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

Seventy-Ninth Session
February 15, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 1:35 p.m. on Wednesday, February 15, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chairman
Assemblywoman Amber Joiner, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Richard Carrillo
Assemblyman Chris Edwards
Assemblyman John Hambrick
Assemblywoman Brittney Miller
Assemblyman James Oscarson
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

Assemblyman William McCurdy II (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant
Melissa Loomis, Committee Assistant

OTHERS PRESENT:

Kathy Paxton, Senior Vice President, Government Relations and Business Development, WestCare Foundation, Las Vegas, Nevada
Tracey Green, M.D., Consultant, WestCare Foundation, Las Vegas, Nevada; Vice Dean for Clinical Affairs, Professor of Family Medicine, University of Nevada, Las Vegas School of Medicine
Amy Roukie, Deputy Administrator of Clinical Services, Division of Public and Behavioral Health, Department of Health and Human Services
Ryan Gustafson, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services
Ellen Richardson-Adams, Outpatient Administrator, Southern Nevada Adult Mental Health Services, Division of Public and Behavioral Health, Department of Health and Human Services
Juanita Clark, Member, Charleston Neighborhood Preservation, Las Vegas, Nevada
Cody Phinney, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services
Helen Foley, representing Nevada Assisted Living Association
Jeanne Bishop Parise, Member, Nevada Assisted Living Association; Administrator, Park Place Assisted Living, Reno, Nevada
Gina Stutchman, Owner, Arbors Memory Care Community, Sparks, Nevada
Dan Musgrove, representing WestCare Foundation; Chair, Clark County Mental Health Consortium

Chairman Sprinkle:
[Roll was called. Committee protocol and rules were explained.] I will open this meeting up for public comment. We will start in southern Nevada.

Kathy Paxton, Senior Vice President, Government Relations and Business Development, WestCare Foundation, Las Vegas, Nevada:
I am representing WestCare Foundation, a large health care and human service provider and also an awardee of the Certified Community Behavioral Health Clinic (CCBHC) model demonstration project. I wanted to discuss a few issues related to the people we serve at WestCare.

We all know that whole health is essential to people with mental health and substance abuse disorders that they developed decades earlier, mostly from untreated, preventable chronic illnesses. Whole-health models are essential in serving our population. Undiagnosed and untreated mental health disorders often lead to self-medication and substance abuse, which can also lead to inefficient access to care or sometimes even criminal behavior. These problems can lead to homelessness and emergency department and jail overcrowding.

At WestCare, we are excited that the certified community behavioral model shifts existing efforts from a Band Aid or stabilization approach to a more community-based-services approach that helps us serve people where, when, and how they need to be served.

The community will benefit from this model because there will be an established organization, and we will be one of them, that will be responsible for providing crisis support 24 hours a day, 7 days a week. There will truly be no wrong door for individuals at any age with mental health and substance abuse problems. There will also be an emphasis on serving veterans and other special populations that have historically been underserved.

Tracey Green, M.D., Consultant, WestCare Foundation, Las Vegas, Nevada; Vice Dean for Clinical Affairs, Professor of Family Medicine, University of Nevada, Las Vegas School of Medicine:

I am serving as a consultant with WestCare for the implementation of the community certified behavioral health centers. I want to alert you to a presentation coming next explaining that the transition to community-based services will be enhanced by the Division of Public and Behavioral Health. As you know, right now we are dealing with fragmented services, lack of integration, and no front door—no places especially for our behavioral health and substance abuse clients to enter into the system. The CCBHC is going to provide three very important things:

- 24/7 access to crisis stabilization for both adults and children.
- WestCare and some other organizations that will be responsible for care coordination and integration, quality outcomes, and quality improvement plans where there are not quality outcomes.
- No wrong door for behavioral health and substance abuse so individuals do not have to utilize emergency rooms anymore.

Chairman Sprinkle:

Is there anyone else in southern Nevada who would like to make public comment or in northern Nevada? Seeing none, we will have a presentation on mental health services and programs in Nevada.

Amy Roukie, Deputy Administrator of Clinical Services, Division of Public and Behavioral Health, Department of Health and Human Services:

I am here to provide an overview of our mental health service delivery system. We are transforming the system to better meet the needs of Nevadans. Historically, the state's systems of care were centralized. The expectation for the mentally ill, specifically the severely mentally ill, was that they receive treatment. The majority of those with the most chronic and severe levels of mental illness were always relegated to the state asylum. This, in some sense, continued the stigma that is associated with behavioral health. These people were not served in traditional settings such as emergency rooms (ERs) or units in medical-surgical hospitals. This stigma required that those people had to go to the asylum. This system of care was mostly focused on not wanting to treat the most difficult who entered into the medical system, especially through the ERs. This has not always worked well. In the past, our agency has been plagued by lawsuits. We have had extremely low nationwide rankings concerning our ability to provide this care in comparison to other states. We have had, and continue to have, professional staff shortages, as well as insensitivity of services in our state. We are not always treating every level of care an individual might need.

We are in the process of transforming. We are seeing an overall increase in demand for behavioral health services because of the expansion of Medicaid and the increases in the Medicaid rate for some behavioral health services. I say "we" collectively, as a state. As our population increases, we are seeing more requests for behavioral health. The parity laws require psychiatric illness to be treated like any other medical condition. Mental and behavioral health should be treated like any other illness—in a hospital setting. The requirements, based on the Centers for Medicare and Medicaid Services (CMS), are to either treat the condition that caused them to arrive in an emergency room, stabilize that condition, or transfer them. That transfer has to occur throughout the continuum of care established by that certified medical ER in order for them to remain CMS-certified. Remember, mental health is not a choice. If one of you walked into an ER experiencing a diabetic crisis, historically the way this would be handled is that you would get care, and all your needs would be met. You might be placed in a bed within the system, treated, and discharged. On the other hand, if I walked into an ER today experiencing a mental health crisis, I would be told that I would have to be held there in the ER until such time as a bed could be found—someplace other that at that facility. In some ways, that is segregation and unfair to the behavioral health population we are serving at this time.

There are many risks and opportunities with regard to change. Our Division sees an opportunity to offer consumers a choice. The influx of managed care organizations—there are currently two within the state, and we will have four by July 1—offers consumers an opportunity to choose where they receive services. They no longer have to receive services at the asylum. This provides them with access to whole health care. It helps them develop relationships for primary care. In addition to that, these additional service providers create competition in the marketplace. That competition will help drive costs down and increase the quality of the care they receive. Additionally, there is an opportunity and a need for capacity to be built in long-term services for those who require a longer term stay for behavioral health issues.

We see that the risks in this change include having an adequate network of providers able to accept these patients and able to treat the Medicaid recipients. As a department, we have a responsibility to assure that the rates are adequate to continue to be able to support those new and expanded service-delivery systems. The repeal of the Affordable Care Act (ACA) is something we cannot ignore. As a whole, the Department is closely monitoring the efforts and looking at the federal government for any guidance as to what will happen with the ACA. At this point in time, we have not planned for a repeal or replacement of it, because there is no definition of what it will look like in the future; therefore, we cannot plan for what we do not know. However, we will have to revisit our budget should those changes have an impact on the way we currently serve this population.

Currently, we are looking at the patient services that have already changed. We are already seeing an increased impact, mostly in the south. The diversion of behavioral health individuals out of the criminal justice system is one of the missions we are driving, and one of the goals we have for our agency. For those with mental illness, we are looking at the

criminal justice system to no longer house them, but for us to be able to intercept them and offer treatment so they are no longer connected in that system.

Currently, the ownership of those with behavioral health issues, regardless of their payment source, does not solely rely on the state systems. The treatment needs must be met by the adequacy of the network for those CMS-deemed hospitals. The role of the community partners includes a new definition of what their expectations are. This includes hospitals, law enforcement, local jurisdictions, and the court system. It is our role to discover what each of these partners' role is in ensuring that the people who have behavioral health needs get the services indicated.

In looking at our caseload [page 6, (Exhibit C)], the purple line is representative of the Division of Public and Behavioral Health (DPBH) Medical Clinic Caseload. You can see a significant decline. The blue line is DPBH's Outpatient Services Caseload, which is also declining. As we indicated before, those who are in a Medicaid managed care organization (MCO) can go to any local pharmacy to get their prescriptions filled. In the past before the Medicaid expansion, they had to come to our system in order to get their medications filled. Additionally, with outpatient services, they can be seen by providers in the community and do not need to come to the state for those services.

This chart also shows the amount of spending by Medicaid. Over the course of the years, the blue amounts are the fee-for-service Medicaid. That is a population that can be seen and treated in a medical-surgical hospital. The red colors on the graph represent the State General Fund money our Division is spending in support of, in this example, the medication clinic caseload and the outpatient caseload. Finally, you see the green rising significantly over time. That is the MCO payments. When stating that we are cutting the mental health services budget, something important to note is that we may be reducing some of our services and cutting some of our General Fund expenses based on demand; however, the Department as a whole is investing more, as the green bars reflect, in MCO payments for behavioral health services. We are seeing a significant increase in services and payment for those services. The amount that has been reduced in our direct care services is now a several-fold increase in MCO payments. As the spending rises, the caseload for our state services declines.

The demand in our outpatient clinics is also reflected here [page 7, (Exhibit C)]. This is another way to examine our caseloads and our utilization. It is important to note that the Medicaid managed care spending is the purple line at the very top of the chart. The green line represents state spending, which is Medicaid combined with State General Funds. The clinic caseload is in blue, and the outpatient services caseload is in red. A significant decline is being seen in the number of people we are serving.

This slide [page 8, (Exhibit C)], although quite complex, is representative of the insurance status of all the people seen who are reportedly waiting for placement in a behavioral health facility. The green on this slide is representative of pending Medicaid. The turquoise are considered uninsured, but that population should not be considered uninsured. They should

be proactively signed up for Medicaid and be considered a part of the pending-Medicaid population. The purple shown on this graph represents patients who would not be appropriate to send to the state hospitals. These are privately insured patients who are served in the community in either a free-standing hospital for behavioral health, or in a medical-surgical hospital with a distinct unit that serves behavioral health. The red at the very top is representative of the managed care organization insured, and the blue is fee-for-service Medicaid. Fee-for-service Medicaid would need to be seen for behavioral health issues in a medical-surgical hospital for there to be payment. We are working collaboratively with our state agencies and with our Department about getting those people enrolled in Medicaid. That should be part of that "pending-Medicaid or eligible" services.

Based on this pie chart [page 9, (Exhibit C)], the goldenrod color is the percentage of uninsured who are currently being seen in our inpatient facilities—Rawson-Neal Psychiatric Hospital in the south and Dini-Townsend Psychiatric Hospital in the north. The majority of those patients who are considered uninsured would qualify for Medicaid. We need to enroll those people for future payment and access to services—behavioral health or otherwise—and are working to that end, whether they seek services with us or another provider in the future.

The collaborative we are working on with the Division of Welfare and Supportive Services (DWSS) is the colocation of eligibility workers in many areas of the state. We now have an eligibility worker stationed at Dini-Townsend in northern Nevada. That individual provides real-time eligibility determinations for people who come in for services. Historically, I believe the process of eligibility would take much longer, and that was holding people back from being enrolled in Medicaid. I must compliment the Division of Welfare and Supportive Services on the change they made to their delivery system. Rather than being in state offices, they are colocating in places like the Clark County Detention Center and Casa Grande Transitional Housing in Las Vegas. We are working on a collaborative with the Division of Parole and Probation. They are going to be stationed there as well to ensure that people who walk out of incarceration have eligibility, can access their medications, and get enrolled in behavioral health services as needed. This has made a big difference, and we will start seeing our uninsured population decline because eligibility determinations will be made for everyone who is potentially eligible.

Our role continues to be the safety net for the uninsured. There still are a small number of people who will remain uninsured. Those are the undocumented population, as well as those who exceed the Medicaid resource and income guidelines, but who still cannot afford to pay into the Silver State Health Insurance Exchange and get access to health care there, even though required. There also will be other people who will not cooperate with the process and get on Medicaid. Not everyone wants to cooperate with this. There may also be those who recently lost their jobs and do not know how to get access to services. Working with DWSS, it is our goal to proactively sign up these clients and make sure they have access to care—medical, behavioral health, or otherwise.

We also see our role as filling the gaps in the community for individuals who cannot be served in other delivery systems. That would be specifically for the criminal justice and

forensic populations. We are now working on expanded service models. As was mentioned earlier, the certified community behavioral health centers will provide five access points within the state, two in the rural areas and three in the urban areas, operated by a variety of community providers. Similarly to a federally qualified health center, the centers will integrate behavioral health along with primary care. That way there is a health home for the individual who needs not only to be seen for behavioral health issues, but also for chronic medical conditions that may not have been treated in the past. It will also serve as a 23-hour crisis access center available to meet crisis-service needs.

The sequential intercept model [page 13, (Exhibit C)] is an evidence-based model coming from the federal Substance Abuse and Mental Health Services Administration. On the continuum of care, this indicates where behavioral health professionals should be intervening. Someone interacting with the criminal justice system should be moved into appropriate services. Get them out of the criminal justice system and moved into behavioral health.

We are also expanding our services in the forensic inpatient area. I mentioned certified community behavioral health centers [page 12, (Exhibit C)] and their goal of linking mental health and primary care service delivery for the individuals who seek services there. The intent is to strengthen community-based mental health and addiction treatment services while integrating them with physical health care and wellness programs. There is a link on this page if you are interested in looking at what the CCBHC model is. Nevada is one of the states that was awarded this project. This CCBHC model will be implemented July 1.

The sequential intercept model shows that there are several points along the continuum where an individual is initially interacted with by law enforcement. If there is a call made to 911 concerning a mental health issue, someone is generally performing something illegal enough for the police to get involved; however, it is something that is generally not violent or detrimental to the community. A person can get picked up for being drunk in public, urinating in public, or being disruptive and get put into jail. They are kept in jail for lack of another place to put them. Our goal is to intercept them before they end up in the custody of law enforcement and help get them connected with behavioral health services. We do what we can to ensure that their behavioral health care needs are being met.

When looking at the realignment of our delivery of services [page 14, (Exhibit C)], we are expanding our outpatient forensic and re-entry services as well as diversion services through collaboration with the Department of Public Safety. We are also going into Parole and Probation including the Clark County Detention Center. We currently have staff who work with those who are housed at one part of Casa Grande Transitional Housing. Casa Grande is housing those people who do not have a good parole plan because of a lack of housing or support systems. For example in Las Vegas, our staff are making behavioral health assessments and providing links to what they need; essentially parole and discharge planning to get them connected with the right resources so they are able to be out and independent. We are working with law enforcement, going into the local jails, working with the Department of Corrections, the specialty courts, and the judiciary. We are working to

collaborate at a higher level to divert behavioral health-impacted individuals who are being criminalized, yet they really need care and treatment rather than incarceration.

When I speak of our forensic population, this chart [page 15, (Exhibit C)] shows you the weekly average, the monthly average, and the yearly totals of the orders for commitment we are receiving and the projected 20 percent annual increase. These are individuals we are assessing in the jails who are defined as unable to stand trial based on competency. Our role within this system is to provide psychological assessments. We are also evaluating them to see whether we can provide restoration and help them return to competency so they can be adjudicated for their crimes. Often we cannot restore them to competency; therefore, we end up keeping more of them in our forensic services long-term.

A little over a year ago, we opened Muri Stein Hospital in Las Vegas. Prior to that we only had Lakes Crossing Center. Lakes Crossing Center was able to maintain about 78 patients. Starting in July 2014, the green [page 16, (Exhibit C)] represents Lakes Crossing's long-term clients, the blue represents Lakes Crossing's restoration clients, and the pink represents Lakes Crossing's evaluation clients. When we explored our need to provide additional beds for these services, we were able to renovate and open the Muri Stein Hospital on West Charleston Boulevard in southern Nevada. As you can see, on average we are close to about 140 patients, and we are getting more and more referrals. We are working diligently to expand as you will see in our budget. Based on demand from the civil services, we are increasing our forensic services because there is not another service system that these people can be treated in. The only alternative is to keep them locked up in jail.

We provide a good deal of residential support services. This chart [page 17, (Exhibit C)] shows the adult housing support by type. We provide a safe place for individuals to live who need support. It is an essential component of recovery, whether from behavioral health issues as co-occurring substance abusers, or from mental health issues. Our goal is to allow the individuals we are serving to be independent and able to live in a community setting that is independent of our services. We are committed to continuing to provide safe housing assistance. The bill you will hear later today in this Committee is designed to improve our ability to regulate the quality of those community behavioral health living arrangements.

We are experiencing behavioral health workforce shortages in Nevada [page 18, (Exhibit C)]. The Nevada Primary Care Workforce Development Office, which works out of our Department, has defined a majority of our state as being a Health Professional Shortage Area. This helps us leverage federal funding for recruitment and retention. In behavioral health, there is a significant shortage in clinicians to provide this care. As we are supporting the community as it continues to expand, the workforce has been fairly stagnant. We are sharing a workforce that is limited, so we are working on initiatives at the department level to provide support for loan repayment and to encourage staff to access additional education to go after licensing. We have a program called the Nevada Psychology Internship Consortium (NV-PIC) in which we work with the universities to provide opportunities for psychologists to intern and work with our rural communities. We are doing what we can to address the workforce-shortage issues.

Our clinical services budget [page 19, (Exhibit C)], as you can see by the blue, is majority funded through the State General Fund. These budgets include the activities that occur on the Southern Nevada Adult Mental Services campus, Rawson-Neal Hospital, outpatient housing, Muri Stein Hospital, forensic services, Dini-Townsend Hospital, our outpatient services, Lakes Crossing Center, and our rural clinics.

Under the ACA, most people are eligible to receive insurance. Most of them, especially in our urban areas, are covered by managed care organizations. This affords them opportunities to access care in any environment they choose. They are now not relegated or segregated to a state hospital because they are difficult-to-treat mentally ill. We are supportive of the community capacity growth as it is continuing. We have several beds coming online in Reno in the next 12 months. A new hospital will be opened south of town which is supposed to be 120 beds. Many people receiving services in our civil service and short-term crisis stabilization programs, will be served by that hospital; therefore, we are focusing on those clients who cannot be served in another setting—both the forensic clients and those who have a need to be in a longer-term, locked psychiatric setting.

Chairman Sprinkle:
Thank you. Are there any questions?

Assemblywoman Benitez-Thompson:
During your presentation, when you were talking about the shift of services provided by the state to the managed care organizations, you were speaking about prescriptions and the ability of people to get their prescriptions filled at community-based retailers versus going to a central hub. For example in northern Nevada, does that mean, as opposed to having to check in every day for medications at the state facility on Galletti Way, they can just go to a pharmacy close by that accepts their insurance?

Amy Roukie:
The system we formerly served our patients through involved being seen and evaluated by a psychiatrist in our outpatient setting. The wait list for those programs was very long, and then the prescription would be filled at the Northern Nevada Adult Mental Health Services (NNAMS) campus pharmacy on Galletti Way. Now, they can be seen by a community psychiatrist in an outpatient setting, or they can be seen in an outpatient setting through our services. They have an MCO that will pay for it, and if they get a prescription, they can take that prescription and get it filled at any pharmacy. That vast change is based on the fact that now there is a payment resource for that patient. When the State General Fund supported that payment, they would have to see us and go through our pharmacy because was the only resource they had to get their medications filled.

Assemblywoman Benitez-Thompson:
So at the NNAMS center in Reno, there will not be a clog of people just waiting for meds; it will be much more community-based?

Amy Roukie:
Yes. Under the old system, a person had to get up really early, go over to NNAMS, wait in line, and hope to get seen. You might be there all day. You would get an evaluation, be sent over to the pharmacy, and they would fill your prescription. That is no longer the system; it is for very few people now. That is why our demand has gone down as their access to services has gone up.

Assemblywoman Benitez-Thompson:
This is part of the broader conversation we are having regarding the tradeoffs that come with looking to more community-based providers and services that can be accessed. The state still struggles with having enough service providers and having enough medical and clinician staff available. That will still persist, but it will be interesting to see how the shift to community-based providers through the MCOs ends up working. In this piece, it sounds like it is working well.

Assemblyman Yeager:
You talked about efforts to divert people before they get into the criminal justice system. I would like to hear more about those efforts. In my experience, once someone is in the criminal justice system, it seems as though our district courts are pretty well-equipped to handle mentally ill individuals, but the attorneys and judges in some of the entry-level courts, municipal court and justice court, are not as well equipped. We can get stuck in a situation in which everyone knows we have a mentally ill individual, but there does not seem to be a lot of options, at least initially. That individual tends to languish until the case gets up into district court or maybe into a specialty court. Are there any discussions about what to do once we get past the arrest, and the person makes that first appearance? Are any options being discussed at the entry-level courts to get those folks treatment earlier?

Amy Roukie:
Our ability to intercede with individuals with mental illness occurs on a variety of levels. We want to be able to work with them before they enter into the criminal justice system. As you may be aware, we have our Mobile Outreach Safety Team program as well as our mobile crisis services. In Las Vegas, our mobile crisis services are funded through the county to WestCare. They intervene on the street if a person is in a behavioral health crisis. Law enforcement, with the training they have received, intervenes and, before an arrest or incarceration occurs, tries to connect them with our service system. Our service system can do an assessment and make a determination who best to see them.

The activities that occur for the mobile crisis services include ongoing case management in the community. If someone gets a call that there is an individual who is disruptive, possibly mentally ill, and holed up in a hotel, crisis intervention team (CIT) officers will get involved initially. They will make a referral to the mobile crisis services. As part of the mobile crisis service, clinicians will go out and provide ongoing connection, support, and case management; which may include a trip to the hospital, either our hospital or a medical-surgical hospital, or maybe just an outpatient referral. They do ongoing case management in

the community to determine what is needed. All the while, the individual has not entered the criminal justice system. That is our goal.

Our goal is also to keep them out of the emergency rooms (ERs) when possible. We also provide in-emergency-room clinicians who go on our behalf who will help with planning in the ER. They are part of our service delivery system. These people will do an assessment and make determinations, along with the treating physicians. Decisions will be made about where this patient would be best served and get that individual out of the ER if, in fact, that individual does not need to be there. The MCOs are doing that as well. They are responsible for that individual and can control their costs by going into that ER and making a discharge plan with the individual through a continuum of care that they support. All of this keeps someone from entering the criminal justice system or a medical-surgical hospital beyond the ER.

To your second point, Ellen Richardson-Adams is in the audience. She has been working, especially in southern Nevada, very closely with law enforcement, the court system, and inserting herself in conversations about what we do with those people who are seen as being frequent system users—those people who need more regular attention. There are also some community paramedics intervening earlier. As far as education of the court system, Ms. Richardson-Adams might be a better person to respond. I know that the entire criminal justice and law enforcement system is integrating with our staff and with our outpatient services. We have a number of outpatient programs in which we engage people who otherwise would be in the criminal justice system and divert them. There is a justice-involved diversion program which covers everything from youth in transition to those who are court engaged.

Assemblywoman Titus:
Would you go back to page 6 on your presentation, please? Looking at the graphs, there appears to have been a dramatic increase in moneys spent by Medicaid on MCOs and by the State General Fund. This other layer has been added, but the actual caseload is declining. Based on this graph, it seems as though the MCOs have dramatically increased costs but have not added much-needed services as far as caseloads or solving that problem. Could you clarify that for me?

Amy Roukie:
These are separate items. If you are just looking at the bar graph, it is representative of Medicaid spending on behavioral health clients regardless of the setting. The green bar increase is the MCO payments Medicaid is making regardless of whether it is in a private psychiatric hospital, a nonprofit, or any other setting the individual can be seen in. The lines that show declining caseload are representative of what we at the Division are actually providing services to. Our services are dropping, but the amount of payment indicates that the services are being paid for and received in other places.

Assemblywoman Titus:
I would like to know how much more we are spending on behavioral health having the MCOs added. If you could separate that per patient load, because all the health care payments are morphed in the bar graph, yet you are telling me you are singling out the actual caseload for behavioral health. I do not think it is a fair comparison.

Amy Roukie:
This is only the spending on behavioral health, caseloads, and spending statewide. All the dollars being spent are for people who are diagnosed with behavioral health conditions. The setting is not clear. We are saying that our portion, what you see in the red, is spending in General Funds for our caseload. The blue is the fee-for-service being seen in medical-surgical hospitals. The overall spending for behavioral health is increasing statewide regardless of the setting. This is all behavioral health and not medical care.

Assemblywoman Titus:
So, overall spending for mental health has increased, but the caseload has decreased.

Amy Roukie:
The caseload just for us has decreased. The caseload has not decreased statewide. The caseload the Division is experiencing has decreased; however, it is apparent by the spending that the caseload has increased across the state in other settings. That is why the spending is up.

Assemblywoman Titus:
Could you get to us a graph that shows exact caseload? I am concerned that there may be more mental health issues than we are seeing on this graph. I want to see how they have been offset. Costs do not tell me about care; costs do not tell me how many more citizens of this state have been served by this change. You have shown me that they have assumed some cost, but you have not told me if it has really helped. We have offloaded, so we can say our caseload for the state has gone down, but I am concerned and want to make sure our citizens are being served. I would like to see how they have assumed the caseload and where that cost is being shifted, just to be sure the citizens of Nevada have access.

Amy Roukie:
We will get that for you.

Assemblyman Oscarson:
As my colleague indicates, I think that is important; but I think this is exactly what we anticipated or wanted to happen. We wanted to push those patients to other facilities rather than to NNAMS or SNAMS (Southern) to get more expedient services, and have them reimbursed at a higher rate, which is what you have done. This graph shows that. Some success has been attained by doing that. I agree with my colleague that those other numbers, where they are going, what is happening, and the length of time for stays, are important. I do see this as a success because it is what we had anticipated was going to happen, or what we have been trying to do for a significant period of time. You were finally able to implement it

18 months ago. From my perspective, I know it is easier now to get patients into these facilities because there is not a long wait list—at least in the south; I cannot speak for the north—to get these folks the care they need. They need care soon; they do not need to sit in an ER for four or five days waiting to get treated.

Amy Roukie:
I agree, and I do have information on demand and wait times for our services; however, in the interest of time, I will provide that to the Committee through your analyst.

Chairman Sprinkle:
I will cut off questioning for right now and begin with the second presentation. However, please expedite the presentation, because we will lose our video feed to the south.

Ryan Gustafson, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services:
Children's mental health is one of three primary programs within the Division of Child and Family Services (Exhibit D), which also includes child welfare and juvenile justice services. The primary goal is to provide evidence-based services and evidence-based practices to children and families that cannot be served elsewhere in the community. We continue to implement our system-of-care grant which is now in year two of four.

Children's mental health incorporates two primary budget accounts [page 4, (Exhibit D)], Budget Account 3281, which includes services primarily delivered in Washoe County through Northern Nevada Child Adolescent Services (NNCAS), and then Budget Account 3646 which is in Clark County for Southern Nevada Child Adolescent Services (SNCAS). This slide reflects the budgets for each of those over the biennium.

Northern Nevada Child Adolescent Services, primarily in Washoe County, includes a number of programs, including our residential programs which are the Adolescent Treatment Center and the Family Learning Homes as well as our newest program—the Mobile Crisis Response Team [page 5, (Exhibit D)].

Slide 6 [page 6, (Exhibit D)] shows clients served over state fiscal year 2016 in NNCAS. As you can see, there were just over one thousand clients across the programs within NNCAS. Looking at SNCAS, you can see that the programs in Clark County and Washoe County very closely mirror one another with the exception of Desert Willow Treatment Center, our state-operated psychiatric hospital. Total clients served in state fiscal year 2016 in Clark County through SNCAS were just over two thousand.

Slide 9 [page 9, (Exhibit D)] shows the number of clients served statewide. It is a 70/30 split between Clark County and Washoe County. The next slide [page 10, (Exhibit D)] shows the breakout of ages of kids we serve across the state in Clark and Washoe Counties with nearly half being adolescents between the ages of 13 and 18.

We are currently engaged in a couple of initiatives [page 12, (Exhibit D)]. The first is our Mobile Crisis Response Team. Mobile crisis response for children and adolescents offers crisis intervention and evidence-based assessment wherever the need is in the community. The mobile crisis teams provide safety planning and short-term stabilization as well as the ability to link families to supports and services that are appropriate within the community. As you can see on this slide [page 13, (Exhibit D)], calls come in from a wide variety of referral sources, including hospitals, schools, parents, and family members. There is a small discrepancy on the call breakdown between the southern region versus the north with a large chunk of calls in the south coming from the ERs. Almost the same percentage in the north come from schools. We are starting to see some shifts in those percentages, which we will continue to report. Our goal is to be able to keep kids from sitting in hospital ERs waiting for placement or recommendations for treatment. Our goal is to get in front of responding in the ER and to be able to respond directly to homes, schools, and other places in the community. We have seen some success with that in Las Vegas and increasing success with that in Washoe County. As you can see, a lot of those calls are coming from agencies in the community, and a big portion are coming directly from the schools.

We also collect data on the nature of the crisis [page 14, (Exhibit D)]. Over half are for suicidal ideation and suicidal behavior. Page 15 [page 15, (Exhibit D)] reflects the total youth and family served per month in Washoe and Clark Counties in fiscal year 2016. Statewide, we have been able to achieve an 85 percent hospital diversion rate. That means when we take a call and make a determination to go out and respond and do a crisis assessment, 85 percent of those responses result in a diversion from the hospital. Those are frequently families who are either in the hospital again, or families who are prepared to take their child to the ER to get services. We had a really significant success in diversion in 2016, and that has carried over the life of the Mobile Crisis Response Team since its inception. We took our first call in January 2014. It is a relatively new program—three years of operation in Las Vegas and even less than that in Washoe County. As you can see [page 16, (Exhibit D)], as of July 2016, we have fielded over 2,800 phone calls and responded over 1,700 times. Those numbers have risen substantially, because we are seven months beyond that now. We have taken well over 3,500 calls and have diverted well over 1,500 youth from hospitalization at this point.

We have also partnered with Welfare and Supportive Services. We recognized when we were responding into the community for mobile crises that there were a percentage of kids and families we were seeing who were not insured. Through our partnership with Welfare and Supportive Services, we have been able to get families plugged in, sometimes even onsite, and get eligibility in place very quickly rather than sending them into an office setting to look at their eligibility options. We have been able to do that right there on site with the collaboration of a welfare worker.

We have partnered with Public and Behavioral Health through our System Of Care Implementation Grant (SOC) to start our Mobile Crisis Response Team in rural Nevada. That is brand new. They started taking their first calls in November of last year. Already we have seen a significant number of phone calls from the rural areas. It is a unique partnership,

because Mobile Crisis is a program where you really want to be able to respond quickly and respond in person to families who are in crisis. As you know, that can be very tricky in the rural areas where oftentimes people sitting in offices are great distances from where the crisis is happening. There have been a lot of partnerships and work with public and behavioral health in getting some of their psychiatric caseworkers trained in the various rural offices. Also, the utilization of telehealth has allowed some of our mental health counselors in the rural areas to get the rural Mobile Crisis Response Team off the ground. We are seeing some tremendous success with that.

Speaking of the System of Care Implementation Grant [page 17, (Exhibit D)], we are in year two of a four-year grant. There are four primary goals of the grant outlined in this slide. With a lot of technical assistance and input from our community partners, we have seen a number of successes at this point in the grant. We have been able to develop both communication and strategic action plans with the SOC as well as produce a community readiness assessment that really does look at readiness for system change within the communities for children's mental and behavioral health across the state, as well as where the gaps in services are. That took collaborative work with mental and behavioral health stakeholders across the state. I can say that all of those documents are on the Division of Child and Family Services' website, and that strategic and communication action plans are updated on a regular basis. The most exciting piece of the grant is that we have been able to execute a number of sub-grants for a variety of services in both Clark and Washoe Counties. These are really boosting home- and community-based services.

Children's mental health has also put significant emphasis on partnering with juvenile justice, both in Washoe County and in Clark County [page 19, (Exhibit D)]. There has been ongoing collaboration with our Wraparound in Nevada Program in the north. We have been doing this for several years with the goal of offering diversion for kids who are at risk of going out of state and for kids coming back in state to keep them in state by providing intensive wrap around and targeted case management and care coordination services for those youth and families. That has been a juvenile justice and children's mental health partnership. In the south, a number of mental health staff have been stationed at Summit View Youth Center. We have provided clinical services to over 60 youth who have been in and through the Summit View program.

In addition, children's mental health has and will continue to provide evidence-based training to the juvenile justice programs and their staff. We have done a number of those trainings. We focus on evidence-based practices in trainings. Recent examples of this include trainings in both trauma and informed care and aggression-replacement training to the staff at the Summit View Youth Center.

Chairman Sprinkle:
Would it be possible for you to stop your presentation here and come back at the end of our bill hearing? We need to get certain things on the record before we lose our video feed to Las Vegas at 3:00 p.m.

Ryan Gustafson:
Absolutely.

Chairman Sprinkle:
At this time, I will open up the hearing on Assembly Bill 46.

Assembly Bill 46: Revises provisions governing services provided to persons with mental illness and other disabilities. (BDR 39-132)

Ellen Richardson-Adams, Outpatient Administrator, Southern Nevada Adult Mental Health Services, Division of Public and Behavioral Health, Department of Health and Human Services:
This past year, Administrator Phinney and I worked to improve the residential living arrangements for individuals with mental illness. We appreciate the support and consultation of our community providers, associations, and partners who have helped us develop the community-based living arrangement regulations and processes (CBLAs). Assembly Bill 46 provides certification and regulation of providers for community-based living arrangements through the Division of Public and Behavioral Health (DPBH). Currently, *Nevada Revised Statutes* Chapter 433 does not have language for regulatory provisions of CBLAs. The regulations will allow for DPBH to provide regulatory oversite for individuals served by the Division in a community home setting with a community provider. This type of living arrangement is different than a group residential facility. Individuals living in a CBLA are working towards independent living in their natural community settings. The homes generally have one person per bedroom. The average size is three- or four-bedroom homes. A small business provider is then contracted with the Division to support the individuals and work with them toward independence through their daily routines, skills development, and the attending of different medical appointments.

The services provided are for compensation, and each person has an individual treatment plan and programming plan. The major difference in skill levels of each individual is the ability to independently evacuate themselves—for instance if there is a fire or other crisis—whereas in a group residential facility, they require the support and supervision of a caregiver to do so.

The proposed regulations for CBLAs are to help ensure oversight and regulatory authority for the health, safety, and care for these individuals, and also to establish requirements for the providers in statute and provide regulatory authority and oversight to the Division. An amendment adding two words (Exhibit E) has been submitted today. The intent of the amendment is to allow for the Division of Public and Behavioral Health to certify all the CBLA homes in communities, including those that contract with Southern Nevada Adult

Mental Health Services, Northern Nevada Adult Mental Health Services, and Rural Health Services. For clarification, individuals who require a level of skill for care and supervision, such as memory care or skilled nursing, are not intended for community-based living. It is intended that they continue to be cared for at their required level of regulatory oversight.

The disability portion of the bill in section 17 mentions contracting with the Aging and Disability Services Division of the Department of Health and Human Services. That is for the respite care component. Those two additions provide for the additional oversight and authority. We believe that these regulations provide for the health, safety, and oversight of individuals with mental illness, the community providers who are providing the services, the public, communities, and the state overall.

Chairman Sprinkle:
Is there anyone in southern Nevada who would like to speak in support of this bill? [There was no reply.] Is there anyone in opposition to this bill in southern Nevada?

Juanita Clark, Member, Charleston Neighborhood Preservation, Las Vegas, Nevada:
I am looking for a definition of being mentally healthy. In the area where I live, there has been a vast increase in the number of suicides. I am close to the hospital at Oakey and Jones, and know that there is a lot of drug use.

Chairman Sprinkle:
I want to confirm that your comments are in regard to opposition to A.B. 46?

Juanita Clark:
They are. We are in opposition to it because we see lots of deaths, drugs, increased hospitalization, and increased services subduing. Is it more subduing these problems or is it making someone more healthy? There are no criteria for mental health. It is mentioned as treatment, but I would call it submission, or not being capable, or of being a problem. For that reason, we are against the format of how this is done.

Chairman Sprinkle:
Is there anyone else in southern Nevada who wishes to speak in opposition to this bill? [There was no one.] Does anyone wish to speak as neutral to this bill? [There was no one.] We will open up to questions from the Committee on this bill.

Assemblywoman Joiner:
I need background and clarification concerning how this came about. I am familiar with the supported living arrangements (SLAs) we have had for a while. How are these different? I am concerned about resident safety. I do not see anywhere in this bill where there are background checks or any sort of requirements for training or anything like that. We have had concerns in the past with SLAs. I want to be sure we are not creating another category where we have people being harmed.

Cody Phinney, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services:
The impetus for our work is in large part to address exactly the concern about resident safety. There were some newspaper articles and other issues we are very concerned about, and we want to make sure we have all the necessary authority and resources in place to ensure that these critical services are available, safe, and appropriately regulated without being overregulated. That is the intent of this measure. We want to make sure that people who suffer with mental illness have the ability to live as integrated as possible in our communities. That is also in keeping with law and regulation. This is one factor in making sure that the journey to recovery is available to all Nevadans, especially those with significant mental illness issues.

Assemblywoman Joiner:
It is good to hear that this is in response to wanting to be more helpful and protective of people in these situations; however, I am reading through the bill, trying to figure out where those are. I see that people have to apply for a certificate, and there are provisions that if they do something wrong, the certificate can be revoked. However, I do not want to be in a situation where someone must be harmed before we can yank a certificate. I do not see background checks; I do not see inspections. Are there going to be inspections? I am curious on the front-end. How do we do some prevention on that?

Ellen Richardson-Adams:
Through the State Board of Health, we had the Legislative Counsel Bureau (LCB) file R090-16 (Exhibit F). Through that process, with public workshops, et cetera, the State Board of Health on December 9, 2016, adopted regulations for the community-based living arrangements (CBLAs). Potentially we could, and may need to have, further adoptions of amended regulations, but the exact components you are speaking of are in those regulations. It goes through the certification requirement, the background check components, et cetera.

Chairman Sprinkle:
If you could get that to the entire Committee, we would all be very interested in seeing those regulations.

Assemblywoman Titus:
Specifically relating to the bill, in section 5, subsection 2, it says, "A natural person who has not been issued a certificate but is employed by the holder of a certificate may provide services within the scope of his or her employment by the holder." I am concerned about that wording. Does the employer decide the scope of the practice? Does the employer decide what the employee can do? I am anxious about that. Is the scope of the practice within the scope of their capabilities? Who is going to regulate the scope of the capabilities? Can you clarify that for me?

Ellen Richardson-Adams:
The intent of section 5, subsection 2 is that it marries with the other component of R090-16. It will narrow it down, but what is the design and intent of someone who can and will

provide for a CBLA? I understand what your question is getting at because it appears to be very broad. Could it just be anybody? But the R090-16 regulation does specify that more clearly. The language in sections 2 through 12 is the more general language that goes along when someone becomes the provider when applying under the business license component.

Assemblywoman Titus:
I will need to see more of that definition. Section 8, subsection 2, mentions the complaint process. "Upon receipt of a complaint against a provider of services, except for a complaint concerning the cost of services, conduct an investigation into the qualifications of the personnel, methods of operation, policies, procedures and records of the provider of services." Where is that going to be defined? We are missing another component. What policy and procedure manuals are they going to be required to have? Are those going to be public record? What if I want to place a family member there? Under the rules you are setting, are they going to be provided somewhere online? Can we find what rules and regulations that group has to have? I am concerned. You are going to regulate them, but I am not sure what you are going to be looking at. Are you going to be looking at the policy? Is it that the refrigerator has to be at 40 degrees; or is it a policy that the personnel have to have cardiopulmonary resuscitation (CPR) training? I am concerned about what they are actually going to be required to show to the agencies inspecting them or the families. I just need some definition.

Ellen Richardson-Adams:
For section 8, in terms of conducting the investigation when individuals receive complaints, et cetera, it is another complementary process with R090-16, which will be provided to the whole Committee.

When individuals live in a CBLA, they sign not only a contract but also a lease. The intent really goes with the Olmstead decision—being able to live in the least-restrictive environment and really gaining toward that independence. To your question concerning how they would know they could file a complaint and have those rights, we review their policies and procedures to ensure that individuals who are signing them have access to them and have the ability to review and use them. We ensure they are doing that. In terms of the online piece or public record, I will have to get back to you on that because I do not have that answer.

Cody Phinney:
The overall purpose of the policies and procedures we are looking at is related to ensuring that those individuals' rights are not being violated and ensuring that the home is safe. We also ensure that their treatment plan is being followed appropriately, and that the providers are keeping adequate documentation we can monitor. We verify that treatment is being provided appropriately, that there is appropriate consent from family members if necessary, and we ensure all those things are in place. I would have to check to see whether that is required to be public, or available only to the families and clients involved.

Assemblywoman Titus:
Where in these regulations does it mandate that they have a treatment plan for the folks who stay there?

Cody Phinney:
That is specified in the regulations, and it has also been our practice historically with the former iterations of this type of service.

Assemblyman Carrillo:
Concerning section 5, subsection 2, why would the state not require that all providers of community-based living services be certified?

Cody Phinney:
I believe our intention is to assure that they are certified.

Assemblyman Carrillo:
It states, "A natural person who has not been issued a certificate . . . may provide services." I understand it is a question of being certified or not certified. Is it going to be the home or the agency that takes upon the certification? So people work underneath that certification, is that correct?

Cody Phinney:
Yes, that is correct.

Assemblyman Carrillo:
What kind of safeguards would be put in place? Will the agency take on all liability of the person or persons, so it would be responsible and not the people working underneath the agency or home?

Cody Phinney:
I would have to review that legal liability issue with our legal counsel. It is not within my area of expertise to answer that question, but I would be happy to do that.

Assemblyman Carrillo:
In section 8, it is "may" versus "shall." In my mind, the Division should have to conduct an investigation into the qualifications of personnel when they apply, and any complaint should be investigated, would you agree? It is also in section 9, and I have the same concerns about using the word "may" versus "shall."

Cody Phinney:
In section 8, it would be our intention that the initial certification would be conducted in compliance with both law and regulation requiring any investigation to be completed. In subsection 2 of section 8, I am familiar with situations in which a complaint is received that may not rise to the level of requiring a full investigation. It might be handled on a fairly

informal basis to get to a resolution, and I suspect that may be the purpose in subsection 2. What was the other section?

Assemblyman Carrillo:
It is in section 9 where it states, "The Division may bring an action in the name of the State of Nevada."

Cody Phinney:
My understanding is that the use of the term "may" there is likely to address the fact that, should an investigation find that we need not take follow-up action, we would not be required to.

Assemblyman Carrillo:
You are saying everything would be subjective, and it could be decided if they wanted to do an investigation or not. There are a lot of vulnerable people here, and I am really concerned about the fact that it is subjective. That is a concern of mine, and I want it on the record.

Assemblywoman Benitez-Thompson:
Thank you for bringing A.B. 46. It is the first step toward making sure the state has more oversight of these kinds of living arrangements, and that we are keeping tabs on them and what is happening there. We need to take into account the quality of the care that is being provided in these community-based living arrangements.

This is a good start, but there are some things I would definitely like to see go a little bit further toward our goal of ensuring quality SLAs in the community. I would love to see some posting requirements; the same as in other types of facilities. When you walk in the door, you see names and numbers you can contact. The rights of the consumers mentioned in section 6, subsection 1, paragraph (c), should be laid out, so the minute you walk into this home, you would have an understanding that this is some type of licensed home—posting of a certificate and other postings.

I understand that there might be a big cost in annual surveys. I know it is typical for us to go into other types of care homes, like the residential homes for groups, and have annual surveys. I do not know if it is necessary. I think a piece of that is the state, but there is also a piece of responsibility that falls on the families and organizations working with these homes. A lot of the times, the state is the funding source, but there are other, intermediary organizations in place helping to find these homes. I do not want to say that is necessarily a burden we should carry, but as we think about how to better do this, I think there should be an official eyes-and-ears component inside once a year doing a qualitative look and a qualitative review.

I will not go into some similar things other legislators mentioned that could really clarify some of the terms we are talking about or the intent, but this is the right direction to be headed in. We want to leave session with something like this versus leaving session without

anything and finding ourselves back in the same spot we have been in. I look forward to working with you on this.

Cody Phinney:
Thank you, we very much appreciate that.

Chairman Sprinkle:
I certainly agree with your comments, Assemblywoman Benitez-Thompson. I would like to see that as well. Are there any other questions from the Committee at this point? [There were none.] Does anyone wish to speak in support of this bill? Seeing none, is anybody in opposition?

Helen Foley, representing Nevada Assisted Living Association:
We are opposed to A.B. 46 (Exhibit G). We just discovered today that the State Board of Health developed regulations concerning A.B. 46. I started serving in the Legislature in 1981, and I have never seen regulations adopted before a bill was adopted. I think what has occurred is that supportive living arrangements were adopted in 2009 and the Aging and Disability Services Division was asked to promulgate regulations at that time, but did not [page 7, (Exhibit G)]. They were asked a couple of times, but there still were no regulations. In fact, your auditors just came out with a report on this, stating that the Division had not yet adopted regulations with more rigorous certification requirements, as required by legislation passed in 2009. In addition, the Division had not documented that additional certification requirements from legislation passed in 2011 had been met.

As a result, there have been a number of articles in the newspapers, and there have been deaths in southern Nevada related to individuals, many of whom have mental-illness issues, living in homes. The homes do not have to be licensed. There is a credential that a corporation receives, then I guess they keep a ledger detailing the different places all over the town or the state where people have been housed. What kind of training requirements are there for the caregivers who take these people from transitional situations to being back on their feet and out in society? There have not been any. Maybe the corporations have some guidelines, but there has been absolutely nothing.

We are extremely proud of the regulations Nevada has adopted for group residential facilities. That includes facilities that may be in your neighborhood that you do not even know are there. A lot of them are beautiful group residential facilities with between three and ten people living in them. The two women with me today have spectacular facilities providing services in the Sparks and Reno area including memory care for up to a hundred individuals. There are a lot of mental health patients at these women's places, but these facilities must have special endorsements to take care of these patients. They also must have certain lock-down provisions. There are 38 pages of regulations for residential facilities for groups, and now we hear that the State Board of Health has come out with regulations for the others. We are anxious to see whether it is just the owner of the corporation who has to have a certificate, or whether it is every one of the facilities. We want to be sure every one of

them includes background checks, training, medication management, and has the skills to provide services to these people to get them back on their feet and out into society.

Jeanne Bishop Parise, Member, Nevada Assisted Living Association; Administrator, Park Place Assisted Living, Reno, Nevada:
I have a long history in the state of Nevada. I was originally licensed as a nursing facility administrator by the Board of Examiners for Long-term Care Administrators. Throughout the course of my service to Nevada and my professional affiliations, I was the president of the Nevada Health Care Association. I even served the pediatric population at the skilled-nursing-facility level. We in the industry worked with the state on the special pediatric specialty rate within the Medicaid system to serve those needs. In 2010, I loaded in a GPS tracking and monitoring system in a secure operation in Henderson. In 2010, I was the skilled nursing advisory chairperson and worked again with the State and with the industry in developing behavioral rates and services. I am now also licensed as a residential facility administrator. I serve the very population they are talking about in A.B. 46, but I am licensed. I have a life-safety system in my facility that is inspected every three months, and I have to run drills on a regular basis. Contrary to earlier testimony, I do have category I clientele who are able to get themselves out during a fire situation within four minutes, which is a requirement for us.

I also serve category II clientele and have both the mental illness endorsement on my license and the chronically-ill endorsement I am required to have to serve those residents. The State comes out and surveys my facility; they make sure I have a contract, that I have a plan of care, that I have postings, such as were referenced. The State makes sure I am taking residents out for their medical appointments. The ones I have served I have taken to Northern Nevada Adult Mental Health Services on Galletti Way and waited with them all day to get their medications, so I am delighted we can now do that through local pharmacies. We have an electronic system that will support multiple pharmacies.

We serve some for short stays who are on a respite basis; some who are working toward independence; and some whose plan of care is to transition them back out. Some may only be with us for one to three months, and then there are those who we see through death. All of them have to be stable and predictable to be within our care. That has always been a requirement. In wrapping this up, I would suggest that this problem be solved within the very good care that is offered in *Nevada Revised Statutes* Chapter 449. Within A.B. 46 are exemptions for personal care and exemptions for respite care.

Gina Stutchman, Owner, Arbors Memory Care Community, Sparks, Nevada:
I would like to direct your attention to *Nevada Administrative Code* 449.2758, 449.2762, and 449.2764, which are all related to people with chronic mental illness and intellectual disabilities. These are people this industry has been quite successfully taking care of for a number of years and under a very large umbrella of regulation. It is very hard for us to understand why a group of people taking care of a similar population and providing the same services for them are under a completely different set of regulations. Being taxpayer funded,

it would seem that they would have a heavier set of regulations than would a private-pay industry, but that is not the case here—it is inverse.

I understand that the SLAs serve a younger population. I have never seen any indication that there is an assessment process in place that says they are on a trajectory toward transition, or that they have become custodial because they are either unable to work or do not want to work, or because they have aged in place and need a different environment. There does not seem to be any mechanism in place to address when that happens, and it clearly does happen at times.

Helen Foley:
Another key finding in the audit was that 27 of the 29 largest SLA providers were not certified in a timely fashion; and that included inspections, and testing, and ensuring that the clients' living conditions were safe. When they did inspections, 43 percent of the homes did not have documentation showing that there were deficiencies, and the Division did not have any documentation showing that any corrective actions were taken. Because they have had very bad press this last year, we are very concerned that they are being slipped into a new category without anything being done to resolve the problem. All these issues are covered under NRS Chapter 449. If people want to provide those services, they should be licensed under NRS Chapter 449 where all of them can be managed and there will be background checks. The ombudsman is one of the most important things. If people have a problem, the ombudsman can go out to any facility regulated under NRS Chapter 449. Under SLAs and this new provision, they are banned from going out there. The ombudsman is turned away and cannot help that person in need. We think this is a bad idea.

Jeanne Bishop Parise:
Also, the regulations at NRS Chapter 446 allow for our resident population to be 18 or older.

Assemblywoman Benitez-Thompson:
The concept of putting them under NRS Chapter 449 is interesting, but I keep thinking about the population that is traditionally served by SLAs, about federal regulations, and the Olmstead decision. I feel as though there is a conflict between the size of the facility and where folks with mental disabilities live and can choose to live. Public policy made the decision to not warehouse folks who are physically and mentally challenged and to move them away from larger facilities and into more community-based homes. I wonder if we are going to run afoul of federal regulations by treating them as if they are one of those larger facilities.

Jeanne Bishop Parise:
The size of the facilities within *Nevada Revised Statutes* Chapter 449 can be as little as two bedrooms. The adult, group-care facilities that are small residential homes may have three, four, or five bedrooms—the same configuration as was given in the prior testimony.

Chairman Sprinkle:
At this point, I will cut off further testimony. Typically, when there is such significant opposition to a bill, I would like to know that those in opposition have reached out to the sponsors of the bill first before it comes to a hearing. My suggestion is that you start having conversations offline with the sponsors of this bill to see what we can do to reach some sort of consensus.

Helen Foley:
We are happy to do that.

Chairman Sprinkle:
Does anyone else want to speak in opposition to this bill? Seeing none, does anyone want to speak in neutral? Seeing none, do the sponsors have any last words?

Ellen Richardson-Adams:
No, we are having the regulations sent over to you.

Chairman Sprinkle:
It sounds as though several Committee members have concerns, and you have heard from others during testimony who have concerns. I recommend reaching out to them, and I am more than happy to help. I will not speak for my colleagues here, but I think there are some others who would be more than happy to participate in this process. By the end of session, I would like to get to a place where we have something everyone is in agreement with that is protective of the patients we are talking about here. That is what I ask of you as we close this hearing today.

Mr. Gustafson, please come up and finish your presentation.

Ryan Gustafson, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services:
I will pick up where I left off. I already talked about some initiatives we are working on, including a proposed reduction within the Division of Child and Family Services, and specifically within mental health. I want to discuss the Division's proposal to reduce our Desert Willow Treatment Center—our acute hospital in Las Vegas. It is currently licensed for 58 beds. We are anticipating a relocation and reduction to a 20-bed program with 10 beds specifically aligned to work with adolescents who are acute, and an additional 10 beds for adolescents for a residential program. This is based on decreasing census trends we have seen. The belief is that a 20-bed program will still be able to meet the unmet needs in the Clark County area.

We have worked in collaboration with the Department of Health and Human Services, as well as with the Division of Public and Behavioral Health, and there is space in the Rawson-Neal Hospital that we could occupy that would still allow us to maintain complete segregation from the adult population. There is a pod over there with a unit with ten beds on each side. There are locked doors, so there is no access to other areas of the hospital.

We could occupy those two ten-bed units within that pod. There is even a separate entrance so youth could be admitted in a separate setting from the adult side.

I was asked to get the most current census information I could get, and this slide [page 22, (Exhibit D)] shows the acute placements at Desert Willow by month for calendar year 2016. Of note, these are the acute placements over the course of each of those months. Acute placements are rapid turn-around placements—usually a matter of several days. Those are the clients at Desert Willow over the course of a month and not at any one given time. In the acute unit at Desert Willow Hospital this morning, there were only two clients.

The next slide [page 23, (Exhibit D)] outlines for calendar year 2016 the number of youth who were in the residential programs month over month. A larger snapshot that has three years combined [page 24, (Exhibit D)] shows both the acute and residential numbers. As you can see, there has been an overall decreasing trend year over year with our census at Desert Willow. With this reduction and relocation, 54 positions will be retained, which would eliminate the remaining 53 positions. We are also in discussions with community partners, including a federally-qualified health center. If this reduction and relocation passes, the Department of Child and Family Services (DCFS) will work to ensure that the Desert Willow Treatment Center building is utilized properly and continues to serve youth who demonstrate significant need and who are at risk to go out of state.

Chairman Sprinkle:
Are there any questions?

Assemblyman Carrillo:
Are there any kids currently placed out of state who could be served at Desert Willow Treatment Center?

Ryan Gustafson:
There are youth admittedly who are still in out-of-state facilities. Specifically within the child welfare and juvenile justice populations, we have seen those numbers trend downward month over month for the last many months, which is a really good sign. We would like to see that number reach zero.

One of the problems at Desert Willow is that we are unable to keep all the units open in the hospital. It is a five-unit hospital, but we have had to close units because we have ongoing issues with staff recruitment and retention efforts. The state traditionally works with kids with the most significant mental and behavioral health needs, so sometimes there are staffing-ratio issues. Occasionally, we need to have one-on-one or even two-on-one with certain youth in the facility. We have had significant, ongoing staffing issues to the point where we have not been able to keep those additional units open. We have over 30 vacancies in the hospital alone.

Assemblyman Carrillo:
Will reducing the number of beds available further prevent kids and youth from coming home due to the reduced census?

Ryan Gustafson:
Based on the census we have seen over the last several months, this would not change the numbers of youth we are serving. This is about the numbers we have been serving over the last several months anyway. What we would really like to see is a repurposing of that facility. We have been communicating with some interested parties, including a federally-qualified health center. If we could get one of those entities to take over that facility, we believe we could see additional success in keeping kids from going out of state. In addition, the goal of our System of Care Grant is to boost community- and home-based services. Again, our Mobile Crisis Response Team has kept kids out of facilities and hospitals. Our Wraparound in Nevada Program has seen success with less restrictive options and more home- and community-based options rather than placing children in facilities—whether in state or out of state. We do not feel this would have an overall negative impact on youth in the State as far as what their placement options would look like.

Assemblyman Carrillo:
You mentioned Rawson-Neal. What would the cost be to the State to retrofit the area of Rawson-Neal that would house youth to prevent them from leaving or hurting themselves or others?

Ryan Gustafson:
We are still assessing what any retrofitting efforts would cost. I have toured Rawson-Neal several times. It is my feeling that it will take minimal changes and renovations to make this work. It is already set up with two separate ten-bed pods separated by locked doors and combined by a large nurses' station. The rooms were already being utilized for the adult mental-health population. There are some minor things we will need to do to ensure the safety of those who would go over there. It is my feeling that it would be fairly negligible.

Chairman Sprinkle:
Are there any other questions? [There were none.] We will open up public comment one more time.

Dan Musgrove, representing WestCare Foundation; Chair, Clark County Children's Mental Health Consortium:
I want to applaud the efforts of the Department for gaining the CCBHC grant. I am so excited about this program. As Tracey Green testified, and especially in southern Nevada, the fact is we do not have a no-wrong-door facility where folks can go. The fifteen hospitals strategically placed all over the Valley become where our mental health folks go for treatment until they can be moved into the system. After this pilot program, if we can expand three or four strategically placed hospitals, that would be an excellent way to get folks into a system of care where they can be assessed properly and taken care of holistically.

In my free time, I am Chair of the Clark County Children's Mental Health Consortium. The Consortiums were formed by Assembly Bill 1 of the 2001 Special Session to be the fiduciary for children with behavioral health needs throughout the state—whether with school issues or home-based issues. There is an eclectic group of members who are part of our consortium. There are three consortiums in the state—a rural, a Washoe County, and a Clark County. I want to applaud both Kelly Wooldridge and Ryan Gustafson for the work they are doing on children's mental health. I applaud the Committee on having a presentation on children's mental health. It is so important that those kids' issues get heard by this Legislature.

Every year, the Consortium puts together priorities that we deliver to Richard Whitley, Director of the Department of Health and Human Services. We were lucky enough to get both the Interim Health Care Committee and the Interim Committee on Child Welfare and Juvenile Justice to take our priorities, support them, and send them to both the Governor and to the Legislature's budget committees for consideration. Many of them are included in the Budget. The most important is mobile crisis. The work that is being done with mobile crisis throughout the state is invaluable. I want to applaud the Department and appeal to this Legislature that it focus on kids' issues, because it is so important that their behavioral health needs are met.

Chairman Sprinkle:
Thank you for your comments. Does anyone else wish to come up under public comment? [There was no response.] I want to say that, once amendments are going to be presented to this Committee, could you be clear as to the intent of the amendment. It would make it far easier for us to understand how to draft the language for them.

With that, we are adjourned [at 3:41 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblyman Michael C. Sprinkle, Chairman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "Behavioral Health Presentation" dated February 2017, presented by Amy Roukie, Deputy Administrator of Clinical Services, Division of Public and Behavioral Health, Department of Health and Human Services.

Exhibit D is a copy of a PowerPoint presentation titled "Children's Mental Health" dated February 2017, presented by Ryan Gustafson, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services.

Exhibit E is a proposed amendment to A.B. 46, dated February 15, 2017, sponsored and presented by Ellen Richardson-Adams, Outpatient Administrator, Southern Nevada Adult Mental Health Services, Division of Public and Behavioral Health, Department of Health and Human Services.

Exhibit F is a copy of "Proposed Regulation of the State Board of Health" LCB File No. R090-16, dated August 3, 2016, supplied by Ellen Richardson-Adams, Outpatient Administrator, Southern Nevada Adult Mental Health Services, Division of Public and Behavioral Health, Department of Health and Human Services.

Exhibit G is a document titled "Critical AB 46 Information" presented by Helen Foley, representing the Nevada Assisted Living Association in opposition to the bill.