MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-first Session
March 2, 2021

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:31 p.m. on Tuesday, March 2, 2021, Online. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Dallas Harris
Senator Joseph P. Hardy
Senator Ben Kieckhefer

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Vickie Polzien, Committee Secretary

OTHERS PRESENT:

DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Stephanie Woodard, Psy.D., Senior Advisor, Division of Public and Behavioral Health, Department of Health and Human Services
Robin Reedy, National Alliance on Mental Illness Nevada
Christopher Rose, Valley Health System Acute Care Hospitals
Taryn Hiatt, American Foundation for Suicide Prevention, Nevada Chapter
Mary Walker, Carson Tahoe Health
Joan Hall, Nevada Rural Hospital Partners
Kimberly Buchholz
Allison Zednicek, CEO, Desert Parkway Behavioral Healthcare Hospital, Las Vegas, Interim CEO, Reno Behavioral Healthcare Hospital
Lea Case, Nevada Psychiatric Association
Steven Cohen

CHAIR RATTI:
I will open the meeting with the work session on Senate Bill (S.B.) 69.

SENATE BILL 69: Revises provisions relating to behavioral health. (BDR 39-431)

MEGAN COMLOSSY (Policy Analyst):
I will read the summary of the bill and the amendments from the work session document (Exhibit B).

CHAIR RATTI:
The representatives of the board and presenters of the bill met and discussed the requests for amendments after the hearing on this bill. The product you have reflects the decisions made. We have a representative from the Washoe County Behavioral Health Policy Board, Clark County Public Defender's Office and myself to answer any clarifying questions.

This is a long bill with multiple lengthy amendments. I would like to move this bill forward and recognize it will be helpful for us, and the public, to see it all in one bill so we can take another look at it. Whether it ends up in the Senate Committee on Finance or goes to the Floor, we want to ensure we are comfortable putting this bill on the desk and giving people time to digest it.

SENATOR HARDY:
I appreciate S.B. 69; however, I am concerned about the "or its successor organization" that is undefined in section 5 on page 2 of the conceptual amendment to S.B. No. 69 and have some disquiet about it. I will be voting no, reserving my right to change my vote on the Floor when I have seen everything come together with the amendments.

SENATOR KIECKHEFER:
I will vote yes for now, reserving my right to change my vote on the Floor when we have seen the full bill. I have concerns on scope of practice and potential overlap and people doing this for compensation.

CHAIR RATTI:
I will entertain a motion on S.B. 69.

> SENATOR HARRIS MOVED TO AMEND AND DO PASS AS AMENDED S.B. 69.

SENATOR SPEARMAN SECONDED THE MOTION.

THE MOTION CARRIED (SENATOR HARDY VOTED NO.)

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CHAIR RATTI:
This bill is not intended in any way to affect family-to-family peer programs where a family member is supporting another family member.

I will open the work session on S.B. 70.

SENATE BILL 70: Revises provisions governing mental health. (BDR 39-418)

MS. COMLOSSY:
I will read the summary of the bill and the amendments from the work session document (Exhibit C).

SENATOR HARDY:
I have concerns on "any other person" mentioned throughout the proposed amendment, Exhibit C, and protecting civil rights. I will be voting no, reserving my right to change my vote on the Floor.

SENATOR KIECKHEFER:
I will be voting yes, reserving my right to change my vote on the Floor.

CHAIR RATTI:
I will entertain a motion on S.B. 70.

SENATOR SPEARMAN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 70.

SENATOR HARRIS SECONDED THE MOTION.

THE MOTION CARRIED (SENATOR HARDY VOTED NO.)

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CHAIR RATTI:
I will open the work session on S.B. 93.

SENATE BILL 93: Revises provisions relating to Medicaid. (BDR 38-193)

MS. COMLOSSY:
I will read the summary of the bill from the work session document (Exhibit D).

CHAIR RATTI:
I will entertain a motion on S.B. 93.

SENATOR KIECKHEFER MOVED TO DO PASS S.B. 93.

SENATOR HARDY SECONDED THE MOTION.

MOTION CARRIED UNANIMOUSLY.

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CHAIR RATTI:
I will open the work session on S.B. 123.

SENATE BILL 123: Revises provisions relating to the Nevada Silver Haired Legislative Forum. (BDR 38-6)

MS. COMLOSSY:
I will read the summary of the bill and the amendments from the work session document (Exhibit E).

CHAIR RATTI:
I will entertain a motion on S.B. 123.

SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED S.B. 123.

SENATOR SPEARMAN SECONDED THE MOTION.

MOTION CARRIED UNANIMOUSLY.

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SENATOR HARRIS:
I will open the hearing on S.B. 156.

SENATE BILL 156: Revises provisions relating to crisis stabilization centers. (BDR 40-488)

SENATOR JULIA RATTI (Senatorial District No. 13):
Senate Bill 156 builds off significant work done in the State, taking a look at how Nevada can modernize our response to a person experiencing a behavioral health crisis. I will share a video about responses to a mental health crisis.

I am excited to bring forward a group of bills that will help the State of Nevada take steps to rebuild our crisis response system and address the needs of a person in a behavioral health crisis. As the video alluded, a person will call 911 and the operator will dispatch police, fire or medical personnel. For many families or an individual experiencing a behavioral health crisis, the person calling does not fit into one of these categories. Starting with work done in Maricopa County in Arizona and in other states across the Nation such Colorado and Oregon, we have begun to adopt and build a specific system designed to address behavioral health.

This has significant overlap between the criminal and social justice reform work we have been tackling as a State, as well as the appropriate behavioral health response. When we roll law enforcement to every, or many behavioral health crises, the person may need a behavioral health professional or peer specifically trained to help. We are asking police to do what they were never designed to do. Rather than continuing down this path, we seek to partner with and train law enforcement, building an appropriate behavioral health response that partners with law enforcement but whenever possible does not include law enforcement.

For many people experiencing a behavioral health crisis, interaction with law enforcement can often be retraumatizing. It is a significant shift in how we think about responding to a behavioral health crisis with four critical elements I will review on the following presentation (Exhibit F).

The model built in Phoenix, Arizona, was picked up by Substance Abuse and Mental Health Services Administration at the national level and is now being distributed as a national best practice. That model has four critical components, the first being a High Tech Crisis Call Center. I will bring forward another bill sponsored by the Health and Human Services Committee that will specifically talk about the work happening around 988, the National Suicide Prevention Hotline, and centralizing behavioral health crises into a separate system with this High Tech Crisis Call Center. Ninety percent of those experiencing a behavioral health crisis in the best practice models are able to be stabilized over the phone through these call centers. The centers have specialists who do air traffic control and are critically important as they know where there may be a mobile crisis team and where a bed may be available in an outpatient treatment program. We immediately lean into the case management necessary to support that person in the immediate crisis and with any follow-up care.

Next is the 24/7 Mobile Crisis unit for the 10 percent of callers who cannot be stabilized over the phone. These teams typically are comprised of a behavioral health specialist and a peer. This is why, to the prior bill S.B. 69, we are spending the time and attention necessary to ensure we are developing our peer workforce since this model is highly dependent on having those peers as part of the response. Someone with lived experience along with a behavioral health professional can be dispatched by the air traffic control system to meet people in the hospital emergency room, on a street corner or in the family's home or wherever necessary to help stabilize that crisis.

Senate Bill 156 specifically addresses the crisis stabilization center. Last Session, the Washoe County Behavioral Health Policy Board brought forward a bill to do licensing for crisis stabilization centers in an effort to help build this model. We learned the language we put together was too narrow by limiting crisis stabilization centers to psychiatric hospitals only, which was not an appropriate approach. This bill seeks to expand the number of agencies that can be considered and pursue endorsements to become crisis stabilization centers. Along with that would be a model to bill Medicaid for those services so we can build the financial model allowing these crisis stabilization programs to become a reality.

That is the meat of this particular bill. It is important the crisis stabilization and all of the components of the crisis stabilization program have these essential principles and practices. These principles include an orientation to recovery, skill

and training in trauma informed care, significant use of peer staff, commitment to zero suicide and suicide safer care principles, safety to consumer and staff, and collaboration with law enforcement so these components get woven through the entire system of care.

In Phoenix, it took 13 years to build this system. We hope to accelerate that; however, there has been a solid two years of ground work laid by Leadership and the Department of Health and Human Services working with the regional behavioral health policy boards. I was invited to Phoenix to see their program in practice which sold me on the fact this is the direction we need to move as a State. The best outcomes will be for patients getting better immediate care and more positive behavioral health crisis response.

Long-term savings could potentially benefit both local governments and the State. This would give the ability to redirect the significant amount of resources law enforcement agencies are spending now toward behavioral health crises back toward public safety and keeping people out of local hospital rooms, which is not good for the patient or our budget.

DuAne Young (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
The goal of S.B. 156 is to modify the positions of Assembly Bill No. 66 of the 80th Session. The removal of the 16-bed requirement would assist in allowing current psychiatric facilities to overcome the burden of creating a hospital within a hospital. Expanding this to acute hospitals will allow them to be endorsed and reimbursed, providing a higher standard of care to individuals already presenting in an emergency room, and these cases would be triaged to the most appropriate level of care.

The Division of Health Care Financing and Policy (DHCFP) met with multiple facilities and hospitals willing to participate in models such as Crisis Now and EmPath if these restrictions are removed, allowing for greater flexibility and a reimbursement mechanism for Medicaid higher than the observation codes. This would allow facilities to provide higher standards of care and recruit and retain more professionals in behavioral health.

STEPHANIE WOODARD, PSY.D. (Senior Advisor, Division of Public and Behavioral Health, Department of Health and Human Services):
Several years ago, the National Association of State Mental Health Program Directors issued a number of policy briefs looking at the need to move beyond beds. The majority of individuals in a behavioral health crisis will, more often than not, end up in an emergency room where they may or may not end up with specialty psychiatric care. Oftentimes, they wait hours, if not days, for an appropriate placement and may not receive a comprehensive evaluation to help determine what level of care they need and match them with the appropriate services.

The living room model is a completely different paradigm. We are talking about a large room enabling people to be actively engaged and one of the reasons the infusion of peers is vitally important. We work with individuals where they are in relation to their crisis, actively engaging them in problem solving and de-escalation. We recognize the need for safety if an individual needs additional support or access to a bed and see this as one of the reasons hospitals need to be able to do this.

Living room models are considered warm and welcoming. There are no staff behind plexiglass windows. The models are designed to invite individuals to engage with treatment providers and peers in meaningful interactions.

SENATOR RATTI:
An important concept of this is a subacute model and is traditionally meant to last 24 hours or less. If people cannot be stabilized in that period of time, the next step would be to put them in an appropriate level of care in an inpatient facility. If they can be stabilized, it ensures they are discharged with a good case management plan, with outpatient care and appropriate medications.

SENATOR KIECKHEFER:
Do you anticipate some of these programs would be built within our existing acute care facilities?

MR. YOUNG:
With the 16-bed requirement, it was not advantageous for hospitals and psychiatric facilities because it is expensive to run a separate 16-bed facility. Striking the language as it is in the bill and allowing acute hospitals would provide a separate area within the hospital without restraints from the bed

count, which would be more flexible for staffing. It would be an area within the hospital. Both the EmPath model and Crisis Now look at separate areas that are more comfortable and conducive to an environment of recovery within the facility. Someone would be moved out the emergency room into this area, triaged appropriately within the first 24 hours, and given an appropriate level of care or plan of safe discharge to return home.

SENATOR KIECKHEFER:
If someone is on a Legal 2000 hold, is that person eligible for placement in a crisis stabilization center?

MS. WOODARD:
It is possible. We would expect that a number of individuals presenting for care in a crisis stabilization unit or center would already be initiated on a Legal 2000 hold. We have found the vast majority of individuals coming in on legal holds do not meet criteria where this is in place. A thorough evaluation can determine if an individual does meet criteria for a legal hold, and the center staff can do the transfer of care whether in their hospital or a hospital within their region, ensuring the individual is placed most appropriately depending upon the need.

SENATOR KIECKHEFER:
Are there security requirements around withholding someone under legal custody?

MS. WOODARD:
This is one of the reasons we want our crisis stabilization units or centers to be in existing hospitals. They must meet a number of safety and security measures, including antiligature for the ability to do seclusion and restraint if necessary. In hospitals or crisis stabilization centers that have used this model, the need for seclusion and restraint is very little. Much of this has to do with not only the philosophy behind the care provided, but the way the staff are trained to engage with individuals in crisis.

SENATOR RATTI:
The important piece to making this successful is the ability to say yes to everyone. Whether it is a Legal 2000 hold, a substance use withdrawal issue or any other type of mental health issue, if law enforcement or a mobile crisis team has brought these individuals to the door, the idea is that it is a very quick turnaround. This lets law enforcement get back to their job, and the crisis

stabilization center is set up to address any concern. Over time, you can train law enforcement to say yes. Other communities have learned you cannot say yes to everyone so individuals are not taken to these crisis stabilization centers. When we start making that decision, we lose the efficacy of the program. They have the capabilities built in and therefore a higher reimbursement rate. Communities have also found they are spending less money on individuals than those sitting in an emergency room.

SENATOR KIECKHEFER:
We are talking about allowing places such as the Mallory Behavioral Health Crisis Center in Carson City to be built within the walls of a larger hospital, is that correct?

SENATOR RATTI:
It could be built within in the walls of a larger hospital but would not have to be, as long as a center can meet the licensing criteria.

MR. YOUNG:
The Mallory Behavioral Health Crisis Center is one of the reasons we asked to bring forth this type of legislation because it did not fit in the existing language. This would allow a center to receive the Medicaid reimbursement.

SENATOR KIECKHEFER:
Is the Mallory Behavioral Health Crisis Center too large, with too many beds?

MR. YOUNG:
No, as it is considered licensed as an acute care hospital, not a free standing psychiatric hospital, it did not qualify. The removal of that language will allow a center to qualify to perform these services even though the staff are performing them without a proper reimbursement.

SENATOR RATTI:
The first version of this bill limited it to psychiatric hospitals.

SENATOR HARDY:
How does this affect, for instance, WestCare. Is that model still allowed under this bill, or does it need to be a hospital, separate and distinct?

SENATOR RATTI:
As for WestCare, or what is created in the *Nevada Revised Statutes* as a crisis triage center, it is not eliminated. The crisis triage centers have evolved differently than anyone had anticipated and have perhaps evolved differently in Clark County than they have in Washoe County. They do not meet the full need of a robust behavioral health crisis stabilization, so we believe this bill is needed in addition to what is happening in care, treatment and services standards.

SENATOR HARRIS:
Homelessness often co-occurs with a mental disorder. Do these stabilization centers need to offer services for those who are homeless and experiencing mental health crises?

SENATOR RATTI:
The experience of other communities has been that individuals experiencing homelessness also experience behavioral health crises. If you have a more appropriate behavioral health response, you have a higher likelihood of helping that individual move away from homelessness and into a more stable situation. However, not every individual experiencing homelessness coming through a crisis stabilization will get housed. Their behavioral health crises will be stabilized. Due to the high tech, high touch air traffic control system and ability to connect them back to their case managers and case management programs embedded into the system, there will be a significant effort to attempt to get them housed. We cannot guarantee everyone getting a crisis stabilized will be ready and willing to go into housing. It does dramatically increase the odds this may happen.

SENATOR HARRIS:
If officers respond, is there any way to be sure they will take individuals to a crisis stabilization center versus jail? Someone may be combative and has assaulted an officer and is taken to jail. Is there some way to ensure when being picked up by an officer the person will end up at one of these centers?

SENATOR RATTI:
Another bill is coming forward where we can dig a little deeper into your question, which is the 988 National Suicide Prevention Hotline. What is important for the crisis stabilization system is there is a strong partnership with law enforcement. A big part of that is working with dispatch and ensuring the appropriate dispatch is happening for every situation. There will be times when

someone experiencing a behavioral health crisis is putting self or others in such a level of danger a public safety response is appropriate. There will be other situations where law enforcement will never be dispatched because there is not a public safety issue. I cannot say there is a once-size-fits-all or guarantee. Where the model works is when you dispatch the right response for what is happening. This is where the learning we need to do with law enforcement, dispatch and behavioral health professionals ensures we are getting the appropriate care to the individual.

ROBIN REEDY (National Alliance on Mental Illness Nevada):
The National Alliance on Mental Illness supports S.B. 156 and the idea of Crisis Now throughout our Nation and in Nevada.

CHRISTOPHER ROSE (Valley Health System Acute Care Hospitals Nevada):
While we appreciate the work done on A.B. No. 66 of the 80th Session, it did limit the kind of hospitals that could provide crisis stabilization services. Senate Bill 156 rectifies that unintended consequence. Valley Health Systems supports S.B. 156.

TARYN HIATT (American Foundation for Suicide Prevention, Nevada Chapter):
To see crisis services be improved and implement access to care, specifically suicide safe care, we know this bill will save lives. The Nevada Chapter of the American Foundation for Suicide Prevention supports S.B. 156.

MARY WALKER (Carson Tahoe Health):
Carson Tahoe Health supports S.B. 156. This bill will incentivize local hospitals to provide crisis stabilization services and is a great way for the State to partner with hospitals to provide these services. It potentially expands access to these critical services throughout Nevada.

JOAN HALL (Nevada Rural Hospital Partners):
Nevada Rural Hospital Partners supports S.B. 156 and licensed hospitals being allowed an endorsement as a crisis stabilization center. We have seen other states successfully use this type of service to increase access to the most beneficial behavioral health care in an appropriate setting. There are several rural and frontier critical access hospitals in Nevada that are interested in providing this type of service.

Section 1, subsection 5, paragraph (b) of the bill requires proof the hospital is accredited by the Commission on Accreditation of Rehabilitation Facilities or the Joint Commission. The majority of critical access hospitals in Nevada are not accredited but rather licensed and certified by the Bureau of Healthcare Quality and Compliance of the Division of Public and Behavioral Health. We hope there is an opportunity to allow these hospitals to receive this endorsement if they meet the requirements in this bill.

KIMBERLY BUCHHOLZ:
I lost a brother to suicide and would appreciate having had more resources for him to able to reach out. If this had been available, he might be alive today. Before the crisis that took his life, he had an interaction with law enforcement, was not sure how to handle the situation and passed from suicide a month later. This is someone who had never had previous interaction with law enforcement. This could be beneficial to our community, and I support S.B. 156.

SENATOR RATTI:
The comments made by Joan Hall regarding the accreditation at the Rural and Frontier hospitals is something we will look into because we want to ensure this model is available in as many Nevada communities as possible.

SENATOR HARRIS:
I will close the hearing on S.B. 156.

VICE CHAIR SPEARMAN:
I will open the hearing on S.B. 154.

SENATE BILL 154: Makes changed related to Medicaid coverage of certain treatments administered at institutions for mental diseases. (BDR 38.451)

SENATOR JULIA RATTI (Senatorial District No. 13):
This is a bill that came out of the Interim Committee on Healthcare focused on behavioral health challenges. Building off the last bill we heard, S.B. 156, it will be wonderful to get to a place where 90 percent of people experiencing a crisis can be stabilized over the phone; another 8 percent or 9 percent stabilized by a mobile crisis team; and another percentage being stabilized in a crisis stabilization center. The truth of the matter is there will still be people in our community, once stabilized, needing beds. They will need beds to pursue their

substance use or mental illness recovery, or it could be a child with a serious emotional disturbance.

One of the barriers that exist in our community could be addressed if we were to apply to Medicaid for a waiver. The 1915(i) waiver we applied for last Session gave us the ability to work with the Centers for Medicare & Medicaid Services (CMS) to do some things around tenancy support and supportive housing. This is the first step in a process allowing us to work with our federal partners build a better model and ensure we have the behavioral health resources we need.

I will review the Institution for Mental Disease (IMD) Exclusion Waiver presentation (Exhibit G), which explains what an IMD waiver is. This is defined as a facility that has 16 or more psychiatric beds, or 50 percent or more of their admissions are for a behavioral health disorder. If you are an IMD, you are excluded from being eligible for Medicaid reimbursement. This means if we want to invest in more beds in these settings, it would be a 100 percent General Fund contribution. We would have to do this all with State dollars. In reality this does not happen, and there is not a business model that works in our community allowing us to get to the number of beds required.

This exclusion from Medicaid reimbursement creates a roadblock for patients experiencing these challenges. The first step to getting rid of this roadblock is S.B. 154. We get caught in a vicious cycle where if the Legislature has not directed Medicaid to apply for a waiver, they do not have the budget authority needed to move forward with that waiver. They cannot figure out how much programs are going to cost without going through an extensive process with the CMS. The budget bill which directs them to apply for the waiver will allow for some analysis to figure out if it makes sense to move forward.

In this case, this is a Medicaid waiver that does allow for Medicaid match to be used in these facilities. It is required to be budget neutral over the course of five years. There are usually some start-up costs and upfront investment required to get these services underway, which is a challenge. Once they are underway, we save money on the backend by diverting people out of emergency rooms and higher-expense services and facilities.

That is the nature of Medicaid waivers and generally how they work. Step one would be to pass S.B. 154. Step two would be the waiver application put

together by the DHCFP, our State Medicaid would go through the extensive process. Over 30 states have done this for substance use disorder treatment, and we are closing in on 10 states that have pending approval for serious mental illness and the emotionally disturbed. After we get the approval, we can start implementing some of this treatment.

The problem is there is not enough access to care for behavioral health, partially due to an improper business model. The waiver to Medicaid would allow us to apply for the IMD waiver and do it differently, proving we can make it budget neutral and be able to seek reimbursement for these facilities known as IMDs.

MR. YOUNG:
In Nevada, only two facilities in the north and one in the south qualify as not meeting the IMD rule. These are all acute hospitals with inpatient psychiatric units. Fee-for-Service Medicaid, which includes seriously and persistently mentally ill individuals within the medically aged, blind and disabled populations, are dependent on these facilities and the two state hospitals.

Over the years, this has created a consistent bottleneck with people waiting for treatment in emergency rooms and facilities. Managed care organizations have up to 15 days per month for crisis care for an individual in an inpatient setting in lieu of more expensive care. This does not account for individuals needing more intensive or longer-term care.

Due to the inability for Nevada to pay, we are without any clinically managed detoxification programs that could treat individuals with any source of Medicaid. The Substance Use Disorder Initiative seeks to supplement current Medicaid and Children's Health Insurance Program State Plan benefits by adding residential and withdrawal management services consistent with the American Society of Addiction Medicine levels 3.1, 3.5 and 3.7. These are levels missing within Nevada's health scope for Medicaid recipients.

Allowing the DHCFP to apply for the 1115 Demonstration Waiver gives the State the flexibility to provide services proving their budget neutrality over the five-year life of the waiver. This can be done by adherence to the robust CMS measurements and standards of neutrality. Nevada's unique position with the support grant allows us to leverage the expertise and guidance we have received and technical assistance and planning.

If we are selected for the Demonstration waiver, it will allow us to utilize the Enhanced Federal Medical Assistance Percentages to cover the administrative cost of waiver development and implementation of this service.

SENATOR RATTI:
From the Health and Human Services policy side, we are asking to endorse the need for beds; the backlog in emergency rooms is not appropriate. There are a lot of fiscal questions in terms of how we get started with the waiver, and we suspect this bill will be pulled into the Finance Committee where we can dig deeper into how this would affect the Medicaid budget specifically.

SENATOR KIECKHEFER:
You stated four states have this waiver, is this correct?

MS. COMLOSSY:
There are two separate waivers. The waiver for substance use disorder services is up to 31 states. The waiver the DHCFP is authorized to apply for, which relates to individuals with serious mental illness or severe emotional disorder, is up to seven states.

SENATOR KIECKHEFER:
Since the number of waivers the DHCFP is authorized to apply for is so low, has it been difficult for states to get their waivers, or is CMS denying waiver applications?

MR. YOUNG:
The CMS has advised states to apply for the substance use disorder waiver first and then use that as a template to apply for the waiver regarding serious mental illness and serious emotional disturbance. This is why those numbers are higher on the substance use disorder side.

SENATOR KIECKHEFER:
So states are making their way into a blind IMD waiver?

MR. YOUNG:
Yes, that is correct.

SENATOR HARRIS:
Section 1, subsection 4, paragraph (b) defines a child with a serious emotional disturbance and exempts mental disorders designated as a Code V disorder in the Manual. Code V disorders are already not mental disorders by definition. There may be some confusion in that wording.

ERIC ROBBINS (Counsel):
I will look into any revisions that may be necessary.

VICE CHAIR SPEARMAN:
Will there be funding to ensure law enforcement is trained in recognizing a mental illness if called to a crisis situation? Will there be anything done so the family called will not end up planning a funeral for the person in crisis?

SENATOR RATTI:
This particular bill is not about crisis intervention. We are well past that intervention with this bill. This person has now been evaluated and offered, or mandated in some cases, to be in a substance use disorder or psychiatric treatment facility and in an inpatient bed. With this bill we are several steps past the call to a law enforcement officer and crisis stabilization.

Senate Bill 156 is about rebuilding the crisis stabilization system. While there is not explicitly money for training law enforcement in that bill, it seeks to not have law enforcement respond at all. Where you reduce the interaction between law enforcement and a person experiencing a behavioral health crisis, you have a behavior health professional and peer with lived experience sent out to handle the crisis. There will be another bill presented introducing the crisis call line and how, who and where we dispatch the calls.

To answer your question, there is no funding in this or any other bills we heard today specifically directed at training for law enforcement, but overall, multiple bills are working on dramatic improvements to crisis response. In most cases, we are trying not to send out law enforcement and ensuring when we do send law enforcement, we have a better outcome.

ALLISON ZEDNICEK, CEO (Desert Parkway Behavioral Healthcare Hospital, Las Vegas, Reno Behavioral Healthcare Hospital):
I support S.B. 154. This bill would increase access exponentially, especially in the north where it is limited. When I am working with our hospital CEOs and

directors of the emergency rooms, the majority of patients remaining are waiting for state beds and on Medicaid. There is a gap in services since we are not able to treat patients and be compensated for Medicaid, often acquiring quite a bit of charity when we have patients with Medicaid. We are also 30 percent less costly than the short-term acute hospitals. In the long run, the IMD would create a cost savings.

This would also help bypass the emergency rooms creating a direct relationship with mobile crisis, metro police officers and all agencies in the north responding to crises in the communities. Our full intention would be to partner and bypass the emergency room with individuals coming directly to us. It allows a more progressive way of thinking as explained by Mr. Young and Dr. Woodard with regard to having additional funding available.

MS. REEDY:
The National Alliance on Mental Illness supports S.B. 154. I will read from my written testimony (Exhibit H).

LEA CASE (Nevada Psychiatric Association):
I echo the comments from the two previous speakers and support S.B. 154.

STEVEN COHEN:
I echo the comments from previous speakers and support S.B. 154.

SENATOR RATTI:
I would like to express gratitude to the Nevada Psychiatric Association who advocated for this bill at the Washoe Regional Behavioral Health Policy Board with the Interim Committee on Health Care. I also thank the Department of Health and Human Services, specifically Mr. Young and Dr. Woodard, for their work on ensuring this bill was viable and something we can move forward.

VICE CHAIR SPEARMAN:
I will close the hearing on S.B. 154 and turn the meeting over to Chair Ratti.

CHAIR RATTI:
As there is no public comment, the meeting is adjourned at 5:04 p.m.

RESPECTFULLY SUBMITTED:

Vickie Polzien,
Committee Secretary

APPROVED BY:

Senator Julia Ratti, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Begins on Page**	**Witness / Entity**	**Description**
	A	1		Agenda
S.B. 69	B	1	Megan Comlossy	Work Session Document
S.B. 70	C	1	Megan Comlossy	Work Session Document
S.B. 93	D	1	Megan Comlossy	Work Session Document
S.B. 123	E	1	Megan Comlossy	Work Session Document
S.B. 156	F	1	Senator Julia Ratti	Crisis Now Deck Presentation
S.B. 154	G	1	Senator Julia Ratti	IMB Exclusion Infographic
S.B. 154	H	1	Robin Reedy / National Alliance on Mental Illness	IMD Exclusion Statement