Crisis Stabilization Services

A.B. 66 OVERVIEW – PRESENTED BY THE WASHOE REGIONAL BEHAVIORAL HEALTH POLICY BOARD

Overview of the Policy Board

A.B. 366 of the 79th Legislative Session established four behavioral health policy boards including the Washoe Regional Behavioral Health Policy Board (WRBHPB).

The legislation sought to give local behavioral health experts and advocates more of a voice in policies affecting services in their region and included a provision allowing each board to request the drafting of not more than one legislative measure which relates to matters within the scope of the policy board.

Members of the WRBHPB strive to increase awareness and understanding of mental health and substance use disorders, promote emotional health and wellness, address prevention of substance use disorders and mental illness, including those with serious mental illness and to increase access to effective treatment and support recovery.

Current Members of the WRBHPB

CHARLES DUARTE

Chief Executive Officer

Community Health Alliance

Policy Board Chairman

SENATOR JULIA RATTI

District 13

Nevada State Senate

KEVIN DICK

District Health Officer

Washoe County Health District

SHARON CHAMBERLAIN

Chief Executive Officer

Northern Nevada HOPES

HENRY SOTELO

Attorney

Reno Muni Legal Defender

JENNIFER DELETT- SNYDER

Executive Director

Join Together Northern Nevada

THOMAS ZUMTOBEL

Vice-President, Population Health

Renown Hospital

SANDRA STAMATES

National Alliance on Mental Illness

Community/Family Representative for Behavioral Health Families.

WADE CLARK

Sergeant, Reno Police Department

MOST Team

DR. JEREMY MATUSZAK

M.D. Psychiatry

CHARMAANE BUEHRLE

Director, Business Development

West Hills Hospital

J.W. HODGE

Chief Operating Officer

HealthCare Services

REMSA

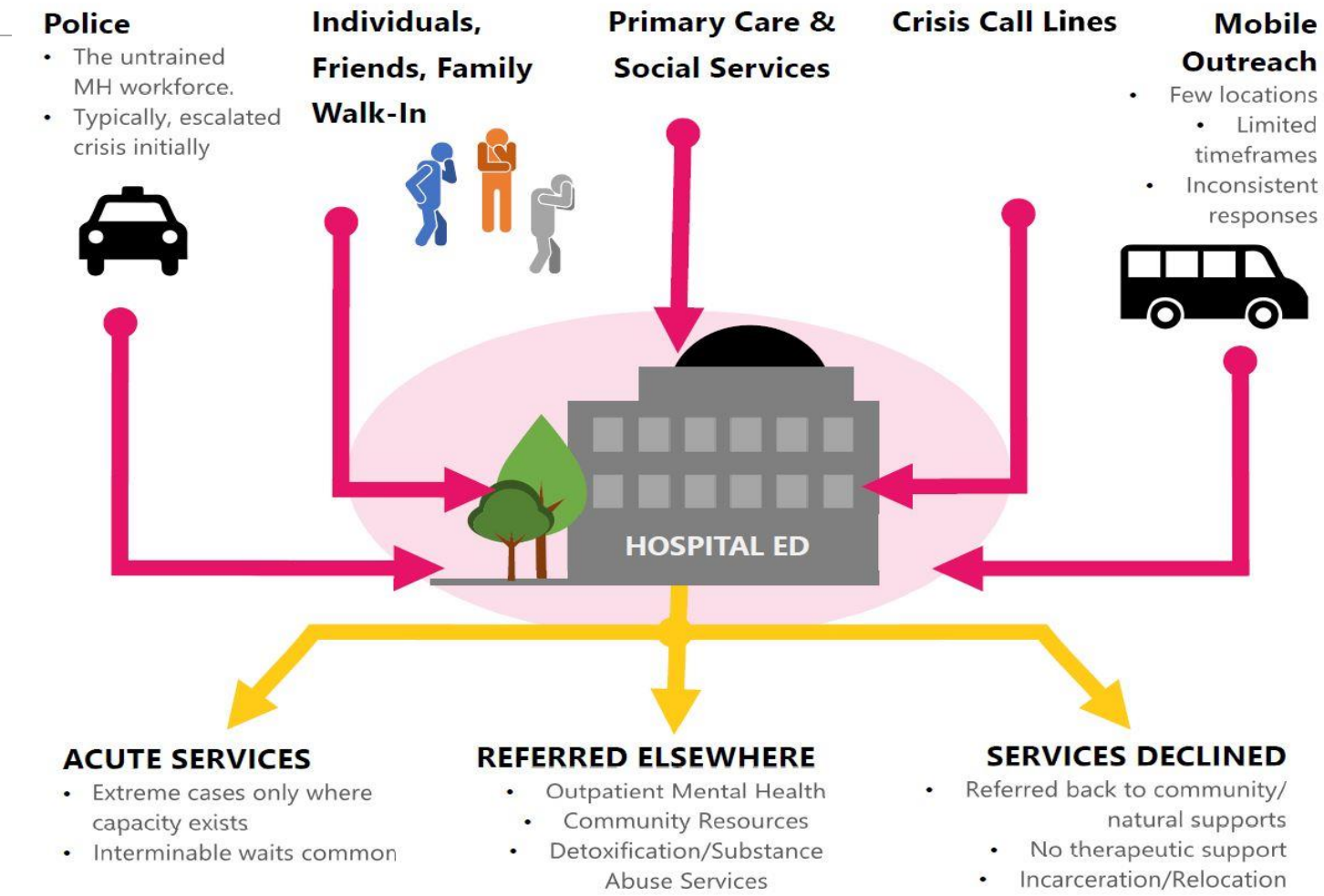
DR. KRISTEN DAVIS-COELHO

Administrator, Renown Behavioral Health & Addiction Institute

DOROTHY EDWARDS

Washoe Regional Behavioral Health Coordinator

Where is the choke point in the current model of Crisis Services?



Justification for A.B. 66

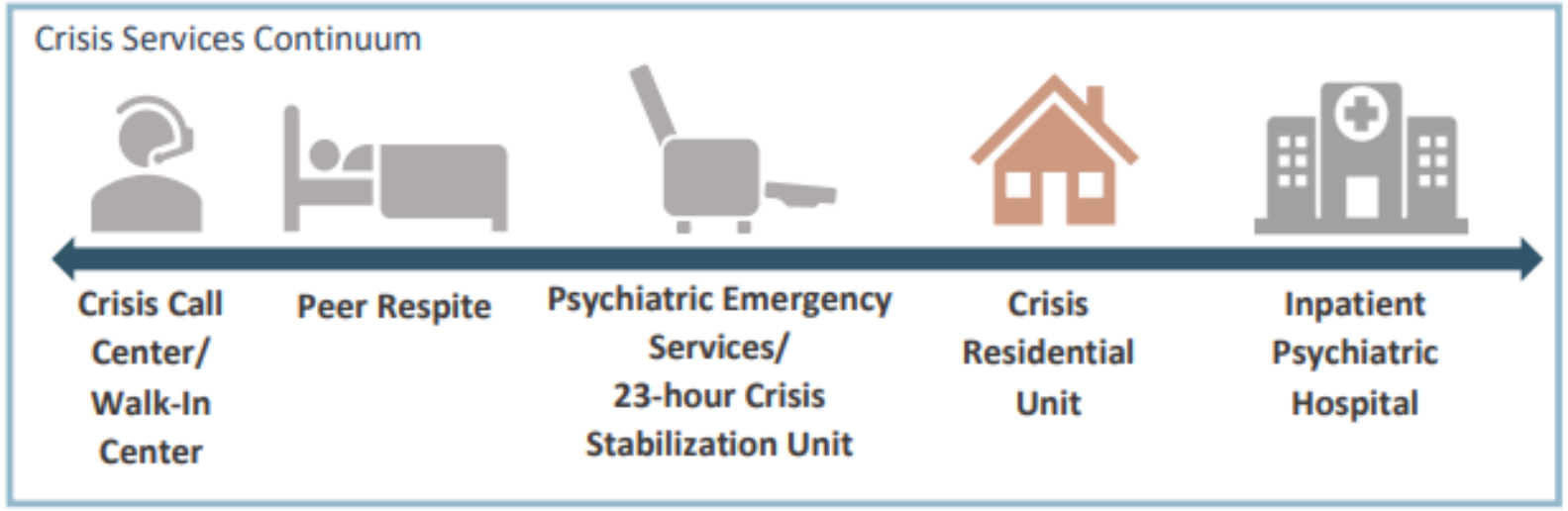
In 2018, the WRBHPB utilized three major mechanisms to determine the behavioral health needs and gaps in services in Washoe County. These included a variety of presentations at monthly Policy Board meetings from local, state, and national experts, community surveys, five stakeholder interviews and community focus groups.

The board also completed a regional behavioral health profile which further defined behavioral health needs across the region.

As a result of this work, a number of regional behavioral health priorities were identified. The need for a Crisis Stabilization Facility emerged as the top priority for a proposed bill draft request. With a recent closure of a crisis triage center in the region, the need for these services was brought to the forefront of needs identified by the board.

Crisis Now – A Model of Crisis Services

DHHS staff recommended the board consider a model called Crisis Now. The program is located in a number of areas including Maricopa County, Arizona. CSFs are an essential part of a crisis services continuum that should include:



What are CSFs?

Crisis Stabilization Facilities (CSFs) are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders) with prompt action, gentle response and effective support in a respectful environment.

CSFs are a part of a healthy continuum of crisis services designed to stabilize and improve symptoms of distress and feature a continuum of core services including 23-hour crisis stabilization/observation beds, medical detox, short term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, psychiatric advance directive statements, and peer crisis services.

These programs offer short-term “sub-acute” care for individuals who need support and observation, at lower costs and without the overhead of hospital-based acute care. They accept walk-in patients as well as 100% of drop-offs by EMS and law enforcement unless the patient requires medical clearance at a medical/surgical hospital emergency department prior to behavioral health treatment. While CSFs can be licensed as psychiatric hospitals, they have the floor plan and “culture” of a residential program. They are clinically staffed with nursing and psychiatric support 24/7. Their multi-disciplinary care teams also include peer supporters who are often the first and last person a patient may encounter.

They are also have average lengths of stay for stabilization days at or below 3 days for a patient population with acuity levels equivalent to those of an inpatient psychiatric hospital.

Crisis Stabilization Facilities – Business Case

A 2016 study examined the results of 22,000 metro police and EMS transfers directly to crisis facilities and identified the following savings and outcomes:

- Reduced potential state inpatient psychiatric spending by $260 million;
- Saved hospital emergency departments an estimated $37 million in avoided costs;
- 70% of patients discharged to community after 23 hour observation stay;
- 6X improvement in clinical fit for acute care and other behavioral health services;
- Saved the equivalent of 37 FTE law enforcement officers (2017 data). The program allowed for a 5-7 minute turnaround police drop off; and
- Reduced hospital psychiatric boarding in emergency rooms by an estimated 45 years!

What's the difference between a CTC and CSF?

Crisis Triage Center (CTC)

- Licensed as a CTC.
- Serves an important need in community by offering triage services for clients that require stay/treatment less than 24 hours. Services can provide referrals for services.
- EMS cannot get paid by Medicare and some insurance to drop off patients at a CSF.
- Stabilization days are not Medicaid and Medicare reimbursable.
- Will not be able to take 100% clients.

Crisis Stabilization Facility (CSF)

- Licensed as a psychiatric hospital.
- Working almost exclusively with the patients that are not discharge ready in the 23-hour observation unit before their time is up. Services include mental, physical, emotional stabilization and aftercare wrap around services and referrals.
- EMS can get paid by Medicare to drop off patients at a CSF.
- EMS can get paid by Medicare to drop off patients at a CSF.
- As a psychiatric hospital they can take 100% of the patient admissions including some of the higher acuity, higher risk clients.

What does a CSF look like?

https://www.youtube.com/watch?v=QtnJrVZxTkU

A.B. 66 Amendments

A number of bill amendments may be needed. These resulted from new information gathered by the WRBHPB and coordinator after the bill submittal deadline passed. These changes include:

- Describing Crisis Stabilization Facilities as a licensed psychiatric hospital rather than a unique and new facility type;
- Increasing the number of stabilization beds to a maximum of 16. This helps to avoid issues associated with the Medicaid Institute for Mental Disease (IMD) exclusion rule.
- Eliminating the reference to an average length of stay up to 14 days; and
- Deleting the section describing the CSF as consumer-directed, owned and/or operated. As a facility licensed under existing hospital licensing regulations, this may present concerns.

Questions?

For questions please contact:

CHARLES DUARTE

Email: cduarte@chanevada.org

PH: 775-336-3017

Cell: 775-781-1603