MINUTES OF THE
JOINT SUBCOMMITTEE ON K-12/HUMAN SERVICES
OF THE SENATE COMMITTEE ON FINANCE
AND THE ASSEMBLY COMMITTEE ON WAYS AND MEANS

Seventy-fourth Session
March 1, 2007

The Joint Subcommittee on K-12/Human Services of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order at 8:09 a.m. on Thursday, March 1, 2007. Chair Barbara K. Cegavske presided 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 Barbara K. Cegavske, Chair
Senator William J. Raggio
Senator Dina Titus
Senator Bernice Mathews

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman Sheila Leslie, Chair
Assemblywoman Barbara E. Buckley
Assemblyman Mo Denis
Assemblywoman Heidi S. Gansert
Assemblywoman Debbie Smith
Assemblywoman Valerie E. Weber

STAFF MEMBERS PRESENT:

Steven J. Abba, Principal Deputy Fiscal Analyst
Michael J. Chapman, Senior Program Analyst
Gary L. Ghiggeri, Senate Fiscal Analyst
Jo Greenslate, Committee Secretary

OTHERS PRESENT:

Maria Canfield, Chief, Substance Abuse Prevention and Treatment Agency, Division of Mental Health and Developmental Services, Department of Health and Human Services
Greg Weyland, Deputy Director, Substance Abuse Prevention and Treatment Agency, Division of Mental Health and Developmental Services, Department of Health and Human Services
Carlos Brandenburg, Ph.D., Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services
Jeffrey Mohlenkamp, Administrative Services Officer, Mental Health and Developmental Services, Department of Health and Human Services
Jack Mayes, Chairman, Strategic Plan Accountability Committee, Department of Health and Human Services
Jan Crandy, Vice Chairman, Strategic Plan Accountability Committee, Department of Health and Human Services
Brian M. Patchett, President/CEO, Easter Seals Southern Nevada
LaVonne Brooks, CEO, High Desert Industries

Jon L. Sasser, Washoe Legal Services and Nevada Legal Services
Tammra Pearce, Executive Director of Bristlecone Family Resources
Kevin Quint, President, Nevada AADAPTS
Christy McGill, Statewide Partnership of Coalitions
Beverly Lassiter, Big Brothers Big Sisters of Northern Nevada
Michael Pomi, Director, Washoe County Juvenile Services and President, Nevada Association of Juvenile Justice Administrators
Scott Shick, Douglas County Juvenile Services and the Nevada Association of Juvenile Justice Administrators
Dick Steinberg, President and CEO, WestCare Nevada, Inc.
Ed Guthrie, Executive Director, Opportunity Village
James L. Meyer, President and CEO, Washoe Arc
Leslie Spracklin, Fallon Industries
Brian Patchett, Easter Seals Southern Nevada
Donald Stromquist, Easter Seals Sierra Nevada

CHAIR CEGAVSKE:
The first budget account (B/A) we will review is 101-3170.

HUMAN SERVICES

MENTAL HEALTH AND DEVELOPMENTAL SERVICES

HHS – Bureau of Alcohol and Drug Abuse – Budget Page MHDS-98 (Volume II)
Budget Account 101-3170

MARIA CANFIELD (Chief, Substance Abuse Prevention and Treatment Agency, Division of Mental Health and Developmental Services, Department of Health and Human Services):
We have three enhancement units. The first is E-412.

E-412 Access to Health Care and Health Insurance – Page MHDS-102

Decision unit E-412 is a replacement of lost federal funds from our federally-funded State Prevention Infrastructure Grant or SIG. We are requesting $2.3 million in the first year of the biennium and $3 million in the second year to support the work currently funded by the grant. We fund 13 substance-abuse-prevention coalitions to support 51 sub-grantees serving approximately 8,100 youth and families each year.

CHAIR CEGAVSKE:
Could you explain the difference in the amount of the SIG grant revenue authorized compared to the actual amount received?

GREG WEYLAND (Deputy Director, Substance Abuse Prevention and Treatment Agency, Division of Mental Health and Developmental Services, Department of Health and Human Services):
The SIG grant will be fully expended at the end of the current project period which is in September 2007. The original project period ran from 2003 to 2005, and, due to delays, requirements of the federal government and planning, the actual implementation of the plan was extended with two no-cost extensions. It was actually a three-year project that extended over five years.

CHAIR CEGAVSKE:
Could you explain the need for the General Fund appropriations recommended for $2.3 million in fiscal year (FY) 2007-2008 and $3 million in FY 2008-2009 for continuation of the program?

CARLOS BRANDENBURG, PH.D. (Administrator, Division of Mental Health and Developmental Services, Department of Health and Human Services):
You received a handout entitled "Reimbursement Rates for Supported Living Arrangements" (Exhibit C). The reason we requested the funds is in case we lose federal funding. If we lose federal funding and we do not have this decision unit, many of the prevention programs currently in place for drug abuse, especially for youth aged 12 to 25, would have to be cut.

CHAIR CEGAVSKE:
Could you talk about targeting methamphetamine-abuse prevention in Nevada and how the Substance Abuse Prevention and Treatment Agency (SAPTA) will record expenditures in a separate category, similar to the SIG expenditures?

DR. BRANDENBURG:
In enhancement unit E-412, providers currently use 50 percent of the funding for methamphetamine-abuse prevention. In decision unit E-413, 45 percent goes to methamphetamine-abuse prevention.

E-413 Access to Health Care and Health Insurance – Page MHDS-102

In decision unit E-414, 45 percent goes to methamphetamine-abuse prevention.

E-414 Access to Health Care and Health Insurance – Page MHDS-102

This decision unit is not broken out in terms of expenditures but in terms of the number of individuals receiving services from prevention and treatment facilities. It will not be a problem for us to break out the exact dollar amount for you.

CHAIR CEGAVSKE:
In his State of the State address, the Governor indicated $17 million will be allocated for methamphetamine-abuse prevention. According to your statement, approximately half that amount is going for methamphetamine-abuse prevention. Would you explain?

DR. BRANDENBURG:
I cannot explain the figures given to the Governor. The services provided by our staff are not strictly for methamphetamine, but for a variety of drug abuses. Methamphetamine happens to be one of many drugs being abused in Nevada. One thing we brought to the attention of the Budget Division is this funding is predicated on the actual cases currently being served for methamphetamine. When we say 50 percent of the funding, currently in the Base Budget, is going to prevention, 50 percent of prevention services are going toward methamphetamine, and 45 percent of treatment funding is going toward methamphetamine. The budget request includes treatment of alcohol, marijuana, cocaine and other drugs being abused in Nevada.

CHAIR LESLIE:
It is my understanding there is no specific methamphetamine-prevention campaign. Methamphetamine is the drug of choice for many people, but it does not mean they are not using other drugs. The federal government has not been interested in methamphetamine. They are more interested in marijuana. This needs to be clarified, because the Attorney General's methamphetamine task force is meeting today, and we will be talking about this. Is there any methamphetamine-specific prevention campaign in Nevada or is it geared more toward drugs in which the federal government is interested?

MS. CANFIELD:
In our planning system for prevention, we rely on our community partners, which are the 13 coalitions, to identify the needs in their particular communities. Many of the evidence-based practices work with methamphetamine as well as other drugs in terms of prevention. There is not a methamphetamine-only focus in what we have done since we have not had methamphetamine funding directly in the agency. Because the federal funds come with strings, the strings we have to follow guide the process. We have been able to use the funding to support our coalitions and their planning efforts.

CHAIR LESLIE:
You were responding to our budget personnel by saying 45 percent of the funding is going to methamphetamine because it is a significant issue in Nevada. The Governor's intent is for the money he allocated to be used specifically for methamphetamine-only types of prevention.

DR. BRANDENBURG:
The Committee should be aware that alcohol remains the leading primary drug of abuse for adults in Nevada. Marijuana is the primary drug of abuse for adolescents in Nevada. However, the data we have collected from providers indicates 45 percent of adults, 41 percent of adolescents and 81 percent of pregnant and parenting women who seek treatment in the SAPTA-funded programs present methamphetamine as one of their top three drugs of choice. The federal government does not fund a methamphetamine-only program; they fund a drug-abuse program to cut across a variety of drugs in Nevada.

CHAIR LESLIE:
I know there are many more people who abuse alcohol and marijuana. The Committee needs to keep in mind the damage caused by methamphetamine affects so many other things such as Child Protective Services, our jails and prisons. You cannot judge the problem merely by the numbers of people who are using a particular drug but need to look at the whole picture.

CHAIR CEGAVSKE:
We will discuss decision unit E-413, the reduced wait list. Can you tell us how you accumulated the wait-list data, how often it is updated and if there is duplication of people seeking treatment?

MS. CANFIELD:
In FY 2005-2006, we used an antiquated data system that collected wait-list information largely with paper and pencil. We entered the data the provider submitted into a database. On a weekly basis, providers updated their wait list

by sending us a piece of paper, and we removed clients from the wait list. With that cumbersome, labor-intensive system, we were able to determine there were 2,226 individuals who waited an average of 24 days in FY 2005-2006. The problem with that list is it includes clients who have been identified and diagnosed. It does not include people at the front end who are waiting for an assessment or who call and need help. We lose many people in that system because of the lack of capacity.

This year, we have a new data system that is a live system in which providers are entering clients onto the wait list and removing them as they enter treatment. The day before the budget overview testimony, we ran numbers and found there were 257 individuals waiting. As of February 14, they had waited an average of 22.5 days for admission into treatment.

CHAIR CEGAVSKE:
In an earlier budget hearing, we requested a list of providers for the State. We would appreciate that information.

MS. CANFIELD:
At the last meeting, we distributed our biennial report which included a provider list for both treatment and prevention through December 2006. Our Website also includes a list of providers and services for treatment and prevention that are available as of the most recent update which would be this month.

CHAIR CEGAVSKE:
If the $1.5 million is approved for FY 2007-2008 and $2.3 million in FY 2008-2009 is approved, what impact will it have on the wait list and wait times?

MS. CANFIELD:
We anticipate we will be able to address 25.4 percent of the wait list in the first year of the biennium. Of individuals on the 2006 wait list, there will be at least 567 who will receive treatment who would not ordinarily have received treatment in the first year of the biennium. That number rises to 850 in the second year of the biennium, which is 38 percent of the 2006 wait list, for a total of at least 1,417 clients who will receive treatment.

CHAIR LESLIE:
Did you say you break out the inpatient versus the outpatient wait-list numbers?

MS. CANFIELD:
We could probably obtain an estimate of how much is inpatient or residential and how much is outpatient. I will check with staff.

CHAIR LESLIE:
That is important to me from my experience at the drug court. We have people on wait lists for five to seven weeks before getting out of jail and into inpatient treatment. These numbers do not appear to be solid. Would you supply the information by region?

MS. CANFIELD:
In June, we will be implementing the new data system with the ability to track who calls a provider and is screened and determined to need services from that point. That is the part of the wait list we are missing.

CHAIR LESLIE:
Do you update the list regularly?

MS. CANFIELD:
We update the list weekly.

CHAIR LESLIE:
We need a better understanding of our substance-abuse wait list to gain more confidence in its accuracy.

DR. BRANDENBURG:
Currently, the SAPTA has their methodology and the Division of Mental Health and Developmental Services (MHDS) has their methodology. Due to the short time frame available in which to compile the budget, we were unable to assist the SAPTA with their wait-list methodology. The numbers do not accurately reflect the demands and needs of drug abusers. In the coming biennium, we will be able to merge the two methodologies and develop a system to provide solid numbers on the wait list and a system to use with providers in tracking those numbers. It is one thing to have the wait list, but the other is to ensure we are making contact with individuals on an ongoing basis to ensure they are still seeking services.

ASSEMBLYWOMAN BUCKLEY:
Is there separate data on the need in the child welfare system? The federal government has requested we prioritize the array of services needed by families in the child welfare system. Since we are in danger of losing our federal funding for child welfare, unless we make specified improvements, I was wondering about the status of providing that data.

DR. BRANDENBURG:
From the MHDS point of view, I am unaware of the status. As part of the merger of the SAPTA into the MHDS, we plan to address the adult drug issue as well as the child and adolescent drug issue and work with providers, on the child and adolescent side, with both juvenile justice and child welfare. We will be doing that, but I cannot tell you the current status.

ASSEMBLYWOMAN BUCKLEY:
Would you follow up and provide the Committee with a status report, including situations in which the judge sets the completion of certain services as a condition for parents getting their children back? We would like answers to questions such as: what is the anticipated need, is there a wait list, what services need to be provided and how are you coordinating with those various systems?

CHAIR LESLIE:
I am certain that information is not being collected. We need a plan for collecting the information. Do we need a combination of funding sources from the child welfare system and other relevant agencies?

DR. BRANDENBURG:
Yes, we do. That issue has never been brought to my attention or to Ms. Canfield's attention. We will be happy to develop a plan.

CHAIR CEGAVSKE:
We will move to the pilot program for co-occurring disorders. You are requesting $3 million in General Funds and estimating 90 clients in this program.

DR. BRANDENBURG:
If there is a major gap in our service-delivery system, it is with the co-occurring disorders. Co-occurring disorders cover individuals who not only have substance abuse but some degree of mental disorder. We specifically put decision unit E-414 into our budget to develop an integrated model for treatment of individuals with substance-abuse problems and mental illness who currently fall through the cracks. This pilot program addresses the tremendous gap in the two divisions' system. The MHDS did not include funding in the budget for co-occurring disorders. I wanted it specifically under the SAPTA's budget, to be integrated and to go across the variety of service systems, to start building an infrastructure we desperately need at the provider level.

CHAIR CEGAVSKE:
How do you envision individuals with co-occurring disorders will be treated?

DR. BRANDENBURG:
Currently, we are asking the regions to develop their pilot programs. Las Vegas is looking at a variety of models. The juvenile justice people are reviewing their model. Most of the program will consist of outpatient services. It could be providers coming into, for example, the Dini-Townsend State Psychiatric Hospital to provide services. The program will be community specific driven by what the community wants. The important thing is to start developing the integrated-treatment approach for both disorders.

CHAIR CEGAVSKE:
How would you develop performance indicators for this pilot program?

DR. BRANDENBURG:
We will develop outcome measures depending on how the programs are developed. The outcome measures would be abstinence, community tenure, deflection away from the criminal justice system and so forth. On the mental-health side, 70 percent of individuals currently entering our service-delivery system have some degree of substance abuse. We do a good job with the mental illness part, but not as good a job with substance abuse because we do not have that service system. This will help us start treating individuals, work on the infrastructure, keep people out of jails and hospitals and in the community longer.

CHAIR CEGAVSKE:
What are you doing to resolve this problem? Are people currently being treated for a mental illness and then going wherever they need to go for the next problem?

DR. BRANDENBURG:
That is correct. Unfortunately, there is a lot of finger pointing. Many mental health providers are saying, no, they are substance abusers and vice versa. The consumer is falling through the cracks and not receiving needed services. The pilot program will develop the integrated model to treat both populations.

CHAIR CEGAVSKE:
Have you developed a cost-based estimate to treat individuals with co-occurring disorders?

DR. BRANDENBURG:
We have, and it is predicated on the current average cost of treating the SAPTA consumer. We increased it due to the complexity of the consumer and the need to license providers. We will need employees who are licensed as substance-abuse counselors with some degree of mental health competence.

CHAIR LESLIE:
We are concerned about the maintenance-of-effort (MOE) requirement. I understand why you want to include the pilot program for co-occurring disorders in this budget, but would it be a problem if we put it back into the mental health budget to avoid the MOE?

DR. BRANDENBURG:
We are asking the Legislature to commit to funding this program under the SAPTA. The SAPTA program has not received funding since 1999. The only funding it has received is $500,000 which, at that time, was the maximum funding available. I am asking the Committee to commit ongoing funding to the SAPTA. You could put the money into the MHDS, but the federal government will see the money in the MHDS budget and the caseload in the SAPTA budget. I do not like to hide money in one budget to provide services in another.

CHAIR LESLIE:
I will take this opportunity to raise the caseload growth issue and point out the old Bureau of Alcohol and Drug Abuse (BADA) program. When it was at the Department of Education, Training and Rehabilitation, it never received enough attention. We moved it to the Health Division where it still was overlooked. We finally have it where it belongs in terms of structure. In reading through the materials to prepare for today's meeting, I was struck by caseload growth formulas in other developmental disabilities departments' budgets. Those are appropriate. We are a growing State, and we need to serve people better. We know what the wait lists are, and we have our regression formulas which we look at every Legislative Session. Yet, in substance-abuse services, we do not have any of these things. This is the only human service program that does not have a way for this Committee to grapple with caseload growth. Are you going to be looking at that?

DR. BRANDENBURG:
Absolutely. That is exactly what we plan to do. Within two years, you will see the SAPTA's methodology, in terms of caseload and wait lists, will match the MHDS's methodology or caseload and wait-list documentation. You will have the confidence you need to continue funding this program on an ongoing basis.

CHAIR CEGAVSKE:
The MOE beyond the 2007-2009 biennium will probably increase to $11.1 million. What impact would there be on federal SAPTA funds if the minimum MOE is not met?

DR. BRANDENBURG:
If the General Fund dollars are put into the SAPTA budget, the MOE for FY 2008-2009 will be $6.2 million. For FY 2009-2010, it will be $9.82 million, and for FY 2010-2011 it will be $11.06 million. The Legislature will be committing itself to that ongoing funding.

CHAIR CEGAVSKE:
It will commit future Legislatures, and that is a decision this Committee must seriously consider.

DR. BRANDENBURG:
I am asking you to not only commit yourself but to commit future Legislatures to this extremely important program. This program, as far as I am concerned, has not received the administrative financial support needed to keep consumers out of jails and prisons due to a lack of funds.

CHAIR CEGAVSKE:
We will move on to decision units E-125 and E-127. Could you explain the need for the General Fund appropriations recommended in the support of 1.49 full-time equivalent (FTE) increases in these decision units?

E-125 Equitable, Stable Tax Structure – Page MHDS-101

E-127 Equitable, Stable Tax Structure – Page MHDS-101

JEFFREY MOHLENKAMP (Administrative Services Officer, Mental Health and Developmental Services, Department of Health and Human Services):
These two decision units are doing what the Health Division has been doing for the last several years. Decision unit E-125 is the transfer of over $322,000 in the first year of the biennium of the SAPTA administrative funds, and in the second year, $387,000. These funds are to support a management analyst III, which will provide contracts and grants review directly supporting the SAPTA; a management analyst IV position which will be involved in budget tracking, caseload and revenue analysis; and a new information technology (IT) position that will provide direct support for the SAPTA once it is moved into the Division.

CHAIR CEGAVSKE:
Could you explain why we are not bringing over the positions from the BADA?

MR. MOHLENKAMP:
My understanding is the Health Division has caseload growth built in. The Health Division wants to retain those individuals in their budget as part of their caseload growth. I could obtain details from the Health Division.

CHAIR CEGAVSKE:
Please supply those details as we are now trying to justify new positions.

MR. MOHLENKAMP:
Yes, I will.

DR. BRANDENBURG:
The Health Division was allocated $438,133 for administrative services they were providing to the SAPTA. When the SAPTA split off in July, these funds were to go to the MHDS to provide services the Health Division was providing to the SAPTA.

CHAIR LESLIE:
My only other major concern is how these funds are awarded to community agencies. I was unhappy about what happened in northern Nevada in the last cycle. Are you going to be reviewing that process? How are you going to award funds for substance-abuse treatment?

DR. BRANDENBURG:
Ms. Canfield will walk you through the specific procedure. However, in general, the applications are reviewed by the SAPTA staff. They also bring in outside community experts.

CHAIR LESLIE:
This sounds like the existing system. My question is, are you going to do it differently, or are we going to stay with the existing system which is not good?

DR. BRANDENBURG:
I wish I could tell you I am going to change the system, but, to be honest, I will have to take a look at the system. The bottom line is the decision will be made by me. The recommendation comes to me, the decision will be made by me, and I assure you I will make an objective decision based on outcome measures and indicators.

CHAIR LESLIE:
Northern Nevada lost funding last time; other places in the State have lost funding other years. I would like to see stability provided to these agencies so they know in advance approximately how much money they will receive.

DR. BRANDENBURG:
I will review the process and meet with staff on the procedure. The last thing we need is a lack of continuity. At the same time, however, much of this is predicated on outcome measures and indicators. We have some providers that have bought into indicators and outcome measures. Other providers want to continue doing business the old-fashioned way. If they do not have good outcomes and indicators, we are going to have to make difficult decisions.

CHAIR LESLIE:
I have no problem with accountability.

ASSEMBLYWOMAN GANSERT:
I appreciate the Governor's efforts to fund the attack on the methamphetamine problem. Even though some of it is in ongoing programs or programs that would be eliminated, he has made a huge effort.

CHAIR CEGAVSKE:
We will review Developmental Services. The major issues are caseload increases in decision unit M-200, the wait list and the elimination of the intermediate care facility and mental retardation (ICF/MR) beds and salary adjustments.

M-200 Demographics/Caseload Changes – Page MHDS-65, 74, 85

We will cover caseloads first. You need to justify the quality assurance specialist positions and explain why those positions are recommended in a caseload module instead of a separate maintenance or enhancement module.

DR. BRANDENBURG:
The four quality assurance (QA) positions you are referring to are under the Desert Regional Center (DRC). One reason we put these positions in this particular decision unit is because we recently had three separate reviews. We were reviewed by the Bureau of Licensure and Certification, Medicaid and the Council on Quality and Leadership. All three reviews indicated we were remiss in not providing QA to our consumers. As a consequence, in terms of caseload growth, we determined we needed these positions in this decision unit to maintain quality and safety of our consumers. It is a health-safety issue, a quality issue and a certification issue. All of our providers are certified by our staff. We provide ongoing evaluation to our consumers. The DRC caseload is over 2,669 individuals we are serving in Las Vegas.

CHAIR CEGAVSKE:
How did you determine the ratio of 200 residential supports for each QA position recommended?

MR. MOHLENKAMP:
Initially, last biennium, we realized to comply with Medicaid-waiver requirements, we needed to provide these QA positions or would risk a loss of funding. We determined we needed approximately 3.1 hours a case to support the QA needed. Now we realize it is not only Medicaid-waiver people who need QA but everyone who is being provided service. Staff at the DRC has identified the number of hours needed for each individual and for each provider to ensure they have proper safety equipment, cleanliness and are providing proper services. We have numbers indicating hours-per-case and hours-per-provider which we would be happy to provide to you.

CHAIR CEGAVSKE:
I would appreciate receiving that information. Is that to satisfy a federal mandate?

MR. MOHLENKAMP:
It is partially to comply with requirements from the federal government to receive Medicaid-waiver funds. They do not require certain staffing levels but do require certain levels of compliance in meeting our obligations.

CHAIR CEGAVSKE:
What would be the potential consequences of not filling these QA positions?

DR. BRANDENBURG:
Potentially, we could lose Medicaid funding.

CHAIR CEGAVSKE:
We will move to the wait list, decision unit M-540.

M-540 Mandates-Olmstead – Page MHDS-67, 75

DR. BRANDENBURG:
The U.S. Supreme Court ruled in *Olmstead v. Lois Curtis and E.W.*, 527 U.S. 581 (1999), that the states could not discriminate against people with disabilities by providing long-term care services only in institutions, especially when these individuals could be treated in a least-restrictive integrated manner. Decision unit M-540 allows us to meet the intent of the Olmstead decision by trying to provide residential services to our consumers within a 90-day window. Decision unit M-540 provides $1.09 million for FY 2007-2008 and $3.1 million for FY 2008-2009 for the DRC; $637,000 in FY 2007-2008 and $1.8 million in FY 2008-2009 for Sierra Regional Center (SRC) to address the wait list. The wait list numbers of 167 for the DRC and 127 for the SRC were as of September 2006. The wait-list numbers as of December 2006 are 194 and 152. As you can see, the wait-list numbers are fluid. People are added to the wait list as they become eligible.

CHAIR CEGAVSKE:
How are wait lists developed for various services?

DR. BRANDENBURG:
The manner in which the wait list is developed for residential services is that people come in and we find them eligible. Once a person is eligible for services, he or she will request residential services. At that point, we put them onto the wait list. The wait lists are reviewed monthly by staff. Funding and costs determine who is put onto or taken off the wait list. We also look at the length of time a person is on the wait list, the acuity level and whether the person is in the ICF/MR. If so, they go to the top of the list because we need to move individuals out of our institutions and into the community.

CHAIR CEGAVSKE:
If your request is approved, will you be able to get below the 90-day target?

DR. BRANDENBURG:
I wish I could answer yes. The average wait for FY 2005-2006 was ten months.

CHAIR CEGAVSKE:
You touched on residential placements, but you did not discuss the Jobs and Day Training (JDT) slots.

DR. BRANDENBURG:
As of September 2006, the wait lists for the JDT slots were 25 at the DRC and 12 at the SRC.

CHAIR CEGAVSKE:
We will move to decision units M-541 and E-900, the elimination of ICF/MR beds and increase in community placements.

M-541 Mandates-Olmstead – Page MHDS-67, 75

E-900 Transfer from 3168 to 3164 – Page MHDS-69, 89

DR. BRANDENBURG:
As a Division, we are proud of eliminating the ICF/MR beds. Currently, there are approximately seven states that have completely eliminated all of their institutional beds. When we first started this process, we had 85 beds at the SRC and over 100 beds at the DRC. This decision unit completely eliminates all the ICF/MR beds at the SRC and reduces the beds at the DRC from 54 to 48. It also eliminates 66.47 staff at the SRC. At the same time, we are asking you to fund 13.5 positions as part of the crisis prevention team (CPT). The CPT will be staffed by individuals hired by the SRC who will work both at the SRC and the Rural Regional Center (RRC) in northern Nevada to keep our consumers in the community. The positions are to support the 20 people leaving the ICF/MRs, 950 consumers in northern Nevada and 587 consumers in rural Nevada, as well as providers in northern Nevada. The final reduction of staff at the SRC is 53.97 positions.

CHAIR CEGAVSKE:
Could you also address the staff-to-patient ratio and justification for the agency program information specialist position for the SRC? We are curious because the technical series position's job duties appear to be related to those of a management analyst. Additionally, could you tell us why this position is recommended in a decision that eliminates 53.97 positions due to the ICF/MR bed closure?

DR. BRANDENBURG:
The staff-to-consumer ratio is 1:45. The agency program information specialist position is for a new program we are developing to track consumers in the community. The position will help with developing the new information system to track consumers in the community on an ongoing basis.

CHAIR CEGAVSKE:
What are you calling that system?

DR. BRANDENBURG:
It is a home-grown system called Developmental Services (DS) News Organization and Web Access (NOW). It was developed by the staff at the SRC.

CHAIR CEGAVSKE:
Will all employees be able to input patient information?

DR. BRANDENBURG:
Yes, in terms of billing and tracking.

CHAIR CEGAVSKE:
Will the program information specialist design or administer the program?

DR. BRANDENBURG:
We were cited by the Legislative Counsel Bureau (LCB) during an audit because our data information system does not include ongoing tracking of consumers in the community. The position will continue to maintain this off-the-shelf system on an ongoing basis.

ASSEMBLYMAN DENIS:
Is this a database program you have modified?

MR. MOHLENKAMP:
We have an Access-based data system developed in house called DS NOW mentioned earlier by Dr. Brandenburg. This position is critical, not only to support the CPT, but also to provide necessary infrastructure to document the system and provide the levels of segregation of duties identified by the LCB as missing when they performed their audit in 2006.

ASSEMBLYMAN DENIS:
Is this position actually developing the Access database?

MR. MOHLENKAMP:
We have staff currently engaged in that process, but we need additional support to fully document the system.

CHAIR CEGAVSKE:
Could you explain why fewer positions are recommended for elimination this biennium compared to last biennium for the same reduction in the number of beds at the DRC?

DR. BRANDENBURG:
Last biennium we did not request any positions; we eliminated positions. This biennium, we have the beginning of the CPT in Clark County. We have the 11-member team in the north, and the 3 positions we are requesting in the south starts that team. As we continue to downsize, the DRC will continue to add staff.

CHAIR LESLIE:
I like the concept of the CPTs. I understand you want them in all three regions, although in rural Nevada we have never had clients in institutions. They have always been in communities. Perhaps you could address that since it is new. You will have some institutional beds for crisis situations, but are they staffed by the same team?

DR. BRANDENBURG:
We looked at several states that eliminated all their institutional beds. Many states, as they eliminated their institutional beds, built a team. The team provides support to keep consumers out of institutional beds as well as for providers and family members in the community. Occasionally, we will have a crisis and a consumer will need a respite. The team working in a proactive and preventative manner in the community will be the same team working for the adult side while we are providing emergency treatment.

CHAIR LESLIE:
Would they move in with the client?

DR. BRANDENBURG:
No. We will have four beds at the SRC set up as intensive beds to be used only as crisis-respite beds. The team members will staff those crisis beds on a shift basis.

CHAIR LESLIE:
Are they willing to perform that kind of work and community work?

DR. BRANDENBURG:
Yes. That is what other states have done. The model seems to be working. It has worked for New Mexico and Vermont. It provides continuity. It is important to emphasize the preventative side. The team will be working to avoid crises.

CHAIR LESLIE:
Who will be responsible for recruiting more providers or placing clients? Would it be the same team?

DR. BRANDENBURG:
It will be the same team. The team will be working to enhance the infrastructure. We do not have institutional beds in rural Nevada, but we have consumers who reside in rural Nevada who will sometimes go to either the SRC or the DRC and then return to the community. This crisis team will also work in rural Nevada to keep the providers and consumers in the community.

CHAIR LESLIE:
There are many miles in rural Nevada. Are team members going to spend a lot of time driving? Do you have documentation for this? I would like a better understanding of how this is going to work.

DR. BRANDENBURG:
Yes, we do. The CPT adds to the services we are currently providing at the RRC. This team will augment what staff is doing. We will provide you with the document that explains this plan.

CHAIR CEGAVSKE:
Regarding the emergency-room crisis that fluctuates, would the CPT help?

DR. BRANDENBURG:
Not really, because our population is not the one going into emergency rooms.

CHAIR CEGAVSKE:
We will next review B/A 101-3280.

HHS-Sierra Regional Center – Budget Page MHDS-64 (Volume II)
Budget Account 101-3280

The major issues in this B/A are caseload growth and wait lists. You have covered everything in that area.

We will move to B/A 101-3279.

HHS-Desert Regional Center – Budget Page MHDS-72 (Volume II)
Budget Account 101-3279

Is there anything you would like to add to the transition of 18 ICF/MR beds to community placement and the addition of 6 intensive supported-living arrangements due to the private facility closure? Is that the facility on Warm Springs and Stephanie? Did it close completely?

DR. BRANDENBURG:
We were notified the facility was closing, and we had 12 consumers there. We were not given advance notice. Our sister agency, Medicaid, was able to place six consumers. We did not want to send any of these consumers out of state, and we found placements for them. Decision unit M-542 gives us six additional intensive supported-living arrangements and closes three ICF/MRs considered institutional beds.

M-542 Mandates-Olmstead – Page MHDS-76

We will move 18 ICF/MR beds into the community which will leave us with 18 other ICF/MRs for children and adolescents.

CHAIR CEGAVSKE:
You had six children at the facility at the time of closure?

DR. BRANDENBURG:
Actually, we had 12.

CHAIR CEGAVSKE:
Has everyone been placed at this time?

DR. BRANDENBURG:
Yes. Staff and Medicaid worked hard to place them and to ensure none were placed out of state.

CHAIR CEGAVSKE:
Do you know why it closed?

DR. BRANDENBURG:
It closed due to the bottom line. Facility owners could make more money providing other services for which they could bill more hours.

CHAIR CEGAVSKE:
Can you talk about additional staff for the court-ordered services in decision unit M-602?

M-602 Court Orders – Page MHDS-76

DR. BRANDENBURG:
The Division and Department have been approached by the Las Vegas district courts and have been threatened with lawsuits because there are a number of children in Clark County who are dually diagnosed. They have mental retardation and mental illness, and they are falling through the cracks. We are working with a committee consisting of county representatives, the Division of Child and Family Services (DCFS) and the MHDS to develop a joint cooperative study. We have identified 76 children who need services. Decision unit M-602 provides the necessary support and services for the children. The ratio was predicated on the intensive caseload ratio of 1:12. These will be highly-intensive cases that need to be supervised and monitored closely. That is why we have staffing of 10 for a caseload of 76.

ASSEMBLYWOMAN BUCKLEY:
How did you derive the estimate of 76?

DR. BRANDENBURG:
It was derived by all three parties counting the individuals determined to need the services.

ASSEMBLYWOMAN BUCKLEY:
Will these be services to only children who are wards of the county or the State?

DR. BRANDENBURG:
It was more general than that. It was children the parties thought needed these services.

ASSEMBLYWOMAN BUCKLEY:
How did you derive your staffing ratio?

DR. BRANDENBURG:
We have an intensive service-coordination program at Southern Nevada Adult Mental Health Services that has a staffing ratio of 1:12 for highly-intensive cases.

ASSEMBLYWOMAN BUCKLEY:
How do you plan to deal with the age-old problem of the mental retardation side saying the problem is mental illness, and the mental illness side saying the problem is more related to mental retardation?

DR. BRANDENBURG:
An increase in staff will go a long way in dealing with that. A lot of the problem of finger pointing is due to a lack of resources. We do not have enough residential resources or funds. This particular decision unit of $997,000 the first

year of the biennium and $2.8 million the second year will provide the infrastructure we need to provide the children's program in Las Vegas.

ASSEMBLYWOMAN BUCKLEY:
There is nothing worse than a case where a child is both mentally ill and mentally retarded, in the care of the State due to abuse and neglect, and State agencies are fighting not to provide services to the child. It makes me ashamed to be a State Legislator. If it is a matter of resources, I support adding resources to serve the children.

DR. BRANDENBURG:
It is resource driven. Mr. Michael J. Willden, Director, Department of Health and Human Services, asked us to be fair. Mr. Fernando Serrano, Administrator, the DCFS and I created a memorandum of understanding (MOU) between our two divisions that clearly stipulates who is responsible for what. When our staff is not working together in a collaborative manner, Mr. Serrano and I get together and solve the problem. We have been able to do that on every case so far. I am comfortable the MOU, along with the resources, will go a long way toward alleviating the problem.

CHAIR LESLIE:
Do we have situations in northern Nevada and the balance of the State that would fall under the MOU? The way I read it, this is all directed at southern Nevada, or perhaps the judges in the north have not been as active as they could be.

DR. BRANDENBURG:
No, they have been active. The problem is larger in southern Nevada. The issue with Clark County is infrastructure. In Washoe County and rural Nevada, we have been able to deal with this issue with our current resources.

CHAIR CEGAVSKE:
We will move to B/A 101-3166.

HHS-Family Preservation Program – Budget Page MHDS-81 (Volume II)
Budget Account 101-3166

Dr. Brandenburg, could you talk about the caseload in decision unit M-200 and increased monthly payments in decision unit E-333?

M-200 Demographics/Caseload Changes – Page MHDS-81

E-333 Services at Level Closest to People – Page MHDS-82

DR. BRANDENBURG:
This program has proven to be not only cost effective but extremely important. The purpose of the Family Preservation Program is to provide monthly cash assistance to families that care for family members with severe or profound development disabilities. This helps individuals with disabilities to remain at home with their families and not require institutional care. To qualify, families must have an income less than 300 percent of poverty. In decision unit M-200, payments to families of $350 a month amounts to less than $12 a day. The

cost for institutional beds is between $350 and $450 a day. At any given time, if family members wanted, they could ask for their loved one to be institutionalized. Currently, our caseload is 458 profoundly- and severely-retarded individuals who are living with family members in their community. The addition of 126 families under this decision unit provides the caseload growth we need to help disabled family members remain at home. Not only does this program provide families some degree of support, it also maintains the integrity of the family. We are requesting a $12-a-month cost-of-living increase in each year of the biennium to be built into this budget on an ongoing basis. It is an extremely important program, and I urge the Committee's continued support.

ASSEMBLYMAN DENIS:
In this particular program, do we find the care individuals receive is equal to or better than they would receive in an institution?

DR. BRANDENBURG:
Yes. I wish I could tell you we could love our consumers the way parents love their family members at home. There is an incredible amount of affection and support from family members. We provide great care, but there is no way we can match the care a family member gives to their loved ones in their home. There is no comparison.

ASSEMBLYMAN DENIS:
Do we also find we have cost savings, overall, when the family is providing care in the home?

DR. BRANDENBURG:
Absolutely. If the families were not taking care of these 458 individuals, there is no way I could downsize the DRC or the SRC.

ASSEMBLYMAN DENIS:
Is there a wait list for this program?

DR. BRANDENBURG:
Yes, there is a wait list. The way the program was developed, we would have a $350 maximum. The person would come in, and because it was a dollar allocation we could not exceed, the dollar amount would decrease on an ongoing basis. Last Legislative Session, we could come before the Legislature and get a supplemental increase to maintain the $350 payment and come in for additional resources as we brought on additional family members.

CHAIR LESLIE:
On the supplemental request that is coming forward, is it going to be approximately $60,000? Do you have new information in that regard?

MR. MOHLENKAMP:
The supplemental request will be about $40,000.

CHAIR CEGAVSKE:
We will next cover B/A 101-3167. Is there anything you have not covered in this account?

HHS-Rural Regional Center – Budget Page MHDS-84 (Volume II)
Budget Account 101-3167

DR. BRANDENBURG:
No. The decision unit E-900 is the positions in the CPT.

CHAIR CEGAVSKE:
We will move to B/A 101-3164.

HHS-Mental Health Information System – Budget Page MHDS-91 (Volume II)
Budget Account 101-3164

You are asking for a new position and a position transfer from the MHDS Administration under decision unit E-252.

E-252 Working Environment and Wage – Page MHDS-93

MR. MOHLENKAMP:
We are adding the IT professional position to provide direct support for the SAPTA when they move over as part of the merger. They will become part of the MHDS, from a fiscal and IT perspective, beginning July 1, 2007. We will need the support to continue providing IT services to the SAPTA.

CHAIR CEGAVSKE:
Are you going to integrate that with the five technology positions you currently have in that account?

MR. MOHLENKAMP:
Yes. They will be integrated and report directly to our head of IT. They will provide direct support to the SAPTA's two major systems in addition to providing technical support on an ongoing basis.

ASSEMBLYMAN DENIS:
Since 2003, with the positions you are requesting, you will have had a 100-percent increase in IT personnel. Have things changed so much that you had to double the number of IT personnel?

DR. BRANDENBURG:
We implemented the AVATAR software system on the mental-health side. We have an integrated management information system that integrates billing, a pharmacy system with inpatient and outpatient services for all three regions, standardized and integrated, and we have a clinical workstation for all regions. Our infrastructure is lacking when it comes to maintaining the clinical workstations, the AVATAR training and the ongoing management system. We are now being requested to review the SAPTA's data system including data elements, data dictionary and wait lists. The only way we will be able to do that is to have the IT person on that side integrate with our staff. It is going to be a team effort.

ASSEMBLYMAN DENIS:
Are your IT people in one location, or are they spread out to provide support where needed?

DR. BRANDENBURG:
Both. There are IT personnel in the central office to provide oversight and in each of the major locations.

ASSEMBLYMAN DENIS:
Are IT people traveling a lot with associated travel costs?

DR. BRANDENBURG:
I still must have people travel, especially in the rural clinics. There are 16 sites. A problem we are facing from an IT perspective is maintaining training in rural locations.

ASSEMBLYMAN DENIS:
Do you have any remote support?

DR. BRANDENBURG:
We are reviewing that option and providing remote support where we can. We are doing everything we can to maximize our efforts with existing resources.

CHAIR CEGAVSKE:
We will next discuss autism services. Could you talk about the pilot program initiated in FY 2005-2006?

DR. BRANDENBURG:
The autism pilot project targeted services to the highest-risk children with autism during their critical developmental period between the ages of two and ten. The aim of the intervention was to allow families most severely affected by autism access to additional therapies, interventions and support. Research has shown the earlier the intervention, the greater the impact on the child's future skills, language acquisition and the possibility of decreasing the need for long-term behavior intervention. We decided to use funds from the Temporary Assistance for Needy Families (TANF) to develop a pilot program. Currently, we have 52 individuals in the pilot program, and we have a wait list of 24. The families participate in a self-directed program in which they choose the type of services they want. If they wish, they can use money for behavior intervention or speech therapy and so forth. To qualify, participants must be at 500 percent of the federal poverty level. The average monthly allocation for families is currently $1,100 a month. The age for pilot program participation is between two and five. Between those ages, families receive up to $1,200 a month. Between the ages of six and eight, families receive $800 a month; between the ages of nine and ten, families receive $600 a month.

CHAIR CEGAVSKE:
You indicated you used funding approved for the TANF for the autism pilot program. Did that take funding for services from the TANF families?

DR. BRANDENBURG:
No. We met our obligations in terms of caseload, and if there were funds remaining, we brought in the family members.

CHAIR CEGAVSKE:
Can you tell us the expected goals and outcomes as a result of the pilot project and to what extent goals and outcomes have been achieved?

DR. BRANDENBURG:
One major goal is keeping families intact. Family members who have an autistic child are subjected to a great deal of stress. Another is assisting families with this extremely debilitating disorder, providing funds to enable them to secure behavior-intervention therapy, speech therapy, occupational therapy or a respite. Family members in the program we have spoken to praise the program and have reported a vast improvement in their autistic children's behavior due to early intervention. Without early intervention, the likelihood of the child acquiring language and social skills at an older age diminishes greatly.

CHAIR CEGAVSKE:
The testimony heard last Legislative Session regarding success of the autism program was incredible. How many families do you intend to include in the pilot program?

DR. BRANDENBURG:
I do not have a number but will meet with staff and provide it to you.

CHAIR CEGAVSKE:
Have you determined an end date for the pilot program?

DR. BRANDENBURG:
If we receive the requested funding, we will continue the pilot program on an indefinite basis.

CHAIR LESLIE:
The enhanced decision unit did not come forward in the budget. In that decision unit, we talked about intensive behavioral intervention. Is the intensive behavioral intervention in the pilot project similar to the self-directed program?

DR. BRANDENBURG:
Yes.

CHAIR LESLIE:
Was the pilot project your agency's response to the fact we did not fund that decision unit?

DR. BRANDENBURG:
Yes. We were approached by many family members. We had to make a decision. We knew the decision unit we had put forward for autism did not get funded, but the need was still there. My staff, being creative, looked at ways to use existing resources without affecting caseloads, the families and legislative intent, to provide the services.

CHAIR LESLIE:
The intent of this Subcommittee last Legislative Session was to fund the decision unit. However, we ran out of money. Did you say the TANF requirement is 500 percent of poverty? We rarely get to 500 percent; we are

usually trying to get around 133 percent. I am not clear in my mind what 500 percent of poverty means. I know many working families have a difficult time affording $1,200 a month. Are there families we are not serving because of that 500-percent cutoff?

DR. BRANDENBURG:
I am certain there are.

CHAIR LESLIE:
How many are there, and do you hear from those families?

DR. BRANDENBURG:
I do not have that figure with me, but I can provide that to you. There are people who will qualify because they meet the criteria, and there are those who will not.

CHAIR LESLIE:
We have a Committee bill from our policy committee in the Assembly Committee on Health and Human Services. We have been meeting with Mrs. Gibbons and some of the parents, and we will be holding a hearing on autism. Some of the information we have heard today will be discussed in that hearing as well.

ASSEMBLYWOMAN BUCKLEY:
Is the average cost of the program $5,000 for each family?

DR. BRANDENBURG:
It is $1,100 a month.

ASSEMBLYWOMAN BUCKLEY:
On an annual basis, the cost is $12,000?

DR. BRANDENBURG:
That is correct. In FY 2005-2006, we spent $221,766. In FY 2006-2007 up to December 2006, we spent $310,888.

ASSEMBLYWOMAN BUCKLEY:
That is a lot of money for each family. By pooling our resources, is there any way we could expand the number of families served? For example, if there is one provider most families find is best, offer an exclusive-provider contract if the provider would serve an increased number of families. In that manner, we could use our funds in the most cost-effective manner to help more families.

DR. BRANDENBURG:
That is something we can explore.

ASSEMBLYWOMAN BUCKLEY:
How did most families use the money?

DR. BRANDENBURG:
Over 50 percent of the funds are being used for behavioral intervention training.

ASSEMBLYWOMAN BUCKLEY:
Is there one provider for most of that training or is there a list of providers?

DR. BRANDENBURG:
I am certain I can provide a list for you.

ASSEMBLYWOMAN BUCKLEY:
I would like a one- or two-page list of what the money is being spent for to get a better sense of the services and whether we can provide more help to more people.

ASSEMBLYWOMAN WEBER:
In your professional opinion, do we have enough services to provide families in the areas of behavioral, speech, occupational and respite care, or do we find some families have to go out of state for treatment?

DR. BRANDENBURG:
There are families that must go out of state to receive treatment. I can provide that information to you. My professional sense is treatment resources in our communities are sorely lacking. Families that have the resources are able to secure services out of state. Families that lack resources are struggling.

CHAIR CEGAVSKE:
I have communicated with parents who have told me they either hire someone who comes from California to provide services or they go to California for services.

SENATOR MATHEWS:
How can I quickly obtain information from the State? Is there a central location to obtain information regarding resources available in the State?

DR. BRANDENBURG:
Mr. Willden has created an autism fact book available to anyone who wants it. I will give you my copy today.

SENATOR MATHEWS:
As you stated, people with resources go out of state. I know a few residents who have utilized the University of Nevada, Reno (UNR) Education Department who learned about it by word of mouth. We need a contact with the State to guide people to resources.

DR. BRANDENBURG:
The services cut across a variety of agencies and disciplines. Services are being provided by the UNR and private foundations. I will ask staff to compile a list and post it to our Website.

SENATOR MATHEWS:
There are autism support groups that could be included as well.

ASSEMBLYWOMAN SMITH:
Does the Nevada 2-1-1 line have resource information?

DR. BRANDENBURG:
I do not know but will find out for you.

SENATOR RAGGIO:
Dr. Brandenburg, I want to compliment you on the decision you made to fund this to the extent to which you were able. This Subcommittee heard compelling testimony last Legislative Session. We made this request a matter of special consideration to be given a high priority when we closed budgets. I suggest we do the same this session. The request in the 2005 Legislative Session was approximately $4.5 million for a program. Since that time, the incidence of autism has been found to be much more prevalent than originally believed. The $4.5 million request contained positions and program funding. If that were requested today, can you furnish us with an appropriate amount to implement a program and reduce the wait list? Was a request made this session?

DR. BRANDENBURG:
Yes. The request was in decision unit E-334. Unfortunately, due to the cap and because of other priorities within the Division and Department, it did not make the Governor's list. However, decision unit E-334 was for $4,517,415 of General Funds, serving 147 clients.

SENATOR RAGGIO:
In addition to that, is there any federal money available?

DR. BRANDENBURG:
There was a potential to receive federal funds in the second year because we were going to request a waiver, a portion of which are federal funds.

SENATOR RAGGIO:
Is there still a potential for applying for a waiver?

DR. BRANDENBURG:
There is definitely a potential of applying for a waiver, but all new waiver applications are receiving a great deal of scrutiny, and there is no guarantee the federal government would accept it.

SENATOR RAGGIO:
It was disturbing to me that we did not fund the autism program in the 2005 Legislative Session, and it is not quite accurate to say we ran out of money. During budget closings, the Senate was willing to fund this program with half the money available for appropriation from the two Houses. The Assembly was not. I want to reestablish the high priority of this program.

SENATOR TITUS:
I understand the Nevada System of Higher Education (NSHE) received a federal grant of approximately $1 million to establish a study center to conduct research and provide services for autism. Are you working with the NSHE on that project?

DR. BRANDENBURG:
I am unaware of that project.

SENATOR TITUS:
Can you get more information about that program and coordinate and work with them?

DR. BRANDENBURG:
I will direct staff to do that and will let the Subcommittee know what we discover.

SENATOR MATHEWS:
I know there are families with multiple family members diagnosed with autism. Do you pay the family $1,100 for each autistic child? I see people in the audience nodding their heads indicating the answer is yes. When you put information onto your Website, can you tell us what is happening in southern Nevada? I understand there are services available in southern Nevada that are not available in northern Nevada.

DR. BRANDENBURG:
Yes. We will make the information available statewide.

ASSEMBLYWOMAN BUCKLEY:
I do not want the impression to remain the Assembly does not support treatment hours for families with autism. I had the honor of working with a number of families when I sponsored A.B. No. 280 of the 70th Session to prevent the use of aversive techniques on children with autism. At the time, children were having ankle weights put on their legs and told to run on a treadmill to tire them out to prevent them from getting up from their seats during class. Members of this Subcommittee from the Assembly last Legislative Session were just as passionate and committed to seeing funding for autism approved. I was not on the Assembly Committee on Ways and Means last session, and I do not know what the debates were. What is most important is we send the message to these families their issues are important to all of us.

SENATOR RAGGIO:
I appreciate that. The fact is this Subcommittee last session did put autism funding as a high priority and for special consideration. When we got to the closing days of appropriating funds available to both Houses, the Senate agreed to fund half of it. Let us put that behind us. I accept what you are saying. Let us make this a high priority, and when we get down to closing budgets, whether there is an amendment from the Executive Branch or not, make this a high priority. This has a higher priority than many other appropriations being suggested that are not in the *Executive Budget*.

CHAIR CEGAVSKE:
I will open the hearing to public comment.

JACK MAYES (Chairman, Strategic Plan Accountability Committee, Department of Health and Human Services):
I sent a letter to Senator Raggio, Chairman of the Senate Committee on Finance, and to Assemblyman Arberry, Chairman of the Assembly Committee on Ways and Means, expressing our concern about autism services and the fact it has been our number one priority for the last two sessions. I see the commitment and hope you shepherd that through the system.

JAN CRANDY (Vice Chairman, Strategic Plan Accountability Committee, Department of Health and Human Services):
I am a member of the Autism Coalition of Nevada. We are requesting an amendment to the autism budget decision unit that states the eligible age for autism benefits is from two to ten years old. We are requesting the screening age be changed to 18 months of age.

BRIAN M. PATCHETT (President/CEO, Easter Seals Southern Nevada):
The largest group we serve is children with autism. It is a growing need. You have the full support of Easter Seals Southern Nevada.

LAVONNE BROOKS (CEO, High Desert Industries):
We provide support to individuals with disabilities, many of whom have autism. We are concerned about planning for the future. I agree with Senator Titus that we need collaboration with all providers of autism services. This particular tide of mental/intellectual disability has grown exponentially to the extent where we know we need to act. We need a plan of action that collaborates and utilizes the existing systems. For example, we have a statewide system for delivering services to people with intellectual disability. The challenge for us is to be connected through proper training. It would be unfortunate to fund an entirely separate program when we already have existing infrastructure. There is a great program for autism at the UNR, yet they have precious little resources by way of a facility for the program. This is a systemic issue and we need to think into the future around systemic solutions. A one-provider solution will not work. We all need to train our staffs to deal with this issue. I also agree that 18 months should be the assessment age.

CHAIR CEGAVSKE:
When Assemblywoman Weber asked about out-of-state resources, you were shaking your head yes. Did you wish to comment on that?

MS. BROOKS:
I have a handout entitled "Washoe Arc, CTC Provider Rates and AB 513" (Exhibit D). If you recall, A.B. No. 513 of the 71st Session was the study about autism that stated it is a systemic issue that is not going away. Families move here, and are finding they have to move to other states where services are better provided.

CHAIR CEGAVSKE:
What services are bringing staff into Nevada? I have heard there are people who will travel to Nevada to help. What positions are they?

MS. BROOKS:
These are people trained in the early-intervention techniques that are intensive and expensive.

MS. CRANDY:
The Clark County School District is funding approximately 82 children for a program in which out-of-state providers are being brought to Nevada at a cost of at least $1,000 a month. That is for supervision in setting up their applied behavior analysis home program. There are also families bringing in providers independently.

CHAIR CEGAVSKE:
I had heard families were unable to find providers in State. You indicated people were moving away, but I heard they were staying and bringing services into Nevada from out of state.

MS. CRANDY:
There are now companies in southern Nevada that have set up shop and are doing business in Nevada. There are also a few in northern Nevada but not many.

CHAIR CEGAVSKE:
Could you work with our staff and provide the names of those organizations and the positions to see if the NSHE is providing similar services?

MS. CRANDY:
The UNR has a behavior program through the psychology department and they provide certification. Mr. Matthew Tincani, at the University of Nevada, Las Vegas, is certified and can provide certification.

JON L. SASSER (Washoe Legal Services and Nevada Legal Services):
I want to clarify we are discussing two separate programs. One is the proposal that did not make it last Legislative Session and is reflected in decision unit E-334. It is an expansion of the current waiver for people with mental retardation and related conditions to add autism services to that waiver. That population includes people most severely impacted by autism to the degree they would need institutionalization if it were not for this waiver. Because it is a Medicaid waiver, it is limited to lower-income individuals, at 300 percent of Supplemental Security Income and below, much below the 500 percent of poverty, the criteria of the current pilot program. That is the program that did not receive funding. The pilot program that filled in the gap covers higher-income individuals and is more flexible because it is not limited to those so severely impacted they need institutionalization. There is a need for both programs.

CHAIR CEGAVSKE:
We will move to discussion of the SAPTA.

TAMMRA PEARCE (Executive Director of Bristlecone Family Resources):
I will read from written testimony (Exhibit E). Bristlecone Family Resources has been operating in the community for the past 40 years. It is a 38-bed facility that serves more than 500 outpatient clients at one time. The past year has been a difficult one for Bristlecone. An internal evaluation of the programs by the Board of Directors revealed our adolescent treatment program, known as SageWind, was losing approximately $150,000 a year. We consulted with the SAPTA to determine if additional funding was available and were told it was not. As a consequence, we suspended services and transferred clients to another agency.

Shortly after this decision was made, it was time for us to submit our grant request to the SAPTA for funding of our adult detoxification, residential and outpatient programs. Of the $1.3 million requested, we were awarded $800,000, a $500,000 cut that represented a 38-percent reduction in our

primary funding. To adjust to our new funding level, we cut staff positions and eliminated 12 beds, a 24-percent reduction in services. With the support of our board and community, we have made it work. We have generated slightly more than $100,000 through fund-raising and private grant-writing efforts.

We must relocate our facility because our current site is in the process of being acquired by the Washoe County Flood Control Project. The city of Reno has stepped up to assist us in identifying a vacant building or empty lot for our new home. Our goal is to provide 50 beds in the hope we can find funding to restore services lost over the past year. It costs our agency approximately $70,000 a year to operate a bed, about $190 a day. We receive $36,000 a year from the State to operate each bed. That represents a 52-percent reimbursement rate for services. We filled a gap with internal efficiencies, fund-raising, private donations and by soliciting a large amount of in-kind contributions from community members for things such as food, clothes and linens for the clients and some professional services.

While the budget before you represents an improvement for treatment agencies like Bristlecone, the need is great and continues to grow. Our biggest concern is the issue of stable funding. Providing a caseload growth formula in the budget would help address this issue and allow for stability. Substance-abuse treatment is the only human services program in the State that does not have a formula for caseload growth. We are experiencing a treatment crisis, and the costs are severe in terms of crime, homelessness, domestic violence, child abuse, lost productivity and more. I urge you to do whatever you can to expand the capacity for treatment in our State and help ensure a stable source of funding for these important programs.

ASSEMBLYWOMAN LESLIE:
You said you made it work, but making it work still meant losing 12 beds.

MS. PEARCE:
That is correct. We lost 12 beds and approximately 6 counselors who were providing not only residential treatment but outpatient treatment as well. We have huge caseloads and a new data system provided by the SAPTA which is a new learning process. Our caseloads are from 20 to 40 people.

ASSEMBLYWOMAN LESLIE:
You made it work by staying in business. The citizens of northern Nevada lost access, but in southern Nevada we take people from all over the State. The whole system is so under funded and under capacity that everyone sends their client to whatever bed happens to be available or whoever has the shortest wait list.

KEVIN QUINT (President, Nevada AADAPTS):
The acronym AADAPTS stands for Nevada Alliance for Addictive Disorders Advocacy, Prevention and Treatment Services. We represent many of the SAPTA-funded providers. I distributed a handout titled "The Treatment Need in Nevada" (Exhibit F) which is a cover page for my written testimony. I would like to reiterate something that is a familiar refrain from our field, "Treatment works." With the advent and proliferation of evidence-based treatment practices, the field is making even greater strides in effectively treating

substance-use disorders. For example, people with methamphetamine problems are treated at all 61 sites in 26 communities funded by the SAPTA. Of those completing treatment, 90 percent do so without substance abuse at discharge. That is good news. However, the need keeps growing. According to the 2006 SAPTA *Biennial Report*, 2,226 people last year in Nevada waited an average of 24 days for substance-abuse treatment. Nevada AADAPTS performed a survey in 2006 that found over 100 individuals requesting treatment each week in Nevada never scheduled an appointment due to the approximate three-week wait for a first appointment.

According to numbers of people estimated to be in need of treatment in Nevada, the total unmet treatment need is over 146,000 adolescents and adults. Even if only 20 percent were willing to seek treatment, that is almost 30,000 people. In FY 2005-2006, programs funded by the SAPTA treated 11,354 clients. Simply stated, there is not enough treatment available to even address the existing wait lists. Telling a person on methamphetamine to wait three weeks for treatment is like telling a person in the emergency room who is bleeding to death to hang on and try a little harder. We need to review our requests for treatment as emergent requests. People who do not receive treatment commit more crime, have more health-care costs, less employment and incur more damage and human suffering.

Nevada AADAPTS supports the $3.8 million increase in wait list-related treatment funding for the biennium in decision unit E-413.

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We need even more than the $3.8 million. Our treatment systems are greatly impacted by the State's ever-growing population and by an advancing drug problem fueled by methamphetamine issues. As wait lists grow, treatment programs become similar to battlefield triage in that the worst are treated first. These are the people who are the most expensive and complex to treat. Those on the wait lists, who are not quite as severe or expensive to treat, have to wait until they may progress further and their problem becomes more severe and expensive to treat. As the problem grows, treatment capacity has decreased. Last year a major treatment center in Las Vegas closed with a loss of over 50 residential beds. The front page of Exhibit F shows there are 637 beds statewide. Considering the need and the fact every residential program has long wait lists, this is not enough. Nevada ADDAPTS is also encouraged to see a $3 million increase for the biennium in treatment funding to address co-occurring disorders. This is a great start, but again, we need more. We know there are more than 135 individuals with co-occurring disorders in the State.

In conclusion, it is imperative adequate funding be allocated to cover existing wait lists. Finally, caseload growth formulas need to be built into this budget so the Nevada substance-abuse treatment system can grow with our population and with the need.

CHAIR CEGAVSKE:
Everyone on this Committee can relate to a family member or a friend of someone who has talked to them about drug or alcohol addictions and the devastation. Unfortunately, it seems to be more prevalent and we are talking

about it more than in the past. It is good we are talking about it, but our biggest issue is treatment and getting addicts to want treatment.

CHRISTY MCGILL (Statewide Partnership of Coalitions):
I am going to shift your attention to prevention. The coalitions across the State are different than agencies. They represent multiple sectors in a community. For example, typical coalitions include law enforcement representatives, school districts, county human services, parents, youth and other citizens. We are concerned because our State-incentive grant that we work with the SAPTA is ending. In prevention, we look at programs that have breadth and depth. The breadth programs are media campaigns, marketing, social norms and so forth.

The other aspect of prevention is the depth aspect. That is what the State-incentive-grant funded communities do. The communities got together and asked which populations of our youth are most at risk and what type of evidence-based prevention programs we could bring into the community. We did that, and it was a success. With the State-incentive grant we served over 95,000 youths. This type of program is the most painful for communities to lose. Examples of programs include an after-school program in Lyon County, and a program for the Boys and Girls Club called "The Passport to Manhood" which provides male mentors for young men experiencing difficulties. There are many creative programs throughout the State to ensure young people have what they need to succeed and attain a high quality of life. We hope you consider partnering with local communities to continue this program and continue empowering communities to target populations of youth at greatest risk to ensure they have prevention programs to keep them out of treatment programs.

BEVERLY LASSITER (Big Brothers Big Sisters of Northern Nevada):
I will read from my written testimony (Exhibit G). I am here to show appreciation for Governor Gibbons' General Fund increase for prevention for the first time since 1999. This SAPTA funding is an important step in preventing substance-abuse problems that plague Nevada. At Big Brothers Big Sisters of Northern Nevada, 100 percent of new families enrolled in the past six months have had substance-abuse problems in the family. Research and our experience show children who are matched with a Big Brother or Big Sister volunteer mentor are less likely to initiate drug or alcohol use. I would like to share one local story with you.

When we first met Joey, age 10, he had already been in 14 different elementary schools. His family was continually being evicted from their housing for nonpayment of rent. He was withdrawn, sullen and disengaged in school. His mother, father and stepfather were all in prison. They had alcohol, drug and gambling problems. His Big Sister would spend time with him each week doing simple activities like having lunch together, playing Frisbee or chess or reading. Each week, Joey acted surprised to see her. She eventually realized Joey did not believe she would come back each week since no adult had ever kept promises made to him.

After about six months, Joey asked his Big Sister if she could change her day from Tuesday to Friday to visit him. When she asked why, he explained this was the best thing in his life and he wanted something to look forward to all

week. It was then she knew trust was forming. Early on, Joey told his Big Sister he thought all adults had alcohol or drug problems. That had been his reality. When she told him she did not, and there were hundreds of other Big Brothers and Big Sisters in Reno and Sparks who did not have those problems, he was surprised there were that many people in our community without those problems.

Through his Big Sister, Joey has been exposed to her friends, colleagues and other positive adults in the community, and he is learning there are others besides his Big Sister who make healthy choices. Now when you meet Joey, he confidently reaches out and shakes your hand, makes eye contact and has a big smile. When he gets into his Big Sister's car, he talks nonstop about his life, friends and goals for the future. Joey is one example of the children whose lives we are changing every day at Big Brothers Big Sisters. Prevention funding will enable us to change more lives like Joey's.

MICHAEL POMI (Director, Washoe County Juvenile Services and President, Nevada Association of Juvenile Justice Administrators):
I am testifying in support of the SAPTA's request for enhanced funding under decision units E-413 and E-414 for the treatment of individuals with co-occurring substance and mental-health disorders. In our system, we perform a screening in Clark and Washoe Counties and in the rural communities called the "Mazy." We found approximately 25 percent of our deep-end juvenile justice youth could be described as having co-occurring substance-abuse and mental-health disorders. Should this funding be approved, it is the intent of Washoe and Clark Counties and the rural communities to work with the SAPTA and the DCFS to gain an understanding of and develop a statewide evidence-based approach to implement necessary programming for this population.

SCOTT SHICK (Douglas County Juvenile Services and the Nevada Association of Juvenile Justice Administrators):
We support the co-occurring disorder proposal and would like to participate in the pilot program since youth coming into our offices often display both mental-health and substance-abuse disorders. If we could approach them at that level and resolve the problem, we would have a direct impact on what we do in the juvenile justice system. I also encourage the Committee to support the prevention systems. The BADA trained us in how to organize prevention programs with good outcomes and a strong foundation in our rural and urban jurisdictions. We would like to see it enhanced so we can build on it and continue the efforts we have started within the last ten years. I would also like to emphasize the high impact of methamphetamine abuse on young women in Nevada. We wish to participate in addressing this tragedy.

CHAIR CEGAVSKE:
You have hit on something near and dear to me. I have a niece whose methamphetamine abuse started in high school; it had to do with weight. This was an easy way to reduce her appetite but brought addiction with it. She is 28 years old and still struggling with the addiction.

MR. SHICK:
Gender-specific services can help these young women with their methamphetamine addiction and related problems.

DICK STEINBERG (President and CEO, WestCare Nevada, Inc.):
I am pleased to see there is a request to increase the budget. Twenty-five years ago, I came before this same Subcommittee. Senator Raggio and Assemblyman Marvin Sedway co-chaired the hearing. At the time, there was a commercial about changing your oil that said, "Pay me now or pay me later." Assemblyman Sedway said if we do not take a serious look at this, we will be paying in many different ways later. Funding over the last 25 years for drug treatment, on a national and state basis, has been all right. However, when these types of budgets are not increased, one taxpayer cost that continues is for law enforcement. Seventy percent or more of the people in prison, nationally and in Nevada, are there due to drug problems. That does not get put into the equation. Taxpayers in the United States and in Nevada are paying a tremendous amount for untreated situations. The slight increase in the SAPTA budget is great, but those of us in the business see it as a drop in the bucket for people waiting for treatment services.

ED GUTHRIE (Executive Director, Opportunity Village):
I have provided a handout entitled "Opportunity Village CTC Provider Rates and AB 513" (Exhibit H). I would like to address the DRC budget on two issues. One is A.B. No. 513 of the 71st Session. A study from that bill, specifically requested by Senator Raggio and Assemblyman Arberry, was conducted on community training centers and supported-living arrangements. We also conducted a general study of all Medicaid rates in the State of Nevada. A third study, on autism, was mentioned earlier. The study requested by Senator Raggio and Assemblyman Arberry projected rate increases, as needed, in 2002 and 2003. We are within striking distance of reaching those rates if we continue adding to the rates currently being paid. For example, with the JDT program, if we had a 3-percent increase in 2008 and a 3-percent increase in 2009, we would approach 99 percent of the rates recommended four years ago. The same reasons for which Senator Raggio and Assemblyman Arberry requested the rate study are still valid. People with developmental disabilities do best when they have low turnover in staff, and raising wages on a regular basis helps maintain staff and reduce turnover.

The second issue is the wait list. I thought I heard Dr. Brandenburg say there are about 25 people on the wait list for the JDT services. My numbers do not match those numbers. In a report by the MHDS, supplied to the Commission on Mental Health and Developmental Services for the period ending September 30, 2005, there were 134 people on the JDT wait list. On January 25, 2007, there were 174 people on the JDT wait list.

CHAIR CEGAVSKE:
We were given the figures of 25 for the DRC and 12 for the SRC wait lists as of June 2006.

MR. GUTHRIE:
Currently, according to information supplied by the LCB, there are 174 people on the wait list. There appeared to have been 134 at the end of September.

Forty people have been added to the JDT wait list in southern Nevada in a four-month period. The wait list for this service appears to be growing in an exponential manner. I understand the Division has moved some funding and will be able to serve another 100 people and move them off the wait list. That is great; it will reduce the wait list to 74. However, if ten people a month are added to the wait list, we may not have enough money in the budget to reduce the list any time soon. On page 3 of Exhibit H, there is a picture of a number of people forming an "O" and a "V." That is a visual representation of all the people on the wait list for the JDT services in southern Nevada.

JAMES L. MEYER (President and CEO, Washoe Arc):
I moved to Nevada four years ago when A.B. No. 513 of the 71st Session was being implemented and am pleased to see the Legislature and people of Nevada recognize the need to increase funding and rates for community training centers (CTCs) providing services to people with disabilities. I would like to add to what Mr. Guthrie said about one of the reasons for trying to raise wages for people we hire, particularly those in our direct care. At Washoe Arc, we have increased entry-level direct-care positions by over 20 percent since receiving increased funding.

One of the things you hear daily at the Legislature is the request for money. Human service agencies and networks need to be able to share with the community and the Legislators the impact we have in the community. In addition to the valuable quality services we provide to people with disabilities and involving them in the community, we are an excellent community partner. In FY 2004-2005, we received approximately $1 million from the State of Nevada to provide services to 150 people. We returned to the community over $3 million: $1.5 million in staff payroll, $362,000 in payroll to people with disabilities, $466,000 in rent, over $100,000 in utility costs, $137,000 in advertising and almost $12,000 in fuel for our vehicles. When people question you about the money you spend, we multiply that five times in our return to the community.

LESLIE SPRACKLIN (Fallon Industries):
I have provided a handout entitled "Fallon Industries Serving Churchill and Lyon Counties" (Exhibit I). We provide services in Churchill and Lyon Counties for children, adults and seniors with disabilities. We are now building a program starting with three individuals with autism. I want to draw attention to the rural communities and the fact an increase in the CTCs and supported living is justified and badly needed. We have spent years building these programs and service providers. To slide backward would be detrimental to everything we have done.

MS. BROOKS:
I would like to talk about residential-care services. Please refer to the middle of the first page of Exhibit C. Chair Cegavske, earlier you asked why the ICF/MR facility in Las Vegas closed. The chart in the middle of the page gives you an idea of the cost to serve one person a day in residential care. This does not cover intensive support, but 24-hour-a-day support. This shows the most recent dollars as a result of the raise in the minimum wage. At the High Desert Industries (HDI), we lose money on a contract of this nature. On page 5 of Exhibit C, the highlighted rows reflect the provider-rate increase for residential

services which reflects a 3-percent increase over the next two years. Originally, we were being considered as providers to be included in the increase but were later removed from the budget.

Another challenge is nursing-care hours were pulled from our contracts with regard to residential services. We are required by the Medicaid waiver to have nursing oversight of medications, assessments and so forth. We are wondering what happened to that funding in our contracts. We now have to ask for those funds.

CHAIR CEGAVSKE:
We will ask staff to find out and provide that information to you.

BRIAN PATCHETT (Easter Seals Southern Nevada):
I support a rate increase for both the CTCs and supportive-living arrangements. Easter Seals Southern Nevada and Easter Seals Sierra Nevada provide some of these services, but with the rise in the cost of living, it is difficult to hire and retain quality staff.

DONALD STROMQUIST (Easter Seals Sierra Nevada):
Currently, our main issues are retaining staff and training staff to improve the system. The lack of a rate increase would cause major barriers to those goals.

CHAIR CEGAVSKE:
There being no further business to come before the Subcommittee, the meeting is adjourned at 10:52 a.m.

RESPECTFULLY SUBMITTED:

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Jo Greenslate,
Committee Secretary

APPROVED BY:

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Senator Barbara K. Cegavske, Chair

DATE:____________________________________

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Assemblywoman Sheila Leslie, Chair

DATE:____________________________________