Brian Sandoval
Governor

Joel A. Dvoskin, Ph.D.
Chair

Hon. Jackie Glass, Ret.
Vice-Chair

Behavioral Health and Wellness Council

Draft Action Minutes

Monday, October 6, 2014, 9:00 a.m.

Meeting Location:
Grant Sawyer State Office Building
555 East Washington Avenue, Room 4401
Las Vegas, NV 89101

Videoconference Location:
Legislative Building
401 South Carson Street, Room 3137
Carson City, NV 89701

Members Present
Joel Dvoskin, Chair
Jackie Glass, Vice-Chair
Sue Gaines
Marilyn Kirkpatrick
Karla Perez
Susan Roske
Michael Roberson
Romaine Gilliland
Randolph Townsend
Richard Whitley
Steven Wolfson
Monte Miller
Doug Gillespie
Dick Steinberg
Tim Burch
Dale Carrison
Pat Hickey
Katherine Miller

Members Absent
Debbie Smith
Michael Kelley-Babbitt

Assisting Staff
Melissa Slayden (Las Vegas)
Christina Griffith (Carson City)

I. Call to order, Welcome, Roll Call, Announcements, Updates
The meeting began at 9:05 a.m. Melissa Slayden called roll, a quorum was noted. Dr. Dvoskin shared that he had attended a meeting of the Southern Nevada Legislative Forum. He announced that Tori Carreon

would be presenting on Governance at the December meeting of the Behavioral Health and Wellness Council. Karla Perez shared that Valley Hospital is on its way to completing construction of the psych unit by November 1st and is set to admit the first patients on December 1st.

II. Public Comment

A. Bob Bennett shared three recommendations with the Council: implement use of trauma screenings, check magnesium levels in patients, and implement the open dialogue program of the Finnish. (Click here for his materials)

B. Dr. David Slattery spoke to the obstacles to taking patients to directly the psychiatric hospitals, namely, the physical exam which could be done in the field by EMS technicians. He asked that the Council recommend a change to the Nevada Revised Statutes allowing for EMS to perform the physicals rather than requiring emergency department physicians to do so. This would stop EMS professionals from being required to take persons in behavioral emergencies, without physical ailments, to the emergency departments at Valley Hospitals. Dr. Dvoskin asked if the requested changes would require additional training for emergency medical personnel. Dr. Slattery confirmed the need for additional training. Dr. Dvoskin asked if there would be no additional cost for the change, and that there would be savings because of a reduction in admissions to emergency departments. Dr. Slattery confirmed that there would be no additional cost and that the real cost savings comes from having patients in the appropriate facility based on individual needs. (Click here for his suggested language change)

C. Dr. Lesley Dickson discussed her concern that outpatient services had not been appropriately addressed by the Council. Seriously Mentally Ill patients who had previously been receiving outpatient care from Northern and Southern Nevada state facilities are now being referred to community, private sector, and non-profit organizations. The services are "just not there" as there are too few psychiatrists and other providers. She also spoke to downcoding, turning away of Medicaid patients because of reimbursement rates, speed of reimbursements, prior authorizations, the refusal of Managed Care Organizations to pay for psychiatric evaluation of emergency department patients, and the lack of competitive salaries at State mental health facilities. (Click here for her materials)

D. Dr. Dave Marlon spoke to three items which concern him. First is the lack of developments in alternative outpatient services (such as outpatient access to medications, psychiatric urgent cares, case management services, short term housing, or crisis management services). Second is the fact that Substance Abuse Prevention and Treatment Agency (SAPTA) providers are now obligated to become providers for managed care and change service delivery models. Finally, managed care organizations are not participating in housing or occupational assistance/placement. He asked that Managed Care and Medicaid be required to appropriately fund all reimbursable services. (Click here for his materials)

I. Approval of August 20, 2014 Meeting Minutes
Motion to Approve: Jackie Glass
2nd: Sue Gaines
Unanimous approval.

II. Presentation and discussion regarding Senior Mental Health
Jane Gruner, Administrator, Aging and Disability Services Division
Dr. Peter S. Reed, PhD, MPH, Sanford Center for Aging
Jeffrey Klein, FACHE, CEO Nevada Senior Services
Susan Hirsch, MSW, Nevada Senior Services

Connie McMullen, Commissioner, Commission on Aging
Sally Ramm, Elder Rights Attorney, Aging and Disability Services Division

Connie McMullen presented on Mental Health and Growing Needs of Seniors. Mrs. McMullen spoke to recognizing the needs for services for seniors, Medicare Improvements for Patients and Providers Act, Medicare changes to mental health access, mental health statistics, the Older Americans Act, current behavioral health services for Nevada seniors, gaps in service and treatment in the Northern and Southern Nevada inpatient and outpatient programs. In Las Vegas Southern Hills Senior Intensive Outpatient Program is the first and only one of its kind to fill in the service gaps with outpatient care and promising results.

Mrs. McMullen highlighted limits to the system:

- Lifetime benefit of 190 days in general hospital, geriatric hospital
- Limited professionals, facilities, housing
- Limited number of professionals trained in geriatrics
- Medicare reimbursement rates are low
- Decline in psychiatrists accepting new patients

She shared these mental health statistics:

- One in four experience a mental health disorder
- 58 million are affected
- Of those 55 and older, 20% suffer from a mental disorder, most commonly anxiety
- There are an estimated 552,000 mental health professionals working in the U.S., which equates to one mental health professional to 564 people

As of January 1, 2014 Medicare does not pay for:

- Environmental intervention
- Geriatric daycare programs
- Individual psychophysiological therapy that incorporates biofeedback training
- Marriage and pastoral counseling
- Report preparation
- Interpretation of explanation of results and data
- Transportation, meals, telephone service

Mrs. McMullen shared her personal experience of watching a family member go through the mental health system in Nevada. She shared that without supportive services, people self-destruct, impacting their families, communities, and caregivers. People with mental illnesses are more likely to self-medicate and attempt suicide. In the case of mentally ill elderly, who are bounced from facility to facility (both in- and out-of-state), individuals can become a law enforcement issue, safety liability, erode capacity, and cost taxpayers. These individuals can become incarcerated or homeless.

Nevada Division of Health Care Financing and Policy: Behaviorally Complex Care Program may open beds for mentally ill, behavioral, dementia elders. This program offers higher reimbursement rates for providers. A wider range of therapists and therapies (with varying levels of training) is needed for service delivery. She indicated that Medicare should pay for coordination between primary care, psychiatrists, psychologists or social workers.

Mrs. McMullen shared these recommendations with the Council:

- In-home mental health screening, counseling for: depression, grief, loss, suicide, family issues, for people who will not participate in an outpatient program.

- Mental health, alcohol, drug screening during intake at senior centers, assessment, review family support.
- Behavioral management, more community education.
- Closer cognitive evaluations, treatment if unavailable.
    - Limited geropsych and geriatric evaluations in North, especially for vascular, and frontotemporal dementia and care.
    - Telemedicine for rural communities, education, transportation options for long commutes.
- Collaborations with mental health professionals in schools, prisons, to increase their role in the community, work with non-profits.
    - Develop crisis intervention programs, work with law enforcement, Multidisciplinary Teams.
    - Medicare pays limited stays, need to be longer periods of treatment, discharge care plans (190 day cap).
- Medicare only covers one depression screening per year. Not adequate. Depression and suicide monitoring, follow-up.
- Medicare does not cover recreational therapies or other modalities.

Dr. Peter Reed presented on Health and Aging. He spoke to the Aging experience, and the complex needs which exist among elders. Depression, anxiety, substance abuse, and suicide, as well as pain and stigma, compromise the wellbeing of seniors. He indicated that as we age we must be able to embrace the supports and services which are available to maintain quality of life until the end of life. Compress morbidity to maintain functionality through the end of life. It is then our prerogative to develop systems to enable folks to age well throughout life. In that way elderhood is a stage of life akin to childhood or adulthood.

Nevada is the second fastest aging state in the country (2000-2010), with a rapidly growing population of elder adults. This growth is occurring at the same time as a rapid decrease in providers. The data showed that this growth is happening primarily in the rural communities. For a rurally centered population with complex needs, telemedicine and rural outreach become very significant.

Alzheimer's Disease is growing at a rapid pace in Nevada. Currently there are 37,000 individuals in Nevada with Alzheimer's Disease. This population is expected to grow by 73% to 64,000 by 2025. Alzheimer's affects a person's physical and cognitive function, as well as causes changes in behavior and personality.

CMS has mandated that skilled nursing homes reduce their use of anti-psychotics by 15% (in 10 years that rate of reduction will be increased to 25%). Dr. Reed explained that antipsychotics really should not be used by dementia patients as they treat the symptoms while masking an underlying condition. Dementia is a shift in perception of the world which needs to be understood by caregivers in order to provide appropriate care. This means that staff needs to change the way they interact with individuals to underlying needs. He reiterated that promoting a sense of wellbeing in care homes can help an individual maintain a quality of life.

The physical and mental health conditions of older adults are very interrelated. As a state we need to develop a system of support and service to enable folks to live the life they want to live. This will have the greatest impact on reducing the costs and reducing the challenges of the complex and multidimensional aspects of aging. In order to achieve that there has to be training for medical providers, neurologists, geriatricians, long-term care providers (at every level), etc. It should be provided to everyone involved in the community (such as law enforcement).

The Nevada State Plan Alzheimer's Task Force has a whole series of recommendations related to training around Alzheimer's disease and cognitive impairment, to inform mental health providers and help us understand behaviors of individuals living with Alzheimer's as the population continues to grow.

Jeff Klein and Susan Hirsch of Nevada Senior Services gave a Senior Mental Health Presentation. Mr. Klein began with behavioral and cognitive health issues for older adults. Seniors do not report their mental and behavioral health issues so the numbers reflected nationally are anywhere from 25-40% off the mark. Seniors do not seek treatment or visit the emergency rooms or hospitals for these issues. Mr. Klein spoke to the difference between those with pre-existing mental health issues or aging into them, and those acquiring behavioral issues secondary to medical frailties, and caregivers who suffer from stress and anxiety.

The current system has not evolved to deal with senior issues in the behavioral and cognitive world. Conditions are typically undiagnosed, under-reported, and untreated. Key behavioral and cognitive health issues for older adults include: mood disorders, depression, anxiety, suicide, cognitive changes, challenging behaviors resulting from dementia (Alzheimer's is the most common type of dementia). Along with these health issues comes medication management. Secondary sufferers to Alzheimer's Disease are the caregivers, who suffer from stress as caregiving takes its toll financially, physically, and emotionally.

Our healthcare system is usually looking for physical symptoms, so the signs and symptoms of depression and anxiety are not recognized. Mr. Klein mentioned the evidence-based tools available which need to be made a part of every doctor training program, which may take regulation change. Nevada is first in senior suicide, 50% see their doctor in one month before attempting suicide. Dr. Dvoskin asked what the Council needed to do. Mr. Klein replied that the tools need to be a regular part of the curriculum for any healthcare professions. Secondly, resources need to be better integrated, such as the online programs and the phone programs for seniors in the community. In the 211 program, Mr. Klein said, the decision tree would have standards to ensure it is understood why a person is calling. Ms. Hirsch reiterated that training for the professionals and paraprofessionals who answer the phones would prepare them to ask the questions and connect callers to the correct resources. Dr. Dvoskin asked that the group bring the suggested language for the 211 training to the Council.

Mr. Klein showed a video: PBS Newshour "War on Alzheimer's" with Meryl Comer which exemplified the issues facing caregivers of people with Alzheimer's.

Ms. Hirsch spoke to cognitive changes and challenges of behavior, the prevalence of the behaviors (listed below), and the Nevada State Plan to Address Alzheimer's Disease. She also spoke to the call to action for each behavior. Ms. Hirsch discussed the fragmented system of care. Dr. Dvoskin asked that Ms. Hirsch speak to Sarah McCrea to have senior issues and resources be included in the expanded CIT training.

Call to action regarding depression and anxiety:

- Increase awareness of warning signs of depression and anxiety
- Assess current availability of specialized mental health care options for older adults; identify gaps in services
- Promote training and implementation of evidence-based protocols to screen, diagnose, and treat mood disorders

Call to action regarding suicide:

- Collaborate with organizations with expertise in suicide prevention to develop public relations and training materials to increase awareness of suicide risk in older adults
- Train health care and mental health professionals to detect, intervene, and manage suicide risk for older adults
- Implement evidence-based screening tools designed to detect risk for suicide in older adults in a variety of health care and community settings

Call to action regarding cognitive changes and challenging behaviors as a result of dementia:

- Implement recommendations of Nevada State Plan to Address Alzheimer's Disease
- Sustain and expand implementation of evidence-based protocols designed to address challenging behaviors
- Provide education and training for health care, mental health and family caregivers to effectively manage cognitive and psychiatric symptoms of dementia

Call to action regarding medication management:

- Increase awareness of medication management issues among health care providers, pharmacists, aging service providers, and caregivers
- Implement evidence-based protocols to increase coordination among healthcare providers and pharmacists to reduce the incidence of medication management issues
- Collaborate with experts in substance abuse to provide education and training on medication misuse an abuse

Call to action regarding caregiving:

- Sustain and expand implementation of evidence-based interventions to support caregivers
- Offer support for AARP's Care Act
- Increase awareness and availability of respite services which offer caregivers a break from responsibilities of caregiving

Sally C. Ramm spoke to guardianship of the elderly. In her testimony she shared her experiences with private citizens who have behavior issues, are arrested, and have no resources for further placement. With guardianship a person has to be deemed unable to care for his/herself and a second person has to come forward to show they can take full responsibility for the needs of the individual. The person under guardianship loses almost all civil rights, and is often moved into a long-term care facility. She shared these critical needs for changes to the system:

- Facilities in which people with a diagnosis of dementia can be placed on both temporary and long-term bases when their behavior is inappropriate for general populations
- Revision of NRS 433.115 to include people who have diseases of the brain other than mental illness, including but not limited to all types of dementia, Parkinson's disease, and stroke. This would allow existing facilities to treat people with behavioral health issues of all kinds; not just those that are considered "mental illness"
- Training of health care providers regarding the unintended consequences of the remarks they put on charts. Once a person is labeled with being a behavioral problem, they are likely to be placed out of state, regardless of the circumstances surrounding the problem or when and how it may be controlled
- Reviewing manner in which long-term care facilities are surveyed by regulators to be certain that the facilities can appropriately medicate persons with behavioral issues without receiving a negative report

Dr. Carrison mentioned Nevada Adult Day Healthcare Centers which are providing services to older adults, such as: podiatry, dental, health education, physical therapy, etc. This could help with medication

management and all sorts of health care needs for seniors.

Mrs. Jane Gruner wrapped up all of the Senior Mental Health presentations with the following integrated recommendations:

- Recommendation #1 - Develop education and training opportunities to assist health care and social service organizations develop strategies to serve older adults with depression and anxiety.

- Recommendation #2 – Provide specialized and practiced training regarding important risk factors for suicide in older adults for primary health care providers, behavioral health providers and social service providers.

- Recommendation #3 – Develop a continuum of care that includes options appropriate to the level of need for individuals experiencing cognitive changes and challenging behaviors resulting from Neurodegenerative illness.

- Recommendation #4 – Develop and implement a medication management protocol specifically for use with older adults.

- Recommendation #5 - Enhance services for caregivers. Care provided by family members and friends is the backbone of long-term care services in the United States.

III. Discussion and Possible recommendations regarding Senior Mental Health
This item was postponed until December.

IV. DBPH, State of the Division presentation and discussion
Dr. Tracey Green, Chief Medical Officer for State of Nevada
Chelsea Szklany, Deputy Administrator, Clinical Services, Division of Public and Behavioral Health (DPBH)
Kelly Wooldridge, Deputy Administrator, Mental Health, Division of Child and Family Services (DCFS)
Dr. Green gave a brief update on the items the State has acted on in response to the May recommendations. There have been no barriers since the August update by Mike Willden. Dr. Green spoke to the Mobile Outreach Safety Team (MOST). On September 16th, Clark County Board approved Spirit and WestCare as the providers of the subgrant. On September 18th a strategic planning meeting was held. A start date of no later than November 17th has been set by Clark County Social Services. Substance Abuse Prevention and Treatment Agency (SAPTA) at DPBH is working with WestCare to maximize Medicaid and managed care reimbursement. DPBH continues to work with WestCare, hospitals, and local government to secure funding. The additional beds at WestCare are targeted for patient use on November 1st. Reimbursable services were discussed, namely sobering centers.

Chelsea Szklany gave an update on Mental Health Court, which currently has 74 individuals enrolled from Southern Nevada Adult Mental Health Services (SNAMHS). The 21 new beds in Building 3A are full and are being maintained at full, even with some discharges.

Kelly Wooldridge reported that every one of the 27 positions, for Mobile Crisis expansion, approved at the June Interim Finance Committee (IFC) has been filled. November 1st training will begin.

V. Department of Health and Human Services, additional opportunities for programs and services that can be funded by Medicaid reimbursement presentation and discussion

Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy
Laurie Squartsoff gave two presentations. She began with Additional Opportunities for Behavioral Health Programs and Services. This presentation covered the Medicaid service expansion overview. She discussed Medicaid service impact, outpatient services, substance abuse, rehabilitative services, and behavioral health services. Dr. Dvoskin asked for clarification on the substance abuse provider information. Some services provided in the past are not reimbursable and some services are not being offered. The providers are at different stages in adapting to the new structure. Mr. Whitley assured the Council that, though moving to the billing environment has been challenging, the Division of Public and Behavioral Health is helping them get there.

In her Update from Nevada Medicaid Highlights 2014 presentation, Mrs. Squartsoff showed the current insurance coverage for Nevadans, eligibility among uninsured non-elderly Nevadans, Medicaid expansion through the Affordable Care Act, growth in caseloads, applications pending, managed care enrollment, and the rise in behavioral health clients with Medicaid. She discussed the statewide access to care issue, as an increased number of Nevadans seek care from the provider pool which has seen no growth. DHCFP and DPBH are working together to increase that provider base.

Mrs. Squartsoff highlighted the changes to the Medicaid program:

- Implementation of Telehealth Expansion
- Advanced Practice Registered Nurses
- Physician Forums with FFS and MCO
- Prior Authorization Alignment between FFS and MCO
- Health Care Guidance Program for high need Fee for Service Recipients
- Increased Inpatient Psychiatric Rate
- Pursuing In Lieu of Option for MCO

VI. Presentations by the Managed Care Organizations

A. Amerigroup

Altamit Lewis and Brian Brooks presented on Amerigroup's Management of Behavioral Health. Amerigroup began with enrollment statistics since September 2013. Membership has grown from 88,469 to 180,456. In Clark County 100% of members live within 25 miles of a contracted behavioral health facility, prescribing provider, and mental health outpatient provider. In Washoe County 99.7% of members are within 25 miles of a contracted facility, 99.8% within 25 miles of a prescribing provider, and 99.8% are within 25 miles of a contracted mental health outpatient provider.

The presenters described their behavioral health networks by county, new member appointments, process flow in emergency departments, and rapid response team in hospital assessments. The Amerigroup presenters described the partnerships they have concerning Behavioral Health, BH Contracting, Case Management, SAPTA Providers, PC-INSITE, and Inpatient Units. The Amerigroup recommendations include:

- Change the L2K form, requiring legislation
- Approval of IMD In Lieu of language
- Observation rate
- Specialized case management needs
- Telemedicine

B. Health Plan of Nevada (HPN)

Michelle Agnew presented Health Plan of Nevada (HPN) Medicaid Overview. She began her

presentation with a year-to-date membership increase of 118,000 across plans. Ms. Agnew described the population of members in the Capitated Provider (with extensive HPN/BHO oversight) and the HPN/BHO managed expansion.

The HPN provider network has shown growth, though many providers do not accept Medicaid due to no-show rates (40%). She explained that there is a shortage of providers and there is a need for a higher reimbursement rate.

HPN's contract with Nevada Medicaid requires that they follow NCQA standards, so no psychiatrist or therapy group has been denied unless the provider did not meet the credentialing requirements. Ms. Agnew described the credentialing purpose, facts, examples of practitioners, and denials.

Ms. Agnew described the provider population, access, and availability. She described challenges that members and providers might face, though training and education could provide a fix for these issues. For members at risk of a no-show solutions have been built, including: group visits, reminder calls, and paying a higher reimbursement to prescribers over the Medicaid fee schedule.

Ms. Agnew gave the Council information on SNAMHS Transfers of the Seriously Mentally Ill success rate, SAPTA provider information, and an update on emergency room assessments. She described the enhancements HPN is making in shifting to the Behavioral Health Home Model, as well as community enhancement ideas.

VII. Discussion regarding presentations on Medicaid reimbursements, Amerigroup, and HPN
This item was not discussed.

VIII. Discussion and possible drafting of recommendations for the December 31 report to the Governor
A. Areas of emphasis:
1. Senior Mental Health
2. Governance
3. Medicaid
4. Children's Mental Health
B. Specific recommendations
C. Drafting the report, responsibilities.
D. Anticipated discussion and approval during the December meeting
These items were not discussed.

IX. Public Comment
Wendy Wood from the office of Steve Shell, CEO of Desert Parkway Behavioral Health Hospital, provided public comment on behalf of Mr. Shell. His recommendation is that changes are made to the State Medicaid Plan to allow free-standing psychiatric hospitals to be reimbursed for ages 21 to 64. Currently the rate is $300 less than the inpatient psychiatric units in medical hospitals. 25 other states have been approved by CMS to allow providers to reimburse the free-standing psych hospitals. This would provide a cost savings to the State and the Federal Government.

X. Adjournment
The meeting adjourned at 4:18 p.m.