Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

NORTHERN REGIONAL BEHAVIORAL HEALTH POLICY BOARD

MINUTES

September 29, 2020

1:00 pm to Adjournment

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.

Meeting Locations: Teleconference only
Teleconference: Call in number: 16699006833, meeting ID: 6665788969
Password: 488389

Teleconference weblink:
https://us02web.zoom.us/j/6665788969?pwd=MUNJRStSdTY5UDExSCt3ZnJSSFA1UT09

Password: Northern

1. Call to order/roll call – Taylor Allison, Chair or Dr. Ali Banister, Vice-Chair
Ms. Allison called the meeting to order at 1:04 p.m. She determined a quorum was present.

Members: Taylor Allison (Chair), Dr. Ali Banister (Vice-Chair), Sandie Draper, Nicki Aaker, Dr. Ali Banister, Matt Law, Sheriff Ken Furlong, Shayla Holmes, Dr. Daniel Gunnarson, Erik Schoen, Amy Hynes-Sutherland
Members Absent: Dave Fogerson, Lana Robards, Dr. Robin Titus
Staff and Guests Present: Jessica Flood, Northern Regional Behavioral Health Policy Board Coordinator; Ben Trevino, Dawn Yohey, Stephen Wood, Joan Waldock, Division of Public and Behavioral Health; DuAne Young, Division of Health Care Financing and Policy; Ross Armstrong, Division of Child and Family Services; Shawn Thomas; Tray Abney; Frankie Lemus and Amy Reynolds, Washoe County Social Services; Valerie Balen; Michelle Sandoval; Stacy York; Kendall Holcomb, Nevada Resilience Project; Joan Hall, Nevada Rural Hospital Partners

2. Public Comment
There was no public comment.

3. Review and approval of minutes from August 20, 2020

Dr. Banister moved to approve the minutes from the August meeting. Mr. Schoen seconded the motion. The motion passed unanimously.

4. Overview of insurance industry and associated healthcare drivers related to the provision of behavioral health services
The information was covered in the next agenda item.

5. "Medicare: Affordable Care and Improved Access for Nevada"
Mr. Law stated that insurance companies and provider groups are targeting Douglas County, Carson City, Storey County, and Lyon County. He explained that accountable care organizations (ACOs) have their own hospitals, doctors, pharmacies, and insurance plans under one roof, keeping their costs low. Renown and Northern Nevada Medical Center are joining the ACO market. A person enrolled in Medicare Parts A and B, living in a county that has Medicare Advantage, and signing up during the Medicare enrollment period can become a Medicare Advantage member. The ACOs are driven by the private sector and are funded by the Centers for Medicare and Medicaid Services (CMS) star rating reimbursement. He suggested that the State encourage provider groups to build facilities in counties that have high profit margins for them and require them to have mental health therapists onsite. Increasing provider offices would expand the Medicare Advantage programs in rural counties.
Ms. Allison summarized he proposed the Board prioritize increasing enrollees in Medicare Advantage plans and building relationships with provider groups. Mr. Law this could solve access to care issues in semirural counties. As insurance carriers transition to the ACO model, they will try to improve their CMS star rating to generate higher reimbursements which will increase cash flow to expand service areas for Medicare Advantage plans in more counties. During this expansion, the State of Nevada could provide funds to encourage construction of more provider offices in counties in need. To qualify for those funds, providers could be required to have behavioral health therapists in their medical groups, increasing procedural coding and further increasing CMS star ratings for each insurance company. The private sector would benefit and further expand provider access without relying on funds from the State. Consumers would benefit from focused healthcare with primary care physicians and behavioral health therapists in the same office. Patients who are dual eligible for state assistance could leverage current programs with little to no out-of-pocket costs. Anyone eligible for Medicare Advantage plans could access medical care with affordable out-of-pocket costs due to the strong Medicare Advantage market in Nevada. Providers would benefit from private sector reimbursements rates through Medicare Advantage programs.

6. Division of Healthcare and Finance Policy (DHCFP) and Division of Child and Family Services (DCFS) update on budget changes due to COVID epidemic
Mr. Young reported services considered for elimination were kept in the budget. Assembly Bill 3 contained a six percent rate cut to providers. The Division held a public hearing which over 300 people attended to discuss the rates. An access to care and

review plan was posted to the Division's website. Rate cuts will be considered by CMS. The Division requested any additional funds received by extending the national declaration of emergency or granted through the next legislative session be used to restore provider rates. The Interim Finance Committee made changes for state fiscal year 2020. Senate Bill 425 concerning the 1915i state plan option for tenancy support should launch in early 2021. Rather than contracting with a provider for Legal 2000 nonemergency transport, providers can enroll to be eligible to bill Medicaid for services. Mr. Young explained that the alternative payment model, value-based payment arrangements, and provider incentive models could restore previous reimbursement rates. The Division will have a Dual-Eligible Special Needs Program (DSNP) to allow those in Medicare Advantage plans and covered under fee-for-service Medicaid to have specialized programming if they sign up for DSNP. Plans can offer incentives. Four plans will operate in Nevada in 2021; three more may offer plans in 2022.

Mr. Armstrong spoke about budget cuts to the Division of Child and Family Services (DCFS) that oversees child welfare, juvenile justice, children's mental health, and victims' services. During COVID-19, they needed to protect their workforce and the facilities they operate.

The role of DCFS in juvenile justice is with juvenile justice correctional facilities and parole. Those in correctional facilities are prisoners and ineligible for federal assistance for services received there. The three youth facilities are funded by the Nevada General Fund. The special legislative session called for a $3.6 million budget cut, accomplished by reducing the budgeted capacity at Elko and Caliente. The Division will ensure the reduction in juvenile justice beds does not result in more certifications to adult court and adult prisons. Mr. Armstrong said the Community Corrections Block Grant funds county prevention efforts. A proposed bill would take savings from corrections facilities and transfer them to the counties for prevention work the next year. Ms. Flood clarified DCFS is moving toward justice reinvestment. Ms. Hynes-Sutherland suggested the Board support this.

Mr. Armstrong reported the Children's Mental Health budget was cut by $600,000. Eleven positions were frozen in children's clinical services, early childhood mental health, and rural care coordination through Wraparound in Nevada (WIN) for Children and Families. They determined what they were obligated to provide and preserved safety services, keeping children's mobile crisis and urban WIN positions. Some of rural WIN did can be done by Child Welfare clinical staff and plugging children into certified community behavioral health clinics (CCBHCs) or federally qualified health centers for care for the entire family. In addition, DPBH provides services through rural clinics. His children's mental health team can assist DPBH staff.

Mr. Armstrong explained that DCFS provides Child Welfare services for the rural counties; Washoe and Clark Counties provide those services for their counties. They held five positions vacant throughout the rural region for a cut of $400,000.

7. Presentation of Washoe County's Crossroads project focused on tiered housing for individuals with complex behavioral health needs

Crossroads is a Washoe County Human Services Agency-funded and -led initiative targeting moderate-to-highest system users who are homeless or near to being homeless and are Washoe County residents. Mr. Lemus provided an overview of the CrossRoads program that is provided by Catholic Charities of Northern Nevada. Ms. Reynolds shared about their women's program. Mr. Lemus also spoke about the Hope Home and CrossRoads Off-Campus (CROC).

Ms. Flood pointed out that the program was small in scale in the beginning. She noted the braided funding stream. Mr. Lemus said Washoe County accesses State General Funds, there are contracts with specialty courts, and community providers are reimbursed by Medicaid. Two of their houses were gifts from a local church which also remodeled the cottages and donated two large vans. Mr. Lemus said Housing and Urban Development (HUD) funds are not directly used. The County provides vision and guidance to create the opportunity for the collaborative relationships.

8. ***This agenda item was taken out of order.***

Update on Northern Regional Behavioral Health Policy Board Bill Draft Request (BDR) focused on updating and clarifying the mental health crisis hold process in *Nevada Revised Statutes* (NRS) Chapter 433

Ms. Flood explained that the BDR defines emergency admission, clarifying that an involuntary emergency admission begins when a patient is admitted to an inpatient facility; the mental health crisis hold is another process. In Nevada, involuntary admission requires that a patient is a danger to self or others or is unable to care for self. The Treatment Advocacy Center suggested adding "psychiatric deterioration" to the criteria. Arizona defines this as "suffering or continuing to suffer severe and abnormal mental, emotional, and physical harm that significantly impairs judgment, reason, behavior, and capacity to recognize reality." This would mean not having to wait until a patient reaches the point of severe deterioration to be detained for observation.

Ms. Flood suggested having the Treatment Advocacy Center give a presentation about how psychiatric deterioration has been used and abused. She pointed out the intent is to more clearly describe it. Ongoing psychosis damages people's brains. These people can be helped before the damage they incur is debilitating. She said these people already come to hospital emergency rooms. What is being considered is more coercive treatment. It is not out of the norm for other states. It would expand assisted outpatient treatment to other counties; Washoe County and Clark County already use it. Conditional release has been in state law since 1975 but has been unworkable. There is an argument for patients' rights, but Ms. Flood stressed the argument that doing nothing can do harm, especially with criminal justice diversion. She suggested mandating training for law enforcement or others regarding holds. She said the south has crisis hold mental health training; she suggested the Board develop training for this region. She asked members to email her at Jessica@NRHP.org with thoughts or concerns before bill language is submitted October 14. She verified the Board agreed to change "emergency admission" to "mental health crisis hold."

She went through the changes regarding youth. A small change will increase parents' rights. Assembly Bill 378 was not written to allow a child to be placed in an inpatient psychiatric facility without parental consent, but that is how the law reads. The proposed change would allow a youth to be held for evaluation, observation, and treatment, but not admitted to an inpatient psychiatric facility without parental consent. There are two philosophies regarding youth. One is that all children, whether they are in the child welfare system or not, should be treated the same. A youth on a mental health crisis hold whose parent consents to the hold would go through a process resulting in a court petition, then the court ordering the youth into treatment. This could happen if the parent feels the child is out of control and wants to have the hold placed by other people. If a youth is on a hold and the parent does not consent, the hospital can report to child welfare, triggering an investigation for medical neglect. If medical neglect is substantiated, the child welfare agency assumes custody of the child. *Nevada Revised Statutes* 432B says once child welfare has custody, the youth can be admitted to an inpatient psychiatric facility with a mental health crisis hold, triggering the court-ordered petition. Clark and Washoe Counties use their own paperwork and then follow NRS 432B giving them five days to notify the court. There is a drastic difference in due process for children in versus not in the child welfare system. Both sets of children should go through the petition process.

Ms. Flood said mental hold packet for a youth does not allow release to a parent, especially if the child is in a mental health crisis. The only one way to be decertified off a hold is to no longer be in a mental health crisis. It would be helpful to have a mechanism of release to the parent. If it is not in law, it cannot be in the packet. It seems practical the inpatient psychiatric facility should notify parents not more than 24 hours after the emergency admission of a person alleged to be in a mental health crisis. What was intended was that not more than 24 hours after a mental health crisis hold is initiated, the parent should be notified. When a youth gets to the emergency room, the hospital should try to notify the parent.

Assisted outpatient treatment (AOT) formalizes communities' efforts in diversion. It includes individuals with intellectual disabilities who have been found incompetent by the court. Programs can assist individuals before they enter the criminal justice system. Assisted outpatient treatment is a mechanism whereby the courts can partner with community agencies willing to provide the treatment. There are discussions about providing certification in assisted outpatient treatment and developing best practices for treating individuals. The outpatient treatment is for individuals with a history of not complying with treatment for mental illness. Ms. Flood said judges in the region want a way to order people into treatment in the Forensic Assessment Services Triage Team (FASTT) discharge plan. The Northern Region was focused on criminal justice diversion. Crisis Now helps everyone and does not involve law enforcement or coercion. It is easy for us to move past criminal justice diversion, but the problem still exists. There are sick individuals in our communities, so these types of interventions are necessary. People with serious mental illness fall through the cracks because their needs are not being addressed and they continue to get sicker.

Ms. Flood said conditional release is a reflection of AOT, so people want to know why both are needed. Conditional release is court-ordered at the end of the hospital process. When someone is admitted to the hospital, the hospital stabilizes them and does not want to release them too soon or with nowhere to go, so they keep them for six months. After that, if the patient does not meet the criteria for another court-ordered admission, they are released into the community. An AOT discharge plan would identify if a person is at risk of deterioration. If so, the hospital can reach out to a community partner. It is flexible—it could be a mobile outreach safety team (MOST) program, a multidisciplinary team, a treatment provider, or a social services agency. If a partner is willing to check in with the individual and encourage them with their conditional release plan, including going to treatment, then the community is ready for them when they are released. If the person starts to deteriorate, the partner identified in the conditional release plan can go to the judge and ask law enforcement to pick them up for readmission. The hospital emergency room would determine if they meet the criteria for inpatient hospitalization. This is why "psychiatric deterioration" is important because they will not have to wait until the person is a harm to self or is psychotic. The other thing that could happen is the person could end up back on a hold. When the hospital attempts to do a court-ordered admission, the court can view the conditional release as a psychiatric advanced directive to get them back on track. When the hospital can collect information, the conditional release can act as continuity of care or care coordination.

There is a coercive part. Within the six-month order into treatment, the team could try the patient at a lower level of care if the patient will follow the conditions. The person must agree to the conditions in order to be released or the hospital has to decide whether to keep or to unconditionally release the patient. Ms. Flood said conditional release has been in Nevada law since the 1970s. Currently, it does not have a mechanism for the hospital to readmit a person. It says a public facility is not liable when the decision to release was made in good faith.

9. Presentation on Nevada Resilience Project
This item was tabled at the Chair's discretion.

10. Board member updates on behavioral health concerns, initiatives, and successes in their area of specialty
This item was tabled.

11. Regional Behavioral Health Coordinator update on current local, regional, and statewide efforts and initiatives including the Northern Regional Behavioral Health Emergency Operations Planning Committee, Northern Regional Behavioral Health Communications committee, and Nevada Crisis Now Initiative meetings
This item was tabled.

12. Board member recommendations for future presentation and topics for board consideration
This item was tabled.

13. Public Comment

Joan Hall commented that the region's three smaller hospitals—Carson Valley Medical Center, South Lyon Medical Center, and Banner Churchill—are critical access hospitals and have their affiliated rural health clinics (RHCs). Members are critical access hospitals, which is a separate provider type as they are RHCs. They are paid differently. Typically, Medicare Advantage plans take a deep discount from the providers. These types of contracts are not beneficial to the hospitals. Critical access hospitals and RHCs were put together by CMS as a provider type when rural hospitals were closing across the country in the late 1990s to prop them up. With the other programs, the provider and the hospitals have to be credentialed with the plan to make it work. If they are not, it is a disservice to the patient who purchases the program and finds out their providers are not enrolled.

Mr. Law asked how the rural hospitals would help mitigate that. Ms. Hall said federal payments and guidelines and their payments are beneficial to rural hospitals. Taking capitated contracts diminished that benefit. If the Medicare Advantage plans wanted to pay costs, it would help. It is a disadvantage to sell those programs in the rural areas.

Ms. Allison adjourned the meeting at 4:16 p.m.