Brian Sandoval
Governor

Joel A. Dvoskin, Ph.D.
Chair

Hon. Jackie Glass, Ret.
Vice-Chair

Behavioral Health and Wellness Council

Behavioral Health and Wellness Council
Meeting Action Minutes
February 26, 2014

Meeting Location
Grant Sawyer State Office Building
555 East Washington Avenue, Room 4401
Las Vegas, NV 89101

Videoconference Location
Legislative Building
401 South Carson Street, Room 2134
Carson City, NV 89701

Members Present	Members Absent	Assisting Staff
Las Vegas:	Hon. Jackie Glass, Ret. (arrived at 1 p.m.)	Melissa Slayden
Joel Dvoskin, Ph.D., ABPP		
Michael Babbitt		
Timothy Burch		
Dale Carrison, D.O.		
Sue Gaines		
Doug Gillespie		
Marilyn Kirkpatrick		
Katherine Miller		
Karla Perez		
Michael Roberson		
Susan Roske		
Debbie Smith		
Dick Steinberg		
Randolph Townsend		
Richard Whitley		
Michael Willden		
Steven Wolfson		
Monte Miller		
Pat Hickey		

I. Call to Order, Welcome, Roll Call, Announcements
Dr. Joel Dvoskin chaired the meeting and called to order at 9:32. He welcomed the public. Roll call was taken by Melissa Slayden; quorum was noted.

II. Approve January Minutes
Minutes from the January meeting were approved. First Motion: To approve the January meeting minutes, by Dick Steinberg. Second Motion: Randolph Townsend. Pass: Unanimously approved.

III. Public Comment

There were no public comments.

IV. Presentation of the Department of Health and Human Services Short-Term and Long-term Goals

Richard Whitley, Administrator, Division of Public and Behavioral Health
Dr. Tracey Green, Chief Medical Officer, Division of Public and Behavioral Health
Ellen Richardson-Adams, Deputy Administrator of Clinical Services, Division of Public and Behavioral Health
Called to the table: Chelsea Szklany and Frank Reagan

Current strategic initiatives are works in progress because the Department is building budget for the biennium and considering policies. Last session, the Legislature approved combining public health and behavioral health. On the Behavioral Health side, Nevada is one of only three states where the State is in the primary role of service delivery. It looks different compared to Public Health and the Substance Abuse Treatment and Prevention Agency (SAPTA), where the State provides funds in order to provide treatment. Public Health uses data to identify where a disease can be prevented by intervening on behavior change or policy. Early intervention prevents costly crisis. So one looks to the data for investments in intervention and prevention. Priorities:

A. Build Community Capacity

a. Best serve the consumer with prevention, intervention, and treatment at a community level.

b. Formalize a local community consortium or coalition to address the mental health needs at the local level. Historically, in Nevada we have retained the mental health system at the State level, giving us the opportunity to examine how best to build capacity in a community. This will look differently across the state.

c. Identify roles at local and state levels.

d. Payer source, for most consumers, is not an issue. The issue is access to services which must be created locally. The state must meet locally to engage the community service system and support development of a community plan. This will look different across the State in order to meet local needs.

B. Crisis Prevention

a. Crisis prevention includes screening and early intervention. Those in a mental health crisis and mental health urgency (need) must have an entry point into the system aside from local emergency rooms, especially since 90% of those individuals are not in need of acute medical care.

b. MOST (Mobile Outreach Safety Team): Comprised of mental health clinicians, social workers, techs and psychologists, MOST team rides with law enforcement or are available 24 hours a day to deal with those having mental health crises. They can deal with individuals in the field, triage, and refer them. This team is not in the south; it only exists in the north. In the south the counterpart to MOST is a mobile crisis team. The MOST team is involved in training CIT officers.

c. Look to alternatives to the emergency room: crisis intervention centers, expand beds for community triage, sobering units, clubhouses, and respite centers. Expand school-based health centers, integrating with school of medicine.

d. There is a need for an established communication plan that supports a user-friendly, community-updated, service system accessible by family members and individuals in crisis. This would provide a single entry point which allows individuals to navigate and inventory resources in an emergency mental health system.

e. Identify "super utilizers," expand PACT (Program of Assertive Community Treatment) teams, and more intensive wraparound services. The ultimate goal is to reduce the return of "super utilizers" to crisis. The State, in partnership with the detention centers and emergency rooms (Clark, Washoe, and Carson City), compared data. It was found, in Clark County, that approximately 120 individuals were identified as "super utilizers" because they had two or more hospital admissions and two or more jail admissions in one year. All or part of crisis intervention services are reimbursable under Medicaid.

f. A Community Crisis Team was developed in the South on a needs basis. There was a great emergency room need that was focus of the team, as it was the crisis at hand. Currently the expanse of the problem and number of regions of the Las Vegas valley is part of the issue. The State is repurposing the mobile crisis team to do what was being done as part of mobile outreach team. There is a need for training and expansion of multiple additional teams in order to saturate the valley, beginning with the highest needs region.

g. There are opportunities we have to build on in order to address the "super-utilizers:" specialized PACT teams, assisted outpatient treatment, or outpatient civil commitment (court mandated medication, outpatient treatment, and housing compliance – the State and other community partners will assess and deliver those services).

C. Hospital Beds

a. Include treatment capacity, children under 21 are reimbursable, but for single adults 21-64 in a free standing psych facility with greater than 16 beds, Medicaid cannot be billed (based on the Institute for Mental Disease rule). We have very few acute mental hospitals with psychiatric beds. We do have about 100 beds a day in free standing facilities which are not reimbursable.

b. Improve the Legal 2000 process to allow for qualified people to decertify.

c. It is critical that at all entry points clients need to be enrolled in Medicaid.

d. The State is still looking to other opportunities for urgent care services for the clients. The State has separated each outpatient clinic from the provider number to allow the State to pursue other opportunities.

D. Stable Housing

a. For clients with mental illness and many other clients, homelessness is one of the priorities, and stabilized housing is crisis prevention. The State wants to develop community based housing plans and community based housing authorities to assist in the delivery of housing services for our clients.

b. Some residential types (i.e., residential treatment facilities, long term housing for the mentally ill, medically complex housing) do not exist in Nevada and the Division is working on regulations and resources to allow for them to come in to the state.

c. Develop a focused housing plan.

d. The state has funds to support Mental Health Court clients who are referred for housing. There are not enough of these beds. The State has used all of its Mental Health Court housing

dollars and a waiting list was created. Through the Interim Finance Committee dollars have been moved so that services can continue to be provided. For inpatient referral average wait time is 4 to 5 days.

E. Workforce Development

a. Look to the root cause about the variables which make it difficult to grow a capacity for mental health workforce: psychiatrists, advanced nurse practitioners in psychiatry, social workers, nurses, marriage and family counselors, mental health counselors, and substance abuse counselors. The State collaborated with the University system to see if we are producing enough of these professionals and if they are staying in Nevada. The State then looked at underserved areas and met with licensing boards for each discipline. There are existing programs that need to be maximized.

F. Mental Health Literacy

a. Educate families and communities about mental illness and resources. People must know where to go in case of a crisis. Inform consumers' family and providers about the system in a culturally sensitive and respectful manner. Develop and provide a single communication plan so that clients and providers can understand the system. Peer support and community health workers are two strategies we have.

V. Discussion regarding Department of Health and Human Services Short-Term and Long-Term Goals
Discussion was limited to clarifying questions and comments during the presentation itself.

VI. Presentation on Emergency Room Issues

A. Sherry Harney, Police Officer, ODB/CIT Detail, Las Vegas Metro Police Department
A.J. Delap, Police Officer, Government Liason, Las Vegas Metro Police Department

CIT training began for officers at LVMPD in 2003 to train and educate police officers to deal with those suffering from mental illness and those in mental health crisis. CIT officers are uniformed police officers in the field, the calls they go on are very specific. Dispatchers have also been trained so they can dispatch CIT officers to those calls.

a. Disturbances involving a subject known or reported to have a mental illness
b. Events involving a subject who is threatening suicide under violent or volatile circumstances
c. Subjects that show signs of excited delirium
d. Assist in taking into custody "walk away" mental patients who have been located

Crisis Intervention Team Officers take part in a 40 hour course in which they receive professional training on mental illnesses, juvenile mental illnesses, suicide prevention, Legal 2000s, and crisis intervention. To pass the course they are given a practical examination reviewed by a panel. 1499 LVMPD personnel have been CIT trained since 2003. 997 of the 1499 are police officers, 869 of which are in the field. An Officer is required to report Legal 2000s to the records department (Scope) by the end of shift. There is a recertification every 2 years and certification has been implemented in the Academy so that those Officers graduating are CIT certified.

e. CIT calls for service
   i. 2011: 10,541
   ii. 2012: 12,496
   iii. 2013: 18,707
   iv. 2014: 2763 (stats pulled just days before meeting), potentially rise over 20,000
f. Legal 2000 statistics (may or may not be a CIT call, all officers have the authority to Legal 2000 an individual). Medical personnel do not have access to the police records on Legal 2000s. LVMPD tracks Legal 2000s and compile monthly reports on individuals who have

been placed on a Legal 2000 hold four or more times in the last six months. This is provided to Officers and SNAMHS. Of the 18/day placed on Legal 2000 hold, approximately 15/month are repeat offenders. LVMPD is working with SNAMHS to develop Forensic Outreach Team (FORT) in order to follow-up with repeat offenders and to develop relationships through case management for these individuals in order to reduce future contact with police.

i. 2011: 5,989
ii. 2012: 6,185
iii. 2013: 6,727
iv. 2014: 868 (to date)

g. CIT After Action Reports are also reviewed and flagged in Scope if they involve
   i. Threats to others
   ii. Violence
   iii. Weapons
   iv. Homeland Security threats
h. In the planning stages is a collaboration with the University of Phoenix, in which they can provide a list of mental health clinicians to volunteer their time (24 hours a day) to be on call for officers in the field.

B. Dr. Dale Carrison, DO, Chief of Staff, University Medical Center
Dr. Carrison explained that we are in a mental health crisis due to unanswered need in emergency departments in the Las Vegas Valley. This crisis stems from patients, without present medical needs but who are in need of evaluation for mental illness by a mental health professional. These patients occupy local emergency department beds while waiting to access local psych treatment services at SNAMH. Once placed on a Legal 2000 hold, these patients wait for medical clearance and, for some, admission to the psych hospital.

The Las Vegas Valley has a lack of services for people with mental illness including medication and emergency services. These patients arrive at the emergency department as walk-ins, brought by law enforcement or by EMS. Some may be looking for refills. Others need to be restrained and may become violent, attacking their nurses or physicians. Less than 1% has an acute medical problem. Patients with mental illness who have insurance spend a relatively short time in the emergency departments compared to those without, though few have insurance. Emergency physicians are not typically comfortable instituting a medication for a patient with mental illness, though they will resume a patient's medication if it is known.

It is important to look to alternatives for clearing mentally ill patients, improve resources for follow up, and look to residential treatment centers so that those with acute medical problems including medical emergencies can receive services from emergency departments. The Legal 2000 form needs to be addressed in order to give psychologists the right to release patients from a hold.

The Council discussed the need for a crisis system with less expensive ways to provide better care. There has to be some alternative to the ER or the Jail. Legal 2000 were discussed concerning juveniles, out of state placement of juveniles during treatment.

C. Chris Bosse, VP Government Relations, Renown Health
Dan Musgrove, Dan Musgrove Advocacy, Inc.
Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy
Sherry Harney, Police Officer, LVMPD – called to the table

There is overcrowding in the hospitals, as they are required to provide safe discharges for their patients. That may be alternative levels of care or a safe discharge home. They are required to find solutions before they let people go. Medicaid and underinsured patients are helping to crowd the hospitals because they don't have access to alternative levels of care as insured patients. The hospitals are not prepared or

designed to care for mentally health patients or substance abusers. This lends itself to the hospitals being unable to provide timely care and a rise in costs as patients are held while resources are tracked down. There is an inadequate number of POU (Psychiatric Observation Unit) beds and lack of wrap-around services, and additional outpatient services such as case management, transitional housing, medication clinic, urgent care.

a. Private free-standing psychiatric facilities
    i. Total beds: 491
    ii. Beds under construction: 52
    iii. Beds available: 165 (based on average unoccupied rate)
    iv. Acute care inpatient adult psychiatric beds
    v. Total beds: 62
    vi. Beds under construction: 6
    vii. Beds available: 21 (based on average unoccupied rate)

b. State facilities
    i. Total licensed beds: 359
    ii. Staffed beds: 220
    iii. Beds available: 49 (based on average occupied rate)

TOTAL AVAILABILITY ON ANY GIVEN DAY – 235 BEDS

Only two facilities have acute care inpatient adult psychiatric beds. They are located in the north, in Elko and Carson City.

c. Solutions:
    i. Alternative sites for medical screening
    ii. POU Capacity
    iii. Transitional beds
    iv. Wrap around services
    v. OSCAR model

d. IMD exclusion applies for all Medicaid beneficiaries though there are some alternatives to be considered utilizing managed care. For those between 21 and 64, in an IMD, Medicaid does not provide reimbursements for hospital stays. If, in lieu of hospitalization, the managed care can provide services at less than or equal to the hospitalization rate then services can be provided through managed care.

e. OSCaR (One System of Care and Resources) 2014 & the Continuum of Care
   Dan Musgrove described the OSCAR Model components
    i. No wrong door
    ii. Community triage center
        Has had many successes and saved the community money. It is seen as a model program. It is funded 1/3 by local hospitals, 1/3 by local governments, and 1/3 by the state. Mike Willden clarified: The State will pay half of the combined input funds of the county and the hospitals. Now community members know where they can go to get services for a family member in crisis or for themselves.
    iii. Transitional living with integrated services
    iv. Community housing/supportive transitional living

   Through the OSCaR model the needs of the patient are addressed in the least restrictive environment and centralize services to be cost effective and navigable.
    v. Utilize diversion efforts with 24 hour admissions
    vi. Mr. Musgrove described the clients utilizing CTC, their socio-economic factors, referral sources, discharge (reasons and placements), and mental health services in

other states.

vii. Director Kat Miller asked for clarification on costs to operate a single CTC in the Las Vegas Valley.

viii. Dick Steinberg gave a brief history of the CTC program in Las Vegas, describing that police and EMS dropped off the greatest amount of clients. The program pilot was not continued because it was funded only once for training.

ix. The local government contribution has decreased due to the economy. It has yet to rebound as it has in other areas of the state. Without the local contribution the overall program funding is reduced which puts pressure on the local entities (i.e., CIT Officers, CTC, and emergency departments).

f. Laurie Squartsoff, Administrator, Nevada Medicaid

i. Nevada Medicaid is working with community partners and Division of Welfare and Supportive Services to enroll Nevadans in Medicaid and that they have access. The goal is to expand outreach for enrollment and increase the number of Nevadans covered.

ii. A full review of reimbursement rate of services for Medicaid and options for addressing concerns is under way.

iii. Evaluating opportunities to maximize draw down of federal dollars -- 62% of funding is through the federal government so it is important to find the resources to maximize the use of federal funds. This lends itself to a discussion about the types of facilities available in Nevada.

iv. Reduce recidivism by reactivating eligibility once an individual leaves a correctional center (either jail or prison) -- This is an information technology issue to ensure clients are transitioned from "eligible" to "pending" and connect with Corrections and the jails to make the adjustment.

v. Karla Perez explained the conversion of med/surg beds to psych beds at the acute hospital is costly and psych beds do not reimburse at the rate that med/surg beds do. The hospitals would need reimbursement assurances in order to make adult psychiatric inpatient services at the hospital.

vi. Laurie Squartsoff : The Department is continuing to work with managed care partners to ensure access to delivery of services. This is a new patient population (behavioral health and SAPTA providers). These partners have done lots of outreach, even through their non-traditional network of providers. The Department is working on treatment for these particular patients and medical justification for services, and to be sure the providers are being reimbursed for services appropriately.

VII. Discussion regarding Emergency Room Issues

A. Dale Carrison: It is the community resources that need to be focused on and to create an innovative way to fund the communities to address mental health at a grassroots level. Once individuals are thoroughly in the system it is too late.

B. Jackie Glass: Wraparound services dropped the recidivism rate to prevent people needing to go to ER and jail. It is significantly cheaper to provide wraparound services compared to housing them in jail, prison, or backing up the ER. There needs to be a change in how services are provided to individuals in the community.

C. Marilyn Kirkpatrick: Money needs to be spent in order to be more efficient.

D. Joel Dvoskin: There are two emergent problems here. People are stacking up in emergency departments. The solution is an alternative place where the police or family can take the individual which is not the ER or jail – there are not enough beds like that in southern Nevada. The second piece is ongoing comprehensive care to prevent crises, change the lives of those with mental illness, and is still less expensive than inpatient beds or emergency department. This is usually a low-caseload case management model which must be cost effective for the patients with the highest need.

E. Jackie Glass: The model is different in other states and we need to take a step back to see what is

working best in other places to build a model. The Council needs to hear from some of them.

F. Joel Dvoskin: I have compiled some of those things from North Carolina and New York (called Parachute), which serve different purposes but are having successes.
G. Jackie Glass: We need to prioritize what we can and cannot do by the deadline.
H. Marilyn Kirkpatrick: How much does OSCaR cost?
I. Kat Miller: How do we define success of these programs?
J. Dick Steinberg: This is not a short-term issue. The concept and grouping needs to continue. The people and these issues do not go away.
K. Debbie Smith: There is an immediate crisis to deal with emergency departments and make recommendations we can address at IFC. Then the next budget, followed by the long-term plan. There are broad stroke issues and what are the solutions? Let's look at these as solutions not programs. There was a community school and safety forum as a result of the Sparks school shooting. It was about mental health rather than guns and what our community can and cannot provide. Suicide crisis is also a huge part of our mental health in this state.

VIII. Public Comment

Dr. Robert Durette, Healthy Minds

There are "roughly" 10 active child and adolescent psychologists in the Las Vegas Valley. Healthy Minds employs half of the child and adolescent psychiatrists in the Valley. In comparable cities, such as San Diego has greater than 64 and Charleston, SC has greater than 60. This speaks to capacity. Psychologists are now requesting that pre-doc psychologists bill for Medicaid and providing therapy, indicating the lack of psychologists in the Valley. Healthy Minds has suggestions to make changes, they have reduced psychotropic medications and hospitalizations. The Chair invited Dr. Durette to return and present as part of a panel.

IX. Adjournment

Dr. Dvoskin thanked the public and the meeting adjourned at 4:06 p.m.