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
Action Minutes
Monday, April 21, 2014, 9:00 a.m.

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
Dr. Joel Dvoskin, Chair
Tim Burch
Sue Gaines
Speaker Marilyn Kirkpatrick (arrived at 1:15 PM)
Karla Perez (arrived at 10 AM)
Sen. Michael Roberson (arrived at 10AM)
Dick Steinberg
Sen. Randolph Townsend, Ret.
Susan Roske
Michael Kelley-Babbitt
Richard Whitley
Monte Miller
Sheriff Doug Gillespie
Sen. Debbie Smith
Asm. Pat Hickey
Katherine Miller

Members Absent
Hon. Jackie Glass, Ret.
Dr. Dale Carrison
Mike Willden
Steve Wolfson

Assisting Staff
Melissa Slayden (Las Vegas)
Christina Griffith (Carson City)

I. Call to order, Welcome, Roll Call, Announcements
Dr. Joel Dvoskin welcomed everyone and called the meeting to order at 9:12 AM. Melissa Slayden called roll. There were no announcements.

II. Public Comment
Dave Marlon, President of Solutions Recovery, whose clients have a co-occurring disorder with serious mental illness and drug dependency as, he explained, is the case for half of the State-funded clients in Southern Nevada. He expressed his concerns about the current Mental Health system in Southern Nevada, calling it broken. He explained that it is not good clinical or cost effective care to mandate patients be brought to the emergency room for medical clearance and then taken to Rawson-Neal, where 50% do not meet admission criteria. He pressed that the long-term systemic problems must be addressed

first. Solutions he offered included Psychiatric Emergency Service (outpatient, psychiatric crisis, walk-in clinic combined with crisis hotline, mobile crisis and police liaison services) and Psychiatric Healthcare Facility (hybrid inpatient and outpatient facilities, which provide outpatient, walk-in, crisis stabilization and short-term sub-acute psychiatric inpatient services). Other priorities he named included: wrap-around services (with the expansion of case management, mobile crisis, outpatient transitional services, peer-to-peer services, transitional housing, and priority access in outpatient services for triage). He asked that managed Medicaid health providers be invited to testify in front of the Council as they will be the primary players in the delivery of care. Randolph Townsend asked how Mr. Marlon would address housing. Mr. Marlon described that with Co-occurring patients housing is a critical component in recovery. More is needed but an exact number is not known. About half of patients become self-sufficient. Dr. Dvoskin delineated the difference between those in crisis and those with persistent serious mental illness.

III. Approval of March 24, 2014 Minutes
Motion to Approve: Senator Roberson
2nd: Senator Smith
Unanimously approved.

IV. Approval of March 25, 2014 Minutes
Motion to Approve: Senator Roberson
2nd: Senator Smith
Unanimously approved.

V. Report from Division of Public and Behavioral Health
Richard Whitley, Administrator, Division of Public and Behavioral Health
Mr. Whitley presented to the Council updates. He began with facilities and moved on to policy.
Hospitals:

- CMS exclusion from reimbursement for psychiatric hospitalization in stand-alone psychiatric hospitals with more than 16 beds.
- There are no acute hospitals with mental health units in Las Vegas. There are only two in Nevada, one in Carson City and one in Elko. Part of the problem is the State rate of reimbursement, $465 per day, far below the cost of psychiatric hospitalization. State Medicaid is working to increase the rate to $944 per day, which covers the cost and will likely add beds in Las Vegas. The anticipated approval of the rate is July 1, 2014. It will take acute hospitals time to reconfigure or build to add psychiatric beds.
- In response to the Institute for Mental Disease (IMD) Exclusion, which prevents reimbursement for facilities with greater than 16 beds, the State has been approached by one facility to create a 16 bed unit. Other states have utilized contracts with managed care to reimburse the free-standing psych hospitals. In order to reimburse the rate would have to be lower than the Medicaid rate, which is not possible in Nevada because the rate of reimbursement is so low. By raising the rate managed care can negotiate with the stand-alone psychiatric hospitals. This can then be an opportunity to expand beds.
- Building 3A, on the SNAMHS campus, is licensed for 21 beds and moving toward full-capacity.

Senator Smith asked that the managed care organizations join the conversation as they are a critical component. Dan Musgrove came to the table, as he represents Amerigroup, one of the two managed care organizations. He explained that they are ramping up for the increased number of participants and determining the appropriate levels of care. The problem is finding providers (many of which need to become Medicaid providers in order to bill for services) and dealing with the backlog of new patients. For now managed care is only in Washoe County and Clark County and the rest of the State remains in fee for service.

Other facility types:

- Community Triage Centers (as defined in statute): assessment and short-term monitoring for persons with mental illness or substance abuse. CTCs are not a CMS certified facility type, rather a Nevada licensed facility type. There are only two in our state, both under WestCare. Twenty beds in the Northern Nevada and 50 beds in Las Vegas are licensed. The issue is with funding: 1/3 is provided by the State, 1/3 is from local government, and 1/3 is from local hospitals. Historically local government and local hospitals reduced funding so WestCare had to reduce staffing in Las Vegas to cover only 36 beds. Mr. Steinberg explained that WestCare is prepared to go back to the 50 beds, and that the reduction to 36 beds is strictly because of funding. Mr. Steinberg is ready to meet with Mr. Whitley to discuss incorporating Federal funding to get bed utilization back to 50. Tim Burch asked about the 1/3 rule and clarification on over-contribution. Mr. Whitley explained that it is a budgeted item and there are ways at arriving at what the contribution is. In the north the local government provides the facility. Mr. Burch explained that all the municipalities give in to the local 1/3 (City of Las Vegas, City of North Las Vegas, City of Henderson, and Clark County). Mr. Burch wanted to be clear that in-kind contributions would be included in the local government 1/3 as Clark County develops the new WestCare facility. Mr. Steinberg included that the daily bed-rate was developed eight years ago, which never increased and actually had cuts. As a result, the burden fell to WestCare, their quality of care, and response time. He explained that there are opportunities in the private sector and the non-profit sector at a much reduced rate. Dr. Dvoskin asked if Clark County can replace its reduced funding or make it up with in-kind services or change the formula to get the beds in operation. Karla Perez clarified that the hospitals reduced their portion, following local government cuts, but have not been asked to return to historical levels. Dr. Dvoskin asked what needs to happen to maximize the reimbursable costs and how much that change will help.
- Substance Abuse Prevention and Treatment Agency (SAPTA): Historically dependent on public dollars never adapted to the reimbursement environment for billing for services. All providers are now enrolled in Medicaid and managed care and they have to provide the services which are reimbursable. So the providers have to change their service model. Treatment providers were used to inpatient treatment, but, Managed Care is designed for intensive outpatient. This created a crisis for some providers. The delay in processing applications for their clients created a delay in reimbursements and a hardship for the providers.
- Psychiatric Residential Treatment Facility (Children 21 and under): Previously asked why so many adolescents are sent out of state for treatment. On the Medicaid website at any given time there are between 175 and 220 children receiving services from outside of Nevada for psychiatric residential treatment. In Nevada you have to be licensed as a hospital but Medicaid only reimburses for a residential treatment facility. The Bureau of Health Care Quality and Compliance has licensing authority and certification on behalf of CMS. This licensure type will be heard by the Board of Health for adoption in June. In establishing this facility type the hope is businesses will show interest in creating these facilities. When children age out they are brought back to Nevada. Creating these facilities will help to smooth the transition process when they do age-out.

<u>Programs</u>:

- Peer-to-Peer: Is present in the State Medicaid Plan but is not being utilized. Some elements are, such as the training required for being a Peer, but the way the plan is written it would be better if community non-profits kept a registry of available Peers. The Nevada State Plan requires it be referred by a physician to initiate Peer support services but the Plan does not indicate how the physician would access the Peers. Other states are more sophisticated, which we can look to for models. Sue Gaines said she would get as much information as possible on the Arizona model from one of her NAMI peers who has spent time studying the Arizona Peer Support programs. Mr. Steinberg looked to lend WestCare support to the development of the program. Mr. Whitley discussed that the agency responsible for the Peer should be licensed rather than each Peer. In that way a non-profit would provide training and oversight for the Peers, as well as outreach to the providers. Dr. Dvoskin impressed upon the Council that Peer programs must be local, as the resources and needs are unique to the locality.

<u>Other Follow-Up:</u>

- Adequate medication upon discharge was discussed previously by the Council. At Rawson-Neal it is policy to provide adequate medication with enough quantities (up to 14 day supply and up to two refills) to last the patient until the next clinic appointment. The language has consistently been in policy. Mr. Whitley stated that if a patient is having difficulty getting necessary prescriptions to last to the next appointment, it is in violation of policy. Dr. Dvoskin asked about tracking. Chelsea Szklany explained that some instances have occurred where (with certain medications) patients have had to come back more frequently. Dr. Dvoskin wanted to know if patients are actually showing to get their medications. Yes, appointments and medications are tracked with a 30-35% no-show rate. Dr. Leon Ravin was asked to the table. He indicated that typically a 2 week supply and two additional refills are given to patients.
- Super-Utilizers defined: Diagnosed with mental illness and two or more inpatient hospitalizations in a 30 day period and two or more jail stays in a one year period. There has been discussion of using ER data, which proves difficult at this point as aggregate data rather than individual identifier data is available. 144 Super-Utilizers have been identified by the Division of Public and Behavioral Health. There are likely other individuals which are missing from the data because they are frequent flyers in the ER who have not qualified for inpatient hospitalization.

VI. Discussion regarding Report from Division of Public and Behavioral Health

Dr. Leon Ravin was called to the table. He gave a brief overview on psychiatrist training in Nevada. He used information from the University of Nevada School Of Medicine (UNSOM). The Accreditation Council for Medical Education regulates residency programs nationwide. Once a program is given a certain number of spots for residents, students must advance through all four years before the number of slots for residents can be expanded. They primarily look at the Joint Commission Accreditation for inpatient psychiatry. Dr. Dvoskin asked if the IMD Exclusion prevents a more than 16 bed hospital from being a training site. Chelsea Skzlany told him no. Dr. Ravin went on to discuss the number of residents completing programs in Nevada and their incentives, or lack thereof, to stay within Nevada.

VII. Discussion, drafting, and possible approval of recommendations to the Governor's Office (See presentation).

Dr. Dvoskin arranged how the recommendations would be approached based on the information the Council had received in all prior meetings and that agreement should be tantamount to the decision making process. Potential areas for recommendations discussed:

- **The Super-User Project**:
  - Include housing
  - Maximize reimbursements
  - Reduce jail days, inpatient hospital days, and ER visits
  - Low-Caseload Case Management (10:1) Every consumer would have a case manager.
  - A general number of $20,000 per consumer per year, including housing, with $12,000 Medicaid reimbursable services. This leaves approximately $8,000 for housing one third of which can be paid from disability benefits by the consumer. Conservatively $10,000 is the expected price equaling approximately $1.44 million a year. It would include wrap-around services and vocational rehabilitation
  - Use the PACT model and/or MH Court
  - Mr. Steinberg explained that there should be more cost anticipated at the front end for costliness, review, training, and oversight.
  - An anticipated goal would be 6 months
  - Sen. Smith asked about IT needs for tracking Super-Users
  - Mr. Burch included that housing would be done through existing relationships with property owners but that some individuals would need more intensive supervision (24/7 support) when it comes to housing, which means they would need to be co-located. Mr. Burch explained the difference between congregate living and co-location: for instance,

not a group living home, rather a converted hotel with 20 single residency apartments. Adding 144 individuals to the existing system would not be too difficult.
    - When including MH Court in the costs, the Council would need to include costs for adding another docket including court coordinators, administration, and staff. Sen. Smith asked to hear from the court.
- Dr. Dvoskin asked, that with Council's permission, if there was a consensus and if he could then begin writing recommendations for the Council to consider. There was no disagreement.
- **Increase Capacity for Short-Term Crisis Triage Service**:
    - Community Triage Center
    - Includes short-term housing
    - Alternative to jail, E.D., and inpatient
    - Services: Sobering Centers, Respite Care, Mental Health Crisis Beds
    - Funding issues – State, County and Hospitals
    - Space appears to be available
    - Requires contribution from State, County, and Hospitals
        - One-Third Rule: No one has asked the hospitals to increase its portion of the reduction that occurred when the County reduced its contribution
        - This caused a reduction in WestCare beds from 50 to 36
        - A significant increase in beds would be ideal
    - Is there a way to make it reimbursable?
        - Mr. Whitley and Mr. Steinberg will work together to figure out how to defray costs by making services reimbursable
    - Benefits: Reduction in jail, ER, and inpatient admissions
    - Sen. Townsend asked how an interactive Officer decides whether an individual will go to WestCare, ER, or a law enforcement facility. Sheriff Gillespie answered:
        - If there are criminal charges, then jail is an option.
        - If there is a Legal 2000, Officer balances whether or not the issue will be resolved if the individual is taken to the ER. Sometimes the Officer is required to stay at the ER. Officers examine the threat an individual presents to themselves or others.
        - When looking at WestCare as an option, an Officer must factor in intoxication and "ability to get along."
    - Karla Perez expressed her concerns about all of the variables that go into the funding issue which make funding so vulnerable. The current contracts are only for one year and every year they have to be renegotiated. Thirteen hospitals have to participate and sign off; if any one decides not to participate the program can die. The same goes when the County decides not to participate. She asked that the Council look to a long-term funding solution for the Crisis Center. Dr. Dvoskin indicated that this is closely tied to governance, and likely local/regional control. Dan Musgrove was asked to the table to explain the system employed to finalize the contracts. He explained that they begin as an MOU (Memorandum of Understanding) generated by the local governments (involving going in front of local jurisdictions and their attorneys). It has to go through their budgetary process, be approved by each jurisdiction's elected board, the State then waits for WestCare to receive monies (from the hospitals and local jurisdictions) and pays half of that received. The State's match goes directly to WestCare. Mr. Steinberg explained that WestCare is obligated to provide the services which becomes difficult when waiting on the "Who goes first?" method. Many times in Nevada payments are made late and WestCare is in a holding pattern because bills are paid anywhere from 90 to 180 days late. Dr. Dvoskin explained that all of the entities need to have input and the system needs to be more predictable and orderly. Sen. Townsend explained that there needs to be an agreement between the State, local governments, private hospitals, and non-profit service providers, about moving away from a yearly contract and negotiating a long-term agreement. Then look to governance and oversight. At the same time, make a sale to the

public about what a community is. Dan Musgrove impressed upon the Council to ask the Governor and the four Legislative leaders to send a letter to each local government asking that each puts a Community Triage Center in their budgets for next year. Mrs. Perez spoke to the Upper Payment Limits (UPL), the hospitals will be paying the State's portion of WestCare under the private UPL program during this cycle. Whether that can be expanded or used to cover another CTC, she did not know. Mr. Musgrove explained the UPL program, which includes taking on a financial responsibility (such as an existing contracted service on a current State contract) in order to have State dollars matched with Federal dollars. It has to exist in the budget first. Mr. Musgrove let the Council know that this caused a change in the law (2013) allowing this kind of relationship between State and private entities. Currently there is no money flowing from the UPL. In other states where triage centers are operating there are full funders, be it the State or local government. Speaker Kirkpatrick asked for incentives to fast-track to get payments turned around more quickly. Dr. Dvoskin asked that Speaker Kirkpatrick, Mrs. Perez, and Sen. Townsend, to come back before the May meeting with explicit action steps.

- **Inpatient Bed Capacity**:
    - Building 3A is done with 21 inpatient beds
    - General Hospital Psych Unit
        - Mrs. Perez announced that Universal Health Services has agreed to develop an adult psychiatric unit at Valley Hospital with 50 to 55 inpatient beds. Thanks to the announcement on the increase in the Medicaid rate this project will get underway immediately. The Chair thanked and congratulated Mrs. Perez and Mr. Willden. The unit should be open within 6 months.
- **Institutes for Mental Disease Exclusion**:
    - Dr. Dvoskin gave a brief history of the exclusion and explained why the Exclusion is no longer well-deserved, and is in fact arbitrary. He asked the Council to look to getting around the Exclusion or deal with it with governance. Sen. Townsend asked for a one page synopsis on the history of the IMB to share with the Governor and congressional delegation about the resources we have and our inability to utilize them because of this exclusion.
- **Workforce**:
    - The problem includes all clinical positions, but the emergency is with psychiatrists. This group is underpaid by $30,000/year compared to the State's greatest competition. Dr. Dvoskin spoke to incentives to bring psychiatrists to Nevada and keep them here. Sen. Smith suggested that the pay issues are examined in a larger context as all State employees are still on furloughs. Other options were discussed: loan repayment, benefits, additional board certifications, tuition reimbursements, change the 'no moonlighting' provision, signing bonuses, etc.
    - Mr. Whitley discussed loan forgiveness, which is underutilized in Nevada. There are 15 participants in Nevada compared to 150 in Idaho. The loan forgiveness program occurs in underserved areas and one qualification is that you have to receive Medicare or Medicaid clients, which benefits for-profit hospitals too. The dollars used are Federal monies. The formula for determining underserved areas is HRSA prescribed, so parts of Clark County are considered underserved while others are not.
    - "Includes all clinical disciplines, examine need for increase in salaries for State psychiatrists and others clinical specialties. Options include:
        - Eliminate furloughs
        - Incremental increases
        - Consider amending the 'no moonlighting" provision for psychiatrists (does not require legislation)
        - Signing bonuses
        - Increase residencies

        - Explore private partnerships to enhance Federal reimbursements
        - Use nurse practitioners
        - Create post-doctoral fellowships
        - Look at possibilities for other incentives
            - Expand/Advertise loan forgiveness
            - Pay incentives for Board Certification
            - Moving reimbursement"
    - Dr. Dixon came to the table to clarify the number of psychiatrists completing the program in Southern Nevada. Of the four one did not complete the program and two are leaving the State. Graduating residents make decisions about where they will go in January each year. The Council would need to look to begin recruiting now for next year's graduates.
- **Mental Health Professionals in Schools**:
    - Direct service and referral for kids with Serious Emotional Disabilities
    - Suicide Prevention
    - Mental Health Screening, Intervention, Referral
    - Child Protection: Identification, service, and referral of maltreated children
    - Possibly supported by (district) psychologists
    - Consultative support for teachers
    - Can these services be reimbursable?
        - Combined with School Based Health Centers
    - Consistent with Safe Schools, Healthy Kids Initiative
    - Offer resource to school districts by whichever strategy is adopted
        - Strict requirements for how money is used
        - If they decline, direct state service as a last resort
    - Dr. Dvoskin asked the Council for general consensus regarding Mental Health Professionals in Schools and suggested that he would ask Dale Erquiaga, the State Superintendent of Schools, to develop a plan for the Council to consider as a proposal.
    - The K-12 Subcommittee on Children's Mental Health was discussed. Rather than develop a subcommittee, the Council will utilize the Subcommittee of the Commission on Behavioral Health and Developmental Services, and of the Nevada Behavioral Health Consortium. In the future the Subcommittee of the Commission and of the Consortia will have regular updates for the Council to serve that function.
- **EMT's and Paramedics**:
    - Train EMT's and allow them greater discretion
        - Allow EMT to triage without transport in SMI cases that do not require Emergency Department care
        - Change state Medicaid plan to pay for non-transport services, such as field triage
    - Limit liability for Medicaid patients
        - Speaker Kirkpatrick asked how much discretion the private ambulance companies have flexibility to make changes to the franchise agreements with local governments or if those contracts would have to be reopened.
    - Need Medicaid rate for not transporting
    - IT Infrastructure Needs
    - Costs and benefits
    - TIRs – Technology Improvement Requests
    - Department of Public and Behavioral Health to provide summary of most pressing needs
    - Client specific data and/or statistical information

VIII. Public Comment

- Dan Musgrove clarified that the State does not receive the full benefit of the UPL match. UPL is designed because there is not a full reimbursement for cost. This is a voluntary arrangement (per

CMS rules), in which the State receives approximately $0.15 of every dollar that comes back in matched funds.

- Robert Bennett discussed his background in Mental Health Court, mental illness, homelessness, recovery methods, and his new book. He read from a book sections on magnesium deficiency and behaviors associated with it. He also discussed trauma and how it relates to his experiences.
- Dr. Leon Ravin clarified that APNs are not required to have psychiatric specialty when hired.

IX. Adjournment

Dr. Joel Dvoskin thanked the public and the Council for attending the meeting. He adjourned the meeting at 4:10 PM.