DIVISION OF PUBLIC AND BEHAVORIAL HEALTH

WASHOE REGIONAL BEHAVIORAL HEALTH POLICY BOARD

Washoe County Social Services

350 South Center Street

Reno, NV 89501

February 20, 2019

8:00 a.m. to Adjournment

DRAFT MINUTES

1. **Call to Order**

   Chuck Duarte, Chair

   In Attendance: No members of the public attended this meeting.

   Introductions, Members of the Washoe Regional Behavioral Health Policy Board in Attendance:

   Charles Duarte, Kevin Dick, J.W. Hodges, Sandy Stamates, Wade Clark, Dr. Kristin Davis-Coelho, Thomas Zumtobel, Charmaane Buehrle, Dr. Jeremy Matuszak

   Absent: Henry Sotelo, Sharon Chamberlain, Senator Julia Ratti, Jennifer Delett-Snyder,

   Regional Behavioral Health Coordinator: Dorothy Edwards

2. **Public Comment:** No public comment

3. **Make and/or approve recommendations for amendments on Assembly Bill 66: Provides for the establishment of crisis stabilization centers in certain counties. (BDR 39-486) – Chuck Duarte, Chair and Board Members**

   Chuck Duarte explained the idea of Assembly Bill (AB) 66 would be to establish a facility type that would be a short-stay psychiatric hospital and not have long lengths of residential treatment. Mr. Duarte added the establishment of crisis stabilization facilities would not be a replacement for crisis triage centers and long-term psychiatric treatment. Mr. Duarte stated AB 66 is going through the revision process of the bill draft and explained what the proposed changes are.

   - The first item being considered is to eliminate the requirement for the Division of Public and Behavioral Health (DPBH) to establish pilot facilities. Mr. Duarte added initially the bill included some legislative language to establish pilot facilities in counties with a population of more than 100,000 individuals; however, because it required DPBH to establish a new set of facilities, the fiscal note was more than five million dollars. Mr. Duarte stated the recommendation is to take that language

away and let the market dictate what the criteria would be for these facilities and establish themselves.

- The second item being considered is to establish crisis stabilization facilities as essential community providers for health plans overseen by the Nevada Medicaid Division and the Division of Insurance, under the insurance commissioner's jurisdiction. Mr. Duarte added this would include employer sponsored plans and exclude union plans or completely self-funded plans. Mr. Duarte explained plans that are governed under the Division of Insurance to include the Nevada Health Insurance Exchange, would be listed as essential community providers. Mr. Duarte added in regulatory terms, the insurance companies would be required to make a good faith effort to contract with the facility.

- The third item being considered is to identify a crisis stabilization facility as a licensed psychiatric hospital rather than a unique facility type. Mr. Duarte added this would not be a replacement for long-term psychiatric care and would be more of a short-stay psychiatric treatment. Charmaane Buehrle asked Mr. Duarte what the length of stay would be for a short-stay psychiatric treatment facility. Mr. Duarte stated the average length of stay would be three days; however, it can be longer in specific cases involving individuals who have a mixed diagnosis of mental illness and an intellectual or developmental disability because placement is more challenging.

- The fourth item being considered is to increase the number of stabilization beds in the statute from a maximum of eight to a maximum of sixteen, as well as, include language that avoids problems with payment associated with the Medicaid Institutions for Mental Disease (IMD) exclusion. Mr. Duarte stated there are some regulatory criteria associated with the IMD exclusion that would need to be met but the facility side has only one criterion; therefore, facilities could essentially be paid for those services. Mr. Duarte added there is language specifically in AB 66 to have an average length of stay of fourteen days that will possibly be changed to a cap of five days.

- The fifth item being considered is to eliminate the section describing crisis stabilization facilities as a consumer directed, owned, or operated facility because that is more in line with a social stabilization model.

Sandy Stamates asked what happens if the five-day cap is reached and an individual is still not ready to be released. Mr. Duarte stated there most likely would not be a penalty if an individual is kept longer than five days, but the goal would be to transfer the individual to a higher level of care if needed in three days or less. Ms. Stamates asked how the crisis triage center will be involved. Mr. Duarte stated there could be referrals from a crisis stabilization facility to residential treatment that is connected to the crisis triage center. Mr.

Duarte added the crisis stabilization facility will want to utilize the entire referral continuum including inpatient psychiatric care, partial hospital care, intensive outpatient care, residential care, etc. after three days or sooner.

Ms. Stamates asked where the crisis triage center and crisis stabilization facility will be located. Dorothy Edwards stated the crisis triage center, WellCare, will be located on Record Street in Reno, Nevada. Mr. Duarte stated the crisis stabilization facility could be affiliated with existing facilities or it could be in a completely different area. Ms. Stamates stated it was her understanding that the crisis stabilization facility cannot be co-located on a campus of a psychiatric hospital. Mr. Duarte stated the specific federal rule states to avoid the IMD exclusion from payment, the facility cannot have the character of a free-standing psychiatric hospital. Mr. Duarte added in his experience in apply federal tests, the facility can be on the campus; however, it must operate as a separate facility and not share governance with a psychiatric hospital.

Ms. Buehrle stated there are already services being provided by Westcare and Reno Behavioral Health who have contracts with managed Medicaid companies that are managing the population; she asked if services would be duplicated. Mr. Duarte stated the facility in Arizona had to learn to live with free-standing psychiatric facilities and they serve one hundred percent of patients regardless of their ability to pay which makes it easier for law enforcement and first responders. Dr. Kristin Davis-Coelho stated there is still a gap for some patients on Medicaid Fee or Service and uninsured patients who are boarded in emergency rooms that are unable to receive services. Dr. Davis-Coelho added crisis stabilization would most likely fit that market and end up serving those patients.

Dr. Davis-Coelho asked if there was flexibility in terms of the culture of the facility to provide crisis case management; for example, an individual could come in as a crisis patient, not needing psychiatric observation or an inpatient stay and would be still be connected with referral resources, or would that be eliminated by licensing it as a psychiatric hospital. Mr. Duarte stated the legislation contains language around the requirement for case management for after care. Ms. Edwards stated one of the distinctions was although it is licensed as a psychiatric hospital, the culture and feel is different, and the intake process would allow case managers to help individuals who walk-in off the street.

Mr. Duarte stated the model itself utilizes peer supporters; therefore, a peer supporter who would do all the intake and be the first person a patient would see whether they're dropped off by emergency services or law enforcement or walk-in off the street. Ms. Stamates stated peer supporters are the standard model for a crisis center because an individual might just need to talk to somebody and in an hour or two they will be okay and maybe get a referral. Ms. Stamates added the most important process would be to have a "warm hand-off" meaning someone would be released after three to five days with a treatment plan going forward and know where to go next. Dr. Davis-Coelho stated as long as the language is

flexible and generic enough, it could meet the need and benefit the community significantly, avoiding hospitalization.

Kevin Dick thanked Mr. Duarte for the time and effort he has put into researching and coming up with the proposals. Mr. Dick asked if the facility in Arizona, Recovery International, has stated these changes would be enough interest them or another entity to establish a facility in Nevada. Mr. Duarte stated the facility's chief strategy officer has not mentioned that; however, they have worked closely on creating some of the language. Mr. Duarte added the issue is going to involve how to handle non-paying patients, which will be financially difficult for any organization. Mr. Duarte sated he and Ms. Edwards have had conversations with county officials as well at Senator Julia Ratti and Assemblyman Mike Sprinkle around identifying potential financial sources; however, that bridge has not been crossed.

Dr. Jeremy Matuszak motioned to approve the revisions presented by Mr. Duarte. Ms. Stamates seconded the motion and the motion was approved. Dr. Davis-Coelho asked Mr. Duarte what the next steps where for AB 66 as far as legislation goes. Mr. Duarte stated AB 66 is in the process of being redrafted and the board will have a chance to review the revised document. Mr. Duarte added the turnaround time is usually very short so the board may not have the chance to vote on it. Mr. Duarte urged board members to express their concerns to himself and Ms. Edwards.

4. **Public Comment:** No public comment

5. **Adjournment – Chuck Duarte, Chair**