NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

(*Nevada Revised Statutes* [NRS] 218.E320)

MINUTES

June 10, 2024

The fifth meeting of the Joint Interim Standing Committee on Health and Human Services for the 2023–2024 Interim was held on Monday, June 10, 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
Senator Rochelle T. Nguyen
Assemblywoman Tracy Brown-May
Assemblyman Brian Hibbetts
Assemblyman Duy Nguyen
Assemblyman David Orentlicher, Vice Chair

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Robin L. Titus
Assemblyman Ken Gray

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Patrick B. Ashton, 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—OPENING REMARKS

Chair Doñate:

Good morning, everyone, and welcome again to the Joint Interim Standing Committee on Health and Human Services (JISC HHS). Today is a very exciting meeting. We are going to be talking about children's behavioral health, and I am sure there are a lot of folks gladly interested. It is pre-primary election eve, or close enough, so for folks who have not voted, we always encourage everyone to please do so before tomorrow, which is primary election day. We have a lot of good presentations scheduled throughout the day, so we encourage folks to please participate.

[Chair Doñate reviewed meeting protocols and information related to providing public comment.]

AGENDA ITEM II—PUBLIC COMMENT

We will open public comment here in Southern Nevada and then move up to Carson City.

Michelle Paul, Ph.D., Assistant Vice President of Mental and Behavioral Health, University of Nevada, Las Vegas (UNLV):

I am also the Executive Director of UNLV Practice, a community mental health training clinic. As a member of the Children's Mental Health Action Coalition, I represent our support for investment in mental health training programs. Nevada faces a shortage of mental health professionals with existing programs focused primarily on adults. We need more child-focused mental and developmental health training programs. (Agenda Item II A)

We propose a tiered and integrated system to develop a child-centric workforce skilled in prevention, early identification, assessment, and intervention. This would involve a curriculum from bachelor's to doctoral levels, sequential and graded in complexity, including whole child assessment, evidence-based practices, developmental considerations, trauma-informed care, systems integration, and cultural responsiveness. We ask for funding to support bachelor's-level training for prevention and early intervention and to expand master's and doctoral programs, including internships and postdoctoral fellowships.

Currently, for example, Nevada has zero accredited psychology doctoral internships for children, forcing the few trainees we do have to leave the State. Incentives for licensed providers to pursue professional development in child mental health would also help enhance skills and willingness to work with our most vulnerable.

With funding, we can readily leverage existing resources, which include the motivation, talent, and expertise within the Nevada System of Higher Education (NSHE), not only at UNLV, but among our other institutions, including our colleagues at Great Basin College and Nevada State University. Expanding our mental health training programs with a focus on children's needs will develop the qualified workforce needed to support Nevada's youth.

Damon Schilling, Director of Government Relations, Intermountain Health:

I am here today to speak to you on Agenda Items V, VI, and VII. We commend the State and this Committee for the focus on this much-needed area in health care for our children.

We also have a focus on children's comprehensive health. We look forward to working with the State, this Committee, our fellow health care systems, and members of the community like the Children's Advocacy Alliance (CAA) and others to fill the gaps and help provide world-class health care for the children and families of Nevada.

Stephen Benning, Ph.D., Director of Clinical Training, Clinical Psychology Doctoral Program, UNLV:

I am pleased to speak in support of the Children's Mental Health Action Coalition's request to the Legislature in Item VI. In particular, I speak to the need for greater opportunities for graduate training and early assessment for common mental health and developmental disorders.

Our doctoral training program brings in students from around the world to train in providing psychological services. However, our students must often seek internships outside of Nevada to complete their doctoral training. As a result, Nevada loses them and their clinical skills. Having additional funding to finish students' internship training in Nevada would keep them in our workforce as would funding postdoctoral training that would prepare students for their careers in Nevada.

Furthermore, funding an array of mental health training programs at the bachelor's and master's levels would broaden the professional base of service providers to children. Each year, these programs could train around ten times more providers than our clinical psychology program can.

Psychology's assessment competency provides mechanisms for identifying children with attention deficit hyperactivity disorder (ADHD), specific learning disorder, intellectual development disorder (IDD), and other neurodevelopmental conditions. With legislative support, our profession could provide early screening and assessment of these conditions that would guide interventions allowing such children to find their full potential. With your support, we can improve the mental health training landscape of Nevada and support children who need our help most.

Will Rucker, Community Health Director, Intermountain Health:

As a not-for-profit health care system, we strongly support the CAA's recommendations addressing child mental health priorities. Our recent Community Health Needs Assessment highlighted critical gaps in pediatric health services that these recommendations directly address. Implementing these recommendations is crucial for effectively enhancing the health and well-being of our children.

Our vision at Intermountain Health is to be a model health system by providing extraordinary care and superior service at an affordable cost. Rooted in our values of clinical excellence, empathy, and collaboration, we believe in partnering with our communities to ensure every child has access to the care they need. Supporting these recommendations is not only the right thing to do, but it demonstrates the truth that we are in fact better together.

Rebeka Acosta, Act4Kids Nevada:

Today I am speaking to you as a member of Act4Kids Nevada, a group of parents and health care professionals advocating for comprehensive pediatric health care in our State, beginning with a standalone children's hospital. As a voice for families and advocates for the

health and well-being of all children, Act4Kids understands that collaboration with health care providers and health systems is crucial to our efforts. (Agenda Item II B)

Today, we are pleased to present a letter of community support endorsed by over 20 youth-serving organizations as well as a policy recommendation to create a statewide task force. Detailed in our letter are actions we believe will move Nevada closer to having comprehensive pediatric health care, such as increasing insurance reimbursement rates, building provider recruitment and retention programs, streamlining licensure applications, and reviewing the scope of practice requirements for physician assistants and nurse practitioners.

The proposed task force would identify obstacles to having a standalone, comprehensive children's hospital, develop policy recommendations to solve those challenges, and report back to this Committee in summer 2026, allowing ample time for actionable changes in the 2027 Legislative Session. Led by patients and families, the task force would bring together key stakeholders in pediatric health care delivery to ensure collaborative efforts that best meet the needs of our most vulnerable population: our children.

Families and providers across Nevada are sharing their stories with us. Family stories start similarly, praising the great providers we have here in our State, but then ask for more resources, more specialists, and more coordinated care. Providers echo these families' sentiments, calling for comprehensive care for all of Nevada's children.

I would like to end my public comment today with two quotes. First, from one of our families: "Our children's surgeon is great. However, he is limited in what he can do for our child because the pediatric infrastructure is not here." Second, from a medical provider: "We are often referring children out of State now because some specialists have a three year wait list."

Magdalena Ruiz, Family Peer Support Services Program Director, Nevada PEP:

Family peer support services are crucial for helping families address the behavioral health needs of their children. Each month, we support over 500 families of children with autism, emotional disturbance, ADHD, and intellectual disabilities who have behavioral health care needs. Unfortunately, the families we serve report significant challenges to accessing the behavioral health services their child needs. The most frequent concern we hear from parents is waiting lists for assessments and services.

We know youth outcomes are much better in communities that have an array of robust services which include emergency and planned respite care, in-home intensive services, family and youth peer support, and step-down programs. Currently in Nevada, we have a very limited service array as documented in the United States Department of Justice (DOJ) investigation. This lack of services leads to over-reliance on residential treatment and poor outcomes for Nevada's youth and their families. Your support to improve Nevada's behavioral health care is urgently needed.

Shana Tello, Academic and External Affairs Administrator, University Medical Center:

I am here speaking on behalf of the Child Mental Health Action Coalition Insurance Subgroup to discuss opportunities to improve access and delivery of mental health care for Nevada's children. The Coalition has highlighted a few key items for your attention. Areas of focus include early assessment and treatment for certain mental health diagnoses, easing

administrative burden for prior authorization, aligning reimbursement rates with the national average, and fair expectations for submitting claims.

Although I am here representing our Coalition, I am also representing my family and the barriers we have personally experienced when trying to receive mental health services here in Nevada. I will share with you our history. My grandfather was diagnosed with schizophrenia at age 42 and committed suicide. I am also a parent of an adult with a mental health diagnosis. My daughter did not choose her illness. She was an honor roll student. She graduated at the top of her class, was accepted at Cornell University, and went on to attend Saint Mary's on a full scholarship. Stress, environmental factors, and genetics were the perfect storm for her mental break.

To put things in perspective, mental illness is a medical condition like hypertension, diabetes, and cancer. These individuals have significant challenges that impair their ability to think and cope. Daily challenges can be overwhelming. This can also lead to substance use disorders. There is stigma and shame that creates embarrassment and reluctance to seek and receive help. There is also a need to expand some infrastructure here, more acute care setting, transitional subacute care coordination, and therapy.

I want to share with you that last week my daughter was discharged from the hospital and not able to get her psychiatric medications she was taking while hospitalized due to prior authorization requirements. I attempted to purchase her meds. It would have cost me $1,400 for a 30-day supply. From a parent's perspective, I ask, how will my daughter navigate the system on her own when I am no longer here? Will there be services for her, or will she become homeless? Will my daughter be treated with dignity and respect despite her illness?

Establishing a system of care that prioritizes availability of resources and adequate insurance coverage will not only provide optimal outcomes for our children but also uplift the well-being of the families overall that care for them. Finally, Las Vegas is fortunate to have you all as incredible leaders in our organizations and our community that are remaining steadfast to design a system to care for this population.

Brandon Ford, Health Care Consultant, Best Practices Nevada:

Thank you for this opportunity to present our recommendations to address the barriers related to insurance coverage of behavioral and mental health pediatric disorders in Nevada. Here are the key points we propose will help. First, we urge a reduction in the burden of prior authorizations. Many providers are choosing not to take Medicaid and other plans because they do not feel it is worth the headache. The current multi-step process is lengthy and uncompensated. Streamlining this process or supporting legislation for reimbursement of these administrative costs is crucial. Simplifying this process will allow providers to focus on delivering care over paperwork. This, in turn, will increase provider retention and recruitment into these networks.

Second, we call for expanded coverages related to the screening, diagnosis, and treatment of common neurodevelopmental disorders such as Fetal Alcohol Syndrome (FAS), autism, and other learning and intellectual disabilities. Timely and proper treatment hinges on the ability to test for and diagnose these conditions without restrictions. I know providers in the community who had waiting lists over six months long for testing and could never keep up with the paperwork required to do so.

Lastly, we propose establishing insurance overpayment recovery laws. Many surrounding states have laws that set limits where our providers face recoupments for years after the services have been delivered and paid for. Punitive audits can lead to practices closing their doors and increase the provider shortage. I know providers being audited for minor technicalities in their documentation for services performed years ago. Setting reasonable time limits and rules will protect providers from unjust financial penalties and ensure a stable health care environment.

Implementing these recommendations will significantly enhance access to behavioral and mental health services for children, alleviate administrative burdens on providers, and attract more health care professionals to serve in our community. We are grateful for your time and attention to children's mental health in Nevada and we hope you will consider some of these steps towards improvement.

Tami Hance-Lehr, Chief Executive Officer, State Director, Communities in Schools of Nevada:

I represent Communities in Schools of Nevada, the State's largest and most effective evidence-based, stay-in-school organization. We serve more than 100,000 students across the State. As this group of distinguished policymakers knows, Nevada's mental and behavioral sector faces a supply and demand problem. When you look at the need in our youth, the problem becomes even more acute with the U.S. Surgeon General declaring a national emergency and Nevada's ranking at 51st in youth mental health access and services. The opportunity that presents us is to be innovative, collaborative, and agile in how we respond to that reality. (Agenda Item II C)

There is a third dimension to supply and demand, and that is the pace at which we will address this challenge. To wait until we have the necessary licensed personnel will simply take too long. We cannot "therapy" our way out of the problem, so how do we address the supply and demand urgency? Through cost-effective, nonclinical interventions that alleviate the suffering our young people are experiencing in our schools each and every day. Those include activities and programs that promote good health, peer support, training caring adults with certain skills, and screening and facilitating referrals to community-based services for more intensive treatment.

The Communities in Schools model of integrated student supports and the developmental relationship frameworks that our site coordinators are trained on is an example of a nonclinical intervention. It has a proven track record, and it is scalable through public and private partnerships. With our program in close to 120 Title I and high-need schools across Nevada, our trained full-time site coordinators are weaving community, brokering resources, and improving campus climate and culture to create a sense of belonging for our students.

We often see the compounding efforts that poverty has on the mental and behavioral health of our children. With chronic stressors in their household, community, and educational environments coupled with the lack of resources to mitigate those stressors, our students are often showing up to school with a host of emotional challenges. Through a variety of campus-wide initiatives, small group interventions, and individual case management, our site coordinators equip students with the skills and resources they need to manage their own mental and behavioral health. I thank the Committee for your time to offer public comment today and for all the good work and deliberation you are doing on behalf of Nevada's children and families.

Stacie Sasso, Executive Director, Health Services Coalition:

The Coalition is a member organization representing 25 union- and employer-sponsored, self-funded health plans in Southern Nevada providing coverage to over 280,000 lives. Our membership includes hospitality workers, including MGM, the Culinary Health Fund, and Boyd Gaming; construction trades, including plumbers, pipefitters, and teamsters; public safety; and municipalities such as Clark County and the City of Henderson. We are also members of the Children's Mental Health Action Coalition.

The Coalition is supportive of expansion of access to mental health care providers in Nevada for our children. Nevada needs additional graduate training programs, and we support Nevada and the federal government investing those in community nonprofit settings. Providing these programs and nonprofit academic settings help keep providers in the State post-training and can keep the focus on care. Providing additional access will assist many families currently struggling with mental health and behavioral health issues.

The creation of the Office of Children's Mental Health might help provide accountability, consistency, and coordination and help families navigate the many issues regarding mental health access in Nevada. This is an important topic for our members and the participants they represent.

Maya Holmes, Health Policy Director, Culinary Health Fund:

We are pleased that the Interim HHS Committee today and others like the Children's Mental Health Action Coalition are taking such focus and effort and care to address the behavioral and mental health needs of Nevada's youth. We all know mental health services are a critical need in our State, especially for our kids. Youth mental health in Nevada is in dire need of long-term and sustainable focus, resources, and accountability. We are members of the Health Services Coalition and echo their comments.

We support efforts to grow and build the youth mental health workforce, streamline the licensing process for mental health professionals, and create new educational opportunities at the undergraduate level. We know UNLV is doing tremendous work in this area, which is exciting and needs support.

I also wanted to address another issue that is not mental health-related on the agenda today, Item X, pertaining to the statutorily required update on the implementation of Assembly Bill 7 (2023), adoption of the framework, and regulations for the interoperability of health information. We closely followed AB 7 through the Patient Protection Commission in the 2023 Legislative Session, and the goal of the bill was to require electronic health record interoperability consistent with national standards and best practices and ensure that patients can access their electronic health records directly from their providers and forward that information electronically.

We are concerned that the proposed regulations for AB 7 indicate that compliance for covered parties is based on either maintaining an electronic health record system that meets specified interoperability standards or maintaining a connection with the health information exchange. A connection to a health information exchange should not be an alternative to having an interoperable health record system.

We believe this provision in the draft regulations conflicts with the provisions of Section 1.08 in AB 7 which require the Department to establish standards that allow patients to directly access their electronic health records and forward that information

electronically. Essentially, AB 7 did not have a provision stating providers can use health information exchange connection to be compliant, so we do not understand why such a connection is an alternative to having an interoperable electronic health system in the regulations. It will prevent patient access, which is the basis of the law.

Leann D. McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics (AAP):

As you have heard this morning, children and teens and their families are facing a lot of stress and challenges to mental wellness and while some families can navigate routine stress, it is not uncommon for Nevada families, including mine, to incorporate mental health professionals into their health care routine. Mental health care is basic health care and encompasses a full range of pediatric mental and behavioral health services across multiple settings: at home, at school, and at the child's medical home with their pediatrician. (Agenda Item II D)

The Nevada AAP advocates for policies that support a comprehensive approach to children's mental health that addresses prevention, early treatment, and crisis response. In the letter I have submitted today, I have highlighted several policies the AAP believes are pragmatic, feasible, and will have an impact on youth mental health for our State.

I will highlight two. To reduce the suicide rate, we are advocating for waiting periods for firearm purchases. The Nevada AAP is also advocating for later school start times to address the sleep deprivation health crisis that is leading to damaging chronic problems such as obesity, hypertension, headaches, irritability, difficulty concentrating, poor school and poor sport performance, dangerous driving, and depression. I am looking forward to hearing today's presentations.

Carissa Pearce, Health Policy Manager, CAA:

You have heard a lot about groups we are supporting, and we have made a mental health coalition to try to address some of the issues. And so, this sheet is over at our table up here that we submitted (Agenda Item VI). We also submitted a few letters. Thank you for the opportunity to submit recommendations. Many of our stories today support the need for better services for mental health, and they are all outlined in our recommendations, but we especially want to highlight the desire for a streamlined behavioral health board. This will reduce the administrative burden on individual boards that are often staffed with only one or two people who are burdened with supporting the licensure and renewals for the State. We feel a single board would support and expand professional development opportunities for professionals in the State.

Chair Doñate:

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

Carley Murray, Statewide Family Network Director, Nevada PEP:

I am the parent of a youth with behavioral health care challenges. The Statewide Family Network Program at Nevada PEP, funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), is charged with ensuring family and youth involvement is incorporated in decision making in system-level policies, procedures, and priorities for children's mental health systems of care. We also work to improve systems that serve

children, youth, and families as a partner in Nevada's System of Care Grant operated by the Division of Child and Family Services (DCFS).

Family involvement is important when talking about issues surrounding children's mental health or when trying to improve systems because they are the individuals who need and receive services and support. They know if the services work, if the services are difficult to access, and how long they have waited for a service. Families know the policy and funding barriers that have kept their child from receiving the services they need. You can read through the DOJ investigation and see how families and youth with behavioral health challenges experience a system of care in Nevada. Their knowledge and expertise should help guide the necessary reform efforts in our State.

Britt Young, Statewide Family Network Coordinator, Nevada PEP:

I am the parent of a child with multiple disabilities and mental health needs. I know that a broad array of community-based services helps to identify mental health concerns at an early stage, which reduces the need for crisis intervention, hospitalization, and placement in residential treatment. Investing in community-based children's behavioral health services benefits families, alleviates the burden on emergency services, and reduces the overall cost of mental health care while keeping children close to home.

Today, I want to shed light on the needs of children, youth, and their families in rural communities in accessing mental health services. Families report that they must travel out of their communities to access services or they are on wait lists that are months long, and when telehealth is the only option, unreliable Internet can impede access to necessary care. The system of care philosophy in the foundation of children's mental health service delivery includes the core values of family- and youth-driven, community-based, and culturally and linguistically competent services. Nevada should develop solutions that are built on these nationally recognized core values in frontier, rural, and urban areas of the State. Thank you for your time, and the investment that you can make can have a lasting positive impact on their future.

Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities:

We want to remind you that individuals with intellectual and developmental disabilities are at an increased risk of co-occurring disabilities with mental health conditions, including, but not limited to, major depressive disorder, bipolar disorder, and anxiety, and people with IDD and mental health conditions often experience symptoms that lead to services being provided within the mental health service system framework, and most mental health professionals do not receive sufficient training on the needs of this diverse population.

We recognize the challenges policymakers and administrators face in addressing the current mental health care needs in Nevada and currently available treatment options in Nevada are not sufficient enough to serve the current needs of this community. Increased access to mental health services is necessary to meet the needs of those with IDD in our State and other mental health conditions. We are very excited to see this on the agenda today.

Dora Martinez, Legislative Liaison, Nevada Council of the Blind:

I wanted to ditto Executive Director Nielsen's point and many of the Nevada PEP people. I also want to bring it to your attention, Chair, Members of this Committee, LCB, and whoever is putting the agenda on your website to please, please, please make it accessible.

It was hard for me to locate the number and even to read the packet being discussed today. We need to do better.

This is going through that saying, "nothing about us without us." I am a blind activist, and I want to be involved, and I want to bring good points to you all because I am a person with a disability, and I live the life. My point would be valuable to you all considering that I deal with a disability and other things, so it would be helpful if the agenda and the packet is accessible to us all so we can access it. Like the counterpart, this is America, and everything is great here, and I want to be an informed constituent. I appreciate all of you, and let us do better.

Ashley Pruitt, Private Citizen:

I am a student at UNLV's Doctorate of Public Policy program, and my focus area is children's mental health navigation. I am also part of the Coalition here today. I would like to remind you to remember that children with mental health disabilities and needs become adults with mental health disabilities and needs. The decisions we make today are going to impact us in the future, so I strongly urge the Committee to continue to set us up for future success. Consider the key points offered here today by the Coalition. They have been thoughtfully researched and whittled down to areas that we believe we can make an effort and make a difference for us here in Nevada. Thank you again for having us here and allowing our thoughts to be heard.

Chair Doñate:

I will now close public comment.

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

Chair Doñate:

We will move on to the approval of minutes for the meeting on March 11, 2024. Committee Members, are there any questions regarding the minutes? Seeing none, I will entertain a motion to approve the minutes.

ASSEMBLYWOMAN BROWN-MAY MADE A MOTION TO APPROVE THE MINUTES OF THE MEETING HELD ON MARCH 11, 2024.

VICE CHAIR ORENTLICHER SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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

Chair Doñate:

As always, Mr. Robbins will give us an overview, and then we will go to questions and discussion.

Eric W. Robbins, Previously Identified:

We have four regulations for the Committee's consideration today:

- LCB File R026-24 of the Aging and Disability Services Division (ADSD), Department of Health and Human Services (DHHS) (Agenda Item IV A);
- LCB File R002-24 of the Board of Psychological Examiners (Agenda Item IV B);
- LCB File R084-24 of the Board of Psychological Examiners (Agenda Item IV C); and
- LCB File R053-24 of the State Board of Pharmacy (Agenda Item IV D).

There are representatives from ADSD and the State Board of Pharmacy here to answer any questions about those regulations. If you have questions concerning the regulations of the Board of Psychological Examiners, unfortunately, they were not able to have someone be available today. They had their adoption hearing on Friday, and I am not sure if the regulations were adopted or not, but because they are on a quick schedule with these, we decided it was best to have the Committee hearing since the input from the Committee is not very useful if the regulations have already been adopted and approved by the Legislative Commission. If you do have questions or comments regarding those regulations, please note them on the record. I have provided Committee Members with the contact information for the Executive Director of the Board of Psychological Examiners so you can provide your feedback to them that way.

Chair Doñate:

Committee Members, do we have questions that we would like to pull out? It sounds like we have questions on LCB File R026-24 of ADSD. Are there any others we would like to pull out?

Senator Titus:

Chair, I have a quick question for Mr. Robbins.

Chair Doñate:

Please proceed.

Senator Titus:

Thank you for sending that email to all of us, I believe it was yesterday very early in the morning. My concern is that some of these regulations do go to the boards to get adopted and passed prior to us having an opportunity to look at them and ask questions. I would hope that we try to get these in as timely a manner as possible in case we did have questions. Although I am not pulling anything today, I appreciate the update on the status of these regulations.

Chair Doñate:

Are there any others we would like to pull out? As you mentioned, the Board of Psychological Examiners is not here today so if you have any questions, they would be for the record. Let us start with LCB File R026-24.

Assemblywoman Brown-May:

I have three quick questions related to this regulation. The first is a reference to page 28 of the draft proposed regulation where the language changes from "at least six years after termination of" to "the date of payment for the provision of the supported living arrangement services." That notation is made again for jobs and day training services on page 44. I am curious to know if it is date of payment from the State of Nevada, or is it the date the provider organization submits payment to request for reimbursement of that service? There are times the State has 90 days to make payment to the provider organization, so I am curious to know, what is the date?

Jessica Adams, Deputy Administrator, ADSD, DHHS:

Regarding the date of payment, it is from the date the provider receives payment. We made this change to the regulation at the providers' request. Previously, when we said six years after the termination of services, providers felt they had to keep every single record they ever carried on the person, even if they served them for 20 years. They asked for us to change it to the date of payment of service so they would know they could get rid of records and still maintain the six years they had to have for the possible Medicaid "look back."

Assemblywoman Brown-May:

Thank you for that clarification. It is good to see you here today. I would also like to offer my congratulations and really good work for the provisions put in with regard to medication administration. Good work done there.

My second question is about Section 33, subsection 15 on page 47 of our documentation where it says, "The provider of jobs and day training services has failed to accept a written service authorization or deliver services." It is saying that the certification can be eliminated if a provider of jobs and day training has not delivered service within 12 months after the issuance of a provisional certificate. Is that upon initial approval? Is that a new certificate? There seemed to be a bit of confusion around that piece.

Ms. Adams:

We have a small number of providers who will have gone through the entire certification process, received their provisional certificate, and then never provide a single service over the course of 12 months, and those would be the providers from whom we would be revoking that certification because they do not seem to want to work with us.

Assemblywoman Brown-May:

My last question is probably not going to need a response today but is something for us to think about. On page 18, it says that we need three or more letters of professional reference when looking to first apply to become a provider. As we have conversations throughout the State with regard to licensure and how we help people get into service more quickly, it seems like this keeps popping up—three or more letters of professional reference. Once the organization has already gone through fingerprinting and background checks and other certifications to licensure, I am curious to know, what is the implication of three reference letters, and are we slowing the process down?

Ms. Adams:

When it comes to applicants, these would be brand new applicants for a provider agency. We have made a lot of changes to the certification standards when it comes to individual staff because they used to also need reference checks. We have made changes to that, so we do not hold anything up there. I am not aware of any issue with provider agencies having difficulty providing us with references.

Assemblywoman Brown-May:

I want to congratulate you on the really good efforts for this regulation in particular. I know it is a lot of work.

Chair Doñate:

Are there any other questions?

Senator Titus:

You got me curious: you take away a license after one year if they have not seen a patient without any due cause other than the fact that they have not seen a patient or a client?

Ms. Adams:

It would not be without contact. Typically, the way our services work is once they are approved and are a certified vendor, we have things called vendor calls. For anybody who would need services, those vendor calls go out to every provider who is eligible, so that provider likely would have gotten many referrals over the course of that year and has not taken a single one of them. We also would have had conversations with them saying, "Hey, what is going on?"

This is a rare circumstance. I think it has happened two or three times. Our certification is not an easy process to go through. They are working with a vulnerable population of people, so we make sure they are able to do that. Like I said, this has happened maybe three times and we have had somebody go through all of that and then decide to not serve us.

Senator Titus:

This may be more of a question for staff: are there any other professional licensing boards that take away a license if they do not have a client or a patient? I think after all the effort, to take it away in a year if they have not accepted anybody is—I am not so sure that is a good policy at all, and I was curious to see if that is standard practice in other licensing boards, especially after all the effort folks go to get that license.

Mr. Robbins:

I am not aware of any professional licensing boards that do that. I can conduct a more thorough search and follow up.

Senator Titus:

I would appreciate that.

Chair Doñate:

Are there any other questions? Seeing none, we will close this agenda item.

AGENDA ITEM V—OVERVIEW OF NEVADA MEDICAID'S CHILDREN'S BEHAVIORAL HEALTH SERVICES TRANSFORMATION

Chair Doñate:

We will now move on to an overview of Nevada Medicaid's children's behavioral health services transformation.

Stacie Weeks, J.D., M.P.H., Administrator, Division of Health Care Financing and Policy (DHCFP), DHHS:

It is helpful to hear everyone's comments beforehand. There are a lot of issues in our system when it comes to providing services for children with behavioral health challenges. Today, we are going to go through background on the data about what we know about the children we serve in Medicaid and the reforms we are undergoing right now because of the DOJ findings that we are out of compliance with the U.S. Americans with Disabilities Act (ADA) for this population. (Agenda Item V)

I wanted to walk folks through that as well as the delivery system reforms we are going to be taking over, or at least taking on, over the next two years. It is going to take us time to reform the system, but that is something we know we need to tackle. At the end, I wanted to remind folks about the funding we have for this work. Thanks to lawmakers and hospitals for the private hospital tax, we do have funding for children's behavioral health, but the funding is not unlimited, so we will talk a bit about that. Then I want to walk you through our timeline and open it up for questions. I have a list at the end of gaps and opportunities for Members' consideration, and I am happy to dive into any of those as well as provide follow-up information if Members are interested.

In October of 2022, the DOJ found that Nevada was out of compliance with the ADA for children with behavioral health disorders, specifically because we do not provide adequate community services in our programs from a public perspective. When we look at the system, we rely on the segregated institutional settings like hospital and patient services and residential treatment facilities, and sometimes this is the only option families have for children with serious behavioral health challenges. The DOJ's findings are that we need to develop a Home and Community Based Services (HCBS) system for these children.

We are currently still in confidential negotiations. I know it feels like a long time, but I was talking to other states at a conference, and they have been in confidential negotiations with the DOJ as well for years. It is a process, as it always is with attorneys, but we are still in those negotiations. We all know here today that the need is too great for us to wait until this is done. We have the funding, and we want to move forward on these reforms. We have taken some things to the Interim Finance Committee (IFC) already to begin to develop these services, and we will talk about that in a minute.

A snapshot of the children in Medicaid with a serious emotional disorder (SED) because when children are younger, they are not diagnosed with serious mental illness (SMI) like an adult would be. A lot of that has to do with stigma but also recognizing children grow, and hopefully they do not end up with SMI. Maybe we can get them early enough to help treat the issue, but when we look at the population of children we currently serve, we think about

one in six have a SED. That is a lot of children when you think about nearly half of the population we cover is children.

Most of the children who have SED or behavioral health challenges just have the behavioral health challenge, but we estimate 6 percent also have a substance use problem and have been diagnosed with some sort of substance use-related disorder, challenge, or condition. We estimate that another 6 percent have what we consider an IDD. This could be a child with FAS or autism. Typically, they exhibit right conditions in both categories of a developmental disorder as well as a behavioral health condition. The population we are trying to look at under the DOJ settlement agreement includes all children, so we cannot pull these populations out because they have a dual diagnosis. Our new system needs to address these issues, but it also cannot use a wait list to cap that group. We have to look at the entire population and not limit services.

I wanted to give you more data on this population. A majority, no surprise, live in Clark County since most of our State lives in Clark County, but do not forget the North. In Washoe County, when you compare that to the rural areas, it is a bit more than our rural areas, and a huge, significant number of children with behavioral health challenges who need services live in Clark County, and 1 in 12 in Medicaid with SED are in our State's foster care system as well.

The challenges around behavioral health affect female and male children mostly equally. We looked at it by gender. We also looked at the most common reason for out-of-state care for this population, and that is residential treatment. That is no surprise because we do not have any community-based services or anything that families can bring into their homes that we pay for to help families meet the needs of their children. A lot of children are being placed in residential treatment centers and when there are no placements here, we are sending them out of state. The State’s share of the cost annually for this out-of-state service is roughly $5.8 million with the federal share covering the remaining cost, so it is definitely bigger than that.

About 60 percent of the kids being sent out of state are in our foster care system, with the majority of them being between the ages of 13 and 20. It is challenging to find a place for them in the State and then also a center that will take some of these challenges. Some of these kids present with significant behavioral health challenges and conditions that are hard to meet, so we end up looking out of state.

Looking at our work with the DOJ and what can we do better from a payer system and building a business model to support behavioral health in the community and home, and then what can we do with our partners as we want to set a vision and values around this work. The vision for children at DHHS is that these children have access to behavioral health services when they need it to live and thrive with their families and their communities. They should not have to go to residential treatment unless they absolutely need to. Some kids will still need those services, but we want to get to children early and upstream to try to prevent that.

The values are that we build this in a child-centered, family-focused way. We often struggle to get family voices at the table, and that is something we will be doing in the next few months or years as we build this model, making sure we are doing it with not only the provider community, but also families at the table and looking at it to be community-based and accountable, which is something I think all states struggle with. Who is accountable for this work, and who do we hold accountable for making sure children get these services in their home and community and we do that in a coordinated way? We are working hard with

DCFS and other sister divisions to make sure that as we build this, we are working together, and we do that in a coordinated way.

I wanted to give a quick reminder that when we think of the continuum for behavioral health care, we want to make sure we are building and growing. Right now, we are primarily relying on that high-intensity residential inpatient treatment when children or even adults are not stable in the community, and they need those intense services. That is where we are with this population, and we want to screen, assess, and identify kids earlier so they get services they need in their community in that bubble number two, so they are not cycling in and out of our crisis, high-intensity services. We are building that second bubble that we lack in this State. Those are more cost effective as well, so from a State budgeting perspective, the cost-effective services are in those first two bubbles as well as the third; crisis mobile response is preventing and, in some ways, stabilizing people, hopefully, in their community. Some people do not need to go inpatient, so we are trying to get on that left side of the continuum.

This is a visual we shared with IFC in April when we went to ask for new services to develop a system for children in Medicaid. Today, some of these services are covered, but the way we cover them is inadequate and primarily for our foster care families. We want to open up that box in the middle, HCBS for children with SEDs and foster care children in a way that supports any family that falls in that bucket and any family with a child who may have SED as well as an IDD to have the support they need in their community. That is what we are trying to build. When a child is entering school or going to a primary care clinic or any time entering the system in some way, either State or county or the health care system, we are looking at trying to mandate or incentivize comprehensive screenings and assessments of all children who are entering some sort of setting that we can do this work. The school system is a great place that we know we can do better.

Our hope is we will screen, assess, identify, and when someone is coming in the system and they are screened and assessed for at-risk, we are looking at also creating a bucket for eligibility, so if a child is at risk of SED, they would have access to these services to help prevent having that designation. We are looking at that as also an eligibility criteria, and we got feedback from stakeholders on that, but when they are identified as needing services, they would get what most people call wraparound facilitation where you get a child and family team and someone who is going to actually manage that child's case. It is intensive case management and care management for that child and family. Additionally, they would have family and youth care supports available, individual and family therapy in their community or in their home—we are looking at telehealth for some of our rural areas where we are challenged with provider access—psychosocial rehab services, and planned and emergency respite care.

Planned and emergency respite care and wraparound are two big new services. Planned emergency respite care is not cheap, but we have found that it is one of the most needed services for families and one of the ways that families may keep their child longer in their home and not feel the need to put them into placement or give up custody of their child so the child can access care.

Here are services that we already cover except for employment supports, but making sure that families know they can access these services. What we find is a lot of folks—because many of these children are in our fee-for-service system, they lack some sort of management, and they lack knowing they have access to these services—so making sure that if a child is eligible, they get transportation, have psychiatric care, and we have medication management, mobile crisis and stabilization service, and they know how to

access them. Day treatment, intensive outpatient services where available—same with partial hospitalization and youth employment support—I will talk a little bit more about that shortly.

We have a residential treatment system. We do not want to only reform the HCBS system; we want to look at when we do have children who need residential and patient care, they are getting quality care, and we are paying for those services adequately. We will be reforming payments as of January 1, and we will be doing a quality incentive payment for residential treatment centers that show good outcomes, like shorter stays, so children are not staying there forever, and they have successful discharges, meaning they are successfully transitioning into their community and doing well. We are looking at ways to measure that now and are setting a baseline year for next year. Those bonus payments would be about $100 a day per child that we could pay the facility. The other bonus payments we are looking at adding into a residential treatment center program is bonus payments for centers that accept children with complex needs or young children. We will talk a little bit more about this, but a new step-down group home model for youth with shorter stays.

We are also looking at creating a dashboard with our Office of Analytics. We want to monitor children and track their outcomes in a better way and make sure we are not losing children, and where there are gaps, we are going to be looking at trying to fill those gaps. It is definitely a multi-year process. It is going to take time for us to build that. That is why we went to IFC in April to ask to get the funding we had available to start this work in building these services.

Depending on what kind of visual person you are, this table might help you look at the buckets of the continuum by service, so when you think of wraparound, it would be available for a family regardless of where that child is in our continuum. That child and family team is there to support them, manage their care, and provide that intensive care coordination as well. Care supports would also be available. In light blue, there are what we would consider new covered service, or we are increasing rates, so for wraparound, that is new, and for peer supports and services, we will be increasing the rates for these services and adding youth and family peer support starting January 1, 2025.

For residential treatment, we will be increasing the rates to a flat rate of $800. No longer will the rates be lower or higher for children in certain areas of the State depending on where they are. We want equity across the system for kids, so we will increase that to $800 a day, which we think is a fair market rate, and add those bonus payments depending on quality and complex needs.

We are also adding planned and emergency respite care as a new benefit. The Qualified Residential Treatment Program (QRTP) is a model that came out of the Family Services Support Act. We are looking at a similar group home model for youth, maybe foster care but maybe not foster care. We are looking at other states that have added this Medicaid program as a way to support youth as a step-down to a residential setting if they are not quite ready to go back at home or maybe they do not have a home to go to yet, so this is a step-down model where they are in a community setting, but they still have supports in that group home model to support the child or the youth.

Regarding intensive targeted case management services, we will look at different ways to provide those services, and we will talk about that in a minute for the delivery reform. For intensive in-home supports, we are expanding that to not just foster care kids, but also to

all families and children who need these services with SEDs. This is also a bucket where we are increasing rates for services that fall under that category.

We are also increasing inpatient hospital psych rates to give them parity with acute care. When someone comes into an acute setting and needs psychiatric services, we are creating parity and supporting our psychiatric hospital system, which I think you all know is struggling statewide. For psychosocial rehab services, we are increasing rates there as well as individual family therapy services, and on those rates, we are also adding a bonus payment for services provided in rural communities even through telehealth. We are trying to really encourage people to serve rural areas of the State and not forget children in those communities.

For the blue buckets we currently have in place, we are looking at ways and will probably try to increase rates for other areas in these buckets based on our quadrennial rate review, which showed gaps for some of these provider types. We are looking at whether or not we have sufficient funding now to do some bare minimum rate increases in these areas around access. Lastly, regarding 988, we are looking at ways to leverage Medicaid funding to support 988 and referrals coming out of that system.

As a reminder, we have a new flat rate of $800 per day for residential treatment centers starting January 1, 2025, and those add-on payments that we are hoping will incentivize quality and accepting some of our children where we have a hard time now that we have to place a lot of children out of state who have the complex, challenging needs or are younger children. We do not have many places for children under the age of 9 or even 12 for placement. The quality bonus for our residential treatment centers means making sure we are driving quality in how we pay them and rewarding those that help children transition back to their families or in their communities.

Regarding other Medicaid investments we got approved at IFC, I already mentioned the QRTP. The other one we have not brought to IFC, but it is something we are already doing: we will be removing the requirement that counties have to pay the State share. This should be a statewide program. School health services are covered by Medicaid, so we are no longer requiring that the county pay the State share. We are picking up the State share cost. It is affordable for us. We need to do it, and this will hopefully help improve access to services for children who are Medicaid eligible in the school system, but we are looking at that as a way to start to increase screening. We will be working with the Nevada Department of Education (NDE) and other partners on ways to increase screening for behavioral health conditions in the school setting as well as trying to help children in schools get services for behavioral health needs.

I mentioned the rate parity for psych, and we are also removing any barriers around prior authorization. We have had some barriers for crisis intervention, so we are we are removing prior authorization in that way. We heard a lot of public comment earlier about prior authorization, and we hear that quite often and it is a struggle on our end. If we just paid everything, we often find that there is fraud, and we have to be mindful of that. That piece is important, but we also want to make sure people are getting services, so one thing we are planning to do is revisit prior authorization and how it is used and look at data around how often it is already being approved.

For example, if a service is being approved 90 percent of the time, why do we have the prior authorization? What is it there for and why, and are there other ways we can be preventing fraud? We are looking at that not just for behavioral health, but more broadly for our entire program. These are tools we have to help prevent fraud, and unfortunately,

behavioral health is the largest area of fraud for the Medicaid program when it comes to provider fraud. That is very unfortunate and disappointing for us because this is an area where we have the most need right now, so we are looking at other ways to address fraud without always using prior authorization.

Regarding delivery system needs, the other piece we are bringing to IFC later this week is a proposal for staffing and funding for a vendor to support delivery system reform for children. Today, children in foster care and many children with serious behavioral health conditions are served through our fee-for-service system. What other states have found, and I think it is true in Nevada, is that our fee-for-service system is outdated and many times can lead to fragmented care because there is no clear line of accountability for coordinating care, managing services, developing an adequate network, or even ensuring quality services. We do not have the capacity to do it, and it is not required at the federal level, so we are not doing the same level of service that we are in the managed care system.

What other states have found for this specialized population is that looking at a specialized managed care plan with one entity being responsible for filling that void at the State and local levels—it is a lot for both the State and the county, even the counties that do the case management for these children, to have all the expertise and services they need to provide these services. We are looking at ways to bring in a specialized managed care plan in the next two years to assist the State with better managing this program, overseeing quality tracking outcomes, supplementing county support where we need it, and doing what we know other states are doing, and it is at least doing more than we can today with what we have.

Ohio, Arizona, and Washington are three states we are looking at as models in this area, and they have found they can bolster resources and support kids, including care coordination and case management for children in foster care. As I mentioned, we are going to be adding children with behavioral health needs in that bucket so we can make sure they have access to their HCBS program.

This is a visual of what we are trying to build for this new specialized program for this population. On the left side is what we would consider best practice integrated benefits, treating behavioral health not as a separate program, but trying to make sure the HCBS model behavioral health care system is part of health care and that it is an integrated benefit so families know they have medical services, behavioral health services, access to all of the services we talked about earlier, and transportation. I heard the other day that some of our foster care families did not even know that they have access to transportation, which is shocking, but again, with that fee-for-service model where we do not have a managed care entity, making sure they are being reminded that they have these services to help get the child to the care and the treatment, and that intensive case and care management bucket is a piece of this integrated model.

And then on the right side is all the types of requirements we must have in managed care. Some of them are nice flexibilities we also get through managed care that we cannot get through fee-for-service. Federal law requires certain network adequacy standards and testing before we go live, and if we do not have access, the U.S. Centers for Medicare and Medicaid Services (CMS) will not sign off on it, so a lot of work has to go into building that network. We have an external quality vendor that works on that and assesses the network, not us, so it brings that expertise to the table but also gives us that independent look at our network.

One nice thing about the managed care is the profits. When these entities profit or come to the table, we can ask them if we cannot cover it through Medicaid and it benefits the program and lowers the cost, they will often do what is called a value-added service. Employment and housing supports are areas we know we can add as value-added services, so we are going to be working hard to get a plan in that can provide those services to families as value adds. It does not affect the Medicaid program or budget, but it is a value add to this program.

The other piece is that states that have these specialized managed care plans, they all have collaboration agreements, specifically with schools, child welfare systems, counties, states, and all the partners that are involved with these children, including judges and courts, to ensure coordination is going on and roles and responsibilities—which we all know is really important to this work—are very clear. We will play a big part in that, and we want to make sure we have folks from all areas at the table when we are developing our model contract for this plan so everyone understands what they can get from this and how they can hold that managed care entity accountable. The other piece we will provide through this is a 24-hour family nurse support line for families.

We are also looking at quality incentives for providers and performance monitoring, which will be nice to have like we have in our managed care program, but in a way where we can track provider outcomes in a better way and measure them to national Healthcare Effectiveness Data and Information Set metrics and other standards where we can look to see how we are doing nationally.

Regarding community reinvestment and workforce development, the other piece Nevada started doing on its own during the last contract period was to ask about their plans to reinvest their profit. We have for-profit managed care entities, and unlike nonprofits that invest their profits, for-profits do not have to, so our contracts include a provision requiring them to invest at least 3 percent of their profits back into their communities. We would be asking this plan to invest a percentage of its profits back into communities and services these children and families need and possibly even workforce development. That is an area we are looking at since we know it is a huge need in our State. To make any of this work, we need the workforce so we can have investments back into not only social services, but also that workforce piece.

As a reminder, Senate Bill 435 (2023), Senator Titus's legislation, allows Nevada Medicaid to use up to 15 percent of revenue from the private hospital tax for administrative costs for the tax and to improve access to Medicaid behavioral health care services. This funding is not unlimited, but it is sufficient at this time to help us build this new system and build out these services. We went to IFC in April, and everything was approved. I am very pleased, so thank you to those of you who sat on IFC. We will be coming back later this week to talk about the managed care system and the vendor and staffing support we need within Medicaid to build out this new program and make sure we are monitoring services for children in our State.

The estimated timeline is here. We are currently in the process right now of developing new benefits, so once we get through IFC, if all goes well, we will be working hard to get everything submitted to CMS, working with stakeholders before we submit to make sure the benefits align with feedback, and looking for a vendor to help us start drafting a model contract for this new specialized managed care plan. We are looking at an effective date of January 1, 2025, for all the rate increases and rate changes and possibly looking at adding more. We are costing that out at this time for day treatment and other services. Our goal for our HCBS package approval is July 1, 2025. I hesitate because I never know what CMS’s

backlog is because I know we have one, but they have a greater one. We hope we can choose the right authority that gets us to the shortest line. I am looking at a 1959 State Plan because it seems to be quicker for us to get, so we are looking at that as an option at this time. We hope to post and do a procurement January 1, 2026, for the new specialized plan.

In the meantime, for intensive stakeholder engagement, we are going to have several forums for the public. Two of them will be advisory committees looking and putting out an application process, but we want to make sure we have families at the table. When it comes to the procurement and the new specialized managed care plan, we want to make sure we have our counties, court systems, and everyone that touches a child in the system at that table to make sure the system we put together supports their needs and is improving and moving us forward, because otherwise this would not be worth all this work. It needs to make sure it is moving us forward. We are hopeful we will have everything set up by January 1, 2027. The benefits will come online before then so families can access them through the traditional fee-for-service system, but we believe the specialized managed care plan will help boost that system in a way we have not been able to do today.

Regarding gaps and opportunities, some of these are familiar from last time. An area where we think there is a gap in the State is the bundled rate and a bundled package for community treatment model. It is an evidence-based model we think could help with services with young adults and youth as well as adults in the community for behavioral health. With school behavioral health services, one thing other states are looking at—and other schools in the state have done this already—is looking to get a billing vendor to help them bill, because the capacity to bill for Medicaid requires someone like a billing specialist to understand all the codes and requirements. As much as we want to streamline and improve it, insurance is insurance, and there is going to be burden regardless, so we are looking at ways to streamline our school health services and looking at one manual so when schools want to bill, it is not as confusing and they do not have to go to three or four different chapters of our policy to figure out how to bill. We are looking at opportunities to fund a centralized school billing service for schools as well as an electronic health record system for them.

We also lack a sufficiently skilled, licensed, certified workforce for a lot of these services, so we are looking at ways to build that workforce. We have been talking to our university partners. That is a struggle of the State, and a lot of states struggle in this area, but Nevada is extremely struggling with workforce at this time. What types of services and system can we put together that [meet] the needs of children who have dual diagnosis, especially IDD and SED? Right now, there is a bifurcated system, so how do we make sure children can get the services they need regardless?

We are also looking at rate gaps for different outpatient services and ways we can increase those rates. You have heard that over and over again. It seems to be a theme, and we would agree that historically, we have underfunded our system in Nevada for a variety of reasons, good and bad. We have to budget, but if there is something to say here about increasing rates for our provider system.

Looking at gaps in primary care and pediatrics, this is where we can start helping families earlier before a child has hit the point where they have to go into a residential treatment center. The primary care workforce in this State is lacking. What can we do to increase that access? Other states are looking at that as well, especially in the pediatric side.

Regarding rural access challenges, we are looking at creative payment strategies and telehealth to help with this need, but we recognize there is also a lack of trust sometimes in our rural areas. How do we also create a system with this new specialized managed care entity where we can build trust and ensure families in those areas access the services they have available to them, and we remove any stigma associated with that? I will now stand for questions.

Chair Doñate:

Are there any questions from Committee Members?

Assemblywoman Brown-May:

I appreciate all your hard work on this and supporting our children. I have two questions. When you talk about the snapshot of children in Medicaid with social emotional disturbance, diet disorder, substance use disorder, and IDD, we are talking about dual diagnosis populations. I am curious to know, and this has come up in the past: when they see children, providers offer diagnosis in order to bill for services. Are we diagnosing children in the beginning of a support service that may not be necessary and which will follow them through the rest of their lives? Is there any incentive to add perhaps a family wellness check in the billing code so we can allow children in distress or in crisis an opportunity to seek services without having a lifelong diagnosis follow them?

Ms. Weeks:

I appreciate the question because it has come up a couple of times in our stakeholder meetings and is one of the reasons we are trying to create this at-risk category, so we do not always need this diagnosis. We can get kids who have certain symptoms or have had circumstances like a mobile crisis visit or other challenges like juvenile justice, or anything where they have had some interaction or required certain services, and we can say, "Ok, they are at risk of SED." We look at the community for advice on that because we do not want to stigmatize children and families to also avoid services because they are afraid of some sort of stigma that comes along with the designation of SED. I think that is why we have that designation. People did not want SMI, but even SED on its own has stigma, so how can we create an eligibility category that is really for at-risk children? That is the goal, but I think we need to flesh that out more and would love your advice if you have any or comments you want to share. We will be working with expert vendors, but we are looking for feedback.

Assemblywoman Brown-May:

I look forward to following up with you offline about that. We have children who go through crisis situations like divorce, SMI, or serious illness in a family member, which are times of crisis we are able to help children navigate through. Care coordination in those situations would not necessarily lead to a long-term diagnosis, so I would like to work with you on that.

My second question is, you talk about wraparound services, intensive care management, and care coordination. Do we have care coordinators now? While you are getting ready to make this wonderful transition to managed care that will have care coordination as part of a managed care billing and service plan, do we have care coordinators currently who are not State employees who we are able to contract and bill for care coordination services?

Ms. Weeks:

We have State employees at our district offices in our Division who do care coordination, but they are not specialized in behavioral health disorders. Part of our IFC request is to add two positions with the managed care entity that will assist us as well because one of the things we are lacking right now is enough people doing care coordination who have the expertise we need to do this for children. We are looking at adding that in the interim. To answer your question, no, we do not, and that is one of the reasons we feel like we need the specialized managed care plan with the capacity and resources to support this population.

Senator Titus:

Thank you for the presentation on the lofty hopes for the future of what the State is trying to accomplish. I appreciate all the efforts. I want to piggy back on what was just asked, and for some clarification. You mentioned the fee-for-service delivery model can often lead to fragmented care. My concern is that we are there now. We have fee-for-service for these programs, and you are looking at going for a provider network to do managed care. In the meantime, who is overseeing it? Where do we go? What happens? I am hearing more and more about kids lost in the system and concerns about who is out there monitoring this process, these children, and these agencies. What are we doing now?

Ms. Weeks:

That is one of the reasons we did not want to wait for the settlement agreement, because all of this takes a long time to set up and get CMS approval for these services, and the longer we wait—it is years from now. I think that is one of the reasons we are asking for those care coordinators to try to start doing more now. We are also looking at hopefully bringing in some clinicians, and we got a clinical position last IFC to help support Medicaid and our team and to work with DCFS and the counties, and we meet regularly with the counties. Once we get these positions, we need to create a diversion team to help children in the system, focusing on our foster care program for now. That is one of the reasons we are here and trying to do this now, because it takes so long to stand things up. And that is the unfortunate piece. I apologize. I do not have a better answer.

Senator Titus:

It is unfortunate, but I understand you are trying. On the same line of concern, on page 8, this is excellent forward thinking, but I am in the here and now of where these kids are, and I am wondering about available beds we have our kids in right now and looking at numbers that perhaps you can get to this Committee on what available beds we have in State, How many of our children are out of State? This is going to start in January 2025, but we have kids now who need these services. Yes, we are going to increase services, but do we have folks waiting who will take these kids when this increase happens? Those are my concerns, so perhaps you can give us an update.

I know you are you are not in the State right now, and I understand all that, but perhaps you can get somebody who works with you to send us these numbers. What is the status for our kids right now? How many are going out of State? Do we have providers out there who are willing to step up if we increase the reimbursement rate? Again, this looks great. I like the concept and the plan, but it is only a plan right now, and I am hoping that maybe it is like, "if you build it, they will come." I am hoping we have that kind of opportunity. I am looking forward to that information.

Senator Nguyen:

I have had several people come up to me, advocates in the community, providers in the community, people working on the ground in the field talking about the placement of these children, and they have been advocating for "no eject, no reject" policies at these facilities. Are there facilities that are open, that have beds and availability, and they are either ejecting these children with high needs or rejecting them from placement in those facilities because they do not meet their needs 100 percent, and then we do not have placement for these children? Do you have any information or data on those kinds of scenarios?

Ms. Weeks:

I would have to follow up with you. Some of that lies with our Division of Public and Behavioral Health (DPBH) as well, so for licensing, they are probably tracking that more closely. What we end up doing—and that is one of the reasons we raised the rates, because we end up doing a lot of agreement, which is essentially a special arrangement where we will offer a higher rate. I will be frank with you. Sometimes we feel like we are being price gouged so we can place a child who has a lot of challenges, but for the most part, we find a placement, though it is a challenge, and that is one of the reasons we need care coordinators to help us do that better and to make sure they have the expertise and know all the right providers as well.

The challenge we have is that out-of-State or even in our own State, we find out they are not good actors or there are not good conditions for these children. That is one of the reasons we are trying to build these HCBS, because we want to see fewer children having to be placed. In the meantime, we are struggling, and we hope these rate increases will help, especially with our more complex children who we end up doing a higher rate for regardless. What we are doing now is a patchwork to get to this new system with more information. We can follow up with more information.

Senator Nguyen:

That would be wonderful. You said it briefly, but my concern is what you alluded to that some of these facilities perhaps are not taking these children because they want additional fees. What kind of metrics or accountability do we have to ensure that? Would these care managers be the ones to determine and follow up to make sure these kids actually need additional resources and that they are receiving them based on this increased pay?

Ms. Weeks:

In addition to care coordinators that we would be getting who are specialized for these children, they would also be working with the case managers in Clark and Washoe County. For rural counties, they would be working with DCFS case managers. We find case managers now who do that work, but that is one of the reasons we want to have the care coordination team do this too, so we have that feedback for Medicaid so we can better track it.

Chair Doñate:

I had a quick question. My interpretation in terms of where the State needs to go is, based on the public comment and the recurrent themes nationally, that more needs to be focused on early intervention. You mentioned that towards pediatric services and early intervention, so what gaps are you seeing in terms of school-based systems of care? States like New Mexico require that every student in the state goes through a mental health screening

with the permission of the parent. There is an idea that we are screening all kids to understand if they are going through emotions of sadness, depression, and so forth, and then providing them with the level of services so they do not end up in a residential treatment facility or causing disruption in classrooms. Are there opportunities that you see in school-based systems of care? Does more support need to be done through your Office to be able to administer such a program, or is this more for NDE? I would love your feedback on what we can do in that setting.

Ms. Weeks:

We have been working very closely with NDE for six months since we started digging into the school health service side, and there is more room there to do that work. One of the things we realized in our work is that we need to first help schools start billing for these services. In Nevada, my understanding is that schools are under local control. It is a very different model than other states, so it could be working with NDE to see what they need to institute a blanket behavioral health screening policy.

The University of Nevada, Reno (UNR) is very involved as well. They have a program that provides schools that want to participate with training, screening resources, tools, and how to do evidence-based practice around behavioral health. It is called the Multi-Tiered System of Support Project. From my perspective, we need more of that and more resources around that way of supporting schools.

From our perspective, what we could do in Medicaid is broaden the type of providers we will reimburse for—because we often hear that schools cannot afford to have a licensed psychologist, for example, on staff. Of course they cannot; we all know what public school is like. I grew up in a small town. What can we do to help them get those services? Is it telehealth that we can reimburse them for, or do we do we train their counselors to do some of this work? We are open to strategies and looking at other states for best practices and models, but I think because of the workforce shortage, that is a big challenge for schools to provide a lot of these services.

Chair Doñate:

I would agree with that sentiment. I think the difficulty that comes with it is the mission. At some point, the problems schools face could grow to such a capacity where—our schools are not meant to be health care providers. They are meant to serve as educational institutions. What I have seen in other states is, the model works, and you are providing services of care, whether it is physical or mental to students, but if the problem gets too big, how do we provide school districts with the ability to at least provide some level of services?

To me, it sounds like we need to create a system where there is either a pool funding or the support services here to provide technical assistance so school staff, educators, and families understand what it means to have a mental health diagnosis or maybe not even arrive at that and that we are screening each child, so we do not end up down the line having to fund residential treatment centers because they are at full capacity. That would probably make the most sense. I do not have any other questions. Is there is anyone else? Seeing none, we will now close this agenda item.

AGENDA ITEM VI—DISCUSSION OF POLICY RECOMMENDATIONS RELATING TO CHILDREN'S BEHAVIORAL HEALTH

Chair Doñate:

Let us move on to our next agenda item, a discussion of policy recommendations relating to children's behavioral health.

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

I appreciate the opportunity to be here. I am going to talk for a second about my past experience, which may give some credibility to why I stay here today, and then talk about some personal experiences. Then I will go right into my recommendations based on a lot of the public comment you have heard already. (Agenda Item VI)

By way of background, I moved to Las Vegas in 2006. In my first couple of years here, I managed an after-school tutoring company, so I was with a lot of children from kindergarten all the way through middle school kids. One of the things I learned early on is that kids are struggling with behavioral health challenges. If you have been around children, you are going to identify them pretty quickly. It takes about five minutes to walk into a room and identify those kids who may have some challenges that set them apart from the other children in the classroom.

Following my time tutoring, I worked for the City of Las Vegas for ten years in policy and strategy, so I have been working in the public policy landscape for quite a while now. I was also the Chief Executive Officer of the Boys and Girls Clubs of Southern Nevada, and I want to share one quick story with you to let you know the complexity of this issue. Staff members in the Boys and Girls Clubs are between the ages of 18 and 25, so they are young and doing their very best to manage their own lives, and all the staff members in one particular clubhouse came to me and said, "A lot of these kids are sexually abused. You can sense it. You know it when you see the parents drop them off. They are doing drugs in the parking lot, dropping off their children. There is a level of abuse there that is not appropriate."

That led me to start working with the University at that time, six or seven years ago, to talk to law enforcement and the county, at which time there was not a remedy. There are a lot of issues in our community. We have a lot of abuse going on. We have a lot of behavioral issues with students, so the question was how we inform parents there is an issue or a challenge that if they were to address it early on, that behavioral health challenge Ms. Weeks talked about does not become a SED later on. We started working with staff members to train them on how to talk to a parent to say, "Hey, let us pull you aside. Here is something that makes your kid special and a bit different, and we need to address some of those issues early on."

Fast forward: I am a parent. I have an eight-year-old and a six-year-old, and this is what brings me here today, because I had not thought about children's mental health in a long time. I spent a lot of time thinking about crisis response, and from the last meeting, I think the State is doing a lot in crisis response. There are a lot of efforts going on there where we will see improvements. That is not the same for children's mental health. That is a huge gap.

I will talk about it from personal experience. My eight-year-old son and my six-year-old daughter both were adopted. I thought he was doing really well in school, but about

six months into the first-grade school year, the dean of the school said, "We are about ready to kick him out," and I said, "Do you know who I am? Do not kick him out. Do not do that." It was because my son was acting in a way that was not productive. It was not what the other kids were doing. He was climbing on the walls and acting out in class, and I did not realize what that issue was. He also had a nervous tick where he would eat strings, and he would be embarrassed ten years from now if I told this story, but I used to bite my nails when I was a kid, and it was a serious issue. I used to bite my nails all the time. He ate strings. I had a hard time with that, and we struggled with it for a couple of years. It started becoming an issue when teachers and students would point it out. I would classify that as a behavioral health challenge.

Now, if I did not do anything about it, there is a real chance that later in his life, he would have SED because it becomes a big issue when you are in kindergarten, first grade, second grade, and third grade, when all you hear is negative comments back about who you are. Based on my connections and resources—I have a double coverage insurance. I am a public servant. I am an elected official. There was nobody available to take a call, not a single person. This was based on two insurance companies—not Medicaid—two private insurance companies.

So, I did what I should do: I reached out to my network, and many of them are here in this room today. I said, "What do I do with a kid who is struggling with a behavioral health issue? As a family, it is tearing us apart because it is stressful to see your kids struggling and you do not understand why." I got about ten different recommendations, and of those, eight never returned a call. One did not take my insurance, one was cash pay, so we ended up with that, and it was a wonderful relationship and still continues.

That is the issue at hand, and I think that you all need to be very concerned about, is with whatever system you set up as a State, if you do not have providers that are plugged into the system, cash pay does not work. It only works for people like me. I have enormous access, enormous privilege, and I used it, but I was only able to get cash pay.

Also, there is the conversation around identifying SEDs, and in order to get to someone to identify a diagnosis, you have to wait for a couple of years. That is the system we have in Nevada, so for all of those folks who have access, resources, and privilege, it sorts of works. I made it, I pulled together the team of people to support my son, and he is doing amazing now. It was a random conversation with an occupational therapist who takes cash who said, "He is eating strings because he has an oral fixation, like me biting my nails. Give him a Starburst. He will be fine," and over the course of six months, Starbursts fixed the issue. Now he is happy and doing well in school. He has no behavioral health issues, and he is doing fine.

That is the kind of system I think we need to focus on as a State. When I was stressed out and I could not figure out how to deal with all that anxiety of having kids who were not fitting in, and I was not fitting in, I pulled together a team of mental health professionals, and I asked them, "What would make this State better? How can we fix what I consider to be nonexistent, not even broken?

One thing that shocked me is how many providers are cash pay, and that is something I am going to probably say a few more times: as a State, we need to understand what would make a provider go to cash pay as opposed to taking Medicaid or private insurance. If we cannot understand why they are not plugging into the system, there is a whole segment of the population you will never be talking about in this room today.

The next thing I thought was shocking is that there is no connective tissue between providers. A lot of these things will come out in these recommendations, but if you are seeing a patient, and you want to make a referral, I am willing to bet all of them say, "Go to this Facebook page," because they make referrals via Facebook because there is no connectivity. There is also very little professional development or training around children's mental health in the State, so to get your continuing education credits, you have to go online or out of State. Those are some of the challenges that are relatively easy to fix if we focus on them.

It is me as a dad struggling to figure out why my own family could not do this alone, only in partnership with people who understand the system in general, so I partnered with the CAA and asked, "What is the best in the country? How can we replicate that?" We ended up bringing a group in from the University of Oregon, the Ballmer Institute for Children's Behavioral Health, where they focused on developing an undergraduate program for children's mental health.

Ms. Weeks mentioned many of these ideas in her comments, and I am going to talk about those briefly, but this undergraduate degree in children's mental health is important because across the country, you do not specialize in children's mental health, you specialize in mental health and then fall into children's mental health. At the Ballmer Institute, they focus on developing undergraduate professionals who have an understanding of what children's behavioral health looks like and some of the mitigation strategies and that connective tissue to a system in order to connect children. We brought in UNLV, UNR, and Nevada State University and asked them if it was possible. There is an enormous opportunity right there if the State were to help us get that off the ground.

I want to take a moment to talk about what makes an undergraduate professional different. One is that in the medical sector, you have doctors and nurses who have a graduate degree and an undergraduate degree. You do not have that same thing in mental health, but I think we absolutely need it. If I put my councilman hat on for a second, I spend quite a bit of time with teachers and principals. I do not know if you have seen reports on it, but absenteeism right now in Clark County School District (CCSD) is off the charts, and I think you can link absenteeism to this because I can see kids who may not want to go to school and parents who may not want them to go to school because of some behavioral health issue.

Having spoken to a number of teachers leaving the system, it is directly tied to children who they are having a hard time managing in class. I can tell you from personal experience that the Coronavirus Disease of 2019 (COVID-19) exacerbated whatever was happening already and made it significantly worse. Principals are losing teachers, teachers cannot stay in the classroom, and absenteeism is at an all-time high, and this creates the perfect opportunity for the State to jump in and create something new. That will take time to develop, but we will have an opportunity to rectify what I think is a system that is nonexistent. I am happy to walk through these recommendations. I am going to read them and talk about how they came about, and then I will open myself to any questions you might have.

Chair Doñate:

As we are going through them, can you state how much they are going to cost? I think that would be helpful.

Councilman Knudsen:

The first one, the Office of Children's Mental Health, I do not think is a significant investment. The State already has some like this in the behavioral health boards in the north and the south. What I am saying is probably within the Medicaid Office—and you heard Ms. Weeks talk about that professional clinician who is focused on children's mental health—building out two or three people to help staff that within Medicaid or DPBH, either one of the divisions within DHHS, creating a connection to who gets licensed within our State and a matrix of those folks so we can help them connect with each other and create that referral network. I do not think that is the significant investment from the State of Nevada.

I also think it is helpful, as every two years you meet, to have someone with direct experience working in children's mental health talk about who is part of the system and who is not part of the system. I would also recommend funding a study around why providers are not enrolling in Medicaid or why they are not credentialing with health insurance companies. That is going to be a critical investment.

Number two is prevention oriented, a Bachelor of Arts (B.A.) in mental health training. We have a proposal in with DHHS now. We have been working with Director Whitley, Administrator Weeks, and several members of their team on what that funding would look like, and while the immediate thought is going to the State General Fund, the State has access to multiple funding sources. I would recommend you use opioid settlement funds to fund this. I think there is enough funding and enough creativity there. I also think this mitigates the impacts of what Administrator Weeks was talking about when it comes to comprehensive screenings and assessments happening in schools. Right now, there are no personnel to do that, so I am offering you a solution to some of the opportunities she suggested.

Senator Nguyen mentioned care coordinators, and a B.A.-level professional is the right kind of person you want in that care coordination experience. We have a funding model in with DHHS. We are advocating for the opioid settlement funds to get the program off and running with UNLV, and DHHS has recommended bringing on somebody at UNLV to work with Medicaid to figure out how we can build in Current Procedural Terminology or Medicaid billing codes so Medicaid can eventually fund those positions, whether they be in a school, hospital, or any other system. That one should be ready to go anytime you are ready.

The third recommendation is funding child-focused mental health graduate programs. We have another proposal in with DHHS around the opioid settlement funds for UNLV to fund additional graduate-level programs. As we build out the undergraduate workforce, we want to have more graduate program-level professionals in that space as well. To get to that early childhood assessment, diagnosis, and treatment, you want to have graduate-level professionals.

The fourth recommendation is to streamline licensure and accountability processes for clinicians. I have worked with several of you. This is a common issue with the medical community in general, and I cannot figure this one out to be honest with you. I think it is critical the State jump into licensure, and how we do that, I do not know. I am going to defer to you because I do not understand what stops it. We need to get people licensed in an appropriate time frame because the barriers to licensure stop them from wanting to come to Nevada. I am not sure how we do that.

Number five is to bring reimbursement rates to the national average. You have a cadre of supporters in the mental health community who want to work with you on that. If we need to identify certain codes that make it more financially feasible, that is appropriate, but we should take some step forward so we can get children into care.

Recommendation six is to reduce reimbursement barriers for providers who support Medicaid clients. This relates to that study of why we see so many people leaving or not signing up for Medicaid in general. I know the cost question comes up all the time, but understanding what prevents them from signing up for Medicaid is the first question I would ask.

Number seven is early assessment intervention for specific child mental health diagnosis, and that is a bit more complicated. It gets into the graduate professionals that we have within the space. Chair, you asked me for a specific dollar figure, and that is with DHHS right now. It is well within the means of the State of Nevada outside of your General Fund. I think it is within specialty funds, and it is not reoccurring funds that are the issue; it is setting up a system that is the issue. So if this is appealing to you, I strongly encourage you to continue to work with this coalition of folks behind us. We would support the next steps. I am happy to answer any questions, and there are a bunch of professionals behind me. I am just a dad trying to make it easier for me to navigate a system for my kid.

Chair Doñate:

Are there any questions from Committee Members?

Assemblywoman Brown-May:

I appreciate the presentation and all of your hard work on these issues. My family also has diagnoses in their history, and I understand what it is like when your family is trying to address your needs and keep your family unit together and healthy. I appreciate your work on that behalf.

My question is relative to recommendation number two, the prevention-oriented B.A. and mental health training. I was recently at a conference where we talked about eliminating barriers to entry for some professional or bachelor-level positions. If I am 18 years old, and I go to college and decide that I want to study social services, but I do not know I want to pursue professional licensure because of the cost associated with a medical degree or licensure, and I end up on a path my counselor has given me as my preferred direction at that point, I take a number of classes and invest in my education and then decide that I see something important and want to go into mental health, but I have half a dozen or a dozen classes that now do not apply to this degree. I am curious to know, is there a way we can work through NSHE to help streamline preliminary work done by our students to help them move into this field when they discover it is their area of passion? How do we get psychology, sociology, and biology classes all applicable to this bachelor's degree program that would help a student move into mental health services when they discover that is what they want to do?

It is probably a question for more of those behind you. Given where we are in higher education and in NSHE, how do we help students navigate the list of classes they have when they declare a degree program, a major, and then pivot their major? How do we help them not waste dollars and get them where we need them to be in the end? It is kind of rhetorical, but I am going to throw it out there to the community behind you.

Councilman Knudsen:

I am always comfortable talking. Michelle Paul is the Vice president of the mental health programs at UNLV, and she is here if you want her to come up and speak, but UNLV expressed interest in developing this program. It is multi-department, so it is not only in the Education Department, but also Psychiatry, Social Work, and Public Health—multiple departments contributing to the curriculum and the development of an undergraduate program so students within any of those disciplines have access to courses that are multidisciplinary.

For me, one of the most exciting parts about talking about this, because it does not exist anywhere else in the country, is that UNR is interested in developing a micro-credential for all those teachers I mentioned who are leaving the classroom because they cannot figure out how to deal with quite difficult children, giving them a six- to nine-credit course to say, "Here are some skills on how you manage those children." Maybe that becomes part of an incentive through their hiring authority, whether it be CCSD, a private school, charter school, or a Boys and Girls Club employee, and they get six to nine college credit courses to teach them how to recognize a kid who is struggling and how to provide a Starburst as opposed to having a kid sit in the corner by themselves. There are lots of opportunities there, and it opens itself up to people who have thought about this field before.

Assemblywoman Brown-May:

I appreciate that. I look forward to continuing to work on that in particular, so we can help our students gain access to mental health as part of a B.A. program. It is important that we do that. Micro-credentialing is going to be a great way to go. I have a teacher who is 23 who minored in special education as a way to be able to supply some of those high behavioral support needs. Positive behavioral supports are a great way to go about serving our students.

On number four, I have to concur. We have talked a lot about streamlining the licensure, and I would be remiss if I did not put that publicly on the record. We continue to address that with all different types of licensure boards so we can get professionals into the field, so I appreciate your work there as well. I will follow up with you in great detail.

Senator Nguyen:

I see that these are listed one through seven. Is this a priority list of one through seven, or is there anything I should take away from this numbering?

Councilman Knudsen:

My recommendation is that all of them start a system. Administrator Weeks mentioned multiple versions of these priorities within her presentation. This provides you a game plan as to bill draft requests (BDRs), and I think any one of them is worthwhile, and if you are only able to get two or three, that is great. If you can get all seven, it becomes the beginning of an actual children's health system.

Assemblyman Nguyen:

I am echoing what Senator Nguyen asked in terms of a list of priorities and trying to figure out how we can deliver a wholesome situation. As we try to solve problems, we do not want to create new ones. One of the things I have always been a broken record about during my time here in the Legislature is ensuring we take ten steps forward but not take a few steps

back because we have to do certain things looking into the cultural competency piece as Nevada is becoming more diverse, and there are a lot of layers of diversity in communities that make Nevada home. I represent a diverse district in District 8, and I want to make sure we have priorities here addressing language and cultural barriers. What are your thoughts on your end on how we can accomplish that with all these priorities in mind?

Councilman Knudsen:

That is an excellent question. With support from the CAA, when I brought together anybody involved in children's mental health, it was a broad range of people who came forward. What was interesting is that for leaders yourselves—as you try to build consensus amongst the Committee or the Legislature, it is hard to build consensus. These priorities were not hard to build. Everyone was consistent in their thinking, which is nice. It makes it easy as an elected official if you can build consistency.

One of the things that came up and I mentioned earlier—there is not a connection point for these groups of professionals; they are not meeting to confer upon what is best for children. They have individual online trainings, or they can go out of State for trainings. I think the best way to build cultural competency is to ingrain it in the education system so that as we develop undergraduate or graduate students, we are incorporating that training and awareness about what our community looks, speaks, and feels like. You have to incorporate that into education and training, and that can only happen in a higher education setting, as we recommend in this set of recommendations. It is important to continually bring people back for continuing education, so they understand the changing landscape. I think the best way to identify and bring about resolution is to incorporate that within the University.

Chair Doñate:

Do you, have any questions, Senator Titus?

Senator Titus:

No, but I want to thank the Councilman for a thorough and thoughtful presentation, and I concur about the need for especially the reduction in obstruction to licensure and streamlining that, and I would like to see perhaps one mental health licensure where everybody goes. Thank you for bringing this up.

Chair Doñate:

I would agree. In some of these, we have heard similar themes. For instance, when talking about licensure, we started off our hearings earlier in the year talking about licensure and health care, and in Administrator Weeks' presentation earlier about fee-for-service, traditionally, health care has always been fragmented. We refer the problem to someone else to take care of. We need to focus more on having a centralized system that sets goals and parameters and then empower our physicians and local practitioners to deliver care. I think that is what you are alluding to with the Office of Children's Mental Health and so forth. We all greatly appreciate your service and your personal experiences, and I think we all look forward as we explore what potential BDRs we can introduce.

Councilman Knudsen:

I have one last comment to put on the record because I know you asked for dollar figures. Having worked around education and children for so many years now, for children who struggle, who miss more than ten days of school in a school year, they are considered

chronically absent. They struggle to learn how to read, and this is true in kindergarten through third grade. If you do not learn how to read by the time you are in third grade, you are 80 percent less likely to graduate from high school. Having personal experience with the Boys and Girls Clubs, what you see is children who cannot read end up dropping out of school around eighth grade. Those are the children we are seeing in the University Medical Center of Southern Nevada emergency rooms (ERs) and jails struggling with the criminal justice system. That is far more expensive than what we are proposing here. I have dollar figures outlined for each of these recommendations, and I will be happy to send those to the Committee, so you are familiar with what we are working on with DHHS. I appreciate your time and your investment in this conversation.

Chair Doñate:

Thank you so much, Councilman. We will now close this agenda item.

AGENDA ITEM VII—DISCUSSION OF BEHAVIORAL HEALTH CHALLENGES AMONG TRIBAL CHILDREN AND RECOMMENDATIONS FOR THE COMMITTEE

Chair Doñate:

We will move on to a discussion of the behavioral health challenges among tribal children and recommendations to the Committee.

Angie Wilson, Director, Tribal Health Center, Reno-Sparks Indian Colony:

I appreciate being welcomed back. It is a pleasure to be here today. I am here with Councilman Thomas from Duck Valley, who will be talking a bit about a situation in his community at the end of this presentation. I would like to first express my sincere gratitude for the invitation to return and discuss the behavioral health challenges for our tribal youth, an important issue for all our tribal nations. We are grateful to and proud of the Committee's inclusion of our tribal input and encourage you all to continue this incredible effort moving forward.

As you know, the Reno-Sparks Indian Colony has been attending the U.S. DHHS Region 9 Tribal Consultation meeting and immediately following that, the annual National Indian Health Board Tribal Health Conference, so we were unable to submit these documents to you ahead of time.

As detailed in my prior presentation to the Committee in February, it is the responsibility of the federal government to uphold its trust responsibility to our tribal nations, and as an American Indian, a health care advocate, and elected tribal leadership, we always have to keep that in the forefront when we are talking about the health and wellness of our Indian people.

As presented and in review, our American Indian and Alaska Native people face some of the greatest challenges to physical health, mental health and well-being of any ethnic or racial group in the United States, and although disparaging outcomes, our tribal communities continue to represent strength and resilience despite a history of genocide, cultural assault, and systemic oppression.

As an overview from the last time we spoke, according to the Office of Minority Health, in 2019, suicide was the second leading cause of death for American Indians and Alaska Natives between the ages of 10 and 34 years old. Our adolescent females aged 15 to

24 had a death rate that was five times higher than non-Hispanic whites, and our males 15 to 24 had a death rate that was twice that of non-Hispanic white males in the same age group. Our American Indian and Alaska Native people are 60 percent more likely to experience the feeling that everything is an effort all or most of the time as compared to non-Hispanic whites. Violent deaths, unintentional injuries, homicide, and suicide account for 75 percent of all mortality in the second decade of life for American Indians and Alaska Natives.

While we are here today to discuss the behavioral health challenges for our tribal youth, we must understand that this is not entirely possible without addressing the dynamics of tribal communities at large, and oftentimes, extenuating and intergenerational circumstances directly impact our youth. Issues such as domestic violence and alcohol and/or substance use can greatly contribute to the dynamics of a household, leaving significant gaps in the psychological needs, safety and security, love and belonging, self-esteem, and self-actualization of our tribal youth.

The numbers in the statistics you are hearing are our relatives, our loved ones, and our children, but it is important that you understand the behavioral health needs that ripple through our communities and the serious need to be appropriately and culturally responsive in serving our tribal communities. Today, what we talk about is not focusing on the symptoms—alcohol, drug abuse—but knowing that the hurt comes from historical, intergenerational trauma.

Today, I want to express my gratitude to the family of Amanda Davis for allowing me to tell her story in an effort to bring awareness that these are not numbers or statistics and that the true behavioral health interventions are much needed to bring change in our tribal communities. Just before Christmas, which is supposed to be a time of joy and celebration, Amanda, a beautiful mom of three children, is seven months pregnant. She has been in a longstanding domestic violence relationship, and as you know, it is difficult for many women in that case to leave domestic violence situations, but she had made her decision to leave the relationship earlier that day.

When the whole family went to sleep in the early morning of December 15, her 15-year-old daughter was awakened by her 8-year-old brother reporting to her that their mom was being stabbed by the boyfriend. The daughter immediately called 911. Amanda broke free and made it into the room with her children, all of them working hard to barricade the door with furniture. The perpetrator broke into the room and began to drag Amanda out of the room while all three of her children adamantly tried to fight him off of their mom. He continued to drag her into the bathroom where he repeatedly stabbed her. The children ran for help and the perpetrator fled the scene. While emergency services arrived trying to save her life, she and her unborn boy, Ezra, succumbed to their injuries. Amanda's mom and auntie arrived on the scene having to break the news to her children.

The impact of this incident is not a simple ripple; rather, it is a tsunami hitting the entire tribal community. For a moment, I would like the Committee to imagine the generational impact this situation right here will have. Imagine the impact to her children long-term, to her mother and her extended family, a significant range of feelings and the loss of their mom, their inability to help her in that moment they will never forget, of course the significant grief and loss, and then for the heartbreak and trauma of having to relive this horrible incident through the court hearing that happened this past September. If this was not hard enough, earlier this year, Amanda's mom lost her grandson in a traffic accident east of Reno.

I want to acknowledge their heartbreak and honor their resiliency to continue to hold on when I know that is pain that some of us cannot even imagine. I want you to consider Maslow's Hierarchy of Needs. How can we begin to consider the significant impact to this family, the children and the grandparent, to ever achieve self-actualization at the highest level of that scale? The importance of appropriate assistance and access to behavioral health services is paramount.

I am going to share some barriers to such care and make recommendations for assisting and resolving them. Stigma and shame associated with seeking behavioral health services is one of the most consistent barriers across our tribal communities. It always has been. Our American Indian people have described this stigma about seeking services and concerns that they look at it as being weak or, "Hey, you are crazy," or you get a lot of shame and how others will view you. Oftentimes our youth are told, "Hey, snap out of it," or You will grow out of it," or, "Stop crying around and man up," leaving tribal youth to feel isolated, alone, and unsupported or treated for behavioral health needs. Sometimes the interactions going on in the family unit make it hard because the family does not want their business to be out, so nobody can seek help.

Other barriers include concerns about maintaining privacy, and this is especially true in small tribal communities. Sometimes you may have family members working at the tribal health clinic or relatives or concerns that someone might see you while you are in the behavioral health services, and there is always fear that your confidentiality may be violated, so people do not access care.

Mistrust of providers can also present challenges for our youth to obtain services. Non-Indian clinicians sometimes may not understand the dynamics of multigenerational homes or common disparities within a tribal health setting, leaving youth to feel disconnected from their clinician or sometimes judged.

Transportation issues also cause barriers in obtaining care. In addition, parents are not able to leave work or afford to take time off due to rising costs, and this leads to the inability to access groups or individual therapy sessions. The Nevada tribes have been addressing concerns with non-emergency medical transport services, and we thank DHCFP for their assistance on this important matter.

There is a lack of tribal behavioral health workforce to keep up with the growing demands of our tribal communities. This includes challenges and recruitment, retention, salaries, et cetera. Health care workforce is the highest issue noted amongst all 12 regional areas of the Indian Health Services (IHS) spanning concerns of Indian health, tribal health, and urban Indian programs across the nation. It is the number one hot topic.

There is also a lack of non-tribal behavioral health providers willing to see children or youth at the local level. Many providers in the local areas are unwilling to provide care to youth, causing significant backlog in access to care for behavioral health needs.

Lack of Medicaid providers willing to take or see children and youth continues to be a growing concern. Medicaid coverage in tribal communities is high—we have a lot of folks on Medicaid—leaving many of our youth without a viable option to access care, and this is becoming a growing issue for our patient populations.

Lack of cultural competency can derail the trust of American Indian patients and impact the ability of our youth to see a pathway forward for cultural revitalization or cultural

connection. Cultural-based practices are significant in the healing of our American Indian youth, our families, and our communities at large.

I want to talk a moment about traditional views of mental health, healing, and wellness. When addressing the needs of mental health care in tribal communities, it is vital to understand their cultural views, traditional ways, and cultural practices related to healing and wellness. Our traditional beliefs and practices can include things like prayer, ceremony, storytelling, traditional medicine, and cultural practices to sustain balance and wellness. As evidence, there is a direct correlation between historical trauma and depression, anxiety, substance abuse, suicide, and chronic disease. As such, effective interventions for American Indians should always be focused on cultural-based practices at both the individual and the community level. This includes, but is not limited to, the revitalization of our languages, engagement with cultural practices, and reconnection to the land.

Western mental health care is different from traditional belief systems in a number of ways, and as I discussed in my last presentation to the Committee, the nine Oregon tribes developed a cultural-based practice document which the Oregon State Legislature adopted into the *Oregon Administrative Rules*, allowing for tribal health programs to utilize cultural-based practices equal to evidence-based practices.

The integration of traditional healing and Western mental health care emphasizes working together on culturally based programs, respect for each system of care, and the importance of communication between the two. This effort has led to tribal advocacy across the nation and proposed 1115 demonstration waivers in various states proposing Medicaid reimbursement for traditional healing. Utilizing cultural strengths to promote and sustain wellness for culturally informed mental health care for American Indians is paramount to the healing within our tribal communities.

Regarding recommendations for consideration, one is a Tribal Behavioral Health Aid Program. American Indians and Alaska Natives are overrepresented in statistics defining mental health disparities while at the same time underrepresented in the availability of mental health professionals. There is a pronounced need for American Indian and Alaska Native mental health providers and/or behavioral health aids.

The State of Alaska approved the Alaska Native Behavioral Health Aide Program, which promotes behavioral health and wellness in Alaska Native individuals, families, and communities through culturally relevant training and education for village-based counselors. A behavioral health aide is a village-based counselor, a health educator, or an advocate who is trained to work with community members to address behavioral health topics that affect individuals, families, or whole communities. Using a holistic approach to well-being, behavioral health assistants apply their knowledge, skills, and training to address the unique and social-cultural needs of our tribal communities. They support clients dealing with issues such as grief, depression, domestic violence, suicide, trauma, and substance abuse.

In addition, the scope of practice can include a wide range of services like wellness promotion, community education and prevention, case management and referrals, substance use assessments and treatment, recovery aftercare, teaching life skills and healthy coping strategies, and crisis management. They are employed by tribal health organizations and are a valuable part of the continuum of care for community members needing behavioral health resources and services. The behavioral health assistant is familiar with the local tribal culture and traditions and could provide services using a combination of traditional and Western models of care. They identify people early in their behavioral health struggles and provide direct services, so clients can receive care within their community and

with the support of their loved ones. If needed, they make referrals and coordinate services to higher levels of care in or outside of the tribal community. They also provide aftercare to ensure that clients have continued access to care when they return home.

Over the past decade, SAMHSA funded programs that have demonstrated the significant role native community mental health workers can provide in suicide prevention, which is detailed in the National Tribal Behavioral Health Agenda. As an example, American Indian community mental health workers have delivered a culturally adapted, evidence-based intervention to youth who have attempted suicide and for their family member support. Benefits of native community mental health workers leading this work included increased cultural awareness and understanding during the intervention as well as openness and comfort in meeting regarding the sensitive topic, thereby reducing stigma.

It would be a strong recommendation to consider this effort here in Nevada among the 28 tribal nations, as many of our tribal nations are located in frontier-based counties with little behavioral health resources. This particular program was also picked up by the Northwest Portland Area Indian Health Board, who provides the certification for behavioral health assistance to the Oregon, Washington, and Idaho tribes.

Another recommendation would be to support the adoption of cultural-based practices. While we look at developing the cultural-based practices manual, it is important to consider potential adoption of this effort through our legislation here. It is imperative that the State recognize cultural-based practices as acceptable measures in the effect of prevention, intervention, and treatment modalities within our tribal communities.

In addition, as tribes continue to move toward CMS consideration of traditional medicine or traditional healing reimbursement allowances on a national level, the concept of mental illness and traditional beliefs have different meanings and interpretations within our tribal communities. Our American Indian people may express emotional distress in ways that are not consistent with standard diagnosis categories. Our Indian people with anxiety, depression, or other disorders will often seek help from traditional healers as their primary choice before reaching out to mental health services. Ceremonial practices may result in the connection with the unseen world, not necessarily what would be considered hallucination or mental illness.

Another recommendation would be child-focused mental health graduate programs. We support the need for additional graduate training programs focused on child mental health, including internships and postdoctoral fellowships. This effort would allow the increase of behavioral health with knowledge and understanding of children, adolescents, and transitional-aged youth at risk for behavioral health disorders. In addition, it would allow further collaboration between our tribes and UNR or UNLV and our tribal clinics for fellowship opportunities.

Another would be to reduce Medicaid barriers—and this is a big one—to reduce administrative barriers and reimbursement disparities for Medicaid providers serving the behavioral health needs of our youth. While the Reno-Sparks Tribal Health Center is a Tribal Medicaid Federally Qualified Health Center, it will take time for us to negotiate potential written care coordination agreements and negotiated rates with Medicaid providers. It is imperative that Nevada youth are not held in the administrative crosshairs in accessing necessary support for their behavioral health needs.

In addition, it is important to always remember that American Indian and Alaska Native Medicaid beneficiaries are 100 percent Federal Medical Assistance Percentage to the State, and that is a big reminder on the cost of care as a pass through.

I want to make one more comment before I turn it over to Councilman Thomas. Earlier during the presentation by Ms. Weeks, there was discussion in regard to the managed care organizations, or fee-for-service, and I will tell you there are significant issues when it comes to managed care organizations and the tribal programs. Here in this State, we have two counties that are mandated to manage care: Clark County and Washoe County. The Reno-Sparks Indian Colony's Tribal Health Center is directly impacted by this.

I sit on the National CMS Tribal Technical Advisory Group representing the Nevada, Arizona, and Utah tribes, and I can assure you that across Indian country and this nation, managed care organizations with Medicaid have been a significant barrier for tribal programs, so much so that we have had to develop a subcommittee to address how to educate people and build a tool kit for the provisions of American Indians and Alaska Natives so we do not get people caught in the crosshairs of not understanding the provisions of what tribal clinics are allowed to do and access to care for our Medicaid beneficiaries.

I hope that while we are talking about fee-for-service, it directly impacts the Reno-Sparks Indian Colony, and I would venture to say that when managed care is rolled out for the rest of this State, we will start to see those issues in tribal communities across the State as well. We will do our best to continue to educate our other tribal programs and support the managed care organizations, but I will tell you it is a heavy lift for the tribal health programs.

I do believe that Nevada is a great State, and we have been very innovative on a multitude of things. Even though we hear there are opportunities for fraud, there has to be a better design to reduce administrative barriers for access to behavioral health services, especially for youth needing those services, and I believe wholeheartedly that we have smart folks here in the State who can address those particular needs.

Brian Thomas, Councilman, Shoshone-Paiute Tribal Business Council, Duck Valley Indian Reservation:

I want to start out with a big thank you to DHHS for being there in 2020 when we had a line of six suicides within five months. They showed up on Christmas Eve, and they spent the weekend there, and that was touching to the community, the people who went and visited them because of the six losses. There were a lot of children who were part of that loss of their parents and some young children in suicide.

I also want to inform you that we had success with the Idaho Army National Guard, bringing them out there during our time of need for emergency medical technicians and health care providers as well as our BIA (Bureau of Indian Affairs, U.S. Department of the Interior) police to help talk with them about suicide, how they have managed, and share their thoughts with them. That helped the community out a lot, especially the emergency medical services (EMS), and it impacted my brother.

In closing, I am going to tell you the story about how it impacted my family, but going back to the children being discussed today, our children go to school, tell the teachers of abuse, and if a child at a young age tells the teacher that there is abuse within their family or they are being abused, it must be addressed to the next level. However, that is not happening. This came from a grandparent who called me. I was not with the Business Council or

anything. He asked me, "How could I approach this? How could I do this? How could I make it better for myself and my grandchild?" and I could really answer him. I found out today that school teachers are to report each and every single one of them. Also, there is a lot of favoritism going on in schools, and you could help us fix at the State level favoritism and bullying from teachers. There are a lot of complicated emotions that are bringing with this into the school system where children are not wanting to go to school, not wanting to learn, having a hard time understanding, paying attention, and staying awake in school because of the hard times they are getting at home.

That is what I wanted to tell you about that was brought to me by a family member. The empathy of seeing that with the close connections with family members, it is very heartbreaking emotionally to myself or to the people who have given me a call to discuss issues with me, especially the surviving family members, the grandparents who take care of their grandchildren. Today, they have a hardship, they have enough to what they have to do to provide them to survive, but they are crying out for help, and the State could help through the school system.

There are a lot of children who have lost loved ones, and we can never understand why the individual took his own life knowing that he or she has children. There is always a question that comes from the child who does not understand death, when their uncle or auntie is going to come back who is gone for two years. They still ask that question. It is hard [inaudible] people's emotions, the children. You see it when the elders come to visit you. There are a lot of Native American elder survivors who have seen many before in the past years, and it is not hard for them to accept that the State could help.

I cry to you for help. It is emotionally tough for me because I am a parent of a suicide, possibly a homicide. I never will never understand it. It is a cold case. Before I say any further, always tell your children, your grandchildren, your mothers, your daughters that you love them. No matter how hard it is going through this tough love today with all the drugs and alcohol abuse, tell them you love them, because there is going to be a time where I wish I traded all my tomorrows for one more yesterday to say I love you because a person that you love might be gone. Always tell them that you love them. You do not want to say I will tell you that tomorrow; tomorrow will be too late. I should have done that yesterday.

To the elders, two heartbeats, I want to talk about is a carrier of life. The mothers who are so closely connected to their children and the story she told. They are so close, they carried them for nine months. Losing a child is one of the worst things to hear, a federal police officer knocking at your door to tell you, "I have some bad news." We have news that your son, your daughter, your grandchild has committed suicide. How do you take it? It is going to break you down no matter how strong you think you are. You are no Superman when it comes to death. Going back to the mothers with a close connection, every single mother has the closest connection to their child, carrying them for nine months and delivering them to give life. It is not easy.

A death by suicide could be prevented by bullying and favoritism. When you get news like that, it changes every parent, brother, or sister's life. It will change your life and impact you immediately. How do you tell? Or who do I turn to? I am the oldest one in my family. I lost a son to possibly suicide or homicide. Mother's gone. Dad's gone. Who do I turn to? Nobody. My aunts were there. I called my aunt I was the closest to, and I told her, and she said be there, stay there, be strong. I will find a way down, and I am going to go see your boys and girls. So she shows up.

This is one of the toughest subjects to talk about. There is nothing harder than to tell a story of a suicide or death of a family member. This time will never—the seconds go by so fast. A two-mile drive to the place of where a suicide or homicide happened felt like 200 miles following the federal officer and seeing the people there at two seconds, minutes. The days, weeks, months, and years go by so fast and everything. After four years, it is still fresh in your mind. It is hard. It is so complicated in life, but listening to us and the State of Nevada, helping us, and supporting any further assistance and financially, we would very much appreciate it in any way you can help because this is a true story. Always tell your children, your mom, your dad that you love them.

Chair Doñate:

Thank you so much, Councilman. We greatly appreciate your remarks. Committee Members, are there any questions?

Senator Titus:

First, you touched all of us, and thank you for sharing personal stories. I know it is hard, and as you said, four years ago, it still lives in front of you. Having done hundreds of hours in the ER in rural Nevada with native populations, I have had to deliver news of young folks who I could not save in the ER to family members and felt sick with them with that delivery of news. Although I have not had a loved one commit suicide, and hopefully, I do not have to experience that, I have had to deliver that to families. Having that emotional component and sharing that, my hope is that we can deliver positive changes because delivering change will be the key so we can limit the families in the future who have to experience this.

Going back to your comment about the cultural-based reimbursement, that is a possibility that other states have entered into. What does that resource look like as far as, did they get National Provider Identifier (NPI) numbers, which is a protect practitioner numbers? Did they bill to get reimbursement for Medicaid for those interventions? Do they have the resources to do that? I would like to see more information regarding that and deal with some numbers because it seems like that is a good avenue and is making a difference. How do we make that happen in the real sense?

Ms. Wilson:

There have been years of tribal advocacy for recognizing that in our tribal communities, health and wellness does not start and end with Western medicine, although we respect it. I run the largest tribal health clinic in the State and all those priorities of primary health care are important, but in our tribal communities, there is also traditional medicine. As far back as I could remember, there has always been advocacy to recognize traditional medicine.

There has been a large push in tribal communities across the board in working with CMS to look at the possibility of getting to a point where we can agree on traditional medicine and what that would look like. There is a White House task force working specifically with traditional healers across the nation in this conversation, and there are multiple states that have put in an 1115 Demonstration Waiver, but that has not been approved yet. Those issues are still under discussion with CMS at this point.

The reality is they are not in discussion to stop the discussion. It has been closer than ever to looking at pathways of what that would look like or be authorized under CMS, specifically for Medicaid reimbursement for traditional medicine. One of the big issues is how would tort

coverage come through that, so those are still things that are in discussion. It is a different concept to think outside of the mindset of what a regular provider with an NPI would look like tribal health facilities bill under the tribal clinics NPI, but it is getting the authority or the authorization and working closely with CMS on a national level to see what that will end up being. I am proud of the level of advocacy happening in that direction and I am hopeful that in my lifetime, we will see that come to fruition.

Senator Titus:

One of the things we in health care have looked at is that patients do best if they have a provider who looks like them or comes from the same background so they feel they can communicate. We have heard that conversation in multiple committees I sit on, and I am curious about the pipeline of native children in your schools. Is there any State people or anybody reaching out to you to encourage your children to go into STEM programs or health care science programs? Are we reaching out to those school children to become providers and physicians like myself. Do you see anything from the State? Is there anybody coming out to help with that pipeline, so we capture the brilliant students out there in your culture to become health care providers?

Ms. Wilson:

We work closely with Nevadaworks and Thurman Roberts, a tribal representative with Good Jobs Nevada and Nevadaworks and hosted one of the first events at our clinic to encourage youth to consider going into the health care field, especially with the tuition program that was passed here in this State, which is great to be able to start look at people getting into the field in any aspect, whether they want to be a doctor or for you, Assemblyman Gray, on the EMS side. It is needed across the spectrum of health care. Those are all things we are looking at encouraging. We had a greatly successful event starting those wheels turning.

One of the things I will be working on here in my advocacy in this State is to look at the Behavioral Health Aide Program because of what has been done in Alaska, the Northwest Portland Area Indian Health Board, and the tribes operating the Behavioral Health Aide Programs. These are folks who are from the community, go through training, go through that certification process, and work under a certain level provider but are out in the field with more immediate help right now, because we know that pipeline to get our kids through the system where they become providers takes time. That is what we are looking at doing. I am proud of the effort in working with our cohorts and collaborative networks in our community.

Senator Titus:

I am glad to hear that because I have had the privilege of working with Dr. Loren Simpson and Dr. Sharon Mallote, both Native Nevadans who I feel make a difference by being there, so thank you for that. It is good to know we are doing something positive.

Assemblyman Gray:

Dr. Titus took the question out of my mouth, so it is good that we are thinking along the same lines, but with that Behavioral Health Aide Program, that may be an opportunity to identify kids or members who have an interest would be a great feeder program into other aspects. There is nobody better culturally who will be able to understand you than your own people and be able to work with those issues. We can try, but we are never going to fully understand. I stand ready to help you guys any way I can to get those programs up and running and help you in that aspect.

Chair Doñate:

I was reading about how the Behavioral Health Aide Program grew from a statewide counselor in every village initiative and how now there are different levels of tertiary services: there is a training center, resources, an apprenticeship program, technical assistance for the tribal health organizations throughout the state, and then it goes into certification, as you mentioned in your presentation. For such a program to be established—say the Committee created a BDR to stand up this type of programming in this State—do you see that administered by DHHS, by NSHE, or by the tribal organizations itself? I know this is a continuation of the discussion we had back in February about the model we need to follow as a State to help empower our tribes but also set up your own streamlining autonomy to make sure we are delivering care. Is this a subset of that? What would be an ideal situation for how this Program is run and who is tasked with making sure the Program runs efficiently?

Ms. Wilson:

In all the cases that run the Behavioral Health Aide Programs and certifications, they are all tribal organizations, so the preference would be that certification would fall under the tribal sovereignty, but in collaboration with the State and ensuring that certification meets the threshold. I think it is one of the biggest programs that could have an immediate impact even in starting off the Program. There is a lot of great work happening out here in Indian country, and it is not necessarily us having to reinvent the wheel. There is remarkable work being done, and our colleagues at the Northwest Portland Area Indian Health Board or the Alaska Native [Tribal] Health Consortium would be more than happy to assist in getting us off the ground. That would be the preference.

Chair Doñate:

Thinking more short-term, refresh my memory: in your Tribal Health Center at the Reno-Sparks Indian Colony, I assume you are utilizing community health workers. I know that there has been national discussion of empowering Indigenous community health workers and looking at different reimbursement mechanisms for them. What have been the successes you have had with community health workers, challenges, and ideas with how to improve our current model?

Ms. Wilson:

We have seven community health workers in our clinic. These were existing staff, health educators, and personal trainers working closely doing health education discussions on healthy choices and physical activity. When the Community Health Worker Program came out, one of the challenges we felt it was up against is that historically, the Community Health Representative (CHR) Program under IHS is one of the longest-running programs of IHS from 1969. A lot of folks in our tribal clinics throughout the nation have been trained by IHS and have gotten their certification as a CHR. When the Community Health Worker Program was established in the State, it was something we were already doing, but it was not recognized under the State, and we had to look for funding, and some of our tribes did pull together the funds.

We hosted the training at the Reno-Sparks Tribal Health Center where folks from the State came out and did the certification training for a number of tribal CHRs so we can get to a point to get reimbursed for Medicaid encounters. Since then, the Reno-Sparks Tribal Health Center has implemented a diabetic day where we utilize our community health workers with that Program and assist people in learning how to make healthier choices in regards to

physical activity and talk about their pathways or challenges for motivation in that particular area. So far, things have gone well.

The one challenge we are up against is one of our own, and that is we have an electronic health record system and building a customized template they can document that encounter for those billable encounters, so we can make sure we are doing everything we need to do to be compliant on our end. But for the most part, the Community Health Worker Program has been a success, and we are happy to be a part of it at this point.

Chair Doñate:

It is important that we hear those concerns. In the last two sessions that I have served, we have always looked at community health workers, and it was an idea that I was looking at in terms of how we bill for those workers and the level of services that we are expecting from them. Especially in an Indian colony where you are in farther areas, it is hard to staff when you are only being allowed to bill for a certain amount of increment. You need to be incentivized to actually go out there in certain parts of the State where oftentimes the community health worker is going to be the only provider folks get. I am open to revisiting that for you, but I know we have to focus on a greater infrastructure. That is an area that could be more short-term if we learn how to tighten it up a bit. I appreciate your comments and the Councilman for being here, and we look forward to working together before the BDR deadline in August.

Ms. Wilson:

Thank you to the entire Committee for the invite to come back. The Reno-Sparks Indian Colony's Tribal Health Program won a national award for their advocacy and for the work happening at the local level, and that was due in part to being able to present to you all the first time. I genuinely appreciate the opportunity to come back and have a tribal voice at this juncture, and I applaud the Committee for this effort. I will come back any time I am asked to have any discussion on tribal health issues or impacts to our tribal communities.

Chair Doñate:

Thank you so much, Ms. Wilson. If we end up going to Carson City anytime soon this year, I would love to do a tour of your facility, and I am sure other legislators would love to be a part of it.

AGENDA ITEM VIII—PRESENTATIONS ON CHILDREN'S MENTAL HEALTH SERVICES ACROSS NEVADA, GAPS AND CHALLENGES IN THE SYSTEM, AND RECOMMENDATIONS FOR THE COMMITTEE

Chair Doñate:

We will move on to presentations on children's mental health services across Nevada, gaps and challenges in the system, and recommendations for the Committee.

A. DCFS, DHHS

Marla McDade Williams, Administrator, DCFS, DHHS:

Today we are here to give an overview of children's mental health services provided by DCFS as well as a discussion of challenges with children's mental health in Nevada. We have a number of services at DCFS. We are a provider of services, and our role is to fill gaps in

the community, so we are not out here to replace any services provided in the community. We are a provider, and as such, we also submit to Medicaid for reimbursement where we have clients who are Medicaid eligible, but Medicaid is the payer of services. (Agenda Item VIII A-1) (Agenda Item VIII A-2)

We fill gaps as it relates to children's mental health services, so we offer a number of services for children and families ages 0 to 17 depending on their needs. We recently stood up a latency day treatment program that is fully operational in Las Vegas in response to gaps we identified that are needed in the community. We offer mobile crisis response as well as wraparound in Nevada, a program that is sustained statewide.

We also have inpatient facilities. We manage a State-licensed psychiatric hospital for children up to 17 years old. We have a State-licensed psychiatric residential treatment facility in Northern Nevada, and over the summer, we also contracted out to a private vendor who is operating in a DCFS building as a residential treatment facility to provide services previously provided by State staff as Oasis. That facility sits in our facility and bills Medicaid and private vendors as needed.

We have funded an intermediate care facility and leased a building to Clark County for boys with significant needs related to developmental disabilities, and it is a six-bed residential setting. We have a current proposal to renovate a building on the West Charleston campus that may be used for girls with developmental disabilities, also a six-bed residential facility, potentially double occupancy depending on the acuity level of the potential residents.

Through the American Rescue Plan Act (ARPA) funding, we funded Connect Nevada, care coordination provided by Magellan to support children and families who are at risk for out-of-home placements or other family disruption, and that includes peer support services, and again, ARPA funding allowed us to stand up the latency day treatment program.

In terms of challenges and gaps, we are a safety net provider, and like everybody else, there is a lack of access due to providers not enrolled in Medicaid. Youth are coming in with very complex behavioral, developmental, and psychiatric needs. Juvenile justice-involved youth with behavioral, developmental, and psychiatric needs are very difficult for us to maintain in our juvenile justice facilities, and there is a lack of third-party entities to manage facilities such as Enterprise here in Northern Nevada, which right now is also a facility that is vacant. We had contracted that out, but we are going to have to go back to the drawing board on that particular issue.

I will say anecdotally, and it did not come up in the earlier presentation, but there are vacant wings of children's psychiatric facilities in Nevada, not necessarily because of reimbursement rates, but because the cost of doing business is so high. After the pandemic, costs for nurses' salaries increased significantly, and it is making a challenge for everybody, the private sector as well as us, to maintain nurses and have staffing in all our facilities. Desert Willow has significant vacancies, and in our non-residential programs, we also have significant vacancies. In terms of step-down facilities as part of a system of care, we could have more QRTPs, intermediate care facilities, partial hospitalization programs, intensive outpatient programs. Some of the services being stood up by Medicaid will hopefully help these issues, but we are all facing the same challenges throughout the system. I am happy to answer any questions.

Chair Doñate:

Committee Members, do we have any questions?

Assemblywoman Brown-May:

You talked about the proposal to renovate a building on the West Charleston campus that may be used for girls with developmental disabilities as a six-bed residential setting. I am curious, is that State operated, or would that be county or potentially a private provider?

Ms. McDade Williams:

The plan is that through ARPA funding, we will do renovations to the building. Right now, it is serving as an office building. We will renovate it back to being the residential facility and then issue a contract to see if we can get a private provider to come in and meet that need.

Assemblywoman Brown-May:

Thank you for that clarification. Do we have any intermediate care providers currently providing that service in Nevada, or is that an area where we need to grow?

Ms. McDade Williams:

I was afraid you were going to ask me that question. I am aware of a provider who would bid for that particular service, but as far as the broader spectrum, not under my purview. We are responding to a need for the foster care and juvenile justice systems and needs we have identified for youth coming through there, and that is why we are moving in this direction with this particular facility.

Administrator Weeks has worked very closely with us as we identify issues, and one we identified, for example, is that we have youth coming into our facilities, but they also need Applied Behavior Analysis (ABA) treatment, and because an inpatient residential facility cannot bill twice for an ABA service as well as the residential service, Administrator Weeks has worked with us, and ABA services will be allowed to be provided at the same time. We will bring them in on contract, but whatever their identified need is, they will be able to get that service in addition to the residential treatment at the same time billed separately. Dr. Wade will have more details about that if you want to know more, but I am excited about that and appreciative of having Administrator Weeks available to help us problem solve and navigate through things we are finding we need in our communities.

Chair Doñate:

Are there any other questions for Committee Members on this presentation?

Senator Titus:

I have a question on page 6, number two on staffing: when you say the private sector has closed wings and facilities due to the cost of doing business, what do you mean by that? They are not getting reimbursed for the cost of doing business, so it does not pay them to stay open. Explain that to me. I know we are understaffed at your Department. Perhaps the State is understaffed for supervision, review, and accountability, but I am wondering if the private sector is closing facilities because they cannot get reimbursed.

Ms. McDade Williams:

Anecdotally, we have heard they cannot hire nurses because of the cost of hiring nurses, so they cannot manage their staffing either and make it profitable or even break even. That is what I have heard anecdotally. Private sector facilities in the State are a completely

different issue, but with the complex needs we are facing with some kids, they will not accept kids with very complex needs, so even if they accept the reimbursement level, they will not accept those kids. We end up looking out of State for those youth, and if that facility will not accept Medicaid, then we are doing single case agreements with them. You heard Administrator Weeks talk about that earlier, that the costs of those single case agreements are not coming in anywhere close to what Medicaid reimbursement is going to be.

These are very difficult decisions, and at some time at some point are very expensive to provide care as a safety net provider. I cannot take everybody in Desert Willow. I cannot take everybody in all of our facilities due to the comprehensive nature of their behaviors, so we must figure out other solutions to how we distribute the care of these youth, so we are not overburdening one provider more than another. Those are real issues for us all to deal with.

Senator Titus:

I appreciate that as a medical director for a long-term care hospital. We cannot accept all the patients Medicaid would want us to accept because we cannot do the services required. I understand that from a behavioral health issue for children, even though questions earlier were asked about why these facilities are not accepting these kids. Even if we could do 80 percent of it legally, from a health care standpoint, if we do not have the services required, we cannot take them, whether they are young or old. I think a lot of folks do not understand that the services are not available there, so thank you for making that clear.

Chair Doñate:

Let us move on to our next presentation from Clark County, and then we will have Washoe County as well.

B. Clark County

Jill Marano, Director, Clark County Department of Family Services (DFS):

I have a quick presentation to give you a bit of information about what we are experiencing here in Clark County within the child welfare system. For your information, this is taken from the SAMHSA continuum for mental health care, and when we talk about the continuum from least restrictive to most restrictive mental health care, this is the continuum we are looking at. (Agenda Item VIII B)

We have identified three areas where there are significant gaps: intensive in-home services, early screening and services, and community-based residential treatment. Some of this has been spoken about earlier today. One of the things I wanted to highlight is the number of children who have been relinquished to Clark County Child Welfare solely for the reason of needing access to mental or behavioral health services, not due to any abuse or neglect. We have seen a bit of a decrease in this last year, so that is good news.

One of the priorities we thought this Committee might be interested in considering is the need for data. This has been talked about at the Nevada Children's Commission. When we are trying to develop or build services, how much of what we need often becomes a topic of conversation, so the Nevada Children's Commission has identified three overarching areas where we need more data to understand the availability in the community and the need for services [the number of children utilizing services, current and projected provider capacity, and high needs groups].

As we shift into the foster care continuum, you can see it is set up like the mental health services continuum. For Clark County, we have Child Haven, our emergency shelter where children often start out their foster care stay, then our ideal placement of relative and fictive kin to our most restrictive placement in a psychiatric hospital. What we see as the unmet need, and one of the things I want to highlight here is that we are not looking at huge numbers like QRTPs where we are looking at an unmet need of probably 40 beds. For psychiatric residential treatment facilities and psychiatric hospitals, it is 20 and 10 beds, respectively. If you look at what the actual need is, it seems to be a solvable problem because it is not like we need hundreds or thousands of these beds and resources.

When we do not have access to those kinds of resources, what we are seeing is a lot more kids sitting in Child Haven with significant behavioral and mental health needs. In the last couple years, we have had to enhance our mental and behavioral health services at Child Haven, and as we have increased our number of child well-being visits and added clinical staff to our emergency shelter, our direct admissions to acute hospitals went down by 53 percent. We are encouraged, and this shows that those early interventions and community-based services work to keep kids out of the end of the system. We have seen that in a microcosm in Child Haven alone.

Regarding referrals and resources that we provide specifically to children in Child Haven, but also to all kids in foster care in Clark County, I wanted to highlight the 518 children referred to Healthy Minds for outpatient therapy because what is different about Healthy Minds compared to other outpatient providers is that we have a contract with them. We pay them in addition to what they are getting from Medicaid, and that additional funding is necessary for kids in foster care because they do that care coordination referenced earlier in the day.

Examples of things Healthy Minds does that a regular outpatient therapy provider is not funded to do are things like come to court and talk about the child's needs, prepare specific reports for court, or even participate in child and family teams to negotiate the bigger number of adults involved in a child's life when they are in foster care. All of that ends up costing a provider more. It is hard for us to find services specifically in the community that can meet the bigger need when you are working with aunts, biological parents, caseworkers, children's attorneys, independent living workers, uncles, and all those other people that are involved in a child's life.

I mentioned the QRTP earlier. We believe this is a needed solution to one of our problems. It is an intermediate, community-based, and what we would have historically thought of as more of a group home model for children with behavioral mental health concerns. We are trying to keep them out of more restrictive hospitals and in more of a community-based setting. The federal government has identified guidelines and criteria around QRTPs. We have developed two in Clark County thus far, but they do not have a sustainable funding mechanism at this point.

On the higher end of the spectrum, I wanted to highlight our numbers and where we are with placing children in psychiatric residential treatment facilities or psychiatric hospitals, which are the highest level of care. Some of our numbers have decreased over the years. I do not know that that is necessarily a good thing. I think one could look at the numbers and say that is great, they are being treated in the community, but the alternative is that they are not getting treatment at all. They are sitting in detention or Child Haven.

I did a bit of digging this morning, and we have identified seven children between Child Haven and Clark County Detention sitting in those two facilities because we do not have a residential treatment facility for them right now. The number is small, which means

it is solvable. It is not that there is not a problem, but I think there is a way to get to this solution. Sometimes when we see our kids sitting in care—specifically, the reasons they are not approved for placement in the current facilities tends to be aggressive behavior or developmental delays and developmental needs. When we look at those additional 10 to 20 beds that we need in each of these levels of care, we are looking at specialized beds that can handle children who are aggressive and those who are maybe lower functioning on their intelligence quotient (IQ) or have other developmental delays.

As far as our policy recommendations, it is not a new one, but to recruit and develop the mental health workforce is definitely a need. I do not need to talk more about that today. We wanted to highlight a couple of statutes as something to consider. In NRS Chapter 433B, the statutes that cover children's mental health, it is very permissive in nature who is providing services and what services must be provided, so potentially clarification around that would resolve some of this ambiguity and the time children end up spending in Child Haven or detention because we are waiting to resolve whose responsibility it is to meet the needs of the child.

The same thing goes for NRS Chapter 62, the juvenile justice statutes, because when children are committed to the State, they are committed for the purposes of placement, whether or not they go correctional or mental health, and making that decision can create some delays. We see children sitting in detention for longer periods of time while that decision is made. With that, I can take any questions.

Chair Doñate:

With the last two policy recommendations, specifically Chapters 433B or 62, do you know which section specifically you are referring to? That would be helpful for context for us.

Ms. Marano:

I can provide that later. I do not have it written out right now.

Chair Doñate:

But there are sections you would like for us to review specifically that you have already outlined within your team internally, correct?

Ms. Marano:

Yes, that is correct. We know exactly where they are.

Chair Doñate:

Committee Members, are there any questions?

Assemblyman Nguyen:

I want to touch on the timeline. On the slide, it says federal standards. It says, "after care support for six months," and then I noticed that there is 90 days language around there. What happens after that time frame? Are there Nevada standards we follow, or is it like, "Ok, good luck," after six months?

Ms. Marano:

At this point, there are no standards specific to Nevada for continued services. These are the requirements from the federal government if we want to seek Title IV-E reimbursement, which is a child welfare funding reimbursement, so this is as far as they have gone, and we have not developed anything further in Nevada.

Assemblyman Nguyen:

What happens to families after that six months where you give them family support care? What do they do after that?

Ms. Marano:

We do not have any families at that point yet because this is so new, but ideally, they would be going to an outpatient provider who would be assessing with them what is required or needed after those six months. If they are covered by insurance, they would be able to pick it up if it is an insurance-approved service, but as of right now, this is the service that is required to be provided through the IV-E funding or the funding the QRTP is providing.

Assemblyman Nguyen:

Are any of your policy recommendations linking to the time frame it requires for us? You are saying there is some ambiguity in terms of the length of time and how to truly clarify some of these questions. Do you think that has anything to do with your policy recommendation as well?

Ms. Marano:

We have not previously considered that, but I do think that those make good sense.

Assemblyman Nguyen:

I would love to hear your thoughts on that as we go along because I think it does matter. If we have all these temporary time frames, but these things are not temporary. They are going to be with these children for a long time, and we do not want to not clarify it all the way.

Assemblywoman Brown-May:

I have one clarifying question. You talked about clinical child well-being visits, and those are up 279 percent. First, congratulations. That is good work, but I am curious to know, is that specific to the kids at Child Haven? Do you go out once a child has been reunited with family or placed in foster care? How does that visit continue, or does it end?

Ms. Marano:

These numbers solely apply to Child Haven. We have made new structural changes within Family Services, so new that I do not have any data yet in this presentation, and we have now reassigned mental health counselors to each of our geographic zones, so they have children they are specifically assigned to manage mental health services for. We hope that helps do those things you referenced, but right now, it is not routinely happening because they are getting their mental health services from whatever outpatient provider they are going to.

Senator Nguyen:

I am looking at NRS 433B, and you are talking about permissive or ambiguity. Are you referencing the fact that right now as it currently stands, Clark County and Washoe County are responsible for these child welfare needs, and are you suggesting that the State should be responsible for it? What are the specific suggestions you are making in this policy recommendation?

Ms. Marano:

This is related to provision of children's mental health services. There are lines in there such as. "The Division of Child and Family Services may provide services" or "they may provide a residential program," so our recommendation would be to clearly state they are the ones responsible for providing a residential program. This could potentially also fall in line with language like a "no eject, no reject," although I do not know that we would recommend being as declarative as "no eject, no reject" because we want to make sure children are in an appropriate placement.

In other states where we have seen similar language, the practice would be that if we refer a child to a residential treatment facility that should be able to meet the child's needs, but they say no, they are responsible to find a like setting for that child. That responsibility does not go back to the child welfare agency in this instance. That is an example of how we have seen other states manage that "no eject, no reject" language. We do not want children staying in placements inappropriately or where their needs are not getting met only because they cannot eject or reject the child, but we do want assistance in helping make a placement into an appropriate setting.

Senator Nguyen:

You mentioned that you have seven children right now, which is something that is solvable, but seven children are still too many. For those seven children who need highly specialized care they are not receiving because they are either in a detention facility or Child Haven, how long have they been in this limbo?

Ms. Marano:

I can get back to you with the exact length of stay for all of the children. Off the top of my head, I know one has been there a few days and another one has been there a matter of months. I do not know all of them off the top of my head, but I can get that for you.

Senator Nguyen:

My other question is in line with this "no eject, no reject" policy consideration. Arguably, it would be better for any one of these seven children to be in a facility, anywhere but Child Haven or a detention center. Is there something that prohibits other facilities from taking these kids, other than saying they cannot take care of them because their needs are too high? It is maybe not perfect, but it is way better than a detention center. We are treating children in the same way we already treat adults, which is unfortunate as well in our detention centers or in Child Haven. Is there something that prohibits Desert Willow or some other agency from taking these children?

Ms. Marano:

From our experience in Clark County, we hear there might be a waiting list. Maybe there is a milieu issue where they do not believe a child would fit in well with some of the other children in the facility. It may be that they do not feel the services could meet the child's needs. Maybe there is a need for ABA treatment and historically, we have not been able to access ABA when the child is in a residential treatment center. Ms. McDade Williams addressed that earlier. That is something we are working on a solution for right now, but those are the big things we hear as reasons for denial on the child welfare side. I do not know if the facilities might have additional information.

Senator Nguyen:

I do not know if Ms. McDade Williams is still available and may have answers to whether they are prohibited from taking these children while we are looking for a better scenario.

Ms. McDade Williams:

Right now, Desert Willow has a 90-day waiting list. We are full to capacity at this point. It is not that we are prohibited, but as Senator Titus talked about earlier, we must ensure we can provide safe and applicable services to the youth that we are taking. If I am working at a staffing vacancy, which right now is the issue in our detention facilities, we are performing significant overtime to maintain the youth we have. It is not that we do not want to take them, but our staffing capacity is our biggest limit. There is no prohibition.

I have one youth who came in at a 4 to 1 ratio and does not want to be anywhere, and we have gotten her down to a 1 to 1, but she has significant needs, and I get pressure to get her off the 1 to 1. I would love to get her off the 1 to 1, but doing so could mean that she ends up killing herself. These are not easy issues that any of us deal with at any given time. Those are the decisions that go into decisions for placement. I know people think they are arbitrary, but they are not.

I have Desert Willow. I have Psychiatric Residential Treatment Facilities (PRTF) North. We tried to contract out to another facility for Oasis, and I have one vacant residential treatment facility. If I had staff today, I would have people in there, but as the Legislature has already made decisions looking at our staffing, we will try to contract this out and see if we can be more successful that way. These are significant limitations for us. I cannot compete with the private sector in hiring, and I have already said the private sector has closed down beds. I am here for any solutions, but none of these are arbitrary decisions we are making on admittance for these youth, and courts get frustrated with us as well. We do our best, which is why we stood up ABA services in residential facilities trying to respond to that expectation in the community.

We used to have a juvenile sex offender program in Desert Willow because that was a need, and for whatever reason, the community decided they did not want to use those services in that facility anymore, so we no longer do that. I have had a thought running around in my head recently that if I make Desert Willow only open to youth through child welfare and juvenile justice, all the private sector providers whose insurance is inadequate to provide coverage out in the community will then be left without anybody to treat their needs. Medicaid is a payer in the system. We take significant Medicaid kids outside of child welfare and juvenile justice. If I limit all of my admittance only to child welfare and juvenile justice, then where do those Medicaid kids go? These are real issues, and I look forward to continued discussion and trying to figure out how we resolve all those issues.

Senator Nguyen:

Obviously, we have difficulties on all ends and all areas within the system, but I have to believe there must be something that is better than a detention center or Child Haven. How many of these kids end up in ERs or hospitals? We know the employees at Child Haven are not trained to deal with these types of medical and complex cases.

Senator Titus:

I recognize and understand your limitations, and it is all about staffing, and the one on one is huge. In my own facility, if I accept a patient who is somewhat disruptive, escaped, confused, or combative, that requires one on one when we have limited staffing, and that is to the detriment of the rest of the patients. It is not that simple that you find a bed. We have the bed. Yes, there is an empty bed, but there is not the personnel, and it puts other people in increased risk. I cannot emphasize enough how important it is that you hold steady. It is easy to be pressured, "Take these folks because they should not be in jail." But the reality is you have to also take care of the people you have already accepted there and the risk for everybody. It is not that easy, unfortunately.

I will take the State off the hot seat for a second. Back to Clark County with this presentation. They talk about policy recommendations—because we are trying to find solutions. The Chair of this Committee has made it very clear we want to come up with possible BDRs—true solutions we can offer. One of the recommendations is address the length of time required for professional licensure. Is there any particular licensure group or subgroup you have identified? I hear anecdotally from medical doctors and how long it takes and sometimes nursing. It is a big broad paintbrush there about professional licensure because we have a lot of health care licensures in our State. Are there any particular groups of licensure you have identified that are delayed, more than anything else?

Ms. Marano:

Yes. When we wrote that, we were specifically referencing concerns we have seen internally with our licensed clinical social workers and our licensed marriage and family therapists and the amount of time it takes for them to get their clinical hours so they can get their licenses.

Senator Titus:

Are you aware of any State compacts regarding those two particular licensures we could address to help with that?

Ms. Marano:

We did not look at anything other states are doing, but when we were reviewing the statutes, the restrictions around how the hours can be earned to get your clinical hours seems to be a barrier. I would be happy to provide more detail regarding specific changes we would like to see that could be helpful in that area.

Senator Titus:

That is excellent. We would love to see that. As we start looking at these BDRs, I think that is the kind of thing we can get concrete changes in. If there is simple stuff like hours or something we can do to address this, that is what we need to hear. I am looking forward to that information.

Chair Doñate:

Any other questions? I want to take this moment to digest the content of these presentations so far. I already asked about the two policy recommendations of pointing out the NRS. Correct me if I am wrong. My understanding of your policy recommendations is right now, there is a debate between what is the State's role versus the County's role in facilitating these services? Is that a correct assessment?

Ms. Marano:

Yes.

Chair Doñate:

I do not want to get you in trouble. If the County was being directly funded to take on these services, would you be okay with taking them on? That is the first question. Or do you still feel there should be a differentiation between the State's responsibility versus a County's responsibility, and we need to draw the line? Is the County in a position to take on moving that line, as long as they are receiving the funding for it? Is that what is ideal? Or we, as policymakers, need to define what is the red line that divides the State versus the County?

Ms. Marano:

We have had internal conversations around what it would it look like. I do not know that we have enough details for me to be able to definitively say what the County's position is today; but I think more conversation would help us get there, if we understood more about what it looked like.

Chair Doñate:

Ms. Marla McDade Williams, in terms of your colleagues from other states, how is that relationship administered? Is it a fine line, or is it the State is responsible for administration, and the localities are entrusted to deliver on those services? I know oftentimes in the realm of HHS, for example, Clark and Washoe Counties do one thing and then because the rurals are not set up to succeed, the State takes on that responsibility. We also have to take on the responsibility of administration of everything overarching. I would love to hear your feedback as to what best practices are. Does this need to be reformed? What is your input from what you have seen so far?

Ms. McDade Williams:

I do not have any knowledge base to talk about what other states are doing with respect to this right now. With child welfare, which I think is what leads Clark County into making these recommendations, we are a bifurcated system. In that transfer of child welfare services, the child welfare agency is expected to provide a certain level of services. They get compensated from the Medicaid program to do case management to manage the kids they have in their child welfare system. From my perspective, that includes finding facilities that meet the needs of kids in child welfare. When it comes specifically to the mental health side, the State of Nevada, through DHHS, has multiple agencies that are designed to try and meet the gaps in services—to be that safety net provider. Medicaid is the payer of services. All kids in child welfare are eligible for Medicaid. As that payer of services, as Administrator Weeks noted, they have the responsibility to maintain the network; so, DHHS through DHCFP is the entity that takes on that responsibility to maintain that provider network. Charging DCFS to stand up facilities because there are not enough providers to

participate in the system is a policy decision that is laid out before you. To charge DCFS with ensuring that we stand up all the needed mental health services facilities in the State means we have to consider how to ensure we can properly pay all the staff that are needed for these services.

Chair Doñate:

Thank you. I think that was a great clarification to try to figure out what needs to be done to take the next steps forward. In your presentation with Child Haven, you talked about conducting well-being visits. What are the early intervention efforts you feel the County does right, and where can we improve to prevent kids from even heading to Child Haven?

Ms. Marano:

I think the areas where we have seen the biggest improvements are the areas where we have a strong collaboration. One of them I would like to highlight is with ADSD's Nevada Early Intervention. They have staff that come to Child Haven on a weekly basis to meet the children that are there, to identify the services they may need, and help get them set up for assessments. We are seeing children who are on that intellectual developmental delay—maybe autism spectrum—those kids are getting identified earlier. I think if we could figure out how to make that happen before Child Welfare gets involved, that would be ideal. Some of the things we have talked about in various work groups or other areas are things like getting more involved with community-based services. Maybe when a child has a first episode psychosis, and they are in an acute hospital, making sure they are discharging with access to outpatient services and mental health services, that there is some sort of care coordination as a child leaves there, prior to any system involvement. The schools, of course, are a great place to identify children. But getting into the schools in a way that would maybe identify more children earlier has been a challenge. On the mental health side of the house, it is about identifying those children when they are starting to show some sort of behavioral, mental health, or developmental need; as opposed to when we see them, it is typically because a parent has said, "I cannot do this anymore. I have been trying to figure it out for three years, and I am done." At that point, it is hard for us to be able to keep the child in the home. It is better if we can get them earlier. I think seeing them in the hospitals and in the schools is really the place where you are typically going to see kids early.

Chair Doñate:

Thank you so much. Let us go to Washoe County's presentation, and then we can continue asking questions for all the presenters. Please begin when you are ready.

Ms. McDade Williams:

Mr. Chair, if I could follow up on what Ms. Marano said. As it relates to the schools, we are working with NDE right now. You may be aware that their Elementary and Secondary School Emergency Relief (ESSER) funding is expiring for the behavioral health providers they have in schools, so we are working directly with them right now to figure out how we can meet those needs in schools directly through DCFS. Also, maybe we can transfer some of the vacant positions we have to the schools because they actually have mental health providers there. I do not have mental health providers; so, if I can make them fit, then maybe we can meet their needs there as well.

With the care coordination, that is one of the reasons we stood up Connect Nevada through Magellan is to try to intervene with families prior to them disrupting. One of our key partners in this effort is the DFS in Clark County. If we can get them connected to

Connect Nevada, and they are providing intensive behavioral health services to families, then hopefully we can keep them from coming in the system. That is the entire goal of that whole project.

C. Washoe County

Ryan Gustafson, Director, Washoe County Human Services Agency (HSA):

Good afternoon. I have the unique opportunity to go last, so I will try to be succinct and not duplicative. I can say a strong ditto to everything Ms. Marano said, on a smaller scale in Washoe County, but we see very similar challenges to what they have. There were a couple comments about the difficulty in navigating the mental and behavioral health service system, and I cannot iterate how true that is. I myself am a clinician, and I can barely navigate the mental health system. I will have to go onto the Facebook Therapist Group to find the correct provider for a correct need, and that is an unfortunate situation we are facing. (Agenda Item VIII C)

In Washoe County specifically, to have a robust mental health service system, you have to have a very solid continuum of care. When you start to see gaps in that continuum of mental health care, then you start to see the dominoes falling in one direction or the other as far as where the service needs are. What I mean by a good continuum of care is—obviously what we would like to do is to keep children in the least restrictive setting possible. If they can be in their home with their family and go to see a counselor once a week, that is fantastic. The next level up from that might be intensive outpatient, where you are doing a few hours a day, a couple of days a week. The next level up from that would be a day treatment program or partial hospitalization program. From there, you could be looking at a community-based group home with specialized services. From there, you could be looking at a residential program. From there, you could be looking at an acute treatment option. We are missing a good amount of those levels in Washoe County, and across the State, quite honestly. We have to lean on each other quite a bit to try to fill those gaps. I think we were moving in a pretty good direction pre-COVID. I think post-COVID, we have gone in the wrong direction. We have lost services and opportunities, and perhaps most importantly, we have lost timeliness to services.

What we did in Washoe County—and I will preface saying I have a unique perspective because I worked for DCFS Children's Mental Health for 14 years before I came to Washoe County HSA where I have been for the last 7 years. I got to do the mental health side with DCFS in the State and now the child welfare side. I can say that those two—which you will see because we have a second set of presentations—it is really hard to untie child welfare and mental health. For better or for worse, they tend to go hand in hand, and there are a lot of mental health needs when you start talking about child welfare.

Several years ago in Washoe County, we did a little bit of a reorganization. We had a small clinical team with it baked into child welfare in Washoe County, and that was intentional because we could not get services in a timely manner and there was not a robust enough service array, so we had clinicians plugged in doing a variety of different things. We shifted that in 2017 to be a little bit more front end—more crisis management—where we saw the kids, got the assessments done quickly, and then did a warm handoff to a longer-term provider.

We got 373 referrals last year. Those are mostly kids from within Child Welfare, but that is not 100 percent the case. There is federal legislation from 2018 called the Family First Prevention Services Act (FFPSA) that Ms. Marano also referred to, which is trying to get

services in the community in front of child welfare, where you can get services before you have to touch our systems. There was not a great way to plug that in, so a lot of the resources were given to Child Welfare to try to stand up these programs. That has come with a number of challenges, but within child welfare and without—our Agency, we will see several hundred kids a year, where we will either take referrals, do assessments, or we will do interventions.

I had referenced the specialized group homes earlier. This is one of the biggest issues we have, and you will hear it again in my next presentation. What has happened is because we have a gap in this continuum of care—it will come as no surprise to anybody at this point that one of our acute hospitals is closed. That has had a significant impact where kids are staying in inappropriate placements at times, or they are going into ERs—which is also an inappropriate placement because when you are in a hospital ER versus in an acute psychiatric facility, you are in a bed versus in a treatment milieu, where you are seeing a psychiatrist, you are going to group, you are talking to a therapist. You do not get that when you are in a medical hospital because of an acute mental health concern. So, it is keeping kids in incorrect placements.

We have 90 kids now in our specialized foster homes. Those are foster homes where the providers have specialized training and skills to be able to work with these children on basic and rehabilitative skills. They know they have a lot of mental health needs, so they get them to their appointments, and they understand those needs, and they get compensated more for operating those homes. I wanted to make sure this Committee was aware that we constantly sit between 95 and 100 percent full. Oftentimes, we do not have a single specialized bed within Washoe County—we are at 510,000 people now, and we are often at zero beds.

Kids will sit in our shelter. Kids Kottage is the Washoe County version of Child Haven, which was discussed today. We are operating at 100 percent capacity. In fact, there are three buildings on the campus—two of them are operated by Kids Kottage, and we have had to overflow where HSA staff are providing assistance because we are right at capacity—we will be at 30 kids, and then new kids will need to be placed into the shelter. We do our very best to keep kids out of sitting in offices or in motels with staff and other very inappropriate placements. I know both DCFS and DFS have faced that challenge as well. That shelter is operating now at 100 percent capacity, and over half of the kids there have pretty significant behavioral and mental health needs. Many of them are at commitment-level needs—for that you will have to go to the court, talk to the judge, and then you can get a child committed to a residential treatment program. Many of the children have reached that threshold of need, but we do not have the facilities in the State. You heard DCFS say they are operating on a 90-day waitlist. We see significant waitlists across programs.

Current upcoming initiatives—some of these can be challenges; some of them can be potential solutions as well. I had referenced FFPSA implementation—this is very difficult. The idea was to keep kids out of the child welfare system. It is very difficult because it is very data intensive. This was legislation in 2018. We got our plan approved a year ago in the State, and that was a combined effort between DCFS, Washoe County, and Clark County. It is mandatory to do evidence-based practices, which is a good thing. The difficulty is if you are doing something that is anything less than evidence-based—it could be a well-supported practice or a promising practice; I am talking about generally clinical interventions for kids—you have to do a very robust evaluation plan, which needs to also be approved by the federal government. That comes with challenges because if I am a clinician in the community, and I can provide a service and not have to collect data and get the same amount of money versus doing a service and collecting data—I will probably take the

path of least resistance. As you heard, there are a lot more cash payers now, as far as providers. There are less Medicaid providers, and I know Ms. Weeks with Medicaid is working on that; but it has certainly created a challenge.

The West Hills project is a big initiative. As this Committee may know, Washoe County purchased this building. We are getting started on some of the renovative work. The plan is to use about two-thirds of that facility specific to children, pediatrics, and adolescents. When this facility closed in December 2001, it left no pediatric acute mental health beds. There is another hospital in town that has some beds, but they do not serve pediatrics at the moment, and they have not for a while. That certainly creates challenges where, unfortunately, you will have children under 12 winding up in hospitals, or they will wind up in other inappropriate settings. Getting this facility back online is a big initiative. We feel it is going to be important, not only for Washoe County, but for the State as a whole.

We have started the process of the Mobile Crisis Response Team, which has been operating since 2014 or 2015 in the north and the south. We are partnering with DCFS right now to explore our options to shift that to a County-operated program. We are right in the front-end discussions and planning phases of that, and it should provide some much-needed support as well.

When it comes to challenges, I had referenced a lack of a continuum of services. I mentioned a lack of Medicaid providers and a lack of community-based treatments as well. You heard there are challenges with rates that Ms. Weeks is working on. Another challenge we have is the reimbursement model with [Title] IV-E. When the FFPSA was put into place, there are rule sets that went into play along with that. For example, one is if a child is in congregate care for more than two weeks, you do not get IV-E reimbursement for beyond those two weeks. That was to "incentivize" agencies to get kids out of congregate care. That was planned pre-COVID. Then with the post-COVID challenges, the rule sets have stayed the same, and we see children sitting in our shelters much longer than we did, and there is no IV-E reimbursement, which ends up ultimately hurting the children when it comes to getting services in place. You heard Ms. Marano talk about lengths of time of children in their shelter. We have had children in our emergency shelter for going on a year. Most of them are in and out fairly quickly, but we have some very long stays because of their complex behavioral needs. It is hard to get approvals to get them into an appropriate setting, so they end up sitting in shelters and other places. With that, I will answer any questions the Committee has. Thank you.

Chair Doñate:

Thank you so much. Committee Members, any questions? I do not see any in the south. Senator Titus, do you have any questions?

Senator Titus:

I received and I think all Members of this Body received an important or concerning email regarding the Mobile Crisis Response Team this morning. I am not sure you need to address all of that, but I do have concerns about staffing, monitoring—and I understand it always comes down to staffing. I felt I needed to address that.

Ms. McDade Williams:

In this process, I think when we started, we had 14 staff, and we are down to 10. Part of the process requires us to issue a layoff notice to someone. Washoe County has been very

generous in the package they are offering for staff to transfer to Washoe County to do the exact same function they were doing with us. It is a phenomenal package, and there is no detriment to staff if they choose to move over to Washoe County. If they choose not to move over to Washoe County, we have positions identified at DCFS that they are able to step into. Mr. Gustafson worked in that program prior to going over to Washoe County. They have an extensive transition plan they have outlined. They have talked to community stakeholders. It is understandable—this is a change, and change is always hard. I think there was an allegation that staff are being forced to sign resignation notices. They are not being forced to do so. If they choose to go to Washoe County, the process is for them to submit a resignation, so we can ensure we have the paperwork in place to make a smooth transition for them. Nobody is being forced to do anything. Washoe County has a very generous package and is working with anybody who has questions. They have answered all the questions they can answer, and it is an individual decision at this point for staff.

Mr. Gustafson:

Thank you. Yes, I was fortunate enough to be at the State when we started Mobile Crisis. I started it in Washoe County, alongside Clark County and Ann Polakowski—who was starting it down there. It was an exciting time to be able to start a new program, and we had tremendous success right off the get go. We had done work with Michelle Sandoval and the rural team to make sure that was being pushed out to the rurals as well, which we fully intend to do. I think one of the advantages—besides the fact that I love clinical work, and all of this is exciting for me and the team—is we have a robust clinical team at Washoe County. We have over two dozen clinical staff—between therapists, case workers, and leadership. Our vacancy rate is only 3 percent; we are 97 percent full. I think one of the big advantages is there will be opportunities to do a lot of cross training and cross work. As those teams come over, if they choose to, we can provide a ton of assistance with our clinical folks who are very excited to onboard them and do that mobile work and get out into the community. We do some of that now, especially at our shelter where our team is constantly going out into the shelter and pushing in; but they are very excited to partner with the folks who come over so we can continue to evolve and show success with that program. In particular, with the loss of a psychiatric hospital, it is very much needed. I know in the first three years while we were still doing it, we had an 86 percent hospital diversion rate where we were able to keep kids in their homes and safety plan with them. If we, as the team, can keep kids out of needing hospitalization, it minimizes our need for a facility that no longer exists.

Senator Titus:

Great, thank you for the clarification. I sit on the money committees, and I was impressed with Washoe County and West Hills taking over there. As a young resident in Reno and family practice, I did medical physicals at West Hills for their psychiatric units. I am hoping that progresses. How close are we to getting that online?

Mr. Gustafson:

It is going to take a while to get West Hills onboarded. I said this at the last IFC—I was a tech there back in 2000, so I got five years of adventures at West Hills. It is going to take us a while to get the renovative work done that we have already started. We are having a lot of meetings as far as what the structure, the licensure, and the renovation is going to look like. There is indeed a good amount of work to do. I would say it is probably going to take about 20 to 24 months before we are ready to open the doors. Obviously, as we go

through that process, we will start working on getting providers. We will start looking at proposals from potential providers.

Senator Titus:

Great, glad to hear that because, and hopefully I wanted to make sure you were anticipating the need for the providers even as you work on that building. So I want to commend Washoe County on that acquisition and that forward thinking. Thank you.

Ms. McDade Williams:

Mr. Chair, if I could offer an additional comment about the Mobile Crisis transfer. As you may know, Adult Mobile Crisis was transferred to Las Vegas Fire a number of years ago, and it has been a very successful transfer of that program. I have been with DCFS in this role since September. We began these discussions in December and when Washoe County expanded its services, it made sense for us to continue to build that capacity in that local community.

Chair Doñate:

Anyone else with any other questions? Seeing none, let us go close this agenda item.

AGENDA ITEM IX—PRESENTATIONS ON CHILD WELFARE SERVICES ACROSS NEVADA, GAPS AND CHALLENGES IN THE SYSTEM, AND RECOMMENDATIONS FOR THE COMMITTEE

Chair Doñate:

We are going to go on to the next one, which is a presentation on child and welfare services across Nevada, gaps and challenges in the system, and recommendations to the Committee. Same structure—I think it is the same presenters, but we will move first with the DCFS, followed by Clark County and Washoe County. Ms. McDade Williams, if you want to begin, let me know when you are ready.

A. DCFS

Ms. McDade Williams, Previously Identified:

We will do a brief overview, and then we will discuss challenges. Betsey Crumrine is our Acting Deputy Administrator over at Child Welfare Services, and she will join me in case there are questions I am not able to answer. As we discussed earlier, DCFS is responsible for child welfare services, including Child Protective Services (CPS), foster care, and adoption; and DCFS is the recipient of the federal Title IV-E matching funds from the Children's Bureau to manage these programs statewide. We have a bifurcated system with Clark and Washoe Counties managing their own child welfare systems, and then we manage in the 15 rural counties. The 15 counties pay a CPS assessment for the cost of providing CPS in their counties. (Agenda Item IX A)

It is a State-supervised, county-administered structure. We have State oversight for the county-administered, child protective and child welfare services and fiscal oversight for federal dollars and quality improvement activities. There is another allocation for projected caseload and adoption assistance. The legislative session authorizes funding based on the historical adoption growth.

We provide a continuum of services as child welfare agencies. The foundation for case planning is the assessment and comprehensive case management services that support the child, parents, and caregivers. As you have heard about the continuum—there are additional services to support the child and family, such as in-home counseling, early childhood services, and other outpatient [services]. There is a performance improvement plan the counties are by statute required to submit. There is information about those, and we approve them. I think counties have a perspective on that as well, but this is the overview of that.

We keep a significant amount of data on a data dashboard that is maintained by the Office of Analytics. It includes all of the child welfare numbers anybody could ever want, but if there is anything missing, we are always happy to figure out what we need to add to that dashboard.

Challenges—child welfare is a very difficult industry to be in. Child Protective Services—there are a lot of different expectations of what constitutes neglect or even abuse. As child welfare agencies, we work through that every day, all day long. It is a very significant challenge for all of us. There is a lack of foster homes, so if we remove a child from their home, we have to ensure we have homes to place them in. All of us, as agencies, struggle with that. Families are resource-poor—affordable housing is a real issue for families, as well as childcare access. You can name it whatever it is—if families are having struggles economically, it is going to translate to how they are able to care for their kids.

In our child welfare system, we have vacancies. We have staff who are still gaining experience. Those are additional challenges we work through. As Ms. Marano noted, if a family is having difficulty caring for a child with significant behavioral, developmental, and psychiatric needs, what do they do? "I cannot manage my child; I need somebody else to manage them," and they relinquish them to the State system. Then we are responsible for trying to figure out how to meet their needs. Ideally, we would be able to support families so that does not happen.

For us, in rural child welfare, we have a lack of legal representation. The Attorney General (AG)'s Office represents us as individuals, as an agency; but they do not represent the work we do on the ground as a child welfare agency. Our caseworkers go into court with no legal guidance most of the time. I get pulled into court—there is a subpoena, and the AG is going to represent me when I get pulled into court. But for every one of our child welfare cases, our caseworkers are out there on their own—in all the 15 rural counties—trying to manage these issues.

We talked about the lack of Medicaid providers. I have one dental case, I think in a family of eight, and there is no dental access. The school system sees that, and they call it neglect. All they need is access to a dentist, but there is no dentist in that rural area. We are trying to figure out how to get them access to a dentist, so we do not have to bring them into the system. How do we support these families? If you have four, five, six, seven, eight kids, these are very hard-to-manage situations.

There is a lack of domestic violence treatment services for batterers, particularly in rural Nevada. Lack of providers throughout the spectrum— fetal alcohol syndrome (FAS), autism evaluators and providers, substance abuse treatment, home health visiting nurses, and then there is our own staff who are suffering from secondary trauma in our workforce. It makes it very difficult for us to keep staff, and you get to a point where you do not want to do it anymore. If you are a social worker, you can go out and do some other social work. Those

are the big challenges we deal with in rural child welfare. I am happy to answer any questions.

Chair Doñate:

Thank you so much. Committee Members, any questions? Senator Nguyen.

Senator Nguyen:

If the other agencies might be able to pay attention to this because I am not sure who should answer it. This is what I alluded to before. I was curious about when foster kids are in the system, and they receive special benefits, like if they are eligible for Social Security Disability Insurance (SSDI), or they have a Social Security death benefit, or a Veterans Affairs (VA) benefit—who are those benefits paid to? Are they held in a special trust, like a minor's compromise, or are they saved, or are they deposited and spent on that child? Is there any kind of accounting of those resources, of those special additional funds? I am not sure who can answer that. I do not know if it is the State or—I will let you all jump in.

Ms. Marano:

If the Chair wants, I can take a stab at it from Clark County. Yes, to all the above, is the short answer to what you asked. I may need to get back to you with specifics on the difference. There is a difference between Supplemental Security Income (SSI) and the SSDI for the death benefits. We use a portion of it for the room and board rate that we use to pay foster parents, because that is going to the care of the child. There is a portion of it that is used for that in both instances. There is also a balance that is carried over, which is given to the child to use for whatever they want. There are limits on how much you can maintain as a balance, which creates challenges. I am in danger of not being accurate right now, so I might need to come back and correct this—but with the death benefits, you can have $2,000 as a balance all the time. We watch that and track the balances, and when the child's balance is starting to creep up, the Clark County DFS staff will reach out to a foster parent and say, "Does the child want to go buy something? You are you getting up to your benefits area." Then they can go buy things. There is a significant amount of management of all the different funds. There are different rules for each of them about how much of a balance can be maintained for each of the different types of insurances they are getting.

Senator Nguyen:

Is that set in State statute, or is that a federal guideline?

Ms. Marano:

I believe it is federal.

Vice Chair Orentlicher:

Thank you for the presentations and for working in this area. I know it is often difficult to find foster homes and adoptive homes. I have also heard concerns on the other side where people who seem to be well qualified to be an adoptive home find it is unduly burdensome to be approved. I wish I could remember details. I do not know whether it was a single parent—that single-parent household, or is that is an issue? Is that something that needs to be addressed to make sure when somebody does step up and really would provide a good

home that it does not take six months or a year? I know you want to screen carefully, but are we overdoing it?

Mr. Gustafson:

We, and I think all of the agencies have really tried to market or advertise that it does not matter if you are a single parent, it does not matter if you are married, it does not matter if you do not have kids or you do have kids—none of those things matter as far as what it takes to become a foster parent or potentially even an adoptive parent. You are not incorrect in that it is a timely process. Home studies need to be done, which feel a little bit invasive. That is the general feedback we get, because you have a home study expert who is coming in and asking you a lot of questions and looking at all the safety factors. Obviously, we need to ensure all the safety factors are in place, and those can vary based on the age and needs of the child. There is a pretty strict rule set. We have and are also continuously looking at what those expectations for licenses need to look like. Certainly, a lot of that was prompted by the exceptional needs in the rural areas, where the service array is hurting even more than in the urban areas. We are really trying to find ways to expedite the process and find opportunities to get homes licensed. We are looking at various factors to speed that process up, but it is hard to make that happen in a shorter time frame. It is a process that takes months, not weeks.

Chair Doñate:

Any questions specifically—I know we are still on the presentation from Ms. McDade Williams. Any other questions right now specifically for her before we move on? Senator Titus.

Senator Titus:

I would like to piggyback on what my fellow physician asked—that question regarding the training. Have you had a significant decline in the applications for foster homes in the last several years?

Mr. Gustafson:

It is one of my slides for Washoe County. I do not want to speak for the other two regions, but yes, post-COVID we have lost 53 percent of our foster homes.

Senator Titus:

I am also anxious to see what Washoe County has on your statistics. I have concerns regarding the mandatory trainings we have now put on these families and access to that, and I am wondering if they are online. Because that is one of the complaints I hear from folks. I certainly understand that you have to make sure it is a safe environment. You have to make sure the home is safe by getting somebody out there. It might be a staffing issue on your end—getting somebody to get into the home to make sure these kids are safe, and the background checks—all those mandatory things. The trainings required of these families, how accessible are those?

Ms. McDade Williams:

I will start, and then if Ms. Betsey Crumrine wants to offer anything. We have been looking at how to refine our processes for licensing to ensure it is not as much of a barrier to families coming in. We have done a lot of work; we had an analysis done that identified

system changes for our side in rural child welfare. We have been responsive to many of those changes, particularly with the training requirements. At one point, we offered trainings four times a year, and now I believe it is every month. We have made significant changes so we can ensure—and I will let Ms. Crumrine take credit for the licensing. Ms.Crumrine, if you want to talk about our numbers recently.

Betsey Crumrine, Acting Deputy Administrator, Child Welfare Services, DCFS:

I did not bring that data with me, but foster care licensing is heavily regulated, and we are constantly looking at our processes, at the regulations, and at what we can do to make it less cumbersome and to break down the barriers for people who want to become foster parents.

Senator Titus:

Thank you for that because I worry that you have regulated yourselves to death and now you have nobody that is going to go through that process to the detriment of our kids.

Ms. McDade Williams:

We also have made changes with relative licensing so that process is more streamlined. I want to say that last year we maybe licensed 18 homes and that right now to date we have licensed about 32; so, it is making significant changes for us in the rural areas.

Assemblywoman Brown-May:

Thank you. Following up on an earlier question with regard to benefits—payments benefits. Maybe a little bit of clarification—I know in the adult services realm, folks who are not able to manage their money independently have a representative payee that their checks or benefits go to that are then monitored, and there is a report that is put out. For youth who have benefits, who is the representative payee for a youth that would receive whether a death benefit, as you heard earlier, or Social Security in general. Who is that representative payee? Where does that money go? How is it accounted for?

Ms. Marano:

In Clark County, we become the payee. The money comes to us; we track it within our eligibility team. As I said, there is a little bit of a difference between the death benefits and the regular SSI. I would be happy to get the breakdown of how we manage each of those, but we do get the funding, and we primarily apply it to room and board. Something is a little bit different that I cannot remember right now, so I want to get back to you on the death benefits, because those are a little bit different. But we apply it to the room and board and then the extra is saved in a savings account for the child. There are limits on those savings accounts, and I would want to confirm exactly what those amounts are.

Assemblywoman Brown-May:

Thank you, Ms. Marano, for that explanation. Ms. McDade Williams, I am curious to know, is there anything different at a State level? Do we have representative payees at the State level to help administer those funds?

Ms. Crumrine:

Similar to Clark County, the State becomes the representative payee essentially because we are the custodian of the child. However, when the child turns 18, 19, or 20 and exits care, we have had to apply for representative payees for older youth who we felt like needed the support in managing the money—especially if they were going to be getting a large sum of money. Recently, the State has started to convert some of those trust savings accounts into something called an Achieving a Better Life Experience (ABLE) account, which allows us to accumulate more money in the account without having to spend it, so we can actually create a bigger savings account for kids when they exit care. Those spend down amounts do not apply if it is an ABLE account, so we have recently started to do that as well.

Assemblywoman Brown-May:

Thank you, I appreciate that. I am following up on the ABLE account. There are restrictions relative to what that money can be spent on, according to federal regulation. I am curious to know that you are doing that alongside the child and their resource group, so we are not making financial decisions as a State on behalf of the children who have been in the foster care system.

Ms. Crumrine:

Yes, we are well aware. There is a large book that educates you about what is acceptable and not acceptable to spend the money on. I am not the person creating the PO for the money, but I know fiscal is involved, and we are consulting with them before any expenses are paid.

Chair Doñate:

Thank you so much. Let us proceed with the presentation from Clark County.

B. Clark County

Ms. Marano, Previously Identified:

Ms. McDade Williams already covered the primary services that Child Welfare provides. In our presentation today, we are talking a lot about foster care. One of the things I want to highlight is our placement priorities and preferences. When we have to remove a child from their home, and they cannot be safely maintained, we always try to place with relatives and fictive kin as the first choice, regular family foster care or a specialized level of care if that does not work, then shelter care, primarily Child Haven in Clark County, if there are no other options. Adoption and reunification are the two primary ways children exit foster care. (Agenda Item IX B)

I wanted to show you the number of youth entering foster care each year. This is not the total number of children in care; it is the total number that have entered in that year. In 2023, Clark County had over 80 percent of all the children that entered foster care.

This is a quick data snapshot of highlights specifically for Clark County. We talked a little bit about licensed foster homes earlier—we have made a lot of efforts over the last year to increase our number of licensed foster homes. We have increased over 100 homes in about the last year between regular, relative, and specialized foster homes—we are very excited about that. A lot of that we did by streamlining our process. We realized doing everything sequentially was creating a lot of those months-long delays of licensure. First, you do your

background check, then your training, then your home study, then your home safety inspection—and it was taking a long time. We have contracted out our training, and now we are starting the home study and licensure process at the same time that people are starting their training, so we are able to get it done quicker. We have been able to significantly shorten the length of time for people to get licensed.

We also decreased our number of required classes from nine to seven. In those seven, we also include our cardiopulmonary resuscitation (CPR) and car seat training. Previously, those two classes were in addition to the nine required classes. We have clearly made efforts to shorten the training. As a note—because there was a conversation about doing things online—we were doing mostly online training during COVID-19. We maintained some of that once we came out of the COVID-19 restrictions, but what we found with our families that had gone through the online training is that they were much more likely to disrupt placements than people that were doing it in person. Therefore, we have gone back to primarily an in-person training. I think that engagement helps. One of the things that helps foster parents is when they are connected to other foster parents and have that community support, which they can develop when they are in-person in a cohort that is going through training together. They were not getting that when they were doing online [training], so that is why we made the decision to go back to in-person.

One of the policy recommendations we wanted to give to you was regarding the block grant and restructuring the current block grant that funds child welfare. As a very brief summary, typically, the counties are responsible for providing what we call the front-end services—the child protection/CPS work. Then the block grant should fund what we call the back-end services, which is the foster care and the permanency services. The block grant has had very limited growth because it is written in statute to be a static block grant. There has been very limited growth in the block grant, but yet we have seen a significant amount of growth of services that are required to be provided on the back end.

Here are examples of those areas that have been significant programmatic changes for our block grant services. Since the inception of the block grant, Clark County population in general has gone up 20 percent. We also have a new program, the Kinship Guardianship Assistance (KinGAP) program, which is a subsidy for families that do kinship guardianships. The thing that is significant about these is that if you finalize a guardianship on, say, a five-year-old, we are still paying that subsidy out of the block grant until they turn 18. This is a growing expense each month as more and more children's guardianships happen. It is creating a problem for our static block grant. The other thing is when children are adopted, the adoption subsidy is a separate line item in the State budget, and that is what pays for it, so we do not have a fiscal hit if a child goes to adoption. When they go through a guardianship though, those are often cases that did not go to adoption. While you see in some of these data points a decrease in our number of adoptions, there is not necessarily a decrease in our number of children achieving permanency because they are going through the guardianship process instead. Commercially Sexually Exploited Children (CSEC) is another new population we have begun serving. Then, of course, extended foster care, which is sometimes still referred to as the bill that established it in 2011—AB 350. We did not recognize the fiscal impact all these things were going to have when they were initially created.

Here is a little bit more information on the KinGAP and the monthly cost of KinGAP right now. It keeps increasing until a child turns 18, and then they fall off because the family is not getting that support anymore.

Here is additional information on CSEC. There are two pots of expenses here: (1) the staff to case manage the children or the youth; and (2) the payment for the placements. These placements—these are more high-intensive youth, and they often need a group home or residential level of care that is not a traditional foster home. Right now, we have two providers that are specifically providing services to victims of human trafficking.

The next slide is on extended foster care. We originally thought we would have around 80 youth a year that would be participating. We are finding more than 97 percent of all children that age out of foster care choose to participate; so, we have about 280 to 300 youth at any given time.

These are additional details about consequences of not changing the block grant. We continue to have additional financial deficits and are unable to provide many of the services we would like to. The other issue is the statewide oversight activities. On this slide are the different reports and plans we have to provide federally. There are probably four or five other areas of oversight we have that we thought of after we created the slide for the State. It becomes very labor and time intensive to try to manage all these plans, and you are constantly creating new improvement plans; and some of them, for example, the agency incentive application, is a one-year plan. It is very difficult to create meaningful change and be able to report on something that matters in a year's time, in an agency and in a system as big as this. Quite honestly, we have not seen the benefit of creating these plans and doing these activities. We have not necessarily seen that it has turned into better outcomes for kids and families; so, we think there could be an opportunity to condense this oversight into something that might be more meaningful—where we could actually see better outcomes for kids and families.

This policy recommendation—it feels a little counterintuitive for me to even be proposing it. As we have looked at the data and the research on educational neglect, the majority of states do not investigate educational neglect as a child welfare issue. The reason for not investigating it is because child welfare is typically charged with issues around child safety. While children not getting an education is of concern, it is typically not a safety concern. Truancy and chronic absenteeism are really significant problems, but investigating these cases as educational neglect is not giving us any improvements in addressing the concerns that are causing chronic absenteeism.

We have done research into what other states are doing in this area, and the states that are making progress with addressing chronic absenteeism are using a service approach by providing wraparound services to families. Mandatory meetings for families with the school help address the concerns regarding why the children are not going to school. They are moving away from more formal processes, like court systems, to help encourage families to make their children start attending school again. We had roughly 600 educational neglect referrals in Clark County last year. The number that resulted in a removal was zero, as you can tell from the chart. There were a few substantiations—most of them have been unsubstantiated or were not even investigated. In a system that is overtaxed and overburdened—where workers are getting sometimes two and three reports a day—getting an educational neglect report is adding to a workload that is, in our opinion, taking them away from being able to do the work they need to do. We believe there are other more appropriate solutions to addressing chronic absenteeism. We wanted to propose to the Committee that you consider removing educational neglect as something the child welfare agencies are required to investigate. On that point, it does not stop a school district from calling in or addressing other kinds of neglect—environmental neglect, emotional neglect—anything like that, we would still be investigating, but educational neglect with no other concerns seems more appropriately served in another system.

Our last policy recommendation is regarding adoption savings. Adoption savings was a federal law that passed a while ago. Essentially, what it did was create an opportunity for local child welfare agencies to receive more federal dollars for children who are on an adoption subsidy. The caveat to that funding is the savings that was created was supposed to be reinvested in the child welfare system. Due to issues with State law around the Appropriations Act, we are being required to revert that money back to the State General Fund. For Clark County, it amounts to around $2 million a year that is being reverted back to the State that could be more appropriately—and should be—invested in supporting adoptions. The relevancy to today is a lot of these children that are relinquished due to their behavioral health concerns are children that were adopted. Having this funding back in our budget would allow us to provide additional and ongoing support for families once they have adopted children. With that, I will take any questions.

Chair Doñate:

Thank you. Let us roll over to the Washoe County presentation, and then we can do questions from Committee Members for both sides.

C. Washoe County

Mr. Gustafson, Previously Identified:

This breaks down what we do at Washoe County HSA—we do more than children's services within HSA. This breaks down what it is that we do, which would fall in line with the other regions as well. (Agenda Item IX C)

Reports—to put it in context, and I know Ms. Marano gave the full statewide number to see the majority of the child welfare business definitely occurs in Clark County as far as the numbers go. In Washoe County, we have taken between 6,000 and 7,300 reports of child abuse or neglect in any given year over the last five years. It went down quite a bit last year, and we are getting close to the Fiscal Year (FY) 2023–2024 numbers, and it looks like we will be pretty close to the FY 2022–2023 numbers as well. Then you can see the rest of the information on those we go out on and those we put into our child welfare information system (CWIS) as information only, then our differential response team works with the rest.

Removals—we have decreased almost every year, with the exception of a little bit in 2020 and 2021. We have done a lot of work to decrease the removals. We understand removing a child is traumatic, not only for the child, but for the family. We have also been in the midst of a multiyear child and family services review, which is basically a federal review with a lot of goals—that is statewide, not only for Washoe County—a lot of goals to get services in line with federal expectations. We have also plugged in a lot of evidence-based clinical work that helps us with our goal of being able to do safety planning in the home, to be able to do work in the home and not have to get to removal. Those numbers have gone down; we are proud of that.

Foster care—this was a [data] snapshot from June 30, 2023. It is about a year old, but ironically, we are within five of that right now. I think this morning we were at 624 as far as the number of children in our legal custody in Washoe County. Seven years ago, that number was closer to 1,000. We have stayed in the 600 to 700 range in Washoe County for close to three years; that number has been pretty static.

This is regarding family foster licenses. I mentioned we lost 53 percent of our foster homes since COVID-19. This data shows the amount of issued licenses and closed licenses. In

2020, we started closing more than we were issuing. You can see how bad that got in 2022; we were only able to issue 42, and we closed down 80. That has been a trend. You can see in 2023 we are getting close to breaking even at this point, but we are still not there. We have done things—like you heard from Ms. Marano and from the State—for better or for worse, COVID-19 forced us to get technologically savvy. We started doing virtual training for folks; now we do some hybrid stuff. As we are learning what we can do virtually and what we should not do virtually, we are getting a little bit better at that. I think Ms. Marano was correct: when you do too much virtually, you start alienating families and they do not have that community there, it is much more likely to have placement disruptions. We are figuring out where we can do that and making the process smoother and where we should not do that.

We have 144 family foster homes in Washoe County, and 57 of those homes are "on hold." We have a number of licensed foster families who are not taking any kids, and there are a variety of reasons—we did workshops with families over the last couple of years, and a lot of it is tied to the challenges. The COVID-19 pandemic created a lot of challenges. As you could imagine when COVID-19 hit—why that impacted the system so much is because families were encouraged to stay with their primary family members, so bringing in a child from the outside was taboo based on what COVID-19 expectations were. That created additional challenges, and you had sibling groups that may not be in the same home that impacted visits. I think that was very hard on not only the kids and the biological families, but it was hard on the foster families as well. We have seen a number of families stay on hold for a while they are still—I know it is 2024 now, but some folks are catching up on life and not in a space where they are wanting to take kids. We are working on these 57 families to get them to reengage because they are technically licensed and have gone through that arduous licensing process, but they are sitting in a holding pattern not wanting to take any new children at this time.

Our Kids Kottage monthly population—the trendline does not look too impressive. It looks like it is slightly going up. If you look at FY 2020–2021, you can see how few kids we had in Kids Kottage. We were down to five to six kids at any given time in the shelter. In fact, that shelter at one point in time was licensed for 82 children, and we got that license down to 15. We were contemplating not needing to have that shelter because we were down to four to six kids at any given time. Our plan was to open up community-based emergency homes and close down the "congregate setting." Once COVID-19 hit and we started losing placements and foster homes, those numbers have spiked back up to more than they were in FY 2018–2019. The 2024 numbers are going to trend higher than the 2023 numbers, and we set our capacity at 30. We are working on a capacity increase, a license increase, to get us to 45 kids effective July 1st because we are constantly sitting at maximum capacity.

Quick numbers on adoptions—I think Ms. Marano made a very good point in that these numbers are not necessarily indicative of the number of children who have reached permanency because there are different options with kinship care—but we did see a huge drop off with COVID-19. We saw a lot of court closure or some sort of bottlenecking there, as we were navigating the pandemic.

Recent and upcoming service expansion—we have the CSEC program we are still working on in Washoe County. We expect the West Hills project is going to assist in those efforts and getting a receiving center stood up and then getting some aftercare and appropriate services for that. Extended foster care—we had the AB 350 program from 2011. Extended foster care is set to expand in 2025 potentially to all youth up to 21 years old. That is a significant project for all three regions. Because of extended foster care, we have

implemented LifeSet, which is an independent living skills program, the Sobriety Treatment and Recovery Teams (START) Model, and then the West Hills purchase I talked about.

Lastly, upcoming challenges: decrease in foster homes; increase in emergency care; and lack of services. Another thing I did not put on here, but I wanted to bring up is when you start to see bottlenecks in other service areas, you see how it impacts other areas that you may not have considered. My example is when you can count the number of foster beds that you have on one hand, what can happen in Washoe County is that it can take 40 minutes to drive from one side of the Valley to the other side. If I have a youth in foster care who is coming from Cold Springs, and the only foster home available is down in Galena, then I have to get that child, and we have to keep the child in their home school, which makes good sense because that may be the only normalcy that they have—the only constant they have is the school that they are going to. That creates additional burdens in getting children to their school and getting them to appointments. When you have a surplus of foster homes, you can place children in a home that is close in proximity to the home they came from. When you do not have those homes, you have to take what you can get, and oftentimes that requires significant transportation needs. We have onboarded additional staff to help with that, but it has created a challenge. Oone of the top three concerns from existing foster families was the need for assistance with transportation. With that, I will answer any questions.

Chair Doñate:

Thank you so much. Committee Members, any questions? Assemblywoman Brown-May.

Assemblywoman Brown-May:

This is probably for both counties. The Washoe County presentation noted the START Model. Do we have specialized support services for substance use disorder or recovery that we are able to deploy for our foster kids?

Mr. Gustafson:

We are getting started with this program. It is a peer support specialist model, which is a little bit tricky when it comes to youth. We understand the importance of recovery support specialists and peer-based support. We are working on that program, and we are getting our staff trained. We are getting there, but it has been a slow start. As we see that need increase in our youth—as we see the evolution of substance use and substance abuse in our communities and unfortunately, how that carries over to our younger crowd. We were trying to get in front of that by launching up this START Model, but we do not have a ton of data yet to show exactly how that is going to pan out. We are trying to be preventative in our planning.

Ms. Marano:

In Clark County, we do not have anything like that right now. Primarily, when we have youth in need of substance abuse treatment services, we are referring to our contracted mental health provider, Healthy Minds, who does have licensed alcohol and drug counselors.

Chair Doñate:

Great, thank you so much. Any other questions? Senator Titus.

Senator Titus:

I want to thank Washoe County for not revoking licenses because they have not been used, unlike ADSD, who have proposed to remove licenses if you do not use them in a year and recognizing these are resources you need to nurture and not to penalize. I would be curious to see how successful you are in regaining the confidence of those providers.

Chair Doñate:

Any other questions from Committee Members?

Assemblyman Gray:

This is for Washoe County. I want to go back to your slide on placements in Washoe County and how you said they have been stable over the past couple of years. It seems counterintuitive with the growth in population, how they went from a high, then dropped, and then have leveled off. What has changed? Are they either not being abused or not being placed? What is the difference there? Is it a business practice difference?

Mr. Gustafson:

Are you referring to slide number five regarding removals?

Assemblyman Gray:

Yes, I believe that was it.

Mr. Gustafson:

Honestly, this has been much more of a practice shift. I think what has happened over the course of years is—yes, it does look counterintuitive because we have seen a population increase and removals of children from their homes decrease. We are proud of being able to keep children in their homes. The kids we remove are kids who absolutely must be removed without significant intervention. I think that is where things have changed. We did not necessarily have the intervention models in place in years prior. Over the last few years, we have been able to implement a lot of evidence-based practices. Some of it was encouraged on us by the Feds through the FFPSA.

The goal is to bring in evidence-based practices. You push into homes in a much more meaningful and significant way. You meet families where they are at, and you do everything you can to keep children in their homes. Not that we did not always try to do that, but we also have a much more robust clinical team that can push into homes than we did in years past. We have greatly enhanced our training, not only to our clinical team, but to our child welfare—our primary workforce team. What you see here with this data is those efforts finally paying off for us.

Assemblyman Gray:

When you talk about paying off, have there been any negative outcomes? Have you had to go back and remove those kids at a later date? Have any of them been hurt, killed, or injured? I am going to be paying a lot of attention to this—not so much with Washoe County—but I do not know if you saw Joe Hart's report last week. We had a home in Lyon County with 42 complaints, and the excuse that came back was, "They are teenagers. They are not at risk." When you read those complaints and see the living

conditions, those kids should have been yanked the first time. I am not saying anything that has not been on the news. Now there are charges being filed with the District Attorney's Office, and I want to make sure those kids across the board are being taken care of. I want to make sure we are not leaving kids at home who should not be left there for any reason.

Mr. Gustafson:

I appreciate that concern, and yes, we track recidivism rates of kids. We have a CWIS where, when we put information in, once we get a follow-up report or a second follow-up report, we can look at past reports that have been entered into the system, and that helps our decision-making process. I will knock on wood that our child fatality numbers in Washoe County—we would like to get to zero—we are not at zero, but our numbers are pretty low. I cannot think off the top of my head of a specific time where, because we left a child in a home, that we have seen a fatality based on us trying to push services into the home. I cannot think of one of those, but I can certainly take a look at that.

There are instances where we remove kids and then return them home, and we have to re-remove kids; that does happen from time to time. There are times where we take a report and do an investigation, leave the child in the home, get another report, and then have to make another decision to remove that child. Those happen, and we certainly keep all that recidivism data and all that report data as well. We would never want to leave a child in their home in unsafe conditions, and there are variations on what safety looks like.

For example, if you have a 1-year-old who is crawling, the cleanliness of the home might be more impactful than a 17-year-old-who has a job and who is hopefully not crawling—they are walking around the home. We take all those considerations into account, but we would never want to leave a child if there is any imminent or impending safety or danger concerns in the home.

Assemblyman Gray:

With those numbers, because it seems like you are doing it, is there any chance we can get a report that says what you see and what the recidivism rates are? One more question along these lines: are there allegations, founded or unfounded, that you guys will absolutely remove kids from their home until it is hammered out?

Ms. McDade Williams:

I will let Mr. Gustafson and Ms. Marano respond to that last question if they choose. Going back to the issue you described, I mentioned our dashboard, which identifies screened-in and screened-out rates for all the jurisdictions. That includes the 15 rural counties, so you can go online and look at how many cases we investigated and how many we chose not to investigate based on the reports that came in. As Mr. Gustafson noted, all of these are case-by-case discussions.

I will give you my personal perspective. I grew up on a reservation. At any given time, something could happen in my family. I was a kid, and I would have had to trust that the people coming in and making decisions about whether or not to remove my brother and I from our families. Was it based on some other perspective they had about how we should be living, or was it based on them understanding our current environment and whether or not we are actually being taken care of because my parents messed up?

Every case worker we have is faced with that decision every day when they go into a home, and they are faced with making the decision to remove someone when that family does not believe they should have been removed. They are going to get every political person they can to tell everybody how badly we did our job because we removed someone. All these cases are confidential. There is never ever any intent to leave anybody in a dangerous home. We can second guess decisions like the cleanliness of a home. I am embarrassed to say this, but there was a time when I was so busy working, if you came into my home, it is like, "Is she is neglecting her daughter as well?" because I was working 16-hour days. Every one of these decisions is hard for every case worker we have when they go into any home, and again, they are confidential.

I can tell you that the 44 allegations are not correct, but we can talk about that offline. State law requires all reporting of children's deaths, and if there is a death related to a child welfare agency, there is a required investigation of that death. I see all those numbers every day, and they are very small, almost negligible, the number of kids where a situation has resulted in death because a child welfare agency did not do the job they were expected to do. We have all that information, and it is available. We have child death review teams that go through all that information in terms of aggregate numbers, so that is all available.

Chair Doñate:

Are there any further questions from Committee Members at this time? Seeing none, I will close this item. I appreciate all the folks from the different localities and jurisdictions for presenting. I know it is a difficult subject to review this, but it was important for us to understand the similar themes and differences we are seeing, at least for policy considerations.

AGENDA ITEM X—STATUTORILY REQUIRED UPDATE ON THE IMPLEMENTATION OF ASSEMBLY BILL 7 (2023)—ADOPTION OF FRAMEWORK AND REGULATIONS FOR THE INTEROPERABILITY OF HEALTH INFORMATION

Chair Doñate:

We will move on to the next agenda item. This is the last one before we go on to the general review of recommendations submitted to the Committee.

Malinda Southard, D.C., C.P.M., Deputy Administrator, DHCFP, DHHS:

Before I begin the update on regulation development in regard to AB 7 (2023), I would like to acknowledge the Chair for his leadership and hard work on this bill, which revises provisions relating to electronic health records (EHRs). One of the provisions of the bill required DHHS to establish an advisory group and develop regulations pertaining to EHRs. I have included an excerpt from the bill in Section 2.7, subsection 8, noting the responsibility of the advisory group as well as NRS 439.589 directing the adoption of regulations to prescribe standards relating to electronic health records, health-related information, and health information exchanges for reference. (Agenda Item X)

In response to the bill, DHCFP stood up the Electronic Health Information Advisory Group, which includes a total of 20 voting members all appointed by the DHHS Director. Out of the ten categories listed in the bill for voting member representation, the Advisory Group has only one vacant category: representatives of social service agencies. The Advisory Group also includes eight ex-officio members. The Advisory Group has only held a total of

three meetings to date. The originally scheduled June 6 meeting was forced to be rescheduled to June 17 due to a discrepancy in the agenda. The primary output of the Advisory Group at this time will be one set of draft regulations speaking to the requirements as outlined in AB 7 in advisement to the DHHS Director.

Regarding the progress to date in developing and implementing the regulations, due to the Division's workload and responsibility for implementing over 50 bills passed this last session, the Electronic Health Information Advisory Group did not have its first meeting until March of this year. However, the group has been on a good path forward since then, beginning with an introduction to Open Meeting Law, the Nevada regulations development process, and the statutory charge of this Advisory Group during that inaugural meeting.

Next, the Advisory Group met in April to have its first discussion on proposed draft regulatory language. This first draft of proposed language presented to the Advisory Group was developed out of the requirements that were outlined in the bill as well as some proposed language from Advisory Group voting members and in consultation with the National Coordinator for Health Information Technology. The Group had some good discussions on the initial draft, making adjustments and voicing considerations along the way. The draft regulatory language was revised again based upon the discussions during that April meeting to be presented as draft two to the members during the May meeting for further discussion and revision.

Lastly, at the June meeting, the intent is for this Advisory Group to have a final discussion on the proposed draft regulatory language before the deadline to submit the draft to LCB by June 30, 2024, to initiate the permanent regulations process. With the upcoming scheduled meeting of the Advisory Group on June 17th, we do not foresee any potential challenges with meeting this deadline to submit the draft language to the LCB.

I wanted to give an overview of the proposed timeline once DHHS submits the draft regulations, also known as the agency draft, to the LCB. Once the LCB receives the agency draft, they will assign that R-number that will be used to track the regulations through the development process.

In July, DHCFP will be conducting a survey of impact on small business. As a side note, AB 7 appropriated State General Funds to be used for awarding grants to providers of health care and medical facilities for the purposes of complying with the requirements set forth in the bill and subsequent regulations.

In May, DHCFP launched a short online survey to all providers of health care as listed in NRS 629.031 through the corresponding licensing and regulatory boards and agencies in an effort to gauge the level of interest, request contact information, and solicit additional comments on the grant program. Contact information gained from that survey, in addition to several applicable list serves, will be used to solicit feedback in an additional survey to further inform the small business impact statement, and DHCFP plans to draft and post the small business impact statement and host the public workshop in August. We will hold the public hearing in September and will submit the required list of documents here to LCB in support of the proposed regulations in October. Lastly, the goal will be to seek approval of the regulations by the Legislative Commission in November and file with the Secretary of State.

All throughout this process, there is potential for public comment and input on the draft language, and DHCFP is committed to following this permanent regulations timeline closely, has noted the tight turnaround in seeking permanent regulations before the 2025 session,

and highly values the recommendations of the Electronic Health Information Advisory Group for what these regulations should contain.

Speaking further on the implementation of these regulations, once approved by the Legislative Commission, DHCFP will immediately notify all NRS 629.031 licensing and regulatory boards, agencies, licensees, all stakeholder groups potentially impacted, and all points of contact that had been gathered throughout the rulemaking process for these regulations.

I wanted to leave you with the future proposed actions in implementing these regulations. As I mentioned previously, DHCFP had launched in May a survey to all licensing agencies associated with health care providers as identified in NRS 629.031. We requested licensing agencies to distribute broadly to their licensees so that we could gauge level of interest in the available grant funding by provider type, request contact information from those interested in learning more, and provide an opportunity for providers to ask initial questions about the program or the provisions of the bill regarding the regulations This summer, we will release a request for application regarding grant funding to facilitate eligible providers of health care and medical facilities in meeting the requirements of the bill and regulations. Later this fall, DHCFP will develop the waiver application associated with the bill to allow providers to apply for a waiver if they feel they do not have the infrastructure necessary to comply. I am happy to answer any questions from the Committee.

Chair Doñate:

Committee Members, are there any questions at this time?

Vice Chair Orentlicher:

Did you hear the public comment this morning about this bill?

Ms. Southard:

Yes, I did. We received that in writing as well, and I will be sending that out to the members of the Electronic Health Information Advisory Group for discussion at the upcoming meeting.

Vice Chair Orentlicher:

I appreciate that. Do you have any preliminary response to it?

Ms. Southard:

I would like to leave that discussion for the Advisory Group to discuss further.

Chair Doñate:

I have a quick comment regarding these regulations. I know we met offline to discuss it, so I will reiterate it for the record because I know that board members are probably watching the presentation and are eager to hear my feedback. I would argue that from last session, in terms of reforming and modernizing our health care system, this is one of the bills that stands out, not because I helped write it, but because ultimately, we need to modernize how patients access their health records and how those records communicate with each other. If we have any plan to address health care costs or understand the data of what folks are going through, that starts by making sure that our providers are uplifted and supported.

I am thankful we were able to expend funds to this program. I do not think it is going to be nearly enough. It is going to be a larger need as we go through the waiver process.

The only part that I have a concern with is on Section B regarding the requirements to either maintain an electronic health record system or maintain a connection with the Health Information Exchange (HIE). I have had conversations with folks from the White House and from U.S. DHHS, and there is discussion nationally about HIEs, which are not to be confused with the exchange of health information—that is the action versus the entity. I think HIEs nationally have gone through this effort to decide for themselves what their market value is or their proposition of where they see themselves fit, and there is a debate about whether it should remain as a nonprofit or if it should be a State-based entity, a mix of both, or a mix of neither.

From my perspective, my alignment has always been that we need to focus on the Trusted Exchange Framework and Common Agreement (TEFCA), which are the federal standards that are going to be required of us, and then work our way backwards from there because ultimately, we have to align towards that. I do not see a requirement of connecting to an HIE substantial because to me, we should align towards TEFCA and then figure out the rest of how the situation goes.

There are many providers in the State that have chosen not to align to our HIE, and there is a reason for that. There is a national conversation of whether repositories make sense, and I think there are plenty of outcomes or case studies, especially with Change Healthcare and those cyber-attacks that have occurred in health care, where repositories might not make the most sense, especially our State-based ones. I want to make sure we align towards TEFCA and not towards the HIE. That has always been my preference, and if the HIEs find their ways as being part of the process, so be it. That has always been my perspective. I do not know if any other folks have other comments, but it will be interesting how we go through the next five years in this process.

Assemblyman Gray:

You rattled my brain a bit. It has been a long day. Will there be any exemptions for doctors and practices who do solely concierge medicine or do not bill Medicare or Medicaid? I have been working with a constituent now who brought this issue up last week. He is a younger physician and does not see a need for his practice go to an EHR. That is one of the reasons a lot of his patients come to him: they do not want their records online. Another reason is the minute you go online, you are subject to ransomware. The way he does his practice and sees his patients, he does not have his computer sitting in front of his face. He does it pen and paper. He has an algorithm he follows on the paper. It is not like an old guy writing notes down. It is seen as an unnecessary, burdensome cost for no reason that is going to saddle his practice with things he does not want to do.

Long ago, I worked with a company here in Nevada bringing EHR systems to physicians and practices. One of the things I realized quickly is, none of those systems are a "one size fits all" for a practice. The dropdown boxes and the information you are required to capture have no effect on patient outcome. Why would we saddle physicians who do not want to use a system with those requirements?

When you create your list of exemptions, there should be exemptions made for physicians who do not want to participate or have valid reasons for not participating. They do not bill Medicare or Medicaid. They have nothing to do with the government whatsoever other than

having to maintain the requirements to have a medical license. What are your comments on that?

Chair Doñate:

From my understanding, in the waiver process, our ultimate goal, at least when the bill was passed, was to target larger physician practices—not so much ones that probably have one, two, or three staff members—and more from the consumer perspective of being able to access your records. That is something the task force can add through the recommendations before they approve the regulation if they wanted to. Maybe Dr. Southard can describe this further, but this will go through a public hearing process, so that could also be an opportunity for folks to participate.

Assemblyman Gray:

I do not disagree with you on the intent of the bill, but the way it has come out and the physician who contacted me on this incidentally has no staff. He and his wife run it as a husband-and-wife practice. She does billings they have to do for their memberships, but he is being told that he will have to comply with this law, and that is how it came back to me. It was like, "Oh, wait a second here. This does not make any sense." I think when we are developing regulations for this or when they are finally approved, we need to take into account what the intent of the initial bill was.

Ms. Southard:

We have a waiver process we will be developing and will come up with an application for that, so we can take into consideration, your point exactly, because we need to stay in alignment with the intent of the bill, and there are some extenuating circumstances the advisory group can consider for that.

Assemblyman Gray:

I would take another approach. I would say that physicians meeting these requirements do not even need to apply for the waiver. Why expend the time, money, and possible legal resources to defend against something where they do not deal with the government at all. There is nothing they do that interfaces with the public health system. I would highly recommend you look at something like that as well.

Chair Doñate:

The only thing I would push back on is that there could be a scenario where if patients at the concierge practice deals with end up getting hospitalized, the hospital should have an understanding of what that patient has been diagnosed with or what medications they are taking before ordering duplicative tests. How does the system all interconnect with one another even if that individual provider has chosen not to participate as part of the law? That is part of modernization that must exist. The concern we have to figure out as lawmakers is, how do we make that accessible, so the practice does not see it as a burden? I think that is what your comments were, and I agree with those sentiments.

Are there any other questions or comments? Seeing none, I will close this agenda item.

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

Chair Doñate:

We will move on to our next agenda item, submitted policy recommendations to be reviewed by the Committee.

Yvette Williams, Chair, Clark County Black Caucus:

It is good to see so many familiar faces today, but I would like to acknowledge my State representative, Senator Nguyen, who is on the Committee. Thank you for your service to our community. I am here today regarding a critical issue that has been a driving force for me since 2018, and now with more determination since COVID-19. For mental health, America ranked Nevada 51st—or dead last—based on the prevalence of mental health needs and access to care, and with warning signs for what we fear may be a long-lasting mental health crisis for teens, finding ways to support youth mental health requires developing new strategies. (Agenda Item XI A-1) (Agenda Item XI A-2) (Agenda Item XI A-3) (Agenda Item XI A-4)

The good news is that it is a challenge we can meet with combined efforts. In October 2021, 97 percent of nearly 500 students attending our African American Student Summit indicated that they or someone they knew had a mental health crisis and shared that their number one concern was accessing a mental health professional to deal with depression, stress, sadness, and suicidal thoughts. That request from students has not changed in the past two years we have done this polling, and based on those needs, we launched the Mental Wellness Ambassador Program in partnership with Hazel Health, where our students on 44 campuses serve as peer-to-peer support for their fellow students, helping them become informed, educated, and normalizing accessing mental health services. Now they are expressing an interest in pursuing careers as mental health professionals.

As a result of students wanting to take control of their mental health and wellness, the Clark County Black Caucus has advocated for access to mental health for all students in Nevada, and CCSD agreed to use $2.5 million of their U.S. ESSER dollars to ensure their students' needs are met. Given the long delays and limitations of available therapists to serve them in our State, Hazel Health was contracted to fill the gap through the telehealth protocol called "HEART," serving all students with no out-of-pocket expense to families, both at school and at home.

There is a sense of urgency today that I would like to stress before this Committee. Currently, services for CCSD students will run out after the 2024–2025 school year due to the expiration of ESSER funds currently paying for these services. The return on investment is extremely promising, which you will hear more about shortly. So far this year, excluding the last two months of school, Hazel Health has provided over 20,000 clinical hours to students with the capacity to serve the entire State.

I am most impressed by the huge benefit to students in quickly seeing a therapist, all licensed master-level clinicians of whom 51 percent are Black, Indigenous People of Color (BIPOC) and speak 15 different languages, making them completely culturally competent and responsive. Their quick response has also helped keep students in school. Because of our long-term relationship and the investment Hazel Health has already made in the State of Nevada over the years, they are willing to honor the greatly reduced pricing CCSD

currently enjoys supporting the expansion to Northern Nevada and the rural communities, saving Nevada millions of dollars. This pricing is no longer available in the marketplace and unique to Nevada.

Andrew Post, Chief Innovative Officer, Hazel Health:

It is a great pleasure and honor to present on this topic. Since our inception, Hazel Health has been a close partner with the State of Nevada through our partnership with CCSD, so everything we have done and built for, around, and with schools has happened in large part due to our position in your State. We genuinely appreciate that.

Chair Doñate:

I have a quick question. I know you have submitted an abundance of items that go over student outcomes, but in the interest of time, would you be able to go through the finite details and then go straight to the proposal or request so we can provide questions or feedback for you?

Mr. Post:

Absolutely. The study we commissioned was with Clemson University because what is most important aside from the fact that children can access care quickly is that it is effective, that clinical outcomes happen and therefore that impact can be seen. What we saw is that of 3,500 students, 50 percent identified as BIPOC, and 14 percent of that sample population was in Nevada. We initially believed we would see more mild to moderate concerns brought through telehealth in schools. However, we saw that anywhere from 28 percent to 43 percent of children tested or screened more in the moderately severe to severe range for depression and anxiety, and that is an indication that not only has the need for mental health services become wider, it has also become a deeper need. It was a large and diverse sample size and a large portion from Nevada.

What we saw was incredibly promising, which is that 75 percent of students made a clinically significant reduction for both depression and anxiety symptoms, and in this definition, that means going down a minimum of one severity level, either from moderately severe to moderate or moderate to mild. I have three children, and 75 percent will never be enough. We hope to positively impact 100 percent in that manner, but the reality is that using a telehealth modality, using schools as both a place of care and a partner to be available at school and at home produces the results we had hoped for and more while we still strive to ensure that every child sees level of clinically significant reduction in symptoms.

The last point I will make is that we serve roughly 190 school districts throughout the nation, totaling almost 4 million students. While we have not commissioned that study in Nevada to date—although we are working on that—we are now seeing an impact of those outcomes on things like chronic absenteeism, suspensions, and behavior, leading to higher attendance in school and higher ability of those children to be present when they are present. We are excited about our future in the State of Nevada and immensely appreciative of the partnership with CCSD.

You asked about the proposal. Where we sit today, it would take $1.35 million to expand Hazel Health for the remainder of the State as well as $4.5 million to the pricing that Ms. Williams alluded to for a year that covered all public school students in the State, so

traditional, charter, and everyone enrolled in a public school based on the publicly available data. That would be the request.

Chair Doñate:

Great. Committee Members were flipping through the statistics and exhibits. Are there any questions or discussion?

Assemblywoman Brown-May:

I have a couple of clarifying questions. You are advocating for the methodology that has been used by Hazel Health, and you said in your statement that we are currently in 44 schools with Hazel Health locally. You are advocating for a continuation of only this organization and not mental health support services overall.

Ms. Williams:

No. I want to apologize for confusing you. Hazel Health is serving every student in CCSD, all 300,000 students. They serve all of them. However, through our Black Student Union (BSU) Network, our students expressed such a need for this that they want it to have more buy-in and more control over their own mental health. I asked Hazel Health if they would partner with us in putting together an ambassador program where students could do peer-to-peer, and they have been a wonderful partner. The BSU Network is in 44 schools, so that peer-to-peer support is there.

Assemblywoman Brown-May:

Thank you for that clarification. For Hazel Health, I see that a lot of your data is aggregated across all the states you are currently serving. I have met previously with your leadership from Hazel Health and appreciate what you are doing for our students. As I look at the reporting, it looks like eighth and ninth grade seems to be where your highest numbers of students are served, which I think is in trend. I am curious to know, are you able to aggregate the data out specifically to Nevada students? While Missouri is important, I do not care about Missouri students as much as I care about Nevada students, so I am curious to know if you are able to talk about or detail the severity that we are experiencing and the ages or grade levels of students that are accessing services. What are those outcomes? Can you aggregate for Nevada?

Mr. Post:

We absolutely can, and I do not want to give you all the answers off the cuff, but I can tell you, number one, we can take that as a follow up. Number two, roughly 45 percent of our visits are at the elementary grade levels for this study in particular. Because it was done by a university, the screeners used were 11 years old and up, which are the clinically appropriate ages to use, so that is why this focused on it. The data will not be validated by Clemson in this case, but I can follow up with the data specific to Nevada if that would be helpful.

Assemblywoman Brown-May:

Your current contract to provide these services in the State of Nevada is with CCSD. Is that correct?

Mr. Post:

That is correct.

Assemblywoman Brown-May:

This proposal would purport to move the contract away from the School District and into a State appropriation. Is that what I am understanding?

Mr. Post:

I will not speak on behalf of the School District, but from my standpoint, for the remainder of the State for the upcoming school year, after that would be when we would request that. Any time we have ever done this, I would never speak on behalf of the School District. They would have to select that they wanted to continue to do this, but we have done similar things where that would be the request but not to take over what they are paying today.

Ms. Williams:

I am an advocate on this, so I want to speak up because I want to be clear: we are asking for a statewide protocol for all students. The fact that only CCSD students have this is sad. I know the need in rural counties is huge, and I see this as a statewide solution. Whether that goes through an appropriation through DHHS or NDE, we leave that up to your great minds on how that should be done, but Hazel Health is already doing statewide programs, and they are making a huge impact in Los Angeles, which is millions of kids. Mr. Post, maybe you can speak a bit more about the things you are doing as a statewide program.

Chair Doñate:

There is more room for discussion, and I would encourage you to reach out to Committee Members individually. I want to make sure we provide enough time to the other presentations as well, but I think we are good on questions.

Senator Nguyen:

As a follow up to what Assemblywoman Brown-May requested, it would be helpful for the Committee if we could see any of the disaggregated data to see if there is a way to find out if there are particular schools within CCSD that are utilizing these services more. That might be helpful for Committee Members as well. Thank you for your presentation, and it is always good to see Senate District 3 residents getting involved.

Ms. Williams:

I want to close out by saying that students are embracing, and families are accustomed now, to using this down here in Southern Nevada. They are expecting it now, and usage of the program has doubled.

Chair Doñate:

We will now move on to the next presentation.

Madalyn Jo Larson, Private Citizen:

I am a newly graduated Master of Public Health student from UNR and a proud native Nevadan. I am co-presenting with Lisette Hernandez, a prevention education specialist from Join Together Northern Nevada. (Agenda Item XI B)

During my seven consecutive years as a student at UNR, I noticed a lot of drug use. This is not unusual because college and young adult years are a time for experimentation, but what is unusual is the inability to find access to harm reduction tools across the University's campus to empower students to use drugs safely. Over the past several years, overdose deaths have skyrocketed due to fentanyl being put in just about any illicit substance you can find, and with that, harm reduction tools such as naloxone, also known as Narcan, an opiate overdose reversal medication, have become widely accepted and available for the layperson's use.

Currently, NSHE does not have a policy allowing accessibility and distribution of naloxone across its eight institutions despite there being a need for it. However, during the 2021 Legislative Session, Nevada Legislators understood the risk of overdose within the K-12 population and passed AB 205 (2021) which allowed naloxone to be accessible throughout all K–12 institutions. Now, NSHE needs a similar bill which would ideally require each institution to distribute naloxone and provide education to students about opioid overdose.

This recommendation is not only supported by data and previous policy, but it also fits beautifully into the goals, objectives, and recommendations of two major influences across our State. This includes the Attorney General's Substance Use Response Working Group (SURG), and the first ever Silver State Health Improvement Plan (SHIP), and SURG's 2023 annual report is comprised of recommendations crafted by Nevada's subject matter experts on substance use.

This report includes recommendations for the use of opioid settlement dollars to fund stable and sustainable sources of overdose reversal medications and to model future legislation off Maryland's Statewide Targeted Overdose Prevention Act, which requires certain community service programs, private and public entities, and hospitals to have a protocol to dispense naloxone to certain individuals free of charge under certain circumstances. Furthermore, the SHIP outlined goals and objectives which advocate for increased access to naloxone to reduce overdoses.

The justification for access to Naloxone across entry campuses is there. Now we need to talk about legislation and implementation science. Due to the high rates of overdose across the country, other states have passed legislation similar to what I am proposing. In 2019, Connecticut passed a bill which required all higher education institutions to develop and implement a plan for naloxone access on each of their campuses. In addition, this year—I think it went into effect a few days ago—Washington State passed House Bill 2112, which requires higher education institutions to stock naloxone and fentanyl test strips as well as educate students on opioid overdose.

These are a few examples of legislation that Nevada can utilize to model this type of bill recommendation. The actual rates of opioid overdose—both fatal and nonfatal—among our NSHE students is unclear, but we know that from the Nevada Office of Analytics data that the 15 to 24 age range is one of the top demographics for opioid poisonings and opioid overdose deaths across our State. With the widespread availability and acceptability of naloxone. it is truly a no-brainer for entry institutions to supply it to their students. I do not

want one of my fellow college students to die because they or their friends did not know where to get naloxone or how to use it. This type of scenario is unacceptable for the tools that we have access to now in our State.

To help support the implementation of this potential legislation, there are many partnerships currently in place to get it off the ground. I have been developing an NSHE naloxone working group with representation from the various NSHE institutions which can help guide the development of this recommendation through each unique institutional lens. Regarding funding, there are funding streams at the State level which are in alignment with this recommendation and can be used to support this initiative. Furthermore, the State of Nevada's supply of naloxone sits at the UNR's campus at the Center for the Application of Substance Abuse Technologies. This puts NSHE in a good place to implement widespread naloxone access. Overall, this recommendation can be operationalized through current Nevada systems and funding streams.

In conclusion, a bill to require NSHE institutions to ensure access to naloxone and education on opioid overdose to students is imperative to uphold the values of public health and public safety in our State.

Chair Doñate:

Committee Members, do you have any questions or recommendations?

Assemblywoman Brown-May:

I have a comment. First, I want to say congratulations on your good work. I have just returned from the Opioid Policy Fellows Program with the National Conference of State Legislatures, and this is clearly a national concern. As we work to address it, I am surprised that NSHE does not currently have a policy relative to your recommendations. I would like to follow up with you for further discussion.

Ms. Larson:

That sounds great.

Chair Doñate:

Are there any other comments or recommendations?

Senator Titus:

Thank you for bringing this forward. I have been involved in this legislation from the beginning, way back when we offered it and allowed it. Access is key, so I have also been involved with NSHE about possibly carrying a bill that would allow access to naloxone on campus. It is interesting that you are out there and that I have not been aware of that before, so thank you for your presentation. I would also like to have further conversations regarding this issue, making sure NSHE is engaged with this, as some of this conversation has already happened.

Chair Doñate:

I would like to be credited for helping connect the bipartisan bill. Let us get the bill started. I do not have any other comments or recommendations, but it is always a pleasure to have our students present. Thank you so much for the outreach, and if there is anything

else we can provide to you or any advice, it sounds like you have two people on this Committee who are committed to helping you. Let us go on to our last recommendation.

Char Frost, Vice Chair, Nevada Children's Behavioral Health Consortium:

As you may know, the 17th Special Session in 2001 enacted Assembly Bill 1, which put the three regional consortia into law. The consortia are special, and I like to brag about them a lot. Some of it was a legislative mandate that we are so great, but all the consortia are comprised of DCFS, child welfare representatives, Medicaid, school districts, juvenile probation, business communities, mental health care providers, a foster care provider, and the most important part to me as a parent, the parent representative.

On the Clark County Consortium, I am the parent representative, so I often talk about mental health, and although a lot of these professionals are also parents, they do not necessarily come to meetings with their parent hat on. I wanted to make sure that was clear. Also, the consortia often have in their bylaws included additional voting members in addition to what was legislatively mandated, so it gets even more diverse as we go along.

As you may know, during even-numbered years, we produce a priorities report, and during odd-numbered years, we produce status reports to deliver to the Commission on Behavioral Health as well as to you. We got our legislative mandate in 2001, and it is important to know that part of that mandate is that we have to have a ten-year strategic plan. The most recent one was done in 2020 during the height of the pandemic, so we kept working all through it.

A lot of the things within this recommendation I have heard over and over today, which makes me happy that we are on the same footing with a lot of community members, but I am going to highlight a couple of them. We have talked about the Children's Mobile Crisis Response Team (MCRT), and it is super special because they are able to go into homes before we have to remove youth to the hospital, which is the worst case scenario for any family, especially given that a lot of times, our families go to the hospital and can be there for days and weeks before they are finally able to find a place to receive treatment or they finally give up. I will be quite honest. This was important to our community that we were able to start this in Clark County and expand it to the rest of the State. I also want to mention that out in the rural counties, the Department of Behavioral Health, the rural mental health clinics are the ones who handle MCRT, and they are responding in person now in Elko.

The first priority for Clark County children's mental health was that we continue to increase and sustain funding for mobile crisis. The second priority was to expand family peer support services, and we are lucky enough to have heard from Administrator Weeks that that is something they are working on at Medicaid now. Priority three was fully implementing the building bridges model of care. Coming out of COVID-19, we realized there is a strong need for intensive in-home services, so we need a way to fund those and make sure they are available to families no matter where they are in the State, as well as more service array options, so youth and families can access care at earlier stages to reduce the need for crisis service intervention and hopefully reduce the need for hospitalization. Part of this was larger investments in the system of care core services, and if you do not know what those are, I am happy to provide that to you at any time.

There is a big focus for the rural consortium to make sure the system of care is expanded and sustained in the rural counties and increase access to mental and behavioral health care. In Elko, they are doing pilot programs for in-person mobile crisis response, but there is a lot more work to be done there because we do not have the providers needed to serve our youth in rural counites.

We also need increased access to treatment in the least restrictive environment to divert our youth and our families away from hospitals from psychiatric emergency care and from juvenile justice, which goes along with the fourth priority, increase health promotion, prevention, and early identification and activities and develop, strengthen, and implement statewide policies and administrative practices that increase equity and access to mental and behavioral health care for youth and families.

In Washoe County, their first priority is to commit funding infrastructure and legislative support to maintain and expand existing programs and services that benefit youth and families in Washoe County, and they highlighted MCRT and respite services, which is something families of children with mental health traditionally have not been able to access. It is very hard to find somebody who is willing to watch some of our kids, depending on the severity of their behavioral health care needs. They also highlighted the National Alliance on Mental Illness of Northern Nevada's family-to-family model and Nevada PEP's family peer support model.

Their second priority was to promote innovative programs to respond effectively to the ongoing and increasing mental health crisis in Washoe County, and they want the creation of an intensive in-home crisis stabilization program, reduced contact with ERs, and they are asking for a pilot for children with an emphasis or special point of entry for under 12 to access a triage and stabilization center located in close vicinity to the pediatric ER at Renown Regional Medical Center in order to divert youth from the ER and into appropriate care and a QRTP. I believe Jill Marano talked at length about QRTPs, so I am not going to belabor the conversation.

I also wanted to point out that earlier, we heard in public comment and through several points in this meeting about a lot of providers not accepting Medicaid or insurance and preferring to do cash pay. We are hearing that from all the counties across Nevada. It is very real. They also mentioned that in the Washoe County recommendations.

Chair Doñate:

Ms. Frost, I know you spent a lot of time in this field. If you had the ability to focus on one thing relating to children’s behavioral health that was the most important for next session, what would you do?

Ms. Frost:

Prevention, reducing the bias and prejudice. As a person who lives with a mental health disability and parents children with mental health disabilities, it is very real and prevents people from seeking services, but if we can get past that and get to parents early on and understand that parents do not know what they do not know, we can meet them where they are and show them it is not their fault.

Chair Doñate:

It sounds like early detection and prevention.

Ms. Frost:

The consortia also do a large amount of public awareness to reduce stigma. The Clark County Consortium did a photo contest this year. We did one in 2020, but it was overshadowed by COVID-19. These are all photos done by youth with mental health messages. I brought copies and will leave them at the table if anybody wants to grab one.

Chair Doñate:

Are there any further questions? Seeing none, we will now close out this agenda item.

AGENDA ITEM XII—PUBLIC COMMENT

Chair Doñate:

We will move on to public comment. Is there anyone in Southern Nevada or in Carson City who would like to provide public comment? Seeing none, BPS, is there anyone virtually?

BPS:

The public line is open and working, and there are no callers at this time.

Chair Doñate:

Our next meeting is a joint meeting with the Joint Interim Standing Committee on Growth and Infrastructure. We have conducted most of our work here in the Interim HHS Committee, so our next meeting will be focused on traffic safety, looking at our built communities, and seeing how we can improve the health and well-being of folks throughout the State. That meeting will be on July 17, 2024, and we look forward to seeing everyone there.

The following written public comment was submitted:

- Chelsea Bishop, Act4Kids Nevada (Agenda Item XII A);
- Tahnee Forolini, Pharm.D., B.C.P.S. (Agenda Item XII B); and
- Tara Raines, Ph.D., N.C.S.P., Deputy Director, CAA (Agenda Item XII C).

AGENDA ITEM XIII—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 3:41 p.m.

Respectfully submitted,

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Sarah Baker
Research Policy Assistant

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Patrick B. Ashton
Chief Principal Policy Analyst

APPROVED BY:

_____

Senator Fabian Doñate, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II A	Michelle Paul, Ph.D., Assistant Vice President of Mental and Behavioral Health, University of Nevada, Las Vegas	Written Public Comment
Agenda Item II B	Rebeka Acosta, Act4Kids Nevada	Written Public Comment
Agenda Item II C	Tami Hance-Lehr, Chief Executive Officer, State Director, Communities in Schools of Nevada	Written Public Comment
Agenda Item II D	Leann D. McAllister, Executive Director, Nevada Chapter, American Academy of Pediatrics	Written Public Comment
Agenda Item IV A	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB)	LCB File R026-24 of the Aging and Disability Services Division, Department of Health and Human Services (DHHS)
Agenda Item IV B	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R002-24 of the Board of Psychological Examiners
Agenda Item IV C	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R084-24 of the Board of Psychological Examiners
Agenda Item IV D	Eric W. Robbins, Senior Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R053-24 of the State Board of Pharmacy
Agenda Item V	Stacie Weeks, J.D., M.P.H., Administrator, Division of Health Care Financing and Policy (DHCFP), DHHS	PowerPoint Presentation
Agenda Item VI	Brian Knudsen, Councilman, Ward 1, City of Las Vegas	Child Mental Health Priorities Flier
Agenda Item VIII A-1	Marla McDade Williams, Administrator, Division of Child and Family Services (DCFS), DHHS	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item VIII A-2	Marla McDade Williams, Administrator, DCFS, DHHS	Children's Mental Health Programs Chart
Agenda Item VIII B	Jill Marano, Director, Clark County Department of Family Services (DFS)	PowerPoint Presentation
Agenda Item VIII C	Ryan Gustafson, Director, Washoe County Human Services	PowerPoint Presentation This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.
Agenda Item IX A	Marla McDade Williams, Administrator, DCFS, DHHS	PowerPoint Presentation
Agenda Item IX B	Jill Marano, Director, Clark County DFS	PowerPoint Presentation This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.
Agenda Item IX C	Ryan Gustafson, Director, Washoe County Human Services Agency	PowerPoint Presentation This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.
Agenda Item X	Malinda Southard, D.C., C.P.M., Deputy Administrator, DHCFP, DHHS	PowerPoint Presentation
Agenda Item XI A-1	Yvette Williams, Chair, Clark County Black Caucus	Hazel Health Policy Recommendation
Agenda Item XI A-2	Yvette Williams, Chair, Clark County Black Caucus	PowerPoint Presentation This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item XI A-3	Yvette Williams, Chair, Clark County Black Caucus	Hazel Health Clemson Study One Pager This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.
Agenda Item XI A-4	Yvette Williams, Clark County Black Caucus	Executive Summary of Hazel Health Teletherapy Program Analysis This is on file in the Research Library of the LCB, Carson City, Nevada. For copies, contact the Library at (775) 684-6825.
Agenda Item XI B	Madalyn Jo Larson, Private Citizen	Naloxone Network Policy Proposal
Agenda Item XII A	Chelsea Bishop, Act4Kids Nevada	Written Public Comment
Agenda Item XII B	Tahnee Forolini, Pharm.D., B.C.P.S.	Written Public Comment
Agenda Item XII C	Tara Raines, Ph.D., N.C.S.P., Deputy Director, Children's Advocacy Alliance	Written Public Comment

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