

State of Nevada
Governor's Advisory Council on
Behavioral Health and Wellness

Proposed Council Recommendations

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Nevada Governor's Advisory Council on Behavioral Health and Wellness

During the past nearly five months, the Council has heard from a wide variety of knowledgeable individuals and agencies, each of which has a strong interest in improving the quality of behavioral health services in the State of Nevada.

We have debated, discussed, and sought additional information on a wide variety of topics. Early on, the Council agreed upon several overarching principles that would guide our deliberations and recommendations.

1. If at all possible, the Council would seek to reach consensus on each and every recommendation. Achieving consensus requires that each member exercise flexibility, and that the Council would be willing to continue to discuss points of apparently diverse opinion until consensus could be reached. While the possibility always remained that a recommendation could be the subject of a majority vote, I am happy to report that all members of the Council have agreed upon each and every recommendation that follows. So say we all.
2. At the request of Governor Sandoval, the Council agreed to create a first set of recommendations by May 31, 2014. This deadline was intended to allow the Department of Health and Human Services (DHHS), other government agencies, the Office of the Governor, and both houses of the Nevada Legislature to consider the fiscal, policy, and legislative implications of each recommendation.
3. The Council agreed to focus its first set of recommendations according to the following priorities:
 - Emergencies that have important and urgent consequences for the health and welfare of citizens and communities.
 - Expenditures that would be likely to save as much money as they cost within the same budget cycle.
 - Steps that would enable the State of Nevada to maximize and receive its fair share of federal entitlements.
4. The Council also unanimously agreed that we would not shy away from requests for additional resources. However, we believe that it is equally important that every part of the behavioral health system use existing resources in the most cost-effective and quality-driven ways possible. This includes an effort to ensure that Nevada's citizens obtain their fair share of federal entitlements. We also tried to identify the consequences of possibly

wasteful practices. The most important example of this principle in action is to reduce the unnecessary use of jail, inpatient, and emergency room beds by creating more appropriate options for people in crisis, so that they can be better served at lower cost to taxpayers.

As Chairman, I would like to add a personal note of gratitude to the individual members of the Council, who performed their duties with remarkable excellence and focus, abandoning partisan politics for the good of all of the citizens of Nevada. Despite their very busy schedules, the members devoted the necessary time to attend our meetings, and in many cases worked behind the scenes to investigate additional perspectives and resources. Discussions were substantive, enthusiastic, and respectful as each of us learned from the other members of this diverse and experienced group of people. In my opinion, they have provided a model of public service and leadership that should guide public officials across the country.

We have organized our recommendations according to emergent problem areas. The recommendations below are respectfully submitted to Governor Sandoval.

Overcrowded Emergency Rooms in Southern Nevada

During the entire first 5 months of the Council's existence, we were repeatedly told of recent overcrowding in the emergency rooms in Southern Nevada. There was widespread consensus that this problem was the most serious issue facing people with and without mental illnesses who were in genuine need of emergency medicine. When emergency room beds are filled with people who have been inappropriately admitted, it decreases the capacity of the emergency room staff to attend to the kinds of life-threatening illnesses and injuries for which they are designed.

Between 2007 and April of 2013, there was a daily average of between 40 and 50 individuals on Legal 2000 (L2K) holds waiting for psychiatric inpatient admission. In the spring and summer of 2013 (May-July), there was a rapid increase in the number of individuals waiting in emergency rooms, peaking in October of 2013 with 126 individuals waiting for admission to a psychiatric hospital. On a few occasions, emergency departments were on "divert status" because of overcrowding due largely to the number of patients who had been admitted due to a mental health crisis (See Appendix C). Note, however, that these numbers only include persons awaiting inpatient psychiatric beds, and do not include people who were simply waiting to be assessed before eventually being released.

The predominant reason for the overcrowding of emergency rooms was reportedly a high number of emergency room admissions for people in real or apparent psychiatric or emotional crisis. Some of these admissions were clearly appropriate; for example, a person suddenly experiencing psychosis for the first time or a dramatic change in mental status may be subject to a life threatening illness or injury. Many others, however, were clearly unnecessary. For example, people who

have had long histories of diagnosed serious mental illnesses could often be better served in less restrictive, less intensive, and less expensive settings, such as crisis residences, respite care, or their own homes. Thus, while the Council is not suggesting that every person in psychiatric or emotional crisis is inappropriate for emergency room admission, there is widespread agreement that a substantial proportion of people admitted to emergency rooms due to emotional or psychiatric crisis could be better served at lower cost in other settings.

At the same time, many people in psychiatric or emotional crisis end up as admissions to the Clark County Detention Center (CCDC), which is neither designed nor optimal for the treatment of psychiatric emergencies. The Council heard testimony that many people who are admitted to CCDC could be more appropriately served in other settings. Oftentimes, persons are booked into the jail for low-level criminal activity that appears more related to their mental condition than criminal intent. These persons could be better served by receiving the mental health assistance they need in less restrictive, more therapeutic environments as opposed to being arrested and jailed. Despite the CCDC's admirable efforts to accommodate this inappropriate population, the experience of being incarcerated often exacerbates the feelings of despair that led to the crisis in the first place.

The Council heard testimony that many inappropriate transports to emergency rooms were due to policies and practices that were required of paramedics and emergency medical technicians, who work for Las Vegas Fire and Rescue, private ambulance companies, and others. For example, in many cases paramedics and EMT's feel compelled to transport people despite their clinical judgment that the person could be better treated in some other setting or by remaining in their own home. It appears that there is some ambiguity about this requirement; however, even when emergency medical personnel do not transport people in crisis to an emergency department, they often feel vulnerable because policies reportedly do not authorize or support this decision. Further, private ambulance companies can only be reimbursed if the person in crisis is transported to an emergency room, thus providing a fiscal incentive for them to do so, even if transport to an emergency room is deemed to be unnecessary, inappropriate, and wasteful.

Finally, poor and inappropriate treatment of psychiatric emergencies increases the need for expensive inpatient care, which has been in short supply in Southern Nevada. (See Recommendation #3 below.) While inpatient care is sometimes necessary and appropriate, it is far too important and expensive a resource to be wasted on unnecessary admissions.

In all regions of the state of Nevada there are mental health crises that are putting stress on available resources. Northern Nevada has initiated some innovative, integrated strategies to begin to address the needs of people in emotional and psychiatric crisis. In Carson City, the Forensic Assessment Services Triage Team (FASTT) program integrates Rural State Mental Health services, community law enforcement, and local mental health and substance abuse treatment centers to

better address the needs of individuals with mental illness and co-occurring disorder that have found themselves in the criminal justice system. This program has shown that integrated services can reduce hospital admissions and re-admissions, as well as improve an individual's productivity and sobriety duration. Also, in Northern Nevada the Crossroads program provides housing and transitional living through independent housing opportunities for individuals that were previously homeless and residing in Washoe County. However, despite these effective programs, Northern Nevada and Rural Nevada still struggle with provider shortages, limited resources for crisis services, and lack of adequate housing options for individuals suffering with serious mental illness.

In an attempt to address the lack of alternatives to emergency room admissions, Southern Nevada Adult Mental Health Services (SNAMHS) opened a psychiatric urgent care service. Unfortunately, because of a decision by the Centers for Medicare and Medicaid Services (CMS), the urgent care service created by SNAMHS was forced to close. This service had been created to alleviate the overcrowding in emergency rooms, and its forced closure contributed to an already serious problem.

Initially, the Council supported efforts to re-create this state-run urgent care service. However, in light of the changed landscape in healthcare financing (e.g., the Affordable Care Act and Medicaid Expansion), it is not clear why this service could not be provided by private or not-for-profit entities. Further, to the extent that the Council's recommendations (below) are implemented, the need for this service may decrease.

Thus, the Council quickly realized that an important and emergent goal would be the reduction of unnecessary or inappropriate admissions to emergency departments, jails, and inpatient beds. We decided to attack these goals with four primary strategies: 1) Intensive outpatient care, with high intensity, quality, and continuity, for the heaviest users of the most expensive services; 2) An increase in the number of crisis triage beds, sobering or detox center beds, and/or respite care beds in Nevada, to create less expensive and more clinically appropriate alternatives to emergency rooms, jail, and inpatient admissions and beds for people who are in crisis; 3) An increase in the number of reimbursable inpatient beds available in Nevada; and 4) Encouragement of stakeholders to review their policies and procedures that govern EMT's, paramedics, and ambulances; specifically reviewing policies for assessment and transportation of patients.

Recommendation #1 -- The Super-User Project: Create a special, high intensity, low-caseload program targeted specifically at the heaviest users of the most expensive forms of care.

As is almost always the case in public human services, a relatively small number of individuals appear to be accounting for a very high number of emergency room, jail, and inpatient admissions. The Council believes that targeted efforts to reduce the

high number of crises among these “Super-Users” will significantly improve the conditions in Southern Nevada’s emergency rooms, thereby improving services to the people who truly need emergency medical care. In addition, by changing the chaotic trajectory of their lives, the people who receive this service will have a chance to remain stable, housed, in treatment, with fewer and less severe crises.

Often, these “super-users” are people with multiple problems and disabilities, including diagnoses of serious mental illness, co-occurring substance use disorders, homelessness, social and familial disconnectedness, and a lack of hope and motivation. Their lives are characterized by chaos and despair.

Research has shown that user-friendly and intensive services, when provided by case managers with low caseloads and accompanied by safe and stable housing, can reduce the use of the most expensive and often counter-therapeutic community resources. It is clear that the frequency and intensity of crises among people with serious mental illnesses can be significantly reduced by low-caseload, high intensity case management, especially when coupled with safe and stable housing. Perhaps more importantly, these services allow the creation of real therapeutic relationships that can help these clients to regain hope for a better future; and no one ever recovered from anything without hope.

- The Council recommends expansion of high intensity case management and housing services for the heaviest users of the most expensive behavioral health services (i.e., emergency room, jail, and inpatient admissions.) We especially recommend expansion of existing programs such as Psychiatric Assertive Community Treatment (PACT) teams and Mental Health Courts.¹
- These slots should be targeted to specifically identified individuals based on service utilization criteria; specifically, a diagnosis of serious mental illness or co-occurring mental illness and substance abuse disorders, and multiple, repetitive inpatient, emergency room, and jail admissions.
- Every slot should receive services at a 10:1 caseload or its equivalent. (For example, PACT teams might provide 5 clinicians for 50 clients.)
- Every slot should be accompanied by safe and stable housing assistance where needed, in the form of scattered site, co-located, or congregate housing, as well as support to families.

¹ Note that funding for mental health courts should allow flexibility, as the expansion of mental health courts might include court-related resources, including but not limited to public defenders and prosecutors with special mental health expertise.

- The annual cost of each slot (including housing) is estimated to average \$20,000-\$30,000² per person, per year, a significant portion of which is expected to be reimbursed by third party payers or federal reimbursements.
- All providers of behavioral health services must take every possible measure to maximize reimbursement possibilities to ensure that Nevadans receive their fair share of federal reimbursements (especially Medicaid) for these services. The State may consider establishment of Health Homes or other mechanisms to maximize federal reimbursements.
- Housing costs will be reimbursed in part by entitlements such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). It is estimated that such reimbursements can account for approximately one-third of housing costs.

The anticipated benefits of these programs are based on the reported experience of numerous states and counties across the US. They include the following:

- Reduction in jail days.
- Reduction in frequency of emergency room visits and admissions.
- Reduction in frequency and duration of inpatient psychiatric hospitalizations.
- Improvements in client satisfaction and treatment participation.

Recommendation #2 - Increase Availability of Short-Term Crisis Triage Services

According to a variety of sources, crisis calls involving emotional or psychiatric crises are very likely to result in transport to nearby emergency rooms or admission to jails. According to a variety of sources, a significant percentage of these “mental health admissions” are inappropriate, in that the person does not need emergency medical examination or treatment, poses no significant threat to public safety; and the chaotic atmosphere of jails and emergency rooms often serves to exacerbate the person’s sense of confusion, despair, or distress. There are a variety of different situations that lead to these calls, including public inebriation, vague or non-imminent reports of suicidal ideation, trespassing by confused and disruptive persons, among others.

While there are several reasons for these inappropriate admissions to emergency rooms and jails, the most important appears to be the absence of reasonable

² When this service is first implemented, per-client costs are likely to be higher, reducing to a more reasonable average as clients become stabilized.

alternatives. The Council therefore recommends a significant increase in one or more of the services that have been shown to effectively reduce inappropriate or unnecessary admissions to emergency rooms, jails, and eventually inpatient psychiatric beds.

Some examples of crisis alternatives include the following types of services:

- Mental Health (MH) Crisis Triage Beds
- Small crisis residences, including peer-run programs
- Respite Care
- Sobering Centers
- Medical or social detox programs

Crisis Triage Beds - One example of this type of service in Nevada is the Community Triage Center (CTC). This center is an alternative to emergency rooms for individuals in crisis that are inebriated, suffering with mental illness or co-occurring disorders, or experiencing an emotional or psychiatric crisis. The funding for CTC's is shared by local hospitals, local governments, and the State of Nevada. In Southern Nevada there are 50 CTC beds, of which only 36 are operational; in Northern Nevada there are 12 CTC beds. There is widespread agreement that 62 beds are far too few. Police and Fire Department personnel in Southern Nevada report that they "don't even bother calling the CTC because there is never an open bed." The Council urges immediate steps to expand CTC capacity. Again, CTC providers should make every effort to maximize federal/Medicaid funding.

It is unreasonable to expect providers of these essential services to operate in the absence of predictable, multi-year funding commitments. Thus, they should have stable, long-term funding. The Council recommends that each of the contributing entities, as well as the Division of Health Care Financing and Policy (DHCFP), review the need for CTC beds and determine the best way to stabilize funding and maximize all potential federal reimbursement opportunities.

Throughout the US, systems of care have successfully avoided expensive inpatient and emergency room admissions by creating alternatives. Often, people in crisis need few or no services other than a safe place to stay for a few days, assessment by a mental health professional, an adjustment or simply filling their prescriptions, and perhaps a few days to stabilize in the face of a temporary exacerbation of disturbing or confusing symptoms.

Peer Managed Crisis Residences and Diversion Programs – For many people in crisis, the emergency room is not only wasteful but a negative experience. Emergency

rooms are often loud, hectic, and chaotic. Further, because they must treat life-threatening illnesses and injuries, emergency room staff members are often unable to provide a calming and therapeutic environment when people need it most. This is not in any way a criticism of emergency room staff, whose job is to save lives in the face of life-threatening illnesses and injuries. Nevertheless, patients report many negative experiences in the emergency room including being asked or forced to undress, long waiting periods, and an environment that is hectic and anxiety provoking. Peer managed residences can provide supportive, therapeutic environments that can promote success and stability for individuals with like conditions.

Peer managed diversion programs, such as Parachute in New York City, have also proven to be successful alternatives to emergency rooms. Parachute NYC offers access, within 24 hours, to a home-based treatment visit by a Need Adapted Mobile Crisis Team (NA-MCT). During the initial meeting the NA-MCT will work with those in crisis to listen and discuss options for treatment. NA-MCT is available to work with an individual at home over the course of a year to provide support and information. The program also includes a Crisis Respite center, a support line (for those who need someone to talk to) and LIFENET (for those in crisis). Parachute NYC is supported by funding from the CMS Center for Medicare and Medicaid Innovation.

As one such program explains:

In the peer community of people with the lived experience of psychiatric or emotional issues, it is well known that there is a connection to the relationship among peers and wellness. For some people, developing a peer-to-peer relationship has long been more healing than traditional treatment. Studies on the perceived benefits of peer-run support services have shown that participation in these services yields improvement in psychiatric symptoms and decreased hospitalization (Galanter, 1988; Kennedy, 1990; Kurtz, 1988). In studies of persons dually diagnosed with serious mental illness and substance abuse, DoubleTrouble in Recovery was found to significantly reduce substance abuse, mental illness symptoms, and crisis (Magura, Laudet, Rosenblum, Vogel, & Knight, in press; Magura, Laudet, Rosenblum, & Knight, 2002).

Consumers participating in peer support had better adherence to medication regimens (Magura, S., Laudet, A., Mahmood, D., Rosenblum, A. & Knight, E.), had better healing outcomes, greater levels of empowerment, shorter hospital stays and fewer hospital admissions (which resulted in lower costs than the control group) (Dumont, J. & Jones, K. 2002). Peer-to-peer engagement has often provided efficient and effective outcomes that traditional services cannot or do not provide due in part to limited or poor engagement between the provider and person and/or barriers to trust between the provider and person in need.

Respite Care - Even in the absence of a mental health or emotional crisis, there are times when people with serious mental illnesses are in need of safe, short-term housing that can actually help to prevent a crisis from developing in the first place. For example, if there is a dispute between a landlord and a tenant with serious mental illness, a brief separation can allow case managers to negotiate or mediate the dispute, allowing the person to keep their apartment. If the dispute cannot be resolved, it may allow time for the person to find alternative housing and avoid a destructive episode of homelessness. Even more importantly, respite care programs provide a “break” for family caregivers, who often play a crucial role in supporting and housing loved ones with serious mental illnesses. Again, a brief period of respite can often allow the person to remain housed and supported by family members, thus preventing the crises that typically follow disruptions in housing and support. Again, the Council recommends fully exploring and maximizing all federal/Medicaid reimbursement opportunities.

Sobering Centers - Sobering centers are safe places for people under the influence of alcohol or other drugs to “sleep off” the effects of their acute intoxication. Their average lengths of stay are often 8-12 hours. The centers typically utilize cots or beds for sleeping, hot showers, and may provide snacks, water, and coffee. However, these centers seldom provide meals, and are typically inexpensive to operate, especially in comparison to the alternatives mentioned above. While the centers are typically open to any person found to be inebriated in public, they often focus their location and outreach services to people who do not have stable housing. These beds should be easily accessed, with referrals coming from family, case management personnel, police, and emergency medical staff, as well as self-referrals. While on-site staff should be trained to provide emergency first aid, they are expected to send people in need of emergency medical care to area hospitals. Unfortunately, sobering centers are not reimbursable, and must be funded by other sources.

Drug Detoxification Programs - Drug detoxification typically consists of three components: evaluation, stabilization, and referral to treatment. These services are typically provided in response to physical drug dependence and withdrawal; and may include medical treatment of a drug overdose. Upon beginning drug detoxification, clients are typically assessed regarding the type and severity of their addiction, acute medical problems that may require referral to an emergency room, as well as co-occurring mental health disorders. The process of detoxification can be managed with (medical detox) or without (social detox) medications. Finally, programs should attend to referral and motivation for treatment of a substance use disorder or addiction. The last step of the detoxification process is to ready the patient for the actual recovery process. Like sobering centers, social detoxification services are not reimbursable under Medicaid. In contrast, medical detoxification programs can be reimbursable. Finally, as noted below in recommendation #3, it is important that emergency medical providers be empowered and informed to access these resources once they are created and expanded.

These recommendations are expected to have the following benefits:

- Improved crisis care
- Reductions in unnecessary expenditures for inpatient, emergency room, and jail beds

Recommendation #3 - Allow Emergency Medical Personnel to Make Triage Decisions regarding Mental Health Crises, and Stop Requiring Them to Transport People to Emergency Rooms

One of the important factors contributing to crowding in Southern Nevada's emergency rooms has been a policy requiring transport of all mental health crisis clients to emergency rooms, even if such transfer was not medically necessary. Some paramedics reported that they often decline to transport such patients, but feel somewhat vulnerable, as no policy explicitly authorizes them to do so. Other emergency medical personnel reported that they believe they are required to transport any call that is labeled by the dispatcher as a mental health emergency. Finally, many emergency medical providers feel that while their training on medical triage is outstanding, there is a need for more training specifically regarding responding to mental health emergencies.

Thus, the Council heard testimony that only a small percentage of people with serious mental illnesses who have been transported and admitted to emergency rooms actually are in need of emergency medical evaluation and treatment, and could have been better served elsewhere. The Council therefore recommends a review of existing policies and ordinances for (EMS) providers, including EMT, Advanced EMT, and Paramedics to assure that appropriate transports are both allowed and funded when appropriate, and to ensure that the training of emergency medical services personnel includes content regarding assessing and responding to psychiatric and emotional crises.

Currently, according to the state Medicaid plan, private ambulance companies are allowed to seek reimbursement only for transportation to an emergency room, even if that is an inappropriate destination according to the patient's clinical needs. It makes little sense to reimburse them for an unwanted outcome, and to deny them reimbursement for the appropriate outcome, which may be non-transport triage or transportation to a more appropriate and less expensive alternative. The Council recommends consideration of a change in the state Medicaid plan to allow reimbursement of non-transport triage or transporting to an appropriate alternative location.

Recommendation #4 – Increase Number of Reimbursable Psychiatric Inpatient Beds in Southern Nevada

While the Council was prepared to recommend an increase in the number of reimbursable psychiatric inpatient beds in Southern Nevada, thanks to the efforts of the Department of Health and Human Services and private acute medical hospitals, this situation has already been addressed, both immediately and in the near future.

1. Southern Nevada Adult Mental Health Services (SNAMHS) recently added 21 inpatient psychiatric beds by re-opening Building 3A on its campus. These beds are being filled progressively, and should be fully occupied within a few weeks.
2. Fortunately, one of the largest acute medical hospitals recently announced that it is creating an acute inpatient psychiatric unit, which will provide approximately 50 beds. This unit will be eligible for Medicaid reimbursement, because the IMD exclusion applies only to freestanding psychiatric institutions. Creating this unit will require significant capital improvements, which are likely to take 8-10 months to complete. In order to bring this valuable resource to fruition as quickly as possible, the Council recommends expedited processing of all relevant licensing and building permit applications.
3. The Department of Health and Human Services with its Division of Health Care Financing and Policy has reviewed the reimbursement rate for inpatient psychiatric patients in Medical Hospitals and has established new rates that will be effective July 1, 2014. These increased rates have led to a renewed interest in reimbursable psychiatric beds in many hospitals in Nevada.
4. The Council and DHHS have also explored more immediate solutions, including the use of vacant private psychiatric hospital beds (i.e., IMD's) for short-term observation (i.e., less than 48 hours), partial hospitalization, and intensive outpatient care, which are billable services, even when provided in an Institution for Mental Disease.

Recommendation #5 – Reconsideration of the Institutions for Mental Disease (IMD) Exclusion

According to federal law, freestanding psychiatric facilities with more than 16 beds are defined as Institutions for Mental Disease (IMD). Since the creation of Medicaid in 1965, IMD's have been precluded from reimbursement for inpatient services. Initially, the IMD exclusion, as it has come to be known, was effective and necessary to prevent "warehousing" of people with mental disabilities in large facilities where treatment was criticized as poor or even non-existent. In far too many cases, people committed to these institutions never returned to their home communities.

Today, the IMD exclusion may still have value, especially for stable or chronic conditions such as intellectual disabilities or dementias, where the person's needs can be equally well served in small, community-based settings. However, serious mental illnesses are often characterized by occasionally severe exacerbations that require brief but intensive inpatient treatment.

At the time that the IMD exclusion became law, the vast majority of inpatient psychiatric beds in the US were in large state hospitals. That of course is no longer the case. Unfortunately, it is not logistically or financially feasible to run a freestanding psychiatric hospital of only 16 beds, which has contributed to the dearth of reimbursable inpatient beds in Nevada.

In Las Vegas, there are new and established freestanding psychiatric hospitals that have many open beds while nearby emergency departments are overflowing with psychiatric patients. While the Division of Public and Behavioral Health (DPBH) and the Council have been exploring ways to make at least some use of these beds, if the IMD exclusion did not exist, they would be immediately available for Nevadans in need of inpatient psychiatric care.

Fortunately, there appears to be evidence that the IMD exclusion is currently being reconsidered. Congress has initiated a pilot program in several states that is designed to assess the effects of changing the IMD exclusion. The Council recommends an executive branch letter recommending Congressional consideration of exceptions or waivers to the IMD exclusion. (See Appendix A for a brief summary of the IMD exclusion).

Children's Services

The Council heard a great deal of testimony regarding children's mental health services. Frankly, it is a subject of such complexity and importance that the Council has committed to keep it prominently on our agenda for the duration of the Council's existence. The Council plans to rely heavily on the regional and statewide children's consortia that have been working hard to address these challenges, and we are grateful for their dedication and expertise.

In Nevada, studies have suggested that 19.3 percent of elementary school children have behavioral health care needs and over 30 percent of adolescents self-reported significant levels of anxiety or depression. According to the Clark County Community Mental Health Center, in 2009, almost one-quarter of Nevada's public middle school students seriously thought about killing themselves, more than 30 percent had used alcohol or illegal drugs, and over 13 percent had attempted suicide.

Without easy access to crisis intervention and stabilization services, families have been forced to utilize local emergency rooms in order to obtain behavioral health

care for their children. The National Center for Children in Poverty has identified youth emergency room visits for behavioral health care as a national problem (Cooper, 2007). A national study of children's behavioral health services utilization in the Medicaid program showed that eligible adolescents used disproportionately more services, particularly facility-based care, due to the lack of more cost effective approaches such as mobile crisis intervention services (Pires et al., 2013).

Child mental health-related visits to hospital emergency rooms have increased steadily in Nevada over the last five years. There is also an increasing trend of children requiring a costly inpatient admission to a hospital due to a mental health crisis.

Recommendation #6 – Provide Appropriate Mental Health Professionals (MHP) to Public Schools

While the Council believes that mental health services to children and adolescents is deserving of much further inquiry, several issues deserve more immediate attention. In order to increase the percentage of children with mental health and behavioral problems that are identified, the Council recommends that Nevada begin, as soon as possible, the process of ensuring that every school in Nevada will have access to the services of a mental health professional.

In addition to their duties in assessing the special education needs of Nevada's children, mental health professionals in schools can provide several other services that are essential to the well-being of Nevada's children and adolescence.

Foremost among these duties is the prevention of suicide, which has become an increasingly important problem among teenagers throughout the US. (See also Recommendation #10 below.) When youth with suicidal ideation are referred, it is important that someone can assess the child's needs and make appropriate referrals.

A related and equally important duty is to identify and refer children who have suffered maltreatment. One of the evidence based methods for evaluating and documenting traumatic events in children is through measuring Adverse Childhood Events (ACE). Some examples of ACE include verbal, physical, or sexual abuse, family dysfunction (e.g., an incarcerated or substance-abusing family member; domestic violence; or absence of a parent because of divorce or separation). Exposure to ACEs is associated with an increased risk of depressive disorders up to decades after their occurrence. In addition there is an association with increased numbers of ACEs and increased utilization of psychotropic medications. Research clearly demonstrates that adverse experiences, especially physical and sexual abuse, can change the entire course of a person's life, resulting in problems that have significant and expensive health and mental health consequences in adulthood.

In addition to providing mental health screening, intervention, and referral services to children, mental health professionals in schools also provide valuable consultative support for teachers who are dealing with troubled and troubling students. Further, they can connect with other school-based health care providers, such as school-based health centers, which are reimbursable by Medicaid.

Recommendation #7 – Expand Mobile Crisis for Children

Mobile crisis response services provide immediate care and treatment from specialized teams which include qualified mental health professionals and psychiatric case managers to any child or adolescent requiring support and intervention with a psychiatric emergency. Crisis interventions reduce symptoms, stabilize the situation, restore the youth and family to their previous level of functioning and assist the youth in remaining in or returning home. Mobile services are provided in a variety of settings, including but not limited to homes, schools, homeless shelters, and emergency rooms. Crisis response services include follow-up and de-briefing sessions utilizing evidence based mental health interventions to ensure stabilization.

The Mobile Crisis Response Team is designed to reduce unnecessary psychiatric hospitalizations and placement disruptions of children and youth, and to reduce the need for youth to go to emergency rooms or detention centers to have their mental and behavioral health needs addressed. Services include community-based, office based, and telephonic consultation and crisis intervention, as well as referral for assessment, stabilization, and treatment. Case management services are provided to link youth and their families to needed resources in the community. The Council recommends expansion of mobile crisis services for children.

Recommendation #8 – Create Licensure Category for Residential Treatment

The Council heard testimony explaining that residential treatment centers have been unable to establish themselves in Nevada, primarily due to the absence of a licensing category for this service. This has resulted in large numbers of Nevada youth being transferred out-of-state for residential care. However, thanks to the efforts of Richard Whitley, Administrator of the DHHS Division of Public and Behavioral Health, this problem is well on its way to being resolved, and the appropriate licensure categories are expected to be in place by June of this year.

Access to Mental Health Care

Recommendation #9 - Changes to Legal 2000 Process

When a person is found to be at risk of hurting themselves (suicidal) or others (homicidal), certain healthcare and safety individuals are able to initiate the process for an involuntary legal hold for up to 72 hours to evaluate and provide a safe and secure place for the person in crisis. This hold is referred to as a “Legal 2000” or “L2K”. Nevada Revised Statute (NRS) 433A.200 defines the individuals that can initiate a Legal 2000; however, mid-level providers (i.e., Nurse Practitioners and Physicians Assistants) are left off of this list. In the 2011 Legislative Session, the Independent Practice Act of Certified Nurse Practitioners was passed; the Council believes that allowing nurse practitioners to certify people enhances the ability of these practitioners to provide independent medical care.

The Council recommends amending NRS 433A.200 to expand the practitioners that may file a petition for involuntary court-ordered admission of a person. In addition to the existing practitioners authorized in NRS 433A.200, we recommend the addition of physicians’ assistants licensed pursuant to NRS Chapter 630 or Chapter 633 of the NRS and nurse practitioners licensed pursuant to Chapter 632 of the NRS.

As described in depth in this document, many individuals are in emergency rooms, held on a legal hold, even when they no longer require either an emergency room or an involuntary hold. An example is when an individual is intoxicated or off medications and states they are planning to kill themselves. These individuals are brought to emergency rooms and await petition and admission to a psychiatric bed. For some, within 24 hours they are clear and no longer suicidal. Unfortunately, once a Legal 2000 has been initiated, there is no statutory authority for any provider to take a person off (decertify) an involuntary hold. In fact, there is only statutory language for “discharge” from the emergency room by a physician. The absence of explicit statutory authority to decertify a person from a Legal 2000 hold results in unnecessary involuntary inpatient commitments. The Council therefore recommends adding a new section to NRS Chapter 433A to allow for *decertification of a person* who has had a petition initiated for involuntary court-ordered admission by certain trained personal, including physicians, psychiatrists, physicians’ assistants, nurse practitioners, and psychologists. (See Appendix D for suggested language changes and Appendix E for a sample *DPBH Involuntary Hold Form*.)

Recommendation #10 - Anti-stigma and Suicide Prevention Public Information Campaign

The Council repeatedly heard testimony regarding the role that stigma plays in preventing people from accessing needed care for mental illnesses and substance abuse problems. This is true across the US, and Nevada is no exception.

Stigma also prevents people experiencing suicidal crises, either personally or regarding a friend or loved one, from calling for help. If we are to successfully lower the alarming rates of suicide in the US, it will be necessary to change public attitudes and behaviors.

Television, in addition to its obvious role as entertainment, has enormous power to inform the public and change behavior. (Witness the role of television advertising in changing buying habits.) The Council therefore recommends an aggressive public information campaign, utilizing television, radio, billboards, and other media, aimed at changing attitudes toward mental illness and addictions, and changing public behavior regarding reporting suicidal ideation and threats.

The target audience for this campaign should be as broad as possible, including employers, teachers, students, and family members. The process of creating this campaign presents a wonderful opportunity for collaboration among a variety of players.

The Council also recommends that the state's universities be encouraged to participate in a competition, utilizing the talents of multidisciplinary teams of undergraduate and graduate students, from departments of behavioral science, psychology, marketing, etc., vying for gubernatorial recognition and an honorarium, as well as the opportunity to see their work produced and aired on television.

In addition, the Council recommends a thorough review of public information and referral systems, such as the 211 phone service and web site, to ensure that they contain appropriate and comprehensive information regarding social, health, and mental health resources.

Every school should have access to DVD's that can be shown to students of all ages, encouraging them to "find an adult you trust" when they or a friend appear to be experiencing a mental health crisis or suicidal ideation.

Recommendation #11 - Engage in Serious Efforts toward Workforce Development for Mental Health Professionals

As noted above, the Affordable Care Act and Medicaid expansion have created new funding streams, and the Council applauds the State's efforts to maximize federal reimbursements so that Nevadans receive their fair share. However, as Nevada extends mental health treatment to more people with serious and disabling mental conditions, it is clear that there will be a need for more mental health professionals to serve this expanding population. Further, many of the Council's own recommendations have important implications for workforce development.

For example, Recommendation #6 would require the recruitment and hiring of many additional social workers and other kinds of mental health professionals to serve Nevada's schools. There are more than 600 schools in the state of Nevada, and it is unlikely that the state will be able to recruit hundreds of additional mental health workers in the near future.

Equally important, there is a shortage of psychiatrists throughout the country, and Nevada is no exception. Over half of the psychiatry positions in state service are currently vacant, requiring the state to fill positions with contracted or *locum tenens* psychiatrists. In addition to the higher cost of these contracted professionals, many of them only work in Nevada for a short time, decreasing the continuity and quality of care they can provide. Currently, the salaries for state-employed psychiatrists in Nevada are significantly lower than those offered by the Veterans Administration, a primary source of competition for these professionals.

While higher salaries are likely to improve the situation for psychiatrists in the short run, the shortage of mental health professionals is likely to be a profound and serious problem for some time to come. Nevada should therefore begin to engage in a workforce development project, enlisting the state universities, as soon as possible. These efforts should include all clinical disciplines, especially psychiatry, psychology, social work, nursing, and physician's assistant programs.

The Council also heard testimony regarding the absence of integrated treatment programs for co-occurring mental illness and substance use diagnoses. A plethora of research confirms that serial and parallel treatment of co-occurring disorders are seldom successful. In contrast, integrated treatment is much more likely to result in measurable improvements, including reductions in the frequency and severity of exacerbations and relapses, arrests, inpatient days, and emergency room admissions. The Council recommends collaborative enhancement of knowledge and skills among mental health professionals (including psychiatrists, psychologists, nurses, social workers, counselors, and peers) through psychiatry residencies, psychology internships, continuing education, and creation of specialized fellowships and centers of excellence.

Specific recommendations include the following:

- Examine need for increase in salaries for state-employed psychiatrists and other clinical specialties. These increases could be immediate or staggered over several years.
- Consider exempting essential and difficult-to-recruit positions (e.g., psychiatry and nursing) from current and future mandatory furloughs.
- Consider recruiting incentives such as signing bonuses or reimbursement of moving expenses for the positions that are most difficult to fill.
- Consider amending the so-called no-moonlighting provision for psychiatrists. According to experts, this does not require legislation, and can be accomplished by presenting to the Board of Examiners for waivers for specific jobs.
- Increase residency slots, internships, practica, fellowships, and other training slots for psychiatrists and other mental health professionals.
- Provide appropriate training and maximize use of mental health nurse practitioners as independent providers.
- Include training in co-occurring disorders and trauma-informed care
- Create reimbursable post-doctoral fellowships.
- Provide pay incentives for additional board certifications (e.g., child psychiatry).
- Advertise loan forgiveness in underserved areas.
- State professional boards should consider allowing reciprocity for mental health professionals licensed in other states and willing to move to Nevada.
- Provide training for paramedics and EMT's in responding to emotional and psychiatric crises.
- As recommendation #6 is implemented, there will be a large increase in demand for social workers in Nevada, especially those with training in service to children and schools. State university masters programs in social work should consider expanding to meet this predictable workforce need.

Recommendation #12 - Telepsychiatry and PCP Consultation

The supply of psychiatrists in the US is significantly short of demand, a situation that is likely to get worse before it gets better. The unavailability of psychiatrists is especially serious in rural areas. As a result, it has become increasingly clear that the use of telepsychiatry is an evidence-based and acceptable way to maximize the productivity of psychiatrists, for example, by eliminating long hours of travel time to reach rural locations in Nevada. The State Medicaid plan currently allows for telepsychiatry in rural areas, however, it has become increasingly clear that the shortage of psychiatrists is not limited to rural Nevada. The Council therefore recommends expansion of this resource, to include opportunity to receive reimbursement for telepsychiatry in urban Nevada, and consideration of amending state rules and the State Medicaid plan to also consider reimbursement for out of state psychiatry services provided to patients in Nevada.

Currently, more than half of all psychotropic prescriptions in the US are written by non-psychiatrists, most often primary care physicians. While some primary care physicians are skillful and experienced in diagnosing mental illnesses and writing psychotropic prescriptions, many are not.

Because the need for psychiatrists significantly exceeds their numbers, this situation is not likely to change in the foreseeable future. For that reason, the Council recommends consideration of telephonic or video psychopharmacological consultation and continuing medical education (CME) on psychiatric topics either provided by, or reimbursed by, the Division of Health Care Financing and Policy or the Nevada System of Higher education.

Recommendation #13 - Enhancing Peer Services

Among the evidence-based practices supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), few are more exciting than peer-run services and the expanded use of peers as providers.

According to the President's New Freedom Commission, "Recovery-oriented services and supports are often successfully provided by consumers through consumer-run organizations. Studies show that consumer-run services and consumer providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with psychiatric diagnosis."

Peer services have numerous advantages. Peer providers and peer-run organizations can provide advocacy, mutual support, community building, and direct services. Perhaps most importantly, peers provide a prospective source of many new service providers, and the community of potential peer providers is culturally and demographically similar to that of the people they will serve. Services

provided can include peer-run drop-in programs, independent living centers, housing, supported employment, crisis response and respite, substance abuse services, among others.

There is rich research literature supporting these peer-provided services. For a complete summary, please see the SAMHA web site, at SAMHSA.gov.

The Council recommends expanded use of peers as providers for MH clients. While some of these programs and services are already reimbursable under Medicaid, they are not being used to best advantage, for several reasons, including training and certification. The Council recommends creation of a peer training program to certify peer agencies providing employment opportunities, reimbursable services and a career path. This career path would allow peers for example to work as peer specialists and advocates; and also take additional training to become case managers or community health workers.

In some cases, peer service providers need additional training and certification, including training in how to appropriately document and bill for services provided. The State Medicaid Plan may need to be amended to enhance the value and accessibility of these services, for example, by expanding the ways in which clients can be referred to peer-provided services.

In addition, the Council notes that family-to-family programs are helpful in similar ways to families who are, often courageously, willing to remain supportive of a loved one with a serious mental illness. Family-to-family programs provide emotional support as well as substantive knowledge about how to advocate and gain access to the best services for their loved one.

Finally, all of these recommended steps apply to the entire array of behavioral health challenges in Nevada, including but not limited to mental health treatment, substance abuse treatment, crisis programs, employment programs, and housing. It is the Council's recommendation that all Federal/Medicaid opportunities for reimbursement are maximized for peer and family services.

Recommendation #14 - Discharge Planning

In part, this Council owes its creation to allegations that were raised in 2013 about discharge practices at the Rawson-Neal Psychiatric Hospital. These allegations were intensively investigated, and it is beyond the scope of the Council's charge to re-investigate them. However, the Council did explicitly request confirmation that the current status of discharge planning at Rawson-Neal meets professional standards. The Council also wants to be clear in communicating these same standards to all inpatient settings in Nevada.

The Council's recommendations for discharge practice apply to both in-state and out-of-state discharges, and largely repeats the recommendations previously provided by Dr. Ken Appelbaum and Dr. Joel Dvoskin following their audit of the Rawson-Neal Hospital. Following that audit and pursuant to their recommendations, Governor Sandoval and the Legislature made additional resources available to assist the Hospital in ensuring routine adherence to these standards.

Rawson-Neal is certified by CMS, which carefully scrutinized Rawson-Neal following the allegations regarding poor discharge practices. DHHS has confirmed to the Council that Rawson-Neal's issues regarding patient discharge have been addressed, and that CMS has confirmed that Rawson-Neal is in compliance with national standards. (See Appendix B for a copy of the letter from CMS.)

In addition to these well-known national standards, the Council asserts the following standards for psychiatric hospital discharge, and recommends that they be shared with all inpatient psychiatric providers in the State of Nevada:

- Hospital treatment staff must assess patient safety for transportation, both in-state and out-of-state.
- Specifically, treatment staff must assess and document the patient's ability to make the trip alone, or arrange for appropriate supervision.
- Upon discharge, an appointment with an outpatient provider should be scheduled.
- Upon discharge, patients should be provided with appropriate medication and prescriptions to last until the scheduled outpatient appointment, including a plan for how to get their prescriptions filled.

Recommendation #15 - Medicaid and Jail or Juvenile Justice

Currently, jail detainees have their disability entitlements, including Medicaid, terminated upon admission to the jail. As a result, when released from jail, people with serious mental illnesses must reapply for benefits, thus leaving them with no Medicaid coverage for weeks or months.

The Council recommends that all jail detainees in the State of Nevada have their Medicaid and disability entitlements suspended instead of terminated, and immediately reinstated upon their release from jail. It is still unclear to the Council what would be necessary to achieve this; however, the current practice of terminating these entitlements is clinically harmful and fiscally wasteful.

Recommendation #16 - One-Way Information Portal for Family Members

One source of frustration for loved ones and family members are the many restrictions on information sharing that are created by federal and state confidentiality laws. On the other hand, adults have a right to privacy and confidentiality regarding their medical (including psychiatric) treatment.

Further, families are often rich sources of clinically valuable information, such as which medications have worked best in the past, triggers for crises, effective ways of deescalating a person in crisis, etc. The challenge, then, is to make it easier for families to provide clinically valuable information, as well as contact information in the event that a person with mental illness wants clinicians to contact the person's family.

As one strategy to resolve this dilemma, the Council recommends consideration of creating a one-way information portal from parents and loved ones to hospitals and other mental health care providers and organizations. This Internet-based resource would allow family members to help without implicating confidentiality rights, since providers need not confirm or deny the presence of the client without permission.

Future Consideration after May 31, 2014

In large part due to the severe overcrowding in Southern Nevada emergency rooms, the bulk of the Council's immediate recommendations have necessarily focused on Southern Nevada. However, many of the problems and solutions discussed in this report will be equally applicable to other parts of the state, including Northern and rural Nevada.

Further, some issues were of such complexity that they clearly require a great deal more investigation and consideration than was possible if we were to meet our May 31, 2014 deadline.

Thus, the Council is aware that these recommendations do not address certain important aspects of Nevada's mental health service delivery systems. In the coming months and years, the Council plans to address these additional and important issues:

- **Governance** - Foremost among the statewide questions that the Council plans to address is the question of governance, control, responsibility, and funding of mental health services in Nevada, especially including aggressive efforts to assure and continuously improve the quality and continuity of care. This is a topic that the Council plans to address comprehensively over the next two years. By looking at systems of governance across the US, we hope to be able to design a system that empowers and enables communities to make important decisions about the mental health of their citizens.

- Prison Mental Health - Because of its importance and complexity, the Council was not able to adequately consider the mental health service needs of Nevada's prison system, and we plan to do so in the coming months.
- Children's Mental Health and Wellness – Although the Council has made several emergent recommendations regarding children and adolescent mental health services, much more remains to be done. Thanks to the efforts and wisdom of the many members of the Children's Mental Health Consortia, much work has already been done, and the Council plans to continue to look into the mental health needs of Nevada's youth in the coming months.
- Senior MH Issues – Another age group with particular and important mental health needs are older Nevadans, including those with serious mental illnesses, various forms of dementia, and co-occurring physical and mental health challenges. Despite the existence of Medicare, many of these needs remain unmet, and the Council plans to invite testimony from senior advocates and experts in geriatric mental health to educate us, so that we can formulate appropriate recommendation to improve services to this rapidly growing population.
- Forensic MH Services – Across the country, the percentage of state inpatients in forensic legal statuses has been climbing. SNAMHS has begun the process of creating secure space for forensic patients on their campus in Building 3, which promises to reduce unnecessary waiting periods for incompetent, pre-trial defendants, and to reduce associated transportation costs. The Council plans to conduct an inquiry into the treatment and management of patients who have been found incompetent to stand trial and not guilty by reason of insanity, as well as other people who are simultaneously involved in criminal justice and mental health systems.
- Increased use of crisis planning and advanced directives and crisis planning for individuals with SMI – Obviously, the worst time to plan for any crisis is during a crisis, and mental health crises are no exception. There are exciting new methods of assisting clients in planning for crises that have been shown to reduce the incidence and severity of crises when they occur. While many peer providers already use these mechanisms (e.g., Wellness Recovery Action Plans), clinicians and families can benefit from training.
- Information sharing – In addition to our recommendations regarding the Legal 2000 process, the Council also heard testimony regarding the need for real-time information sharing regarding mental health crises and care across systems. Currently, there is no effective centralized depository for data sharing. In the coming months, the Council will investigate options to include appropriate information sharing, seeking to maximize and balance several

competing concerns, including: 1) Continuity of care; 2) Safety of consumers, first responders, health care staff, and the general public; 3) Cost-effectiveness.

Conclusion

The Council is well aware of the importance and gravity of the task we have been assigned. These recommendations will not solve every problem that faces Nevadans with serious mental illnesses, their families, their communities, and the people who serve them. Nevertheless, we believe that these recommendations will set Nevada on a path toward a system that provides excellent care in the most cost-effective way possible, and the Council hopes that these recommendations will be used to develop an emergent, short-term, and long-term plan to improve the mental health of all Nevadans.

We are deeply indebted to the many people who testified before us and provided us with guidance, information, and wisdom. We look forward to their continued support in the coming months.

Appendix A: The IMD Exclusion

Since the inception of Medicaid in 1965, institutes for mental disease (i.e., freestanding psychiatric hospitals of more than 16 beds) have been excluded by federal statute from receiving matching Medicaid funds for inpatient treatment provided to adults ages 21 to 64. This exclusion has not applied to small psychiatric facilities (16 beds or less) or psychiatric units of general hospitals.

The so-called IMD exclusion has made it far more difficult to create inpatient beds psychiatric beds and alternative crisis settings (e.g., sobering centers, respite care, peer-run crisis centers, and crisis triage beds). Unless they consist of fewer than 16 beds, these alternatives can't be reimbursed by Medicaid, and must be 100% funded by local or state dollars. Further, because of EMTALA (Emergency Medical Labor and Treatment Act), emergency departments cannot turn these admissions away. The other entity that cannot refuse admissions are local and county jails. This prohibition has largely precluded the creation of freestanding psychiatric hospitals that serve Medicaid patients, regardless of their quality.

There is a window of opportunity at the moment to dramatically increase the quality and quantity of better alternative settings, due to Medicaid expansion and the Affordable Care Act, but unless the IMD exclusion is revisited, this problem will likely persist. It is time to reconsider the IMD exclusion.

The IMD exclusion was a great idea when there were gigantic warehouses (e.g. Willowbrook) in which people with various kinds of alleged mental disabilities were housed, often for decades, scandalously poor conditions. It is probably still a good idea for people with stable intellectual disabilities, who do not need an institution; their needs can usually be met equally well in small group homes or independent, supported housing.

The IMD exclusion may also have a continuing role in long-term care of people with chronic and severe physical or cognitive disabilities, often related to their age, although even there the IMD exclusion may need revisiting. For example, why should a safe and well-run nursing home be prevented from specializing in geropsychiatric care? Indeed, they should receive a higher rate of Medicaid reimbursement, because they could provide specialized and high quality geropsychiatric care. Instead, it is reported that nursing homes often discriminate against older people with psychiatric problems, or fail to diagnose and treat those problems, in order to avoid the dreaded IMD exclusion. If this is correct, it is indeed ironic and counter-productive.

At the time the IMD exclusion was passed, a very high percentage of inpatient psychiatric beds in the US were large state hospitals, with unnecessarily long lengths of stay. That is no longer the case, and it hasn't been for a long time. The IMD exclusion was probably a good idea in 1965, but that was then and this is

now. The average length of stay for psychiatric inpatient care is now a matter of days or weeks, not years, and state hospitals have become fewer and smaller all over the US.

Serious mental illnesses are conditions that have occasional or recurrent acute exacerbations, which can include confusion, terrifying hallucinations, sometimes with acute risks of suicide or interpersonal violence. They are often exacerbated further by alcohol or stimulants. These emotional or psychiatric crises are what bring people to emergency departments or local jails, which are usually inappropriate settings to meet their needs.

However, for people who are frequently admitted to ED's and jails, and whose conditions are well known, alternative crisis placements or brief, acute inpatient stays would be a far better and less expensive alternative, but the IMD exclusion often makes them cost-prohibitive. For example, 16 beds is often a very inefficient size for an acute, freestanding psychiatric unit or a sobering center.

It should be added that many people in emotional or psychiatric crisis can be served in small residential programs that are not currently subject to the IMD exclusion, and more of these programs should be created. However, the IMD exclusion has not created enough of these sites, and removing it will not preclude them as viable alternatives.

The Council is not necessarily advocating abolition of the IMD exclusion, which may continue to serve some specific, positive purposes. However, it should be revisited. If the IMD exclusion is to remain in existence, it should attend separately to types of facilities based upon the conditions they serve. Sixteen beds is an arbitrary and often counterproductive size for at least some of these facilities, especially freestanding crisis triage and psychiatric inpatient care.

As one example of the effects of the IMD exclusion, adding more inpatient psychiatric beds could significantly alleviate Southern Nevada's current emergency room crisis. This could literally occur immediately if the IMD exclusion did not exist. A brand new, 83 bed, state-of-the-art freestanding psychiatric hospital currently sits virtually empty because as an IMD it cannot accept Medicaid inpatients.

Appendix B

Letter From CMS Reinstating SNAMHS and Rawson-Neal To Full Participation

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707



Refer to: WDSC- mc

April 9, 2014

Chelsea Szklany
Southern Nevada Adult Mental Health Services
6161 W Charleston Blvd
Las Vegas, NV 89146

CMS Certification Number (CCN): 294002

Dear Ms. Szklany:

Based on the results of a Medicare certification revisit survey conducted on March 12, 2014, the Nevada Department of Health and Human Services (NV DHHS) determined that Southern Nevada Adult Mental Health Services now meets the Medicare Conditions of Participation (CoPs) for a provider of hospital services. Because your facility is back in compliance with the applicable Medicare CoPs, this office will not proceed with the termination action previously noticed on January 9, 2014.

While the survey found compliance with the CoPs, standard-level deficiencies were cited. The enclosed Statement of Deficiencies (Form CMS-2567) documents the findings of the resurvey.

You are not required to submit a plan of correction for any of the standard-level deficiencies. However, under Federal disclosure rules a copy of the findings of this Medicare survey must be publicly disclosed within 90 days of completion. You may therefore choose to submit for public disclosure, your comments on the survey findings, and any plans you may have for correcting the cited deficiencies.

Should you choose to submit a plan for correction, the evidence of correction is to be entered on the right side of Form CMS-2567, opposite the deficiency, and must be signed and dated by the administrator or other authorized official. Please submit any such evidence of correction to this San Francisco office **and** the NV DHHS, Las Vegas District office by close of business, within ten (10) days of receipt of this letter.

The evidence of correction of each item must contain the following:

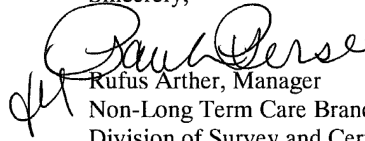
1. How the correction was accomplished, both temporarily and permanently for each individual affected by the deficient practice, including any system changes that must be made.
2. The title or position of the person responsible for correction, i.e., Administrator, Director of Nursing or other responsible supervisory personnel.

3. A description of the monitoring process to prevent recurrences of the deficiency, the frequency of the monitoring and the individual(s) responsible for the monitoring.
4. The date when the immediate correction of the deficiency will be accomplished, normally this will be no more than thirty (30) calendar days from the date of the exit conferences.

Copies of this letter are being sent to the NV DHHS and the State Medicaid agency.

If you have any questions about this matter, please contact Alex Garza at 415-744-2830, Linda Brim at 415-744-2831, or Maureen Calacal of my staff at 415-744-3727.

Sincerely,

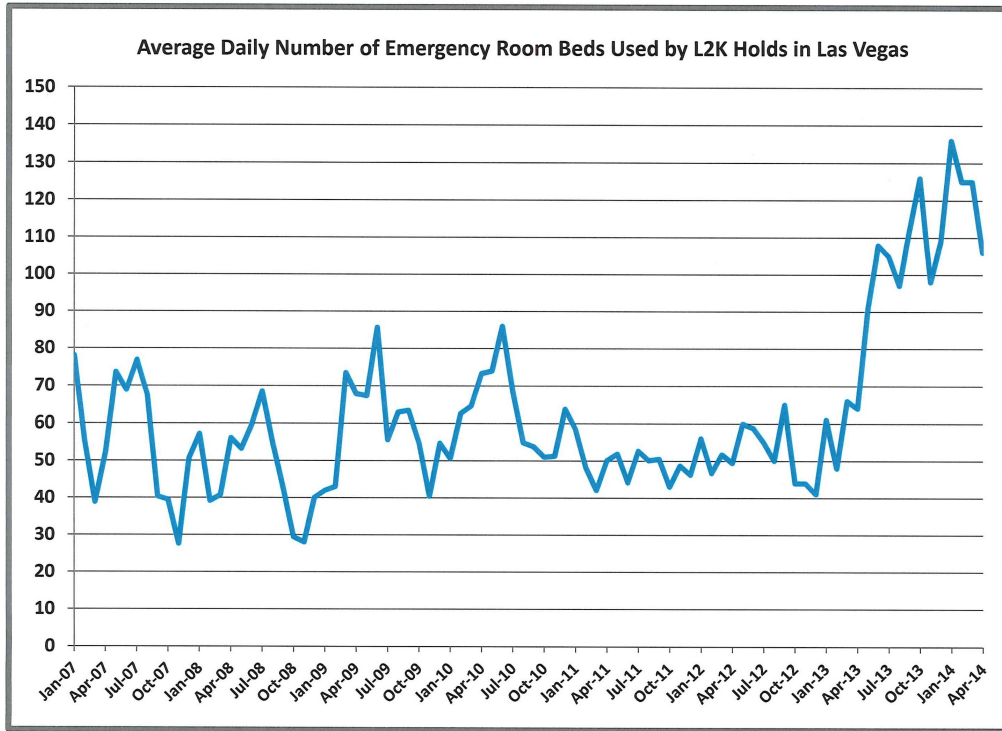
A handwritten signature in black ink, appearing to read "Rufus Arther". The signature is written in a cursive style with a large initial "R".

Rufus Arther, Manager
Non-Long Term Care Branch
Division of Survey and Certification

Enclosure

Appendix C

Emergency Room Data 2007-2014



Appendix D

Bill Draft Request to Amend NRS 433A.200

BILL DRAFT REQUEST TO PROVIDE FOR A PROCESS OF DECERTIFICATION OF A PERSON WITH A MENTAL ILLNESS

The purpose of this document is to make revisions to the Nevada Revised Statutes (NRS) governing involuntary court-ordered admission of persons with a mental illness. The revisions will establish a new procedure to decertify a person for involuntary court-ordered admission.

1. Amend NRS 433A.200 to expand the practitioners that may file a petition for involuntary court-ordered admission of a person. In addition to the existing practitioners authorized in NRS 433A.200, add a physician assistant licensed pursuant to NRS Chapter 630 or Chapter 633 of the NRS and a nurse practitioner licensed pursuant to Chapter 632 of the NRS.

NRS 433A.200 Petition: Filing; certificate or statement of alleged mental illness; statement of parent consenting to treatment of minor.

1. Except as otherwise provided in NRS 432B.6075, a proceeding for an involuntary court-ordered admission of any person in the State of Nevada may be commenced by the filing of a petition for the involuntary admission to a mental health facility or to a program of community-based or outpatient services with the clerk of the district court of the county where the person who is to be treated resides. The petition may be filed by the spouse, parent, adult children or legal guardian of the person to be treated or by any physician, *physician's assistant*, psychologist, social worker, ~~or~~ registered nurse, *or nurse practitioner*, by an accredited agent of the Department or by any officer authorized to make arrests in the State of Nevada. The petition must be accompanied:

(a) By a certificate of a physician, psychiatrist or licensed psychologist stating that he or she has examined the person alleged to be a person with mental illness and has concluded that the person has a mental illness and, because of that illness, is likely to harm himself or herself or others if allowed his or her liberty or if not required to participate in a program of community-based or outpatient services; or

(b) By a sworn written statement by the petitioner that:

(1) The petitioner has, based upon the petitioner's personal observation of the person alleged to be a person with mental illness, probable cause to believe that the person has a mental illness and, because of that illness, is likely to harm himself or herself or others if allowed his or her liberty or if not required to participate in a program of community-based or outpatient services; and

(2) The person alleged to be a person with mental illness has refused to submit to examination or treatment by a physician, psychiatrist or licensed psychologist.

2. Except as otherwise provided in NRS 432B.6075, if the person to be treated is a minor and the petitioner is a person other than a parent or guardian of the minor, the petition must, in addition to the certificate or statement required by subsection 1, include a statement signed by a parent or guardian of the minor that the parent or guardian does not object to the filing of the petition.

2. Add a new section to NRS Chapter 433A to allow for decertification of a person who has had a petition initiated for involuntary court-ordered admission. Suggested language follows below:

A physician, physician's assistant, psychologist, social worker, or nurse practitioner may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person (is not a person with a mental illness 433A.195) no longer meets the criteria for involuntary court-ordered admission and stating the observations upon which that conclusion is based.

Appendix E

DPBH Involuntary Hold Form 1

PATIENT NAME: _____

433A.165 EMERGENCY ADMISSION: EXAMINATION REQUIRED BEFORE PERSON MAY BE ADMITTED TO A MENTAL HEALTH FACILITY.

1. Before an allegedly mentally ill person may be admitted to a public or private mental health facility pursuant to NRS 433A.160, (s)he must:
 - a. First be examined by a licensed physician, physician assistant or advanced practitioner of nursing at a location where a practitioner is authorized to conduct such an examination to determine whether (s)he has medical problems, other than a psychiatric problem which require immediate treatment, and
 - b. If such treatment is required, be admitted to a hospital for the appropriate medical care.

MEDICAL CLEARANCE: MUST BE COMPLETED IN ITS ENTIRETY AND A COPY OF THE EXAMINATION REPORT ATTACHED.
On the basis of my personal examination of this allegedly mentally ill person on _____ day at _____ o'clock, a.m. /p.m., this person has no medical disorder or disease other than a psychiatric problem that requires hospitalization for treatment.

Name of examining medical professional: _____ Current Nevada license number: _____
(Print)

Signature: _____ Date: _____ Time: _____

CERTIFICATION: Describe in detail the behaviors you observed in the person leading you to believe (s)he is mentally ill and a danger to self or others as described in NRS 433A.115 and no longer meets the criteria for involuntary court-ordered admission.
I have personally observed and examined this allegedly mentally ill person and have concluded that, as a result of mental illness, this person is likely to harm self or others. My opinions and conclusions are based on the following facts and reasons (Do not give diagnosis to describe behaviors):

I am currently licensed in the state of Nevada as a Physician, psychiatrist, psychologist, APN, PA. License #: _____

Name of Examiner: _____
(Print)

Signature: _____ Date: _____ Time: _____

DECERTIFICATION: Describe in detail the behaviors you observed in the person leading you to believe (s)he is no longer a danger to self or others as described in NRS 433A.115.
I have personally observed and examined this allegedly mentally ill person and have concluded that this person is not likely to harm self or others. My opinions and conclusions are based on the following facts and reasons:

I am currently licensed in the state of Nevada as a Physician, psychiatrist, psychologist, APN, PA. License #: _____

Name of Examiner: _____
(Print)

Signature: _____ Date: _____ Time: _____

DISCHARGE: I have personally observed and examined this allegedly mentally ill person and have concluded that (s)he is not or is no longer a danger to self or others as a result of mental illness. My opinions and conclusions are based on the following facts and reasons:

I am currently licensed in the state of Nevada as a Physician

Name of Examiner: _____
(Print)

Signature: _____ Date: _____ Time: _____

Page 5 of 5

DPBH IV 1