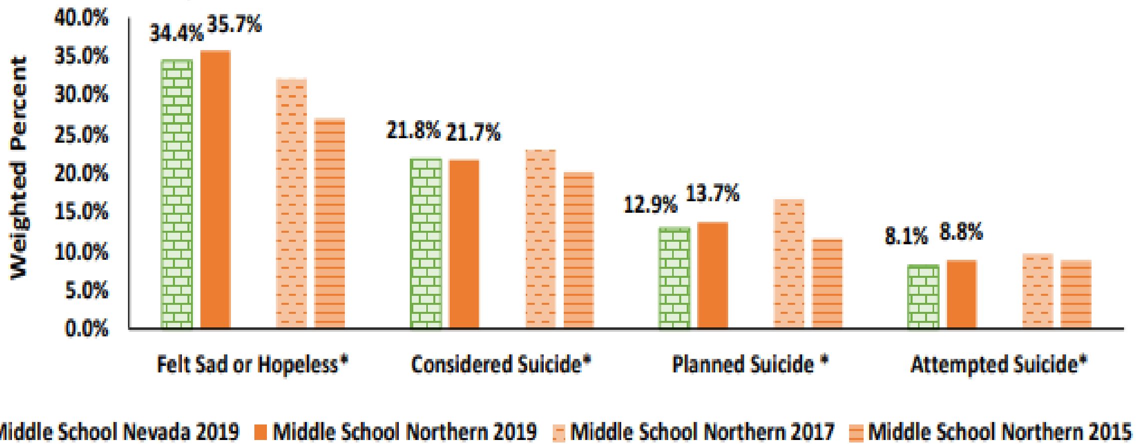
Figure 8a. Mental Health Behaviors, Northern Region High School Students 2015, 2017, and 2019, and Nevada High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 50% to display differences among groups.
Questions worded differently in 2019 and therefore not comparable to previous years.

The questions relating to suicide and feelings of sadness and hopelessness were worded differently in 2019 to past years and therefore should not be compared.

Figure 8b. Mental Health Behaviors, Northern Region Middle School Students 2015, 2017, and 2019, and Nevada Middle School, 2019.



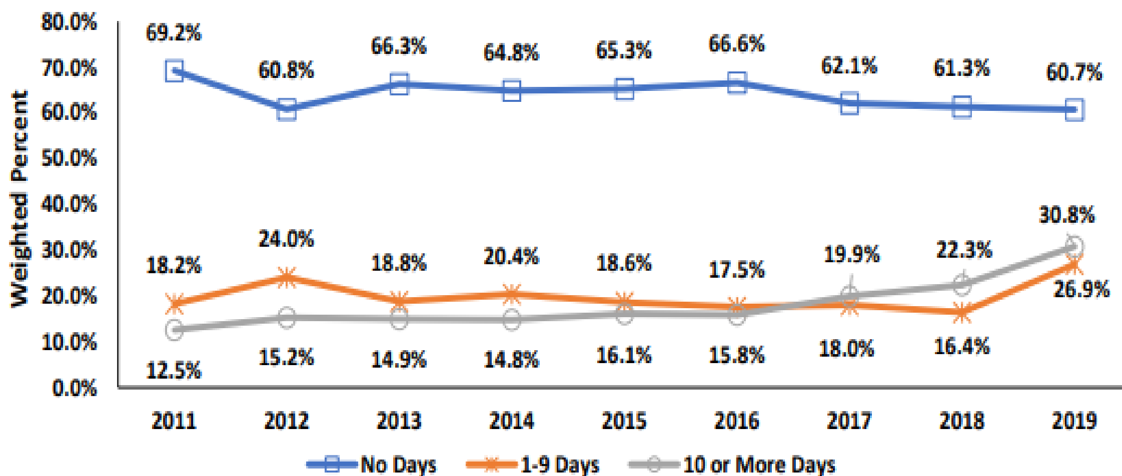
Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 40% to display differences among groups.
Questions worded differently in 2019 and therefore not comparable to previous years.

Mental Health:

Mental Health-Related Deaths Mental health-related deaths are deaths with the following ICD-10 codes groups listed as a contributing cause of death (F00-F99 excluding F10-F19):

- Organic, including symptomatic, mental disorders
- Schizophrenia, schizotypal, and delusional disorders
- Mood [affective] disorders
- Neurotic, stress-related and somatoform disorders
- Behavioral syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behavior
- Mental retardation
- Disorders of psychological development
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence; Unspecified mental disorder

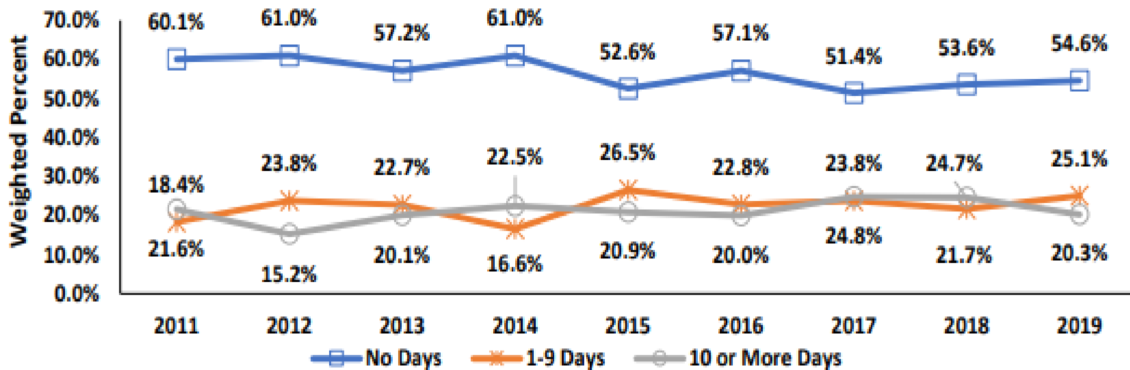
Figure 10. Percentages of Adults in which Their Mental Health was Not Good by Number of Days Experienced in the Past Month, Northern Region, 2011-2019.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 80% to display differences among groups.
Specific question asked in survey: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

In 2019, 26.9% of the Northern Region residents reported 10 or more days of poor mental health, a significant increase from 2018 at 16.4%. Of adults in the Northern Region, 60.7% experienced no days in which their mental health was not good.

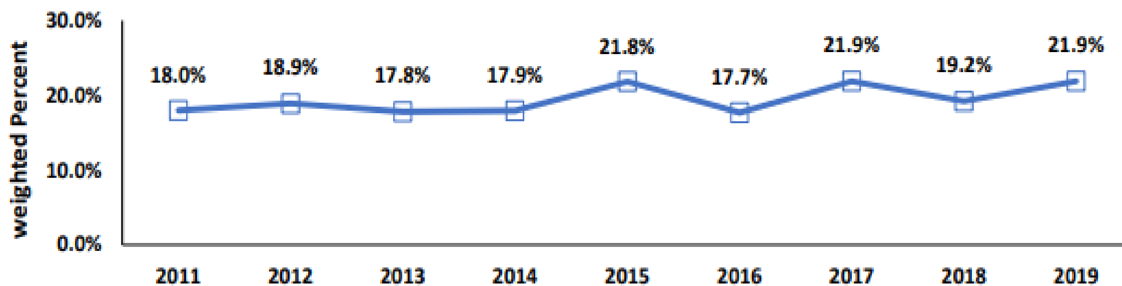
Figure 9. Percentages of Adults Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Northern Region, 2011-2019.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70% to display differences among groups.
Specific question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"

Of adults in the Northern Region, 54.6% reported experiencing no days of poor mental health or physical health that prevented them from doing usual activities in 2019. There was little change in adults who had reported 1-9 days as well as those who reported 10 or more days of experiencing poor mental health or physical health that prevent them from doing usual activities in 2019.

Figure 11. Percentages of Adults Who Have Ever Been Told They have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Northern Region, 2011-2019.



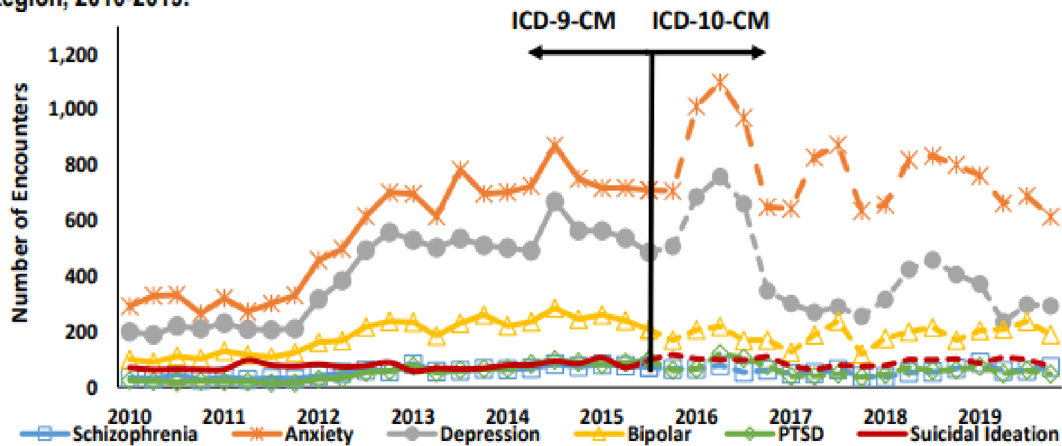
Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 30% to display differences among groups.
Specific question asked in survey: "(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

In the Northern Region, 21.9% of adults were told they have a depressive disorder in 2019, in increase from 19.2% in 2018.

Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients for Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers reflect the number of times a diagnosis in each of these categories was given, and therefore the following numbers are not mutually exclusive.

Figure 12. Mental Health-Related Emergency Department Encounters, by Quarter and Year, Northern Region, 2010-2019.



Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Anxiety has been the leading mental health-related diagnosis since 2010 in emergency department encounters. Anxiety-related encounters increased significantly from 2010 to 2019 in both counts and rates. However, ED encounters for depression have decreased from 2016.

Data Limitations:

While this quantitative data provides perspective on the prevalence rates on behavioral health issues, substance, opioid, and alcohol misuse the Board recognizes the need to capture and identify additional and more accurate up-to-date sources to understand the true gaps, barriers, and needs in the Northern Region. One issue that has been ongoing is the delay in most of the needed data to truly grasp the ongoing problems and concerns our state has faced. The Northern Board looks forward to obtaining more recent data to understand the pandemic's profound continued effects on our communities.

Conclusion:

The Northern Board was very active in 2022, meeting monthly, actively participating in the goals and objectives of their strategic plan, wrote numerous grants for the board's region. Receiving the AG's COSSAP grant to continue upstanding and robustly building on to the already vibrant jail diversion programs existing in the Northern Region. We still have a lot of work to do but

these teams are growing and filling the gaps and barriers in the recidivism of our jails with those living with a mental health diagnosis or that are in a mental health Crisis.

The Northern Board aims to continue learning more about priority topics, practicing advocacy, and moving forward with the implementation of recommendations and identified solutions. The Board members request coordination and partnership with the state as the region works to develop access to behavioral health, the 988 crisis response system, and the development of new plans from each county aligning with the States BHCI 2023 Strategic plan.