MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-ninth Session
February 8, 2017

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 3:32 p.m. on Wednesday, February 8, 2017, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 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.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Julia Ratti, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Debbie Carmichael, Committee Secretary

OTHERS PRESENT:

Stephanie Woodard, Psy.D., Project Director, Certified Community Behavioral Health Clinics, Division of Public and Behavioral Health, Department of Health and Human Services
Helen Foley, Nevada Assisted Living Association
Darryl Fisher, Nevada Assisted Living Association
Amy Roukie, Deputy Administrator, Clinical Services, Division of Public and Behavioral Health, Department of Health and Human Services
Bill M. Welch, Nevada Hospital Association
Cody L. Phinney, Administrator, 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

David Tristan, Deputy Director, Programs, Nevada Department of Corrections
Joan Hall, President, Nevada Rural Hospital Partners
Jodi Tyson, Three Square; Food Bank of Northern Nevada, Inc.

CHAIR SPEARMAN:
Our first order of business is the Senate Committee on Health and Human Services Rules for the 2017 Session (Exhibit C).

> SENATOR HARDY MOVED TO ADOPT THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES RULES FOR THE 2017 SESSION.
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> SENATOR WOODHOUSE SECONDED THE MOTION.
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> THE MOTION CARRIED UNANIMOUSLY.

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MEGAN COMLOSSY (Policy Analyst):
The Senate Committee on Health and Human Services Committee Brief (Exhibit D) is designed to provide background information on Committee jurisdiction, workload and to serve as a resource for Committee members and the public. The Committee staff is listed on page 1 of Exhibit D. Committee jurisdiction pursuant to Senate Standing Rule No. 40 is provided on page 2. A breakdown of the bills referred to the Committee during the 2015 Legislative Session is provided on page 4. Pages 4 through 7 provide a variety of health care issues that were discussed during the 2015-2016 Interim, and many of these will likely be considered during the 2017 Legislative Session. These issues include health care workforce, public health, Medicaid reimbursement rates and behavioral health. Session deadlines are listed on page 8. The remaining pages provide resources which include reports, publications, audits relating to health and human services in Nevada, contact information for health and human services agencies and entities and common health and human services acronyms.

CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 27.

SENATE BILL 27: Revises the definition of the term "mental illness" for purposes of provisions relating to criminal procedure, mental health and intellectual disabilities. (BDR 39-133)

STEPHANIE WOODARD, PSY.D. (Project Director, Certified Community Behavioral Health Clinics, Division of Public and Behavioral Health, Department of Health and Human Services):
Senate Bill 27 is considered a housekeeping bill. The bill language was last updated in 2003. The bill proposes changes to the language by deleting outdated reference texts, such as the *Diagnostic and Statistical Manual of Mental Disorders*, and adds specific language that broadens the definition of mental illness to include diagnoses such as dementia and intellectual disability.

The proposed amendment (Exhibit E) clarifies diagnoses excluded from the *Nevada Revised Statutes* (NRS) and does not seek to broaden the definition of mental illness to include individuals who are excluded from the definition. Research into other states' definitions of mental illness found no state using reference texts and diagnostic codes to define mental illness. The proposed amendment language is consistent with the way other states have defined mental illness. The proposed amendment language is consistent with current NRS exclusions of individuals with diagnoses such as dementia and intellectual disabilities as found in the definition of persons with mental illness in NRS 433A.115.

SENATOR RATTI:
Will changing the definition expand or reduce the availability of services by Medicaid or a private payer? Does anyone rely on the definition to determine to whom services will be provided?

DR. WOODARD:
To my knowledge, no. The way the definition language has been recrafted does not change those who meet the criteria under the definition of mental illness. The intent is to clean up the language so the NRS does not have to be continually updated because of reference text changes.

CHAIR SPEARMAN:
Over the decades the definition of mental illness has changed. Does the proposed amendment take into account any possible future revisions that might happen with respect to the *International Statistical Classification of Diseases*

and Related Health Problems or the *Diagnostic and Statistical Manual of Mental Disorders*? I am speaking specifically to an antiquated practice of conversion therapy, which occurs in many states.

DR. WOODARD:
The language in this definition is purposefully kept flexible because the definitions do change over time. What is included in regards to the exclusionary language is consistent with the NRS and likely will not change over time.

CHAIR SPEARMAN:
More specifically, the language will not change so any particular group of people will be castigated because of …

DR. WOODARD:
Yes, that is correct. The purpose set forth in NRS 433 is to protect the civil rights and responsibilities of individuals with mental illness.

SENATOR HARDY:
Was the amendment produced by the Legislative Counsel Bureau (LCB) attorneys?

DR. WOODARD:
No.

CHAIR SPEARMAN:
The LCB attorneys will draft the appropriate language, based on the proposed amendment, in preparation for a work session and the Committee vote.

The Committee received a letter and an email in support of S.B. 27. The letter is from the National Alliance on Mental Illness, Ginger B. Paulsen (Exhibit F), and the email is from Don Williams (Exhibit G).

HELEN FOLEY (Nevada Assisted Living Association):
Members of the Nevada Assisted Living Association were confused by S.B. 27 and would have testified in opposition had the proposed amendment not come forward. There is still confusion with the wording on the amendment, what is excluded and what is included. The Association is anxious to participate in the next hearing and work session on the proposed amendment. The Association wants all people in Nevada who need mental health services to receive them.

The Association wants to make sure the people who provide mental health services, especially when relating to long-term care, are licensed by the State, regulated by administrators and trained in the services provided. Sprinkler systems need to be provided in the homes. The ombudsman needs to inspect every facility where people are provided mental health services or long-term care services. There is a special type of licensing for residential facilities for groups and assisted living centers to provide services for memory care, Alzheimer's Disease and other issues. The Association wants adequately trained people to provide those services. The language in the bill would have opened up the door. The proposed amendment will close the door. The Association does not have a problem with the proposed amendment if the language stays as just heard.

DARRYL FISHER (Nevada Assisted Living Association):
The primary concern is with broadening the definition relating to dementia. There are special training regulations and special environments to adequately provide care and service to the elderly with dementia. If the language were broadened without the training, support system and controlled environment, vulnerable seniors and the elderly would be at risk. We at the Nevada Assisted Living Association did not know about the proposed amendment until now. We want to be cautious and review the redrafted bill with the proposed amendment to make sure seniors and the elderly are not at risk.

CHAIR SPEARMAN:
Can you share your concerns if the language does not change?

MR. FISHER:
There are different types of mental health care. One example is supportive living arrangements for the higher functioning younger people. If the definition was broadened, it would allow expansion into senior care or people with dementia. That is not the appropriate placement for those individuals.

MS. FOLEY:
The Nevada Assisted Living Association does not have a problem expanding the number of providers. During the Interim, the Committee heard about facilities that are certified but not licensed, never inspected, and have no oversight. People living in those facilities do not require an expansive level of care like those in assisted living centers and residential facilities for groups. The Association would not have concerns if all facilities had to follow the rules and become certified and licensed. Many people have fallen through the cracks;

there have been deaths and squalor. There have been disturbing and alarming situations reported by the *Reno Gazette-Journal* over the last year. The placement facilities are regulated by different State divisions. The ombudsman should always go into those facilities to guarantee the quality of care is up to snuff. People sent to these facilities do not understand the differences in care.

SENATOR HARDY:
I have concerns about the proposed amendment using certain wording such as: seriously limits, personal relationships, recreation, brief periods, dependence upon, mental illness, be diagnosed and diminished capacity. These terms need to be defined. *Nevada Revised Statutes* states a patient can be discharged unless there is a mental illness. A doctor cannot discharge a person with anxiety from the hospital. The proposed amendment affects post-acute care, the person with chronic mental issues and the acute Legal 2000 hold. It is premature for the Committee to debate the proposed bill when it is more than "clean-up language."

MS. COMLOSSY:
It will be helpful to have the Legislative Counsel Bureau Legal Department draft the amendment. The proposers of the amendment are requested to include the intent. The Committee can then review the proposed amendment with the concerns on the record.

CHAIR SPEARMAN:
There will be three presentations that will provide more detailed information on specific topics.

AMY ROUKIE (Deputy Administrator, Clinical Services, Division of Public and Behavioral Health, Department of Health and Human Services):
Our presentation, (Exhibit H), pages 2 and 3 cover the structure of the Department of Health and Human Services (DHHS) as it relates to State mental health services. There are major issues facing the Division of Public and Behavioral Health (DPBH) going into the biennium as shown on page 4. The Muri Stein Hospital, which opened one year ago in Las Vegas, is used to grow the expanded referred population that was served only at Lakes Crossing Center in Sparks. The *Burnside v. Whitley* Consent Decree requires DHHS to offer a bed within seven days of receipt of the commitment order from the courts once the patient has been medically cleared. Short-term crisis stabilization services are decreasing where community capacity is available. Civil patients are served

in hospital emergency rooms (ERs) and in expanded Medicaid providers that provide private, sometimes for profit, care. Patients are no longer relegated to choosing only the State mental health system. The delivery model changes are explained on pages 5 through 7. The expansion of Medicaid and the DPBH's focus on the decriminalization of individuals with mental illness are a few examples. The chart on page 6 shows the adult forensic restoration clients. The chart shows the number of clients and the average length of stay are increasing. The clients shown on the chart were referred to the DPBH. The belief prior to adjudication was the clients had problems with competency. The hope is to stabilize the clients' mental illnesses to restore them to a competency level, and through adjudication, deal within the criminal justice system if appropriate.

CHAIR SPEARMAN:
How will Governor Sandoval's proposed $20 million budget cut from the mental health budget affect the programs you just mentioned?

MS. ROUKIE:
I will briefly discuss the budget and the impact of the proposed budget cut later in my presentation.

CHAIR SPEARMAN:
How mature or not is the wraparound service? Has it been implemented? Have you had success? How much money do you need to make it a success?

MS. ROUKIE:
Many of the wraparound services are under way. The competency evaluation is provided to the jails in Clark County and Washoe County. Connections are made for the people exiting the programs like eligibility for Medicaid so they have access to services when they leave incarceration. The Sequential Intercept Model is explained on pages 8 and 9. The model shows five points where opportunities exist to raise mental illness concerns and appropriately divert the person to mental health rather than retaining him or her in the criminal justice system. The goal is to shift services to allow expansion on the incarceration side or at risk of incarceration and intervene with mental health services rather than focusing on the civil side of services. In private settings, there are many opportunities where people can get care. In Reno, for example, there is an expansion of a 120-bed psychiatric hospital projected to open this fall. The entire hospital will accept Medicaid managed care, and the civil population can

be treated. People who are incarcerated are not eligible for Medicaid until they are no longer engaged within the criminal justice system.

SENATOR HARDY:
Is the mandatory outpatient treatment a part of this and helpful in keeping people out of institutions?

MS. ROUKIE:
Yes. The assisted outpatient treatment services is a court ordered outpatient treatment for people in the south who have not voluntarily signed up for outpatient services. The goal is to keep them out of the criminal justice system. It is working very well and includes intensive case management. Funds were received to support the services in the north. A complement of services will be available in the larger urban areas of the State. That is one of the diversion programs achieved.

SENATOR HARDY:
Has the program saved money?

MS. ROUKIE:
Yes, that is the goal. The reflected savings may be seen in the Nevada Department of Corrections or other places. The goal is to provide treatment in lieu of incarceration, hoping to keep them out of the other systems where they do not need to be.

SENATOR RATTI:
Can you give more information on the new facility in Washoe County and Medicaid going into a psychiatric facility?

MS. ROUKIE:
The hospital will replicate the signature health product that is provided by the Desert View Hospital in Las Vegas. The Desert View Hospital CEO has been in discussions with DHHS and DPBH about the 120-bed hospital, accepting Medicaid managed care, Medicaid fee-for-service and commercial insurance. Desert View Hospital is confident they can work with this population, and it will expand the capacity in Washoe County for services. Desert View Hospital has a complement of services that have not been specifically defined. I cannot speak for Desert View Hospital, but I can connect you to them.

SENATOR RATTI:
The Governor's budget assumes that private pay services, Medicaid, pay as you go and managed health care will be expanded. How do you know if those services will be provided at Desert View Hospital? The hospital is scheduled to be opened in February, but the budget starts in July. How will that work?

MS. ROUKIE:
We at the DHHS have been told the hospital will open in the fall of 2017. The population Desert View Hospital will serve was identified during the meeting with DPBH. There has been a decrease in the overall service provisions and the requests for inpatient and outpatient services over time. The University Medical Center in Las Vegas has a 20-bed unit and has had discussions asking for more space to expand its services now there is a payer available. This is not an isolated example but is predicated on the caseloads proving people are seeking and receiving services in other places in the community. That is beyond future capacity. This does not completely resolve the issue of wait times in the ER and people not receiving services. Because of the *Olmstead v. LC.* (98-536) 527 U.S. 581 (1999) decision, there will be more availability of services, and people will be encouraged to seek services where they choose, when possible. Services will not be completely eliminated but reduced in favor of growing the forensic population. The forensic population will not be served by another provider.

SENATOR RATTI:
If a sufficient amount of community-based services exist, is it only a choice?

MS. ROUKIE:
That is not my understanding. The drop in caseload in a variety of different settings is a direct result of patients going elsewhere for outpatient, pharmacy services and civil services. There is sufficient capacity and opportunity for growth for more places to choose. Existing capacity is meeting the need to the extent it can. There may never be capacity in the State to serve 100 percent of the population 100 percent of the time. When a person is seen in the ER, the hospital is paid for services when there is managed Medicaid. We can treat them as well, but we do not have to. There are opportunities for people to go to different venues in the community where there is expanded capacity that meets the needs based on what our capacity is now and declining demand.

SENATOR RATTI:
Are there still mental health patients in hospitals who cannot get community placement?

MS. ROUKIE:
Yes. A medical clearance is required with many community-based providers when an emergency responder intercepts someone in the community. They have to go to the ER before they will be accepted by a community provider. Placement becomes a priority. There are other options if a patient has Medicaid managed care. The majority of people who are uninsured are the people needing treatment. There is a huge population of uninsured that continue to be uninsured. For instance, those people who are undocumented, those who do not meet the income requirements to be eligible under the Affordable Care Act (ACA) and those who are slightly beyond the income level to allow them to sign up for the Silver State Insurance Health Exchange. The goal is to meet the unmet need.

SENATOR RATTI:
I am still perplexed by the reduction in budget with those gaps in services. It is well-documented that the State's mental health system has many gaps. Even if the dollars are not required where they are today, there are needs here.

CHAIR SPEARMAN:
There are people going to other places because they believe there are other options. I am concerned what those options might be. If one of the options is a hospital, what does that look like in terms of census and patient load at the ER? What type of impact does it have on overall operating budgets of hospitals?

BILL M. WELCH (Nevada Hospital Association):
A number of private psychiatric hospitals are developing and have expanded over the last couple of years. For some time there has been an excess capacity of behavioral health beds in private psychiatric facilities. There is a challenge moving Medicaid patients into those facilities. That challenge is referred to on the federal level as the Medicaid Institutions for Mental Diseases (IMD) exclusion. Several recommendations came out of the Governor's Advisory Council on Behavioral Health and Wellness a number of years ago that assisted in developing a work-around. The work-around is that as long as the State can demonstrate its inability to place Medicaid recipients, patients that are in Medicaid managed care can be moved into a freestanding psychiatric facility as

long as there is demonstrated savings to the State. The IMD exclusion still continues to be in place.

I am surprised that one of the private psychiatric hospitals has indicated it will take Medicaid fee-for-service. Unless the rule has changed at the federal level, the State is not able to receive federal matching dollars for Medicaid fee-for-service paid in a private psychiatric facility. Psychiatric facilities can receive matching dollars for psychiatric patients that have fee-for-service in a full-service acute care hospital that has a distinct psychiatric unit. There are a number of those hospitals in the State. The benefit that came out of the recommendations from the Governor's Council was the inpatient rates for inpatient acute care psychiatric distinct part units was raised. That motivated a number of those hospitals to develop or expand inpatient psychiatric units. Valley Hospital Medical Center, Boulder City Hospital and North Vista Hospital are examples. Other hospitals are looking at developing inpatient psychiatric units. There has been significant growth in the number of beds in the private sector. There are a significant number of self-paid patients that are processed through the ERs. There are high-risk patients that are processed through the ER. Many Medicaid patients are coming into the hospitals. All of them are coming in for medical clearance once they have been placed on a Legal 2000 hold. There is a concern at the suggestion there is a decline in the need for State inpatient services. When the hospitals were surveyed, there were 151 patients brought in on Legal 2000 holds; 122 of them had been cleared and were being held in the hospital waiting for appropriate placement. Yesterday, I surveyed the hospitals again. There were 151 patients in the hospital ERs on Legal 2000 hold, 112 had been medically cleared and were waiting for placement. Most were self-paid and high-risk patients. There were some patients on Medicaid fee-for-service, but not many.

CHAIR SPEARMAN:
Can you clarify the term high-risk?

MR. WELCH:
High-risk patients are those who have demonstrated violence. Some other categories are high risk for suicide and having a sexual predator-type behavior that has been demonstrated over time. Those patients have a hard time finding placement. This continues to create challenges for the hospital ERs as a significant number of patients are held there. Three years ago when the recommendations came into play, there was a decrease in patients. Now there

is an increase, possibly because of the population increase in the State. There may be other factors causing more mental health patients. It is a challenge for mental health patients in the ERs who have been medically cleared and are waiting for placement. The patients are not getting the care they should be. Several months ago, a medical director of one of the local hospitals called me and asked what I was going to do to help clear out the ER. More than 25 percent of the capacity was tied up holding patients for placement. This is an issue that is becoming a significant problem. I would encourage a presentation from Desert View Hospital. It would be interesting to hear if the hospital will take self-pay and Medicaid fee-for-service as that is not the typical business model a free-standing, independent psychiatric hospital uses. All independent free-standing psychiatric hospitals take some self-pay; they do take Medicaid and did before the changes came into place. There is still a significant void for this service. There are many repeat patients and it is a challenge. It is a financial risk. Most patients are not paid for or are covered at a minimum rate far below the cost to treat. I can research and provide the exact number of the financial impact. There has been effort by many people to address the needs of the community. Progress was made three years ago, but the demand has caused a loss of ground.

I would encourage the Legislature to convene a summit much like the one the Governor did several years ago. Included in the summit would be the State, Medicaid payers, outpatient providers of behavioral health services, inpatient providers, licensed health care professionals, emergency medical services (EMS), law enforcement, the court systems and any agencies that are engaged and involved in treating this population. The Nevada Hospital Association would be willing to participate and support any initiative to facilitate a summit. We like people to bring forward issues and problems in meetings concerning the population's needs. Why is this happening and what are the solutions? There are many people working on this but not as a complete integrated review. It is time to delete the silos and come together to work collaboratively on a comprehensive plan. There are questions about why inpatient capacity is decreasing at the State mental health facilities while there are significant problems placing patients in hospital ERs.

CHAIR SPEARMAN:
Since 2013, there have been changes regarding managed care. Is it, or is it not, available for people deemed mentally incapacitated or not able to care for themselves? That could explain why things are being done differently now. This

issue will be discussed several times during this Session because it is "the chicken or the egg." If there is more money, can more patients receive treatment? What are the options? Are the options suitable for proper treatment or are they simply options someone came up with that may or may not be suitable? This is a concern and it does not have to be answered right now. There are 151 patients in the ERs, 112 are still in the ERs waiting for placement. That has implications for the nurse-patient ratios versus staffing concerns. At another time I would like to understand how that is being addressed. It is a difference between getting the oil changed or waiting until the engine or the car has to be replaced. It is my firm belief that the State being fifty-first in the Nation with respect to mental health care issues is because we are oblivious to them and they have not been dealt with.

MS. ROUKIE:
The Department of Health and Human Services provides mobile crisis services. The program was started in July 2014, and at any given time licensed clinical social workers are sent to the ERs to help with the discharge disposition of patients if they are not going to State facilities. Staff performed discharge dispositions on over 250 patients. The Department of Health and Human Services is trying to meet the needs of patient discharges. There are a variety of options for treatment from community-based organizations. One is WestCare Nevada's non-locked placement for someone on a Legal 2000 hold. It is a community placement where treatment is provided. I can provide a list of treatment options to the Committee at some point in the future.

CODY L. PHINNEY (Administrator, Division of Public and Behavioral Health, Department of Health and Human Services):
The Division of Public and Behavioral Health wants to work together with other agencies. To address this very critical issue, DHHS needs the help of the community including ERs, hospitals, Medicaid managed care and our partners at Medicaid. The State has struggled with this problem. It is critical for the whole system to be considered and worked on as a system. Because people have access to whole health care they are asking for mental health care, and that is an improvement. In the past, people had given up and stopped asking for help. Broadening mental health care across the whole system is incredibly critical.

MS. ROUKIE:
A new program called the Certified Community Behavioral Health Clinics (CCBHC) from the federal Substance Abuse and Mental Health Services

Administration, U.S. Department of Health and Human Services, which sets up centers, is identified on page 10 of Exhibit H. This is a pilot project where the centers provide mental health services, addiction treatment, integrated behavioral health care and physical health care using an evidence-based model. There are efforts in Elko, Fallon, Las Vegas and a satellite center in Reno. There will be four CCBHC Centers with five access points across the State. This will expand access to care on the community level. The Affordable Care Act is addressed on pages 11 and 12. The Medicaid Managed Care Organizations (MCO) want patients to enroll in their care plan. The MCOs are incentivized by keeping patients well, whether there are behavioral health issues or physical health issues. This saves the organizations money. It is the goal of DPBH to work closely with the MCOs to ensure the organizations have access to the plans. When an individual is covered by a plan, the MCOs know what resources are available and how to get them. The DPBH is working on this with the National Alliance on Mental Illness Nevada. Mental health budgets are explained on page 13. The DHHS is monitoring the ACA repeal efforts very closely. There is no way to develop the budgets until there is a repeal or replacement that affects this population.

CHAIR SPEARMAN:
Have any best- or worst-case scenario projections been done if the ACA is tampered with or repealed without an adequate replacement?

MS. ROUKIE:
The DHHS has not been able to do any best-case, worst-case projections because the best information available from the federal partners is funding could come as a block grant to the states. There is no concrete evidence of what an amendment or a replacement to the ACA would look like. The one thing that can be done is to go back to before the implementation of the ACA. What was in the budget prior to ACA and what we needed to afford. That would create waiting lists and longer lines because access would be lost in the community.

CHAIR SPEARMAN:
If the State were to continue at the prior ACA support level, although inadequate as it is, what would the costs be? The human cost would be waiting times.

MS. ROUKIE:
I am not prepared to provide those numbers. I can provide you an estimate.

CHAIR SPEARMAN:
Would it be safe to say it would be a lot?

MS. ROUKIE:
Yes, that would be safe to say.

Exhibit H, page 14, continues to cover the mental health budget. There was a study provided by the LCB on the Regionalization of Mental Health Services. The study is a very good representation of where mental health services are and the potential evaluation for changing the structure in the organization on how health care is provided in the State. It is hoped the pilot project will grow a service delivery system that is non-existent in the State. Nevada was one of nine states that was awarded the program. The program in Nevada is under the leadership of Dr. Woodard. Page 15 shows budget numbers for clinical services Statewide. The largest portion of the budget is the State General Fund. The DPBH is heavily dependent on the State General Fund. As budgets were prepared, there were expectations of change to the budgets. It became onerous to the clinical services budget to make required reductions in the General Fund because of the high percentage of the General Fund that is used in the State mental health services. The calculations on page 16 show the changes in the budget.

The volume of patients who do not have insurance is shown on page 17. The DHHS's role is that of a safety net for patients and for facilities that also take Medicaid fee-for-service. There is hope that Medicaid managed care patients will be served in another setting—as long as they are not the patients Mr. Welsh spoke about earlier who are in facilities where there is reluctance to treat them and they become the responsibility of DHHS. Eligibility is explained on page 18. The DHHS is co-locating eligible staff workers in the facilities. We are also collaborating with the criminal justice system. They are enrolling approximately 192 adults and 82 juveniles per month across the State. There are partnerships with criminal justice agencies, medical partnerships, social services partnerships, Northern Nevada Hopes, the Children's Cabinet and others. The partnerships available to the State's uninsured are listed on page 19. These are opportune times to catch people who could be eligible but have yet to be found eligible. The DHHS's goal is to get those deemed eligible to have access to services. If they are not eligible with DHHS, then they may be eligible with another provider even for medical care.

CHAIR SPEARMAN:
Some veterans do not know they are veterans. Some people who have served believe if they did not retire from the military, they are not veterans. Has DHHS considered doing something with Veteran Services to identify veterans in need of services? Some of the population DHHS is trying to serve may be eligible for benefits through other means.

MS. ROUKIE:
That is a question for the Division of Welfare and Supportive Services (DWSS), Department of Health and Human Services, as they are continually expanding their partnerships. It depends on whether the veterans' service centers welcome DWSS to provide eligibility information. For instance, the Division of Parole and Probation, Department of Public Safety has to give permission for remote access to the welfare agency so they can provide eligibility determinations on-site. That is a future option.

CHAIR SPEARMAN:
I am suggesting just asking the question, "Have you ever served in the military?" If they have, additional information is available. Veterans are not forced to go, but they will be aware of eligible services.

MS. ROUKIE:
That is one of the assessment questions asked when someone is enrolling in services. Available benefits or connections for future continuum of care services is then known in the veteran's care system. I would have to ask our data people to pull the information to determine how many people are veterans.

Examples of services are listed on pages 20 and 21 of Exhibit H. Page 22 describes the Mobile Outreach Safety Team (MOST), and page 23 is a graph that shows the volume of clients served by the MOST program. In Clark County, crisis intervention-trained metro police officers respond to individuals experiencing mental health crises. A recommendation is made to WestCare Nevada once law enforcement has intervened with an individual. WestCare Nevada engages with the individual to provide ongoing case management for stabilization or to provide additional care if needed. In Washoe County, mental health clinicians accompany crisis intervention-trained police officers and sheriff deputies when responding to mental health crisis calls. The DPBH supports the clinicians who accompany law enforcement personnel. The funding will be transferred to Washoe County Social Services once an agreement is reached,

hopefully, by the end of the fiscal year. Page 26 explains the MOST program for Carson City. There are discussions about potential programs in rural counties like Churchill and Lyon. Page 27 covers staff changes. The DPBH is working hard to ensure no impacted employee will experience job loss.

CHAIR SPEARMAN:
Part of the strategic plan covers how to mitigate additional shortages. Do you have a percent of positions held vacant? What is the percent of current shortages? What is the percent collectively?

MS. ROUKIE:
I do not have the percentage available. I can get that information for you.

The next couple of pages of the presentation show the specific workforce shortage issues. In the behavioral health field, there are workforce shortages across many of the disciplines. Health professional shortage areas have been defined across the State. This allows for leverage of federal funding for recruitment and retention through the Nevada Health Planning and Primary Care Office. Recruitment and retention works when there are creative solutions and competitive providers. The Workforce Strategy Team is working with universities to creatively incentivize people to continue their educations. Employees can be retained while going to school.

Pages 29 and 30 show the workforce shortages by disciplines. The initiatives to retain people in the workforce is listed on page 31. Telehealth is used to make assessments in the ER, like making Legal 2000 hold determinations. The information on the percent of people involved in the criminal justice system receiving mental health treatment is provided on page 32.

SENATOR RATTI:
Do the percentages include the local jails?

MS. ROUKIE:
The percentages are just for the Nevada Department of Corrections. Information for the Lyon County Jail is shown on page 34. I can provide you information on a specific county or for all counties.

SENATOR RATTI:
I am interested in seeing the jail populations as well.

MS. ROUKIE:
On Exhibit H, page 33 shows the percentage of people on parole and probation who have received mental health treatment. Page 34 shows, specifically, Lyon County Jail data. The most common mental health diagnosis among clients in Nevada is shown on page 35. Points of reference about crimes and individuals with mental illness are provided on pages 36 and 37. A summary of the presentation is shown on pages 38 and 39.

RYAN GUSTAFSON (Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services):
Children's Mental Health Services, Child Welfare Services and the Juvenile Justice Services are programs within the Division of Child and Family Services (DCFS). The primary goals for Children's Mental Health are shown on page 3 of our presentation (Exhibit I). Children's Mental Health Services incorporates two budget accounts and they are shown on page 4. Budget account 3281 is primarily for Washoe County and budget account 3646 is for Clark County. Northern Nevada Child and Adolescent Services includes a number of programs as shown on page 5. Page 6 reflects the number breakdown of clients served across the programs. Southern Nevada Child and Adolescent Services are listed on pages 7 and 8. In fiscal year 2016, the number of clients across the programs served by southern Nevada Child and Adolescent Services are shown on page 9. The percentage of children served Statewide is shown on page 10. The age breakdown of children served Statewide is shown on page 11. One of the initiatives that DCFS and Children's Mental Health Services are working on is the Mobile Crisis Response Team (MCRT). Information about MCRT is shown on page 13. Calls come in from a variety of different referral sources and they are shown on page 14. There is a mobile crisis Website. Shifts have been seen with the Website in place. Crisis assessments are done with evidence-based tools in Las Vegas ERs that allow a determination in service provisions for family needs. Families are involved with feedback and assistance in making determinations whether a child needs to be hospitalized versus can the child be stabilized in the community with services and support. In the north, the phone calls were coming from various schools within the Washoe County School District. Assessments were provided on-site with the parents present, and a determination was made right then.

The reasons for the crises are listed on page 15. Clients served by the MCRT are shown on page 16. The MCRT has been in operation for about three years in Clark County and over two years in Washoe County. During the three-year

time period 2,839 calls were fielded. Page 17 provides more details of the program. The DCFS has partnered with the DWSS. If families are willing and there is an opportunity after the initial assessment, insurance options are explored if they are uninsured. The uninsured is a portion of the children and families that are served with the MCRT. Someone from the DWSS can ride along or an appointment can be made for the families to get insurance in place. The partnership with the Department of Public and Behavioral Health and the assistance of the System of Care grant enabled the MCRT to go to the rural areas. It is important to respond quickly if there is a crisis in the rural areas, which can be challenging. There has been co-training, co-locating and co-supervision with DPBH, which has enabled response calls through telehealth methods to provide crisis response in the rural regions. Page 18 outlines four primary goals for the System of Care implementation grant. With ongoing technical assistance from Southern Nevada Adult Mental Health Services (SNAMHS) and community partners, there have been a number of successes.

The System of Care grant process is explained on page 19. The strategic and communication action plans are updated regularly as the goals are moved through that have specific benchmarks and action items on them. There are over a dozen sub-grantees in place that are providing a variety of services like transitional age youth services. Community-based and day treatment programming is ready to be launched. Children's Mental Health has placed an emphasis on partnering with the Juvenile Justice System in Washoe County and Clark County as explained on pages 20 and 21. The Division proposes to reduce and relocate the licensed 58-bed State-operated Desert Willow Treatment Center (DWTC), located in Las Vegas. Page 22 explains the proposed reduction. A 20-bed program would meet the unmet needs in Clark County. The graph on page 23 shows the clients served in the DWTC acute programs over each month in 2016. As of this morning in the acute center at DWTC there was one person, yesterday there were two. The census in the acute program has decreased over time. The graph on page 24 shows the clients served in the DWTC residential program in 2016. The graph on page 25 shows the clients served in the DWTC acute and residential programs from 2014 through 2016. There has been a significant decrease in trend. The DWTC proposed reduction benefits are shown on page 26. With the reduction, 54 positions will be retained, eliminating 53 positions. Of the 53 positions, 33 positions are vacant. A large portion of employees in the 20 positions to be eliminated can be moved into other vacancies. It is very hard to recruit and retain mental health technicians and psychiatric nurses. It has been an ongoing challenge to have

adequate staff at DWTC. There is a large vacancy pool, so the reduction is not as significant as it appears.

SENATOR RATTI:
Page 15 of Exhibit I shows the reasons for crisis. Can you explain why substance abuse does not show up? Are you screening those out and putting them in another category?

MR. GUSTAFSON:
The MCRT program is still new and community, school, hospital and family education is ongoing. Substance abuse, suicidal ideation or significant mental health issues are not mutually exclusive. If substance abuse was paired with suicidal ideation or something else, then it could fall into those categories. Substance abuse could fall into the catchall category of other. The majority of calls come from youth who are already in the hospital. The goal is to get to them before they go into the hospital and then must wait for services. In Washoe County many calls come from schools, so youths are prevented from going to hospital ERs. Substance abuse is not a typical call, but what a family would consider a critical need is a typical call.

DAVID TRISTAN (Deputy Director, Nevada Department of Corrections):
The Nevada Department of Corrections (NDOC) has administrative regulations pertaining to the treatment of mentally ill inmates as explained on page 2 of our presentation (Exhibit J). The NDOC did not have a director of mental health, and pages 3 and 4 describe the problems that have occurred. Studies have shown the longer a person stays in a segregation unit, the more likely they are to decompensate rather than improve relative to their mental health status. Pages 5 and 6 explain what is being done to reform the mental health policy in NDOC. There are 52 beds for the most seriously mentally ill at the Northern Nevada Correctional Center (NNCC). In the structured care unit, which is a step-down unit, there are 60 beds. There are 168 beds designated for stabilized inmates. However, there are 397 mentally ill inmates at NDOC. This demonstrates the problem of stretching the resources to deal with the mentally ill even at the place where there are the most amounts of resources. The correctional officers were asked how inmates interacted. The inmates' behavior, hygiene and whether or not they ate meals was logged. Typically, the logs were not good enough to provide information to the clinical workers or psychologists as to how the inmates were functioning in the unit. The NDOC wants to create

a multidisciplinary treatment team approach so the clinicians can better treat inmates.

Current data on the NDOC population including the mentally ill and the aging population are listed on page 7. The inmates on psychotropic medication, identified by facility, are shown on page 8. This gives an example of the concentration of inmates and the need to place them where there are the most resources. The number of veterans in the NDOC is shown on page 9. The NDOC has many partnerships and they are listed on page 10. The NDOC identified issues, and proposed plans are shown on pages 11 through 17. The NDOC is requesting $2.3 million for an electronic medical health information system. As training is developed and delivered to staff, it will help staff recognize how to communicate with the inmate population.

CHAIR SPEARMAN:
Is the training cost included in or is it in addition to the $2.3 million?

MR. TRISTAN:
The training is not included. The NDOC is working with several grants such as the U.S. Department of Justice's Second Chance Grant to develop a treatment team approach between custody, classification and program staff and the mental health system. The Bureau of Justice Assistance grant will allow NDOC to look at the segregation units and develop training. The NDOC was awarded a grant through the National Institute of Corrections to assist in the development of a mental health delivery system.

CHAIR SPEARMAN:
What would the training cost be without the grants?

MR. TRISTAN:
I do not have a dollar figure for the training costs. Some training may be done in-house relative to shutting down the Police Officers' Standards and Training Commission and redirecting staff for training. It may not cost as much as opposed to wholesale training, where a major portion of the clinical medical custody casework staff comes into one classroom for training. I can provide the cost to you.

CHAIR SPEARMAN:
You can send the information to me by email.

SENATOR WOODHOUSE:
Please also make the cost of training available to the Senate Committee on Finance. Your budget will come before the Subcommittee on Public Safety, Natural Resources and Transportation and they will need the information.

MR. TRISTAN:
There is an absence of information in the logs, like simple things that would demonstrate an inmate's condition. Changes to the logs would not require any additional funding. Officers would gain an understanding of how important it is to document inmate behavior. One of the plans to be implemented in the near future are standardized treatment plans that are well documented in the inmate's file so there is consistency between institutions in the north and south. Another plan is to change regulations on how a treatment plan is handed from one facility to another. A constant complaint from wardens is lack of information relative to an inmate's mental health, i.e., condition, diagnosis, treatment plan, and when the inmate arrived from another facility. The NDOC is working with the Division of Parole and Probation on transitioning inmates from an institutional setting into parole. For example, inmates who were seriously mentally ill have been paroled directly from segregation units into the community. The process is being changed. The NDOC is working with DHHS to help inmates whose sentences have expired go into the community. Plans are being made on how to handle inmates on forced medications transitioning from an institution into the community. It was discovered that some seriously mentally ill inmates were placed in segregation for up to five years or longer. The proposed regulations will change that situation. Clinicians will be required to review a mentally ill inmate's status, and if deemed seriously mentally ill, the inmate will go the mental health unit at NNCC instead of a segregation unit.

CHAIR SPEARMAN:
Is it a violation of the inmate's civil rights? How would being in segregation for five years affect the inmate's mental illness? If there is a liability, how is it mitigated? How is it corrected?

MR. TRISTAN:
California federal courts and other states certified me as an expert relative to conditions, confinement and use of force. I dealt with these issues in court settings. As a subject matter expert, and from my perspective, the conditions that existed in Nevada at the time the Director and I arrived were unconstitutional relative to the housing of seriously mentally ill inmates in

segregation units. The staff members where the inmates were housed were doing their best to provide the most humane level of care possible, given their resources at the time. Nonetheless, that was excessive beyond anything I have ever seen relative to putting a mentally ill person in segregation. We have mitigated the situation by moving inmates as soon as they were found in this situation to the mental health unit at NNCC. By doing that, a crisis was created at NNCC because of the influx of seriously mentally ill inmates. The numbers of seriously mentally ill inmates have been reduced in the segregation units. That is the best that can be done at this time relative to mitigating the problem. I cannot speak to the liability issue, as I am not an attorney. Moving forward, drastic changes will be made in how NDOC operates, which may put NDOC in good stead with the courts.

The administrative regulation change that directly affects the mentally ill is the inmate discipline regulation. There is a practice referred to as stacking. That meant an inmate could get a number of charges behind one incident. The charges would be stacked, which created excessively long stays in the segregation unit. That practice will be eliminated. For instance, if there was an incident between two inmates, an inmate could be charged with a fight, resisting orders, failure to comply and being disrespectful. Each one of the charges would carry a sanction. Now the hearing officer can only pick one charge. In addition, if the inmate is diagnosed as mentally ill, before a sanction can be imposed, a clinician has to be consulted. The clinician makes the determination whether the behavior was a result of the mental illness or not. If it is a result of the mental illness, the sanction will be mitigated and the inmate will be treated. If the inmate begins to demonstrate any signs or symptoms of mental illness, the hearing officer will stop the hearing and refer the inmate to a mental health clinician. The hearing will take place with the information from the mental clinician. These two regulations will bring NDOC into compliance with national standards of the American Correctional Association and others. This should mitigate the liability.

Additional proposed changes and enhancements are listed on pages 18 through 20 of Exhibit J. Mental illness is a chronic condition. It does not go away. It can be treated and people can function fairly normally and even normally, but they need to be continually monitored. They need to take medication. They cannot receive treatment, like before, if they are force medicated. The inmate would drop from a level 4 to a level 1, therefore, labeling them as “well.” They are not well and need to be monitored. Changes will be made in the levels of care.

SENATOR RATTI:
Everything that has been shared is incredibly disturbing. How long will it take to get to a place where looking at the overall mental health system in NDOC feels like it is adequate to meet the needs?

MR. TRISTAN:
It will take at least a year to get the basic foundation into place. We have the pieces of the puzzle and we are trying to put those pieces together in one coherent operation. That is going to be a difficult task.

CHAIR SPEARMAN:
Some things have not been done correctly in addressing mental health issues. The presentations heard today punctuate the need to get busy and do something about it. We have talked about people who are experiencing mental health issues as a life condition. We have not talked about if the people affected on the other end as victims when we do not do what needs to be done. Dollars and cents have been discussed about training and staffing, but when it comes to what happens to those that are victimized because people who have a mental illness are not treated at all or not treated correctly. If it is a family member, a price tag cannot be placed on it.

SENATOR RATTI:
Do they have the tools they need? Are there any barriers in the way? Do they have the money they need to be successful? Are there solutions that we can help with in the next 117 days to be part of the solution? To a certain degree, there sounds like a management leadership issue got us to this situation. I want to make sure, if there is a transition in management leadership at NDOC, that things do not go back to the way they were before. How do we make sure things are not dependent on the fact that there is good talent? Some things came through on the presentation, regulations and training that would be a part of institutionalizing the process. How else can we make sure we do not go back to things the way they were before the current leadership?

CHAIR SPEARMAN:
Due to technical difficulties between Las Vegas and Carson City, Mr. Tristan cannot answer the questions asked by Senator Ratti.

JOAN HALL (President, Nevada Rural Hospital Partners):
There was a federal grant integrating behavioral health into primary care in rural Nevada. We have worked with many of the speakers today, DHHS and DPBH to problem solve. A tele medic process is used with DPBH's licensed clinical social workers and the transfers to Northern Nevada Adult Mental Health Services hospital and the Southern Nevada Adult Mental Services Health hospital have been decreased by 50 percent. That is a great success. Those patients with private insurance who need a higher level of care took 24 hours to be placed. If a patient had Medicaid, it took between 24 and 144 hours to be placed. If there was no pay source, it took between 24 and 240 hours to place the patient. This has been discussed with the director about including Medicaid and DWSS in assisting with placement. In the meantime, those patients are not getting the behavioral health consultations and assistance because services are not available in rural Nevada. Adding the travel distance and time, it becomes a big issue. We are looking forward to solutions to these issues. *Nevada Revised Statute* 433A is outdated. It was written long ago, and it is law for an outdated delivery model that no longer exists. Changes need to be made. We are in agreement with the statements from Bill Welch about having a summit with all individuals involved with behavioral health. Jessica Flood is in charge of the rural regional behavioral health coalition that includes judges, law enforcement, behavioral health providers, EMS, faith-based groups, the National Alliance on Mental Illness and hospitals. There has been an impact with behavioral health patients who do not get good care in any community, specifically rural communities. It affects the whole community. Jessica was able to bring all the entities together to begin discussions. It is our own silo. We need to come together and look at the big issues.

JODI TYSON (Three Square; Food Bank of Northern Nevada, Inc.):
Three Square has a staff outreach program that assists people who are looking to apply for public assistance benefits. The staff outreach workers are trained in suicide prevention called safeTALK through the Statewide Program of Suicide Prevention. The workers know to ask questions to explore things that come out during conversations when things do not seem right with the individual. There have been two instances, during the course of the outreach program where people who were applying for assistance were connected to food pantry directors, chaplains or to the metro crisis services because they were having active suicidal ideologies. People who come to the pantries come for a variety of reasons, and hunger is never a part of the isolation but a symptom of many things going on. There are times when the outreach worker or community-based

provider offered help, when no other services were available, that allowed people to open up and to start conversations. If the worker did not have the right training, he would not know how to make sure people stayed safe. I would encourage the Committee to keep in mind the nonprofit organizations are here to support the State agencies and to provide services. Nonprofit organizations are a part of the solution and want to be involved. Training is necessary, but it can come with a price tag. Three Square is able provide some of the costs for materials that is not always available to other nonprofit organizations. If no community-based providers are trained in this work, the right questions will not be asked to connect people to the right types of mental health services.

CHAIR SPEARMAN:
This is a complicated and complex issue. Seeing no further business on the agenda, this meeting is adjourned at 6:43 p.m.

RESPECTFULLY SUBMITTED:

_____
Debbie Carmichael,
Committee Secretary

APPROVED BY:

_____
Senator Pat Spearman, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	4		Attendance Roster
	C	2	Senator Pat Spearman	Senate Committee on Health and Human Services Rules for the 2017 Session
	D	26	Megan Comlossy	Senate Community on Health and Human Services Committee Brief
S.B. 27	E	2	Stephanie Woodard/Department of Health and Human Services	S.B. 27 Proposed Amendment, DPBH
S.B. 27	F	1	Senator Pat Spearman	Letter of Support
S.B. 27	G	1	Donald Williams	Email of Support
	H	39	Amy Roukie/Division of Public and Behavioral Health, Department of Health and Human Services	Mental Health Presentation, DPBH and DHHS
	I	29	Ryan Gustafson/Division of Child and Family Services, Department of Health and Human Services	Children's Mental Health Presentation, DCFS and DHHS
	J	22	David Tristan/Nevada Department of Corrections	NDOC Presentation to Senate Health and Human Services