400 AUTHORITY

In 1965, the 89th Congress added Title XIX of the Social Security Act (SSA) authorizing varying percentages of federal financial participation (FFP) for states that elected to offer medical programs. States must offer the 11 basic required medical services. Two of these are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20). All other mental health and substance abuse services provided in a setting other than an inpatient or outpatient hospital are covered by Medicaid as optional services. Additionally, state Medicaid programs are required to correct or ameliorate defects and physical and mental illnesses and conditions discovered as the result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening for children 21 years or younger, whether or not such services are covered under the state plan (Section 1905(a)).

Other authorities include:

- Section 1902(a)(20) of the SSA (State Provisions for Mental Institution Patients 65 and Older)
- Section 1905(a)(13) of the SSA (Other Diagnostic Screening, Preventative and Rehabilitative Services)
- Section 1905(h) of the SSA (Inpatient Psychiatric Services to Individuals Under Age 21)
- Section 1905(i) of the SSA (Definition of an Institution for Mental Diseases)
- Section 1905(r)(5) of the SSA (Mental Health Services for Children as it relates to EPSDT)
- Section 1947 of the SSA (Qualifying Community-Based Mobile Crisis Intervention Services)
- 42 CFR 435.1009 (2) (Definition of Institution for Mental Diseases (IMD))
- 42 CFR 435.1010 (Definitions Relating to Institutional Status)
- 42 CFR 440.160 (Inpatient Psychiatric Services to Individuals Under Age 21)
- 42 CFR 440.2(a) (Specific Definitions of Services for Inpatient vs. Outpatient)
- 42 CFR 441.150 to 441.156 (Inpatient Psychiatric Services for Individuals under age 21 in Psychiatric Facilities or Programs)
- 42 CFR, Part 482 (Conditions of Participation for Hospitals)
- 42 CFR, Part 483 (Requirements for States and Long-Term Care Facilities)

DRAFT

- 42 CFR, PART 435 (Eligibility in the States, District of Columbia, the Northern Mariana Islands and American Samoa), 440.130 (Definitions relating to institutional status)
- 42 CFR, PART 440 (Services: General Provisions), 440.130 (Diagnostic, screening, preventive and rehabilitative services)
- CMS 2261-P, Centers for Medicare and Medicaid Services (CMS) (Medicaid Program; Coverage for Rehabilitative Services)
- CMS State Medicaid Manual, Chapter 4, Section 4390 (Requirements and Limits applicable to Specific Services (IMD))
- Nevada Revised Statute (NRS), Chapter 629 (Healing Arts Generally)
- NRS 432.B (Protection of Children from Abuse and Neglect)
- NRS, Chapter 630 (Physicians, Physician Assistants and Practitioners of Respiratory Care)
- NRS Chapter 632 (Nursing)
- NRS 433.B.010 to 433.B.350 (Mental Health of Children)
- NRS 433.A.010 to 433.A.750 (Mental Health of Adults)
- NRS 433.704(2) (Mobile Crisis Teams)
- NRS 449 (Medical and other Related Facilities)
- NRS 449.01566 (Peer Support Services Defined)
- NRS 449.0915 (Endorsement of Hospital as a Crisis Stabilization Center)
- NRS 641 (Psychologists)
- NRS 641.A (Marriage and Family Therapists and Clinical Professional Counselors)
- NRS 641B (Social Workers)
- NRS 695C.194 (Provision of Health Care Services to Recipients of Medicaid or enrollees in Children's Health Insurance Program: Requirement for Health Maintenance Organizations (HMOs) to contract with hospitals with endorsements as Crisis Stabilization Centers)
- NRS 695G.320 (Provision of Health Care Services to Recipients of Medicaid or enrollees in Children's Health Insurance Program: Requirement for Managed Care Organizations

DRAFT

(MCOs) to contract with hospitals with endorsements as Crisis Stabilization Centers)

- Nevada State Plan, Section 4.19-A, Page 4
- Nevada Medicaid Inpatient Psychiatric and Substance Abuse Policy, Procedures and Requirements. The Joint Commission Restraint and Seclusion Standards for Behavioral Health.

DRAFT

3. Service Limitations: Recipients may receive a maximum of four hours per day over a three-day period (one occurrence) without prior authorization. Recipients may receive a maximum of three occurrences over a 90-day period without prior authorization.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I to VI	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period

4. Admission Criteria: Clinical documentation must demonstrate that the recipient meets any combination of the following:

   a. Recipient's behavior requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;

   b. Recipient presents a moderate risk of danger to themselves and others (or to deteriorate to this dysfunctional level);

   c. Recipient's immediate behavior is unmanageable by family and/or community members; and/or

   d. Recipient will benefit from the stabilization, continuity of care and the referrals for ongoing community mental and/or behavioral health services.

403.6I MOBILE CRISIS RESPONSE DELIVERED BY DESIGNATED MOBILE CRISIS TEAM

On September 17, 2021, per Section 9813 of the American Rescue Plan Act (ARPA), the Nevada Department of Health and Human Services (DHHS) was awarded a state planning grant by the US Centers for Medicare & Medicaid Services (CMS) to assist in the development and implementation of qualifying community-based mobile crisis intervention services under its Medicaid state plan. In addition, Section 9813 of the ARPA established Section 1947 of the US Social Security Act, which authorizes optional state plan coverage and reimbursement for qualifying mobile crisis intervention services with a temporarily enhanced 85 percent federal medical assistance percentage (FMAP) for 12 quarters during the timeframe of April 2022 to March 2027. Section 1947 also waives standard state plan requirements for statewideness, comparability, and provider choice, in addition to providing definition for qualifying community-based mobile crisis services.

The following policy is contingent upon State Plan Amendment (SPA) approval by CMS.

DRAFT

1. Scope of Services

Nevada shall ensure that Mobile Crisis Response teams respond in person at the location in the community where a crisis arises, or a location agreed upon by the family and Team within a *proposed average response time* of 30 minutes in Clark and Washoe Counties and one hour in the rest of the state. Nevada identifies these Mobile Crisis Response teams that comply with ARPA and the US Social Security Act as Designated Mobile Crisis Teams (DMCT).

The primary objective of this Mobile Crisis Response service is to offer "someone to come" in the crisis continuum, established through Senate Bill 390 (during the 81st Nevada Legislative Session) and subsequent legislation that formulates a comprehensive safety net of crisis services for all Nevadans. DMCTs will respond to an individual in crisis at the individual's location, 24 hours a day, 7 days a week, 365 days a year (24/7/365).

While a crisis episode is not defined outside of the individual experiencing the crisis, the dispatch of a DMCT indicates a higher level of care is needed through an in-person response for the individual's acute episode of crisis. An assessment, including the evaluation of suicidality, is required to be delivered by a qualified and licensed behavioral health professional. The resulting intervention and stabilization of the crisis by the DMCT includes care coordination (through active engagement and "warm hand-off") and follow-up by providers. Care coordination is inclusive of recipients receiving facility-based care as needed, with coordinated transportation to other locations.

2. DMCT Access and Accessibility

a. DMCT services shall be available 24/7/365 for in-person response and ensure 24 hour/7 days per week on-call coverage and back-up availability.

b. DMCT services shall not be restricted to certain locations or days/times within the covered area.

c. DMCTs shall attempt to meet the needs of all Nevadans, with consideration given to the providers' identified catchment area and including specific populations (i.e., Tribal communities and multicultural communities, LGBTQ+, children and adolescents, aging populations, individuals with disabilities, individuals experiencing substance use, etc.)

d. For all DMCT providers, the individual served does not have to be a previous or existing client.

DRAFT

e. Continuity of operations/disaster plans shall comply with State standards per endorsement or credentialing requirements and DHCFP enrollment .

f. DMCTs shall:
   1. Respond to wherever the recipient is in the community outside of a hospital or other facility settings.
   2. Never require the individual in crisis to travel to the DMCT
   3. Respond to the preferred location based on individual in crisis and/or caregiver preference
   4. Respond with the least restrictive means possible, only involving public safety personnel when necessary
   5. DMCTs are expected to respond to dispatch through a designated call center and shall advise the designated call center of any changes to the DMCT's availability (i.e., in the event of self-dispatch to a crisis on-site).

g. DMCTs shall have GPS devices linked to the designated call center(s) and a means of direct communication available at all times with all partners (including the crisis call center, Emergency Medical Services, Law Enforcement, Intensive Crisis Stabilization Service providers, and other community partners), such as a cellular phone or radio for dispatch.

h. DMCTs shall not refuse a request for dispatch unless safety considerations warrant involvement of public safety.
   1. In such cases, DMCTs shall have established standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, medical emergency, and imminent risk of harm).
   2. Policies shall appropriately balance a willingness to help those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., Individuals actively using substances or those with a criminal history).
   ~~3.~~ Ensure all interventions are offered in a clinically appropriate manner that respects the preferences of the individual in crisis and their supportive family systems while recognizing the need to maintain safety.

i. DMCTs shall accept all referrals from a designated call center and respond without reassessing the individual on-site only if the designated call center has completed an initial safety screen and provided the screening information to the DMCT.

j. DMCTs shall use available technology to support care coordination activities and to determine access to available post-crisis care options (e.g., access to health information technology, prior treatment information through crisis including safety plans and psychiatric advance directive (PAD), hospital/provider bed availability, and appointment availability/scheduling).

k. DMCTs shall provide culturally and linguistically appropriate care.

l. Individuals with limited English proficiency or communication/language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary aids, and ADA-compliant services (e.g., sign language interpreters, TTY lines).

m. Services to children and youth up to 18 years old shall adhere to DHHS Division of Child and Family Services system of care core values and guiding principles.

n. DMCTs shall provide timely services to individuals in crisis as defined by state and federal regulations, policy, and/or guidance, including the DMCT Certification Criteria.

4. DMCT OPERATIONAL REQUIREMENTS

a. Inclusive Services

1. Screening

a. DMCTs must establish policies and protocols to ensure:

1. Consistent screening of all individuals, and
2. Documentation of all screenings and screening findings, and
3. Screenings are conducted only by QMHPs and QMHAs who have continuous access to a QMHP for consultation.

b. Selected screening tools must include use of adopted tools for evaluation of risk, violence, and suicidality.

1. Tools chosen must be nationally-accepted or evidenced-based, peer-reviewed tools, and
2. Screening tools include the Columbia Suicide Screening Tool (Columbia) and other tools that meet state requirements.

2. Assessment

DRAFT

a. Mobile crisis teams must ensure a qualified team member (as outline in Provider Qualifications) completes a behavioral health assessment and documents the findings, when indicated.

b. Selected assessments tools must be:

   1. Nationally-accepted or evidenced-based, peer reviewed tools, and

   2. Support evaluations necessary for an involuntary hold, when a hold is initiated

c. Selected assessments tools include the state-required Collaborative Assessment & Management of Suicidality and other tools that meet state requirements.

d. Mobile crisis teams shall establish policies and protocols to ensure:

   1. Consistent application of assessment tools as appropriate to the age of the individual receiving mobile crisis services and the circumstances, and

   2. Documentation of assessment results.

e. Crisis and Safety Plans

   1. Crisis and safety plans shall be shared with the individualand documented in their clinical record, and

   2. As part of the crisis and safety planning, DMCTs must **either** complete an assessment indicating individual is able stay in current placement/location **or** coordinate the transfer of the individual to an appropriate higher level of care.

3. Medical Records

   a. Medical records shall be kept in accordance with documentation standards set forth in MSM Chapter 100 Section and MSM Chapter 400, and

   b. Shared with whomever is providing the services (the follow up provider where the individual is being discharged) to support coordination of care (i.e., triggering words, specific circumstances of individual, etc.)

4. Advance Directives

   1. DMCTs shall establish protocols regarding when to consider and assist with the completion of a Psychiatric Advance Directive (PAD), in accordance with Nevada laws and regulations, and

   2. DMCTs must follow Nevada Medicaid guidance on advance directives, as set forth in MSM 100.

5. Harm Reduction

1. When applicable, DMCTs shall educate individuals on harm reduction practices
2. DMCTs shall carry harm reduction supplies, including Fentanyl test strips
3. Mobile crisis teams shall carry Naloxone and have team members trained on its administration (as specified in Section 403.6I(4)(d) - Provider Training).

6. Family Engagement

   1. Mobile crisis teams shall establish protocols to allow family members or other collateral contacts to represent an individual in crisis.
   2. DMCTs shall follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM 100 Section 103.11

7. Coordination of Care

   a. DMCT providers shall coordinate timely follow-up services and/or referrals with providers, social supports, and other services as needed, including by not limited to

      1. Assigned case managers
      2. Primary Care Providers (PCP)
      3. Existing (or referral) behavioral health providers/care teams, including mental health and substance use disorder (SUD) support, where available
      4. Harm-reduction resources, where available
      5. Appropriately shared information with whomever is providing the services, the follow up provider, to where the individual is being discharged – to support coordination of care (i.e., triggering words, specific circumstances to individual, etc.)

   b. Discharge from episode of care

      1. DMCTs shall document discharge of the individual from the crisis episode in situations where

         a. Acute presentation of the crisis is resolved
         b. Appropriate referral(s) and service engagement(s) to stabilize the crisis are completed, including transfer to a Crisis Stabilization Center (CSC) or other level of

care

c. Ongoing services, supports, and linkages have been recommended and documented

d. Services provided (in-person or via telehealth) up to 72 hours following the initial engagement with the DMCT are considered part of the crisis episode (i.e., pre-discharge)

e. DMCTs may continue to provide bridge services and supports to the individual for up to 45 days for continued stabilization in an outpatient setting; these covered services rendered by enrolled providers after 72 hours shall be billed to the appropriate outpatient billing codes.

8. Telehealth

a. Reference Chapter 3400 related to telehealth modality. The use of telehealth shall be

1. Dictated by client preference

2. Utilized to include additional member(s) of the team not on-site

3. Utilized to provide follow-up services to the individual following an initial encounter with the DMCT

4. Utilized to include highly trained members of the team, such as psychiatrists, psychiatric nurse practitioners or others who can prescribe and/or administer medications.

b. Best Practices – THIS SECTION MAY NOT BE INCLUDED IN FINAL POLICY LANGUAGE AND MAY BE PUBLISHED IN A SEPARATE PROCEDURAL DOCUMENT.

1. An individual in crisis is to be represented in screening/assessment, crisis planning, and follow-up by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning, especially when working with children and youth

2. Reduce duplicative screening and assessments

3. Access and review existing medical records/treatment information when available to support crisis intervention activities (e.g., seeking and leveraging clinical information from an existing crisis or safety plan, if available)

DRAFT

4. Providers are expected to develop and maintain a strengths-based, person-centered, trauma-informed, and culturally sensitive/respectful relationship with the individual

5. Co-creation of a safety/crisis plan, when applicable.

6. Education for the individual on harm reduction practices, when applicable.

7. Regarding Peer-to-Peer Support Services, it is the intent of policy that the DMCT include one team member who is a peer and recovery support services provider, to the greatest extend possible, as Peer Supporters will become mandatory team service providers, certified by DHHS and enrolled with Nevada Medicaid (per SB 390), by July 1, 2026.

c. Privacy and Confidentiality Protocols

1. Policies

a. Providers shall have established/written policies in compliance with State and Federal privacy and confidentiality laws (e.g., Health Insurance Portability and Accountability Act (HIPAA)), as well as established protocols set forth in accordance with MSM Chapter 100, Chapter 400, and Chapter 3300.

2. Training

a. DMCT Clinical Supervision is responsible for the initial and ongoing training of staff on privacy and confidentiality practices and protocols.

3. Collaboration and Data Sharing

a. DMCTs shall establish and maintain privacy and confidentiality policies and procedures to protect beneficiary information in accordance with State and Federal requirements, as well as Department of Health and Human Services (DHHS) oversight requirements.

b. Address what can and cannot be shared, especially in emergency situations.

c. Share screening and assessment information with the receiving clinical/medical provider, including crisis plans and PADs.

d. Develop and implement appropriate data-sharing agreements with partners, ensuring partners are also securing any data covered by State and Federal privacy regulations.

e. Develop data sharing protocols and member information release authorizations to support collaboration practices in accordance with

DRAFT

State and Federal requirements.

f. Have formal, written, collaborative protocols, memorandums of understanding (MOU), and other agreements with community partners, as necessary:

1 Local Law Enforcement agencies

2 Emergency Medical Services (EMS) providers

3 988 crisis lines, designated crisis call centers, and dispatch centers providing service coordination among respondents

4 Medicaid Managed Care Organizations (MCO), as applicable in their catchment area.

d. Excluded Services

1. Services not eligible for reimbursement when rendered by a DMCT under Nevada Medicaid include:

a. Crisis services delivered without a screening or assessment, and/or

b. Crisis services delivered solely via telehealth without the availability of an in-person response to the individual in crisis, and/or

c. Crisis services delivered by one-member teams or one individual provider only, and/or

d. Crisis services delivered by a provider who is not enrolled in Nevada Medicaid at the time service is rendered, and/or

e. Crisis services delivered by a Law Enforcement officer, and/or

f. Crisis services delivered within a hospital or nursing facility setting.

5. DMCT PROVIDER ELIGIBILITY REQUIREMENTS

a. DMCTs must be endorsed or certified by DHHS

b. DMCTs must be Medicaid enrolled providers under Designated Mobile Crisis Team (DMCT) Provider Type 87.

c. DMCTs must include at least two team members, one of which shall be able to deliver the service at the location of the individual in crisis. DMCTs must be led by a Nevada Medicaid-enrolled

1. QMHP-level Independent Professional, or

2. QMHP-level Intern under Direct Supervision of an enrolled QMHP-level Independent Professional, or

d. DMCT members shall fall into one of the following categories:

1. Physician
2. Physician Assistant
3. Advance Practice Registered Nurse (APRN) and Independent Nurse Practitioner (NP) and a focus in psychiatric mental health
4. Psychologist
5. LMFT, LCSW, LCPC, and qualified Post-Graduate Interns (under clinical supervision)
6. Registered Nurse and Qualified Mental Health Associate (QMHA)-level
7. Substance use disorder (SUD) specialists: Licensed clinical alcohol and drug counselors (LCADCs), licensed alcohol and drug counselors (LADCs), certified alcohol and drug counselor (CADCs), and/or associated interns of these specialties (under supervision)
8. Peer Supporter and Qualified Behavioral Aide (QBA)-level

e. Provider Supervision

1. All clinical supervision expectations shall align with existing requirements in Chapter 400 Supervision Standards for an outpatient behavioral health delivery model

2. Real-time clinical consultation and supervision shall be available 24/7/365 to assist the DMCT

3. DMCTs shall have policies and procedures in place for Clinical Supervision, including a staffing plan that identifies the supervisory structure with the employees' names and positions within the agency, and must ensure:

a. Case records are kept updated in accordance with Documentation standards; and

b. Protocols are regularly updated on when and how to engage the on-call clinician in the crisis episode responded to by the DMCT; and

c. Supervisors review in-person or via telehealth the response to crisis episode with all involved QMHA staff, and shall appropriately document the time and content of that supervisory discussion; and

d. The supervisor reviews and co-signs with the rendering QMHA the documented screening within 24 hours or next business day; and

e. Documentation of supervisory contacts with all engaged DMCT supervisee staff, including date of supervisor review, date of observation of individual staff, log of indirect supervision contacts (e.g., paperwork reviewed), as well as date, agenda and action plan for all conferences with supervisee staff; and

DRAFT

f. Each engaged QMHA-level staff has the documented necessary training, competencies, and skills to conduct mental health screens.

f. Provider Training

1. DMCT providers must develop a staff training and competency plan to be reviewed annually as requested by DHHS.
   a. The plan will include all required trainings listed in Chapter 400 Provider Eligibility Requirements and other core competencies defined by the State.
   b. The plan will outline the process for ongoing review of clinical skills and supervision of staff.
2. All engaged DMCT staff shall receive training in the following areas prior to participating in a mobile response to a crisis episode:
   a. Safety/risk screening
      1. Training in safety and risk screening shall include methods to:
         1. Adapt to cultural and linguistic needs of individuals during the screening process; and
         2. Select the appropriate screening tool; and
         3. Engage with collaterals; and
         4. Interpret screening tool results.
   b. Stabilization and verbal de-escalation techniques, including when and how to adjust based on the circumstances of the individual in crisis, the site of the crisis response, and the severity of the situation;
   c. Harm reduction strategies for individuals with SUD should include:
      a. Use of Naloxone in the field; and/or
      b. How to educate individuals at risk (and their significant others) about Naloxone use; and/or
      c. How to educate individuals about harm reduction techniques and resources.
   d. Crisis/safety planning
   e. Appropriate privacy and confidentiality policies and procedures
   f. Use of Telehealth equipment
   g. Electronic health record or other systems utilized in the provision, documentation, and/or reporting of mobile crisis services.
4. All DMCT staff shall receive training on trauma-informed care within 90 days of employment as a DMCT staff
5. All DMCT staff shall receive annual refresher trainings on the training

topics identified in this section

6. All DMCT staff shall demonstrate competency on all post-tests, for each topic in which they have been trained
7. Each training topic shall be covered in separate training modules dedicated to specific topics
8. DMCTs shall maintain documentation to demonstrate satisfactory and timely completion of all required trainings.
   a. When requested by the State, DMCTs must submit training logs, training schedules, and post-test results for endorsement and certification monitoring purposes

6. DMCT RECIPIENT ELIGIBILITY REQUIREMENTS

a. DMCT services are available to all Medicaid eligible individuals who are: 1) outside of a hospital or other facility setting, and 2) experiencing a behavioral health crisis (including mental health and substance use disorder-related crises).

b. Symptoms are indicative of a crisis which requires coordinated clinical response, through the implementation of intervention and stabilization services, for the safety and protection of the individual in crisis and others involved on-site (e.g. harm to self, harm to others, inability to care for oneself).

c. Referral from a designated crisis call center or self-referral by a DMCT.

7. AUTHORIZATION PROCESS AND CLINICAL DOCUMENTATION OF SERVICE

a. Documentation of DMCT service by 1) an enrolled QMHP-level Independent Professional supervising and/or delivering service and 2) at least one additional enrolled team member rendering the intervention/stabilization service on-site.

b. No prior authorization is required for the delivery of services by a DMCT, unless an outpatient service requiring prior authorization (according to service limitations) is delivered in association with but separate from the crisis episode lasting 72 hours.

c. DMCTs shall maintain a daily log of DMCT responses within its catchment area, as dispatched by a crisis call center, and self-dispatched. Log will be made available to DHHS upon request. The log will include up to and including

   1. HIPPA compliant identifier for crisis response episode, and
   2. Date of crisis response episode, and
   3. Start and end time of crisis response episode (for the recipient on that day), and
   4. Mechanism of response (dispatch), and

5. Name and credentials of supervising QMHP-level Independently Licensed provider.

403.6J CRISIS STABLIZATION CENTER

1. Scope of Service: Crisis stabilization is an unplanned, expedited service, to, or on behalf of, an individual to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services, which, if the condition and symptoms are not treated, present an imminent threat to the ~~recipient~~ individualor others, or substantially increase the risk of the ~~recipient~~ individualbecoming gravely disabled.

   Crisis Stabilization Centers (CSCs) are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders) with prompt action, gentle response, and effective support in a respectful environment. CSCs are a no-wrong-door access. CSCs are a short-term, subacute care for recipients which support an individual's stabilization and return to active participation in the community. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose. This model is traditionally meant to last 24 hours or less. If recipients cannot be stabilized in this period, the next step would be to refer them to an appropriate level of care at an inpatient facility. CSCs are part of a continuum of crisis services designed to stabilize and improve symptoms of distress. Recipients who can be stabilized in a CSC are anticipated to be discharged to a lower level of care.

   The primary objective of the crisis stabilization service is to promptly conduct a comprehensive assessment of the individual and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that can be managed at a lower level of care. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated. Crisis stabilization services means behavioral health services designed to:

   a. De-escalate or stabilize a behavioral health crisis, whether this is occurring concurrently with a substance use disorder; and

   b. When appropriate, avoid admission of a patient to another inpatient mental health facility or hospital and connect the patient with providers of ongoing care as appropriate for the unique needs of the patient.

2. Requirements: CSCs must operate in accordance with established administrative protocols, evidenced-based protocols for providing treatment and evidence-based standards for documenting information concerning services rendered to recipients of such

DRAFT

services in accordance with best practices for providing crisis stabilization services. Has a policy structure in place that establishes, including but not limited to:

a. Procedures to ensure that a mental health professional is on-site 24 hours a day, seven days a week;

b. Procedures to ensure that a licensed physician, physician assistant, or psychiatric Advanced Practice Registered Nurse (APRN) is available for consultation to direct care staff 24 hours a day, seven days a week;

c. Procedures to ensure RNs, Licensed Practical Nurses (LPNs), social workers, community health workers, and peer support specialists (as defined per Chapter 449 of the Nevada Revised Statutes) are available to adequately meet the needs of recipients;

d. Procedures to assure that restraint and seclusion are utilized only to the extent necessary to ensure the safety of patients and others;

e. Delivers crisis stabilization services:

   1. To all persons who come in the door, whether as walk-ins or drop-offs from law enforcement or a mobile crisis team.

f. Uses a data management tool to collect and maintain data relating to admissions, discharges, diagnoses, and long-term outcomes for recipients of crisis stabilization services;

g. Operating in accordance with best practices for the delivery of crisis stabilization services, CSCs must include:

   1. Recovery Orientation

      a. In a manner that promotes concepts that are integral to recovery for persons with behavioral health issues, including, without limitation, hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

   2. Trauma-informed care

      a. Many individuals experiencing a behavioral health crisis or substance use disorder have experienced some sort of trauma in the past.

   3. Significant use of peer staff

DRAFT

a. People with lived experience who have something in common with the recipients needing help.

4. Commitment to Zero Suicide/Suicide Safer Care.

5. Strong commitments to safety for consumers/staff.

6. Collaboration with law enforcement.

3. Provider Responsibilities:

a. An endorsement as a CSC must be renewed at the same time as the license to which the endorsement applies. An application to renew an endorsement as a CSC must include, without limitation:

1. Proof that the applicant meets the requirements per NRS 449.0915; and

2. Proof that the hospital is a rural hospital or is accredited by the Commission on Accreditation of Rehabilitation Facilities, the Center for Improvement in Healthcare Quality, DNV GL Healthcare, the Accreditation Commission for Health Care, or the Joint Commission, or their successor organizations.

b. Medical Records: A medical record shall be maintained for each ~~recipient~~ individualand shall contain, including but not limited to the following. Please also consult medical documentation requirements listed in 403.9B(2):

1. An assessment for substance use disorder and co-occurring mental health and substance abuse disorder, including a statement of the circumstances under which the person was brought to the unit and the admission date and time;

2. An evaluation by a mental health professional to include at a minimum:

a. Mental status examination; and

b. Assessment of risk of harm to self, others, or property.

3. Review of the person's current crisis plan;

4. The admission diagnosis and what information the determination was based upon;

DRAFT

5. Coordination with the person's current treatment provider, if applicable;

6. A plan for discharge, including a plan for follow up that includes, but is not limited to:

   a. The name, address, and telephone number of the provider of follow-up services; and

   b. The follow up appointment date and time, if known.

7. The clinical record must contain a crisis stabilization plan developed collaboratively with the ~~recipient~~ individualand/or guardian that includes, but is not limited to:

   a. Strategies and interventions to resolve the crisis in the least restrictive manner possible;

   b. Language that is understandable to the ~~recipient~~ individualand members of the recipient's support system; and

   c. Measurable goals for progress toward resolving the crisis and returning to an optimal level of functioning.

8. If antipsychotic medications are administered, the clinical record must document:

   a. The physician’s attempt to obtain informed consent for antipsychotic medication; and

   b. The reasons why any antipsychotic medication is administered over the recipient's objection or lack of consent.

4. Admission Criteria: Accepts all patients, without regard to:

   a. Race, ethnicity, gender, socioeconomic status, sexual orientation or place of residence of the patient;

   b. Any social conditions that affect the patient;

   c. The ability of the patient to pay; or

   d. Whether the patient is admitted voluntarily to the hospital pursuant to NRS 433A.140 or admitted to the hospital under an emergency admission pursuant to NRS 433A.150;

DRAFT

e. Performs an initial assessment on any patient who presents at the hospital, regardless of the severity of the behavioral health issues that the patient is experiencing.

1. All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. Assessment and stabilization services will be provided by the appropriate staff. If outside services are needed, a referral that corresponds with the recipient's needs shall be made.

2. Has the equipment and personnel necessary to conduct a medical examination of a patient pursuant to NRS 433A.165.

a. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies.

3. Considers whether each patient would be better served by another facility and transfers a patient to another facility when appropriate.

f. Crisis stabilization services that may be provided include but are not limited to:

1. Case management services, including, without limitation, such services to assist patients to obtain housing, food, primary health care and other basic needs;

2. Services to intervene effectively when a behavioral health crisis occurs and address underlying issues that lead to repeated behavioral health crises;

3. Treatment specific to the diagnosis of a patient; and

4. Coordination of aftercare for patients, including, without limitation, at least one follow-up contact with a patient not later than 72 hours after the patient is discharged.

5. Authorization Process:

a. All recipients in a CSC may be rolled over for inpatient admission any time the patient requires acute care services.

b. When transitioning a recipient, documentation should include but is not limited to: outreach efforts to inpatient hospitals including reasons for delays in transitioning

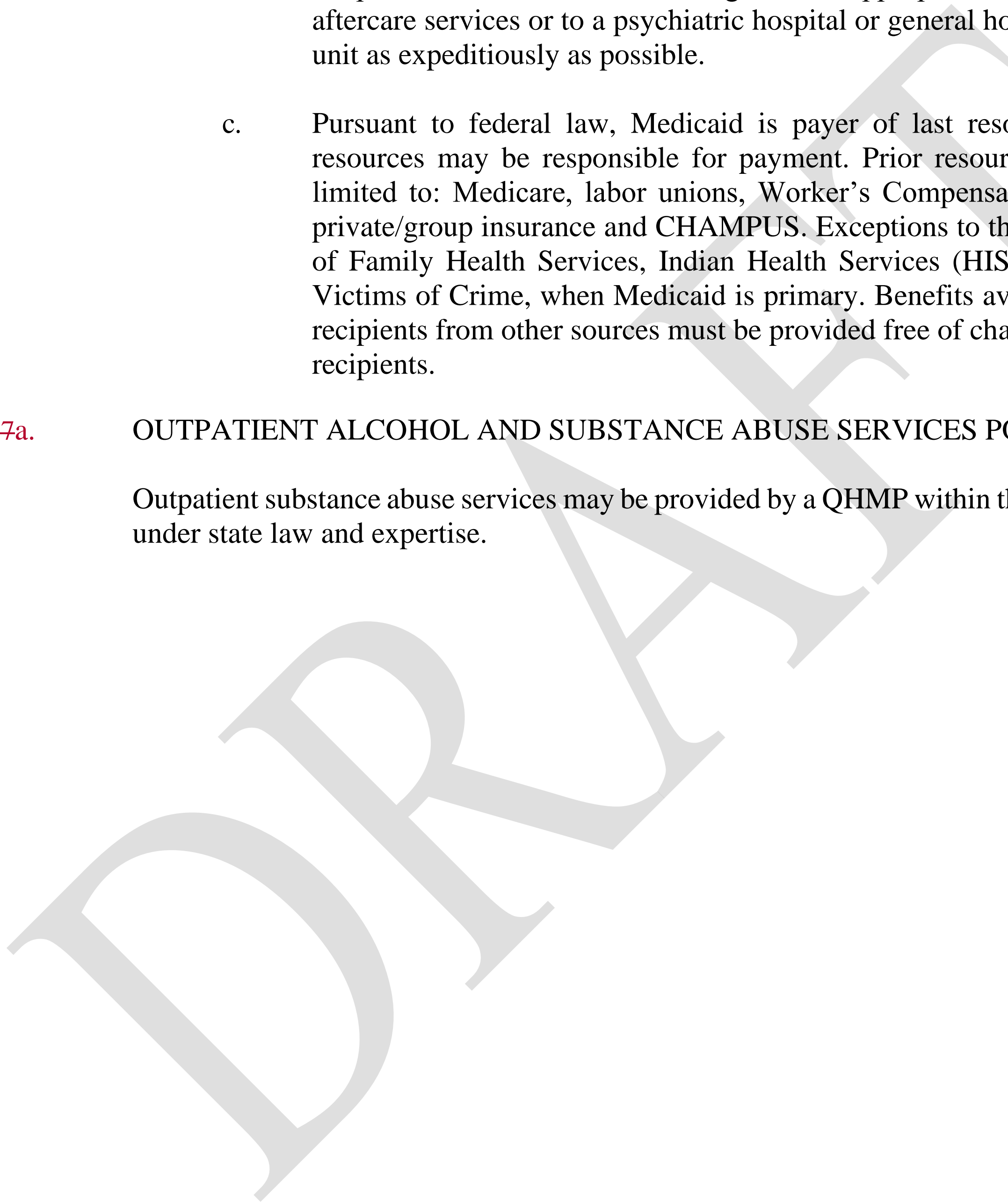
DRAFT

to an inpatient Level of Care, including any denial reasons and/or outreach efforts within the community to establish appropriate aftercare services and reasons for any delay in obtaining this. The CSC must make all efforts to stabilize the recipient's condition and discharge to an appropriate community setting with aftercare services or to a psychiatric hospital or general hospital with a psychiatric unit as expeditiously as possible.

c. Pursuant to federal law, Medicaid is payer of last resort whenever any other resources may be responsible for payment. Prior resources include but are not limited to: Medicare, labor unions, Worker's Compensation Insurance Carriers, private/group insurance and CHAMPUS. Exceptions to this regulation are Bureau of Family Health Services, Indian Health Services (HIS), Ryan White Act and Victims of Crime, when Medicaid is primary. Benefits available free of charge to recipients from other sources must be provided free of charge to Nevada Medicaid recipients.

~~403.7~~a. OUTPATIENT ALCOHOL AND SUBSTANCE ABUSE SERVICES POLICY

Outpatient substance abuse services may be provided by a QHMP within the scope of their practice under state law and expertise.



DRAFT