AGENCY DIRECTORS' REPORT

AGENCY: Lake's Crossing Center SUBMITTED BY: Elizabeth Neighbors, Ph.D DATE: 3/4/2016

Reporting Period: 3/18/2016

STAFFING

Positions filled: 96

Vacancies: 20

Difficulties filling: Forensic Specialist III; Psychiatric Nurse II and III; Clinical Social Worker II; AA II

CASELOADS/WAITING LISTS

Program: Inpatient Restoration Program

Caseload: 76

Waiting List: 8

Program: Washoe Interlocal Ageement

Caseload: 70

Waiting List: 15 pending

Program: Long Term Commitments

Caseload: 10

Waiting List: 2

Program: Conditional Release

Caseload: 2

Waiting List: 3

Program: Misdemeanor Re-Commitment Evaluations

Caseload: 10/month

Waiting List: 5 pending

Program: Click here to enter text.

Caseload: Click here to enter text.

Waiting List: Click here to enter text.

PROGRAMS

New Programs: Start Now implementation is in the planning stages. This program is a therapeutic program to address criminogenic thinking for individuals involved in the criminal justice system. It has been implemented with prison inmates and is in process of being modified for pre-trial detainees. LCC is planning to participate in this national effort through the National Association of State Mental Health Program Directors, Forensic Division.

Program Changes: The facility is working on transitioning Clark County clients back to their county of origin and reducing the numbers transported to the North from that region. The facility is also working on completing the Capital Improvement Projects begun in June. These projects will help prepare the agency for CMS application along with the updates in programming.

Service Needs/Recommendations

LCC continues to have a large number of medically ill clients for whom there are limited resources. There is a need for expanded access to outside medical consultation and service.

Agency Concerns/Issues

Recruiting has become a problem again with other criminal justice agencies providing more attractive opportunities based on competitive salary. We have had several forensic specialists leave for employment at police agencies shortly after we completed

training them at POST. This movement has placed a lot of strain on the agency as we have had to do a lot of overtime in the face of construction and lost staff. This factor also effects nursing staff who can earn higher salaries at other agencies.

AGENCY DIRECTORS' REPORT

AGENCY: Desert Regional Center SUBMITTED BY: Leslie Brown DATE: 3/4/2016

Reporting Period: 12/31/2015

STAFFING

Positions filled: 283

Vacancies: 29

Difficulties filling: DRC continues to have difficulty recruiting qualified candidates for the Licensed Psychologist 2 position that has been available since 12/2014; several interview sessions have taken place without success. Recruitments/advertisements continue to be made locally and nationally. A unique combination of experience in leadership and supervision, and as a clinician/psychologist is desired for this position.

CASELOADS/WAITING LISTS

Program: Service Coordination

Caseload: 4380

Waiting List: N/A

Program: Jobs and Day Program

Caseload: 1720

Waiting List: 506

Program: Autism

Caseload: 15

Waiting List: N/A

Program: Residential Support

Caseload: 1121

Waiting List: 291

Program: Family Support

Caseload: 2286

Waiting List: 487

Program: Developmental Center ICF/ID

Caseload: 48

Waiting List: 52

PROGRAMS

New Programs: The Harmony Case Management computer system remains in development and testing. Workgroups have been meeting weekly in an effort to meet the new "Go Live" date of 7/1/16. Train-the-Trainer training is scheduled for late April 2016 and end user training is scheduled to begin 5/8/16 for DRC. DRC is in the process of establishing two computer training labs so that two trainings can occur simultaneously in an effort to train all DRC staff by the 7/1/16 deadline. Contracted providers will also require training, which has not yet been developed or scheduled.

Program Changes: SLA budget continues to have a shortfall for FY 2016 based on the Legislatively approved budget and as a result, DRC has only been making new SLA placements who have been deemed emergencies. Efforts are being made to submit a work program to the Interim Finance Committee in February 2016 to obtain approval to utilize the projected excess Medicaid revenues to serve individuals on the wait lists. Alternatives to DRC-paid SLA placements are being explored, partnerships have been established with community resources to aid in serving the needs of individuals on wait lists, and cost sharing between State and private agencies has occurred. DRC has begun funding new JDT placements/certifications and over 100 individuals have been released for the wait list based on date and priority level order. Service Coordinators are encouraged to prioritize the coordination of these placements to maximize our utilization this FY. The DRC Respite program continues its new process of monthly allocation and bi-monthly utilization review in an effort to provide funding to individuals on the wait list; cases are being evaluated for non-usage and funding is reallocated. The non-usage rate per a two month period has averaged at 20%. Some

families defer usage across months in an effort to save for a special recreational trip or provide assistance to the family at a specific time. DRC's goal continues to be to maximize this budget and allocate unspent monies to individuals waiting for respite services. At the ICF/ID, a reorganization of the residences took place in December 2015 following lengthly and arduous planning. The goals of this reorganization include the increase in the quality of care of the residents, the reduction in overtime expenses, and the reduction in suspected caregiver fatigue among the direct support technicians. DRC management continues its partnership with sister agencies via monthly DCFS/DPBH/DS Collaboration Meetings; its current focus is updating the MOU.

Service Needs/Recommendations

DRC is in need of increased funding in SLA (Category 11) to provide services to individuals on the wait lists. Mojave Mental Health discontinued service to individuals served by DRC and individuals/families/service coordinators have experienced challenges with seeking alternative psychiatric services in the community without interruption to their care.

Agency Concerns/Issues

Home and Community Based Services Annual Waiver Audit occurred in October and DRC is waiting for findings. DHCFP has chosed to delay the delivery of findings until they are able to provide statewide results. Preparations are being made at the ICF/ID for the annual HCQC survey that is due after the first of the year. LCB Auditors continue their audit of Developmental Services statewide and continue to meet with DRC staff regularly.

AGENCY DIRECTORS' REPORT

AGENCY: NNAMHS SUBMITTED BY: Tom Durante DATE: 3/3/2016

Reporting Period: Click here to enter a date.

STAFFING

Positions filled: Pharmacy Tech. 2; Lab. Tech. 1; Personnel Tech. 1; AA 2; Therapeutic Recreation Spec. 1; Mental Health Counselor 3; Mental Health Counselor 2; Psychiatric Caseworker 2; and Clinical Social Worker 2

Vacancies: Sr. Psychiatrist(x2); Microbiologist 4; PN 2 (x5.6); Custodial Worker 1; Accounting Assist. 2; Vocational Habilitation Tr.; Mid-Level Medical Practitioner; Licensed Psychologist 1; Psychological Assistant; Substance Abuse Counselor 2; Clinical Program Manager 1

Difficulties filling: Sr. Psychiatrist; Mid-Level Medical Practitioner; PN 2

CASELOADS/WAITING LISTS

Program: Med Clinic

Caseload: 2,209

Waiting List: 32

Program: PACT

Caseload: 86

Waiting List: 10

Program: Mental Health Court

Caseload: 160

Waiting List: 0

Program: SLA

Caseload: 227

Waiting List: 4

Program: OP Counseling

Caseload: 137

Waiting List: 3

Program: Service Coordination

Caseload: 170

Waiting List: 45

PROGRAMS

New Programs: We are in the process of developing an Assisted Outpatient Treatment program for the Northern area to assist individuals that have frequent admissions to the inpatient unit and/or involved in the criminal justice system. Several meetings have been held to review this treatment option and to develop protocol with the court and we may have our first AOT referral within the next month.

Program Changes: Our inpatient programming at Dini-Townsend Hospital has recently had significant changes with increased group offerings including Pet Therapy, Music Therapy, and a Grief and Loss Group. We now have several interns (an MFT intern and a Professional Counseling intern) that are working with clinical staff in a collaborative effort as a teaching hospital. We are scheduled for a Dual Diagnosis Capability in Mental Health Treatment assessment as we look at expanding programming for dually diagnosed individuals. A new process for Utilization Review has been initiated. .

Service Needs/Recommendations

Filling nursing and psychiatry positions has been challenging. We have a number of empty nursing positions and must rely on contract agency support. . Our Chief of Staff has resigned and we are actively looking for a psychiatrist to fill this role. Additional incentives for working in State positions may be helpful in attracting applicants. Housing options for outpatients and for

inpatients waiting for discharge also is of concern. The need for additional housing providers, especially providers that are able to work with consumers that have significant behavioral challenges, is growing.

Agency Concerns/Issues

The list of individuals that are in the community emergency rooms waiting for a bed on our inpatient unit continues to be a major concern. Although we are hoping that by initiating a new utilization review process we may decrease our length of stay and, in turn, have more bed availability, our efforts do not appear to be sufficient in staying ahead of the number of those waiting. We are exploring the use of video conferencing to assist with consultations to emergency rooms, especially in rural communities where psychiatric services are scarce.

AGENCY DIRECTORS' REPORT

AGENCY: Rural Regional Center SUBMITTED BY: Robin Williams DATE: 2/29/2016

Reporting Period: 1/31/2016

STAFFING

Positions filled: AA II .51 – Winnemucca;

Vacancies: DS III – Elko; DS III – Fallon; QA DS III – Winnemucca/Carson; MHC II – Carson; Program Officer – Sparks;

Difficulties filling: It is difficult to find qualified professional staff in the rural areas

CASELOADS/WAITING LISTS

Program: Targeted Case Management (January 2016)

Caseload: 702 (175 youth, 527 adults)

Waiting List: N/A

Program: Supported Living Arrangement

Caseload: 333 (22 youth, 311 adults) (January 2015)

Waiting List: 19 (January 2016)

Program: Jobs & Day Training

Caseload: 245 (0 youth, 245 adults) (January 2015)

Waiting List: 13 (January 2016)

Program: Family Support

Caseload: 104 (December 2015)

Waiting List: 0 (January 2016)

Program: Respite

Caseload: 104 (December 2015)

Waiting List: 18 (January 2016)

Program: Autism

Caseload: 2 (2 youth, 0 adults (Nov 2015)

Waitlist: Transferred to ATAP July 1, 2011

PROGRAMS

New Programs: N/A

Program Changes: Rural Regional Center continues to experience significant growth

Service Needs/Recommendations

Rural Regional Center is beginning the process of budget planning for the FY 2018 – 2019 budget.

Agency Concerns/Issues

Filling positions continues to be an ongoing concern. Rural Regional Center is also participating in the state-wide roll-out of the Harmony case management, involving staff training and testing of the system, as well as a transition from our current system.

AGENCY DIRECTORS' REPORT

AGENCY: SNAMHS	SUBMITTED BY: Ellen Richardson-Adams	DATE: 2/29/16

Reporting Period: February 2016

STAFFING

Positions filled: 645.53 FTE

Vacancies: 114.53 FTE

Difficulties filling: 69.53 FTE Clinical Social Workers – 1.98 FTE, Licensed Psychologist – 6.00 FTE, Psychiatric Nurses – 32.02, Senior Psychiatrists – 29.53

CASELOADS/WAITING LISTS

Program: SLA+Shelter+ISLA
Caseload: 483
Waiting List: 2

Program: PACT
Caseload: 76
Waiting List: 0

Program: Counseling
Caseload: 320
Waiting List: 5

Program: MHC
Caseload: 65
Waiting List: 0

Program: AOT
Caseload: 72
Waiting List: 0

Program: Residential
Caseload: 794
Waiting List: 0

Program: Laughlin Mesquite SC
Caseload: 38

Program: Group Care + Sp. Needs
Caseload: 274
Waiting List: 2

Program: Medication Clinic
Caseload: 3048
Waiting List: 351

Program: Service Coord. + Intensive
Caseload: 485
Waiting List: 1

Program: IP
Caseload: licensed beds; 211
Waiting List: See ER Data

Program: Co-Occurring Program[1]
Caseload: 35
Waiting List: 8

Program: Laughlin Mesquite Med Clin
Caseload: 171
Waiting List: 10

Program: Laughlin Mesquite OP Coun
Caseload: 128

Waiting List: 0

Waiting List: 3

PROGRAMS

Service Needs/Recommendations

Agency Concerns/Issues

AGENCY DIRECTORS' REPORT

AGENCY: Rural Community Health Services SUBMITTED BY: Dr. Sean Dodge, PhD DATE: 3/4/2016

Reporting Period: 2/29/2016

STAFFING

Positions filled: Accounting Assistant II; Administrative Assistant II; Mental Health Counselor II

Vacancies: Administrative Assistant I; Agency Manager; Clinical Social Worker III; Community Health Nurse II, III, and IV; Disease Control Specialist II; Licensed Psychologist I; Three (3) Mental Health Counselor II's; Mental Health Technician II; Two (2) Psychiatric Caseworker II's; Two (2) Psychiatric Nurse II's

Difficulties filling: Recruiting in rural Nevada is difficult. There are a limited number of providers that reside and/or are willing to move to our rural communities.

CASELOADS/WAITING LISTS

Program: Outpatient Counseling

Caseload: 281 youth; 1082 adult

Waiting List: 39 youth; 120 adult

Program: Service Coordination

Caseload: 22 youth; 316 adult

Waiting List: 1 youth; 19 adult

Program: Medication Clinic

Caseload: 216 youth; 1386 adult

Waiting List: 21 youth; 91 adult

Program: Residential Supports

Caseload: 0 youth; 35 adult

Waiting List: 0 youth; 0 adult

Program: Psychosocial Rehabilitation

Caseload: 9 youth; 118 adult

Waiting List: 3 youth; 2 adult

Program: N/A

Caseload: N/A

Waiting List: N/A

PROGRAMS

RCHS is in the process of collocating our behavioral and community health nursing (CHN) programs in Silver Springs, Battle Mountain, Tonopah, Lovelock, and Panaca. This project is part of our integrated care effort. The moves are projected to be completed by June 2016.

Service Needs/Recommendations

RCHS is seeking the ongoing support from the Commission for our jail diversion and integrated care programs. We are looking to expand these programs over the upcoming year.

Agency Concerns/Issues

RCHS continues to work with rural hospitals to explore ways to address the needs of legal 2000 patients in an efficient and timely manner. RCHS also continues to work with counties on transportation issues. Whereof, transportation from rural areas to Dini-Townsend and Rawson-Neal is limited.

AGENCY DIRECTORS' REPORT

AGENCY: SAPTA SUBMITTED BY: Kevin Quint, Bureau Chief DATE: 3/7/2016

Reporting Period: 3/18/2016

STAFFING

Positions filled: 18 of 22 positions filled

Vacancies: 4 of 22 positions vacant (Epidemiologist, Business Process Analyst I, HPS I, and HPS I)

Difficulties filling: HPS I positions are difficult to fill as we have gone through the hiring process, made several offers, and been turned down by several candidates.

CASELOADS/WAITING LISTS

Program: Treatment Services: 2/16

Caseload: 953 Clients (SAPTA funded, only)

Waiting List: Not collected

Program: Treatment Providers/Locations

Caseload: 19 providers, 49 locations

Waiting List: Not collected

Program: Prevention

Caseload: Not applicable

Waiting List: Not applicable

Program: Prevention

Caseload: 47 programs--subgrants with coalitions

Waiting List: Not applicable

Program: Community Coalitions

Caseload: 12 coalitions

Waiting List: Not applicable

Program: Special Populations-Pregnant Women

Caseload: 19 Westcare; Info from Step 2 not available

Waiting List: Not collected

PROGRAMS

New Programs: The Bureau has received a planning grant called the State Youth Treatment (SYT) grant that is designed to identify and disseminate evidenced based practices for treating youth with co-occuring disorders. This grant effort is working closely with the Safe Schools Healthy Students grant as well as other initiatives to coordinate their efforts on behalf of the youth treatment needs in the state. After the planning phase is completed in 9/30/17, we will be eligible to apply for a SYT implementation grant for the federal fiscal year beginning 10/1/17. In addition, the Bureau is working closely with Maternal and Child Health (in DPBH) to identify areas of common work with pregnant women and women of child bearing age. This includes work on the Sober Moms Healthy Babies website and PSAs.

Program Changes: We have published our first ever Request for Qualifications (RFQ) to the providers. This is a treatment funding solicitation that covers the next four years and will expand the number and type of providers we are able to fund. The "bidders' conference" was held on March 4th and the proposals are due April 4th.

Service Needs/Recommendations

None at this time.

Agency Concerns/Issues

None at this time.

AGENCY DIRECTORS' REPORT

AGENCY: Sierra Regional Center SUBMITTED BY: Elaine Brown DATE: 3/4/2016

Reporting Period: 1/31/2016

STAFFING

Positions filled: QA II position; In process of filling 3 DS positions

Vacancies: Psychologist 1 position; MHC III position, CPM II-Agency Manager position; QA III position; 4 DS III positions

Difficulties filling: Competition with other public and private human service agencies; Difficulty recruiting bilingual staff

CASELOADS/WAITING LISTS

Program: Targeted Case Management (January 2016)

Caseload: 1315 (405 youth, 910 adults)

Waiting List: N/A

Program: Supported Living Arrangement

Caseload: 612 (65 youth, 547 adults) (January 2016)

Waiting List: 109 (January 2016)

Program: Jobs & Day raining

Caseload: 440 (0 youth, 440 adults) (December 2016)

Waiting List: 26 (January 2016)

Program: Family Support

Caseload: 210 (November 2015)

Waiting List: 0 (January 2016)

Program: Respite

Caseload: 173 (November 2015)

Waiting List: 60 (January 2016)

Program: Autism

Caseload: 4 (4 youth, 0 adults (January 2016)

Waitlist: Transferred to ATAP July 1, 2011

PROGRAMS

New Programs: None

Program Changes: None

Service Needs/Recommendations

Identified need for increased behavioral supports for youth with co-occurring Intellectual Disability and Mental Health/Behavioral disorder. AB 307 pilot to address service needs for these children and youth; AB307 workgroups and subcommittees formed and meeting.

Agency Concerns/Issues

Preparing for use of new IT system within ADSD/DS that will require all agency staff to be trained in May/June 2016. SRC has identified the need to work with JDT providers to increase capacity for supported employment in our community. The CMS final ruling will require DS to work with our JDT providers in re-vamping their programs to be more community based (as opposed to facility based). Our current JDT structure (facility based) does limit the number of people they can serve – our goal is to move toward a more community based service system. (2) DS providers express concern about the current provider rate and report that it is impacting their ability to recruit qualified employees. The 24 hour SLA providers report a high turnover rate which impacts consistency of supports offered to individual's served.

Nevada Division of Public & Behavioral Health - Commission on Behavioral Health

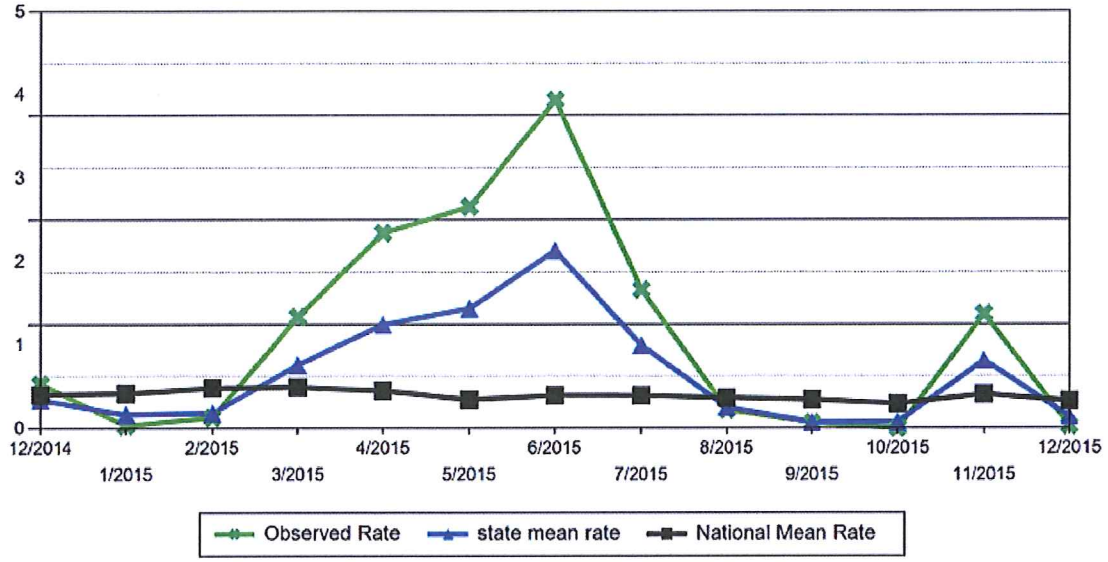
Seclusion and Restraint Report

Friday, March 18, 2016

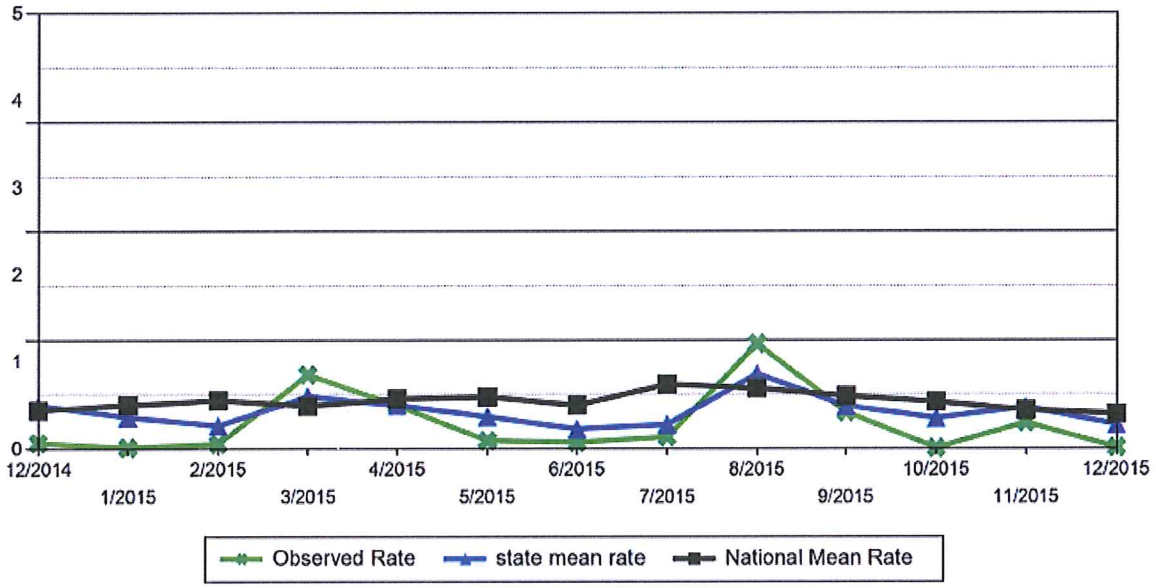
COMPARATIVE STATISTICS

NOTE: The graphs below represent the number of patient hours spent in seclusion or restrain for every 1000 inpatient hours. National Mean represents State-run inpatient psychiatric facilities serving adults 18+.

NNAMHS Seclusion Data



NNAMHS Restraint Data

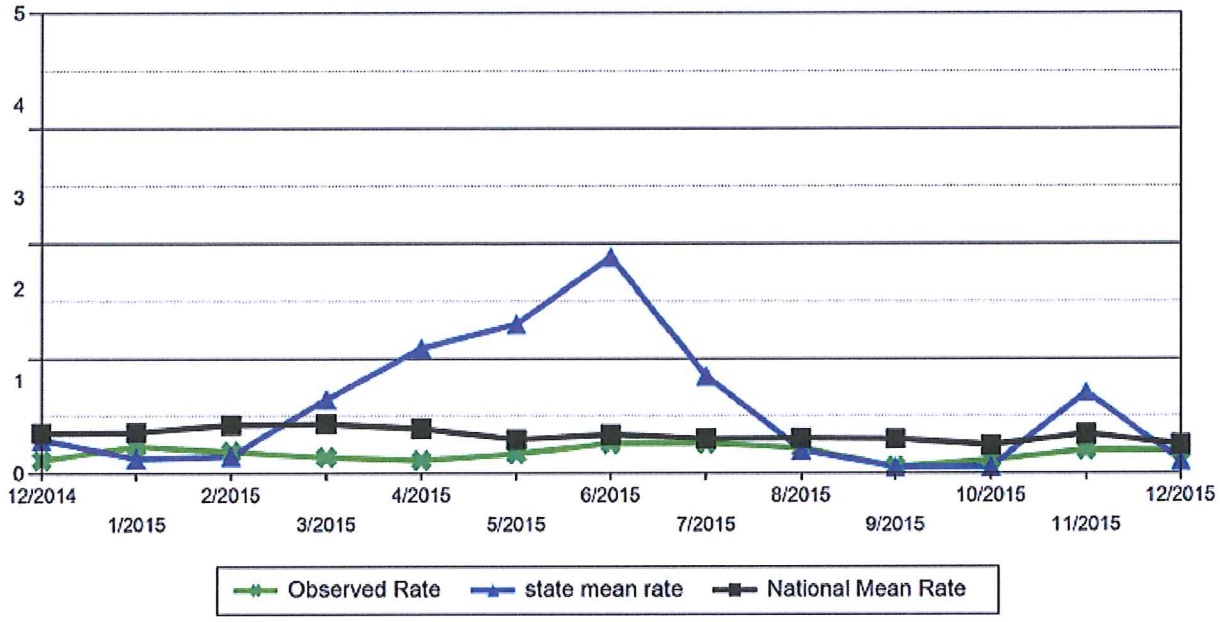


Nevada Division of Public & Behavioral Health - Commission on Behavioral Health

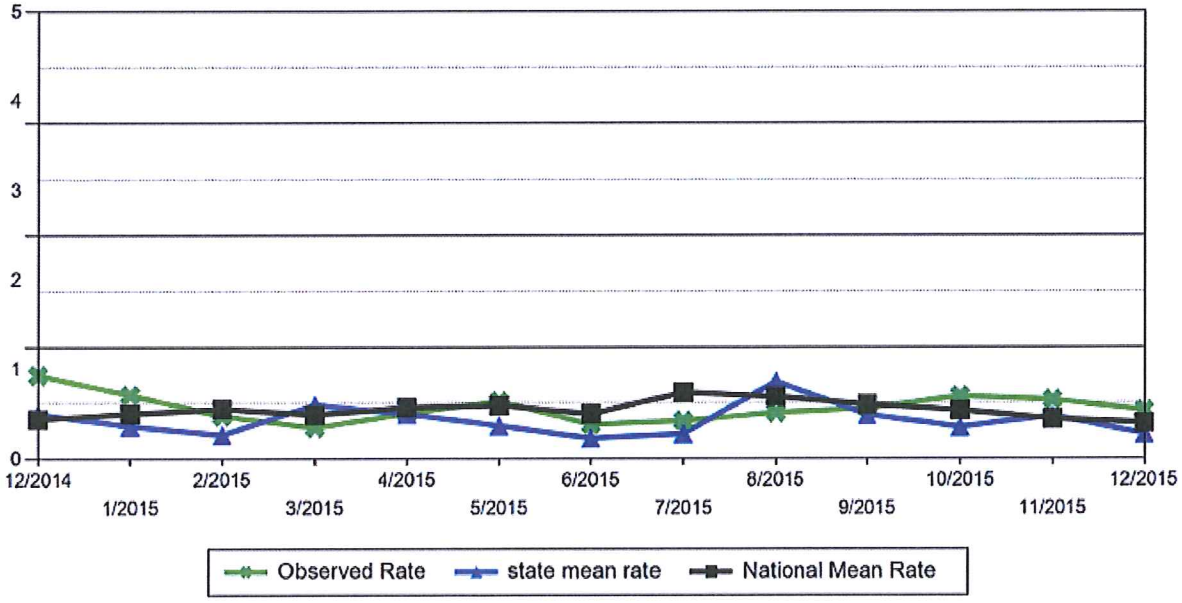
Seclusion and Restraint Report

Friday, March 18, 2016

SNAMHS Seclusion Data



SNAMHS Restraint Data



REDUCING SECLUSION AND RESTRAINT

The DPBH Clinical Services Branch is currently undertaking the following activities to reduce incidents of seclusion and restraint:

- **CPART** - DPBH has provided and will continue to provide all of its staff members with **Conflict Prevention and Response Training** (CPART) during Agency orientation. CPART is an approved curriculum of de-escalation techniques and increasingly intrusive/restrictive intervention procedures used by trained staff to re-establish and/or maintain safety in the presence of threatening or dangerous behavior. All nursing staff are required to complete CPART training during orientation and are re-trained and re-certified annually.

- **CPI** – The Division is currently piloting the *Nonviolent Crisis Intervention®* program developed by the Crisis Prevention Institute® (CPI). This program is considered the worldwide standard for crisis prevention and intervention training. With a core philosophy of providing for the care, welfare, safety, and security of everyone involved in a crisis situation, this evidence-based program's proven strategies give human service providers the skills to safely and effectively respond to anxious, hostile, or violent behavior while balancing the responsibilities of care. Budget Concept papers will be submitted to request financing for purchasing this program Division-wide.

- **PBSP** - A **Positive Behavior Support Plan** is a specialized part of the treatment plan that is written for a patient and that provides directions to all staff regarding:
  - What to on a daily basis to decrease and/or prevent the occurrence of maladaptive and/or dangerous behaviors;
  - How to reinforce the identified adaptive coping skill and/or socially acceptable behavior;
  - What to do in the event that a patient engages in a specific maladaptive behavior;
  - When to use restrictive procedures to ensure the safety of the patient and others in the environment.

  A Positive Behavior Support Plan is utilized before, after and/or in lieu of seclusion and/or restraint whenever possible. Seclusion and/or restraint procedures are reserved for emergency situations in which less restrictive techniques have failed, and the patient and/or others in the environment are in imminent danger due to a patient's behavior.

- **Increased Programing**
  - *SNAMHS Treatment Mall* - A model of person-centered care in which the development of coping and recovery awareness and skills, as well as, life skills, leisure and recreational skills are provided. Clients will receive therapeutic care in group settings with the intent of normalizing clients' daily lives and returning them to their community in a successful transition. By normalizing the routine of hospitalized clients, they will have a routine of going to various treatments offered for their rehabilitation as in a normal work or school day.
  - *NNAMHS* – Increased programming on swing shift, which, in the past, had a higher incident of S&R. Programming now includes pet therapy and music therapy, both of which have received positive feedback from patients. Adding an additional psychologist to the inpatient NNAMHS treatment team.

- **Token Economy** - The Token Economy Program has an empirically proven record of being successful in addressing a multitude of behavioral concerns. The effectiveness of the token program for the chronic psychiatric population has been extensively examined. The Token Economy Program can be perceived in terms of a systems approach toward behavioral management. A token reinforcer is an object with redeemable value, one that can be traded for an actual reinforcer of another kind of material, social or activity. The token program's theoretical basis is grounded in well-established learning theories of reinforcement motivation.

- **DPBH Quality Assessment and Performance Improvement (QAPI) Department**
    - The QAPI Team is conducting a national search of comparable State Psychiatric Hospitals to determine what processes, protocols and/or programs they are using to reduce seclusion and restraint.
    - The QAPI Team is beginning to collect data on the antecedents to episodes seclusion and restraint to determine if there are trends, commonalities or systemic issues or concerns that tend to increase or promote episodes of seclusion and restraint.

DEFINITIONS OF SECLUSION AND RESTRAINT

NEVADA REVISED STATUTES

"Chemical restraint" means the administration of drugs for the specific and exclusive purpose of controlling an acute or episodic aggressive behavior when alternative intervention techniques have failed to limit or control the behavior. The term does not include the administration of drugs on a regular basis, as prescribed by a physician, to treat the symptoms of mental, physical, emotional or behavioral disorders and for assisting a person in gaining self-control over his or her impulses. (NRS 433.5456)

"***Mechanical restraint"*** means the use of devices, including, without limitation, mittens, straps, restraint chairs, handcuffs, belly chains and four-point restraints to limit a person's movement or hold a person immobile. (NRS 433.547)

"Physical restraint" means the use of physical contact to limit a person's movement or hold a person immobile. (NRS 433.5476)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

According to 42 CFR Part 482, Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Final Rule, CMS defines seclusion and restraint as follows:

RESTRAINT: A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

A restraint does ***not*** include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

SECLUSION: Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

Seclusion does ***not*** include confinement on a locked unit, ward, or other area where the patient is with others. Seclusion is not just confining a patient to an area but involuntarily confining the patient alone in a room or area where the patient is physically prevented from leaving. A situation where a patient is restricted to a room or area alone and staff are physically intervening to prevent the patient from leaving the room or area is also considered seclusion.

TIME OUT: If a patient is free to leave a ***time out*** area whenever the patient chooses, this would ***not*** be considered seclusion based on this definition. The key distinction in deciding whether an intervention is seclusion or a time out is whether the patient is physically prevented from leaving a room or area. Another distinction is the patient's level of personal control. In the case of seclusion, boundaries are placed on the patient's behavior based on the clinical determination that the patient's behavior poses a risk to the safety of the patient or others. In a ***time out***, the patient is able to respond to staff direction encouraging a time out or to independently decide that such action is needed. In a time out, the staff and patient collaboratively determine when the patient has regained self-control and is able to return to the treatment milieu. In seclusion, this judgment is made by the clinicians—that is, an agitated patient may feel that he or she should be released, even though the patient's behavior continues to be violent or self-destructive.

THE JOINT COMMISSION (TJC)

RESTRAINT:

1. Any method (chemical or physical) of restricting an individual's freedom of movement, including seclusion, physical activity, or normal access to his or her body that (1) is not a usual and customary part of a medical diagnostic or treatment procedure to which the individual or his or her legal representative has consented, (2) is not indicated to treat the individual's medical condition or symptoms, or (3) does not promote the individual's independent functioning.
2. For hospitals and rehabilitation and psychiatric distinct part units in critical access hospitals that elect The Joint Commission deemed status option: 42 CFR 482.13(e)(1) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
3. 42 CFR 482.13(e)(1)(i)(c) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

SECLUSION:

1. The involuntary confinement of an individual in a room alone, for any period of time, from which the individual is physically prevented from leaving. Seclusion does not include involuntary confinement for legally mandated but nonclinical purposes, such as the confinement of a person who is facing serious criminal charges or who is serving a criminal sentence.
2. For hospitals and rehabilitation and psychiatric distinct part units in critical access hospitals that elect The Joint Commission deemed status option: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior. (42 CFR 482.13(e)(1)(ii))

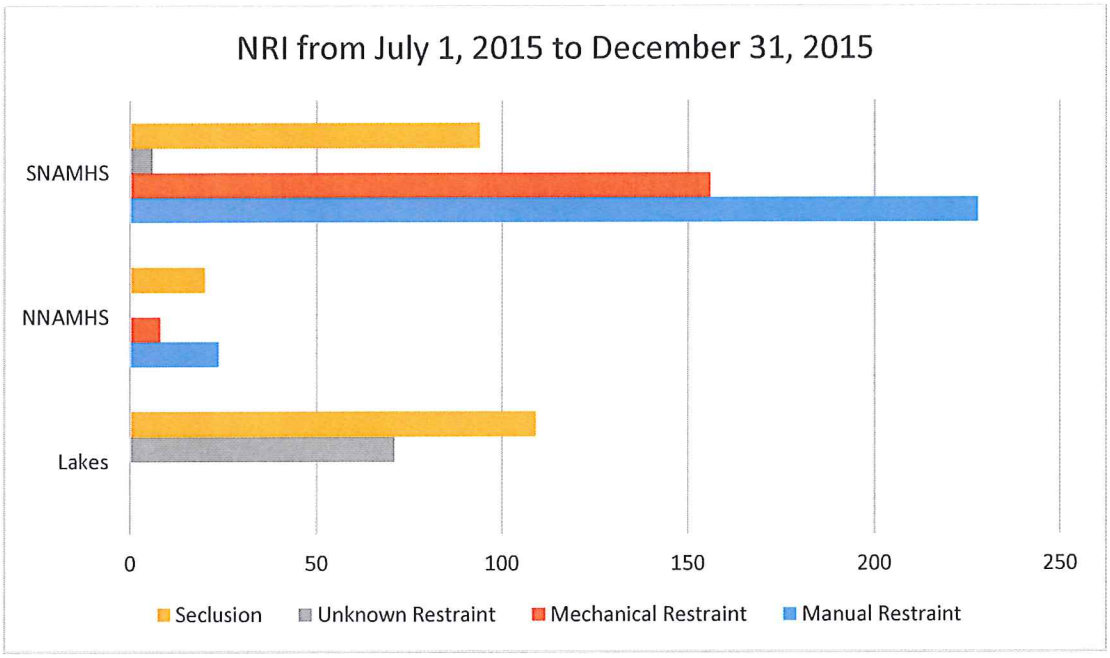
RAW DATA

Note: These facilities are of varying size and function. Comparisons between facilities should be made with extreme caution.

Tables 1 & 2: All State of Nevada Adult Hospitals

NRI from July 1, 2015 to December 31, 2015

	Manual Restraint	Mechanical Restraint	Unknown Restraint	Seclusion	Total
SNAMHS	228	156	6	94	484
NNAMHS	24	8	0	20	52
Lake's Crossing	0	0	71	109	180
Total	252	164	77	223	716



Average Daily Census from July 1, 2015 to December 31, 2015

SNAMHS	129
NNAMHS	28
Lake's Crossing	75

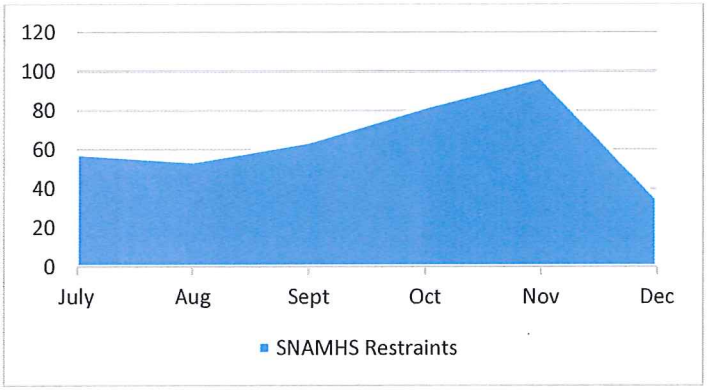
Tables 3 – 4 – 5: SNAMHS Restraints & Seclusions

Nevada Division of Public & Behavioral Health - Commission on Behavioral Health

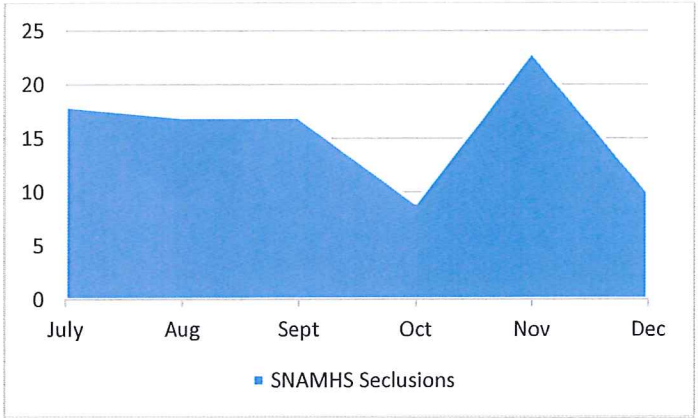
Seclusion and Restraint Report

Friday, March 18, 2016

SNAMHS - Restraints							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Restraints	58	54	64	82	97	35	**390**
Individuals with Multiple Events	15	18	12	18	16	11	**90**
≤4 hours	57	52	64	78	92	32	**375**
4 to 8 hours	1	2	0	3	4	2	**12**
>8 hours	0	0	0	1	1	1	**3**



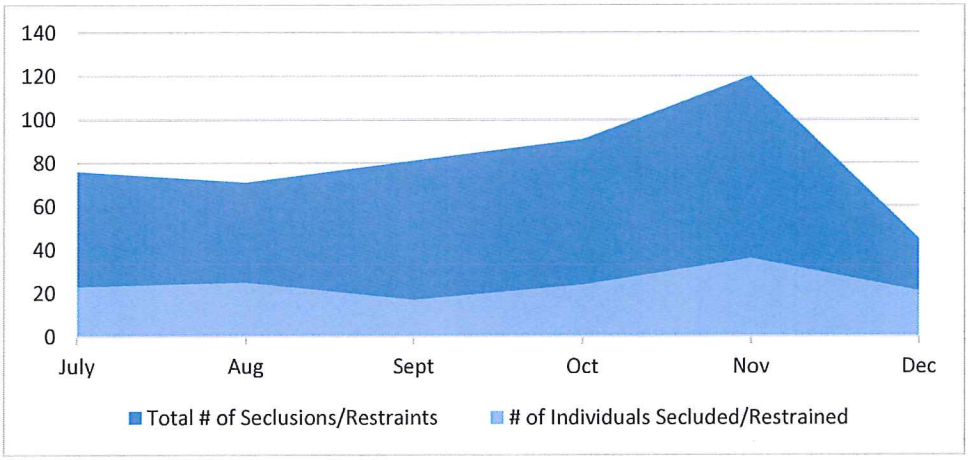
SNAMHS - Seclusions							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Seclusions	18	17	17	9	23	10	**94**
Individuals with Multiple Events	3	3	1	2	5	2	**16**
≤4 hours	16	17	17	9	23	8	**90**
4 to 8 hours	2	0	0	0	0	2	**4**



Seclusion and Restraint Report

Friday, March 18, 2016

SNAMHS – Seclusions/Restraints							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Number of Individuals Secluded/Restrained	23	25	17	24	36	21	**146**
Total Number of Seclusion/Restraint Events	76	71	81	91	120	45	**484**
Events with Treatment Plan Review	51	52	38	16	1	0	**158**
Events with Progress Note Completed	74	68	81	91	120	45	**479**
Positive Behavioral Support Plan in Place at Time of Event	26	39	39	0	47	18	**187**
Events with Patient Injuries	6	8	9	7	10	4	**44**
Events with Staff Injuries	12	12	10	11	13	7	**65**



Tables 6 – 7 – 8: NNAMHS Restraints & Seclusions

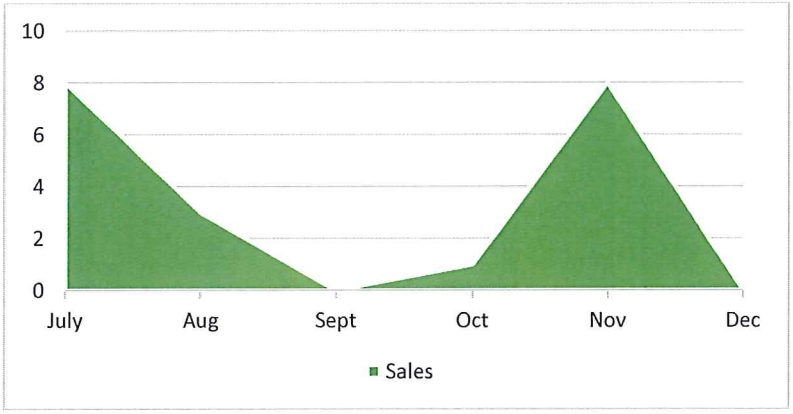
NNAMHS - Restraints							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Restraints	7	9	1	3	12	0	**32**
Individuals with Multiple Events	1	1	0	1	4	0	**7**
≤4 hours	7	9	1	3	12	0	**32**

Nevada Division of Public & Behavioral Health - Commission on Behavioral Health

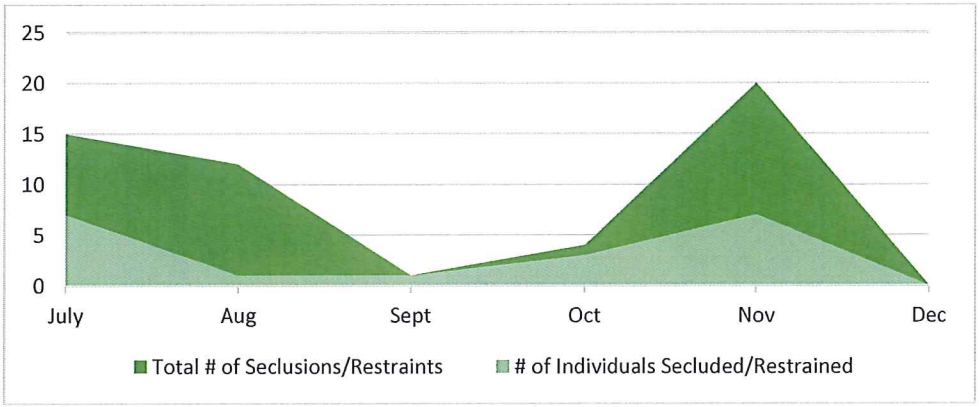
Seclusion and Restraint Report

Friday, March 18, 2016

NNAMHS - Seclusions							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Seclusions	8	3	0	1	8	0	**20**
Individuals with Multiple Events	2	1	0	0	1	0	**4**
≤4 hours	8	3	0	1	7	0	**19**
4 to 8 hours	0	0	0	0	1	0	**1**



NNAMHS – Seclusions/Restraints							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Number of Individuals Secluded/Restrained	7	1	1	3	7	0	**19**
Total Number of Seclusion/Restraint Events	15	12	1	4	20	0	**52**
Events with Treatment Plan Review	5	0	0	0	0	0	**5**
Events with Progress Note Completed	12	12	0	1	20	0	**45**
Events with Patient Injuries	0	0	0	0	0	0	**0**
Events with Staff Injuries	0	1	0	0	0	0	**1**

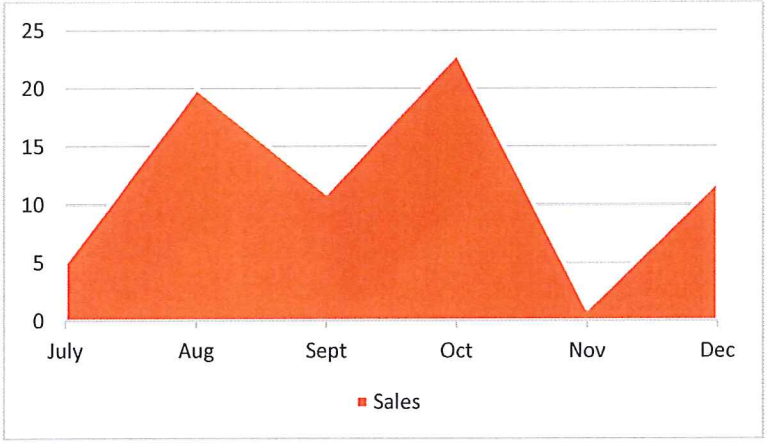


Seclusion and Restraint Report

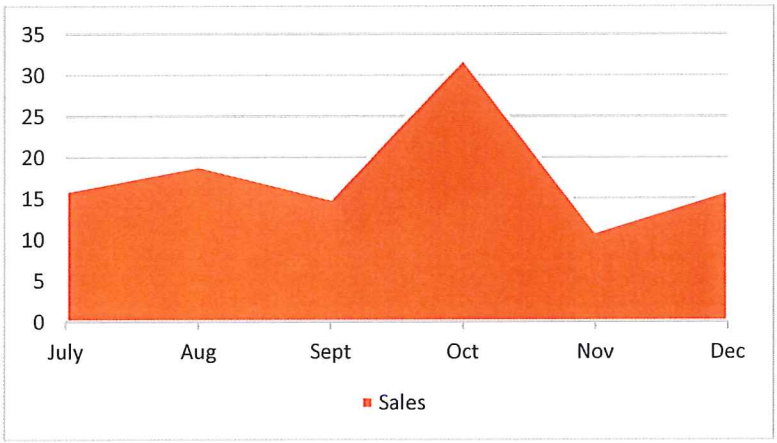
Friday, March 18, 2016

Tables 9 – 10 – 11: Lake's Crossing Restraints & Seclusions

Lake's Crossing - Restraints							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Restraints	5	20	11	23	1	12	**72**
Individuals with Multiple Events	2	5	2	5	0	1	**15**
≤4 hours	5	20	11	20	1	12	**69**



Lake's Crossing - Seclusions							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Seclusions	16	19	15	32	11	16	**109**
Individuals with Multiple Events	3	6	2	12	0	1	**24**
≤4 hours	2	1	2	5	4	5	**19**
4 to 8 hours	0	3	1	0	1	2	**7**
>8 hours	12	10	12	16	6	9	**65**

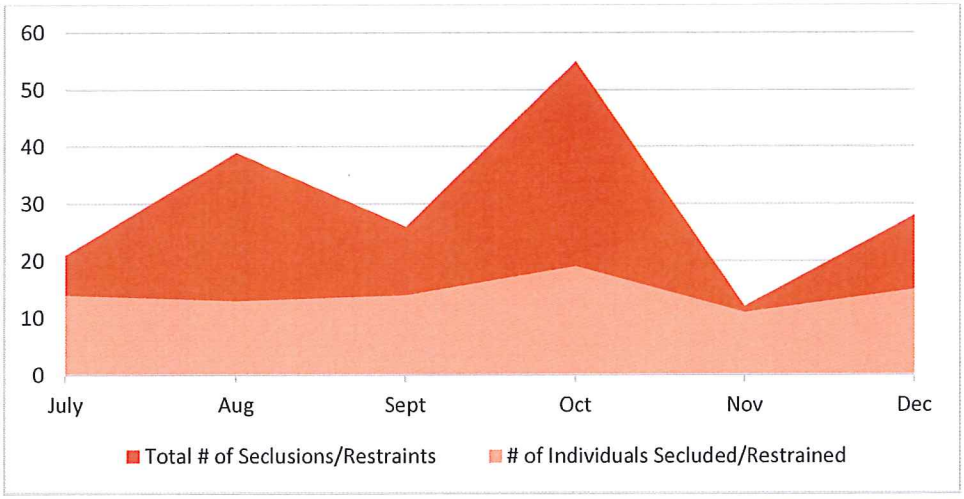


Nevada Division of Public & Behavioral Health - Commission on Behavioral Health

Seclusion and Restraint Report

Friday, March 18, 2016

Lake's Crossing – Seclusions/Restraints							
Month	July	Aug	Sept	Oct	Nov	Dec	Total
Number of Individuals Secluded/Restrained	14	13	14	19	11	15	**86**
Total Number of Seclusion/Restraint Events	21	39	26	55	12	28	**181**
Events with Progress Note Completed	21	39	25	51	11	26	**173**



Control #	Rev.	Title	Effective Date 2/16
Gov1.1	New 2/16	Clinical Services Hospital Governing Body Policy	Review Date 2/18

1.0 POLICY

The Division of Public and Behavioral Health (DBPH) in accordance with Nevada Revised Statutes NRS 449.0302 and NAC 449.286 has an established Governing Body that is legally responsible for the conduct of DBPH Inpatient Facilities. One Governing Body may be responsible for all DBPH inpatient facilities regardless of differing CMS Certification Numbers

2.0 PURPOSE

To define procedures that guide the process of DBPH inpatient facility governance and to define the shared and unique responsibilities of Hospital Administration, Medical Staff Leadership and the Governing Body.

3.0 SCOPE

Division wide, including all DBPH run inpatient facilities

4.0 DEFINITIONS

4.1 Governing Body (NRS 440.0302 and NAC 449.286) - the person or group of persons, including a board of trustees, board of directors or other body, in whom the final authority and responsibility is vested for conduct of a hospital.

5.0 PROCEDURES

5.1 The Governing Body will:

5.1.1 Include a member or members of the hospital's medical staff

5.1.2 Identify those responsible for the provision of care.

5.1.3 Hold meetings at least quarterly and more frequently when needed.

5.1.4 Adopt a workable set of bylaws which must be in writing and available to all members.

5.1.5 Establish mechanisms for formal approval of policies, bylaws, rules and regulations of the medical staff and its departments in the hospital.

5.1.6 Participate in the appointment of a qualified Chief Executive Officer (hospital administrator) using as its criteria the actual experience, nature and duration, or similar field, of the appointee.

5.1.7 A member of the Governing Body may participate in the hiring panel for the Chief Executive Officer (Hospital Administrator).

5.1.8 Determine, in accordance with state law, which categories of practitioners are eligible for appointment to the medical staff.

5.1.9 Appoint members of the medical staff after considering the recommendations of the existing medical staff.

5.1.10 Ensure that the medical staff has bylaws.

5.1.11 Approve medical staff bylaws and other medical staff rules and regulations.

5.1.12 Review written and verbal reports from the medical staff highlighting the quality of care which the medical staff provide to patients.

5.1.13 Ensure the criteria for selection of medical staff includes individual competence, training, experience and judgment.

5.1.14 The Governing Body will assure that every patient is under the care of:

- 5.1.14.1 A doctor of medicine or osteopathy
- 5.1.14.2 A clinical psychiatrist
- 5.1.14.3 Advanced Practice Registered Nurse (APRN)

5.1.15 Patients are admitted to the hospital only on the recommendation of a licensed practitioner, permitted by the state to admit patients to a hospital.

5.1.16 A doctor of medicine, osteopathy or psychiatry is on duty or on call at all times.

5.1.17 A doctor of medicine, osteopathy, psychiatry and/or and APRN is responsible for the care of each patient with respect to the medical or psychiatric problem that a present on admission or develops during the hospitalization.

5.1.18 Meetings of the Governing Body shall be to:

- 5.1.18.1 Evaluate the conduct of the hospital, including the care and treatment of patients.
- 5.1.18.2 The Governing Body shall take necessary actions sufficient to correct noted problems.
- 5.1.18.3 A record of all governing body proceedings which reflects all business conducted, including findings, conclusions and recommendations, shall be maintained for review and analysis.
- 5.1.18.4 Take all appropriate and necessary action to monitor and restore compliance when deficiencies in the hospital's compliance with statutory and/or regulatory requirements

are identified, including but not limited to monitoring the hospital administrator's submission and implementation of all plans of correction.

5.1.18.5 Shall be responsible for the quality of patient care services, for the conduct of the agencies and for ensuring compliance with all Federal, State, and Local law.

5.2 Medical Staff will:

5.2.1 Ensure that the medical staff is accountable to the Governing Body for the quality of care provided to the patients.

5.2.2 Ensure that under no circumstances is the accordance of medical staff membership or professional privileges dependent solely upon certification, fellowship or membership in a specialty body or society.

5.2.3 Ensure that when telemedicine services are furnished to patients through an agreement with a distance-site hospital, the agreement is written and that it specifies that it is the responsibility of the Governing Body of the distance site hospital to meet the requirements in sections (A)(1) through (A)(8) of this section with regard to the distance site hospital's physicians and practitioners that are authorized to provide telemedicine services.

5.2.3.1 The Governing Body of the hospital whose patients are receiving telemedicine services may in accordance with CFR 482.33(A)(3) grant privileges based on its medical staff recommendations that rely on information provided by the distance site hospital.

5.2.4 Ensure that when telemedicine services are provided to patients through an agreement with a distance-site telemedicine entity, the written agreement specifies that the distance-site telemedicine entity is a contractor of services.

5.2.4.1 The contractor furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including but not limited to the paragraphs of this section with regard to the distance-site's medical staff.

5.2.4.2 The distant site's medical staff providing telemedicine services may be granted privileges based on said hospital's medical staff recommendations;

5.2.4.3 Staff recommendations may rely on information provided by the distance-site telemedicine entity.

5.3 The Chief Executive Officer is/will:

5.3.1 Assume responsibility for management of the hospital and for providing liaisons among the governing body, medical staff, nursing staff and other departments, units or services of the hospital.

5.3.2 Keep the governing body fully informed of the conduct of the hospital through regular written reports.

5.3.3 Ensure that the hospital has an overall institutional plan which includes an annual operating budget that is prepared in accordance with generally accepted accounting principles (GAAP)

5.3.3.1 The annual budget must include anticipated income and expenses.

5.3.3.2 The hospital is not required to identify item-by-item components of each anticipated income or expense.

5.4 Contracted Services – The Governing Body is responsible for services whether or not they are provided by contractors. The Governing Body ensures that contractor services comply with all applicable conditions of participation and standards.

5.4.1 The Governing Body must ensure that the services performed under a contract are provided in a safe and effective manner via the Medical Director.

6.0 ATTACHMENTS

7.0 IMPLEMENTATION OF POLICY

Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

ADMINISTRATOR

Presentation to the Behavioral Health Commission on SAPTA
Kevin Quint, Bureau Chief
Bureau of Behavioral Health, Wellness, and Prevention
March 18, 2016

Good morning. My name is Kevin Quint and I serve as the Bureau Chief for the Bureau of Behavioral Health, Wellness, and Prevention. I am here this morning to provide to the Commission my regular update on our Bureau. Today I wanted to update you on our funding process.

Our Bureau manages and administers about $50 million a year in Substance Abuse and Mental Health Block Grant funds, HIV federal funds, a number of federal grants, and State General Funds. The funds that are considered in this funding opportunity today are Substance Abuse and Mental Health Block Grant and State General Funds.

The last three years and especially the last two, have brought changes to our field that are unprecedented. The advent of the Affordable Care Act, wider use of Medicaid in reimbursing for services, increased emphasis on audits and compliance with funding source rules and laws, and more have changed the provider and overall business landscape in ways that were unimaginable just three or four years ago. The change has been difficult and all of us have done our best to move with and manage that change.

The first big change I'd like to discuss is that we've departed from our usual grant format and are engaged in a Request for Qualifications or RFQ process. We are excited about the possibilities of the RFQ system as it lends itself to more flexibility in how we award money and enables us to reach out to a wider variety and number of providers. Our RFQ went out to the community on February 25th. We held a Kick Off Meeting (like a bidders' conference) on March 4th. And proposals are due on April 4th.

Related to the new RFQ process, we are implementing other changes. Some of these include the following:

- We have included Mental Health BG funds in this solicitation. That has never been done before.

- Internally, we have braided some of our SUD and MH funds for certain projects.

- We are looking for a wider group of providers to fund what will represent a wider range of services.

- That said, with the advent of the ACA and Medicaid involvement, we are looking to fund the levels of care that are not funded by Medicaid. Our funds are considered "payment of

last resort," which means that if someone else pays for it, we do not. What this means, for example, is because Medicaid reimburses for outpatient, we are going to fund fewer outpatient services and more services that Medicaid does not typically fund such as residential, transitional housing, targeted case management, recovery support services and more.

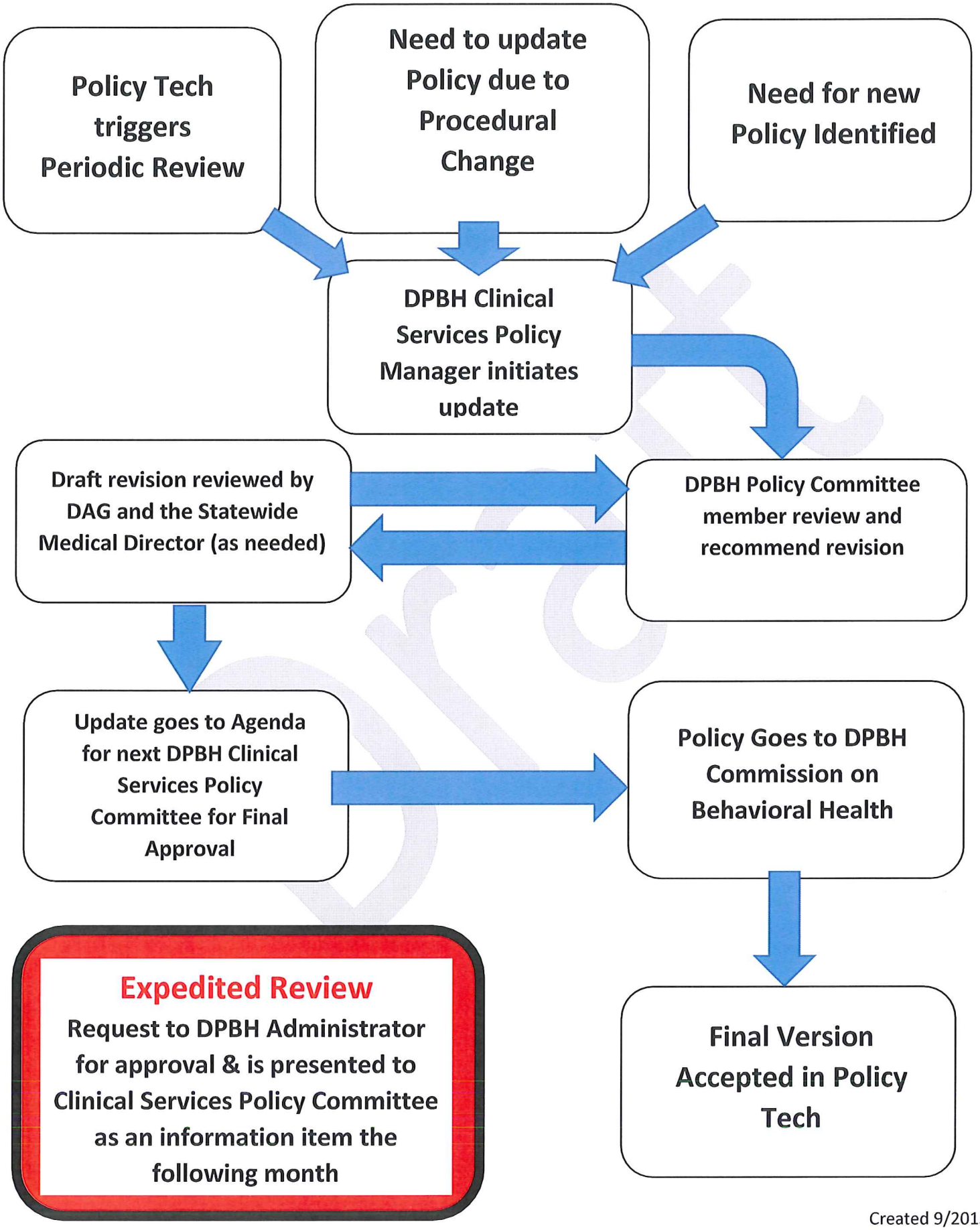
- We want to fund a full system of care that includes all levels of care but that also provides opportunity for a person to get help, especially recovery supports, until that person is able to become self-sufficient in their recovery. We are particularly interested in underserved and at risk populations such as pregnant women with substance use disorders, youth experiencing first episode psychosis, and those at risk for contracting HIV.

- While we are looking at the whole of Nevada's population, we are interested in projects that address youth and adults in the juvenile and criminal justice systems anywhere from first arrest to release from incarceration. We are not just looking for more beds or for one level of care to be expanded, although that would be good. More importantly we are looking to fund a continuum of care for these populations in which a client has access and the ability to receive the wide range of services he or she needs. We are talking about a "recovery oriented system of care" that considers all the needs of the clients and that brings all services necessary to bear to provide that client with the best opportunity for recovery.

- Finally, we are working with the Steering Committee of the Certified Community Behavioral Health Centers grant. CCBHC is a concept that will afford clients to access a range of behavioral and primary care services in one place. This is cutting edge and we are very glad to be part of this movement. We will carve out some of our Block Grant funds to help get some of the CCBHC projects initiated.

Ultimately, we are working toward helping the system we fund become a full continuum of care that will help our providers serve people's needs in an accessible and complete way.

DPBH CLINICAL SERVICES POLICY PROCESS



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