COMMISSION ON BEHAVIORAL HEALTH
DIVISION OF CHILD AND FAMILY SERVICES
APRIL 8, 2021
DRAFT MINUTES

In accordance with Governor Sisolak's Declaration of Emergency Directive 006; Subsection 1; The requirement contained in NRS 241.023 (1)(b) that there be a physical location designated for meetings of public bodies where members of the public are permitted to attend and participate is suspended.

This meeting used TEAMS Technology for video and audio capability.

COMMISSIONERS PRESENT:
Lisa Durette
Gregory Giron
Tabitha Johnson
Jasmine Troop
Lisa Ruiz-Lee
Braden Schrag

COMMISSIONERS NOT PRESENT:
Natasha Mosby

STAFF AND GUESTS:
Ross Armstrong, Division of Child and Family Services
Susie Miller, Division of Child and Family Services
Kathryn Roose, Division of Child and Family Services
Megan Freeman, Division of Child and Family Services
Kathryn Wellington-Cavakis, Division of Child and Family Services
Linda Guastella, Division of Child and Family Services
Kristen Rivas, Division of Child and Family Services
Kathryn Martin Waldman, Division of Child and Family Services
K.T. Greene, Division of Child and Family Services
Gwen Greene, Division of Child and Family Services
Sarah Dearborn, Division of Health Care Financing and Policy
Julie Slabaugh, Deputy Attorney General
Susanne Sliwa, Deputy Attorney General
Michelle Sandoval, Division of Public and Behavioral Health
Yeni Medina, Aging and Disability Services Division
Joseph Filippi, Division of Public and Behavioral Health
Rex Gifford, Division of Public and Behavioral Health
Char Frost, Clark County Regional Behavioral Health Policy Board
Jessica Flood, Regional Behavioral Health Coordinator for the Northern Region
Lynn Smith, MFT Board
Mindy Montoya, Division of Child and Family Services

DRAFT

1. Call to Order and Introduction – *Lisa Durette, Chair*. Chair Durette called the meeting to order at 9:01 a.m.

2. Public Comment – *Commissioners/Public*
There was no public comment.

3. For Possible Action. Approval of the January 20, 2021 Meeting Minutes – *Lisa Durette, Chair*

MOTION: Commissioner Johnson made a motion to approve the minutes from the January 20, 2021 meeting. There was no discussion, and no one opposed the motion.

4. **For Possible Action.** Reno Behavioral Healthcare Hospital Presentation of their Management of Seclusion and Restraint and How they Address Patterns to Mitigate Repeat Offenses. Discussion, Formulation and Approval of any Plan of Action Needed – *Ceira Reeder, Director of Performance Improvement and Risk Management, Reno Behavioral Healthcare Hospital and Commissioners*

Ms. Reeder notified Ms. Rivas that she would not be able to attend this meeting. This agenda item will be tabled for the next meeting.

5. **For Possible Action**. Discussion and Approval of the DCFS Agency Reports – *Susie Miller, Deputy Administrator Residential Services, Division of Child and Family Services (DCFS)*

Ross Armstrong reported that the agency report was submitted. Susie Miller has great information if there are any specific questions. Of note, about staffing, the Governor's office has terminated the JTF justification, so it makes it easier to hire folks. As the need for COVID nurses winds down, we hope it will be easier to recruit nurses to our facilities. In the report are the caseload, and accomplishments. Of significant note: we shut down the Desert Willow acute unit for a bit and it is back up and running in a limited capacity. It will be up to full capacity in the next couple of weeks.

We are still plugging through the general pandemic. There are no cuts to mental health services in our budget. Our budget is recommended to be closed on Tuesday by the Subcommittee on Health and Human Services. There is nothing harmful to kids in the budget and we are trying to promote things that are helpful to kids.

MOTION: Commissioner Schrag made a motion to approve the report.
SECOND: Greg Giron.
VOTE: The motion passed unanimously

6. Division of Child and Family Services Update – *Susie Miller, Deputy Administrator DCFS*

Mr. Armstrong reported that The Department of Justice (DOJ) opened an investigation into the state of Nevada for its practices of institutionalization of children for potential violation of the ADA Act via Olmstead. He cannot comment on the investigation. We received our first document request and have about 75% of the information into the DOJ. We expect this to be a lengthy process. It will give us a good sense of what our practices in the state are. We will continue to have the engagement with the DOJ throughout the investigation.

(Q) Chair Durette asked what the specific allegation is about.
(A) Mr. Armstrong. There is a letter we can provide that we received. His understanding is that you do not have the structural practices set up to provide sufficient community-based services and so your system is overly relying on having children isolated in facilities rather than being part of the community. He thinks that is the standard Olmstead allegation. They asked for information from all Child Welfare agencies and Juvenile Justice.

Commissioner Giron works with children. The idea of being able to provide community-based services is a dream and trying to get our children in the state facility for treatment sometimes requires out-of-state facilities to provide some things we cannot. The investigation is good to understand what we can and cannot do. Hopefully the DOJ will enlighten the Legislature on what we need.

7. Information on Medication Management – *Kristen Rivas, DCFS*

Ms. Kristen reported there is a workgroup working in this policy. That policy will be on the agenda of the next meeting.

8. Aging and Disability Services Division (ADSD) Update – *Jennifer Ahn, Nevada Early Intervention Services Program (NEIS), Yeni Medina, Autism Treatment Assessment Program (ATAP)*

There was no representative present from NEIS.

Yeni Medina reported for Autism Treatment Assessment Program

Ms. Medina reported on numbers for February 2021 and a handout was distributed with the information.

- 46 new application. 896 active children with an average age of 9 years old.
- 84 inactive children.
- Average wait time for all ATAP children was 161 days.
- Waitlist consists of 211 children as of February 2021.
- The handout provided shows more details.
- They are working to increase their providers.
- Offered new funds to AB providers and those funds will continue through 6/30/21.

Chair Durette said the earlier we can intervene, the better. Ms. Medina said they work closely with NEIS to close that gap with the youngest children needing services.

9. Medicaid Update and Changes – *Sarah Dearborn, Division of Health Care Financing and Policy*

- Update on 1915i Home and Community Based State (HCBS) Plan Option Services for Specialized Foster Care (SFC)

These services include instances in home support and crisis stabilization services. This was a new proposed 1915i waiver approved in September. We worked with a lot of system implementation, so it required us to develop a new provider type and new CPP codes. We are in discussion with local county agencies, providers, and partners at DCFS. Determined we needed to do a state plan amendment to these services to include the local counties agency care

coordination model, which are used to determine eligibility to these services. We submitted a state plan amendment in January to include the local county agency model called Safety Assessment Family Evaluation (SAFE). That was submitted in January. Working with DCFS and CMS in discussion to get that approved soon. System updates have been finalized and the new provider type and codes are available. Working with the SFC agencies to determine what implementation of starting these new services looks like. Working on getting them all enrolled. Have two providers enrolled. While transitioning the SFC providers into these new services we have allowed for an administrative exception for SFC agencies that are still providing Basic Skills Training (BST) to youth so they can be supported through the transition process.

- Update on Certified Community Behavioral Health Clinics (CCBHC).

We have 9 CCBHCs currently, scattered across Nevada in urban and rural. Medicaid is consistently working with them, DPBH, and CASAT to support their needs. Recently, SAMSHA released some grant awards and 4 agencies in Nevada received it. Medicaid with DPBH and CASAT are having conversations with these agencies to answer questions about CCBHCs.

Chair Durette asked what the process is for the four agencies that got the federal grant. Ms. Dearborn described the process. We hope to expand the CCBHCs in the future.

(Q) Commissioner Schrag asked how this would positively impact the Olmstead Investigation when we have all these folks interconnected? Does the plan to have an implementation for more CCBHCs bode well, is that helpful.

(A) Ms. Dearborn. Absolutely it bodes well. She is all for CCBHCs.

(A) Mr. Armstrong thinks so. If the DOJ finds us out of compliance, they might say, we need to have a CCBHC and we can check that box. With programs we have like Mobile Crisis and expanding CCBHCs he thinks it will be helpful to the investigation. We will find out.

Kathy Cavakis reported that through the System of Care (SOC) they are partnering with the CCBHCs in the rural communities. Part of their work is to push services out into the communities. The CCBHCs have been at the table and we are helping them build capacity with additional services. This is specifically in rural Nevada, but we will transition into the urban communities.

Dr. KT Greene is working with one of the four in Las Vegas that was awarded the federal grant to help them get launched. Both Dr. Greenes on this call have doctorates/expertise on CCBHCs.

- Other Updates

  1. They have another State Plan Amendment (SPA) with CMS. This is not about new services but about CMS wanting a specific dedicated area in our state plan that addressed Medicaid Assisted Treatment (MAT). We already cover this. This SPA is more of a mechanical change to our SPA. Hope to get this approved soon.
  2. Working with partners at DPBH and CASAT on a Support Act Planning Grant. This has been able to identify some gaps we have related to Substance Use Disorder services.
  (Q) Commissioner Durette. Does your MAT Policy extend to youth?
  (A) Ms. Dearborn. No, it is not age restrictive, it is based on eligibility.
  3. Web announcements. There is one related to prior authorization requirements. It is more educational. They will pursue a web announcement for providers to be sure to enroll their appropriate provider type and specialty so their specialty can provide the services to the scope.

(Q) Commissioner Schrag. On the MAT Services, are you seeing an increase in people wanting those services?
(A) Ms. Dearborn. There are many efforts to increase substance use services. There is a lot of data out there, but she doesn't have it currently.
(Q) Commissioner Schrag. Primary care has a generalized substance use screening. As we move out of the pandemic there is greater impact on folks. Are we looking to have initial touchpoints on those screening efforts for opioids, etc. from a primary care, etc?
(A) Ms. Dearborn. They promoted a code that various providers can utilize in an effort to do the initial touchpoints. They promoted it across provider types by asking providers to be able to do the Columbia Suicide Rating Severity Skill test and there can be some reimbursement for this.
(Q) Chair Durette asked if there is a code for reimbursement for ESPER?
(A) Ms. Dearborn listed the providers ESPER is open to and they are listed in the MAT Billing Guide.

(Q) Commissioner Ruiz-Lee requested more information regarding the SPA amendments related to one of the Foster Care therapeutic activities, which Medicaid submitted a new SPA for the local Child Welfare agency related to the SAFE model.

(A) Ms. Dearborn gave a detailed explanation of this. Medicaid submitted to CMS an amendment to our state plan to get the SAFE model included.

(Q) Commissioner Ruiz-Lee works for Child Protection which is the original developer of SAFE. She asked if she could see the documentation of how this was done because it could benefit other states.

(A) Mr. Armstrong can send Commissioner Ruiz-Lee and the other Commissioners the justification he developed for this particular population. That model should be viewed similar to a care coordination model and trigger the availability of the Medicaid Resources

10. Update on the Children's System of Care (SOC) Grant – *Kathryn Wellington-Cavakis, Division of Child and Family Services*
Kathy Wellington-Cavakis

- They got their positions reclassified to align with the work they do through SOC. They got a Health Program Specialist and Manager Series. One QA position approved. They will be posted for recruitment. They are excited to get the 7 positions filled so they can move more expeditiously.
- Three priorities identified in Rural Nevada are being focused on: 1. Early Childhood services in rural Nevada. There is limited capacity currently. Partnering with the CCBHCs and will provide some funding to support two clinicians at two CCBHCs to participate in the Child Parent Psychotherapy evidence-based model we identified to work with this population. We initiated conversations about other services we can push out into the community under the Children's Mental Health Authority. 2. Psychiatric services in rural Nevada and serving families. There has been a waitlist at rural clinics. We partnered with our Pediatric Access Grant and UNLV Fellows to expand services to that population. They will kick it off on 4/12/21. 3. Respite. Families are now needing more respite care. We are in the contract phase of getting the self-directed model we adopted moving forward. We are waiting for the Board of Examiners (BOE) on 6/8/21.

- Meeting with our Regional Behavioral Health Coordinators, the Hospital Association, Dr. Freeman, Dr. Woodard, and other mangers to look at opportunities to assist the Division in moving into the CMH Authority roll-out.
- Dr. Freeman. We are moving into a more active phase of the CMH Authority especially with SOC coming online.
- The Pediatric Access Grant was not on the agenda. She believes for the next meeting Stephanie Dotson will be back. Is the Commission interested to hear a report?

11. **For Possible Action.** Discussion and Approval of Division of Child and Family Services Children's Mental Health Policy:

- CRR-1 Seclusion and Restraint of Clients Policy – *Gwen Greene and KT Greene, DCFS*

Dr. KT Greene reported that in preparing for accreditation, we were required by the Commission on Accreditation of Rehabilitation Facilities (CARF) to update this policy. She gave some background on the development of the updates to the policy. All Children's Mental Health managers were consulted. There are a couple of big changes. We took out some of the specifics because we have now become licensed by HCQC and accredited by CARF and are Medicaid Provider Type 63. Our requirements are different than Desert Willow which is accredited by the Joint Commission. We ran it past Karen Taycher of Nevada PEP for person-centered language.

Some processes were getting done improperly because a lot of the reports that were labeled by appendices instead of by their name. We changed that. Those forms should be presented with the policy. No changes were made to any content of those other than the Incident Report which was approved by the Commission about six months ago. They put the title of the form in the footer for clarity. the most important change to the policy is that it is person-centered. It is no longer called Seclusion and Restraint it is called either Seclusion or Restraint or both Seclusion and Restraint. We are abbreviated it S/R. We are asking for approval of the policy and the forms. She can forward the forms to Ms. Rivas for distribution, but there has been no change in the content of any of them.

(Q) Commissioner Schrag. With that person-centered look will there be any other significant changes to how reporting is done with those forms, how the documentation would otherwise proceed?
(A) Dr. K. Greene. No and yes. Medicaid has a requirement about reporting to the Nevada Disability Accessibility and Law Center (NDALC). We have a Standard Operating Procedure (SOP) that goes along with this and we are addressing reporting requirements there. As for restraints other than that portion in our SOP, there were no reporting changes.

Commissioner Giron does not like the wording in the policy that goes into the notion that this is a restriction, or that restraints or seclusions are treatment failures. Most people requiring inpatient services, trained staff, and dedicated efforts through this crisis, it is part of a therapeutic milieus, not a treatment. It is a tool to help people through a crisis. He thinks the need to make sure things are done safely and carefully is essential. The treatment and preparation and the care of these facilities requires this kind of oversight. There is no substitute for a well-trained staff and the oversight of supervisors. But he does not like the idea that it is a failure.

Dr. KT Greene said that as part of CARF we are required to have a plan in place for the elimination of S/R. We are having to adopt that attitude. Dr. Freeman is a huge advocate for eliminating that practice. Dr. Greene agrees with him personally that we could not do what we do

if we did not use the practice of restraint. Do you have a suggestion instead of saying treatment failure?

Commissioner Giron recommended using 'Treatment Process'. We are not going to fail these people. They need this help. Safety for staff is important. He would try to use safety and welfare in that policy description. It just one tool we need to keep our clients safe.

Dr. KT Greene is grateful for Commissioner Giron bringing up that point. If it is okay with everyone, we can reconsider that sentence and bring the policy back with no other changes. If we agree to change it to Treatment of Last Resort, is that okay?

Dr. Freeman – or Action of Last Resort'. We all agree it is not a treatment. We can consider the language to be more precise. The national trend toward the elimination of S/R is because it can be so re-traumatizing for this population. There are staff and youth injuries. She wants to make sure that however we massage the wording and it acknowledges that although we will probably never get to zero, but we want to strive toward it.

Commissioner Schrag. With the severity of the language and the national picture, it would be prudent to take a few more minutes to work on the specific language. Treatment v action. If everything else is good, come back with the one lexicon change. Dr. KT Greene will do that by the next meeting.

(Q) Chair Durette asked if since this is a Division policy, does this extend to Child Welfare and Youth Parole?
(A) Mr. Armstrong. This is unique to the mental health facilities and not the JJ facilities. We can provide our Use of Force policies from the JJ if you like.

Commissioner Durette said action would not be taken at this time. It will be taken back to the drawing board to use potentially Action of last resort or treatment of last resort wording would be used.

12. **For Possible Action.** Discuss, Develop, and Approve Ways the Commission on Behavioral Health Can Be More Active in Outreach for Suicide Prevention Throughout the State of Nevada for Youth and Families – *Commissioners*
Chair Durette said this topic came up previously. She does not have any ideas or suggestions. No one had suggestions for this topic.

13. **For Possible Action.** Presentation on the Use of Chemical Restraint Within Nevada's Reporting Agencies on their Seclusion and/or Restraint Forms. Discussion and Approval of Any Action for Improvement the Commissioners Determine they Wish to Take with Agencies that Report Chemical Restraints – *Kristen Rivas, DCFS and Commissioners*

Ms. Rivas reported that several meetings ago DCFS presented a report based on the Commission's request on Thorazine. It was discussed about looking at chemical restraints. PEU put together a report in your packet. It shows total number of S/R incidents from 2018 to 2020. We did a 3-year trend and the number of those incidents that were chemical restraints. We did an overall table on the first page that shows all the facilities. It is broken down on the following two pages by facility and by medication and the totals for each of the 2018 to 2020 years.

Chair Durette asked now that we have this data how can we use it as an educational resource for the various facilities to incorporate into a QI process? For each facility should we send them their data to let them know we are tracking it and ideally the outcome being the reduction of chemical restraints for each facility?

Commissioner Troop thinks it is a spectacular idea. The numbers are large, and being able to share with the agency's successes too, and then inviting them to come and talk to us about it. When we had the providers from the hospitals previously, they were very receptive and open to suggestions and to discussion.

Commissioner Schrag thinks we should encourage them prior to coming to a Commission meeting to get together independently and we could provide them some guided questions or recommendations for discussion and see if they are willing to look at that. If there were drops, was it policy change, systems change? Could that be replicated by other agencies prior to meeting with this body. Allow some organic activity to occur internally and then bring that to the group so there is more of a vested interest. There would be more of a decision making rather than an adversarial situation. We could include this idea when we provide that information to them. Chair Durette commented this is a good idea.

Commissioner Giron thinks the numbers are very helpful. He hopes we can continue the monitoring. Some facilities get challenging cases and have to decide which medication they use. There is a notion that this is helpful. Some of the newer medications can be effective and not so dangerous. We can see if when they get the numbers, they might see that too, and in policy go with the safer medication.

Commissioner Troop said from the counseling side, she did not know that some of these medications were given for S/R. It might open up some administrator's eyes.

MOTION: Commissioner Giron made a motion that we provide some of these ideas to the facilities – the directors of facilities and have them review that with their physicians to see what they make of those numbers as we continue monitoring this use.
SECOND: Commissioner Schrag
REVISION TO MOTION: Chair Durette made a revised motion to send each facility their individual data with the message that we are tracking this. We look forward to seeing improved trends. We also welcome you to discussion and conversation should you desire to do so. Our team will continue to follow up on future trends by monitoring data.

Is Commissioner Giron comfortable with that edit. Yes, he is.

SECOND: Commissioner Schrag.
VOTE: The motion passed unanimously.

Ms. Rivas asked how often the Commission wants to see this report? As an agenda item for every meeting, or just after we follow up from the motion and see if we receive any feedback.

Chair Durette and Commissioner Troop prefer the latter. Commissioner Giron said "They need to make their changes and adjust and let's see how it looks each year".

14. **For Possible Action.** Discussion by Commissioners to Change/Edit Instructions Given to Agencies Regarding Completing Seclusion and/or Restraint Emergency Procedures Form. Develop and Approve a Plan of Action Including the Possibility of Forming a Subcommittee – *Commissioners*

Chair Durette believes this is regard to facilities not marking chemical restraints on the S/R forms. Pending SB70 which would properly define chemical restraint. Should SB70 be approved, it would make sense to hold off on this until the definition aligns with the fact.

Commissioner Schrag. If we have an NRS or NAC that will be pushed forward, that would supersede anything this body would do. He believes it is prudent to hold off and then see if there is further refinement we can provide from there.

Ms. Flood gave an update on the progress of SB70. The amendment is being processed into the updated bill. It is going through proofreading. It will be put on the Senate floor for review and then going up for a vote. If successful, then it will go to the Assembly Committee on Health and Human Services.

Chair Durette worked with Dr. Raven and they crafted the most up to date definition of chemical restraint which will then be applicable to the policies and procedures of the state should it be adopted.

Ms. Rivas said the Commission had asked her to send out each of the facilities the form with the instructions and the fillable form they created which is in TEAMS. She also sent to the Commissioners the criteria and the forms to look at for the new Commissioners. Both of those tasks were completed.

Chair Durette. One of our tasks as Commissioners is to review the S/R reports. We have moved to do so in an electronic process. This has been an enormous lift for Kristen and her team, and Joseph and his team. The Commissioners are very appreciative of the new electronic process. We thank Ms. Rivas and her team for the work they did to make a smooth process of tracking forms electronically.

KT Greene. They got the technology as well and all their forms are now electronic including the Commission's report. They are able to move them from person to person electronically.

15. **For Possible Action.** Approve the Revised 2021 Commission on Behavioral Health Meeting Dates - *Commissioners*

Ms. Rivas explained that the meeting schedule changed a little bit. We worked with Dr. Durette and DPBH to look at the schedule that would work best. That is why the schedule changed in days to accommodate the Commissioners for quorum.

MOTION: Chair Durette made a motion to approve the dates.
SECOND: Lisa Ruiz-Lee.
VOTE: Motion passed unanimously.

16. Announcements – *Lisa Durette, Chair*
None

17. **For Possible Action.** Discussion and Identification of Future Agenda Items. – *Lisa Durette, Chair*

18. Public Comment – *Lisa Durette, Chair*
None

19. For Possible Action. Adjournment of Public Session – *Lisa Durette, Chair*

Chair Durette adjourned the meeting at 10:27 am and the we will come back in session for the Executive session in five to ten minutes.