COMMISSION ON BEHAVIORAL HEALTH WITH DCFS

DIVISION OF CHILD AND FAMILY SERVICES

JULY 28, 2022

MEETING MINUTES

This meeting used Microsoft TEAMS technology for video and audio capability.

COMMISSIONERS PRESENT:

1. Arvin Operario
2. Braden Schrag
3. Daniel Ficalora
4. Gregory Giron
5. Jasmine Cooper
6. Lisa Durette

COMMISSIONERS NOT PRESENT

1. Lisa Ruiz Lee
2. Natasha Mosby

STAFF AND GUESTS

1. Amanda Haboush
2. Amna Khawaja
3. Beth Kurtz
4. Beverly Burton
5. Carrisa Tashiro
6. Char Frost
7. Jennifer Conrad
8. Don (Guest)
9. Dorothy Edwards
10. Chris English
11. Gwendolyn Greene
12. Jack Mayes
13. Jacqueline Wade
14. Jacquelyn Kleinedler
15. Jennifer Spencer

16. Joelle McNutt
17. Karen Oppenlander
18. Kary Wilder
19. Kathryn Martin
20. Lea Case
21. Linda Anderson
22. Lindsey Wood-Lopez
23. Michelle Bennett
24. Samantha Cohen
25. Sarah Dearborn
26. Shannon Hill
27. Stephanie Dotson
28. Vanessa Dunn
29. William Wyss
30. Yeni Medina
31. Yumi Yamamoto
32. 775-434-9011
33. 775-687-7101

1. **Call to Order and Introductions.** *Braden Schrag, Commission on Behavioral Health with DCFS Chair,* called the meeting to order at 9:07 a.m. *Kathryn Martin, Division of Child and Family Services (DCFS),* conducted roll call and quorum was established with six members present.

2. **For Possible Action.** Approval of the January 13, 2022 Commission on Behavioral Health Executive Meeting Minutes – Braden Schrag, Chair.

MOTION: Approve January 13, 2022 Commission on Behavioral Health with DCFS Meeting Minutes
BY: Lisa Durette
SECOND: Jasmine Cooper
VOTE: Motion passed unanimously with no opposition or abstention.

3. **Public Comment and Discussion.** No action may be taken on a matter raised under this item of the agenda until the matter itself has been specifically included on the agenda as an item upon which action can be taken.

There was no public comment.

4. **For Information Only.** Presentation of Washoe County Consortium Report – *Jacquelyn Kleinedler, Chair, Washoe County Children's Mental Health Consortium (WCCMHC)*

Jacqueline Kleinedler shared a PowerPoint presentation summarizing the WCCMHC Ten Year Strategic Plan. Long terms goals are to increase access to compassionate care and

the least restrictive environment for children in the community to decrease or buffer children and youth exposure to toxic stress and to increase child, youth, and family access to positive community-based experiences. The report was framed in the context of important and relevant systemic factors in Washoe County including the COVID pandemic, and the county housing crisis which took off in 2022 and continues to be extremely problematic for families seeking affordable and safe housing. In December of 2021, the Surgeon General released an advisory on youth mental health outlining characteristics and qualities about youth mental health across the nation that Washoe County's youth and families are also experiencing. Washoe County is also experiencing a significant lack of mental health providers and services. There is a continuing concern about mental health parity, health insurance programs, and difficulties with Medicaid supports and services and accessing resources for families.

Ms. Kleinedler explained that WCCMHC highly values anecdotal data from providers and families in the community and as a result, those conversations from 2021 were organized into five themes (education concerns, bullying concerns, youth suicide concerns, substance use concerns and overall health and access to compassionate care). The report contains details about each of them. In the community snapshot section, the report pulled together a comprehensive community scan, discusses where successes occurred and describes the positive impacts benefitting youth and families.

WCCMHC coordinated legislative recommendations with the other Consortia and was able to create a comprehensive message of what supports youth and families in Washoe County need that also reflect the needs of families across the state of Nevada. The first recommendation was for the legislature to commit funding, infrastructure and legislative support to maintain and expand existing programs and services that benefit youth and families. The second recommendation was to promote innovative programs to respond effectively to the ongoing and increasing mental health crisis. Additional recommendations were made under both of these two main general recommendations.

WCCMHC is working hard to be responsive to families which is a reflection of the lack of resources and how much they are having to collaborate and work together to be creative to meet needs of families with the closing of West Hills Hospital and the lack of providers.

Accomplishments achieved through 2021 were highlighted, with 14 major goals completed. One example was the launch of the Dynamic Resource Directory on the WCCMHC website which allows providers to own and enter their own information and update their own directory listings. This allows updated information on new programs to be available quickly to families vs. using paper resources and emailed listings. Early in 2021, a letter was written to the Nevada Department of Education asking for a review of the types of polices, requirements, and expectations they had of the Washoe County School District that could be eased up, lessened or removed completely so that teachers and students could be successful in the second half of the year. The chaotic year and hybrid in-home/in-school schedules were a burden and WCCMHC's goal was to

advocate for Washoe County schools and teachers because they were extremely stressed in hopes of lessening that burden. A digital mental health newsletter was released in the spring which was a representation of the work put into the comprehensive report at the end of the year (a mini version of the community snapshot).

Aspirational activities were also planned and work continues on these activities in coordination with multiple community partners. Ms. Kleinedler stated that it is not just one agency that really moves the needle on youth mental health in the community, it is all agencies, collaborating, working together, and sharing information. Ms. Kleinedler concluded the presentation by sharing a list of Consortium members and encouraged everyone to visit the website at http://wccmhc.com.

Commissioner Schrag asked about innovative legislative recommendations and Ms. Kleinedler described one idea the Consortium was hoping to get off the ground this year which is called "home-based crisis stabilization". This is an innovative program where when a young person presents with suicidal ideation or is coming off of a suicide attempt, agencies work together to stabilize that youth in their home by providing the support services, information, reassurance, and supervision families need to feel like they can keep their child safe in their home setting. There are a couple similar models across the state and the report references a similar program from Maryland. Ms. Kleinedler described that often what happens is a young person will present to the emergency room with suicidal ideation or coming post-attempt or mid-attempt, and the outcome of that is they are referred directly into an inpatient setting. As is commonly known, inpatient settings are not appropriate for all youth who present with suicide and suicidal features. Commissioner Schrag said the idea was fantastic and encouraged everyone share information and ideas to help offset some of the resource deprivation occurring in Nevada. Commissioner Gregory Giron suggested also looking at more preventative measures (especially in the schools) and commented that the report was well done.

5. **For Information Only.** Presentation of Clark County Consortium Report – *Amanda Haboush-Deloye, Chair, Clark County Children's Mental Health Consortium (CCCMHC)*

Amanda Haboush reported that the CCCMHC completed a needs assessment and selected the four highest priorities as the focus. The first priority is to make mobile crisis intervention and stabilization services available to Clark County youth in crisis. Services are provided by Mobile Crisis through DCFS, however there is a need for increased services and quick responses within 30-60 minutes. Importantly, after youth receive immediate crisis intervention, they need to be connected to aftercare stabilization services. When youth in crisis do not receive quick services, they can end up hospitalized and often leave before receiving ongoing stabilization care. The goal is to close loopholes and strengthen the crisis care system.

The second priority is expansion of family peer to peer support. Nevada PEP does a fantastic job providing services for families with children with mental or behavioral challenges, as well as children with disabilities. The Nevada PEP staff is wonderful, but they are the only agency with

these services. The goal is to expand help for more families and to help them navigate the system. That way, for example, when Mobile Crisis is called out, youth and families can be connected to a pure family support that remains with them through the process and provides support to find resources, help navigate systems, help with insurance, and all of the complications known to be a struggle for many families.

The third priority is to fully implement the Building Bridges Model of Care to support youth and families transitioning from residential care back into the community. While the first priority is to keep youth at home and to be able to provide services in the least restrictive environment, sometimes the best services are residential support within the community vs. out-of-state placements. The goal is to connect youth and families to supports before they enter back into the community to give a smooth transition and supported, individualized step-down services. Some youth coming out of residential care may only need outpatient therapeutic services and others will need more intensive home support services in order to prevent needing more intensive residential care in the future. The focus is to make sure families are connected and supported during a scary time and many current policies prevent interaction at the very beginning from families with those youth that can be very traumatic. The best transition back home can occur when families understand and feel they have the tools to assist their child back into the home.

The last priority is to ensure the service array is expanded so youth and families have access at earlier stages to reduce the need for crisis intervention services. Before the pandemic there was already a mental health crisis which was exacerbated by all of the struggles that came with COVID-19. While there has been an influx of increasing youth services, families need to be made aware of them. We need expand the service array so families have access to in-home services and access to respite care to allow families to have the capacity to maintain their own mental health. There are day programs, behavioral programs and other types of support that need to be made immediately accessible vs. families experiencing months-long waiting lists for this type of care. There is also a need for early childhood therapy, mental behavioral health, and early intervention support as options are very limited for children between two and ten years old.

Ms. Deloye-Haboush summarized the report stating that these are challenging goals which have been priorities for a long time in Nevada, but things move slowly in the state. She appreciated the support from the Commission and is hopeful progress can be made this year.

Commissioner Schrag asked if there was something that the Commission could support from a legislative perspective in relation to facilitating smooth transitions and understanding for families, for example adjusting or changing polices or removing communication barriers. He said there is an advocacy role that could be provided as professional communicators from a functional standpoint to help alleviate family stressors and concerns. Ms. Haboush will take the question back to share with the Consortium. Char Frost said that Medicaid is one of the barriers to getting early care coordination services in place with a requirement of no earlier than two weeks' notice before a youth comes home from residential care. This is not adequate time to get services in place, to develop safety plans or have the family feel prepared for the return back into the community. In addition, it can be a very quick turn-around, especially if a youth is in an out-of-state facility. Potentially a lack of communication between the hospital and the family may be

due to multiple issues (work, time zones, etc.) which prevent families from being involved with their youth in out-of-state treatment centers. Ms. Frost said there needs to be more emphasis put on how critical that whole family piece is because everyone is impacted. Commissioner Schrag said this was at a federal level and asked if there was anything that could be done at a state or local level that could maybe fill in some of the gaps and redirect. Ms. Frost replied that one of the items to work on would be to get Medicaid to expand the timeframe. Ms. Haboush recommended looking at Medicaid's reimbursement rates for providers since this is impacting the number of Medicaid clients providers will accept due to low rates and slow reimbursements. This issue is impacting community providers as well as treatment centers since they do not have infrastructure to sustain practices for months at a time while waiting for Medicaid payments. Ms. Haboush also recommended looking at options for attracting providers to Nevada and giving them appropriate wages to expand state services. Commissioner Schrag asked Ms. Martin to put this topic on the agenda item for the Commission to review and work on in the future.

6. **For Possible Action.** Review and Approval of the Annual Letter to the Governor of the State of Nevada – *Braden Schrag, Chair*

Commissioner Durette thanked Chair Schrag for taking on the role of spearheading the development of the letter. Commissioner Schrag expressed his appreciation of the time and dedication of Commissioners to contribute their section content for the draft. Commissioner Cooper requested her professional licensing initials (LCPC) be added behind her name. Kathryn Martin will follow up to make the change.

MOTION: To approve the Governor's letter as final for signature with the adjustment to Commissioner Cooper's licensure and send it to the Governor.
BY: Jasmine Cooper
SECOND: Gregory Giron
VOTE: Motion passed unanimously with no opposition or abstention.

7. **For Information Only.** Aging and Disability Services Division (ADSD) Update – *Yeni Medina, Autism Treatment Assistance Program (ATAP) and Jennifer Ahn, Nevada Early Intervention Services (NEIS)*

a. Autism Treatment Assistance Program

Yeni Medina provided a PowerPoint presentation demonstrating ATAP outcomes reported on referrals, caseload, wait list, and program type through June 30, 2022. She reported 71 new applications were made in June and the program is currently serving 974 children, with an average age of 8.7 years old. Eight children were in inactive status and the average wait time for all ATAP children was 33 days. Work continues to eliminate the wait list (141 days were reported in January, decreasing to less than a month currently), and there are approximately eight inactive children waiting for services. The amount of time children wait is now dependent primarily on the time it takes for the parent to complete the intake process. New referrals usually decrease slightly in the summer and increase when school starts in the fall. Historically caseloads consist of mostly what is considered straight ATAP cases vs. Medicaid cases. Ms. Medina shared

graphs illustrating professional growth throughout the years for Board Certified Behavioral Analyst (BCBA), Board Certified Assistant Behavioral Analyst (BCaBA), and consultant levels, and included paraprofessional groups (registered behavioral technicians that actually deliver one-on-one services). There were currently 767 children with an ATAP provider and 193 children without an ATAP provider who are waiting for a provider to have open availability. The majority of the active caseload is in the age range of 6 to 10, and with waiting children, the majority of those are 0 to 5 in age.

Commissioner Schrag asked what was contributing to being able to provide a more response timeframe to serving youth? Ms. Media replied that coordination of services and staff availability were contributors and that unfortunately they still do not have much control over how quickly a child is picked up by providers, due to various factors. One of the biggest barriers is that there is a lot of demand for after school hours services which makes it hard for providers to meet the need. Younger age children who can access services during the day are more likely to get picked up by providers. Location also continues to be an issue and children living in rural areas have a harder time finding available providers. Commissioner Schrag said telehealth could help address this and asked if there are some barriers through Medicaid or existing policies that would limit getting that service out to those who need it. Ms. Medina agreed that prospective providers may be interested in seeing if telehealth would be something they are willing to explore, even though telehealth is not the preferred method of engaging with children vs. physical face-to-face contact. Commissioner Schrag encouraged addressing some of the potential ways innovations in technology could help overcome barriers.

Commissioner Durette asked if children were on the wait list for Applied Behavioral Analysis (ABA) services or case management? Ms. Medica explained children are on the wait list for case management and once they become active with an ATAP provider, they start receiving case management. But whether they actually receive ABA therapy or another therapeutic service depends on when a provider is able to start working directly with the child. Commissioner Durette stated that in Clark County there are many children who have moderate to severe autism spectrum disorder, comorbid intellectual disabilities, and other conditions and it is very difficult to get these kids into ABA services. She asked what was actively being done to try to increase either the pool of ABA providers and/or provide them fiscal supplementation so they can treat these children. Ms. Medina replied that they are constantly outreaching to try to recruit new providers into the network and working with liaisons of new providers (such as assisting with the application process). There are currently 34 providers in Southern Nevada and about 22 in Northern Nevada, but unfortunately they can't keep up with demand. Commissioner Schrag asked about the wait list and if younger children for whom you can really make more of a significant intervention early on and set them up for greater success are being prioritized? Ms. Medina said they are trying to work closely with Nevada Intervention Services (NEIS) and are getting referrals from them as soon as they see an autism diagnosis. They are trying to prioritize those children so there is a smooth transition. They are looking at more ways to provide support to parents during the intake process because currently the wait time for a child just really depends on how quickly the parent can complete the application process. They are looking at identifying any possible barriers and educating families about the importance of ABA therapy at

a young age in order to gain parental buy-in and consistency, not only in the clinic or ABA sessions in the home, but also throughout the child's entire environment.

b. Nevada Early Intervention Services - Jennifer Ahn was not present.

8. **For Information Only.** Presentation of the Pediatric Mental Health Care Access Program Grant – *Stephanie Dotson, Nevada Pediatric Psychiatry Solutions, Division of Child and Family Services (DCFS)*

Stephanie Dotson reported the Nevada Pediatric Psychiatry Solutions Program (NVPeds) has changed as they are no longer offering mental health consultation or care coordination. Instead, the program is focused on providing training and education opportunities for pediatric providers and with this change of scope, they have been able to broaden the providers they reach, including behavioral clinicians, allied professionals, caseworkers, school-based providers, as well as community health workers. They are currently in the planning stages of bringing the REACH Institute Pediatric Primary Care Program to 45 pediatric providers in the state. They are working on the circle of security to train 75 behavioral health clinicians and allied professionals, and then another 50 providers on the CAMS-care Suicide Prevention Training and Risk Assessment program. They are currently sponsoring trauma informed relationship-based child/parent hypnotherapy and 18-month training for over 15 clinicians and supervisors, primarily based in rural areas. An Issue Brief covering youth suicide prevention was recently released and work is in progress on the 5th Issue Brief focused on substance abuse amongst youth. Several newsletters and infographics on important children's mental health topics and resources for pediatric providers were released. During the past year, the program reached 4,000 providers and community partners with educational and informational content.

Commissioner Lisa Durette said, with all due respect, the HRSA Grant is being used to fund all of this for child psychiatry access programs and yet access is not what's happening. Moving towards education is wonderful, but for example, Chicanos Por La Causa (UNLV) is running the child psychiatry access program for the State. To date they have done 265 child psychiatry consultations and 1,169 care coordination encounters statewide. There are currently 250 primary care physicians enrolled and the program has opportunities to grow. They are hindered by funding and are running on a very skinny budget through mental health block grants but understand that there are several millions of dollars in funds from the HRSA Grant that are going to DCFS for what was supposed to be the State's child psychiatry access program, which Chicanos Por La Causa is running themselves through mental health block grant funds. Commissioner Durette stated that she wanted this on the record and asked for other thoughts and feedback about how that funding stream can be shared so that Nevada's children's psychiatric access program can be grown. Ms. Dotson asked Commissioner Durette if she had a question for her? Commissioner Dr. Durette replied that she wanted to understand and that Ms. Dotson might not be the one to answer what may come across as an extraordinarily aggressive question. She said that it was with great apology, but the millions of dollars that have gone through the HRSA Grant to DCFS have not achieved what the grant funding was for. She asked how some of those monies can be shifted to the group that is doing the child psychiatry access and consultation

program for Nevada? Chicanos Por La Causa is struggling with funding and doing the best they can but could grow and expand with more funding. Ms. Dotson said that to respond to a portion of the question, they are working consistent within their scope which is approved by HRSA, and that is the piece she could respond to. Commissioner Schrag recommended either statutorily or operationally to continue those conversations to see what can be done to better access to the State's youth and programming and to look at what is working and replicate that.

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

Sarah Dearborn reported that currently the Behavioral Health Unit is involved in the State Plan Amendment (SPA) in regard to the reimbursement methodology for crisis stabilization centers. This is not necessarily the services provided at crisis stabilization centers, but for the rate methodology authorized by Assembly Bill 66 of the 80th Nevada Legislative Session in 2018. It was also updated under Senate Bill 156 during the 81st legislative session. This SPA proposed the reimbursement methodology needed to establish crisis stabilization centers within hospitals which are defined by legislation as behavioral health services designed to:

1. Identify and escalate stabilization of a behavioral crisis.

2. Avoid admission of a patient to another inpatient mental health facility or hospital when appropriate. The SPA language will address the rate methodology utilized for a daily rate of services. Initially providers will be reimbursed a daily default rate that is market-based using a model to reflect service definitions, provider requirements, operational service delivery, and administrative considerations. After a provider has a complete fiscal year of providing services the provider will be allowed to complete a cost report to be used to determine an individual or provider-specific rate that is market-based using a model to reflect service definitions, provider requirements, operational service delivery, and administrative considerations. In conjunction with that SPA, Medicaid Services Manual (MSM) policy was developed and approved during the Marth 29th public hearing with an effective date of March 30th. This new policy documentation within MSM Chapter 400 incudes the scope of services for crisis stabilization centers; their primary objective requirements, best practices, provider responsibilities, admission criteria, and authorization processes. Crisis stabilization centers outcomes will be for patients getting better, immediate care in a more positive behavioral health crisis response. Also associated with the Medicaid Services Manual update, a new provider type specialty was created under hospital outpatient hospital provider type 12. The specialty is 250 for crisis stabilization centers that are endorsed under a hospital licensure. The SPA is still active and is actually on request for additional information (RAI) which pauses this 90-day clock under the Centers for Medicare and Medicaid Services (CMS). There have been discussions about where this rate methodology was being put since it was first located under the hospital sections of the state plan.

3. As they discuss the rate methodology more, they are seeing that these are more rehabilitative services which may be better suited under the rehabilitative rate

methodology. Work is in progress with their sister agency at the Division of Public and Behavioral Health (DPBH) and the Bureau of Healthcare Quality and Compliance who are the licensing and certifying body. They are the ones that will be providing the endorsement and work continues to ensure their endorsement process aligns with Medicaid policy.

Ms. Dearborn reported there are new projects which she hoped could add to some of the discussion moving forward about how to be innovative and creative when it comes to children's mental health services. Nevada Medicaid was approved to use some Home and Community Based Services American Rescue Plan Act of 202 (ARPA) funding. During the February Interim Finance Committee, they were asking to hire a consultant to help look at Medicaid policies and how children's behavioral health policies are funded. Some states fund children's mental health services primarily under their managed care organizations and there are several existing models. The goal was to obtain a consultant to look at gaps and barriers and identify some innovative models to be utilized. Ms. Dearborn reported that the consultant was recently secured (Health Management Associations) and they are working on scheduling one-to-one stakeholder interviews to discuss challenges for children's mental health. These meetings will help to prepare for a meeting that brings stakeholders all together, hopefully around mid-August to collaborate on goals, timelines, and desired outcomes for these efforts to improve Medicaid services and the overall system of care for children. This is a great opportunity to hopefully identify gaps in the system and redesign some of those issues.

Medicaid Services Manual updates are coming to Chapter 400 around provider qualifications to clarify the rules of individual rehabilitative mental health providers. These providers currently deliver outpatient mental health and rehabilitative mental health services under the behavioral health outpatient treatment model, also known as Medicaid Provider Type 14, or they deliver Rehabilitative Mental Health Services (RMH) services under that behavioral health rehabilitative treatment model, also known as Provider Type 82. A public workshop about this was hosted in June and they are hoping to move this forward as a goal for proposed policy language for the September public hearing.

By restructuring their chapter, they are hoping to: 1. Clarify qualifications for qualified behavioral aides and mental health peer supporters, qualified mental health associates, and qualified mental health professional providers, 2. They are hoping to create a ladder for providers to enter the field of behavioral health services and gain skills to continue careers in behavioral health, and 3. Improve the ease with which providers can access information, aligning provider enrollment checklists with Medicaid policy so that it is clearer for providers to enroll. Provider enrollment documents will also be included with these updates.

A one-year Mobile Crisis Planning Grant was awarded last September, which goes through September 2022, which was to help state Medicaid agencies prepare for what has already been rolled out with the National 988 Mental Health Crisis Lifeline Program (988). To ensure that Mobile Crisis Services are aligned to meet increased capacity around 988, CMS put out an opportunity for Medicaid agencies to receive enhanced federal matching for qualifying community-based mobile crisis services. They recognize providers can utilize crisis intervention

services and want to build up a separate service for designated mobile crisis teams that will be eligible for this or that will perform services required to receive this enhanced Federal Medical Assistance Percentage for Medicaid (FMAP). There will be a separate rate for those services. There are many requirements under mobile crisis teams, and they recognize events may occur that might not meet those required qualifications, but the goal is to ensure they are still available and reimbursable under current crisis intervention services. Work is in progress with a contractor (Mercer) through this mobile crisis grant and their recommendations report was received. Ms. Dearborn said that she was 99% sure that a SPA will be done with the goal to ensure that each member of a mobile crisis team has the ability to engage in crisis services. Determination of how to delineate these teams from other mobile crisis teams or crisis intervention that does not qualify for the enhanced FMAP is underway. For example, they are looking at possible certification processes for these kinds of designated mobile crisis teams and development of a new provider type and use of modifiers or specialties for these qualifying services. The services must align with certain requirements and would need to be available to all Medicaid-eligible individuals experiencing behavioral health or substance abuse crisis. The services have to be community-based and provided outside of a facility, so a hospital setting would not meet that requirement. A multidisciplinary team is required to include at least one behavioral health professional and professional peer or paraprofessional. Senate Bill 390 was passed during the last legislative session which does require a peer to be on that team. They are looking at how they can align Medicaid SPA and SB 390 with Medicaid policy and make it all work together. Services delivered are required to be trauma-informed and everyone on the team is required to be trained in trauma informed care de-escalation and harm reduction. Mobile crisis services are also offered or are required to be offered 24/7, 365 days a year and include screening, assessment, stabilization, de-escalation, and coordination to appropriate referrals. Mobile crisis teams are also required to maintain relationships with community partners. During this planning grant, they have been connecting to current providers of mobile crisis and analyzing how they are aligned with these requirements. The majority of the mobile crisis teams are very close to meeting the requirements, which is great news and establishing Medicaid policy around it, similar to the crisis stabilization services policy will help increase provider standards in delivering these mobile crisis services. CMS did offer a no-cost extension for states to maximize their funds to allow for a possible additional year of the grant. This will be rolled out for a maximum of another 12 months so there is opportunity to spend the money received during the grant to finish up the SPA process, engage providers in the policy and even the rate methodology development. The stake holder meetings are planned for August or September.

The 1115 Substance Use Disorder Demonstration Waiver for the Support Act Post-Demonstration Planning Grant was initially submitted in November of 2021 and several meetings held with CMS. The application made at that time was deemed incomplete and work has been done to bring it up to standards and meet transparency requirements. Additional documents were developed including a public notice document to support the overall applications, A dedicated 1115 webpage was created and Ms. Dearborn put the link in the Chat. The public can now go to this one place on the Medicaid website and see all documents associated with 1115. The 1115 goal is for Medicaid to waive the institution for mental disease

rule that currently prohibits Medicaid agencies from reimbursing services in an Institution for Mental Disease (IMD) setting. This specific 1115 waiver is focused on substance use treatment and will allow for those residential levels of care (American Society of Addiction Medicine (ASAM Levels 3.1, 3.2 Withdrawal Management (WM) 3.5, and 3.7 WM) which are focused on substance use treatment. Medicaid is able to target those with the substance use disorder as well as co-occurring mental health diagnosis. There are additional 1115 waivers available for the Seriously Mentally Ill (SMI) population and the Severely Emotionally Disturbed (SED) population. Senate Bill 154, during the last legislative session, allowed and permitted Nevada Medicaid to be able to apply for another 1115 waiver. The good news is that CMS finally accepted the application as complete and it is out for public comment on the CMS website. Ms. Dearborn will also put those links into the Chat. Next steps will be for CMS to provide feedback on what changes need to be made, implementation plans will be developed on how goals will be met, and milestones of the 5-year Demonstration Waiver will be developed. The implementation plan will be posted when complete.

There are now 12 specialized foster care agencies enrolled under Provider Type 86 and biweekly calls continue with these providers, fiscal agent Gainwell, and the Division of Health Care Financing and Policy (DHCFP) to identify if there are challenges to enrolling or billing. It is an informal meeting to ensure the program runs smoothly.

Chairman Schrag asked Ms. Dearborn to talk about the community providers engaged in implementation activities of crisis stabilization and mobile crisis services, in terms of supplemental activity not necessary as primary stakeholders, but as providers of those proximal services. Ms. Dearborn replied that for both the development of crisis stabilization centers and for mobile crisis, it is going to take the whole system to accomplish the goals and a whole system is required to shift in order to build successful outcomes. Through the Mobile Crisis Planning Grant, some fact-finding sessions have been held again with current providers of mobile crisis services, the Mobile Outreach Safety Team (MOST) - which are a law enforcement model, Las Vegas Fire and Rescue, and the DCFS Mobile Crisis Response Team (MCRT) Immediate Mental Health CARE Team (CARES) which focus children and adolescents. The CARES Team has also been engaged, which is the telehealth delivery model utilized in rural settings. They have started with groups who are currently providing mobile crisis services (not all of whom are reimbursed through Medicaid) to learn about how they function, what pieces Medicaid can reimburse for, and how to make the process easier for providers to enroll and understand the billing language. The goal is to involve everyone in the crisis system and include 988, crisis stabilization centers, mobile crisis services, etc. in discussions. There will also be public meetings available to the general public as well as more focused meetings to work through specifics. Commissioner Schrag recommended involving youth sports groups, the Children's Mental Health Consortia, and other groups who could help guide towards care in the middle of a crisis. There may be city, county or private organizations who interact with youth that may not normally be considered stakeholders. Ms. Dearborn agreed and reported that Medicaid is working closely with DPBH more frequently to build awareness of the whole crisis system and programs. Once crisis stabilization centers are enrolled and getting their endorsements, there will be more providers available to meet the need. Follow-up services, whether a peer provider,

responding to the family the next day or after a crisis will be eligible for the enhanced FMAP also because they are a component of the whole crisis episode, which will help bridge gaps between agencies. Commissioner Schrag asked about the details of the communication plan related to the crisis services, mobile crisis and crisis intervention programs. Ms. Dearborn explained there are several meetings in progress with 988, Las Vegas Fire and Rescue and others with ongoing discussion, in addition to planned Medicaid public workshops and public hearings. Commissioner Ficalora commented that he attends many of those meetings and agrees there is a lot of information that is hard to understand and interpret about how the plans are all going to work out and who is responsible and what individual roles are. He also commented that it was very important to bring all of the voices together at the table and make decisions on the plan and define roles. He was also looking forward to the recommendations made by the consultants at Mercer.

Sarah Dearborn added a quick comment unrelated to any of the updates, regarding the two-week requirement for residential treatment center and psychiatric residential treatment facilities that was mentioned by Char Frost. Ms. Dearborn said that Ms. Frost was correct that for the target group of the severely emotionally disturbed (SED), Medicaid policy does allow for two weeks of transitional case management services. For some other target groups (Child Protective Services and the Juvenile Probation target groups), if they are in a psychiatric residential treatment facility, the policy does indicate that there is 180 of transitional targeted case management services that could be reimbursed. Medicaid is taking a significant look at the residential treatment center policy right now because there is a lack of provider standards in the current policy and a recognition of existing barriers. With the current children's mental health crisis and the entire mental health crisis, Medicaid does want to look at current policies and how they are benefitting recipients to identify updates that can be made. They are trying to move in the direction of making it less difficult for providers while balancing how to ensure good care is provided for recipients.

Commissioner Durette asked about the transition period for care coordination and described an example of the way things are currently when a patient that a social worker or therapist may be treating in the community, ends up at a higher level of care such as inpatient residential treatment for which there is no reimbursement for the care coordination needed to ensure a smooth transition back. The therapist can't work with the patient and get reimbursed. She asked if there was going to be a similar window for the clinical team to be able to get reimbursed to support those transitions smoothly. Ms. Dearborn said that she is not able to put those decisions on her updates presently and shared that this is a topic of discussion that needs to be pushed forward, and does not have funding, but may be presented during future legislative years. This is an example of a collaborative care model and there are some reimbursable codes that CMS has put out. While this is not within the current funding capacity, it is a very well-known and important issue.

Ms. Dearborn said that she provided a couple updates under the Support Act earlier and described a patient-centered opioid addiction treatment model, also known as the P-COAT Model, which was focused for substance use treatment, but is really a value-based payment

system that incorporates collaborative care codes within that reimbursement methodology. This could potentially be more in general across medical and behavioral health services, especially as these services are becoming more integrated with Certified Community Behavioral Health Centers (CCBHC) and Federally Qualified Health Centers (FQHC). Commissioner Durette said that although the money may not be currently available, there is an overall cost savings, because if the teams are coordinating on care, there will be less cost on the back end, which is similar to prevention funding. Ms. Dearborn agreed and stated that it is has been difficult to make a case for that picture on paper. Commissioner Schrag encouraged everyone to look at reviewing policies for efficient and effectiveness through the rest of 2022 and bring recommended updates to the Commission or other oversight bodies. It is challenging in government and large structures that the more complex something looks, the more important it is considered, when really the simple solution may be the most effective and efficient. He encouraged everyone to scrutinize policies and operating procedures which impact direct patient care and client contact and bring issues forward as future Commission meeting agenda items. He would like everyone to take this on as an action item for the rest of the year for their own organizations.

10. **For Information Only.** Update on System of Care (SOC) Grant – *William Wyss, Division of Child and Family Services (DCFS*)

Bill Wyss introduced himself as the Project Director for the federal Systems Abuse Administration System of Care Sustainability Grant which runs until September 29, 2023. He thanked and commended the Commission for the excellent letter to the governor and the comprehensive report which acknowledged the geographic challenges in Nevada and provided specific recommendations to build a behavioral health system.

Mr. Wyss shared a PowerPoint presentation in conjunction with team members Beverly Burton, Shannon Hill, and Amna Khawaja. He reported the SOC grant was initiated in October 2019, ending in September 2023, with an expansion sustainability grant targeting the rural and frontier communities of Nevada. There is an opportunity to apply for a no-cost extension after the grant expires which requires demonstrating that goals for the year were not completed and providing details of what would be accomplished in Year 4 to complete them. No new work or hiring of new staff can be done in the grant extension period.

A key core value of the grant is family and youth engagement and SOC partners with Nevada PEP and Youth M.O.V.E to help make families and youth the focal point of the work and build cultural responsiveness. Community-based treatment is a major component and it is important for young people and their families to be the most trusted decision makers about their mental health care and they must be positioned as such in the child's mental health system.

Five goals were submitted to Substance Abuse and Mental Health Services Administration (SAMSA): Children's Mental Health Authority, Point of Access, Tiered Care Coordination, Expansion of Service Array, and Focus on Special Populations. SOC is partnering with Dr. Freeman and working to move the work forward. SOC directly invested in the communities to help promote services, which includes a contract with Community Chest to provide in-home and community-based services, and also includes community health workers in Mineral and Lyon

counties. SOC contracts with the University of Reno (UNR) to provide positive behavioral interventions and support through a direct service pilot to serve youth with intellectual developmental disabilities and co-occurring mental health diagnosis. Eligible youth have an interdisciplinary team, case management behavioral assessments, and a treatment plan. This is the model for staff training, data collection, and oversight. An additional contract with UNR provides the Positive Behavioral Intervention and Supports (PBIS) in residential care facilities and provides a Tier 3 framework for system assessments, analysis, planning, and development of policies and procedures for preventing and addressing behavioral health issues across the continuum of needs. SOC also has a contract with Pacific Behavioral Health to provide outpatient services, including group and individual counseling. A contract is in place with the University of Las Vegas (UNLV) to fund Fellows in training to become child psychiatrists. The Fellows have completed four years of training, will complete two years of specialty program training, and they provide consultation to rural clinics and mobile crisis teams. Nye Community Coalition has been contracted to provide clinical intervention, community training, and case management. Carson Community Counseling and New Frontier are under contract and focus on early childhood, specifically the child/parent psychotherapy of evidence-based practice through certified community behavioral health centers. SOC is committed to quality, evidence-based interventions, including multidimensional family therapy and care coordination. SOC also has a contract partnering with the Nevada Department of Education (NDE) and this collaboration illustrates the commitment to youth and family voice in system building with child-serving agencies.

Support services (including flex funds) provide for the purchase of goods and services to support youth and family needs in the social and education domain. Flex funds can be utilized to support individual and unique needs of youth and families seeking to meet their goals. SOC is funding a self-directed pilot project which puts the family in charge of what they need to choose community services and providers. SOC focuses on frontier and rural communities and emphasizes training, technical assistance, and evidenced-based practices which engage youth at a young age to help cost down the road in terms of child parent psychotherapy care coordination.

SOC provides many training opportunities and Beverly Burton reported there is now a three-module Advanced Health Equity and Improving Cultural Competency and Practice training which is available to be scheduled. The training is also on the Centers for the Application of Substance Abuse Technologies (CASAT) learning platform for individuals to take a self-directed pace. Additional SOC supports included consultations and a survey to help measure the SOC bills that are being absorbed into organizations.

Mr. Wyss shared a graph showing how funds were distributed to different categories; direct service training, technical assistance, COVID supports, consultation, and partnerships. He stated these distributions demonstrate a good balance of what SOC has contributed to help Nevada youth and families. Currently the SOC grant is approaching the end of year three and Mr. Wyss explained that the structure of the grant requires liquidation of funds every year, even though the four-year grant was for $12 million. An application is made every year of the four years to show all activities and SOC has instituted a system of looking at each contract utilization to determine

where different entities should be at their spending per year in order to be fiscally responsible for these federal monies.

Commissioner Schrag asked about the communication plan to push out training, raise awareness, and get people to participate. Ms. Burton explained that the focus of the training platform and targeted population is mental health workers and it is accessible to all SOC partners. Nevada PEP staff access the training opportunities. The majority of the trainings focus on how to implement and embed System of Care values and cultural competencies within the practices of serving Nevada's children and families. The majority of the offerings are not open to the public and require a special CASAT learning platform access code. Training presentations and updates are made at consortium and community meetings and training sessions are provided to organizations statewide. She encouraged everyone to contact her for more training information and posted her email in the Chat. Commissioner Schrag asked if there had been any roadblocks or issues with being people being able to get access? Ms. Burton said that CASAT is very responsible in a timely manner and things run smoothly.

11. **For Information Only.** Announcements – *Braden Schrag, Chair*

Commissioner Durette announced that Healthy Minds in the southern region is opening their partial hospitalization and intensive outpatient program for ages six and up. There is a grand opening on August 1st. She will put her email in the Chat and anyone interested can contact her and she will forward the invitation. The program is excited to begin serving children at this level and keep them out of the hospital when they don't need to go.

12. **For Information Only.** Discussion and Identification of Future Agenda Items. – *Braden Schrag, Chair*

- Development of a recommendation to expand the current Medicaid two-week notification and transitional case management services requirement for severely emotionally disturbed (SED) youth transitioning from residential treatment and psychiatric residential treatment facilities back into the home and community.
- Update on the Department of Justice/DCFS investigation.
- Invite all of the licensing boards to present and discuss efforts they are making to make licensure in Nevada easier.

13. **Public Comment.** *No action may be taken upon a matter raised during a period devoted to comments by the general public until the matter itself has been specifically included on an agenda as an item upon which action may be taken.*

Commissioner Troop commented that she was responsible for drafting the section content for the Governor's letter on substance abuse and gambling and noticed that these topics were not included in any of the reports received by the Commission. She had to go to a variety of different resources to find Nevada gambling information and statistics. She wanted to bring this to everyone's attention, especially since there are members of the licensing boards at this meeting and gambling is not really being accounted for anywhere. She said that Nevada is the gaming capital of the world and it is something that should definitely be kept on the radar. Dorothy

Edwards (Washoe Regional Behavioral Health Coordinator) agreed and said that she will take this point to their next board meeting next week. She said this topic has been discussed in the past as an important aspect to be included under substance abuse and she will follow up with the Washoe Policy Board.

14. **Adjournment. –** *Braden Schrag, Chair*

The meeting was adjourned at 11:18 a.m.