

Steve Sisolak
Governor

Richard Whitley, MS
Director



DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Public and Behavioral Health
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Lisa Sherych
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

Notice of Open Comment Period

Pertaining to 2019 Assembly Bill 206, Section 11, which amended Chapter 232 of NRS by adding a new section:

The Department of Health and Human Services is required to develop a written plan to address behavioral health needs in an emergency or disaster. Such a plan must, without limitation:

- (a) *Prescribe a process* for assessing the need for behavioral health resources during & after an emergency or disaster based on the estimated impact of the situation and the estimated depletion of resources.
- (b) *Ensure continuity of services* for existing patients with a mental illness, developmental disability, or intellectual disability during an emergency or disaster.
- (c) *Prescribe strategies* to deploy triage & psychological first aid during an emergency or disaster.
- (d) *Identify opportunities* for the rendering of mutual aid during an emergency or disaster.
- (e) *Prescribe procedures* to address the behavioral health needs of first responders during & after an emergency or disaster; and
- (f) *Prescribe measures* to aid the recovery of the behavioral health system after an emergency or disaster.

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Email comments to: ddavis@health.nv.gov

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For additional information, please contact:

Darcy Davis, PhD, Statewide Disaster Behavioral Health Coordinator
Nevada Department of Health and Human Services
Division of Public and Behavioral Health
4126 Technology Way, Suite 200
Carson City, NV 89706
Email: ddavis@health.nv.gov
Telephone: (775) 684-4229

AB 206, Section 11

The Department shall develop a written plan to address behavioral health needs in an emergency or disaster. Such a plan must, without limitations:

(a) Prescribe a process for assessing the need for behavioral health resources during & after an emergency or disaster based on the estimated impact of the situation and the estimated depletion of resources:

- The Division of Public Behavioral Health (DPBH) will designate a Statewide Disaster Behavioral Health Coordinator (coordinator) who will work collaboratively with the local jurisdictions and tribal governments to develop an assessment process.
- The coordinator, the Nevada Resilience Advisory Committee, and the Nevada Tribal Emergency Coordinating Council will begin the assessment process by working collaboratively with the local jurisdictions and tribal governments to develop culturally-diverse, community-based assessment teams (CATs).
- The CATs will use a collaborative, whole-community approach to build on the work already being accomplished in the local communities and to ensure the process is inclusive of the natural helping community and healers and that all Nevada communities have an opportunity to participate in the assessment and in the statewide behavioral health emergency and disaster planning process.
- The CATs will use state and local data to identify their unique populations at-risk of developing behavioral health conditions.
- The CATs will develop a community-based communications plan specific to developing the needs assessment.
- The CATs will actively reach out to their local communities by soliciting participation through methods such as in-person regional and community gatherings, forums, meetings, focus groups, and on-line surveys.
- Each CAT will conduct at least a rudimentary (depending on capability and funding mandates) community-specific Threat and Hazard Identification and Risk Assessment (THIRA): Step 1: Develop a community-specific list of threats and hazards (natural hazards, technological hazards, human-caused incidents) that could affect the community and challenge the community's ability to deliver behavioral health services during or after an emergency. Step 2: Create context descriptions and estimate the impacts of the threats and hazards identified in Step 1 by providing details about the threats or hazards in order to identify and estimate the impacts the incidence will have on the community and by including critical details such as location, magnitude, and time of an incident. Step 3: Establish behavioral health capability targets by considering what resources are required to address the impacts of the threats and hazards (FEMA, 2018). Step 4: Conduct a THIRA reassessment each year.

(b) Ensure continuity of services for existing patients with a mental illness, developmental disability, or intellectual disability *during* an emergency or disaster:

- There are many State and Federal regulations to help ensure continuity of services for existing patients with mental illness, developmental disability, or intellectual disability during an emergency or disaster (occurrence):
 - Each State agency includes continuity of services in their Emergency Operations Plan.
 - All Rural Regional Center contracted-providers who support individuals with intellectual disabilities and/or related conditions have specific emergency procedures, and they receive consistent training on emergency responses.
 - Under the Protecting Access to Medicare Act of 2014, *Program Requirement 2.a.8: Availability and Accessibility of Services*, all Certified Community Behavioral Health Clinics are required to have a continuity of operations/disaster plan in place.
 - The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF) both require programs to have disaster plans in place in order to be accredited.
 - The *Federal Guidelines for Opioid Treatment Programs* require programs to develop and maintain effective policies and procedures addressing client and staff safety, program emergencies, and adverse events that require immediate response and investigation.
 - As regulated through the Office of the Assistant Secretary for Preparedness and Response, behavioral health treatment programs that are part of the regional healthcare coalitions receiving federal funding under the 2019 *Pandemic and All-Hazards Preparedness and Advancing Innovation Act* are required to ensure services for at-risk individuals. At-risk individuals are people with access-based and functional-based needs that may interfere with their ability to access or receive medical care before, during, or after an occurrence.
 - The Centers for Medicare and Medicaid Services requires organizations registered with Medicare as Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Centers, and Intermediate Care Facilities to develop and implement emergency plans to follow in the event of a natural disaster or other emergency.
- The DPBH coordinator will work cooperatively with local government entities and behavioral health treatment organizations and agencies to develop continuity of operations plans (COOPs), as needed.
- Once the individual COOPs are developed, the coordinator will help align the plans with those of other behavioral health treatment programs, the State, other jurisdictions, voluntary organizations (e.g., American Red Cross; faith-based organizations; mutual-help and self-help groups; consumer advocacy groups for client populations with mental illnesses, developmental disabilities, or intellectual disabilities), and Federal coordinating agencies (SAMHSA, TAP 34).

- The COOPs will identify the program's essential functions and essential staff in order to continue vital services to clients; to meet regulations or laws; to maintain onsite safety of clients, visitors, and staff; and to support the essential functions of Federal coordinating agencies (SAMHSA, TAP 34):

Essential Functions for All Behavioral Health Programs:

- Provide for continuity of leadership, including order of succession and delegation of authority.
- Provide for the physical safety of all clients, visitors, and staff at the facility, including access to shelters.
- Provide behavioral health emergency services.
- Conduct basic screening, intake, and discharge procedures.
- Provide crisis and relapse prevention counseling and supportive services.
- Reduce the clients' risk of developing traumatic stress by providing stress-prevention guidance (e.g., self-care, reach out to others, minimize media exposure) and training (e.g., in-the-moment calming techniques and relaxation techniques).
- Assist clients in accessing any needed medications.
- Conduct drug testing for mandated clients.
- Prearrange for services to be provided in a different location or facility (e.g., another space within the facility, another location of the organization, space borrowed from or shared with another organization, telework, mobile workstations).
- Document any transfer of clients and their records to another agency.
- Track clients affected by any dispersal and evacuation to ensure they continue to receive needed behavioral services or to reengage them in programming, as necessary.
- Adhere to State licensing standards.
- Protect client rights and privacy, including the integrity of protected health information records.
- Maintain treatment and billing records in accordance with payor and regulatory requirements.
- As resources are available and based on mandates, provide disaster mental health services to the community as requested by the Emergency Operations Center or the Emergency Support Function #8 Coordinator.

Essential Functions for Outpatient Treatment Programs:

- Provide case management activities, such as linking clients to needed resources and helping them obtain any needed medication replacements or refills.
- Provide crisis stabilization, crisis intervention, or other emergency services.

Essential Functions for Residential Treatment Programs:

- Provide residential care for patients who do not meet discharge criteria.
- Stabilize patients undergoing nonmedical (social) detoxification.
- Continue medications and supportive counseling to patients to prevent decompensation or escalation of symptoms of behavioral health disorders.
- Coordinate or address patient transportation needs for accessing medical services.
- Provide case management services, as appropriate, to move patients toward discharge readiness.

Essential Functions for Medically Managed Detoxification Programs:

- Follow established medically managed detoxification protocols.
- Medically stabilize patients; closely monitor their withdrawal symptoms.
- Transfer patients to an appropriate facility if they require a higher level of medical care than the program can offer; provide residential care for patients who remain at the facility.

Essential Functions for Opioid Treatment Programs:

- Confirm identities and dose information for patients receiving medication.
- Provide or facilitate access to prescribed or dispensed medications (e.g., methadone, buprenorphine).
- Provide case management to assist with medically appropriate transfer or discharge.

SAMHSA (TAP 34) General COOP Recommendations

- Develop multiple means to broadcast alerts to staff and clients (e.g., establish agreements with local TV and radio states to communicate the program's status to the staff and public, create a communications tree, partner with amateur radio operators.)
- Distribute staff emergency contact information in multiple formats.
- Issue routine reminders to staff to print or back up, to a second location, their computer-based information.
- Develop the capability to support clients during an occurrence by providing staff with live, in-person trainings that address incident-related behavioral health topics (e.g., recognizing symptoms of psychological trauma in clients, referring such clients to psychology first aid services, supporting clients' coping skills, conducting trauma-informed therapy).
- Prepare staff to give extra support to clients with mental illnesses, developmental disabilities, and intellectual disabilities; staff preparation may also include planning to give extra support to clients who are pregnant or have dependents, are older, are experiencing homelessness, or are on medications.

- Ensure staff have access to interoperable communications systems such as, dedicated phone lines; cell phones with text messaging capabilities; personal digital assistance or Internet-based telephone accounts; two-way radios; satellite phones; and other devices for person-to-person communications when cell and landline phones are inoperable; an Intranet hot site, which provides a private, password-protected area accessed only by authorized users and can be used to send and receive status information to staff; an offsite telephone number staff can call to report status and to obtain information; battery operated laptops with software and memory capacity enabling access to clinical data; computers at guest locations that are loaded with software capable of running the program's necessary files and databases or that have the ability to access the program's hosted software site containing that information.
- Prepare clients for occurrences by providing resources (e.g., trainings, handouts, brochures).
- Prepare for program financial resiliency by considering how to support client retention through active outreach following an occurrence; by informing staff about procedures for enrolling clients in Medicaid under emergency conditions; by educating payors about modified counseling services (e.g., telephone or Web-based counseling) in order to facilitate reimbursement; by establishing a contingency or reserve fund or a line of credit for unexpected cash flow issues (e.g., maintaining payroll when billing is disrupted); and by making plans for low revenue after an occurrence (e.g., planning ahead for emergency grant proposal writing; careful tracking and documentation of services provided so reimbursements will be facilitated).
- Develop resources to manage human capital in advance of an occurrence:
 - Issue a list of social service providers who will be available to support staff with personal emergency needs (e.g., medical assistance, crisis counseling, temporary housing). If necessary, plan to use mutual aid for this purpose.
 - Develop policies that will support staff as they serve during an occurrence (e.g., provide staff with advance training in disaster self-care, ensure staff have access to phones or the Internet to check on family members while staff are deployed, allow for adjustments to staff work schedules in order for staff to perform essential functions while also managing person responsibilities, provide compensation to staff who work additional hours during the occurrence).

Memoranda of Understanding

SAMHSA (TAP 34) also recommends COOPs include Memoranda of Understanding (MOUs) for mutual aid, including but not limited to:

- Arranging to use other programs' facilities as alternative treatment spaces.
- Providing essential services to another program's clients.

- Supporting computer system services in the event a program needs to move to an alternative address.
- Providing evacuation transportation assistance.
- Lending or borrowing staff to temporarily fill key staffing gaps.
- Arranging payments for any mutual aid.

(c) Prescribe strategies to deploy triage & psychological first aid *during* an emergency or disaster:

DPBH Strategies for Deployment Preparation

- Formalize Emergency Support Function 8.1 in the DPBH Emergency Operations Plan.
- Work with the local communities/jurisdictions to ensure any community behavioral health teams are integrated into the statewide disaster plan.
- Collaborate with the local communities/jurisdictions to ensure triage and psychological first aid strategies are standardized and based on best practices by adopting a training standard of practice for individuals wanting to participate in disaster behavioral health. Examples: Introduction to the Incident Command System (IS-100), An Introduction to the National Incident Management System (IS-700.B), Psychological First Aid, and the American Red Cross Disaster Mental Health Fundamentals.
- Work with the local communities/jurisdictions to develop and implement a standardized statewide initial and refresher training-plan to deliver the recommended psychological first aid and crisis counseling classes.
- Work with the professional licensing boards covered in Assembly Bill 534 Sec. 21 to develop deployment strategies specific to professionals licensed by said boards. This particular legislation authorizes the Governor to suspend certain licensure requirements in response to an occurrence; requires certain professional licensing boards to maintain lists of licensees trained in the treatment of short- and long-term mental and emotional trauma; and requires said boards to provide those lists to a governmental entity responding to an occurrence.
- Expand the State's triage and psychological first aid capability by working with the local communities/jurisdictions to recruit and train community-based peer supporters, the faith-based community, and other natural community helpers and healers.
- Collaborate with the local communities/jurisdictions to provide refresher training for the large contingent of individuals across the state who are trained on the recommended psychological first aid and crisis counseling curricula.
- Collaborate with the local communities/jurisdictions to identify and use evidence-informed, standardized curricula to train behavioral health providers who are new to disaster response.
- Work with the local communities/jurisdictions to train responders to standards regarding cultural sensitivity, appropriate crisis-situation interactions with culturally

diverse groups, and appropriate interactions within the context of the cultural considerations.

- As needed, work with the local communities/jurisdictions to help them to establish intra-state mutual aid MOUs in order to quickly deploy triage and psychological first aid to their partners during an occurrence.
- Work with the local communities/jurisdictions to develop and disseminate an intra-state mutual aid behavioral health resource inventory.
- Collaborate with local communities/jurisdictions (as needed) to develop comprehensive behavioral health mobilization and deployment plans and related protocols in order for the entities to quickly and efficiently identify; process; mobilize; and deploy staff during an occurrence (Herrmann, 2005).
- Work across systems to ensure the behavioral health plan is integrated into all statewide, full-scale, exercises.
- The Department of Health and Human Services (DHHS) administers the Everbridge mass notification system for all DHHS employees and volunteer crisis counselors who opt to participate in the system. Use the system to conduct drills to assess the responders' ability to mobilize, their ability to coordinate across systems, and their ability to work together.
- Encourage all DPBH state employees be enrolled in Everbridge.
- Nevada maintains the State Emergency Registry of Volunteers-Nevada (SERV-NV), which is a volunteer registry developed in compliance with the Emergency System for Advanced Registration of Volunteer Health Professional Guidelines. The registry is a national, web-based network of state-based systems used to register, qualify, and credential Nevada's volunteer healthcare professionals before an occurrence. The system provides for swift deployment during an occurrence.
- Work with the State's licensing boards to encourage behavioral health professionals to affiliate with any local community/jurisdiction behavioral health response teams and to register with SERV-NV.
- Work with the local communities/jurisdictions to promote SERV-NV and to provide a concentrated recruitment strategy.
- Work with the local communities/jurisdictions to develop operational protocols to address the spontaneous self-deployment of volunteers during an occurrence.

Local Community/Jurisdiction Deployment Strategies

- Based on the cooperative planning with DPBH, the local communities/jurisdictions will activate the behavioral health mobilization deployment protocols and processes.

(d) Identify opportunities for the rendering of mutual aid *during* an emergency or disaster:

- DPBH and other governmental and non-governmental entities have behavioral health interstate mutual aid agreements and systems in place to provide a variety of resources, facilities, services, and support to other jurisdictions during an incident.
- The Nevada Intrastate Mutual Aid System, as authorized by Nevada Revised Statutes (NRS) 414A, allows the Nevada Department of Public Safety, Division of Emergency Management to coordinate the provision of equipment, services, or facilities owned or organized by the State or its political subdivisions for use in the affected areas upon request of the duly constituted authority of the areas during the response to and recovery from an occurrence.
- The Nevada Emergency Management Assistance Compact, as authorized by NRS 415 complies with the nationally adopted Mutual Aid Agreement to provide for mutual assistance between the States entering into the Compact.
- The Nevada Hospital Association and participating hospitals within the geographical boundaries of the State of Nevada have a mutual aid agreement to share resources during disasters to include personnel, equipment, supplies, pharmaceuticals, and transfers of patients.
- The Division of Child and Family Services Behavioral Health Coordinator who works with the Vegas Strong Resiliency Center maintains a list of available trained disaster response mental health and supportive services providers within Nevada as well as in other communities and states.
- SERV-NV-registered volunteers (see Section (c)) can be mobilized to render mutual aid.
- Work with the local communities/jurisdictions to develop mutual aid agreements with the criminal justice agencies and to include the criminal justice system in drills.

e) Prescribe procedures to address the behavioral health needs of first responders *during & after* an emergency or disaster:

Preparing for an Occurrence

- DPBH will work with the local communities/jurisdictions to adopt a preventive perspective to address the behavioral health needs of first responders (responders).
- DPBH will work with the local communities/jurisdictions to develop a strategy to address the stigma, misunderstanding, and perceptions about responders who use behavioral health services.
- DPBH will collaborate with the local communities/jurisdictions to develop mobilization plans that, whenever possible, are in alignment with the Incident Command System. Planning includes developing policies for the organizational care of responders, writing strategic plans, and developing clear written protocols.

- With support and assistance from DPBH, the local communities/jurisdictions will provide pre-emergency/pre-disaster education for responders on topics such as, stress management; coping skills; self-care; personal vulnerability; burnout; and compassion fatigue.
- The local communities/jurisdictions will address the behavioral health needs of responders in employee handbooks and orientations.
- As needed, and with support of DPBH, the local communities/jurisdictions will offer training for employee assistance program (EAP) professionals on how to provide psychological first aid and crisis counselling specific to responders.
- The local communities/jurisdictions will develop policies and procedures to provide responders with initial and follow up incident debriefing sessions.
- DPBH in collaboration with the communities/jurisdictions will enhance the statewide public and private-sector response-capacity by expanding the standardized psychological first aid and crisis counseling trainings.
- DPBH in collaboration with the local communities/jurisdictions will work to establish a network of peer-support teams trained in crisis response that can be mobilized when local peer-support providers are involved in responding to an occurrence and are not available to assist responders within their own agencies (Usher, et.al., 2016).

During an Occurrence

During an occurrence, as determined in collaborative planning with DPBH, each local community/jurisdiction will:

- Follow protocols to use the identified mass notification system to alert, mobilize, and deploy behavioral health providers.
- Provide a staging area in the affected area for deployed behavioral health providers to provide services.
- Provide confidential, one-on-one crisis interventions and assistance any time during the occurrence, as requested by the responder.
- Monitor responders throughout the occurrence and provide confidential outreach, interventions, assistance, and referrals to those who show obvious signs of distress, or as otherwise indicated.
- Provide respite centers where responders can rest and obtain food, clothing, and other basic support services.
- Provide confidential individual crisis intervention immediately any time symptoms occur. Goal is symptom mitigation & return to functioning, if possible. Make and facilitate referrals to the EAP or other behavioral health programs, as indicated. (US Army Corp of Engineers).
- Conduct confidential, brief (30-60 minutes), and informal one-on-one defusing sessions with each responder at the end of their event-shifts to defuse their immediate reactions to the occurrence and to vent their emotions in order to transition back to their normal routines. Make and facilitate referrals to the EAP or

other behavioral health programs, as indicated. Make referrals to a critical incident stress debriefing group. (US Army Corp of Engineers).

- Conduct confidential one-on-one debriefing sessions with each responder at the end of their event-shifts. Make and facilitate referrals to the EAP or other behavioral health programs, as indicated. Make referrals to a critical incident stress debriefing group if one is available (US Army Corp of Engineers).
- As available, offer group defusing and/or debriefing sessions for the appropriate homogeneous groups according to guidelines established by the model to be used.

Supervisors

- Actively manage responder stress and functioning by continually walking through work areas and by providing real-time support.
- Remind responders how to monitor themselves and their peers for stress and how to obtain assistance if they need it.
- Provide brochures and handouts on the potential reactions and behavioral health consequences of an occurrence, how to manage their stressors, and when and where to seek assistance.
- Be contentious about the effects of prolonged mandatory overtime, increased workloads, and assignments to unfamiliar work.
- Ensure enough staff are available from all levels of the organization, including administration, supervision, and support. Use mutual intra- or inter-state mutual aid, as necessary.
- Design shift schedules and mobilize backup responders to ensure the responders only work 12 hours with 12 hours off. Use intra-or inter-state mutual aid, as necessary.
- Whenever possible, rotate responders among low-, mid-, and high-stress tasks.
- Ensure responders take breaks and time away from the assignment.
- Delegate responders' regular work to others so the responders do not attempt to respond to the occurrence in addition to their usual workloads. As needed, use staffing garnered through mutual aid agreements.
- Mandate time off.
- Nurture team support.
- Create a buddy system to support and monitor stress reactions.
- Provide frequent praise to promote a positive atmosphere of support and tolerance.
- Manage conflicts between responders.
- Provide regular stress-reducing activities, such as music; movies; meditation; and yoga.
- Help reduce responder isolation by providing access to email, the Web, and telephones.
- Address responder concerns about personal and/or family risks.

After an Occurrence

After an occurrence, as determined in collaborative planning with DPBH, each local community/jurisdiction will:

- Conduct a confidential, one-on-one demobilization debriefing session with each responder at the time of her or his demobilization and provide information about how to communicate with her or his family about their work. Provide formal recognition of the responder's service. Make and facilitate referrals to the EAP or other behavioral health programs, as indicated. Make referrals to a critical incident stress debriefing group, as available. (US Army Corp of Engineers). Use intra- or inter-state mutual aid, as necessary.
- Provide small critical incident *stress defusion* groups 8 to 12 hours post-occurrence, if available. Make and facilitate referrals to the EAP or to other behavioral health programs, as indicated. Make referrals to a critical incident stress debriefing group. (US Army Corp of Engineers). Use intra- or inter-state mutual aid, as necessary.
- Conduct a confidential, one-on-one, intermediate debriefing session with each responder within 72 hours of the occurrence. Provide formal recognition of her or his service. Make and facilitate referrals to the EAP or to other behavioral health programs, as indicated. Make referrals to a critical incident stress debriefing group. (US Army Corp of Engineers). Use intra- or inter-state mutual aid, as necessary.
- Provide small, homogenous, critical incident stress *debriefing* groups for the responders within 24 to 72 hours of the occurrence. The groups should follow a standardized curriculum and should be staffed by teams of trained behavioral health specialists and peer support specialists. (US Army Corp of Engineers). Use mutual intra- or inter-state mutual aid, as necessary.
- Approximately 30 days post-occurrence, conduct a confidential one-on-one follow up debriefing session with each responder. Provide formal recognition of her or his service. Make and facilitate referrals to the EAP and peer-support providers, as indicated. As appropriate, make referrals to self- and peer-help groups (Alcoholics Anonymous, Gamblers Anonymous, Narcotics Anonymous, SMART Recovery, Women for Sobriety, etc.). (US Army Corp of Engineers). Use mutual intra- or inter-state mutual aid, as necessary.
- Provide family information sessions and family support services. Use intra- or inter-state mutual aid, as necessary.
- Create on-going formal and informal opportunities for responders to discuss their experiences, to critique the operation, to receive support, to prevent compassion fatigue, and to receive formal recognition for their service.
- Facilitate ways responders can communicate with each other by establishing listservs and/or an online communications platform, by encouraging the sharing of contact information, and by providing conference calls.
- Encourage time off for responders who have experienced personal trauma or loss.
- Monitor responders who meet certain high-risk criteria, such as those who:

- Are survivors of the occurrence.
- Have regular exposure to severely affected individuals or communities.
- Have pre-existing conditions.
- Have multiple stressors, including those who have responded to multiple disasters in a short period of time.

(f) Prescribe measures to aid the recovery of the behavioral health system *after* an emergency or disaster:

- DPBH and the local communities/jurisdictions will work together to integrate behavioral health activities and programming into other local sectors (e.g., education, health care, social services) to reduce stand-alone services, to reach more people, to foster resilience and sustainability, and to reduce stigma.
- DPBH and the local communities/jurisdictions will collaborate to promote the community's increased understanding of the importance of behavioral health in relation to individual health and community health.
- DPBH and the local communities/jurisdictions will work together to focus on strategies known to impart resilience (e.g., coping skills, social connectedness).
- DPBH and the local communities/jurisdictions will work together to plan for the recovery of the local behavioral health system by identifying and building on each community's unique resources and capacities and by developing strong community networks that include families, friends, schools, responder-peer support communities, self- and peer-help communities, and natural community helpers and healers.
- DPBH and the local communities/jurisdictions will work together to enhance the system's capacity to respond to the surge in behavioral health care needs by providing clinicians and other behavioral health service providers with emergency- and disaster-specific education, training, and skill building.
- DPBH will work with the local communities/jurisdictions to develop an intra-state mutual aid behavioral health resource inventory; DPBH will disseminate the inventory to the local communities.
- DPBH, in collaboration with the local communities/jurisdictions, will develop a recovery-specific section in the statewide behavioral health plan that addresses how to resume mission-critical functions, how to determine system-continuity needs, and how to develop a system recovery timeline.
- DPBH will work with the local communities/jurisdictions to determine a coordinated and unified post-disaster messaging system using entities such as, the Joint Information Center; state/county/local crisis communication groups; regional behavioral health coordinators; regional healthcare coalitions; and the Nevada Tribal Emergency Coordinating Council.
- The State will integrate the Nevada Security Awareness Committee into any emergency preparedness groups in order to ensure recovery of electronic health records and to ensure the continuation of the Medication Management Program after an occurrence.