MINUTES OF THE
JOINT SUBCOMMITTEE ON HUMAN SERVICES/CIPS
OF THE SENATE COMMITTEE ON FINANCE
AND THE ASSEMBLY COMMITTEE ON WAYS AND MEANS

Seventy-sixth Session
March 10, 2011

The Joint Subcommittee on Human Services/CIPS of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Sheila Leslie at 7:39 a.m. on Thursday, March 10, 2011, in Room 3137 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412E, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Sheila Leslie, Chair
Senator Steven A. Horsford
Senator Barbara K. Cegavske

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblywoman Debbie Smith, Vice Chair
Assemblyman David P. Bobzien
Assemblywoman Maggie Carlton
Assemblyman Pete Goicoechea
Assemblyman Cresent Hardy
Assemblyman Joseph M. Hogan

STAFF MEMBERS PRESENT:

Michael J. Chapman, Principal Deputy Fiscal Analyst
Rex Goodman, Principal Deputy Fiscal Analyst
Mark Krmpotic, Senate Fiscal Analyst
Eileen O'Grady, Counsel
Brenda Erdoes, Legislative Counsel
Jackie Cheney, Committee Secretary

OTHERS PRESENT:

Dave Prather, Administrative Services Officer, Division of Mental Health and Developmental Services, Department of Health and Human Services
Harold Cook, Ph.D, Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services.
Deborah A. McBride, Health Bureau Chief, Substance Abuse Prevention and Treatment Agency, Division of Mental Health and Developmental Services, Department of Health and Human Services
Jane Gruner, Deputy Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services
Jan M. Crandy, Commissioner, Nevada Commission on Autism Spectrum Disorders
Shannon Springer
Toni Richard
Joey Alexander
Kelly Upp
LaVonne Brooks, President and Chief Executive Officer, High Sierra Industries
Edward R. Guthrie, Executive Director, Opportunity Village
Brian M. Patchett, President and Chief Executive Officer, Easter Seals Southern Nevada
Dana R. MacDonald, Executive Director, Disability Resources, Inc.
Martha Brown
Christy McGill, Executive Director, Healthy Communities Coalition of Lyon and Storey Counties
Kevin Quint, Executive Director, Join Together Northern Nevada (JTNN)
Barry Lovgren
Stuart Gordon, Executive Director, Family Counseling Service of Northern Nevada

CHAIR LESLIE:
We will begin with the mental health budgets and then proceed to the developmental services budgets. The first budget account is (B/A) 101-3168.

HUMAN SERVICES

HHS – MHDS – Administration — Budget Page DHHS MHDS-1 (Volume II)
Budget Account 101-3168

DAVE PRATHER (Administrative Services Officer, Division of Mental Health and Developmental Services, Department of Health and Human Services):
Decision unit E-606 eliminates one clinical program manager II, saving $225,640 for the 2011-2013 biennium. The duties will be absorbed by the remaining staff. This position is currently not vacant.

E-606 Staffing and Operating Reductions — Page DHHS MHDS-4

Decision unit E-607 eliminates one management analyst IV, saving $195,733 for the 2011-2013 biennium. Due to forecasted vacancies, it should not cause a layoff. The duties of this position will shift to remaining staff.

E-607 Staffing and Operating Reductions — Page DHHS MHDS-4

Decision unit E-692 eliminates one accounting assistant I in the central billing office, saving $80,194 for the 2011-2013 biennium. This position is currently vacant. The workload is expected to decrease in conjunction with the reductions in mental health and developmental services. The remaining duties of this position will be assumed by other staff.

E-692 Budget Reductions — Page DHHS MHDS-6

Decision unit E-693 eliminates one quality assurance specialist III resulting in a reduction of $187,645 for the 2011-2013 biennium. This position is currently vacant and the workload is expected to decrease in conjunction with the reductions in mental health and developmental services. The duties will be absorbed by remaining staff.

E-693 Budget Reductions — Page DHHS MHDS-7

CHAIR LESLIE:
These are central office positions responsible for overseeing and monitoring the various programs, services and activities of the entire Division. While some of the duties will be reduced because of decreased services, there will be increased

work for the remaining staff. How will the extra work be managed and what are the ramifications of operating with fewer staff?

HAROLD COOK, Ph.D. (Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services):
There could be delays in investigations, reports and some of the administrative work. The duties of the clinical program manager will revert back to the deputy administrator who was responsible for those duties in the past.

CHAIR LESLIE:
How long will the delays be?

DR. COOK:
It is hard to quantify, but these delays could be days or weeks; nothing more than that.

CHAIR LESLIE:
The performance indicators are mostly the same and in some instances, there is expectation for improvement. How will this occur with fewer staff?

DR. COOK:
We are all going to work harder.

ASSEMBLYWOMAN MASTROLUCA:
Are you concerned about the reduction in the grant management staff? With all the budget cuts, it seems prudent to retain grant management staff to take advantage of all grant opportunities.

DR. COOK:
The proposed staffing reductions have essentially already occurred since all the positions to be eliminated are vacant, except one. The Division administers three large grants received from the federal government, the Community Mental Health Block Grant, the Substance Abuse Prevention and Treatment Agency (SAPTA) block grant, and the Data Infrastructure Grant. These grants have been adequately managed and will continue to be managed by existing staff. The Division will continue to find ways to streamline and operate more efficiently with less staff.

CHAIR LESLIE:
The next budget is B/A 101-3164. The concerns related to this budget begin with the budget reductions. Please discuss decision unit E-691 in which the position responsible for maintaining the mental health information system is being eliminated.

HHS – MHDS – Mental Health Information System — Budget Page DHHS MHDS-11 (Volume II)
Budget Account 101-3164

E-691 Budget Reductions — Page DHHS MHDS-14

MR. PRATHER:
One IT professional II position is eliminated resulting in a reduction of $180,049 for the 2011-2013 biennium. This was done to meet reduction targets. According to forecasted vacancies, it is anticipated this will not result in a layoff. The duties will be redistributed among remaining staff.

CHAIR LESLIE:
Who will manage the Division's Website?

DR. COOK:
The Division is in the process of developing a centralized informational technology (IT) system. As part of this, we are reorganizing the duties of our staff. Website development and maintenance will be assigned to one or more individuals within our Division.

CHAIR LESLIE:
Will this require additional services from the Department of Technology (DoIT)?

DR. COOK:
No, additional DoIT services are not required.

CHAIR LESLIE:
Will you be able to get the data to meet your measurement standards without this position?

DR. COOK:
We will be redistributing the duties to other staff. Much of our data gathering has been automated and we will continue to automate more in an effort to use fewer staff resources.

CHAIR LESLIE:
Will you expand your automated system with fewer IT resources?

DR. COOK:
Yes.

CHAIR LESLIE:
How will the Division collect the data for compiling the core measure reports? Will the ability to bill for Medicaid or Medicare services be impacted if the Joint Commission accreditation is jeopardized?

DR. COOK:
Information is reported quarterly for both Southern Nevada Adult Mental Health Services (SNAMHS) and Northern Nevada Adult Mental Health Services (NNAMHS). This is a priority for the Division. We anticipate being able to continue meeting the reporting obligations with reduced staff.

CHAIR LESLIE:
Please provide a brief update on AVATAR, the division's client information and billing system. Is it working and will more money be needed in the future for this system?

DR. COOK:
The Division completed a significant upgrade to AVATAR approximately six months ago. Since then, the system has been more stable and the ability to extract data has improved. Although there are difficulties with user interface, particularly with the clinicians, that is being addressed.

Next session, a Technology Investment Request will be considered for reviewing the system and evaluating other systems. This could result in recommendations for change. Health care reform and standards for electronic medical records are other areas for possible change that are being evaluated. The Division is

developing an IT strategic plan which includes the ongoing operations of AVATAR.

CHAIR LESLIE:
Can we make it for two more years without a system upgrade?

DR. COOK:
Yes. Additionally, our IT manager has been working with NetSmart, Inc., the vendor for AVATAR, and has achieved some significant savings in that contract.

CHAIR LESLIE:
We will move to B/A 101-3161. Please begin by explaining the budget reductions in inpatient beds, decision units M-160 and E-696.

HHS – MHDS – So NV Adult Mental Health Services — Budget Page DHHS MHDS-83 (Volume II)
Budget Account 101-3161

M-160 Position Reductions Approved During Biennium — Page DHHS MHDS-85

E-696 Budget Reductions — Page DHHS MHDS-98

MR. PRATHER:
Decision unit M-160 eliminates 23.35 full-time equivalents (FTE), 27 positions, resulting from the closure of the 22-bed unit in building 3 of the old Stein Hospital located on the SNAMHS campus in Las Vegas.

The Twenty-sixth Special Session in 2010 approved the temporary closure of this unit as part of the budget reduction solution due to the General Fund shortfall in the 2009-2011 biennium. Consequently, these positions have been held vacant. We are now recommending the continued closure of this unit. The eliminated positions include one accounting assistant, one grounds maintenance worker, one laboratory technician, two licensed practical nurses, three licensed psychologists, one maintenance repair worker, nine mental health technicians, two mid-level practitioners, one pharmacy technician, and six psychiatric nurses.

Decision unit E-696 contains a reduction of approximately $4.9 million. This request proposes to close 22 inpatient beds in building 3A in the old Stein Hospital and eliminates 27 positions. The eliminated positions include 1 administrative assistant, 3 clinical social workers, 12 mental health technicians, 9 psychiatric nurses, and 2 senior psychiatrics.

CHAIR LESLIE:
Are two 22 bed units being closed?

DR. COOK:
Yes, we already closed the 22 bed unit in building 3 as a result of the 26th Special Session. Now, we are proposing to close an additional 22 beds in building 3A. A total of 44 beds will be permanently closed in the SNAMHS old Stein Hospital located on Charleston Boulevard in Las Vegas.

CHAIR LESLIE:
Please explain what the current daily census is and where this reduction in beds will leave us in terms of capacity.

DR. COOK:
None of the beds proposed to be eliminated have been used for six to eight months. We are operating the inpatient program in southern Nevada solely out of the Rawson-Neal Hospital. The total capacity at Rawson-Neal Hospital is 190 beds. Our daily census has not exceeded 185 beds during the past 6 months. Typically, the census runs between 160 and 175 beds. We have been able to achieve this by reducing the length of stay. A year ago, the length of stay was close to 30 days; it is currently between 15 to 17 days.

CHAIR LESLIE:
You stated before this is due to operational efficiencies. Please describe what this means in greater detail.

DR. COOK:
The primary driver of the operational efficiency is reducing the length of stay by providing quick stabilization and discharge planning. In the past, if the patient refused medication, the process for involuntary medication took an inordinate amount of time. The process has been streamlined so everything is

accomplished more quickly. We get the doctors to the patients faster and begin planning the discharge immediately upon admission.

SENATOR CEGAVSKE:
After patients are discharged, do they receive aftercare services to help them survive as outpatients? How long do individuals receive aftercare services?

DR. COOK:
Everyone who leaves the hospital is offered aftercare services. If they want aftercare services and they qualify for those services, the length of their treatment is determined on an individual basis. It is provided for as long as needed.

SENATOR CEGAVSKE:
Are the aftercare services being cut?

DR. COOK:
The outpatient budget reductions in SNAMHS include the elimination of one Program for Assertive Community Treatment (PACT) team and a reduction in outpatient counseling.

ASSEMBLYWOMAN MASTROLUCA:
Based on previous hearings on the mental health budgets, there are substantial reductions to outpatient services throughout the Division's programs. How will those reductions impact the census after this budget is approved?

DR. COOK:
The elimination of one PACT team will have an impact on hospital utilization for approximately 75 clients who will lose support services from this team. The individuals served by PACT are the most acutely ill who typically have a high use of emergency, hospital and law enforcement services. The PACT teams work in an interdisciplinary manner to support individuals with living in the community, adherence to their medication programs, and employment rehabilitation. The Division will continue to provide some measure of services to try to diminish some of the impact of losing the PACT services but it is anticipated these individuals will definitely be using the hospital more.

ASSEMBLYWOMAN MASTROLUCA:
Later in this budget there are reductions, and in some cases eliminations, of subsidies for home care. These subsidies have been successful in keeping people in their homes with their families. Will those cuts also affect the hospital census?

DR. COOK:
I believe you are referring to the cuts in residential support. These reductions could have an impact on the hospital census. The proposed reductions will not affect current recipients, but will affect future clients needing those services.

CHAIR LESLIE:
Is any information available that tracks the acuity levels of people coming into the hospital? Are there any notable changes?

DR. COOK:
I do not have any data indicating there is a significant difference. I will see what information may be available in this area.

CHAIR LESLIE:
It would also be important to track information regarding increases in hospitalization for clients who lose services. How much does it cost per day for hospitalization?

DR. COOK:
The cost of hospitalization at Rawson-Neal Hospital is $650 a day.

CHAIR LESLIE:
Regarding performance indicators, why is the percentage of people with a length of stay over 90 days projected to be higher in fiscal years (FY) 2011, 2012 and 2013 than FY 2010?

DR. COOK:
My information shows the percentage was 3 percent in FY 2009-2010 and is projected to decrease to 2 percent in FY 2010-2011, 2011-2012 and 2012-2013.

CHAIR LESLIE:
We will have Fiscal Staff review this.

There are 201 slots proposed to be eliminated in supported living arrangements (SLA) housing. What is the total number of SLA slots in southern Nevada prior to these reductions?

DR. COOK:
There are 900 to 1,000 slots which would be reduced by 201 for next biennium if this budget is approved.

CHAIR LESLIE:
The magnitude of these reductions is disconcerting. Please continue with decision unit E-607.

E-607 Staffing and Operating Reductions — Page DHHS MHDS-91

MR. PRATHER:
Decision unit E-607 proposes a reduction of approximately $1.8 million for the 2011-2013 biennium. The closures of buildings 3 and 3A resulted in the ability to consolidate positions as all operations will be performed in one building. This request eliminates 11.31 FTEs (13 positions) including 3 administrative assistants, 1 clinical program manager, 4 clinical social workers, 1 driver, 1 licensed psychologist, 1 pharmacy technician, 1 registered dietitian and 1 senior psychiatrist.

CHAIR LESLIE:
How did you determine which positions to eliminate? Why were these positions not eliminated in the decision units specific to the program or service reductions? Why are these position eliminations grouped into this one decision unit?

DR. COOK:
The elimination of this staff is related to the closure of buildings 3 and 3A. These positions have been vacant and are not necessary for ongoing operations. When buildings 3 and 3A were active, extra staff was required to operate those

units because the buildings are older and are located some distance from the main hospital. After streamlining, consolidating job responsibilities and applying staffing ratios for the ongoing workload, we determined that these positions are not needed.

CHAIR LESLIE:
I have additional questions regarding the elimination of one PACT team. As I understand, there are two PACT teams in southern Nevada. One is being eliminated, affecting 75 individuals. What is the average length of time for PACT services?

DR. COOK:
Basically, when someone receives PACT services they remain in the program for years; they rarely leave. The national experience has shown people primarily leave the PACT team only when they leave on a voluntary basis, move out of the area, or die.

CHAIR LESLIE:
Can you please explain what types of individuals are receiving PACT services?

DR. COOK:
These are some of the most acutely mentally ill individuals. They may have an acute stage of bipolar disorder, schizophrenia, or major depression. Generally, they have a high need for all kinds of intensive coordinated services including psychological, medication and clinical services. The PACT team is often referred to as an outpatient hospital. Everything in terms of psychological support that is available in the hospital is made available through the PACT team. The PACT provides services on an intense level and has been extremely successful in helping these individuals live successfully in the community and avoid repeated hospitalization.

CHAIR LESLIE:
I have heard some of the individuals who receive PACT services are resistant to taking their medications. Is that correct?

DR. COOK:
Typically, they cycle through their illness and when they are in a difficult place within their cycle, they become more treatment resistant in many ways including medication compliance. One of the advantages of the PACT team is they are able to take the services to the client. If an individual does not comply or show up for appointments, a psychiatrist may actually go to their home.

CHAIR LESLIE:
The 75 people who will lose PACT services will have to go to the various sites offering outpatient services. Since these services are being reduced, the services may not be readily available, or the person may have to wait longer to receive help. Without PACT, when problems occur, no one will be going out to their home to check on them.

DR. COOK:
That is correct.

CHAIR LESLIE:
People who go off their medications can be dangerous to themselves or others and may end up in the criminal justice system or hospital.

DR. COOK:
Yes, these are possible consequences resulting from the elimination of a PACT team.

CHAIR LESLIE:
If there are no more questions regarding the PACT team, we will move to decision unit E-601 and discuss the reductions to the Consumer Assistance Program.

E-601 Budget Reductions — Page DHHS MHDS-88

MR. PRATHER:
Decision unit E-601 reduces the 2011-2013 biennium budget by $303,193. It includes a reduction in the Consumer Assistance Program services and eliminates one clinical social worker and one consumer services coordinator.

CHAIR LESLIE:
Which of these positions supervises and trains the consumer services assistants?

MR. PRATHER:
The clinical social worker is responsible for the supervision and training of consumer services assistants.

CHAIR LESLIE:
Who will perform this function?

DR. COOK:
I do not know who these duties will be assigned to. I will get back to you on this.

CHAIR LESLIE:
The Subcommittee needs to know this. Additionally, who will be supervising the volunteers?

DR. COOK:
The consumer services assistant supervises the volunteers in the north. I am not as familiar with the southern program, so I will have to get back to you with that information.

CHAIR LESLIE:
Please address the consolidations and reductions in the Pahrump office in decision units E-605 and E-695.

E-605 Budget Reductions — Page DHHS MHDS-90

E-695 Budget Reductions — Page DHHS MHDS-97

MR. PRATHER:
Decision unit E-605 replaces three part-time positions, an administrative assistant and two psychiatric caseworkers, with a full-time psychiatric caseworker located at the southern rural clinics. This will result in a savings of

$97,145 for the 2011-2013 biennium. No impact to client services is anticipated.

Decision unit E-695 eliminates a licensed psychologist in the Pahrump Clinic, saving $238,966 in the 2011-2013 biennium.

CHAIR LESLIE:
Does this mean psychological testing is being eliminated in the Pahrump Clinic?

DR. COOK:
Decision unit E-695 eliminates a psychologist in the Pahrump Clinic. Although the narrative says psychological testing is being eliminated, the current incumbent has not done testing for years.

CHAIR LESLIE:
What has this person been doing?

DR. COOK:
This person does individual and group counseling.

CHAIR LESLIE:
Is this the service being eliminated?

DR. COOK:
Individual and group counseling will be reduced. Staff will be sent to Pahrump on an itinerant basis to provide some counseling services.

CHAIR LESLIE:
Please provide specific information regarding how many people will lose their services with elimination of this position. Where will people have to go to get help?

DR. COOK:
The services will continue to be provided in Pahrump at a reduced level. There are currently 95 people who have been receiving counseling services. These individuals will continue to receive services, to the extent possible, from a

Mental Health Counselor II. The 27 individuals on the waiting list will not be served.

CHAIR LESLIE:
Please discuss the elimination of the grounds maintenance workers in decision unit E-606.

E-606 Staffing and Operating Reductions — Page DHHS MHDS-90

MR. PRATHER:
Decision unit E-606 eliminates three grounds maintenance worker positions and replaces them with a contracted vendor. This will reduce the 2011-2013 biennium budget by $110,366. No impact to services is expected.

CHAIR LESLIE:
What is the contracted vendor going to do?

MR. PRATHER:
The vendor will provide the maintenance landscaping services for the SNAMHS campus.

CHAIR LESLIE:
Last session, approval was given to purchase equipment so we could save money by having our own staff do this work. What equipment was purchased with those monies?

MR. PRATHER:
A lawn mower was purchased. This piece of equipment will be transferred to the NNAMHS campus.

ASSEMBLYWOMAN MASTROLUCA:
When the equipment was purchased in 2009, I thought the intent was to use State workers to perform the work to save money. Now you claim going back to using a vendor will save money.

MR. PRATHER:
That is correct.

ASSEMBLYWOMAN MASTROLUCA:
How many times will we be doing this? It does not make sense that in 2009 it was more economical for State employees do the work, and now it costs more.

MR. PRATHER:
I agree it looks odd to be going back to the way it was. However, considering the economy, the ability to procure those services is less expensive now.

ASSEMBLYWOMAN MASTROLUCA:
Was the lawnmower the only item purchased, or did you also purchase the trimmers, blowers and other accessories? As I recall, there was money available to purchase other items.

MR. PRATHER:
I do not have the answer to that question. I will get back to you with that information.

ASSEMBLYWOMAN SMITH:
How many positions are being eliminated? Will those people be laid off or transferred to another position?

MR. PRATHER:
There are three positions. There is one layoff, one vacancy and one person who will be transferred to another position.

ASSEMBLYWOMAN SMITH:
Will you be contracting with a landscaping company?

DR. COOK:
Yes.

CHAIR LESLIE:
We will consider decision unit E-807.

E-807 Position Upgrades — Page DHHS MHDS-99

MR. PRATHER:
Decision unit E-807 proposes a reduction of $110,078 for the 2011-2013 biennium. This request eliminates an accountant and reclassifies four positions. This is due to the consolidation and transfer of the Rural Clinics responsibilities to the SNAMHS budget account. The cost of these upgrades is more than offset by the elimination of the accountant position. The duties of the accountant will be distributed among the remaining staff. No impact to services is expected.

ASSEMBLYWOMAN MASTROLUCA:
Is the accountant position currently filled?

MR. PRATHER:
The position is vacant.

CHAIR LESLIE:
The next item for consideration is decision unit E-663, regarding outsourcing psychiatric services.

E-663 Program Reductions/Reductions to Services — Page DHHS MHDS-93

MR. PRATHER:
Decision unit E-663 proposes to outsource internal medicine doctors. Two senior physicians and three senior psychiatrists are eliminated and replaced with contracted services. This results in a savings of $360,462 for the 2011-2013 biennium. No impact on services is anticipated.

CHAIR LESLIE:
Why do you want to replace staff with contracted services? Will you be contracting back with the same doctors?

DR. COOK:
There is a need for scheduling flexibility beyond the normal workday week. This will accomplish that goal and will make internal medicine resources available throughout the hospital.

The plan is to contract with an outside medical management organization for an internal medicine department. The contract would include one internal medicine medical director and four midlevel practitioners (advanced practical nurses) who can prescribe medications and perform medical physician functions. Scheduling would continue to be available throughout the normal workday, but appointments would also be available beyond the typical workday and on the weekends. The contract is anticipated to cost approximately $800,000. The positions we are proposing to eliminate equate to approximately $1 million.

Regarding the five positions to be eliminated, the three psychiatrist positions are vacant. One of the physicians has been on family and medical leave under the Family and Medical Leave Act since November of 2010 and plans to retire at the end of the fiscal year. Therefore, there is potentially only one layoff.

SENATOR HORSFORD:
You said the overall cost for this contract is $800,000. What is the cost per hour?

DR. COOK:
There has been no assessment on the hourly rate.

SENATOR HORSFORD:
How did you come up with the $800,000?

DR. COOK:
The Division is anticipating a contract with a medical management company. The Division estimates $175,000 a year for one physician and $100,000 a year for each of four mid-level practitioners. The medical management company will add on overhead costs for licensing, insurance and administration.

SENATOR HORSFORD:
Do you have a health organization in mind? What type of procurement would be required? What is the liability to the State resulting from privatizing this function? What is the capacity of this organization? Where is the precedence in this? You are essentially privatizing mental health services. I do not see a plan, the justification or the rationale behind the decision.

DR. COOK:
The Agency is proposing to privatize a portion of mental health services. A number of factors were considered in developing this proposal. The Division of Internal Audits found the Division was losing approximately $2.5 million a year from low physician productivity. Some of those physicians were the internal medicine physicians.

SENATOR HORSFORD:
It appears this audit has primarily identified management problems. Did you consider increasing the utilization capacity of those internal positions or attempt to improve their production rate before jumping to outsourcing and privatization of the entire function?

DR. COOK:
The SNAMHS has been working on this problem for almost ten years, through several administrators and several medical directors. One of the main difficulties is not being able to recruit and retain medical directors. I agree this is a management issue, but when you cannot hire a medical director manager and maintain consistency in that position, it is difficult to manage the staff working for the medical director.

The Division has 59 psychiatric positions and 4 internal medicine positions. Of the 59 psychiatric positions, 22 are vacant. Of the 37 that are filled, 14 are part-time because those incumbents do not want to work full-time. Of the four internal medicine positions, two are vacant. Of the three medical director positions, two are vacant and the third will be vacant next week.

SENATOR HORSFORD:
I understand the challenges from a workforce standpoint, but if you gave me those positions, I guarantee I would get them filled. It is called strategic recruitment. Have you worked with the Department of Employment, Training and Rehabilitation (DETR)? What types of efforts have been made? To suggest that no one exists with these skill sets is a misrepresentation of what is out there.

DR. COOK:
I did not say no one exists with these skill sets. Recruitment is difficult. For a typical psychiatric position, it can take from six months to one year to hire someone. Typically, we have to recruit someone from out-of-state. The other issue is retention. Very few medical students start their career with the goal of becoming a State employee. Some physicians migrate into State employment, but not many. The State salary scale for these positions has fallen behind. When someone leaves State service for another position, their salary is usually increased a minimum of $25,000 to $50,000 annually. These are the barriers faced by the Division. A national recruitment is done. A year ago, SNAMHS sent staff to a conference in San Diego where we set up a recruitment booth. Not one application resulted from this effort.

SENATOR HORSFORD:
Please provide a written plan justifying privatization of these functions. The costs need to be analyzed. I find it interesting this can be privatized and someone will make a profit, but the State cannot figure out a way to make it work within the available resources.

I am very concerned about this concept. The other day, in another committee hearing, we learned $200 to $300 an hour is being paid for a private contractor to perform a mental health function that should be provided by a full-time permanent State employee.

DR. COOK:
I do not know of anyone we are paying $200 to $300 an hour.

SENATOR HORSFORD:
I am talking about a contracted rate. This is what the individuals under this proposed medical management contract will end up making for the hours they work.

DR. COOK:
We have not done that analysis.

SENATOR HORSFORD:
My comments are based on the analysis I have seen on other State contracts that resulted in full-time public service positions being replaced with privatization. The privatization ends up costing much more per hour than it would cost using State employees. I understand how challenging it is to fill your positions, but recruiting and retaining employees is a better long-term approach than privatization.

Is it even permissible for the State to contract for these services in the private sector considering constitutional requirements say these services are to be provided by the State? Without a plan that I can review, I cannot make a decision on this. My initial inclination is that privatization is not the solution.

CHAIR LESLIE:
There are a couple of contract issues here. Regarding decision unit E-663, the Subcommittee would like to see more detail on what the plan is with specific responses to Senator Horsford's questions.

I was not aware you were planning to use advanced practical nurses (APN). I like the idea of using APNs with psychiatric specialization.

DR. COOK:
This particular contract is for internal medicine. These nurses would be doing histories and physicals, and minor internal medicine procedures. They would not necessarily need a psychiatric background.

CHAIR LESLIE:
If they are working with severely mentally ill people in an inpatient hospital, I would expect they should have a psychiatric specialty. The Subcommittee will need more information before making a decision.

Last Session, two new medical director positions were approved for southern Nevada; one inpatient and one outpatient. Are these positions filled?

DR. COOK:
We do not have a permanent medical director in southern Nevada in either of these positions. Medical staff are being rotated through that duty on a monthly basis.

CHAIR LESLIE:
Is that for the same reasons you have given regarding recruitment and retention difficulties?

DR. COOK:
Yes. I have been doing this job for three years and, during that time, we have been recruiting constantly for a medical director in southern Nevada. We have had a couple of good applicants, one from California and one from the East Coast, who wanted to work four ten-hour days so they could also have a private practice. I was not comfortable with that, so consequently did not pursue those applicants. Frankly, I am regretful that I did not hire these individuals. Without the ability to supplement their income on the outside, physicians are often reluctant to work for us.

CHAIR LESLIE:
The lack of leadership may have contributed to the problems that have occurred in scheduling and other areas identified by the internal audit where doctors were not on duty when they should have been.

DR. COOK:
I agree. This is a huge issue. Effective management by a medical director makes an enormous difference in how hospitals operate and how the staff functions.

CHAIR LESLIE:
What is the plan?

DR. COOK:
For southern Nevada, we are working with the Department of Corrections (NDOC), to develop a Request for Proposal (RFP) to contract with a medical management company for the complete provision of medical and psychiatric services.

CHAIR LESLIE:
This needs to be fleshed out and is the next item on the agenda. What are the benefits to the State to outsource all of the medical and psychiatric services?

DR. COOK:
This is not being done to save money. The Division will be using every dollar it has to initiate this proposal.

As previously stated, there has been a high vacancy rate for years and many of the staff filling our positions are working part-time. Most of the staff find it necessary, or at least advantageous, to have another job while working for the State. They want to work simultaneously in a private practice or for other facilities. This, added to the continuing problem of recruiting and retaining medical directors, has resulted in a lack of management oversight of the current physicians.

The internal audit did not tell us anything that we did not already know about suffering from productivity problems with medical staff. These are problems SNAMHS has been trying to address for years. After reviewing the recommendations from the auditors about providing greater oversight and adding electronic systems to monitor the staff, we decided their recommendations would not work. We have tried those kinds of management tools in the past and they have been less than effective.

CHAIR LESLIE:
On that point, what makes you believe outsourcing will be more effective? If you have not been able to manage the doctors yourself, how do you think the medical company will be able to do that?

DR. COOK:
The proposal is to write a contract that will hold the medical management company responsible for the staffing, productivity of the staffing, and the quality of the services delivered by the staff. The Division will have the ability to monitor them and if the performance is not up to standard, my intention is to withhold funding for failure to meet the contract standards.

CHAIR LESLIE:
What happens to the patients in the meantime?

DR. COOK:
The out clause would be to fire the management company. I am talking about penalizing rather than eliminating the management company. For example, in a situation where an inpatient doctor does not show up for work one day and the management company does not replace that doctor, the management company would be fiscally penalized for that management failure.

CHAIR LESLIE:
People need to see the same doctor. Usually these kinds of contracts result in a different doctor for every visit in an outpatient clinic which would not be in the best interest of the patients.

DR. COOK:
I agree that having one physician over time is of great benefit to the clients. I do not know if this would occur. The contract language could require the vendor to maintain, to the extent possible, stable staffing within the clinics. As a side note, the Division has not achieved the goal of maintaining one doctor for each patient considering the vacancies and turnover in the physician positions.

SENATOR HORSFORD:
I will elaborate on my view. I am not totally opposed to privatization options. I am against making this type of radical change without a plan. I do not understand how your Division can be doing an RFP of this magnitude without providing a plan showing the pros and cons of the current situation compared to how it would be done under this contract.

Many concerns have been expressed by the chair and other committee members concerning continuity of care, liability issues, and management oversight. You say you will have a penalty clause. If a private contractor does not get paid, they will not show up. When that function falls back to you, as the administrator, how will you ensure there is no interruption of services? These things must be resolved before making a change of this magnitude.

It appears the Division has already reached a conclusion. This is a policy decision to be decided by the Legislature. In order to make that decision, we need a plan. I cannot make decisions as an elected official if I do not have the information, the options, and a plan to evaluate. Where is that plan? When you submitted this idea to the Governor, is this the type of presentation you gave him? Did he agree to this change without a plan?

DR. COOK:
The budget proposals before you have been approved by the Governor's Office.

SENATOR HORSFORD:
That was not my question.

DR. COOK:
I have had no direct communication with the Governor on this.

SENATOR HORSFORD:
Was a plan, including the justification for privatizing these functions, submitted for review as part of the *Executive Budget*?

DR. COOK:
No written plan was provided. There were only verbal discussions regarding this budget item.

SENATOR HORSFORD:
How is this Subcommittee supposed to make a decision to privatize mental health services, which is a constitutional obligation, with no plan and nothing more than opinion about how it will work?

ASSEMBLYWOMAN MASTROLUCA:
I have concerns about how the contracted staff will be supervised. It appears you are passing the problem from one hand to the other. The audit reports indicate the Division has not done well in supervising and managing these services by ensuring adequate staff coverage. Who will be supervising and overseeing the medical management company? Is the contracted company going to supervise itself? Once again, where is the plan?

You have indicated if the doctor does not show up you will not pay the contractor. You have had that option with your State employees and that has not worked. I do not understand how you intend to employ a better sense of responsibility to a medical management company, who will be making a profit off the State, versus employees. I understand the difficulties you have had in filling these positions, but what makes you think a management company is going to find people to hire any better than the State?

DR. COOK:
It is not easy to withhold payment from an employee when they are not performing well.

ASSEMBLYWOMAN MASTROLUCA:
I understand, but there are progressive disciplinary actions that can be taken with an employee. If you withhold payment from a medical management company, they can simply stop providing the service.

DR. COOK:
There is that possibility. We are proposing a very large contract involving SNAMHS as well as NDOC. The successful bidder will need to have a large medical staff with the ability to cover for those who may not come to work. In the Division of Mental Health and Developmental Services (MHDS), we have to find someone to cover that vacancy when someone calls in sick.

ASSEMBLYWOMAN MASTROLUCA:
I understand this. My specific question is who is going to supervise these contract employees? Will it be a State employee or is the contract going to provide for those supervisors?

DR. COOK:
The director of SNAMHS will be responsible for supervising the contract with support from the central office fiscal staff.

SENATOR CEGAVSKE:
How long have you been trying to hire qualified people to fill these positions? Has the Division ever privatized services in any of these areas?

DR. COOK:
I have been working for Nevada MHDS since 1999. I was initially hired as the NNAMHS director and worked there for nine years. During that time, there were six medical directors; one lasted two days, and two of them only lasted a couple of months. Because we were unable to recruit successfully, there were significant periods of time where there were acting medical directors.

Regarding SNAMHS, Rawson-Neal Hospital opened in 2006 with a new medical director. That medical director left within two months. Another medical director was hired from existing staff. Since then, they have gone through six more medical directors. The last permanent director was in the position for about six weeks. The Division has been struggling with recruitment and retention of these positions for years.

The Division has never proposed the privatization of an entire program. We do, however, have six contracts with medical management companies to provide temporary medical staff to fill vacancies that occur in our positions.

SENATOR CEGAVSKE:
Have these contracts been successful?

DR. COOK:
Although they are expensive, these contracts have worked well. When a vacancy occurs, the Division requests a temporary replacement to cover for a period of time. There is more than one company to draw from. If one company cannot do it, the next company will.

SENATOR CEGAVSKE:
Is this about offering salaries that compete with other States or about improving the Division's internal management? Are the contracted providers paying their medical staff a more competitive wage? If the way we have been doing things has not worked for years, it is time to try something new.

ASSEMBLYWOMAN CARLTON:
If we do not pay competitively for the services offered by our own staff, we will pay even more for contracted services. It is not rational to pay someone else more than we value our own employees who are expected to do the job every

day. However, it does not appear to be solely a pay issue since some people accept the job and then leave after a short period. There must be other issues involved. It appears we have become the training ground or reference center for people to come in, take the job, get the reference and then move on to a better job. This has occurred in other agencies and I think this is what is happening in MHDS.

SENATOR HORSFORD:
Can you explain why people leave these positions? It sounds like poor working conditions may play a role. The Division is underfunded and there may not be adequate resources for staff to do their job. Before jumping to the conclusion that you cannot find the people to hire, all the factors need to be evaluated including the work environment, pay, supervision, support and workload.

Medical services were privatized in the Ely and women's State prisons years ago. It did not work. The contract was terminated and the services had to be rebuilt from the ground up. Please review what happened with that contract including what the challenges were and why the contract was ended and report back to this Subcommittee. If we did it once and it did not work, why would we do it again? This is the type of information needed to make informed decisions.

DR. COOK:
I will provide that information.

ASSEMBLYMAN HOGAN:
As cited in the June 2009 Division of Internal Audits report, there are fundamental supervision and management problems within SNAMHS related to overseeing the medical and psychiatric services. It appears these problems have existed for a long time. The audit indicates there are standards in place that have not been enforced. Management is all about managing performance, setting standards and meeting standards. Whether the Agency continues to provide the medical and psychiatric services with their own doctors or outsources the services, if these core issues are not addressed, the same supervision and management problems will continue. Solutions and corrective action for providing close oversight of the medical and psychiatric services must be incorporated as part of the plan requested by Senator Horsford.

CHAIR LESLIE:
The fiscal staff has been taking notes on the concerns and requests for additional information. There are a few more items to add to the list. Since the privatization of medical and psychiatric services is a joint venture between MHDS and NDOC, what coordination efforts are occurring on the RFP? What are the time lines? Are there security issues that need to be addressed and will State equipment be used? You indicated there were no cost savings, but the Subcommittee needs more detail about the total fiscal impact for the 2011-2013 biennium budgets for both MHDS and NDOC.

I am not convinced it is wise to jump into total privatization of these services. If we proceed, are there options for contracting for a portion of the services and expanding those services if that proves successful? I understand doing all the inpatient and outpatient services may offer efficiencies for the contractor, but making such a large leap may jeopardize the care of the population being served. Are there any other States that have done this successfully that we could learn from? Obviously, the Subcommittee has numerous concerns. More information is needed before the Subcommittee can endorse this plan.

We will now move to the nonemergency transportation services in decision unit E-325. I have several questions and concerns. First, it does not make sense to provide these transportation services when budget reductions are being made in triage centers, outpatient and inpatient services. What about the liability? There have been situations in southern Nevada where people have jumped out of private transport units. Why are the counties not sharing in these costs? What kind of precedent does this set for the State? Will Washoe County expect a similar transportation service?

E-325 Deliver Public Services Directly and Efficiently — Page DHHS MHDS-87

DR. COOK:
In decision unit E-325, $1,272,000 in FY 2011-2012 and $1,752,000 in FY 2012-2013 is proposed for nonemergency transportation of mentally ill individuals who are medically cleared from local hospital rooms to inpatient and outpatient services at SNAMHS.

This proposal was a last minute addition after the Budget Office advised all the proposed reductions were not needed and there was money that could be added back into this budget for services. The intent is to relieve some of the overcrowding of the emergency rooms in the local hospitals in southern Nevada and move the individuals to an appropriate level of care.

CHAIR LESLIE:
I do not agree with this decision. This is a substantial amount of money that could be used better in other areas. I will be working in the subcommittees to shift this money into services.

We will move on to B/A 101-3645 regarding the Facility for the Mental Offender. The areas of discussion will begin with decision units M-160 and E-603.

HHS – MHDS – Facility for the Mental Offender — Budget Page DHHS MHDS-04 (Volume II)
Budget Account 101-3645

M-160 Position Reductions Approved During Biennium — Page DHHS MHDS-105

E-603 Budget Reductions — Page DHHS MHDS-106

MR. PRATHER:
Decision unit M-160 proposes the reduction of $1,411,689 for the 2011-2013 biennium. The Governor's budget eliminates 12 positions held vacant as approved in the Twenty-sixth Special Session. The positions eliminated include eight forensic specialists, one senior correctional officer, one administrative assistant, one quality assurance specialist, and one psychiatric nurse.

CHAIR LESLIE:
What is the current census at the Lake's Crossing Center compared to the total capacity?

DR. COOK:
This week the census is in the low 60s. The capacity of the main building is 56 and the capacity in the annex is 14.

CHAIR LESLIE:
Has the Agency been able to intake clients who are referred for treatment to competency within the seven-day period required by Division policy?

DR. COOK:
Yes.

CHAIR LESLIE:
Will the Agency be able to meet this requirement if the proposed reductions are approved?

DR. COOK:
We hope so. The agency would not recommend these reductions if it were not for the lack of funding.

CHAIR LESLIE:
These clients cannot be put on a waiting list.

DR. COOK:
This is correct. The patients are committed to the facility by the courts. Once the court has signed the order, the Agency has seven days to admit the individual into the facility.

CHAIR LESLIE:
Does the Agency have a contingency plan if there are more people to admit than there are beds?

DR. COOK:
People could be housed on mats in the gymnasium. This has been done in the past.

CHAIR LESLIE:
These are dangerous people by definition. This is not a good plan.

CHAIR LESLIE:
Have the acuity levels of the Lake's Crossing Center patients increased in recent years?

DR. COOK:
In the past six to nine months, the agency has seen an uptick in aggressive behavior by patients. Typically, when the main facility reaches capacity and the conditions are crowded, the patients become more agitated. Many of these patients can be dangerous and many may not be on medications because they have refused it. When Lake's Crossing was built, it had a capacity of 48. Modifications have been made over the years converting some of the closets and other space into additional beds. The current capacity is 56.

CHAIR LESLIE:
I am always concerned about staff safety at this facility.

DR. COOK:
It is difficult for the Agency to make reductions to this budget. It puts the State at risk for a lawsuit. The crowding of that facility is not desirable. There are plans for a new facility in Las Vegas. Although the State owns the land, there are no funds for building.

CHAIR LESLIE:
There is a point at which budget reductions cause too much risk for staff, the State and the patients. I think we are approaching that point.

Next is B/A 101-3170, regarding Substance Abuse, Prevention and Treatment.

HHS – MHDS – Substance Abuse Prev & Treatment Agcy — Budget Page DHHS MHDS-19 (Volume II)
Budget Account 101-3170

The federal Substance Abuse Prevention and Treatment Agency (SAPTA) block grant requires a maintenance of effort (MOE) specifying that State-funded expenditures remain at a level equal to or greater than the average of those expenditures for the two-year period preceding each federal grant year. A waiver was received in 2010 for not meeting this requirement. Now, it appears

there may be continuing difficulties in meeting this requirement. Also, information has come forth from the Health Division, in a recent Safety Committee, that the State may not receive the $700,000 per year as planned from the Marijuana Registry. Please speak to this issue.

DEBORAH A. MCBRIDE (Health Bureau Chief II, Substance Abuse Prevention and Treatment Agency, Division of Mental Health and Developmental Services, Department of Health and Human Services):
It appears the MOE will be met for this year, spending an estimated $123,630 over the required amount. If the proposed budget reductions for FY 2011-2012 and FY 2012-2013 are approved and monies for the Marijuana Registry are not received, the MOE will be approximately $2.4 million short in FY 2011-2012 and about $1.3 million short in FY 2012-2013.

CHAIR LESLIE:
Do you think it is possible to get waivers for these years?

MS. MCBRIDE:
There are many States throughout the country experiencing the same problems as Nevada. The SAMHSA is aware of the difficulties States are experiencing and has been granting waivers.

CHAIR LESLIE:
What are the consequences if Nevada does not get a waiver?

MS. MCBRIDE:
It is possible federal dollars could be lost. However, I have not heard about that occurring with any other States.

CHAIR LESLIE:
Please explain the position eliminations in decision units E-606 and E-690.

E-606 Staffing and Operating Reductions — Page DHHS MHDS-21

E-690 Budget Reductions — Page DHHS MHDS-23

MR. PRATHER:
Decision unit E-606 proposes a reduction of $180,845 for the 2011-2013 biennium and eliminates an administrative services officer. These duties are being assumed by another administrative services officer.

CHAIR LESLIE:
When are you planning to eliminate it? We understand this position was refilled in November 2010.

DR. COOK:
The plan is to eliminate that position. The incumbent in that position was promoted, rejected during the probationary period and subsequently returned to this position.

CHAIR LESLIE:
Does that mean this person will be laid off at the end of June when the position is eliminated?

DR. COOK:
Yes, unless we are able to transfer the individual to another position.

CHAIR LESLIE:
In decision unit E-690, 5.51 FTEs are being eliminated. Please explain why these particular positions were selected for elimination and what impact this will have on the remaining staff.

MS. MCBRIDE:
Those positions became vacant through attrition. The Agency streamlined and consolidated job functions through reassignment of duties to existing staff so operations can continue without these positions.

CHAIR LESLIE:
Individuals in the community have expressed concerns about management problems in SAPTA. Please provide an organizational chart with a brief narrative describing the staff assignments and staffing plan going forward without these positions.

MS. MCBRIDE:
Yes, I will provide that to you.

SENATOR HORSFORD:
Am I correct in understanding that the State is short by $2.4 million in meeting the MOE required to get approximately $13.7 million in federal funding?

MS. MCBRIDE:
That is correct.

SENATOR HORSFORD:
Does Nevada stand to lose the full $13.7 million in federal funding?

MS. MCBRIDE:
If Nevada does not meet the MOE and is not granted a waiver, the amount of block grant allotment for the next fiscal year is reduced by $1 for every $1 that the MOE is not met. For example, if Nevada was short $2.4 million in meeting the MOE, $2.4 million could be lost in federal funds.

SENATOR HORSFORD:
Nevada is fiftieth in the Nation in dollars spent for substance abuse prevention and treatment. Is that correct?

MS. MCBRIDE:
Yes.

SENATOR HORSFORD:
After this 30 percent reduction it only gets worse. Why would Nevada even consider putting itself at risk of losing any federal dollars?

How did the Agency determine the disproportionate share of the recommended funding reductions? Why are co-occurring disorders treatment reduced by 68 percent, prevention programs by 13 percent, and substance abuse treatment services by 29 percent?

MS. MCBRIDE:
Prevention has already been reduced by approximately 34 percent. It was determined some of the services for co-occurring disorders could be covered under our block grant, enabling us to lessen the cost of treatment dollars in this budget.

SENATOR HORSFORD:
I want to speak in terms of real people. There are 173 individuals who will no longer receive support in co-occurring disorders treatment, 301 adolescents who will no longer receive direct service programs under prevention and community coalition, 273 individuals who participate in treatment provided by community nonprofit providers who will no longer be served. These are real people who will not have anywhere else to go for help.

I know your decisions are difficult. You were probably told to just get to a cost savings number. However, it appears your Division has a larger share of reductions compared to other agencies. The overall funding is being reduced almost 25 percent from two years ago. This is not shared sacrifice among agencies. People should not have to lose basic treatment services because other agencies are not paying their share.

CHAIR LESLIE:
I agree. You cannot imagine how discouraged I am after fighting so hard to put more money into treatment over the past four years to be losing so much ground.

The co-occurring disorders program was a pilot program last year that I heard had excellent results, yet it is now being cut 68 percent. What services will be left?

MS. MCBRIDE:
The same services will continue but funding will shift to SAPTA. The infrastructure and networking with mental health agencies and providers is already set up.

CHAIR LESLIE:
Will the core program continue at the same capacity?

MS. MCBRIDE:
It is estimated the number of clients served will be reduced by 173.

CHAIR LESLIE:
How many people are served now?

MS. MCBRIDE:
Last year, 653 clients were served by utilizing a network of services offered by mental health agencies and providers.

CHAIR LESLIE:
You contract with organizations for services north and south for this program. Will the community contracts be reduced by 68 percent?

MS. MCBRIDE:
Some of the reduction will be backfilled with SAPTA dollars.

CHAIR LESLIE:
Please provide the reduction amount that will occur for the community providers and the total amount of individuals planned to be served in this program for the 2011-2013 biennium. What amount will be shifted to SAPTA and what services will be supplanted by block grant funds that this program is replacing?

MS. MCBRIDE:
I will provide this information.

CHAIR LESLIE:
Prevention grants are being reduced by 13 percent. How did the Agency come up with this amount?

MS. MCBRIDE:
The Agency is proposing a reduction of $112,000 or 4.5 percent, in the State Prevention Infrastructure funding for each fiscal year.

CHAIR LESLIE:
What will that mean?

MS. MCBRIDE:
There will be an estimated 301 fewer clients receiving prevention services throughout Nevada.

CHAIR LESLIE:
Nevada has never had enough treatment funding and now another 29 percent reduction is proposed. This is devastating. What is the reduced amount for treatment services and how many people will not get treatment?

MS. MCBRIDE:
The reduction for the waiting list is going to be approximately $1.85 million for each fiscal year. That will leave about $420,000 for the waiting list for each fiscal year. This will impact about 273 clients. Wait times for access to treatment programs will increase and the average number of days may also increase.

CHAIR LESLIE:
Will both inpatient and outpatient services be cut?

MS. MCBRIDE:
Both would be reduced.

CHAIR LESLIE:
Are new RFPs being done or will all providers experience a reduction?

MS. MCBRIDE:
That decision has not been made. Most likely, there will be an evenly distributed reduction across the board to all existing providers receiving the waiting list funding.

CHAIR LESLIE:
Are some of these providers getting to the point where they will not be able to participate due to inadequate funding?

MS. MCBRIDE:
I cannot answer that question.

CHAIR LESLIE:
Please remember to get the updated information to correct the amount of the funds coming into this account from the Marijuana Registry. Are you planning to use these funds to meet the requirements of Senate Bill (S.B.) No. 343 of the 75th Session regarding treatment services for abused children?

DR. COOK:
The plan is to provide treatment services as required in S.B. No. 343 of the 75th Session for the parents of children in the custody of child welfare.

CHAIR LESLIE:
How will the Agency determine who gets these funds?

MS. MCBRIDE:
An RFP will be done to determine which providers are interested in providing this service.

SENATOR HORSFORD:
Was the $700,000 transfer from the Marijuana Registry for each of the fiscal years part of the recommendation in the *Executive Budget*?

DR. COOK:
Yes, it was.

SENATOR HORSFORD:
If this has to be adjusted to a lower amount, will the Agency reduce this budget further or meet with the Governor to revise this budget? This budget already has more than a 24 percent reduction.

DR. COOK:
This money is for a new program. If there are no adequate funds, the program will not be implemented or will be implemented with less funds.

CHAIR LESLIE:
This transfer was excess money from the Marijuana Registry that was not being used. It was a creative effort by the Department of Health and Human Services (DHHS) to offer treatment services for parents of abused children. If this money

is reduced, fewer treatment services will be available for this particular clientele and some may not get the substance abuse treatment they need.

SENATOR HORSFORD:
Any reduction in these funds will leave another hole in this budget. The Agency needs to talk to the Health Division to find out the corrected amount of the Marijuana Registry transfer. If the available amount is less, the disproportionate reduction in treatment services will be greater than 24 percent. There must be an amendment to this budget if that full funding will not be available.

CHAIR LESLIE:
I agree. Reducing this transfer will also increase the MOE shortfall.

DR. COOK:
I will make the necessary modifications and report back.

ASSEMBLYWOMAN MASTROLUCA:
Has the Agency provided the services discussed in S.B. No. 343 of the 75th Session?

DR. COOK:
These services are not currently being provided. The Department has had difficulty implementing the legislation passed in S.B. No. 343 of the 75th Session. The Marijuana Registry funds were intended to set up programs to specifically provide those services.

ASSEMBLYWOMAN MASTROLUCA:
Have performance indicators and outcomes been established for this program in anticipation of it starting in 2012?

DR. COOK:
No, the Agency has not done this.

ASSEMBLYWOMAN MASTROLUCA:
It would be helpful to have performance indicators.

DR. COOK:
I will provide performance indicators.

CHAIR LESLIE:
I have one more question regarding the co-occurring disorders program. I understand many of the clients referred to the co-occurring disorders program come from the criminal justice system. There may be an impact in the criminal justice area if that program is reduced and the prevention and treatment programs are also reduced.

MS. MCBRIDE:
I do not have that information with me but I will get it and report back.

CHAIR LESLIE:
Next, we will address B/A 101-3166 regarding the Family Preservation Program (FPP). The major issue here is the caseload increase in decision M-200.

HHS – MHDS – Family Preservation Program — Budget Page DHHS MHDS-27 (Volume II)
Budget Account 101-3166

M-200 Demographics/Caseload Changes — Page DHHS MHDS-27

MR. PRATHER:
Decision unit M-200 provides funding for caseload growth during FY 2011-2012 and FY 2012-2013 at the FY 2006-2007 legislatively approved rate of $374 per family. The caseload projection is based on a linear regression of 36 months ending April 30, 2010. Projections indicate an additional 72 FPP participants will be added in FY 2011-2012 and another 26 participants in FY 2012-2013 totaling 98 participants to be added over the biennium.

ASSEMBLYWOMAN MASTROLUCA:
Will the monthly allotments decrease below the legislatively approved funding levels?

JANE GRUNER (Deputy Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services):
No, they remain at $374.

ASSEMBLYWOMAN MASTROLUCA:
Does this mean you will not be able to serve everyone who applies?

MS. GRUNER:
Yes, that is correct. There is a bill draft request that will be heard this session to allow for a waiting list. The reason the number served is limited versus dropping the monthly allotment is because dropping the monthly amount any lower results in not providing the benefit it was designed to do.

ASSEMBLYWOMAN MASTROLUCA:
How will the waiting list work?

MS. GRUNER:
When a family leaves the program, another family from the waiting list would take their place.

ASSEMBLYWOMAN MASTROLUCA:
Is the Agency confident there will be adequate funding to cover the projected caseload?

MS. GRUNER:
We have had an unusual occurrence with the downturn in the economy. More individuals are choosing to stay home with their families, increasing the demand for FPP as well as the jobs and day training programs. If the economy continues to decline, this budget may not cover the need.

MR. PRATHER:
Decision unit E-690 replaces General Fund with Tobacco Settlement funds for FFP in FY 2012-2013 only. This item resulted from item 10 in the *Reforms to State Government* section of the final *Report of the Legislative Committee for the Fundamental Review of Base Budgets of State Agencies* as presented to the Interim Finance Committee on December 17, 2010.

ASSEMBLYWOMAN MASTROLUCA:
How did the Division prioritize the use of Tobacco Settlement funds to offset General Fund support in this budget?

DR. COOK:
This was done in coordination with the other divisions within DHHS. An effort was made to identify programs that could best utilize these funds and this was determined to be the best choice.

ASSEMBLYWOMAN MASTROLUCA:
Since this is limited to FY 2012-2013, what happens after that?

DR. COOK:
I will have to get back to you with the response to this question.

ASSEMBLYWOMAN MASTROLUCA:
I am stunned. We are talking about $1.2 million. It seems it would be important to be looking ahead to what will happen after FY 2012-2013.

CHAIR LESLIE:
We will now discuss developmental services. The developmental services agencies of MHDS provide service coordination, family support/respite, community residential services, and jobs and day training to individuals with developmental disabilities and related conditions Statewide through three regional centers: Desert Regional Center in Clark County; Sierra Regional Center in Washoe County; and the Rural Regional Center for the remainder of the State with its main office located in Carson City. There are service reductions in several of the developmental services programs. We will begin with the elimination of the self-directed autism services.

MS. GRUNER:
The *Executive Budget* for 2011-2013 biennium budget eliminates Self Directed Autism Services in B/A 101-3167, B/A 101-3279, and B/A 101-3280. The specific decision units for each account are E-601 and E-664. These budget reductions eliminate 174 slots for individuals with autism.

HHS – MHDS – Rural Regional Center — Budget Page DHHS MHDS-48 (Volume II)
Budget Account 101-3167

E-601 Budget Reductions — Page DHHS MHDS-50

E-664 Program Reductions/Reductions to Services — Page DHHS MHDS-51

HHS – MHDS – Desert Regional Center — Budget Page DHHS MHDS-38 (Volume II)
Budget Account 101-3279

E-601 Budget Reductions — Page DHHS MHDS-40

E-664 Program Reductions/Reductions to Services — Page DHHS MHDS-42

HHS – MHDS – Sierra Regional Center — Budget Page DHHS MHDS-29 (Volume II)
Budget Account 101-3280

E-601 Budget Reductions — Page DHHS MHDS-32

E-664 Program Reductions/Reductions to Services — Page DHHS MHDS-33

Many gains, including vast improvements in the skill acquisition levels of the participants, have been made for those who have received autism services.

Historically, these services were funded with the Temporary Assistance to Needy Families (TANF) monies and General Fund appropriations in the Twenty-sixth Special Session, the TANF money had to be redirected to its core mission. The legislators added General Fund monies for autism services. Unfortunately, this funding ends June 30, 2011. The proposed 2011-2013 *Executive Budget* moves the individuals who are currently receiving autism services to the residential support program which will allow them to complete their program with the same level of funding. There are no funds to add new participants.

In the meantime, representatives from the Commission on Autism, the DHHS have developed a proposal for a process entitled "One Path for Autism Treatment." This model program is aimed at getting the most out of the dollars spent, places the child as the core of the service delivery model with emphasis on early diagnosis and provider intensive evidence based service delivery focused on children from birth to six years old. Research strongly supports this as the critical time period where the most gains will occur.

CHAIR LESLIE:
I am aware of these efforts and believe they are noteworthy; however, those discussions will be deferred to the policy committee.

In summary, regarding the proposed cuts to the autism services, 174 families currently receiving services will continue to receive services until their program is finished. No new people will be added.

MS. GRUNER:
That is correct.

CHAIR LESLIE:
I will take testimony before continuing with the budget hearings.

JAN M. CRANDY (Commissioner, Nevada Commission on Autism Spectrum Disorders):
Please refer to my prepared testimony (Exhibit C). Also, please refer to the report from Wisconsin summarizing their findings for postponing treatment for persons with autism (Exhibit D).

SHANNON SPRINGER:
My 11-year old daughter, Joy, has autism. Joy did not receive early intervention services. She is progressing, but not doing as well as she would have if she had help at an earlier age.

I am here today on behalf of the families and children on the waiting list who will not receive services because of these proposed budget reductions. I do not want them to suffer through the difficulties my husband and I have had to go through. It is hard enough to have a child with autism, but far more difficult

with no help. There are 300 children waiting to get autism services. Early intervention provides approximately seven hours per week. With help, they have a chance. Without help, they will become lifelong dependents costing far more in the long run.

Parents are doing their part to help their children. It is, however, extremely stressful to have a child with autism. In my case, both my husband and I are working and are trying to homeschool Joy. Because of her special needs, she does not fit into the public education system. Beyond being a parent, I must be a teacher, lawyer, advocate, doctor and friend to my child. Early intervention is critical, but people with autism also need help as they get older. Most will probably need some support services for their entire lives. Please do everything you can to make autism funds available to the children on the waiting list and to preserve funding for disabled adults living in supported living environments.

CHAIR LESLIE:
We will do our best. Thank you for taking the time to share your comments with us.

TONI RICHARD:
My son, Tyler, has autism. One and one-half years ago, when he first started receiving autism services, he could only speak two words. Tyler is now speaking many words and is starting to read. He will read a statement to the Subcommittee that we wrote a few minutes ago in the lobby (Exhibit E). Early intervention does work.

JOEY ALEXANDER:
My son has autism and has benefited from the autism services. Thank you for this funding which has made a difference in my son's life. He can now tell me he loves me and he is cognitive enough to have a wonderful sense of humor. When he plays on the playground with normal children, the teachers cannot visibly see a difference between him and the other children. At the same time, his special needs are not met in the public school system. The school district's job is not to rehabilitate, but merely to accommodate. That means my son is allowed to attend and sit there with everyone else. They do not have the resources, or even the ability, to teach my son. The autism services received through the program you are proposing to terminate have improved my son's

life and have increased his skills. If you cut these services, the children on the waiting list will not get the same chance my son was given. They will be denied the help they so desperately need.

KELLY UPP:
I am a parent of a child who has autism. My son, Tyler, turned five years old last week. He was diagnosed with autism at 22 months of age. Instead of thinking about kindergarten and birthday parties and doing other things normal kids do, he struggled with the afflictions of autism. My husband and I do not know how we will be able to continue his therapy services if these funds are terminated. We were lucky to get this funding. In three years, our son has made amazing progress learning so many basic skills to help him become independent. We hope with only another year or two he will never need therapy or State services again. While most families in Nevada are struggling to pay rent and buy food, families with autism are struggling to do the same, but with the added costs of thousands of dollars trying to get help for their child's disability. Sometimes we feel like our kids really do not count. My husband and I have spent our entire savings and have walked away from our home. We have spent over $80,000 in the last three years to continue programs to help our son.

We were devastated to learn we are one of many families who will not get help. Our money is gone and there is no relief in sight. With no money, no insurance and this funding being terminated, we are left with nothing to help our son. If our son loses his autism therapy, we will lose the best chance he has for having a good outcome. We do not want him to be a burden on the system longer than necessary. Autistic children need and deserve these services. While we are so grateful for the funding we have received, we ask you to please find it in your hearts not to cut any funding so those children on the waiting lists can be reached.

CHAIR LESLIE:
Please be assured your children do count.

We will finish the budgets and then will reopen the hearing for public comment.

MS. GRUNER:
The next item is the family support program. This program provides financial assistance to 230 low-income families with children under the age of 18 in their own homes. This funding purchases direct services such as speech, behavioral therapies and adaptive skill development training which are delivered through three regional center budgets, 101-3167, 101-3279 and 101-3280 in decision units E-602 and E-664 of each budget. The *Executive Budget* for the 2011-2013 biennium recommends eliminating the family support program.

HHS – MHDS – Rural Regional Center — Budget Page DHHS MHDS-48 (Volume II)
Budget Account 101-3167

E-602 Budget Reductions — Page DHHS MHDS-51

E-664 Program Reductions/Reductions to Services — Page DHHS MHDS-51

HHS – MHDS – Desert Regional Center — Budget Page DHHS MHDS-38 (Volume II)
Budget Account 101-3279

E-602 Budget Reductions — Page DHHS MHDS-41

E-664 Program Reductions/Reductions to Services — Page DHHS MHDS-42

HHS – MHDS – Sierra Regional Center — Budget Page DHHS MHDS-29 (Volume II)
Budget Account 101-3280

E-602 Budget Reductions — Page DHHS MHDS-32

E-664 Program Reductions/Reductions to Services — Page DHHS MHDS-33

CHAIR LESLIE:
If these services are terminated, are any other services available to these families?

MS. GRUNER:
The only service left at the regional centers will be respite care. There will be a waiting list to get in-home support through the residential program.

CHAIR LESLIE:
Have these families been notified and, if so, what has the feedback been?

MS. GRUNER:
The families have not been notified. Most of them may have heard from their service coordinators whom they meet with on a regular basis.

CHAIR LESLIE:
We will move on to the elimination of behavioral supports and crisis intervention within the same three regional budgets, decision units E-600 and E-697.

HHS – MHDS – Rural Regional Center — Budget Page DHHS MHDS-48 (Volume II)
Budget Account 101-3167

E-697 Budget Reductions — Page DHHS MHDS-54

HHS – MHDS – Desert Regional Center — Budget Page DHHS MHDS-38 (Volume II)
Budget Account 101-3279

E-697 Budget Reductions — Page DHHS MHDS-45

HHS – MHDS – Sierra Regional Center — Budget Page DHHS MHDS-29 (Volume II)
Budget Account 101-3280

E-600 Budget Reductions — Page DHHS MHDS-31

E-697 Budget Reductions — Page DHHS MHDS-35

MR. PRATHER:
Decision unit E-697 proposes the elimination of approximately $687,000 supporting behavioral health and eliminates four FTEs. The eliminated positions include one licensed psychologist and three mental health counselors for the Behavioral Health/Crisis Intervention programs. These positions provide mental health treatment and counseling services, along with psychoeducational support for individuals with developmental disabilities who have intensive behavioral problems and their families to live safely in their communities. In addition, these positions assist community partners when individuals are disruptive within their supported living environments.

CHAIR LESLIE:
What does that mean in terms of impact to the clients and families?

MS. GRUNER:
This will affect the psychosocial groups and counseling services received by families.

CHAIR LESLIE:
With this elimination, will they have any access to these services?

MS. GRUNER:
They would have access to services offered at the regional centers where some counseling staff will continue.

The majority of the crisis and intervention team was eliminated during the last budget cycle. This reduction will eliminate the remaining crisis intervention staff who have been working closely with the providers in resolving serious behavior issues.

CHAIR LESLIE:
Through my own work, I have encountered some of the people utilizing these services and have observed some of the behaviors. I have seen the work that these crisis intervention people do to maintain placements. Now, it is being eliminated and the counselors at the regional centers will have to address these crises.

MS. GRUNER:
Yes, the crisis intervention staff have done an incredible job and this reduction will be a huge loss to our agency.

CHAIR LESLIE:
Without the intervention, some of the recipients may end up in jail due to behavior issues that may be classified as domestic violence. If they go to jail, the jail is not prepared to deal with the mental health issues.

MS. GRUNER:
Unfortunately, that is true.

CHAIR LESLIE:
This is so devastating. Let us get through this budget. Next, we will review reducing supported living arrangements at Desert Regional Center, in decision unit E-650 of B/A 101-3279.

E-650 Program Limits or Rate Reductions — Page DHHS MHDS-41

MR. PRATHER:
Decision Unit E-650 proposes the elimination of $4.9 million in the SLA program for the 2011-2013 biennium. This decision unit eliminates funding for 54 SLA residential placements at the Desert Regional Center that are not currently filled.

CHAIR LESLIE:
Are they not filled because there is no need for them?

MS. GRUNER:
This is one of the areas impacted by the economy. Fewer people have requested out of home placements. There are more individuals choosing to live with family members. The SLA caseload has stabilized.

CHAIR LESLIE:
What if the demand increases?

MS. GRUNER:
I am assuming that will happen. This allowed us to get to the targeted budget without cutting as many current services. If the demand increases, people requesting services would be put on a waiting list.

SENATOR HORSFORD:
I have a couple of questions going back to the self-directed autism program. How long will the program be continued for the families receiving autism services utilizing the TANF funding? Secondly, what is the number of families currently on the waiting list for autism services?

MS. GRUNER:
The autism services will continue for TANF funded families using residential services funds. The program will continue until the children finish their programs or until the children reach age ten. The number of families on the waiting list for autism services is 134 statewide.

SENATOR HORSFORD:
In summary, we are currently serving 174 children with 134 on the waiting list for the self-directed autism program.

MS. GRUNER:
That is correct.

SENATOR HORSFORD:
How many are on the waiting list for the Self-Directed Family Support Program?

MS. GRUNER:
There is no waiting list. People receive services if funding is available.

SENATOR HORSFORD:
How many people are on the waiting list for behavioral support services?

MS. GRUNER:
There is no waiting list for this program. Currently everyone is being served. There has been enough staff to address the needs up to this point.

CHAIR LESLIE:
We will now move to county reimbursements for services to children. Once again this crosses over into three budgets, 101-3167, 101-3279 and 101-3280, decision unit E-694 in each account.

HHS – MHDS – Rural Regional Center — Budget Page DHHS MHDS-48 (Volume II)
Budget Account 101-3167

E-694 Budget Reductions — Page DHHS MHDS-53

HHS – MHDS – Desert Regional Center — Budget Page DHHS MHDS-38 (Volume II)
Budget Account 101-3279

E-694 Budget Reductions — Page DHHS MHDS-44

HHS – MHDS – Sierra Regional Center — Budget Page DHHS MHDS-29 (Volume II)
Budget Account 101-3280

E-694 Budget Reductions — Page DHHS MHDS-35

MR. PRATHER:
The cost of children's services, in the amount of approximately $11.5 million, will be transferred to the county in which the child resides. This is being done in accordance with *Nevada Revised Statutes* (NRS) 435.010.

MS. GRUNER:
The State works diligently with the county in coordinating services. The consequence of this change is the counties will have a small amount of time to fiscally make the transition.

CHAIR LESLIE:
Before going any further, what is the premise for making this change?

As I understand it, this is based on NRS 435.010 which indicates Boards and County Commissioners of the various counties shall make provisions for the support, education and care of children with mental retardation and children with related conditions through their respective counties.

Has the State ever charged the counties previously?

MS. GRUNER:
No, to my knowledge the State has never charged the counties under this provision.

CHAIR LESLIE:
Has anyone talked to the counties about this?

MS. GRUNER:
As an administrator, I have not talked to the counties on this issue. From working with many county partners during the past two years consolidating efforts to deliver services, I know the counties are struggling with their own budget shortfalls. This added financial responsibility will be difficult for them to assume.

CHAIR LESLIE:
This is a situation in which the State will provide the services and send the bill to the counties. If the counties do not pay the bill, what happens to these clients?

MS. GRUNER:
The regional centers would lose approximately 34 service coordinators and the State would not be able to provide children's services outside the Home and Community Based Waiver program.

CHAIR LESLIE:
Is there a concern that if some rural counties do not pay, those families will move to Washoe or Clark County?

MS. GRUNER:
There is potential that may occur.

CHAIR LESLIE:
Do you have a chart showing how much each county will have to pay?

MS. GRUNER:
It is a moving target but that information is available.

ASSEMBLYWOMAN MASTROLUCA:
Please explain how you arrived at $11.5 million.

MS. GRUNER:
The $11.5 million is the estimated General Fund cost for the services of approximately 1,545 children. The costs were extrapolated using one typical month of services including out of home placements not supported by the Home and Community Based Waiver, respite and the family support monthly allotments. This number can change daily considering the number of services and number of children served.

ASSEMBLYWOMAN MASTROLUCA:
If this transfer to the counties is based solely on NRS 435.010, I suggest you also look at NRS 436.230 which states that counties are given reimbursement by the State for a list of services including mental health services.

CHAIR LESLIE:
Is the State putting some of the Medicaid reimbursements at risk if the counties do not pay?

MS. GRUNER:
Yes, this could affect the service coordination piece.

CHAIR LESLIE:
This looks problematic to me.

MICHAEL J. CHAPMAN (Principal Deputy Fiscal Analyst, Fiscal Analysis Division, Legislative Counsel Bureau):
During the course of reviewing this item, it came to Staff's attention that there appears to be an overstatement of the General Fund reduction as well as the County reimbursement amount. Will there be a budget amendment on this item

for further consideration by the Subcommittee? This number would change the General Fund and county reimbursement by $385,460 in FY 2011-2012 and $604,292 in FY 2012-2013. I brought it to Dr. Cook's attention earlier in the week.

MS. GRUNER:
Yes, there will be a budget amendment correcting these amounts.

CHAIR LESLIE:
It appears we have covered everything in B/A 101-3280 regarding Sierra Regional Center and B/A 101-3279 for Desert Regional Center. The last item for discussion is Rural Regional Center B/A 101-3167, decision unit E-667, which eliminates two developmental specialist III positions, one in Gardnerville and one in Elko. Why are these positions being eliminated?

HHS – MHDS – Rural Regional Center — Budget Page DHHS MHDS-48 (Volume II)
Budget Account 101-3167

E-667 Program Reductions/Reductions to Services — Page DHHS MHDS-51

MS. GRUNER:
The reason these two positions are being eliminated is because of reduced caseload. Staffing is based on a ratio of 1:45.

CHAIR LESLIE:
Do you believe you will be able to handle all the clients for Gardnerville and Elko with the reduced staff?

MS. GRUNER:
Yes, that is the plan.

SENATOR HORSFORD:
When the budgets were prepared, were you given a directive to reduce the budgets by a specified percentage?

DR. COOK:
Yes, the Agency was given a budget reduction target. The proposed budget before you meets that target.

SENATOR HORSFORD:
When the Agency budget was prepared, was it approached with a plan to make strategic reductions and possibly even eliminations of certain functions versus an across the board approach to simply get to a targeted number?

DR. COOK:
We utilized the priorities and performance measure budgeting system in part. We took a look at what we considered core services and started the reductions from the outside, or fringes of the budget, and worked our way toward the core services. This is why you see no equipment purchases in this budget. This is why you see positions deleted that have been vacant for a period of time. Programs considered to be valuable, but not considered core programs, are being eliminated.

SENATOR HORSFORD:
What was the target budget number by which you were told to reduce spending?

DR. COOK:
The goal was to create a budget that did not increase above the FY 2011-2012 amount of $617 million.

SENATOR HORSFORD:
That was not my question. You said you were required to meet a reduction percentage. Can you provide a ballpark number of what that reduction is?

DR. COOK:
The target reduction was somewhere between 15 percent and 20 percent overall.

SENATOR HORSFORD:
Were you told this would be your number and you had to figure out a way to operate within that number? Someone made a decision to reduce mental health

services in these program areas up to 20 percent to get you to that target number.

DR. COOK:
That is correct.

SENATOR HORSFORD:
The point I am trying to make is that, despite ideological views or personal passion or experience with these programs, when one measures the decisions in these budgets against the decisions across all the other agencies, this is not fair and equitable, and it is not shared sacrifice. This budget represents a disproportionate reduction in funding. I find it alarming because of the constitutional requirement that we provide these services over others funded in our State government.

This is about Nevada's commitment to Nevada's families and their children. We have talked about the optimism of our State and the State being a great place, but when it comes to mental health services, Nevada has never done well. We made some advancement over the last decade but now are dismantling that progress. We are not just dismantling it in a specific budget account number; we are dismantling it for the children and families who depend on these vital services. How can we expect to have a strong, vibrant State if our families and children are not strong? These are our most vulnerable families and children. These are families who are literally trying to make every end meet. It sounds as though they are doing their part, but we are turning our backs on them considering the level of proposed reductions in these services.

We must question why mental health and developmental services were targeted at all. I have not heard an explanation. There is no rationale. I hear there are waiting lists and the needs are great. We know Nevada is fiftieth in all of these things so it is not likely there is waste, inefficiency, or duplication. We heard none of those things today. I am waiting for someone to tell me why this budget was disproportionately targeted for reduction.

CHAIR LESLIE:
It is clear why. This is where a large amount of General Fund dollars are spent and there is not enough revenue. Regardless of the reasons, these reductions are unacceptable.

We will take some public testimony starting with developmental services, and then substance abuse and if there is time, some testimony on mental health.

LAVONNE BROOKS (President and Chief Executive Officer, High Sierra Industries):
I am here today as the president and CEO of High Sierra Industries and Washoe Association for Retarded Citizens of Northern Nevada. I am also a member of the Northern Nevada Association of Service Providers. There are several of us who will be speaking today on behalf of many hundreds of providers that support over 5,300 people with disabilities who are supported by the regional centers, and many hundreds more served through organizations like DETR, Vocational Rehab and Nevada Early Intervention.

We will be touching briefly on three major areas in our testimony this morning. First is our concern that this budget has no funding for caseload growth. Secondly, organizations like ours are already stretched to a breaking point. The rates we are receiving were established in 2002 and are no longer adequate to cover expenses. Please refer to the graph entitled, "HSI Supported Living Arrangements Trend Report" (Exhibit F) which illustrates the revenue, total expenses and net loss experienced by High Sierra Industries supported living arrangements for 2005 through the first two months in 2011.

Today you will hear from several people served in Southern Nevada and here in Northern Nevada. In a few minutes, we will share some information with you regarding the paper that is taped on the wall relative to the process improvement efforts that we have been collaboratively working on throughout the State.

EDWARD R. GUTHRIE (Executive Director, Opportunity Village):
Opportunity Village is a community training center that provides assessment training, employment and therapeutic day training services for some of the most vulnerable people in our community, people with intellectual and developmental disabilities. Refer to the handout entitled "Opportunity Village, Caseload Growth

for Jobs & Day Training," (Exhibit G) for specific information regarding the increased need for our services. In the 12 months that ended in December 2010, Opportunity Village provided services to over 1,500 different individuals which do not include the hundreds of people who attend our recreation events and the hundreds more who receive advocacy and referral services from us.

People with disabilities, especially people with intellectual disabilities, need champions to represent them because they often find it difficult to speak for themselves. Many of you on this Subcommittee have been champions for them in the past by helping to protect services and benefits for them.

As you probably know, jobs and day training was started as a partnership between community training centers and the State. Nonprofit agencies, like Opportunity Village, were supposed to leverage State funds to generate additional funds through charitable donations and contract revenue. Last year the jobs and day training services provided about 25 percent of the revenue for Opportunity Village. The other 75 percent of those revenues came from contract revenues and private donations. The program is doing what you intended for it to do. Additionally, the State uses home and community based services to finance part of the jobs and day training program.

Through the jobs and day training programs people with disabilities have real jobs with real pay. Opportunity Village provided people with $3.8 million in wages last year. Another 142 individuals were referred to competitive employment where they generated another $2.4 million in wages. This money, in part, pays for the extra support and supervision needed for these participants to retain their jobs. Research shows for every person placed in a job, dependency on Welfare, Medicaid and other benefits is reduced by $5,000 a year. Placing 142 people in jobs and other people in community jobs has saved the taxpayer at least $1 million a year. There are savings in other areas. For example, many adults with intellectual disabilities live with their family members. If the State had to pay for those individuals to receive services in community residences, or other areas, it would cost the State tens of millions of dollars more than the State is already paying.

There are waiting lists for jobs and training services in all areas of Nevada. At the first of the year, Desert Regional Center had 353 people on a waiting list for jobs and day training services. This waiting list only includes the people who have received an assessment from Desert Regional Center. There are more people awaiting assessments. Clark County School District representatives report there are 295 additional students between the ages of 19 and 21 who will graduate over the next 2 years who will need jobs and training services. This means there is a total potential service load of 648 individuals who will need services and there are no funds for caseload growth.

Opportunity Village has tried to do its part to deal with this caseload growth. The people in the audience with the blue t-shirts represent over 50 people that we recruited to sponsor services for individuals who are on the waiting list. We were successful in recruiting donors to provide us with $700,000 last year to help support people who are on the waiting list for services. Therefore, we were able to serve 150 of the 350 people who are currently on the waiting list. However, that leaves 250 people on the waiting list in Southern Nevada and another 295 individuals who will be graduating from the schools in the next 2 years who also need services. Opportunity Village has made its best effort to fill the gap with private donations. We have been relatively successful. However, there are still many people waiting for services. If there is any money available through the State, we hope the State will recognize the value of these services for these individuals and their families and consider adding some funds for caseload growth to take care of those waiting for services.

BRIAN M. PATCHETT (President and Chief Executive Officer, Easter Seals Southern Nevada):
In addition to being the President and Chief Executive Officer of Easter Seals, I am also a member of the State of Nevada Association of Providers which is a group of providers in southern Nevada. Easter Seals over the last year interacted with, or served, approximately 6,000 individuals in southern Nevada. Please refer to my prepared testimony (Exhibit H).

What Easter Seals has seen over the past several months is a reduction in not only the total service dollars, but also the number of hours is being reduced. In some mental health cases, the hours have been reduced so much we have been unable to take care of them and they had to be institutionalized.

The only way Easter Seals has continued to survive is because of donations. Unfortunately, donations have declined as much as 25 percent.

MS. BROOKS:
What you see on the wall is the collaboration work started almost a year ago with a group of people from the regional centers and providers. This is the first step in a process improvement effort. What is immediately obvious is the complexity of the process. Inefficiencies exist with endless and needless approval loops. Collectively, we want to pay our employees, whether they are State employees or providers, to deliver services rather than to sit in an office filling out reams of paper.

Improvement efforts will be focused in three major areas: Improve the provider qualification, contracting and accountability process up front, develop and implement an assessment process for individuals served that follows the person, is evidence-based, and holistic in that it assesses the person in several natural environments; and work on understanding and reducing the number of coalitions, committees, groups, and task forces and reduce them to a vital few that are collaborative and working Statewide.

Our plan is to pilot these changes within the three regional centers with participation from State leadership and staff as well as from private providers.

DANA R. MACDONALD (Executive Director, Disability Resources, Inc):
I am an SLA provider in Sparks, Nevada. I am also a member of the Northern Nevada Services Providers and Vice President of the Board for the Alliance for Nevada Nonprofits. I would like to introduce Martha Brown who is here representing the thousands of Nevadans with intellectual disabilities whose lives depend on SLAs.

MARTHA BROWN:
I am a resident of Sparks, Nevada. I have an intellectual disability. I have lived in Nevada since 1964 and graduated from Wooster High School in 1968. Thank you for all that you have done for people with disabilities. With the State's support, I have been allowed to exercise my civil rights. I have been able to live in my own apartment, visit with my friends and go to the church of my choice. Unfortunately, things have not always been this good. I have seen changes in

the way people with disabilities have been treated in our State. In the past, I and others were treated badly. I had to live in group homes or the State hospital where sometimes I was not even fed properly. There were times I was isolated from my friends; caregivers would hit me or yell at me and tell me they were going to kick me out. Please do not make me return to living in a group home. Please protect the SLA services for people like me with disabilities. We need your help to protect those who cannot protect themselves.

CHAIR LESLIE:
Thank you for that great testimony. Next, we will hear some testimony regarding substance abuse.

CHRISTY MCGILL (Executive Director, Healthy Communities Coalition of Lyon and Storey Counties):
Our substance abuse prevention and treatment system is no frills. On the treatment side, when you are talking about cuts, these are cuts to services. I will give you one quick recent example where the lack of services cost someone their life. I was trying to get a veteran into treatment. I was unable to do it. It took three or four days and we lost him. It was especially unfortunate because his elderly parents also needed support. This is one of many examples where people are getting passed over because of lack of services.

The role of prevention is to do whatever it takes. Prevention providers do a lot with a small amount of money. Their role in the system is to help families and students. Do not underestimate the power of our compassion. I am proud to be a Nevadan and I want to provide services. I also own a business and come from a very conservative family. I would rather shoulder some of this than to continue to hear these sad stories and have the weakest individuals shoulder this budget deficit.

KEVIN QUINT (Executive Director, Join Together Northern Nevada):
I have submitted prepared testimony (Exhibit I) in support of preserving the core services for prevention and treatment so that both can continue to serve as a continuum of services throughout all the Nevada communities.

BARRY LOVGREN:
Please refer to my attached prepared testimony (Exhibit J) regarding problems I have identified with SAPTA budget and State Plan.

CHAIR LESLIE:
I would like to announce that during the meeting I received e-mails from Washoe and Clark Counties saying they have not been consulted about the transfer of fiscal responsibility of any of the programs discussed in today's meeting.

STUART GORDON (Executive Director, Family Counseling Service of Northern Nevada):
Family counseling was approached by NNAMHS in 1996 to provide co-occurring treatment for the citizens of northern Nevada. We have been providing services on the campus of NNAMHS since 1996. If the $96,800 reduction in the waiting list funds and $210,000 reduction for the co-occurring disorders totaling $306,800 occurs, we will have to abandon the program for the State of Nevada. With permission from our Board of Directors, I have also been told we will be possibly closing our agency's doors of family counseling after 50 years of doing business. We are only one of two agencies the Department of Justice approved for bankruptcy counseling for the consumer credit division. We often serve as a pseudo-State agency providing services for the State at a State location without State benefits, State insurance or State pay.

If we are eliminated, the mental health courts will be severely affected. The new Reno co-occurring court will be seriously affected and NNAMHS will have to find a way to provide treatment for these clients to whom the University of Nevada, Reno has been providing service to for over 12 years. We have a contract with the School of Medicine to provide psychiatric services. A fourth-year resident that works through family counseling to provide these services will also be affected.

We are talking about people who have severe extreme co-occurring disorders who are sitting on waiting lists already. We are at capacity at the State hospital. We have 45 individuals at the State hospital right now. That will go away. I am extremely concerned about the co-occurring and waiting list dollars going away. It is not a realistic plan for the citizens of Nevada.

CHAIR LESLIE:
I agree it is not realistic. We will do what we can to try to fix this. Your agency does a great job in providing some much needed services.

We are out of time and not everyone who wanted to testify has been afforded an opportunity to speak. Michele Tombari and Korri Ward, parents of children with autism, have submitted written testimony (Exhibit K and Exhibit L). The Nevada Association for Behavior Analysis has provided a letter (Exhibit M) supporting funding for self-directed autism services. The Community Counseling Center of Southern Nevada has presented a letter supporting SAPTA funding (Exhibit N). Finally, a letter from the Mental Health Planning Advisory Counsel (Exhibit O) is submitted for the record expressing their views.

This meeting is adjourned at 11:02 a.m.

RESPECTFULLY SUBMITTED:

Jackie Cheney,
Committee Secretary

APPROVED BY:

Senator Sheila Leslie, Chair

DATE:

Assemblywoman April Mastroluca, Chair

DATE:

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
	C	Jan M. Crandy, Commissioner, Nevada Commission on Autism Spectrum Disorders	
	D	Wisconsin Early Autism Project	Report
	E	Toni and Tyler Richard	Prepared Testimony
	F	LaVonne Brooks	High Sierra Industries Supported Living Arrangements Trend Report
	G	Edward R. Guthrie	Caseload Growth for Jobs & Day Training
	H	Brian M. Patchett	Prepared Testimony
	I	Kevin Quint	Prepared Testimony
	J.	Barry Lovgren	Prepared Testimony
	K	Michele Tombari	Written Submission
	L	Korri Ward	Written Submission
	M	Molly L. Dubuque	Written Submission
	N	Ronald W. Lawrence	Written Submission
	O	Rene Norris, Chair	Written Submission