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Governor

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State of Nevada
Department of Health and Human Services

Behavioral Health Presentation
Division of Public and Behavioral Health
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Behavioral Health History in Nevada



- Historically, Nevada has had an unusually centralized state mental health system—state employees providing services directly to patients.
- Designed to be a safety net for individuals who had no other alternative access to services, this system did its best to provide the most basic care.
- This structure resulted in many people receiving behavioral health services only after contact with law enforcement.
- Nevada consistently rated low or last in reports ranking the states on the issue.
- Lawsuits and negative press about the quality of services abounded.
- Consistent shortage of professional staff throughout the community persisted.
- Inadequate intensity of services for those most severely affected by behavioral health needs.

Transformational Changes

Recently, the Division of Public and Behavioral Health (DPBH) has experienced several transformative changes that impact the behavioral health system:

- Increase in overall demand for behavioral health services
- Increase in the Nevada population
- Parity laws that require psychiatric illnesses to be treated like other medical conditions
- Expansion of Medicaid
- Changes in Nevada Medicaid rates for some behavioral health services



Risks and Opportunities are Inherent in this Change

Opportunities—Thinking about the system in a new way:

- Choice for consumers—access to a broader array of providers rather than just the state employees.
- Access to “whole health” services for a population that previously received only psychiatric services.
- Benefits of the market to the services—competition can have the effect of driving down costs and increasing quality.
- Capacity for long-term services that have not existed historically.

Risks/Threats—We must monitor in making this transformation successful:

- Assurance of an adequate network of providers to Medicaid recipients.
- Assurance that rates are adequate to maintain the expanded capacity.
- Repeal of the Affordable Care Act.

A New Paradigm

A systemic approach for public funding to behavioral health services.

- Patient services largely provided by community providers and paid for by Medicaid.
- DPBH clinical services focused on diverting people who need behavioral health services away from the criminal justice system and into the appropriate BH services.

A new discussion will identify new challenges:

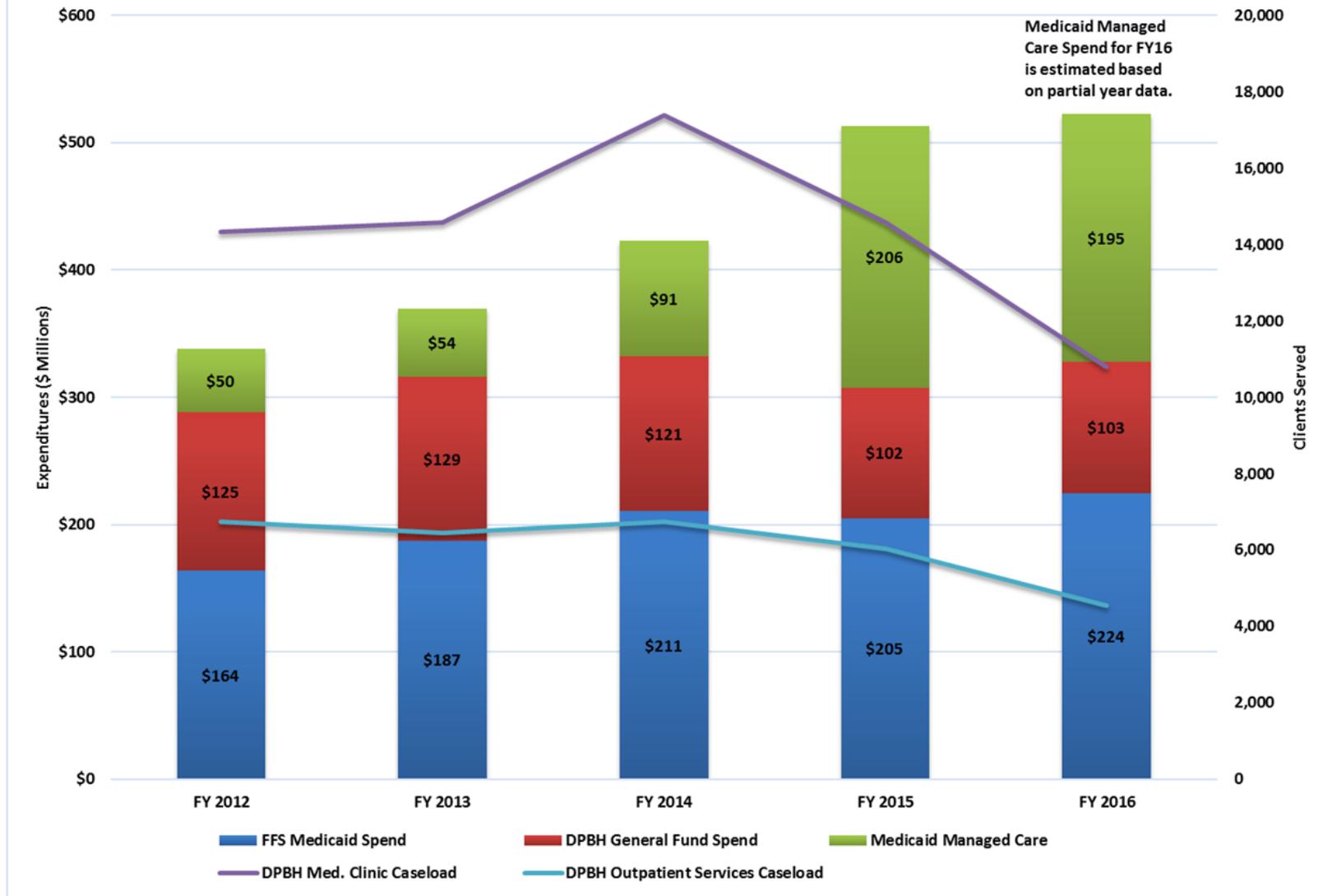
- Services have to be cost-effective, and reimbursement rates have to be adequate.
- Role of community partners have to be redefined
 - Hospitals
 - Law enforcement
 - Local jurisdictions
 - Court system

A new paradigm requires a new discussion:

- “What role does each of these pieces play in ensuring that we get people the behavioral health services they need?”

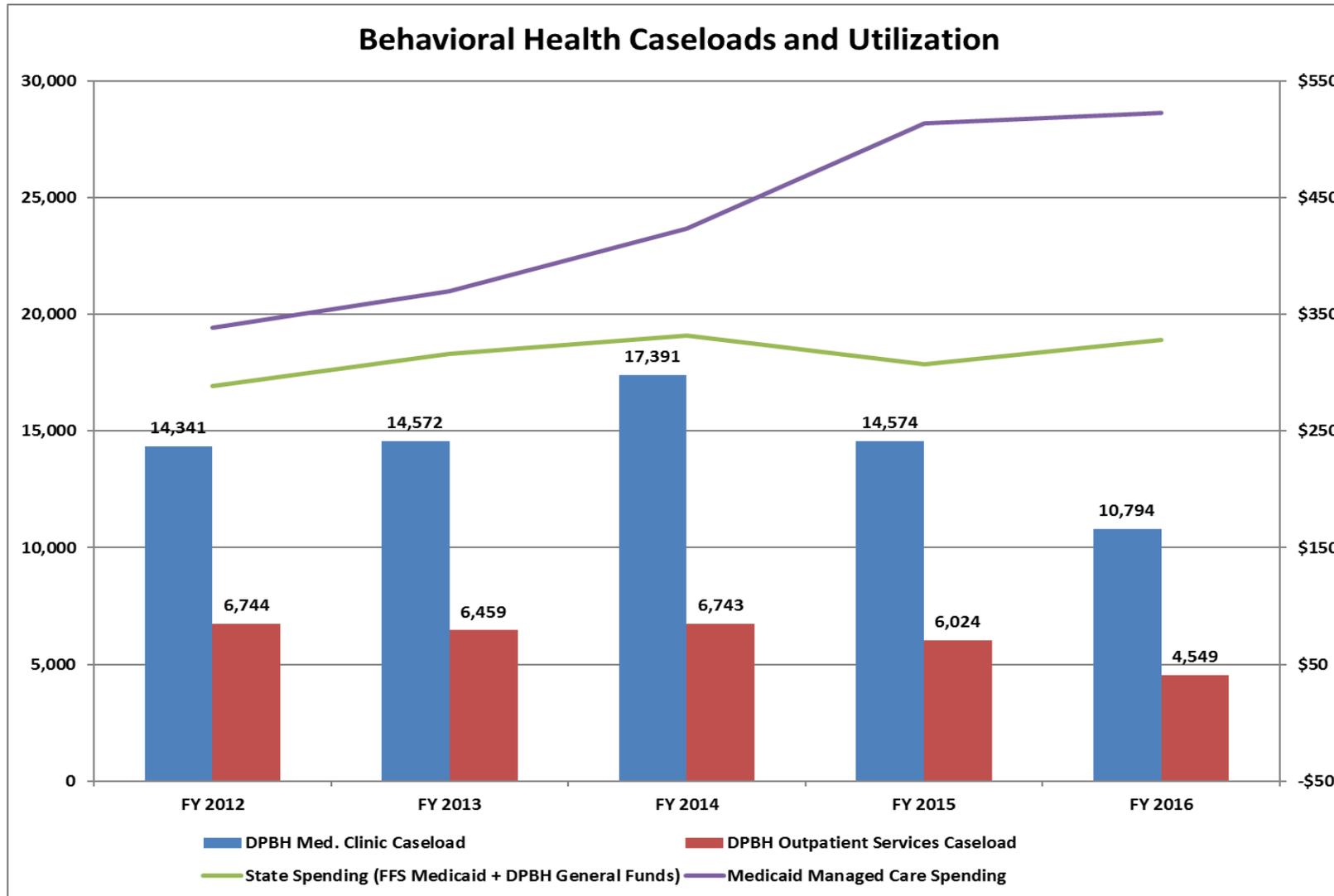


Behavioral Health Spend and Caseloads

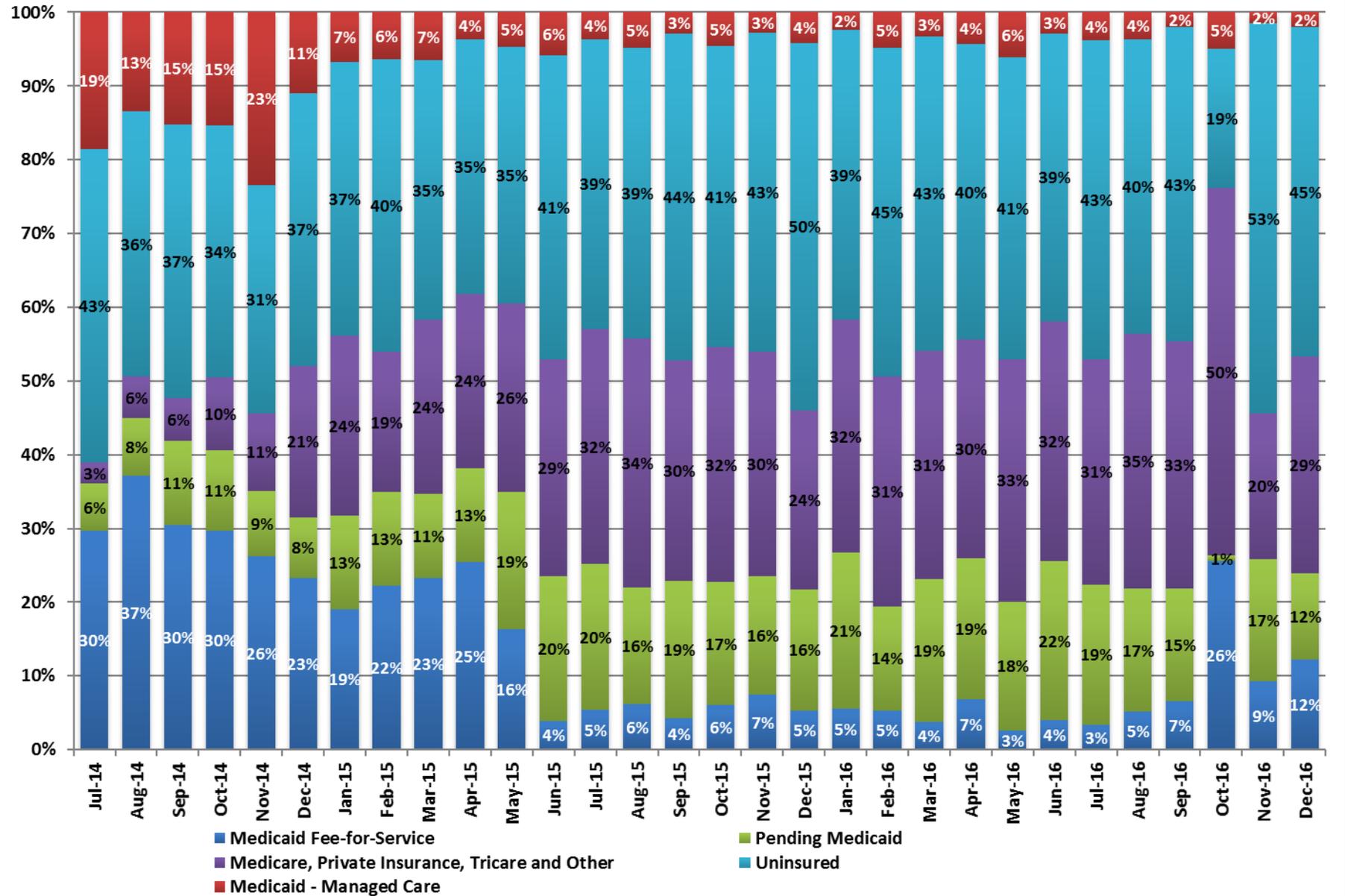


Based on Behavioral Health spending, there are more services being paid for through the Medicaid managed care and fewer services requiring General Fund support.

Demand Changes—Outpatient/ Medication Clinics



Insurance Status of Adults Waiting in Emergency Rooms for Behavioral Health Services

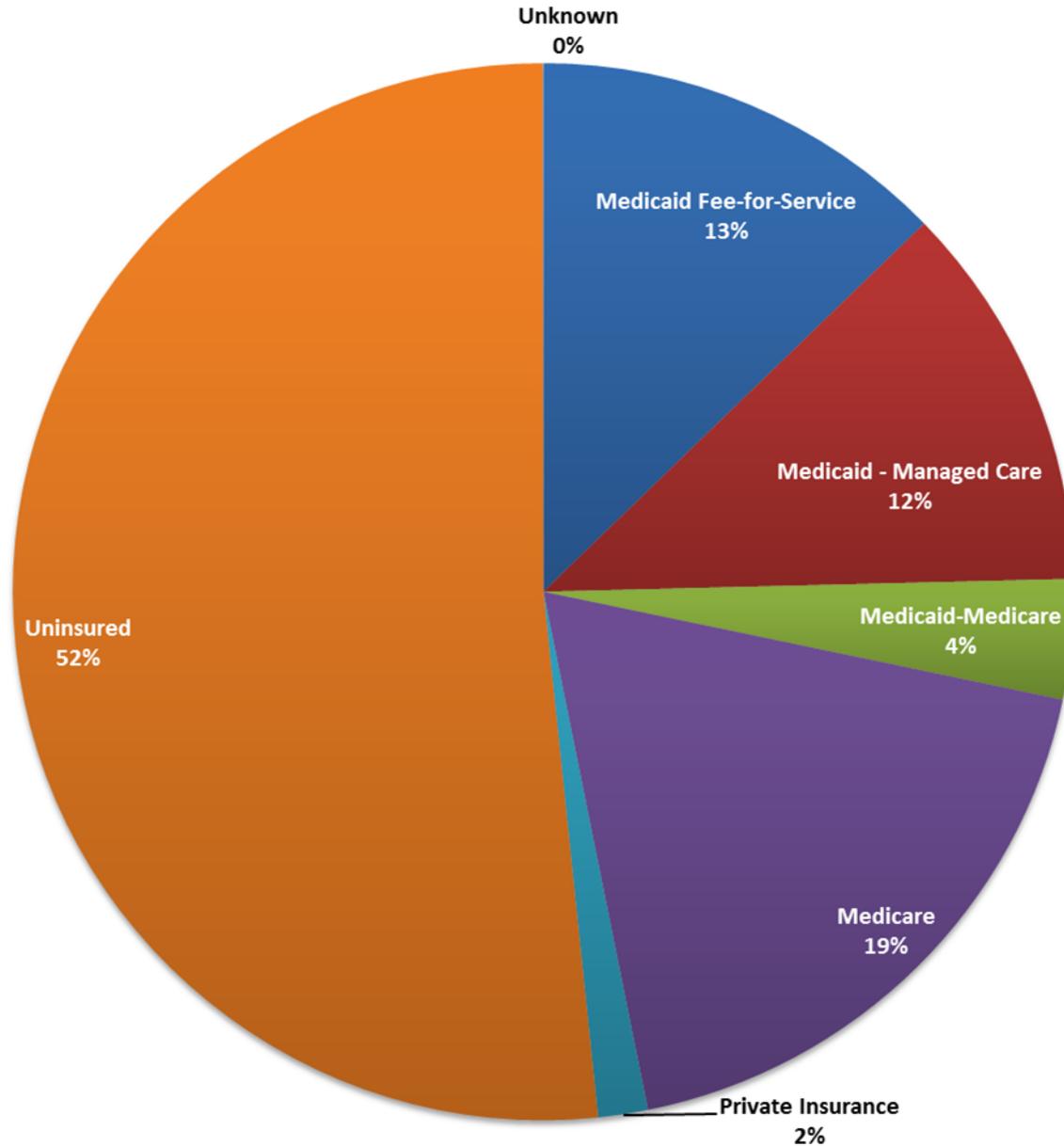


Which of these insurance status groups is 'waiting' for the state beds?

Medicaid managed care providers have reduced the numbers of covered individuals in emergency rooms.

There is a need to shift the focus of the uninsured to Medicaid pending.

Insurance Status of Inpatient Clients - Statewide, FY17 to date



As additional acute psychiatric services become available in the community, patients with payers such as managed care, Medicare and private insurance, will have the option of being served in settings other than the State hospital.

Medicaid fee-for-service patients can be served in psychiatric capacity that is attached to a medical/surgical hospital because those are not subject to the IMD exclusion.

Eligibility Collaborative

- The uninsured numbers noted on the chart on the prior slide demonstrate that we can continue to impact the wait by connecting people with health insurance and other benefits.
- The remedy for this is the co-locating of welfare eligibility workers from the Division of Welfare and Supportive Services (DWSS) in many settings to provide determinations for the uninsured, in real-time.

DPBH Role in the New Paradigm

- Maintain a safety net for the uninsured – a very small number of people
- Fill the gaps for those who cannot be served in other settings
- Support for the expansion of community capacity
- Develop programming that encourages services rather than incarceration

New and Expanded Service Models

- CCBHC
- Sequential intercept
- Forensic inpatient
- Telehealth services



Certified Community Behavioral Health Centers (CCBHC)

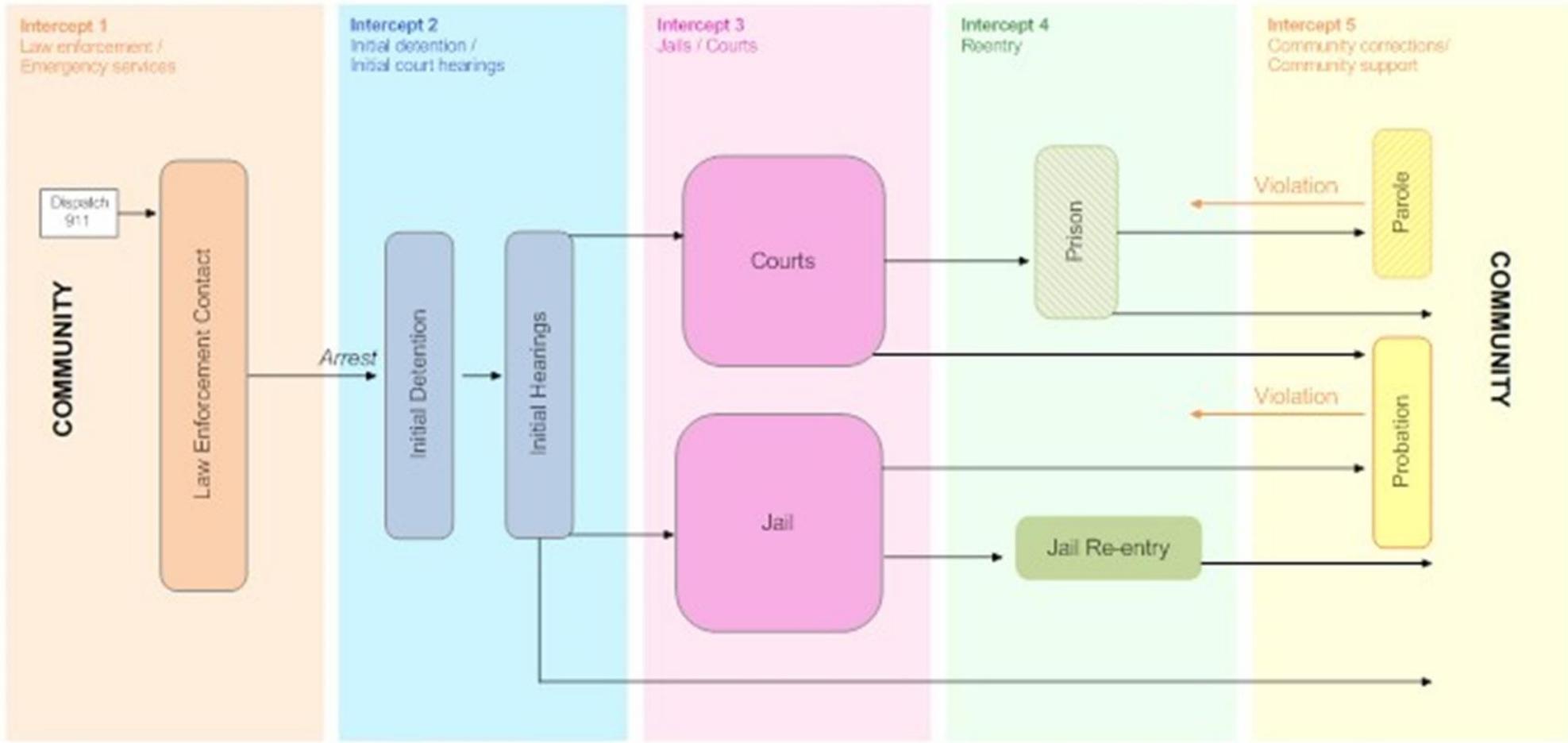
- CCBHC is the new model of care which standardizes expectations for quality and service delivery in community mental health centers, and provides linkages which tie payments to outcomes.
- The goal of the CCBHC is to strengthen community-based mental health and addiction treatment services, integrate behavioral health care with physical health care, and use evidence-based care more consistently.
- For more information on CCBHC, from SAMHSA, go to: <https://www.samhsa.gov/section-223>

CCBHC

Section 223 Demonstration Program
for Certified Community Behavioral
Health Clinics



Sequential Intercept Model



Delivery Model Realignment

Expansion of outpatient forensic, re-entry and diversion services

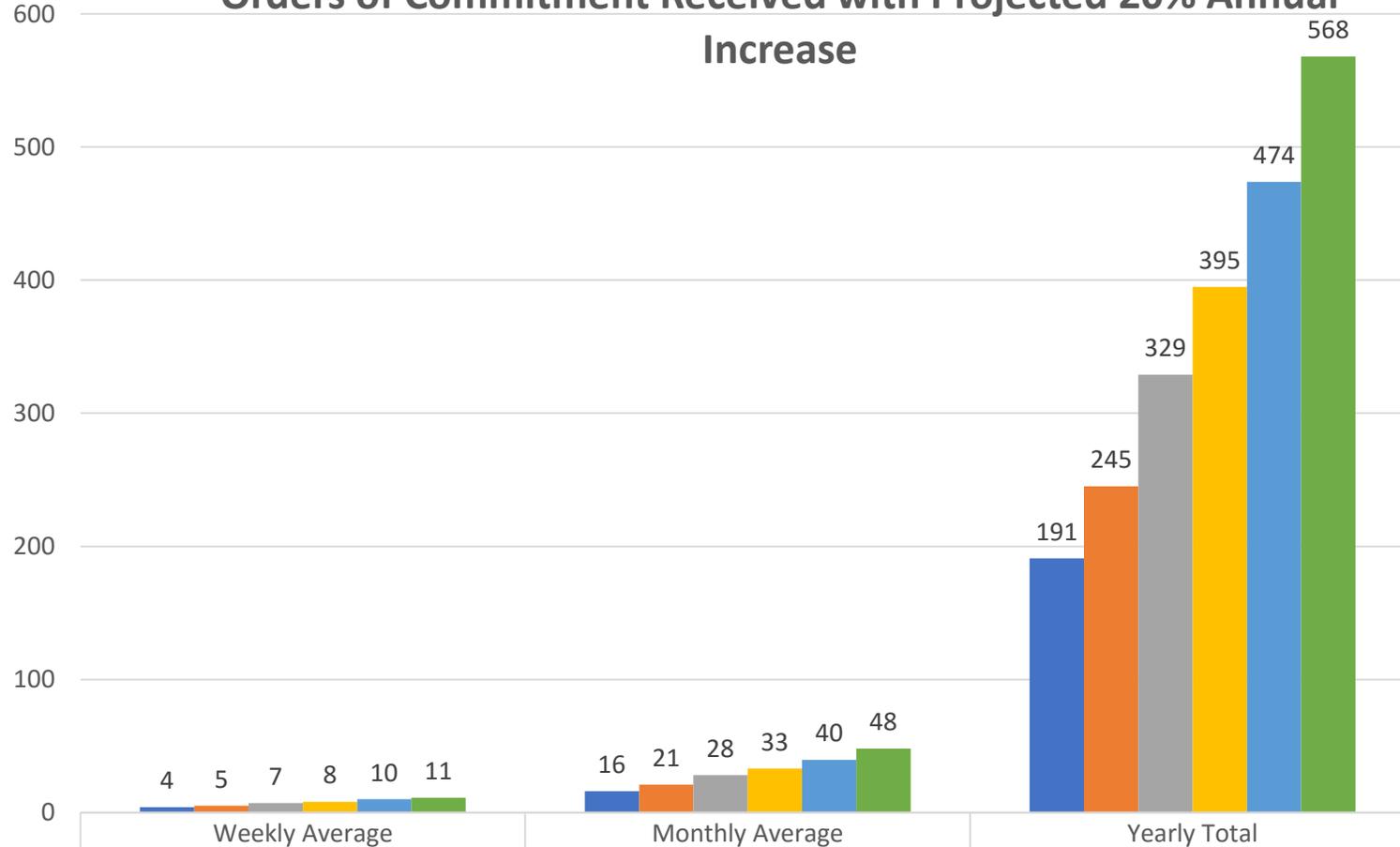
Partners:

- Department of Public Safety-Parole and Probation
- Local jails and law enforcement
- Nevada Department of Corrections
- Specialty courts
- Judiciary



Mental health assessments and connection to benefits for those exiting jail/prison and entering parole or probation provides for a seamless approach to post-release services in outpatient settings. This approach will reduce recidivism for this population.

Orders of Commitment Received with Projected 20% Annual Increase

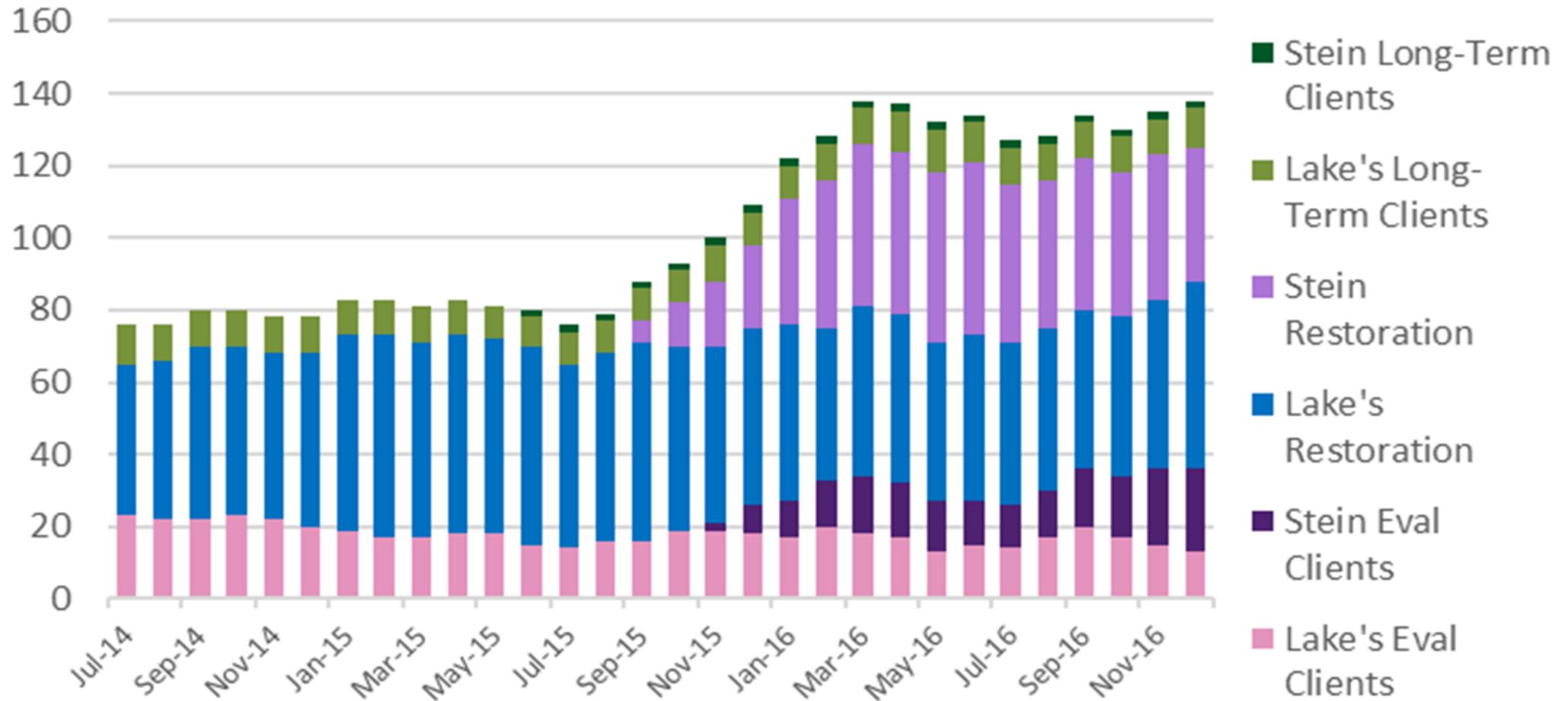


This projection of growth in demand for forensic services provides some indication of the demand we have experienced in since 2012.

This demand was the impetus for Stein and realignment of portions of hospital staff to forensic services.

■ SFY12	4	16	191
■ SFY14	5	21	245
■ SFY15	7	28	329
■ SFY16 Projected	8	33	395
■ SFY17 Projected	10	40	474
■ SFY18 Projected	11	48	568

All Forensic -Statewide



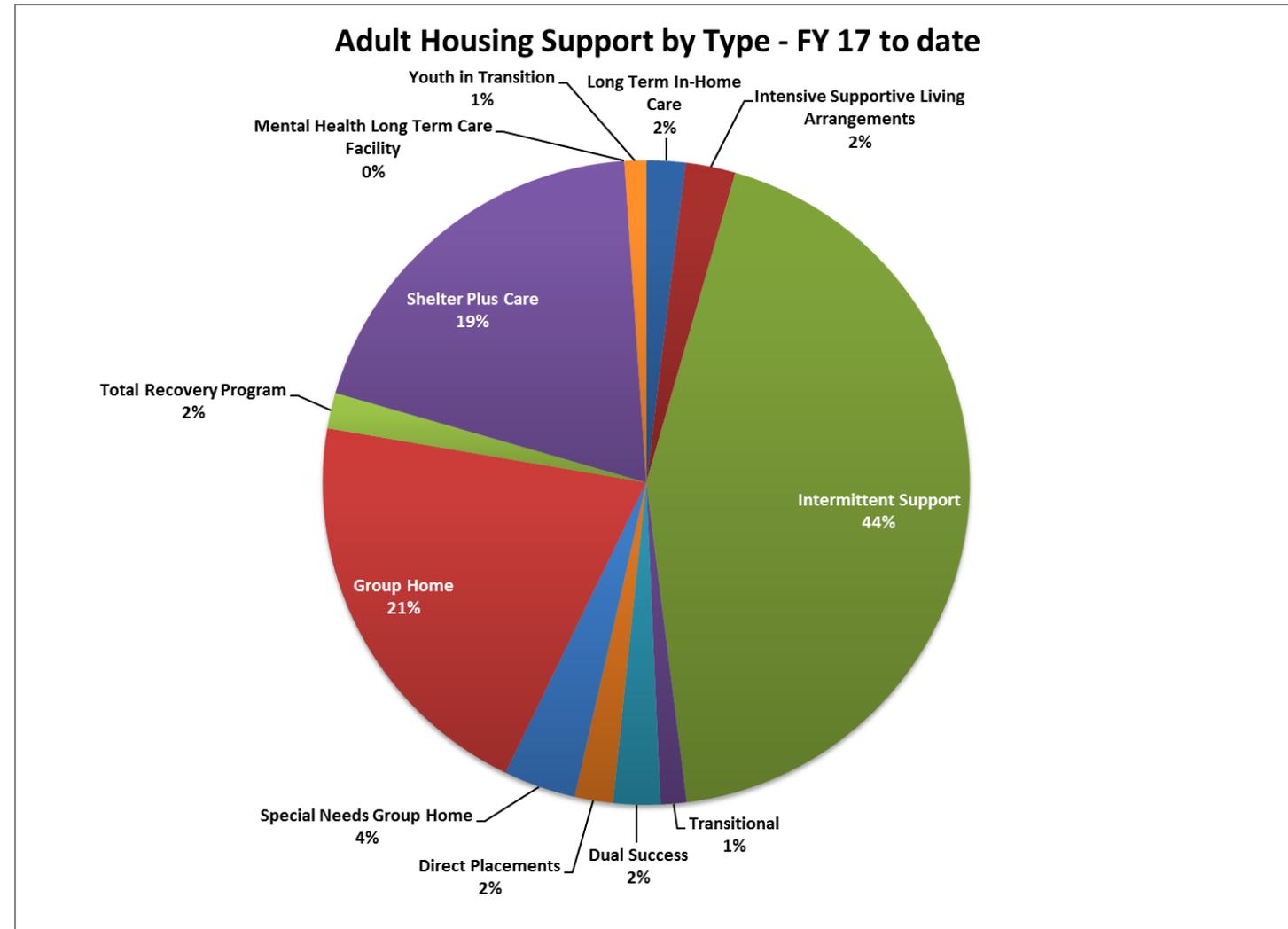
Residential Support Services

A safe place to live remains an essential component of recovery.

Our goal for every client is to live independently in the community in a setting chosen by the individual.

DPBH is committed to ensuring that people with behavioral health needs have access to safe housing assistance.

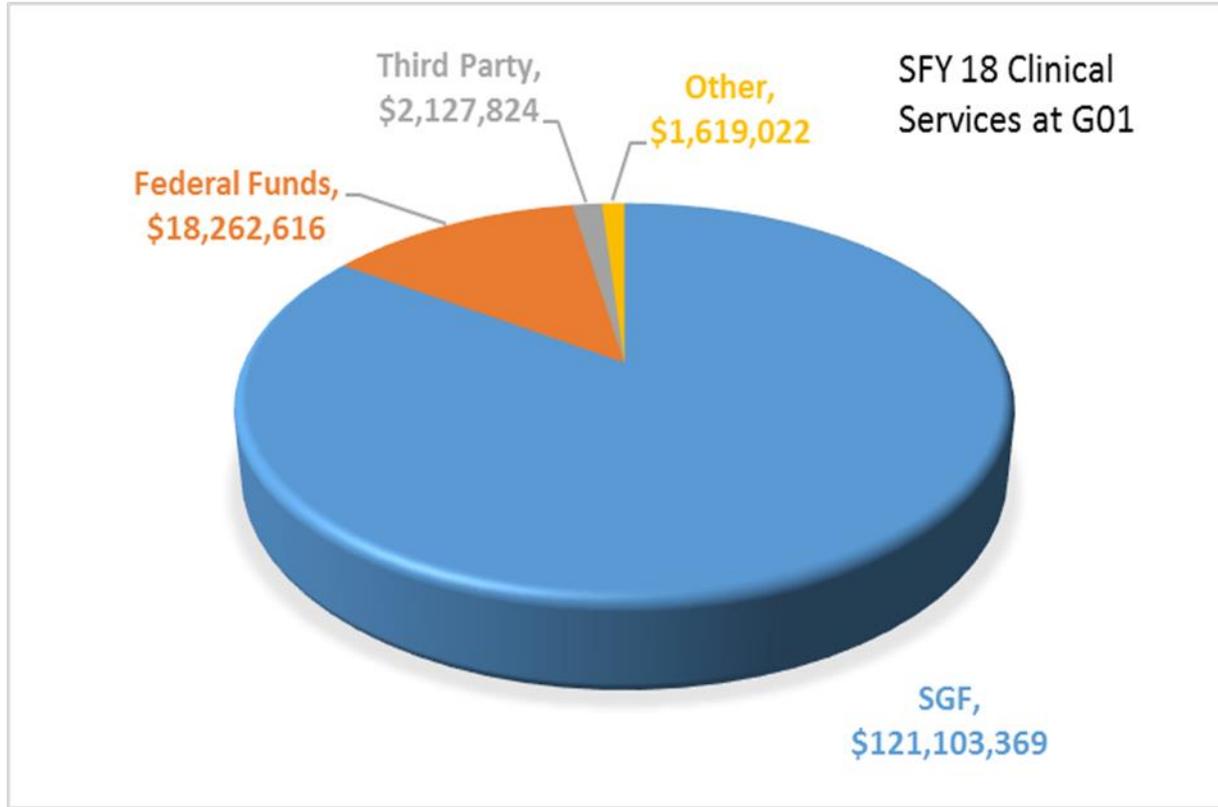
AB 46 is designed to improve our ability to regulate the quality of these services.



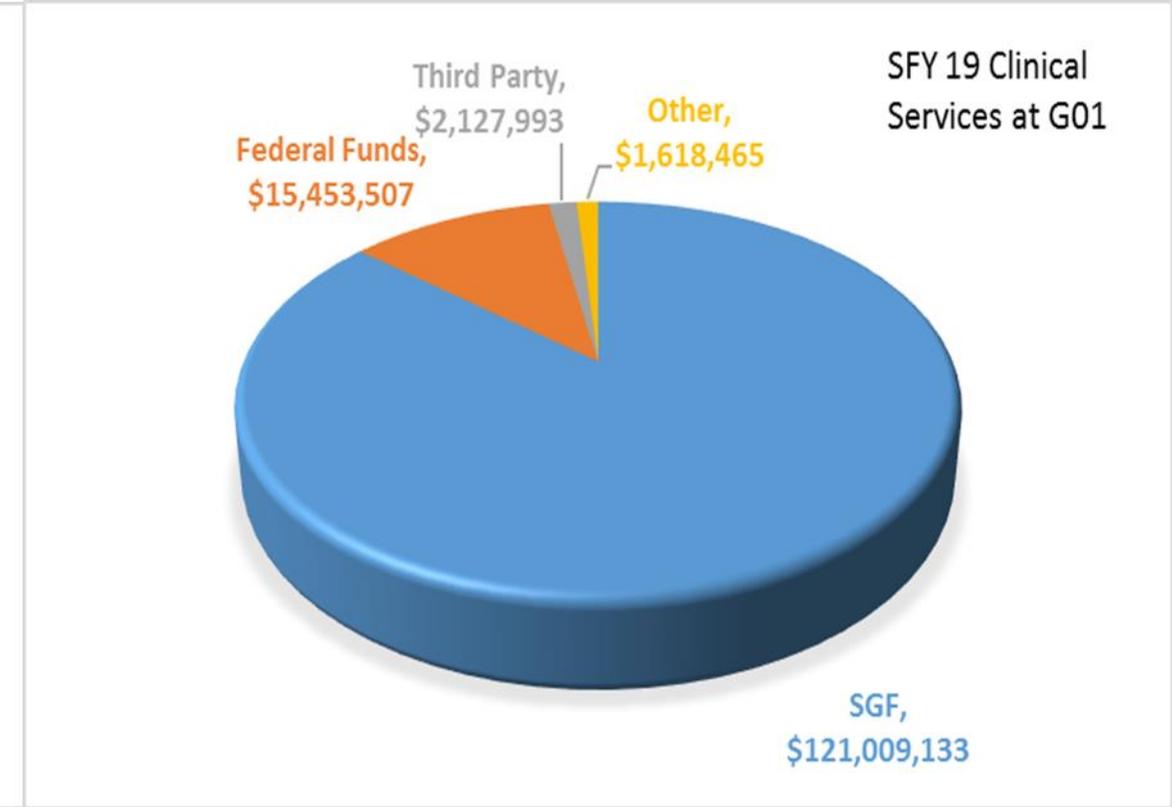
Behavioral Health Workforce Shortages

- Mental health services in Nevada are experiencing a severe workforce shortage of behavioral health professionals.
- The Nevada Primary Care and Workforce Development Office works with the federal Health Resources Services Administration (HRSA) to designate *Health Professional Shortage Areas (HPSAs)* in Nevada to leverage federal funding for recruitment and retention.
- For behavioral health, most of Nevada is a designated HPSA, with a single catchment area in all of northern Nevada, and multiple designations in southern Nevada.

Clinical Services Statewide



Total Budget SFY 18: \$143,112,831



Total Budget SFY 19: \$140,209,103

SGF-State General Fund

Federal Funds-Medicaid, grants, etc.

Third Party-commercial insurance

Other-fees, cash pay, other sources

Behavioral Health Highlights

Under the ACA, most people have insurance and are now covered under the Medicaid Managed Care.

Individuals can access services at any clinic, in any hospital, and fill prescriptions at any pharmacy that accepts Medicaid or is in the Managed Care Network.



This has resulted in reduced demand for some services historically provided directly by the state.

DPBH remains the safety net for those who do not have insurance, and becomes a leader in de-criminalizing behavioral health needs.

Capacity freed by expansion in the community can augment the need for some long-term services that have been available only through the court system.

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