2018 Behavioral Health Annual Report

Prepared by:
Southern Nevada Behavioral Health Policy Board
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Contents

Executive Summary

[Placeholder] The Southern Nevada Regional Behavioral Health Policy Board consists of the following members:

- Steve Yeager, Board Chairman/ Legislator
- Nita Schmidt, Corrections Captain, Las Vegas Metropolitan Police Department;
- Jamie Ross, Executive Director, PACT Coalition
- Larry Clarke, CEO, Your Choice Behavioral Services
- Dr. Lesley Dickson, Center for Behavioral Health
- Jaqueline Harris, Marriage and Family Therapist
- Dr. James Jobin, Chief Operation Officer, Vogue Recovery Center
- Dr. Joseph Iser, Sourthern Nevada Health District
- Dr. Ken McKay, Healthy Minds
- Eric Lloyd, President, Anthem Blue Cross Blue Shield NV/CO
- Charlene Frost, Clark County Children's Mental Health Consortium
- Angelo Aragon, Las Vegas Fire and Rescue
- Alexandra Fernandes, Detective, Nye County Sheriff's Office

The Regional Policy Boards have been charged with the responsibility to advise three state entities, including the Commission on Behavioral Health, the Department of Health and Human Services, and the Department of Public and Behavioral Health, on the priorities for allocating money to develop behavioral health services in view of regional priorities.

Southern Nevada Behavioral Health Profile

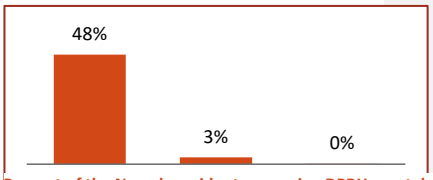
Below is a summary of some significant data in the Southern Nevada Epidemiologic Profile Report. The full report is available in Appendix A.

2017 Mental Health data

- 47% adults indicated that they missed one or more days of work or activities due to their mental or emotional health
- Anxiety was the leading mental health-related diagnosis in emergency department encounters; increased significantly from 2009 to 2017 in both counts and rates
- Depression is the leading diagnosis for mental health-related inpatient admissions; increased significantly from 2009 to 2017 both in counts and rates

2017 DPBH Utilization Rates

- 24% were 45-54-year olds
- 46% female; 54% male
- Top 3 ethnic groups: 42% White, 18% Black, 15% Hispanic



Percent of the Nevada residents accessing DPBH mental health services in 2017 by the county of residence

2017 Suicide Rates

- 1,218 inpatient admissions for attempted suicides
  - 77% were for substance and drugs overdoses
- Age group with the highest prevalence was the 45-54 age group
- For level of education, high school graduates had the highest prevalence
- Age-adjusted suicide rates for White non-Hispanics were significantly higher for each year from 2009 to 2017, with 27.7 per 100,000 population in 2017
- High school students: 34.4% felt sad or hopeless, 15.9% considered suicide, 13.8% planned to commit suicide and 8.2% have attempted suicide in the past 12 months
- Middle school students: 29.8% of have felt sad or hopeless, 21.3% considered suicide, 15.4% planned to commit suicide and 8.1% attempted suicide in the past 12 months

2017 Substance Abuse Data

- 60% of high school students have had a drink of alcohol, 25.2% currently drink alcohol, 43.1% had alcohol provided to them by someone else, 17.9% had alcohol before the age of 13
- 33.4% of high school students reported trying marijuana, 18.4% currently use marijuana and 7.9% used marijuana before the age of 13, lower than Nevada at 8.8%
- 15% of high school students have used prescription drugs that were not prescribed to them
- 24.0% of men reported binge drinking
- From October 2015, marijuana/cannabis use alone is more common for emergency department encounters then hallucinogens, opioids, and heroin
- In 2017, 3,427 deaths were related to alcohol and drugs (147.8 age adjusted rate).
  - Alcohol-related deaths make up 19% of alcohol and/or drug-related deaths

Regional Needs

The Southern Nevada Policy Board sought to embrace a data-driven approach to identifying the behavioral health needs and system gaps of the region. That said, the success of a data-driven approach depends on the existence of data, the quality of the data gathered, as well as the rigor and pertinence of its analysis and interpretation. What follows is a description of the Southern Nevada Policy Board's methods of gathering data and information, a summary of that data, and a brief description of the data's limitations.

In-person presentations during Board meetings

All meeting materials, including minutes and presentation documents (handouts, PowerPoint slides) are available here on the Board's website. The table below outlines each presentation conducted during the board meetings in 2018.

Date	Topic	Presenter(s)
2/9/2018	Southern Nevada Behavioral Health Data Report	Jennifer Thompson, Department of Health and Human Services
	Southern Nevada Behavioral Health Services Study	Ariana Saunders, Coordinator
3/7/2018	Mental Health: School-based supports	Dr. Katie A. Dockweiler, President of Nevada Association of School Psychologists, and Dr. Joseph Roberts, Department of Student Threat and Crisis Response
	Southern Nevada Juvenile Justice Behavioral Health and Diversion efforts	Cheryl L. Wright, Clinical Services Manager, Clark County Juvenile Justice Services
	Clark County Children's Mental Health Consortium Priorities	Dan Musgrove, Clark County Children's Mental Health Consortium Chair
4/20/2018	Presentation on United Citizens Foundation	
	Legal 2000 Procedure from Court Perspective	Hearing Master Bita Yeager
	Legal 2000 Procedure from Law Enforcement Perspective	Detective Dana Dipalma of the Crisis Intervention Team, Las Vegas Metro Police Department
	Legal 2000 Procedure from Firefighter Perspective	Angelo Aragon, Board member
	League of Women Voters on their Behavior Health Priorities	Sondra Cosgrove, President League of Women Voters of Southern Nevada
	Southern Nevada Forum Effort and Priorities	Dr. Ken McKay, Board member
5/29/2018	WestCare Crisis Triage Center	Dan Musgrove
	Crisis Response Team	Deputy Chief Jon Stevenson, Las Vegas Fire & Rescue; Alexandria Anderson, CHIPs Director; Heather Thanepohn, CRT Las

		Vegas Fire & Rescue
	Desert Parkway Behavioral Hospital	Allison Zednicek, CEO of Desert Parkway Behavioral Hospital
	Spring Mountain Treatment Center	Alan Eaks, CEO of Spring Mountain Treatment Center
	Seven Hills Behavioral Hospital	Christopher West, CEO of Seven Hills Behavioral Hospital
	Nevada Counseling Association.	Dr. Katherine Unthank - Executive Director of the Nevada Counseling Association
	Legal 2000 Procedure from psychiatry perspective	Dr. Lesley Dickson, Board member
6/29/2018	Homelessness and Mental Health	Ariana Saunders, Behavioral Health Coordinator
	Medicaid and Behavioral Health	Alexis Tucey, DHHS, Division of Health Care Financing and Policy and Kirsten Coulombe, DHHS, Division of Health Care Financing and Policy
	One System of Care and Resources (OSCAR) report	Dan Musgrove
7/24/2018	Substance use strategies, needs and challenges	Jamie Ross, Executive Director, PACT Coalition
	Recreational marijuana taxes and revenues	LCB Staff
10/18/2018	Review of Behavioral Health Epidemiological profile	Jen Thompson, DHHS
	Update on statewide priorities and plans related to behavioral health and substance abuse	Dr. Stephanie Woodard, DPBH

Community Survey

In an effort to increase community engagement and awareness of the Policy Boards, the Board created a 6-question survey and received 56 responses from an unknown total number of recipients. The Southern Nevada Policy Board enlisted the assistance of a UNLV professor in the School of Medicine and Director of the Marriage and Family Therapy Program, Dr. Katherine Hertlein, to help analyze and interpret the survey results. The Board did not have the results of this survey until early October and thus could only discuss and incorporate them into this report within the final few weeks before writing this report. The results are summarized in a report and presentation Dr. Hertlein completed for the Board, which is available in Appendix B. The survey asked respondents to list the following bullet-point items, and the top three responses for each prompt is listed below:

- Top 3 behavioral health problems in the region
    1. Lack of quality specialized providers and programs (89.79%)
    2. Insurance issues (coverage and provider reimbursement) (60.37%)
    3. Access difficult due to health insurance (30.82%)

- Top 2 solutions to each identified problem (not broken out by problem)
    1. Funding (67.31%)
    2. Increase reimbursement rates from insurances (specifically Medicaid) (43.13%)
    3. Insurance reimbursement (49.02%)
- Top 3 recent policy changes or promising areas of practice in the state or region
    1. Increased hiring, funding, training, or community education (52.17%)
    2. Expanded programs (e.g., CANS, mobile crisis response team) (45.65%)
    3. Increased programs/access/website/data reporting (47.82%)
- Top 3 sources of behavioral health data in the state or region
    1. Internet searches, such as Google (65.21%)
    2. Personal experience (32.61%)
    3. Word of mouth (30.43%)
- Top 3 suggestions for improving behavioral health data collection
    1. Create a website or data-sharing platform for all mental health fields, including research and reporting of data (55.06%)
    2. Increase in funding (36.95%)
    3. Collaboration between all health providers (collaborative care) (30.43%)
- Describe their experience accessing and receiving behavioral health care (for patients)
    1. Challenges navigating the system (31.11%)
    2. Challenges overcoming insurance barriers, such as insurance coverage (21.11%)
    3. Difficulty finding/locating providers (20.55%)
    4. Long wait lists (20.51%)

Summative review of previous behavioral health reports

In an effort to avoid reinventing the wheel and to build on an existing knowledge base, the Board reviewed 9 large-scale reports from the past 5 years that also sought to hone in on Nevada's behavioral health needs, problems, and gaps and to make recommendations:

- 2013 Nevada DHHS/DCFS via Social Entrepreneurs, Inc.: "Comprehensive Gaps Analysis of Behavioral Health Services Recommendations"
- March 25, 2014 Southern Nevada Forum on Healthcare: "Short-term Recommendations to the Governor's Behavioral Health and Wellness Council"
- April 2014 Dr. Dvoskin, Governor's Advisory Council on Behavioral Health and Wellness: "Potential Areas for Council Recommendations"
- June 2016 Department of Child and Family Services: "Nevada System of Care, Implementation Grant Strategic Plan, '4 broad goals'"
- October 3, 2016 Strategic Progress, LLC: "Nevada Children's Mental Health Needs Assessment Recommendations" (Clark portion)
- 2016 American Foundation for Suicide Prevention: "Suicide: 2016 Facts 7 Figures"
- 2017 Applied Analysis: Behavioral Health Services in Southern Nevada
- 2017 Clark County Children's Mental Health Consortium (CCCMHC): 10-year Strategic Plan
- 2018 Southern Nevada Forum on Healthcare (priorities currently in process)

The Board's review of this data revealed the following top 4 behavioral health needs in random order:

Priority/Need	# of mentions	Specific descriptions

Crisis intervention & transitional services	**8**	1. Increase Capacity for Crisis Triage Service: sobering center, respite care, crisis beds 2. Transitional services improvement (e.g., diversion or stepdown services/supports, improved case management to reduce recidivism) 3. Establish strategically located mental health triage centers to divert hospitalizations and incarcerations (e.g., sobering centers, triage centers) 4. Group homes 5. Respite care 6. Housing options and support for patients stepping down in therapy intensity 7. Provide mobile crisis intervention and stabilization services to Clark County youths in crisis. 8. EMT's and Paramedics: triage without transport, transport reimbursement, address liability limits
Workforce development	**10**	1. Workforce development across disciplines: increase reimbursement & training programs 2. Increase provider supply across all disciplines via loan repayment, higher reimbursement, and terminal training programs 3. Growing the pool of medical professionals, especially psychiatrists 4. Expand number of clinicians 5. Lack of quality providers 6. Healthcare for people with Autism 7. Healthcare professionals in schools 8. Develop community and state capacity to implement no wrong door 9. Implement workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared to provide effective services and support consistent with the SOC approach. 10. Inadequate insurance coverage and difficult treatment approval process
Program development	**10**	1. Co-Occurring Disorders: enhance skills, training opportunities, consultation 2. County-wide programs will be available to facilitate all children's healthy social and emotional development, identify behavioral health issues as early as possible, and assist all families in caring for their children. 3. Develop community and state capacity to implement no wrong door 4. Restore funding to mental health courts as another effort at diversion 5. "Super-User Project" w/ low caseloads for heaviest users of inpatient, emergency, and jail beds

		6. Mental Health in Public Schools: screening, intervention, referral, staffing, reimbursement 7. Anti-Stigma and Suicide Prevention Campaign 8. Tele-psychiatry and PCP Consultation: billing codes & reimbursement 9. Enhancing Peer Services: training, certification, and reimbursement 10. New diversion initiatives to reduce restrictive interventions (inpatient/detention stays)
Data management & application	**8**	1. Ensure accountability, credibility and high quality services. 2. Centralized, accessible mental health information system that facilitate interdisciplinary coordination of care and an inventory of available services that is publicly available and updated regularly 3. Generate support among families and youth, providers, and decision policy makers at state and local levels, to support expansion of the SOC approach, transitioning DCFS's Children's Mental Health from a direct care provider to an agency that primarily provides planning, provider enrollment, utilization management through an assessment center, technical assistance and training, continuous quality improvement. 4. Establish an on-going locus of management and accountability for SOC to ensure accountable, reliable, responsible, evidence and data-based decision making to improve child and family outcomes and to provide transparency at all levels. 5. Data Infrastructure: better communication between state and county (e.g., case management systems, referral tracking, case processing, outcomes 6. Streamline use of research screening/assessment tools 7. Facilitate streamlined communication of critical incidents to providers and agencies 8. Increase quality via increased oversight and quality assurance measures

When coupled with in-person presentations during Board meetings, this information served as a springboard for discussion among Southern Nevada Policy Board members. The existing policy barriers were considered that may be preventing the development of more crisis and transitional centers. Dan Musgrove reported to the Board that WestCare faced a $1,500,000 budget shortfall when attempting to operate its crisis triage center. Mr. Musgrove also reported that 47% of WestCare's clients lacked adequate funding, estimating that about 20% either have no payer source or refuse to complete government forms. Authorization to transport patients to crisis centers was another barrier in situations when it had been determined that patients met criteria for civil commitment. The need for crisis intervention services was clear and supported by the fact that at least 5-6 separate mobile crisis programs were identified during Board meetings. The need for transitional services was also highlighted

in the media when the state closed 18 community-based group homes (13 in Southern Nevada) offering housing and supportive services as a result of substandard living conditions.

In terms of access to care, Mental Health America (MHA) ranked Nevada 49th in 2011, 51st in 2014, and 51st in 2017. According to MHA, "Lack of movement at the bottom [i.e., when states do not improve] indicates continued neglect of the mental health needs of constituencies. States can compare policies among other better performing states of equivalent size, geography, culture, or political affiliation to identify potential policy changes to improve their numbers and rankings." The nine measures that make up the Access to Care ranking include:

1. Adults with any mental illness who did not receive treatment
2. Adults with any mental illness reporting unmet need
3. Adults with any mental illness who are uninsured
4. Adults with disability who could not see a doctor due to costs
5. Youth with a Major Depressive Episode who did not receive mental health services
6. Youth with Severe Major Depressive Episode who received some consistent treatment
7. Children with private insurance that did not cover mental or emotional problems
8. Students identified with emotional disturbance for an Individualized Education Program
9. Mental health workforce availability

Thus, the Board pondered the distinctions among access to care, workforce development, and network adequacy. In April of 2018, the Nevada Psychological Association surveyed 156 psychologists and found that 69 psychologists trying to credential with insurance companies were denied 114 times from panels. Similarly, other behavioral health professionals reported being denied by insurance panels. If Nevada has numerous professionals across behavioral health disciplines willing and able to deliver services who are told panels are full, perhaps the workforce exists. This brings into focus other issues that affect access to care, such as the definition of network adequacy, the scope of network adequacy policy, and other matters that preclude willing providers from delivering care. One suggestion was the proposal of a "Freedom to Heal Act," which would allow patients to select any provider who is willing to accept reimbursement from the patients' insurance, and the insurance carrier would be obligated to cover the cost.

Commented [A1]: Do we have similar information on other BH professionals?

Commented [A2R1]: Not that I am aware of

With regard to the collection, management, and application of behavioral health data, the Board had little access to what state, regional, or local behavioral health entities currently receive. Previous reports and in-person presentations demonstrate that lots of data has been and is still being gathered, but it seemed clear that multiple stakeholders are unaware of 1) who is gathering data, 2) what data is being gathered, 3) where said data is/will/can be available, 4) how and why any data is gathered, and 5) what, if any, action is taken in response to problems or gaps the data uncover. In the spirit of a data-driven approach to decision making, the Board agreed that whatever data is collected ought to be accurate, actionable, and accessible in an organized, user-friendly manner. An organized, sustainable repository of behavioral health data that houses up-to-date information on community resources (e.g., location, contact information, eligibility criteria, accepted forms of payment, service availability, outcomes, etc.), providers on insurance panels, and programs' effectiveness would facilitate data-driven decisions about regional behavioral health needs, problems, gaps, and progress. In the absence of such a repository, status quo will remain where decisions makers, including the Regional Policy Boards, resort to reviewing whatever data they can at the time, inviting stakeholders to deliver the same presentations, and piecing them together to justify decisions without any visibility on what other entities are doing or what other data may be available.

Limitations and areas for future inquiry

The Southern Nevada Policy Board would have preferred to gather information from additional sources prior to making recommendations, including:

- Medicaid
- Private insurance carriers and managed care organizations
- Certified Community Behavioral Health Clinics
- More professional providers and associations
- More members of the judiciary
- Other state, regional, and local entities addressing mental-health-related issues

The Board also seeks to invite targeted presentations wherein the Board submits specific questions and topic areas for presenters to address. Moving forward there is a need to seek targeted information that identifies system gaps or needs and informs decision making.

Collaboration with UNLV revealed that there were a number of limitations associated with the community survey as well. The survey gathered no demographic information about respondents, which makes it impossible to hone in on any group differences, such as providers vs. payer sources or patients vs. providers or Clark County vs. Nye County or other counties. The strategy for disseminating the survey left no means for determining whether the respondents were representative of Southern Nevada's behavioral health stakeholders. Thus, the Board will define more clearly its target stakeholders when carrying out future surveys. The survey questions did not ask respondents to put their responses in order of importance or priority, so respondents' order of priority on relevant questions remains unknown.

Dr. Hertlein's team also identified potential areas for future inquiry. They suggested the Board focus future data collection on the themes presented in this round of data collection. One suggestion was to conduct interviews or to hold a panel discussion or town hall meeting of sorts to give stakeholders the opportunity to put their concerns into their own words as opposed to answering narrow questions. Another recommendation was to ask respondents to rank issues in order of importance or to rate each area of concern on a 1-5 scale. Dr. Hertlein's team also provided a list of over 30 new potential questions to ask in the next community survey, which also available in Appendix C.

Finally, each previous behavioral health report described its own distinct limitations, leaving each report's accuracy and generalizability up to interpretation. Common limitations among reports and in-person presentations alike included poor community engagement (i.e., response rates) and questionable validity of secondary sources of information.

One example that illustrates the challenges in gathering accurate data about behavioral health resources in Southern Nevada is the challenge in fully understanding crisis services. At first, it was presumed that there was a significant scarcity of crisis intervention services. However, the Board learned that multiple jurisdictions, agencies, and clinics had or were developing mobile crisis services. While each entity did not necessarily serve the same geographical area, target the same population, or approach crisis intervention in exactly the same way, there was clearly not a systematic approach to coordination or collaboration of efforts. For example, these entities do not share or have access to the

same data, making it impossible to identify acceptance of referrals, frequent users, and so on. What impact would a platform for coordination have on the communities' ability to maximize resources?

Regional Priorities and Strategies

After reviewing the data sources discussed above and discussions during Board meetings, Board members submitted at least two areas of focus. The chair then synthesized this information, in the interest of distilling the most important priorities in Southern Nevada. That list includes, in random order the following priorities:

1. Shifting Esmeralda and Nye counties into the rural Regional Policy Board
2. Shifting Lincoln and White Pine counties
3. Allocating tax revenue from marijuana sales to mental health and substance abuse services
4. Reliably funding mobile crisis for children
5. Reliably funding mobile crisis for adults
6. The "Freedom to Heal Act": allowing patients to select any provider who is willing to accept reimbursement from the patients' insurance, and the insurance carrier would be obligated to cover the cost
7. Editing and updating the Nevada Revised Statutes and the Nevada Administrative Code such that they use more positive, professional language
8. Improving enforcement of Nevada's Expedited Licensure Bill
9. Requiring treatment for youth in residential treatment facilities or psychiatric institutions to include family therapy
10. Instituting a mental health oversight agency for Medicaid akin to the role SAPTA has for Medicaid with substance abuse
11. Consolidating the mental-health-related professional licensing boards
12. Addressing workforce development issues
13. Altering civil commitment procedures
14. Reliably funding family- and peer-support services
15. Developing an organized, sustainable, and accessible repository of valid, actionable, and up-to-date behavioral health data that is relevant to behavioral health stakeholders
16. Broadening the duties of the Regional Policy Boards in statute, including collection of data that supports recommendations
17. Legislatively create a Committee that has the charge to collect data, including civil commitment details involving law enforcement, transports by EMS to hospital ERs, the course of treatment in the ERs, and a summary of any transition to psychiatric services
18. Ensuring ongoing funding for specialty courts

Commented [A3]: I may have inadvertently omitted some priorities members submitted. This list was from my personal notes, so it might be courteous for us to explicitly ask Board members if this list includes their recommendations.

Following further discussion, the Southern Nevada Policy Board's chair further refined this list into the following five key areas, in random order:

1. Adjust marijuana excise tax revenue to fund mental health programs, such as Mental Health Court or Assisted Outpatient Treatment – could seek an allocation of existing money, redirect part of the 10% excise tax going forward, or make adjustments to local government's ability to add a local license tax for revenue or regulation
2. Revise language from Assembly Bill 366 (2017) to adjust regional Board membership, increase the Board's duties, and more effectively coordinate and amass information, including revising

the annual report requirements and secure funding for staff to help the Board meet increased duties and/or develop a first-rate website and track Legal 2000 data

3. Rewrite appropriate NRS chapters to remove inappropriate/stigmatizing language as it relates to mental/behavioral health.
4. Seek stable funding source for adult and child mobile crisis services, potentially implementing the OSCAR (One System of Care And Resources) system recommended in 2008 by the Southern Nevada Mental Health Design Work Group, and possibly create/update emergency management protocols to better coordinate mental/behavioral health response
5. Enact the "Freedom to Heal Act" – any willing and qualified provider for mental/behavioral health, either for private insurers, state Medicaid, or both

The Board voted to advance the second option in an effort to ensure the Boards have the means to fill in aforementioned data gaps and base future priorities and recommendations on solid data.

Recommendations

A. Regional Allocation of funds

The Southern Nevada Policy Board's top priority for allocating money is to ensure the Boards have designated staff or resources for the purpose of meeting the new duties outlined above for NRS 433.4295. Most Board members do not have the expertise or time to dedicate to scientifically gathering valid data and analyzing and interpreting it, and the time and expertise is expected to come at a cost, which may be incurred through legislative staff or external contracts.

Commented [A4]: I don't think it's accurate to state that duties were outlined above. Item 2 from the refined list mentions increased duties among other edits to AB366, and NRS 433 isn't mentioned. If I were tasked to assign staff or resources to an entity, I'd like to receive an idea of the work that needs to be done. Thus, I suggest including the list of new duties I included in my original draft.

Additionally, it is recommended that DHHS and DPBH review the allocation of funds to meet the identified needs for the Southern Region. Specifically, additional resources are needed for:

- Transitional and crisis services, including additional triage centers and mobile crisis services
- Development and maintenance of a website or database of relevant behavioral health information
- Workforce development (e.g. tuition reimbursement, enhanced rates, etc.)
- Additional program development to meet various needs mentioned above

Commented [A5]: I suggest this list focus on the top 5 items from the refined list above. If we include issues from the list of 18 above, I suggest we provide our rationale.

B. Standards for data collection and reporting

The Board is charged with reviewing existing data collection and reporting standards for behavioral health and then determining standards for such data collection and reporting. At the time of this report, the Southern Nevada Policy Board does not yet have a clear understanding of the data the Commission, DHHS or DPBH currently receive or their perspective on the data they receive, such as any desired changes or additional data. Thus, the Board is unable to comment or report on existing behavioral health data collection and reporting standards but will gather and report this information in the 2019 report.

It should be noted that a number of concerns about data arose during multiple Board meetings. On one hand, there appears to be a fair amount of data available in the form of PowerPoint presentations, reports, analyses, and documents that were delivered during Board meetings, distributed at other public meetings, or discovered on the internet (see Appendix A). However, the Board noted several consistent

weaknesses that appeared across multiple data sources, including poor community engagement, questionable validity and generalizability, obscurity around reports' catalyst, a lack of continuity among reports, and a lack of user-friendly public accessibility. Comments were made about a tendency to study and develop a report on a given issue without much attention given to increasing awareness or user-friendly accessibility of the report, following through on actions resulting from the study, or coordination among entities on the study of behavioral health matters. The Southern Nevada Policy Board discussed solutions to overcoming some of these challenges:

- Obtain and evaluate all routine data each state entity currently receives, including its source and purpose
- Increase coordination among public entities when addressing behavioral health matters
- Publicize and maintain an online organized, user-friendly repository of information on behavioral health relevant to all stakeholders
- Identify and eliminate barriers to community engagement when evaluating behavioral health systems
- Identify and coalesce state, regional, and local groups currently engaged in similar behavioral health data-related activities and explore potential for collaboration

As previously stated, the Southern Nevada Policy Board does not believe it has adequate data to assert that it has a complete, accurate depiction of the region's behavioral health needs, problems, gaps, and progress on which to base its priorities and recommendations. Thus, it seems prudent that the Board's first step would be to remove any barriers to obtaining the information necessary to make data-driven decisions and recommendations. The data the Board did gather clearly identified data management and application as a broad gap—an impediment to making data-based decisions, providing transparency, streamlining communication among stakeholders, and ensuring accountability, credibility, and ultimately high quality services. Obtaining accurate, actionable behavioral health data is the first step toward lowering the cost of access to such information, making information easier to find, increasing the speed at which information is made available, and fostering a collaborative style of decision making.

The Southern Nevada Policy Board retains as one potential future data-related recommendation a records management policy such that any bill draft request pertaining to behavioral health include a data note, just as they do with fiscal notes.

Another potential future recommendation is the development of an organized, sustainable repository of behavioral health data that houses up-to-date information on community resources (e.g., location, contact information, website, eligibility criteria, required documentation, enrollment application, hours of operation, accepted forms of payment, service availability, outcomes, etc.), providers on insurance panels, and programs' effectiveness. Not only would this repository facilitate data-driven decisions about regional behavioral health needs, problems, gaps, and progress, it could also increase the capacity for streamlined information exchange among all behavioral health stakeholders via effectively publicizing and maintaining an organized, up-to-date, and user-friendly online database similar to Wikipedia and Yelp for behavioral health information and services in Southern Nevada. Providers and patients may wish to access a list of behavioral health insurance plans, the providers and clinics credentialed with each, and each provider's or clinic's area of expertise. Payer sources and public

officials may wish to access a list of ongoing state, regional, and local efforts, studies, workgroups, task forces, committees, consortia, coalitions, commissions, councils, collaboratives, leagues, alliances, boards, and associations relating to behavioral health, including their mission/purpose, meeting location, point of contact, and published reports. This information would be available in the repository as would any available behavioral health contracts or grant opportunities as well as any published or publicly available reports, assessments, presentations, articles, columns, and legislative efforts.

Finally, it could include a mechanism for users to report updates proactively or request new data as Wikipedia does. The Regional Policy Boards could collaborate with existing state, regional, local, and private entities or sites publishing resources lists with the goal of encouraging participation in the development of a single primary online source of behavioral health data, minimizing duplication of efforts, maximizing financial and staffing resources, and focusing on accurate, up-to-date data.

Legislative Request

The Southern Nevada Policy Board proposes modifying Assembly Bill 366 of the 2017 Session of the Nevada Legislature to amend NRS Chapter 433, sections 2-7 to accomplish the following:

- Re-align the counties that comprise the Southern Board, by adding Lincoln County to the Southern Board.
- Provide for flexibility of membership if appointing body cannot find a qualified appointee. For example, the rural region does not have a public health officer, does not have a psychiatrist or psychologist, and does not have a private or public insurer.
- Clarify that the mandate to meet at least quarterly does not apply during the 120-day legislative session or, if the board does meet then, that the Legislator is excused.
- Seek an allocation of funds for full-time coordinators to help each Board carry out its duties in its region and to coordinate with the four other Boards.
- Edit the Boards' existing duties and what needs to be included in the Board's reports, such as:
    - A description of the methods of collecting and analyzing regional data about behavioral health needs, problems, and gaps, including all data sources.
    - A description of the efforts to coordinate and exchange information to ensure unified, coordinated recommendations that balance statewide goals with region-specific priorities.
    - A description of any duplicative, conflicting, or obscure federal, state, regional, or local regulations.
- Task each Board with tracking data relating to Legal-2000 civil commitments happening in their respective regions, with a focus on collective data relative to what happened on the back end of the process, including whether the person was civilly committed or not and any aftercare that took place.
- Task each Board with creating/maintaining a website or providing information to be uploaded to an existing website so that there is a "one-stop shop" for information in those regions.
- Name the specific entities with whom the Bboards must coordinate. It may be prudent to ask the state, counties, and cities which of their entities ought to coordinate with the Regional Policy Boards. Including them in the discussion could gain buy-in, increase awareness of the Boards' existence, and begin the process of routing behavioral health issues through the Boards.

Commented [A6]: I suggest this be one website. I also believe it is premature to make this request. It will be resource intensive and perhaps best to suggest at a later date. On the other hand, its repetition could also be useful.

- Include language that calls upon the Regional Policy Boards to organize and consolidate accurate, actionable, and easily accessible behavioral health data.

Appendix A- Epidemiologic Report

[placeholder]

Appendix B- Community Survey Results

Appendix C- Suggested Community Survey Questions