COMMISSION ON BEHAVIORAL HEALTH WITH DCFS

DIVISION OF CHILD AND FAMILY SERVICES

SEPTEMBER 8, 2022

MEETING MINUTES

This meeting used Microsoft TEAMS technology for video and audio capability.

COMMISSIONERS PRESENT:
1. Arvin Operario
2. Braden Schrag
3. Daniel Ficalora
4. Gregory Giron
5. Jasmine Cooper
6. Lisa Durette

COMMISSIONERS NOT PRESENT
1. Lisa Ruiz Lee
2. Natasha Mosby

STAFF AND GUESTS
1. Ann Polakowski
2. Autumn Blattman
3. Beverly Burton
4. Carissa Pearce
5. Charlene Frost
6. Cindy Pitlock
7. Daniel Cox
8. David Levin
9. Don (Guest)
10. Dorothy Edwards
11. Drew Cross
12. Gwendolyn Greene
13. Jacquelyn Kleinedler

14. Jennifer Atlas
15. Jennifer Spencer
16. Karen Oppenlander
17. Kary Wilder
18. Kathryn Martin
19. Kendall Lyons
20. Kyle Dunlap
21. Linda Anderson
22. Matthew Cox
23. Melissa Washabaugh
24. Michelle Bennett
25. Michelle Sandoval
26. Sarah Dearborn
27. Serene Pack
28. Shannon Hill
29. Stephanie Dotson
30. Stephanie Woodard
31. Vanessa Dunn
32. William Wyss
33. Yeni Medina
34. Zoë Houghton
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1. **Call to Order and Introductions.** *Braden Schrag, Commission on Behavioral Health with DCFS Chair*, called the meeting to order at 9:07 a.m. *Kary Wilder, Division of Child and Family Services (DCFS),* conducted roll call and quorum was established with six members present.

Commissioner Schrag thanked and appreciated the Commissioners and Commission body for all the work they do and the experience, diversity, and professionalism everyone brings together to help in a collaborative leadership platform to move the needle for the betterment of Nevada's communities. He encouraged everyone to reach across social, economic, racial, gender, ethnic, religious connotations to share resources, expand capabilities, and avoid silos that sometimes

occur in government, non-profit, and other organizational systems. There is no one individual or organization that can solve Nevada's problems. He said it was with drive and passion, he encouraged everyone to come together support those we serve and those who absolutely rely on us, to work together, share resources, and share strengths in a collaborative effort. He asked everyone to look at ways to jointly collaborate, break down silos, connect, communicate, and strengthen each other with the goal of strengthening the systems that help Nevada's children and adults with behavioral health needs.

2. **For Possible Action.** Approval of the July 28, 2022 Commission on Behavioral Health with DCFS Meeting *Minutes – Braden Schrag, Chair.*

MOTION: Approve July 28, 2022 Commission on Behavioral Health with DCFS Meeting Minutes
BY: Lisa Durette
SECOND: Jasmine Cooper
VOTE: Motion passed unanimously with no opposition or abstention.

3. **Public Comment and Discussion.** No action may be taken on a matter raised under this item of the agenda until the matter itself has been specifically included on the agenda as an item upon which action can be taken.

Dr. Cindy Pitlock announced that August saw a huge win for Nevada children's mental health with the Interim Finance Committee (IFC) support of the Division of Child and Family Services (DCFS) request for American Rescue Plan Act (ARPA) funds for build out of the children's system of care and the oversight of those programs. DCFS has been fully approved to move forward with wraparound and intensive care coordination, intensive in-home family treatment and stabilization, emergency services, planned respite care, mobile crisis response team support to Clark County and Washoe School Districts, staffing for the Oasis Residential Treatment Center, and hardening of the Desert Willow Treatment Center. She was grateful for the support DCFS received from the Commission, the County, and community stakeholders. DCFS is excited to roll out these programs and the intent is to lean in and partner with community providers, which will also serve to build out a more robust system of network adequacy. The next Interim Finance Committee meeting is scheduled for October 20th and Dr. Pitlock said her focus for that meeting would be workforce development projects She said she was available for additional discussion during Agenda Item No. 10 if there were any questions about the ARPA rollout.

Commissioner Dr. Lisa Durette reported that Healthy Minds opened partial hospitalization and intensive outpatient programs a few weeks ago for latency age kids 7 and up. Healthy Minds is located behind the Nevada PEP office at Rainbow and Charleston in Las Vegas. All types of Medicaid coverages are accepted. The program was opened to try and close gaps existing in the system of care with outpatient programs and a queued inpatient and residential program, however, a middle of the road program is not offered. Dr. Durrett asked Dr. Pitlock if they could coordinate and collaborate on this after the meeting. A transportation program was started to assist children getting to and from treatment, however it has minimal funding for the unique needs of transportation for kids with mental and behavioral health challenges who need a partial

level of care (a full-time mental health tech is required to always supervise and engage the kids). She hoped there were some flexible funding options and wanted to put that on the record because support is desperately needed to be able to continue this very necessary level of care.

Char Frost (Statewide Family Network Director, Nevada PEP) encouraged everyone to remember parents and youth are a big part of what everyone does and what everyone is trying to make better. She asked everyone to remember the importance of family perspective and family voice. Over 30 families provided public comment during the last Interim Finance Committee Meeting and encouraged the State to invest in children and families. She said it filled her heart these families care so much. She congratulated DCFS because everything requested was part of the menu of services that System of Care (SOC) determines are needed in order to be a healthy system of care and she was excited to see a real investment in SOC services. Funds were also requested for respite services (which parents of children with mental health needs traditionally do not have) and were awarded at the same time. This will provide critical training for respite providers working with kids with dual diagnosis, which will translate to children straight out of mental health. Ms. Frost mentioned SOC is doing a cultural and linguistically appropriate services training scheduled over next three Mondays (with free continuing education credits). She will provide the information to Kary Wilder to distribute to Commission members and encouraged everyone to get as many providers as possible trained in culturally and linguistically appropriate services.

Michael Spindler, Licensed Clinical Social Worker Consultant, Never Give Up Youth Healing Center (NGU), announced the facility implemented a sanctuary model of care, a cultural model focused on nonviolence and safety. A feature of the model includes a service planning review committee which brings the treatment team together with campus leadership at the nine-month mark of a child’s placement. The purpose is to have a thorough discussion with the team having the responsibility about whether a child can be discharged or whether the request is for continued care. The goal is to share evidence-based clinical information and documentation to support a request for continued care. The committee looks at possibilities of discharge to partial hospitalization or discharge home with appropriate outpatient services. This feature of the sanctuary model is going to be monitored by NGU’s quality assurance and compliance department. The goal is to reduce the amount of time a child spends at the residential facility. Other features of the sanctuary model are referred to as both red flag meetings and safety plans, providing enhanced opportunity (after children develop better coping mechanisms) to work with them to come up with three alternate possibilities when they begin to experience an emotional dysfunction of control. Already NGU has seen children beginning to self-identify triggers before they become in this state of control. Children can ask to speak to a particular staff member or therapist privately. There are several options children can choose from when they feel like they are moving in the direction of emotional dysfunctional control. When staff observe a child beginning to lose control, they can suggest the child exercise one of their safety plans. The other side of this particular feature of the sanctuary model is what is referred to as a red flag meeting which provides opportunity for any staff member to identify a child they feel may be experiencing a rise in acuity. A red flag meeting with leadership and the treatment team is immediately scheduled to look at what is going on with the child, giving opportunity to modify

treatment based on the child's clinical needs. Braden Schrag, Chair, reminded Mr. Spindler of the two-minute limit for public comments, Mr. Spindler will address this information further under Agenda Item No. 5.

David Levine, CEO, Epic Behavioral Health (EBH), congratulated Dr. Pitlock and her team on the funding award from IFC. He reported he and his team entered into the Nevada market recently and right away realized the lack of several levels of care. Acute and outpatient care exist; however, everything in between is missing. EBH realized that they were going to have to take on the entire system of care in order to be the Nevada premier provider because essentially to be a good provider requires places to discharge to for appropriate levels of care. He has been working with Dr. Pitlock and has met with Kimberley Abbott, Children's Attorneys Project, at Barbara E. Buckley's office (Legal Aid Center of Southern Nevada). They are working on adding another line of care, another level of care to provide step down, transitional housing for children so they can go to school and get necessary therapy and intervention for reintegration into the community. Healthy Minds has also been identified as a great discharge location. Mr. Levine asked Kyle Dunlap to reach out to Dr. Durette as NGU builds out their system. Mr. Levine said he appreciates the collaboration and the fact Chairman Schrag started the meeting with that approach. He said working together is the only way to build solutions and he appreciated how Dr. Pitlock's focus is to help kids, work together, bring everyone to the table and hit the issues straight on. It is important to determine what can be done together as a team and identify barriers needing to be overcome to get to the next level, without organizational silos or pointing fingers. Mr. Levine said he was honored to be at the meeting and Epic Behavioral Health, as a private company, would take the conversation and feedback very seriously. The mission is to bring Nevada up, to be part of the solution and address every level of care to assure the best future for our children.

4. **For Information Only.** Presentation of Rural Children's Mental Health Consortium Report – *Melissa Washabaugh, Rural Children's Mental Health Consortium (RCMHC)*

Melissa Washabaugh shared the 2022 RCMHC Service Priorities Report and reported RCMHC's mission is to advance an integrated system in which youth and their families/caregivers with mental health needs are accepted into their communities, feel meaningfully connected to services and supports in the least restrictive environment, and experience equity in opportunities to access care. The report provided population and mental health statistics for rural Nevada and identified five goals from the long-term Strategic Plan:

a. Expand and sustain the Nevada System of Care to rural and frontier Nevada
b. Increase access to mental and behavioral health care
c. Increase access to treatment in the least restrictive environment
d. Increase health promotion, prevention, and early identification activities
e. Develop, strengthen, and implement statewide policies and administrative practices that increase equity in access to mental and behavioral health care for youth the families.

2022 Priorities are: 1. Creation of a comprehensive website, 2. Awareness and de-stigmatizing messaging, 3. Support/encourage training at the community level, 4. Increase the Consortium's influence on mental health policy, and 5. Increase access to evidence-based and evidence-informed mental health supports and services in rural communities.

In 2020-2021, the Consortium implemented strategies to adapt to changes due to the ongoing COVID-19 pandemic (adjustments to budget, planned events, and staffing) with redirection of funds into proactive community outreach and wellness projects. RCMHC collaborates with community partners including DCFS, Nevada System of Care, Access to Care Grant, Youth M.O.V.E, Nevada PEP, and others.

5. **For Possible Action**. Draft Letter of Concern to Never Give Up Youth Healing Center Facility – *Braden Schrag, Chair*

Mr. Schrag outlined the Commission's roles and responsibilities to review seclusion and restraint data from facilities throughout Nevada and analyze trends and patterns to determine if there is anything that needs to be addressed; policy recommendations or guidance needed, documentation modifications, correct signatures, medication distribution, and others. Commissioners look at restraint reports from a multidisciplinary perspective and noticed concerns with Never Give Up Youth Healing Center (NGU) facility reports. The purpose is to give Never Give Up an opportunity to speak to these concerns before the Commission takes further action.

Commissioner Durrett described three core recurrent themes noted at NGU that raised concerns. The first concern was around lengths of stay with an average of two-years, even in some latency age children under 11 years old. Commissioners noted this as extraordinarily concerning given that the standard of care is to treat kids in the least restrictive manner possible.

Dr. Durette explained that reviews of seclusion and restraints present multiple events for each youth which can be compared over the course of time. For example, if one child had ten events over a one-month period, all events can be reviewed and compared together. Commissioners noted a second area of concern around these children who had multiple events. Many times, there was no documentation or evidence of treatment plans being adjusted to help mitigate repeating incidents. This lack of documentation was a recurrent concerning pattern.

Dr. Durette noted the third concern related to the statue and standard of care which require a physician or physician's designee to attend a child and see them within 24 hours of an incident, however, the reports had no documentation of that. On almost all reports, a rubber stamp was used instead of the actual physician or physician-designee signature. It was noted that one nurse practitioner used a rubber stamp, typically stamping and dating reports over two-months after an event actually occurred. Commissioners raised concerns that the standard of care was not being met.

Mr. Schrag thanked Mr. Cox for being at the meeting and stated in full disclosure that he and Mr. Cox previously had a very brief discussion. He notified Mr. Cox of Commissioner concerns without specific details. Mr. Schrag said he did not anticipate or expect Never Give up to

respond immediately and it would be inappropriate to do so. He said in full disclosure to Commissioners and members present at the meeting; the purpose of today was to give Never Give Up an opportunity to hear the concerns. Mr. Schrag said NGU may have plausible explanations and already indicated earlier in the meeting that changes are being implemented with new training offered. This is an opportunity for the Commission to hear NGU may have identified these issues independently and is putting measures in place. The goal is to develop a collaborative partnership and part of the Commission's policy guidance and oversight is to have that independent look at what is going on and then provide recommendations or observations. The Commission's role is to help find solutions and provide guidance. The goal is to help everyone be successful and assist in providing solution driven outcomes and adjustments. The beauty of a multidisciplinary cross-sector team is the ability to come from different avenues to be a resource. Mr. Schrag encouraged everyone to come to the Commission for assistance with challenges to get recommendations and suggestions.

Commissioner Ficalora said peer reviews and review processing are standard practice and all practitioners go through audits, site reviews, and Medicaid reviews. He said his mindset is that there is no such thing as bad feedback which provides opportunities to identify areas of growth. While this is a public forum, it is important for everyone to be committed to moving Nevada forward to ensure the highest level of care is provided for state citizens. This is the part of the review process to identify shortcomings, determine improvements, and work together within individual organizations and as a state to build best practices.

Michael Spindler said one of the functions he performs at the facility is review of all referrals and NGU has seen over the last two years, an increased level of acuity, relative to the impact COVID has had on young people; on young people without mental health disorders and the exacerbation of symptomology for young people with preexisting conditions. The population they are now working with is more challenged and more challenging than he has seen at any time in his career. He said NGU is equally aware of that and shares concerns with issues such as length of stay, duration of restraint, use of time-out, etc. NGU is motivated to implement the sanctuary model of care which represents a sea change, a full-program cultural change in the way children's residential treatment services are provided. NGU is hypersensitive to the length of care and how long children remain in the program. A protocol has been developed and specifically designed to examine at the nine-month mark of a child's stay whether there is justification for continued care based on documented evidence of progress and success. They simultaneously look at alternatives of discharging that child back home with aftercare services or to a partial hospitalization program.

Mr. Spindler said NGU understands and shares the concerns articulated earlier and said that quite candidly, NGU has had those same concerns for a while now and has begun working to address them. This is the reason the sanctuary model of care was introduced. To begin with, NGU is equally focused on issues of restraint. NGU is a trauma-informed program and understands implications of the trauma that restraint sometimes brings to a child. He said that probably in the neighborhood of between 90-95% of children NGU is seeing on referral and admitting, are children with significant histories of self-harm; self-hanging, suffocation, or running into traffic.

These children have a whole myriad of attempts to take their own life, which unfortunately even at a program such NGU, continues and requires restraint from time to time.

Mr. Spindler continued, saying that having said that, the sanctuary model does focus on working aggressively with children to develop healthy coping mechanisms, helping them to develop an aptitude to put feelings into words and mitigating against aggressive and self-harming behavior. NGU has invested 100% of their energy and time to implement the sanctuary model of care. He said, just as an aside for his colleagues on the phone, this model was developed by Dr. Sandra Bloom in Philadelphia in the 1980's and was the genesis of what is now called trauma informed care. The notion of trauma informed care is an extension of the sanctuary model of care. NGU has been working for months now, implementing and integrating sanctuary care into everything they do because they are equally determined to reduce the length of care and reduce the use of physical restraint. The goal is to work with children to develop healthier ways of expressing themselves and they are beginning to realize some desired outcomes based on the sanctuary model. NGU believes that going forward, as this model becomes increasingly integrated into the fabric of the programs, their outcomes will improve, particularly in the areas Commissioners identified. Mr. Spindler said he assured the Commission they are moving in the right direction,

Commissioner Schrag said that Commissioners recognize there is a delay sometimes in when reports are received and they can review them. They recognize there may be a delay with something NGU has identified and is working on. The purpose of the collaborative platform is for everyone to be connecting together.

Mr. Cox thanked Chair Schrag and said he appreciated the opportunity to speak with the Commission about NGU's activities and their ability to work collaboratively with stakeholders. NGU is actively working on the concerns Commissioner Durette articulated and he said, as Chair Schrag mentioned, it would maybe be a little premature to ask NGU for a response. However, in light of the immense amount of work that NGU has done over several months with stakeholders like Medicaid, state licensing, and Dr. Pitlock's group at DCFS, they have had extensive conversations to troubleshoot many areas that are being identified and are working on implementing policy recommendations and even documentation improvements. These issues are intensively being worked on and NGU has identified improvements so children can benefit from their continued work in light of the really difficult system of care they are currently operating in. NGU was very energized to see Dr. Pitlock's work and how Nevada in general is working to understand that the system of care needs to be addressed to allow them to move children through to get the length of stays down to the least restrictive manner as possible. Mr. Cox said that with providers like Commissioner Durette's work (partial hospitalization program, PHP, and intensive outpatient program, IOP), the community is starting to answer the call to fill service gaps which will help NGU, as the subacute and acute provider, to really be able to start to lower those length of stays. NGU found themselves stuck over the last five years. They are the initial standalone psychiatric residential treatment facility (PRTF) in the State of Nevada and currently NGU might hold 34% of the state's available PRTF beds and if some of the beds that aren't active are removed, NGU holds 50% of the subacute PRTF beds. As a provider being one of the initial PRTF facilities that pioneered this particular service line and being one of the largest facilities

holding capacity for the state, NGU needs the Commission's help to navigate this particular environment. NGU is taking strong note of the Commission's invitation to come more often to reach out to the multidisciplinary team for assistance troubleshooting problems they are facing with staffing crises, system of care lags, service gaps, and others. They are actively working each of the areas Commissioner Durette pointed out, even down to the medical director and providers reviewing restraint incidents at a faster pace and utilizing designees under the medical director to provide insight to help move to better safety intervention plans. Avoiding showing a trend like Dr. Durette pointed out in seeing ten restraints of a single child without seeing a major reflection of the treatment team's energy to change the interventions is something they identified. Mr. Cox said as Michael Spindler pointed out, they are bringing in the sanctuary model and intervention models which include motivational interviewing, social-emotional learning platforms and many of the evidence-based and evidence-supported practices they know must begin integrating quickly. Mr. Cox said they could speed that process up by working with the multidisciplinary team to troubleshoot the system of care and barriers in Nevada. Mr. Cox appreciated the collaboration and partnership, said it was welcomed, and NGU would actively pursue it from this point forward.

Kyle Dunlap (Regional Vice President, Epic Behavioral Health and Never Give Up Youth Healing Center, Board President of NAMI, National Alliance on Mental Illness) said he appreciated the Commission assembling the best minds and advocates in the behavioral health space in Nevada. Mr. Dunlap was encouraged by the consistent theme of highlighting elimination of silos. He said as an advocate and mental health professional, he always championed this because it is imperative to furthering progress for Nevada's most disproportionally affected populations. He gave a shout out to Dr. Pitlock, her team at DCFS, and other community stakeholders and agencies which have provided weekly oversight for their organization, facility, and the Amargosa Valley Psychiatric Treatment Center.

Chair Schrag said he would like to move from the action of a letter to a request for Mr. Dunlap, Mr. Cox, Mr. Levine, and Mr. Spindler come back and formally address these concerns with the Commission. He said, as he mentioned earlier, he did not think it was a fair and appropriate moment at present, and while he respected the immediacy of the concerns and NGU's need and desire to respond, it would be best to allow and offer NGU the opportunity to provide more comprehensive answers to Commission. He said he did not want to get into addressing these concerns in a piecemeal manner and instead preferred to allow NGU to provide a comprehensive response and reply to explore the issues further with the nuance and context required in a larger picture. This is an awareness and a placeholder to have a broader, more detailed discussion within 30 to 60 days to have NGU and Epic Behavioral Health come back with a collaborative understanding to address the issues identified by Commission and allow opportunity to provide the nuance and context of how they will be addressed. Chair Schrag said he did not think it would be fair to anyone from Epic or Never Give Up to provide immediate response and instead preferred they come back with a seamless message rather than being reactive. Mr. Levine agreed and said that would be appreciated. Mr. Cox said that they were in complete agreement.

Commissioner Cooper said there was one further concern to discuss prior to making a motion. This additional concern was the length of time a child was in a hold. The reports included children being placed in a physical hold in for duration times that exceeded one hour. She said she wanted to make sure that concern was part of that discussion and part of those answers coming back.

Commissioner Schrag said in full disclosure to the Commission, that he would connect with Mr. Cox tomorrow briefly over the phone to provide additional context and would not make any suggestions or recommendations on behalf of the Commission as that must done in a public forum with the approval and permission of a full quorum vote.

MOTION: Dr. Durette made a motion to officially request Never Give Up and Epic Behavioral Health attend a special follow-up meeting to be scheduled in October with the Commission on Behavioral Health with DCFS to respond to Commissioner concerns regarding seclusion and restraint and provide a plan of action and discussion to address the following issues:

- Length of physical holds exceeding an hour
- Length of stay
- Length of time between the event and the evidence of physician or physician designee's involvement and signage
- Repeated events without change in the treatment plan

SECOND: Dr. Gregory Giron
VOTE: Unanimous with no objections, abstention, or further discussion.

Kathryn Martin will distribute a Doodle Poll to schedule the special meeting in October which will comply with Nevada Open Meeting law.

6. **For Information Only.** Aging and Disability Services Division (ADSD) Update – *Yeni Medina, Autism Treatment Assistance Program (ATAP) and Jennifer Ahn, Nevada Early Intervention Services (NEIS)*

a. Autism Treatment Assistance Program - Yeni Medina reported the program received 88 new applications and was serving 967 children with an average age of 8.7 years. The wait list had 15 children (eight children waiting for straight up funding for ABA therapy and seven children on service coordination – basically children that do have Medicaid coverage). Average time on the wait list was 40 days and a statistical graph demonstrated these times have been significantly reduced while caseloads have grown. The biggest barrier is typically the wait time needed for families to return additional documentation and information before they officially get placed on the list

b. Nevada Early Intervention Services – Tabled. Jennifer Ahn was not present.

7. **For Information Only.** Presentation of the Pediatric Mental Health Care Access Program Grant – *Stephanie Dotson, Nevada Pediatric Psychiatry Solution (NV Peds), Division of Child and Family Services (DCFS)*

Stephanie Dotson reported the program continues focusing on training and education. An Issue Brief on youth suicide prevention was released in August which was specifically written for primary care providers. The Brief illuminated and described provider roles in preventing youth suicide and how a provider's practice and support of families is an integral part of youth suicide prevention. The Telegram publication also focused on youth suicide prevention and supplied even more provider resources and services. A Telegram was published which featured the REACH Institute Program (Resource for Advancing Children's Mental Health) program that NV Peds will be bringing in the coming months. This is a three-day training program offering six months of consultation for pediatric primary care providers who are working on integrating mental health into their practices. NV Peds is bringing back the Ripple Effect Training which SOC sponsored last year. The training received positive feedback from providers and stakeholders and NV Peds is expanding the opportunity to more individuals including clinicians, child welfare workers, juvenile justice workers, foster families, and general family members. Attendees will learn about inter-generational trauma and specific interventions for working with children and families who have experienced trauma. Six trainings are being recertified with continuing medical education credits and an application has been submitted to the Office of Continuing Education at the University of Nevada (UNR). The next Issue Brief will focus on youth substance abuse. Issue Briefs are written specifically for pediatric primary care providers and Infographics are also released providing small chunks of easily consumable information for providers to understand what they can do to support children and families with substance abuse as a challenge. NV Peds also offers training for Child and Adolescent Needs and Strengths (CANS), Suicide Intervention, and the Treatment Model Circle of Security. Ms. Dotson said more information on the CANs and other trainings will be distributed when available.

Dr, Durette asked how many people have attended these trainings so far? Ms. Dotson replied that in year four of the Health Resources and Services (HRSA) grant, over 100 clinicians attended trainings and earned continuing medical education credits. Approximately 50-75 people attended trainings available on the UNR website, Training and education is now the program focus in year five of the grant and prior to that the program was focused on other project components.

Dr. Durette asked how NV Peds was justifying to HRSA the fact that the scope of work for child psychiatry access programs involves the consultative piece which NV Peds is no longer providing. Ms. Dotson answered that the pediatric mental healthcare access program has three components: mental health consultation, care coordination, and training and education. HRSA accepted and approved a proposal submitted in June that NV Peds would only focus on the training and education piece.

Dr. Durette asked Ms. Dotson for the record if in her communications with HRSA there was interest in partnering with the team that is actually doing the child psychiatry access consultative work? Dr. Durette said this would provide needed funding for sustainability as the federal government had made millions of dollars available for pediatric access through the HRSA grant. Ms. Dotson said she would take the question about the possibility of partnering with the HRSA grant back and share it with those who make the

decisions about the grant application which comes out in the spring of next year. Ms. Dotson said made sense for all partners to be brought to the table to allow for program enhancements.

8. **For Information Only.** Medicaid Update and Changes – *Sarah Dearborn, Division of Health Care Financing and Policy*

State Plan Amendment – Reimbursement Methodology for Crisis Stabilization Centers

- This SPA is on Request for Additional Information (RAI), which essentially pauses the 90-day clock under the Centers for Medicare and Medicaid Services (CMS) review. The latest discussions involve adding the methodology to different pages within the state plan since the services provided under a crisis stabilization center are outpatient based and may fit better under the rehabilitative services area rather than the hospital reimbursement pages where we originally placed them.
- A new Provider Type 12 Specialty 250 – Crisis Stabilization Center was created.

During February IFC, Nevada Medicaid was approved to use Home and Community Based Services (HCBS) American Rescue Plan Act (ARPA) quarterly spending, to provide funding for a consultant to assist with recommendations for strengthening behavioral health services available to children through Medicaid. This will include things like facilitating stakeholder engagement; conducting a gap analysis, providing recommendations and assistance with identifying authority needed for CMS approval for identified services; providing recommendations related to service delivery model; and assistance with fiscal impact and projections for identified services. The consultant, Health Management Associates (HMA), is working on scheduling one-on-one interviews currently with stakeholders to discuss the current children's mental health challenges. These meetings will help prepare for a meeting that brings stakeholders together in September to collaborate around goals, timelines, and desired outcomes for this effort to improve Medicaid services and the overall system of care for children and youth with behavioral health needs and their families. There is a larger stakeholder meeting bringing everyone together later September in Clark County and there will be one scheduled in Washoe County as well.

Upcoming MSM 400 – Mental Health and Alcohol and Substance Abuse Services – Provider Qualifications

- Public Hearing will be held on September 27, 2022 to approve updated policy.
- This policy will help clarify the qualifications for Qualified Behavioral Aids and Mental Health Peer Supporters, Qualified Mental Health Associates, and Qualified Mental Health Professional providers.

Mobile Crisis Planning Grant

- The Mobile Crisis Planning Grant Project and Core teams have been working hard on developing how Nevada will build mobile crisis teams that will be eligible under enhanced Federal Medical Assistance Percentage (FMAP) offered through Section 1947 of the SUPPORT Act. Medicaid has been working with Mercer on this project and they have delivered their final recommendation report to the state. Medicaid is working through these recommendations and making determinations regarding moving forward. For example, it is

likely a state plan amendment will be pursued rather than a waiver to ensure already covered crisis intervention services include the requirements needed and outlined for qualifying mobile crisis teams to receive enhanced FMAP. A tentative timeline has been established to propose new Medicaid Services Manual (MSM) policy and state plan amendment in April 2023. Also, determining how to delineate these teams from other mobile crisis or crisis intervention that does not qualify for the enhanced FMAP, for example, identifying if a possible certification would be needed, development of a new provider type and use other system updates to include modifiers for qualifying services.

- Stakeholder meetings to include Certified Community Behavioral Health Clinics (CCBHCs), mobile crisis teams and other established mobile crisis teams will begin in late September and October. Provider slide decks are currently being put together.
- System work to build a new Crisis services provider type is beginning.

SUPPORT Act Post Planning Grant

- Work being done through the SUPPORT Act Post Planning grant has been related to the 1115 Substance Use Disorder Demonstration Waiver
    - The enhanced benefits being requested are clinically managed residential and withdrawal management services consistent with ASAM levels of care 3.1, 3.2, 3.5, and 3.7 that are not covered for individuals 22-64 under the State Plan due to Institution for Mental Disease (IMD) rule that prohibits Medicaid from reimbursing for services in and IMD.
- Ms. Dearborn reminded the group to visit Medicaid's SUPPORT Act webpage https://dhcfp.nv.gov/Pgms/SUPPORTActGrant/ to find the Substance Use Disorder (SUD) Data Book, the Strategic Plan, Infrastructure Assessment Report, and Sustainability Plan.
- Medicaid is working on looking at the data submitted to CMS on a quarterly basis that identifies if in fact the work being done to increase substance use treatment provider capacity is working. For example, we saw an increase in Nurse Practitioners performing substance use treatment services.

9. **For Information Only.** Discussion on Medicaid Update and Changes – *Sarah Dearborn, Division of Health Care Financing and Policy (DHCFP)*

a. Quadrennial Rate Reviews (QRR)

- NRS 422.2704 requires that, every four (4) years, the State of Nevada, Division of Health Care Financing and Policy (DHCFP) review the rate of reimbursement for each service or item provided under the State Plan for Medicaid to determine whether the rate of reimbursement accurately reflects the actual cost of providing the service or item. If the Division determines that the rate of reimbursement for a service or item does not accurately reflect the actual cost of providing the service or item, the Division must calculate the rate of reimbursement that accurately reflects the actual cost of providing the service or item and recommend that rate to the Director of Health and Human Services (DHHS) for possible inclusion in the State Plan for Medicaid.
- DHCFP has established a schedule for completing rate reviews by provider type. Surveys will be made available on this page for the designated providers. Completed surveys must be emailed to QRR@dhcfp.nv.gov in Excel format. Various channels may be used to notify affected providers of the availability of surveys for selected provider types to include email and fax blasts from DHCFP's fiscal agent (Gainwell Technologies),

correspondence to provider associations, web announcements on the Provider Portal, and updated postings on the bottom of this webpage.
  - Provider surveys will request information regarding the Cost of Providing Service for each CPT/HCPCS/Revenue code allowed under the designated provider type. Providers should ensure surveys are completed and submitted by the deadline listed on the survey. These surveys will help DHCFP determine if the current reimbursement rates paid to providers accurately reflect the cost of providing the service or item.
  - The deadline for completing the surveys is Friday, September 16, 2022.

10. **For Information Only.** Update on System of Care (SOC) Grant – *William Wyss, Division of Child and Family Services (DCFS*)

Bill Wyss said SOC principles are anchored in youth and family engagement, cultural responsiveness, and community-based services. Young people and their families are the most important decision makers for their own health and they need to be positioned in the system to be able to provide their voice. The SOC vision is to build healthy communities through partnership for innovation and hope for all Nevada children and families.

The SOC grant has one year remaining, unless there are funds remaining and a no-cost extension is done. SOC continues to work with grantees to mature their work, collect data, and provide technical assistance. Shannon Hill, Health Program Manager II, SOC Unit, reported that the grant focus as they head into the last year, is to continue direct service projects funded in the prior year, knowing the importance of supporting community-based and direct services. SOC is going to continue funding those items. Looking at unobligated funds, SOC recognizes there are additional dollars available for community investment. The grant focuses on rural, frontier, and tribal communities and in the last year SOC wants to make a concerted effort at collaboration with tribal communities. SOC is currently partnering with the Fort McDermitt Tribal Wellness Center to fund a clinical position to provide substance abuse treatment for children, youth, and families, through both direct individual therapeutic services, and group services. The partnership was developed through attending a tribal outreach event and other summer outreach events in Lovelock and Fallon. Meetings with tribal leaders and other regional individuals are scheduled for next week. The self-directed Respite Care Program will also continue.

Beverly Burton, Clinical Program Planner I Training and Technical Assistance, SOC Unit, announced Cultural Competency and Improving Healthcare Disparities Training are now available which focus on cultural and linguistic competency, healthcare disparities, and cultural and linguistically appropriate services standards. The class is scheduled over three weeks on Monday, September 12th, 19th, and 26th. System of Care training is scheduled for October 27th, 8:30 am to 12:30 pm and is open to anyone interested. Ms. Burton put her email address in the Chat and encouraged everyone contact her for more information.

Mr. Wyss said SOC activity communication and risk management plans are being developed to update SOC partners.

11. **For Information Only.** Announcements – *Braden Schrag, Chair*

There were no announcements.

12. **Information Only.** Discussion and Identification of Future Agenda Items. – *Braden Schrag, Chair*

Commissioner Schrag said he would like to like to review developing Bill Draft Requests (BDRs) at the next meeting for the purpose of information sharing and to potentially determine if there is duplication of effort that could be funneled into one direction, or support and recommendations the Commission might want to address

- Never Give Up and Epic Behavioral Response to Commissioner Seclusion and Restraint Concerns
- Bill Draft Request Review

13. **Public Comment.** *No action may be taken upon a matter raised during a period devoted to comments by the general public until the matter itself has been specifically included on an agenda as an item upon which action may be taken.*

There was no public comment.

14. **Adjournment. –** *Braden Schrag, Chair*

The meeting was adjourned at 11:18 a.m.