Joint Interim Standing Committee on Health and Human Services[1]

Selected items of possible interest to SURG members:

March 11, 2024 (Provided to the SURG members on April 10, 2024)

- Overview of the Medical Licensing Process and Provisional Licensure, Potential Barriers to Licensing, and Future Considerations, Nevada State Board of Medical Examiners.
    - Potential BDRs to clean up and simplify Continuing Medical Education requirements including:
        - SBIRT, misuse or abuse of controlled substances, pain management or addiction care, prescribing of opioids, cultural competency and DEI.
    - Chair Doñate mentioned the possibility of changing renewal dates to providers' birthdays.

February 16, 2024

- Public comment related to pharmacist provision of MAT under regulation AB156/R059-23P.
    - Vice Chair Orentlicher supports AB156/R059-23P to implement best practices for SUD; need to take full advantage of health professionals, particularly with current shortages.
- State Health Improvement Plan (Megan Comlossy, Public Affairs and Policy, UNR School of Public Health) includes:
    - Access to Health Care Workforce:
        - Increase integration of CHWs who increase minorities' access to care and serve as liaisons between health care providers and the communities they serve.
        - Improve cultural competence within HCP workforce to improve provider-patient communication, reduce health disparities, and improve health outcomes.
    - Mental Health and Substance Use – Crisis Response:
        - Enhance 988 call center operations and improve response times.
    - Substance Use Prevention, Harm Reduction, Treatment and Recovery:
        - Increase public awareness and education about SUD and available services/resources and reduce stigma.
        - Improve access to affordable and equitable treatment.
        - Strengthen and elevate early intervention strategies, including creation of a robust drug surveillance program.
        - Support recovery-oriented systems of care, including access to harm reduction services.

[1]For details, follow this Committee link and then click on the **Meetings** tab for this committee. Scroll down to the meeting of interest and click on the **View Meeting** box. To move the recording to a specific item of interest, click on the **Expand All Meeting Links** box, and then click on the **Agenda Item** of interest.

        - Foster collaboration including government agencies, healthcare providers, school districts, community organizations, and law enforcement to create a unified approach to addressing substance use issues.
    - Mental Health and Substance Use Investment:
        - Increase overall State General Fund investment in Medicaid to raise reimbursement rates for behavioral health services.
        - Increase investment in (non-medical) wraparound services to assist those experiencing mental health challenges and substance use disorders.
        - Increase financial incentives to attract and retain behavioral health professionals in Nevada.
        - Increase private sector and philanthropic investment and financial support of robust behavioral health services to help all Nevadans receive appropriate care.
        - Pursue/encourage implementation of strategies to increase sustainable funding and reimbursement in Nevada's behavioral health system.
- DHHS Director Whitley on ARPA Funding.
    - Fiscal cliff and services cliff coming; providing spreadsheet to committee.
    - Assemblyman Gray wants BDR for the Interstate Compact to address the social worker shortage.
- Updates from NV Medicaid:[2]
    - Rate increases for a range of providers effective 1/1/2024.
    - Received federal approval for CHWs (expanded supervision) (SB117).
    - 1115 waiver – federal funds to cover cost of substance use treatment in residential settings; approved May 24, 2023; reimbursement approved Aug 1, 2023. Currently updating rate methodology with CMS.
    - Coverage of services for incarcerated individuals (AB389): Recently secured vendor contract; waiver development to begin this quarter.
    - Covid Unwind: Able to retain 88% enrollees.
    - Chair Doñate:
        - Value Based Payments – Physicians don't want to participate in managed care. What are the incentives?
        - Public Health Unwinding – what kind of outreach?
            - Office in a Box, Food stamps card; notifications via text, pharmacist, "how to tear offs" regain access.
            - Coordinate with Dept. of Education, et al.
            - Outreach to MCOs to retain members.
            - Reapplying within 90 days can retain coverage back to expiry date.
    - Chair Doñate:
        - What resources are in place to engage MCOs?
    - Senator Titus: Increased number of providers accepting NV Medicaid?
        - Malinda Southard, DHCFP, DHHS, to provide information in a follow-up.

[2] SURG may want a separate presentation from NV Medicaid.

- Vice Chair Orentlicher asked about provider assessment with increased rates; how do they compare to benchmarks such as actual costs, Medicare, private insurance, et al.
    - Lynette Aaron, DHCFP, to take question offline.

April 8, 2024 (Updates for the July SURG meeting)

- This meeting focused on public health priorities. Meeting material available at https://www.leg.state.nv.us/App/InterimCommittee/REL/Interim2023/Meeting/34456

May 13, 2024 (Updates for the July SURG meeting)

- Attorney General Ford presented an overview of SURG recommendations and responded to committee member questions with Dr. Terry Kerns and SURG members Dr. Leslie Dickson, Erik Schoen, and Steve Shell.
    - The SURG does not make funding decisions but does make recommendations for funding as well as bill draft requests and expansion of SURG membership.
    - Lack of resources – human, facilities, professional – impacts all SURG recommendations.
    - Four Psychology Residency slots were added for Nevada, but they don't stay in Nevada because other states pay better. Nationally, only 60% of addiction medicine slots are filled, possibly due to low reimbursement rates under Medicaid (e.g., daily methadone rates are the same as 40 years ago).
    - Harm reduction services are available through Trac-B with multiple vending machine locations as well as mail services, but there is pushback in some communities.
    - A Statewide Plan was developed through the Advisory Committee for Resilient Nevada under the Department of Health and Human Services, including coordination with local planning.
    - Recommendation for increased prevention funding is a starting point after decades of underinvestment.
- Local officials from Clark and Washoe Counties presented on behavioral health efforts.
    - Crisis Intervention Model includes: 1) 988 mental health crisis line; 2) mobile crisis teams; and 3) transportation to crisis stabilization facility.
    - One-time funds do not fill the need in Nevada; a pilot program at UMC is scheduled to open at the end of 2024. A dedicated funding stream is needed for viability.
    - Mental health programs are supported by taxes in other states.
    - Renown is working with the state and local government to set up a Crisis Stabilization Center with ARPA funds; working with Medicaid to establish rates, but sustainability is still in question. They anticipate opening the facility in August or September 2024.
    - The Washoe County Commission approved the purchase of the West Hills facility with $14.5 million renovation in 2023.
    - Chair Doñate referenced cuts to mental health services in the 90s and again during the 2008 recession that were never replaced at the state level. He emphasized the responsibility of the state to work together with local government across sectors.

- Stacie Weeks, Administrator for the Division of Health Care Finance and Policy, provided an overview of enrollment and policy for behavioral health continuum of care.
- The Administration for Division of Public and Behavioral Health and DHHS Director's Office provided an overview of behavioral health and crisis intervention services and forensic mental health services.
    - 988 generated $14.8 million by SFY2024:
        - Need to invest in whole crisis response system, from 24-7 response teams and crisis stabilization centers to workforce development.
        - Substance use funding is twice the amount of other mental health funding.
    - There is an increased demand for forensic services; a new facility is being designed for SNAMHS campus.
    - The Fund for Resilient Nevada receives 44% of opioid settlement funds. 39% goes to local government through the One Nevada Agreement and about 17% goes to Medicaid match, $11 – 21 million projected over 20 years.
        - School-based prevention is identified as a gap by the ACRN.
    - Chair Doñate asked for a spreadsheet showing funds received with expenditures and projections. He also asked presenters for their priorities:
        - S. Bennett - Need to build out a comprehensive mental health system.
        - D. Cross – Relationship with partners; sequential intercept model.
        - S. Litz – Parents with children; prenatal care.
    - Responses to other committee member questions:
        - 96 days is the median stay in forensic facilities.
        - Non-federal funding for forensic services is to be awarded in July or August, and again 6 months later; these are state general funds.
        - Ongoing collaboration with NSHE for workforce development; training takes decades, but residency slots will eventually have dividends.
        - Clinical programs in Washoe and Clark Counties are under development with sole source funding through County Commissions.
        - Legal 2000 or other civil holds are at the forefront of the legal process with release to wrap-around services; they work with clinicians at the jail and forensic facilities.
        - 67% of 988 calls are answered in-state; improvement is expected with RFP award. Other system components need funding.
    - Chair Doñate wants to bring more information to the 2025 session regarding forensic service requirements and what is not currently covered by health insurance.
- Local and regional representatives presented on crisis stabilization efforts, successes, challenges, and gaps in Nevada's Crisis Response System.
    - Julia Ratti for Washoe County:
        - Need long term sustainable funding for mobile crisis teams.
    - Responses to committee member questions
        - Services for respite/hospice will be separated from crisis stabilization in new 2-story building in Clark County.
        - Plans are under development for coordination across city/county jurisdictions.

        - Jail-based programs under LVMPD will be up and running in late June with screening for mental health and behavioral health needs.
    - Chair Doñate asked how to incentivize wrap-around services with hospitals, mental health, law enforcement, and emergency management services.
        - Julia Ratti described a complex system with a mix of providers and payers. Local government and built-in accountability is a challenge to delivery of core missions due to incoming mental health cases and a focus on provider payment systems. Rates to incentivize providers are more effective than mandates.
        - Mobile pharmacies are not piloted, but street medicine is a conduit from street to pharmacy.
        - More research is necessary regarding regionalization of RBHPBs; they are not like public health districts that can carry grants – rather, they help provide oversight on quality of services.
- Dr. Sarah Hunt provided updates on the establishment of the Behavioral Health Workforce Development Center of Nevada, BeHERE NV, supported by 2023 legislation.
    - First Annual Report due to Legislature at the end of June; scheduled to present to the SURG in July.
    - Responses to questions from Committee:
        - Recruitment efforts for entry level providers will be included.
        - There may be policy suggestions related to partnering with employers.
- A representative of the National Conference of State Legislatures presented state policy options for telehealth provider shortage in behavioral health care services.
    - Telehealth Registries are used in other states.
    - Nevada allows interstate support for consultations only.
    - Other states support Medicaid reimbursement for tele-prescribing (including for OUD), prohibit facility fees, increase broadband access, or provide grants.
- Policy recommendations for review by the Committee:
    - Pat Kelly, Nevada Hospital Association, submitted Behavioral Health Recommended Initiatives, including:
        - Discourage law enforcement, EMS, and other first responders from bringing people experiencing a mental health crisis to hospital emergency rooms unless they have a medical condition.
        - Hospitals need places to discharge behavioral health patients once they are medically cleared for discharge.
        - Inpatient behavioral health services should be reimbursed by Medicaid at higher rates and tailored to patient acuity.
        - The State needs to ensure/enforce network adequacy with a limited number of providers operating under multiple names.
        - Recommended 60-Minutes episode on ultrasound treatment to eliminate addiction cravings.
    - Dan Musgrove, Nathan Adelson Hospice, submitted a White Paper Case for Hospice Moratorium.

        - Other states have seen an increase in fraud and abuse that needs to be investigated by the federal Centers for Medicare and Medicaid Services.
        - Chair Doñate said this is also happening with Home Health Care, so they need to ensure regulations and competency are met.
        - Vice Chair Orentlicher agreed with the need to prevent abusive programs but was concerned with preventing recruitment and retention of good providers.
            - Mr. Musgrove suggested a pause on recruitment to support legislative consideration. The Bureau for Health Care Quality and Compliance is aware of the problem but their response is driven by complaint investigation.

June 10, 2024 (Updates for the July SURG meeting)

- Public Comment
    - NV Board of Psychology recommends a tiered integrated system to develop child-centric workforce for prevention, early identification, assessment, and intervention.
    - ACT4Kids NV recommends creation of a task force to increase insurance rates, increase recruitment and retention, streamline licensure, and review scopes of practice for physician assistants and nurse practitioners.
    - NV Chapter of American Academy of Pediatrics recommends comprehensive child mental health services.
    - Communities in Schools recommends youth mental health assessment and services.
    - NV PEP utilizes family peer support for autism.
    - University Medical Center referenced issues with prior authorization requirements for children's mental health and substance use disorder.
    - Health Services Coalition supports increased access to mental health care and increased graduate training.
- V. Stacie Weeks, NV Medicaid's Children's Behavior Health Services
    - Responding to the Department of Justice 2022 finding that Nevada does not provide children with behavioral health disorders with adequate community-based services:
        - Limited funding for children's behavioral health.
        - Inadequate community-based services due to segregated settings.
        - Still in confidential negotiations regarding violated ADA requirements.
        - Work is underway for dual diagnosis with combination of severe emotional disturbance (SED), substance use disorder (SUD), or intellectual and developmental disabilities (IDD).
        - Out-of-state residential treatment has high cost; there is no community-based service in Nevada.
        - Need earlier screening and treatment.
    - See slides for Vision & Values, New Medicaid Home and Community Services, Detailed Continuum of Care with Benefit Changes, Strengthening Quality in Residential Settings, Other Medicaid Investments & Changes, including the following:
        - **Expansion of school health services statewide.**

        - **Individual and family therapy rate increases.**
        - **Behavioral Support Services & Psychosocial Rehabilitation Services rate increases and expansion to all children with SED.**
        - **Rate parity for inpatient psychiatry with acute hospital for psychiatry and detox.**
        - **Removal of prior authorization for crisis intervention services.**
    - **SB435 allows Nevada Medicaid to use up to 15% of the revenue from the private hospital tax for administrative costs for the tax and any remaining funds to improve access to Medicaid behavioral health care services in the community; federal match dollars will be leveraged with IFC approval**.
    - Estimated timeline:
        - Develop new benefits July-Dec 2024.
        - Rate Increases effective January 2025.
        - Home and Community Based Service package approval July 2025.
        - New delivery system in place (new contract period begins for specialty plan).
    - Committee Questions:
        - Titus: Is there an incentive to add family wellness code without lifelong diagnosis? Are wrap-around services staff and/or care coordinators non-state employees or contractors? Are State employees not specialized in behavioral health disorders?
            - DHCFP wants to do more with coordination of care. Kids need services now, and more providers are needed.
        - Nguyen: Do they advocate for no ejection or rejection related to child placement?
            - Placement conditions are challenging, which include follow-up on price gouging where case managers must ensure the need for increased resources.
        - Chair Doñate: What are the statuses of intervention, school-based system of care, and universal mental health screening?
            - Ongoing work with NV Department of Education for 6 months on school-based system of care to help them bill for services. There is local control in Nevada, and they are increasing provision of MTSS (Multi-Tiered System of Support) through UNR. There are affordability issues, but they are looking at telehealth and counselor training.
- VI. Policy Recommendations Relating to Children's Behavioral Health
    - Brian Knudsen, Las Vegas City Council cited multiple problems:
        - Parental sexual abuse and drug use.
        - Long-term provider coverage; many are cash pay only.
        - 2-years to get a diagnosis for SED.
        - No connectivity and limited training for children's mental health.
        - Undergraduate degrees in child mental health are limited.

        - Absentee rate is very high for Clark County schools with teacher turnover and mental/behavioral health issues.
    - Recommendations (Children's Advocacy Alliance):
        - Office of Children's Mental Health
        - Prevention-oriented BA mental health training.
        - Funding child-focused mental health graduate programs.
        - Streamline licensure and accountability processes for clinicians.
        - Bring reimbursement rates to the national average.
        - Reduce reimbursement barriers for providers who support Medicaid clients.
        - Early assessment interventions for specific child mental health diagnoses.
    - Councilman Knudsen recommends using opioid settlement funds to support these recommendations.
    - Committee Questions:
        - Brown-May: Orient behavioral/mental health training?
            - Work with NSHE to streamline course requirements micro-credentialing with 6-9 credit course to incentivize.
        - Assemblyman Nguyen: Ensure cultural competency?
            - Incorporate awareness of community.
        - Titus: Concurs on need for reduction of obstruction to licensure, particularly mental health.
        - Chair Doñate: Increase licensure to empower physicians to coordinate care.
    - Councilman Knudsen noted that the cost of chronic absence is a decline in reading skills, with 80% less likely to finish school.
- VII. Discussion of Behavioral Health Challenges Among Tribal Children and Recommendations for the Committee
    - Angie Wilson, Tribal Health Center, Reno-Sparks Indian Colony:
        - Domestic violence and substance use rates are high.
        - High rates of suicide: 2nd highest cause of death among ages 10-34.
        - Teen death rates are 2X higher and females aged 15-24 are 5X higher.
        - Behavioral intervention is needed to address a tsunami of long-term trauma.
        - Children cannot achieve self-actualization when their basic needs aren't met.
        - Cultural issues of shame and stigma prevent people from seeking mental health care, including privacy issues within the tribal community.
        - Limited tribal health care workforce in all 12 regional Indian Health areas, especially for Medicaid providers for youth.
        - Cycle of trauma with mental health, substance use, and disease.
        - Oregon State Legislature allows an alternative practice that is evidence based to increase tribal advocacy through traditional healing combined with modern methods, and aftercare services when returning home, through native provider roles.
            - CMS should consider reimbursement for services such as traditional healing before other mental health services.
            - Health care for American Indians receives 100% FMAP for the state.

        - Managed care and fee for service both have issues, including opportunities for fraud. A better design is needed for access.
        - State authority can help address challenges with school system related to favoritism and bullying.
    - Committee Questions:
        - Titus: Is there cultural-based reimbursement? How do other states manage Medicaid billing?
            - A White House task force is working with tribes on an 1115 demonstration waiver that is not yet approved to consider Medicaid reimbursement for traditional medicine. Tribal Health facilities have a single NPI# for billing.
        - Titus: Is there a cultural provider pipeline? Do they encourage STEM to support providers?
            - NV Works tribal representatives held a successful event to encourage youth via a tuition program for physicians or EMS; they are also looking at a behavioral health aid program similar to a program in Alaska. There is also a field program in West Portland to work under providers.
        - Gray: Supports behavioral health aid programs to identify kids for feeder programs and is ready to help.
        - Chair Doñate: Suggested creating a BDR relating to behavioral health aids with training center resources administered by DHHS, NSHE, or Tribal Health Centers. The model would empower tribes to set up their own streamlined system.
            - Angie Wilson: All Behavioral Health Aid programs are tribal with tribal sovereignty under the state. They could get assistance from Alaska and Portland. There are seven CHWs in their clinic for health education and personal trainers. The challenge is in understanding Indian Health Services. They need a template for billable encounters.
- VIII. Presentations on Children's Mental Health Services Across Nevada, Gaps and Challenges in the System, and Recommendations for the Committee
    - Marla McDade Williams, Division of Child and Family Services (DCFS):
        - Their role is to fill gaps in the community by leveraging Medicaid reimbursements.
        - Serve ages 0-18 with four inpatient facilities, peer support services (NV PEP), and out-of-home placement (Connect NV) with ARPA funding.
        - Challenges and Gaps include the following:
            - Safety Net Provider:
                - Lack of access due to providers not enrolled in Medicaid.
                - Complex behavioral, developmental, and psychiatric needs for youth.
                - Juvenile justice involved youth with behavioral, developmental, and psychiatric needs.

        - Lack of third-party entities to manage facilities such as Enterprise.
    - Staffing:
        - DCFS has numerous vacancies in Desert Willow and in non-residential programs.
        - Private sector has closed wings and facilities due to the cost of doing business.
    - Step-Down Facilities:
        - Qualified Residential Treatment Programs
        - Intermediate Care Facilities
        - Partial Hospitalization Program
        - Intensive Outpatient Program
- Committee Questions:
    - Brown-May: ARPA funds used to renovate residential facility with private provider contract; intermediate care providers in Nevada?
        - There is one provider who will bid, but the need is broader and there are billing challenges.
    - Titus: Is the State understaffed due to cost of reimbursements?
        - Can't hire nurses due to cost; some facilities won't accept kids with complex needs; high costs of single case agreements exceed Medicaid funds; and issues with caseload distribution.
- Clark County Family Services:
    - Gaps include intensive in-home services, early screening and services, community-based residential treatment, and foster care.
    - Sustainable funding is needed to support goal of least restrictive settings, such as Healthy Minds, for outpatient therapy.
    - Policy Recommendation: Recruit and Develop Mental Health Workforce.
        - Incentivize workforce development.
        - Research states with diverse array of mental health service providers for successful strategies.
        - Address length of time required for professional licensure.
        - Address ambiguity in 433B regarding responsibilities and duties for provisions for mental health services.
        - Give authority to the court to determine whether or not placement should be correctional or mental health in nature.
- Committee Questions:
    - Chair Doñate: Will get specific sections for legislation.
    - Li: What are federal and state standards
        - It's a new system, but ideally, follow up with outpatient providers.
    - Brown-May: Clinical child wellbeing percentages are up.
        - Child Haven numbers only; county mental health counselors are assigned by area to follow up.
    - Nguyen: Does 233B specify county responsibility for child welfare versus state?
        - Provision of child mental health services specifies county "may provide" rather than "shall provide."

        - Nguyen: Other facilities are better than Child Haven or detention center?
            - Clark County has a waiting list; if services don't match personal needs, there is a denial on the child welfare side.
        - Nguyen: Desert Willow has current 90-day wait time.
            - Need to ensure the safe application of services. Staffing vacancies in detention centers lead to increased overtime. Some children require a 4:1 staffing ratio. DCFS tries to contract out but can't compete with the private sector. If Desert Willow only serves youth and juvenile offenders, that leaves out child welfare cases under Medicaid.
        - Nguyen: They need something better than detention centers or Child Haven with untrained staff.
            - Titus understands staff limits; it's not a bed issue.
        - Titus: What are the Clark County recommendations related to length of time for professional licensure? Are there interstate compacts?
            - The clinical hours requirement is high for LCSWs and LMFTs.
            - Statutory restriction on clinical hours create barriers in Nevada though not in other states.
        - Chair Doñate: What are the county interventions?
            - Interface is good with Aging & Disability Early Intervention Services. Identified services are needed earlier for care coordination and mental health services at schools.
            - DCFS works with NV Department of Education to support behavioral health prior to disruption.
    - Ryan Gustafson, Washoe County Child Services:
        - Difficulty navigating mental health/behavioral health system; need solid continuum of care for least restrictive settings: intensive outpatient, day treatment/partial hospitalization, community-based housing, residential home, and acute treatment. They are missing levels in Washoe County and in Nevada. Some services and opportunities were lost during the covid pandemic, as well as decreased timeliness to service.
        - It's hard to untie child welfare from mental health. Challenges include specialized foster care placements, federal submission for evaluation plans, and fewer Medicaid providers.
        - West Hills project is important for Washoe County and for the State of Nevada.
        - The Mobile Crisis Response Team is shifting from DCFS to the County.
    - Committee Questions:
        - Titus: Staffing and monitoring?
            - McDade-Williams: DCFS went from 14 staff down to 10, including some transfers to Washoe County with better employment packages.
            - Gustafson: Coordination with state and rural counties is required for Mobile Crisis Response Team transition. Washoe County has a robust clinical team with a 3% vacancy rate. There is an increased opportunity for cross-training, and they have an 86% hospital diversion rate.
        - Titus: Impressed with the Washoe County transition with West Hills project.

- Gustafson: Anticipates 20-24 months onboarding and will work on provider recruitment along the way.
- McDade-Williams: Adult mobile crisis is transitioning to Clark County Fire Department. Discussions for a similar transition in Washoe County began in December.

- IX. Presentations on Child Welfare Services Across Nevada, Gaps and Challenges in the System, and Recommendations for the Committee.
  - Marla McDade Williams, DCFS:
    - Services provided through a bifurcated system with state supervision and county administration through Clark, Washoe, and rural counties.
    - The improvement plan includes performance targets and strategies and data dashboards.
    - Challenges include the following:
      - Expectations of what constitutes neglect.
      - Lack of foster homes.
      - Families that are resource poor.
      - No affordable housing.
      - Child care access.
      - Vacancies and staff who are still gaining experience.
      - Inability of families to care for kids with significant behavioral, developmental, and psychiatric needs.
      - Lack of legal representation for Rural Child Welfare.
      - Lack of Medicaid providers in rural areas (dental, medical, psychiatric).
      - Lack of domestic violence treatment services for batterers.
      - Lack of providers.
      - Fetal alcohol syndrome.
      - Autism evaluators and providers.
      - Substance abuse treatment.
      - Home health visiting nurses.
      - Array of services, including lower levels of care.
      - Impact of secondary trauma amongst the workforce.
  - Committee Questions:
    - Nguyen: Who pays for special benefits for foster kids?
      - Clark County: SSI or SSDI can be used for room and board rates with carryover balance for child discretion; the balance amount is limited to around $2000 based on federal guidance.
    - Orentlicher: Is it difficult to find homes under increased burden for approval?
      - Gustafson: It is a time-consuming process and home studies can be invasive to ensure safety factors based on age and needs of the child. The expedited licensure review process takes months, not weeks.
    - Titus: Is there a decline for foster care applications?
      - Gustafson: 53% of foster homes were lost post-covid.
    - Titus: Are there mandatory trainings? Are they online?

        - McDade-Williams: They are currently reviewing this process to decrease barriers and be responsive, with monthly training rather than quarterly.
        - Crumrine: Foster care is heavily regulated, and they constantly review services.
        - McDade-Williams: Relative licensing is being streamlined, with 32 placements year-to-date.
    - Brown-May: How are payments/benefits managed for clients?
        - Clark County is payee; they track in eligibility team and apply primarily to room and board.
        - Crumrine: The State operates like Clark County; sometimes they apply for supplemental to manage funds. They try to build savings through accumulation within accounts to support clients upon exit from care.
    - Jill Morano, Clark County Family Services:
        - Contracted out training for licensed foster care.
        - There has been a 20% increase in the Clark County population since block grant inception.
        - AB350 created an unfunded mandate and deficit funding support for aging out of foster care.
        - Required reporting is onerous.
- Policy recommendations:
    - Reevaluate the need for child welfare to investigate educational neglect and chronic absenteeism.
    - Other states use a service approach with wrap-around services, mandatory meetings with school, and less formal court processing.
    - 432B.219 adoption savings are supposed to reinvest with child welfare but have reverted back to the general fund. Funds are needed for ongoing support of families who adopt children.
- Ryan Gustafson, Washoe County Human Services Agency:
    - Child Protective Services reports and removals are going down.
    - Foster family licenses are going down and virtual services are increasing placement disruptions.
    - 54 out of 177 homes are on hold.
    - Congregational home numbers spiked post-covid.
    - Adoption options expanded with kinship care.
    - START Model includes sobriety treatment and recovery teams.
    - West Hills purchase is significant for challenges with foster homes, emergency shelter care, residential and acute mental health services, and kinship guardianship assistance.
- Committee Questions:
    - Brown-May: Is the START Model specialized for substance use foster kids?
        - Washoe County is just getting started implementing Peer Recovery Support and Peer Support Specialists training; there is limited data
        - Clark County is continuing with youth for substance use treatment and the Healthy Minds program.

        - Titus thanked Washoe County for not revoking unused licenses (unlike Aging and Disability Services) so they could regain providers.
        - Gray thought it was counterintuitive that placements in Washoe County had stabilized given population growth.
            - Gustafson explained that the intervention model was not in place previously. The evidence-based practice is to push into homes in a more meaningful way with robust clinical teams with training, together with child welfare teams.
        - Gray asked if there were any downfalls or removal requirements.
            - Gustafson said recidivism rates are tracked with review of past reports. Child fatality numbers are low but not zero. There are no cases where a child was left in a home. There are variations on what safety looks like from cleanliness to issues related to the age of the child.
            - McDade-Williams said the dashboard identifies screening rates for all 15 rural counties with the number of investigations and case by case discussions. There can be fallout for removal around cultural differences or presumptions. All cases are confidential, and it is never the intent to leave anyone in a dangerous home. Death requires an investigation, and the numbers are very, very small.
- X. Statutorily Required Update on AB 7 (2023) (Revises provisions relating to electronic health records.)
    - Melinda Southard, DHCFP, said DHHS has set up an Advisory Group for EHR provisions as required, with three meetings to date. Regulation development is underway.
    - Committee Questions/Comments:
        - Orentlicher:
            - Question raised during public comment.
            - Dr. Southard will send that out to advisory group for preliminary response.
        - Chair Doñate comments/feedback to advisory group:
            - More funds will likely be needed.
            - Focus on TEFCA: what are national standards for alignment?
            - Some providers do not want to align. Do repositories make sense?
            - His preference is to align toward TEFCA and not toward HIE.
        - Gray:
            - Will there be exemptions for doctors and practitioners who don't need EHR because they only do concierge for patients who don't want online records due to issues with ransomware? Some regulations impact patient outcomes.
        - Chair Doñate:
            - The bill captures waiver practices and a larger percentage of practices and consumer perspectives. Hospitals need uninsured referred patients and an interconnected system so it's a question of access versus burden. The Advisory Group can make recommendations based on the public hearing process.
        - Southard:

        - They are reviewing a waiver process.
- XI. Policy Recommendations for Review
    - Ms. Williams, Hazel Health presented on Recommendation for statewide Hazel Health Telehealth Services for youth (see materials).
    - Committee Questions:
        - Brown-May: Are they advocating a methodology? Is there data for NV students? Are they contracted with Clark County School District?
            - They service all Clark County students and want more buy in; it is an ambassador program.
            - Serving age 11 and up.
            - After this school year, it depends on Clark County School District; they are asking for a statewide protocol.
        - Chair Doñate: Requested presenters to reach out to community members individually.
        - Nguyen: Is there aggregate data versus individual school data and utilization?
            - Students are expecting this now; usage has doubled.
    - NSHE Naloxone Network Proposal:
        - XIB Madalyn Larson presented a harm reduction recommendation to require all NSHE institutions to provide low-barrier access to naloxone, along with naloxone training. Ms. Larson referenced the SURG recommendation for a stable and sustainable source of opioid overdose medication throughout the entire state.
        - Brown-May and Titus supported follow-up on this recommendation.
        - Chairman Doñate noted bipartisan support for a bill draft.
    - Children's Health Consortium
        - Char Frost, Vice Chair of the Nevada Behavioral Health Children's Consortium described the consortium under AB1 (2001 Special Session) with representation from DCFS, Child Welfare, Medicaid, school districts, juvenile probation, businesses, mental health providers, foster care and parents. They publish Priority Reports and Status Reports in alternate years. Additionally, they publish a 10-year plan, most recently in 2020 at the height of the pandemic. They share many priorities with earlier presenters, including children's mobile crisis response, Medicaid coverage, fully implementing building bridges model of care for in-home services, and more options to decrease need for crisis intervention and hospitalization. They want to expand and sustain a system of care in rural areas. There are cash pay issues across all Nevada counties.
        - Ms. Frost identified early detection and prevention and reducing bias and prejudice as the most important focus for the next session.