MEETING NOTES

Statewide Substance Use Response Working Group
Treatment and Recovery Subcommittee Meeting

Tuesday, June 4, 2024
12:00 p.m.

Zoom Meeting ID: 894 8937 5298
No Physical Public Location

Members Present via Zoom or Telephone
Chelsi Cheatom, Dr. Lesley Dickson, Dorothy Edwards, Steve Shell, and Assemblywoman Claire Thomas

Members Absent
Jeffrey Iverson

Social Entrepreneurs, Inc. Support Team
Kelly Marschall and Laura Hale

Office of the Attorney General
Deputy Attorney General Rosalie Bordelove, Dr. Terry Kerns

Members of the Public via Zoom
Tray Abney, Jordan Baez, Lauren Beal, Brandon Beckman, Belz & Case Government Affairs (scribe), Morgan Biaselli (SSGR), Trey Delap, Jennifer Duncan, Abigail Hatefi, Donna Laffey, Olivia Grafmank, Dr. Yoojin Lee-Sedara, Dr. Kelly Morgan, Notetaker Morgan, CL Pearson, Tracie Rogers, Sabrina Schnur

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Shell called the meeting to order at 12:01p.m. Ms. Marschall called the roll and established a quorum.

2. **Public Comment**
   Chair Shell read the statement on public comment and Ms. Marschall provided call-in information. There was no public comment.

3. **Review and Approve Meeting Minutes from May 7, 2024, Treatment and Recovery Subcommittee Meeting**
   - Ms. Edwards made the motion to approve the minutes.
   - Assemblywoman Thomas seconded the motion.
   - The motion carried unanimously.

4. **Update on Bridge Program Implementation in Hospitals in Nevada**
   Dr. Kelly Morgan presented slides (available on SURG website) including a disclosure regarding a State Opioid Response (SOR) 3.0 grant. In addition to having served on the Nevada Hospital Association Bridge program, she is an emergency physician for emergency medical services and the Medical Director for Las Vegas Fire and Rescue. She has worked closely with different Bridge groups, nationally and in Nevada. They have worked on trying to bring peer support specialists (PSS) or peer navigators into emergency departments to link care to outpatient treatment for people using

substances, which is an evidence-based practice, but still in its early stages, and in its absolute infancy in Nevada.

Trac-B Exchange, University Medical Center (UMC), Dignity Health, and Renown have used this practice but were unable to sustain it. The Valley Health system is getting a PSS with plans for a second navigator to help Dr. Morgan with implementation at other hospitals, as well, to increase sustainability. They are trying to increase education and awareness among emergency department (ED) providers for medication assisted treatment (MAT) and buprenorphine (BUP) initiation as an "ED problem" that needs to be addressed themselves.

Issues include sustainability of practice with sufficient reimbursement rates under Medicaid/Medicare to support PSS or navigators who have lived experience and a specific skill set to support these patients relationally. There are no other funding sources currently to incentivize hospitals to provide these services.

A majority of people coming to the ED for substance use disorder (SUD) have lower socioeconomic status, including unhoused populations and they also see a lot of women in early-stage pregnancy before they are connected to an obstetrician.

Hospital administrators support PSS or navigators if they don't have to pay for them, but grant funds run out and sustainable strategies are needed to get long-term support. They try to cross train navigators as community health workers, but most EDs don't have a social worker or case manager 24/7. Safe discharge planning is problematic as well.

Other barriers include background checks for people with lived experience and HIPAA training to access electronic health records, and general access issues within the hospital system, including data tracking and protected information for mental health and SUD.

There needs to be an honest discussion with Medicaid for reimbursement rates and incentives to flow from the hospital down to providers to engage these services similar to what is done with bundled care for other chronic diseases, in person or via telehealth. Service lines for addiction medicine are needed to delineate privileges within hospitals for consultations, palliative care, infectious disease, or other specialties. Navigators could go hand-in-hand with that. Telehealth could break down some of the barriers of staffing affordability or background checks.

Chair Shell realized the benefits of PSS and Navigators when he helped bring Trac-B to the ED at Renown Regional Medical Center; they were very disappointed to lose them. They are now pursuing funding to bring them back with grant funds or philanthropy. He noted that the Empowered program has also been very successful in southern Nevada, and they have recently launched in Northern Nevada. This program works to link pregnant people to care.

Dr. Morgan noted frequent questions related to pregnancy are whether they are drug testing, or how many of the patients they see for SUD know about their pregnancy, or if they are linked to care. Empowered does great work but it's a relatively unknown resource within EDs. Knowledge of the range of resources needs to be facilitated through navigators and/or telehealth, stretching resources in more meaningful ways.

Chair Shell reiterated the issue with background checks being a barrier for a lot of hospitals, noting the Subcommittee members would be discussing this issue later in the agenda.

Assemblywoman Thomas asked if numbers of pregnant people and veterans were identified as part of the data tracking at Dr. Morgan's hospital. Dr. Morgan said this was a questionable issue depending on who is tracking the data and what they are doing with protected information. There are so many layers of security and coding that go into the data system, and they aren't always entered consistently. They don't have mechanisms in place across hospital systems.

Assemblywoman Thomas was very impressed with Dr. Morgan's presentation, and she suggested that Medicaid coverage could help with data collection, taking some of the pressure off the hospitals. Dr. Morgan agreed completely, reiterating the challenge of tracking some of this data within hospital systems, including pregnancy, SUD, allergies, etc. There is no good linkage of communication between hospital systems. Nevada is currently an "opt in state" rather than "opt out state" for the health information exchange (HIE), so every patient must be asked if they want their information included, and to grant consent for their information to be included in the HIE, and the hospital must actively participate. Dr. Morgan thought the Affordable Care Act was intended to institute electronic health records (EHR) to communicate across hospital systems, but that's still not the case. Decisionmakers could require integrated systems in order to get reimbursement and reduce patient harms.

Chair Shell referenced working for the last five years on opening a crisis stabilization center in Washoe County, which is finally launching in the next three months where over 65% of the employed staff will be peer support navigators, included as part of their bundled rate with Medicaid. He is optimistic Medicaid will figure out how to carve out specific reimbursement for peers, but this is a good start. UMC is also now in the process of opening a crisis stabilization center next year.

Dr. Morgan received guidance from the state to tell Medicaid staff what is needed and why, but they need a better understanding of the process for getting onto meeting agendas and what kind of information to provide related to these barriers.

Dr. Dickson referenced legislation requiring meta electronic medical records by 2030, to interact across systems. Dr. Morgan cited federal TEFCA[1] which also supports interoperability. Dr. Dickson reiterated the challenges of treating patients without having complete information.

Chair Shell thanked Dr. Morgan for her presentation.

5. **How Acupuncture Can Help Recovery & Prevention of Substance Use**

Dr. Yoojin Lee-Sedera, Co-founder, Medical Director, Las Vegas Integrative Medicine introduced herself noting that she currently practices both acupuncture and naturopathic medicine, along with multiple other providers who also practice acupuncture. (Slides available on SURG website)

Acupuncture has been practiced in Asian countries for thousands of years as a complete system for the whole body, with yin and yang and connected meridians from head to toe. When the meridians or channels are blocked, pain or health issues occur. Needles are inserted into specific points to unblock the meridians and restore physiological function.

There has been limited access to acupuncture for substance use treatment, but it could be helpful to various special populations with chronic conditions, such as addiction, rather than for acute care. Acupuncture can help the change in brain function or nervous system, by regulating

[1] Trusted Exchange Framework and Common Agreement was expanded under the U.S. Department of Health and Human Services in February 2024. https://www.hhs.gov/about/news/2024/02/12/hhs-expands-tefca-by-adding-two-additional-qhins.html.

neurotransmitters, as cited in studies Dr. Lee-Sedera included on her slides. While drugs may be used to address pain, anxiety, sleep or for recreational purposes, acupuncture is a drug-free source for pain management, stress management, detoxification support, addressing co-occurring conditions, or promoting holistic wellness.

In addition to needing more funding and insurance coverage, more education is also needed around acupuncture. Medicare currently limits coverage to treatment for chronic low back pain and only medical doctors can bill insurance, so they typically have an acupuncturist working under them. In addition, acupuncture is only covered for a limited number of treatments, but chronic issues require ongoing treatment.

These present many hurdles for most small business acupuncture providers and will take time to integrate into federal or other comprehensive systems.

Chair Shell asked Dr. Lee-Sedera if she knew of any commercial payers or managed care organizations that have approved acupuncture around the country, even if on a trial basis.

Dr. Lee-Sedera referenced University Health Center and working with veterans. Each company is different regarding whether referrals are required and whether they are in or out of network. Payment is determined by CPT code coverage, and any reimbursement is limited to only covering overhead costs, so many providers don't take insurance. She would say that acupuncture is more of an art than anything, but insurance companies want protocols for providers, so it's hard to implement the architecture for policies and rules.

Assemblywoman Thomas referenced the cultural environment for needing proof with data on success rates or studies that could be used to support this method. Dr. Lee-Sedera said she has not treated people with serious addiction, but she has some patients with mental health issues, and has also supported patients for smoking cessation. Paying out of pocket would be a big challenge for many of these patients. She will check with her colleagues for possible data or studies on efficacy.

Chair Shell suggested Dr. Lee-Sedera could email any information to Kelly Marschall for distribution to the Subcommittee members.

6. 2023 Presentation Safer Consumption Sites Discussion for 2024

Ms. Marschall reviewed slides (available on SURG website) from Kailin See's 2023 presentation on OnPoint NYC to this subcommittee. The following link was provided after the meeting: Guidelines for Overdose Prevention Centers in New York City (nyc.gov). The full recording for Ms. See's 2023 presentation and related discussion is available on request.

With over 93,000 walk-in patrons, 11,031 resulted in overdose interventions, and only 40 resulted in an ambulance call and ED services. In 68% of the interventions, they didn't need to use naloxone, but were able to revive people with hydration and walking them around.

Dr. Dickson confirmed that naloxone precipitates withdrawal, whereas before naloxone they would work to stimulate people long enough to start clearing the overdose substance. She reviewed various other overdose responses and procedures prior to naloxone. She presumed that the Safer Consumption Sites staff watch for people taking too much substance, but she thought this would be tricky with Fentanyl because it's hard to know what dose they're getting.

Ms. Marschall recalled for Assemblywoman Thomas that OnPoint NYC staff would build relationships in the community by cleaning up parks and picking up syringes to support broader

partnerships. Additionally, they provided data on cost savings to the New York Police Department, as well as EMS, emergency rooms, and hospitals, due to having access to a safe consumption site. The concept of collective responsibility for community safety was promoted along with the visible labor to broker community capital. They were one of the first centers of this kind so there isn't a lot of research, but it is being followed closely.

At the previous meeting of this Subcommittee, Dr. Stephanie Woodard was in attendance and referenced AB 345 and the Clark County Regional Opioid Task Force as possible resources for the Subcommittee members, regarding this topic.

Chair Shell expressed interest in following up with Lisa Lee for possible direction or interest in this concept. Dr. Dickson thought the Southern Nevada Health Department may have some interest in this, but she didn't think the PACT Coalition was interested. She also clarified that while a lot of people inject heroin, they do not inject Fentanyl, but they smoke it to have more control over how much they are using.

Dr. Morgan asked if there had been any thought about utilizing crisis stabilization centers to also provide a safe consumption site or to have one in close proximity. Chair Shell was glad she brought this up and said it was worth exploration.

Ms. Cheatom said Trac-B Exchange was interested in community readiness for this service, so the next steps would be to consider where this could go, or whether it would be utilized. Ms. Edwards supported further exploration of this concept with more information from various partners.

Assemblywoman Thomas reiterated that Assemblyman Ohrentlicher was the primary sponsor of AB345 and Senator Doñate sponsored it for the senate. It went into effect on May 28, 2021. Members agreed to invite Dr. Ohrentlicher to present to the Subcommittee at a future meeting. Ms. Marschall will reach out to him with an invitation and background information.

7. **2024 Subcommittee Recommendations**

Ms. Cheatom reviewed the recommendation she had submitted for the Subcommittee to consider:

- **Recommendation #2:** Support access and linkage for treatment of trauma for people with substance use disorder (SUD) or those who have overdosed and for surviving family members after an overdose fatality. Support training for healthcare professionals to identify and address trauma.
- **Justification:** Treating trauma is an important step in supporting people with SUD and mental health. Trauma -informed treatment would include looking at the effects of violence, adverse childhood experiences (ACES), sexual assault, incarceration, overdose, etc. as well as supporting trauma related care for surviving family members after an overdose or overdose fatality.
    - According to SAMHSA, the impact of child traumatic stress can last well beyond childhood. In fact, research shows that child trauma survivors are more likely to have:
    - Learning problems, including lower grades and more suspensions and expulsions
    - Increased use of health services, including mental health services
    - Increased involvement with the child welfare and juvenile justice systems
    - Long term health problems, such as diabetes and heart disease
    - Trauma is a risk factor for nearly all behavioral health and substance use disorders (https://www.samhsa.gov/child-trauma/recognizing-and-treating-child-traumatic-stress#impact).

- **Research link(s):**
  - https://www.chcs.org/project/advancing-trauma-informed-care/
  - https://www.pacesconnection.com/blog/bad-news-good-news-each-additional-ace-increases-opioid-relapse-rate-by-17-each-ace-informed-treatment-visit-reduces-it-by-2
  - https://www.chcs.org/at-the-front-lines-in-tennessee-rural-clinic-offers-trauma-informed-treatment-for-substance-use-disorder/

- **Possible presenters:** Becky Haas, an ACES trainer, or Dr. Dan Sumrok, a trauma informed care expert.

Chair Shell presented the recommendation he had submitted for the Subcommittee to consider:

- **Recommendation #3:** The Nevada Bureau of Health Care Quality and Compliance should reevaluate the employment guidelines for hospitals, including behavioral health hospitals, to hire certified peer recovery support specialists who have felony backgrounds and are within five years of their last felony conviction. I recommend that individuals who were convicted of drug offenses or other offenses that do not involve violent acts or sexual exploitation be considered for employment as certified peer recovery support specialists in hospitals.
- **Justification:** Individuals who have felony backgrounds have limited opportunities to work as certified peer recovery support specialists in hospitals, including behavioral health hospitals, due to requirements that are set by the Nevada Bureau of Health Care Quality and Compliance. Current requirements do not allow a hospital to hire a peer specialist who has had a felony in the last five years. As a result, this has excluded some peers who are stable and in recovery but are still within the five-year period from their felony conviction. I believe individuals who were convicted of drug offenses or other offenses that do not involve violent acts or sexual exploitation should be considered. In a hospital setting peers would only work under the supervision of a physician, nurse or a therapist and would not be working independently with patients.
- **Research link(s): (**Chair Shell noted there is a lot of research to show efficacy of peer support navigators, particularly in behavioral health hospitals.)
- **Possible presenters:** A representative from the Nevada Bureau of Health Care Quality and Compliance or Division of Public and Behavioral Health.

(See Chat note from Jordan Baez, PRSS)

Dr. Dickson asked if the Bureau of Health Care Quality and Compliance would be able to do this on their own or would it require legislation. Chair Shell agreed that it might require legislation. Assemblywoman Thomas noted the importance of lived experience and didn't understand why there should be a barrier when they are the experts; she supported moving this forward.

Ms. Edwards asked Chair Shell if they were thinking about utilizing PSS at the crisis stabilization center he is working on. If so, was he aware of best practices from other states or other centers where they might have changed any related laws? Chair Shell was aware of other states that do not have as strict requirements as Nevada, although there are some restrictions for violence or sexual exploitation. Dr. Dickson noted this goes along with other movements to reduce penalties for drug use and actually doing away with some of them altogether.

Ms. Marschall suggested the possibility of getting additional presentations before moving a recommendation forward. Chair Shell asked the members to consider each recommendation separately for the next steps.

Recommendation #2 for trauma treatment:

- Dr. Dickson made a motion to move forward.
- Ms. Edwards seconded the motion.
- The motion carried unanimously.

Recommendation #3 for Reevaluation of Employment Guidelines:

- Ms. Edwards made a motion to move forward.
- Dr. Dickson seconded the motion.
- The motion carried unanimously.

8. Presentations and Potential Recommendations for 2024

Ms. Edwards reviewed the recommendation she brought forward at the last Subcommittee meeting, based on input from Michael Barry, for a bill draft request (BDR) to place Narcan in dorms with requisite training for the administration of Narcan. She noted this had been presented to the Washoe Regional Behavioral Health Policy Board previously, but they have not yet made a decision for BDRs with a September deadline.

Ms. Marschall reviewed possible next steps, including follow-up from today's presentations and additional new presentations in August. She will help coordinate the following:

- Dr. Ohrentlicher on AB345 and safe consumption sites;
- Follow up on Dr. Morgan's recommendations;
- Follow up on Dr. Lee-Sedara's recommendations; and
- Follow up on Ms. Edwards's recommendation.

Dr. Dickson asked about getting a presentation from the Bureau of Health Care Quality and Compliance (HCQC) regarding their oversight role for hiring felons in hospital settings. Chair Shell supported learning more about these barriers and whether a legislative change is needed. Ms. Marschall offered to reach out to HCQC staff for a possible presentation.

(See attached copy of email response from Paul Schubert, Bureau Chief, HCQC)

9. Discuss Report Out for July SURG Meeting

(Covered under Item #8)

10. Public Comment

Chair Shell read instructions for public comment and call-in information. There was no public comment.

11. Adjournment

This meeting was adjourned at 1:46 p.m.

Chat File

01:41:05 Jordan Baez: Jordan Baez, Nevada Certification Board PRSS Coordinator. Very interested in the conversation around changing criminal background requirements for Peers. Not sure if I am breaking meeting rules right now (much apologies) and have a 1:30 PM I must get to but please email me at jbaez@casat.org if I can play a role.

June 6, 2024, Email from Paul Schubert, Bureau Chief, Health Care Quality and Compliance

Laura,

Thanks for your inquiry and information about the request from the subcommittee for a presentation. Due to the nature of this issue, I believe distribution of this response should be sufficient as the issue appears to be a statutory prohibition, not a regulatory issue that would allow for variance.

HCQC does not have regulations within our jurisdiction specific to peer recovery support specialists. The statutory requirement for background checks and prohibitions is driving the issue. Any employee or employee of a temporary employment service or independent contractor may not be employed if they have been convicted of a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS, within the immediately preceding 7 years (NRS 449.174).

Under NRS 449.0915 Endorsement of hospital as crisis stabilization center – the hospital may employee a peer recovery specialist to provide peer recovery support services, However, the peer recovery specialist must also meet the background check requirements for hospitals. As always, the most stringent requirement applies.

We (HCQC) cannot change or vary the statutory requirement. So, if the subcommittee has a desire for relief, they would need to approach this legislatively.

Reference:

NRS 449.123 Initial and periodic investigations of employee, employee of temporary employment service or independent contractor of facility, hospital, agency, program or home; penalty.

1. Except as otherwise provided in subsections 2 and 3, within 10 days after hiring an employee, accepting an employee of a temporary employment service or entering into a contract with an independent contractor, the administrator of, or the person licensed to operate a facility, hospital, agency, program or home shall:

(a) Obtain a written statement from the employee, employee of the temporary employment service or independent contractor stating whether he or she has been convicted of any crime listed in NRS 449.174;

(b) Obtain an oral and written confirmation of the information contained in the written statement obtained pursuant to paragraph (a);

(c) Obtain proof that the employee, employee of the temporary employment service or independent contractor holds any required license, permit or certificate;

(d) Obtain from the employee, employee of the temporary employment service or independent contractor one set of fingerprints and a written authorization to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report;

(e) Submit to the Central Repository for Nevada Records of Criminal History the fingerprints obtained pursuant to paragraph (d) to obtain information on the background and personal history of each employee, employee of a temporary employment service or independent contractor to determine whether the person has been convicted of any crime listed in NRS 449.174; and

(f) If an Internet website has been established pursuant to NRS 439.942:

(1) Screen the employee, employee of the temporary employment service or independent contractor using the Internet website. Upon request of the Division, proof that the employee, temporary employee or independent contractor was screened pursuant to this subparagraph must be provided to the Division.

(2) Enter on the Internet website information to be maintained on the website concerning the employee, employee of the temporary employment service or independent contractor.

2. The administrator of, or the person licensed to operate, a facility, hospital, agency, program or home is not required to obtain the information described in subsection 1 from an employee, employee of a temporary employment service or independent contractor if his or her fingerprints have been submitted to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report within the immediately preceding 6 months and the report of the Federal Bureau of Investigation indicated that the employee, employee of the temporary employment service or independent contractor has not been convicted of any crime set forth in NRS 449.174.

3. The administrator of, or the person licensed to operate, a facility, hospital, agency, program or home is not required to obtain the information described in subsection 1, other than the information described in paragraph (c) of subsection 1, from an employee, employee of a temporary employment service or independent contractor if:

(a) The employee, employee of the temporary employment service or independent contractor agrees to allow the administrator of, or the person licensed to operate, a facility, hospital, agency, program or home to receive notice from the Central Repository for Nevada Records of Criminal History regarding any conviction and subsequent conviction of the employee, employee of the temporary employment service or independent contractor of a crime listed in NRS 449.174;

(b) An agency, board or commission that regulates an occupation or profession pursuant to title 54 of NRS or temporary employment service has, within the immediately preceding 5 years, submitted the fingerprints of the employee, employee of the temporary employment service or independent contractor to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and

(c) The report of the Federal Bureau of Investigation indicated that the employee, employee of the temporary employment service or independent contractor has not been convicted of any crime set forth in NRS 449.174.

4. The administrator of, or the person licensed to operate, a facility, hospital, agency, program or home shall ensure that the information concerning the background and personal history of each employee, employee of a temporary employment service or independent contractor who works at the facility, hospital, agency, program or home:

(a) Except as otherwise provided in subsection 2, is completed as soon as practicable, and if residential services are provided to children or the facility is a psychiatric hospital that provides inpatient services to children or a psychiatric residential treatment facility, before the employee, employee of the temporary employment service or independent contractor provides any care or services to a child in the facility, hospital, agency, program or home without supervision; and

(b) At least once every 5 years after the date of the initial investigation.

5. The administrator or person shall, when required:

(a) Obtain one set of fingerprints from the employee, employee of the temporary employment service or independent contractor;

(b) Obtain written authorization from the employee, employee of the temporary employment service or independent contractor to forward the fingerprints obtained pursuant to paragraph (a) to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and

(c) Submit the fingerprints to the Central Repository for Nevada Records of Criminal History or, if the fingerprints were submitted electronically, obtain proof of electronic submission of the fingerprints to the Central Repository for Nevada Records of Criminal History.

6. Upon receiving fingerprints submitted pursuant to this section, the Central Repository for Nevada Records of Criminal History shall determine whether the employee, employee of the temporary employment service or independent contractor has been convicted of a crime listed in NRS 449.174 and immediately inform the Division and the administrator of, or the person licensed to operate, the facility, hospital, agency, program or home at which the person works whether the employee, employee of the temporary employment service or independent contractor has been convicted of such a crime.

7. The Central Repository for Nevada Records of Criminal History may impose a fee upon a facility, hospital, agency, program or home that submits fingerprints pursuant to this section for the reasonable cost of the investigation. The facility, hospital, agency, program or home may recover from the employee or independent contractor whose fingerprints are submitted not more than one-half of the fee imposed by the Central Repository. If the facility, hospital, agency, program or home requires the employee or independent contractor to pay for any part of the fee imposed by the Central Repository, it shall allow the employee or independent contractor to pay the amount through periodic payments. The facility, hospital, agency, program or home may require a temporary employment service which employs a temporary employee whose fingerprints are submitted to pay the fee imposed by the Central Repository. A facility, hospital, agency, program or home shall notify a temporary employment service if a person employed by the temporary employment service is determined to be ineligible to provide services at the facility, hospital, agency, program or home based upon the results of an investigation conducted pursuant to this section.

8. Unless a greater penalty is provided by law, a person who willfully provides a false statement or information in connection with an investigation of the background and personal history of the person pursuant to this section that would disqualify the person from employment, including, without limitation, a conviction of a crime listed in NRS 449.174, is guilty of a misdemeanor.

(Added to NRS by 1997, 442; A 1999, 1946; 2005, 2170; 2009, 504; 2011, 3556; 2013, 2890; 2017, 1902)

Regards,

Paul Shubert

Chief | Bureau of Health Care Quality and Compliance

June 7, 2024, Email from Paul Schubert, Bureau Chief, Health Care Quality and Compliance

HCQC does have some very rudimentary regulations regarding peer recovery support specialists (attached). These regulations authorize DPBH to conduct investigations and allow for petitions regarding convictions related to child sexual abuse, corporal punishment and aversive intervention (Section 5). None of these regulations relieve the licensed health care facility's responsibilities regarding NRS 449.123.

It should also be noted that hospital (in this section, under the heading "Background Investigations" in chapter 449) is defined as follows:

NRS 449.119 "Facility, hospital, agency, program or home" defined. "Facility, hospital, agency, program or home" means an agency to provide personal care services in the home, an employment agency that contracts with persons to provide nonmedical services related to personal care to elderly persons or persons with disabilities in the home, an agency to provide nursing in the home, a community health worker pool, a facility for intermediate care, a facility for skilled nursing, a provider of community-based living arrangement services, a hospital described in 42 U.S.C. § 1395ww(d)(1)(B)(iv), a psychiatric hospital that provides inpatient services to children, a psychiatric residential treatment facility, a residential facility for groups, a program of hospice care, a home for individual residential care, a facility for the care of adults during the day, a facility for hospice care, a nursing pool, the distinct part of a hospital which meets the requirements of a skilled nursing facility or nursing facility pursuant to 42 C.F.R. § 483.5, a hospital that provides swing-bed services as described in 42 C.F.R. § 482.58 or, if residential services are provided to children, a medical facility or facility for the treatment of alcohol or other substance use disorders.