NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

(*Nevada Revised Statutes* [NRS] 218E.320)

MINUTES

May 13, 2024

The fourth meeting of the Joint Interim Standing Committee on Health and Human Services for the 2023–2024 Interim was held on Monday, May 13, 2024, at 9 a.m. in Room 4401, Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. The meeting was videoconferenced to Room 3138, Legislative Building, 401 South Carson Street, Carson City, Nevada.

The agenda, minutes, meeting materials, and audio or video recording of the meeting are available on the Committee's meeting page. The audio or video recording may also be found at https://www.leg.state.nv.us/Video/. Copies of the audio or video record can be obtained through the Publications Office of the Legislative Counsel Bureau (LCB) (publications@lcb.state.nv.us or 775/684-6835).

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Fabian Doñate, Chair
Assemblyman David Orentlicher, Vice Chair
Senator Rochelle T. Nguyen
Assemblywoman Tracy Brown-May
Assemblywoman Michelle Gorelow (Alternate for Assemblyman Nguyen)

Assemblyman Brian Hibbetts

COMMITTEE MEMBER ATTENDING REMOTELY:

Assemblyman Ken Gray

COMMITTEE MEMBERS ABSENT:

Senator Robin L. Titus (Excused)
Assemblyman Duy Nguyen (Excused)

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Jered McDonald, Chief Principal Policy Analyst, Research Division
Davis H. Florence, Senior Policy Analyst, Research Division
Sarah Baker, Research Policy Assistant, Research Division
Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division
Aaron McDonald, Principal Deputy Legislative Counsel, Legal Division
Jeff Koelemay, Deputy Legislative Counsel, Legal Division
Kimbra Ellsworth, Senior Program Analyst, Fiscal Analysis Division

Items taken out of sequence during the meeting have been placed in agenda order.
[Indicate a summary of comments.]

AGENDA ITEM I—CALL TO ORDER

Chair Doñate:

Good morning, everyone, and welcome to our fourth meeting of the Joint Interim Standing Committee on Health and Human Services. Today is one of the most exciting meetings we have. I believe it is Mental Health Awareness Month, so today is probably one of the most important meetings we will have during the interim. It starts off with our conversation on mental health and the infrastructure we need to improve our State with. Today's focus is strictly on adult behavioral health. I know there is interest, of course, in children's mental health. That meeting will happen in June. Today we will start the conversation with what we are doing to improve our mental health system. We do have a few elected officials that will be starting our meeting today. It is exciting to be in that conversation. I know that we are eager to have conversations of where we are and where we need to go. I am truly excited and thankful for everyone here today.

[Chair Doñate reviewed housekeeping measures and public comment protocols.]

AGENDA ITEM II—PUBLIC COMMENT

Chair Doñate:

We will start here in Las Vegas, then move on to Carson City, and virtually. Is there anyone who would like to provide public comment at this time? Please proceed.

Giuseppe Mandell, Desert Hope Treatment Center and American Addiction Centers:

This is not much of a public comment; it is more of a thank you to all of you in the community. Those I have not collaborated with; I look forward to collaborating with. Thank you to the Attorney General and his office for always being fully transparent and open to working with organizations like ours and the continued collaboration. I am a person in long-term recovery. I have a presidential award for service hours in the community with law enforcement. I have several sales awards. I was an all-state athlete at a very prestigious number one football school in the nation here in the community. I come from a good family. That was all before I ended up homeless due to an opiate addiction. [It was] prescribed and then [I] ended up switching to heroin. I know these meetings get long. I know they get tiring. One thing about drug addiction or substance use disorder or alcoholism, it does not care what side of the aisle you vote on. It does not care who you identify as. It does not care who you sleep with. It does not care what race, gender, or orientation you are. It is across all boards and affects all of us from family as well as individuals. [This is] just more of an inspiration that there are people like me due to all the committees and boards and representatives that work out there. Just to give you a little inspiration on those long, hard argumentative meetings; sometimes I have been a part of them. Keep going because there are those that you do save lives with. In return, there are thousands of us out there that go and help to bring our lived experience to you guys and hope for better change.

Amanda Haboush-Deloye, Director, Nevada Institute for Children's Research and Policy, University of Nevada, Las Vegas (UNLV):

I am also the immediate past Chair for the Clark County Children's Mental Health Consortium. As stated, I know you are not talking about children's mental health today, but as you talk about adult mental health, we want to encourage and remind you that adults and children are separate, and to make sure when you are making decisions about adults, children are not looped in when it is not appropriate to do so in those terms. Keep that in mind as you are having discussions. We look forward to talking to you next month about children's mental health. Thank you for all you do.

Chair Doñate:

A point of personal privilege, Doctor Haboush-Deloye was my former professor. Thank you for being here today.

Chelsea Bishop, Act4Kids Nevada:

I am here also on the same strain about children. We are Act4Kids Nevada. We are a neutral group advocating for a freestanding children's hospital. We have been collecting stories from families that live here in Nevada. I would like to read a quote from one of them, "Families traveling out of State must leave work, school, and family behind. Having to make the decision to either travel and fear job loss or stay locally and not get the care my child needs is no way to live." This is a family that lives in Las Vegas. So many children are having trouble accessing health care right now in Nevada. We look forward to a day this does not need to happen, and our health care is not siloed in different hospitals and siloed in private medical practices.

As a group, we are looking for change. We look forward to the change. Here are a few things we think will help this issue: physician licensure; other health care worker's licensure; working on measures to retain these health care workers; the general need for awareness for a children's hospital—I think people see a lot of signs, and they do not understand it is a fragmented system—and Medicaid reimbursement rate—seeing increases for these providers that are working so tirelessly to help our children here in Nevada. Thank you for your time and dedication to our kids.

Kinnsi Sigler, Act4Kids Nevada:

We are a grassroots movement trying to bring awareness to this need we have for comprehensive pediatric care in Nevada. Specifically, a freestanding children's hospital. I am the mother to four children who are medically involved, two of which are deaf or hard of hearing. We have experienced the challenges of needing to travel out of State for care and also accessing comprehensive care here in the State of Nevada. Our family has experienced the struggles of chasing symptoms instead of being a champion of solutions. When we go out of State, we are able to meet with a comprehensive team who can really come up with those solutions, and we see that need here.

I would like to share a brief story of another family through our organization who has experienced similar struggles. This is a Henderson family, and they say, "Without a full children's hospital, much of the communication between doctors and facilities is left to the parents to handle. When we visit a children's hospital out of State, clinics work together to coordinate our child's care. We are always impressed with how easy it is. As our State population grows, coordination of care is critical." Is that not true? This coordination of care is critical. We hope to help bring forth solutions to help be a part of a team that can

champion these solutions instead of chasing these symptoms with our children. I echo the things Chelsea has shared: finding solutions for retainment of physicians, Medicaid reimbursement, and of course raising awareness for a freestanding children's hospital.

Chair Doñate:

Is there anyone else in Las Vegas? We will go to Carson City. It looks like there are a few folks.

Madalyn Larson, Student, University of Nevada, Reno (UNR):

I want to express from a student's point of view that we, as students, need access to Naloxone on campus to prevent accidental overdoses off campus. Students are using drugs, have always used drugs, and will continue to do so. Now, more than ever, drugs used by college students—like cocaine and Adderall—are being laced with Fentanyl. We must recognize that providing lifesaving access to Naloxone will not encourage drug use, but [it will] equip students to respond swiftly if an overdose were to occur. College is a time of experimentation, and no college student should be at the risk of death because of this. We cannot wait until a student overdoses to take action. Please consider sponsoring a bill that provides equitable access to Naloxone to all Nevada System of Higher Education (NSHE) students to prevent a fatal overdose. Thank you so much for your time.

Chair Doñate:

Is there anyone else in Carson City? Broadcast and Production Services (BPS), is there anyone virtually?

BPS:

If you would like to participate in public comment, please press *9 now to take your place in the queue.

Katrin Sienkiewicz, Stand for Health Freedom Nevada:

During the public comment portion of the last meeting of this Committee, we heard from the Director of the Nevada Chapter of the American Academy of Pediatrics (AAP) that they strongly encourage the removal of vaccine exemptions in our State. We presume, based on this statement, they are working to accomplish this in Nevada. Of course, this industry trade organization, which exists to protect vaccine profits, would like nothing better than to require each of us to consume their products without the ability to opt out. Does this benefit the people you represent, the citizens that elected you all to represent them? This statement from the AAP comes at a time where public support of vaccine and medical mandates is at an all-time low, at a time where courts in other states are overturning laws that had previously removed vaccine exemptions for school attendance, at a time where many people have noticed that "safe and effective" is just a marketing slogan, and the classic "one in a million" line used to discuss the vaccine injury rate is simply not true. Last week, *The New York Times* published an article titled "Thousands believe COVID Vaccines Harmed Them. [Is Anyone Listening?]" Also, last week, AstraZeneca withdrew their Coronavirus Disease of 2019 (COVID-19) vaccine from the market after admitting in a courtroom they knew early on their vaccine caused blood clotting. Much more information is coming out every day about vaccines, and it indicates the risks associated with taking them is much higher than we have previously been led to believe. The federal Vaccine Adverse Event Reporting System (VAERS) shows 6,469 reports filed by Nevadans—population 3.2 million—for the COVID-19 vaccines alone. That includes 53 deaths, not exactly one in a million now, is it? We are here to encourage this Committee to consider the will of the

people of Nevada, to prioritize your constituents over corporate interests, to keep in mind, should you be approached by the vaccine lobby for legislation that would eliminate exemptions, that the majority of Nevadans do not support vaccine mandates. Thank you very much for your time.

Michael Berry, Private Citizen:

I am from Senate District 15. I am also a Certified Peer Support Specialist and a Community Health Worker in Reno. I attend UNR as a full-time social work student, and I am also employed full-time working with Reno's unsheltered community. My interest and my stake in this community has to do with community outreach and harm reduction. I would like to say I am in support of having statewide access to the opioid overdose reversal medication known as Narcan. I would like to see—one day soon—it offered from vending machines throughout our State at health centers, clinics, and the Sheriff's Department; just to name a few. I am also interested in getting it into the NSHE. I would like them to take the responsibility for the care of all their students and grant the Agency to their Residential Advisor to allow them permission to provide this life saving medication to someone in the throes of an opioid overdose. Currently, this is not the protocol. Currently, as it stands, the Residential Adviser, if someone is overdosing on their floor, is to call 9-1-1 and wait. We know there is plenty of information and science that backs up that those minutes are crucial. I am also interested in safe consumption sites in our great State of Nevada. I hope to see bills related to this matter in the future soon. Thank you for your time and allowing me to comment publicly about what I am passionate about.

BPS:

Chair, you have no more callers at this time.

Chair Doñate:

We will close public comment.

AGENDA ITEM III—APPROVAL OF THE MINUTES FOR THE MEETING ON MARCH 11, 2024

[This agenda item was not heard.]

AGENDA ITEM IV—CONSIDERATION OF REGULATIONS PROPOSED OR ADOPTED BY CERTAIN LICENSING BOARDS PURSUANT TO *NEVADA REVISED STATUTES* 439B.225

Chair Doñate:

We will move on to our first item, consideration of regulations proposed or adopted by certain licensing boards pursuant to NRS 439B. We will allow Eric Robbins to begin, and we can ask any questions following.

Mr. Robbins:

We have six regulations to be considered by the Committee today; two regulations from the Board of Medical Examiners, two regulations from the State Board of Osteopathic Medicine, and two regulations from the State Board of Pharmacy. We should have representatives from each Board attending either in person or virtually to answer any questions the

Committee may have. (Agenda Item IV A) (Agenda Item IV B) (Agenda Item IV C) (Agenda Item IV D) (Agenda Item IV E) (Agenda Item IV F)

Chair Doñate:

Committee Members, are there any questions with any of the regulations, or any of them we would like to pull out?

Vice Chair Orentlicher:

I have questions on the first two from the Board of [Medical Examiners], R033-24 and R068-23.

Chair Doñate:

Are there any other ones we would like to pull out? The only one I have questions on is R001-24 from the State Board of Osteopathic Medicine.

Chair Doñate:

Let us begin with LCB File R033-24 from the Board of Medical Examiners. Vice Chair Orentlicher, do you have any questions specifically on that one?

Vice Chair Orentlicher:

Section 2, which talks about if you are going to practice in a specialty to have completed a residency in that specialty. I know we had a requirement of three years of residency. I am wondering about the doctor who has completed three years of a surgical residency for example. They have not completed a full residency. It sounds like they are not able to practice. Are there problems out there we are seeing with doctors that led to this? I know more than 30 states license on the basis of one year of residency training. Obviously, it has been in statute for a while that we have three years, but it seems like we are tightening up at a time when we have a doctor shortage. I am curious about the background of this.

Sarah Bradley, Deputy Executive Director, Nevada State Board of Medical Examiners:

The background on this is because we have people practicing in areas they are not trained in and perhaps should not be practicing in. The intent here is to make sure they document to the Board. It is not about the residency. It is about them designating to the Board the specialty area they intend to practice, and then basically making sure there is some proof or backup support for that. It would be a Board certification by a Specialty Board of the American Board of Medical Specialties or the successful completion of a graduate program that provides training in that specialty area. There is also an option they got approval from the Board if the first two do not apply. The intent is to make sure they have documented to the Board the area they intend to practice, and it is one they are trained and skilled in. This also would affect their physician assistants (PAs) and make sure those PAs only practice in that area the supervising physician is competent and skilled in. The concern we are seeing is public protection issues of people practicing outside the area of their training. We are trying to document and enforce that better.

Vice Chair Orentlicher:

Let us say somebody is specialized in an area and wants to deliver primary care, but they did not do a residency in family medicine or internal medicine. Are they therefore not able to become a primary care provider? Is that the result of that?

Ms. Bradley:

They would have to have some sort of training. Obviously, they go to medical school and that provides them a broad foundation basis. They are going to have to have some residency because we require residency for licensure. I suppose if they do not meet A or B, they would have to submit for the Board to approve them to practice in family medicine. I have never seen someone practicing in family medicine or primary care that is not an internal medicine or family medicine resident, and they have completed that.

Vice Chair Orentlicher:

The other thing, and obviously this is nothing you can change because it is in statute, we have a three-year residency requirement. The person who has completed one or two years of residency, and I think has at least the training of an advanced practice registered nurse (APRN), would not be able to practice in the way an APRN can practice. Obviously, there is one difference: one person has completed their training, the other has not. Maybe that is a red flag that they did not finish their residency. Have we set up a system where if you are a doctor, you cannot practice even though your training is at least as rigorous as the APRN? Is that where we are within the studying of a provider shortage?

Ms. Bradley:

I do not think I am qualified to speak to the qualifications of an APRN. I am not sure how to answer that question. The shortest residency time is for internal medicine and family practice medicine as you are talking about. I do not think we are seeing issues with them completing their residency. As for the rest of your question, I would have to defer to another entity that can better answer.

Chair Doñate:

I am still trying to digest the reason why we are going through this proposal. It would be helpful to understand. Was there a scenario that prompted this regulation? Is it a repercussion? The future of medicine is more on the collaborative care model. This feels like it is working retroactively. Was there a complaint filed, or are you are seeing an influx of complaints of physicians that were not supposed to be treating the diseases they were treating to the level of acuity it needs? I am trying to better understand what the purpose behind this was.

Ms. Bradley:

We get a lot of complaints of people practicing outside their scope. These tend to be people practicing in cosmetic medicine. This is not medicine and treatment that is necessary. It is not medically necessary. We have situations where individuals trained in obstetrics (OB) and gynecology are doing breast augmentations, sometimes in their office, because they are not able to get hospital privileges and other privileges to do them in the proper way because with certain sedation, they have to have certain permitting. We also are seeing Emergency Medical Technician (EMT) doctors doing breast augmentations. Both of those things would be outside their scope according to the Board and their training. We are also seeing PAs

practicing outside the scope of their supervising physician, potentially with their supervising physician's authorization. This goes against—we already have a regulation and statutes in place that talk about competence and keeping your practice within the competence of your training and education. This is our attempt to not only follow that, but say, "Please provide that information to the Board." We have most of this already when they apply for licensure. This would make them designate a specialty. We would have it on record. For supervising physicians, we would know their PA should stay within their same realm. It is emergency medicine doctors doing liposuction, not in a hospital, not medically necessary. Those are the things we are seeing, and that is why we are trying to clarify and be more careful about that. The concerns we have are patient safety. We have had patients end up in hospitals almost dying from having incompetent, untrained folks doing these procedures. We are trying to minimize that. It is the cosmetic area, non-medically necessary issues, we are concerned about. Those are the ones that seem to be hurting the public at the moment.

Chair Doñate:

I am struggling to grasp the unintended consequences that could result from such regulation. This feels like this could impact the rurals the most, because the physicians out there have to wear multiple hats and they might not have the full residency training, but simply because of the encounters they have coming through the doors, they find themselves more in the training aspect where they work in the field versus a formal training of what a residency would be required. I have seen scenarios where you might have a psychiatrist work with an internist or family medicine doctor, and they work together in a collaborative agreement. If they have been working together for years and they work simultaneously together, in terms of the patient population they are seeing, does this requirement now arbitrarily limit the access to care model we are seeing more and more progressively moving on? I do not know if that would mean revising it to if there is a collaborative agreement, they have to submit that in exchange if they do not have a formal residency training program. I see the rationale of what you are trying to do, but I fear there might be consequences of the actual delivery of care simply because now we are requiring you have to go get formal training. That is the only comment I have. I would implore you to explore a bit more. Let us go to Assemblywoman Gorelow.

Assemblywoman Gorelow:

I appreciate looking at patient safety. I think that is important. I am curious how this regulation is similar or not similar to other states. Would it take care of those bad actors you mentioned? Is it those bad actors are still going to be bad actors, and it does not matter, unfortunately, what kind of regulations you have in place? How does this compare to other states?

Ms. Bradley:

That is not something I have information for at this time. I would have to do research and bring it back to the Committee. I believe some states license by specialty. We tend not to. We license one thing which is Doctor of Medicine (MD). However, we already have them designate on their application. We know where they went to residency. We have all of that. This is going to ask them to tell us in the system—here is my internal medicine documentation, and I am going to practice internal medicine, family medicine, or whatever it might be. We can definitely do research on other states and see how they are handling this. I can tell you all states that I am aware of, are struggling with the same issue. I think the reasoning is cosmetic medicine, as we are all aware, is lucrative. Doing it as a side gig, as an add on, or even I do not make enough doing family medicine. I am going to do

liposuction full-time. Those things are attractive, I think. However, our patients are suffering.

Senator Nguyen:

It seems like this is overly broad. I have some of the same concerns the Chair mentioned. Is there any way to make the regulation more specific to capture some of these cosmetic procedures or injectables? Do you have a way to quantify how many complaints we are getting in this area? Is it doctors acting out of the scope of their specialties, or is it other licensed medical professionals that are engaging in these more commercially lucrative cosmetic procedures and injectables?

Ms. Bradley:

We are having an equal number of MDs and PAs engaging in this activity. We license three other practitioner types, but they do not do procedures like this, so it is not an issue with them. I cannot speak to the other Boards. I am guessing the Board of Nursing and perhaps the Board of Osteopathic Medicine are also seeing some of the same things. As far as tailoring it, the law already says a physician must keep their work to the scope of their training and competence, period. It already says that. All we are doing here is saying you need to tell us, "I am going to practice internal medicine" for example. They already have a statutory rule to keep their practice limited to their scope. They already have to tell us their residency. This is when they apply and/or renew saying that I am practicing family medicine or whatever it might be. We already have the documentation. They are licensed. Essentially, it is making sure they put it on paper.

We occasionally see other situations regarding treatment, meaning necessary treatment where people are outside their scope, but I would say that is rare. It is more people that are trained in classical medicine, the specialties, probably OBs, gynecology, emergency medicine, and otolaryngology are the ones doing this the most, I think. It is not injectables we are concerned about quite as much because the risks are a lot lower. There is a long statutory list of folks that can do injectables. This is for surgeries. It is people doing surgeries without proper training, and we are seeing it a lot. We are seeing patients nearly die. We are not aware of a patient that has died from it yet, but multiple have ended up in the emergency room (ER), had severe infections, and other complications.

Our goal is to make sure it is documented, and they have told the Board, "I am going to practice in this area." Once they designate that, and we have it in black and white, as well as their PAs, we have agreements. When we are talking about collaborative agreements, the only ones we have is with MDs and PAs, or MDs collaborating with an APRN during their initial phase of training their hours. Otherwise, MDs do not have them with each other or with others. It is making sure we have the documentation, so if we have a complaint, we have them designated, and we can say, "That is outside the scope." It makes it easier for us to take action against the bad actors. That is what we are struggling with: having the law clear and clarified enough that we can take action against the bad actors.

Chair Doñate:

I want to move on because we are on a fairly limited time today. I think your idea is correct where physicians should be trained to do the services they do. If they are performing a surgery they have never been formally trained for, obviously, that is problematic. I think what we see, at least in the primary care space, is a lot of collaboration exists. Maybe we could say if you are a physician and you do not have formal training in this capacity because

you did not go through this residency requirement, but you are practicing in the space—like the example I made, an internist or family medicine doctor working with a psychiatrist. You can submit to the Board a collaborative agreement that these two physicians are working together. They do not oversee one another, but they are working together to serve the patient population they have based on the needs of the community. To me, that would solve this instance if you are not formally trained here, you cannot practice here, but you are still accomplishing the ability to reach the community where the services are needed. We will finalize questions. We will probably circle back with you all for this policy proposal.

Chair Doñate:

Let us go to LCB File R068-23 from the Board of Medical Examiners. Vice Chair Orentlicher, you had a question.

Vice Chair Orentlicher:

I like the idea in Section 7 requiring doctors, as part of informed consent, to disclose their qualifications. That is great. Is there a definition anywhere of qualifications? That could mean where you went to medical school or where you did your residency. It also could mean how often you have done this procedure, if it is a surgical procedure, or what your results are. Is that going to be sorted out by the courts? How are we going to know about that?

Ms. Bradley:

We are working on refining this language a bit. The way I drafted it, my intent was the person would say their Board certification. In other words, if a doctor is practicing in family medicine, the example would be they are probably board certified by the American Board of Internal Medicine or a related American Board of Medical Specialties related to family care or internal medicine. My intent would be that they would say, "I am Doctor X. This is my Board training." That is it. Depending on the kind of procedure, obviously, if you are going to have a surgery, there is going to be written, signed informed consent. If it is more routine care, it is ensuring the patient knows this physician is trained in whatever the area is they are trained in. I think it helps that consumer make a more informed choice about who provides certain procedures to them.

For a PA, it would be similar. It would be, something like, "I am Sarah. I work with Dr. Jones. He is a Board-Certified Dermatologist." That would be what we are looking for regarding the qualifications. Initially, the way I had written this, I referred to another statute that talked about board certifications. We are working on refining that. There is going to be an addition that says something like, "Qualifications include the Specialty Board the physician is certified by." That was our intent. We wanted to make sure if PAs are providing care, they at least verbally tell their patients who their supervisor is. If something goes wrong, I know there have been situations where patients will see a PA—of course, they do amazing care 99.9 percent of the time—but there have been times where they will have a question or concern, and they do not always realize who the supervising physician is that they could reach out to if they would like.

Chair Doñate:

Let us go to LCB File R001-24 from the State Board of Osteopathic Medicine. It seems like I repeat the same issues, and I see the problems go from one agency to the other, and it is the same thing over and over again. I have alluded to my frustration when we require applicants to have proficiency in English. This is more of a concern that if we are in a

position of accepting physicians or medical professionals from other countries, when we put things like this in statute, it limits our ability to serve the population.

We are already in a critical need. I know a lot of times we copy and paste regulations from other states or from other statutes. I had LCB poll how many professions we have in the State that require English proficiency. It is about five or six. It is not many. I implore you to take into consideration and remove that portion of the regulation and instead allow the flexibility of the Board to decide whether or not that person has a proficiency to practice. To me, that is more preferential than saying, "You do not speak English; you cannot come here." That is my only recommendation.

I thank all the Boards and Commissions for joining us. I know we had a lot of questions. I implore my Committee Members to ask offline before these become finalized. We will now close this agenda item.

AGENDA ITEM V—DISCUSSION OF RECOMMENDATIONS FROM THE SUBSTANCE USE RESPONSE WORKING GROUP ESTABLISHED BY ASSEMBLY BILL 374 (2021)

Chair Doñate:

We will now move on to Item V, a discussion of recommendations from the Substance Use Response Working Group (SURG) established by Assembly Bill 374 with us. We have a special guest, Attorney General Ford.

Aaron Ford, Attorney General (AG), Office of the Attorney General; Chair, SURG Committee:

I am delighted to be here today to talk about recommendations coming out of the Substance Use Response Working Group Committee, affectionately known as the SURG Committee. We have a lot of slides here but fret not, we are not going through all of them. It is intended as a reference for public engagement, and you to review at your leisure. We will talk about specifically the recommendations as they come out. Let me introduce my colleague, Dr. Terry Kerns, who is a partner of mine at the Nevada Office of the Attorney General. Dr. Kerns is my specialist, so to speak in the opioids arena and in substance use and abuse disorder arenas. She has a master's degree in nursing and a Doctor of Philosophy (Ph.D.) in emergency management and has been an instrumental part of this office before I got here and will continue to do so. In the audience, we have some members of the SURG Committee, one of which is our Chair, Senator Doñate, thank you for your service on that Committee. In Carson City, we have Steve Shell and Erik Schoen. In Las Vegas we have Dr. (Lesley) Dickson. To the extent there are questions that may touch on their expertise, I encourage them to present to the Committee. I would like to thank the Joint Interim Standing Committee on Health and Human Services Chair, Members, as well as members of the public for the opportunity to present the recommendations from the SURG Committee's 2023 *Annual Report* (Agenda Item V A) (Agenda Item V B).

We note NRS have established the SURG Committee to highlight a few of the mandates of the SURG. One is to comprehensively review various aspects of substance misuse and substance use disorders and programs and activities to combat substance misuse and substance use disorders in the State. Also, to annually get a report from the Department of Health and Human Services (DHHS) on the use of State and local money to address substance misuse and substance use disorders as well as to study, evaluate, and make recommendations concerning the use of that money.

Membership of the SURG Committee, as laid out in NRS, there are 18 members that make up the SURG Committee. The membership crosses many disciplines involved in substance use, prevention, treatment, and harm reduction. It includes Legislators and those who have been affected by substance use. Giuseppe Mandell, who you heard from earlier, is not on the Committee, but he attends almost all our committees as an individual who can provide firsthand experience and public comment on these types of issues as well. We thank him for his appearances.

I have outlined the NRS what the SURG is to do, and what is outlined and tasked to do. The NRS also included special populations SURG was to consider when making its recommendations. The way the SURG decided to approach our work, as outlined in NRS 459, was to establish three subcommittees and assign the tasks previously discussed to the appropriate subcommittee. Substance Use Response Working Group members were asked to work with one of the subcommittees they had expertise or interest in. The three subcommittees are: prevention, which also addresses harm reduction; treatment and recovery; and response. There were also tasks that were crosscutting. There could have been many more subcommittees but due to personnel and funding, we had to limit our subcommittee number to three.

The Prevention Subcommittee addressed items (a), (g), and (j). Harm reduction, which the Prevention Subcommittee took the lead on, addressed (j). The Treatment and Recovery Subcommittee addressed mandate items (c), (e), and (f). The Response Subcommittee had most of the items comprised of (d), (l), (k), (m), (n), (o), and (p). The crosscutting items are (b), (h), and (q). The subcommittees met more often than SURG. The SURG Committee met quarterly.

The subcommittees developed the recommendations by either having members make suggestions or there were subject matter experts (SMEs) that presented information to the subcommittees. Recommendations also came from these SMEs. The Subcommittee worked on the recommendations by addressing justification and background which included: research and evidence-based practices; what was the impact, capacity, and feasibility of implementation; urgency and how the recommendation advances racial and health equity; and the recommended action step. After the Subcommittee developed the recommendations, they were presented to the larger SURG Committee. The SURG Committee either accepted the recommendations as they were, suggested they go back to the Subcommittee for future work, or in some cases, there were recommendations submitted by different subcommittees that were similar in nature, so one subcommittee was tasked with combining similar recommendations. After the Subcommittee has completed the recommendation, SURG ranked and voted on these recommendations, which you will see in the SURG 2023 *Annual Report*.

That process resulted in 18 ranked recommendations and 2 unranked recommendations. Of the recommendations, there were 12 recommendations to expend opioid litigation settlement funds. There were 5 recommendations with an action step for a proposed bill draft request (BDR). There were 4 with a policy action step. Finally, there were 2 recommendations to spend other than opioid litigation settlement funds. These do not add up to 18 recommendations. Some of the recommendations have more than one action step, such as a proposal of a policy change in spending funding. The SURG has no funding nor does SURG have BDRs. The recommendation for funding has to go to the appropriate place such as DHHS or the Fund for a Resilient Nevada; someone has to sponsor BDRs. The Office of the Attorney General will sponsor some as well, but we would be looking to Legislators to help sponsor some of the legislation proposed. Policy changes have to go to the Agency with the actual policy.

There are 11 ranked and 1 unranked recommendation to spend opioid litigation funding. The SURG Committee makes no decision regarding the expenditure of opioid settlement funds. None whatsoever. Nor does the Office of the Attorney General make any decisions regarding how this money should be spent. It is by statute deferred to and referred to DHHS and the committees therein. We make recommendations.

The first recommendation was to DHHS, the Division of Public and Behavioral Health (DPBH), and the Bureau of Behavioral Health Wellness and Prevention (BBHWP) to double the amount of investment in primary prevention programming—that is to increase from the current $12 million that is allocated to $24 million for this biennium—for ages 0 to 24 and to review the funding allocations annually. This funding should not be at the expense of existing programming. We are not suggesting supplanting other programs. We are asking for additional monies to be expended for this purpose.

The second recommendation was to expand access to Medicaid Assisted Treatment (MAT) and recovery support for Substance Use Disorder (SUD), limit barriers to individuals seeking treatment regardless of the ability to pay, and to encourage the use of hub and spoke systems as well as recovery support, including the use and promotion of telehealth, considering the modifications that have been made under the emergency policies, and pursuing innovative programs such as establishing bridge MAT Programs in emergency departments. I believe it was Assemblyman Orentlicher that worked on MAT-based issues last session as did my office as well. This is in line with that type of approach.

The sixth recommendation is to implement a specialized child welfare service delivery model with follow up, referral, and linkage to care that improves outcomes for children and families affected by parental substance use and child maltreatment, and pregnant or birthing persons with substance use disorder.

Chair Doñate:

Pardon the interruption, AG Ford. Would it be helpful instead if we have Committee Members review the recommendations in the report? That way, we can have more of a conversation. Is there anything you wanted to mention before we start our questions?

AG Ford:

Recommendation eight is one of the things we wanted to highlight. That recommendation had an action step of a BDR. It is to support harm reduction through implementing changes to recruit, retain, and compensate health and behavioral health care workers and enhance compensation and alignment with the Commission on Behavioral Health Board's letter to the Governor dated June 22, 2022. Additionally, continue to sustain and expand investment in community health care workers, peer recovery specialists, and certified prevention specialists.

Recommendation nine, which will require an amendment to existing legislation, is to evaluate current availability and readiness to provide comprehensive behavioral health services to include, but not limited to, screening, assessment, treatment, recovery support, and transitions for reentry in local and State carceral facilities, to also recommend the allocation of funding to support the development of a Medicaid Reentry Section 1115 Waiver to increase health care for people leaving the carceral facilities, to support readiness of carceral facilities to implement Medicaid Reentry Section 1115 Waivers, and to recommend legislation to require the State to apply for and implement Medicaid Reentry Section 1115 Waivers. There is also a BDR to change the Nevada paraphernalia definition as it relates to

smoking supplies, a recommendation that a compliance study be completed for NRS 259.050, and a recommendation regarding additional harm reduction—that is Recommendation 18. The final one I will mention is there has been a request that we add a few seats to the SURG Committee, which would likewise require a BDR for that purpose. With that, Chair Doñate, I will tender the microphone back to you.

Chair Doñate:

I think the most important thing in this moment is to have more of a dialogue. Obviously, the mental health system in our State is complex. There are a lot of different positions and opinions of what you tackle first, what needs to be prioritized versus what can wait. Developing today's agenda was difficult because there are a lot of things to do. I think you included that as part of your recommendations where some of the community folks have already helped illustrate what needs to be done to take our mental health system to the next step.

To start the questions from our Committee Members, let us start with a basic question. I want all the presenters today to answer this base question: if you had one chance to fix the mental health system, what would you focus on first? I think that is the most important thing. Regardless of the funds or the expediency of what needs to get done, between Dr. Kerns and of course the AG, what needs to be done now? Even from a personal stance, I think it would be helpful. We have had the conversations of trafficking of Fentanyl and so forth. Perhaps from a human perspective, what do you think needs to be done to fix the system?

AG Ford:

I have invited additional SURG Committee members to chime in as well. You asked for a personal opinion. I will offer that to you based on overlapping work my office does outside of the SURG Committee, in our mental health, criminal justice systems. What has been reiterated to me and what I learned when I was sitting in your seats, was a lack of resources. Not just capital resources, but also human resources, facilities, and professionals. For example, we do not have enough beds to deal with the mental health issues we see coming either through the criminal justice system or those who are not entering the criminal justice system, but also need this assistance. It is a pie in the sky wish. There is nothing you can do about it at this juncture. It is a long-term strategy the State has to undertake relative to constructing facilities, relative to recruiting and retaining professionals who can work in the area of mental health, and ensuring we are able to provide the wraparound services to those individuals who need these types of services in the mental health arena. We are seeing big problems even outside of the SURG Committee in those particular arenas: not having enough beds to be able to house those who need the assistance that mental health service providers are providing.

Terry Kerns, Ph.D., Registered Nurse, MSM, Substance Abuse and Law Enforcement Coordinator, Office of the Attorney General:

I would agree with what AG Ford said, it is the ability to have access to care not only in facilities but also in that personnel capital. Oftentimes, when someone is ready to get into treatment, there is not a bed available for them. Our emergency rooms are used as holding areas until a bed becomes available for those needing it. In talking to colleagues trying to get medication assistants in jails and prisons, it is not just a funding issue. It is having the personnel available to do those types of programs.

AG Ford:

It is beyond the scope of your Committee, but it is worth noting that our State is being sanctioned by courts almost weekly because defendants who are also in need of mental health have no bed to go to. Even if a court requires us to send them to a mental health institution, we cannot and have not been able to do that. The waiting list is humongous. We are being sanctioned by courts, north and south, on this issue. That is happening on a weekly basis and further demonstrates the need for that particular resource I laid out.

Lesley Dickson, MD, FAPM, LFAPA, Addiction Psychiatrist:

I have been practicing addiction psychiatry for about 30 years, both in New York and Nevada. I have to echo the problem that resources are limited. One of the things the AG was referring to is the beds. There are a lot of folks that end up in the criminal justice system that have competency issues. Therefore, they have to be referred to a State facility for an evaluation of competency and restoration of competency. There has been an effort, there are more beds now than there were five years ago with Rawson-Neal adding the Muri Stein Hospital. What is happening now is there is such a demand for that, the forensic units have taken over much of the civil beds in Rawson-Neal, so we have lost a lot of our civil beds. For those who are committed for mental health treatment, we do not have as many beds as we used to. This is the kind of thing that keeps happening. I do not feel there is any overall planning going on.

As far as resources, in terms of people and the workforce, we have done a good job of getting more psychiatrists. We now have four psych residencies in the State. One of them increased their number by two, but our residents are not staying. One of the reasons they are not staying is they can get much better paying jobs in other states. There are few jobs. Psychiatrists—and probably a lot of other medical doctors—are no longer wanting to open an office, hang out a shingle, take out a loan for $300,000 or $400,000 to open their office when they already owe $300,000 or $400,000 in medical school debt. We are looking for more jobs. Those places do not exist to any great extent. We are not getting the interest when it comes to substance abuse. There is not a lot of interest in treating substance abuse. It is hard.

An Addiction Medicine Fellowship Program started a couple of years ago. We are now going into our fourth year. Across the nation, the addiction medicine and addiction psychiatry fellowships only filled 60 percent of the positions available. It is not a big interest. Why is it not a big interest? I cannot answer that question. I love doing it myself, but there is no money in it. Medicaid rates are extremely low. One of my clinic supervisors was telling me about the Medicaid problem. We do both methadone and buprenorphine. The methadone rate per day is the same as it was 40 years ago. Something has to be done about reimbursement if we are going to have people stay here, work, and take care of these folks.

Chair Doñate:

Committee Members, are there any questions?

Vice Chair Orentlicher:

Thank for the work of SURG. It is great to see the recommendations for harm reduction and some of the other needs. One question I have is whether the recommendations will address a problem I have seen in Clark County. We clearly have a big problem with opioid use and substance use dependence. We have a program, Track-B, which has a harm reduction

facility, but they only have one brick-and-mortar facility for the whole county. I have been working with them to try to set up a second one in an area on the east side where there is a lot of need. Just finding a location—it is not for lack of money; they have the resources to fund it—finding a place to set it up. There are restrictions. You cannot be too close to a church or school, and it turns out there are not a lot of places. Do the recommendations address that problem of trying to find a location so you can set up the facility, get it going, and have it near the users, where it is convenient for them?

Dr. Kerns:

The SURG does have recommendations on harm reduction and specifically calls out some of Track-B's programs. The recommendation looks more at their mail program they have throughout the State, not just here in Clark County. It is my understanding that oftentimes on grants and funding, there are limitations on how the funding can be used such as for buildings. I believe with the Fund for a Resilient Nevada, there is not that restriction on how the funding can be used. I think you are going to be hearing more from Dawn Yohey today on how those funds will be used.

AG Ford:

I will ask Mr. Shell and Mr. Schoen to offer an opinion.

Dr. Dickson:

What exactly is it you are asking that it is not available?

Vice Chair Orentlicher:

A parcel of land that will accept this kind of a facility.

Dr. Dickson:

The facility does what?

Vice Chair Orentlicher:

Provides harm reduction services, needle exchange, wound care, advice, and connection to therapy, counseling; a range of services for users to help them address their dependence and reduce the harm from their dependence. A county as big as Clark County, we ought to have more than one brick-and-mortar facility. As I said, it is not for lack of funding. The money is there. It is where can you put this facility that the landlord will allow it, or it does not violate any zoning ordinances. This has turned out to be a serious problem; a bigger problem than I expected.

Dr. Dickson:

I am not going to answer all that because I do not know the answer to that. I do know the clinics I work in, which do medication assisted treatment, we have vending machines for those items that you would get in a special place. I know we are going to hear later from the crisis centers that they are trying to establish and all the problems that go into establishing these kinds of freestanding places. It is expensive, and there is a lot of liability. I am not sure, but I think there are problems in getting it going. I do not know what has been attempted.

Dr. Kerns:

I would add that there are vending machines throughout Clark County, throughout the State, as well as the mail program provided by Track-B. This has been a problem even with the vending machines. The folks who put those out had community meetings and then they went to put one in and [were met with,] "Not in our neighborhood." It is going to be a continued effort of education. It is also a safety issue. How many people are getting stuck by needles because they are not getting returned and end up on the street? We do have a former representative from Track-B, Chelsi Cheatom, on our Board who does address many of these things as well as harm reduction.

AG Ford:

It sounded like a zoning question to me, frankly. Fortunately, my former Senate colleague and roommate, Commissioner Justin Jones, is here as well. He said he can speak to the zoning questions and issues. I know Clark County is utilizing opioid funds. [Inaudible] is also looking at establishing a new facility for opioid use and beyond that, disorders as well.

Senator Nguyen:

I know the SURG Committee is 18 people. That is a lot of individuals. I brought legislation in 2019, again in 2021, and then again in 2023 around the Medicaid Reentry Section 1115 Waiver. It is my understanding in talking with Medicaid they are in the process of doing that. It does not seem like this needs an action step of a BDR because it already is in law. I am wondering about that. I am sure Medicaid can speak to that as well.

We see all these recommendations—and I am thankful for the work the group has done—are any of these recommendations a part of a more overall strategic plan on how we are addressing this. It seems like some of them are more substantial, and some of them are more like a band-aid like where a tourniquet is needed. More appropriately, is there any action going to be taken by SURG to come up with a more comprehensive strategic plan, so we know where these recommendations fall within this plan? I would hate to take one of these things that are like a piece of a pyramid with no foundation.

AG Ford:

Let me address the question about a strategic plan from the Chair's perspective, but my colleagues can also speak to it. We make recommendations to the Committee that is required to have the strategic plan. There is a strategic plan, a statewide needs assessment that has been created by DHHS, the Advisory Committee for Resilient Nevada has been working on that as well. There is a strategic plan that exists in several counties, Clark County included, is also either working on or has already implemented a strategic plan themselves. This is specific to opioid based issues that the settlement funds are able to fund. I cannot speak to whether there is a broader plan for substance use disorder beyond that, whether it is methamphetamine or whatever the case may be. For opioids, [former] Senator Julia Ratti established the structure for the ways in which this Committee would operate, including the membership. We make recommendations only. We do not make decisions. Those recommendations go to not only the Legislature, but they also go to the Advisory Committee for Resilient Nevada and DHHS for implementation to the extent they want to utilize that for purposes of their strategic plan and the needs assessment. That is the short answer to your question in that regard.

Dr. Kerns:

There is the statewide plan that was required to be done as part of the opioid litigation settlements, the needs assessment, and the State plan. In addition to that, we get a reporting from DHHS. They did do fund mapping to look at where the opioid funding is, whether that is through grants and endowments, so we already know what is being funded versus trying to put more money on top of something that is already [funded] and trying to make it more equitable across the different areas we talked about within the committees. I did talk to Sarah Dearborn about that 1115 Waiver. I think it is possibly an amendment to look at the reimbursement rates.

Assemblywoman Brown-May:

Over the course of this last year, I have had the opportunity to serve as the Nevada Fellow for opioid crisis with regard to the National Conference of State Legislators. I have been investing in this recovery area, and how do we get the correct items to the people in need. With regard to funding and duplicative efforts, your recommendation number one is about DHHS and increasing the current funding from $12 million to $24 million. Can you talk about if have you had conversations with DHHS, or have we engaged the DPBH? How are you being received in those conversations? Does it look like a budget presentation is being considered as they develop the next biennial budget?

Dr. Kerns:

We did have a presentation from DHHS on the funding that was done. I believe that was to the Prevention Subcommittee to know what is already being funded. Admittedly, the Committee may have asked for more than what they thought they could get but wanted to at least put a starting place on an amount to look at. These recommendations have also been provided to DHHS. I would ask if Erik Schoen in Carson City has anything to add. He was on the Prevention Subcommittee.

Erik Schoen, Vice Chair, Prevention Subcommittee, SURG:

Specific to the recommendation to double the amount of funding for prevention, I have been providing services in rural Nevada for 30 years. Currently, as a Chief Executive Officer (CEO) of Community Chest where I have been working for 28 years, [we] provide blended integrated health and human services including mental health and substance use disorders. When I am asked what we need, it is basically two things, and it comes down to funding. Funding for personnel or creative ways for getting more personnel out there. One of the other highlighted recommendations is to support the development of community health workers, peers, and prevention specialists so they can help us with the work that needs to be done.

Secondarily, funding for facilities and program overhead. We have decades of under investment in all of these needed, critical areas. The recommendation was made to prompt the conversation we are having. What is an appropriate level of funding? What we currently have is not nearly enough to meet the needs. We have acknowledged that several different times from different speakers already. What is an appropriate level? We are not saying that funding cannot also be increased for treatment and harm reduction. We on the Prevention Subcommittee felt strongly that we needed to put a statement out there that this needs to be increased. After looking at all of the different funding that was coming through based on the presentation from DHHS, we thought that was an appropriate level to recommend. Is it compelling? I think so, which is what we wanted that to be. We wanted that to be something that would prompt conversation. What would be a good level to start

funding these services, so we can provide the level of support we want to for all Nevadans so they can not only survive but thrive.

AG Ford:

I want to highlight that I sent the Subcommittee back when they came with $24 million. I said, "You need to be certain that you have a delineation as to how this money would be spent, and why you came up with that number." I knew there would be questions specifically to that particular number. They came back and have been able to identify—I literally sent them back and said, "I am not going to submit this until you do extra work on it."

Chair Doñate:

The challenge that exists—I have gone through my own version of training of legislative history before this agenda came forward, because I feel like we are having conversations that have persistently happened over the years; and we are in the same cycle. I think the answer, obviously, is funding. The question is, if these funds do come, and we are doubling the amount of efforts that can go into primary care or prevention, so we are upstream, not downstream. We are focusing on prevention versus treatment. It is obviously difficult because there is this nuance of, we did that, but that did not work. We did this, but it is not working exactly the right step. What is the vision?

I think there is a conversation of accountability. If you receive these funds, who is accountable for making sure at the end of the day, the person receives the care they need? If we do not have enough beds, once we fix that situation, which I think we all have to have a conversation of where does that funding come from sustainably, so we do not find ourselves in this band-aid approach to the end of who has an appropriate accountability to make sure it gets done? To me, it seems like that is more of a theme of the situation we are currently in. I think the SURG Committee, if we provide you more finite resources, I think you can get to the point where it can be the community driven approach where we have physicians, and we have community members that have been impacted by this crisis. If you have the right support, you can provide direction of what needs to get done first, and there is a level of accountability. This got done, let us make sure it gets done correctly. I think that would be the next step.

I do not think there are any other questions for this item. I sincerely thank all of you for being here. Obviously, there is more work to be done. Hopefully we can work together as we review the BDRs ahead of August.

AGENDA ITEM VI—DISCUSSION OF BEHAVIORAL HEALTH EFFORTS BY CERTAIN LOCAL GOVERNMENTS IN NEVADA

Chair Doñate:

We will move on to our next agenda item, a discussion of behavioral health efforts by certain local governments in Nevada. I mentioned to our guest presenters that today is bring your elected official to workday. We have a lot of elected officials representing different jurisdictions. It is important to hear from our colleagues that serve in different parts of the State as to what is going on, and what they are focusing on primarily. In Southern Nevada we have Commissioner Justin Jones; Councilman Knudsen will be a couple of minutes late. In Northern Nevada we have Commissioner Mariluz Garcia and

Mayor Schieve. There are a lot of different perspectives for this conversation. Let us start with Commissioner Jones.

Justin Jones, County Commissioner, Clark County:

Thank you for the opportunity to appear before you this morning alongside my counterparts from the City of Las Vegas, City of Reno, and Washoe County for a discussion on the efforts we are making on the local level to address behavioral health concerns in our respective communities. I want to say on a personal level, as someone who has battled depression for years, I appreciate your time and attention to this issue because it is something so many people suffer from in our communities.

Two years ago, I joined Councilman Knudsen in a community-wide stakeholder discussion on how to better serve the needs of individuals facing mental health crises in our community. Over the past few years, the Las Vegas Metropolitan Police Department (LVMPD) and other law enforcement agencies in Southern Nevada have made significant investments in crisis intervention training for officers. However, the system in large part operates as follows: a person in crisis or a family member calls 911 dispatch; law enforcement officers are deployed; law enforcement officers handcuff the person in crisis and transport them to one of two locations, the Clark County Detention Center or University Medical Center (UMC) Emergency Room.

Dr. Stephanie Woodard, who was at DHHS for many years and is now at the Guinn Center, educated on a different evidence-based model for assisting those in crisis. Under this model: a person in crisis or a family member calls the 988 Mental Health Crisis Lifeline where they can talk to a mental health professional; if the situation is not deescalated by phone, mobile crisis response teams consisting of mental health professionals and peer support specialists are deployed to the scene; if the mobile crisis team is unable to deescalate, the person in crisis is then transported to a crisis stabilization facility, which is staffed by mental health professionals and peer support specialists. Dr. Woodard arranged for a hands-on tour and discussion with crisis intervention professionals in Phoenix, Arizona, which has successfully implemented the model for many years.

Last year, several of us were able to meet with leaders in other jurisdictions that had successfully implemented the Crisis Intervention Model including San Diego, Denver, and Miami-Dade County. The State issued a Request for Proposal (RFP) for crisis stabilization centers in Southern Nevada. Although there was interest from both medical-surgical (med-surg) hospitals and psychiatric facilities, none moved forward because they could not make it pencil financially. Having seen the model and caught the vision for how to better serve the needs of those in crisis, the Clark County Commission and our senior management team decided to step in, work with the State, cities, and other local partners to stand up a pilot program for crisis stabilization. Clark County recently purchased a turnkey behavioral health facility to serve as Southern Nevada's first of its kind crisis stabilization center. It will be operated under UMC's hospital licensure, and we are optimistic it will open by the end of this year. Thank you to DHHS and the Legislative Interim Finance Committee (IFC) for agreeing to fund the purchase of this building with American Rescue Plan Act (ARPA) dollars.

Working through the Clark County Criminal Justice Coordinating Council, Clark County has also collaborated with Metro and the Justice Court to stand up a mental health court. There are many opportunities in our community for standing up these types of facilities. Many of the jurisdictions that have been successful have access to funds we simply do not. San Diego County benefits from a millionaire tax. Miami-Dade County collects a 1 percent

sales tax on food and beverage for homeless programs that support mental health services. Denver has a 1/4 cent sales tax that funds their programs. Clark County appreciates all the Legislature and State are doing to meet the needs of those with behavioral health concerns. We look forward to working with you during this interim to come up with ideas for long-term stable funding options to meet the pressing needs of our community.

To address the question you posed, Chair Doñate, that is the number one issue we face. The State has provided fantastic one-time funds for many programs such as the funding for the purchase of the crisis stabilization center. However, in order to make that facility—or frankly any facility—viable, there has to be a dedicated funding stream for years to come, whether it be a local government entity or a private or nonprofit health care agency. Without the ability to count on those funds for years to come, it is not viable to move forward with the capital investment costs that go into funding these programs. I am happy to answer your questions and engage in a dialogue.

Chair Doñate:

Thank you, Commissioner. Let us go to Mayor Schieve and Commissioner Mariluz Garcia.

Hillary Schieve, Mayor, City of Reno:

I appreciate everyone's time and attention to this. I think it is truly the number one crisis in America. As a mayor, cities are at ground zero. Truly, we are at ground zero of this crisis. I cannot begin to tell you how challenging and how disheartening it is to watch. Literally people's loved ones are having to be arrested to get them access to mental health care. It is unbelievable that is what it comes down to in this country. It is the only health care crisis that we send police officers to. Does that make any sense? That is outrageous. If we do send a clinician, you better hope it is between 9 a.m. to 5 p.m. because that is the only time we have most teams and clinical workers to address the situation.

I am passionate about this. Listening to a lot of the testimony, it was so evident, we have got to stop using our jails as mental health hospitals. It has got to stop. That is how we treat mental health and addiction in this country. We also use ERs however, ERs are great if you have broken bones, but what about broken brains? As a mayor who has been talking about this all year in my presidency for the United States Conference of Mayors along with Steve Shell—I should recognize some of my mental health care heroes in this room, Julia Ratti, I love you to pieces. This would never have happened without you. Steve Shell, and Dr. Stephanie Woodard, I love you. We started this seven years ago. It is something that is so stark on our streets every single day. As a mayor, there is no place to take them or treat them. Yes, we have services here and there, but we are kidding ourselves if we think we are going to be making a difference when it comes to mental health and addiction.

Something I never talked about is I lost my brother and my sister a few years ago due to mental health within a few weeks of each other. It is something I was ashamed of and knew the stigma about. I never wanted to shame them, but I kept it quiet for so long. Now that they are gone, I feel like I have the strength to tell their story because they would want me to. It is the story I see every single day, day-in and day-out, on our streets. I cannot begin to tell you how discouraging it is that we have to have our loved ones arrested to get them help. That is where I found myself as a mayor. If your mayor cannot get help, who can? I know your challenges are the same ones I have. Every time people come to the dais and speak to you about public comment, and where are we going to find the money? If we do not, I do not know how we will ever have a healthy America or healthy cities. It is the number one crisis. If you think about it, if you do not have your mental health, what do you

have? You have no education. You have no infrastructure. You have nothing. Yet we act like it is not even a thing. We walk past people laying on the streets that are screaming in pain. Yes, if they had a ruptured appendix, we would get them help, but because they have schizophrenia or addiction, we walk over them. It is unacceptable. All I can say is I am so fortunate to be here with Commissioner Garcia, Julia Ratti, Steve Shell, and Stephanie Woodard begging and desperately hoping you will hear us. When it comes to crisis services, we are standing up a 24/7 crisis service. It is a living room model. It is not a bed model like you see in ERs. That is not where you can treat mental health and addiction. That is not the environment people can thrive in when they are truly suffering. We have been working on this for five years—it feels like seven. This did not happen overnight. It came with a lot of love, care, data, and statistics.

Senator Doñate, to your point, what are outcomes? What do they look like? This is something that has been studied. It is a model that has been around for decades. It would be a shame if we did not have one in Nevada. Obviously, I am going to advocate for my cities, but I am speaking on behalf of mayors across America. The Crisis Care Model is 24/7. Anyone can be brought there. It gives officers resources to take them directly, so they are not going to our jails and ERs. Mayors have a lot of frustration, especially mayors that do not have the support of their counties because that is where health and human services lie. I am fortunate because I have Commissioner Garcia, Commissioner Hill, and Commissioner Andriola helping me. Julia Ratti, I am fortunate. That is not typically how the system works. Cities do not get any of that funding, period. We do not have any resources, so we have to rely on our partners. I am relying on you today to make us one of our biggest partners throughout Nevada, not only for the City of Reno, but also for cities across Nevada.

Steve Shell, Chair, Treatment and Recovery Subcommittee, SURG:

It is great to be here today to talk about such an important topic. I want to first say that Mayor Schieve was instrumental about five years ago in meeting with Director Richard Whitley to identify space in our Reno community where we could stand up a crisis stabilization center. We are grateful that Director Whitley was able to identify space within our State Hospital, Dini-Townsend, which has been sitting vacant for quite a while that we are now going to repurpose as a crisis stabilization center under the license of Renown Regional Medical Center. This will truly be a public-private partnership. The State of Nevada is using ARPA funds to be able to renovate the space and covering operating expenses for the first year. I want to stress that we have to think beyond the first year of the sustainability. It is great to stand up centers like this, but we are going to need to make sure they can sustain for the long haul. I do not think any of us want to stand up a new model that cannot continue beyond a certain time. I think that is going to be critical we keep a close eye on that. We have worked closely with Nevada Medicaid to create a rate for crisis stabilization centers. None of us know, at this point, whether that is truly going to be sustainable or not. That is what we will be using this first year of operation to look at.

We will be opening our Center at the end of August or early September. As Mayor Schieve alluded to, this will be a 24/7 Center. It will serve as a walk-in center, law enforcement drop-offs, and ambulance drop-offs. The goal is to truly divert individuals from the ERs, as well as the jails where we know these individuals do not belong. We are going to be staffing with registered nurses, peer support specialists, psychiatrist, and other medical personnel to be able to figure out what the individual in crisis truly needs. Not everyone needs a bed for treatment. There are individuals who simply need a therapist or other wraparound services. The purpose of the Crisis Center is to identify what that individual needs and get them help at that moment.

Mariluz Garcia, County Commissioner, Washoe County:

I represent District 3. I am grateful we have so many champions in the room today. I am also looking forward to working with those of you in the south who I have not had a chance to meet yet. I landed in Washoe County 26 years ago. I am originally from Elko.
I remember the first job I had was working with the families of a Title I school and seeing and hearing the issues they were facing. Fast forward, I can now see this topic, and I have lived it as not only an educator but as a mom and a policymaker. District 3, for those of you who are not familiar, is an area of Washoe County that is densely populated. It is a high percentage of working-class families. It is comprised of the most diverse people in our county. I have only worked with low-income, first-generation students in Title I schools. The conversations I had as a school counselor were always real and raw for the parents that walked in. There were concerns about housing and substance abuse in the home, domestic violence, issues with housing, and many other things these parents walked in-day in day-out and were struggling with. Not only were they struggling, but their children were also struggling. It was proof that trauma can breed more trauma, and that is the root cause. To me, that is the most critical epidemic we have in this country.

I have also had the fortune to work with young adults. I do not know if she is still in the room today, but I appreciated the student who spoke about the behavioral health needs facing our young adults who work and live at the university—challenges with anxiety, depression, and substance use. I appreciated that perspective. It is a population we do not talk about or hear about very much. I have seen a huge shift in our college student population. They are starting off their adult lives with these challenges, and it is not getting any easier for them.

I am grateful to be in this role, working with amazing mayors who are leading this charge. Being part of Washoe County is an exciting time right now because we, as practitioners, saw what a huge loss it was to lose West Hills Behavioral Health Hospital when they closed the door in December 2021. I remember texting my colleagues saying, "What do we do now?" It was such a huge loss for our community in Washoe County. One of the best things that happened to me last year was sitting at the dais and voting to approve the purchase of this building that had been boarded up—a resource that had been gone for years. The Washoe County Commission approved the purchase of West Hills in August 2023. It was my favorite vote last year. It was a happy spot.

I wanted to say thank you to the State of Nevada for also investing in this amazing opportunity for us to renovate this building at $14.5 million which was recently approved. I am grateful and appreciative because I know it is going to be transformative with the leadership we have with the amazing Julia Ratti. Things are looking and moving in the right direction in Washoe County.

I wanted to end with the fact that my first touch point with Washoe County was through being an adoptive mother, a foster mother. I know we are here to talk about adults today, but I cannot talk about mental health without talking about what happens on the front end. Without going into too many details my children did not start off in this world at the same level that many other healthy children do in Nevada. They were, by no choice of their own, impacted by generational poverty, family histories of mental health and substance use, and homelessness. You name it, we have worked hard to get them access to all the early intervention they need to help them heal from that trauma and help put them on the right trajectory.

We are not out of the woods yet. As a school counselor and as somebody who has a Ph.D. in education, I struggled during the pandemic to find access to resources. Overnight everything was gone. Our special education team, play therapist, occupational therapist, family respite, everything was gone. If I struggled, I know many Nevada families struggled. I always bring to the table that rural perspective too. We think we have it bad in Washoe and Clark Counties. You should visit the rural counties. It is incredibly challenging and there is still a lot of stigma in the rurals with accessing mental health. We need to push that mental health is health, bottom line. It is all connected. I would love to see us continue to have the collaboration between the State and counties because—to Mayor Schieve's point—we are the health and human services arm, and we want to continue to do this work. We are grateful and excited for this opportunity.

Chair Doñate:

Councilman Knudsen is still on his way. Hopefully he makes it. If not, we will have to take things out of order when he comes. I do not know if there are any questions; through this conversation it will trigger some. Commissioner Garcia and Mayor Schieve, I do not know if I heard your answer. I heard Commissioner Jones' answer. If there is one thing, the first thing to focus on to fix the mental health system, what would you fix?

Ms. Garcia:

Medicaid reimbursements.

Mayor Schieve:

Ditto. Without them, we have nothing.

Chair Doñate:

That is straightforward, and I think it is helpful. The reason I wanted this agenda item was as part of the legislative history that I reviewed from minutes of meetings that happened in the 1990s and the early 2000s was—and this is my interpretation of how the system came to be—there were a lot of cuts to the mental health system in the early 1990s that occurred nationally, including here in the State. From my understanding, we never replaced a lot of that funding to be reinstituted because of budget cuts. Obviously, during the 2008 recession, the State of Nevada did the same thing. Often when we make budget cuts, even as close as the pandemic, it forces us to cut much needed programs and sometimes that is mental health. We put ourselves into these dire situations, but then we never come back to fix all of them.

I think what we have learned over time is—to me, it seems like over the last few decades, we passed the buck to local governments. What should be the responsibility of the State versus the responsibility of local government when it comes to mental health? How do we work together when jurisdictions have different modes of focusing on addressing this? If the City of Reno disagrees with Washoe County on how to fix the mental health system, one wants to build more housing while the other wants to build more navigation for example. How do we work together to address the system in its place?

Ms. Garcia:

I think we have already shown that we can work together in so many ways. We hosted a Mental Health Summit. I believe it was the first time we saw so many agencies come together, local jurisdictions, our elected officials, and members from the law enforcement

community. I think that is a special example of how our region has come together to tackle homelessness and many other regional issues. Historically, I think we are siloed. In the time I have been in the seat, I have been pleased and inspired by the way everybody has taken hold of this important issue because mental health touches so many facets of our life.

Mayor Schieve:

This is probably not a traditional answer, but I am going to stress this, and I know I am preaching to the choir. This is why it matters who you elect quite honestly. That is what happens when you elect people that truly want to get something done and work together in collaboration. That is hard these days with the political environment. I wish more people understood how important it is to elect the right people that care about the same things they do. That is neither here nor there.

The other piece of that, especially being a city, is that it is critical to get this funding into the county and also at the city level because if we do not get it, we go to the county. Let us say in the event we are not working together because we might have political differences—who knows, political environments change dramatically—that is not how the funding source goes. Remember, we are ground zero. It goes to the county, and it never goes to the city.

First of all, I want to commend all of you and whoever invited me here today. This is the first time in the 12 years I have been Mayor that I have ever been invited here to speak on this topic. It makes me feel like you are hearing me, you are listening, and you truly care. That is another gap that needs to be filled. I think our representatives need to come to council meetings or commissioner meetings before you get into session. We are doing this job every single day, 24/7, 365 days a year. There are many times I do not even sleep because it is a full-time job. I know your jobs are extensive, but at the city level, it is where the rubber meets the road, and we need that help and assistance. I am lucky I get to work with my fantastic partners at the County Commission. I shudder to think if that were not the case based on political divides and the political landscape we live in today.

Ms. Garcia:

My short answer would be that your trust in the counties is important. To Mayor Schieve's point, we see this day-in and day-out. We live and experience it. We know our people, and we know our communities. I know the higher you climb, the further removed you can become. If you continue to trust us and find opportunities to collaborate with the counties and cities, I believe that is money and time well spent.

Mayor Schieve:

Last week I was in Washington with 40 mayors. Mayor Bass from Los Angeles has 46,000 homeless residents in her city. Being with those 40 mayors is something that is so astonishing to that level when you hear, and you see it firsthand. I visited Los Angeles with her. I would say that mayors across the country are saying this is our number one crisis, and we do not have the resources. Especially when it goes to the states and then it goes to the counties, a lot of times mayors and cities never see that assistance. Think about it, it is our police force, jails, and ERs. It is where the rubber meets the road.

I want to say this to give everyone hope. I met with Congressman Amodei and Senator Cortez Masto. I have met with Senator Rosen before. I will tell everyone; you are very lucky to have the representation you have. It is truly remarkable. Even if you are on different sides of parties. They have been accessible and open on the federal level for the

State of Nevada. It has been impressive. I am a nonpartisan. I do not care about parties. I care about people. Both sides have been tremendous, and we should be so lucky that we have great representation there. It is impressive. I hear from other mayors, and I see other mayors trying to get into their delegations. Sometimes they have zero access at all. Everyone, when you see our delegation, please tell them we are lucky. I wanted you to know too that they are working as hard as they possibly can as well on this issue. I truly believe they are hearing us loud and clear because they want to be able to help you as well when it comes to how this trickles down.

Chair Doñate:

Let us go to Commissioner Jones and Councilman Knudsen has joined us. I will give him a chance to speak as well.

Commissioner Jones:

It was a philosophical question about who should bear the burden of addressing mental health. I do not have the answer for that because there are different models across the country. However, to Mayor Schieve's point, everything we do in local government is pervaded by this issue, substance use disorder and mental health. We have to run the jails. We have to provide public safety. We have to address homelessness. We have to assist when it comes to our schools. Mental health concerns are pervasive through all of the functions of local government across 39 departments of the County. The same thing goes for the City. I would say we are in it whether we like it or not. We want to be partners with the State when it comes to finding that dedicated funding stream, so collectively we can address the issue.

Chair Doñate:

If there are different models that are followed across the country, what is the model you think should work? The reason I am asking that is historically, there has been this conversation of a mental health agency. There needs to be one authoritative figure that is deciding as the local townships, this is what you are entrusted to do. This is what the State is going to do. Here is where we are going to go forward. What does the model look like, does it need to be revised, or do we continue the status quo and fix the funding issue? I will come back to you on that. Let us go to Councilman Knudsen.

Brian Knudsen, Councilman, Ward 1, City of Las Vegas:

I am grateful for the leadership of you, Mister Chair, and the Committee for allowing cities and counties to talk about this issue. I do not know what I missed; I apologize. I would say the opportunities for cities, counties, and the State to work together on this issue is imperative, and it is right now. I would give a shout-out to your staff at DHHS. I have been working with them for more than 15 years. You have incredibly bright and talented people that probably know a lot of the answers you are asking for. They have been actively working with us at the city and county level. We are working together to try to figure out what that next step is. Nevada is different in how we fund things, but the opportunities are there, and the right people are in place. To the question of what I would change about the system, that is fundamentally the issue. I do not think we have much of a system to change. I think we have the right people, and we need to build a system. It should also focus on preventing. A lot of the conversations myself and the Commissioner have been focusing on is a crisis response, which we absolutely have to do. We also need to split our time in talking about how we prevent people from ending up in that situation in the

first place? I am happy to talk through any of those questions or the activities we have been working on the last couple of years.

Commissioner Jones:

I do not know what the right model is, but there are things you all know better than anyone that are unique to the State. We have a Legislature that only meets once every two years. In local government, we must do this every single day. We get paid for it, which I know you guys do not. I would say a response that involves the local government folks in providing those services is instrumental. When I chaired this Committee a decade ago, we worked on the Regional Behavioral Health Policy Board discussion which ended up getting adopted in 2015 or 2017. That was one piece of it. In terms of regional policy discussions, we are important. At the end of the day, the Regional Behavioral Health Policy Boards are recommending committees to you as policy makers. They are not the ones that are operating the actual systems themselves. It is a collaboration between State DHHS and us in local government to make sure that on the ground they happen.

Chair Doñate:

Mayor Schieve and Commissioner Garcia, I do not know if you guys have any other comments. I know my question was more philosophical on the change of model. I do not know if there is anything you wanted to discuss.

Mayor Schieve:

I was hearing you loud and clear when you said it was hard to make this agenda because especially mental health and addiction is incredibly broad. I think Mr. Jones raised the question Nevada is different. Obviously, it is for many reasons. Let us talk about—we are the only state that does it with depreciation. It is no wonder we constantly, "rob Peter to pay Paul" to fund anything in this State. Until someone has the political will and the guts to do it, funding will continue to be incredibly problematic. If we are going to call a spade a spade, that is where we constantly see it. Every single day, day-in and day-out. With every funding we do from housing to health care to education. I think we have to wake up if we want to be bold and big and have the political fight in us. Everyone needs to start talking about what that looks like if we want things to change in Nevada. I know that is the big broad view that we all have talked about in circles. To be honest with you, to change Nevada and stop being last on the list, which is where it is going to happen. I am sending you guys lots of strength because I know how difficult your jobs are. We have the same job. I am an entrepreneur. I have been for—I own my own businesses. I always said I wanted to be my own boss. Now, I have 250,000 of them, so I understand how difficult your jobs are every single day. Thank you for all you do in your service.

Senator Nguyen:

I will second what the Mayor said. I think we do need to be bold in how we are going to rise out of the bottom of all of these top 50 lists. We seem to be the best at being the worst. I look forward to having continued conversations about what that looks like for our State moving forward. City Councilman Knudsen, I know you were not here for part of this. During the AG's presentation, I asked a question about opioid, the funds, and the recommendations they made. Some of them were more aggressive. Some of them were smaller. I asked if they were a part of an overall strategic plan. The AG mentioned it was his understanding—and this probably goes to those of you in Carson City as well—do you find that your own county and city strategic plans around opioid addiction and crisis intervention

or any of those are in alignment with the State plans or other strategic plans? Are we all operating in silos?

Councilman Knudsen:

I think it is a little bit of both. We do operate in silos to a certain extent. The amount of funding dictates that as well. The City is going to have a couple million dollars, which in the grand scheme of things is not going to have the greatest impact. I have been working closely with your DHHS staff. I think they have much greater access to funding. It is thinking through how to leverage that funding with the local jurisdiction. It would be great to have a staff who are responsible for that decision-making, staff you trust who can make recommendations to you, and meet with staff from the cities and counties to brainstorm. I do not think the City has gotten to the point where we are allocating funds yet. We have asked for advice from groups who are responsible for opioid addiction issues because there is no expertise in the City. It relies on the community. If there was a bringing together of State folks to say to the City and County folks, there is a lot of opportunity, and it is not just the couple of million dollars the City may get. It is future Community Development Block Grant allocations, it is future how we align all our existing resources. It is a great conversation to have. The City and County work regularly on those issues in Southern Nevada. It would be great to integrate the State into those conversations.

Commissioner Jones:

I would echo that with regards to opioid funding. It is similar to all of the other discussions we have had. It is great we have this windfall of opioid litigation settlement money. Under the One Nevada Plan, the County gets so much, the City gets so much, and the State retains so much. We are working through our Regional Clark County Plan on how we are using our funds. We already made the allocation last year for the first $65 million of our County funds to go to a State world-class opioid treatment center. We still need a large chunk of money to start construction on the facility. That does not even take into consideration how we are going to fund the program going forward. We are looking at payer mix and other things to make sure once we open that kind of a facility, it can serve the needs of our community for the long-term.

Councilman Knudsen:

That is a good point because the one-time money, which the opioid settlement is a one-time funding shot, is super helpful. It is great to start something. At the end of the day, where we need that State integration is understanding what the long-term implications are, and the operations and maintenance of any service. It is going to come in through Medicaid or insurance reimbursement rate that allows something to maintain in perpetuity. The one-time shot helps get us started.

Senator Nguyen:

I know you two work well together, but is there an overall formalized communication between cities and counties to make sure there is or there is not overlap in the type of resources and priorities the county is taking on as opposed to the city who may have a larger allocation of even these one-time funds? Is there an ideal model? Do we have a model? I think back to the money we received during the pandemic, the ARPA funds. A lot of times we did not have any strategic plan to plug even these one-time funds into because we were like, "There is no money. We do not have the money. We do not even have a plan for what we would do when it came in." Let us say we are in a situation where we are able

to increase and come up with a permanent funding source. Do we even have programming set up to accept that ongoing funding source?

Councilman Knudsen:

I would answer that in two parts. First, we do not overlap because there are so many big gaps it is almost impossible to overlap. Are we duplicative? Maybe, but there is such a huge need that is okay. We can overlap and duplicate and still not meet one-tenth of what the need is. With the question of plans, there have been a number of plans. It is easier for local governments to create a plan and follow it. What I have seen with the State in particular, not to place blame on anybody, the State comes up with studies and plans to be able to follow through with them in the next legislative session. With people who are elected and have different policy goals, it may not get enacted. A good example of that was I think three sessions ago. It started out as the city trying to do a tax on sewers, and it turned into a study of what the overall arching plan for homelessness is. That was a big document that took thousands of hours of local governments to come together and decide, it was supported by the State Legislature, and that plan still sits on a shelf. I would push back to say it would be great if we came up with a plan and then follow through with it.

Commissioner Jones:

When I joined the County Commission five and a half years ago, the relationships between the city and county were nonexistent. I will not take credit for the relationship between the city and county now. Brian and I worked well together, but we are not alone. I think our staffs are fantastic. Regardless of the political members of our boards, the staff have been working together for years to make sure they are addressing the needs of our community.

I think our current boards are trying to work together in a regional way on everything from mental health to homelessness for sure to make sure we are not duplicating services. Things that may have been done in the past; the Courtyard is a good example. The city went down one pathway with the Courtyard. It is now being integrated back into a larger system to address homelessness across the valley. We are optimistic in terms of the Legislature being creative. The last legislative session, the opportunity for $100 million the State allocated to be matched by private funds and mandating the local jurisdictions all be bought in through navigation centers was a great model for you all as Legislators to essentially arm twist local government to collaborate with one another. Chair Doñate, back to your point of what is the optimal model. To the extent you are hamstrung by constitutional limitations, which is at least one way to make sure we all play nice in the sandbox: tie State funding to collaboration.

Chair Doñate:

That leads to the conversation of accountability. If we decide to do some funding mechanism—you threw out a few that other states, counties, and jurisdictions do—whether it is rural property tax reform or a quarter from the sales tax. Whatever the scenario is, if we arrive to that point, not talking about the one-time dollars we have already allocated through ARPA. If we have a surplus, that is a completely separate thing. If we find a scenario where we agree to fund or revamp our tax structures, our funding mechanisms, we want to make sure there is accountability for the local governments and say, "You are going to receive these dollars, this is what you are required to do. You have to reduce readmissions." There is no denial. You are going to have to work together. There has to be a plan. If you fail to do so, you get the funding taken away or you do not get an increase in

funding in the next two years. There has to be a plan of where do we need to go between now and the next ten years? Are we following through?

If we are not following through, we can focus on the subset of the system that is not working. That is where we can work from session to session to make sure we are still on track to meet the guidelines of what we decided five or ten years from now. That sounds like the bigger trajectory if we arrive to more funding. It is not enough to say we are going to improve and increase Medicaid reimbursements. That does not solve anything, it makes sure our providers get paid more. There needs to be a robust conversation of how each sector of the system all work together, and that includes local governments.

Are there any further questions? I think this was a helpful presentation. Do any of you have any closing comments?

Commissioner Jones:

Thank you on behalf of Clark County for making this such a priority for this Committee. We also look forward to the discussion of children's mental health, which I know is near and dear to the heart of my friend Councilman Knudsen.

Councilman Knudsen:

The conversation around crisis prevention in the mental health system, which the State has to be an active role player in, also allows us to talk about prevention services and what we need to do to prevent the next 20 years of looking like it has the last couple of years.
I would also argue if you have not had the chance to do a ride along with a police officer in Metro or with the Fire Department, it makes it much easier to understand the implications a lack of a system has on our Southern Nevada community. I am sure this is true in Northern Nevada as well. If you do a walk through at UMC, Valley Hospital Medical Center, or any of the ERs or a ride along, you will see firsthand the impacts a lack of planning has on our first responder system. If we can get to the point where we are thinking about the future as well as addressing the current state, I think we will be in a much better place, and I know we serve as active participants in the process.

Chair Doñate:

I have done the ride along. I did a full shift. It was incredible what you learn within the short time frame you are with them. I think that is something we need to cater to.
I appreciate the work you all do. I know it is tough working in local governments. There are issues that sometimes it feels like we are putting one fire out and then we move onto the next one, and it feels like it adds up. Hopefully we can work together to the point we can at least fix some of it, and we can focus more upstream. Councilman Knudsen, I will invite you back to the next meeting we have in June when we talk about children's mental health.
I would be eager to hear your recommendations.

We will now close this agenda item. Thank you to our elected officials from both Northern and Southern Nevada.

AGENDA ITEM VII—OVERVIEW ON ACCESS TO BEHAVIORAL HEALTH SERVICES FOR ADULTS ENROLLED WITH NEVADA MEDICAID AND POLICY CONSIDERATIONS REGARDING THE BEHAVIORAL HEALTH CONTINUUM OF CARE

Chair Doñate:

We will move on to Item VII, an overview on access to behavioral health services for adults enrolled with Nevada Medicaid and policy considerations for the behavioral health continuum of care. We have Administrator Weeks from the Division of Health Care Financing and Policy (DHCFP). Please begin when you are ready.

Stacie Weeks, Administrator and Nevada Medicaid Director, DHCFP, DHHS:

Thank you for having us today. It has been an interesting discussion, and I appreciate the focus on this topic. It is a big need for Medicaid and our recipients. A big theme so far has been money. I think there are a couple other things that, as a policy Committee, are worth noting and talking about that could be helpful to improving access for behavioral health services (Agenda Item VII).

I am going to touch on some statistics we have. I think it is important to inform our conversations with data. We have a lot of data at Nevada Medicaid and the Office of Analytics which is housed under DHHS. I think sometimes we report a lot, we admire the problem, and we do not take a chance to look at that problem. I am hoping today we can look at some data and start thinking about how some of the things we already report on could be useful to your Committee going forward.

I am also going to give you a preliminary rate review finding from our quadrennial rate review. I am excited our team was able to do initial data for you, so you could have it here today. I think that will be helpful for conversations around where we could focus new investments on rates. The other thing I want to talk about are gaps and opportunities in Medicaid. We have a lot of—I like to think of gaps as opportunities, but sometimes they are gaps. I think they are worth noting here today, but I think a lot of them could be opportunities for next session and generally working together on these issues. Then I want to talk about workforce and access issues, because rates are not the only problem in our State impacting access. At the end, I want to touch on Medicaid's role in this. As you know, it is a big player in Medicaid financing for behavioral health.

First, I wanted to give you an overview about who in Medicaid we have data on for who we consider as diagnosed with serious mental illness. For serious mental illness, when we look at the program today—right now, we are focusing on adults on this slide—we look at all adults. That includes seniors over 65 that are in Medicaid. One in seven people on Nevada Medicaid have a serious mental illness (SMI). Of those, almost half have a SUD. About 10 percent of those with a SMI diagnosis have what we consider opioid use disorder. A smaller percentage, but worth noting, about 2 percent of this population also have autism and/or fetal alcohol syndrome. This is for adults 21 and older all the way to the end of the life cycle. When we look at national statistics, you might hear one in four adults. That is true for Nevada Medicaid too because when we only look at those 21-to 64-years-of-age, it is one in four. That is on par with the national data of what we know in terms of Medicaid enrollees having a mental health disorder or SMI. Again, it is one in seven when we include seniors, but it is one in four on average when we consider adults up to age 64.

We look at the number of people in Medicaid currently with diagnosis. I want to point out, before we dive in, that often what we know about this population is they are struggling with mental health issues, but they are not quite yet screened, assessed, and diagnosed. These are numbers of people who we have a diagnosis for. I think that is an important point to remember. There is probably a larger percentage of folks in our population that have not yet been screened and diagnosed for mental health, and they are not yet getting treatment and services.

When we look at the population, the majority of them are our families, our parents, and some of our lowest income families. About 63 percent of the total population is our parent population; they are on our Cash Assistance Program. They are also struggling with employment and keeping jobs. Often, mental health has a big role in that. I think that is important to remember. That is why often many states are looking at adding employment supports as a part of Medicaid funded programs through waivers and things like that. Also, 20 percent of this population are our seniors and blind-to-disabled population. Another roughly 18 percent are what we consider our expansion adults and parents, who we added in Nevada with the Medicaid expansion. It feels like many moons ago, but it was not that long ago.

I want to note too, that expanded 20 percent is a much lower number than the national number. We are going to dig into this data more because I think we might be missing some folks in that category. What we know about our expansion population is they are usually our adults without children who are homeless, so I think either we have not quite identified them, diagnosed them, as could be the indicator here, or we may not have the full number here. I want to note that number is lower, and we are looking more into that. We look at spending as a whole of our pie.

As a reminder, Medicaid is partially State funded. For our State it is General Fund, and the rest is federally funded. We do not draw down that money like a grant. We draw it down on the actual service being used for the recipient. That money is tied per claim when we have a service that has been received. Currently, on utilization and actual spending, it is only about 4 percent. In 2021, it was 4.5 percent. I think you saw that drop a little bit because of COVID-19 or potentially other things that were going on. We are picking back up in 2023 at 4.4 percent. The total spending is about $4 billion on behavioral health services. I think there definitely could be an increase in spending if it is at 4 percent today.

I want to walk us through a little bit of the behavioral health care continuum to ground us in what we are talking about. Everyone is saying, "We need more, we need more." What do we need more of and where? When we think about the behavioral health care continuum, broadly speaking, there are four service categories. The first is the early identification intervention part of our system. This might be our primary care clinics. This could be our schools. This could be any area where someone comes in contact with the health care system, the State, or county system, is screened and diagnosed or is at least identified for some sort of assessment later down the road. I think this is an area you have heard others talk about today. We need a little more work in this area. There is something we are trying to do on the children's side with schools. We can talk about that in a future hearing. I think there is more opportunity here we have not captured fully in Nevada. This is our low intensity area of our service, and typically our lower cost services fall in this category.

As you move to the next bubble, this is someone who has been diagnosed, hopefully, and is identified. They are moving into what we consider outpatient and community treatment. This is where we want people to be. We want people to be able to get the behavioral health services they need: therapy, treatment, medication management, and whatever they need

in their community in an outpatient setting. It is not only cost effective, but it is the best place because they can still function in our society. This is where they can still live and function within the community.

Sometimes though, things turn into a crisis, or we have an emergency response, and that is the next bubble. This is our crisis stabilization mobile crisis. This sometimes leads to inpatient services. People sometimes cycle back and forth between outpatient and crisis. Some people go straight to crisis, and that is where we are identifying them. I think that is when the system has failed somewhere. Someone did not get into their primary care clinic. Someone did not find a way to get diagnosed and treated early before they ended up in a crisis. Something we try to think about as we are building our system is trying to get people services earlier to avoid some of those costly crisis situations.

Some folks end up in our residential and inpatient treatment. These are folks that end up in our psych wards at the hospital or in what we consider institutions for mental disease (IMD) under federal law, which are our residential psych centers. Currently in Nevada, we do not cover services with Medicaid dollars for serious mental illness in a residential treatment center. This is anything that qualifies as an IMD, which is more than 16 beds. We are seeking an amendment to our waiver where we cover SUD treatment in a residential setting, so we will be adding these services hopefully soon. I can never predict the U.S. Centers for Medicare and Medicaid Services (CMS). If I had my magic eight ball, it probably would say at least 9 to 12 months depending on how long CMS takes to review our amendment request. That is something we are working on. We want to keep most folks in those first two buckets. That is where we not only see better outcomes for people, but also less cost to the system and less expenses.

I wanted to note, too, that the less we have in our community to support people, the more we put ourselves at risk for a department of justice finding for adults as well. We currently have a finding for children that we do not have enough services in our community to avoid institutionalizing people or children with mental disorders. Any state that does not invest enough in that outpatient community service also risk that finding as well. That is because of the Americans with Disabilities Act; all states have to try their best to provide the services people need in their communities.

Moving on to data around access. Members may know about this. All State Medicaid programs must monitor and track access metrics and report those findings to CMS. Each state has done it a little differently, unfortunately. That makes it hard to compare across states. Recently, CMS released a lengthy rule on the access report increasing our requirements for tracking access. You will see some items hopefully next session for Medicaid to do this work. They are holding states to a higher standard around access. Often, this is not just about rates, it is making sure people have access in the rural areas as well, not just in urban areas. If you look at that chart, the line is dropping. That is the number we have been tracking of enrolled providers in Medicaid for behavioral health. It is a pretty big group of providers. I have listed them at the bottom for you that are included in this breakdown. Early on during COVID-19, we were up to a little over 6,000. We slowly started dropping during COVID-19. A lot of this reasoning could be people were not seeking services during those times, and that also affected businesses and finances for providers. We did see it pick back up a little bit and then drop back down. Now we are seeing it drop even more at about 5,860.

There are other reasons besides COVID-19. There could be rates. We talk about that, but it could also be some of the issues we have had with fraud in this area. That is the unfortunate part of our work at Medicaid. While we want to be flexible and remove every

burden in the world for providers, we also have a lot of fraud amongst providers. Behavioral health providers, unfortunately, are one of our biggest areas for fraud. There have been a number of folks that we have closed in the last year around fraud. It is significant, and it is unfortunate because it has an impact on our program. It causes us to not be so flexible on our requirements, like prior authorization. Those bad actors have an unfortunate impact on how we run our program. It is an area we definitely want to make sure is not occurring, so that also has impacted the drop. Also, some of our behavioral health providers did not revalidate. That is a part of the system where every couple of years people have to reenroll as a Medicaid provider. We make sure they still meet all the requirements and licensure requirements. We did have some folks drop off, but we are seeing people pick back up once they realize they did not get revalidated. We are hopeful that number plateaus for the next year or increases and does not continue to decrease. On the far right, we have the number of providers by county. There is no behavioral health access in Esmeralda County and Eureka County. No surprise, the largest number of providers enrolled are in Clark County. Washoe County follows suit at 966 providers.

I want to show you some other data we track for CMS. We often report this data and do not take a dive into it. I think it is helpful to have hearings like this so we can talk about what does it mean, and what is a provider-to-patient ratio supposed to look like for these services? I did some research on my own. There is no standard for us to pluck out of the national best practices. When you think of a primary care physician, one provider for 1,000 patients does seem high, but that is the one that many states are going with. When we think about behavioral health and patients' needs, they are not going in once or twice a year. They are going in more often which makes that workload higher. To have a high patient load for one provider is a lot when behavioral health needs do more touch points with the patient.

When we look at these numbers, you can see for substance use providers, we have some of our worst provider-to-patient ratios in our rural regions. That is something to note. Certified Community Behavioral Health Centers (CCBHCs) are one provider for every 84,000 individuals. That is not enough in Clark County, for example. Clinical psychologists are some of the worst provider-to-patient ratios in our rural regions. Same for psychiatrists. Outpatient treatment looks fairly good in Clark County, surprisingly, but when you look at Washoe County and rural regions, we are about one provider for every 1,000 patients. Clinical social workers are worst in our rural regions. It is the same for marriage and family counselors and clinical professional counselors. There are some gaps in the rural areas, and that is why telehealth is such an important piece. Not only is covering it important in Medicaid, we often add a benefit or recover something and then no one takes it up. I think a big piece of that for telehealth is access to broadband wireless, but also access to the equipment that folks need to be able to communicate with their provider through telehealth.

One other thing I want to note from a policy perspective for the Committee is for you to think about if you have legislation next year on these topics as we are starting to do bonus payments or tiering payments in a way where we are encouraging rural access. We pay a little more for a rural visit, so hopefully someone will actually drive out there in some cases or at least want to serve our rural region. Something I want to throw out there, is that our payment models can be used to drive better outcomes in our system.

We wanted to provide folks today with an early glimpse at our preliminary quadrennial rate review findings. This time we looked at the top behavioral health provider types that we currently pay in the system. The first one we call our qualified mental health professional. These are nurse practitioners, APRNs, psychiatrists, doctors, PAs, clinical psychologists, and

certified professional coders (CPCs). These are all the folks who are licensed and work with the behavioral health and mental health population. The second one is our qualified mental health associates. These are our registered nurses (RNs), those who have bachelor's or associate degrees and work in mental health. Our behavior health aides are typically high school diplomas or general educational development (GEDs) and are supporting our mental health associates and professionals.

We also looked at rates for clinical social workers, marriage and family therapists, clinical professional counselors, day treatment models, psychologists, targeted case management specific to behavioral health, as well as behavioral health rehabilitative treatment. We looked at applied behavioral analysis (ABA). As you may recall, last session we had rates that were changed for ABA, but that did not include psychologists. This is looking at the psychologist perspective for ABA rates. I want to point out this is not duplicative of what you already funded and addressed last session.

I am going to walk you through a high level and hit the big points here. For each of those behavioral health provider types, we looked at all the codes we cover. Basically, these are what we consider our service components of a benefit. We will pay providers under these codes. We compared those codes to other states. I want to say we looked at ten other states. It is often hard, though. I want to point out it is not always apples to apples when we are looking at other states. Other states pay for things differently. They may bundle a rate. They may pay for it in 15-minute increments, and we do not. Sometimes it is not an easy apples to apples comparison because every state can do what they want when it comes to Medicaid. Medicaid is different than Medicare. Medicaid is run at the state level. We were able to look at most of these services and compare to other codes and rates in other states.

We looked at qualified mental health professionals. Again, these are our high-level professionals, psychologists, psychiatrists, and others that work in this field. Other State rates exceed our rates for this provider type about 65 percent of the time. We look at qualified mental health associates, about 53 percent of the time other state's rates are higher. We looked at behavioral health aids. Those are the ones we saw some significant differences, about 80 percent of the time other states pay a much higher rate. I want to point that one out as being significant on this list. Licensed clinical social workers, about 51 percent of the time other states are paying higher rates. It is the same for marriage and family therapists and clinical professional counselors.

When we got to the day treatment model, it was interesting to find we are either at the same rate as other states, or we are doing better than other states. There were no findings here for any need for an increase there. When it comes to children, this is an area we probably will be wanting to invest more. We can talk about that in the next meeting. With the U.S. Department of Justice (DOJ), we are trying to increase more of that community model. We may be looking at that population for day treatment to try to help families in the community more. It is something to consider that we are roughly on par with other states at the adult population. Psychologists, 65 percent of the time other states are paying more than we are. When we look at targeted case management, we are at or doing better than other states, so we do not have a recommendation to increase rates. Behavioral health rehabilitative treatment, 72 percent of the time other states are paying higher. Psychologists that do ABA, 70 percent of states are paying higher than we are.

Where the rubber meets the road is how much does it cost? When we look at trying to increase rates up to where other states are, we did not look at decreasing or anything of that nature. At this point, we all know behavioral health is underfunded. We all agree with

that. If we are going to ask the State to give us more funding to get us where we need to be, it would be about $18 million from the State General Fund. I know people talk about sustainable funding and trying to find that funding, but truly, the State General Fund is the sustainable funding. It may come from taxes. It could come from other places, but that is the hard decision you all make, and we do not. The amount we would need to at least get up to where other states are is about $18 million State General Fund, which would be a full investment of about $54.5 million with the federal dollars. The feds pick up a big portion of this at about 60 percent or higher depending on the Federal Medical Assistance Percentage (FMAP) rate. As I mentioned, there are levers to getting that funding, but for Medicaid, it does need to be ongoing. It cannot be one-time funding or CMS will not approve federal funding.

We have a lot of gaps in Medicaid, but we are not alone nationally. When we look at rankings, like others have mentioned today, we are at the bottom ten when it comes to mental health access. I think it is important to remember we are not the only state struggling to meet these needs, but we are not doing well. As a State, that is something Medicaid takes seriously, and we are trying to improve our policies to make things better. There are challenges to doing that, and a big piece of that is funding. The first opportunity, even though it is a lot more work for my team, is this new federal access rule. I think there is real opportunity for not only better finding access problems but being required now to put money in this direction. As we dive in and digest this big rule, we will be coming forward with recommendations from that addressing access issues, especially in behavioral health.

Another one I have on the list is community paramedicine. This is an area ripe for improvement. We do have a Community Paramedic Program that we fund in Medicaid. It has not been taken up and used like other states. Several other states have this type of program, and it has been helpful for behavioral health, especially in rural communities. As we look to try to meet the need and keep people in their homes, community paramedics in other states are doing this work. We are looking at this program and trying to figure out if it is the rate that needs to be improved, and what else we can do to make it easier for these providers to build for services and provide them, especially in our rural communities.

Another one we need to build is the Assertive Community Treatment (ACT) Program in Nevada. I think that is an opportunity. If we paid more funding, fund it appropriately, and build a full model, this could be a helpful program for our State and help offset funding. That is already being used at DPBH.

First episode psychosis is another model we do not fully fund or even completely cover. I think it is a model we need to look at expanding.

Peer support services are other opportunities we have. Right now, we are working on increasing rates for these services as part of the children's behavioral health transformation. We are looking at expanding it to family and youth peer supports. That is exciting. We are hopefully moving that forward soon.

Another area we have heard a lot about, and we know our rates are very low for, is occupational therapists (OT). That was from a prior quadrennial rate review, but a big piece we have seen in other states is using OT for mental health. They do a lot of different therapies to help children and adults stay in their homes and communities.

There is another opportunity in looking at how Medicaid could support Project ECHO and get approval to fund it, especially around areas that get at our access issues. Primary care and

psychiatrists would be a big one to help us screen people at their primary clinics and then support primary care providers in supporting patients with mental health needs.

Mobile crisis response, you have heard today, and you will probably hear it time and time again. We need to look at the system fully and put more money into it. We are doing a lot of work in this area now, but there is always room to grow. There is more room for money to be invested in that system.

Mental health services for adults in residential settings, we are working to get that amendment in our 1115 Waiver, so we can cover these services which will help a lot of our inpatient psych and our residential treatment centers for adults.

Housing supports and meal supports is another area we often forget. People have other needs that impact their health like housing and meals, especially around homelessness. One of the things we are going to be adding into our Waiver is permanent funding, support, and authority to cover these services broadly. Right now, we are adding them into our Managed Care Program, but we do need them in our Fee-For-Service Program, so we are looking at adding it through the Waiver.

Crisis stabilization service, fingers crossed, I am going to get federal approval soon. I feel like we have been waiting a long time for this one from CMS. The other thing I think we often get stuck with is that things get passed, and it takes us over a year or two to implement them. That is unfortunate and is something we are trying to work on; we have been waiting for some time from CMS for crisis stabilization services.

Home- and community-based model for adults, we are working on a home- and community-based model for children. For the children's behavioral health work we are doing under the DOJ settlement agreement, the one thing we have not talked about, and we need to think about, which is why I mentioned the ACT Program and community paramedics, is how do we keep adults in their communities and out of our ERs and residential treatment centers? There are some service models.

Last but not least, you heard AG Ford mention the need for coverage and services and for incarcerated adults and juveniles in our justice system. Right now, we are working to implement this. This is a huge lift. We have a vendor underway. We kicked off the project with Manet Community Health Center. They are the ones that helped California do their Waiver for incarcerated adults to implement that coverage. That will be covering a lot of our mental health services and other care for people in the corrections system up to 90 days prerelease.

For juveniles in our justice system, there is a new mandate from the federal government that we need to cover services for juveniles. They will be eligible for Medicaid while they are in the system for the first time, but only for that first 30 days prerelease. We have to get in there, either with our care coordinators or managed care plans, and help children access services, not only in the justice system, but when they leave and make sure they have their appointments set up and all their medication managed and ready when they are released.

Medicaid’s role in all of this, generally speaking, when we think about payers and often providers coming to the Legislature because everywhere in health care there is not enough money, so it is important to remember Medicaid is your second largest payer in the State. Medicare is third. Medicaid is about 21 percent of the payer mix. If a provider takes a lot of these other types of payers, there are other areas, but when you think of what the State has, it is has levers to improve. The employer bucket is hard to touch. Unless it is our public

employee benefit plan, employer sponsored insurance (ESI) is federal. It is hard to impact that large payer there. The other area is the Medicaid bucket. Medicare is one you cannot touch, is also federal. Military is federal. Individual market is our private insurance markets, our exchange. That is an area you can have an impact in with the insurance laws and mandates. The uninsured bucket, obviously, is uncompensated care. We are still roughly about 10 to 11 percent uninsured in this State.

One thing to note about behavioral health that is different because sometimes providers come to me and I am like, "What is Medicaid's makeup of your payer mix?" Often it is 15 percent or lower. I can increase my rates all day, and it is not going to improve their salaries. When it comes to behavioral health providers, especially our high-intensive service providers, it is primarily Medicaid that they rely on. I think that is important to remember. That is because a lot of times people with mental health needs are our populations struggling with employment or homelessness, and they are on our Medicaid program. Private insurance is less robust in covering especially our high-intensive, high-cost services like residential treatment, inpatient psych, and those types of services. There are a lot more limits in that area.

Not only is putting money into our program important, but also reminding all of us that when we put money into our program, we are getting the outcomes we want to see. Just increasing rates is not the solution. We need to drive policy with our rates methodologies. We need to make sure we have quality. We cannot overlook quality because we are desperate for providers. I want to always remember that. It is important. That is where we get away from our fraud risk and ensure people go into these centers and get good outcomes. That is something I want to note. It is not just about increasing rates; it is about making sure we do that in a way that is going to drive the outcomes we want to see.

I thought it would be a miss today if we just talked about rates. States have done studies, we can put money into the system, and it does not always solve the problem. Especially right away. I am not saying behavioral health is not underfunded. I think Nevada has room to grow in this area. We have to think about our workforce, and what else can we do to help increase the workforce in our State in behavioral health. [We need to] not only increase it, but look at the ones we currently have here, the ones not taking Medicaid, and figure out how we get them to serve this population. Rates are one piece of that solution, but there are other challenges to being a provider in this area.

When I think of improving access, I think of a three-pronged approach. The first one is the biggest: finances. You guys hold the purse, and that is a big piece of this. Medicaid rates, like I mentioned earlier, are a big piece for our behavioral health provider system. Just because we increase the rates, does not necessarily always mean every system is going to increase salaries and bonuses for these providers. I think it is important to note we can increase rates, but it does not necessarily mean we are increasing the salaries for providers. The State economy is a big piece to attracting business and providers into our State. Other payers and any restrictions they have and how they pay for these services should be noted because not everyone is on Medicaid.

Our other big piece to remember as a policy Committee is our practice and licensure laws around workforce. Reciprocity laws are one area other states are looking at to increase providers coming in, providing services, and trying to make that easier. If someone is practicing in another state, their license is reciprocal in this State and removing any of those barriers to doing that. Another area states are looking at is the timeline of how long it takes to get licensed and making sure it is—obviously, we want quality providers—but removing any unnecessary burdens in that process. We are also working on credentialing. We are

currently implementing Medicaid centralized credentialing, so providers do not have to go through four different credentialing processes to become a Medicaid provider. Right now, they do. Once we have this up and going next year, providers will only have a one-stop shop for getting credentialed. I am hopeful that will help in getting more providers enrolled with Medicaid to provide these services.

Last but not least, is our workforce pipeline. We have a good relationship with our universities trying to make sure we can maximize residency programs not just for physicians, but also for other providers. Looking at loan repayment is an area where other states are driving a lot of their funds and investments, not just loan repayments but having loan repayments with strings attached making sure people stay and serve a community long enough or they owe their loan back to the State. Also, looking at in-state residencies that are focused on our largest gap, not just doing residencies for specialists, but looking at residencies for certain areas. If we need behavioral health providers in a certain area, focusing on funding residencies for psychiatrists, clinical psychologists, as well as primary care providers to help screen and identify patients earlier. With that, I will open for questions.

Chair Doñate:

Let us start with the first basic question, the one I asked everyone who has presented today. If there was one thing you could focus on to fix the mental health system, what would you fund or fix first? Maybe that can start the conversation for our Legislators today.

Ms. Weeks:

That is a million-dollar question. I think sustainable funding for behavioral health, not just for children. We have some of that now with the provider tax for hospitals, which is amazing and helpful. I think more of that would be helpful to address the rate issues we have. Starting there is the first step. Again, it cannot be the only thing the State does. We have to look at the full system.

Chair Doñate:

I think that is helpful. I want to commend you. I think your comments were spot on with fixing Medicaid reimbursements. I have had this conversation with so many of our providers. Fixing Medicaid reimbursements is not the end all solution. Fixing it does not mean our problems are going to go away. It is a systemic focus. There are different parts of the system that need to be fixed. It is not just financially. Of course, now that we have the provider assessment fee help is on the way. Let us make sure that is implemented correctly, which your office has—thankfully—taken the lead on. I will let my Committee Members ask questions. I am limiting it to two questions, if we can.

Assemblywoman Brown-May:

Thank you for a great presentation this morning. I love the data. It is important to wrap our heads around how big the issues are. The Medicaid gaps equals opportunities slide 11 points us, as a Committee, in a direction where we have an opportunity to move into solutions. Thank you for your hard work and dedication to our State and the work your team does. I want to go back to AG Ford's presentation earlier today. The recommendation that came from the SURG Committee, recommendation number one, was for DHHS, the DPBH, and the BBHWP to double the amount of investment into a Primary Prevention Program by an additional $12 million. Knowing you are the DHCFP and many of the funding models are going to come through your Division, have you engaged in those conversations relative to

the proposals that are coming out of the SURG Committee? Have you all had a conversation about this?

Ms. Weeks:

I have not, but my Director may have, so I want to follow-up with him. I have not been at those tables. I think funding and prevention—but I have not looked in detail at what that means and what types of opportunities that means for Medicaid—is an area we need more help and more investment from the Legislature.

Assemblywoman Brown-May:

There are a number of recommendations coming from lots of different parties. We are all working toward the same solutions, mental health, public and behavioral health. How do we stabilize in a crisis situation? I would like the opportunity to follow up with you all in your Division relative to the recommendations that will go into the next biennial budget as we prioritize how we address crisis prevention.

Assemblyman Hibbetts:

I would like to draw your attention to slide seven where it says, "provider-to-patient ratios." During your presentation, you used patient ratios and people ratios. Is this provider to patients or provider to people?

Ms. Weeks:

I think it is people, so it is not just the ones utilizing services.

Assemblyman Hibbetts:

Let us look at CCBHCs in Clark County: 1 to 84,291. That would assume every person in Clark County is at some point going to need to use the services of that provider or one of those providers. Is that correct?

Ms. Weeks:

I want to make sure I answer your question correctly. These are the folks we believe would be accessing these services since they have a diagnosis. These are the folks that per provider how many they would need to see. Does that make sense? For every one [provider], there is going to be about 84,000 people with that diagnosis or potential need. I can follow up with you if you want the whole report. That will probably answer the question better; I apologize.

Assemblyman Hibbetts:

That would be wonderful if you could send that to the Committee.

Senator Nguyen:

Thank you for your presentation. It is always incredibly thorough whenever you speak at the table. I am looking at the payment models. You talked about bonus payments you are starting to institute. I am looking at these preliminary rate review findings and recommendations on where we need to go and the areas where there is the most need. You

also mentioned in the mental health area, so much of it is occupied by the private sector. I think you said it was about 15 percent. Is that correct?

Ms. Weeks:

I apologize. I was referring to if other types of providers come forward, often not behavioral health. Typically, it is 15 to 20 percent of their payer mix. Behavioral health is largely Medicaid because the population's needs are so great, and they are often struggling to keep employment and other needs. Sorry if that confused you.

Senator Nguyen:

That is what I wanted to clarify. I misunderstood, but that is what I thought it was at first. Let us say these rate increases were to be included in the budget proposals and the budget is passed. What kind of accountability measures do we have, or what kind of metrics can we use to show those increased rates? What is the return on investment (ROI) on things like this? Is there a way to quantify that?

Ms. Weeks:

Right now, we do not do that. One thing I would love for us to start doing is looking at after we significantly increase a set of rates, did it increase utilization? That we track, and we could specifically track for these providers utilization increases, we could look at by region, or even age. There are ways to see if it worked. We could also look at doing quality metrics for the certain types of providers, especially on those high intensity services to see are we getting the outcomes we want to see. We could tie an additional pay bump—that is what we are doing with the children's behavioral health, for example. For our residential treatment centers for children, we are looking at flattening that rate up so everyone knows they are getting $800 a day for these children. If you serve the children with the most complex needs, we are going to give you an additional $100. If you also meet certain quality metrics, we will give you an additional $100 on top of that.

My point earlier was not just incentivizing, but rewarding providers that are doing it well, so we are putting the money in a way where we are going to drive the outcomes we see. Often, we put the money in, and we are not getting the outcomes we see because sometimes the business model is not set up to incentivize what we want. I would encourage the Legislature to think about that when we are doing a rate increase. Are we trying to drive better rural access, for example? Then let us fund it that way. Are we trying to make sure the outcomes we have are the quality metrics we are tracking? Are these facilities meeting that? Then let us pay them a little more for that. That is a way to invest. It would be a wise way to do our investments going forward. We could track the ROI if lawmakers would like us to. I think that is something that would be helpful to see if it is working.

Senator Nguyen:

Something I am passionate about is to figure out what we can do to actually see results in these areas, so I appreciate that. You said you are starting to do that with these bonus payments and looking at these quality metrics. Is that something you decided to take on in this particular instance? Does this exist within other Medicaid rates, or is this something as a Legislature we would need to mandate? What do you need? Quality metrics teams? Do you need individual people associated with these to track and report this data? What would you need from us, as a Legislature, to make sure we had accountability for the dollars we are spending?

Ms. Weeks:

To answer the first part of your question, we are doing it as part of the response to the DOJ. We did go to IFC in April for funding. That included those bonus payments, but that was a page taken from other states. Other states are making sure if they are going to put these significant investments into the system, you are going to see the outcomes you want. That is where we started through that new funding opportunity as part of the private hospital tax and the work, we are trying to do to address the DOJ issues we have for children's behavioral health. For adults, if you want to see more of that and have a couple management analysts, we could use to track these dollars, we could do that. I do not think it would be a significant, large team. A couple more would be fine, but not for every rate increase and quality metric—I think one or two. Right now, we are doing this as part of our children's behavioral health work. I think it is something we need to continue to do. As you know, dollars are limited. I always try to remind people we are not a bank. We do not have a lot of money as a State either. We have to be thoughtful about how we spend it. If you want to put that in legislation, it will help drive that and ensure we are building that into all our work, especially for provider types like behavioral health. It is one that would be helpful to see the outcomes we are getting.

Assemblyman Gray:

Assemblyman Hibbetts hit on the head what I was going to bring up. I do not know if that is a per people ratio. I am wondering if that is a per capita ratio. That provider to patient load would be wholly unsustainable. I would like to see that report as well. Having been in health care, I cannot see that being a realistic number at all.

Ms. Weeks:

I will get you that report. That is one of the reasons I wanted to show it to you because I think it is unsustainable. We need to have a lower number of patients per provider. Let me get you the actual data specifics and the assumptions around how we put that together, so you can see it. We have had it for the last three or four years. I will also send you the link, so you can see the ones that have progressed. It is not just behavioral health. It looks at a lot of the medical area and other service areas too. You might find that helpful.

Chair Doñate:

We have had conversations of mental health screenings being a part of primary care. As someone who works in primary care, obviously, there are similarities between Medicaid and Medicare. Oftentimes, because of the reimbursement of Medicare, there are different incentives. What I noticed is that in Medicare, there are always these incentives going after annual wellness visits (AWVs). We have to do these AWVs to make sure we are meeting the gaps, and we have to do them in a certain time frame. Otherwise, providers are not being equipped with the right resources to tackle the needs of the patients. When you were talking about coupling behavioral health with primary care, is there a scenario where the State can do a rate enhancement if you do it as part of the AWV a patient goes through? This is a standard level rate for the current procedural terminology (CPT) code you are billing for, but if you include a mental health screening, you can get a rate enhancement. Would we do it through the managed care organizations (MCOs)? What are your ideas that we can incentivize primary care to start including this as part of the standard of care?

Ms. Weeks:

That is exactly right. I think that is how we incentivize providers to do it. Mandates are harder and often do not work. If we add the additional bump around behavioral health and incentivize our primary care providers to be our frontline providers, I think that is important. When it comes to the managed care piece, remember, we do not negotiate the managed care rates. This is often where states struggle when we are trying to do these types of different payment models.

If you were going to do something like that, you could put in the legislation we would need to direct that type of payment, that the managed care plan would, at a minimum, have to provide a similar bump onto the fee schedule. For example, if we say you at least pay the fee schedule, and let us say they pay a little more, they will still have to pass through that bump. You could require them to do that. You would have to put that explicitly in the legislation, and we would implement it that way.

Chair Doñate:

That is what I was trying to get at. A lot of the rates that are predetermined between the provider and the MCOs are negotiated, and it is proprietary based on the different MCO. It is the same way with insurance companies. If a provider was delivering on the request the State government has entrusted the provider to do, which is we want more mental health screenings at the front line as patients are coming in. If we have them for 30 minutes, let us ask those critical questions. I want to make sure the money actually flows, and we can incentivize them. If we are doing it right and are meeting the request of the State, we can use those funds to bring in more mental health providers from out of state and so forth and build our capacity.

Historically, with the federal government, we have talked about presumptive eligibility. I know the Biden Administration has made a priority of looking at presumptive eligibility to improve access to care. From my understanding, right now, presumptive eligibility is only based on hospitals here in Nevada. I am looking for your feedback. What would be the feedback if we added more entities outside of hospitals to qualify for sites that could retain for presumptive eligibility? Can we add mental health as a subset as one of the key requirements? Could that lead to more federal dollars that are coming in to get access to care for the folks that need it?

Ms. Weeks:

I would not see it as getting more money. It does have a price tag, but it does help people get enrolled easier. I am not over eligibility, so I am not an expert on that area, and I do not have my colleagues in the room today. The State did expand beyond hospitals, but I would like to confirm and follow up with you. There could be some low-hanging fruit and other opportunities. I know there is a federal law around who can do presumptive eligibility. If you would not mind, I would like to take that back, follow up with you directly, and have DWSS part of that conversation.

Chair Doñate:

The reason I was asking that was I was looking at Cornell Law this morning before the meeting started. Historically, from the federal government, there is a track record of doing presumptive eligibility for mental health. They called it psychosis, but it is specifically for Veterans of certain wars. I am wondering if this a conversation other states have looked. Let us not focus on having people go through this paperwork. If the care is there to be

delivered, let us focus on that first, and we can get paid later. That is where my line of questioning was.

Ms. Weeks:

I think that is a good idea. Let me follow up with you on what we currently do. We have a National Association of Medicaid Directors; we have a list so we can send out a question and I can see who all is doing this. We can get more information for you.

Chair Doñate:

When we talk about the services that get sent out of state, a good portion of them are in mental health. Last session we talked about telehealth parity and making sure we continued the items we did during the pandemic. Are there actual mental health services that our State does not have the infrastructure for? Is that why folks are leaving out of state, or are folks leaving out of state because of the proximity to another state? The example would be Mesquite. If someone lives in Mesquite, is it easier for them to go to Utah, or in parts of Northern Nevada where they can go to Utah or Idaho? Is that why we are seeing people leave access to care, or is it because we do not have the infrastructure? If so, what is the infrastructure we need to focus on?

Ms. Weeks:

I did pull data before this hearing about out-of-state services specifically for behavioral health and adults. There were only 43 members. I do not think the problem is as big as it may have been told. I think for children, which is a different story. I do not think it is also significantly large for children's behavioral health other than looking for residential placement. The reason we are doing that is because we do not have the home- and community-based services we need to serve children. We are working on that. I would like to follow up with our data analytics team and look at the actual services for those 43 people to see what they were, so you can have more data on that. My guess is it is those border communities or now we have telehealth, so maybe we are not seeing it as much because people are getting it through telehealth. It is covered, and it is not considered out of state. We are not sending a significant number of people out of state for behavioral health in the adult population.

Chair Doñate:

The difficult aspect of this conversation of mental health we have talked about throughout the day is there is some level of need, especially in the rural counties where there is no presence of a provider type. There is that difficulty of, is the volume there to hire someone full-time, or to stand up that facility? We should not be in a position where our providers are scared to go towards building a facility in north Las Vegas or east Las Vegas or parts of Reno simply because the reimbursement is not there. I think we should try to figure out what makes sense, and what does not make sense. Do we need facilities? Do we not do facilities? Can we have a model that follows the patient? That was what I was asking with primary care as well. I do not know if you have had any discussion on that.

Ms. Weeks:

The whole volume and need issue is a big one. It happens for OB as well in our rural areas. We heard that a lot from our hospitals when we did a rural hospital tour. One thing I think we have an opportunity to do in this next managed care procurement is encourage more of these mobile services as well as telehealth and providing providers out there with the

resources they need to provide those services telehealth. Some states are looking at a regional approach. They are assessing needs by region and then figuring out what is that regional approach. Is it a provider who rotates across the region? Is it part telehealth part in [person] time? I know that is challenging and it depends. The payers are all different, but I know some states are looking more at that regional approach and treating it more like a hub and spoke model for behavioral health services, especially in the rural communities.

Chair Doñate:

I certainly agree. The regionalization is probably what needs to be done more from the State's perspective in terms of where our model needs to go. The needs are different if you are in an urban area or not or if you are in Northern Nevada versus Southern Nevada. There are things we all struggle with, but there are also unique items that perhaps are relevant based on what part of the State we live in.

Medical fraud with billing obviously exists. I want to make sure your team has the support to go after those bad actors. I have seen it firsthand with home healthcare. There seem to be a lot of home health care companies but not actually delivery of care. I want to make sure if we are standing up healthcare businesses, they are catering to the needs of the community, and we are supplying the system as it needs to be. My approach has always been, let us focus on upstream versus downstream. Let us focus on prevention. There needs to be a level of treatment, but we need to work together to ensure the services are there, and they are treating it first versus letting it continue to the tertiary level of prevention or where it is a lost cause. I do not think that is where our State government should be.

Does anyone else have any questions?

Vice Chair Orentlicher:

You mentioned the importance of the hospital provider assessment, and how useful that will be in making sure we have better funding for services. I noticed that normally there are other categories of providers. Hopefully we can expand to other doctors or therapists. I also noticed that services of Medicaid MCOs are a class of potential provider. What does that pick up? Their services include hospital and doctor services, but those are separate categories. What is the category of services of MCOs?

Ms. Weeks:

I think you are referring to the federal law and the categories the federal law allows for provider taxes. My understanding of that would be what we currently have. We have it as a premium tax. We currently tax our managed care plans. I am trying to remember the percentage, but there is a small percentage. It is all healthcare expenditures. Part of that premium tax, called the premium tax revenue, we match with federal funding under that authority you are referencing. That goes straight to the General Fund. It is a driver of State General Fund revenue for the State. When managed care rates go up, the State General Fund gets more money. I know that is not necessarily what we always want to see from a health care cost perspective, but it does drive more revenue for the State.

Vice Chair Orentlicher:

So, we are not using that for Medicaid reimbursement, it is going for other—is that what you are saying?

Ms. Weeks:

Yes. When anything drops to the bottom line of the State General Fund it is used for—however it is appropriated from that bucket. It does not go back into Medicaid, unlike the private hospital tax, which was drafted in a way where the hospitals got their supplemental payments. We took 15 percent for behavioral health needs from the revenue.

Chair Doñate:

I am having LCB staff see how much funding that is. That would be interesting to see what it leads to. There is the caveat that Medicaid is one of the largest recipients for the General Fund allocations, but it would be interesting to see how much it turns out to be. We can have conversations offline about that. I do not think there is anyone else with any other questions. We appreciate you coming back. Of course, we have more work to do in our next meeting in June with children's behavioral health. We look forward to an update. We always thank your team and all the work you do. That concludes that presentation item.

AGENDA ITEM VIII—OVERVIEW OF VARIOUS FUNDING SOURCES DEDICATED TO BEHAVIORAL HEALTH AND CRISIS INTERVENTION SERVICES AND A REVIEW OF FORENSIC MENTAL HEALTH SERVICES PROVISION IN NEVADA

Chair Doñate:

The next section of today's meeting is going to be focusing more on crisis stabilization. In addition, we will be speaking more about what jurisdictions are following up with. Hopefully, by the end, we can have more time to talk about policy recommendations. For our presenters, the most important thing is the dialogue and conversation, not the presentation. The presentation is there for us to reference. As you are presenting, many of us are scrolling through the slides, and we are writing down questions. I want to focus more on the substance of what each of your jurisdictions are doing, and how your Department is operating because that is how we find the gaps and the themes between the state, local jurisdictions, and different entities. It is okay to skip your slides. The substance of conversation is preferred.

Let us start with Item VIII, the overview of various funding sources dedicated to behavioral health and crisis intervention services, and a review of forensic mental health services provisions in Nevada.

Shannon Bennett, Bureau Chief, DPBH, DHHS:

I am going to cover the crisis response system aspect of the presentation today. I am also joined by Drew Cross. I will be passing it off to him shortly. We are going to talk about the crisis response system as a whole, 988, and some of the data we have to share with you today, the Community Health System which you have spoken a lot about today—and I will add to that a bit, and plans for improving mental health in the State of Nevada (Agenda Item VIII).

The crisis response system is comprised of the technology around how our 911 and 988 systems interoperate with each other. It provides someone to call, someone to respond, and somewhere to go in a crisis situation. It is focused on getting people into the most appropriate service and level of care for their situation at hand. It requires a strong

mental health system to get people into the care they need and stop cycling through the system.

We are required by NRS 433.704 to have a suicide crisis and crisis lifeline. That is 988. Additionally, NRS 433.706 explains more requirements and duties of the support center itself, and NRS 433.708 requires us to collect fees. In addition, Senate Bill 237 passed in the 2023 Legislative Session added a requirement to support the provision of crisis stabilization centers at hospitals that hold those endorsements.

At the 988 Nevada Suicide Prevention and Crisis Lifeline, we answer as many calls as we have capacity to answer in-state. All the calls we do not have the capacity to answer or that fall in certain population groups fall to a backup line. There is a network of national backup call lines from across the country. The last three numbers, 156 calls to LGBTQ+ subnetwork, 109 to Spanish speaking, and the staggering 1,097 were transferred to the Veterans Administration (VA), are calls that are transferred off the top by selecting a specific number after you call 988. I wanted to highlight the 1,097 Veterans that called from one of our area codes in the State of Nevada in the month of March. We are averaging—in March we had a 67 percent in-state call answer rate. We have been hovering around 70 percent or so for some time.

The red line indicates when 988 launched in July 2022. It went from the ten-digit call number to just calling 988. You can see our in-State call answer rates over that time. It is important to note here also that the Substance Abuse and Mental Health Services Administration (SAMHSA), our federal partners, have set the goal that we should be answering 90 percent of our calls in-State.

Commissioner Jones from Clark County talked about this earlier. Crisis Now is the model I spoke of at the beginning where you have someone to call, someone to respond, and somewhere to go. That model predicts, with a calculator, rough estimates to give us an idea. It is not necessarily meant to be specific. That calculator indicates the Crisis Now model would cost $347 million to implement in the State of Nevada. That is compared with a staggering $722 million for an emergency department or inpatient scenario as it is more set up now. This was designed by a coalition of mental health partners from across the country that serve as experts in their field. This slide also talks about the number of mobile teams that would be needed to serve the approximate amount of episodes we see each year—this is on an annual basis—the number of crisis chairs we would need, and short-term, and acute psychiatric inpatient beds to serve an annual amount of estimated episodes.

Starting in June 2023 we began collecting 988 fee revenue. We have collected thus far $11,665,091.02. We anticipate collecting $14,812,482.28 this State fiscal year. Our fee is at 35 cents in the State of Nevada. We have eight other states across the country that have enacted legislation and are collecting fees. Those fees range from 12 cents to 60 cents. We were one of the first states to do this. There are many other states in the process of doing it but have not yet enacted it. You can do a state-by-state comparison with an interactive map at that link if that is of interest to you.

As I mentioned at the top of my presentation, and as many of the presenters before me today have spoken about, the mental health system as a whole has to be working appropriately for the crisis response system to work. The idea is that after they have somewhere to go, that crisis stabilization center, or they are deescalated, before they get to that point, we can refer them back into community mental health service organizations that

would be able to care for them appropriately. We have to have the capacity there to be able to take on those folks.

This graph talks about earlier intervention, and the better outcomes with earlier intervention for various mental health challenges.

We can only see success with our crisis response system if we have a comprehensive and well-resourced mental health system as a whole. We need to find ways to be able to invest in that. We will continue the implementation of the crisis response system. We currently are in the evaluation stage of a request for proposals that opened in the spring of 2024. We should be able to announce intent to contract within the next couple of months, which is an exciting time for us. We will continue to work with community partners to explore sustainable and realistic options for designated mobile crisis teams.

We struggle with this a bit in some of our conversations with community partners because—like what you have heard much of today—a designated mobile crisis team requires both a peer and a clinician to be 24/7 available on site at a crisis. We do not have the workforce to support it, and providers are concerned about that. We have been able to work with partners in Clark and Washoe Counties to fund them for crisis stabilization centers using ARPA funding. We are also continuing to support our partners in rural Nevada for options for crisis stabilization centers in rural Nevada as well.

We struggle with the lack of community infrastructure, as you have heard a lot about. A lot of our funding is tied to one diagnosis or another. That has also been a challenge. A lot of the funding is one-time funding. It was ARPA, it was COVID-19 supplement funding, and things of that nature. Those things are coming to an end, and it is hard to uplift programs without sustainable funding. Workforce is a challenge. There are 420 individuals in Nevada for every 1 mental health provider. That is a statistic I wanted to make sure you heard.

The Committee asked for a list of all the funding this Bureau has. I listed it out here. I will not go into it line by line. This breaks it down one-time versus stable funding. About half of the funding we have, $181 million in the Bureau right now, is stable. We will continue to have that. That includes the addition of the 988 fees I talked about. Half of that is planned to end in the next two years. The graph on the right is our funding broken out by topic area. Substance use versus mental health funding—the far left and the second from the left on the graph—I wanted to point out the disparity between substance use and mental health funding.

Here is a list of our strategic plans. The BBHWP is also working on a comprehensive strategic plan to be done in early 2025. We look forward to talking more about that as it is completed. At this time, Chair Doñate, would you like to take questions, or do you want me to pass it to Drew Cross to do the forensic presentation?

Chair Doñate:

Let us go through all the presentations first, and we can come back for questions.

Drew Cross, Statewide Forensic Program Director, DPBH, DHHS:

I would like to discuss what we are covering today regarding forensic services in the State of Nevada. We will start with a brief explanation of the nature and scope of forensic services in the State, describe the challenges facing the system, discuss ARPA initiatives and other programs which will address the challenges, and plan for the future.

Nevada is statutorily required to offer restoration treatment to individuals who have been found not competent to stand trial. For an individual to be competent, they must demonstrate the mental capacity to defend against any charges, they must be able to comprehend the judicial system, their charges, and be able to work with their attorney as defined in NRS 178.400. If a person is deemed by a judge to be incompetent to stand trial due to mental illness or deficiency, the person is then ordered by the court to receive restoration treatment. Restoration treatment is aimed at helping an individual acquire adjudicative functioning, the necessary ability to proceed with his or her case. After treatment, if an individual is deemed to be competent by a judge, he or she is returned to the detention center and the legal process resumes.

The obligation to provide inpatient and outpatient restoration to individuals who are not competent to proceed is spelled out in NRS 178.425. Presently, two secure forensic facilities serve the entire State of Nevada, one in the north and one in the south. We also house a population of long-term clients who are unable to be restored and charged with select A and B felonies as well as those found not guilty by reason of insanity. None of these services are covered by health insurance or federal funding.

I wanted to express gratitude to AG Ford for touching on the challenges facing forensic mental health in Nevada. Similar to other states, Nevada has experienced an increased demand for inpatient forensic services, which has steadily increased over the past 20 years. Nevada has been under two separate consent decrees during that time due to not being able to admit individuals from the jail to a forensic unit in a timely manner. More recently, between 2012 and 2023, DPBH experienced a 148 percent increase in commitments from 202 in 2012 to 502 in 2023 with 2022 being the most commitments Nevada has ever seen topping nearly 600.

Additionally, DPBH's long-term client population, this being persons committed for ten plus years, were found not guilty by reason of insanity, has increased 366 percent between 2013 and 2023, which has led to less available bed space for restoration individuals. The courts have fined DPBH due to the amount of time individuals have waited to be admitted to the inpatient forensic setting. You can see the fines per month and the total amount. The following initiatives will have a positive impact on those awaiting forensic inpatient services, which currently sits at 123 people.

The first of those initiatives I would like to discuss is jail-based programming. Jail-based programming is a collaboration between Clark County, Washoe County, and DPBH. The goal of jail-based programming is to introduce treatment and programming earlier for individuals who exhibit mental health symptoms and whose competency to proceed has been brought into question. This occurs while individuals are in jail awaiting admission to an inpatient forensic facility. One goal of the program is the potential for improvement in adjudicative abilities at which time an individual may be reevaluated, found competent, and removed from the waitlist. In addition, this program will offer support for individuals returning to the detention center from inpatient restoration treatment to increase the likelihood of maintaining psychiatric stabilization and decreasing a possible repeat admission.

Some clients will not be restored to competency and [are] committed long-term to DPBH. This growing group of individuals committed for long-term have aged to the point of being infirm. These individuals receive more appropriate services in a skilled nursing level of care. Historically, funding for this has been a limiting factor. American Rescue Plan Act funds have been made available for qualified clients. To date, DPBH has successfully placed four long-term forensic clients in skilled nursing facilities throughout the State and are

continually assessing other individuals for possible placement. This allows those beds to be utilized for new admissions, reducing the number of clients awaiting forensic services.

Workforce shortages impact services across the State. The specialized training required for forensic work has only exacerbated the issue. Through ARPA funds, DPBH has been able to expand contracted services bringing on several staff through this program and will continue to do so with the available funding.

Additional beds are being added to the Southern Nevada Adult Mental Health Services campus to expand the census and allow for additional admissions. Community collaboration has been identified nationwide as a proven method towards improving the lives of the chronically mentally ill and reducing reincarceration. We have done this through our Jail Liaison and Diversion Program. Our Jail Liaison is a trained clinician who will identify nonviolent offenders with low-level charges who are currently in jail awaiting inpatient forensic services.

Once selected, these individuals are presented and discussed with the competency court, judge, district attorney, and public defender for potential diversion to other services that address their mental health issues. Some of these alternatives include assisted outpatient treatment, outpatient restoration, and civil mental health services. We are active in preventing the criminalization of mental health. Programs like Diversion allow individuals with low-level charges and mental illness to be put into appropriate wraparound services in the least invasive setting in collaboration with our community partners. If approved by the court, the client will be placed on a legal hold and diverted to appropriate services to address their mental health challenges.

The Division of Public and Behavioral Health has taken numerous steps to address the challenges facing forensic services in Nevada. One of those steps is a new forensic facility, which is being designed for placement on the Southern Nevada Adult Mental Health Services (SNAMHS) campus in Clark County. This new facility will be able to serve all the commitments in Clark County and surrounding counties. All these initiatives will help offer adequate treatment to individuals in need in a timely manner, will lead to an elimination of fines, and a decrease in delays offering treatment while also preserving the integrity of the judicial process.

Shannon Litz, Deputy Director, Programs, DHHS:

The Fund for a Resilient Nevada was established in 2021. It is specific to the State's portion of opioid recoveries, which are the funds awarded to the State from the AG's opioid settlements. Through DHHS, the State of Nevada manages 43 percent of the awarded funds. Counties and local governments that are part of the One Nevada Agreement created individual needs assessments, and they receive funding directly. The opioid settlement funds are projected to be available for the next 20 years with allocations made each year. The average amount to the State is going to be between $11 and $21 million, but it can be higher or lower, and there is ongoing litigation.

In the initial development of the program, the Fund for a Resilient Nevada worked to establish the priorities of the funding as outlined by the Advisory Committee for a Resilient Nevada. The Advisory Committee includes members that are appointed by the AG, the Office of Minority Health and Equity, and the Director of DHHS. Those recommendations were categorized as treatment, data, primary and secondary prevention, health equity, harm reduction, recovery support, and system needs. The outlined recommendations were used to inform the needs assessment and statewide plan.

The Department of Health and Human Services is following the principles outlined here on the allocation of funding. Some awards that are in process are related to workforce and support for children's behavioral health needs as well as efforts related to gestational exposure to substances. Earlier this year, we awarded funding to organizations for youth programming to support awareness activities, community prevention, and treatment. Currently, we are focusing on prenatal care, early childhood, and adolescent services.

The next few slides outline the identified gaps. Data and evidence-based practices were used in the development of the needs assessment to determine the gaps and recommendations. The goal is to have funding into the communities to help save lives. Continuing with more of the gaps, one effort we are supporting the needs of the State is through the Nevada Opioid Center of Excellence. The Center will develop and disseminate evidence-based, researched, informed training and offer technical assistance to address opioid use, misuse, abuse, and overdose affecting Nevada communities. That is housed with the UNR School of Public Health.

The next two slides outline additional identified gaps before we move on to the statewide plan goals. The seven goals that have been identified and funding is allocated from the Fund for Resilient Nevada should all fit within one of these goals. The program is working on a notice of funding opportunity that will be released in June. That will include opportunities for funding for all these goals. That information will be posted on the website and shared with our partners. Finally, this is an illustration that shows the funding breakdown as outlined in the One Nevada Agreement. We are happy to take any questions.

Chair Doñate:

I will ask the same question I have of all our presenters. If you have the chance to fix the mental health system, what do you focus on first in terms of programming or initiatives? You cannot say funding because that is the unilateral theme, and that is cheating a bit.

Ms. Bennett:

We need to work on building a comprehensive community mental health system that can feed into each other from multiple angles. Unfortunately, Chair, a lot of that does boil down to funding. Administrator Weeks talked a lot about the different quality pieces and things of that nature that come along with those things. I think that comprehensive community mental health system needs to be built out.

Mr. Cross:

I think continuing to grow the relationships and partnerships we have in place as Nevada comes to realize the sequential intercept model, and continuing to meet with our community partners at the county court level to continue to find additional resources for our population that is very much in need.

Ms. Litz:

I will echo answers you have heard throughout the day. Adding a focus on a focused population of parents with children who are at high risk. We are focusing a lot on prenatal care and screenings to help build stronger families.

Chair Doñate:

I appreciate those responses. Shannon, you were talking about the Fund for a Resilient Nevada. If there is a spreadsheet or a table, we can see that tracks the opioid settlement dollars we have received so far, what has been expended, how much we are receiving, and expected to receive, if you could send that to us that would be helpful for the Legislators to understand. Are there questions from any of the Committee Members?

Assemblyman Hibbetts:

I have two questions for Mr. Cross specifically about the forensic treatment programs. I understand if you do not have the answers right now, I would ask you get the Committee the information. What is the current wait time at let us say a county detention center before they are transferred to the State for treatment? Once they are at the State for treatment, how long is the average person there before they are deemed competent and returned to the local jurisdiction?

Mr. Cross:

As far as the amount of time to get to the facility from the various parts of the counties, it averages around six weeks currently. The median length of stay within the forensic facility once admitted is 96 days.

Assemblyman Hibbetts:

Thank you. I am quite impressed you had that at your fingertips.

Assemblywoman Brown-May:

My question is also for Mr. Cross. Regarding the new forensic facility identified on slide 33, do we have an anticipated groundbreaking? Is it still at the SAMHSA location? I believe that is the west Charleston area in Las Vegas. Do you have additional information regarding the planning and possible opening of that new forensic facility?

Mr. Cross:

We are currently funded through the planning phase for the new facility. I will send along any additional information.

Assemblywoman Gorelow:

My first question is regarding the 988 Lifeline. We are currently taking in-state calls around 67 percent. It looks like we have a bit of a plan on how to get there with the two minimum call centers. Do we have a timeline on when that might be?

Ms. Bennett:

Yes, we do. We believe we will be able to award the vendor a contract either in July or August. At that point, it will take them about six months to stand up the first call center. We believe a Southern Nevada call center will be ready to start taking calls in early 2025. The second call center will follow six months after that. Those are rough estimates based on the request for information we did last year. Once we get into negotiating with the selected vendor, we will be able to provide a lot more finite detail.

Assemblywoman Gorelow:

On slide 22, regarding the forensic service requirements, it was mentioned those three services are not covered by health insurance or federal funding. I was curious why that was.

Mr. Cross:

Forensic services in the State are all funded through the General Fund.

Assemblywoman Gorelow:

Is there a way insurance companies could fund that, or we could get federal funding and take the burden off the State?

Cody Phinney, Administrator, DPBH, DHHS:

To add to what Mr. Cross is saying about why those services are not funded by health insurance, the service is generally for the court. While the individual does receive treatment, the services are actually for the court, so health insurance does not pay for that. It is nationwide that you see these services are generally not covered by health insurance or federal medical programs. I hope that is helpful.

Assemblywoman Gorelow:

That is helpful. My last question is on workforce challenges. We hear this a lot in a variety of areas. Do we have a timeline? How many providers would that result in? Of course, there is the retirement and people leaving in there. My concern is that for some of these providers, it takes a decade for them to get all this training. How can we get an adequate workforce development plan when this is going to take ten years? Do we have an idea of how that shapes up, or a bit more detail on that?

Mr. Cross:

I would say one of the key factors for recruitment in our workforce is a collaboration with our institutions of higher learning. We have a forensic fellowship program. We employ residents throughout the State. We are recently starting an APRN connection with UNR. All of those will eventually pay dividends through a trained workforce prepared to help with forensic mental health in the State.

Senator Nguyen:

I see Metro in the room. I may put them on the spot if they are not planning on covering this in the future. I know in December as a part of the IFC, we allocated some of those ARPA funds for that jail-based programming you referenced. You said the goals were to allow for potential improvement in their abilities to bring them to competency so they could be taken off those waitlists. Has there been a change in statute or agreement with DHHS as well as the jails to allow for the type of treatment that needs to take place in order to restore someone to competency? It is my understanding that has to be done by the State, and you cannot do that in a county jail-based setting. I am wondering if that is a typo or if there has been some sort of partnership with the State to have those treatment professionals in the jail. Can give an update on that?

Mr. Cross:

This would not be restoration. I mentioned in December treatment exists outside of competency. Individuals will improve once treatment and structure are provided through this program, allowing the court to be notified and have the individual reevaluated. This will not be the NRS 178.425 restoration component. This would be the NRS 178.415 pre-commitment evaluation. This would be a second set of evaluations based on improvement of the individual.

Senator Nguyen:

I wanted to clarify because I was not sure if it was restoring people to competency or allowing for a secondary evaluation. I appreciate the clarification. I do not believe any of these programs are up and running. Are any of these programs up and running yet? I know when we allocated that money through IFC, they indicated December of this year. Do you know if any of these programs are up and running right now?

Mr. Cross:

Yes, there has been tremendous progress made in both Washoe County and Clark County for the Jail-based Program. I believe the Board of County Commissioners for both Washoe and Clark had sole source funding approved for the two respective vendors. We are working closely with those providers as we develop the clinical setting, and the type of programming that will be measured throughout the program. We anticipate having additional updates throughout the summer.

Senator Nguyen:

There will be a clinical setting within the jail. How will these individuals be referred into this programming in a clinical setting within the jail pre-adjudication and post- being determined to be incompetent?

Mr. Cross:

Individuals identified by the court in need of pre-commitment evaluations would be a portion of the group that would be in this unit. Additionally, individuals awaiting inpatient forensic services would be part of the milieu. The third group will be individuals who have been found competent, who are returning to the jail. This program will allow them to be stabilized throughout the process. This should cut down on the amount of individuals who come repeatedly back to the forensic setting on the same charge because they decompensated or became non-compliant with medications.

Senator Nguyen:

I was aware of the first and the third components when this was presented to IFC. I would like to see any additional resources or information you have about that middle component where people are receiving treatment when they are in the in-between area.

Chair Doñate:

Are there any gaps we are seeing right now with the legal hold process you are encountering? Are there things we should be mindful of in terms of reforms to the Legal 2000 (L2K) process? There are some mental health providers that are not legally authorized

to process L2Ks because of their facility designation. There is room to revise or to look at it. Has that come up in the conversations you have had, or is there a need to improve that?

Mr. Cross:

The Legal 2,000 or the various types of civil holds that are employed have become more at the forefront recently as we do diversion and attempt to get individuals into the least invasive setting. At times, a L2K from the jail to civil services to wraparound services is the ideal outcome for an individual. I would not say it is a problem as much as the utilization of this process has been expanded to give additional resources and provide the appropriate setting for individuals.

Chair Doñate:

Do we need to have a discussion of enhancements that need to be made to the process in terms of adding more providers, or do you not see that as a problem right now?

Mr. Cross:

Currently, we work primarily with clinicians at the jail who would be qualified to issue a L2K as well as the clinicians in the forensic setting. For us, it is not a particular need.

Chair Doñate:

Regarding 988, I am looking at the 67 percent of the in-state call answer rate. I am trying to understand the context. If an individual calls 9-8-8, it goes to the hotline, right? Is it fair to say 67 percent of the calls are being answered and the rest are going to the national call line? If so, is it because of a capacity issue where we do not have enough staffing to answer the 988 calls responsibly, or does it depend if you call the national line versus calling in-state?

Ms. Bennett:

Yes, someone answers all the calls. Sixty seven percent of them are answered in-state. It is based off your area code. Right now, area codes 775, 725, and 702 calls are being routed to the Nevada call center. We work with our partner, Crisis Support Services of Nevada, to answer those calls. It is capacity that is keeping them at that 70 percent in-state call answer rate. We do anticipate that to be remedied as we get this request for proposal awarded.

Chair Doñate:

It sounds like it would be a staffing issue occurring. As 9-8-8 currently stands—or as we will stand it up to be—are we ready to meet the needs of the community? I know there is the question of the LGBTQ+ calls you are receiving or folks speaking Spanish and so forth. Are we prepared to serve the community needs as we are receiving these calls, or is there still more work to be done? Do you have an estimate of how much funds we will need to get to that point or at least the infrastructure request?

Ms. Bennett:

I believe with this contract we are getting ready to award, we will be in good place infrastructure wise for the calls, for the technology, to better understand the data, and be able to develop programs around it. When we did the request for information, it told us it

was going to cost between $5 million and $11 million per year for this type of system for the technology, people, staffing, case management, follow up care, and all those types of things the call center provides. We are anticipated to bring in under $15 million per year with the fee revenue. I think we are going to have that part handled. Above and beyond that, the mobile crisis teams, crisis stabilization build outs, all those types of things I will not know exactly our capacity to be able to work on those different programs until we get this contract awarded. As you can tell, if the contract ends up being $10 million per year or something like that, it does not leave a ton of revenue to work for those other programs. I hope that answers your question, Chair.

Chair Doñate:

It does. In terms of reoccurring themes, it is challenging for our State to stand up the systems of care, especially because right now we do not have the right processes in place. It is not going to be perfect as we are starting this, but I want to make sure we answer the question of what are the needs that we need to have before we walk into the next legislative session, so we do not have to wait another two years to get the adequate funding or infrastructure. If we can figure that out now, whether it is making sure every call that is received does not have to be diverted to a national hotline, I think we need to get to that point soon answering that request.

My final question was on slide 22, which talks about the forensic service requirements. It says DPBH is required to provide court ordered inpatient and outpatient services, and it goes through different bullet points. The last sentence is the one that triggered me the most in terms of trying to think through it. These three services are not covered by health insurance or federal funding. Have you all seen other states require health insurance companies to mandate this as part of the coverage? Is there federal programming or waivers? Is there some initiative to help at least supplant so that is not all on the State to take this on? That is my question in terms of thinking innovatively.

Ms. Phinney:

We have explored all the options we can come up with to look at funding sources. It is uncommon for health insurance to cover this particular slice of the services in the mental health system. Most direct services that states are providing are focused on this area.

Chair Doñate:

I think it is part of the systemic problem, which is throughout recent history, we have never seen mental health to the same equation as physical health. We are playing catch up of reimbursement. Oftentimes, there has to be a discussion of what is covered versus not covered, what is entitled, what does the government have to entrust for the population versus not? All of these are conversations we have had. I was curious to see if other states had explored this, and if you had any discussions on how to improve the system.

I do not have any other questions. I am sure we will take some of them offline. I appreciate you all. We will close this agenda item.

AGENDA ITEM IX—PRESENTATIONS ON CRISIS STABILIZATION EFFORTS AND SUCCESSES, CHALLENGES, AND GAPS IN NEVADA'S CRISIS RESPONSE SYSTEM

Chair Doñate:

Let us go to Item IX, a presentation on crisis stabilization efforts and successes, challenges, and gaps in Nevada's crisis response teams. We have several jurisdictions that are available to present.

Julie Ratti, Administrator, Behavioral Health, Washoe County:

Thank you for choosing to focus an entire meeting of the Interim Committee on behavioral health. I know your needs are many, so it is noted how much time and attention the Committee has given to this issue. I want to make sure I am clear on what you are expecting. In the invitation to speak there were three questions posed to local government: one was crisis stabilization services; the other was overall challenges in the behavioral health care system; and the final one was gaps in behavioral health. Am I to understand you would like me to focus on the crisis response system portion of that to start?

Chair Doñate:

No, you are correct with the three.

Ms. Ratti:

I will cover those three topics briefly today. I did hear your direction to not go over everything in the slides. I am going to do everything I can to respond to that direction (Agenda Item IX A).

First are crisis stabilization services. There were questions earlier in the day about plans and collaboration across jurisdictions, and how we are working together. I want to pause on this slide for a bit. In Washoe County, we have had a Washoe Crisis Response Coalition that was established in June 2021. It has multiple levels. There is a Coordination and Accountability Team that has leadership from local government, law enforcement, hospitals, MCOs, behavioral health providers, and folks who represent families and individuals with lived experience. They meet about quarterly. That is the leadership of the region intended to help us remove barriers and keep things moving forward. There is also a Provider Accountability Team. In this setting, we have the direct crisis services providers—including Crisis Support Services of Nevada that currently runs 988—our Mobile Outreach Safety Team (MOST), which are law enforcement response teams, our CCBHCs that also have mobile crisis response, Renown Health who you heard from today, and other key stakeholders. These are the boots on the ground folks who will be implementing these crisis response systems. Then we have another group that is a Children and Youth Crisis Team collaboration that meets monthly. These are stakeholders that are focused specifically on the needs of youth and families in the crisis response system. I want to emphasize children are not just small adults, so a crisis response for a child and their family often will be upwards of two months as opposed to when we talk about adults, we tend to think of that first 24 hours. Just a distinction there. There is an entire task group working on that. We have subgroups that are working on memorandum of understanding (MOU) training protocols, data collection, and how to work with our familiar voices. Then we have participation from State representatives in each of those committees. I want to do a significant shout-out to Sarah Dearborn from Medicaid, Cody Phinney from DPBH, Shannon Bennett from DPBH, and several of their team

members who have been attending lots of these meetings since June 2021. I paused there to demonstrate there has been significant momentum and significant collaboration to work to stand up the crisis stabilization system.

Folks have already covered most of this. To remind you, it is somewhere to call, someone to come to you, and somewhere to go. We are anxiously awaiting the results of the RFP Ms. Bennett discussed. We are waiting to find out who our partner is going to be to work with on 988. For mobile crisis teams, we have some in the form of law enforcement-based teams, the CCBHCs.

Earlier in the day, Ms. Weeks discussed that we are waiting from CMS for approval for the Medicaid rate for crisis response systems. Our concern here that I want to emphasize is this is the one part of the system we are struggling to find a sustainable long-term funding model that will make this work. Medicaid funding will be one piece of it, but if you are thinking about this as a public health model that needs to respond to anybody, when a Mobile Crisis Team is needed, billing on a 15-minute increment for a service will not be sufficient to cover the entirety of the model. It will be helpful, but it will not be sufficient to cover the entirety of the model. That is a real area of need if we are going to build out a full crisis response system.

The somewhere to go, we are very excited. You heard from Steve Shell earlier today that Renown Health has been the recipient of several sub awards from the State of ARPA funds to do the startup costs. We have also collaborated with the State for the location at Dini-Townsend, and we anticipate opening that crisis response center, we are calling it our Community Care Center, by the end of the calendar year. In Washoe County, we have 988 today, but the improvements will happen over the next year. The crisis care center is opening within this year. There is the work to be done on that middle piece of mobile crisis teams.

I know today is all about adults, but specifically on crisis stabilization services, I wanted to spend a little time on children and families. We do have mobile crisis teams in this space. They are operated by the Division of Child and Family Services (DCFS), by the State. They are wonderful, but they are not sufficient anywhere near to meet the need. That is an area where we have been working collaboratively between Washoe County and DCFS to increase capacity. For children, you do not want them to go to a community care center if you can avoid it in any meaningful way. To do that, you need strong in-home wraparound services to keep that child in their home, but also to keep them safe. There is a significant need for increased in-home wraparound services to do so. For a small percentage of families that will need to go to a crisis stabilization or a respite center, we are excited to anticipate that with the former West Hills facility—that was referred to earlier—conceptually, we are intending to add a crisis stabilization center and respite care for children. That would open in late 2026. If we can figure out mobile crisis teams for everyone, if we can figure out a bigger investment in in-home crisis wraparound services, we could be in a position by late 2026 to have a fully functional crisis response system in Washoe County.

Moving on from the crisis system of care and talking about challenges in the behavioral health system as a whole, these are the biggies, if you will. These are the big things we are seeing in our communities. One is the volume of need is growing simultaneous to declining available services. We saw during the pandemic that many of our key providers either reduced services or closed altogether. The West Hills facility probably being the most obvious example, but there are a lot of places where folks were scaling back.

As an example, in our foster care system, we have about 50 percent of the foster care families that we had prior to the pandemic. There is some significant shrinking of available services. I am going to quickly say Medicaid rates and then move on. Fentanyl and the opioid epidemic are certainly driving a lot of the challenges for our system of care. It has been mentioned several times today, our jail being our largest behavioral health facility in our community. [I am] appreciative of the innovative work happening in that space and [am] grateful for the collaboration with folks like Drew Cross to help us work on those issues. Finally, there are overall gaps in the continuum of care that include a variety of levels of care. For an individual patient who may not necessarily need acute inpatient care, but outpatient therapy is not sufficient, that missing middle of intensity leads to people either being over serviced or underserved. That creates dysfunction across the entire system. Filling in those gaps of level of care is important.

Crisis response I have mentioned before. Case management and targeted case management, unfortunately, our health care systems are not always easy to navigate. Unfortunately, many families and individuals who are experiencing mental health issues also need other kinds of supportive services, and that often takes case management to get it done. Supportive housing is significant. There has been a reduction in community-based living arrangements that were one of the good options for having a person with a serious mental illness to have a place to stay. Supportive housing continues to be a challenge. It is not that community-based living arrangements (CBLAs) are the entire answer, but supportive housing broadly.

Workforce development you have already heard about. Finally, significant work [is needed] around justice system diversion. Those are the ones I will highlight. I will not spend time going through these other gaps on any level of detail. These were generated by department heads from across the county, where mental health, and behavioral health specifically, is impacting their ability to be successful in their core mission whether that be the courts, law enforcement, jails, juvenile justice, obviously our child welfare system, and our entire human services agency that also deals with adults and seniors. We have a crisis of senior isolation as an example for behavioral health. It could also include our Public Guardian who ends up working with a number of individuals who are no longer able to take care of themselves. Across the spectrum in the county, this issue of behavioral health challenges within our community is directly impacting our ability to be successful. If you spend any time on the next several slides, these were the issues that were generated by those department heads, and they asked I share with you.

I want to take a minute to talk about of the wonderful things happening in Washoe County. This slide is specifically Washoe County programs and what is happening. I think you are familiar with specialty courts and courts having the role of facilitating access to services for many that come through their systems. There has been innovative work done in the Second Judicial District Court around competency court and being able to accelerate the amount of time individuals are in the system with competency questions. That has been super helpful. I also want to give a little credit to the City of Reno and the Reno Municipal Court who is doing innovative programming called Community Court. That takes place in our libraries and helps low-level offenders. Primarily the resource is to deal with the citation or whatever has brought them into Community Court, but far more it is about connecting them to services. They are doing community resource fairs and all kinds of things. I want to give them a nod as well. Our Public Guardian is more and more serving as the legal guardian to individuals who have co-occurring behavioral health and cognitive disorders.

We have the Crossroads Program that is a tiered supportive housing for men, women, and women and children. We are in the supportive housing business ourselves. For staffing,

I want to let folks know in the county we now have 34 clinical positions where we have chosen to be the direct provider of behavioral health services among those many departments and divisions I talked about earlier. More and more the County is finding the need to become the actual provider as the gaps in the community system of care, discussed earlier, have not been filled. We are getting into the direct service. As an example, eight clinicians are at our homeless campus. The Assisted Outpatient Treatment Program is another wonderful program that goes through our civil court system where participants are ordered to comply with outpatient behavioral health treatment. It has had a significant success level. Our Alternative Sentencing Department with funding from DPPH—thanks to the State—has been connecting folks who are part of alternative sentencing with behavior health counselors and an innovative program with the Brain Health Restoration Center. We purchased the West Hills facility. You have heard a lot about the jail-based programs that are happening, but we also have our MOST teams and our Homeless Outreach Proactive Engagement (HOPE) teams out on the street working with folks.

Finally, back to the question; is there a plan? Are folks collaborating? How is that working? Specifically in terms of opioid settlement dollars, which I think is where that conversation started, we did do our needs assessment and our plan. We have our notice of funding opportunity (NOFO) out for agencies to be able to apply and use those opioid settlement dollars. Definitely a good assessment and planning process. At the micro level, we are doing that. At the macro level, there is so much momentum right now around behavioral health and addressing behavioral health and so many meaningful regional collaborations that require all of us to be successful.

We have talked so far in this Committee about the State and the local jurisdictions, and what they need to do. I think there also needs to be recognition that our health care system is primarily a private system of care with for-profit and nonprofit providers. For us to be successful, they also need to be at the table. In many of these instances, it is not about government. It is about the other players in the health care system being a part of the solution. Of course, you are familiar with the Children's Behavioral Health Consortium and the Regional Behavioral Health Policy Board. Those are both established in NRS. They are meeting regularly and do productive work. We have the Crisis Response Coalition that I spoke about.

I want to pause for a minute on the sequential intercept model. I want to give credit to the State for bringing in national level speakers and talking about sequential intercept mode. If you are not familiar, that model is the idea of working with the justice involved population and at every point where we have contact with them in the justice system, having off ramps. If you think of it as a highway with exits and whether we are starting at the crisis stabilization level where hopefully we divert to 988, they never call 911, they never have any contact with the justice system, or we talk about in law enforcement so now you have had contact with law enforcement but concepts within the intercept would be, are law enforcement officers having significant Crisis Intervention Team (CIT) training, or are law enforcement officers having the most teams where they ride along with a behavioral health professional, or many other ideas along those lines.

Once you get to jail, if you do have a mental health issue, are you getting adequate treatment? Are you getting connected with insurance? Are we doing all the things within the jail setting we can do? Each of the intercepts go past jail to now you are in the courts. Now you have been adjudicated. Now you are out of the courts. In every intercept what are we doing to make sure there is an off ramp that both addresses the mental health and behavioral health needs of that individual, but also should also increase public safety because if we are doing a good job of addressing their needs, they are hopefully then not

reoffending and not ending up back in the system. We have an entire Sequential Intercept Model Coalition led by judges Walker and Lu. We are working collaboratively as a community to work across and identify the gaps in each of those intercepts to make sure for our justice involved individuals, we are doing the best we can to address the behavioral health issues.

Our County Commission has prioritized behavioral health as one of their key focus areas in the strategic plan. There is a separate group called the Children's Behavioral Health Collective Impact Project led by a nonprofit partner, the Children's Cabinet, which is working specifically on children's and family issues. We have a lot of collaborative efforts with the Washoe County School District. Too many to list out. The Washoe County School District is an excellent partner, and we are doing a lot of work with them. Finally, the West Hills building will require a public private partnership to be successful. I will pause here for questions.

Chair Doñate:

In the interest of time, let us go through all the presentations, and we can ask questions afterwards. Clark County, begin when you are ready.

Joanna Jacob, Manager, Government Affairs, Clark County:

With me to participate in our presentation is Deputy County Manager Abbie Frierson and from UMC Bud Schawl, who is our Director of Post-Acute Care and is also the lead for us in partnering on our crisis stabilization project we will be presenting today. Also, we have Metro here. Captain Zavsza who heads-up our Detention Center will give you an update about our work on the pre-forensic services as part of our presentation.
(Agenda Item IX B-1)

When we were working on this presentation, it is a bit like peeling back an onion. As we are looking at human services and the County's role, it is not just what we are seeing as gaps today but trying to look at planning for our future. We think this is a significant thing we are working on. In the County, we are projected to grow in our Southern Nevada region from 2.3 million today to over 3 million people in a short amount of time. We have to think strategically about how do we continue to provide our human services and regional services that we provide? We want to think about this collectively with the State because this is where our population is, and where the projected growth is. Southern Nevada is an exciting place to be, but we need to think strategically not only now, but also in the future. We see our role as Clark County has a statutory obligation to provide indigent care. That is for the aged, the infirm, and the disabled. This is where we have focused a lot of our programming.

As my colleague from Washoe County noted, I also want to list where we are intersecting with behavioral health needs in our community. It is through our Department of Social Services, through our Public Guardian, and our Public Defender's Office. We fund the Clark County Detention Center. We have our Clark County Office of Public Safety, that is our police that goes out into our County parks and partners with Metro; Clark County Fire. We share two-thirds of the funding for Metro with the City of Las Vegas. We fund UMC Southern Nevada. I am going to hand it over to Deputy County Manager Frierson to discuss our crisis and gaps, and how Clark County is looking at the problem.

Abbie Frierson, Deputy County Manager, Clark County:

Throughout the day you have heard this lack of a comprehensive mental health crisis system is leading to more people going to the ER or jail than necessary. As we look at that problem, we need someone to call, which is 988, someone to come to you, which are mobile crisis teams, and somewhere to go, which is crisis stabilization. I think what you have not heard as much about is there is fourth area we need to plan around, which is where do people go after the crisis stabilization center or where do people who are unhoused go to continue their care once they have been stabilized? I think there is a fourth category we also need to talk about when we talk about this issue.

In Clark County, we have stood up mobile teams. You will hear there are mobile teams in the County. There are mobile teams in the City. I am sure every model is a little bit different, but at their core, you have a law enforcement public safety response paired with a social work response.

At the County, we have three teams. Each of those teams is doing something slightly different depending on the need in each of those areas. For instance, we have one team that pairs with Metro's Homeless Outreach Team. Those social workers will give resources to the unhoused and will connect them with our Navigation Center and our non-congregate shelter, which Ms. Jacob will speak about. We have a team that pairs with our hospital, UMC, that does a lot of discharge planning to make sure people are able to leave the hospital as quickly as possible, making sure they have plans that will assure their safety. We have a team still in its infancy and finding its way that pairs with our Clark County Detention Center, which is going to be focused around coordinating the medically assisted treatment in the facility, but also working on discharge planning and working on connecting our unhoused folks with those resources we have. I want to make sure it is clear that we do not think one crisis stabilization center is going to meet the entire need in Clark County. We believe we need three to four. We are hopeful that, with Clark County stepping out first, other providers will step out in this space as well.

Bud Schawl, Executive Director, UMC:

We are excited to be working on and developing the crisis stabilization center located near Nellis and Lake Mead in the northeast part of the City. Director Frierson mentioned the County is purchasing the building. It is currently a 24-bed inpatient site facility that never opened. We have got it. We are going to be doing renovations, so we are able to convert to a three-living room, ten lounge chair bed model. The idea is we are going to be doing interventions with anybody that walks in the door or otherwise arrives, whether they walk in, law enforcement brings them in, or emergency medical services (EMS) brings the patient in. No matter how they come in, we will provide them that medical screening, make sure they are safe to be in the facility, and then we are going to be treating them there. The whole idea is we will be helping them to decompress to become more stable from the crisis they are experiencing at the moment. Those that might have severe intoxication, but are still medically safe, we will treat them, help them get more stable, and either connect them with the needed outpatient services through intensive outpatient care or if they need to be housed overnight or go into an inpatient setting, we have the resources and the connections within the community to transfer those patients to an inpatient setting. The whole premise on is that these are all outpatient services. We will treat the patient, get them stable, and then move them on to appropriate levels of care, whether it is within the community or in an inpatient setting.

We will be doing a lot of coordination with Las Vegas Metro and all the rest of the law enforcement agencies in the county in Southern Nevada making sure we do the right thing for the patients. The big premise here is we are going to be taking patients, diverting them from the emergency department (ED). Right now, within the UMC, in the first part of the first quarter, we had over 470 patients who were discharged from the ED into other mental health facilities. They did not need medical care. They showed up in the ED, and we managed them. In the first quarter, over 3,700 hours were spent in the ED with patients who did not require any medical care. It was all mental health. We are looking forward to driving that down.

This is the timeline we are working off. We have closed the RFP. We have led an RFP because UMC is not a mental health provider. We are a trauma center and acute care hospital. We do have UNLV residents and a psych program in the hospital, but we are not a mental health provider. We have led an RFP, which closed, for a provider to come in and operate the mental health side of the crisis stabilization center. We will provide the licensure, administrative oversight, and support. We are excited. We have some great respondents to the RFP. We are expecting to have that completed and a provider decided upon in June. We work through the renovations we are going to be doing. We expect to open for the final surveys in early December and taking patients either late December or January.

Ms. Jacob:

You heard Commissioner Jones speak about the Navigation Center. Many of you may have heard the County present on our housing programs. One of the pieces of the partnership between UMC and the County with our Navigation Center and the crisis stabilization center; the hope is we are able to provide housing navigation that comes with the case management supports that are going to help us successfully discharge the patients from the crisis stabilization center.

Ultimately, we think the success of that model is bringing people in, but more importantly, as Deputy County Manager Frierson noted, where do people go if they need a longer-term period of stabilization? Where can they be handed off and leave the crisis stabilization center? As a way of illustrating what we are working on, and where we are in this space; we have four non-congregate shelters. Non-congregate means it is not a mass shelter with bunk beds but individual rooms. I put the people we are serving in each of those models. We started these non-congregate shelters during COVID-19.

When we talk about using ARPA dollars, the County looked at if we are going to use one-time dollars, how to put something up, but more importantly, plan to sustain it. These are being sustained with County funds. We began with Coronavirus Aid, Relief, and Economic Security (CARES) Act, we continued with ARPA, and we are sustaining with County funds all of these models. The Roadway Inn serves our senior population. We have something we are calling Americana that is a higher level of care assisted living beds available in our community. La Quinta Paradise began when we started looking at where we can prevent families coming into our child welfare setting. This is a facility for families where only housing instability was causing the referral to child welfare system. Our newest one is La Quinta Valley View, which is another master lease hotel, which our model here. This is for adults without children. We began this as another avenue for referral from our Navigation Center.

One of the things the County did was start with this non-congregate shelter and then began the Navigation Center. That was a successful model, not beginning with the referral line, but

beginning where that person would be referred. Once we have that resource in place, then we can start managing the referrals into the system. The Navigation Center, for those who have not seen it, I invite you to come down. It is on East Fremont. It is a short-term facility. It is for 30 days and then we can successfully navigate into these longer-term stays, and we are seeing some tremendous results.

These are the things we are beginning to work on and have coming up next. We have heard a lot about our aged out foster care. As they become 18 and age out of our system, they transfer into our social services system as they become adults. We are working on a facility for our transition age youth that might need assistance. We are working on a specific facility for behavioral health and substance abuse for people who might need stabilization in that space. The hard-to-place adults is one of the gaps we are trying to fill. That is where you have a serious felony or maybe you are a sex offender, those are hard to place in our community. It is hard to find housing. It is hard to find a place, so we are trying to focus on that population next.

I want to note this is data through the end of March from our Navigation Center. This shows where did people go after our Navigation Center. I will note, 172 people were able to transfer into our non-congregate shelter, and 79 went into longer-term housing we link to vouchers. More importantly, in the Navigation Center, we have case management that comes into all these things. Our model is bringing the services to where the people are to try and fill these gaps. We have case management and telepsychology and telepsychiatry that starts at our Navigation Center. We can refer on through a warm handoff into our non-congregate shelter. This is how many people we have served through our non-congregate shelter. In total we have served over 2,300 people, and these are longer term stays. This is a model we began and are able to grow. This illustrates the distribution of who we are serving and where.

There has been a lot of talk about Medicaid rates, and how to improve access in the community. One thing Director Weeks noted was how do we see if it works? She said one of the things she was tracking was utilization. If we are going to do a targeted rate increase, does it help access? Does it help serve more people? We found it does. The county funds long-term care for non-Medicaid patients. This is for people who cannot be covered by Medicaid or have no other pay source. That is a County obligation.

Some of you sit on the IFC. In the last legislative session—this has been years in the making—there was a budget change where the UMC agreed not to accept any more Disproportionate Share Hospital (DSH) funding, and it allowed us to free up more funding. We were able to—and our commitment was—invest in long-term care that would help support the hospital community as a whole. We expanded our rates. On the long-term care we increased our rates in skilled nursing facility coverage as well as group homes. We added a behaviorally complex care rate. We have seen a dramatic increase in the number of people we can serve because of these rates. We are tracking this, and this is showing the premise of a targeted rate increase that is meant to address a need.

When we began thinking about this, we were seeing real delays for the people we were serving in this long-term care space that were waiting for a bed. At one point, we had an individual who was waiting for 592 days in an acute care hospital because they could not find a placement. Once we created the behaviorally complex rate, the facility could accept that individual, and we moved them out of the hospital. When we created the medically complex rate, we had an individual who was waiting 317 days in an acute care hospital. With that medically complex rate, a provider could accept that patient, and we moved them out of the acute care hospital. We increased the amount of clients in the skilled nursing

facility. It does not sound like a lot, but we increased it from 39 people who we were serving to 66. Forty-six people in group homes to 83 people. That is a dramatic increase. That is a doubling in our caseload based on the increases we did and the amount of people we could serve.

A little-known County benefit we do are homemaker personal care services. This for people who are at home who need in-home personal care services. This is grocery shopping, case management, prescription drug refills, and things like that. We added a mileage stipend and were able to dramatically increase the amount of clients we could serve. We have 20 providers of these personal care services through our Homemaker Program.

This morning, I checked with social services, and they are trying to bring on three additional firms. This is the County's initiative, and I wanted to make sure we mentioned it. This is premised on if we can do targeted rate increases that meet a significant need in our community, it can work if you do the tracking to see if it benefits utilization. We would support any initiatives Medicaid is doing to track that, and we will continue to track this as we move forward. I know Bud with UMC has said he is thankful for this as the Director of Post-Acute Care, because it has helped clear some of the patients out of the ER at UMC.

This is a lot to cover in 20 minutes; I apologize. This is our gap, the missing middle. I will let Mr. Schawl go over the impacts from UMC.

Mr. Schawl:

Basically, at UMC 63 percent of our ER patients are either Medicaid or unfunded patients—the 3,700 hours of time in the ER. In our inpatient care, we had roughly 83 patients that had no medical needs. They were in our hospital for 806 days until we were able to find them other discharge options. Based on a telephone survey we did on Friday, there are 23 substance abuse centers in Clark County, and there are 82 open beds. There are 11 mental and behavioral health centers. One had been closed. There are 852 beds total with 154 beds open today. The challenge we have is not so much finding an open bed, but finding an open bed that will take the rate that is being paid for that particular patient. It is as much of a funding issue as it is anything else. Truly, it is not the lack of space, but it is a lack of willingness of the providers to take a rate below their cost.

Ms. Jacob:

I have Captain Zavsza when we go to questions. There was a question about our wait time from Assemblyman Hibbetts. From our last report, the current wait time in detention center averages over the last 12 months 101 days of patients who are waiting to be transmitted to Lakes Crossing Center or Stein Hospital. The State testified about the increase in the number of commitments they have received. In the last 12 months, the number of inmates committed to Lakes Crossing and Stein from Clark County Detention Center was 313. I think over the 500 they said statewide, number of inmates committed to Rawson Neal was 258. I have a slide on our upcoming projects, but we can save that for the questions.

Chair Doñate:

Let us continue the presentations. I think the more important part of these presentations are the questions, answers, and the conversation. I want to make sure we are on track with time. If the City of Las Vegas folks can come forward. That way, we can rotate, and we will have our rural Nevada presenters right after. It is nice to welcome our former Assemblywoman back. Please proceed when you are ready.

Sabra Newby, Deputy City Manager, City of Las Vegas:

Thank you for inviting us to be here today. As one of my former bosses, Mayor Schieve, said earlier today, oftentimes cities are not included or may not be considered as much in this space of mental health care, yet we see the manifestation of it every day, whether it is our responses from our first responders or our [Courtyard Homeless Resource Center] or any other various impacts. (Agenda Item IX B-2)

I would like to talk to you about the Recuperative Care Center (RCC). Specifically, the City has a number of different accesses for our unhoused population including the Courtyard and our Multi-Agency Outreach Resource Engagement (MORE) teams and other aspects. I want to talk about the RCC, because that is the undertaking and effort that we are now transforming to include mental health services and a crisis stabilization center. The RCC is for the unhoused population. When you and I go into the hospital, have surgery, and are recovering, we go home, we make our partner bring us chicken soup, and we watch Netflix. For the unhoused population, that is not the case. They return to the streets, and it makes it much more difficult to fully recover. That is the ethos and the idea in which RCC was born. Shelter staff cannot address medical issues. Oftentimes, the individuals need to leave the shelter during the day. They cannot get their wounds dressed, so it exacerbates their issues, and they often end up right back where they came from in the ER.

While the RCC is the only one of its kind in Nevada, medical respite care is actually a thing. There are 145 of them nationwide in 40 states. The capacity does range. Who runs the medical respite care also ranges; most are nonprofits; some are Federally Qualified Health Centers (FQHCs). There is also a mix of funding, 72 percent of them report a braided funding that support RCCs. Our medical respite care is 40 beds currently, 38 regular and 2 isolations. We have a medication storage room and an on-site lab. We have no predetermined length of stay. It is operated through a contract with Hope Christian Health Center which is a FQHC, so that is the model we follow. They provide 24/7 medical care. We have dedicated medical transport for our patients to get to their follow-up appointments or other appointments they might have. We have intensive case management services, so while our guests are with us, we are trying to find their birth certificates and other forms of identification (ID). We are trying to find them housing and overcome those barriers to housing.

From its beginning in August 2020 to December 2023, it has served over 850 patients. The discharge length of stay is about 45 days. We are proud that 52 percent of our patients leave into some sort of housing and get stabilized. You can see how many patients are referred from various sources and the conditions they are referred for. In terms of discharge outcomes, you can see a bit more detail here and where some of the folks go when they leave us. One of the things we did not expect when we opened, was the level of hospice care we would be providing. It is sad to say, but we did not expect it. We certainly do that now, and it provides a bit more dignity to people experiencing homelessness when they are transitioning out of this life.

Recuperative Care Center expansion plans is where it gets exciting. We were awarded a $10 million ARPA Grant from the State. We also have $7 million of City of Las Vegas ARPA to expand the services to 76 beds from 40. That would add the Crisis Stabilization Unit (CSU) to our facility and let us serve a type of patient we currently cannot serve that may be both recovering from some sort of injury or illness or surgery and may have a higher level of mental health need.

Initially, we were going to expand on to a piece of land adjacent, but that halted because there were too many things to get over on that property. Our current path is to relocate the patients to an empty building at the Salvation Army that we will be renovating. We will demolish the current structure which is a former Smart & Final. It was not built to house people or to be a medical respite care. We will be building a new structure to suit the RCC component and CSU functions. We are out to bid right now on that project, so we do not know the exact cost. We think we will probably have about a $5 million gap, because we think it might come in about $22 million.

This section is called successes, challenges, and gaps, and I want to go over those. Our successes are finding this gap and trying to fill it in a compassionate way for people who otherwise would not have that ability. Of course, we think the hospice care is a success. Challenges, of course, this is uncharted territory for the City of Las Vegas. This is not typically the kind of work we would do. City of Las Vegas employees have three values we name, and they are kind, committed, and smart. While we normally would not be into this kind of work, we are kind, we are committed, and we are smart. We saw a gap, and we are trying to fill it. The limitations, I already talked about, on the physical Smart & Final space.

I did not mention this earlier, but we get a lot of our clients from our partners like Catholic Charities and the Courtyard. Because we get them from there, we know those patients probably left a medical setting, went to a partner, the partner was unable to care for them, so they end up back with us at the RCC. That is a circuitous route for them. A lot of things like paper loss, medical records, and medical charges can get lost in that process. I mentioned gaps including the $5 million, which we are still working on, and our stable funding sources for ongoing operations. I have to give a huge shout-out to Director Whitley and all of his team at DHHS. They have been working hard with us to try and find a Medicaid way to get some funding. We are working on home health care at this point, but we would like to work further with them on a medical respite care inclusion in a Medicaid program.

Chair Doñate:

Let us go with the last presentation on this agenda, and then we can invite everyone back for questions and answers.

The last folks we have are rural Nevada presenters. We have Ms. Valerie Haskin and Cherylyn Rahr-Wood. Thank you for joining us. Please begin when you are ready.

Valerie Haskin, Coordinator, Rural Regional Behavioral Health, The Family Support Center:

Thank you Chair Doñate and Members of the Committee for this opportunity to discuss the challenges and opportunities we see regarding behavioral health systems in rural Nevada. (Agenda Item IX C)

Cherylyn Rahr-Wood, Coordinator, Northern Regional Behavioral Health, Nevada Rural Hospital Partners:

A little bit about the Boards, what we do, and who we represent, but first I wanted to remind you of the five regions, and how they are broken up. Our Boards are multidisciplinary boards bringing people from all over, Legislators, doctors, lawyers, county members, and lived experience people sit on our Board and advise us on what to do, write our scope of work, create our strategic plans, and things of that sort. We are blessed to get

one BDR every legislative session. [We are] excited to have these conversations with the Committee to move forward with our BDR.

Ms. Haskin:

We had originally planned a lot of detail about the challenges and different things, but as most of this has already been covered in previous presentations, we get to cut this down quite a bit. I am going to briefly go over the challenges that are persistent across all regions of rural Nevada. You have already heard about our dearth of behavioral health providers. That is no mystery, but something I want to hit is the physical distance to both emergency and non-emergency behavioral health care, which affects issues related to transportation and how people are able to get there in a timely manner. For the most part, if someone is trying to access inpatient or crisis care, they are probably getting there from their home community in the back of a squad car, maybe an ambulance or likely Care Flight, which is not a good use of resources and not appropriate.

Cherylyn will speak to the availability of Forensic Assessment Services Triage Team (FASTT), MOST, and other deflection programs. There are not deflection programs set up across all counties or jurisdictions in rural Nevada yet. That creates issues and challenges when we are trying to serve our folks.

While telebehavioral health is an option that is frequently brought forward as a solution for our gaps in services in rural Nevada, the lack of reliable and affordable Internet connectivity is a huge issue. I had heard about this from my constituents that I serve out there for quite some time. I moved about 30 minutes outside of Carson, which is not even that far out, and Internet costs twice as much. There is one provider, and it frequently drops Zoom calls. I am seeing this firsthand as a major issue.

Another thing that keeps coming up is the lack of mechanisms to support complex case management across parts of the behavioral health care system. This is not just complex case management, but also care for complex behavioral health challenges. We are talking about people who have one or more mental illness challenges, substance use issues, physical ailments, and/or potentially may be involved in the criminal justice system but may or may not be seeing charges at the moment. Cherylyn and I get frequent calls from our human services agencies, hospitals, and other local stakeholders trying to figure out how to get these people into the care they need so badly when a lot of our care is specifically siloed with specific parameters that do not apply to these individuals. Of course, the lack of access to crisis and inpatient care is not only a physical proximity issue, but also can be related to insurance payer availability. Many facilities other than Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS) do not necessarily take Medicaid fee-for-service. While this will be addressed when the Medicaid MCO for rural Nevadans is ruled out, there are still going to be potential issues there.

Ms. Rahr-Wood:

I am going to speak to the assets in our rural region across the rural and frontier area. We have been lucky to start working in building deflection and diversion programs in the rural regions such as FASTT Programs. Building evidence-based to fidelity deflection and diversion program is important for success for those to keep moving on. As a region, we are able to have six counties come across county lines and work on developing a FASTT handbook for the State of Nevada. We had bigger counties and smaller counties come together and say, "How do we make these programs to fidelity and evidence-based?" For five years, we came across county lines and developed a handbook. We are excited about

how that is going to move forward. That is going to help some of our rural regions put together other FASTT teams comparable to the region and counties they live in. [We are] working on behavioral health task force meetings and coalition meetings coming together and bringing those providers to the table that are needed when we are building a successful State. Crisis stabilization is important. Without having collaboration, it is hard to move needles. I am thankful that in the rural regions, we come across county lines to develop programs and initiate new innovative upstream programs.

Here are some policy opportunities that we looked at. The excellent work done during the last legislative session focused on community health workers and peer recovery support specialists concerning reimbursement rates with Medicaid and the addition of added language recognizing community health workers in behavioral health settings gave rise to these professions. We are seeing a lot more people come to the table and want to do this work. The goal moving forward is to look at developing program collaboration with the Nevada workforce pipeline.

I know Dr. Hunt is going to do a presentation to potentially establish a mechanism such as a career ladder for our peers. Where do they go when they become a certified peer? What does that look like? We have that already with the community health workers where they have a couple of different levels, so we are focusing in on that. We also need to look at changing State law to enable peers with prior convictions to work as State employees as long as they are working within their peer recovery unit. Arkansas passed a bill that did that. House Bill 1433 looked at bringing more peers with lived experience to the table by looking at their record, if it is low level, to be able to employ them.

Chair Doñate:

Sorry to interject. Can you send that to us as an exhibit?

Ms. Rahr-Wood:

Yes. As we move to robust diversion programs and co-responder peer programs, the need for certified professions with lived experience is a must. We cannot build these programs without our peers and community health workers. It will help alleviate the burden and burn out on our licensed professionals. Not that they do that level, they stay in their lane, but it does help during those treatment times to have a peer—kind of like a sponsor—be available. We are looking at that pay parity. That job qualification challenge is a must to look at as we are moving forward with these types of programs. Another policy opportunity is we have a lot of nonprofits that come to the table in our State and bring innovative programs. National Alliance on Mental Illness (NAMI) Western Nevada is one I would like to speak to. They employ peers and community health workers. They operate four successful warmlines. The adult warmline is called Caring Contacts. The Teen Text Line is the youth version of Caring Contacts. These programs have been instrumental in utilizing our peers. Moving forward, funding more of these in-reach programs where we are reaching into our people that need these services is important as we are moving forward.

Ms. Haskin:

We are going to discuss other policy opportunities. Another would be to find a mechanism similar to Aging and Disability Services Division's (ADSD's) multi-disciplinary team (MDT) mechanism, but something that could address people with complex behavioral health concerns like we mentioned earlier. That is not something that will necessarily be completely fixed by the Medicaid MCO, and there is no way to address it right now.

I want to put this out as a trigger warning for anyone who may be listening regarding death scene and loss to suicide. It has come to our attention that while there are mechanisms in place for scene remediation when someone dies because they are murdered or in a murder-suicide situation, this is not the case for death by suicide. This burden is usually left to friends, family members, and property owners.

As you can imagine, this is awful. It is also expensive, usually several thousand dollars to bring a company in. If you live in rural Nevada, the process can take several days to get a quote and then get the company out to do so. That also causes some biohazard issues on top of the rest of the awfulness. Addressing this through policy, creating a funding stream, and maybe a contract mechanism to ensure this burden is not falling to loved ones of the person who has died is an important thing to consider.

Moving on to workforce development, the Rural Regional Behavioral Health Policy Board, which I serve, has focused its last two BDRs on this broad subject—which I am sure you have heard a lot about already. Some of the things that may be considered moving forward are looking at the minimum training for law enforcement regarding behavioral health, taking some of the CIT and other trainings that are becoming common and putting that in statute or something similar.

Furthermore, looking at dispatch and EMS because there are currently no statutory requirements regarding behavioral health, and they are also in the first line of response to persons in crisis. It has been brought up in various conversations that looking at whether or not EMS or paramedics should be allowed to place mental health crisis holds. To be fair, I have not had an opportunity to vet this with those professionals yet, but that is something that has been requested by our stakeholders. I would be remiss if I did not mention the interstate licensure compacts for behavioral health professionals. This essentially allows persons who are licensed within a state that is a part of this compact to practice within the other state with minimal time and paperwork. It is about as close to having a driver's license and crossing state lines as you can get. With that being said, earlier this month, my Board did vote to pursue interstate licensure compacts with its BDR this next legislative session. However, since that time, it has been brought to our attention that this Committee and potentially its Members may be interested in pursuing that as well. If that is the case, we will happily support the work on that one. If not, we will be happy to bring that forward as well.

We have the Nevada Psychological Association presented to my Board noting the changes were made to NRS last year regarding payment parity for behavioral health providers, which requires a bit more teeth. Another issue would be mandating that private insurance companies allow people into their networks when they are in good standing. Currently, I have been hearing from providers, they are trying to enter networks in Health Resources and Services Administration (HRSA) shortage areas and the insurance companies are saying their networks are full, which is hard to believe.

As far as data is concerned, it is difficult to get data that is apples to apples regarding mental health crisis holds, the disposition of those holds, where those people go as far as facilities, and what happens when they leave inpatient. In order to fully evaluate the different pieces of our crisis response system, what is working, and what is not, we need to have that information. It is also outlined in NRS 433.4295 as something the policy boards are supposed to be reporting on. We do not have the data to report because that is not being collected at the levels of various hospitals and other facilities across the State. You have already heard a lot about overdose prevention.

Ms. Rahr-Wood:

I will wrap up with a few more policy opportunities, and then we can open the floor for discussion. This first bullet point focuses on ensuring that residency is feasible in our rural and frontier clinics and hospitals. This comes with adequate financial support, such as more funding for loan repayment programs with continued support and increased funding for the Nevada Health Corps Program focused on our regional frontier source service employees. If we want to build crisis stabilization centers and provide person centered appropriate whole health care across the continuum in Nevada, we must start by helping develop a capable workforce.

Unaffordable and unattainable childcare is a glaring problem across Nevada. At every county behavioral health task force or coalition meeting I attend I hear stories of wait times and cost concerning childcare. The results of this capacity and financial burden affect older siblings within these households as well; truancy rates increase. Kids have to stay home to watch their younger siblings because childcare is not available. Helping move that needle would counteract two things, potentially getting kids back to school and not staying home to watch their siblings. I know Carson City has been implementing a program recently through Project Advancing Wellness and Resiliency in Education (AWARE). It is making a difference because it takes a village.

I think regionalization of behavioral health authorities is important. Moving to this regional structure will enable multiple counties—or regions—to apply for funding. Within the five counties I get to support and facilitate meetings and things like that, a lot of times they cannot apply for funding because they do not meet the qualifications of that funding source. If we are able to regionalize funding, apply as a region, and have oversight of what those programs look like that come from that funding, that could be a possibility, and I think it would implement more viable programs and priorities. One of the regions have been coming together with the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) funding and working on building the FASTT Program and the FASTT book.

Chair Doñate:

We started off the day talking with our elected officials. Now we have the different jurisdictions. I understand there are also law enforcement folks in the room. There are multilevel folks representing different spaces throughout the State being reflected here. Are there any questions from any of the Committee Members for any of these entities? Senator Nguyen.

Senator Nguyen:

This is for the City of Las Vegas. You talked about moving the location of the medical respite care center, and it sounds like combining it with hospice care and this crisis stabilization center. Do you have any concerns about the crossover of those different client bases that are in there? Is that something you have contemplated? Is that typical in other crisis stabilization centers? It seems like a lot of different clients in one potential Smart & Final.

Ms. Newby:

We have thought of that. Currently, the plan is when we move the clients we have now, it will be our typical recuperative care center clients. The new building will be built in place of the Smart & Final and will be two stories. We will be separating the population from one story to the bottom story. The idea would be the recuperative care center would be on the bottom story, and the higher level of care, the CSU patients, would be on the upper

story. Currently at the RCC, we have the clients who are transitioning out of life, the hospice patients, within that population. We would continue keeping them in that population of the RCC on the bottom floor.

Senator Nguyen:

This question is for the County. When it comes to what Clark County is already working on creating this crisis stabilization center—hopefully, this will be the first of many—have you had the different jurisdictions coordinated to see locations and see where the city is thinking about putting theirs? I think there might be other city jurisdictions that are also contemplating this. What kind of coordinated effort is there to catch as much of Clark County as we possibly can?

Ms. Jacob:

I will be honest with you; Commissioner Jones has had conversations as we have been looking to stand up. It has been a long time that we have been talking about a crisis stabilization center in Southern Nevada. I think when we testified earlier, we know we cannot be the only one to serve the whole community. I think it is a matter of collaborating with this—we have not had those conversations to date because I think this conversation as we were preparing for this presentation when we were talking to the City, this is a relatively newer plan that has been developing based on their needs. [We are] certainly open to that conversation.

The second thing is we are hoping that as we stand up this first one—I think everybody was watching to see who was going to go first in Southern Nevada—we are hoping as we see that we can successfully stand up these models, then there will be other people that will step forward to talk about it across the valley. Of course, we are the regional service provider, so if there are needs that the cities have, they need to contact the County. When Commissioner Jones talked about the staff coordinating, I would say that is true. I am staff, but it is not necessarily always going through our elected boards. Our County Social Services works with our City colleagues to try and coordinate where we can. The short story is no, we have not had those conversations yet. I think it is definitely an opportunity for us to do that as we start trying to plan, the timing of all of this, and how we can help serve the need.

Senator Nguyen:

Thank you for those answers, both of you. My next question is for Clark County and probably Metro. I asked previously about the jail-based programming. I know our representative from the State indicated he believed those were up and running, but I do not know if they are. I am wondering if I can get an update on that. I know it is still early, but I am hopeful you have gotten through this faster.

Scott Zavsza, Captain, LVMPD:

We have identified the vendor. We have started weekly meetings. We have identified the module we are going to run pre-restoration in. We are pending Board of County Commissioners approval for the vendor, which we expect to get shortly. Ideally, what we want to do is have the project up and running late June.

Senator Nguyen:

If someone comes in and they are either brought in by a mobile response team and they are presenting at the Clark County Detention Center, what type of mental health or behavioral health screening do they currently undergo? With the implementation of this new program, is there going to be additional types of screening that will help identify people that would benefit from this early detection and start of treatment?

Captain Zavsza:

We have a robust mental health system already in place at the jail with our clinicians and Dr. Orowski. We hit the ground running from the time they come into the facility. We identify those that are in mental crisis or need mental health services. This program is going to be separate from those. Once they are identified to go on the pre-restoration, that vendor will be separate from the current vendor. Those two services, although they will work hand-in-hand, are separate. I hope that explains it.

Assemblywoman Brown-May:

My first question is for Clark County. You talked about long hospital stays that have now been diverted as a result of negotiating specialized rates for complex cases. Is that a pilot program? Do we have an ability to negotiate on a case-by-case basis to move people out of long-term stays? Have we started a new plan to address the financial implication of a complex patient?

Ms. Jacob:

It is a current program. It began January 2024 with the rate increases. We have developed it in collaboration with some of our providers. In terms of negotiated rates, I think the way the rates are structured is a daily rate, but not to exceed amount. Obviously, the needs of the long-term care population are varied. We increased our rates, and it is a daily not to exceed rate. This is a program Clark County has had for many years. All we did was bump the rates up to address the delays we had in trying to obtain care. I do not know if that answers your question about negotiated rates. When we looked at what the providers needed, it was clear we needed to add a medically complex rate and a behaviorally complex rate. If we had a patient who was on a ventilator, it is based on the comparative rate for caring of a patient with those particular needs. We worked with them to determine an appropriate rate.

Assemblywoman Brown-May:

If we had a number of folks in the hospital for an extended period of time or maybe in a less appropriate setting for them because of their high support needs, have we been able to decrease the number of people we have awaiting a more optimal situation? Is there a waiting list to get people out of the hospital?

I am going to defer to my friend Bud Schawl at UMC. I think he can give you anecdotal evidence on that. To be clear, the County's program is for patients who do not have Medicaid coverage. I know he can give you data about the Medicaid wait time. We have Medicaid patients, but the county program is for people who do not have that pay source. I will defer to Mr. Schawl.

Mr. Schawl:

We have seen a dramatic drop in the length of stay of our Medicaid patients, particularly those that require those higher needs that can go to a long-term acute care hospital. Those patients, because of the recent provider assessment fee that went into place the first part of this year, those facilities along with other hospitals in the post-acute world have had their Medicaid rates increased, and they are much more willing and able to accept patients out of our hospital into their levels of care. I hope that answers that question.

Assemblywoman Brown-May:

Senator Ratti, thank you for being here and for your presentation. I have a clarifying question. Slide ten identified the most significant areas of needs and gaps. It starts out looking like it is supporting folks specifically with mental health needs, but as we move down to the areas of significant needs and gaps, it looks like we are moving into multiple populations. Are we talking about co-occurring disorders, or are we moving into other populations? My example for you would be acute beds for children and adolescents and then moving into housing for individuals with mental health (MH) and developmental disabilities (DD). Are you considering MH and DD co-occurring, or are we talking specific to mental health?

Ms. Ratti:

We are using the term behavioral health broadly. When we use the term broadly, behavioral health, we are including both mental health and substance use disorder populations. That specific bullet about intellectual or developmental disability (IDD) recognizes that if you are an individual with a developmental disability who also has either a behavioral health or a substance use disorder or both that requires a whole special set of services to meet the need. I think the answer for you is yes to all of the above.

Assemblywoman Brown-May:

Thank you for that clarification.

Vice Chair Orentlicher:

I have a question about the RCC. It is a great program. I am delighted to hear you have this RCC that you are expanding. Is there a similar unit for the county or if you live in Las Vegas, but not within the city limits or if you are unhoused? Do you screen people based on their address? How do you do that? Is it anybody who is referred you will take in?

Ms. Newby:

We take everyone as long as we have a bed. We do not discriminate based on where the person is coming from. When we look at our data, we see we get patients from hospitals all over the valley and locations all over the valley. We are equal opportunity.

Vice Chair Orentlicher:

Thank you for doing that.

Chair Doñate:

Are there any other questions? I have several questions. I will start with [former] Senator Ratti in Northern Nevada. There has been this steam of what does accountability look like for each entity that is intertwined into the mental health delivery system? I think I saw it in your presentation where there are discharges existing simply because of Medicaid rates or because hospitals do not want to hold on to them because it is expensive care. What I have seen firsthand is that there is obviously a level of accountability that has to come with each separate entity. Whether it is the hospital provider or the mental health facility or law enforcement. How do we have this conversation of what is appropriate versus not appropriate? What are the parameters to making sure we are incentivizing either the hospital or law enforcement to do the work that is necessary?

I will give a good example. I have a lot of friends that work in EMS. Many of the folks they interact with are folks with mental health disorders who are homeless. In the summertime it is common that they might interact with this individual. It is to the point where it is so common, they even know their names. They pick them up and they ask them, "Are you okay? It is hot outside. It is 120 degrees. Do you need anything?" They say, "No, I am fine. Actually, yeah, I do need to go to the hospital." When they arrive at the hospital, it is not even a mental health concern. It is something as basic as I needed to charge my phone and it is hot outside. There are obviously situations where EMS needs to be held to account, the same way law enforcement needs to be held to account, the same way the hospital systems do, and so forth, so we are not passing the buck. If we have a patient in front of us that needs a level of care, we are providing them with the wraparound services, so we do not get to the point where Clark County Detention Center is the facility where they are receiving treatment. I think all of us can agree to that. How do we reach that? It is probably more of a philosophical question, but I think that would be helpful from your background.

Ms. Ratti:

That is a complex question. I would say we do need to remember the overall system of care is complex, has many players, and the bulk of the care that is provided is provided by a mix of providers and payers in the for-profit or nonprofit realm. Local government, whether that be our human services agencies, law enforcement, our courts, or the list my colleague from Clark County went over are providing that safety net role. In local government we have built in accountability, in what we talked about a lot at the beginning of this presentation is our own departments and divisions are having a challenge being successful in delivering to their core mission because of the challenges that come into their systems around behavioral health wherever we can be innovative and on the front end of those issues that means the overall court system or the overall child welfare system, for example, works better. There is a built-in incentive lever there. I think where the Legislature probably needs to focus is more around the provider payer side. What are the levers you can push and/or pull to incentivize the behavior you are looking for? I think Director Weeks from the Medicaid side of the equation gave good examples. My colleague from Clark County, Joanna Jacob, talked about how you can use rates to incentivize the behavior you are looking for. It does end up being a combination of carrots, rates, and different incentives you can provide to get the behavior you are looking for. On the flip side of that, mandates to make sure the things you want to happen are happening. My experience has been that mandates are less effective. We put in mandates and the system will find creative ways to meet the minimum standard of that mandate, but maybe not the true spirit of the mandate. I think a lot of it ends up being on what levers can you push in terms of incentives to get the behavior you are looking for? Was that responsive to your question, Chair?

Chair Doñate:

That is exactly it. I think you are correct. It is a mix of all of the above. What we need to figure out as a Committee is how do we incentivize one lever while also ensuring we are in compliance with what we are requesting, and the dollars actually feed to providing delivery of care. I think it is exactly how you phrased it.

My next question is for the City of Las Vegas—or anyone if this is of interest. Some states have piloted mobile pharmacies. In your presentation you talked about how a lot of the folks you interact with from the City of Las Vegas often go from untreated diseases, whether it is uncontrolled diabetes and so forth. Is that of interest? Is that something we should look at in this State? Perhaps the City of Las Vegas can pilot such a program? Have you talked about that internally?

Ms. Newby:

We have not piloted a mobile pharmacy per se, but we do have what we call our Street Medicine Team who goes out and meets folks where they are and can be that conduit between the streets and the pharmacy. If any of you have been to the Courtyard, you know we have the Street Medicine Team there at the Courtyard. We also have a new clinic we opened. Those are the conduits we try and work on. We would be intrigued about a street pharmacy, but [I am] not sure how that would work.

Chair Doñate:

My last question is for our rural health folks. One of the things you mentioned I thought was interesting. I am glad you mentioned the policies your Board is tackling, especially with workforce. We will not use our BDR if you are already tackling that which is great. What was most interesting to me was exploring regional behavioral health policy boards and exploration of behavioral health authorities. Talk to me about the differences or the evolution of where you think we need to go.

Ms. Haskin:

I believe my sister board, the Northern Regional Behavioral Health Policy Board, was going to attempt to tackle the regionalization of behavioral health last legislative session. However, there was still more research that needed to go into building that out. When I think about what this might look like, I would foresee keeping the Behavioral Health Policy Board separate and maybe advising regional authorities. Having these as separate regional—I do not know if it would necessarily be State or local districts of some sort similar to a public health district I would foresee—in building these out with that behavioral health authority having the ability to carry some of these grants and not only work directly with the local jurisdictions, but also helping to provide that oversight that has come up in conversation regarding what is going on with quality. Are we making sure everyone is doing what they are supposed to be doing? Which, when we are looking at rural Nevada specifically, is a major concern for me and my counterpart to ensure nobody is going out to rural Nevada and not providing the best services because they do not think anybody is watching.

Chair Doñate:

That is helpful. Is it going to be competing with the health districts if there are health districts already? Is it comprised of elected officials, law enforcement, EMS representatives, and emergency management? Those are the things I am interested in. Regionalization

makes sense because you are focused more on the community itself. The rural counties respond differently than Clark County and Northern Nevada does. There is obviously a need of centralization too. The State has to have some level of accountability to oversee the entire delivery of care. That was interesting. I would be eager to learn more. Maybe we can talk offline of what that could look like, and obviously, with power comes funding.

I do not think we have any other questions. We will conclude this Agenda Item.

AGENDA ITEM X—UPDATE ON THE ESTABLISHMENT OF THE BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT CENTER OF NEVADA PURSUANT TO ASSEMBLY BILL 37 (2023)

Chair Doñate:

We are going to move on to Item X, an update on the establishment of the Behavioral Health Workforce Development Center for Nevada pursuant to AB37. We have Dr. Sara Hunt who is the Executive Director of Behavioral Health Education, Retention, & Expansion Network of Nevada (BeHERENV). Please proceed when you are ready.

Sara Hunt, Ph.D., Executive Director, BeHERENV:

Before I get started, I want to take a personal moment of privilege to acknowledge the partners that helped us get this far. Certainly, the Rural Regional Behavioral Health Policy Board. They were the sponsors of AB 37 (2023). Implementation is now under the direction of the Nevada System of Higher Education (NSHE) through the Board of Regents. Our administrative hub for BeHERENV lives in the Kirk Kerkorian School of Medicine at UNLV. We are partnering with the UNR Office of Statewide Initiatives on a lot of our data collection. (Agenda Item X)

I will quickly remind you what AB 37 does. It authorizes the establishment of the Behavioral Health Workforce Development Center of Nevada under NSHE. As a reminder, this is a grow our own pipeline project starting with initiatives and outreach in the kindergarten (K) through 12 system to plant those seeds of career options in mental and behavioral health and working with those students and other individuals along the way to move them into higher education pathways leading to professional licensure, practice, and retention of the existing workforce. Another way to show that is the summary. Assembly Bill 37 requires us to go out and provide more outreach and education about behavioral health professions in K through 12 and to potential adult learners. Those are individuals who may be working in other professions or entry level health positions that would have an interest in coming back to upscale their career skills and connect them to the education pathways in NSHE.

Looking at our behavioral health programs we have at the higher education level, there are opportunities to create new degree programs, expand the ones that we have and make sure we have strong connections within the NSHE system. For students who want to transfer between institutions there is the accessibility to do that. We are looking at retention of the existing workforce, and how we can better bridge from our students graduating to supervision and licensure by one of our licensing boards. One of the things the Rural Board also wanted to see in this initiative is some form of a business technical assistance program for individuals who may be coming into the State of Nevada to do business in the area of mental and behavioral health. They would have a place to go to answer questions; like how do you get a business license? What are all the different licensing boards we have for mental health professions?

A reminder that the infrastructure for the Behavioral Health Education Center is to have an administrative hub at one of the institutions within NSHE with spokes out to the other NSHE institutions across the State. How have we been implementing this? After the bill was passed in the last legislative session, what needed to happen next was the Board of Regents needed to designate the administrative hub. That was done at their September 2023 Board of Regents meeting. The University of Nevada, Las Vegas submitted an application to become that hub, and that was awarded in September. Effectively, BeHERENV started October 1, 2023; BeHERE is the name for the Behavioral Health Workforce Development Center. It is an acronym for the Behavioral Health Education, Retention, & Expansion Network of Nevada, which is a mouthful but shortens nicely to BeHERENV. I wanted to note that you heard a presentation in one of your previous meetings about the Silver State Health Improvement Plan. We are part of that health plan. Officially, Goal 2; Objective 2.1 is to establish the BeHERE.

What have we been doing the fast few months? Since January a lot of time has been spent on filling positions. To do the lift of creating our workforce pipeline, it takes multiple people. I cannot do that myself as the Executive Director. At this time, we have five full-time staff and one graduate assistant. Our staff live in Northern and Southern Nevada. We have been working on developing our outreach and marketing. Having a social media presence and a website, so as we are going out and doing all this education and outreach, we needed to have a place to draw people to get more information. We have also started issuing a monthly newsletter. We have been doing things like this, providing follow-up presentations, and attending meetings with our stakeholders to give them updates. Along the way, we have been doing a bit of a listening tour—that is what we are calling it. We have had meetings with all of our sister NSHE institutions to meet with all of the mental health training programs at all of those different institutions, but also to meet with the staff of the pre-college programs that live in all of those institutions to understand the connections we already have between NSHE and the local K–12 systems.

I wanted to drill down a bit more about what we are doing through the K–12 outreach, because that is where we have launched our efforts so far. I know that says five high school career fairs. Sorry; that should be four. We have attended high school career fairs at Fernley High School, Yerington High School, Dayton High School, and Silver Stage High School. To date, we have probably provided outreach to over 200 students about what it means to work in mental and behavioral health, what are the different options to do that, and what are the different career education pathways to pursue those opportunities? Our staff was also able to be a part of the Pre-Professional Healthcare Summit through High Sierra Area Health Education Center (AHEC) recently. This week our staff were involved in workshops with continued outreach to high schoolers through the UNR Upward Bound Office and the high school health and human services career and technical education (CTE) programs.

At one of our first high school career fairs; we had a table at Fernley High School. I want to show an example of our social media posts. March was social work month. In our post, we made sure to link to all our NSHE social work training programs.

What is next? We are working on that continued outreach to K through 12 to find the best doors we can step into whether it is high school career fairs or workshops. We have had a lot of conversations with the CTE program and are continuing to collaborate with the NSHE mental and behavioral health training programs to make sure they know who we are. We are also working on how we can best connect our graduates to licensure and employment in the State.

One of our next big projects we are hoping to bring on a designated data analyst to help us start to track the mental and behavioral health workforce numbers. That is the agreement we will have with you in our Office of Statewide Initiatives. We have already been exploring grant opportunities. We are patiently waiting for the moment we can announce—we have received a notice of intent to award but are not able to fully announce that yet. Our first legislative report to all of you is due at the end of June. What we want to focus on in the next fiscal year, certainly, we have been doing a lot of seed sowing in K–12. We also want to start balancing that out with focusing on retention, and where we can start doing some outreach initiatives to that. The bill also asked us to convene an advisory consortium to help us work on a strategic plan. We will be working on that in the next fiscal year. I mentioned business technical assistance. We are going to look at the best way to create that and get it going. Continued funding—we are funded through a fiscal note that the data system of higher education has submitted. We are working with them to be included in their budget request going forward.

Opportunities we have picked up so far along the way—there are a lot of great opportunities that are presenting themselves to expand career awareness about mental and behavioral health at all levels of education. Certainly, in K–12, the students we have talked to at the high school career fairs that already have an interest in going into mental and behavioral health, we are learning that starts with taking a psychology class. They have either had an advanced placement (AP) psychology course or some other CTE related psychology course, and that is how they are learning about it. Also, when we talk to our associate degree programs at the higher education level, there is an awareness of needing to plant the seeds with those students finishing their first two years of higher education about the importance of thinking of graduate school if you want to go into mental and behavioral health and do that traditional therapy work.

The acknowledgement of social determinants of education—how can we get those students we are talking to in K–12 and those potential adult learners an awareness of what they need to have to feel best supported to come back into higher education. That leads into the next point, scholarships. While the State has done a lot of things, even in the last session, to expand student loan repayment programs, that is often what people bring up when we talk about workforce development. There is a need to be able to fund students coming into higher education to begin with. Growing higher education training programs—there are a lot of discussions right now within NSHE about do we need to establish new degree programs that could help fill in the workforce shortages. If we needed to expand the number of students we can take in our already existing academic programs, that would require more faculty, and that would require an ask of all of you. Regarding data collection, as we are starting to meet with the licensing boards, we are getting a better understanding of what we collect when our clinicians are renewing their license, or they are applying for licensure for the first time.

Here are some policy considerations. I was at a recent presentation at UNLV from a psychology doctoral student who was presenting her dissertation research looking at school absenteeism in kids in the foster system. One of her conclusions was that certainly there is a shortage of providing behavioral health care. As a doctoral student in our psychology program, she said that we are currently training psychology students to leave our State. What that means is when you are finishing your doctoral program in psychology to become a psychologist, there is one year before you graduate that you have to do an internship, like a residency. We do not currently have any accredited placements for students who are interested in child psychology to do that training within our State.

I wanted to remind you of a few bills that were brought up in the last session that did not pass. Senate Bill 300 (2023) was brought by Senator Heidi Seevers Gansert. That would have asked for an appropriation to fund those specific types of placements: the predoctoral internship placements as well as postdoctoral fellowship placements to retain our psychology students. [Senate Bill 267 (2023) would have] expand[ed] reimbursement for services provided by psychology trainees. Currently, if you are training a doctoral student in psychology, they are doing a practicum placement. If you accept Medicaid, you can bill for their services but beyond Medicaid, you cannot do that. Assembly Bill 69 was from the Washoe Regional Behavioral Health Policy Board. It was looking at student loan repayment with a focused lens on expanding the State student loan repayment program options for behavioral health providers. That included behavioral health providers that work in traditional settings, but also in the K–12 system for the school-based mental health providers. It would have offered a student loan repayment program for faculty who teach in our mental health training programs. That would be a good selling point to help recruit individuals into our open faculty alliance. I will end with that. I am happy to answer any questions.

Assemblywoman Brown-May:

You talked a lot about launching into outreach and developing professionals that are going to support behavioral health. Are we working at all to develop a pipeline for nontraditional students that might not ever see themselves with that professional credentialing? How are we getting the boots on the ground people that are providing services now, whether it is an applied behavioral analyst, a registered behavior technician, a technician, or somebody in an entry level position to develop them in the professional field? Can you speak to that?

Dr. Hunt:

That will be part of our recruitment efforts. In the next fiscal year, we are going to be developing specific outreach to those individuals. We call them potential adult learners. Nontraditional students or individuals that are working or may already have experience working in mental health or health care in general and have an interest in coming back, but they are not sure what their options are. We would be planning that targeted outreach to them.

Assemblywoman Brown-May:

I appreciate that. Building partnerships with potential employers, how are we able to take people that are employed in whatever that facility or location is currently and developing those individuals into professional fields while they are working on the job?

Dr. Hunt:

That speaks to those social determinants of education. What do you have to have in place if you are already a working adult to come back to higher education? Those are the things we want to look at and things we want to talk about when we do our listening tours with the employers. We think about those community health workers. We heard a lot about peer support specialists. Those are groups we want to talk to with the understanding there is a need to continue to support yourself and your families if you have already been working and are thinking about coming back into higher education. We want to have those conversations and see where that leads us with figuring out—that might lead into policy suggestions, so to be continued on that.

Assemblywoman Brown-May:

That is great clarification. There is a pool of people currently working as personal care attendants (PCAs) that may naturally fit into this as a career field or direct support professionals that are serving our folks with developmental disabilities. The likelihood they would move professionally given the right mechanisms would be greater.

Dr. Hunt:

Thank you for that recommendation. We will add them to our future meetings list.

Chair Doñate:

I do not think we have any other questions, so we will close out this Item.

AGENDA ITEM XI—PRESENTATION ON STATE POLICY OPTIONS TO ADDRESS THE TELEHEALTH PROVIDER SHORTAGE IN BEHAVIORAL HEALTH CARE SERVICES

Chair Doñate:

I am going to combine two Items. We have Agenda Item XI, a presentation on state policy options to address the behavioral health care services by the National Conference of State Legislatures (NCSL). We have two that were submitted to us. One of them is from the Hospital Association and the second is from Mr. Musgrove. We are going to start with NCSL. Hopefully you can present around five minutes on the broad policy recommendations other states have implemented. Then we will go to the Hospital Association followed by Mr. Musgrove. The point of this is a brief overview of the policy recommendation, and then if the Committee Members have any thoughts, recommendations, or questions, we would take them after. Ms. Jaromin, if you are ready, please proceed.

Sarah Jaromin, Policy Associate, NCSL:

My portfolio includes all things health technology, as well as health care facilities. I was invited today to share more about state legislative trends related to cross state licensing and telehealth. As you stated, for the sake of time, I will be skipping around quite a bit to get into occupational licensing and the facilitation of telehealth across state lines before finishing up with additional resources. I will then take any questions you may have. (Agenda Item XI)

As a reminder, NCSL is your membership organization. We offer all the services listed on this slide to our members, Legislators, and legislative staffers. Before jumping into content, I have to note NCSL is a bipartisan organization, and NCSL staff are nonpartisan. We do not advocate for or against any state policies. Any policy options I will present today are solely for informational purposes and do not indicate NCSL support.

I am going to skip to licensure by endorsement or reciprocity. Traditional licensure processes may deter out-of-state providers from practicing on in-state patients via telehealth due to their often expensive and lengthy nature. Endorsement and reciprocity licensure processes may remove some of these barriers and make it easier for providers licensed in another jurisdiction to practice on patients located within another state. These options are typically not as comprehensive as universal licensure provisions, and states will often direct their department of occupational licensing or specific licensing boards to develop by rule their own endorsement procedures. Generally, application processes allow the

licensing boards to check in applicants' credentials and their education in whichever state they are already licensed in.

This may be a useful option for states when another state is not a member of a compact or within a reciprocity agreement. I have included a few examples of states with licensure by endorsement or reciprocity on this slide. I will not go through all the examples in this presentation today, but I have included summaries as well as links if you want to explore any of the examples further. I am going to skip past interstate compacts completely.

Let us talk about special registration or licensure. Some states will allow out-of-state providers to practice telehealth in their states through telehealth registries or special telehealth licenses. Licensed out-of-state providers may provide telehealth services after completing the registration or licensure requirements. States have some variation in how they oversee telehealth registration or special licensure, but typically, providers must meet the following terms: they must possess a current, valid, and unrestricted license in another state; they must not have been subject to any past disciplinary proceedings; they must maintain and provide evidence of professional liability insurance; they should agree not to open an office or offer in-person treatment within the state; and they must annually register and pay a fee with the appropriate state licensing board.

The following map shows in green the states that have an active telehealth registry or offered a special license for providing in-state telehealth services as of September 2023. This includes 13 states and the U.S. Virgin Islands. I have included some of these specific state examples you can dive into further via the links. I want to note Vermont in particular created both a special telehealth license and a registry—the house bill is listed—and the rest are one or the other. There is more in-depth information about a few state registries. Registries are often a simpler application process than full or even special licensure. It diminishes the burden for many providers though it does not remove it completely like some of the alternatives I will discuss in a moment. I will not dive into these examples, but they are here with more information if they are of interest.

The last bucket of state options I will talk about today is exceptions to in-state licensure requirements. Some states have created specific exceptions to in-state requirements that will allow out-of-state providers to practice telehealth if certain conditions are met. In some cases, some states have created both special licensure or registration and certain exceptions to in-state requirements. The data used to build this map comes from the Federation of State Medical Boards. The 13 states and Washington, D.C. in green will allow episodic—or in other words, irregular or infrequent care visits—or follow up care exceptions to licensure. The 24 states and Guam in gold—including Nevada—will allow consultations only. Five states and the U.S. Virgin Islands, listed in purple, will allow other exceptions such as Colorado who has limited exceptions for certain out-of-state mental health care providers who provide care that is within their school of practice for less than 20 days to someone in the State of Colorado. They must also disclose their lack of in-state licensure to that patient. Eight states and Puerto Rico do not currently have any exceptions to licensure. Here are some of these examples, including two of Nevada's neighboring states; Idaho and Oregon.

As I wrap up my presentation, I want to share a few related trends we are seeing. I know someone covered reimbursement, so I will not touch on this slide. In addition to reimbursement, there are a few other types of State regulation that may impact telehealth care by out-of-state providers. First, you have teleprescribing or the ability for a provider to initiate a prescription after a telehealth visit. After some of the flexibility that expired in the pandemic, a lot of states are clarifying or defining how and when providers can prescribe via

telehealth. I will note that Pennsylvania, for example, relates to psychologists' ability to prescribe including allowing them to issue prescriptions via telehealth. Vermont allowed authorized providers to prescribe controlled substances for the treatment of opioid use disorder via telehealth.

Facility fees were historically associated with hospitals or other emergency services, but they have become increasingly common in nonhospital settings, and they have increased in both amount and frequency in recent years. As such, a lot of states are exploring legislation to protect consumers from unknown or costly facility fees. Some of these bills, including Connecticut and Ohio, prohibit facility fees for telehealth visits because the high cost associated with facility fees could disincentivize patients from utilizing this care option. I have also included a few examples related to broadband access, particularly in rural communities. I know a presenter earlier talked about how that is an important step in ensuring patients in these types of communities are able to access telehealth care. Lastly, there is one miscellaneous bill from Pennsylvania related to funding for telehealth for behavioral health providers specifically.

The last part of this presentation I have included various resources related to bill options. These next two slides contain a variety of pending or enacted bills from this legislative session that relate to telehealth practice across state lines with links for your further exploration of the bill language. Here is a comprehensive list of all NCSL's relevant telehealth and occupational licensing resources.

Thank you, Chair and Committee Members for your time today. It was an honor to be here. I can take any questions.

Chair Doñate:

Are there any questions from Committee Members? We do not have any. If we have any follow-up questions, we will be sure to share them with you.

AGENDA ITEM XII—SUBMITTED POLICY RECOMMENDATIONS TO BE REVIEWED BY THE JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

Chair Doñate:

Let us invite Mr. Kelly to the dais. Welcome back.

Patrick D. Kelly, President and Chief Executive Officer, Nevada Hospital Association:

We submitted a detailed document of about 11 pages. I would say that today we covered about 80 percent of the items that are in there, so I am not going to go over this. (Agenda Item XII A)

The big theme we heard today was the continuum of care. We do not have a continuum of care in behavioral health, and that is one of the big problems. We talked about the missing of the middle, which I thought was a great term. In some areas of the State, we are also missing the beginning and the end, so please keep that in mind. We talked about crisis stabilization centers.

I want to point out to you there is a crisis stabilization center that is currently operating. It is the Mallory Behavioral Health Crisis Center at Carson Tahoe Regional Medical Center. They have only been licensed for a few months, but they have been operating as a crisis stabilization center for a while. The big problem they are experiencing is reimbursement. They do not think they are going to be able to break even with respect to operating the crisis stabilization center. I know that other providers—that is their biggest fear. They do not think the current rate is going to work. What has been suggested is they separate out the physician component from the per diem care component. The physician is going to be the big issue. They also talk about the fact that they do not have access to 24-hour services. Once they have these patients, they cannot send them on to someone else. This exemplifies the problem. Carson Tahoe originally put this Center in to divert people from the ER, but they are always full, so it is not working anymore. They are taking care of folks in the community, but it is not diverting enough patients from the ER. That is a big problem. That is what the other providers are seeing and are worried about. That is why this has been so slow to take off.

I want to mention something about the uninsured too. That is a problem for crisis stabilization centers. They have people come in who are uninsured or cannot qualify for Medicaid, and they have to provide free care to them. That gets expensive. If you get a lot of those folks that becomes an issue too. That is another reason we need to have the Medicaid rate higher to be able to cover a lot of those uncompensated folks that come in.

I want to talk about the State hospitals for a second. We talked about the fact that a lot of the beds are being converted to forensic beds. Every time they convert a bed to forensic, that means we lose a civil bed. We are also having a problem in some areas where they cannot afford to staff all the beds they have, so we are getting backed up in that area. We need to look at figuring out how to help them financially in terms of staffing, and physicians, and also how are we going to create more civil beds? A court is always going to order something saying we need more forensic beds. There is nobody on the other side ordering that we have more civil beds. It is going to end up being all forensic beds, and I am concerned.

I have talked to the private psychiatric hospitals and one thing they want you to know is the issue is not that we do not have enough beds. The problem is they cannot afford to staff all the beds. At any given time, we have a considerable number of psychiatric hospital beds open, but they cannot afford to staff them. I think the Medicaid Provider Fee Program is going to help with this eventually. One of the things they talk about is we should be reimbursing behavioral health patients based on their acuity. If a patient comes in, and you have to watch them 24 hours a day, that eats up the per diem, and there is nothing left after that. If we have a high once a day (QD) patient, they should be reimbursed at a higher rate because it takes a lot more services to provide that. That is what we talked about with targeting incentives. They take them now, but they are incredibly expensive.

Manage Medicaid now—nobody has talked about. What has happened is that the MCOs get the contract for the whole area. Right now, it is Washoe and Clark Counties. Often, they subcontract the behavioral health portion to another entity. What is occurring is the same entities are naming themselves differently. They have the same ownership, and they are picking up the contract, so it looks like we have different MCOs handling behavioral health, but in reality, it is pretty much the same people who are doing it. This creates an incredible amount of control and ability to negotiate rates. That is going to become a big problem, and I am alerting you to that.

The State should also ensure there is an adequate network, and they are actively accepting patients. They will put somebody on their network and say, "We have this person under contract, but they are not accepting any patients." That does not do you any good. That needs to be looked at too. The time frame should be resolved for provider disputes with claims and denials. We have talked a lot today about getting the providers the higher reimbursement. If you are getting payments denied and claims denied all the time, it is eating away at that. That has to be watched because if not, the money is not going to go to the providers, it is going to end up going into the pockets of the MCOs, and that is not going to help. The rural hospitals and providers do not have this problem now, but starting January 1, 2026, they are going to have this problem because we go statewide with Medicaid. That is going to be an issue that is going to develop.

I want to mention housing. Years ago, we went through a process in America where we deinstitutionalized mental health services. We did not have those big hospitals—the *One Flew Over the Cuckoo's Nest* type of thing—and that was a real positive. One of the problems is there were no facilities for these people to go. That is partially what occurs with the homeless. We have people who we see regularly coming into hospitals who do not take their medications. I wonder if there is a possibility to create a housing situation where there is at least someone to supervise people to make sure they are taking their medications and doing other things—not hospitalizing and not restricting their ability to go out in the community but being there as an additional support.

If you are looking for an innovative idea and where to go, I suggest you watch a 60 Minutes episode. It was called Master of the Mind, and 60 minutes usually does 20-minute segments, but they did 40 minutes because this is so groundbreaking. There is a place that has developed treatment using ultrasound to remove the cravings of addicts. What they do is they put you in a machine, they scan you, and identify what area of your brain is triggered by drugs. Once they identify that, they zap it with an ultrasound. So far, the results have been fantastic. My thought is, if we are looking for something to be on the forefront, we should be following that, seeing where it is going to develop, and seeing if we could bring it here because not only would it help the individuals, but the amount you would save on incarceration and all these other services we are talking about would be fantastic. Imagine those young ladies who have been made addicted to drugs by their handlers in sex trafficking. When they are out of that situation, to be able to be eliminated from that one burden as they are recovering would be fantastic. That is why I think Nevada would be an interesting place to develop that.

Chair Doñate:

That was a good episode of 60 Minutes. I would encourage folks to watch it if they can. It is about 40 minutes long.

Mr. Kelly:

The last ten minutes is the substance abuse part.

Chair Doñate:

Are there any questions from Committee Members? It is an extensive document. I would encourage all of you to read through it. I submitted this request back in December and Mr. Kelly and his team went through the process of digging through what are the problems from all segments of the system. This has been one of the most comprehensive ones we

have received so far. I thank you for that. Are there any recommendations or anything before we move on?

Senator Nguyen:

It was a good presentation; it was short and to the point. The document is more thorough. You can always submit the written words you had so eloquently prepared to the Committee if you would like. Are there ways to quantify the savings there would be if we had increases to Medicaid reimbursement rates that would help improve this system for psychiatric hospitals or other providers when compared with the cost savings of the current model, which is where people come into the ER? That is not cheap.

Mr. Kelly:

You are looking at probably a couple thousand just bringing someone into the ER and going through that process. If we have to transport them to a behavioral health facility, you have the transport cost. Then you start the whole cost with the behavioral health hospital going through. It does become expensive. There was talk about how many people were getting backed up in the hospitals. That is a huge number. At times there have been 400 or 500 people in our hospitals who are medically cleared for discharge, but we cannot move them out. I was glad to hear Bud Schawl talk about the fact that is improving now. It is a big issue not only from a cost standpoint, but the problem is when people are sitting in a hospital, they are not getting the services they need because post-acute care facilities are designed for a purpose, and that is to get them up, moving around, socialization, and all those other things. If they are sitting in a hospital bed for weeks, that is deteriorating their recovery, and it is going to be a harder problem going forward.

Chair Doñate:

I do not think we have any other questions. If we do, we will take them offline.

Let us go to our last presentation for this item. Mr. Musgrove, who has a recommendation on a hospice moratorium white paper.

Dan Musgrove, Nathan Adelson Hospice:

If I can take a moment of privilege, to thank this Committee and the Chair for all the work you are committing to behavioral health. It is refreshing, and it is sorely needed. Thank you for the time invested today. (Agenda Item XII B)

In terms of what is happening in hospice right now, especially here in Clark County, is the potential to cause trauma as well for the families and those that are facing the end of life. Right now, we are seeing a proliferation of in-home hospice care that rivals only a few other states in the nation. California about a couple of years ago got ahead of this. Their Inspector General saw this ripe abuse that was taking place, especially in Medicare hospice care, and they instituted a moratorium.

We are coming to you today because we have seen those operators come to Nevada, Texas, and Arizona. Nevada is now second to California when it comes to the number of hospice care providers per 100,000. I am not sure that is a list we want to be number one or number two on. We are seeing folks being taken advantage of because they do not realize what they are supposed to get when it comes to hospice or palliative care, and what is required under Medicare. These folks that are dealing with end of life, whether it is the family or the individual themselves, are not getting the care they rightfully should have.

Here is a perfect example—so much of what we are talking about is in the white paper we presented—Nathan Adelson, one of only two nonprofits in the State, and the only in Clark County, used to only see five transfers a year from other hospices. Now, we are seeing between two to four a week. Sometimes those are from in-home hospice providers that we have never heard of because of inadequate care.

We are asking the Legislature and the Governor to institute this moratorium. Granted, it is something the Governor can do when you are out of session, but we ask this Committee to think about providing a letter of support for that request. The reason we would ask for this hospice moratorium is we then want the Legislature in 2025 to look at instituting more substantial requirements of those hospice providers to ensure that our loved ones, our constituents, and ourselves are not being taken advantage of by these in-home hospice providers. Things such as mandatory reporting of the quality scores allowing for no delinquencies.

The State should confirm one hospice business license per address. As an example, there is an address on Lake Mead that has 11 hospice providers listed at that 1 single suite number. That is multiple vendors operating one suite. If you go there, knock on the door, there is a security guard who gives you a phone number of who to call if you are having a problem. A survey of new hospice programs receiving Medicare enrollment at the 12-month, 18-month, and 24-month periods to ensure they are providing the care and proof that all four levels of hospice care are being offered in this 2-year survey. Here is what we mean by those four levels: it is routine home care; general inpatient care symptom management; continuous care in the home for symptom management; and respite care. At a minimum, those are the four things any in-home hospice provider should be providing.

I want this to be on the record. This is in no way a reflection on what our State is currently doing when it comes to trying to investigate these claims. The trouble is that these are Medicare, not Medicaid, so it is a CMS responsibility, but we need to get ahead of it. Obviously, CMS is aware of it. They have sent inspectors to investigate, but they have done nothing yet. I would hate to see Nevada not recognize that we have a problem and take action if we can. We are asking for your support. I am open for any questions.

Chair Doñate:

I think you are spot on. I have had conversations with our Federal Delegation where there are instances of fraud and abuse that could exist in our health care system happening in our State borders, but because of the delegation of power, sometimes it falls to CMS. Centers for Medicare and Medicaid Services is so large, they may not be able to do it. What is the role of the State government to make sure the consumers are protected even if they are Medicare patients? At the end of the day, it is still our responsibility to ensure care is delivered.

Hospice care is not the only place where this is happening. This is also happening within-home health care where we are seeing different entities pop up. We heard that from an earlier presentation where in behavioral health, there are signs of fraud and abuse. Ultimately, what is most important is making sure the providers that exist in the State live up to the expectations and that there are requirements of who are starting these businesses, and it is not Joe Schmo that wants to run a health care facility. There has to be some training or requirements about being competent to deliver the care you are entrusted to do if you seek reimbursement. I think that has been the most important thing.

Do Committee Members have any questions?

Vice Chair Orentlicher:

Thank you for bringing this problem to our attention. I think you are right. We need to prevent these abusive programs from starting. I am wondering if this is the right policy because it does not address the ones who are already here, and it prevents good ones from coming in. Is there a way to target our policy at the bad ones, both that might come and that are already here?

Mr. Musgrove:

I think you have hit it on the head, Vice Chair Orentlicher. We certainly want good operators in the State. Certainly, this is not an issue of competition for Nathan Adelson Hospice. That was a conversation I had with Senator Titus about her concerns because there is certainly not enough of these type of providers in the rural counties. I think we have enough in Clark County at the present time. I think this pause gives the Legislature the opportunity to do exactly what you are talking about: look at what can we do, whether it is through regulation or statute, to make sure the State has the tools it needs to make sure operators that want to come to Nevada are the most appropriate and are willing to do what is necessary to take care of our constituents. I do not think we are there yet.

When we talk to the Bureau of Health Care Quality and Compliance (HCQC) within DPBH, they are aware of it, but they are complaint driven. They cannot be proactive because there is not enough tooth in the law, so they have to react to complaints. Candidly, it is tough for us to get a family that is in this position willing to go through the complaint process. Either they have just lost a loved one, they are still grieving, or they are just done with it. They did not realize they were being taken advantage of it is passed now, their loved one has passed away, and it is hard for them to be willing to make that complaint. Everyone we have offered to HCQC they have looked at and they have taken action, but it is not enough. We are asking for some kind of proactive solution. I think you have hit it on the head. What can we do? We think the Legislature should take it up at least until CMS takes that action.

Chair Doñate:

I appreciate that. There are plenty of stories, not just in the State but also nationally, of folks that go into health care thinking they are going to make money. Specifically, sometimes there are Wall Street entrepreneurs that say, "I am going to build this or try to build the next ecosystem or venture in health care." Then they realize it is not as easy as they make it seem. Oftentimes there needs to be some level of compliance of do you have the expertise to run these facilities, or what you have been entrusted to deliver on? I think it is not an effort of competition, it is more do we have the quality metrics in place? That is what we were talking about earlier this morning. It is not simply let me submit the CPT code to get reimbursed for it and call it a day. There has to be accountability of what we are delivering upon. I appreciate the recommendation. I am sure we will have a chance to review it. If there are any revisions, please mention it to us. We greatly appreciate your time. That concludes this Item.

AGENDA ITEM XIII—PUBLIC COMMENT

Chair Doñate:

I am going to open public comment. It is limited to two minutes each. If there is anyone in Las Vegas that would like to provide public comment, please come forward. Please remember to state your name. Please begin.

Mr. Mandell, Previously Identified:

I want to thank every one of you and all the presenters. I learned more today than I probably would have in six months of college. I really appreciate it. Pat Kelly answered just about everything I had written down during the whole presentation. That was phenomenal. I encourage each and every one of you, not to plug our own thing, we are in the private sector of the drug and alcohol treatment. We do service a small portion of Medicaid. We do what we can to help, but we are a for-profit business. I encourage each and every one of you and anyone behind us to come down and take a tour. Just get with me, I will give you a tour, and we can show you how the private industry does it.

We have been successful for years. Maybe you could build a model off that. You never know, maybe be able to help your loved ones, your friends, or family. I lost a brother to fentanyl three years ago. My daughter is the face of the fentanyl advertising campaign out here for "Risk it All with Fentanyl." I am entrenched in the community. I know what it is like to have a loved one or family member that needs treatment as well. If any one of you would love to come take a tour, please let me know. I will give you a tour of our facility. All our information is free of charge to you. It is whatever helps the State. We are more than happy to be transparent.

Chair Doñate:

Thank you for your advocacy. Is there anyone else in Las Vegas? I do not see anyone in Carson City. Broadcast and Production Services, is there anyone virtually?

BPS:

Chair, your public line is open and working, but you have no callers at this time.

Chair Doñate:

Thank you. I will close public comment. As I mentioned, the next meeting is focused on children's mental health. I look forward to seeing everyone. Thank you to our Committee Members for participating in this long but hopefully inspiring meeting.

The following written public comment was submitted:

- Board of Directors, Northern Nevada Harm Reduction Alliance (Agenda Item XIII)

AGENDA ITEM XIV—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 4:07 p.m.

Respectfully submitted,

_____

Sarah Baker
Research Policy Assistant

_____

Davis H. Florence
Senior Principal Policy Analyst

APPROVED BY:

_____

Senator Fabian Doñate, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item IV A	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB) Sarah Bradley, Deputy Executive Director, Nevada State Board of Medical Examiners	LCB File R033-24 of the Board of Medical Examiners
Agenda Item IV B	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB Sarah Bradley, Deputy Executive Director, Nevada State Board of Medical Examiners	LCB File R068-23 of the Board of Medical Examiners
Agenda Item IV C	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R001-24 of the State Board of Osteopathic Medicine
Agenda Item IV D	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R062-24 of the State Board of Osteopathic Medicine
Agenda Item IV E	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R051-24 of the State Board of Pharmacy
Agenda Item IV F	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R100-23 of the State Board of Pharmacy
Agenda Item V A	The Honorable Aaron D. Ford, Attorney General (AG), Office of the AG Terry Kerns, Ph.D., Registered Nurse, MSM, Substance Abuse and Law Enforcement Coordinator, Office of the AG Lesley Dickson, MD, FAPM, LFAPA, Addiction Psychiatrist	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
	Erik Schoen, Vice Chair, Prevention Subcommittee, Substance Use Response Working Group	
Agenda Item V B	The Honorable Aaron D. Ford, AG, Office of the AG	2023 Annual Report of the Statewide Substance Use Response Working Group
Agenda Item VII	Stacie Weeks, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services (DHHS)	PowerPoint Presentation
Agenda Item VIII	Shannon Bennett, Bureau Chief, Division of Public and Behavioral Health (DPBH), DHHS Drew Cross, Statewide Forensic Program Director, DPBH, DHHS Shannon Litz, Deputy Director of Programs, DHHS Cody Phinney, Administrator of Public and Behavioral Health, DHHS	PowerPoint Presentation
Agenda Item IX A	Julia Ratti, Behavioral Health Administrator, Washoe County	PowerPoint Presentation
Agenda Item IX B-1	Joanna Jacob, Government Affairs Manager, Clark County Abbie Frierson, Deputy County Manager, Clark County Bud Schawl, Executive Director, University Medical Center	PowerPoint Presentation
Agenda Item IX B-2	Sabra Newby, Deputy City Manager, City of Las Vegas	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item IX C	Valerie Haskin, Rural Regional Behavioral Health Coordinator, The Family Support Center Cherylyn Rahr-Wood, Northern Regional Behavioral Health Coordinator, Nevada Rural Hospital Partners	PowerPoint Presentation
Agenda Item X	Sara Hunt, Ph.D., Executive Director, Behavioral Health Education, Retention, & Expansion Network of Nevada (BeHERENV)	PowerPoint Presentation
Agenda Item XI	Sarah Jaromin, Policy Associate, National Conference of State Legislatures	PowerPoint Presentation
Agenda Item XII A	Patrick D. Kelly, President and Chief Executive Officer, Nevada Hospital Association	Behavioral Health Recommended Initiatives
Agenda Item XII B	Dan Musgrove, Nathan Adelson Hospice	White Paper Case for Hospice Moratorium
Agenda Item XIII	Board of Directors, Northern Nevada Harm Reduction Alliance	Written Public Comment