MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Third Session
February 14, 2005

The Committee on Health and Human Services was called to order at 1:30 p.m., on Monday, February 14, 2005. Chairwoman Sheila Leslie presided in Room 3138 of the Legislative Building, Carson City, Nevada, and, via simultaneous videoconference, in Room 4401 of the Grant Sawyer State Office Building, Las Vegas, Nevada. Exhibit A is the Agenda. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Ms. Sheila Leslie, Chairwoman
Ms. Kathy McClain, Vice Chairwoman
Mrs. Sharron Angle
Ms. Susan Gerhardt
Mr. Joe Hardy
Mr. William Horne
Mrs. Ellen Koivisto
Mr. Garn Mabey
Ms. Bonnie Parnell
Ms. Peggy Pierce
Ms. Valerie Weber

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Warren Hardy, Clark County Senatorial District No. 12

STAFF MEMBERS PRESENT:

Barbara Dimmitt, Committee Analyst
Joe Bushek, Committee Attaché

OTHERS PRESENT:

Thom Reilly, Ph.D., County Manager, Clark County, Nevada
Mike Willden, Director, Department of Human Resources, State of Nevada
Carlos Brandenburg, Ph.D., Administrator, Division of Mental Health, Department of Human Resources, State of Nevada
Jackie Glass, Judge, Department 5, Eighth Judicial District Court, Clark County, Nevada
Dan Musgrove, Director, Intergovernmental Relations, Office of the County Manager, Clark County, Nevada
Dick Steinberg, President, WestCare Foundation, Las Vegas, Nevada
Kathryn Landreth, Legal Counsel, Las Vegas Metropolitan Police Department
Vic Davis, Board Member, National Alliance for the Mentally Ill of Northern Nevada
James Osti, Grant Writer, Clark County Health District
Margo Brooks, Vice President, Human Resources Development Institute, Reno, Nevada
Bryan Gresh, Legislative Advocate, representing Nevada State Psychological Association and Clark County Health District
Russell Rowe, Legislative Advocate, representing Focus Property Group, Las Vegas, Nevada
Gary Milliken, Legislative Advocate, representing American Medical Response, Las Vegas, Nevada
Rusty McAllister, Legislative Advocate, representing Professional Firefighters of Nevada, Las Vegas, Nevada
Jack Kim, Legislative Advocate, representing Sierra Health Services and Nevada Association of Health Plans, Las Vegas, Nevada
Bobbette Bond, Legislative Advocate, representing HEREIU Welfare Fund, Las Vegas, Nevada
Bill Welch, President, Nevada Hospital Association, Reno, Nevada
Nicole Lamboley, Legislative Advocate, representing the City of Reno, Nevada
Anne Cory, President, United Way of Northern Nevada, and representing Homeless Coalition of Northern Nevada, Reno, Nevada
Ondra Berry, Deputy Chief, Administrative Division, Reno Police Department, Reno, Nevada
Patrick O'Bryan, Officer, Reno Police Department, Reno, Nevada
Steve Johns, Officer, Reno Police Department, Reno, Nevada
Tom Murtha, CEO, Bristlecone Family Resources, Reno, Nevada
Michael Pennington, Legislative Advocate, representing Reno-Sparks Chamber of Commerce, Reno, Nevada
John Berkich, Assistant County Manager, Washoe County, Nevada

Bunchie Tyler, President, National Alliance for the Mentally Ill of Northern Nevada
Mark Burchell, Vice President, National Alliance for the Mentally Ill of Northern Nevada
Pamela Graham, Chief, Bureau of Licensure and Certification, Health Division, State of Nevada Department of Human Resources
Maria Canfield, Chief, Bureau of Alcohol and Drug Abuse, State of Nevada Department of Human Resources

Chairwoman Leslie:
[Meeting called to order and roll called.] First we have a bill draft introduction that we need to take care of that's been assigned to our Committee.

- BDR 38-175: Repeals certain provisions concerning money provided to counties which are unable to pay nonfederal share of expenses for institutional care of medically indigent persons pursuant to State plan for Medicaid. (Assembly Bill 57)

  ASSEMBLYWOMAN McCLAIN MOVED FOR COMMITTEE INTRODUCTION OF BDR 38-175.

  ASSEMBLYWOMAN PARNELL SECONDED THE MOTION.

  THE MOTION PASSED UNANIMOUSLY.

Chairwoman Leslie:
We'd like to start with Senator Hardy. We won't formally open the hearing on Assembly Bill 40 yet because we have some presentations, but we're honored to have you in our Committee, Senator.

Senator Warren Hardy, Clark County Senatorial District No. 12:
I want to thank you, Madam Chairwoman, for allowing me to participate in this bill, for contacting me, and for taking such a leadership role in an issue that's so significant and important to southern Nevada. I am going to allow Dr. Reilly and others from Clark County to take the lead in explaining the bill and walking you through it.

I do want to just give some general comments in terms of how this has impacted my life. This is something that I've heard from a number of constituents; people who call me regularly on this. This is a crisis and this is a problem, but it came home to my family over the summer. My mother

experienced a medical emergency and had to be taken to the emergency room. My father called the ambulance, got her down there, and I met them. The long process of waiting to get her admitted to the emergency room—and then once we got her into the emergency room, the long wait to get her processed through the system, was disturbing enough to watch my mother go through; but as I was standing there talking to my father, there was a gentleman who was out in the waiting room who had a cardiac arrest incident. When they brought him in to where we were standing and got him in to where they could help him, they were indicating that he wasn't responding; he didn't have a pulse.

[Senator Hardy, continued.] I don't know what happened to that gentleman. I am afraid I watched him die. That is troublesome enough, but what really bothered me was that he had been in that room for 14 hours waiting to get into the emergency room, and that's something I simply cannot live with. I think this may be the most important piece of legislation we deal with this Session as a Legislature. I want to encourage this Committee to process this as soon as possible, get it over to our House so we can put it into effect, and perhaps avoid the kinds of challenges that we had last summer and get over those things. Thank you, Madam Chair, for being part of this legislation, and I want to thank you personally for your leadership on this issue.

Chairwoman Leslie:
I understand Thom Reilly, the Clark County Manager, is in the audience. Thom is going to tell us about the public health emergency that he declared last summer in Clark County.

Thom Reilly, Ph.D., County Manager, Clark County, Nevada:
Thank you for your support and interest in dealing with this public health crisis. On July 9, the forward-looking health district and area hospitals asked me to declare an emergency in Clark County after a third of all our beds in the emergency rooms were occupied by those with mental illness. They had no health emergency, but they are in our emergency rooms waiting to be moved to an appropriate setting to deal with the mental health crisis.

It's important to know that since we declared the emergency on July 9, the situation has not dissipated enough for us to revoke or rescind that. We are still in a state of emergency. Although there have been times when we've gone down to around 50 individuals occupying our beds, at other times we still have a third of the hospital beds occupied, which is a little over 100 individuals who have mental health illness occupying our beds.

[Thom Reilly, continued.] What happened on July 9 exacerbates an issue that was brewing for many months. Within 48 hours of declaring the emergency, thanks to the efforts of the Governor's Office, Department of Human Resources, Health District hospitals, and Clark County Emergency Management Department, a mobilization occurred that was quite remarkable. Working with a subcontractor, WestCare, a 40-bed overflow facility was established. The Department of Human Resources allocated $283,000 in order to establish that 40-bed overflow facility. Each of the hospitals participated, and we reduced the number of individuals who were in the emergency rooms by a significant amount.

Those funds did exhaust on July 23 of that month. The State's response to the public health crisis was to renovate an existing building on West Charleston Boulevard to create a 28-bed overflow facility. Many of you are aware of that because on August 12, the State Human Resources and Mental Health Division came and asked for $1.9 million to establish that 28-bed facility, to hire 50 employees, and other related costs.

I can't emphasize enough that we have not been able to lift this emergency. As Senator Hardy has said, this affects every single citizen in southern Nevada. If I can just put it in perspective, at the University Medical Center, in our emergency rooms, an emergency bed can be cleared in about 2.4 hours. For an individual with mental illness, it takes between 80 and 100 hours. What's happening is that not only are we facing capacity issues in this Valley to begin with, but at times a third of those beds are filled with individuals who stay an extraordinarily long period of time because they don't have the appropriate treatment to deal with their illness.

The work that the Governor has done with the Department of Human Resources has been remarkable. The establishment of a mental health hospital and the related resources and the budget are so encouraging. They have done a fantastic job working with us here in southern Nevada. We are excited about the opportunity in April or May of 2006, when we anticipate opening the new hospital, but there has to be an interim solution. It is critical, and there are two components of this interim solution. One is to establish some type of interim bed capacity, 50 beds or so, through contract, to hold us over until these new beds are built in May 2006. The other is what this bill, A.B. 40, does to fund part of the triage. We've been saying here in southern Nevada that this triage system will fall apart. We've cobbled it together through participation of local area hospitals, local governments, with a third being shared by the State. The hospitals and local governments will pull out; there's no question about it. The impact that will have on this already overburdened system of emergency rooms, I can't fathom.

[Thom Reilly, continued.] I don't know what we would do here in southern Nevada if we're talking about additional individuals who are served through triage and preventing them from even coming to deal with us in the emergency rooms. I know that others are going to talk more in detail about the triage, but this is extremely serious. If we face in this Valley a bus turnover or any type of large emergency, our ability to handle that emergency room is severely compromised. In addition to that, it's not appropriate for people who have mental health illness to have them languishing in emergency rooms without the appropriate treatment. Again, this isn't pointing fingers at anyone. The State has been great; the hospitals have been great; local governments have come up to the plate, but we're in crisis, and we can't wait until May 2006. I do appreciate the Committee taking this issue so early in the Session and giving it your attention.

Chairwomen Leslie:
One thing I'm not clear on, Thom, is that you declared the public health emergency last May. Have you declared that it's over, or is that order in effect indefinitely?

Thom Reilly:
We've attempted at different times to rescind it, but every time we attempt to try that, we're back at 100 beds. In fact, over a month ago we talked about trying to rescind it and see what can be done, but we're back at 100 beds again. So the situation in the Valley isn't much different than it was back when we declared the emergency. It's still here. We're not just doing it for the sake of declaring an emergency. I don't know how to lift it if we never get to a point where we have manageable capacity in our emergency rooms. We basically still have the emergency in effect. I don’t know how to rescind it when we still face the same bed situation.

Chairwoman Leslie:
That's what I thought. Do you have a commitment from the hospitals and local governments to continue with their one-third/one-third share of the funding?

Thom Reilly:
I can't speak for everybody, but I know I can speak for Clark County. We're definitely committed, as is UMC [University Medical Center]. In our conversations with the other local governments and the hospitals, they have been committed, and I think they've shown good faith. They've done that by keeping this going. From the conversations I've had, the other cities are on board. The hospitals have been on board. They'll do everything to keep that coalition together, because it's a unique coalition and I think it is working. We'll do everything in our power to keep local governments and hospitals at the table.

Chairwoman Leslie:
Mike Willden is here. I think the Committee would be interested in knowing the current state this week of the emergency room crisis in Las Vegas.

Assemblyman Hardy:
I'm in support of this, as is my counterpart in the Senate, Senator Hardy.

Mike Willden, Director, Nevada Department of Human Resources, State of Nevada:
With me today is Dr. Carlos Brandenburg, Administrator of the Mental Health and Developmental Services Division. We have handed out a briefing paper (Exhibit B), and there's a packet of attachments on the back of it. If we could, we would briefly run through this attachment, and sort out some of the issues that we see with regard to the mental health crisis. I would agree with Dr. Reilly that it's an ongoing concern.

In the handout, the first thing that we do is provide some basic information about ER [emergency room] waiting times, then there's an attachment of about eight months of history on ER waiting times. I would caution the Committee that you can probably get some different statistics. These are the ER wait beds waiting to come to the State hospitals on the southern Nevada campus. So there are additional mental health patients waiting in ERs, but they're not waiting to come to the southern Nevada mental health campus. As Dr. Reilly indicated, the waiting list to come to our hospital peaked last July at 95, and that number has gone up and down all over the board over the last eight months. The February statistics got as low as 26 people waiting to come, and I think the handout says 64, but I think the high was 71 in February, month to date. So we're still fluctuating all over the board.

Wait times have been as little as 40 hours to as high as 120 hours. That's as they've been cleared. As Dr. Reilly indicated, the wait is 2 or 3 hours to get medical clearance, and then on top of that, 40 to 120 hours to come to the hospital.

The new hospital down south is well under way. We now operate 131 psychiatric beds. The Interim Finance Committee did approve us at 28 beds late last summer/early fall, and that took our capacity to 131 psychiatric beds. That's 26 observation beds, 77 inpatient beds, and 28 step-down beds. Those are the new beds that we added into the system.

The Executive Budget includes staffing and operating costs to increase the bed capacity from 131 beds to 217 beds. That will be done through a combination of the opening of the new 150-bed psychiatric hospital, plus running some

step-down beds, and we have the additional capacity to keep beds open in the old hospital.

[Mike Willden, continued.] We broke ground with the new hospital on February 1. Construction is well under way. We get weekly updates and pictures if you're interested in getting any of those. I also would note that under the psychiatric hospital expansion, you will be hearing about a capital improvement project that will add 40 more beds to the 150-bed hospital that's underway. So, the new hospital has a total capacity of 190 beds, plus we could run the 28 step-down beds, and we have 77 inpatient beds in the old hospital. So if push comes to shove, we would have the capacity to run almost 300 inpatient beds in the State mental health system.

Psychiatric beds in general hospitals are the next topic. I think we've been on the record a number of times indicating that we probably are not going to solve the mental health crisis in the Las Vegas Valley by only building State-operated beds. The State can't afford to build those types of beds on an ongoing basis, so we've been having ongoing dialogue with the hospitals to encourage them to have psychiatric units in their general hospitals. To date, no takers. I haven't seen a proposal yet, although I understand one might be forthcoming soon as to what it might cost, or what it would take in the way of encouragement—Medicaid payment rates—to add some beds in general hospitals.

Why is that important? Generally, the only way we can really get federal funding for the mental health crisis is by running psychiatric beds in general hospitals. We get roughly the fifty-fifty match from the feds on those beds, but we don't get federal match when you're in a free-standing psychiatric hospital or a State-run facility. So it's important for us to keep our eye on that ball long-term.

The triage center often gets confused with a crisis unit or a medical clearance unit. We wanted to spend time today talking about the community triage center. The community triage center is to monitor WestCare's facility. I believe it's on Fourth Street in Las Vegas. That is the proposal that is suggested to be one-third/one-third funded by the state, local government, and the hospitals. I believe that's around a 52-bed facility licensed by the Bureau of Licensing Facilities. BADA [Bureau of Alcohol and Drug Abuse] is basically a social model detox facility, and there is an ongoing discussion about the funding for that. Last session there was a bill to put roughly $700,000 of State funding in that facility per year. We haven't yet worked through a funding mechanism through the State to make that happen. As you may remember, we talked during the Interim Finance Committee process a couple of times and a decision was made not to fund that facility through the Interim Finance Committee process, but to

come back to the Legislature as a whole to make that kind of decision, because the legislation fell through in the 2003 session for that funding.

[Mike Willden, continued.] That facility has obviously been a great help in relieving the overall emergency room crisis in the south, but I don't believe they take any of the high-level, of what we call Legal 2000 patients [process by which a person is hospitalized because they are a danger to themselves and others due to a mental illness.] They're all left for us at the State hospital.

The next issue that I want to raise is the medical clearance options, or crisis unit options. We have talked with the Interim Finance Committee, the committees, and a number of players. These are the kinds of options that we've been exploring for the interim, as to what you'd do until May of 2006 when the new psychiatric facility comes on board. We've had, so far, a number of options we've considered.

The first is just to continue the existing process, where medical clearance is done by the local ERs, and then we wait to bring them to the State hospital and all of the problems attendant with that. The people wait many hours for psychiatric services.

Another option was to have medical clearance done by the State mental health organization, and actually move medical clearance out of the ERs to Dr. Brandenburg's southern campus. That has a pretty healthy price tag associated with it in order to create an ER function or medical clearance function.

The third option we've been exploring with a number of local nonprofits. Some organizations are suggesting they could do medical clearance and run a crisis unit. Other organizations are saying “no, somebody else needs to do the medical clearance, but we would run a crisis unit after medical clearance.” We've had three proposals to date; one from WestCare, Mr. Steinberg's organization that runs the existing CTC [community triage center] has also proposed that they could operate a crisis unit or medical clearance. An organization named Human Resources Development, Inc., put a proposal on the table where they believe they could run what they call an acute care unit. It would not be medical clearance, but it would be an acute care unit after medical clearance, similar to the State hospital. We hadn't had a cost estimate from them until this morning. We do have a cost estimate from them now. It's an annual figure of $32 million. Then we're working with another group led by Dr. Joey Billafore. It sounds funny to say, but at $342 per day it's actually significantly less expensive than we would get almost any place else, if in fact they could provide it for that cost.

[Mike Willden, continued.] Another group, led by Dr. Billafore in Las Vegas, proposed running a 50- to 80-bed medical clearance crisis unit for up to 72 hours for observation, and they have a fiscal note of about $8 million. You can see there's a gamut; there is a proposal as low as $5 million for a 40-bed unit; $32 million for a full-blown 200-plus-bed unit to provide medical care or a clearance/crisis unit. Again, I want to emphasize, do not confuse these proposals with the CTC operation that exists.

We've also been trying to explore long-term additional psychiatric bed capacity. We have a concrete proposal in-house from Monte Vista Hospital. Monte Vista is a free-standing psychiatric hospital for the population we're talking about. They would not be eligible for Medicaid reimbursement, but they have put a proposal together that they would basically contract with us for 8 to 12 inpatient psychiatric beds at a cost of $550 a day per bed. Again, that would just add to the 131 beds that we have now. It would add 8 to 12 more beds while we're waiting for the new psychiatric hospital to come on line—in May of 2006.

We also have a proposal from an organization called Rehabilitation Institutes of Nevada. They're in the process of building a post-acute center facility in southwest Las Vegas, associated with some of the hospitals on that side. As part of that post-acute care unit, they're talking about building a 60- to 90-bed geropsychiatric unit to provide psychiatry for our older citizens. A geropsychiatric unit does not directly help our crisis now, but it adds psychiatric beds to the overall need in the community, and we might talk to them about running something other than a geropsychiatric, running an adult psychiatric unit.

We've had some brief conversations with a nursing facility in Las Vegas called TLC Nursing services, and they are currently evaluating opening a 28-bed inpatient psychiatric unit that they would plan to run ongoing, I would assume, and they are looking at a 90- to 120-day time frame. So there are a number of ways we can go, but from the State's perspective right now, we're running at full capacity every day at 131 beds and doing everything we can to bring the new psychiatric hospital on-line as quickly as possible with the scheduled date of May 2006 for the 150-bed hospital in December 2006 for the additional 40-bed expansion.

Chairwoman Leslie:
Just to recap, by December of 2006, how many beds—state beds—will be available in Las Vegas?

Thom Reilly:
I believe 295, if I do the math right; 190 in the new hospital; 28 step-down beds, and up to 77 in the old hospital.

Chairwoman Leslie:
So, we're going to go from 131 today to 295 at the end of December?

Carlos Brandenburg, Administrator, Division of Mental Health, Department of Human Resources, State of Nevada:
We're going to be going from 131 to 217. We'll have 120 in the new hospital, we'll have 39 that we're going to continue running in the old hospital, we're going to have 28 continued running in Building 1300, and then we'll have 30 running in what we call the psychiatric observation unit in the new hospital for a total of 217. This means that what we're going to actually be bringing on is 86 new beds.

Just for the Committee's edification, we've been tracking this emergency room issue since 2002. In 2003, there were roughly 28 individuals waiting in the emergency room for an average of 45 hours. In 2004, there were over 42 individuals in the emergency room waiting for a total of 61 hours. In 2005 to date, we've got 62 individuals waiting an average of 93 hours. It's extremely important to separate these components, like Director Willden and Dr. Reilly indicated.

There are two separate components to the emergency room problem. Regarding the first one, the data you have (Exhibit B) are for those individuals who are in the emergency room under a form 2000, who have been found to be a danger to themselves and others, who are in the emergency room for medical clearance waiting to come into the psychiatric hospital. With the triage center, those are non-acute mentally ill public inebriants who are also in the emergency room. We don't even track that data; and that data compounds and complicates the emergency room problem in Clark County. The point that Dr. Reilly and Director Willden were making, and it is extremely important, is that the triage is an important component to this issue. The problem that we, as a state, and Las Vegas as a community are going to be facing is that the new hospital doesn't come on-line until May of 2006. With our maximum capacity being 131 beds, what are we going to do between now and May 2006? That's why that other component is not the triage that Director Willden discussed in terms of the beds that we need to have between now and May 2006.

Chairwoman Leslie:
Will there be a need for the new triage center even after the new hospital is open?

Carlos Brandenburg:
Absolutely. As you well know, one of the major gaps in our service delivery system is for those individuals who have co-occurring disorders—those individuals who are not acutely psychotic but have the substance abuse. One of the things that we have been working on with Mr. Steinberg is a relationship between ourselves as a mental health system and those individuals who provide the substance abuse treatment in the community. The triage center is an extremely important piece to our service delivery system because they provide the services to those individuals who have co-occurring disorders who might not be psychotic but need to have some type of treatment, and they're triaged into our system of care. So yes, it's extremely important to have the triage not only now, but in terms of the long-term systems planning. They're an extremely important component of the system.

Assemblywoman Koivisto:
Human Resources Development, Inc. [HRDI] are the ones with the $32 million price tag?

Mike Willden:
That's correct.

Assemblywoman Koivisto:
Is the old VA [Veterans' Administration] Building on MLK [Martin Luther King Boulevard] and Owens Avenue the one that's been condemned, that the VA moved out of?

Mike Willden:
I don't believe it's condemned. There's been discussion with structural issues, but I believe it has a clean bill of health, at least in the discussions I've been in. Yes, the VA, for whatever reason, chose to move out. But I've been in enough meetings where people have said it's got a clean bill of health for certain purposes. I would assume that people looking at that building have engineers looking at it, so I think it has a clean bill of health; and yes, in our discussions with HRDI, that is the building they're looking at leasing and utilizing to run their acute care unit.

Chairwoman Leslie:
A lot of the issues that you described—and thank you for taking the time to lay those out—I think it's important for the Committee to see the whole picture. But a lot of these issues we'll be taking up in the room next door with your budget next Tuesday. So if people are interested in hearing more details in the subcommittee, that would be the place to do it. Is that right?

Carlos Brandenburg:
That's correct. Mental Health will be having their budgets on February 22, and I believe Developmental Services on March 8.

Jackie Glass, Judge, Department 5, Eighth Judicial District Court, Clark County, Nevada:
I'm pleased to present for you today information regarding our mental health court in Clark County. As you already know, the chronic, severely mentally ill are crowding our local jails and lack of State resources and a general misunderstanding of this issue will continue to immobilize our community's response to this problem. The judiciary is the most recent partner in the nationwide attempt to address severe mental illness, as mental health courts have evolved as a recent phenomenon and have only been in existence approximately eight years.

Chairwoman Leslie:
Excuse me, Judge. We're taking up the mental health court bill on Wednesday. Today we're talking about the triage center.

Judge Glass:
I understand that, and I had been informed that we were going to do some education here today, as our part of this relates to keeping the folks that Dr. Brandenburg was just talking about. The people who are having co-occurring disorders are just the kind of people who fit squarely in our mental health courts, which will hopefully go along with what you want to do with the triage centers, to keep them off our streets and out of our emergency rooms. We can help the situation by having some of these people who are out there committing the crimes in our community and not taking their medication go through a program such as ours. But if you would like to wait until Wednesday to hear the remainder of the presentation, I would be happy to do that.

Chairwoman Leslie:
I think that would be appropriate because the Committee will be looking closely at mental health court. If you would like to make some remarks about how the triage fits in with the mental health court and the clients and defendants that you see, please do go ahead.

Judge Glass:
After the last remarks were made regarding the people who are chronically mentally ill and the people who end up in our emergency rooms because they don't take their meds, I turned to Kathryn Landreth from Metro [Las Vegas Metropolitan Police Department] and I said, “That’s exactly the kind of people who are crowding our jails.” We have a significant number of people in our jail

population, much more significant than the general population that are in our jails. Our goal for mental health court is that these folks who we're seeing, many of them are mentally ill first and criminals second. Many with mental illness have an inability to take their meds, they lack resources to get their medication, they lack counseling, therapy, and structure that we're providing through our program to these people. It would also assist the people going through the triage, identifying them and getting them going in the right direction, and getting the help they need. We feel that we are an integral part of this whole process in assisting the community in getting the folks who are chronically mentally ill into the right places, getting them off the streets, and, in our instance, preventing them from crowding our jails and committing more crimes; therefore protecting public safety. So we'll wait to give you the rest of the remarks on Wednesday. I thank you for your time and we are certainly in support of this.

Chairwoman Leslie:
Thank you so much, Judge Glass. We appreciate you being here. Let's go ahead then and formally open the hearing on A.B. 40.

Assembly Bill 40: Makes various changes concerning community triage centers. (BDR 40-905)

Dan Musgrove, Director, Intergovernmental Relations, Office of the County Manager, Clark County, Nevada:
I appreciate so much that this Committee, especially Chairwoman Leslie, has taken such an interest in the issues that happened in southern Nevada. When we first began looking at this problem back in 1999, it was law enforcement and the hospitals that came together, because they both were experiencing such impacts on their facilities. The jails were full of these folks that were just on a revolving cycle in the hospitals, as well. So, remember when you hear the stuff Wednesday that it's the same population of folks. It's the same population going to our hospitals needing to be cleared medically, or it's the same folks that law enforcement is picking up on the streets over and over again. They can only find room in their jails because there isn't a facility for them to go to.

Beginning in the late 1990s and early 2000, a group of those folks came together and began looking at it through a vehicle that we call the Chronic Inebriate Task Force. It was then enveloped into the Southern Nevada Regional Planning Coalition, and all of those folks looked at models across the country and came up with this community triage center loosely based on what

happened in Memphis. We know that there is this population of folks that needs to be cleared out of the emergency rooms and jails and helped to get stabilized.

[Dan Musgrove, continued.] Because of the limited resources that our Valley has in mental health, they're going into crisis all the time because they can't get the appointments they need, they can't get into the hospital, and they can't get the outpatient services that they need. They go into crisis, and they're impacted either by law enforcement or the hospitals. It began as this long process of looking for a solution, and we developed this community triage center. It wasn't me; it was a group led by Kathryn Landreth and Janelle Kraft at Metro, the hospitals, ER physicians, and police. I got involved when the circumstances of the 2003 Session did not turn out positively for us in trying to get it funded.

Basically, the model was that we were going to come up with this community triage center that was going to be funded one-third/one-third/one-third by local governments, the State, and local hospitals, something that has not been repeated anywhere else in the country. Because of the situations of the 2003 session, we were not able to get the State's third share.

For us this crisis has meant trying to keep this facility open. So maybe it's more appropriate for you to understand what community triage does. The best person to do that is Dick Steinberg with WestCare, who stepped up because no one else would do it. We came up with this model of community triage on handling these folks, and Dick's facility stepped in and said, "We can do that."

Dick Steinberg, President, WestCare Foundation, Las Vegas, Nevada:
We've been doing social model detox through the State Bureau of Alcohol and Drug Abuse since 1987, and we were doing a piece of it when the hospital and everybody else were having a lot of problems. We became part of a task force to look at the bigger need that was happening. We were real proud to be part of a system that included all the ER doctors, the paramedics, fire department, law enforcement, and all the different folks who were involved in trying to come up with a plan to make the diversion a little bit better.

We expanded on parts of our initial model with the social model detox, because if we go clear back to the 1981 Legislature here, you passed a small bill then on some liquor tax money to actually start a social model detox for some of the same problems as a much smaller issue. But it was divided up to assist the issues in Washoe County and Clark County and to put a couple of small detox beds in Churchill County and Elko County.

From that it grew, and I think the concerns that we had—have not really been readdressed since that time. There's a small rumor out that Las Vegas grew a

little bit since 1981. We dealt with just two or three hospitals in 1981 to make it happen. We're now talking about 12 hospitals in southern Nevada which have come to the plate. What's been most remarkable for us to be a part of is that I've never seen a whole community—unfortunately it's a crisis that had to bring everybody together—come together, including the hospitals in the four cities, the county, the State, and BADA all stepping up to the plate and working with us in order to work on this crisis.

[Dick Steinberg, continued.] The triage center is really a simple system. We've taken from four or five models across the country to create a system that allows quick evaluation of folks and gets them downgraded as quickly as possible. More importantly, it gets them into a level of care that is more appropriate for their situation than an emergency room. When you're having a mental health crisis, sometimes an emergency room can also exacerbate the problem, and you have a lot of other issues happening because they weren't equipped to handle that.

Dr. Brandenburg was talking about the numbers they have, but the numbers for the triage center haven't been kept in the last 20 or so months. Since this thing has really beefed up, there have been 15,613 people diverted to come in through a different system. That's an amazing number of folks. That's about 4,700 on the kids' side and 10,666 on the adult side. That's also in our model that we put in place, and we took part of this out of Seattle on a project they had. We've also put in a transportation model. There was a piece done about 18 or 20 months back, where it allowed us to do transporting of the people from the emergency rooms after they had been downgraded right back out to us, which then got the paramedics out of the middle of it as well. So we've been able to move people back and forth a lot quicker with this system as well.

The thing that's just amazing to me is the fact that everybody has worked so hard on making this happen. This goes clear back to the committees that came from the Southern Nevada Regional Planning Coalition, and Dr. Hardy at that time was sitting on it as a city council member from Boulder City. I don't know if I should be happy with him or mad at him, but he actually made the motion that it was a good idea to put something like this together and move forward with it; but we've seen it really work.

The amazing piece is that it's becoming somewhat of a national model, if you will, and I don't think anybody thought about that. Most of the time we're going around complaining that we're behind the eight-ball on how to deal with it, but I'm being approached by a lot of people throughout the United States now about how to do this in their communities and the fact that it brought together so many different funding sources to make a system work. It's an accounting

nightmare from our side in making it work in that respect, but it also talks about community partnership and people really come together to take care of a major need.

Chairwoman Leslie:
Dick [Steinberg], do you have any kind of commitment from local government and the hospitals to keep this going? What is the status of the financial commitment?

Dan Musgrove:
I think it might be appropriate that I do, because the one thing we have to understand is that this was our community issue that we actually just subcontracted with WestCare. It's always been our problem to figure out the funding, and to keep WestCare when we had somewhat of a crisis this summer in terms of hospitals not paying and local governments threatening to bail out because they, again, didn't feel it fair that the State had not come through with its share. They were also a bit unhappy with the funding formula. At the present time, we have an inter-local that was entered into in October that is keeping the triage center open for this fiscal year, through June 30 of this year. We determined that we could, by cutting back some of the services of the community triage center, keep it open for $229,000 per month; essentially $2.7 million per year. Right now, the hospitals are funding $108,000 per month, and local government and the state's portion of BADA is approximately $120,000. That funding formula was based on actual use, whereas when we first began the program, we looked at just breaking it up based on population and estimates.

To their credit, the hospitals had some consternation. They felt that they were getting billed unnecessary amounts because they weren't utilizing it. Once we had a track record of how many people had gone through the WestCare facility, we would then be able to build this funding formula that was actually user-driven. The local governments, based on what their police and their ambulances bring to the center, paid for that side of it. We could track the exact number of direct referrals with which the hospitals were sending people out of their ERs and sending them directly to WestCare. We essentially said, “If you're going to use WestCare, you need to pay for it.” And that's the model we use.

I sat down with the CFOs [Chief Financial Officers] of the hospitals, we crunched numbers, and we came up with something that we all agreed to and they all stepped up to fund. It's such a tenuous problem right now, because everyone is looking at everyone else and asking, “Are you going to be at the table?” Granted, the State is probably the number-one entity that we're all

looking at, because we all acknowledge that mental health is a State responsibility, but I believe that this triage is something a little bit different. With all the things that we're asking of the State that Mike Willden and Carlos Brandenburg have put in their budget and the Governor has sent to this Legislature, I think that we can't afford to let this community resource go away.

[Dan Musgrove, continued.] I have commitments from all the hospitals and local governments for this fiscal year up to June 30, but I think it all depends on what the Legislature does as to how we go forward. I think I'm going to have some real tough negotiations beginning in May and June of this year. How we go forward depends on how the State steps up in trying to keep the community triage center open. Honestly, I can't see how anyone would want out. At UMC [University Medical Center] we figure it costs about $2,000 to house that mental health person who's sitting there. That's a very conservative figure. Just do the math on how many people are sitting in each hospital room. The little amount that we ask them to fund is a pittance compared to what they get in terms of being able to get those people out of their ERs and get them sent to either the WestCare facility, or on to the hospital at 6161 West Charleston Boulevard.

Chairwoman Leslie:
Do you want to clarify for the Committee the money that's in A.B. 40, what that's intended to be used for and what the time frame is?

Dan Musgrove:
Absolutely. Because the 2003 Session of the Legislature did not really have the opportunity to vote on community triage as a model, as a concept, the efforts of Interim Finance technically could not happen. So, this $500,000 that was put into the bill is essentially the State's share for the fiscal year that we're in right now. In other words, this is almost a peacekeeping kind of offer by the State and this Legislature to say to the local governments and hospitals, "we agree with community triage; we want to help you get through this final year, essentially, through June 30." The $500,000 would serve as the final two months of payment to keep the triage open. Beginning in the next biennium, we need to work with the Governor and the Legislature Ways and Means and Finance Committees to fund triage going forward. That's what this bill does. It really just appropriates money right now to keep the community triage open.

Chairwoman Leslie:
Just for the record, the Assembly never did have the bill from the last session; it was a bill that died in Senate Finance. We never had the opportunity to hear about community triage and we never voted on it. Just to be very clear, it did not fail in this House; it failed in the other House.

Assemblywoman Angle:
I'd just like to follow up. For two months it is $500,000, is that right?

Dan Musgrove:
Technically, it runs about $229,000 a month, and some of the local governments and hospitals have already put their money up. I think we just picked a number out of the air; really the $500,000 was just something that we thought perhaps the Legislature would appropriate. What I will do, probably, if we do get that appropriation, is figure out some way to build that into the formula for whatever remaining time is left in order to give those of us who have been fronting the State's portion some relief in those final two months. The actual cost per month is $229,000. Granted, a lot of local governments have already appropriated that money. Some of the hospitals, like the Saint Rose Group, paid their money for their entire year up front, they were so committed to the concept of community triage. We're looking to get some of those folks some relief in those final two months. It's all a timing issue as to when we get the money and when I'll try to work out an agreement with the hospitals as part of the MOU [Memorandum of Understanding.]

Chairwoman Leslie:
The bill has a concurrent referral to Ways and Means. If we approve it, it just goes next door and I'm sure those questions will be asked there as well.

Dan Musgrove:
There are so many people who are impacted as part of this. We have folks from fire and rescue, and we have the ambulance companies that are willing to step up and talk about the impacts. Dr. Reilly touched on it in terms of the true impact on all our constituents. The numbers that Dr. Brandenburg talked about are, I think, underestimated, because he's talking about strictly the Legal 2000s [process by which a person is hospitalized because they are a danger to themselves and others due to a mental illness.] When you call up, as I did this morning, we have an EMS [Emergency Medical Service] tracking system that actually looks at how many people are in the emergency rooms who have mental health issues. Not all of those folks need to go to 6161 West Charleston Boulevard [Southern Nevada Mental Health], but they do, necessarily, need to go to WestCare. They need to get out of our emergency rooms, is the bottom line.

On Friday the number was 76, Saturday it was 77, Sunday it went down to 63, and this morning it was 66 people that were in our emergency departments. Dr. Reilly talked about the 2.4 hours that UMC uses as kind of a benchmark for when we could normally clear a bed. If you use Dr. Brandenburg's 90 hours that they're waiting to get cleared, essentially 2,475 of our constituents have not

received timely medical care because they're either waiting or walking into an ER and deciding to turn around and leave and try to wait for an appointment or something like that; those people are sitting in there.

[Dan Musgrove, continued.] Then there's a ripple effect on our ambulance companies and we'll have folks here that can testify to that. It just steamrolls because you have this huge population just sitting there, and without WestCare being there, without room in our mental health hospital, it just stops. The system just shuts down.

Chairwoman Leslie:
As you said, it's hard to be against it. I have a number of people signed in who are in support. If you could make your statement of support brief and have it go to your particular perspective as to why you think this is a good idea, we'd love to hear from you.

Kathryn Landreth, Legal Counsel, Las Vegas Metropolitan Police Department:
I want to thank you for taking the leadership and proposing this very important legislation. I agree with the spokesperson who said that this may well be the most important legislation that we have during this Session to deal with. Funding of a community triage center, with or without secure capability, has been the number-one priority of the coalition for four years, and remains the same. As I have said in previous testimony, in the research done by the Coalition and Las Vegas Metro, we determined we could not find a single other metropolitan community of our size that did not have some kind of triage center available, both for walk-ins for mental health crises and for drop-offs by police, other first responders, and other family members.

I am so pleased to hear the remarks of Judge Glass and also Dr. Brandenburg testifying to the long-term need of a triage center, and that this is quite independent of the building of the new hospital, because we do need a place where, particularly speaking on the behalf of police officers, they're able to drop off people experiencing a mental health crisis. Before we had a triage center, the only options were- to put somebody under a Legal 2000 or take them to jail, because many times they could appropriately be charged with a crime, but the officer knew they didn't really need to be jailed; they needed mental health treatment. The existence of the triage center provides the police officer with a good, effective, and prompt remedy for those cases where the person is more appropriately treated in the mental health system rather than in the criminal justice system.

[Kathryn Landreth, continued.] Over the course of the triage's history, WestCare has accepted slightly over 1,500 people who were brought in by police officers from southern Nevada jurisdictions. It's taken almost another 1,000 directly from emergency medical care providers and over 3,000 individuals who hospitals appropriately transferred to WestCare, getting them out of the emergency department. So this is not only a compelling need for today, for yesterday, but a compelling need for our future.

My sincerest hope, and the hope of Las Vegas Metropolitan Police Department and the Coalition, is that the Legislature will recognize the value of the triage center, and will also see the wisdom in long-term funding, because not only is it a more inexpensive and cost-effective way of addressing the needs of a certain group of people with co-occurring disorders and mental health crises, but it is also a far more humane way than being forced to put them in jail for their protection, or the protection of others.

Assemblywoman Angle:
You mentioned the history of the triage center. Could you go over how long it's been in operation? You mentioned three different sets of treatments, 1,500 patients, 3,000 patients, and 1,000 patients. Is that the total of patients that you've seen, or were those just examples?

Kathryn Landreth:
I'm not perhaps the most familiar with the WestCare operation because I'm not employed by them, but let me explain what I understand those statistics to be. I think that Dick Steinberg, who is the CEO, testified that there have been over 15,000 people served by the triage center since it opened in approximately January, 2003. That number is a little deceptive, because my recollection is that there was a ramp-up period of a few months, so I'm not sure that it got to full capacity and started off at full capacity in 2003. I think 15,000-plus is probably a good figure, but doesn't necessarily represent what the capacity of the organization has been over time.

The numbers that I gave you were specific categories that I think are significant because what law enforcement has wanted to see with a triage center is an alternative, where police officers can take people who are in mental health crises and may have committed a low-level crime that does not require arrest or jailing, and take them to a place where they can have their mental health needs addressed.

We've had individuals who have gone off their medications but were diagnosed, and they knew what their diagnosis was, and they ended up in a bad situation. Perhaps they were in the middle of Fremont Street, which is sometimes a

terribly dangerous place to be in a car, much less as a pedestrian. They'd be standing in the middle of the street obstructing traffic and the police officer, on at least one occasion, was able to take one of these individuals and ask him if he might have a mental health diagnosis, and the individual indicated that he had, but that he had run out of his prescription. So this gentleman was appropriately taken to WestCare, where his diagnosis and his prescription were confirmed, and he was allowed to get back on his treatment, overcome his psychosis, and be back with the public.

[Kathryn Landreth, continued.] We've had other examples where people have been in psychotic delusions, throwing rocks, they haven't hurt anybody but they were in danger of hurting somebody. And again, they had a medical diagnosis, they had run out of their prescriptions, and we took them to WestCare. WestCare was able to confirm their diagnosis, get them back on their prescription, and they were back as a functioning member of society again. So, those are the kinds of cases where the police have the discretion and recognize it's more appropriate to get them the medical attention they need rather than to jail them, recognizing that jail is not a good setting for a person with a mental health problem, and that it doesn't address their long-term needs.

In addition to that, I mentioned that in some cases EMS providers or paramedics are able to determine that a person does not need to be taken to an emergency room but instead, because of their particular symptoms, can be taken to WestCare for treatment. We've also, of course, had hospitals who have determined that they might have a patient in the emergency room who might have been brought in on a Legal 2000, but had a mental health problem that needed to be addressed and that WestCare could adequately address their needs. So there are all different kinds of people who are able to access the WestCare triage center for a variety of different situations.

I wouldn't want to leave out family members as well. Sometimes family members can see that their loved one is not behaving normally, is demonstrating erratic behavior, and in some cases there's already a diagnosis and perhaps they're off their medications. The family member can take the person to WestCare, get diagnosis and treatment, and get them back on the road to good mental health.

Chairwoman Leslie:
That was an excellent answer. I don't see any other questions.

Vic Davis, Board Member, National Alliance for the Mentally Ill of Northern Nevada:

I'd like to say some words from the family perspective and senior perspective. As you heard before, probably the biggest reason the consumers go into crisis is because they're off their medications. The point is that they need to get on their medications as quickly as they can. Down here, it may take up to two weeks for a doctor to see them and get them back on their prescription, and of course by then they've decompensated and they're on their way to the emergency room. I've heard it quoted that about 40 percent of the people who walk into the crisis unit for walk-in get tired of waiting and walk out the door. Again, it's only a matter of time until they're seen. The police are probably our major first responders here in the city.

I give great credit to our CIT officers doing a bang-up job. Our families couldn't be happier with what they're doing. They have two approaches. If they can get a person to volunteer to go to a community triage center, they'll go that route. In a lot of cases they're tending toward violence and their only option is a Legal 2000. What happens then is they'll call for the ambulance, the ambulance is going to take them to the emergency room, and then the ambulance will probably sit at the emergency room while they wait to check him in, being out of service for a long period of time. The second part of this, I don't know how many family support groups I've sat in where family members have complained about having to pay the $600 ambulance bill because they don't want their loved one to get bad credit. They end up paying these kinds of bills two or three times a year.

What's really needed is for a CTC [community triage center] to have the lock-down capability that they have in Memphis. A couple things really happened here that make sense. In the situation where there's a Legal 2000—and these are the people who end up in the emergency room—they used to be able to put them in the car, and drive them directly to the CTC, and basically turn them over in 15 minutes or a half hour and be back out on the street. Avoiding putting these people in the emergency room would eliminate the ambulance cost for the families and would make more ambulances available for critical situations.

This is something that's needed for long-term capability down here. There's no funding in this Session for the medical clearance to go into the hospital down here in southern Nevada. So, the interim program that goes into place needs to be something that will continue for a long time.

James Osti, Grant Writer, Clark County Health District:
[Handed out Exhibit C.] I am in full support of this particular bill. As a former director of the community triage center, I know firsthand the invaluable services that this type of facility provides to all of us. The number of individuals who were taken to the community triage center, who would have gone to the emergency departments, averaged ten persons per day for the entire year of 2004. If you add those ten people to the number at the emergency departments, it would have added the additional length of time necessary to put those people into this system either at Southern Nevada Mental Health or to move them back into the home.

When you move more people into the emergency departments, you slow down the system. This is borne out by some statistics that Dr. Brandenburg presented to the Committee. For each year since 2002, the number of people in the emergency departments has increased. At the same time, the wait times have gone up as well. The latest statistic is that individuals are staying at least 90 hours in a facility in their emergency department.

If we were to add ten people tomorrow to that number, because we'll close the community triage center, it wouldn't be 100 hours or 110. Our best estimate is that it would jump to 120 or 130 hours. Without the community triage center, we would immediately and adversely impact the entire system. We need a valuable service like the community triage center in order just to keep where we are today.

I'd also like to alert the Committee that some of the numbers that have been presented were underestimated. One number that we do have is for the month of January. We had one day through the EM [Emergency Medical] system where 116 people were counted at one time as being in the mental health system. That's 116 people spread through 12 emergency departments in the community.

Had that continued, it would have been a far worse crisis than we suffered back in July when only 102 people were in emergency departments at that particular time using the emergency medical system. We must remember that between July and right now, we've added 28 beds at 6161 Charleston Boulevard in order to decompress the system. So the problem is growing more severe almost on a day-by-day basis. It will continue to grow more severe as new individuals enter the system. We are still one of the fastest growing areas in the United States, and the number of people that move into this community each year also adds to our burden. I would like to encourage the Committee to fully support this bill and to ask for additional resources in order to overcome this particular problem.

Chairwoman Leslie:
We're at the point in this bill where I think we've laid out very clearly what the need is and I think there is general support. So if others would like to get on the record indicating their support and if there's something that we haven't heard, please do add it, but please be brief.

Margo Brooks, Vice President, Human Resources Development Institute, Reno, Nevada:
I'm certainly in support of a community triage center or centers, and what I want to add to this discussion is to suggest that the Legislature really take a look at substantive long-term support and broader support for community triage centers. During the period of the statistics that Dr. Brandenburg gave you earlier, I wondered if anyone really totaled up that number from just July 1, 2004, through January 31, 2005. There were 10,947 patients seen in emergency rooms in a mental health crisis. Only 16 percent of those people were admitted to the southern Nevada adult mental health services. Fourteen percent were incarcerated. In other words, equally as many were incarcerated as were admitted for treatment. What happened to the other 7,755 patients who came through the emergency room?

I know that when Mr. Willden presented HRDI's number of $30 million, there was some shock effect there. However, I think we need to consider that we have a shock effect here in the valley. Currently within the Valley, you have about 8 beds per 100,000 people. The national norm is 40 beds per 100,000. What you will have after you have the new hospital is 16 beds per 100,000. On average, you have more people waiting for beds in this Valley between the period of July and January than are actually even seen in the emergency rooms. HRDI proposes an acute care center similar to the community triage in terms of concept and theory. It will provide 2 to 300 beds for community triage services. And I want to encourage the Legislature to think even broader than what we're now looking at. We're looking at perhaps a band-aid effect on open heart surgery when we have a heart here that's hemorrhaging and we need to look for much broader support.

Bryan Gresh, Legislative Advocate, representing Nevada State Psychological Association and Clark County Health District:
Madam Chair, the remarks will be brief. The support, however, is not. It's deep. It is strong for the bill on behalf of both organizations. As Mr. Osti was testifying, we passed out up here his formal remarks (Exhibit C) to be entered into the record, and of course the Psychological Association would also like to be on record in support of A.B. 40.

Russell Rowe, Legislative Advocate, representing Focus Property Group, Las Vegas, Nevada:
As you know, Focus Property Group is a major master developer in southern Nevada. This bill doesn't impact them directly, but we do know that if we're going to continue the quality of life we have in southern Nevada, with the growth that we're experiencing, we need to begin addressing these types of issues in our valley. It's important to Focus Property Group that we see these types of issues addressed. We're in full support of this legislation.

Chairwoman Leslie:
We appreciate having the business perspective.

Gary Milliken, Legislative Advocate, representing American Medical Response, Las Vegas, Nevada:
I'll give you some statistics, but I'll keep it short. In 2004, I'll refer to them as asterisk patients. AMR [American Medical Response] transported 2,645 psychiatric patients.

Because of the lack of psychiatric beds and the overcrowding within the hospitals, sometimes we waited from 6 to 12 hours to drop these patients off in the emergency room. I think what you have to remember is if we have a psychiatric patient, we continually move to the end of the line. If you have someone in an automobile accident with a severe injury, they go ahead of us. That's why our ambulances are tied up so long in some of these situations.

We think it's very important that you include the medical clearance into the triage. Again, if you don't, we have to take the psychiatric patients to the emergency room for clearance. So if you build the triage and you don't have medical clearance in there, we still take our patients to the emergency room; so they'll still be backed up in that situation. We've had several people discuss costs. For those 2,645 patients we transported in 2004, we billed $1.534 million. We collected $38,000 and we wrote off $1.49 million in bad debt.

Chairwoman Leslie:
We got your point. Thank you very much.

Rusty McAllister, Legislative Advocate, representing Professional Firefighters of Nevada, Las Vegas, Nevada:
I would echo the comments of Mr. Milliken. We're in support of A.B. 40 for the same reasons. Basically, once you tie up an ambulance crew in the hospital, that unit is no longer on the streets available to respond to other calls. So with that in mind, we echo his comments.

Jack Kim, Legislative Advocate, representing Sierra Health Services and Nevada Association of Health Plans, Las Vegas, Nevada:
Our health plans cover approximately 920,000 lives in Nevada. We want to echo the remarks made by everyone else. When our members need to get to the emergency room for care, we want that to be available for them. We think this is a positive first step.

Bobbette Bond, Legislative Advocate, representing HEREIU Welfare Fund, Las Vegas, Nevada:
I want to echo the call for broad, deep support and a long-term solution. I'm representing the Culinary Health Fund. I'm also representing today the Health Service Coalition that has the 320,000 members who need access to beds. If we don't create, with this triage program, step-down care and access to their medication quickly, we need to make sure that all those walk-ins don't turn around and walk back out. We must make sure they're not walking out of that facility and into the emergency room. We need to break that cycle. We need the triage centers, but we need a deeper, broader plan overall. I appreciate the attention this is getting.

Bill Welch, President, Nevada Hospital Association, Reno, Nevada:
I've presented staff with my written support of this (Exhibit D). But I'd like to go on the record for the Nevada Hospital Association in support of A.B. 40 and commend the sponsors of this bill. This is a good step towards helping resolve the backlog of the utilization of the hospital emergency room for care that would be better provided elsewhere. It's our hope that if this does pass, it will ensure that we have emergency room beds for those patients who need acute care services at the hospital emergency room.

Chairwoman Leslie:
At this time we'll turn to the other part of the bill; the Reno part of the bill with the triage center.

Nicole Lamboley, Legislative Advocate, representing the City of Reno, Nevada:
Councilman Dwight Dortch was planning to be here, but unfortunately he had to race back to Reno for a meeting, so I will let you know that last month the Reno City Council endorsed the concept of a community triage center in Reno, northern Nevada, and Washoe County, and authorized us to continue discussions with community leaders. We've been working at the staff level to site the facility in the new community assistance center facility that we are building in the city of Reno adjacent to our downtown core. We are putting together a facility that includes a 150-bed men's drop-in center. The shell of that building includes 10,000 square feet of unfinished space on the first floor, and we would allocate some of that space for a community triage center. So

the City Council asked me to convey to you their support for this service within our community.

Anne Cory, President, United Way of Northern Nevada, and representing Homeless Coalition of Northern Nevada, Reno, Nevada:
We're strongly in support of the community triage center. We are working in conjunction with a very broad-based coalition of law enforcement providers, mental health providers, substance abuse treatment providers, and we are very much in support. We believe it's an integral component to the community assistance center that is being developed in the Reno area.

Chairwoman Leslie:
And do you see that this triage center would essentially perform the same functions as the Las Vegas triage center? Are there any differences that you know of?

Anne Cory:
Not substantial differences, although we are talking about doing Legal 2000s in the triage center in the north. Nothing is cast in concrete yet, and we're still developing proposals, but essentially I believe it would be the same concept. We have a very strong emphasis on serving law enforcement, and they're very involved in the process of developing the plan. We see it as an important component.

Assemblywoman Angle:
You mentioned a coalition, and in your coalition, I didn't hear you mention the name of the nonprofit organization. I know there are several nonprofits that see people with these kinds of problems, and I'm just wondering if they're working with you as well.

Anne Cory:
More than 50 nonprofits, actually. This is receiving very broad and strong support from the nonprofit community working together to achieve this.

Ondra Berry, Deputy Chief, Administration Division, Reno Police Department, Reno, Nevada:
[Distributed Exhibit E.] I have Officer O'Bryan and Officer Johns with me today. Under our traditional policing, when we look at mental illness, substance abuse, or medical issues that are out there under traditional policing, the only alternatives we had were Legal 2000s, sending someone to detox, or to jail. Under community policing, one of the things we learned is that you have to have good coalitions, good partnerships, and work across traditional lines. That's what we've learned from this.

[Ondra Berry, continued.] About a year ago, I asked these two individuals to look at some alternative ways of getting people off the street; not for the purposes of incarcerating them, but to look at what else could be done to eliminate this as a growing problem for us in the downtown area. These two individuals stepped up to the plate in going out there and working directly with our Assemblywoman, our nonprofits, and Anne Cory to ensure they were on board from the standpoint of the homeless issue, especially, but also looking at some other mental health issues that are out there. When we looked at the triage center being proposed, this is one place we can take those individuals with urgent but non-acute mental health substance abuse and detox issues. When you think about it from a law enforcement standpoint, that's huge in terms of hours of work. It's huge in terms of officers who don't have the understanding or the training to deal with some of these issues. And let me tell you, this is not our area of expertise, but we do need alternative means because contrary to belief, police officers would rather provide alternative places to take individuals as opposed to jail.

The proposed location of the triage center—which has been discussed before—would be in our main downtown corridor. That's an excellent location, and the concept works. We have worked with social service providers before and there's a proven track record of that being an outstanding relationship. This is the time, and there are strategic locations that the City of Reno is going to provide. This also allows us to provide a proactive working relationship with the experts in this area, and that helps law enforcement. The data suggests that there are over 5,000 cases that could be diverted to the triage center each year. Again, going back to when you had limited law enforcement services, and you have individuals who have been better diagnosed with some of the issues out there, this helps everyone and allows the officers to get back on the street.

We pledge to continue to be involved in this heavily. I sent these two officers to do their research. I tell anybody here from an investigator standpoint that if you want to find something that's going on and you don't want to get in trouble, have these two officers on your back; trust me on that. They went down to Las Vegas, asked all the questions, came back, and became diligent in developing crisis intervention training for us. We've done two trainings so far and we pledge to remain involved in this project if it is successful. We pledge to provide the time, energy, and resources. We pledge to make sure that officers are properly trained and get additional trainings on these issues. The working group has allowed us to get a better understanding. You can call us doctors now because we understand medical issues better than we had before. That's been good for us, because without a doubt we have misdiagnosed a lot of individuals out there on the street. From a law enforcement standpoint, when we send people through a 19-week academy, these are some issues that we

have traditionally not paid attention to. When we look back at it now, we said there's a better way, there's a better strategy, and this will provide for that. We heavily support this legislation; we heavily support the direction. It gives us a resource, gives us a tool. When you look at the men and women who do this job every day and care about the quality of life in our respective communities, we want alternative resources and means to provide the best services to those people out there.

[Ondra Berry, continued.] I believe this is one of the most urgent and critical issues in law enforcement today because of the time, energy, and effort that it takes. We have discovered that crisis intervention works. We have discovered that when officers have this tool, they'll do a better job of it. We understand, from having done our research, that the triage centers do work for communities, and this state is growing at the pace it had been in the past. We need this resource. As members of the Reno Police Department, we heavily support that.

Patrick O'Bryan, Officer, Reno Police Department, Reno, Nevada:
I think probably the only thing left at this time is to try to put a face on what this issue means on the streets for us. You have material (Exhibit E) in front of you, and maybe I'll call your attention to it. It's several stories about one gentleman that we've come in contact with in downtown Reno over and over again. It's kind of an unfortunate photograph on the front page of that, and I will qualify that photograph by saying that he's not deceased in that photo. He's actually still alive. We took that photo out of frustration. This gentleman we actually have come to care for. We found him over and over again in this state on the streets. My partner Steve Johns and I happened to find him. This is that night. This is in the wintertime. This is his state on a city street in downtown Reno in the middle of the night.

This is prior to us calling an ambulance and the fire department for him, and it was pretty common at that point in time to find him in that state once or twice a day. He would be taken to the hospital, detoxed, and then sent back out into the street again so that he can get intoxicated and go through the same process. We got very frustrated with that type of situation on the streets. We attempted to arrest him over and over again, but an arrest was not an answer to his problem. It was frustrating to us to see him degrade over time. It was frustrating to find out the cost to the system for this type of situation, and you can try to place blame; maybe you can blame him; maybe we can blame the system; maybe you can blame the police department. Trying to figure out who to blame is going to be very difficult and pretty much impossible when you start sorting it all out.

[Patrick O'Bryan, continued.] This gentleman here, when we ran down the figures, is responsible in one year's time at one hospital, for a bill of over $100,000. That was the smaller of the two large hospitals in the city of Reno. I've been patrolling downtown Reno for over ten years, and I remember Murray Barr from as far back as I can remember. Murray has been going in and out of our system over that period of time. When you do the math on this, you can figure out that math is probably worth over $1 million. And we never cured him. Never came close. He died in the spring last year.

The frustration of having that situation just down the street kind of propelled us into trying to find some better answers. My partner and I are very driven to serve our community, and our primary objective is to protect. People accuse us of a lot of things; accuse us of being heavy-handed, jaded, and all kinds of other things, but the reality is that we're the ones who find the people in this state over and over again. So we have to become somewhat jaded to handle this situation. We're the ones that deal with the frustration. The community calls upon us to come up with alternatives to deal with people other than arresting them, we go out into the community and ask where to take him and find nowhere, that only adds to our frustration, and that's the story of Murray, as he's the result of that frustration and the result of nowhere to go.

When Deputy Chief Berry challenged my partner and I to go out and find better solutions, he challenged our team—the downtown enforcement team—to go beyond good. He said we're good, but, "Good is not good enough anymore. You need to become excellent at what you do." We went out and started looking for other solutions. We went to the community and started asking what services are available. We asked for a mobile outreach so that perhaps somebody could come to the street and meet with Murray and try to suggest some alternatives for him before he comes to this state here, where the results were a $700 ambulance ride and $1,200 to $6,500 for an emergency room detox bill. You can see how it will add up over time, and perhaps another service might be able to short-circuit some of that. But what we found out was there was no service that could take care of Murray in less than 72 hours, and there was no place for him to stay for 72 hours. The triage center is simply the answer to the gap in that system; a gap in the continuum of care; the 72-hour gap that we have at this time. It's only a step, and we realize that this is something that's going to have to be an ongoing, evolutionary process. But it's something we greatly need on the street if the police department is to respond to the community's pressure on us to change the way that we address our problems in our communities.

Chairwoman Leslie:
As you page through this material (Exhibit E), there's another photo of Murray looking quite different with a tie on. Can you explain that photo to us?

Patrick O'Bryan:
Murray was an interesting man. Obviously the front page is Murray at his worst. We took that photograph so that we would have something to show Murray what he looked like, trying to scare him into saying, "Hey, you know what, you're right. I have to do something." We tried every angle we could to try to convince him to get help. Once he was in the system and he was under what was considered house arrest and being monitored by the system, ironically he felt cared for. The system is what cared for him. He held a job for six months, he had a savings account, he was never late for work, he was a cook at one of the local restaurants, and he did very well. The photograph, (Exhibit E) Madam Chairman, that you're referring to is Murray when he was functional, when he was being monitored, and when he was being cared for by the system. And so in some respects, he could be a success.

Steve Johns, Officer, Reno Police Department, Reno, Nevada:
They've already summed it up quite a bit. We loved Murray, too. My wife, who worked at Saint Mary's Hospital, spent more holidays with him than she and I did together. There's an interesting story in that booklet about an incident that she had with him at the hospital that is very touching. We're not looking to cure people; we can't. But we can certainly help the people who need help, and this is a good tool for that.

Chairwoman Leslie:
I believe there are some other people from the Reno triage center who might want to come up. I believe there's $100,000 in this bill as start-up funding for the Reno center, and I'm not sure if anyone has addressed the timeline.

Anne Cory:
The shelter is breaking ground on February 25. We expect it to be complete by the beginning of winter, perhaps November. The triage center would be finished as part of the ground floor. I believe we will have the triage center operational around January 1, 2006.

Chairwoman Leslie:
The $100,000 that's in this bill would be for what, exactly?

Anne Cory:
It would allow us to complete the design and to finish out the building shell because all we've raised money for so far, on the ground floor, is an empty

shell. We will also need to be financing the furnishings, equipment, and staffing, obviously. There are all kinds of operational start-up costs, but this would allow us to get the building up and running.

Tom Murtha, CEO, Bristlecone Family Resources, Reno, Nevada:
I helped work on cost analysis for this and on the clinical side of how it would all work. We think we can do this in a way that's reasonable for the citizens of Nevada. I want to thank Dr. Harold Cook from the Northern Nevada Adult Mental Health Services, and Dr. Brandenburg. Several of us providers got together and took a look at how to do this right and what it would cost, and have been part of the coalition. It's just a very exciting project because everyone in this coalition believes in it. United Way, law enforcement, and the hospitals, believe in it conceptually. When you get to the cost figures and how we're going to make this happen, that's where the rubber meets the road. But we are absolutely dedicated to this process, and Bristlecone is interested in being a lead agency if this project is fiscally viable, and I know there are a number of providers. Basically what I'm saying is, we will step up to the plate. We can do this. It's a question of wherewithal, and we need your help.

Michael Pennington, Legislative Advocate, representing, Reno-Sparks Chamber of Commerce, Reno, Nevada:
It's my pleasure to join the host of individuals here today supporting A.B. 40. I applaud the leadership in bringing this forward, as well the long-standing advocacy and leadership on mental health issues in Nevada. Being an individual who works in downtown Reno and lives near downtown Reno, I have seen many of these issues for 15 years. Our community has been trying to deal with moving forward with the community assistance center for nearly 22 years. That hasn't been mentioned, but for nearly 22 years we've been looking forward to supporting that. We see the triage center that's been proposed in A.B. 40 as a wonderful complement, and an important complement, to service the needs of the community and the individuals who need the care.

As the hearing has drawn long, I will keep my matters brief and just issue our support. However, one other thing that I did not hear mentioned was that estimates provided by the local hospitals in the Reno-Sparks community, as well as the police agencies, suggest there may be 5,110 individual cases that could be diverted to the triage center in Reno each year. I do think it is important to stress that this is not simply a center that would work with downtown Reno as a whole. I think this focuses on the whole Truckee Meadows community, which is nearing 400,000 in population, and then our northern Nevada community within one hour's drive of downtown Reno is near 750,000 people right now. So I think that this would be a tremendous asset to the whole western Nevada community.

John Berkich, Assistant County Manager, Washoe County, Nevada:
You certainly heard today enough testimony about the huge need that this center will address. We're here simply to echo our support for this. We're here to echo again and reiterate that support. Washoe County will continue to be an active local government participant in our community to establish our center. We urge your approval of this legislation.

Bunchie Tyler, President, National Alliance for the Mentally Ill of Northern Nevada:
As you probably know, I really do back this bill and I really hope that it will go through. Generally, my husband, who is our state president, would be here to do this. Unfortunately, he's ill and sent me to represent us as being in support for southern Nevada as well as northern Nevada. Because as we keep growing, we'll definitely need the triage also. I just want to go on record saying that NAMI [Nevada Alliance for the Mentally Ill] is in great support of this.

Mark Burchell, Vice President, National Alliance for the Mentally Ill of Northern Nevada:
I just want to briefly say that if there was a triage center available when I was suffering from mental illness—I'm bipolar—and I had an episode, it would have made a difference in my recovery. It would have been a place for the police department to take me, because they were really frustrated picking me up off the streets every time I was released. I was so delusional that I would just hang around the bus depots or sleep in somebody else's car and wander around town, and the minute they let me go the next day, I'd be back in jail. It was really frustrating for the police department. I remember they had a stern voice when they took me to jail the last time. I'm really glad they're supporting this triage center, because I think it's going to be good for not only the community, but for the police department. I just want to be on record to say that I support it, too.

Chairwoman Leslie:
Before we get to the technical portion of the bill, is there anybody else who would like to get on the record in support or opposition?

We did want to point out that in A.B. 40, there is a new category for licensing specific to community triage centers.

Pamela Graham, Chief, Bureau of Licensure and Certification, Health Division, State of Nevada Department of Human Resources:

[Handed out Exhibit F.] I am here today to present information on A.B. 40, which creates a definition of a community triage center to provide for mentally

ill persons and abusers of alcohol or drugs to receive medical assessment and short-term monitoring. It is anticipated that the passage of A.B. 40 will provide the state health division with a licensed provider type to address the emergency needs of the mentally ill, the substance abuser, and/or the duly diagnosed client. It is further anticipated that passage of this bill will provide needed relief for the emergency departments in metropolitan areas by addressing the process and protocols for medical clearance of the mentally ill or substance abuser.

[Pamela Graham, continued.] As the new medical facility type, it will be necessary for the Bureau to develop a new set of regulations. Once regulations are developed, staff would anticipate an increase in oversight and workload but does not foresee that program operation would be affected. The Bureau is a fee-based agency. Initial and annual renewal fees are established based on approved methodology, reflecting the workload associated with the particular provider type.

Following the revision of existing *Nevada Administrative Code* regulations, the Bureau anticipates licensure of facilities to be completed before the next legislative session.

Chairwoman Leslie:
I appreciate the work you put into this.

Maria Canfield, Chief, Bureau of Alcohol and Drug Abuse, State of Nevada Department of Human Resources:
[Handed out Exhibit G.] I'm here today to provide testimony and information on A.B. 40, which would create a new facility type for community triage centers to provide medical assessments and short-term monitoring of mentally ill and/or abusers of drugs and alcohol, and make an appropriation of the Department of Human Resources Division of Mental Health and Developmental Services for establishing a mental health and substance abuse screening and stabilization component of two community centers, one each in Clark and Washoe Counties. The bill would create a community triage center in Washoe County similar to the program operated in Clark County. The Clark County program has been successful in easing overcrowding in the emergency departments in southern Nevada. It also provides assistance to individuals who need substance abuse treatment but are beginning a possible treatment episode, and provide referrals to those who need addiction treatment services.

Assemblywoman Weber:
Is there any existing problem in the rurals as well that we need to address?

Chairwoman Leslie:
In Carson City, or the frontier rurals?

Assemblywoman Weber:
Frontier rurals.

Chairwoman Leslie:
The Carson City folks will be here on Wednesday to testify as to the needs of mental health court.

Assemblywoman Parnell:
I really think at this point in time we certainly have a need. But when you compare the tremendous need in Clark County and the growing need in Washoe County, I think the rurals at this point in time would be very happy to say, "You need to take care of the problems and then when we need our day in court, we'll be here."

Chairwoman Leslie:
I think the answer, Mrs. Weber, is yes, there would be a need, but in the hierarchy of priorities of need, I think we start with urban areas and then try and reach out to the rurals as well. They certainly do have these kinds of folks who need attention; absolutely.

Anne Cory:
I've had discussions with the mental health coalition in Carson City about the possibility of transporting patients to the triage center in Reno when it is built. They very definitely have a need. They're willing, because of the smaller numbers in their community, to take advantage of opportunities in the adjoining communities, but eventually I believe the numbers will be there. But it is a prioritization issue at this point.

ASSEMBLYWOMAN PIERCE MOVED TO DO PASS ASSEMBLY BILL 40.

ASSEMBLYMAN HORNE SECONDED THE MOTION

Assemblyman Horne:
I just wanted to make it clear I'm wholeheartedly behind this, as you know, and I'll continue to work diligently to get this passed.

THE MOTION CARRIED UNANIMOUSLY

Chairwoman Leslie:
This meeting is adjourned [at 3:27 p.m.].

RESPECTFULLY SUBMITTED:

_____
Paul Partida
Transcribing Attaché

APPROVED BY:

_____
Assemblywoman Sheila Leslie, Chairwoman

DATE: _____

EXHIBITS

Committee Name: Health and Human Services

Date: 2/14/05 Time of Meeting: 1:30pm

Bill #	Exhibit ID	Witness	Dept.	Description
	A	********	********	Agenda
	B	Mike Willden	State of Nevada Human Resources	Written Testimony
	C	James R. Osti	Clark County Health District	Written Testimony
	D	Bill Welch	Nevada Hospital Association	Written Testimony
	E	Ondra Berry	Reno Police Department	Written Testimony on Murray Barr/Congressional Record
	F	Pamela Graham	Nevada State Health Division	Written Testimony
	G	Maria Canfield	Nevada State Health Division	Written Testimony