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

NORTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD
DRAFT MINUTES
January 6, 2022
2:00 pm to Adjournment

The meeting was held via teleconference.

1. **Call to order/roll call**
   Members Present: Taylor Allison (Chair), Dr. Ali Banister (Vice-Chair), Dr. Robin Titus, Laura Yanez, Nicki Aaker, Heather Korbulic, Sheriff Ken Furlong, Shayla Holmes, Dr. Daniel Gunnarson, Erik Schoen, Dr. Amy Hyne-Sutherland, Sandy Wartgow
   Member Absent: Lana Robards (excused)
   Staff/Guests Present: Tyler Shaw, Cherylyn Rahr-Wood, Elyse Monroy, Dawn Yohey, representative from Carson City Sheriff's Office, Antonia Capparelli, Madison Lopey, Lori Follett, Erin Dudley, Teresa Etcheberry, Peter Ott, Jackee Steward, Rae Scott, Linda Lang, representative from National Alliance of Mental Illness, Michelle Bennett, Kim Donohue, Valerie Balen, Misty Allen, Chris Bosse, J'Amie Webster-Frederick, Jennifer Thompson, Kat S., Mitchell Moen, Tray Abney, Lea Tauchen, Jennifer Matus, Linda Anderson, Alex Tanchek, Wendy Whitsett, Carin Hennessey, Michelle Sandoval, Brian Burriss, Jen Lords, Miranda Branson, Dana Walburn, Jessica Flood Abrass, Joan Waldock

2. Public Comment
   Ms. Rahr-Wood reported they are starting Zero Suicide 2.0 and hope more behavioral health care systems and organizations will implement Zero Suicide.

3. Review and approval of minutes from December 2
   Sheriff Furlong moved to approve the minutes. Mr. Schoen seconded the motion. The motion passed without opposition.

   This item was taken out of order.

4. Review and approve Northern Board letter of support for housing funding and initiatives
   Ms. Flood Abrass explained there is not enough information on mental health housing to develop solutions. Dr. Hyne-Sutherland stated housing is central to behavioral health problems the Board seeks to resolve. Ms. Etcheberry runs HUD-funded housing programs in Clark County. She reported chronically homeless clients with extensive behavioral health issues cannot live independently and need 24/7 support. Ms. Flood Abrass added community-based living arrangements are tiered, based on the level of services needed. Ms. Allison appointed the Behavioral Health Housing Subcommittee: Dr. Hyne-Sutherland, Mr. Schoen, Ms. Holmes, Ms. Aaker, and Ms. Yanez and named Dr. Hyne-Sutherland as its chair. Ms. Allison tabled the letter.

5. Data Workshop: Review current behavioral health data and sources, identify list of important indicators for region, and discuss next steps forward

   Ms. Lopey shared a PowerPoint presentation on behavioral health data. She identified sources of data the Office of Analytics uses and their drawbacks:

   - Behavioral Risk Factor Surveillance System annual survey—small sample size may not represent larger population and only contains information respondents willingly provide. Part of the survey is national; state-specific questions cannot be compared to national data or to data from other states.
   - Electronic Birth/Death Registry System is maintained by the Office of Vital Records.
   - Center for Health Information Analysis contains hospital billing data for emergency departments and inpatient admissions for Nevada's non-federal hospitals. Data is housed at University of Nevada, Las Vegas; they provide quarterly updates that do not contain notes or commentary.
   - National Violent Death Registry System contains deidentified information about violent deaths in Nevada and is delayed about one year.
   - State Unintentional Drug Overdose Reporting System includes accidental and unknown intent drug overdose deaths; data sets are deidentified; there is a reporting delay. Overdose reporting by medical providers within 72 hours of occurrence is required by *Nevada Revised Statutes* Chapter 441A. Data is based on what providers submit; not all hospitals report overdoses; and not all patients present as an overdose.
   - State-funded mental health facilities report through Avatar. Data represent Nevada-operated mental health facilities and are not generalizable to the larger population.
   - Treatment Episode Data Set includes client-level data for persons receiving publicly funded substance use services. Quality relies on what providers submit.
   - Monitoring the Future Survey collects substance use data among students and youth adults. The data is national; the most recent data is from 2019.
   - National Survey on Drug Use and Health includes drug use and mental health issues in the United States and is available only on a statewide level; the most recent data is from 2019.
   - The annual Nevada Report Card is school-related data on truancy, graduation, bullying, and suspensions. It is available at a statewide level, by district, or by school.
   - The biannual Youth Risk Behavior Survey focuses on youth health risk behaviors. The Office of Analytics must request reports from the University of Nevada, Reno.

   Mr. Schoen asked if there are regional provider density or service utilization reports. Ms. Thompson replied information on provider density might be kept by the state examination boards, but passage of Senate Bill (SB) 379, relating to all boards, and Assembly Bill (AB) 278, relating only to physicians, require the Department of Health

and Human Services to create a survey for people who hold health-related licenses; the Office of Analytics will keep the data. They only have Medicaid service utilization data. Mr. Schoen would like to track improvements in provider density since a federal website names Nevada as a health resource provider shortage area. He asked if private insurers report services they provided. Ms. Thompson said an all-payer claims database is being developed and should capture outpatient behavioral health services. A listening session about it is scheduled for February 2. Dr. Gunnarson said licensing boards could provide lists of licensees, but Mr. Schoen clarified their data cannot distill provider density; it only gives the number of licensees. Ms. Flood Abrass announced the Northern region will soon have a full-time data analyst who can work with the Office of Analytics. [The online chat noted the Nevada Department of Education Office of Safe and Respectful Learning Environment is building a consortium for behavioral health providers to try to problem-solve and build in state resources for workforce development.]

Ms. Flood Abrass explained OpenBeds was intended to provide a behavioral health infrastructure to connect people to services, provide data to regional health policy boards on levels of care, and show transfers of mental health crisis holds from hospitals to discharge or to inpatient facilities. Ms. Monroy shared her OpenBeds PowerPoint presentation. OpenBeds ties into the state's prescription drug monitoring program (PDMP), a clinical tool for controlled substance prescribers. Ms. Flood Abrass noted if all providers used OpenBeds for electronic referrals, service utilization information would be available. She suggested that if Northern Nevada Adult Mental Health Services and Southern Nevada Adult Mental Health Services stopped accepting faxes and only used OpenBeds, there would be a change in the system's use. Ms. Monroy noted OpenBeds is not a case management tool or a tracking system; it is a referral system and bed registry. She explained where certain data points are held. A facility's electronic medical record (EMR) holds emergency room (ER) admit times; dual data entry would place that information in OpenBeds. Legal hold information is marked in OpenBeds and is held in the EMR. Level of care information and International Classification of Diseases-10 (ICD-10) diagnosis codes are held in the EMR, but dual data entry would also place them in OpenBeds. Referrals are done through OpenBeds; transfer of care information is held in a facility's EMR. OpenBeds captures the number of staffed beds; the number of occupied beds is in the provider's client management system. Treatment admission information is in the receiving provider's EMR; whether a referral is accepted or denied is held in OpenBeds. Additional assessments are in the receiving provider's EMR. An inhouse transfer is in the EMR. A referral to outpatient community services can be made through OpenBeds, but discharge information is in the facility's EMR. Information from referring providers, receiving providers, and OpenBeds would need to be integrated into one system. To make it usable, an automated interface between the EMRs and OpenBeds would allow systems to talk to each other, or the indicators could be in a daily export from all the vendors or a system like OpenBeds for daily dashboarding. The goal is to have one integrated system. Ms. Flood Abrass said billing data depends on the admitting diagnoses, but a tracking system will not show

if patients were assessed appropriately; an integrated system would show the outcome based on a full assessment at the hospital. Ms. Monroy explained a statewide patient tracking system would include a referral system, but it will require information from EMRs and receiving providers for system transparency. A dual entry system would send information to a dashboarding entity to show real-time service availability. Nevada integrates electronic health records and the PDMP; OpenBeds will soon be integrated, moving a step closer to integration of EMRs and OpenBeds. To make dual data entry work, agency and community buy-in is necessary, along with a commitment to do the data reporting, but mandated use of the system must be enforced. With 988, there will be discussion about tracking how patients move through the crisis system. Which software is used to send referrals or track will not matter if there is not 100 percent commitment from sending and receiving entities. There must be a coordinated plan to train everyone at each organization to ensure multiple levels of redundancy. Dr. Gunnarson commented the system seems impersonal. Ms. Monroy stated OpenBeds facilitates a warm handoff by allowing back-and-forth communication through the system. They worked with the Substance Abuse Prevention and Treatment Agency (SAPTA) to see what opening the receiving provider pool would look like. If providers are held to Medicaid certification criteria, SAPTA can certify quality of care. Ms. Flood Abrass stated that without the full provider pool, there is no warm handoff. Ms. Monroy added when SAPTA told birthing hospitals they would no longer accept Comprehensive Addiction and Recovery Act plans of care by fax or email for babies born substance-exposed; hospitals figured out how to use OpenBeds to submit them. Ms. Bosse noted her hope they can work with the Health Information Exchange (HIE) for integration or electronic data sharing. Ms. Flood Abrass said the HIE would provide integration of all the electronic health records. Ms. Monroy noted Overdose to Action (OD2A) is the state's main source of Centers for Disease Control and Prevention funding for nonfatal and fatal overdose reporting, so overdose data is available. They will soon have ZIP code-level information on emergency medical services data. She noted the overdose mapping application program (ODMAP) has ZIP code reports on suspected overdose data for Las Vegas. Ms. Allison stated she explored using OpenBeds to refer community health workers to replace exhausted hospital social workers. She asked how the Board can help facilitate this integration.

Ms. Rahr-Wood commented it is hard to implement programs and have buy-in through large systems or organizations. Assembly Bill 181 was introduced at the 2021 Legislature to collect real-time data points not being collected. It allows the Office of Suicide Prevention to collect data on suicidal ideation and attempts, but there is an 18-month to 2-year lag. Ms. Flood Abrass said Ms. Bosse noted in the chat that medical examiners will collect the data. Ms. Rahr-Wood said the information will be timelier and allow them to follow ideations and to see who is at risk. Ms. Monroy added mandated AB 474 reporting increased the timeliness of overdose data. They may revise the hospital reporting forms to include reporting data on suicides. The OD2A program's monthly overdose surveillance report compiles syndromic surveillance data—the chief complaint data from the emergency room—to allow

monitoring for spikes. Currently, OD2A looks for spikes in overdoses, but it can also monitor for suicide. In the next year, OD2A will be able to share the information. Dr. Gunnarson asked how they define "suicidal ideation." Ms. Rahr-Wood said Zero Suicide screening is done for everyone who comes into the hospital to recognize suicidal ideations. Ms. Flood Abrass pointed out if hospitals are required to report on suicidal ideation, they will ask the questions. Answers would be placed in the EMR for follow up or to provide better care the next time the patient is admitted. The state will not see patient names. There are two levels of questions—one asks if this is part of a trend. The other has to do with patient care to ensure suicide ideation is discussed. She explained this would allow providers to maintain a continuum of care with a suicidal patient. Data sent to the state would be deidentified. Dr. Gunnarson said the definition of the behavior must be clear. How you ask the questions will affect the data. Ms. Flood Abrass noted the Columbia Suicide Severity Rating Scale takes that into consideration. She compared it to current opioid reporting showing the number of overdoses without associated names. Ms. Monroy said the Mandated Drug Overdose Reporting is data on patients with suspected overdoses admitted to hospitals. Ms. Rahr-Wood said ICD codes define suicidal ideation. Ms. Yanez asked if they gather anecdotal data or information from communities. Ms. Rahr-Wood said they do not look at anecdotal data.

Ms. Flood Abrass asked what Board next steps should be. Ms. Allison suggested they match their priorities with existing gaps. The new data analyst can take a deep dive into those gaps so Board decisions align with their priorities. Mr. Schoen clarified they would cross-map data needs with Board priorities. Ms. Flood Abrass asked if they wanted to look at the HIE, noting it could resolve some of this. Dr. Hyne-Sutherland suggested having a workshop to look at their priorities and what data is available. Ms. Flood Abrass mentioned it would be good to have the Board participate in changing Board priorities into recommendations for the annual report, which is due in March. Dr. Titus asked when the data analyst will be available. Ms. Flood Abrass replied the position must be approved by the Interim Finance Committee in April. Ms. Allison said they can discuss a subcommittee at the next meeting. Dr. Gunnarson suggested the analyst's first assignment could be to map Board goals to the data sets. Ms. Flood Abrass noted they also expressed interest in defining community health workers and peers.

6. Regional Behavioral Health Coordinator and board member or taskforce appointee updates on behavioral health concerns, initiatives, and successes in their area of specialty or county or on behalf of the local behavioral health taskforces. This includes requests and feedback from the taskforces on Policy Board progress.

   Ms. Flood Abrass said Board infrastructure development is the data piece. They discussed their authority in *Nevada Revised Statutes* (NRS). They have a housing subcommittee. Behavioral health workforce has not been discussed yet. They have discussed the regional crisis response system, identifying and expanding the roles of certified community behavioral health clinics, increasing access to treatment at all levels of care, developing services and supporting continuity of care by using

community health workers, and defining community health workers and peers.

7. Update on progress of Northern Regional Behavioral Health Policy Board Next Steps document and discuss agenda items for future meetings
   Ms. Holmes reported Lyon County will have a youth Stepping Up Initiative workshop. They will overlap youth services with the Sequential Intercept Model and have a strategic plan with community partners to fill gaps for juvenile justice diversion. The taskforce is experimenting with how to connect with the community on identified topics. Ms. Flood Abrass said Storey County held a training for social services staff and law enforcement. Dr. Jennifer Carson provided training on dementia. Ms. Holmes is creating a statewide peer network for hospital social services staff. Carson-Tahoe will help with some needed training. They are creating policies and procedures like those for first responders who experience secondary trauma. Ms. Allison reported Douglas County is writing grant applications and trying to expand crisis services. Mr. Schoen recommended housing subcommittee reports as a standing agenda item. Ms. Flood Abrass asked if they wanted to work on their recommendations for the Department of Health and Human Services and the Office of the Governor. Dr. Gunnarson and Mr. Schoen want to review the draft before the meeting. Ms. Flood Abrass announced a mental health crisis hold and involuntary treatment summit will be held via Zoom on March 7-8. Stakeholders—hospitals, law enforcement, treatment providers, lawyers, peers, and families—can present their perspectives and challenges resulting from SB 70. This will provide a full view of the involuntary hold system, mental crisis hold process, and best practices. Dr. Gunnarson asked if attendees could receive continuing education credits. Ms. Flood Abrass is working on that. Ms. Allison requested they discuss ideas for bill draft requests at the February or March meeting. Dr. Hyne-Sutherland asked if they could piggyback off bills from last session regarding workforce development.

8. Public Comment
   Dr. Hyne-Sutherland asked if the Office of Safe and Respectful Learning could make a presentation at the March meeting.

9. Adjournment
   The meeting adjourned at 4:28 p.m.