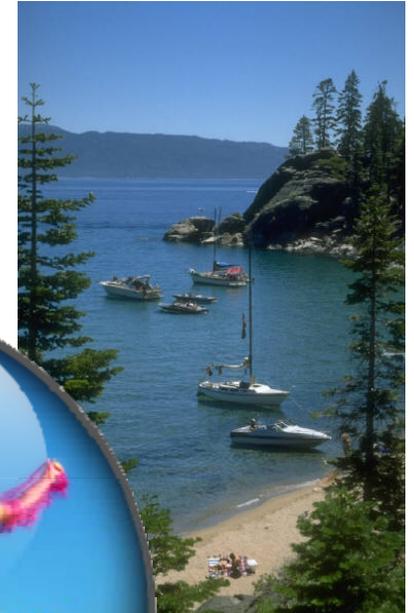


State Plan for Children's Mental Health in Nevada

The Nevada
Commission on
Mental Health &
Developmental
Services

June 30, 2010



**Subcommittee on Children's Statewide
Behavioral Health Planning**

**Gretchen Greiner, Ed.D.
Subcommittee Chair**

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It is with pleasure that the Nevada Commission on Mental Health and Developmental Services (MHDS Commission) presents its initial State Plan for Children's Mental Health Services in Nevada. This plan represents the fine work of Nevada's regional children's mental health consortia, key state agencies, and has the endorsement of every MHDS Commissioner. This initial "roadmap" outlines a 10-year framework, which identifies immediate action strategies to be implemented if we are to be successful in transforming the children's mental health system in Nevada by 2020.

The MHDS Commission envisions a comprehensive, coordinated public health approach to the children's mental health system across Nevada, comprised of prevention, early intervention, and treatment programs and services for children ages birth to 18 years. This vision also includes children transitioning seamlessly into adult mental health services from systems such as child welfare, juvenile justice, and children's mental health. This 2011-12 Plan is a statewide strategic "roadmap" that will guide Nevada to achieve this vision. It begins now, with the 10 immediate action objectives you will find in this report. The MHDS Commission feels progress will be needed in every one, if we are, in fact, to transform the children's mental health system in Nevada.

In submitting this plan, the MHDS Commission recognizes fully that we have just begun our work. True reform of the children's mental health system will require engaging families, communities, policymakers, educators, health care and mental health providers, and many others in a collaborative effort to achieve these recommendations. In addition, while many of these recommendations and strategies are readily achievable, many others will entail a phased-in approach that is implemented over time. This plan will continue to evolve as the MHDS Commission revisits it annually, per NRS. 433.

This has been a task that the Nevada Commission on Mental Health and Developmental Services is deeply committed to. We urge the Governor and DHHS to fully support the plan and to continue to make children's mental health a priority in Nevada.

Respectfully Submitted,



Gretchen Greiner, Ed.D.
Subcommittee Chair

Nevada Commission on Mental Health and Development Services
June 2010

EXECUTIVE SUMMARY

Work began on this 10-year plan in spring 2010 and has continued throughout the spring. The effort to date has identified a 10-year framework, which will result in a sweeping statewide transformation of Nevada's current service delivery system and its governance and accountability structures by June 30, 2020.

This plan recommends the use of a "start-up" two-year plan designed to provide targeted objectives specifically needed to build Nevada's new service delivery system over the subsequent eight years. A cautious approach is also warranted due to the extraordinary economic and social factors that are currently affecting Nevada, including the impact of Federal Health Care reform and Nevada's current economic conditions. One must also consider that, during the 10-year lifecycle of this plan, Nevada is projected to spend over \$1.2 billion dollars just on its existing programs. With expenditures of this magnitude, the MHDS Commission feels that a particularly thoughtful planning process is warranted in order to assure effective oversight in these large future public expenditures.

As a result, the plan you are holding spans only the initial two years of a 10-year framework, beginning July 1, 2010, and continuing through June 30, 2012 (2011-12). The MHDS Commission is confident that, if implemented, this plan will result in a structure that will accurately account for the performance of Nevada's future system of care for children. The MHDS Commission is in position to build a system of care that will help ALL children by offering improved access to services for children and families, efficient use of funding from state, federal, and other sources, quality services using techniques proven effective, and accurate and effective accountability at state and local levels.

This 2011-12 Plan includes 2 goals and 10 measurable objectives, which are provided for immediate action. The measurable objectives include the continuation of resources to support the statewide and regional children's mental health consortia, changing the roles of the MHDS Commission and the Division of Child and Family Services, establishing a policy board, and implementing new federal laws as they relate to children's mental health services.

This plan recommends that the MHDS Commission begin monitoring progress on the State Plan using an ongoing system of reporting via its Subcommittee for the Development of the State Mental Health Plan for Children (Subcommittee). The MHDS Commission recommends a continuous feedback loop with the regional consortia and state agencies to monitor progress towards the goals in the 10-year plans submitted by the regional consortia and this overall state transformation plan.

A key conclusion of the plan is a request for the Nevada Department of Health and Human Services to develop an implementation report that includes provision for ongoing MHDS Commission monitoring.

NEVADA STATE PLAN CHILDREN’S FOR MENTAL HEALTH
July 1, 2010-June 30, 2012

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THE NEVADA COMMISSION ON MENTAL HEALTH AND DEVELOPMENTAL SERVICES:

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Barbara Jackson	Representing Consumers
Vacant	Representing Marriage & Family Therapists
Vacant	Representing General Public – Developmental Svs.



This 2011-12 State Plan was compiled by Kevin Crowe, Ed.D., Nevada MHDS Commission Program Consultant.

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ACKNOWLEDGMENTS

It would have been a monumental task for the MHDS Commission to develop this plan without the participation of the three regional children's mental health consortia (Clark County, Washoe County, and Rural) and the Nevada Children's Behavioral Health Consortium. The hard work of the regional consortia, evident in their respective plans, is testimony to the dedication of these groups to changing the landscape for children with mental health issues. The collective vision of these groups, and the Nevada Children's Behavioral Health Consortium, is reflected in this plan, thanks largely to the members of those groups who participated in this plan's development.

This report would not be possible without the participation of Mary Liveratti, Deputy Administrator, Nevada Department of Health and Human Services (DHHS). The MHDS Commission, on behalf of families and children with mental illnesses in Nevada, remains indebted to her for her resourcefulness in the development of this initial plan.

The MHDS Commission would be remiss if we did not acknowledge Diane Comeaux, Administrator for DCFS, and her administrative staff for their contributions to this plan. They clearly embrace the need for radical change. The DCFS staff assisted the Commission to develop accountable steps within this plan to begin the transformation.

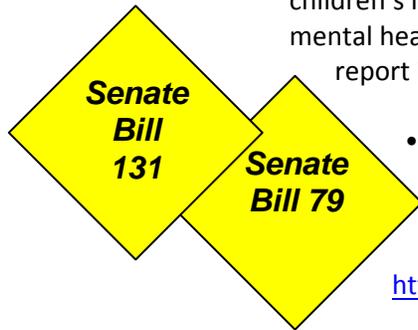
Sincere appreciation to those family members and youth who shared their stories at consortia meetings and with the MHDS Commissioners across the state, with hopes that their personal experiences will guide the transformation of the children's mental health system of care in Nevada.

I. INTRODUCTION

The Nevada Commission on Mental Health and Developmental Services (referred to hereafter as the "MHDS Commission") is appointed, pursuant to NRS Chapter 433, to establish policies to ensure adequate development and administration of services for persons with mental illness, developmental disabilities, and related conditions. The MHDS Commission has several powers related to the oversight of programs within the Department of Health and Human Services (DHHS). There are three principle DHHS divisions directly involved in this planning process: Mental Health and Developmental Services (MHDS), Child and Family Services (DCFS), and Health Care Financing and Policy (HCFAP). The MHDS Commission is also responsible for oversight of programs for co-occurring disorders since the Substance Abuse Prevention & Treatment Agency (SAPTA) is also housed within MHDS.

This 2011-12 State Plan is designed to build upon existing legislation enacted in 2002, which established a children's mental health consortium in each county whose population is 100,000 or more (currently Clark and Washoe Counties) and one children's mental health consortium in the region that comprises all other counties and prescribes the membership of each children's mental health consortium. (NRS 433B.333)

In addition, legislation added during the 2009 Legislative Session assigned new responsibilities to the MHDS Commission. These bills, SB 131 and 79, are interrelated bills that, taken together, place new responsibilities on the MHDS Commission to develop a statewide plan for children's mental health programs. These two bills are also unique in that they require linking each regional children's mental health consortium with DHHS to provide ongoing statewide planning, policy and program development. This report is the MHDS Commission's beginning efforts to implement the intent of this new legislation.



- Senate Bill (SB) 79 requires the MHDS Commission to create a subcommittee on the mental health of children to review the findings and recommendations of each mental health consortium and to create a statewide plan for the provision of mental health services to children. You can read SB 79 in its entirety at:

<http://www.leg.state.nv.us/75th2009/Reports/history.cfm?ID=160>.

Senate Bill (SB) 131 revises regional consortia plan requirements by requiring a long-term strategic plan that is effective for 10 years.

- Each regional children's mental health consortium is required to submit to the Department of Health and Human Services a long-term strategic plan which is effective for 10 years and which includes the strategies and goals of the consortium for providing services to children with emotional disturbance within the jurisdiction of the consortium. In even-numbered years, each consortium is required to submit to the Director of the Department and the MHDS Commission their revisions to the long-term strategic plan and a prioritized list of services and costs necessary to implement the plan.
- This law requires that the Director of the Department of Health and Human Services consider the list of priorities and costs submitted by each consortium as DHHS prepares its biennial budget request to the Governor and Legislature. In odd-numbered years, each consortium must submit a report regarding the status of the long-term strategic plan and any revisions made to the plan.
- Another unique and powerful change is that this statute authorizes each mental health consortium to submit a request for one legislative measure for a regular legislative session. You can read SB 131 in its entirety at:

<http://www.leg.state.nv.us/75th2009/Reports/history.cfm?ID=338>

The MHDS Commission is providing this two-year plan be implemented as the first phase of a 10-year framework (2010-2020). Currently Nevada spends over \$125 million per year on public children's MH services across child-serving systems.¹ Nevada is projected to spend at least \$1.2 billion taxpayer dollars during the 10-year span of this state plan. The MHDS Commission feels that expenditures of this size warrant careful planning and program evaluation.

¹ Pires, S Mayne. (2009). Report on Mental Health Spending for Children and Adolescents in Nevada Across Public Child-Serving Systems. Human Service Collaborative, Washington DC

The MHDS Commission believes that Nevadans are best served by beginning this 10-year framework using a strategic and cautious approach. This is due to two extraordinary factors: 1) impending changes in children's health services effective by 2014, due to the impact of the new federal Patient Protection and Affordable Care Act (PPACA), and 2) Nevada's declining and unstable financial projections. The MHDS Commission has worked to develop a meaningful, specific, and measurable plan to deliver cost-effective mental health services to children within this context. To execute an effective and accountable planning process through 2020, the Nevada MHDS Commission recommends this transformation begin with those immediate, measurable state actions over the next year that must be completed before any further system implementation can proceed.

This 2011-12 State Plan is designed to begin immediately with oversight by the MHDS Commission and active involvement of the consortia and DHHS. This planning collaboration in itself comprises a key structural change, which the MHDS Commission will put in place as a foundation, during this two-year start up process, on which to complete a 10-year transformation by 2020.

Probably the clearest way to illustrate the difference in Nevada's new childcare system is shown when looking at Figures 1 and 2. Comparing these two figures, one can see that Nevada's current services delivery system provides the bulk of its resources towards the most intensive services. By 2020, Nevada's future system of care will distribute funds as shown in Figure 2, shifting expenditures to target a full range of services.

The MHDS Commission proposes to transform the current funding system² (Figure 1), which shows the dollars spent in Nevada during 2007 by levels of service. The careful reader can see Nevada's current system spends the bulk of its resources on the most intensive services. Nevada's transformed system can be seen in Figure 2, which provides an estimate of the children who may be served, based on 2009 school enrollments. The MHDS Commission recommends implementing a child care system, which will, over the course of the 10-year framework, redistribute resources as illustrated in Figure 2.

This plan is intended to help implement an accountable structure that will frame how Nevada's public and private agencies can best support and enhance the lives of Nevada's children through a comprehensive mental health system.

² Excerpted from Pires, S Mayne. (2009). Report on Mental Health Spending for Children and Adolescents in Nevada Across Public Child-Serving Systems. Human Service Collaborative, Washington DC

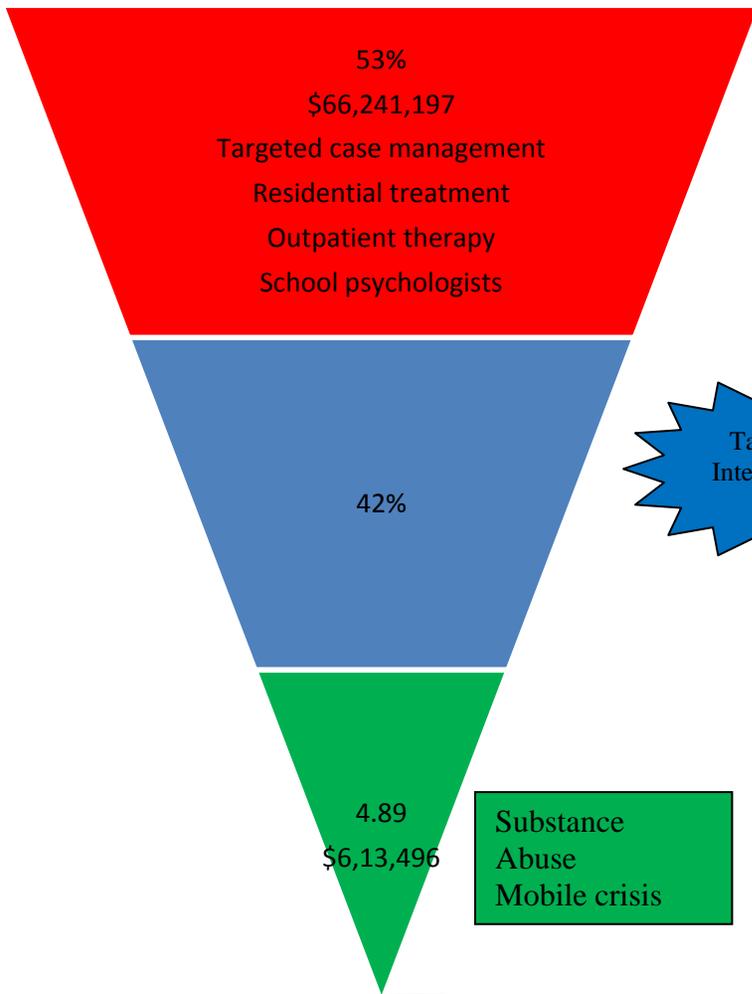


Figure 1. The CURRENT Public Health Approach for Children's Mental Health Services in Nevada

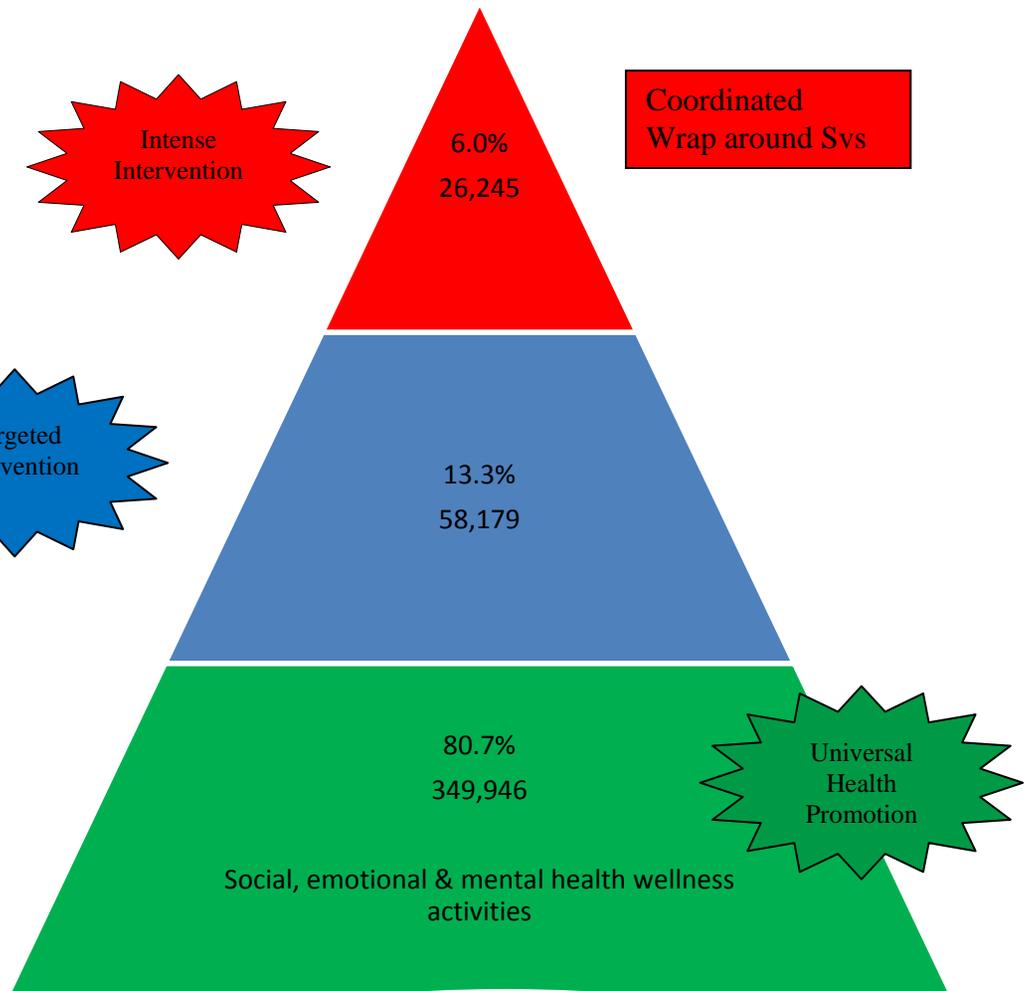


Figure 2. The FUTURE Public Health Approach for Children's Mental Health Services in Nevada

This start-up phase also aligns these immediate actions with the upcoming Nevada legislative cycle to provide full implementation information to the 2011 Legislature. If successful in these initial policy and program actions at the state level, Nevada will have put into place the needed foundation on which to implement statewide governance of a transformed system of care for children’s mental health services in Nevada.



II. The MHDS Commission’s Vision for a Transformed Children’s Mental Health System

Research clearly demonstrates that children’s healthy social and emotional development is an essential underpinning to school readiness, academic success, health, and overall well-being. Prevention and early intervention efforts have been shown to improve school readiness, health status, and academic achievement, and to reduce the need for more costly mental health treatment, grade retention, special education services, and welfare supports.

Unfortunately, a significant number of Nevada children experience serious mental health problems and many of them do not receive the services they need.

Nationally, suicide is among the top three causes of death for young people ages 15-24, and in the top five for younger children ages 5-14.³ In some states, it has been estimated that over 90 percent of these youth have experienced a mental disorder. Even more disconcerting, Nevada has consistently ranked among the top three states for overall suicide rates. While it may be more immediate here in Nevada, the state is not alone in confronting these issues as we plan the future MH system for children. Other state MH systems report that more toddlers are expelled from pre-kindergarten programs due to mental concerns than are students in grades K-12. In some states, over 20 percent of children have a diagnosable mental health problem.⁴ Mental health programs and services for children in Nevada—like that of most states—are highly fragmented, under-resourced and limited in scope, and place little emphasis on promoting children’s social and emotional well-being and preventing mental health problems.

Data such as these indicate that most mental health problems are largely preventable or can be minimized with prevention and early intervention efforts. However, the current children’s mental health system in Nevada places little or no emphasis on prevention or early intervention, and only a small percentage of Nevada children who need mental health treatment receive it. While many agencies and systems in Nevada, including child welfare, public health, education, human service and juvenile justice, attempt to address children’s mental health, there is little coordination, and resources are not maximized, leaving children, families, schools and communities struggling to cope with children’s mental health needs. A comprehensive, coordinated children’s mental health system can help maximize resources and minimize duplication of services.

³Caruso, K. (2010). *Suicide Statistics*. Retrieved June 12, 2010 from <http://www.suicide.org/suicide-statistics.html>

⁴Illinois Children’s Mental Health Partnership (2005). *Strategic Plan for Building a Comprehensive Children’s MH System in Illinois*. 208 LaSalle St., Suite 1490, Chicago, IL 60604-1120. Retrieved from: www.ivpa.org

The MHDS Commission envisions a comprehensive, coordinated children's mental health system comprised of prevention, early intervention, and treatment programs and services for children ages 0-18 years, and for youth ages 19-21 who are transitioning out of key public programs (e.g., juvenile justice, child welfare, schools, and the mental health system). Programs and services will be available and accessible to all Nevada children and their families. Our services will serve new parents adjusting to the demands of parenthood, a toddler struggling to master basic social and emotional developmental tasks, an adolescent experiencing feelings of depression, or a youth with outbursts of uncontrollable rage who is dangerous to themselves or others.

The recommendations found in this report are driven by the excellent work already done by the Nevada Children's Behavioral Health Consortium (Consortium). The state-level recommendations found in this plan build upon and interface with these regional efforts. Nevada's regional consortia remain actively involved in the ongoing MHDS Commission planning process; this assures actions taken at the state level make a measurable difference in each community. The MHDS Commission is convinced that it is critical that these consortia continue in order to provide ongoing technical expertise, community input, and implementation support. They will also be integral in assisting in state-level activities to account for the effectiveness of this plan.

As envisioned by the MHDS Commission and the Consortium, Nevada's transformed children's mental health system will include the following characteristics:

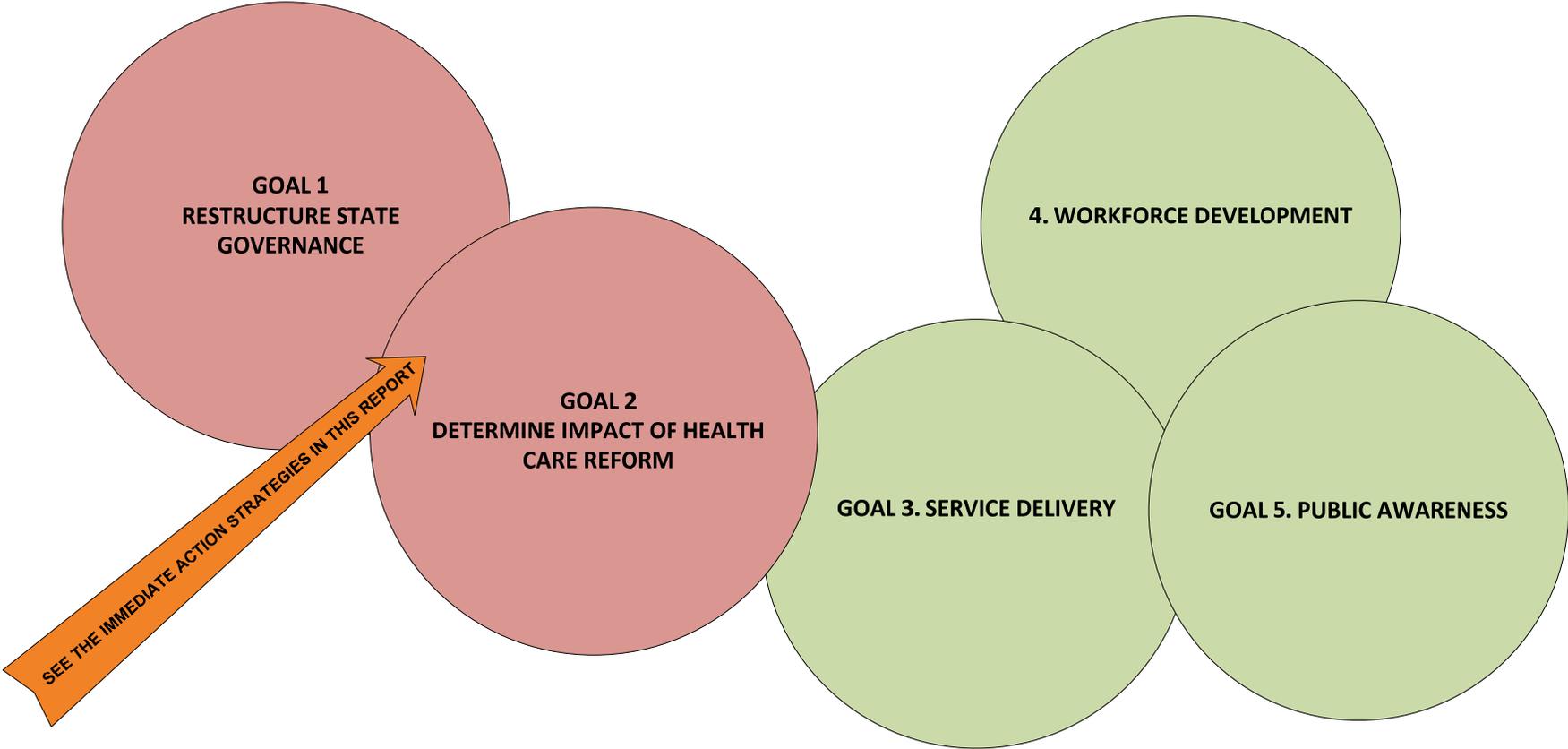
- Starts early, beginning prenatally and at birth, and continues throughout adolescence, including efforts to support youth in making the transition to young adulthood, and through key transitions to adulthood and independent living.
- Engages families/caregivers in all aspects of promoting their child's optimal social and emotional development and overall mental health. Families have easy access to needed information, resources, and supports. Agencies and organizations collaborate with families in policymaking, evaluation, and resource decisions at the state, regional, and local levels.
- Nevada will develop programs that are specifically designed to build resilience in children. Resilience is defined as a dynamic process that allows individuals to exhibit positive mental adaptation when they encounter significant adversity or trauma. Resilience is a two-dimensional construct involving exposure to adversity and the positive adjustment outcomes of that adversity. Especially for children, several factors are found to modify the negative effects of adverse life situations. Many studies show that the primary factor is to have relationships that provide care and support, create love and trust, and offer encouragement, both within and outside the family. There are existing evidence-based programs which can be used as models to improve resilience with children, such as Head Start and Big Brothers, Big Sisters, as well as others which are targeted for youth with emotional or mental difficulties.
- Educates families/caregivers, children, providers, public officials and the public about the importance of children's mental health.

- Adopts a child developmental approach that takes into account the changing needs of children and adolescents, and their families, as youth age.
- Provides quality programs and services that are grounded in evidence-based research and are affordable, family-centered, culturally competent, and developmentally appropriate. Services and systems are responsive to the cultural perspectives and characteristics of the diverse populations served.
- Delivers services in and across natural settings, such as early childhood programs, homes, primary health care settings, and schools, in order to successfully reach children and their families.
- Promotes individualized care for each child and their family, guided by a comprehensive, single plan of care that is family-driven and addresses strengths as well as problems and needs.
- Supports smooth transitions between systems and services that are effectively implemented and family friendly.
- Assures all professionals who provide services to children and their families are adequately prepared and trained to promote, identify, refer, and/or address children's mental health.
- Builds on and integrates existing systems (e.g., early childhood, health care, education, mental health, juvenile justice, substance abuse, child welfare) that serve children and their families.
- Maximizes public and private resources and invests sufficient resources over time.
- Ensures that programs and services are provided in accordance with existing Nevada and federal confidentiality, consent, reporting, and privacy laws and policies.

The MHDS Commission urges the Governor and the Department of Health and Human Services to continue to support and advance the vision and strategies contained within this document. Every strategy is designed to maximize scarce resources, build on system strengths and proven practices, expand resources over time, and ensure that the needs of children and their families are being met.

True system reform will involve implementing these recommendations over time using a phased-in approach. The state level strategies and action steps identified in this plan outline immediate steps, which are linked to the MHDS Commission's strategic vision for improving Nevada's system of children's mental health services.

Fig 3.
Nevada State Plan For Children's Mental Health Plan
Ten Year State Goals
2010-2020

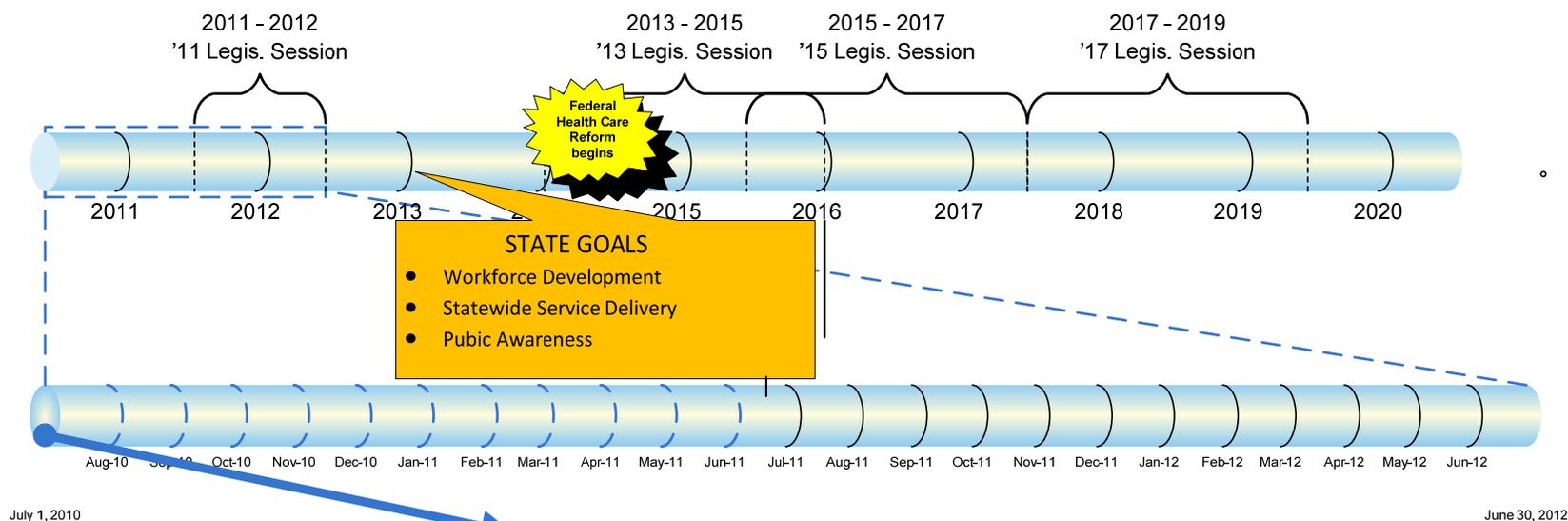


III. THE MHDS COMMISSION LEADS A FRAMEWORK FOR NEVADA'S 10-YEAR TRANSFORMATION

As shown in Figure 3, the MHDS Commission is leading the effort to build a 10-year framework that is projected to add additional state outcomes (shown below) in 2013, based on the successes of the strategies undertaken in this initial report during SFY 11. The MHDS Commission proposes the following statewide goals to be accomplished during this framework:

- | | |
|-------------------------------------|--|
| State Goal 1: | Restructured State System Governance <ul style="list-style-type: none">• Reorganized governance structure for children's mental health |
| State Goal 2 | Impact of Federal Health Care Reform and Mental Health Parity |
| State Goal 3:
(to be added 2013) | Workforce Development <ul style="list-style-type: none">• Cultural competence• Core competencies related to children's mental health• Evidence-based practices• Communication plan/public awareness |
| State Goal 4
(to be added 2013) | Statewide Service Delivery <ul style="list-style-type: none">• Enhancing family involvement• Public health approach• Service coordination• Crisis intervention and stabilization• Developing and strengthening policies, programs, supports and community action |
| State Goal 5
(to be added 2013) | Quality Improvement <ul style="list-style-type: none">• Quality assurance• Developing quality of care standards• Data collection and program evaluation |

**Fig 1. "Immediate action" 2 STATE GOALS AND 14 OBJECTIVES
Begin Nevada's 10-year Transformation of Children's MH Services**



GOAL 1: STATE GOVERNANCE 2011-12 OBJECTIVES

1. Expand the authority of the MHDS Commission as set forth in NRS 433 over public and private providers of children's mental health services.
2. Establish a child and adolescent behavioral health policy board to recommend policies covering public and private behavioral health services. The Nevada Children's Behavioral Health Consortium is an existing structure to be re-constituted to form such a board.
3. Establish the Division of Child and Family Services as the state children's behavioral health authority with the duties to set standards for practice and provider qualifications; conduct quality assurance, develop and monitor contracts, provide financial oversight and performance monitoring for public and private children's behavioral health. This include authority to promulgate regulations.
4. Review and confirm authority and capacity of the MHDS Commission to respond to this authority.
5. Advocate for resources to fully operate statewide and regional consortia to continue.
6. Identify any additional revisions to Nevada Revised Statues necessary to implement the intent of this plan.
7. Develop next two-year state child MH plan (2013-2015).

GOAL 2: DETERMINE IMPACT OF FEDERAL HEALTH CARE REFORM AND MH PARITY 2011-2012 OBJECTIVES

1. Analyze Federal Healthcare Reform and Determine Impacts on Children's Behavioral Services in Nevada and Develop an Implementation Plan.
2. Analyze Mental Health Parity Legislation and Develop an Implementation Plan in Nevada.
3. Based on the outcomes of the above analyses, integrate recommendations into future MHDS Commissions plans.

FEBRUARY 18-19, 2010, KICK-OFF “SUMMIT” – MHDS COMMISSION LEADERSHIP FOR CHILDREN’S MH PLANNING BEGINS!

The MHDS Commission sponsored its first-ever planning meeting with the Nevada children’s mental consortia⁵ on February 18, 2010. This was supported by funding provided from the Nevada Department of Health and Human Services (DHHS). The meeting was designed to bring together family members, the children’s mental health consortia, and the key state agencies that provide public mental health services to children. The purpose was to identify a statewide 10-year framework and state goals and strategies.

This February 2010 meeting was an opportunity to build a framework with active participation from primary stakeholders of the MHDS Commission, DCFS, HCFAP, MHDS, and the Clark, Washoe and Rural Children’s Mental Health Consortia. Figure 5 shows the MHDS Commission’s Subcommittee membership and participants. Although state law indicates only appointed MHDS Commissioners can formally comprise the Subcommittee, the MHDS Commission acknowledges the membership of these individuals as part of the formal advisory structure to the Subcommittee.

The MHDS Commission proposes to continue the work of this Subcommittee as the primary advisory structure to the plan, which will be responsible for ongoing monitoring of this plan. During the February 2010 meeting, the participants also developed a proposed vision statement to guide the 10-year plan development. It was formally approved by the MHDS Commission in February 2010 and is as follows:

The vision statement adopted by the MHDS Commission’s Subcommittee in February 2010:

“Nevada’s System of Care meets the multiple and changing needs of families, children and youth through a strength-based, family-driven, culturally competent, comprehensive, integrated and coordinated continuum of services and support”

To provide follow-up, the MHDS Commission has maintained monthly subcommittee telemeetings with the Nevada children’s mental health consortia and state agencies. These telecalls occurred on March 18, April 26, May 27, and June 11 and 25 (2010). The complete minutes of these meetings can be read at:

http://mhds.nv.gov/index.php?option=com_docman&task=cat_view&gid=29&Itemid=230

⁵ Three children’s MH regional consortia in Nevada were established by NRS 433B.333 in 2001.

Fig. 5. February 18-19, 2010 Summit Invitees The Children's Mental Health State Plan Subcommittee and Advisors

<i>Nevada Children's Mental Health Consortia</i>							
<i>Nevada</i>	<i>Clark County</i>	<i>Washoe County</i>	<i>Rural</i>	<i>Agency Reps</i>	<i>Nevada MHDS Commissioners</i>	<i>Staff</i>	<i>Summit Facilitator</i>
Isabel Cool	Jackie Harris	Pam Becker	Jan Marson	Mary Liveratti-DHHS	Gretchen Greiner	Kevin Crowe	Debra Loesch-Griffin
Scott Reynolds	Karen Taycher	Retta Dermody	Joann Flanagan	Harold Cook-MHDS	Joan McCraw	Susan Mears Patti Merrifield	
Karen Miller	Jannelle Kraft Pearce	Joe Haas		Diane Comeaux-DCFS Chuck Duarte-HCFAP	Julie Beasley	Grace Cruz Cody Phinney	

USE OF A STATEWIDE LOGIC MODEL GUIDED THE DEVELOPMENT OF THE STATE GOALS AND OBJECTIVES

In order to identify state goals and action plans critical to the effectiveness of the regional consortia, the MHDS Commission developed a logic model to identify those state-level goals and strategies found in this two-year start-up plan. Developed in the 1970s, a logic model generally is used to set out how an intervention (such as a project, a program, or a policy) is understood or intended to produce particular results. A logic model is used to address one of the common challenges facing organizations, which is how to measure large-scale outcomes. Because such outcomes are often delayed in time and may be mixed with many other variables, it is often difficult to measure them, even though outcomes are the most important strategic measures. The MHDS Commission desired to begin with such a model to design an accurate on-going feedback loop with DHHS, the Consortium, and other key stakeholders. The logic format is also designed to provide flexibility so additional objectives can be added.

Figure 3 shows the five state goals which resulted from the logic model used at the February 2010 meeting. During this logic model process, consortia members identified not only immediate-action state governance issues, but also specific critical state outcomes they will need to have addressed as part of the 10-year plan.

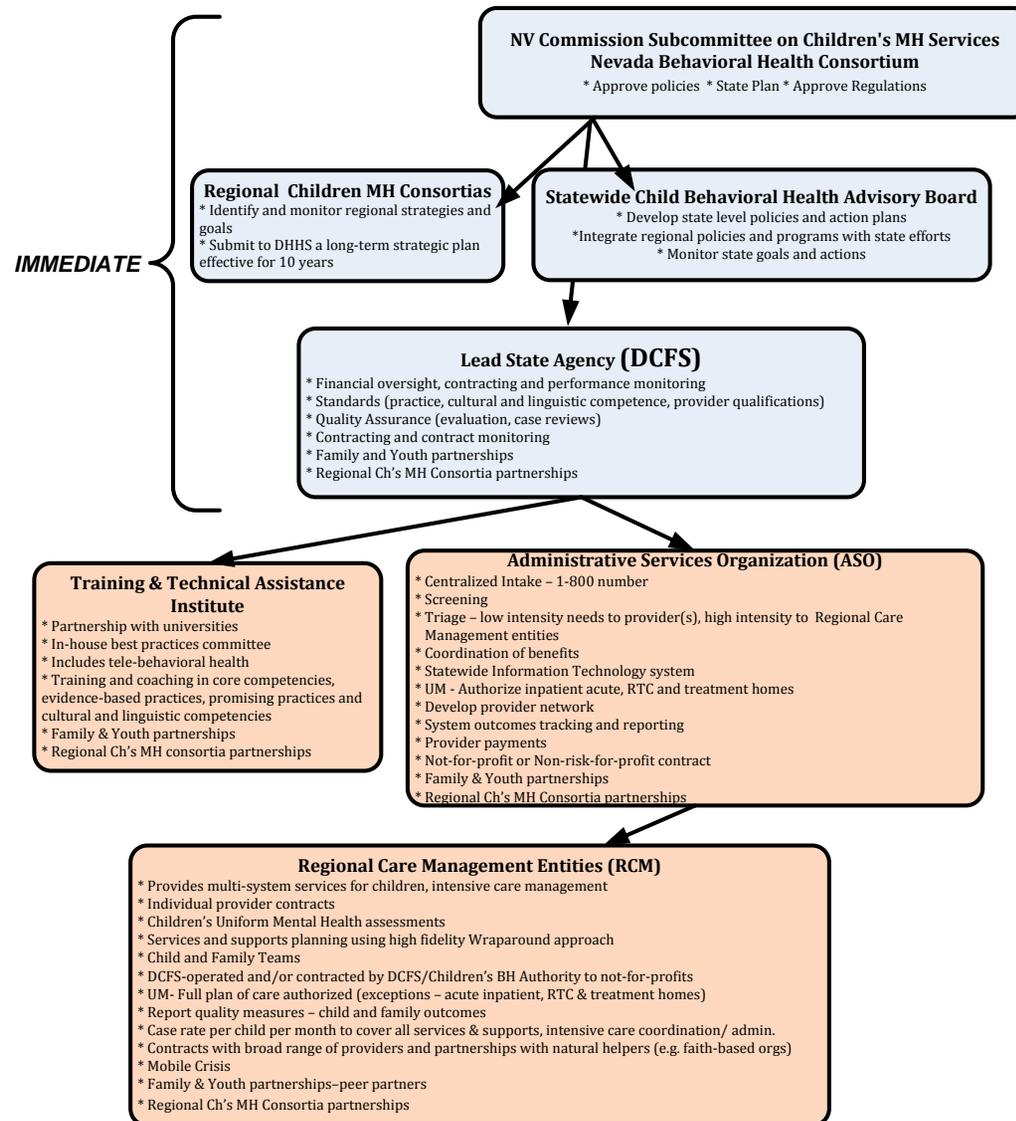
This initial plan lays the groundwork for a long-term plan. The MHDS Commission intends to develop another two-year plan for the years 2013-2015, building sequentially and consistently on each strategy. The MHDS Commission recommends immediate measurable activities on

which to build the framework through 2020. As initial successes pave the way, the MHDS Commission and the Consortium can monitor progress over the 10-year plan.

At the state level, then, virtually every objective in the plan is proposed for immediate action. These objectives will put in place the prerequisite legal and policy changes that must be in effect before service model transformations can occur.

Fig. 6
Nevada's Behavioral Health Care System for Children

To begin July 2014



IV. NEVADA'S SYSTEM OF CARE

The recommendations found in this report are largely driven by the excellent work done by the Consortium. The MHDS Commission has identified two overarching themes on which to focus as the MHDS Commission develops its 10-year framework. These themes build upon, and interface with, efforts and recommendations contained in the reports of the regional children's consortia. Assuring efforts at the state level follow these themes is critical to our Consortium and serves to align measurable state-level efforts with each consortium.

The overall outcomes of this 10-year effort must result in:

① Full implementation of a **system of care** for children with MH needs in Nevada, and ② building a **public health approach** for children's mental health. Each is discussed below.

① As mentioned above, one of the overarching themes identified at the February Summit was the need for a thoughtful plan to assure full implementation of a Nevada statewide children's **system of care**. Nevada's system of care has been developed by the Consortium, and is fully supported by the MHDS Commission. This 2011-12 State Plan builds the needed state infrastructure to implement, and account for, such a system.

System of care as used in this document refers to the overarching structure of principles, core values, and applications that will guide both state and consortia outcomes and objectives. The term "system of care" does not refer to a specific program—it is how care is delivered, whether voluntarily or involuntarily, directly or indirectly. Nevada's proposed system of care for children is illustrated in Figure 6. Nevada's system of care has been designed to address the mental health needs of ALL children and will adhere to the following attributes:

Family Driven: Families have a key-decision role in the care of their own children as well as in policies and procedures governing care for all children in their own community, state, and tribe. This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; collaborating in funding decisions; and determining the effectiveness of all efforts to promote the mental health and wellbeing of children and youth.

Youth Guided/Youth Directed/Youth Driven: Recognizes that youth must be heard, but for their full, authentic involvement, we must provide them with tools and opportunities to participate in the process.

Strengths-Based: Recognizes and builds upon each family's unique strengths, which are the cornerstone for immediate and future success.

Comprehensive Array of Traditional and Non-traditional Services: Includes the full range of services and supports from public and private agencies and the community. Non-traditional services can include, but are not limited to, recreation, faith-based, and the performing arts. These services must be accessible in a timely and meaningful manner to support positive outcomes for families.

Common Intake and Assessment: Commitment by all partners to the collection of common information that, with proper consent, can be shared across systems.

Outcomes, Evaluation, and Quality Improvement: Outcomes are evaluated at the individual, agency, and system levels to measure the quality of care. Results from evaluation and quality improvement processes are used to make decisions and to guide policymaking. Evaluation and quality improvement activities include:

- How to best meet the needs of children, youth and families;
- Determining if services and supports are used and effective;
- Determining the cost of services and supports;
- Assessing the need for additional resources and services;
- Providing feedback to those who provide services and information; and
- Continually assessing the system of care's capacity to respond to feedback and implement change.

Evaluation and quality improvement aid in building a system of care by examining what we are doing and how we can do it better. The results of all evaluations and quality improvement activities are provided to families, system partners, and community stakeholders.

Workforce Practices: Provides state-of-the-art and effective organizational supports to workforce development initiatives and continuous improvement processes in service development and delivery. State-of-the-art workforce development practices include an organizational culture which supports worker well-being, evidence-based practice in recruitment, retention, and selection strategies, clinical supervision programs, mentoring, evaluation and goal setting, team building, organizational culture change management, and other related initiatives. The intention is to facilitate family and youth choice in achieving positive outcomes for children and families, and to support the service delivery system.

Culturally and Linguistically Competent/Responsive: Recognizes that every family has individual cultural values. Services are responsive, with an awareness of and respect for the importance of values, beliefs, traditions, customs, and parenting styles of families. Services also take into account the varying linguistic needs of individuals who speak different languages, have varying literacy skills, and who need a variety of communication formats.

Community-Based Services and Supports: Afford families early intervention and services in the communities where they live. Such services and supports allow families to remain intact and recognizes that children, youth and families thrive in the context of their homes, communities and schools.

② A second area identified by both the Consortium and the MHDS Commission as needing critical state leadership over the next 10 years is to assure that Nevada’s transformed system of care is built using a **Public Health Approach**. Use of a public health approach has been proven to effectively promote the social, emotional, and mental well-being of all children.⁶ The MHDS Commission recommends development of an approach that is illustrated in Figure 2, and can be characterized by the following attributes:

1. *A focus on populations when it comes to children’s mental health in the United States*, which requires an emphasis on the mental health of *all* children. Data need to be gathered at the population level to drive decisions about interventions and to ensure interventions are implemented and sustained effectively for entire populations.
2. *Place greater emphasis on creating environments that promote and support optimal mental health and building skills that enhance resilience*. Environments can be social, such as families, schools, communities, and cultures, or physical, such as buildings, playgrounds, lakes, and mountains.
3. *Balance the focus on children’s mental health problems with a focus on children’s “positive” mental health—increasing measurement of positive mental health and striving to optimize positive mental health for every child*. A public health approach values promotion as well as prevention, so the feature that may most distinguish the new approach from the past is a new commitment to helping each child reach his or her optimal level of health, rather than simply reducing symptoms among those who have problems.
4. *Work collaboratively across a broad range of systems and sectors, from the child mental health care system to the public health system to all of the other settings and structures that impact children’s well-being*. An effective approach requires a comprehensive and coordinated effort among all of the systems and sectors that impact children and their environments.
5. *Adapt the implementation to local contexts—taking local needs and strengths into consideration when implementing the framework*. Considering local needs and strengths means that communities or groups implementing the conceptual framework consider local priorities, values, assets, and concerns when making choices about what language/terminology will be used, what values will ground the approach, the desired goals/impacts, what data will be gathered and analyzed, what array of interventions will be implemented to provide a comprehensive range, and what outcomes and determinants will be evaluated. Data that are crucial in one community may be less relevant in another, interventions that are effective in one setting may not be as successful in another, and factors that ensure success for one group may not be as beneficial for another.

The MHDS Commission recommends immediate action during FY11, which will result in a public health approach being implemented in three broad action steps over the next ten 10 years. These action steps will include:

⁶ Miles, J., Espiritu, R.C., Horen, N., Sebian, J., & Waetzig, E. (2010). *A Public Health Approach to Children’s Mental Health: A Conceptual Framework*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health

1. *Assessing*. The first core function, Assessing, describes a process of collecting and analyzing data about child mental health needs and assets, as well as their determinants, and using the data to drive decisions about intervening and future data gathering. The MHDS Commissions plan to implement a public health approach will begin with this step.

2. *Intervening*. The second core function, Intervening, describes a process of acting to optimize children’s positive mental health and minimize the symptoms and impacts of mental health problems.

3. *Ensuring* is often referred to as quality assurance and/or program evaluation. Nevada’s plans will includes a process of making sure that intervening is done with a high level of quality and effectiveness; that children have access to and are engaged in the interventions that would most benefit them; and that intervening is done in a sustainable way, including training of the workforce, building necessary infrastructure, and conducting ongoing evaluation and adaptation to improve quality.

How will the MHDS Commission account for this plan?

It is recommended that Nevada’s future system of care in 2020 will operate using an entirely different administrative structure than the current structure. Nevada’s new administrative structure will deliver children’s mental health services utilizing the Consortium and will include both public and private providers of children’s mental health services. Providers are to be credentialed or accredited and will use standardized intakes, assessments, and service delivery standards. With this report, the MHDS Commission recommends immediate action on the 2011-12 objectives, and based upon successes, subsequent activities will be developed within the plan for 2013-14.

The framework for Nevada will include implementation of an MHDS Commission oversight and evaluation structure which will monitor the plan and build a process that will rely on quality assurance objectives.

The MHDS Commission intends to begin monitoring progress on its state plan using an ongoing system of reporting via its Subcommittee. At each regularly scheduled MHDS Commission meeting, the Subcommittee Chair will present the latest information available. The MHDS Commission desires to put in place a continuous feedback loop with the regional consortia and state agencies to monitor progress towards the goals in the 10-year plans submitted by the regional consortia and the overall state transformation plan. This same evaluation loop is also expressly designed to include family involvement and input in the evaluation of the plan.

The MHDS Commission intends to put in place an evaluative process that is formative and is to be updated as the plan unfolds. In later years, there will be additional quality assurance data and activities that will be aggregated and analyzed to enhance program evaluation. Until that time, the MHDS Commission intends to begin a “start up” monitoring process. Beginning in September 2010, the MHDS Commission will develop a condensed “report card” format that will allow the MHDS Commission to track progress on all state goals and objectives identified in this 2011 plan.

REPORT CARD				
GRADING PERIOD	1	2	3	4
READING	A			
WRITTEN COMMUNICATION	A			
MATHEMATICS	C			
SCIENCE/HEALTH	B			
SOCIAL STUDIES	B			
ART	A			
MUSIC	A			
PHYSICAL EDUCATION	C			
Grade Average	B			
Attendance:	Present	40		
	Absent	2		
	Tardy	1		
<small>A = Excellent • B = Good • C = Satisfactory • N = Needs Improvement U = Un satisfactory • I = Inefficient / Incomplete</small>				
Student:	Grade:	Year:		

V. STATE GOALS, OBJECTIVES AND STRATEGIES

STATE GOAL 1: Restructured State System Governance

Nevada's proposed future service delivery system is built upon sweeping structural changes, which begin with this report. The first step will be to design and plan for a transformed oversight and accountability structure for the recommended system of care. Governance involves changes in oversight and service delivery structures for children's mental health services in Nevada. These governance changes must be addressed first, as they provide the foundation for future actions. These governance changes will first require the State to undertake marked revisions to NRS to put in place the system of care statewide.

The MHDS Commission recommendations outline a two-year "start-up phase," including these immediate goals and objectives which the MHDS Commission can begin monitoring right away. Future plans will be built upon the achievements of this initial SFY 2011-12 plan. These immediate objectives include:

1. Development of legislative and policy changes which must be undertaken during the 2011 Legislative Session in order to further implement the 10-year plan. Currently there is no oversight authority for both public and private mental health services for children. This has been a major structural barrier in implementing statewide standards of care and accountability actions. The MHDS Commission is aware of the need to plan thoughtfully over the next 10 years due to the impact of the Federal Health Care reforms (which largely take effect in 2014). This plan targets immediate action on those objectives which involve critical necessary legislative changes during the upcoming 2011 Session.

Many of the specific objectives to improve and transform the statewide governance structure of Nevada children's system of care involve successful submission of bill draft requests during the 2011 Legislative Session. Bill Drafts Requests (BDR) are the mechanism used to put in place statewide legislation and mandates which will account for the system operation. These BDRs will change NRS to put in place a state governance structure for both public and private sector programs at the regional level, establish an advisory policy board for children's services, and align with impending Medicaid changes. The MHDS Commission also intends to track the progress on BDRs which are being submitted. Once these initial two-year goals are achieved, the MHDS Commission can proceed with the balance of the 10-year planning framework.

Three BDRs which the MHDS Commission supports being submitted to the 2011 Legislature include:

- Expand existing authority of the MHDS Commission to monitor private providers, not just state providers,
- Establish a statewide children's mental health advisory board, and
- Establish DCFS as the mental health authority.

2. Understanding fiscal and service delivery models and the impact of current federal healthcare reform and mental health parity. Design a plan which reforms the current fee structure for mental health parity.

3. Development of the next two-year strategic plan (2013-14), which will include three additional state goals and objectives, as shown in Figure 3.

The MHDS Commission has identified the following GOVERNANCE related objectives for SFY 2011-12:

STATE GOAL 1: Restructure State System Governance	
Objectives	Strategies
1. Continue to fully operate statewide and regional consortia.	<ul style="list-style-type: none"> • Request budgets from consortia • Prepare testimony in support • Work program funds • Begin budget tracking at regular subcommittee meetings • Develop annual report formats to be used for state reporting • Pilot data formats used by consortia
2. Expand the authority of the MHDS Commission as set forth in NRS 4333 over public and private providers of children’s mental health services.	<ul style="list-style-type: none"> • Bill Draft Request submitted by DCFS by 9/1/10 • Determine any needed regulations, write and adopt by the MHDS Commission • Review and confirm MHDS Commission’s capacity/resources to fulfill statutory functions and advocate for needed resources • Determine resources needed for regional consortia to fulfill statutory functions and advocate for those resources
3. Review and confirm authority of the MHDS Commission and maintain capacity to respond to this authority.	<ul style="list-style-type: none"> • Review framework to determine ongoing MHDS Commission needs and capacity • Identify staffing or resource needs to MHDS and DCFS • Review agency proposals • Implement process • Review as needed
4. Establish a child and adolescent mental health policy board to recommend policies covering public and private mental health services. The Consortium is an existing structure recommended to be re-constituted to form such a board.	<ul style="list-style-type: none"> • Bill Draft Request submitted by DCFS by 9/1/10 • Determine any needed regulations, write and finalize adoption by MHDS Commission • Re-constitute membership and redefine purpose of current Consortium • Determine resources needed for policy board to fulfill statutory functions and advocate for those resources • Determine structure and content areas of statewide policies • Recommend statewide policies for MHDS Commission approval
5. Establish the Division of Child and Family Services as the state children’s mental health authority with the duties to set standards for practice and provider qualifications; conduct quality assurance; develop and monitor contracts; provide financial oversight and performance monitoring for public	<ul style="list-style-type: none"> • Bill Draft Request submitted by DCFS by 9/1/10 • Determine any needed regulations, write and finalize adoption by Nevada MHDS Commission • Develop an implementation plan for 2013 -14 biennium

STATE GOAL 1: Restructure State System Governance	
Objectives	Strategies
and private children's mental health to include the power to adopt regulations.	
6. Identify any additional revisions to Nevada Revised Statutes necessary to implement the intent of this plan.	<ul style="list-style-type: none"> • Written outline for activities; scope of project • Secure funding plan or other staffing resources • Conduct analyses of NRS text and intent • Generate written recommendations for NRS revisions • Evaluate efforts and update plan
7. Develop capacity to provide the next two-year continuation plan (2013-14). Plan must align previous objectives and integrate findings from studies in Goal 2.	<ul style="list-style-type: none"> • Identify scope of plan • Secure resources • Identify overall gaps, concerns in system of care • Integrate study findings (Goal 2) into MHDS Commission plan • Develop budgets or plans to address any gaps • Ongoing monitoring by MHDS Commission and Consortium. • Draft budgets for SFY 2014 reflecting new system of care • Evaluate efforts

STATE GOAL 2: DETERMINE IMPACT OF FEDERAL HEALTH CARE REFORM AND MH PARITY

There is no doubt that there will be major impact on how mental health services are delivered to children in Nevada due to the Patient Protection and Affordable Care Act (PPACA), which begins now and fully takes effect in July 2014. The Federal PPACA was signed into law in the United States by President Barack Obama on March 23, 2010. Along with the Health Care and Education Reconciliation Act of 2010 (signed into law on March 30, 2010), these new laws include a number of health-related provisions to take effect over the next four years, including expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges, and support for medical research. The costs of these provisions are offset by a variety of taxes, fees, and cost-saving measures, such as new Medicare taxes for high-income brackets, taxes on indoor tanning, cuts to the Medicare Advantage program in favor of traditional Medicare, and fees on medical devices and pharmaceutical companies; there is also a tax penalty for citizens who do not obtain health insurance (unless they are exempt due to low income or other reasons).

Medicaid related changes require budget enhancement units and additional state matching funds. Any changes to Medicaid eligibility and any expansions are approved in advance by CMS and budgeted with matching dollars by the state.

These Medicaid and health care reform changes will also have a marked impact on future workforce education activities; this is why workforce goals and strategies will be added to the Nevada MHDS Commission 10-year framework.

Training for health care billing and clinical documentation will be needed. This will be particularly important in the current federal regulatory environment, but also when the Federal PPACA insurance exchanges are in place. There will likely be strict adherence to medical documentation requirements by private sector insurance companies to support payments for any service. This is critical to avoid potential recoupments, disbarments of providers and other sanctions.

The MHDS Commission plan is designed to inform policymakers and stakeholders about the new federal reforms that are coming. Nevada's planning process is designed to transform Nevada's system in a way which will incorporate these changes and take advantage of every opportunity to further improve services to children with mental health needs. An integral part of this 2011-12 State Plan is to assure staff development, service delivery, and QA standards are developed to make maximum use of changes at the federal level and that all MH services offered to children by public and private providers beginning in 2014 are aligned with any mental health insurance requirements as required in the new federal legislation.

Major changes in Medicaid system eligibility to begin in 2014 must be planned for now. For example, while there are no changes for children currently covered by Medicaid and Nevada Check Up (NCU), Nevada's children's MH planning must consider that there will be more children who will become eligible; for example, starting in 2014, federal health care reform will cover more children, since children under 138% of the Federal Poverty Level (FPL) will be eligible, unlike current FPL requirements. Additionally, children who are not Medicaid eligible will be eligible for subsidized private insurance.

This 2011-12 State Plan needs to look beyond Medicaid to insurance coverage provided through private sector exchange plans. Medicaid is assumed consistent with MH Parity, as it is required to cover all medically necessary services for individuals less than 21 years of age. Currently, that same standard does not apply to the private sector when considering coverage under MH Parity. Nevada's future system will address concerns that parents give up their kids to the "system" just to get Medicaid benefits; a focus of this plan will be to include the private sector.

The MHDS Commission plans to, whenever possible, redefine services delivery to maximize use of available federal funds.

The Nevada MHDS Commission has identified the following objectives for DETERMINING THE IMPACT OF HEALTH CARE REFORM AND MH PARITY for SFY 2011-12:

STATE GOAL 2: Determine Impact of Federal Health Care Reform and MH Parity	
Objective	Strategy
8. Analyze federal healthcare reform and determine impacts on children’s mental services in Nevada.	<ul style="list-style-type: none"> • Study the federal legislation and determine changes in eligibility for publicly funded services (Medicaid), service delivery requirements, system structure requirements, etc. • This will include an analysis of current policies, service delivery systems, insurance coverage, and information systems and a “gap” analysis of what needs to be done in order to implement the FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT and the proposed children’s state plan. • Secure resources • MHDS Commission reviews reports • Integrate findings into next Nevada State Plan for Children’s Mental Health 2013
9. Analyze mental health parity legislation and develop an implementation plan in Nevada.	<ul style="list-style-type: none"> • Study federal legislation and develop understanding of requirements • This will include an analysis of insurance coverage changes on services offered to children, and a “gap” analysis of what needs to be done in order to implement the proposed children’s state plan. • Secure resources • Nevada MHDS Commission reviews reports • Integrate findings into next Nevada State Plan for Children’s Mental Health 2013
10. Based on the outcomes of the above analysis, conduct feasibility study related to implementation of the MHDS Commissions 10-year plan in the context of the Federal Patient Protection and Affordable Care Act.	<ul style="list-style-type: none"> • Study staffing, funding, information systems and compliance requirements. This data will be necessary to address any design requirements for information systems necessitated by the Insurance Exchanges, DWSS eligibility systems and Medicaid Management Information Systems in preparation for implementation of the Exchanges and Medicaid expansion under the Federal Patient Protection and Affordable Care Act (start Jan. 1, 2014). • Secure funding • MHDS Commission reviews reports • Integrate findings into next Nevada State Plan for Children’s Mental Health 2013

VI. CONCLUSION

This plan is provided expressly to begin an ongoing process to build essentially an entirely new service delivery system for children with mental health needs in Nevada. At the same time, Nevada is facing extraordinary fiscal and social considerations at the state and federal levels.

To proceed effectively from this point, the MHDS Commission and its stakeholders respectfully conclude this planning report with a request that DHHS now work aggressively to outline an implementation plan, which will undertake the 10 objectives in this plan. These efforts will allow the MHDS Commission to comply with the requirements of NRS 433 to put in place an ongoing, accurate, and efficient planning and oversight process for Nevada's new system. The MHDS Commission will need assistance to maintain a continuous feedback loop with the regional consortia and other state and federal agencies in order to monitor progress towards the goals in the 10-year plans submitted by the regional consortia and the State.



A final conclusion of the current plan is a request to the Nevada Department of Health and Human Services to now develop an implementation report which includes provisions for ongoing MHDS Commission monitoring of each goal and objective in this submitted plan.