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

Seventy-ninth Session
March 9, 2017

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 8:06 a.m. on Thursday, March 9, 2017, in Room 3137 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Moises Denis, Chair
Senator Joyce Woodhouse
Senator Ben Kieckhefer

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblyman Paul Anderson
Assemblyman Nelson Araujo
Assemblywoman Irene Bustamante Adams
Assemblyman Jason Frierson
Assemblyman James Oscarson
Assemblywoman Robin L. Titus

STAFF MEMBERS PRESENT:

Alex Haartz, Principal Deputy Fiscal Analyst
Cindy Jones, Assembly Fiscal Analyst
Karen Hoppe, Senior Program Analyst
Mary Sullivan, Committee Secretary
Barbara Williams, Committee Secretary

OTHERS PRESENT:

Mary C. Walker, Carson City, Douglas, Lyon and Storey Counties
Amber L. Howell, Director, Washoe County Department of Social Services
Kelly Wooldridge, LCSW, Administrator, Division of Child and Family Services, Department of Health and Human Services
Resha Powell, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services
Jason Benshoof, IT Manager III, Division of Child and Family Services, Department of Health and Human Services
Paula Hammack, Acting Director, Clark County Department of Family Services
Ryan Gustafson, Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services
Dan Musgrove, Chair, Clark County Children's Mental Health Consortium
Jared Busker, Policy Analyst, Children's Advocacy Alliance

CHAIR DENIS:
Is there anyone wishing to make public comment before we hear the agenda budgets?

MARY C. WALKER (Carson City, Douglas, Lyon and Storey Counties):
I represent Carson City, Douglas County, Lyon County and Storey County. Senate Bill No. 480 of the 76th Session required rural counties to pay an assessment to the Department of Health and Human Services (DHHS) for the cost of providing child protective services (CPS). The term does not include foster care service or services related to adoption, which are child welfare services. The assessment for CPS began in fiscal year (FY) 2011-2012, and for four years the rural counties paid the assessment.

During the 2015 Legislative Session, rural counties were notified the CPS assessment would increase by 50 percent. When questioned further, DHHS discovered an error in the assessment. It included costs for child welfare services. The Governor's Office and DHHS submitted a budget adjustment to correct the error, but it was not funded. Therefore, over the past two years, the smaller, poorer rural counties had to pay the assessment in error.

Over the past year, I worked with DHHS staff to eliminate the error. Today, I am here on behalf of my four counties to support the Governor's Child Protective Services budget and the rural county assessment.

AMBER L. HOWELL (Director, Washoe County Department of Social Services):
I want to make some comments regarding the specialized foster care (SFC) pilot in Washoe County. In 2011, the child welfare agencies came before the Interim Finance Committee with a business plan to shift basic skills training (BST) dollars to help support redesigning the SFC system.

Washoe County has served 148 children thus far. We had 58 percent reunified, 18 percent adopted, 15 percent discharged to relatives and 10 percent aged out as stable and successful. This data supports the model and proves it is keeping children stable and achieving permanency.

I wanted to thank the money committees and those who were in the last three Legislative Sessions for placing trust in our agency and allocating the resources. This allowed us the necessary funds to do something different and creative that has worked very well in Washoe County.

KELLY WOOLDRIDGE, LCSW (Administrator, Division of Child and Family Services, Department of Health and Human Services):
My budget presentation (Exhibit C) contains an overview of the Division of Child and Family Services (DCFS) within DHHS. Page 2 illustrates our organizational structure. The Division has four areas: Administration, Child Welfare, Children's Mental Health and lastly, Juvenile Justice, which will be heard on March 23, 2017.

The mission of DCFS is to ensure that Nevada's children have safe and permanent home settings. They need to experience a sense of emotional and physical well-being, and receive support for positive choices. Page 4 outlines the distribution of the Division's overall funding. Approximately 47 percent of our budget is from State General Fund allocations, 36 percent from federal funds and 10 percent from grants and fee collections.

Page 5 outlines spending by DCFS program. Approximately 51 percent of spending goes to Clark County and Washoe County for CPS and child welfare

services. About 15 percent is spent on high-end Juvenile Justice services, 13 percent for children's mental health services, and 9 percent for CPS and child welfare services in the rural areas.

Page 6 outlines our funding by budget account (B/A). Overall, DCFS is requesting $267,735,877 over the biennium from the General Fund. Today we will be examining more closely the budgets for administration, child welfare and children's mental health.

Our administrative funding is in B/A 101-3145. This budget houses our administrator position, deputy positions, fiscal positions, human resource positions, the program evaluation unit and the family programs office. The operating request for this budget is $21,184,063 in FY 2017-2018, including $5,962,138 in General Funds; and $21,372,642 in FY 2018-2019, including $6,081,077 in General Funds.

HEALTH AND HUMAN SERVICES

CHILD AND FAMILY SERVICES

HHS-DCFS - Children, Youth & Family Administration — Budget Page DHHS-DCFS-6 (Volume II)
Budget Account 101-3145

Decision unit M-529 supports the Child Welfare Training Academy (the Academy). In order to meet the federal requirements of the Code of Federal Regulations, Title 45, section 235.64 and *Nevada Revised Statutes* (NRS) 432B.195, DCFS has worked with the University of Nevada, Reno (UNR) and the University of Nevada, Las Vegas (UNLV) to enhance our Child Welfare Training Academies. The request is 75 percent funded by federal Title IV-E funds. The universities have agreed to provide the match needed to fully fund this request. Page 8 of Exhibit C shows the increase in authority needed to collect the additional federal funds.

M-529 Mandate - Core Training — Page DHHS-DCFS-11

The child welfare agencies across the State use an evidence-based model to perform their duties. Evidence-based practices require ongoing training and monitoring to ensure guidelines are being followed. The Academy is for new and current child welfare workers. New workers spend 10 to 14 weeks with rotations between classwork and fieldwork. There is also a supervisor manager academy that meets two days per month for five to six months. The Academy also provides refresher training and specialty training to all child welfare workers, supervisors, managers, tribal child welfare staff and some community partners, such as law enforcement and mental health providers.

We have overhauled the scope of the training at the Academy to include specific focus on our child welfare model. The training also focuses on some specialty populations, such as children that have been sexually exploited.

When DCFS requests efficiency transfers, we are doing so for three main reasons. We do so to increase our billing capacity, to provide appropriate supervision and to increase quality of services. Decision unit E-902 transfers a full-time psychologist from B/A 101-3145 to B/A 101-3281, switching with a part-time psychologist. We needed the full-time equivalent (FTE) in this budget in order to increase our billing capacity and provide services to our Mobile Crisis Response Team (MCRT).

E-902 Transfer From BA 3145 To BA 3281 — Page DHHS-DCFS-13

HHS-DCFS - Northern NV Child & Adolescent Services — Budget Page DHHS-DCFS-88 (Volume II)
Budget Account 101-3281

Decision unit E-903 transfers a social services manager 5 from B/A 101-3145 to B/A 101-3229. For closer supervision, the Division needs 2 managers to oversee all of the 15 rural county areas.

E-903 Transfer From BA 3145 To BA 3229 — Page DHHS-DCFS-14

HHS-DCFS - Rural Child Welfare — Budget Page DHHS-DCFS-34 (Volume II)
Budget Account 101-3229

Lastly, E-900 transfers the part-time psychologist from B/A 101-3281 to B/A 101-3145.

E-900 Transfer From BA 3281 To BA 3145 — Page DHHS-DCFS-12

ASSEMBLYMAN SPRINKLE:
Are the Child Welfare Training Academies for those in the process of getting their degree in social work or for new and current employees who already have a degree?

RESHA POWELL (Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services):
Generally, the training is not for students, but for new hiree training and ongoing training of current employees. At UNR, there are stipends available for students preparing to enter the field of child welfare. This allows them to start to carry a caseload immediately upon graduation rather than having to go through the Academy at that time.

ASSEMBLYMAN SPRINKLE:
Do all Social Work degree candidates go through the Academy, or just those that go into CPS?

MS. POWELL:
It is for those that have identified a desire to enter the field of CPS.

ASSEMBLYMAN SPRINKLE:
What is the reason UNLV does not have a stipend program?

MS. POWELL:
Historically, UNLV had a stipend program. We found that it was difficult for the stipend students to be hired by Clark County Social Services. The money being used for the stipend program is now being used for additional training of DCFS staff in southern Nevada.

ASSEMBLYMAN SPRINKLE:
Have there been any recent changes to the curriculum at the Academy?

MS. POWELL:
The training has remained relatively stagnant over the last few years. The increase in funding should enable the universities to provide additional online training and a new learning management system. We hope to add specialty courses such as the identification of commercially sexually exploited children.

CHAIR DENIS:
Is the training both in classrooms and online?

MS. POWELL:
Yes, it is. Right now, our online training is minimal, but additional resources should allow for more to be added.

MS. WOOLDRIDGE:
I will now go over B/A 101-3143. This budget account funds the Unified Nevada Information Technology (UNITY) and Statewide Automated Child Welfare Information System (SACWIS). It also funds the Avatar system, which is our children's mental health electronic medical record system. The operating request funds 45 FTE with $7,125,933 in FY 2017-2018, including $3,882,466 is General Funds; and $7,221,640 in FY 2018-2019, including $3,933,979 in General Funds.

HHS-DCFS - UNITY/SACWIS — Budget Page DHHS-DCFS-20 (Volume II)
Budget Account 101-3143

I have included equipment requests on page 9 of Exhibit C, given the need to stay current with computer equipment. Decision unit E-710 replaces desk chairs, E-711 funds computer hardware and video equipment and E-720 funds virtual servers.

E-710 Equipment Replacement — Page DHHS-DCFS-24
E-711 Equipment Replacement — Page DHHS-DCFS-24
E-720 New Equipment — Page DHHS-DCFS-25

We are asking for an increase in the Master Services Agreement (MSA) funds for contract staffing in E-225. A system conversion from SACWIS to the Comprehensive Child Welfare Information System (CCWIS) is necessary, as the

federal guidelines and funding structures for state child welfare systems receiving Title IV-E funds have changed. The federal Administration for Children and Families released a new regulation, effective August 1, 2016, that replaces SACWIS with CCWIS. The CCWIS guidelines require bidirectional data exchanges, improved reporting capabilities, regular internal data quality reviews and improvement plans, and efficient, economical system design.

E-225 Efficient and Responsive State Government — Page DHHS-DCFS-23

Converting the existing system to a fully compliant CCWIS system will require additional technical expertise beyond the capacity of currently available in-house resources. Acquiring the services of an experienced information technology (IT) consultant is viewed as an ideal strategy to help ensure the project's success and continue our IV-E funding. We have one decision unit, E-900, transferring an IT tech out of Summit View Youth Correctional Center, B/A 101-3148, to the UNITY/SACWIS, B/A 101-3143.

E-900 Transfer From BA 3148 To BA 3143 — Page DHHS-DCFS-25

HHS-DCFS - Summit View Youth Center — Budget Page DHHS-DCFS-60 (Volume II)
Budget Account 101-3148

ASSEMBLYWOMAN CARLTON:
How long will it take to recoup the cost of the new system under the more favorable reimbursement rate?

MS. WOOLDRIDGE:
The reimbursement rate of 50 percent will not increase. The benefit of switching to CCWIS is that Nevada will be better able to match other states when reporting outcomes thereby making us more competitive for federal grant and child welfare funding.

ASSEMBLYWOMAN CARLTON:
Is there a loss of revenue if we do not make the switch?

MS. WOOLDRIDGE:
There could potentially be a loss. We could lose all of the Title IV-E funding if we are not able to report the outcome measures that will eventually be required.

ASSEMBLYWOMAN CARLTON:
The federal government is saying it is optional, but do it, or else. Would that summarize the situation?

MS. WOOLDRIDGE:
It is presented as optional. They strongly suggested that we make the switch. The Division is in favor of making the changes. A review of the requirements showed us that we would have a much greater capability of reporting what is happening in the field and on the street with our child welfare clients.

ASSEMBLYWOMAN CARLTON:
Does the system help DCFS employees at all at the worker level?

MS. WOOLDRIDGE:
They would not see a difference at the fieldwork level.

ASSEMBLYWOMAN CARLTON:
So, we spend money on something that will not really help us except in reporting data.

ASSEMBLYMAN SPRINKLE:
How much Title IV-E funding does DCFS receive?

MS. WOOLDRIDGE:
It is about a 50 percent reimbursement rate and constitutes approximately 24.61 percent of our overall funding.

ASSEMBLYMAN SPRINKLE:
So we could potentially lose $1.4 million?

MS. WOOLDRIDGE:
That sounds correct.

CHAIR DENIS:
Do you anticipate the SACWIS to CCWIS conversion will be done this biennium?

MS. WOOLDRIDGE:
This is a long-term project. We have to notify the federal government of our intention by August 1, 2018. It will span this biennium and, I suspect, extend into the next.

CHAIR DENIS:
Is CCWIS like a module on UNITY that we use for reporting purposes?

JASON BENSHOOF (IT Manager III, Division of Child and Family Services, Department of Health and Human Services):
The number of requirements for CCWIS is actually lower than SACWIS. It changes it into a more modular approach. We would start by building out a framework and then create modules for each of the areas of core functionality within UNITY. We have started rewriting UNITY according to CCWIS requirements. We got started on this before the regulations for CCWIS were even published because they are good ideas and they meet our business needs. For example, we rewrote our framework, commonly referred to internally as UNITY 3. It is a native Microsoft .NET application. Once we got the framework established, we started rewriting some of the other areas. We recently released our intake module. It will be a modular approach to rewriting all of UNITY, following the CCWIS guidelines.

CHAIR DENIS:
With UNITY being 20 years old, are we going to make these changes and then will the Division return in two years saying the whole system needs to be replaced? Are you totally rewriting UNITY at the same time that you are creating these modules to do reporting?

MR. BENSHOOF:
Some of the technology in UNITY is antiquated, but it is not all bad. We are going to build on the parts of it that are working and meeting our business needs and eliminate the parts that are not. There are certain aspects of UNITY that do not need to be changed. We will keep the data source, which is the

mainframe at Enterprise Information Technology Services. We are going to change some of the technology that the users interact with, from a clunky version of Microsoft .NET that does not perform well to more modern technology. The modular approach will allow us to focus on enhancing certain areas of UNITY without rewriting the whole thing at once.

CHAIR DENIS:
How long do you anticipate you will be able to do that before the whole system will need to be replaced? Or are you creating a new UNITY as you go?

MR. BENSHOOF:
We are in the process of replacing UNITY one module at a time. We could speed that up by replacing it with an off-the-shelf application in one fell swoop, but that would be very expensive.

CHAIR DENIS:
Is DCFS using a consultant to do some of this? Is the consultant going to train staff going forward?

MR. BENSHOOF:
Right now, we are using both in-house application developers and a few MSA contractors. The project really needs a professional project manager to fully convert from SACWIS to CCWIS.

CHAIR DENIS:
Is that a long-term plan or just for the project setup?

MR. BENSHOOF:
Depending on the pace and progress of the project, it would be for two years at a minimum. As we develop new modules for UNITY, we are changing some of the ways users interact with the application. To train users, we have two in-house UNITY trainers in southern Nevada and one in the north.

CHAIR DENIS:
Is any part of the project going to enhance the experience for the enduser?

MR. BENSHOOF:
The new application will improve the experience for users that interact with the data. The focus is on meeting business needs that are evolving quickly. Our requirements staff and developers are working to enhance the application, make it easier to navigate and provide faster response times.

CHAIR DENIS:
So if there are fewer requirements under CCWIS, will it be simpler to use than SACWIS?

MR. BENSHOOF:
That is certainly our goal. With SACWIS, the federal government gave us very specific regulations. With CCWIS, we have a lot more flexibility, so we can focus on meeting the business needs of DCFS. A large component of the new program will be data quality. The Division identified, years ago, that we need to do a better job collecting the required data. The CCWIS regulations focus on our responsibility to come up with a comprehensive data quality plan. This would include ad hoc and periodic reports that show missing data, so that it can be collected. We will also have a formal, internal data quality review process to catch problems before we submit federal reports.

ASSEMBLYMAN SPRINKLE:
Will the new system make it easier to work with other agencies when our children are placed out-of-state?

MS. POWELL:
Yes, it will. Nevada has been one of six pilot states for the National Electronic Interstate Compact Enterprise (NEICE) program. It is a computer system that allows us to talk to the other states. Currently, the Interstate Compact for the Placement of Children is all done on paper. More states are coming online into the NEICE program as it grows, and the whole interstate issue will be streamlined.

CHAIR DENIS:
Please continue with Washoe County Child Welfare.

MS. WOOLDRIDGE:
We are now on page 10 of Exhibit C, B/A 101-3141, Washoe County Child Welfare. This budget includes a request of $34,333,753 for FY 2017-2018 and $34,329,446 for FY 2018-2019.

HHS-DCFS - Washoe County Child Welfare — Budget Page DHHS-DCFS-28 (Volume II)
Budget Account 101-3141

This funding goes directly to the County in the form of a block grant. The only funding provided outside the block grant is the adoption caseload. The adoption caseload was kept out of the block grant so as not to deincentivize adoptions. Decision units M-200 and M-201 include an increase in Washoe County caseloads for adoption of $363,632 in FY 2017-2018 and $741,131 for FY 2018-2019. Adoption caseload growth is projected at 3.82 percent over the biennium. The average monthly adoption subsidy in Washoe County is $581.33.

M-200 Demographics/Caseload Changes — Page DHHS-DCFS-29
M-201 Demographics/Caseload Changes — Page DHHS-DCFS-29

ASSEMBLYMAN SPRINKLE:
Please explain the difference between SFC that the Legislature approved in 2015 and the Advanced Foster Care (AFC) program.

MS. WOOLDRIDGE:
When the approved pilot program was rolled out, there were two aspects. One program is the SFC, which includes our agency foster care homes. The other was, at that time, referred to as Turbo Pilot Homes, but is now called AFC. In these homes, our staff employs the "Together Facing the Challenge" (TFC) evidence-based model. Staff does weekly consultation with the foster families.

ASSEMBLYMAN SPRINKLE:
What is the correlation between the programs and the rate changes that were approved two years ago? Is everything being funded at the $115 per day rate?

MS. WOOLDRIDGE:
No, that is not correct. The $115 daily rate in Washoe County is for SFC agency homes. The AFC daily rate is approximately $40.35.

ASSEMBLYMAN SPRINKLE:
Did you stop taking BST money, as was required?

MS. HOWELL:
The BST funds were shut off when we started paying the providers the $115 daily rate. There are two rates. The first is a daily rate of $49.34 for an AFC home. You may think of that as a traditional foster home that is bumped up with services. The $115 daily rate is for the SFC agencies. Staff is monitoring both types of homes. Once any type of home became a pilot home, they were no longer able to bill for BST funds.

ASSEMBLYMAN SPRINKLE:
My figures appear to show that you did bill for BST in FY 2014-2015.

MS. HOWELL:
In Washoe County, the money was for the increase in cost for those homes as well as staff, recruitment and home studies. It was a package deal to roll out the pilot. We only received 50 percent of the funding in the first year to ramp up and 100 percent of the funding in the second year.

ASSEMBLYMAN SPRINKLE:
What kind of population are you serving right now?

MS. HOWELL:
The total population that we are serving within this model is 138.

SENATOR KIECKHEFER:
Is the program now consistent with the pilot program and the program approved by the 2015 Legislature?

MS. HOWELL:
Yes, it is exactly the same model, fully implemented. When we were doing the pilot program, there was a population of 30. In the last two years, we rolled in the additional 108 children.

CHAIR DENIS:
I see the reported outcomes are generally positive. Why has the number of youths prescribed medication increased by 58 percent?

MS. HOWELL:
Washoe County does quarterly reports to monitor our outcomes. We started seeing a significant increase in the use of psychotropic medications once we completely rolled out the pilot. The children that entered the pilot program needed to be assessed and become stable, and an increase in medication use was one of the tools. When our next quarterly report comes out, it will show a decrease in the numbers as children stabilize and titrate off of the medications. The current increase is approximately 7 percent.

CHAIR DENIS:
Please continue with Clark County Child Welfare.

MS. WOOLDRIDGE:
Moving on to page 12 of Exhibit C, B/A 101-3142 is the Clark County Child Welfare budget. Clark County is also funded through a block grant mechanism. This budget includes a request of $104,366,114 for FY 2017-2018 and $104,361,807 for FY 2018-2019. Like Washoe County, it includes an enhancement to fund a 7.89 percent increase in adoption caseload. This increase is $2,754,675 in FY 2017-2018 and $5,727,097 for FY 2018-2019. The average monthly adoption subsidy payment in Clark County is $607.16.

HHS-DCFS - Clark County Child Welfare — Budget Page DHHS-DCFS-31 (Volume II)
Budget Account 101-3142

ASSEMBLYWOMAN CARLTON:
Is Clark County using the AFC model?

PAULA HAMMACK (Acting Director, Clark County Department of Family Services):
Yes. After having conversations with Washoe County, we are going to the tiered rate to be consistent across the State. We will implement the AFC.

ASSEMBLYWOMAN CARLTON:
What was the decision process? The Legislature approved the tiered rate, but it was changed since then.

MS. HAMMACK:
We were looking at better outcomes for our youth and using national best practices. It better serves the children and aligns their needs.

ASSEMBLYWOMAN CARLTON:
This is the problem that I have with block grants. The Legislature has one discussion but then things change. Are you having difficulty finding providers?

MS. HAMMACK:
We are struggling getting providers. We currently have identified a group that will be starting classes next week, and we are working with other groups on our recruitment efforts to recruit more homes for this program.

SENATOR KIECKHEFER:
As I recall, you ran a pilot program and then approached the Legislature in 2015 and said the pilot program was working, and you were seeing great outcomes for the children. You wanted to fully implement the program. The Legislature approved it, and later that year, Clark County changed the program. Please explain what happened.

MS. HAMMACK:
After further discussions, Family Services recognized moving in the direction of AFC better met our needs. In discussions with DCFS, we asked to move toward AFC.

SENATOR KIECKHEFER:
So did the pilot program not work?

MS. HAMMACK:
The outcomes we saw in the pilot program were very effective. We saw a decrease in placement moves, medications and hospitalizations. We believed that by moving toward AFC, we would see the same benefits, and families would benefit from working with our mental health coaches within their own homes.

SENATOR KIECKHEFER:
Why did you allow continued billing of BST dollars?

MS. WOOLDRIDGE:
Clark County Family Services came to DHHS in March of last year and indicated that there had been an error in the amount that they requested. On the tiered rates, it was difficult to specify which youth, programs and reimbursement rates applied.

Upon examining the budget request, we saw that Clark County had requested the $44 daily reimbursement, which for 395 children came to about $7 million. Federal Title IV-E would have accounted for about half of that. They received $4 million over the biennium to run the pilot. At the time, Clark County indicated to DHHS that the error meant they would be unable to fund SFC at the $115 daily rate.

As a remedy, Clark County requested the ability to continue billing for BST. Following a meeting with Nevada Medicaid Division of Health Care Financing and Policy, DHHS made the decision that Clark County would be allowed to continue billing BST. I understand that was a controversial decision, but the SFC providers have businesses to run, and we had 395 children in their placement. If the providers went out of business, we would have 395 children without foster care placement. Basic skills training is permitted in the Nevada Medicaid system as a medically necessary service. The Division chose to allow Clark County to bill for it so children could continue in safe and permanent settings.

At the same time, we used some System of Care (SOC) grant and technical assistance funds to ensure that our SFC homes used the TFC evidence-based model. We continue to collect data regarding the outcomes from these homes. Through our whole Division, through our SOC grant, we are reforming children's

mental health care. That reform includes SFC and therapeutic foster care. It is a reimbursable model through Medicaid. We have done a lot of research into the methodology of other states and how they fund SFC care programs in large communities.

The way that we are funding these programs in Washoe County and the rurals is working, but it did not work for Clark County. As a longer term fix, we are considering going to a Medicaid waiver for the SFC program. Because the Patient Protection and Affordable Care Act (ACA) is under scrutiny in Washington, D.C., the waiver may take a year or more. We are continuing to look at billing the BST. It is a medically necessary service being delivered according to evidence-based guidelines.

SENATOR KIECKHEFER:
Last Session when Clark County came to the Legislature they did not ask for the $115 rate, they asked for the tiered rates. Why are we trying to get them to a rate that they never asked for?

MS. WOOLDRIDGE:
What they asked for was the lowest of the tiered rate, but there was not enough funding to get them to that.

SENATOR KIECKHEFER:
Did you indicate that you were putting additional resources into these programs through the SOC grant?

MS. WOOLDRIDGE:
The SOC grant funding was used for training throughout the State.

SENATOR KIECKHEFER:
Are you going to ask to continue to allow Clark County to bill BST through the upcoming biennium?

MS. WOOLDRIDGE:
Yes, that is correct.

SENATOR KIECKHEFER:
We had a lot of discussion last Session about whether a block grant was the best way to go. Ultimately, the Legislature put the funding in a block grant because DCFS came to us and said that the pilot program worked. Clearly, that was not accurate. This is a mess.

ASSEMBLYMAN SPRINKLE:
I was deeply involved in the discussion two years ago. Why, from a DHHS standpoint, do you now feel it is appropriate to allow continued funding through BST? What the Legislature decided in the 78th Session, based on the Division's request, was that by implementing this program, BST would be eliminated. If Washoe County and the rurals worked through their problems and were able to accomplish what they said they would, why is Clark County unable to do so? I do not think it is fair and equitable to the rest of the State. Please explain your thought process.

MS. WOOLDRIDGE:
I do not disagree that it is a mess, but it is a mess that we need to make right. Specialized foster care homes in Clark County are saying that if we eliminate BST funding, they will be unable to stay in business. We have 395 children that need those homes, and we want to keep them in those homes.

We have not quite figured out what we will be asking for in the coming fiscal year. I am still meeting with Medicaid regarding BST billing. It will not be the two hours they are permitted now. They will be required to prove medical necessity and also comply with quality assurance components.

ASSEMBLYMAN SPRINKLE:
I want to hear from Clark County. I want to hear exactly what went wrong with what was proposed to the Legislature two years ago. I want to learn why you have been unable to meet the promises you made to this Body two years ago.

MS. HAMMACK:
One of the components of the pilot that was not considered in Clark County was the residential component, and moving to AFC allows us to have that. Clark County cannot pay the $115 daily rate being paid by Washoe County and the rurals, based on the funding that we estimated.

ASSEMBLYMAN SPRINKLE:
Your request is very unfair to Washoe County and the rest of the State, because they were able to do what they promised they would do. What assurances can you give us that the current direction you are now requesting will solve the problem? You have not adequately explained what the problem is, or why we now find ourselves in the current position.

MS. HAMMACK:
With the structure and strategic plan that we have in place to move forward with AFC, we will be able to meet the needs of our children. I understand the frustration of the Subcommittees, but we made an error, and we need to correct our course. We are asking for the opportunity to do that, and we will be able to show the Legislature our progress.

ASSEMBLYMAN SPRINKLE:
I do not know if I am totally comfortable with that. At this point, the State may need to have more oversight of the Clark County Department of Family Services.

ASSEMBLYWOMAN TITUS:
The legislatively approved SFC population was 396. According to your information, there were 279 enrolled in the SFC program in FY 2015-2016. I understand that children move in and out of this population. We do not want children to stay there forever, and we would like to see them adopted or reunited with a parent or family. Did you have only two-thirds of your funded population at any one time?

MS. WOOLDRIDGE:
This program was funded 50 percent in the first year, and fully funded in the second year. When the pilot was underway, not all children in SFC in Clark County were in the pilot.

ASSEMBLYWOMAN TITUS:
What is the total number of children in foster care in Clark County, including those in SFC?

MS. WOOLDRIDGE:
As of January 2017, there were 3,201 in out-of-home placement in Clark County.

ASSEMBLYWOMAN TITUS:
Are you requesting $7 million for 395 children?

MS. WOOLDRIDGE:
That is correct.

CHAIR DENIS:
Can you discuss why there has been an increase in prescribed medication for the children in SFC?

MS. HAMMACK:
The increase in the prescribed medication is a reflection of our Department doing a better job in assessing and meeting the needs of the children. We anticipate that it will soon level off.

CHAIR DENIS:
Are you identifying greater needs now? Two years ago, you said the number of youth prescribed medication would go down because you would be more efficient.

MS. HAMMACK:
We are doing better assessments of our children. As in Washoe County, we have seen an initial spike that will level off as children become stabilized.

CHAIR DENIS:
Are they not stabilized now?

MS. HAMMACK:
Children who have been on medication for a while may be stabilizing, but we are continuously doing more assessments to identify their needs. Often, prescribed medication is the best way to meet their needs.

ASSEMBLYMAN ARAUJO:
Please explain how the SFC training has changed over time.

MS. WOOLDRIDGE:
A few years ago in SFC, we were not using an evidence-based model that had been tested nationally with good outcomes. The evidence-based model that we have chosen is the TFC model. It has many different components which include how foster parents interact with youth, how they discipline and how they work with certain specialized behaviors. Another evidence-based model we use is trauma-informed care (TIC). To be abused, pulled from your home and placed in foster care is extremely traumatic. The TIC model works with foster parents on understanding that some behaviors and issues are related to the child's trauma and how to respond to them.

CHAIR DENIS:
Please move on to Rural Child Welfare.

MS. WOOLDRIDGE:
The next budget is B/A 101-3229, Rural Child Welfare. The request is for $44,415,922 over the biennium. Approximately 39 percent comes from the General Fund, 25 percent from Title IV-E, 14 percent from county assessments and various other sources. Page 15 of Exhibit C illustrates the allocated positions in child welfare and child protective services in the 15 rural counties. We have rural child welfare offices in Elko, Carson City, Fallon and Pahrump. These offices also serve Winnemucca, Fernley, Yerington, Ely and Tonopah.

Decision units M-200 and M-201 funds an increase in projected adoption caseload. Unlike Clark County and Washoe County child welfare block grants, the rural child welfare continues to use the line-item budget system. Adoptions are projected to increase 1.93 percent in FY 2017-2018 and 4.1 percent in FY 2018-2019.

M-200 Demographics/Caseload Changes — Page DHHS-DCFS-37
M-201 Demographics/Caseload Changes — Page DHHS-DCFS-37

Decision unit M-201 requests $62,183 for FY 2017-2018, including $29,368 from the General Fund, and $126,062 for FY 2018-2019, including $56,054

from the General Fund. The average monthly adoption subsidy in the rural areas is $624.

Page 18 covers the caseload growth for foster care. In the rural areas, children can be placed in regular foster homes, specialized foster homes, advanced foster homes, a relative-licensed home, a relative-unlicensed home, court jurisdiction for youth 18 to 21, and we are now implementing a program called the Kinship Guardianship Program (KinGAP). The KinGAP program seeks to expedite legal permanency for children in foster care who are not able to return home or be adopted. It is also used for Native American children whose termination of parental rights is contrary to tribal custom. The program gives the child the opportunity to live with relatives who have demonstrated a strong commitment to caring for the child and who have developed a loving and nurturing relationship with the child. The opportunity exists for the relatives to continue to receive financial assistance, have their case closed and permanency achieved. The amount being requested for all foster care placement types in the rural child welfare budget is $1,905,642 for FY 2017-2018 and $2,099,099 for FY 2018-2019.

The charts on page 19 outline these requests. I would point out that the second chart demonstrates that the SFC payment has increased because of the increased program we have been discussing this morning. The Division has asked to increase the rate for foster homes that choose to locate in rural areas in order to keep rural youth in their home communities. When children in rural areas suffer abuse, we not only remove them from their homes, but often we remove them from their communities.

We felt strongly that we wanted to provide incentives for SFC providers to establish homes in the rural areas. One method we used was to increase recruitment efforts for AFC providers. Secondly, we wanted to raise the daily rate to $125 for SFC providers in rural areas. The result is we have eight new AFC homes that have opened in rural counties.

ASSEMBLYWOMAN TITUS:
How many children from rural areas are currently placed in foster care in the urban areas?

MS. WOOLDRIDGE:
Right now, we have one child in Washoe County and six children in SFC in Clark County.

ASSEMBLYWOMAN TITUS:
Can you give me the number of such children as a whole?

MS. WOOLDRIDGE:
As of January 2017, 354 children were in foster care in rural areas.

MS. POWELL:
There are about 380 children in foster care from the rural areas. Some of those are placed in urban areas with their relatives. The seven children previously mentioned are in SFC agency homes.

ASSEMBLYWOMAN TITUS:
Is there truly a lack of nonfamily foster care availability in the rurals?

MS. WOOLDRIDGE:
Yes, there is.

ASSEMBLYWOMAN CARLTON:
Were the higher SFC rates for the rurals approved by the 2015 Legislature?

MS. WOOLDRIDGE:
The 2015 Legislature approved the daily rate of $115. To get children placed in the rurals, we found the $125 within our budget.

ASSEMBLYWOMAN CARLTON:
Where did the money come from to support the higher rate?

MS. WOOLDRIDGE:
The line item funds children in all types of foster care, so it is difficult to say precisely what did not get funded. We had fewer children in SFC than projected.

ASSEMBLYWOMAN CARLTON:
Is the increase you are requesting today from a daily rate of $40 to $125?

MS. WOOLDRIDGE:
The $40 daily rate is for AFC. The increase for SFC daily rate is from $115 to $125, if the home is in a rural area and the youth stays in his community.

ASSEMBLYWOMAN CARLTON:
If we are going to hold one county accountable for not complying with the plan, then we need to hold all accountable. It would seem that the annual cost for providing foster care to a child in a rural region would be about $45,000. The numbers do not seem right.

MS. WOOLDRIDGE:
I will provide the Subcommittees with more specific information regarding what the Division spent in the last biennium on every type of foster care, and a summary of what we are asking for now.

ASSEMBLYWOMAN CARLTON:
Do you continue to need the eight positions that were approved for the Specialized Foster Care Unit?

MS. POWELL:
Yes, we do. We were approved to hire in October 2015, but had an extremely difficult time getting those positions filled with qualified individuals. When we found qualified individuals, they were unwilling to relocate to Nevada for the salary we were offering. We had to request that the positions be brought in at a higher step. Once this was done, the individuals who accepted the positions had to relocate to Nevada. All of that took time.

The individuals who filled these positions are the ones recruiting foster homes and increasing the AFC homes that we have today, as well as providing direct services to those homes. These positions are very necessary.

ASSEMBLYWOMAN CARLTON:
And how many children do these positions serve?

MS. POWELL:
Currently in the rurals, we have 14 children in 12 AFC homes, as well as some foster care agency homes. This unit also does all the data collection for those homes.

MS. WOOLDRIDGE:
We did the caseload projection as 40 because we continue to try and move children out of SFC homes and into AFC homes. We also hope to move those few children in Washoe County and Clark County back to their rural home communities.

ASSEMBLYWOMAN CARLTON:
It would appear we have as many positions in the rurals to serve a population of 40 as we do in Clark County to serve a population 395 and in Washoe County to serve a population of 136. We have to put the resources where the children are.

ASSEMBLYMAN SPRINKLE:
You just said the justification for these positions was to serve foster care children as a whole. When we approved the positions, the justification was to implement the SFC program.

MS. WOOLDRIDGE:
The pilot was to implement SFC and AFC homes. What we now call advanced foster care was called turbo homes originally. One issue with the rurals is the geographical distance between communities, and the time it takes for staff to travel.

ASSEMBLYMAN SPRINKLE:
I want to go back to the projected population of 40 children. In 2017, the approved full implementation cost in FY 2016-2017 was $14,034 per child. Your request of $125 daily rate will bring the cost per child to $45,625. I completely understand that we want to keep rural foster children in their community if possible, but I need a clearer answer.

MS. WOOLDRIDGE:
I am struggling to understand where the $45,625 figure came from. With your indulgence, I would ask to come back to the Subcommittees with a clearer answer.

SENATOR KIECKHEFER:
The number is likely inclusive of the employees based on the number of children being served and the recommendation to increase the daily rate. When you get the information to the Subcommittees, please break out the dollars for each category of foster care population.

CHAIR DENIS:
Regarding the KinGAP program, why are subsidies being introduced for relative placements at this time?

MS. POWELL:
The KinGAP program was introduced in 2011. It took some time for all the child welfare agencies across the State to come to an agreement that they wanted to move forward and implement the program. Once that decision was made, we had to ensure that good policies, procedures and practices were put in place. We had to do outreach to our stakeholders and explain the program to them. We had to develop aspects of our UNITY system in order to make KinGAP payments.

CHAIR DENIS:
How will that impact the regular foster care caseloads?

MS. POWELL:
It is not anticipated that it will impact caseloads. Since it will be a new program, we will be monitoring that closely.

CHAIR DENIS:
What is the benefit of the KinGAP program?

MS. POWELL:
The children in foster care who have been unable to be reunified or adopted can achieve some permanency with family members.

CHAIR DENIS:
Does KinGAP provide financial assistance to families who might otherwise not be able to care for these children?

MS. POWELL:
Yes. We come across families who either do not want to terminate their family member's parental rights, or it is outside of their custom. Children may be in a foster care situation with relatives who are unwilling to go forward with adoption because that would require a termination of parental rights. Under the KinGAP program, they can get guardianship of the child and continue to receive the financial assistance they need to continue caring for the child.

CHAIR DENIS:
Is having them in a home with a relative preferable to having them in traditional foster care?

MS. POWELL:
Yes, it is always better to place children with family members.

ASSEMBLYMAN SPRINKLE:
If it is a guardianship, and parental rights have not been terminated, does the agency maintain custody of the child?

MS. POWELL:
No, the relative has actually obtained a court order and received custody of the child. The agency would close the case at that point.

ASSEMBLYMAN SPRINKLE:
Is the KinGAP subsidy just financial assistance for the guardian who might otherwise be unable to care for the child? What happens if the guardianship falls apart?

MS. POWELL:
If something were to happen and there was a new report of abuse or neglect, the agency would go in and open a new investigation.

CHAIR DENIS:
Can DCFS bill for Targeted Case Management (TCM) and receive Medicaid reimbursement for either FY 2015-2016 or FY 2016-2017?

MS. WOOLDRIDGE:
Decision unit E-241 is our efficiency measure to begin billing TCM in the rurals. We are asking for an increase of $263,298 for FY 2017-2018 and $263,619 for FY 2018-2019. Unfortunately, we cannot go back and bill for FY 2015-2016 because we do not have the documentation that Medicaid requires. We have recently started to do time studies in order to document TCM and we will be able to bill for FY 2016-2017.

E-241 Efficient and Responsive State Government — Page DHHS-DCFS-39

Our next budget is B/A 101-3281, Northern Nevada Child and Adolescent Services. The total budget request for the biennium is $18,776,327, including $7,006,640 in General Fund allocation. Approximately 54 percent of this budget is federal funds, which includes Medicaid reimbursements, federal Title XX block grant and the Community Mental Health Services block grant. Approximately 7 percent of this budget derives from the Fund for a Healthy Nevada (FHN), which funds our Mobile Crisis Response Team. Within B/A 101-3281, there are 105 budgeted positions.

Decision unit E-225 is a request for $6,798 in FY 2017-2018 and $12,763 in FY 2018-2019 to replace four agency-owned vehicles with Fleet Services Division vehicles. The Agency feels it is more efficient to fund vehicles in this manner due to the age and repair costs of the agency-owned vehicles.

E-225 Efficient and Responsive State Government — Page DHHS-DCFS-91

Decision unit E-350 funds our Category 16 children's mental health placements. This funds acute hospitalizations for children in parental custody that are uninsured and underinsured. These children are usually at risk to come into our system for higher-end services, foster care or juvenile justice services. We have requested a total enhancement of $91,502 for each year of the biennium. The increase is due to both increases in daily rates at these facilities and the average length of stay.

E-350 Safe and Livable Communities — Page DHHS-DCFS-92

Decision unit M-501 establishes Category 30 Training according to NRS 433.279 and NRS 424.020. This will provide training for our family learning home, adolescent treatment center, mental health technicians, treatment home providers, treatment home supervisors and our mental health clinician. The total request for the biennium is $14,926.

M-501 Mandates — Page DHHS-DCFS-91

ASSEMBLYMAN SPRINKLE:
What effect has the Medicaid expansion had on uninsured children?

RYAN GUSTAFSON (Deputy Administrator, Division of Child and Family Services, Department of Health and Human Services):
We have seen a decrease in costs through the Medicaid expansion under the ACA. Nevertheless, acute hospitalization cost has increased, due to higher daily rates and longer stays. We continue to hospitalize the most severely behaviorally and emotionally disturbed youth. Thanks to the efforts of our MCRT, we have been able to avoid hospitalizations and use preventative efforts within the community.

ASSEMBLYMAN SPRINKLE:
I am not clear how longer stays are attributable to expanded Medicaid. Please explain.

MR. GUSTAFSON:
With the ACA, we have seen more children with insurance and a concurrent reduction in hospitalization costs.

ASSEMBLYWOMAN CARLTON:
Is the increased cost in northern Nevada for hospitalizations due to the fact that the only facility is a for-profit hospital that receives a daily maximum? Are the costs higher than if it was our facility?

MR. GUSTAFSON:
In northern Nevada, there is only one acute psychiatric hospital that can serve children and adolescents. Their daily rate had been $585 for some time, and was recently renegotiated to $750. The rate may be due to the fact that they are the only acute psychiatric hospital in northern Nevada, but it is also because they serve the most acute children with the most significant needs.

MS. WOOLDRIDGE:
The rates were also raised because the Medicaid rate for acute care went up.

CHAIR DENIS:
Please move on to the next budget.

MS. WOOLDRIDGE:
Our final budget account is B/A 101-3646, the Southern Nevada Child and Adolescent Services, located in Las Vegas. The total biennial budget request is $54,960,652. This consists of approximately 39 percent General Fund appropriation, 41 percent federal funding, 10 percent from our SOC grant, 5 percent from FHN and 5 percent from other sources. The budget funds 276.71 FTEs.

HHS-DCFS - Southern NV Child & Adolescent Services — Budget Page DHHS-DCFS-96 (Volume II)
Budget Account 101-3646

Page 28 of Exhibit C illustrates the clients served by our MCRT in both northern and southern Nevada. We have an 85 percent statewide hospital diversion rate. The program keeps children out of costly acute care stays and keeps them in their homes and communities. Once MCRT has responded, page 29 details where the clients are referred. Please note that clients may receive more than one referral. A referral means the team makes the call for an appointment and may even attend the appointment with the client. Additionally, the team follows up to make sure the client attended the appointment and that their needs are being met.

There are two programs in MCRT. The first is the immediate crisis intervention, in which services are being delivered daily or almost daily to meet the client's

needs for up to five days. The family then has the choice to participate in our MCRT stabilization program. In this program, for 30 to 45 days after the intervention, the family can receive intense services two or three times a week in the home, in the school or wherever the family needs us. In FY 2015-2016, 1,198 clients were referred to the MCRT stabilization program, 673 were referred to family-to-family or peer-to-peer support, 597 were referred to a new mental health provider, 343 were referred back to their mental health provider and 224 were referred to other programs within DCFS. During the same time, 191 clients declined further services and for 60 clients we determined no further services were needed. A total of about 2,500 clients have been served by this program since inception.

Our SOC Implementation Grant was awarded in October 2015 for $11 million. I would remind the Subcommittees that the main goal is to increase access for children in their homes and communities. The most notable first year accomplishments were the completion of a gaps analysis and a strategic action plan. We have increased community providers using subgrants. All the information about the SOC grant is on the DCFS Website.

Decision unit E-225 funds the reduction of three units from the Desert Willow Treatment Center, and relocates two units to a segregated unit of Rawson-Neal Psychiatric Hospital. This decision was based on a number of factors. The census at Desert Willow has been reducing over the last two years with the exception of some bumps during our prime months. This reduction is due to the success of the MCRT program and the increase in providers.

E-225 Efficient and Responsive State Government — Page DHHS-DCFS-99

This request will take Desert Willow from a 58-bed hospital to a 20-bed hospital. It reduces staff by 47 percent, or 56 positions, 35 of which are vacant today. It reduces General Fund requests by approximately $3 million. The plan is for the units to be completely segregated from the adult and forensic sections of Rawson-Neal. This is standard practice in private psychiatric hospitals across the Nation.

We will continue to use Desert Willow staff that are trained in working with adolescents. In certain exceptional cases, we could also use the trained staff

from Rawson-Neal. We remain committed to the programming for Desert Willow. We are currently implementing some evidence-based models and plan to continue using them. The Division will work with current staff to enable them to be transferred to other positions. No layoffs are anticipated.

Pages 34 through 36 of Exhibit C graph the population served at Desert Willow in calendar year 2016. The number on each graph is the total youth served during that month, not necessarily at one time. Today, the acute unit has eight youth and the residential unit has eleven. More youth are covered by Medicaid, so the private hospitals have been admitting more patients.

As you have heard in other presentations, Nevada has a workforce shortage for health care positions. It is difficult to recruit, hire and retain staff at Desert Willow. This includes nurses, psychiatrists and clinical social workers. Desert Willow has had to cobble together a contract workforce in segments to maintain their licensure certification. This is essentially fragmented privatization.

Unfortunately, the State faces some barriers when competing with the private sector. Desert Willow often operates as a safety net for youth. The youth that we serve have often been denied admission by the private hospitals due to their severe, aggressive behavior. Those youth often require one-on-one supervision. In order to maintain the ratios for licensure and certification, we then have to lower the census to keep everyone safe.

Should this budget be approved, DCFS is working on a program proposal with FirstMed Health. FirstMed Health is one of two Federally Qualified Health Centers (FQHC) in southern Nevada. As an FQHC, FirstMed is a not-for-profit agency, that can accept youth with private insurance, Medicaid or no insurance. The program provides that DCFS will enter a provider agreement with FirstMed to open a 54-bed residential treatment program, acute hospitalization and partial hospitalization in the current Desert Willow Treatment Center building. Partial hospitalization is day treatment.

The population will be prioritized to first include those youth at risk of going to out-of-state residential centers, youth with dual diagnoses of behavioral health need and developmental disability, and youth who have been commercially sexually exploited.

This proposal is unique and innovative. As an FQHC, FirstMed will be able to provide behavioral health care and comprehensive medical care to every child in the facility and their families. This is whole health care. If the Legislature approves E-225 and the proposal works out, we will increase available beds in the Las Vegas community.

ASSEMBLYMAN OSCARSON:
I had the opportunity to visit with FirstMed representatives and was impressed by their presentation. I fully support keeping residential treatment youth in the State. I am concerned, however, anytime we go out to a third-party vendor. I encourage DCFS to follow the process very carefully should the Legislature approve the budget.

MS. WOOLDRIDGE:
I understand your concerns. We are looking at doing this as a provider agreement that will include a scope of work with specific outcome measurements. We will be able to monitor the progress on a daily basis.

ASSEMBLYMAN OSCARSON:
The FirstMed representatives discussed the possibility of some philanthropic funds to help develop the facility. They also discussed the possibility of a 30-year lease on the property. Are you aware of either of those issues? I would appreciate DCFS updating us regularly on the progress of negotiations.

MS. WOOLDRIDGE:
I do not have any of the specifics regarding those matters. As of now, the discussion is that FirstMed would not have a lease on the building, but would provide services to DCFS clients in that facility. I will provide the Subcommittees more information as it becomes available.

SENATOR KIECKHEFER:
I, too, have concerns with using a third-party vendor. It feels a lot like what we went through with some juvenile justice programs that did not work out as promised.

The proposal is to move two units to Rawson-Neal. Will that be ten acute beds and ten residential beds?

MR. GUSTAFSON:
Yes, it will.

SENATOR KIECKHEFER:
Where will the specialized treatment beds go, the ones for youth sex offenders?

MS. WOOLDRIDGE:
Clark County Juvenile Justice has changed how they treat juvenile sex offenders. They are using more community-based services for them. Our census for referrals from Clark County Juvenile Justice is nearly zero. Desert Willow was used for moderate-risk juvenile sex offenders. High-risk sex offenders continue to go to out-of-state residential treatment centers.

SENATOR KIECKHEFER:
Do any youth come to you under court order, or is it all voluntary?

MS. WOOLDRIDGE:
We do get some children under court order from Clark County Juvenile Justice. Our population at Desert Willow right now is mostly parental custody youth, with only a small number of welfare and juvenile justice children.

SENATOR KIECKHEFER:
Do you anticipate that the beds at Rawson-Neal will be full?

MR. GUSTAFSON:
As of today, we have 19 youth in Desert Willow. The acute census, particularly, experiences wide fluctuations and has been as low as one during the last few months. According to the Bureau of Health Care Quality and Compliance, there are over 600 potential acute beds in Clark County. We do anticipate that the two ten-bed units at Rawson-Neal would adequately meet DHFS needs.

SENATOR KIECKHEFER:
I agree with the departmental philosophy, which is to use community resources as much as possible and leverage different fund sources to build up community capacity. I worry that creating a safety net ten beds deep may not be strong enough. One change in juvenile judge by election could alter the number of children sent to DHFS in a significant way.

ASSEMBLYWOMAN CARLTON:
It is really crucial that FirstMed is a FQHC. That is a much higher standard than some of the situations we find in the State. They cannot turn anybody away at the door, but do get a higher reasonable reimbursement rate. They submit to required federal audits. All these aspects give me an additional level of comfort. I would like the Subcommittees' members to get more information on what a FQHC entails.

SENATOR KIECKHEFER:
I agree that the FQHC aspect to this proposal gives me an additional level of comfort as well.

ASSEMBLYMAN SPRINKLE:
How did you decide which positions would transfer to Rawson-Neal?

MR. GUSTAFSON:
We currently have 35 vacancies at Desert Willow, for a variety of reasons. The positions being reduced are primarily mental health technicians and psychiatric nurses. That is the nature of going from 58 to 20 beds. There are some positions you must have, whether you have 1 kid or 50 kids.

When considering what positions would be needed to staff the new units at Rawson-Neal, we looked at licensing and ratio standards. We want to know we have what it takes to be adequately staffed. Yes, it is 20 beds, but it is also two separate units with different needs. It is a round-the-clock operation, so it must be staffed at all times. We have always served the children with the most significant mental and behavioral health needs. We had to take that into consideration when determining our staffing ratios.

ASSEMBLYMAN SPRINKLE:
If any employees choose not to transfer, is DCFS comfortable with the cost of buyout expenses?

MR. GUSTAFSON:
We do not anticipate that will happen. We have so many vacancies in our sister programs, such as the Oasis Residential Treatment Center and our medication

clinic, that we feel comfortable all employees will find a new position within the Department.

ASSEMBLYMAN SPRINKLE:
I am familiar with the campus layout at Rawson-Neal. What assurances are in place for the protection of children on the same campus with adult psychiatric patients?

MR. GUSTAFSON:
It is a national standard for psychiatric hospitals to have both youth and adults in the same facility. The unit that we would occupy is the "D" building, which has two units of ten beds each. The building has a separate entrance, so admissions would not interact with adult patients. We are working on a separate area for the intake process for youth as well. All the units within the hospital are separated by locked doors. Of course, we will have ongoing partnering with the Division of Public and Behavioral Health. We do not have any serious concerns, as there will be no intermingling between the adult and youth populations.

CHAIR DENIS:
Please discuss DCFS's progress in increasing the availability of community providers through workforce development.

MR. GUSTAFSON:
We have seen a good increase in community providers, largely thanks to our SOC grant, which is now in the second year. The goal of the SOC Grant is to enhance and expand less restrictive options for youth in crisis. We have provided funding for a number of our community providers, as well as training to staff. There has been a significant push to evidence-based TIC practices. By using this model, we are helping our providers to better understand the effect of trauma to our youth and how to respond to it.

We have opportunities to provide quality assurance and technical assistance to those community providers. We anticipate through the duration of the grant and beyond, that we will continue to be able to develop and support community based providers.

CHAIR DENIS:
It sounds like your goal is to transition from a direct care provider to providing other statewide services. Is DCFS considering closing, or reducing, any of the other State children's mental health facilities in the future?

MR. GUSTAFSON:
The Division does operate other residential facilities that are not hospitals. At this time, we are not looking at reducing those facilities. We will continue to look at the impact of the ACA and how circumstances may change in the future.

MS. WOOLDRIDGE:
The rest of my presentation, Exhibit C, includes our deferred maintenance and capital improvement projects. If you have additional questions about our data, I have included a link to the DCFS data book.

CHAIR DENIS:
Anyone wishing to give public comment, please do so at this time.

DAN MUSGROVE (Chair, Clark County Children's Mental Health Consortium):
I have included a letter (Exhibit D) today in support of the MCRT. The impact of MCRT cannot be overestimated.

The Mental Health Consortiums were created by the 2001 Legislature. We take on a fiduciary role when it comes to children's behavioral health. We are excited about what is being done with the SOC grant.

When we first heard about potentially closing Desert Willow, we were concerned. What gives us ease of mind is that the result will be expanded bed availability. The goal is to have more beds available, to be flexible in the use of those beds and to be purposeful in how we achieve our goals. It is a real asset to be able to repurpose beds on the Rawson-Neal campus.

We are excited about what FirstMed can potentially do. I believe there is opportunity to use the higher reimbursement rates to bring back some of the children who are not housed in Nevada currently. Much of the new budget proposals are things we have been advocating for years. Peer-to-peer support

could be expanded at minimal cost. The Division is doing a great job, but it can always be made better.

JARED BUSKER (Policy Analyst, Children's Advocacy Alliance):
My organization has had concerns with the block grant funding that the Legislature authorized in a previous session. We would advocate for an audit of the two block grants to ensure that funding is being used efficiently and appropriately.

We also have concerns relating to the UNITY system. We believe it is outdated and inefficient.

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CHAIR DENIS:
Seeing no further comment, this meeting is adjourned at 10:29 a.m.

RESPECTFULLY SUBMITTED:

_____
Barbara Williams,
Committee Secretary

APPROVED BY:

_____
Senator Moises Denis, Chair

DATE: _____

_____
Assemblyman Michael C. Sprinkle, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	1		Agenda
	B	4		Attendance Roster
	C	44	Kelly Wooldridge, Division of Child and Family Services	Department of Health and Human Services, DCFS Budget Presentation
	D	2	Dan Musgrove, Clark County Children's Mental Health Consortium	Testimony in Support of the Mobile Crisis Intervention Program