MINUTES OF THE MEETING OF THE
SENATE COMMITTEE ON FINANCE
AND
ASSEMBLY COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEES ON HUMAN SERVICES

Eightieth Session
February 13, 2019

The joint meeting of the Subcommittees on Human Services of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Moises Denis at 8:02 a.m. on Wednesday, February 13, 2019, in Room 3137 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Moises Denis, Chair
Senator Joyce Woodhouse
Senator Kelvin Atkinson
Senator James A. Settelmeyer
Senator Ben Kieckhefer

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblywoman Dina Neal
Assemblywoman Ellen B. Spiegel
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblyman Jason Frierson (Excused)
Assemblyman John Hambrick (Excused)

STAFF MEMBERS PRESENT:

Mark Krmpotic, Senate Fiscal Analyst

Alex Haartz, Principal Deputy Fiscal Analyst
Jennifer Ouellette, Program Analyst
Felicia Archer, Committee Secretary
Desirae Munns, Committee Secretary

OTHERS PRESENT:

Julie Kotchevar, Ph.D., Administrator, Division of Public and Behavioral Health, Department of Health and Human Services
Debi Reynolds, Deputy Administrator, Administrative Services, Division of Public and Behavioral Health, Department of Health and Human Services
Beth A. Handler, MPH, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services
Elisa Cafferata, Planned Parenthood Votes Nevada

CHAIR DENIS:
Seeing no one for public comment. We will begin with the Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH).

JULIE KOTCHEVAR, PH.D. (Administrator, Division of Public and Behavioral Health, Department of Health and Human Services):
We are presenting the DHHS Public Health budget accounts.

HEALTH AND HUMAN SERVICES

PUBLIC AND BEHAVIORAL HEALTH

HHS-DPBH - Radiation Control — Budget Page DHHS-DPBH-17 (Volume II)
Budget Account 101-3101

HHS-DPBH - Child Care Services — Budget Page DHHS-DPBH-24 (Volume II)
Budget Account 101-3149

HHS-DPBH - Nevada Central Cancer Registry — Budget Page DHHS-DPBH-32 (Volume II)
Budget Account 101-3153

HHS-DPBH - Immunization Program — Budget Page DHHS-DPBH-48 (Volume II)
Budget Account 101-3213

HHS-DPBH - Health Care Facilities Reg — Budget Page DHHS-DPBH-65 (Volume II)
Budget Account 101-3216

HHS-DPBH - Public Health Preparedness Program — Budget Page DHHS-DPBH-76 (Volume II)
Budget Account 101-3218

HHS-DPBH - Chronic Disease — Budget Page DHHS-DPBH-94 (Volume II)
Budget Account 101-3220

HHS-DPBH - Office of Health Administration — Budget Page DHHS-DPBH-111 (Volume II)
Budget Account 101-3223

HHS-DPBH - Community Health Services — Budget Page DHHS-DPBH-117 (Volume II)
Budget Account 101-3224

The mission of DPBH is described on page 2 DPBH fiscal year (FY) 2020–2021 budget presentation (Exhibit C). The goal of DPBH is to protect and improve the health and well-being of all Nevadans. It can be further described as helping people without touching people. The difference between healthcare and public health is that healthcare provides individual treatment for the person's individual condition, whereas public health is trying to change healthcare of the entire population. We are not treating an individual's person diabetes, we are trying to prevent diabetes from occurring, or manage it once it does occur. When looking at these budgets it is about protecting and improving health of the total population.

The DPBH organizational chart is on page 3 of Exhibit C. The organizational chart does include contact information as well.

The DPBH budgeted funding sources for the 2017-2019 and 2019-2021 biennia, are shown in pie charts on page 4 of Exhibit C. The "federal funding" category is comprised of federal grants; the "other funding" category is comprised of fees and other sources; the remaining is General Fund appropriations.

A summary of all DPBH budgets are listed on page 5 of Exhibit C. However, we will only be presenting the public health budgets.

The first budget to present is budget account (B/A) 101-3101, the Radiation Control Program (RCP). An overview of the RCP is discussed on page 6 of Exhibit C. The RCP primarily focuses on regulating sources of ionizing radiation; licensing and inspecting radioactive material users; registering and inspecting radiation producing machines, such as mammography and dental x-ray machines. Also, RCP provides oversight to the closed low-level radioactive waste disposal site at Beatty, Nevada.

Budget information and changes for B/A 101-3101 are listed on page 7 of Exhibit C. There are three enhancement decision units requested for this budget, beginning with E-227. This decision unit requests funding to obtain additional training for the RCP regulator positions in order to meet federal requirements.

E-227 Efficient and Responsive State Government — Page DHHS-DPBH-20

The second is enhancement decision unit E-228. This decision unit requests funding for two new administrative assistants II positions to replace contract staff. The RCP has utilized contract staff for an extended amount of time. This request will convert these positions to State full-time equivalent (FTE) employees.

E-228 Efficient and Responsive State Government — Page DHHS-DPBH-20

The final enhancement decision unit for B/A 101-3101 is E-229. This enhancement decision unit requests to reclassify three administrative assistant I positions to administrative assistant II positions. The reclassification of these

positions have been approved by the Department of Administration, Division of Human Resource Management (DHRM).

E-229 Efficient and Responsive State Government — Page DHHS-DPBH-21

ASSEMBLYWOMAN TITUS:
What happens to all the nuclear waste that is created from the machines that RCP licenses and inspects, for example, bone scans that produce nuclear waste? What agency is responsible for the monitoring of the nuclear waste, and if it is RCP, is there a budget for that specific function?

MS. KOTCHEVAR:
The roles concerning nuclear waste are split between the Department of Conservation and Natural Resources, Division of Environmental Protection (DEP) and RCP. It depends on the classification of waste as to which agency is responsible for the management. The RCP does look at healthcare-related waste. For example, if waste is seized, RCP would send someone out to properly dispose of it. The RCP has lead-lined cabinets where they can control waste; facilities are obligated to properly dispose of their own waste.

ASSEMBLYWOMAN TITUS:
There is a difference between radioactive versus nuclear waste, which is used slightly differently. Does RCP have oversight or does DEP?

MS. KOTCHEVAR:
I will provide specific information to the Subcommittees on the specific responsibilities of each agency as it relates to nuclear waste.

ASSEMBLYMAN SPRINKLE:
In FY 2017, the RCP reserve level was approximately $2.2 million. At the end of FY 2021, the reserve level is projected to be approximately $600,000, which represents approximately two months of reserve. Generally, the RCP keeps a three-month reserve level. Can you discuss why the reserves are depleting and if the RCP has a plan to rebuild the reserves?

MS. KOTCHEVAR:
Typically, the RCP does not have to access reserves in order to operate. The reserves are being utilized in order to support the Oral Health Program (OHP) in the Chronic Disease Program B/A 101-3220. Part of the fees generated in the RCP budget comes from dental x-ray machines. The OHP is tasked with finding ways to diversify funding sources, such as applying for grants. The grants are competitive, and the OHP has been unsuccessful in being awarded a grant. The DPBH feels there is sufficient funding to operate both the RCP and OHP throughout the 2019-2021 biennium.

ASSEMBLYMAN SPRINKLE:
What will happen in FY 2022? How will DPBH fund the OHP positions? Will there still be a dependency on reserves moving forward?

MS. KOTCHEVAR:
It is the intent of DPBH to continue to pursue grant funding and other funding sources to support the OHP long term. If funding does not materialize through grants or other sources, DPBH will reevaluate and include in the next budget request a different funding mix for the continued operation of the OHP. This will ensure the reserves of the RCP are not fully depleted.

CHAIR DENIS:
Is the OHP housed in the University of Nevada, Las Vegas, School of Dental Medicine (UNLV-SDM)?

MS. KOTCHEVAR:
Yes, that is correct. We have a subgrant and contract with UNLV-SDM. The reasoning behind being colocated at UNLV is two-fold: to support the activities of the dental school, and to take advantage of the additional resources the dental schools adds to the OHP in order to make the program more competitive for grant applications. We are hoping that the collaboration will result in higher grant funding availability.

CHAIR DENIS:
Is there a possibility the OHP could be funded through UNLV-SDM?

MS. KOTCHEVAR:
Per *Nevada Revised Statute*s (NRS) 439.271 through NRS 439.2794, the State dental officer and dental hygienist are required to reside within DPBH, which is why we maintain responsibility for the OHP. The UNLV-SDM helps us manage the staff and program activities. It would require statutory change to be able to move the positions under UNLV.

ASSEMBLYWOMAN NEAL:
Would it help the OHP, from a competitive grant stand point, to be located within the federally qualified health care center, Martin Luther King Health Center? They serve a large population of Las Vegas residents who would benefit from additional dental services.

MS. KOTCHEVAR:
The OHP is focused on the public health role. The positions do provide limited direct services, but that is not their primary function. Through a grant-funded activity, they participate in the Rural Miles for Smiles program where they go to the underserved rural areas and provide dentistry services. The intent of these positions is to improve the system of oral health, as described in NRS 439.271 through NRS 439.2794.

ASSEMBLYWOMAN CARLTON:
What year did we authorize the State dental officer position? Was it during the 2015 Legislative Session?

MS. KOTCHEVAR:
I believe it was during the 2015 Legislative Session.

ASSEMBLYWOMAN CARLTON:
In the 2015 Legislative Session, funding for the State dental officer position was authorized to utilize radioactive fees from the RCP reserves, rather than the General Fund. If the State dental officer provides services Statewide, then should the position be funded with General Fund appropriations and be cost allocated to other divisions who benefit from the services, rather than rely on fees to fund the position? I do not believe we fund the State medical officer in this manner.

MS. KOTCHEVAR:
The DPBH had discussions regarding requesting General Fund appropriations. Since the RCP reserves were sufficient to support the OHP through the 2019-2021 biennium, we decided to continue utilizing reserves. There is a fair point to be made regarding the General Fund dollars being utilized to fund the position. The chief medical officer is funded through cost allocations which includes General Fund appropriations.

ASSEMBLYWOMAN CARLTON:
Mr. Chairman, as we move forward, we might want to consider the funding stream, as some of the fees being paid to RCP do not have a nexus to this position. We should look at the work that has been completed, where we would like to see the position go in the future and what investment we would like to make into the position.

MS. KOTCHEVAR:
Our next budget is B/A 101-3149 Child Care Services (CCS). An overview of CCS can be found on page 8 of Exhibit C. The staff at CCS is responsible for licensing and monitoring childcare facilities. The staff ensures compliance with standards established with the Child Care Development Block grant from DHHS, Division of Welfare and Supportive Services (DWSS).

Budget information and changes for B/A 101-3149 are discussed on page 9 of Exhibit C. Enhancement decision unit E-225, requests funding for a new administrative assistant I position. This new position would replace a contract position that supports the supervisor and surveyors.

E-225 Efficient and Responsive State Government — Page DHHS-DPBH-26

Enhancement decision unit E-226 requests funding for a new childcare facility surveyor position.

E-226 Efficient and Responsive State Government — Page DHHS-DPBH-27

This new position would replace a contract position to address the workload, which has substantially increased. Since 2015, there has been a 153 percent

increase in complaints. After looking at the caseload analysis, CCS felt it was appropriate to ask for the additional surveyor position.

In January 2019, the Interim Finance Committee approved two contract positions, which are funded by additional available funds from DWSS. The requested FTE positions in enhancement decision units E-225 and E-226 will replace the previously approved contract positions.

ASSEMBLYMAN SPRINKLE:
I am interested in the increase in the amount of complaints, 198 complaints in 2015 to over 500 complaints in 2018. What is attributed to the increase in complaints? Is it a better process for people filing complaints?

MS. KOTCHEVAR:
There was a change in grant goals, which included educating people on how and where to file a complaint, if there was an incident at their childcare facility that caused them concern. Previously, complaints were from competitors complaining about another facility, and there were not a lot of consumer generated complaints. Due to the effort, the workload for investigating complaints increased, and we had to utilize contract staff to manage the workload.

ASSEMBLYMAN SPRINKLE:
Of the complaints investigated, how many of them were justified?

MS. KOTCHEVAR:
I do not have that information. I will provide the number of complaints that were substantiated versus unsubstantiated to the Subcommittees.

ASSEMBLYMAN SPRINKLE:
That information is important considering what you are asking for. Is there a backlog in investigating these complaints? If a number of those complaints have been justified, what have we been missing over the years, and how serious of a problem is this?

MS. KOTCHEVAR:
Currently, there are 115 complaints open for investigation. Each complaint takes approximately five hours to investigate. We are investigating all complaints by utilizing contractors to fill the gap. What we are asking for are State FTE positions to replace current contract staff. This will allow us to reduce the caseload of facilities and number of complaints that are assigned to each staff member. This will ensure that each complaint is promptly investigated to determine if it is substantiated.

ASSEMBLYMAN SPRINKLE:
Again, please provide the number of substantiated complaints to the Subcommittees.

ASSEMBLYWOMAN CARLTON:
In trying to decide what positions are actually appropriate, we would like to see a workload analysis. It is my understanding that the Legislative Counsel Bureau (LCB), Fiscal Analysis Division staff was not provided a workload analysis and that DHRM has not evaluated the requested positions. Having this information available to the Subcommittees will enable us to make an informed decision regarding the need for these positions.

MS. KOTCHEVAR:
We are working on a workload analysis for our regulatory staff as this is something we have in other programs. Unfortunately, it was not completed in time for this meeting.

ASSEMBLYWOMAN CARLTON:
As you get the workload analysis completed, please provide it to the Subcommittees.

MS. KOTCHEVAR:
Our next budget to be presented is B/A 101-3153, the Nevada Central Cancer Registry (NCCR). The overview of the NCCR is discussed on page 10 of Exhibit C. The data collected for the Registry comes from hospitals, medical laboratories, other free-standing facilities and from physicians who diagnose and treat cancer.

Budget information and changes for B/A 101-3153 are discussed on page 11 of Exhibit C. Enhancement decision unit E-225 requests funding for four part-time contract cancer registry specialists (CTR) and one part-time contract administrative assistant positions.

E-225 Efficient and Responsive State Government — Page DHHS-DPBH-34

Historically, the NCCR has been more successful hiring CTR as part-time contract positions rather than full-time. These positions require specialized training in order to complete data abstractions. Many CTR work for more than one program at a time, which limits their availability.

CHAIR DENIS:
Please discuss how much time is spent by CTR staff performing level I cancer abstracting?

MS. KOTCHEVAR:
Essentially, time spent varies depending upon the quality of information we receive from hospitals, physicians, surgery centers, and radiation therapy. There has been internal discussions regarding what constitutes a healthcare record, and what we are abstracting opposed to what we are provided as an abstraction, since it varies across providers. The CTRs do not complete a high number of level I abstractions, but that is only one piece of what is completed by the NCCR. Additionally, CTRs take information and abstract it in a way so it can be entered into the Registry system. The level II and level III abstractions include: looking at case reports and linkages in the system, connecting diagnosis in the reports and scrubbing the data received to make sure it is clean and complete.

CHAIR DENIS:
That was a great explanation of what you do, but how much time are CTRs actually spending on level I abstractions?

MS. KOTCHEVAR:
Looking at the total numbers, an estimate would be 10 to 15 percent. That estimate is based on the number of level I abstractions, not the actual time spent. Based on the quality of records received, one complicated abstraction

can take a significant amount of time to complete. The NCCR can complete a workload analysis to specifically target the percentage of time spent on each level.

CHAIR DENIS:
We are using General Fund appropriations to fund NCCR, but why are we not receiving revenue from healthcare providers who are providing data for abstraction, and whom take advantage of the information? Why are they not being charged?

MS. KOTCHEVAR:
The NRS 457.250 allows us to collect from healthcare facilities. The way the regulation was written it did include healthcare providers, which includes physician offices, but after a discussion with our legal counsel, it was stated that the NRS limits the charging of fees to facilities. Based on that information, we have not charged healthcare providers. Ultimately, we want healthcare facilities and providers to report data, as the data is important in order for us to have insight into cancer rates in Nevada. The DPBH factored in how much we would charge facilities, as most large facilities have their own abstraction staff. The estimate was approximately $3,833 a year that could reduce General Fund appropriations.

CHAIR DENIS:
Does the type of information NCCR collects allow the Agency to apply for grants? Is there a financial benefit somewhere else?

MS. KOTCHEVAR:
The data is very important for a number of reasons: it provide opportunities for the Agency to apply for grants; it is important for surveillance of cancer, since cancer is one of the leading causes of death for Nevadans, as we can supply quality public health responses; it populates into the National registry, which can be accessed Nationwide and be compared to other states.

ASSEMBLYWOMAN CARLTON:
There seems to be a difference of opinion whether the NCCR can charge fees to healthcare providers. The LCB, Legal Division states the *Nevada Administrative Code* (NAC) 457.150 provides authority to charge fees to healthcare providers.

Further discussions to clarify this should occur, and if it is determined that health care providers cannot be charged, then we will have to make a statute change to make sure it is collected. In addition, we hear a lot about the workforce shortage in healthcare, and you stated that CTRs require specialized training. Can training for this field be completed in Nevada? Is this an occupational area that Legislators should focus on to ensure that the services provided by CTRs continue in the future?

MS. KOTCHEVAR:
Yes, training to become a CTR is provided in Nevada. There is a fair amount of training involved to become a CTR, but not to the extent of other healthcare positions. These positions are in demand, which means an individual can make a good wage. The DPBH has mentored a number of administrative assistants into obtaining a CTR license, which is great, right up until they leave for a better paying job at a hospital.

ASSEMBLYWOMAN CARLTON:
Continue mentoring your staff, because eventually hospitals will not have any vacancies, and we will be able to retain staff members.

MS. KOTCHEVAR:
Our next budget is B/A 101-3213, the Immunization Program. The overview of the Immunization Program can be found on page 12 of Exhibit C. The Statewide immunization information system <https://webiz.nv.gov> is maintained by the Immunization Program.

Budget information and changes for B/A 101-3213 are discussed on page 13 of Exhibit C. There are four enhancement decision units to discuss. I will begin with E-225, which requests funding for a program officer I position. The requested program officer I position will replace the current contract position. This position is responsible for vaccine storage and handling. It is important to maintain vaccines at the appropriate temperature in order for them to remain valid.

E-225 Efficient and Responsive State Government — Page DHHS-DPBH-51

The second enhancement decision unit E-226 requests partial funding for the existing health program manager III position.

E-226 Efficient and Responsive State Government — Page DHHS-DPBH-51

The existing health program manager III position serves as the deputy bureau chief. Currently, the position is funded by other funding sources. In order to match funding sources with the work completed by the position, and based on our analysis, we believe including funding from the Chronic Disease budget, B/A 101-3220, is appropriate.

E-226 Efficient and Responsive State Government — Page DHHS-DPBH-99

Lastly, enhancement decision units E-805 and E-806 request to reclassify two health program specialist I positions.

E-805 Classified Position Changes — Page DHHS-DPBH-52

E-806 Classified Position Changes — Page DHHS-DPBH-52

This request is to reclassify two health program specialist I positions to health program specialist II positions. This reclassification has been approved by DHRM and is based on the complexity and workload experienced since the positions were created.

ASSEMBLYMAN THOMPSON:
As to the request to convert the contract pharmacy technician to a full-time State program officer position, I see that this position has been vacant three times in the last six years. Has DPBH done exit interviews with the contracted staff to see why they terminated their employment? If DPBH terminated the service with the contractors can you discuss the issues? Please provide how DPBH reached the decision to convert the position to a State FTE?

MS. KOTCHEVAR:
Generally, we try to match contract staff's pay to what they would earn as a State employee. This match in pay is because contractors do not receive: paid time off, such as, sick leave, or annual leave; retirement benefits; or the same

protections offered to a State FTE. Based on those barriers, most contract staff are short term in nature. If the utilization of contract staff becomes an integral part of an Agency's operation and they are consistently supporting the workload long term, DPBH looks to see if the position should be converted to a State FTE.

SENATOR WOODHOUSE:
What are the differences in the responsibilities of these two positions, the pharmacy technician versus the program officer I?

MS. KOTCHEVAR:
There is no change in duties or responsibilities. When we looked at comparable State position classifications, program officers manage complex or very specific programs. While consulting with DHRM, it was decided that the program officer I position was the most appropriate fit.

SENATOR KIECKHEFER:
Recently, there has been a lot of news regarding outbreaks of preventable disease. Can you give me a quick overview as to how the Immunization Program is doing in terms of vaccinating children in the State? As I recall, our numbers were dramatically improving. In addition, I had a group of pediatricians come to me concerned about a proposed change to the Vaccines for Children (VFC) Program. Is DPBH proposing a change? If not, have you heard anything regarding changes?

MS. KOTCHEVAR:
The DPBH is not proposing a change to the VFC. I believe there was a proposal floating at the community level. The States vaccination rate is improving, and I will provide you the specific numbers. In addition, we have only had two reported cases of measles in the State, and those cases are due to encounters with out-of-state families that were not fully vaccinated. In Nevada, there are only two reasons to opt out of immunizations: a medical reason and a religious reason. Parental preference is not an option. Due to only having those two reasons, we are not seeing a large measles outbreaks like the State of Washington.

CHAIR DENIS:
Regarding the reclassification of the health care specialist position, has DHRM approved the reclassification?

MS. KOTCHEVAR:
Yes, DHRM has approved the reclassification.

CHAIR DENIS:
Please present the next DPBH budget.

MS. KOTCHEVAR:
Our next budget is B/A 101-3216, Health Care Facilities Regulation, more commonly referred to as the Bureau of Health Care Quality and Compliance (HCQC). The overview of HCQC can be found on page 14 of Exhibit C.

Budget information and changes in B/A 101-3216 are discussed on page 15 of Exhibit C. There are several enhancement decision units being requested. Decision unit E-225 requests funding for an administrative assistant III position. We transferred authority for regulating the community-based-living arrangement (CBLA) homes for the mentally ill to HCQC. We reclassified positions to health care facility inspectors to regulate CBLA homes. We have gone through the process of closing a number of CBLA homes. Currently, we have over 100 pending applications for new CBLA homes, and due to the increased workload additional administrative support is needed.

E-225 Efficient and Responsive State Government — Page DHHS-DPBH-68

The second enhancement decision unit E-226 requests funding for two health facility inspector II positions and one health facility inspector III position. These positions will support the increased number of inspections for licensed facilities and complaints for unlicensed facilities. Currently, HCQC licenses 35 facility types, which equates to 1,632 facilities. They certify 4 facility types, which equates to 33 facilities. We now certify two new additional programs: the domestic violence treatment program and the CBLA homes for the mentally ill. We have experienced a 12 percent increase in the number of facilities, which equates to 150 facilities added to the workload.

E-226 Efficient and Responsive State Government — Page DHHS-DPBH-69

The next two enhancement decision units E-901 and E-902 request to transfer seven health facility inspectors and one supervisory position from the mental health B/A's.

E-901 Trans From SNAMHS To Health Care Facility Reg — Page DHHS-DPBH-71

E-902 Trans From NNAMHS To Health Care Facility Reg — Page DHHS-DPBH-71

Six of the health facility inspectors will be transferred from Southern Nevada Adult Mental Health Services (SNAMHS), B/A 101-3161 to B/A 101-3216.

HHS-DPBH - So NV Adult Mental Health Services — Budget Page DHHS-DPBH-165 (Volume II)
Budget Account 101-3161

E-901 Trans From SNAMHS To Health Care Facility Reg — Page DHHS-DPBH-172

The remaining positions will be transferred from Northern Nevada Adult Mental Health Services (NNAMHS) B/A 101-3162 to B/A 101-3216.

HHS-DPBH - No NV Adult Mental Health Svcs — Budget Page DHHS-DPBH-155 (Volume II)
Budget Account 101-3162

E-902 Trans From NNAMHS To Health Care Facility Reg — Page DHHS-DPBH-162

The final enhancement decision unit E-903 requests to transfer an existing education and information officer, which is currently within the Public Health Preparedness Program, B/A 101-3218, but has been doing work in HCQC. This request moves the position to the correct B/A 101-3216.

E-903 Trans From Publ Hlth Prep Prg To Hlth Facil Reg — Page DHHS-DPBH-72

ASSEMBLYMAN SPRINKLE:
Please discuss how HCQC is funded, and why it would be appropriate to transfer these positions, including $1.2 million of General Fund appropriations.

MS. KOTCHEVAR:
The HCQC is primarily fee funded. The transfers of positions from the mental health B/As relate to CBLA homes for the mentally ill.

Historically, the CBLA homes were not charged fees for regulation. When we transferred them under HCQC we did include a $100 application fee. The CBLA homes are not paying fees that would support the level of regulatory oversight that must occur. We had to measure what level of regulation needs to occur in CBLA homes, what staffing that would require and the cost the homes can afford.

ASSEMBLYMAN SPRINKLE:
The majority of these enhancement requests come as a result of the LCB audit on CBLA homes for the mentally ill. Since the HCQC has made significant changes and have had positive results, is there still a necessity for the amount of inspectors you are requesting?

MS. KOTCHEVAR:
Absolutely, and HCQC has made significant changes, one of which is increased oversight. The health facility inspectors are in CBLA homes frequently to ensure those homes are never in the condition they were in during the audit. We are there to ensure that residents are safe and protected. I cannot see a circumstance where I would want to lessen the amount of oversight.

ASSEMBLYMAN SPRINKLE:
I can understand that, but do you feel the current revenue structure of HCQC can award you the ability to fund those positions instead of using the General Fund?

MS. KOTCHEVAR:
The CBLA homes are typically owned by smaller providers. Trying to assess a fee to offset the cost of the level of scrutiny we need them to be under would be unsustainable for the provider.

ASSEMBLYMAN SPRINKLE:
Definitely keep up the oversight.

ASSEMBLYWOMAN NEAL:
In the past, there were approximately 1,200 facilities; currently, there are approximately 1,400. What is the current cost to regulate the old facilities versus the new facilities? It seems like the fee structure that was in place before was paying for the investigations.

MS. KOTCHEVAR:
I am not sure I understand the question. Looking at the increase in healthcare facilities, of which we are asking for new health facility inspectors, the number of facilities has increased, but our number of inspectors have not. While we are collecting more fees, we have had to utilize contract staff in order to try to keep up with inspection of facilities and complaints. We are requesting additional staff in order to grow with caseload.

ASSEMBLYWOMAN NEAL:
How much does it cost to inspect a facility?

MS. KOTCHEVAR:
The amount would vary based on the facility. I can provide you with information regarding the costs associated with inspections for each facility type.

ASSEMBLYWOMAN NEAL:
I am only interested in the cost associated with inspecting a CBLA home.

MS. KOTCHEVAR:
I will have to provide you that information at a later time.

ASSEMBLYWOMAN CARLTON:
Please provide a workload analysis for HCQC. Going back to the fee discussion, I know that there is an initial fee and inspection fees, but is there a fee structure which includes fines or other fees?

MS. KOTCHEVAR:
One change made to the fee structure gave us the ability to assess fines and penalties for noncompliance. There is also a renewal fee, but it is only $100. We operate under the decision; is it appropriate to fine and allow the facility to correct, or revoke the license and move residents to a safer facility?

ASSEMBLYWOMAN CARLTON:
What about charging additional inspection fees for each time our health facility inspectors need to go back into a home?

DEBI REYNOLDS (Deputy Administrator, Administrative Services, Department of Health and Human Resources, Division of Public and Behavioral Health):
A number of years ago, HCQC completed a workload analysis, and it was used to determine the number of positions that should be transferred from the behavioral health budgets, in relation to the number of CBLA homes that were in place at the time of the audit. The Agency is working on updating the workload analysis.

ASSEMBLYWOMAN CARLTON:
Please provide that analysis to our staff when it is available.

MS. KOTCHEVAR:
In response to the question regarding charging additional inspection fees for CBLA homes, we are currently working on what is allowed under the CBLA home regulations versus what HCQC is allowed to charge other facility types. Under the rest of HCQC, we do have the ability to charge multiple inspection fees. We are looking at the possibility of having to make statutory changes to include CBLA homes under the broader HCQC authority.

ASSEMBLYWOMAN CARLTON:
When can we suspect to see that statutory change?

MS. KOTCHEVAR:
We have been working with Senator Ratti, and earlier this week we submitted our recommendations.

ASSEMBLYMAN SPRINKLE:
Can you please discuss why the reserves in B/A 101-3216 have been declining?

MS. KOTCHEVAR:
We have appeared before the Interim Finance Committee on several occasions requesting approval to utilize reserves for contract health facility inspectors to help with the backlog of inspections.

ASSEMBLYMAN SPRINKLE:
According to HCQC fee structure and timeline, the majority of HCQC revenues are due at the end of the calendar year. If the reserve levels are low, how does the Agency plan on budgeting for the first four months of the year?

MS. KOTCHEVAR:
The reserves in the HCQC budget are not that low.

ASSEMBLYMAN SPRINKLE:
In FY 2017, HCQC had a six-month reserve level, and the projected balance at the end of FY 2021 will be 2 1/2 months.

MS. KOTCHEVAR:
To verify, are you referring to B/A 101-3216?

ASSEMBLYMAN SPRINKLE:
Yes, I am referring to HCQC B/A 101-3216.

MS. KOTCHEVAR:
We will have to look at our fee projections and complete a more thorough projection of the reserve levels. We are looking at our projections: FY 2020 shows $6.1 million; FY 2021 shows $4.5 million.

ASSEMBLYMAN SPRINKLE:
After talking to our staff, our numbers appear to be correct, which means further discussion must take place.

CHAIR DENIS:
The numbers that Ms. Kotchevar shared match the Governor's recommended budget, but what we are concerned about is the recommended reserve level of $3.1 million at the end of FY 2021.

MS. KOTCHEVAR:
We will look at completing projections as to what we expect our expenditures, revenue and reserves will be in order to ensure there is a sufficient reserve level.

CHAIR DENIS:
Please meet with our staff after you complete your projections, as it is a concern.

MS. KOTCHEVAR:
We do have to factor in the income we receive, as we do not rely on reserves to operate HCQC. We will definitely take a closer look at expenditures, revenue, and reserves.

CHAIR DENIS:
Please present the next B/A.

MS. KOTCHEVAR:
Our next budget is B/A 101-3218, the Public Health Preparedness Program (PHPP). The overview of the PHPP can be found on page 17 of Exhibit C. When NPBH speaks about the lack of providers in Nevada, this is the program that calculates the statistic.

Budget information and changes for PHPP, B/A 101-3218, are listed on page 18 of Exhibit C. There are four enhancement decision units in this budget. Enhancement decision units E-226 and E-227 request to transfer funds to partially fund existing positions.

E-226 Efficient and Responsive State Government — Page DHHS-DPBH-80

E-227 Efficient and Responsive State Government — Page DHHS-DPBH-80

The PHPP, B/A 101-3218, is requesting to cost allocate position costs for an existing administrative assistant IV and administrative assistant II positions between the Health Statistics and Planning, B/A 101-3190, and the Marijuana Health Registry, B/A 101-4547.

HHS-DPBH - Health Statistics and Planning — Budget Page DHHS-DPBH-37 (Volume II)
Budget Account 101-3190

E-227 Efficient and Responsive State Government — Page DHHS-DPBH-39

HHS-DPBH - Marijuana Health Registry — Budget Page DHHS-DPBH-128 (Volume II)
Budget Account 101-4547

E-225 Efficient and Responsive State Government — Page DHHS-DPBH-130

These positions provide support amongst these three agencies, the cost allocation would be based on time and effort of each position. A work program was approved at the December 2018, IFC meeting to begin cost sharing these positions in FY 2019.

The third, enhancement decision unit E-903, is the companion decision unit for the transfer of the education and information officer from PHPP, B/A 101-3218, to HCQC, B/A 101-3216.

E-903 Trans From Publ Hlth Prep Prg To Hlth Facil Reg — Page DHHS-DPBH-82

The final enhancement decision unit E-490 is discussed on page 19 of Exhibit C. This decision unit requests to eliminate the Ebola Preparedness and Response grant that is expiring. We have worked with staff to make a technical adjustment of $65,000, as the grant will not expire until May 2020, and we had eliminated the costs for the entire 2019-20121 biennium.

E-490 Expiring Grant/Program — Page DHHS-DPBH-81

ASSEMBLYWOMAN CARLTON:
Please provide a workload analysis for PHPP. Based upon the different skill set required for vital statistics versus medical marijuana, why do you want to allocate these positions?

MS. KOTCHEVAR:
These positions complete time and effort tracking. One of the core components for all of these agencies is customer services and processing paperwork, which are duties these positions perform for all three programs.

ASSEMBLYWOMAN CARLTON:
How is time of effort tracked?

MS. KOTCHEVAR:
Staff tracks time spent on each of the program areas in a time tracking system.

ASSEMBLYWOMAN CARLTON:
Please provide the workload analysis for these programs, as it will help clarify your request.

ASSEMBLYMAN SPRINKLE:
Currently, 25 percent of position costs are funded by the Hospital and Health Care Preparedness grant. If this request is approved, where would the savings in the grant funding be used, and who will be covering the duties?

MS. KOTCHEVAR:
The PHPP completed a workload analysis on how much of those responsibilities could be absorbed by other staff, and it was determined that the duties could be redistributed to enable these staff members to support the three agencies.

ASSEMBLYMAN SPRINKLE:
Will the cost savings from the federal grant be used to support these other staff members?

MS. KOTCHEVAR:
The federal funds will be used within PHPP for other grant-related purposes.

MS. REYNOLDS:
These positions do time and effort tracking, and the federal funds are drawn down based upon that information.

MS. KOTCHEVAR:
The next budget is B/A 101-3220, Chronic Disease. An overview of the Chronic Disease Prevention and Health Promotion section is discussed on page 20 of Exhibit C.

Budget information and changes for B/A 101-3220 begin on page 21 of Exhibit C. There are six enhancement decision units being requested. Decision unit E-225 requests a new health program manager III position.

E-225 Efficient and Responsive State Government — Page DHHS-DPBH-98

The requested position will oversee the Nutrition unit within this budget. This unit consists of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program Education (Snap-Ed), the Office of Food Security (OFS), Obesity Prevention and Control, School Nutrition, the Summer Electronic Benefit Transfer for Children, WIC Farmer's Market Program, Breast Feeding Program and the Healthy Hunger Free Kids Program. The funding for this position will be split between WIC B/A 101-3214 and DWSS, B/A 101-3228.

HHS-DPBH - WIC Food Supplement — Budget Page DHHS-DPBH-54 (Volume II)
Budget Account 101-3214

E-225 Efficient and Responsive State Government — Page DHHS-DPBH-57

WELFARE AND SUPPORTIVE SERVICES

HHS-Welfare - Administration — Budget Page DHHS-DWSS-9 (Volume II)
Budget Account 101-3228

Enhancement decision unit E-226 under B/A 101-3220, requests partial funding for an existing health program manager III position, who serves as the deputy

bureau chief, from the Immunization Program, B/A 101-3213. This request will properly allocate this position based upon work being completed.

E-226 Efficient and Responsive State Government — Page DHHS-DPBH-99

E-226 Efficient and Responsive State Government — Page DHHS-DPBH-51

The remaining enhancement decision units for B/A 101-3220 are found on page 22 of Exhibit C. Decision unit E-227 requests to receive funds for tobacco-cessation activities from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. This request is an effort to maximize Medicaid revenue. This is an allowable expense in order to receive 50 percent administrative federal match to offset costs.

E-227 Efficient and Responsive State Government — Page DHHS-DPBH-99

Enhancement decision unit E-228, requests continued funding for the Women's Health Connection program.

E-228 Efficient and Responsive State Government — Page DHHS-DPBH-99

Assembly Bill No. 388 of the 79th Session allowed DBPH to screen 2,500 additional women for breast and cervical cancer. We did have 13 women who were diagnosed with breast cancer. As a result of this funding, we were able to set up treatment for all 13 women within the recommended 60-day timeframe. In addition, during the second year we expanded it to screen for cervical cancer, which is where we had a deficit. We identified 15 cervical cancer diagnoses, and we prevented 92 cases of cervical cancer by utilizing a diagnostic procedure to remove precancerous cells. This enhancement decision unit requests funding to continue these vital services.

Enhancement decision units E-900 and E-500 discussed on page 22 of Exhibit C requests the transfer of the OFS Program including a social services specialist III position from the DHHS grants management unit, B/A 101-3195, to the Chronic Disease section, B/A 101-3220. These decision units are part of our initiative to group food and nutrition programs together. The OFS Program is funded with tobacco funding. The social service specialist III position will be transferred from

DHHS, Grant Management Unit budget, but has been operationally part of the Chronic Disease section.

E-900 Transfer From Grants Mgmt To DPBH Chronic Disease — Page DHHS-DPBH-101

E-500 Adjustments To Transfers — Page DHHS-DPBH-100

DHHS DIRECTOR'S OFFICE

HHS-DO - Grants Management Unit — Budget Page DHHS-DIRECTOR-27 (Volume II)
Budget Account 101-3195

E-900 Transfer From Grants Mgmt To DPBH Chronic Disease — Page DHHS-DIRECTOR-32

SENATOR KIECKHEFER:
Is the requested transfer of tobacco settlement funds from the Fund for a Healthy Nevada a new transfer of $2 million?

MS. KOTCHEVAR:
No, that amount represents what is spent in DHHS Grant Management Unit B/A 101-3195 to support grants for the OFS Program. The request is to not only transfer the OFS Program and the social service specialist III position, but it also includes the transfer of grant funds to the Chronic Disease B/A 101-3220. This is an effort to coordinate all nutrition activities and funding in one place. We will work with the Governor's Council on Food Security to identify where the need exists for these funds.

SENATOR KIECKHEFER:
I thought that you stated that it would be for tobacco cessation.

MS. KOTCHEVAR:
The Medicaid Administration funding is for tobacco cessation.

SENATOR KIECKHEFER:
Is the transfer from the Fund for A Healthy Nevada going into the DHHS Director's Office Upper Payment Limit Holding Account (UPL)?

MS. KOTCHEVAR:
There will be a transfer, the funds will initially be transferred into B/A 101-3220, then transferred to the UPL. This might sound circular, but we want to coordinate the funding with all of the grants we issue for nutrition. If the grants are appropriate under the UPL program, then those monies would be transferred out to the UPL account in the Director's Office.

SENATOR KIECKHEFER:
I am having a hard time following the money. The large increases, from a line item perspective, relate to Nevada Clinical Services and the Obesity Program. Are those correlated to any of the decision units that are specifically outlined?

MS. KOTCHEVAR:
The Nevada Clinical Services is the transfer, which is the agency that assists with the UPL. I would like to get back to you on the Obesity Program, as I do not want to give you wrong information.

ASSEMBLYWOMAN NEAL:
Can you discuss the treatment barriers experienced by the women who received a positive diagnosis through the early detection screening? Please identify any services offered by the DPBH.

MS. KOTCHEVAR:
The DPBH strives to make the screenings accessible to women, such as the utilization of the MammoVan. We will come to the client, as transportation is always a barrier. After a positive screening result, we work to navigate them through the health insurance process: do they have health insurance, do they qualify for Medicaid, or do they qualify for an exchange plan? If they do not qualify for any of those options, we work with them to access Nevada Health Link in order to get them on a medical discount plan so they have assistance with treatment expenses. We help navigate, from diagnosis into treatment, we help navigate any barriers such as: access to a provider, transportation to and from treatment, child care or time of work.

ASSEMBLYWOMAN NEAL:
How do you integrate screenings with clients in WIC or the Obesity and Prevention Program? Is there a blending of those individuals?

MS. KOTCHEVAR:
Most of our screening protocols are for women who are older than those we typically see in the WIC program. This funding allowed us to reduce the age protocol to 40-years of age or older for breast cancer screening. We do have a system in place for referrals and public messages. The DPBH has outreach programs which provides information regarding proper screening, as well as the recommended age for each screening type. The Family Planning Program is a natural entry point for the referral process, as our staff can make clients aware of the screenings that are recommended for their age group.

ASSEMBLYWOMAN NEAL:
In certain communities women are having babies at 40. In communities of color, breast cancer can appear before the woman is 40-years of age. Is DPBH in those communities making them aware of preventative services, such as self-examination?

MS. KOTCHEVAR:
The DPBH utilized this funding for screenings. We do provide education about self-breast exams, and in the Family Planning Program, we make sure that the women are having routine pap smears to check for precancerous cells. In all Programs across DPBH, we get clients into primary care, because primary care provides a broader access to healthcare. Having a primary care physician means that they are more likely to access other parts of healthcare.

ASSEMBLYWOMAN CARLTON:
I have concerns regarding the UPL account. Can you please provide us with conversations or documentation on where DPBH thinks this funding would really work? I do not want to jeopardize the funding by using it inappropriately.

MS. KOTCHEVAR:
Any time we look at whether or not a contract is appropriate to go through the UPL, we evaluate the contract to ensure it meets the criteria. If the contract is

deemed not appropriate for funding through the UPL, then it is put forth as a subgrant or a direct contract with the State.

ASSEMBLYWOMAN CARLTON:
Please provide the list of criteria and the information on the discussions that DPBH has had regarding ensuring this is an appropriate avenue, as this is leveraging federal dollars.

MS. KOTCHEVAR:
I will send over the information regarding the criteria. The next budget account we are presenting requests an additional position to help manage contracts to ensure they are appropriate to utilize the UPL, as we recognize the importance of doing it appropriately.

ASSEMBLYWOMAN CARLTON:
Regarding the women's health connections, it appears that the majority of funding allocated for screenings was spent. Were there unmet needs that the Subcommittees need to consider as we move forward?

MS. KOTCHEVAR:
We screened as many women as the funding allowed. When we expanded the screening to include cervical cancer, this was an area where the need existed. I don't believe we are maintaining a wait list for screening. I have to verify that information and let you know if additional funding is needed.

ASSEMBLYWOMAN CARLTON:
I would like to know that information.

CHAIR DENIS:
Did DHRM approve the reclassification of the health manager III position?

MS. KOTCHEVAR:
Yes, DHRM approved that reclassification.

CHAIR DENIS:
Can you discuss the unmet work load, as it pertains to the health program manager III? Why do we need this position?

BETH HANDLER, MPH (Deputy Administrator, Department of Health and Human Services, Division of Public and Behavioral Health)
The health program manager III position proposed in B/A 101-3220 is a new position. It will service the State's public health nutritionist across DHHS as part of the leadership for the Nutrition Unit. The position will provide oversight to all of the specific nutrition programs, provide guidance to other programs and engage with our State partners. Along with the State's public health nutritionist, a registered dietician, the new position will help move the needle on our health outcomes across the State. This classification title was vetted with DHRM.

CHAIR DENIS:
With the addition of a food security manager, in conjunction with the new health program manager, this would create two managers in the Nutrition Unit. Is that correct?

MS. HANDLER:
The OFS Program is a free standing office, and the manager position already existed. The food security manager position control number (PCN) was budgeted under DHHS, Grants Management Unit, B/A 101-3195, but it was colocated in the Nutrition Unit. We are requesting to move the PCN under DPBH, B/A 101-3220.

MS. KOTCHEVAR:
The OFS Program is one of the programs under the umbrella of the Nutrition Unit that the new health program manager position would oversee.

ASSEMBLYMAN SPRINKLE:
Under enhancement E-226, position cost sharing; currently 100 percent of the position is funded with the federal Cancer Prevention and Control Program. What is the concern that prompted this change in funding sources? Is the federal grant expiring?

MS. KOTCHEVAR:
The main reason is efficiency of staff; organizationally, what programs make sense to group together. Next, we looked to make sure that the appropriate funding source was paying for each activity the position is completing.

ASSEMBLYMAN SPRINKLE:
Currently, is this position working on all the programs within the requested funding sources?

MS. KOTCHEVAR:
When looking at this request, we realized the position would provide a broader touch to all aspects of the DPBH, and the most appropriate way to fund the position was to broaden the funding sources.

ASSEMBLYMAN SPRINKLE:
Would the cost allocation shift increase the position's responsibilities or at least change them?

MS. KOTCHEVAR:
That is correct. As a management position, they would be responsible to manage and coordinate activities across all programs. A manager's role is more diverse and flexible. The DPBH wants to use the position effectively and fund it appropriately.

ASSEMBLYWOMAN NEAL:
The OFS Program will be funded annually by a transfer of tobacco funds in the amount of $2 million, but who will provide the services?

MS. KOTCHEVAR:
Community based grants are provided to organizations to serve needs identified by the Governor's Council on Food Security.

CHAIR DENIS:
I believe that is tied in to what Senator Kieckhefer was asking.

MS. KOTCHEVAR:
The next budget to present is B/A 101-3223, the Office of Health Administration. The overview of this budget is found on page 23 of Exhibit C.

Budget information and changes for this budget start on page 24 of Exhibit C. There are four enhancement decision units requested for B/A 101-3223. Enhancement decision unit E-225, requests a new administrative service

officer II position. This position will be responsible for the management of the Nevada Clinical Services contracts. This is the position I discussed earlier regarding Assemblywoman Carlton's concerns about the UPL. Currently, we have 24 separate contracts spread across 7 budget accounts. The workload, as well as the level of oversight required to ensure the appropriate use of funding, justifies the need for the position.

E-225 Efficient and Responsive State Government — Page DHHS-DPBH-113

Enhancement decision unit E-226 requests a new auditor III position. This position will be responsible for compliance reviews on subgrants. The DPBH has over 250 grants and over 100 subrecipients. Having this position will ensure that DPBH remains in compliance with federal and State audits. In addition, this position will be responsible for grant compliance reporting, which is critical to maintain and continue to be eligible for federal grants funds.

E-226 Efficient and Responsive State Government — Page DHHS-DPBH-114

Enhancement decision unit E-805 requests to reclassify an existing human resource analyst I position, as discussed on page 25 of Exhibit C. The human resource analyst I reclassification to a human resource analyst II was approved by DHRM, based on the size—DPBH has over 1,700 FTE—and complexity of the workload.

E-805 Classified Position Changes — Page DHHS-DPBH-115

The final enhancement decision unit E-906, requests to transfer the medical epidemiologist position from the Office of Public Health Investigations and Epidemiology B/A 101-3219 to Health Administration B/A 101-3223. This position, despite the title, actually provides broad-based support to all of DHHS. The position advises on both mental and public health issues.

E-906 Trans From Biostats To Office of State Hlth Admn — Page DHHS-DPBH-115

HHS-DPBH - Biostatistics and Epidemiology — Budget Page DHHS-DPBH-85 (Volume II)
Budget Account 101-3219

E-906 Trans From Biostats To Office of State Hlth Admn — Page DHHS-DPBH-91

ASSEMBLYMAN SPRINKLE:
In regard to the position transfer, will 100 percent of position costs be covered by allocation reimbursements with no General Fund associated with this request?

MS. KOTCHEVAR:
It is funded through cost allocations, which does include General Fund appropriations.

ASSEMBLYMAN SPRINKLE:
If I look under supplemental appropriations, it appears there is a request for $1.6 million, due to a shortfall in cost allocations. I am looking for assurances that, if the position is approved, there will be funding?

MS. KOTCHEVAR:
Currently, DPBH did have a shortfall in the way we were budgeted for indirect costs in FY 2019. We are working with LCB Fiscal staff to ensure the adjustments made, within the 2019-2021 biennium budget, are what we expect to receive for indirect cost reimbursements. We expect this transfer would be appropriately funded.

ASSEMBLYMAN SPRINKLE:
There will not be concerns of shortfalls in the future?

MS. KOTCHEVAR:
I hope that the corrections we are making, working with the Governor's Office of Finance and LCB Fiscal staff, are correct and complete.

CHAIR DENIS:
Regarding the administrative service officer position in enhancement decision unit E-225, how would that position help increase the number of contracts in Nevada Clinical Services, and what kind of benefits will the State get from having this position?

MS. KOTCHEVAR:
The DPBH is looking to maximize revenue. When we are contracting, subgranting, or we are distributing funding by appropriate methods, this position would be able to evaluate the criteria for Nevada Clinical Services to ensure the contracts meet the criteria, which, if it does, would benefit the General Fund. We need expertise in this area from a position who is focused only on Nevada Clinical Services contracts, as we share the same concerns of Assemblywoman Carlton; are we putting only appropriate contracts through the Nevada Clinical Services?

CHAIR DENIS:
For the auditor position, is DPBH currently in compliance with State and federal policies regarding monitoring and oversight of grants and subgrants?

MS. KOTCHEVAR:
We do complete monitoring, and we are currently in compliance. We do get audited and do have findings, which are corrected. This position will ensure there is not a grant that has fallen out of compliance that would effect DPBH ability to receive grant funds in the future. This request is proactive and ensures that we stay in compliance as the amount of grants increase.

CHAIR DENIS:
Please present the last DPBH budget.

MS. KOTCHEVAR:
The last budget to be heard is B/A 101-3224, Community Health Services (CHS). The overview of the CHS budget is discussed on page 26 of Exhibit C.

Budget information and changes for B/A 101-3224 are discussed on page 27 of Exhibit C. Enhancement decision unit E-227 requests to enhance family planning services throughout the State.

E-227 Efficient and Responsive State Government — Page DHHS-DPBH-121

This enhancement decision unit will provide services to underserved urban areas, with particular targets to: outreach; education; prenatal care and education. This is an area where we lag behind in access, especially in higher-risk populations, which has a direct impact on the health and safety of both mother and baby.

Another targeted area is disease intervention and prevention. Throughout the State there is a high incidence of syphilis. Currently, Nevada has the highest rate of primary infection of syphilis. There are 30 cases of genital syphilis in Las Vegas, which means a baby was born to a mother who actively had syphilis. This will have neurological impacts on the baby for the rest of its life. Part of the funding would target efforts to make sure that women who are pregnant are screened, treated, educated to not be reinfected, until the baby is safely born.

We will also target higher-risk populations for substance use disorder. In addition, there has been growth in long-acting reversible contraception (LARC), the most common form is the Intrauterine Device (IUD). There are two points at which we struggle with access for this service; the first is postpartum insertion, which is one of the easiest ways for women to receive an IUD if they choose too. Hospitals have a difficult time bundling IUD insertion with conducting the delivery of babies. This funding would help hospitals manage this service.

The second point at which we struggle for this service is LARCs for women who are in high risk populations. A portion of the funding we received last Session went towards a pilot program in both northern and southern Nevada. Particularly in the north, we worked with the sheriff's offices to obtain access to women who were incarcerated. We had a dialog which asked if the women wanted to take this opportunity to take control over their life and have a LARC. Having this access for women may make a big difference in their lives. The last targeted area is education outreach services.

This funding would support one new grant and project analyst II FTE. The majority of this funding would be subgranted to the community, only a small portion would support administrative functions within DPBH.

ASSEMBLYMAN THOMPSON:
I see that of the 12 Nevada rural counties, 8 counties operate community health nursing clinics. Transportation is a problem. Are we investing in nursing services and mobile units?

MS. KOTCHEVAR:
This budget provides community health nursing in rural areas, and we did fund southern Nevada Health District, and they did have a mobile van that they took around to access people in underserved areas where transportation is the primary barrier. These services are provided under subgrants that we awarded.

ASSEMBLYMAN THOMPSON:
In the rural communities, specifically, are we looking at bringing the mobile services to the people, instead of expecting them to come to us?

MS. KOTCHEVAR:
We do have community health nurses (CHN) stationed in 12 rural areas. Based upon the availability of CHNs in the smaller communities, the need or desire does not exist for mobile units. The primary service offered by community health nurses is birth control. The passage of S.B. No. 233 of the 79th Session allowed a 12-month prescription to be written and helped with the need for multiple visits. The mobile services are more effective in the urban underdeveloped areas where there is not a community health nurse.

MS. HANDLER:
Even though we have CHN dedicated sites, these funds were also utilized through a request for application (RFA) process, in order to serve additional sites within the rural communities. Even though there was not a mobile unit established through the funding, we had funding available through a Family Planning grant to expand our services, and we were able to work with local organizations to implement additional access.

ASSEMBLYWOMAN NEAL:
Could you please describe the process that was used to disburse the family planning funds awarded in FY 2017 from A.B. No. 397 of the 79th Session?

MS. KOTCHEVAR:
The DPBH issued an RFA for a competitive process. We awarded based upon applications received and those which met the requirements of the funding. We funded rural entities, Washoe County and the Southern Nevada Health Districts.

ASSEMBLYWOMAN NEAL:
How many were funded, and was Southern Nevada Health District a part of that, could they apply?

MS. KOTCHEVAR:
Southern Nevada Health District did apply and they received a grant. They have the mobile family planning van. Planned Parenthood of Reno, Carson City Health and Human Services, Douglas County, Nevada Health Centers, Volunteers of Medicine in Southern Nevada, Washoe County Health District and Southern Nevada Health District were the grantees. We can provide you the list which includes data regarding the screenings they provided.

ASSEMBLYWOMAN NEAL:
What are you doing concerning the increase in human immunodeficiency viruses (HIV) within the teenage population?

MS. KOTCHEVAR:
The Ryan White Program in DPBH, which specifically goes to teenagers and other target groups who tested positive for HIV, can qualify for that program. There is an increase in HIV among African-American teen males, which is a target area for DPBH. We are funding subgrants for education and services. We are doing a lot of outreach, but we will be doing targeted outreach, specifically based on epidemiological data of where we are seeing an increase.

ASSEMBLYWOMAN NEAL:
The DPBH should work with the pharmacies, as they are the front line in getting prescriptions for teenagers.

ASSEMBLYMAN THOMPSON:
Can you share the detailed plan for the additional family planning funding to make sure we do not duplicate services? Is there a focus on community-based programs?

MS. KOTCHEVAR:
Last biennium we received $500,000 per year, for which we had a specific plan for the funding. With the larger dollar amount, we would send out a request for proposals, as we have already identified particular areas of interest, such as prenatal disease prevention, LARC's, information and education targets who are underserved, or people who are in high-risk populations. This is a much broader mission than with the first allocation.

ASSEMBLYMAN THOMPSON:
Can you share with us how DPBH intends to distribute the RFP? Will you physically be going into the communities, including faith-based communities, and speaking with organizations that can provide services? Just sending emails or posting the RFP to the State website is not enough, as some of these organizations are unfamiliar with the State process?

MS. KOTCHEVAR:
We can put together our media and communication plan and submit it to you. We have developed strategies to provide the information to parts of the communities who are not accustomed to applying for grants.

ASSEMBLYWOMAN CARLTON:
Some of the local entities have applied for direct funding by the federal government, in addition to the funding DPBH is providing them. What is the amount of funding coming into the State and the amount of funding they have received?

MS. KOTCHEVAR:
The DPBH received approximately $201,000 from the U.S. Department of Health and Human Services, Title X funding. We can provide all of the grantees of Title X funding to you. Our goal with this funding is not to replicate what Title X is paying to other grantees, but to look at all the gaps that are not being covered.

ASSEMBLYWOMAN CARLTON:
In order to have a real discussion regarding what is being proposed, we do need to know what other funding is coming into the State. It appears there is

approximately $39,000 unallocated from the last federal grant. We need to make sure that the next allocation is spent accordingly.

MS. KOTCHEVAR:
The advantage with this funding is that we have more planning time. We did have a slow start getting the family planning funds out the communities the first year of implementation.

ASSEMBLYWOMAN CARLTON:
The DPBH is showing their success with this funding, and we need to make sure what the appropriate next step looks like and what the total dollars actually are.

ASSEMBLYMAN SPRINKLE:
The total Family Planning grant is $3 million. It appears that $2.3 million will be awarded in subgrants. How is DPBH planning on spending the remaining $700,000?

MS. KOTCHEVAR:
The funding will be spent for administrative functions of DPBH, such as the grants and project analyst II position. We will also have to complete monitoring and data collection. I can provide you a detailed breakdown of how these funds will be spent.

CHAIR DENIS:
We will now hear public comment.

ELISA CAFFERATA (Planned Parenthood Votes Nevada):
I appreciate all the points the Subcommittees made regarding the Family Planning grant allocation. We want to make sure the money is spent as effectively as possible. In the past, Nevada was spending approximately $6 million a year on family planning and only served about 40 percent of the women who needed assistance. With the last allocation of $1 million, fewer than 10 percent of the women in Nevada who needed this help were served. The $3 million allocation will go a long way into making a dent in helping the women who are most at need.

I want to make you aware of Senate Bill 94, which will allow follow up on S.B. No. 122 of the 79th Session, which created the State-funded Family Planning Program. There are a few things that need fine tuning, and some of the issues have been raised here by your Subcommittees. This is a policy bill, which I do not think will be seen by your Subcommittees because we will be taking out the dollars.

I just wanted you to know that we will try to capture all of the concerns you raised here. I just wanted to reiterate that this is a super critical area, the federal government has continued to put rules and regulations on women's ability to access these services and dollars, and they have severely cut the amount of money they are putting into Title X and other preventative services. It is vitally important that the State steps up and fills this role where the federal government has stepped back. We really appreciate your consideration of this budget item.

SENATE BILL 94: Revises provisions governing the Account for Family Planning. (BDR 40-446)

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CHAIR DENIS:
With no further business to come before us, this meeting is adjourned at 9:49 a.m.

RESPECTFULLY SUBMITTED:

_____
Desirae Munns,
Committee Secretary

APPROVED BY:

_____
Senator Moises Denis, Chair

DATE: _____

_____
Assemblywoman Maggie Carlton, Vice Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	3		Attendance Roster
	C	28	Julie Kotchevar, Ph.D. / Division of Public and Behavioral Health	Presentation