

# **STATE OF NEVADA DEPARTMENT OF HUMAN RESOURCES**



## **STRATEGIC PLAN FOR PEOPLE WITH DISABILITIES**

**October 2002**

**The Honorable Kenny C. Guinn  
Governor  
State of Nevada**

**Michael J. Willden  
Director  
Department of Human  
Resources**

**AB 513**  
**71<sup>st</sup> Legislative Session**  
**Requiring the Development of Strategic Plans**  
**Concerning the Health Care Needs of Citizens of Nevada**

A sixteen member Steering Committee was appointed by Governor Kenny Guinn to oversee the completion of four distinct strategic plans approved for passage by the 71<sup>st</sup> Session of the Legislature concerning the health care needs of the citizens of Nevada: 1) a plan to ensure the availability and accessibility of continuum of services that appropriately meets the basic needs of Nevada's senior citizens; 2) a plan to ensure the availability and accessibility of a continuum of health care services in rural areas of Nevada; 3) a plan to ensure the availability and accessibility of a continuum of services appropriately meets the basic needs of people with disabilities in Nevada; and 4) a plan to develop and implement a sound methodology for the establishment and periodic adjustment of rates paid by the State of Nevada for contracted health and human services.

A Task Force of consumers, providers, payors and advocates in each of these four fields was in turn appointed to develop the plan related to their area of expertise. Two members of each Task Force concurrently served on the Governor's Steering Committee to insure coordination throughout the planning effort. The Task Force on Disability responsible for completion of this Strategic Plan wish to express our appreciation of the Steering Committee members and staff who supported our efforts and to whom much of the work of accomplishing our goals will fall:

**STEERING COMMITTEE MEMBERS**

**Michael J. Willden, Chair**  
**Director, Department of Human Resources**

**Raymond D. Rawson – Nevada State Senator**

**Bonnie Parnell – Nevada Assemblywoman**

**Robert Hadfield - Executive Director, Nevada Association of Counties**

**Tom Pierce, Ph.D. - Member, Disability Task Force**

**Paul Gowins - Member, Disability Task Force**

**Mark Innouye - Member, Rates Task Force**

**Diane Ross - Member, Rates Task Force**

**Robin Keith - Chair, Rural Health Task Force**

**Steve Tognoli - Member, Rural Health Task Force**

**Karen Mabry - Member, Senior Services Task Force**

**Susan Rhodes - Chair, Senior Services Task Force**

**Alice Molasky-Arman - State of Nevada Insurance Commissioner**

**John P. Comeaux - Director, Department of Administration**

**Myla C. Florence - Director, Department of Employment, Training, and Rehabilitation**

**Sherrada James - Executive Director, Nevada Indian Commission**

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OFFICE OF COMMUNITY BASED SERVICES

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Disabilities

Nevada Council on  
Independent Living

Nevada Council on  
Assistive Technology

Personal Assistance  
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Nevada Tele-  
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October 10, 2002

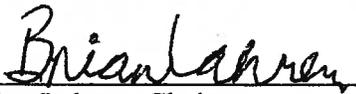
Director Willden,

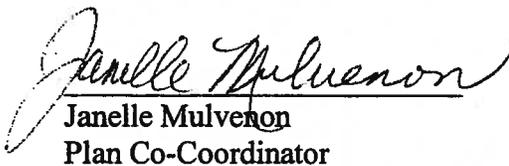
On behalf of the Nevada Task Force on Disability and its four constituent Sub-committees, we are pleased to submit the Strategic Plan for People with Disabilities.

The Plan is the product of nearly two years of work and hundreds of voices of people with disabilities, their families, providers and advocates. It has been carefully structured to insure adherence to U.S. Supreme Court Olmstead provisions and to the principles of inclusive, independent living for all Nevadans.

We speak for everyone involved in expressing our gratitude to you, to Governor Guinn and to our Nevada legislators. It is you who have provided this landmark opportunity for people with disabilities to be heard and to design, for themselves, the service continuum which will best fit their needs today and in the future.

Sincerely,

  
Brian Lahren, Chairman

  
Janelle Mulvenon  
Plan Co-Coordinator

  
Donny Loux  
Plan Co-Coordinator

DL/dlp  
Enclosure



“This is essentially a people’s contest. On the side of the Union, it is a struggle for maintaining in the world that form of government, whose leading object is to elevate the condition of people ... to lift artificial weights from their shoulders ... to afford all, an unfettered start, and a fair chance in the race of life.”

Abraham Lincoln

*Nevada’s Plan is dedicated to  
the memory of Justin Dart,  
friend and colleague...we will  
lead on...*

## FOREWORD

Nevada's system of publicly supported services for people with disabilities has been assembled over time from individual elements designed to access available funding and serve specific populations. The process may be likened to assembling a mosaic out of random bits of tile with only the most vague picture as a guide. The range of services Nevada has provided has not historically covered all persons with significantly challenging conditions, rather it represented discrete elements of service for the most publicly visible, or politically organized, who could garner official support for their most pressing needs. The result has been better services for some parts of the disability community and little or no services for others. In addition, given Nevada's volatile and minimal tax base, the per capita expenditures for even the best funded of Nevada's human services have been, for decades, among the lowest in the nation.

It was in this context that Governor Kenny Guinn and key members of Nevada's 2001 Legislature funded a comprehensive review of existing disability services. Assembly Bill 513 charged state agencies and representatives of Nevada's community of persons with disabilities to work together to develop a comprehensive long-term plan for disability services. The key elements of this plan are to estimate the existing and future need for services, recommend ways to eliminate inefficiency in service delivery, recommend cost-effective and accessible systems of care, and help Nevadans with disabilities to become as productive and self-supporting as their conditions permit.

The actual public process has been exceptionally productive and provided an unprecedented opportunity for service consumers to identify what works, what doesn't, and how the future might be made more humane and productive for all concerned. It has become clear Nevada has not historically been fully aware of the needs of persons with disabilities. In many areas data simply has not ever been collected enabling one to construct a comprehensive picture of Nevada's need for disability services. Likewise, we have not always been aware of the ways in which we might reduce future costs by investing in helping our special citizens become as economically self-sufficient as possible. Nevertheless, it has still been possible to make general assessments of future needs and to define missing elements of service that frustrate the goal of building a cost-effective and humane coordination of public and private service components.

In what follows, a broadly representative consensus of Nevada's disability community has defined its needs. The primary organizing principles of disability service are prominently displayed. Every possible effort has been made to assure representation in the final disability plan includes all disability groups, whether large in number or affecting only a few individuals. Consensus is equally behind the organization of a prioritized implementation schedule covering the next five biennial budget cycles. The implementation schedule is naturally clearer for the first two biennia than for later ones. All participants recognize adjustments will need to occur depending on available funding and actual implementation schedules. However, despite the caveat about budget realities, the present plan will

provide any reader with a useful and consumer-validated perspective on how Nevada must ultimately build an integrated system of care. The described system of care specifically meets the legitimate and socially constructive goals of persons with disabilities who want to be part of our state's economic future.

Relevant state agencies have also contributed to this document. Wherever relevant their authorship of plan components has been noted. This is done for a practical reason. State agencies serve not only people with disabilities, but also a powerful political constituency of politicians and the public. Agency administrators often feel compelled to explain their fiscal and operational limitations, or stress their positive accomplishments, in facing criticisms from the disability and advocacy community. They are likewise aware of the need to assure their own constituencies they are competently dealing with their problems. Where agency statements conflict with the assessments of the disability community, we only hope the astute reader will note the discrepancy and make their own independent judgment of the facts.

We are the most prosperous nation in the history of the world, but we have not yet made ourselves a land of opportunity for those challenged by the wide range of disabilities that might befall any one of us. We will not be a truly admirable society, or one to emulate as an economic or social model, until we are really a land of opportunity for all those willing to do their best to lead useful and productive lives, regardless of their challenges. This plan shows us how to make a huge step in that direction for Nevada.

**Brian Lahren, Ph.D., Chairman  
Nevada Task Force on Disability**

## NEVADA TASK FORCE ON DISABILITY

**Chairman:** Brian Lahren, Director, WARC

**Vice Chair:** George Brown, Chairman, Nevada Council on Developmental Disabilities

### **Members:<sup>1</sup>**

**Robert Deruisseaux**, Northern Nevada  
Center for Independent Living

**Loren Ellery**, Reno/Sparks Indian Colony

**Tina Gerber-Winn**, Nevada Medicaid

**Paul Gowins**, Nevada Council on  
Independent Living

**Fred Hillerby**, Hillerby and Associates

**Bob Hogan**, Nevada Community  
Enrichment Program

**Flo La Roy**, Nevada Task Force on  
Autism

**Shirley Martel**, Foster Parent

**Dr. Tom Pierce**, University of Nevada, Las  
Vegas, Department of Education

**Lupo Quitarano**, Nevada Paralyzed  
Veterans of America

**Jon Sasser**, Washoe Legal Services

**Linda Raymond**, Sensory Deficit Program,  
Clark County School District

**Karen Taycher**, Parents Encouraging  
Parents

**Joe Tyler**, National Association of the  
Mentally Ill of Nevada

**Karen Wyman**, Telecare

### **Mission Statement**

*Develop long-range strategic planning for services to all Nevadans with disabilities which represents a seamless continuum of support options enabling achievement of maximum mainstream personal and economic independence.*

### **Planning Service Policy Goal**

*Services must be available throughout Nevada for every disabling condition in the most integrated setting appropriate, for the purpose of equally including citizens with disabilities of all ages and incomes into the mainstream of Nevada society.*

### **Plan Coordinators:**

**Donny Loux**, Chief  
Office of Community Based Services

**Janelle Mulvenon**, Administrator  
Community Connections Services

**Production Associate:** Diana Peachay

**Final Edit:** Connee McCasland

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<sup>1</sup> Members' biographies are located in Appendix H.

## ACKNOWLEDGEMENTS

We are thankful to the many co-authors of the Plan: Dr. Brian Lahren, Donny Loux, Betty Leyrer, Patty Williams, Gloria O'Brian, Drs. Charlene Harrington and Thomas Pierce, and Karen Taycher. We owe much appreciation to our webmaster Linda Featheringill. Most importantly, we are thankful to the architects of the plan, members of the Task Force and its four constituent subcommittees. We thank Janelle Mulvenon for her skilled and thoughtful guidance through the complex issues of children and families and Tina Perry, Brian Wellins, Jerry Grath, Diane Allen and Juanita Ball Hill for taking time they didn't really have to meet our impossible data deadlines. Thanks to Sue Young and Kraig Schutte who sorted out SSI/SSDI issues and populations and Chris Thompson and Jack Reid who helped us put dollar figures to our dreams. Thanks to Diane Nassir for her patience and organization in keeping us on target with our timelines and getting answers to our endless questions; Christina Harper for assistance with postings, travel and minutes; Mary Evilsizer for helping wherever and whenever we needed her; Ed Guthrie, Mel Phillips, Stephanie Allen and Richard Whitley for keeping us updated on the progress of the Rates, Senior and Rural Plans and their collaboration on mutual goals. County Adult and Social Service staff, our non-profit CEOs, Tribal and Federally Qualified Health Centers, state agencies, UNR and UNLV staff, each were invaluable in helping us fit the pieces of the disability service tapestry together. We apologize that time did not permit a survey of the many excellent private for-profit organizations providing critical disability services. It is our intention to add this needed component to the service section for use as a stand-alone reference in 2003.

Our thanks to Steve Gold, Tony Records and Jo Donlin for providing training and technical assistance in the intent and precepts of Olmstead and to Bobbie Silverstein for assisting us in developing a truly inclusive public policy. Thanks to George Brown, Ken Vogel and the Nevada Developmental Disabilities Council for sponsoring the Olmstead and Public Policy Training and to Chairman Paul Gowins, the Attorneys General, and other members of our Olmstead Technical Advisory Group.

Our appreciation goes to Ginny Oldham, Anita Puentez Stiller, Betty and Gary Shade, Arlene Harbach and the many other consumers and advocates who, although not officially listed as Task Force or Subcommittee members, came to our many meetings to share their ideas and experiences. Thanks to David Sims, Cecilia Leal, Mack Johnson, Sherrada James, Loren Ellery and George Mayes for their insight and guidance in minority concerns; to Jean Peyton and Linda Raymond for sharing their expertise in issues of those with sensory impairments; to Tiffany Hesser who helped us understand the terrible issues of the HIV community; and to Lupo Quitoriano for bringing U.S. Veterans issues forward. Thanks to Karen Wyman, Bill Arent, Pastors Ted Ramey and Charles Bowker for their assistance in identifying the homeless population of people with disabilities; Mary Bryant for her wonderful, innovative higher education model for kids with cognitive disabilities; Connie BoBo and Nina Davenport for their thoughtful analysis of the needs of the ALS and MS communities; Vic Davis and Joe Tyler for their hard work on issues of those with mental illness; Lila Holdsworth for great new ideas in developmental disabilities; and to Paul Martin and Robert Desruisseaux for their guidance in accessibility issues. To the many other consumers and advocates who guided us through the specialized needs of varying disabilities; to the parents who shared their struggles, knowledge and precious time; and to Anna Bravo and other personal assistants who helped make it possible for all voices to be heard, we are truly grateful.

We are deeply grateful to Anne Cory, Executive Director of United Way of Reno, for so quickly pulling together the meetings and proposals needed to establish one of our primary objectives... the implementation of 211 universal access in Nevada with specialized disability call centers. Thanks Anne, great work!

We thank our dissenters for challenging us to go the extra mile, our supporters for believing that together we can change the world and Veronica Hulsey for banging us over the head with "Money Follows the Client" until we got it.

A very special thanks to Diane Randall and Melanie Whitney without whom none of the meetings, travel, recording, last minute arrangements, and crisis resolutions would have been possible.

We owe the greatest appreciation to Diana Peachay. She is our heroine for 1,042 rewrites from more than 60 people and for countless hours of overtime and summer weekends away from her terrific family ... bringing the Plan to completion.

Connee McCasland, our editor, can finish her Ph.D. knowing that she has done the impossible...provide the final edit of 506 pages in one weekend and two days on one day's notice!

Thanks to our ever supportive Legislative Subcommittee on Disability ... Dina Titus, Ray Rawson, Vonne Chowning, Jerry Clayborn, Randy Townsend and Sharron Angle and their wonderful staff, Bob Guernsey, Leslie Hamner and Jim Rodriguez!!! You have fought with us for so many years ... your encouragement and belief that people with disabilities can, and should, assume leadership in the issues that effect them was a truly defining factor in our unity and persistence.

Without the support of Governor Kenny Guinn, there wouldn't be a Plan. It was his decision to prioritize the Plan and his leadership which resulted in the appropriation making the Plan a reality. He is the first Nevada Governor in more than two decades to prioritize services and supports to people with disabilities ... a promise he made in his first State of the State Address ... and one he has honored despite many other pressing and urgent state issues.

Many thanks to Directors Mike Willden, our fearless leader in this effort, and Myla Florence for their support, encouragement and their patience throughout so many starts and stops and midstream changes. Mike and Myla, we owe you so much ... and we know this is really just the beginning!

Special thanks to Krystal Shirley, a wonderful advocate who started out with us but became too ill to continue. We hope this plan will bring about the improvements in services you and your family have fought for.

Finally, to our guide and guru, Tony Records ... when, together, we accomplish the mission and goals of the Plan, we will have done it, in large measure, because of your counsel, candor and not so gentle critique of our efforts at every turn ... to your knowledge and sharing of the innovations of our sister states ... and your tireless advocacy to keep children and adults with disabilities where they belong ... in the mainstream of American society.

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***GLOSSARY:***

- Definitions
- Acronyms and Abbreviations

## **PART I**

### **EXECUTIVE SUMMARY**

Nevada ranks number one in the nation in the increase of people with disability over the past decade. Today, there are more than 375,000 people with disabilities living in Nevada; at least 50,000 are children or young adults. The disability population of the state has, in fact, increased by 157% over the past ten years while that of the nation, as a whole, has decreased by 2%.

Although Nevada has, in many respects, taken a leadership role in specific areas of disability, such as personal assistance services, the state as a whole has not begun to keep pace with the services needed to support the rapid growth in this population.

These circumstances and the U.S. Supreme Court “Olmstead Decision” published in 2000, led people with disabilities and their advocates to request development of this Strategic Plan and a parallel study by the Nevada Legislature.

Focus groups were held throughout the state in 2001, and upwards of 200 consumers and advocates provided recommendations for how the plan should be developed, what should be studied and included, how participation of people with disabilities and families would be assured, who should conduct the study, and how the resulting plan would be monitored and outcomes reported.

The 2001 Legislature appropriated \$150,000 to the Department of Human Resources to prepare the Strategic Plan, and to establish a Task Force of consumers, advocates, parents, providers and payors to guide plan development. The Task Force, in turn, appointed four sub-committees consisting of 49 additional consumers and advocates and a Technical Advisory Group for issues related to the Olmstead Decision.

The firm of Tony Records and Associates, nationally recognized for their work with states and with the federal Office of Civil Rights in issues of Olmstead, served as the primary contractor for plan development. Demographics of people with disabilities in Nevada were provided by the University of California, San Francisco’s Disability Statistics and Research Center and the Special Education Department of the University of Nevada, Las Vegas.

The Legislative Commission simultaneously appointed a legislative “Sub-committee for Study of the State’s Program for Providing Services to Persons with Disabilities,” chaired by Senator Dina Titus. Members of the legislative sub-committee pledged to work hand-in-hand with the Governor’s Executive Task Force on Disabilities toward development of a comprehensive, integrated plan, crossing both branches of government.

The Executive Task Force on Disabilities and its sub-committees held 45 meetings and training sessions, and three public hearings to develop and review the plan. Members and participants initially identified 185 perceived barriers to service, independence and inclusion.

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The task force identified nine goals and 227 strategies to resolve the barriers presented to them, to improve community capacity and to provide quality assurance and monitoring of plan implementation. Those strategies were consolidated, in so far as possible, into 78 by the close of Task Force deliberations. Others are listed in Appendix G. The goals enumerated in Appendix G are no less important than the 78 listed in the text of the plan and no less urgent. The overall system for serving Nevadans with disabilities is perceived by the NTFD and its sub-committees to be so seriously under-funded that only those recommendations needed for alignment with the Americans with Disabilities Act/Olmstead principles of the Center for Medicare and Medicaid Services (CMS) and those most crucial to the future of Nevada children are addressed in the Plan.

Members requested a general review of Nevada's status in complying with Olmstead requisites from Tony Records, and contracted a survey of state and community programs providing services to children and adults with disabilities. Findings of the Records Olmstead review are provided in Section V in their entirety. Generally, findings were as follows:

- For many people with disabilities in Nevada, the choice to be provided services in the most integrated setting does not exist. There is a significant gap between the documented needs of people with disabilities and the services available in integrated settings. At least hundreds, and more likely thousands, of people with disabilities in Nevada are not receiving appropriate services in the most integrated setting. Many people who can live in the community are unnecessarily languishing in nursing facilities or other segregated settings and missing out on the many opportunities the community offers them. There are many others that are at imminent risk of unnecessary institutionalization due to the lack of available community services. The primary cause of this problem is clear – lack of available resources.

Nevada's entire system of services for people with disabilities is grossly under-funded. In nearly every component of community services, funding in Nevada falls far short of the needs of its citizens with disabilities. When compared with other states across the country in terms of both overall spending and per capita fiscal effort for community services, Nevada is either last or almost last in nearly every funding category. In order for sustained compliance with *Olmstead* to occur, this must change. There are numerous proposals and strategies that the Task Force has included in its plan that require resources from the state in order for implementation to occur. Funding of these proposals is essential to compliance with *Olmstead*.

- A primary problem in Nevada is the lack of an effective overall information system for people with disabilities. Each state agency, sub-agency, county and private service provider has its own separate information system. As a result, service delivery is often provided in an inefficient and scattered manner. Information systems are replete with missing pieces in some places, and duplicated counts of people and service units in others, resulting in a common practice of development of service plans and budget projections based on misinformation. The Task Force has recommended support for a comprehensive review of all data systems for people with disabilities in Nevada and the development of a unified information system. The investment needed for the

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development of this system will be significant but medium and long-term benefits of such a system are incalculable.

- There appears to be a potentially significant *Olmstead* compliance problem with regard to people with disabilities that live in nursing homes. Although there has been some movement of people into the community on a small scale in the past two years, much more can and should be done to create and facilitate options in a more integrated setting. More resources are desperately needed in order to increase capacity in the community and create enhanced diversionary services designed to prevent people from entering nursing homes. Needed resources are not limited to increasing “slots” in the home and community-based waivers, but also include enhancing eligibility for waiver services, and providing state-funded services for people with disabilities above all Medicaid income limits.
- There are, reportedly, more than 125 Nevadans with disabilities living in out-of-state residential programs. There was discussion at the Task Force meetings regarding proposals to develop in-state programs for some of these people. It is essential that these proposals are funded and implemented as soon as possible.
- There are extremely limited community options for people in nursing homes or those individuals with acquired brain injury or autism. The state should consider an option of expanding services and eligibility criteria within the existing waivers to allow more people with disabilities to become eligible for these excellent federally matched programs.
- Reportedly, there are 28-30 children attending out-of-state residential schools. Many of these children have either severe emotional disorders and/or autism. Development of in-state community programs should be given high priority. There are also approximately 300 children with severe emotional disorders receiving inpatient residential treatment services within the state. Many of these children and adolescents have lived in these treatment centers for a long time and have not transitioned to more integrated settings. Other children have been on waiting lists for residential treatment centers. Nevada should conduct an independent review of these children to determine whether they can be served in more integrated settings.
- Nevada officials report that at least 158 of Nevada youth in correctional facilities have a disability. National studies indicate that up to 40% of children in youth corrections facilities have disabilities. Many children with disabilities are often placed in correctional facilities due to the courts’ frustrations with the absence of appropriate alternatives. High priority should be given to comprehensive assessment, needs analysis and program development for community alternatives for these children and youth.
- There are more than 11,000 Nevada students with disabilities in special education. It was widely reported during interviews that Nevada’s Vocational Rehabilitation and education agencies are not providing the necessary support in transitioning from school to adult life. Without comprehensive transition services, many of these children will be at risk of

unnecessary institutionalization. It is imperative that state service providers in Nevada, in conjunction with other disability service agencies, provide the transition services already required by law.

- It is important to emphasize that compliance with *Olmstead* is not limited to Medicaid or other federally funded programs. In many instances people with disabilities, due to their inability to meet certain eligibility criteria, cannot receive Medicaid, Medicare or education funds. In Nevada, there are several programs that are funded primarily through state and/or county funds. Each of these programs offers a valuable service that fosters independence and self-sufficiency. Because these programs are state controlled or funded, they also offer a high degree of programmatic flexibility that federally funded programs cannot provide. Many of these programs are key to diverting people with disabilities from unnecessary admissions to institutions, but are under-funded and, as a result, have growing waiting lists. Failure to fully fund these programs will result in two unconstructive results. First, it will result in more people being unnecessarily institutionalized, in violation of *Olmstead* and the ADA. Second, it will relegate more people with disabilities to the Medicaid rolls, resulting in more costly, restrictive services.
- It is clear that the absence of a well-managed waiting list system in Nevada presents a significant compliance and liability problem with regard to *Olmstead* and the ADA. There is significant litigation across the country that is forcing states to establish consistent methodologies and criteria for people with disabilities on waiting lists. It would be prudent and effective for Nevada to proactively develop a valid and meaningful waiting list process to avoid unnecessary litigation.
- The Task Force recommends several important strategies designed to provide comprehensive, setting-neutral assessments for people with disabilities who may be at risk of institutionalization. If implemented, these assessments will provide the state with the actual needs of people with disabilities and provide a concrete basis for planning and resource development.

The Records report examined each of the objectives and corresponding strategies within the draft planning documents for their relationship and relevance to *Olmstead* and found that the Task Force has addressed each of the *Olmstead* compliance concerns listed above.

On September 23, 2002, the task force presented nine goals and 78 strategies for legislative action to the Titus Legislative Study Committee. The Task Force also presented goals and strategies requiring Executive Branch action to Director's Willden and Florence on October 5<sup>th</sup>, 2002.

The nine goals established by the Task Force to guide all disability planning and funding over the upcoming ten-year period are as follows:

***Social policy, program structure, regulation and planning affecting the lives of children and adults with disabilities will fully reflect their views, culture and involvement.***

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*Service provision to people with disabilities in the most integrated, appropriate settings will be assured through the application and resulting service plans of individualized, setting-neutral assessments and expedited service entry.*

*Children and adults with disabilities of all ages will receive services expeditiously and in the most integrated environments appropriate to their needs.*

*Children and adults with unique needs will obtain services in a timely and appropriate manner.*

*The risk of institutionalization will be decreased in the general disability population by improving and protecting critical health care services.*

*Children and adults with disabilities will not be placed at risk of institutionalization while living independently and/or inclusively in their communities for lack of adequate information and support and will easily and appropriately access the services they require.*

*People with disabilities and families of children with disabilities will knowledgeably and appropriately choose and direct the services they receive and receive them at each critical juncture of life.*

*The state system of service delivery and long-term care will be managed and monitored so that services in most integrated settings become the norm throughout Nevada.*

*Independent in-state compliance monitoring and mediation of Olmstead and Americans with Disabilities Act issues will be funded and implemented.*

Strategies designed by the Task Force to accomplish these goals include; involvement of people with disabilities and families in all policy and decision making; development of universal telephone access (211) and web site information, referral and crisis intervention; setting-neutral assessment of people in, or at risk of, institutional care; services and supports for transition from institutional care; implementation of a “money follows the person” initiative; access to waitlisted services within 90 days; substantially increased community capacity; development of a comprehensive, effective and accurate data system; single entry access to health and dental care; early intervention and mental health treatment for children; expansion of EPSDT screening; a pilot program of school to adult life transition services; higher educational opportunities for students with cognitive disabilities through the Millennium Scholarship; outreach to people with disabilities who are homeless; a streamlined, single eligibility application for SSI and Medicaid; a fast track eligibility process for those with terminal disabilities; increased guardianship opportunities; expansion of Medicaid Buy-In; a prescription drug subsidy for low-income people with disabilities; cross disability budget planning; enhanced special education unit funding; development of an Office of Disabilities and cabinet level Chief Deputy for Disabilities; independent disability mediation and ombudsman services; permanent funding for the state’s Positive Behavioral Supports, family respite and Independent Living programs; outsourcing of state funded

services; improvements in quality assurance and infrastructure; continuation of the Legislative Commission's Sub-committee on Services to People with Disabilities; and exemption from budget cutting for poor children, people with disabilities and frail seniors in poor economic climates.

The full text of goals and strategies appears in Section VIII.

Recognizing the economic difficulties faced by the state, the Task Force has taken a measured approach to establishing the strategies presented in the Plan. Recommendations have sought to maximize federal matching dollars, identify existing revenues which might be re-designated, avoid requesting additional state positions, optimize use of community providers for direct care and service and propose structures which promote coordination, rather than duplication, of existing services.

These efforts alone will not, however, result in increasing community capacity to acceptable levels or ensure quality data systems. New revenues must be identified to begin to genuinely address the needs of Nevada's children and adults with disabilities and their families.

The irony of putting forward this ambitious Plan in these, the worst of economic times, has caused reflection on the strength of planning and budgeting in better fiscal climates. The Task Force believes there are lessons to be learned from this irony toward a future of promise and equality for all Nevada citizens.

*The basic things expected by our people of their political and economic systems are simple. They are: Equality of opportunity. Jobs for those who can work. Security for those who need it. The ending of special privilege for the few. The preservation of civil liberties for all.*

**President Franklin D. Roosevelt**

## **PART II**

### **INTRODUCTION**

Nevada has proven to be a leader in many areas of disability, service and policy. In 1972 the state became one of the first in the nation to implement the personal assistance option in the Medicaid State Plan. In 1979, at the request of disability advocates, Nevada expanded services to people with physical disabilities through a home and community-based services waiver. Six years later, again responding to Nevada advocates, the Nevada Legislature established a state-funded consumer directed program of personal assistance services for people above Medicaid waiver income limits. In 1995, advocates were successful in changing Nevada's Nurse Practice Act to allow personal assistants to provide "any service which a person without a disability would normally perform for themselves." In the most recent legislative session, the Nevada Personal Assistance Act was passed assuring that all Nevadans who cannot feed, bathe or toilet themselves will be identified and planned for in the Executive Budget process and establishing a consumer directed State Council on Personal Assistance. In that same session, Nevada Governor Kenny Guinn approved a half million dollars in state funding for the state/federal independent living program.

The state's Mental Health and Developmental Services Division also obtained one of the nation's first Medicaid waivers for mental retardation and related conditions in the early 80s. The waiver originally supported home and community-based care provided in group homes, but was amended in the early 90s to provide for individual, supported living arrangements (SLAs). Supported living now constitutes 95% of all community-based residential supports.

The waiver was again expanded in the mid 90s to cover family support, respite and additional day services. The approved waiver slots are now 1,182, a growth of more than 650% from the 180 slots in 1995. Each person served by the waiver would otherwise qualify for institutional care, thus more than 1,000 developmentally disabled people are being supported in the community as an alternative to institutionalization.

Nevada ranks 7<sup>th</sup> among the states in providing community living in personalized, small settings of three or fewer people. In 2002, 71% of all people served in residential environments are in these settings---almost double the national average of 39%. As state-run institutional beds have simultaneously been reduced by 22%, the state now provides 90% of all residential supports in the community.

For decades Nevada's agency providing service for persons with developmental disabilities and related conditions has been among Nevada's best funded human service agencies. This has been the result of active and organized advocacy, first by parents and later by service-providing agencies. Among the encouraging achievements have been (1) the expansion of the definition of those eligible to receive state support to include those with autism and related conditions, and (2) the commitment to eliminate waiting lists for core services such as community-based residential care and day training. The key features of the long term plan

## **Nevada Strategic Plan for People with Disabilities**

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for this population include establishment of a systematic basis for routine adjustment of the rates paid to providers of care, the proposal to adequately fund essential case management services, and a firm commitment to the continued development and expansion of a truly integrated and self-directed life for persons with developmental disabilities.

The past decade has seen a gratifying increase in public awareness of the need for effective and easily accessible community-based care for persons with serious and persistent mental illness. To facilitate the development of services which help maintain the productive lives of individuals with mental illness and support their families as primary caregivers during periods of crisis, Nevada has shown a willingness to add significant funding to support the purchase of newly developed and more effective psychotropic medications, the purchase of residential supports and the expansion of Professionally Assertive Community Treatment (PACT) teams to provide essential supports at times of crisis. The plan for future services to this population focuses on expansion of community-based systems of support. Individuals with serious and persistent mental illness are more rapidly returned to productive lives if there is a full array of social and vocational services designed to help these challenged citizens attain maximum social and financial independence in their communities.

In response to the dramatically growing population of children and adults with autism and other pervasive developmental disabilities, Nevada instituted a Positive Behavioral Intervention and Supports program which is linked to the national training center. This exciting program, designed to create a preventive continuum of behavior supports, has successfully trained 300 professionals from schools and service agencies and worked with over 50 individuals with severe behavior problems thus far. This program is a top priority for expansion in this Strategic Plan.

Nevada is the only state in the nation in which the three major federal programs responsible for systems change in state disability policy and practice have joined forces to create a single agency through which they collaborate toward fulfillment of their respective federal mandates. These federal programs, Developmental Disabilities, Independent Living Services and Assistive Technology and their consumer directed councils have, together, filled major gaps in service delivery and added millions of dollars to the state's system. Their collaboration and strong, consistent support of Nevada legislators, has resulted in positive legislative change including passage of a Nevada Lemon Law for assistive technology, the Personal Assistance Act, academic credit for American Sign Language, prioritization of city/county land donation and proceeds from real-estate transfer taxes for disability projects, state surplus transfer to disability organizations, a telecommunication device distribution program for Nevadans with sensory impairments, a specialized state disability housing fund, and a \$5 million appropriation for a community service center in Las Vegas co-locating nonprofit and community college programs providing disability services.

Despite these advances, Nevada has fallen short in addressing the needs of the nation's fastest growing disability population: gains made are often lost in budget cuts caused by economic downturns; planning is too often stratified and does not recognize service needs across disability populations; new and developing disabilities are not included in service estimates; integrated services and facilities are not optimized for their potential to serve

people with disabilities; Nevada data systems do not lend themselves to well-advised decision-making; and people in desperate need often wait years for services critical to their health, safety and independence.

There are several underlying assumptions to the Nevada Strategic Plan.

Service Access: Currently, no standard procedure exists for people with disabilities or their families/supporters to apply for, or to find out about available services. No comprehensive directory of services exists, no coordinating agency. Referrals by medical, school, community, and government representatives are often inappropriate, limited to what they happen to know, arbitrary, and are made without the benefit of a reference resource of available options. Access to available services largely depends on the consumer's level of proximity and awareness of knowledgeable referral resources. Physically and culturally isolated groups are often unaware of services for which they may be eligible.

Development of an "access mechanism" that ensures all residents have equitable and full access to available services is needed. This function is especially needed to support specific populations including the homeless, Native American and other minority and low incidence groups.

Transitional Assistance: Transitional assistance for people being discharged from institutions is a complex, multifaceted, and critical support. A myriad of individualized provisions must be considered, evaluated, and facilitated. The effective delivery of this service is often the single most important determinant of successful transitions and, in some cases, is literally a life and death issue.

A Single System with Multiple Access Points: A single point of entry "no wrong door" is needed because:

- There is a geographically broad referral and intake need;
- There is no comprehensive directory of services in the state;
- State residents don't know what agency to contact for guidance;
- Standardization of this basic process will eliminate significant amounts of duplication, misinformation, and reduce the human and fiscal costs associated with people in need or crisis, being bounced around a system where there isn't a common practice, vocabulary, or knowledge; and,
- Citizens need to be informed of the available services provided.

Critical Services: Implementing of the full range of needed supports in a short time frame is unrealistic. However, there are certain components of the service system that are critically needed by residents and a set that have been mandated by the U.S. Supreme Court in the Olmstead ruling which must be addressed immediately:

- Assessments of individuals currently residing in institutions to determine appropriateness for community placement is required. The activity of completing an assessment form is insufficient for compliance. For full compliance the activity must

be performed in an objective, setting-neutral manner, by a qualified professional, without bias by personal or institutional interest;

- Waiting lists need to be closely analyzed for accuracy, completeness, and identification and removal of bottlenecks; and,
- An evaluation of community services is needed to avoid unnecessary institutionalization.

Eligibility: Nevada must ensure the scope and capacity of available services is sufficient to serve all citizens in need, regardless of region, ethnic origin, or living situation. The dynamic nature of the medical, legal, social, and community variables creates a need for periodic review of eligibility requirements. The current eligibility structure contains limitations and restrictions which not only compromise service delivery but prompt concerns of legal action against the state.

Assessment Processes: Assessment processes used to determine eligibility for specific services are critical to the integrity and success of the entire system. Improper assessments often begin a sequence of actions that include improper care, unneeded service, inefficient use of resources, and occasionally legal action. The Olmstead Decision highlights the need for objective, thorough, “setting-neutral” assessments conducted by competent, well-trained professionals. The costs associated with performing the assessment properly should be a fraction of the costs related to the potential consequences of poor assessment efforts. Such assessments will often lead to reduced cost of care, higher quality service, and reduced risk of litigation.

Timely Delivery of Services: This is a key measurement used by federal regulators in determining a state’s level of compliance with the Olmstead ruling. Development of systems to accurately monitor and measure time gaps between application, eligibility determination, and service delivery will be needed to ensure conformance with federal guidelines. Standards for maximum waiting times need to be established and capable systems structured and adequately supported.

System Optimization: System optimization involves ensuring the “right people” receive the “right services” at the “right time” in a way that optimizes the resources dedicated to serve them. Characteristics of an optimal system include 1) standardization, 2) expedient cycle and process times, 3) ready access to pertinent information, 4) leveraging resources with organizations sharing common objectives, 5) investment in services that result in the decrease or elimination of future expenditures, and 6) a decision framework supported by accurate and meaningful data.

Decision Support Systems: Effective use of limited resources requires a robust, ongoing planning and monitoring effort. Assuring allocated dollars are being used as intended and to provide maximum benefit, planning initiatives need to identify ways to maximize the dollars spent to benefit received ratio. The streamlining of processes, elimination of redundancy and duplication, and optimization of support organizations should result in a higher quality of

support with more value realized from system support expenditures. System characteristics include:

- Common data definitions and collection practices;
- Creation of a data repository that can be used as an operational decision support tool as well as a resource for reporting;
- System security that ensures privacy and confidentiality while providing access to appropriate information by authorized individuals; and,
- Cross agency data transfer, coordination, and consolidation to ensure all people are counted – but only counted once.

Leverage Resources through Collaboration: The splintered nature of advocacy, government, and service organizations has produced an inefficient use of financial and human resources. The resulting lack of focus has produced a flurry of activities, but without a commensurate level of result. Additionally, there are a number of resources in the community with the interest and capabilities to contribute, but the system structure is not oriented to fully realize this opportunity. Facilitating collaborative networks and initiatives would again produce efficiencies by having participants concentrate combined resources to benefit from economies of scale, information sharing, and enhanced service to one another. Examples include:

- Organizations like the United Way offer collaborative programs such as web and phone access programs that are available to Nevada at a fraction of the full development cost; and,
- A modest investment in respite care can result in a family providing long term care rather than an extremely costly institutional placement.

Proper System Alignment: Ultimately a service system is only successful if the needs of the consumers are met. Too often well meaning service providers and government agencies design systems in isolation, based on their professional or organizational perspectives of need. Predictably, the result is often dissatisfaction, isolation, resentment, occasional legal action, and often, expensive revamping efforts. Meaningful involvement of the communities being served is a vital component in the development of an effective service system.

Quality Assurance: Quality assurance is more than assuring quality service delivery. Given the magnitude of the need and the fiscal realities of the state, quality assurance includes value of service. Maximizing the dollar to service received ratio is a key issue. The state must have a method of ensuring programs are functioning in a quality and cost effective manner at both the state level and the individual level. Development and implementation of a comprehensive Quality Assurance System is an essential component of this plan. This system, if designed and managed properly, should identify quality concerns, optimize resources, and be the driving mechanism for ongoing quality assured service delivery and outcome tracking. Continual improvement of service should be the expectation of all stakeholders and an operational requirement of each provider. A properly functioning Quality Assurance System includes:

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- Clear and specific outcomes that can be measured from statewide programs to individual service levels;
- Measurement mechanisms that capture and report critical, meaningful data reflecting actual performance in an accurate and timely manner;
- An imbedded organizational process that effectively responds to quality concerns in an open and decisive manner with appropriate analysis and corrective action;
- A strong oversight function where those directly involved, as well as independent monitors evaluate all aspects of service delivery firsthand;
- Rigorous safeguards to quickly identify and remedy issues involving safety and protection;
- An ombudsman function available to consumers;
- The reporting and public dissemination of pertinent information; and,
- Supported Public Advocacy.

It is anticipated that implementation of the recommendations contained in the Strategic Plan will advance the state's efforts to provide a comprehensive, integrated, efficient, and effective array of services for people with disabilities that function in a manner consistent with accepted legal, fiscal, medical, and operational quality standards.

**PART III**

**HISTORICAL BACKGROUND  
AND  
KEY STAKEHOLDER PARTICIPATION**

During 1999-2000, people with disabilities and their advocates provided testimony to the Nevada Legislative Interim Committee on Health Care on the need for the state to develop a Nevada plan for services to people with disabilities in the most appropriate, integrated settings. Advocates and legislators discussed the U.S. Supreme Court Olmstead Decision, published in 2000, which provides an important legal framework for federal and state governments to integrate people with disabilities into the communities in which they live. Under the court's decision, states are required to provide community-based services for people with disabilities who would otherwise be entitled to institutional services when:

- The state's treatment professionals reasonably determine that such placement is appropriate;
- The affected person is in agreement with the decision; and
- The placement can be reasonably recommended, taking into account the resources available to the state and the needs of others who are receiving state-supported disability services.

The court has suggested a state may be found in compliance with these provisions by demonstrating it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate, and a waiting list for community-based care that moves at a reasonable pace and is not controlled by a state's objective of keeping its institutions fully populated.

As a result, state legislators appropriated \$150,000 in the 2001 Legislative Session to develop a long-term Strategic Plan for People with Disabilities.

On June 18, 2001, President George W. Bush issued an Executive Order on Community-Based Alternatives for Individuals with Disabilities. The Executive Order reconfirmed the federal government's support of the Olmstead Decision and directed the United States Office of the Attorney General, the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development, and the Commissioner of the Social Security Administration to "work cooperatively with states to ensure that the Olmstead Decision is implemented in a timely manner." This resulted in the addition of compliance with the guidelines issued under the Bush Executive Order to the objectives of the Nevada study and strategic plan.

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Public hearings were held throughout the state in the fall of 2001 soliciting the perspectives of people with disabilities, families, service-providers and treating professionals for what should be included in the study. Public hearings were held in Reno, Las Vegas, Carson City, Fallon and Elko with upwards of 400 interested parties attending. Participants were asked to give their recommendations for who and what should be studied, how study methodology should be designed, who should represent the interests of people with disabilities in conducting the study and how that representation should be organized. The participants also provided guidance on how study recommendations should be tracked as they are implemented and how the study process should be evaluated.

In September of 2001, Governor Guinn appointed a Steering Committee to oversee activities undertaken in developing of the Strategic Plan for People with Disabilities and three additional state plans designated to address the needs of seniors, service rates structuring and rural healthcare. A Disabilities Task Force comprised of people with disabilities, providers, advocates, family members and payors was subsequently appointed to carryout the work of putting the disabilities plan together. Chairman, Brian Lahren, Ph.D., convened the initial meeting of the Governor's Task Force on Disabilities on August 12, 2001. Members first established the mission of their work, formed five sub-committees to carry out their task and added 48 public members to these teams. The work of the teams was divided as follows:

- **Children's Services:** This included a review of all services and supports potentially needed by children with disabilities and their families from birth through the transition to adulthood. A transitions sub-committee was added to assure needed elements of support in life transitions.
- **Adult Services:** This included a review of services and systems needed by adults with disabilities and their families for medical and behavioral community-based diagnosis and treatment; acute care and/or skilled nursing care through community reentry, community-based medical management; and, implications to the aging process. The vice-chair sub-committee, two young adults and a senior with disabilities were charged with assuring the inclusion of needed supports for life transitions and service in adulthood.
- **Housing and Independent Living:** This included review of services needed for inclusive, independent, assisted and/or supported community living.
- **Rural and Reservation Issues:** This included review of the unique service delivery and support issues of people of all ages living in rural areas and/or on reservations.
- **Olmstead Technical Advisory Group:** This included review of services and systems as they relate to the requirements of the Olmstead Decision and provision of technical assistance to the Task Force and sub-committees in issues of the decision.

Each sub-committee was chaired by a member of the Task Force and co-chaired by a member of the community not serving as a Task Force member. A total of sixty-five people served on these sub-committees of whom 68% were people with disabilities or their family

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members. Forty-two percent (42%) of the members reside in Las Vegas, 35% in Reno, 23% in rural Nevada. Twenty-seven organizations and support groups were represented on these teams.

The Olmstead Technical Assistance Advisory Group (TAG) was chaired by a Task Force member who is a person with a disability, and comprised of the Nevada Disability Advocacy and Law Center (NDALC) representative, Arc, Independent Living and Developmental Disabilities Council representatives, Nevada Departments of Human Resources and Employment, Training and Rehabilitation, Washoe Legal Services and the Legislative Counsel Bureau staff.

The Nevada Council on Developmental Disabilities provided training to the Task Force and subcommittee members on “Strategic Planning for Olmstead” presented by Tony Records, national consultant to the Office of Civil Rights; “Developing Public Policy for People with Disabilities” presented by Bobby Silverstein J.D., Director of the Center for the Study and Advancement of Disability Policy; and “Nevada Implications for Olmstead” presented by Steve Gold, public interest law attorney and representing attorney in the original Helen L. case which laid the basis for the Olmstead Decision.

The firm of Tony Records and Associates, Charlene Harrington, Ph.D. of the Center for Disability Statistics and Research of the University of California, San Francisco (UCSF); and Betty Leyrer, Patty Williams and Gloria O’Brien have assisted the state in its mission to develop the Strategic Plan

During the spring and summer of 2002, the Task Force and its sub-committees met 47 times with meeting sites alternating between Reno and Las Vegas. The Rural Issues Subcommittee held 11 meetings throughout rural Nevada, several of which were held in conjunction with public input meetings of the Task Force on Rural Health Care.

At the September 17, 2002 meeting of the full Task Force, members finalized 77 recommendations for action. The recommendations address the following topics: family respite; community-based service provision to people who would otherwise be entitled to services in an institution; improved services to transitioning students; waiting lists which move at a reasonable pace; a no wrong door system of access to service, referral, and information; improvements in infrastructure, budget review and data management; services to people with autism, independent living and educational opportunities for people with severe disabilities; outreach to people with disabilities who are homeless; creation of a statewide network of Disability Ombudsman offices; establishment of an Office of Disability and improved coordination of state and county resources.

Sub-committee members advising the Task Force in its deliberations are listed on the next page with their respective affiliations.

**TASK FORCE SUB-COMMITTEES \***

**Children and Transitions**

Karen Taycher, Chair  
Flo La Roy, Vice-Chair  
Yvonne Brueggert  
Cheryl Dinnell  
Gloria Dopf  
Lisa Erquiaga  
Les Gruner  
Joe Haas  
Laurie Richardson  
Martha Schott-Bernius  
Winnie Wong  
Judy Wright  
Tina Gerber-Winn  
Shirley Martel  
Dorothy Pomin  
Linda Raymond  
Mary Jo Schimmels  
Stephanie Yates

**Affiliation**

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Nevada Parents Educating Parents (P)  
Nevada Disability, Advocacy and Law Center (P)  
Family TIES of Nevada, Inc. (P)  
Nevada Department of Education  
Nevada Center for Independent Living (P)  
Department of Child and Family Services  
Department of Child and Family Services  
Nevada Disability, Advocacy and Law Center  
HAPPY Program, Dept. of Human Resources  
Desert Regional Services  
Division of Health  
Nevada Medicaid  
Foster Parent  
Sierra Association for Foster Families  
Clark County School District (C)  
Gentiva Health Services/Rehab Without Walls  
Parent Training and Information Center (P)

**Adult Services**

Dr. Tom Pierce, Chair  
Jean Peyton, Vice-Chair  
Nina Davenport  
Vic Davis  
Mary Evilsizer  
Reggie Bennett  
Lila Holdsworth  
Rick Mahone  
Paul Martin  
Ginny Oldham  
Connie BoBo  
George Brown  
Carlos Ramirez  
Santa Perez  
Dale Warby

University of Nevada Las Vegas  
Blind Connect, Inc. (C)  
National Multiple Sclerosis Society (C)  
National Alliance for the Mentally Ill (C)  
Southern Nevada Center for Independent Living  
Nevada Community Enrichment Program  
Holdsworth, Inc.  
Northern Nevada Medical Center  
Nevadans for Equal Access (C)  
Endeavor, Inc. (P)  
Amyotrophic Lateral Sclerosis (ALS) Association  
Nevada Council on Developmental Disabilities  
Stroke Club of America (C)  
Consumer  
Community College of Southern Nevada

**Housing and Independent Living**

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Dedrie Manley, Vice-Chair  
Dr. Ralph Baker  
Lynn Bigley

Paralyzed Veterans of America (C)  
Frost Yasmer Estates  
Lyon County Mental Health Clinic (C)  
Nevada Disability, Advocacy and Law Center

\* Note: C = consumer, P = parent

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Paul Gowins  
Joe Tyler  
Dee Dee Foremaster  
Paul Haugen  
Mylan Hawkins  
Mimi Kimball  
George Mayes  
Jay Segarra  
David Sims  
Kitti Barth

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Office of Community Based Services  
National Alliance for the Mentally Ill (C)  
Center for Independent Living (C)  
Office of Community Based Services (C)  
Nevada Diabetes Association  
Northern Nevada Center for Independent Living (C)  
Nevada Council on Independent Living (C)  
Consumer  
Southern Nevada Center for Independent Living (C)  
Governor's Committee on Employment of People  
with Disabilities

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Veronica Hulse  
Mary Koch  
Ken Vogel  
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**Affiliation**

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Parent  
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Disabilities  
Deputy Attorney General  
Washoe Legal Services  
Deputy Attorney General  
Clark County Legal Services  
Legislative Counsel Bureau

\* Note: C = consumer, P = parent

**PART IV**

**NEVADANS WITH DISABILITIES**

*Prepared by Charlene Harrington, Ph.D., Disability Statistics and  
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Dr. Thomas B. Pierce, Ph.D., Chair, Department of Special Education, University of Nevada, Las Vegas*

**People with Disabilities in the Population**

More than 375,000 Nevadans are people with disabilities. Nevada has experienced a dramatic increase in its disability rate in the past decade, currently ranking number one among states in the rate of increase in disability for ages 16 and above, growing from 13 % for ages 5 and over in 1990 to 20 % in 2000. Nevada’s rate of disability (20 %) is slightly higher than that of the U.S. (18.8 %) with the majority of those with disabilities in the 21 – 64 age range. In 2000, 40 percent of Nevada’s seniors 65 and over, were disabled and 7.7% of the state’s children and young adults, not including those under age 5, were disabled (Table1).

**Table 1  
RATE OF DISABILITY AS A PERCENT OF THE  
POPULATION IN THE US AND NEVADA, 1990 AND 2000**

	1990	% of Population	2000	% of Population
5 – 20	30,311.00	12%	33,466	7.70%
21 – 64	72,939.00	10%	255,628	21.80%
65 - over	42,929.00	34%	86,816	40.60%
Nevada	146,179.00	13%	375,910	20%
U.S.	50,678,195.00	22%	49,746,248	18.80%

Source: US Census Bureau, Census 2000.

Of Nevada’s almost 2 million residents, 375,910 people over the age of five had disabilities in 2000 according to the US Census (Table 2). Although the total disability population age 5 and over in the U.S. declined by 2% between 1990 and 2000, Nevada’s disabled population increased by 157% (Table 2). The disabled population aged 21 to 64 in Nevada increased by 182,689 people, a 250% escalation during this 10-year period.

**Table 2  
NUMBER AND PERCENT CHANGE OF DISABLED  
POPULATION, NEVADA AND THE U.S., 1990 TO 2000**

	1990	2000	# Change	% of Population
5 - 20	30,311	33,466	3,155	10%
21 - 64	72,939	255,628	182,689	250%
65 - over	42,929	86,816	43,887	102%
Nevada	146,179	375,910	229,731	157%
U.S.	50,678,195	49,746,248	(931,947)	-2%

Source: US Census Bureau, Census 2000.

**Medicaid**

Of 153,251 Medicaid eligibles in 1999 (HCFA 2082 Report), 44,801 were children aged 0 to 5 or approximately 31 % of all children in the state (US Bureau of the Census), 26,281 were blind or disabled and 16,447 were aged. (These numbers represent unduplicated counts and may be different from Medicaid numbers found in other parts of this document, which are average monthly counts. Also, the numbers in this part of the report are based on federal fiscal years, while other parts of the report use data based on state fiscal years, resulting in counts which do not match.) Total Medicaid expenditures in that year were \$458.8 million. In 2001, Nevada’s Medicaid program spent \$689.5 million.

**Table 3  
NEVADA MEDICAID CASELOAD INFORMATION  
1998 - 2000**

	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
New Enrollees Each Year	3,612	3,829	4,058	4,302
Total Disabled/Blind Recipients	16,095	17,179	18,037	20,739
Average Annual Cost Per Person	\$10,383	\$10,671	\$11,247	\$11,551

Source: Counts and costs by Categories Provided by Nevada Medicaid Staff

**Social Security Disability Insurance (SSDI)**

Social Security Disability Insurance pays benefits to people with disabilities and certain members of their family when they have worked long enough and recently enough and paid Social Security taxes. As of December 2001, there were 42,468 Nevadans receiving benefits under SSDI, 34,071 of whom were disabled workers. Total SSDI payments in 2001 were \$247,248,000 (Table 4).

**Table 4  
NUMBER OF DISABLED SSDI BENEFICIARIES WITH BENEFITS  
IN CURRENT-PAYMENT STATUS AND  
AMOUNT OF AVERAGE BENEFITS, 2001**

	<b>Disabled Workers</b>	<b>Spouses</b>	<b>Children</b>	<b>Total</b>
Number of Beneficiaries	34,071	602	7,795	42,468
Average Monthly Benefit	\$862	\$231	\$254	\$247,248,000

Source: Social Security Administration, Office of Public Affairs, Region 9, San Francisco - 2001

**Supplemental Security Income (SSI)**

Supplemental Security Income is a federal and state cash assistance program that provides monthly payments to low-income aged, blind and disabled persons. In Nevada in 2001, 27,293 people received payments amounting to approximately \$11 million, and 20,066 were

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disabled or blind (See Table 5). The average benefit paid to SSI recipients monthly was \$452.

**Table 5  
NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS  
AND AMOUNT OF PAYMENTS, BY PROGRAM CATEGORY, AGE AND  
RECEIPT OF OASDI, DECEMBER 2001**

Total	Category		Age			SSI Recipients with OASDI	Total Payments
	Aged	Blind & Disabled	Under 18	18-64	65 or older		
27,293	7,227	20,066	4,310	15,388	7,595	9,214	\$11,190,000

Source: Social Security Administration, Office of Public Affairs, Region 9, San Francisco - 2001

By far, the great majority of SSI recipients with disabilities (72%) reside in Clark County. Washoe County has 16%, Carson has 2% and 9% reside in rural areas of Nevada.

**Total SSI/SSDI Recipients with Disabilities**

On August 23, 2002, a review of data files supplied by the Social Security Administration, Baltimore, MD, showed 62,686 people with disabilities were receiving SSI or SSDI benefits. Those with mental illness (21%), physical disabilities (20%) and children and adults with autism, mental retardation and other pervasive developmental disabilities (12%), accounted for the majority of recipients.

This same review showed there were 1,500 blind and 646 deaf recipients; 5,113 recipients with neurological disabilities including multiple sclerosis, arterial lateral sclerosis, stroke and spinal cord injury; 2,910 with brain injury; 2,309 with chronic obstructive pulmonary disease (COPD) and other respiratory disabilities and 751 recipients with HIV/AIDS.

Fifty-three percent of children ages 17 and under on SSI had pervasive and developmental disabilities. The greatest occurring disabilities in adults were physical disability and mental illness. A full review of all recipients with disabilities on August 23, 2002 is provided in Appendix I.

**SSI/SSDI/Medicaid Recipients**

Although 54,066 Nevadans received SSI or SSDI payments in 2001, only 20,739 people with disabilities were served by the Medicaid program as SSDI payments often exceed Medicaid income eligibility (Table 6). The majority of those who received SSDI payments received their health care through Medicare, however, as Medicare does not pay for long-term personal assistance services, these disabled workers must turn to the state-funded program or other resources for that service.

Medicare offers no prescription benefit, therefore, necessary drugs must be paid for from the SSDI cash allocation, and a 20% co-pay is required for all medical treatments and health care services.

**Table 6  
SSI/SSDI DISABLED RECIPIENTS  
RECEIVING MEDICAID BENEFITS**

	<b>1999</b>	<b>2001</b>
# disabled receiving SSI & SSDI (Dec. count)	47,277	54,137
Monthly avg of disabled receiving Medicaid	17,179	18,037

Nevada Monthly Caseload. SSI/SSDI Beneficiary Report (1999-2001)

**Children and Youth**

The Nevada Department of Education identified a total of 40,227 students enrolled in Nevada schools in December 2001 ages 3 to 21 who had disabilities. These students represent about 11% of the total Nevada student enrollment (356,814) during that period.<sup>1</sup> Of those, 4,966 (12.3%) had mental retardation or other pervasive developmental disabilities; 1,938 (4.8%) had emotional disabilities and 7,700 (19.1%) had speech, vision or hearing impairments. In addition, 153 (0.4%) had a traumatic brain injury, 2,076 (5.2%) had physical disabilities and 756 (1.9%) had multiple disabilities. This is a total of 17,589 (43.7%) children and youth that are most likely to need some health and personal care services. The remaining 22,638 (56.3%) had learning disabilities that may or may not require a comprehensive service array in the future. The Special Education student population grew at a 13% rate over the period from 1999-2001 (Table7).

**Table 7  
STUDENTS IN SPECIAL EDUCATION  
1999-2001**

<b>Eligibility/Impairment</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Mentally Retarded	1,760	1,805	1,875
Hearing Impaired	441	473	505
Speech/Language Impaired	6,231	6,604	7,035
Visually Impaired	135	148	152
Emotional Disturbance	1,642	1,822	1,938
Orthopedically Impaired	317	340	377
Health Impairment	1,270	1,483	1,699
Learning Disabled	20,391	21,840	22,638
Deaf-Blind	7	6	8
Multiple Impairments	685	704	756
Autism	327	483	671
Traumatic Brain Injured	119	149	153
Developmentally Delayed	2,378	2,306	2,420
<b>Totals</b>	<b>35,703</b>	<b>38,163</b>	<b>40,227</b>
% Increase	7.2%	6.9%	5.4%

Source: Nevada Child Count

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<sup>1</sup> Nevada Department of Education

**Nevada Strategic Plan for People with Disabilities**

**Table 8  
STUDENTS BY AGE - DECEMBER 1, 2001**

Eligibility/Impairment	Age Groups			Total
	3-5	6-13	14-21	
Mentally Retarded	58	1,004	813	1,875
Hearing Impaired	56	291	158	505
Speech/Language Impaired	1,084	5,842	109	7,035
Visually Impaired	9	98	45	152
Emotional Disturbance	3	1,156	779	1,938
Orthopedically Impaired	65	232	80	377
Health Impairment	55	1,179	465	1,699
Learning Disabled	19	13,975	8,645	22,639
Deaf-Blind	2	5	1	8
Multiple Impairments	48	438	270	756
Autism	153	438	80	671
Traumatic Brain Injured	5	98	50	153
Developmentally Delayed	2,419			2,419
<b>Totals</b>	<b>3,976</b>	<b>24,756</b>	<b>11,495</b>	<b>40,227</b>

Source: Nevada Child Count

**Table 9  
NUMBERS AND PERCENTAGES OF SPECIAL STUDENT AGES 17-19<sup>2</sup>  
WHO EXITED SPECIAL EDUCATION PROGRAMS DURING 1999-2001**

School Year	Total # 17-19 year olds who exited Spec. Ed.	Regular Education Diploma		Adjusted Diploma or Certificate		Return to Reg. Ed. (no longer eligible)		Dropped Out		Died		Moved, Known to be Continuing		Moved, Not Known to be Continuing	
		#	%*	#	%*	#	%*	#	%*	#	%*	#	%*	#	%*
1998-1999	1,640	375	23%	586	36%	55	3%	278	17%	4	<1%	181	11%	161	10%
1999-2000	1,888	422	22%	564	30%	51	3%	382	20%	5	<1%	327	17%	137	7%
2000-2001	2,225	447	20%	619	28%	74	3%	418	19%	3	<1%	506	23%	158	7%

\*Percentages are rounded to the nearest whole.

Source: Nevada Department of Education, October 2001

In State Fiscal Year 2001, of the estimated 86,767 infants and toddlers in Nevada, ages birth to 3, 1,839 were served with an Individualized Family Service Plan (IFSP) through the Division of Health and the Division of Child and Family Services. An additional 223 were waiting for services beyond the 45-day timeline at the end of SFY 01. In SFY 2002 the number served dropped to 1,741 and number of children waiting for service beyond 45-days with no IFSP at the close of FY 02 had increased to 591 (IDEA Office, 2001). According to the federal government, approximately 3 % of children, ages birth through 2 years, have disabilities. Using the US Census, the federal government computed Nevada was serving just 2 % in 2001.

<sup>2</sup> Caution: These are students who “exited special education”; the relative percentages are therefore affected, e.g., by numbers who MOVE.

**Table 10**  
**SFY 01 EARLY INTERVENTION SERVICES**  
**TOTAL SERVED BY COUNTY AND RACE/ETHNICITY**

County	Total	American Indian or Alaska Native	Asian	Black or African American	Hispanic or Latino	White (not Hispanic)
Carson City	38	4	0	0	6	28
Churchill	29	0	4	2	1	22
Clark	1,233	8	50	191	309	675
Douglas	14	0	2	0	0	12
Elko	57	2	0	3	12	40
Humboldt	25	0	0	1	5	20
Lander	11	1	0	0	1	8
Lincoln	5	0	0	0	0	5
Lyon	22	0	0	0	4	18
Mineral	4	0	0	0	1	3
Nye	39	1	0	7	1	30
Pershing	3	1	0	0	0	2
Storey	1	0	0	0	0	1
Washoe	348	15	18	19	92	204
White Pine	10	0	0	2	1	7
<b>STATE TOTALS</b>	<b>1,839</b>	<b>32</b>	<b>74</b>	<b>225</b>	<b>433</b>	<b>1,075</b>

Source: Community Connections TRAC Data 9/11/02

In FY01 the ethnic backgrounds of children being served through early intervention programs closely reflect the state demographic make up, showing that members of all groups are accessing services:

**Table 11**  
**ETHNIC GROUPS ACCESSING**  
**EARLY INTERVENTION SERVICES**

Ethnic or Cultural Group	* % of NV Population	% accessing or receiving Early Intervention Svcs.**
American Indian	1%	2%
Hispanic	20%	22%
Asian	5%	2%
Black or African/American	7%	12%
Caucasian	67%	62%

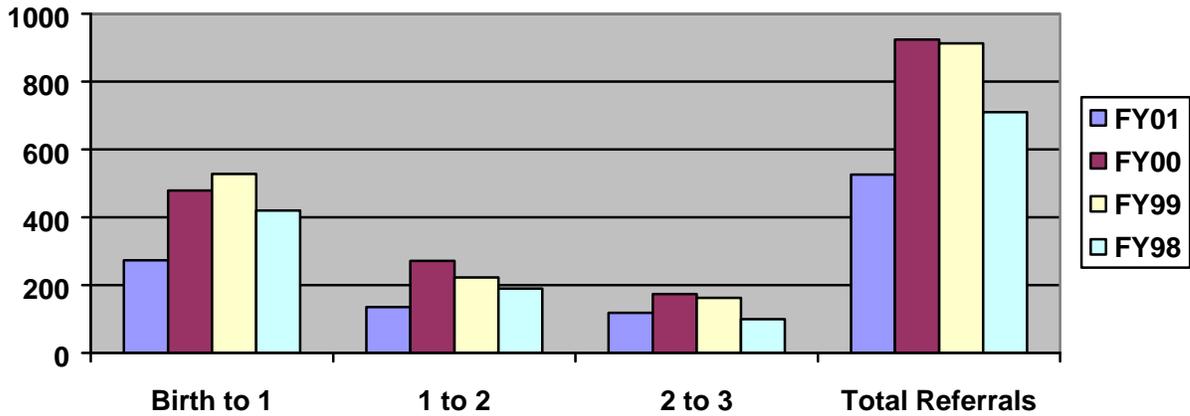
\*Based on NV Vital Statistics estimates.

\*\* Fiscal year 2001 TRAC data

Additionally, early intervention programs in Nevada have developed a systematic approach to identifying children with disabilities or developmental delays with the state's intensive

care nurseries. Based on Community Connections data, over 50% of all referrals come during the birth to one-year-old time period, as compared to the national average of 37%.

**Figure 1  
Early Intervention Referrals**



### **Mental Health**

Estimates of mental disorders in the population are difficult to determine. The National Comorbidity Study reported that almost half of the adult population (aged 15-54) has at least one lifetime mental disorder (Kessler et al., 1994). In the population, 17.2 % had an anxiety disorder and 11.3 % had an affective disorder. Another study by the Epidemiologic Catchment Area (EC) Prospective found that of adults 18 and over, 22.1 % had some form of mental disorder, 12.6 % had anxiety disorders, and 1.1 % had schizophrenic disorders (Regier et al., 1993). Of course not all of these individuals would need treatment by the state.

The Division of Mental Health and Developmental Services operates state-funded community mental health programs, inpatient programs, and mental health forensic services. The Division estimated that approximately 5.4% of the total Nevada population was living with a serious mental illness in 2000. This estimated rate was multiplied by the 2000 population to determine how many individuals may have mental illness (See Table 12).

**Table 12**  
**ESTIMATED NUMBER INDIVIDUALS WITH MENTAL ILLNESS IN THE POPULATION, NEVADA IN 2000**

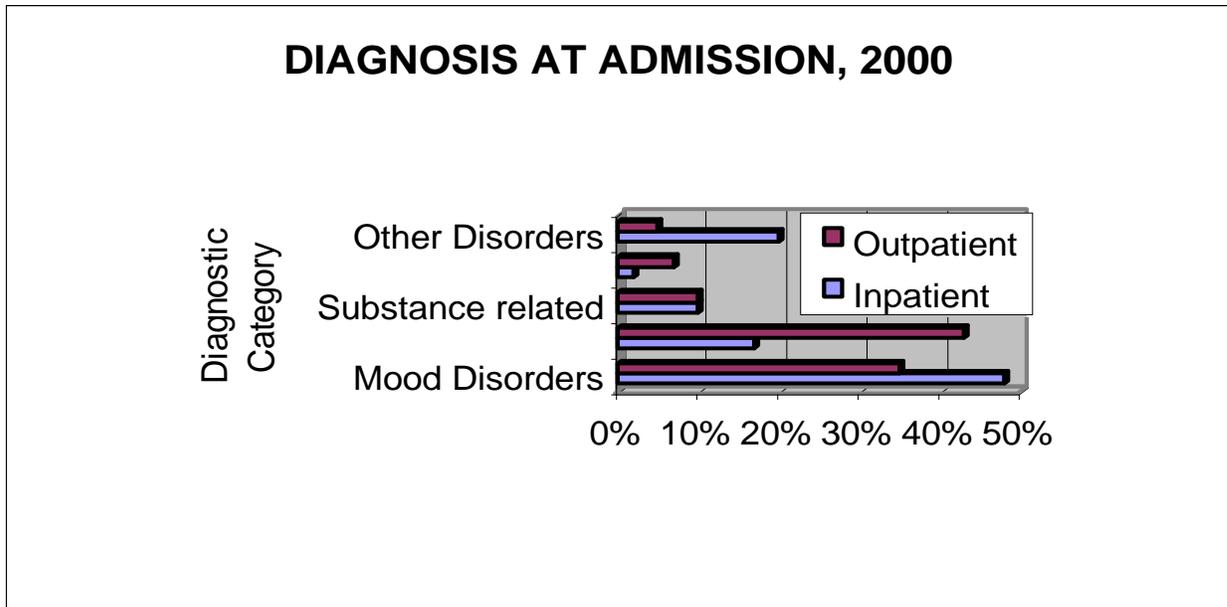
	Total Population	Rate with Mental Illness	Estimated Number with Mental Illness
Nevada	1,998,257	5.4%	107,906

Source: US Census Bureau, Census 2000. Estimated by applying a rate of .054 for the total population.

Nevada’s Rural Clinics provided services to 2,962 clients, and the Northern Nevada Adult Mental Health Services (NNAMHS) served 4,022 clients in 2001. During the same year, the Southern Nevada Adult Mental Health Services (SNAMHS) reported 11,528 clients. The majority of diagnosed mental health patients are suffering from a mood disorder or schizophrenia.

**Figure 2**

Source: Valentine, L. 2002. 2002 Needs Assessment. Division of Mental Health and Developmental Services, Department of Human Resources.



The number of individuals with mental health problems reported to be using residential placement in non-institutional settings in Nevada was 815 in 2002. In addition, another 118 were in institutional placements (See Table 13).

**Table 13**  
**MENTAL HEALTH SERVICES NON-INSTITUTIONAL**  
**AND INSTITUTIONAL RESIDENTS, NEVADA, 2002**

	Statewide	SNAMHS	NNAMHS	RC
Non-institutional - Residential placement	815	537	178	100
Institutional placement	118	78	40	0

Source: Brandenburg, C. 2002. Sub-committee on Disability. Department of Human Resources, Division of Mental Health and Developmental Services

**Developmental Services**

“In 2003, adults qualified for Nevada developmental services will be served by the Division of MHDS in numbers equivalent to 1/8<sup>th</sup> of the number the Centers for Disease Control estimates are currently living in Nevada” (Lahren 2001: 2). The average caseload for a MHDS case manager has increased from 35 to 55+ over the last eight years. Provider turnover rates for residential and vocational services are between 100% and 200% annually, presumably a consequence of low reimbursement rates.

The Division of Mental Health and Developmental Services reported residential placement of just over 1,200 clients in 2002, the majority of which were non-institutional (1,070) (Table 14).

**Table 14**  
**DEVELOPMENTAL SERVICES NON-INSTITUTIONAL**  
**AND INSTITUTIONAL RESIDENTS, NEVADA, 2002**

	Statewide	DRC	SRC	RRC
Non-institutional - Residential placement	1070	602	297	171
Institutional placement	133	82	51	0

Source: Brandenburg, C. 2002. Sub-committee on Disability. Department of Human Resources, Division of Mental Health and Developmental Services

**Estimating Unmet Need for Personal Care Assistance, Housing and Health Care**

**Personal Assistance**

The University of California, San Francisco, assisted the state Office of Community Based Services in conducting a study of the unmet need for personal assistance (*Personal Assistance in Nevada, 2001*). Table 15 shows the number of people and proportion of the population aged 15 and above experiencing various levels of activities of daily living (ADL) limitation. An estimated 28,900 Nevadans have difficulty performing one or more ADLs, but do not need assistance. Another 29,535 need help with at least one ADL, more than half of whom require assistance with two or more ADLs.

**Table 15  
ADL LIMITATIONS AND ASSISTANCE NEEDS  
AMONG NEVADANS AGED 15 AND ABOVE  
IN 2000**

No ADL Limitation	1,520,889	96.3%
Limited in any ADL	58,435	3.7%
Difficulty in 1 or more ADLs, but no assistance needed	28,900	1.8%
Needs assistance, 1 or more	29,535	1.9%
1 ADL	12,237	0.8%
2 ADLs	6,146	0.4%
2 ADLs	3,921	0.3%
4 ADLs	4,700	0.3%
5 ADLs	2,531	0.2%

Source: 1990-91 Survey of Income and Program Participation  
Extrapolated to Nevada

Specific assistance needs are shown in Table 16. Some 21,858 Nevada adults need help from another person in taking a bath or shower, the most common activity for which the assistance is needed. Next most common are dressing (16,583) and transferring (16,314). A much smaller number (9,302) need assistance in order to use the toilet, and only 3,933 need help eating.

**Table 15  
ADL LIMITATIONS AND ASSISTANCE NEEDS  
AMONG NEVADANS AGED 15 AND ABOVE  
IN 2000**

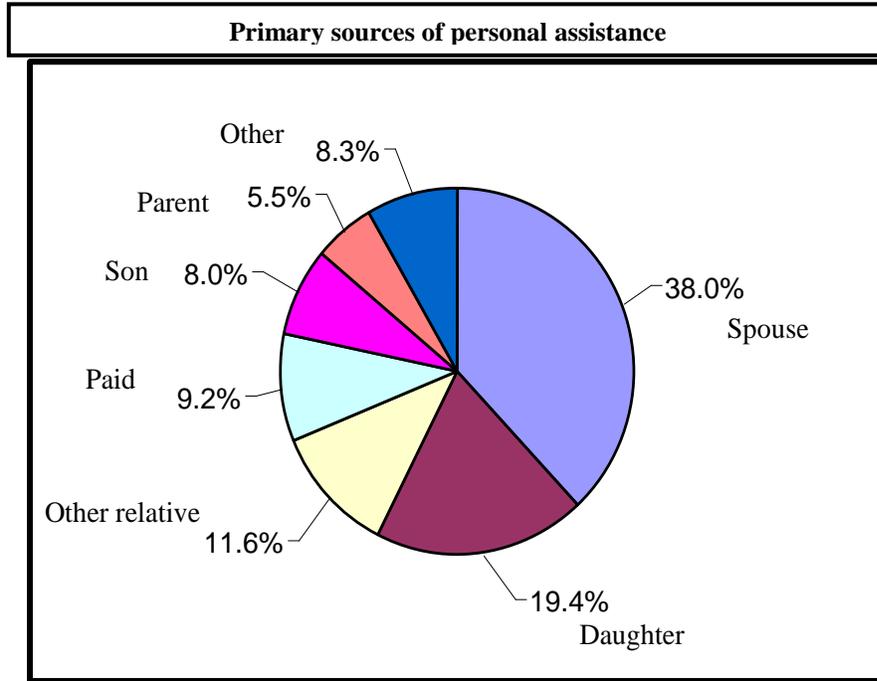
No ADL Limitation	1,520,889	96.3%
Limited in any ADL	58,435	3.7%
Difficulty in 1 or more ADLs, but no assistance needed	28,900	1.8%
Needs assistance, 1 or more	29,535	1.9%
1 ADL	12,237	0.8%
2 ADLs	6,146	0.4%
2 ADLs	3,921	0.3%
4 ADLs	4,700	0.3%
5 ADLs	2,531	0.2%

Source: 1990-91 Survey of Income and Program Participation  
Extrapolated to Nevada

Primary sources of assistance are indicated in Figure 3. Spouses are most often the primary providers (38 %), followed by daughters (19.4 %) and other relatives (11.6 %). An estimated 9.2 % of the population needing ADL assistance use paid providers as their primary source of

assistance. Sons are primary providers of 8 % of the population. Thus, it is clear that family members, who are the primary source of assistance 82.5 % of the time, face the main responsibility for helping those with ADL limitations.

*Figure 3*



Source: Personal Assistance in Nevada, 2001

As shown in Table 17, the likelihood of needing ADL assistance increases markedly with age from 0.3 % at ages 15-24, to 9.6 % at ages 75-84, rising dramatically to nearly one-quarter (23 %) of those aged 85 and above. Although only 16 % of the adult non-institutional population is 65 or older, this group accounts for 63.7 % of those needing personal assistance. Fully 89.5 % of those needing assistance are at least 44 years of age.

A comparison of racial/ethnic groups shows that African Americans have the highest rate of assistance needs, 2.7 %. Non-Hispanic whites have a rate of 1.9 %, followed by those of Hispanic origin (1.3 %). The lowest rate is observed among those belonging to other racial groups, 0.8 %. Differences in the age distributions of these populations account for some of the disparity in rates.

**Table 17  
PREVALENCE OF PERSONAL ASSISTANCE NEEDS  
AMONG NEVADANS AGED 15 AND ABOVE,  
BY GENDER, AGE, RACE, AND ETHNICITY IN 2000**

	<b>Total Nevada Population</b>	<b>Number of Nevadans</b>	<b>Proportion of Nevada Population</b>
Total	1,579,324	29,794	1.9%
Age Group			
15 - 24	250,552	650	0.3%
25 - 34	254,493	1,349	0.5%
35 - 44	341,754	2,970	0.9%
45 - 54	288,274	3,454	1.2%
55 - 64	195,204	4,214	2.2%
65 - 74	140,417	5,723	4.1%
75 - 84	87,434	8,419	9.6%
85+	21,196	4,842	22.8%
Gender			
Male	796,749	12,112	1.5%
Female	782,575	17,448	2.2%
Race and Ethnicity			
Hispanic	211,518	2,842	1.3%
Non-Hispanic White	1,164,460	21,659	1.9%
Non-Hispanic Black	122,938	3,380	2.7%
Non-Hispanic Other	80,407	634	0.8%

Totals may not agree or sum due to rounding.

Source: 1990-91 Survey of Income and Program Participation.

As shown in Table 18, an estimated 2,305 Nevadans with disabilities needing assistance with three or more ADLs are in need of more help than they currently receive.

It is highly probable that a percentage of these consumers are currently receiving services from one of the state's four programs, but need more hours than are available within program service parameters. For example, when consumers of ADL assistance through Personal Assistance Services in Nevada were interviewed in the fall of 2000, 41 % said they needed additional hours, however, the program is capped in the number of hours that can be provided.<sup>3</sup>

The need for additional services as seen from the consumer's perspective may not always agree with the need assessed by the professional(s) authorizing services. These differing perceptions can be expected to account for a significant number of consumers included in the percentage who say they have unmet needs.

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<sup>3</sup> Personal Assistance Services in Nevada, March 2001 publication of the Nevada Council on Independent Living

**Table 18**  
**UNMET NEVADA NEED FOR TWO OR MORE ADLS**

Income Level	With 2 ADLs or more			With 3 ADLs or more		
	Number of People	People Needing Additional Help		Number of People	People Needing Additional Help	
		Percent	Number		Percent	Number
Below 1.00	17,298	20%	3,422	11,152	21%	2,305
1.00 to 2.99	4,634	22%	1,030	2,988	25%	751
3.00 and above	7,119	21%	1,466	4,590	22%	1,025
	5,545	16%	926	3,574	15%	529

1.00 = poverty level

Source: 1990-91 Survey of Income and Program Participation Extrapolated to Nevada

A number of Nevadans included in the 21 % with unmet needs are already waitlisted for services from state programs which are, and have been, backlogged. These waitlisted consumers could account for a significant number of the 2,305 Nevadans estimated to need more help.

**Affordable, Accessible Housing**

In late 2001, BBC Research & Consulting (BBC) was contracted by the State of Nevada Department of Business and Industry, Housing Division, to conduct a housing needs assessment of special needs populations in the greater Las Vegas and greater Reno/Sparks areas. The findings of the housing needs assessment for 1) physical disabilities, 2) developmental disabilities, 3) mental illness, 4) HIV/AIDS, and 5) the homeless population, of which at least 41% is known to be disabled, follows.

**Physical Disability:**

The income level and employability of persons with physical disabilities are dependent on the severity of the disability. On average, 15 % of service and housing provider clients are employed full-time, and 12 % are employed part-time. These low employment rates likely reflect clients who are elderly. An average of 43 % of clients with physical disabilities earn less than \$1,000 per month; 13 % earn between \$1,001 and \$2,000; and 9 % earn between \$2,001 and \$3,000. At these income levels, persons with physical disabilities could afford housing costs ranging from less than \$300 to \$900.

Service providers report the majority of their clients are white English speakers, and between 5 and 15 % are Latino, Spanish speakers.

According to service and housing providers, the top housing types most needed by persons with physical disabilities include small rental units that are accessible and affordable (rents ranging from \$300 to \$1,000 per month).

**Nevada Strategic Plan for People with Disabilities**

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The following illustrations from the BBC Housing Needs Assessment detail the type of housing and living arrangements for people with physical disabilities.

Greater Las Vegas Area	Greater Reno/Sparks Area
<p><b>Designated Housing:</b>                      Assisted living: 3,100 units                      Independent living/housing authorities: 800 units</p> <p><b>Living Arrangements:</b>                      Live with spouse: 55,000 individuals                      Live alone: 18,000 individuals                      Live in group quarters: 1,500 individuals</p> <p><b>Other Housing Arrangements/Housing Gap: 31,600 individuals</b>                      Living with other family/partner, friends, in precarious housing, unsheltered.</p>	<p><b>Designated Housing:</b>                      Assisted living: 350 units                      Independent living/housing authorities: 50 units</p> <p><b>Living Arrangements:</b>                      Live with spouse: 12,000 individuals                      Live alone: 5,000 individuals                      Live in group quarters: 700 individuals</p> <p><b>Other Housing Arrangements/Housing Gap: 5,900 individuals</b>                      Living with other family/partner, friends, in precarious housing, unsheltered.</p>

**Developmental Disability:**

The income level and employability of persons with developmental disabilities are dependent on the severity of the disability. Most service and housing providers report that between 80 and 100 % of their clients with developmental disabilities earn less than \$1,000 per month. Persons with developmental disabilities are most likely to be enrolled in job training programs, employed at work centers, or employed in the community part time.

The Health Division reports that recipients of developmental services in 2000 were 74 % white, 13 % African-American, 9 % Latino, 2 % American Indian and 3.5 % Asian. The service and housing providers surveyed report slightly higher percentages of clients who are white and fewer African-American clients.

According to the service providers, the survey study concluded the State of Nevada is currently able to support persons with developmental disabilities with the highest level of housing needs. Waiting lists for residential services are fairly modest (around 200 persons). For those persons with developmental disabilities who do not need intensive residential services, the top housing need is for affordable, supportive rental housing. Rents should range between \$300 and \$400 per month and the units should be accessible. In the future, there is likely to be an increased need for residential services for those persons with developmental disabilities currently in their 30s and 40s who are receiving care and housing from their parents.

The following illustrations from the BBC Housing Needs Assessment detail the type of housing and living arrangements for people with developmental disabilities.

## **Nevada Strategic Plan for People with Disabilities**

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### Greater Las Vegas Area

<p><b>Designated Housing:</b> Group or residential care facilities: 50 individuals Supported living arrangements: 475 individuals Intermediate care facilities: 150 individuals</p> <p><b>Other Housing Arrangements/Housing Gap:</b> Living with family, friends/guardians: 18,600 individuals Respite care services: 400 families</p>
---

### Greater Reno/Sparks Area

<p><b>Designated Housing:</b> Group or residential care facilities: 110 individuals Supported living arrangements: 110 individuals</p> <p><b>Other Housing Arrangements/Housing Gap:</b> Living with family, friends/guardians: 4,500 individuals Respite care services: 200 families</p>
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### Mental Illness:

According to service and housing providers, 85 to 100 % of their clients who have mental illnesses earn less than \$1,000 per month. The maximum rent or mortgage payment affordable at this income level is \$300 per month. The Division of Mental Health and Developmental Services reports recipients of mental health services from the state are largely from lower income brackets, with 91 % of the Division of Mental Health and Developmental Services clients earning less than \$16,000 per year.

The employment status of persons with mental illnesses ranges considerably depending on the extent of their illness. Service and housing providers who serve persons with mental illnesses who are also homeless report that very few, if any, of their clients are employed or employable.

Service and housing providers in southern Nevada report about half of their clients with mental illnesses are white English speakers, 40 % are African-American English speakers, and 10 % are Latinos who speak Spanish. In northern Nevada, the majority of clients who have mental illnesses are white English speakers.

The top housing need for persons with mental illnesses is affordable, permanent supportive housing. This need is particularly great for persons released from state institutions or care facilities with no housing. Emergency beds and transitional housing to serve persons with mental illnesses are also needed. Many of the housing needs identified for the homeless, e.g., a drop-in shelter that provides supportive services, would also serve persons with mental illnesses due to the high crossover of these population groups.

The following illustrations from the BBC Housing Needs Assessment detail the type of housing and living arrangements for people with mental illness.

## **Nevada Strategic Plan for People with Disabilities**

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### Greater Las Vegas Area

<p><b>Designated Housing:</b> Residential group care facilities serving elderly, disabled persons with mental illness: 900 beds Supported living arrangements, shelter and care: 275 individuals Homeless shelters for mentally ill: 25 beds Transitional housing: 65 beds Permanent supportive housing: 550 beds</p> <p><b>Other Housing Arrangements/Housing Gap:</b> Living with friends, family/living alone: 19,000 people Other homeless shelters: 700 people Unsheltered: 3,400 people</p>
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### Greater Reno/Sparks Area

<p><b>Designated Housing:</b> Residential group care facilities serving elderly, disabled persons with mental illness: 130 beds Supported living arrangements, shelter and care: 130 individuals Transitional housing: 80 beds Permanent supportive housing: 230 beds</p> <p><b>Other Housing Arrangements/Housing Gap:</b> Living with friends, family/living alone: 5,000 people Other homeless shelters: 100 people Unsheltered: 300 people</p>
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### HIV/AIDS:

According to service and housing providers, an average of 85 % of their clients who are persons with HIV/AIDS earn less than \$1,000 per month. The remainder earns between \$1,000 and \$2,000 per month. The maximum rent or mortgage payment affordable at these income levels is \$300 per month. The vast majority of clients with HIV/AIDS are cost burdened (30% of their income is used for shelter expenses) and an average of 50 % are severely cost burdened, according to service and housing providers.

According to service and housing providers, less than half of the persons with HIV/AIDS they serve are employed. Most of those employed work part-time. Undoubtedly, the health status of persons with HIV/AIDS (especially those individuals with AIDS) affects their ability to work.

According to the Health Division, whites make up about two-thirds of known AIDS cases in Nevada; African-Americans make up about 20 %; and Latinos, 12 %. Asians represent just 1 % of the cases. HIV cases had a similar distribution. The types of housing needed to serve this population are small, studio/one or two bedroom, ground level apartments. Rents should range between \$300 and \$600 per month. Transitional housing and housing with supportive services are also needed.

### Homeless:

Service and housing providers report the vast majority of their clients who are homeless (between 85 and 100 %) earn less than \$1,000 per month. The homeless counts conducted in the greater Las Vegas area estimate that between 60 and 80 % of persons who are homeless earn less than \$400 per month. Individuals at this income level (\$400 per month) could only afford to pay \$120 per month toward housing costs without being cost burdened. Providing housing to individuals with income levels this low requires heavy subsidies.

The recent homeless counts in the greater Las Vegas area collected the most comprehensive information about the employment status of the persons who were homeless and interviewed

## **Nevada Strategic Plan for People with Disabilities**

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in the studies. Between 20 and 30 % of the persons interviewed were working; most said they were looking for work. According to service and housing providers, the major barriers persons who are homeless face in trying to find employment are child care, transportation, criminal backgrounds, inability to afford a sheriff's card or other costs, and distrust and lack of understanding about their situation (on behalf of employers).

Persons who are homeless are most often white and African-American English speakers. According to housing and service providers, whites represent about 50 to 60 % of the population; African-Americans represent between 30 and 40 %; and Latinos, between 10 and 15 %. About 30 to 50 % of the population is estimated to be victims of domestic violence, and 50 % of homeless youth is estimated to have experienced sexual abuse.

The following illustrations from the BBC Housing Needs Assessment detail the type of housing and living arrangements for people who are homeless.

### Greater Las Vegas Area

**LITERALLY HOMELESS \***  
**Designated Housing:**  
Emergency shelter beds:  
    Women/families: 630  
    Men: 1,195  
**Housing Gap, Literally Homeless: 8,175**  
  
*\* Includes individuals living on the street or in shelters.*

**PRECARIOUSLY HOUSED \***  
**Designated Housing:**  
Transitional housing beds: 2,650  
**Housing Gap, Precariously Housed: 3,700**  
  
*\* Individuals living in temporary or unstable housing arrangements.*

### Greater Reno Area

**LITERALLY HOMELESS \***  
**Designated Housing:**  
Emergency Shelter Beds:  
    Families/children: 89 beds  
    Individuals: 179 beds  
**Housing Gap, Literally Homeless: 732**

**PRECARIOUSLY HOUSED \***  
**Designated Housing:**  
Transitional housing: 820  
**Housing Gap, Precariously Housed: 3,200 - 4,700**  
Housed in motel/hotel: 4,000

### **Existing Health Services**

The current amount of long-term care services provided in Nevada should be taken into account in determining the need for health care. The Medicaid program provides home and community- based (HCBS) waiver services, home health care, and personal care services to people with disabilities. The Mental Health and Developmental Services Division and the Division for Aging provide long-term care services to their respective populations. The state has also established a state funded (general revenue) personal assistance program for people with disabilities who are over Medicaid income eligibility limits which is operated by the state Office of Community Based Services.

**Nevada Strategic Plan for People with Disabilities**

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Home and Community Based Services:

Nevada has four waiver programs 1) the Elderly (CHIP), 2) Group Home (GH) residents, 3) the Mental Retardation and Related Conditions (MR), and 4) the Physically Disabled (PD) (Gerber-Winn, 2002). Since 1996, the total number of waiver participants increased by 88 % (from 1451 to 2,722) (Table 19). The CHIP program participant growth rate declined between 1995 and 2001. In contrast, the PD waiver participant growth rate was 139 % between 1996 and 2001 while the GH waiver grew from 2 individuals in 1996 to 166 in 2001. The MR waiver participants grew by 185 % in the period.

**Table 19  
MEDICAID HCBS PARTICIPANTS  
BY CALENDAR YEAR**

Waiver Number	Target Population	1996	1997	1998	1999	2000	2001
0152	CHIP	938	955	997	1,130	1,192	1,240
0267	GH	34	65	92	105	138	166
40150	PD	105	102	109	131	149	251
0125	MR	374	392	589	867	969	1,065
Nevada	Total	1,451	1,514	1,787	2,233	2,448	2,722

Source: Kitchener, M. and Harrington, C. 2001. Medicaid 1919(c) Home and Community Based Waiver: Program Data, 1992-1999. HCFA Form 372. San Francisco, CA: University of California, San Francisco.

In 1999, Nevada had a total of 1.23 waiver participants per 1000 population (Table 20). Nevada was ranked 45<sup>th</sup> in the nation on the total number of waiver participants per population (Kitchener and Harrington, 2001). Nevada also offered personal care services to 491 individuals and home health care to 350 individuals. When all Nevada Medicaid participants in the waiver programs, personal care services, and home health care were combined, 2,894 individuals received services (although may be served in more than one program) in 1999. The combined totals ranks Nevada among the last two states nationally (Kitchener et al., 2002).

**Table 20  
MEDICAID HCBS PARTICIPANTS PER 1,000  
POPULATION BY CALENDAR YEAR**

Waiver Number	Target Population	1996	1997	1998	1999	2000	2001
0152	CHIP	0.59	0.57	0.57	0.64	0.59	0.59
0267	GH	0.02	0.04	0.05	0.06	0.07	0.08
40150	PD	0.07	0.06	0.06	0.07	0.07	0.12
0125	MR	0.23	0.23	0.34	0.48	0.48	0.51
Nevada	Total	0.91	0.90	1.02	1.23	1.23	1.29
US	Total	1.84	2.14	2.32	2.52	---	---

Source: Kitchener, M. and Harrington, C. 2001. Medicaid 1919(c) Home and Community Based Waiver: Program Data, 1992-1999. HCFA Form 372. San Francisco, CA: University of California, San Francisco.

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In 2001, 1,240 people were served in the CHIP waiver at a cost of about \$6.7 million (See Table 21). The GH waiver served 166 in that same year, costing \$503,147. At a cost of over \$411,600, the PD waiver served 251 participants in 2001. MR waiver expenditures in 2001 were more than \$19.8 million, serving just over 1000 people.

**Table 21  
MEDICAID HCBS WAIVER EXPENDITURES BY FISCAL YEAR**

Waiver Number	Target Population	1996	1997	1998	1999	2000	2001
0152	CHIP	\$3,340,548	\$3,720,331	\$4,400,593	\$4,946,981	\$5,580,627	\$6,744,796
0267	GH	\$73,643	\$170,728	\$225,344	\$256,793	\$362,233	\$503,147
40150	PD	\$65,677	\$78,886	\$60,190	\$83,673	\$190,981	\$411,600
0125	MR	\$4,697,074	\$5,152,274	\$7,194,715	\$9,342,861	\$13,651,627	\$19,806,488
Nevada	Total	\$8,176,942	\$9,122,219	\$11,880,842	\$14,630,308	\$19,785,468	\$27,466,031

Source: Eiken, S. and Burwell, B. 2002. Medicaid HCBS Waiver Expenditures, FY 1995 Through FY 2001. Cambridge, MA: The MEDSTAT group, May 13.

Table 22 shows the HCBS waiver expenditures per participant. Of all the waivers, the MR waiver had the largest expenditures per participant (\$18,598 in 2001). The physically disabled waiver only spent \$1,640 per participant in 2001. Expenditures for the PD waiver do not include any Medicaid State Plan costs. They are specific to the waiver only. Overall, Nevada spent an average of \$10,090 per participant on waivers but most of the funds were for the MR waiver. In 1999, Nevada spent less than half as much per participant on its waivers as the US average.

**Table 22  
MEDICAID HCBS WAIVER EXPENDITURES  
PER PARTICIPANT BY FISCAL YEAR**

Waiver Number	Target Population	1996	1997	1998	1999	2000	2001
0152	CHIP	\$3,535	\$3,845	\$4,312	\$4,357	\$4,682	\$5,439
0267	GH	\$1,575	\$2,365	\$2,553	\$2,445	\$2,625	\$3,031
40150	PD	\$590	\$763	\$875	\$1,110	\$1,282	\$1,640
0125	MR	\$13,041	\$14,226	\$12,957	\$11,239	\$14,088	\$18,598
Nevada	Total	\$5,635	\$6,025	\$7,847	\$6,552	\$8,082	\$10,090
US	Total	\$13,544	\$13,927	\$14,842	\$15,331	---	---

Calculations based on data from Tables 19 and 21 above.

Nursing Homes

Nursing facility beds grew by 30 % between 1997 and 2000 (See Table 23). In 2001, Nevada had a total of 5,091 certified nursing home beds, but this was a decrease of 94 beds

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over the previous year. Of the total certified beds, 18 % (935 beds) were vacant. Medicaid residents represented 67 % of the occupied beds.

**Table 23  
NURSING FACILITY BEDS AND OCCUPANCY IN NEVADA BY YEAR**

Year	Medicaid	Medicare	County	Private	Vacancies	Certified Beds
1997	2,418	326	92	764	363	3,999
1998	2,425	279	113	726	410	3,997
1999	2,486	278	117	719	746	4,373
2000	2,697	338	126	199	1,213	5,185
2001	2,781	386	137	802	935	5,091

Source: Gerber-Winn, T. 2002. Study of State Program for Providing Services to Persons with Disabilities: Current Status of Medicaid's Home and Community Based Services. Division of Health Care Financing & Policy.

Nevada had a low rate of nursing home beds compared to the elderly population aged 65 and over (21.9 beds per 1000 aged population compared to 52.5 beds for the US) (Harrington et al., 2000). In addition, Nevada had a low number of licensed residential beds for adults and the aged (17.6 per 1000 population compared to 25.5 for the US average). Thus, although the supply of nursing facility beds was low per population, the occupancy rates in nursing facilities was also low.

Nevada's total long term care (TLTC) expenditures, including nursing home (NH) care and ICF/MR services, exceeded \$162 million in 2001 (See Table 24). Per capita expenditures for that year were \$77.02 compared with the U.S. per capita of \$264.38, or less than 30% of national per capita expenditures. Nevada's total home care (THC) expenditures were just over \$41 million in 2001, \$27.5 million of which was spent on home and community-based services (HCBS), while personal care (PC) service expenditures were about \$6.5 million and home health (HH) service expenditures about \$7 million. Per capita spending for home care in 2001 was 25% of the U.S. per capita expenditures (\$19.50 and \$77.99 respectively).

**Table 24  
EXPENDITURES, PER CAPITA EXPENDITURES,  
AND U.S. RANK BY FY, NEVADA AND THE U.S.**

	Rank		1997	1998	1999	2000	2001	Per Capita 2001	US Per Capita 2001
	2001	2002							
NH	49	49	\$67,687,209	\$70,245,071	\$72,163,616	\$86,063,693	\$92,222,995	\$43.79	\$150.04
ICF/MR	38	39	\$22,844,573	\$25,448,550	\$26,715,775	\$28,496,213	\$28,912,477	\$13.73	\$36.35
PC	25	26	\$1,540,123	\$2,025,840	\$2,552,549	\$2,978,720	\$6,521,361	\$3.10	\$18.45
HCBS	49	48	\$9,122,219	\$11,880,842	\$14,630,308	\$19,785,468	\$27,466,031	\$13.04	\$50.51
HH	35	28	\$7,708,771	\$7,354,125	\$8,141,165	\$8,659,534	\$7,073,409	\$3.38	\$9.03
THC	50	49	\$18,371,113	\$21,260,807	\$25,324,022	\$31,423,722	\$41,060,801	\$19.50	\$77.99
TLTC	50	50	\$108,902,895	\$116,954,428	\$124,203,413	\$145,983,628	\$162,196,273	\$77.02	\$264.38

Source: Eiken, S. and Burwell, B. 2002. Medicaid HCBS Waiver Expenditures, FY 1995 Through FY 2001. Cambridge, MA: The MEDSTAT group, May 13

Nevada ranked 50th out of 51 states and the District of Columbia on spending per capita for long term care services (Table 24). The state was also 50<sup>th</sup> in its total home spending and 49<sup>th</sup> in nursing facility spending. It was also 25<sup>th</sup> in spending per capita out of 26 states that had a personal care services program.

## **SUMMARY**

In summary, Nevada has a growing population including a growing number of individuals with disabilities. Although it is difficult to develop estimates for this population, the U.S. Census offers probably the best estimate of 375,910 people in 2000. Approximately 54,000 individuals with disabilities were receiving SSI or SSDI benefits in 2001, and many of those had serious disabilities. Only about 18,000 people with disabilities received Medicaid, probably because those on SSDI often exceed the Medicaid income eligibility limits, but many of these individuals need long term care services and prescription drugs not covered by Medicare.

In addition to those individuals on SSI or SSDI with disabilities, over 40,000 children aged 3 to 21 were reported to have disabilities by the Nevada Department of Education. The estimates of the number of individuals with mental illness in Nevada were about 108,000 individuals in 2000.

When the total number of individuals with disabilities were combined for adults and children and for different diagnoses from a number of sources, these estimates appeared to be somewhat similar to the U.S. Census estimates. It is unknown how many of the approximate 387,000 individuals with disabilities have unmet needs for services.

A recent research study showed that approximately 1.9 % of the population (about 30,000 individuals) need assistance with activities of daily living. Most people with disabilities who need assistance with activities of daily living receive informal assistance from family members and friends. Of those individuals estimated to need assistance with two or more activities of daily living in Nevada (about 17,000), approximately 3,400 are estimated to have unmet needs and need additional assistance over what they receive.

Nevada has a fragmented long term care delivery system spread across several agencies and programs. Although it has a number of excellent programs in place, the programs are small and the expenditures per client are extremely low compared with other states. The Medicaid program offers four waiver programs, personal care services, home care services, as well as nursing home services. The need for services exceeds the availability of home and community services in the Medicaid program, but not for nursing home services. Spending levels for long term care are among the lowest in the nation (ranked 49<sup>th</sup> among states) and participants per capita for waiver services ranked 45<sup>th</sup> in the nation. The waiver program had waiting lists and a number of individuals with mental illness and developmental disability were placed outside the state. The state has an infrastructure in place to deliver long term care services but has failed to fund these programs sufficient to meet the needs of individuals

with disabilities. Certainly the need for housing for individuals with disabilities is also great and is clearly not being met by current Nevada programs.

## **RECOMMENDATIONS**

### **Outreach for Medicaid Enrollment**

Because less than half of those on SSI/SSDI are being served in the Medicaid program, there may be individuals who are eligible for services that are unaware of their eligibility or the benefits of enrollment. Nevada should consider conducting outreach to inform those on SSI/SSDI about Medicaid financial eligibility and need requirements, enrollment procedures, and services available through a combination of letters, advertisements, and other methods and provide assistance with enrollment. Nevada should also conduct outreach to other individuals with disabilities including those with DD and MI, children, the homeless, and other underserved groups to inform them about Medicaid and Nevada Checkup financial eligibility and need requirements, enrollment procedures, and services available through a combination of letters, advertisements, and other methods and provide assistance with enrollment.

Others on Medicaid may not be aware of the availability of personal care services and waiver programs and the option of obtaining these services rather than institutional services. Nevada should work with community organizations and providers to inform individuals on Medicaid about their choices between personal care, waiver and other services and institutional services with the intent of keeping people in their own home and reducing the use of institutional services. All individuals who prefer personal care and waiver programs over institutional services should be given such services.

### **Transition from Nursing Homes to the Home**

Nevada should conduct a survey of nursing home providers in the state to describe the current residents in nursing facilities by age (to identify those who are children, adults under age 45, adults 45-65, 66-84, and 85 and over); by race/ethnicity; gender; length of stay (as of the date of the survey); source of admission (home, hospital, nursing home, etc); and diagnosis (mentally ill, developmentally disabled, physically disabled, and other categories) and how many long stay residents may be able to transition to the community to assist with planning efforts. Agencies such as Centers for Independent Living could conduct these assessments as they do in other states. Ask providers to identify the major barriers to placement of long-stay residents into the community.

The State should consider developing a proposal to CMS for a Medicaid transitional services waiver program that will provide assistance with moving individuals currently institutionalized into the community with appropriate personal care and waiver services. Initially target those individuals under age 65 who would like to move back to the community.

### **Expand HCBS Waiver Programs**

Nevada should expand each Medicaid HCBS waiver program to eliminate the waiting list in each program within the next three years.

Expand the state's personal care services programs to provide new slots for those individuals who need help with 2 or more ADLS, based on the disability estimates from the SIPP study. Those individuals who qualify for Medicaid State Plan or HCBS waiver should be served using Medicaid funds and those individuals above Medicaid income eligibility should be served in the State Office of Community Based Services program using state general funds.

Develop both home and community-based services and institutional long term care services within the state that are specifically designed to serve all those individuals who are currently in out-of-state placements (about 300 individuals currently). The state should ensure that no individual has to be placed out-of-state in the future.

Nevada should redesign the personal care services program to allow and expand the number of individual providers (rather than agency providers) that can be recruited and trained by the clients themselves. Study the California program of individual providers and those in other states in designing this new approach.

### **Assessment and Screening Procedures**

In order to address the fragmentation of the long term care programs in Nevada, the state should establish a uniform setting neutral screening tool for all individuals with disabilities needing services and an algorithm for what services they would be eligible to receive. The Minimum Data Set for Home Care (MDS-HC) could be considered as a basic uniform tool, because it has been shown to be reliable and valid in assessing individuals of all ages in all types of programs (nursing homes, home care waiver programs, personal care and other LTC services).

Consider establishing central screening, assessment, and authorization agencies in each local community that would be operated under contract to the state. These agencies should be independent. This could establish a single entry point for long term care services. This would allow for the state to give individuals who qualify for Medicaid and other state services a choice of institutional or home and community-based services.

### **Housing**

Develop a plan to work with HUD to develop specific housing plans to build and target housing for those with individual disabilities of all types and for all age groups. Follow the new housing plan to target those groups with the greatest need first and phase in the program over time.

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## **PART V**

### **PLAN RELATIONSHIP TO OLMSTEAD**

The following report was prepared for the Nevada Task Force on Disability by Tony Records, president of Tony Records and Associates, Inc. (TRA), a human services consulting firm in Bethesda, Maryland. Mr. Records is chairperson of the Association of Court Monitors and Special Master, administering cases involving people with disabilities. He has consulted in more than 20 states with regard to services for people with disabilities. He served for two years as consultant with the Office of Civil Rights (OCR) of the US Department of Human Services providing technical assistance to OCR staff in evaluating states' compliance with the Olmstead US Supreme Court decision, requiring states to ensure that people with disabilities receive services in the least restrictive settings.

The purpose of this review was to assist the Task Force in developing and refining goals and strategies for the Strategic Plan for People with Disabilities (Strategic Plan). The review provides general compliance findings in the various Nevada disability programs and indicates whether the Objectives and Strategies developed by the Task Force will address these findings.

Please note that this is a general review and not a specific compliance evaluation. The reviewer did not have the opportunity, for example, to visit state-operated facilities or review program records or community programs. Although these additional activities would have helped clarify the findings of the review, it would be unlikely that they would have substantially changed them.

The findings of this report are based on significant review of documents provided by the state and participation in four Governor's Task Force Meetings. Face-to-face interviews were conducted with people with disabilities, families of people with disabilities, and state program and funding staff. Additionally, the reviewer facilitated a consumer focus group in Las Vegas on September 6, 2002. State staff interviewed included the following:

- ✓ Director of the Department of Human Services
- ✓ Associate Administrator, Nevada Developmental Services
- ✓ Program Analyst, Nevada Developmental Services
- ✓ Chief of Planning and Evaluation, Division of Mental Health and Developmental Services
- ✓ Administrator of Health Care Financing and Policy
- ✓ Chief of Home and Community Based Services
- ✓ Chief Finance Officer, Nevada Health Care Financing and Policy
- ✓ Administrative Services Officer, Health Care Financing and Policy
- ✓ Chief, Office of Community Based Services

- ✓ Director of Adult Services, Washoe County Department of Social Services
- ✓ Chief Financial Analyst, Governor’s Council on Disability

### ***Olmstead* and Planning Expectations**

This review applies to general compliance with the landmark U.S Supreme Court decision in *Olmstead v. L.C.*, 119 S. Ct.2176 (1999). In the *Olmstead* decision, the Supreme Court provided the legal framework through which States could comply with the Title II of the Americans with Disabilities Act (ADA) as it applies to public services. The Court ruled that states should:

- Provide community services to individuals whose treatment professionals have determined that community placement is appropriate;
- Determine that the transfer from institutional care to a more integrated setting<sup>4</sup> is not opposed by the affected individual; and
- Determine that the services can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities.

The Court also makes clear that, under ADA regulations, States are required to “make reasonable modifications in policies, practices, or procedures when modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity.” The Court also suggested that a state could establish compliance with the ADA’s reasonable modification requirement if it demonstrates that it has a comprehensive, effectively working plan. This plan should provide for placing qualified persons with disabilities in more integrated settings, and a waiting list that moves at a reasonable pace not controlled by the state’s endeavors to keep institutions fully populated.

In January 2000, the United States Secretary of Health and Human Services, through letters to state governors and Medicaid directors, strongly urged states to increase access to community services for individuals with disabilities.<sup>5</sup> These letters also included guidance and encouragement to states regarding the development of a comprehensive, effectively working plan. This guidance includes basic principles of *Olmstead* planning and components that embrace these principles. Some of the principles and planning components identified in this guidance letter include the following:

- Involvement of people with disabilities and their representatives as well as other interested persons in the planning process to be integral participants in the plan development and follow-up.

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<sup>4</sup> The most integrated setting is defined as that which enables the individual with a disability to interact with non-disabled persons to the fullest. (28 C.F.R. Pt 35app. A § 35.130 {d}).

<sup>5</sup> January 14, 2000 letter from HHS Secretary Donna Shalala to Governors and State Medicaid Directors

- ❑ Development of a reliable sense of how many individuals are currently institutionalized and are eligible for services in a community setting.
- ❑ Evaluation of the existing assessment process to determine whether they are adequate to identify individuals with disabilities who could benefit from services in a more integrated setting.
- ❑ Evaluation of the current capacity within the state to provide integrated services.
- ❑ Review of funding services that are available (both Medicaid and other funding sources) to increase the availability of community services.
- ❑ Examination of how identified supports and services integrate the individual into the community.
- ❑ Examination of the operation(s) of waiting lists and what might need to be done to ensure that people are able to come off waiting lists and receive needed community services.
- ❑ Provisions for individuals with disabilities to make informed choices regarding how and where their needs can be met.
- ❑ Evaluation of the effectiveness of the quality assurance and quality improvement mechanisms for community settings.
- ❑ Examination of the overall infrastructure of the system of health and long terms care so that the most integrated setting becomes the norm.

Currently more than forty states (including Nevada) are involved at some level in an active planning process to ensure compliance with *Olmstead*. Approximately twenty have completed at least a first draft of a plan and have made them available to the public. Other states have taken current state planning documents and modified or supplemented them to ensure compliance with the *Olmstead* provisions.

In development of Nevada's Strategic Plan, the Task Force has been directed to consider compliance with *Olmstead* as a high priority. The findings below are provided to assist this Task Force in developing goals and strategies that are designed to address potential *Olmstead* compliance problems and to develop a long-term services structure that will provide services in the most integrated settings.

## **FINDINGS**

It is important to note that this review is limited to residential services and settings. Nationally, thus far, *Olmstead* is generally viewed as a requirement that is directed to the provision of residential services and supports. Compliance with Title II of the ADA, however, applies to publicly-supported non-residential services as well.

It is also important to state that these findings are not intended in any way to be a negative reflection on the hard work of the many people in Nevada state programs and private services for people with disabilities. Nearly all of the primary concerns stated below are those where there are inadequate resources or systems to address the needs of people. The Nevada Department of Human Resources should be given accolades for getting the most out of the available resources.

These findings are based solely on the reviewers professional opinion and are not in any way formal findings. General findings are as follows:

**General Findings:** In order for people with disabilities to be provided services and supports in the most integrated setting, there should be a full array of community services available to them from which they can choose. For many people with disabilities in Nevada, this choice does not exist. There is significant gap between the documented needs of people with disabilities and the available services in integrated settings. At least hundreds, and more likely thousands (see waiting list findings below) of people with disabilities in Nevada are not receiving appropriate services in the most integrated setting. Many people who can live in the community are unnecessarily languishing in nursing facilities or other segregated settings missing out on the many opportunities the community offers them. There are many others (the exact number is unknown) that are at imminent risk of unnecessary institutionalization due to the lack of available community services.

The primary cause of this problem is clear – lack of available resources. Nevada’s entire system of services for people with disabilities is grossly under-funded. In nearly every component of community services, funding in Nevada falls far short of the needs of its citizens with disabilities. Also, when compared with other states across the country in terms of both overall spending and per capita fiscal effort for community services, Nevada is either last or almost last in nearly every funding category. In order for sustained compliance with *Olmstead* to occur, this must change.

There are numerous proposals and strategies that the Task Force has included in its plans that require resources from the state in order for implementation to occur. Many of these proposals, if funded, will generate significant additional federal matching funds. Funding of these proposals is essential to compliance with *Olmstead*.

Another primary problem in Nevada is the lack of an effective overall information system for people with disabilities. Each state agency, sub-agency, county and private service provider has its own separate information system. As a result, service delivery is often provided in an

inefficient and scattered manner. Information systems are replete with missing gaps in some places, duplicated counts of people and service units in others, resulting in a common practice of development of service plans and budget projections based on misinformation. Although the depth of need for integrated services is vast, there is a significant lack of specificity and detail of what is needed due to the lack of an effective information system.

The Task Force has recommended support for a comprehensive review of all data systems for people with disabilities in Nevada and the development of unified information system. The system that is envisioned is a cross-disability, centralized database throughout the state that will also function as a single-point-of-entry or “no wrong door” system. The investment needed for the development of this system will be significant. The medium and long-term benefits of such a system, however, are incalculable.

**Developmental Disability Services:** Generally, Nevada has a relatively low number of people with mental retardation in large state or privately operated ICF/MR facilities. It was reported that there are approximately 130 people with mental retardation currently living in the two state operated facilities. That number has been steadily on the decline over the past ten years. It appears that this institutional population will continue to decline, albeit slowly, over the next few years. People who live in the two state ICF/MR facilities are assessed on an annual basis and the assessment includes an evaluation of viability of community living. Although the individual assessment process should be further evaluated to ensure that it is consistent with *Olmstead*, it appears that there is not a significant compliance problem with people with developmental disabilities in the state Developmental Centers.

Community services for people with developmental disabilities in Nevada, however, are seriously under-funded. The vast majority of community services are funded through the Medicaid Home and Community-Based (HCBS) waiver. A recent published report showed that, in Fiscal Year 2001, HCBS waiver funding for people with developmental disabilities in Nevada was ranked last of the 50 states in terms of funding per state resident and 45<sup>th</sup> out of fifty states in terms of average daily recipient funding.<sup>6</sup> Funding HCBS waiver services as poorly as this usually results in significant limitations in the system’s capacity and, in particular, its ability to serve people with the most severe disabilities.

The reported residential waiting list of approximately 190 people with developmental disabilities for community services is significantly understated. Reportedly, there are many people who are not counted on the waiting list receiving some services, such as case management, but are waiting for other services. It is quite likely that many of these individuals are at risk for institutionalization.

There may also be a compliance problem with regard to an unknown number of people with developmental disabilities who live in nursing homes. This includes people with mental retardation as well as other developmental disabilities such as autism, cerebral palsy, spina bifida and muscular dystrophy. This is partly due to the funding and eligibility limitations in the Nevada Developmental Services system and HCBS waivers and partly due to an inadequate assessment process.

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<sup>6</sup> Lakin, Braddock & Smith, Trends & Milestones, Mental Retardation Journal, August 2002.

Interviews with families and consumers revealed that Nevada utilizes a narrow and limiting operational definition of developmental disabilities. The long-standing federal Developmental Disabilities Act defines a developmental disability as a severe, chronic disability of an individual that –

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the individual attains age 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
  - a. Self-care
  - b. Receptive and expressive language
  - c. Learning
  - d. Mobility
  - e. Self-direction
  - f. Capacity for independent living
  - g. Economic self-sufficiency; and
5. Reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are lifelong or of extended duration and are individually planned and coordinated.<sup>7</sup>

The federal definition is a non-categorical, functional definition and is not tied to any specific diagnosis. Nevada, however, appears to narrow its operational definition of developmental disabilities to mental retardation and “related conditions.” Reportedly, an individual must have a cognitive impairment or a developmental delay in order to be served by the Developmental Disabilities Services Division. This is not consistent with the federal definition and, as a result, many people with developmental disabilities (under the federal definition) may not be receiving appropriate assessments or services.

There may also be significant problems regarding people with developmental disabilities who are “at risk” of institutionalization. These include people who are un-served or underserved and likely to be placed in an institution or segregated setting if appropriate community living services are not available. They may be currently living alone or with their families, but are not receiving the necessary supports. More is discussed regarding these people in the waiting list section below.

**Mental Health Services:** Similar to the situation in mental retardation services, there are not unusually large numbers of people living long-term in the state psychiatric hospital. Reportedly, there is only one state hospital with an inpatient census of less than 150 people and an additional 60 court-ordered forensic patients. There are significant activities and evaluations in place that are designed to reduce the time of inpatient hospital services.

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<sup>7</sup> Developmental Disabilities Assistance and Bill of Rights Act of 2000, P.L. 106.402: Section 1, Title I, Subtitle A, Section 102.

The primary problem in mental health services is the lack of availability of comprehensive community mental health services. It is difficult to assess the exact extent of the needs in community services as the waiting lists data appear to be inconsistent and outdated. Counties do not provide community mental health services for adults. Some state mental health services, such as the Program for Assertive Community Treatment (PACT), Intensive Case Management and Psychiatric Emergency Services (PES) are not even available in rural Nevada.

The number of people in Nevada who require mental health services has skyrocketed over the past three years, increasing more than 50% since 1999.<sup>8</sup> Projections for future needs for people with mental illness indicate a continuation of this upward climb. The number of people with mental illness who are waiting for community services has nearly doubled in the past two years.<sup>9</sup>

There are insufficient resources throughout the state to provide case management services with mental illness. In the past year, an estimated 16% of persons in southern Nevada who needed case management services were not getting them with a wait time of five months. The intensive case management services program started in southern Nevada in 1997, with a caseload increase of more than 400% since that time.

In addition, Nevada has a rapidly growing homeless population, many of whom are in need of mental health and/or substance abuse services. Estimates of more than 9,000 people in the southern Nevada area and another 3,000 in northern Nevada were reported during my visits. National statistics indicate that, conservatively, nearly 40% of this population has a severe mental and/or physical disability and 25% have been previously institutionalized. Thus, there is likely to be a large “at-risk population” who needs some level of community support. There are a few relatively small programs that are expanding or now being developed to serve people who are homeless with severe and persistent mental illness. These resources, however, are not nearly enough to address the magnitude of need.

It also appears that there is a growing number of seniors with mental health problems that are moving into nursing facilities. This trend is likely to continue without significant expansion of community services.

**Nursing Home Services:** There appears to be a potentially significant *Olmstead* compliance problem with regard to people with disabilities who live in nursing homes. Although there has some been movement of people into the community on a small scale in the past two years, much more can and should be done to create and facilitate options in a more integrated setting. The Medicaid Community Integration and Diversion Project, operated by the Medicaid Division, for example, has the potential to become an excellent program. There are insufficient resources, however, to operate this program statewide. Much more should be done in the areas of assessment and transition as well as increasing community capacity for people who are at-risk for nursing facilities.

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<sup>8</sup> MHDS Biennial Reports

<sup>9</sup> MHDS CLEO Reports, August 2002

The reviewer visited a 24-year old woman in a nursing facility in Las Vegas. Although she has severe physical disabilities, she carries a full-time course load at the University of Nevada, Las Vegas. She expects to begin attending law school in the next two years. She leaves the nursing facility and goes to classes 5 days a week. In order for her to live in the community she would need several hours of nursing support a day and ongoing personal care. It is not available. This woman, with the proper supports can and should be given the opportunity to live in the community and enjoy life with her non-disabled friends. It was reported that there are many others who are similarly situated in nursing homes, with little hope of leaving in the foreseeable future. This is unacceptable.

More resources are desperately needed in order to increase capacity in the community and create enhanced diversionary services designed to prevent people from entering nursing homes. Needed resources are not limited to increasing “slots” in the home and community-based waivers, but also to enhance eligibility for waiver services, and provide state-funded services for people with disabilities above Medicaid income limits. The need for equity in the income eligibility for Medicaid services, for example, is important to provide a reasonable incentive toward services in the most integrated setting. Nevada must recognize, for example, that the same criterion of 300% above poverty level eligibility for people living in nursing homes should apply to home and community-based services as well. It is important that the state plan and waiver application be revised to enable all recipients of either state plan or waiver services to be eligible for these services at 300% of the poverty rate.

**Out-of-State Residential Services:** There are, reportedly, more than 125 people with disabilities living in out-of-state residential programs. These include children and adults, many of whom have a history of significant mental-health and/or behavioral problems. There appear to be others who have autism and are in out-of-state facilities due to the lack of available programs in Nevada that serve people with autism. There was discussion at the Task Force meetings regarding some proposals to develop in-state programs for some of these people. It is essential that these proposals are funded and implemented as soon as possible.

**Medicaid Home and Community Based Services:** Nevada has four Medicaid Waivers for Home and Community- Based Services (HCBS). These include: 1) Frail Elderly at Home (CHIP); 2) Elderly in Group Home; 3) Persons with Physical Disabilities; and 4) Persons with Mental Retardation and Related Conditions. These waivers, while effective to an extent, are grossly under-funded. They are under-funded insofar as the reimbursement rates for services as well as the overall quality of “slot” for services that are authorized. Significant increases will be needed in both areas. The Task Force on Rates will offer specific recommendations in this regard. Funding increases in these waivers will result in immediate positive results.

There are limited community options for people in nursing homes for those individuals with acquired brain injury. There appear to be limited options for people with autism, unless they have a diagnosis of mental retardation as well. There are reported recommendations to

establish separate stand-alone HCBS waivers to serve these populations. The state should consider an option of expanding eligibility criteria within the existing waivers to allow more people with disabilities to become eligible for these excellent federally matched programs.

**Children's Services:** Nevada's services for children with disabilities are provided through a variety of programs and agencies. Some of these agencies include:

- ❑ Division of Health
- ❑ Division of Child and Family Services
- ❑ Community Connections
- ❑ Department of Education
- ❑ Nevada Check-Up

In terms of *Olmstead* compliance, focus is given to those components of children's programs that may directly affect out-of-home residential services. There are some programs, however, that may well have an indirect impact on residential services. These include early intervention, rural respite services, family support services, home activity programs and infant enhancement programs. While these programs do not have specific residential components, if they are not fully supported, many of the children served by these programs are at increased risk for unnecessary institutionalization.

Reportedly, there are 28-30 children attending out-of-state residential schools. Many of these children have either severe emotional disorders and/or autism. The costs of these programs are very high. Development of in-state community programs should be given high priority. These should be done through a partnering relationship between the Departments of Human Resources and Education.

There are also approximately 300 children with severe emotional disorders receiving inpatient residential treatment services within the state.<sup>10</sup> Many of these children and adolescents have lived in these treatment centers for a long time and have not transitioned to more integrated settings. There are other children who have been on waiting lists for residential treatment centers. Nevada should conduct an independent review of these children to determine whether they can be served in more integrated settings.

There are more than 900 children and youth currently living in state youth corrections institutions.<sup>11</sup> Reports indicate that at least 158 of these youth have a disability. The Nevada Youth Parole Bureau provides aftercare services to an additional 1,000 youth who have been released from correctional institutions. National studies indicate that up to 40% of children in youth corrections facilities have disabilities. Many children with disabilities are often placed in correctional facilities due to the courts' frustrations with the absence of appropriate alternatives. High priority should be given to comprehensive assessment, needs analysis and program development for community alternatives for these children and youth.

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<sup>10</sup> DCFS, SNCAS Special Report, August 2002

<sup>11</sup> DCFS, Juvenile Corrections, Special Report, August 2000

In Nevada, there are more than 11,000 students with disabilities in special education between the ages of 14-21.<sup>12</sup> It was widely reported in several instances during interviews that Nevada's Vocational Rehabilitation and states education agencies are not providing the necessary support in transitioning from school to adult life. Appropriate special education transition services are required by the federal Individuals with Disabilities Education Act (IDEA) and the Rehabilitation Act. Without comprehensive transition services, many of these children will be at risk of unnecessary institutionalization. It is imperative that state and county special education services in Nevada, in conjunction with other disability service agencies provide the transition services already required by law.

**State Supported Services:** Most of the community services in Nevada utilize programs that take advantage of available federal funding. It is important to emphasize, however, that compliance with Olmstead is not limited to Medicaid or other federally funded programs. In many instances, people with disabilities, due to their inability to meet certain eligibility criteria, cannot receive Medicaid, Medicare or education funds. In some instances, people use their own funds or private health insurance to pay for needed services. Most people with disabilities, however, who do not qualify for federally funded programs, must rely on state and/or county subsidized programs.

In Nevada, there are several programs that are funded primarily through state and/or county funds. The primary conduit for most of these programs is the Office of Community Based Services (OCBS). OCBS uses a mix of federal discretionary funds, state appropriated funds and community match funds to support an array of community services. Most programs supported by OCBS also provide services to people with any disability and do not exclude people due to a particular disability or diagnosis. Programs supported by OCBS include:

- ❑ In-Home Personal Assistance;
- ❑ Independent Living Services;
- ❑ Assistive Technology Loans Programs;
- ❑ TTY Distribution Program;
- ❑ Deaf Resources Centers;
- ❑ Nevada Supportive Housing;
- ❑ Nevada Community Enrichment Program; and
- ❑ Community Leadership Development.

Each of these programs offers a valuable service that fosters independence and self-sufficiency. Because these programs are state controlled or funded, they also offer a high degree of programmatic flexibility that federally funded programs cannot provide. Many of these programs are key to diverting people with disabilities from unnecessary admissions to institutions, however, are under-funded and, as a result, have growing waiting lists. These programs include:

- ❑ **In-Home Personal Assistance** has 166 people with disabilities waiting for an estimated average waiting time of 19 months;

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<sup>12</sup> Nevada Department of Special Education Report, January 2002

- ❑ **Independent Living Services** has 118 people waiting for services for an estimated average waiting time of 6 months;
- ❑ **Nevada Supportive Housing** has 152 people waiting for services with an estimated average waiting time of 12-18 months.

These three programs are all considered highly cost effective and essential to the prevention of unnecessary institutionalization for hundreds of people with disabilities. Failure to fully fund these programs will result in two unconstructive results. First, it will result in more people being unnecessarily institutionalized in violation of *Olmsted* and the ADA. Secondly, it will relegate more people with disabilities to the Medicaid rolls, resulting in more costly, restrictive services.

**Waiting Lists:** On August 24, a separate memo regarding waiting lists was provided to the task force. It is clear that the absence of a well-managed waiting list system in Nevada presents a significant compliance and liability problem with regard to *Olmstead* and the ADA. Nevada's plan needs to ensure that there is an organized and well-managed waiting list that moves at a reasonable pace. There is significant litigation across the country that is forcing states to establish consistent methodologies and criteria for people with disabilities on waiting lists. It would be prudent and effective for Nevada to proactively develop a valid and meaningful waiting list process and avoid unnecessary litigation.

Also, federal courts, the US Department of Justice and US Health and Human Services Office for Civil Rights have determined that the ADA integration regulation is not limited to individuals in institutions and can apply to individuals who live in the community but are "at risk" of institutionalization. Unfortunately, while court decisions provide some guidance regarding when and under what circumstances an individual is considered "at risk" there is no generally applicable "bright line" standard. Rather, the question of whether an individual is "at risk" of institutionalization will depend on the careful investigation and analysis of relevant facts. In Nevada, the assessment and waiting list processes currently in place do not incorporate mechanisms for identifying those individuals with disabilities who are "at risk."

Based on the emerging case law and public policy, the question of whether an individual is "at risk" of institutionalization is determined by careful identification and analysis of specific circumstances of the individual. Relevant facts include, but are not limited to:

- ❑ The individual's current physical and mental health;
- ❑ Likelihood of change or deterioration of physical or mental health status and/or functioning in the absence of services;
- ❑ Stability of current living environment and supports including ability of caretakers to provide needed support;
- ❑ Presence and or lack of needed supports and services;

## **Nevada Strategic Plan for People with Disabilities**

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- ❑ Availability of alternatives to institutions;
- ❑ Eligibility for institutional services; and
- ❑ Whether the likelihood of institutionalization is concrete, personal and imminent.

In a recent settlement agreement in the state of Louisiana, a person is defined as being “at imminent risk” of being admitted to a nursing facility when he or she:

1) meets the level of care criteria needed for nursing home admission, and 2) either (a) is likely to require admission to a nursing facility within the next one hundred and twenty [120] days, or (b) has a primary caregiver who has a disability or is over the age of seventy [70]; or (c) faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing facility services are not provided in less than one hundred and twenty [120] days.

The Task Force recommends several important strategies designed to provide comprehensive, setting-neutral assessments for people with disabilities who may be at risk of institutionalization. If implemented, these assessments will provide the state with the actual needs of people with disabilities and provide a concrete basis for planning and resource development.

### **Nevada’s Strategic Plan for People with Disabilities**

Nevada’s Strategic Plan has taken compliance with *Olmstead* requirements quite seriously. Each of the objectives and corresponding strategies within the draft planning documents have been reviewed regarding their relationship and relevance to *Olmstead*. From the draft planning documents reviewed, it appears that the Task Force has addressed each of the *Olmstead* compliance concerns listed above.

## **PART VI**

### **BARRIERS TO SERVICE ACCESS**

With nine months of deliberation and public testimony taken throughout the state, the Nevada Task Force on Disability (NTFD) collected the observations and perceptions of people with disabilities, families, advocates, legal advisors, professionals, providers and faith-based organizations. The NTFD did not formally validate these perceptions, however many of the barriers listed by them, e.g., lack of information, poor data systems, need for improved access to advocacy and legal services, inadequate planning for school to adult life transitions, underfunded early intervention programs, personal assistance, assistive technology, independent living programs, lack of dental and health care services, long waiting lists for medication clinics and community mental health services have appeared repeatedly in studies conducted over the years. These views are strongly held and have been repeated over the course of at least a decade. The issues remain unresolved to the detriment of Nevada children and adults with disabilities and the families who care for them. The Technical Advisory Group on Olmstead issues reviewed these perceived barriers for their potential implications to the Olmstead Decision. Those issues are tagged with a justice symbol (Ψ).

#### Medicaid/Medicare/Social Security

1. Eligibility determinations for Social Security Insurance (SSI) take an average of 100 days to complete. Reapplications may take up to two years for final resolution. Medicaid approval is tied to (SSI) eligibility; so the 100 days is also applicable to this process, plus an additional 10 to 45 days for final Medicaid approval. Because they can't access their services, newly injured people with severe disabilities leave acute care with only the option of transferring to an institution unless they reside in a county which provides and pays for services they require. Rural counties provide few, if any, services and no Nevada county provides personal assistance. There is a two year waiting period for personal assistance services from the state's non-Medicaid program, thus institutionalization is the reality for people requiring this service and generally those residing in rural counties. Ψ

2. Newly injured people with severe disabilities are not immediately advised and therefore many are unaware of their potential eligibility for Medicaid. As a result, they do not begin the application process early enough during the acute stage of disability. This leaves them no option except institutional care as they exit the hospital even though their stay may have exceeded the time needed for SSI/Medicaid approval. Ψ

3. Critical health care services are limited to those available through Nevada counties and through the Office of Community Based Services (OCBS) during the two-year, five-month period required to qualify for Medicare Social Security Disability Insurance (SSDI). Most

Ψ = Olmstead Related

counties cannot afford and do not provide community-based services. People must wait up to two years for OCBS services. This situation has great potential for familial or personal bankruptcy, unnecessary institutionalization, family separation, homelessness and suicide.

Ψ

4. Many people currently and prospectively eligible for Medicaid by virtue of SSI approval do not and may never access those services because they must request Medicaid services through a separate application process. These people do not receive the full range of services they may need (i.e., personal assistance).

5. Nevada counties pay the non-federal Medicaid share for institutionalized person's with monthly income above \$851 and less than \$1,635. Medicaid draws down the federal match dollars for these expenditures. The level of services needed for independent community living, e.g., daily personal assistance is not generally available through counties thus no institutional alternative exists for these consumers excepting those who may be eligible for a Medicaid Home and Community Based Services (HCBS) waiver program. With their transfer to waived services, the total costs for all care and services shifts from the counties to the state, a situation which is believed, by advocates across the board, to present a disincentive to de-institutionalization and community placement. Ψ

6. For people with disabling and chronic conditions, even the best-intentioned and designed managed care programs are often inadequate to provide the high level of care they need. Although limited in Nevada, these programs are causing difficulty for people with disabilities. Should Nevada proceed to enroll disabled Medicaid beneficiaries in managed care programs, the state must find ways to ensure that beneficiaries with disabling and chronic conditions get the medical care they need. People with disabilities **MUST** be involved in every phase of planning, implementation and evaluation of managed care programs which affect them as people do not fit neatly into categories of disability and chronic conditions. Their individual care needs should drive the provision of services as many people with disabling and chronic conditions have complex service needs issues, e.g. housing and/or need for special equipment that directly affects their health. Managed care plans must work closely with state and local agencies to ensure the provision and coordination of services from many different providers. Chronic and disabling conditions can be managed, though many have no cure. Treatment must be available for as long as necessary to maintain optimal functioning and quality of life. Managed care planning for people with disabilities must include, at a minimum, all recommendations contained in the Health Care Financing Administration (HCFA) 2000 Report to Congress. Ψ

7. Although Nevada law and the Nurse Practice Act allow for provision of certain medically related tasks of personal assistance services by unlicensed personnel, Medicaid is not providing services in this less costly, consumer-preferred model under the general Medicaid state plan services because of a current interpretation of federal regulation. This significantly drives up the cost of service and disallows a consumer-preferred model. Ψ

Ψ = Olmstead Related

8. Medicaid/Medicare recipients are not receiving the nursing services needed because of an acute shortage of nurses in Nevada. As those services, which could be provided by personal assistants under the Nurse Practice Act, are not being provided, people with disabilities are at extreme risk of exacerbation of disability and institutional care. Ψ

9. For the Medicaid Program to pay for a rehabilitation program and continuation of that program, consumers must show/be able to show progress. Problems arise when experienced staff directly working with consumers differ with gatekeepers in these determinations and when certain consumers, i.e., those with brain injury, reach a plateau which, although temporary, may give the appearance of inability to progress further.

10. SSI approval is dependent upon the client's inability to participate in employment for 12 months after injury or diagnoses of disabling condition. Medicaid eligibility is dependent upon SSI approval. Newly disabled consumers which are Medicaid pending are referred to transitional rehabilitation programs in the hope that rehabilitation will enable them to return to independent living. However, should their rehabilitation be successful and they are able to return to work before the 12-month period ends, they may not qualify for SSI and therefore be approved for Medicaid. As a result the provider is not paid for the costs incurred in the successful rehabilitation and work return of the consumer. Because of this policy, providers are somewhat reluctant to accept these people into their rehab programs.

11. No Medicaid payment option exists for assisted living, and personal assistance hours are capped at 61.5 hours. People with disabilities who do not have families and require more than 61.5 hours of personal assistance have no alternative except institutional care. Ψ

12. Many doctors choose to terminate their Medicaid provider status because of bad experiences with the program and low provider reimbursement rates. It is sometimes necessary for an individual to seek the services of a non-Medicaid physician, although Medicaid will not pay for the service. The state should examine reasons for the reluctance of physicians to become Medicaid providers and monitor reasons for termination. Implement provisions for paying for non-provider services if Medicaid does not have another choice available in a needed specialty. Ψ

13. As Nevada has no medically needy Medicaid provision. There are only two pathways into the Medicaid system: 1) basic eligibility for services offered under the state plan and 2) eligibility under Home and Community Based Waiver provisions. Basic eligibility is currently established at 100% of the federal poverty level rate (\$531 countable income). This is too low for many people with disabilities to meet. Eligibility for waivers is higher, 300% of SSI, but applicants are always waitlisted for periods of six months to a year. These eligibility criteria exclude many people from the services they require to maintain or to return to community independence. Ψ

Ψ = Olmstead Related

14. Because Medicaid Buy-In is not currently operating in Nevada, people with disabilities are unable to seek full-time employment opportunities without losing essential health care services. Ψ

15. Only 51% of Nevadans with disabilities of working age are employed. For many, work is precluded because health care benefits received through Medicaid would be lost. Frequently, private insurance and employer health care plans do not cover services like personal assistance. State funded services which are available to pick up some of the services needed to work, e.g., personal assistance, have long waiting lists.

Waiting Lists

16. Waiting lists are not consistently portrayed in agency budgeting for “caseload growth.” Many people requiring services to maintain community independence and avoid institutional care are not considered in the legislative appropriation process which adds cost to state and county government and forces people into more restrictive care. Ψ

17. Consumers are not always apprised of their “place” on waiting lists so they can track their progress on the list. Ψ

18. People in or at risk of being placed in institutions/acute care above the Medicaid eligibility monthly income level of \$531 who could qualify for the HCBS waiver services or for state funded personal assistance and independent living, are most often waitlisted for services for up to three years. These people miss opportunities for appropriate affordable housing.

19. Subsidized housing is so limited that people are currently waitlisted for up to three years or become discouraged from applying for housing which does exist. During this time many are admitted to institutions. Ψ

20. People who cannot access the services they need to live independently have no option but to enter institutions. In so doing they relinquish homes, vehicles, furnishings and other material goods which are difficult, if not impossible, to replace at a later date. This presents a major disincentive to community return as payment sources for new material goods and furnishings needed for community re-entry, e.g. first and last months rent, a new accessible apartment and transportation arrangements must be reestablished. Ψ

21. Medication clinics for people with mental illness exist, however, in order to eliminate months long waiting lists, many more sites and personnel are needed. In the interim, clients should be allowed to use local pharmacies and outsourced prescription approval. Ψ

22. MR waiver applicants are not officially waitlisted for services. Rather they are accepted into the program, provided minimal case management and then must “wait” for

Ψ = Olmstead Related

the particular services they need under the waiver to become available. This has the effect of inadvertently understating the waiting lists. Ψ

23. Medicaid recipients report great difficulty in accessing their caseworkers and an inability to negotiate change with caseworkers should conflicts arise. Ψ

24. A link between medical necessity and professional practice standards does not currently exist. An insurer/Medicaid payor should be able to set aside the decision of the treating physician if they can show 1) the proposed treatment conflicts with clinical standards of care or there is substantial scientific evidence, regardless of clinical practices, 2) the proposed care would be unsafe or ineffective, or 3) an alternative course would lead to an equally good outcome. Substantial evidence should equate to a sizable number of studies published in peer-reviewed journals that meet professionally recognized standards of validity and replicability and that are free of conflicts of interest.

Non-Medicaid State Service

25. So called non-entitlement services, those funded through state appropriations to provide services and supports to people with disabilities whose incomes exceed above Medicaid limits, are often viewed as non-essential or dispensable. These services, which include personal assistance, durable medical equipment, assistive devices and aids, residential and outpatient rehabilitation, home and environmental modification are very often the difference between community independence and institutional care for 1) people with incomes above \$1,600 per month (generally those who are working, were working when they became disabled, or retired); and 2) people with lower monthly incomes but with countable assets above \$2,000. These services are the difference between continuing financial independence and bankruptcy and/or poverty. Ψ

26. State funded personal assistance hours are capped at 35 hours per week. As with Medicaid, this cap disallows community independence for many people without families who require more than 35 hours per week to remain in their homes. Ψ

Private Insurance

27. Insurance plans will not cover what is deemed to be “custodial care.” It is far less expensive to cover the cost of a personal care aid to assist in the home than it is to cover the cost of keeping a severely disabled or terminally disabled consumer in a long-term facility. Ψ

28. Generally, plans do not cover specialty pharmaceutical health supplies, personal assistance and assistive technology. Additionally, drug and necessary supplies coverage is often inadequate. Ψ

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29. Long-term care insurers will not cover pre-existing activities of daily living (ADL) leaving working people with disabilities any option for service excepting state dependence even when they can access private insurance.

30. People with pre-existing disabilities are excluded from most individual insurance plans or, if offered, plans require premiums for above the disabled person's (families') ability to pay. Although some group plans offer long-term care coverage to people with disabilities, premiums again are often prohibitive and plans do not offer coverage for preexisting ADLs.

31. Many private insurance plans have an annual limit on prescriptions, leaving consumers without coverage for 1-2 months each year.

### Private and Non-Profit Providers

32. Hospital, rehabilitation and skilled nursing facility social workers, discharge planners and clients/patients are unaware of the full range of community services available. This results in people with disabilities being maintained/placed in inappropriate settings. Ψ

33. Medical offices and hospitals often do not permit the display of resource/service directories. This seemingly insignificant prohibition, if rectified, could lead to early intervention and needed service entry for hundreds of people with disabilities. Ψ

34. Poor wages and benefits for personal assistants and other direct care staff lower the quality and retention of people applying for positions which serve people with disabilities. This lowers the quality of care received by people with disabilities, results in a constant flux of caregivers, and causes extreme frustration for the disabled person and their family. Wages for direct service staff in community-based programs are not competitive with state and county employees who provide similar services. Service providers have high turnover rates from 75%-200% per year. The key to quality services is staff continuity and they must feel they are paid a "competitive living wage." Nevada must assure the money that is allocated goes to direct service staff, not corporate profits. Ψ

35. Advocacy and provider agencies are often reported as unresponsive or delayed in their responses, not returning phone calls, etc. This negative response rate may impact an impending institutionalization. Ψ

### General and Disability Specific Barriers

36. Childcare is currently not provided for people with disabilities presenting a major disincentive to employment. Childcare subsidies for those who do work should also be considered.

37. While policy, attitudinal and access issues are crucial to the independence of people with disabilities, the two most prevalent barriers to freedom from institutionalization are

Ψ = Olmstead Related

reported at state and national levels as the lack of: 1) affordable, appropriate housing, especially assisted living and 2) in-home personal assistance individualized to the needs of unique, disparate disabilities falls far below identified need. In-home personal assistance has been declared by Congress to be the single service most utilized by people with disabilities to remain free of institutional care. Every resource for provision of these services, public, private and non-profit should be identified, matched against need and projected growth, and a means of funding unmet need found. Ψ

38. Lack of respite care results in family disruption, unsafe care and unnecessary institutionalization. These services do not exist for many families critically in need and those that are available are fragmented, have long waiting lists and lack coordination across disability groups and differing eligibility criteria. Ψ

39. Life planning for newly disabled people is available only to those who, because of large insurance injury settlements, access this service through attorneys. For others, although it often makes the difference between wise resource utilization, and institutionalization or impoverishment, it is not available. Ψ

40. The State does not provide reimbursement for community-based housing and support services such as personal assistance and assisted living at a level which can support availability of the array of community-based services and provider agencies needed to keep people in their communities and free of institutional care. Ψ

41. People with disabilities regularly move from state facilities, acute care and other institutions to community-based care without resources for appropriate supports having been established or even available. This lack of planning often results in an eventual return to institutional care or homelessness. Ψ

42. The state's service system often reportedly drops individuals from service whose behaviors are difficult to manage. This is particularly apparent when the individual functions at, or near, the upper limit of eligibility. The rationale for discontinuing service is that the individual has "chosen" to leave the system. When an individual dropped from services runs afoul of the law it is asserted that they have "chosen" criminal activity and thus deserve "natural consequences". The actuality is that people of diminished cognitive capacity and those with behavioral disorders are dropped from the system. Lacking constructive activities they become a problem for society and, too often, get arrested. Both "choice" and "the dignity of risk" may serve to rationalize systemic failures stemming from lack of case management and service systems unwilling to serve the people it was created to serve. The final indignity is the acute lack of advocacy for people with mental retardation, autism, pervasive developmental disabilities and brain injury within the criminal justice system, which often leads to serving unwarranted jail or prison time. Ψ

Ψ = Olmstead Related

43. Ventilator and trachea dependent consumers currently have no options for community-based housing as no accessible and/or assisted housing is equipped for this purpose. Ψ

44. Community-based residential placement providers and even nursing homes are reluctant to take people with mental illness, behavioral problems, and those with HIV/AIDS. Most nursing homes annually screen their residents to eliminate those with a primary diagnosis of mental illness. These attitudes exacerbate the critical shortage of residential options in the state, lead to out-of-state placement and isolation from family supports. Ψ

45. Client placement/service plans are too often driven by what is readily available rather than by what is preferred by the consumer and directed by professionals rather than clients and/or families. Copies are not consistently provided to the consumer or followed up for changes in need and functioning levels. They may not reflect the holistic needs of the consumer for ancillary services and supports or provide needed information on client rights, agency procedures/grievance policies and advocacy alternatives. Control of care plans should be the primary responsibility of the consumer and the family. Ψ

46. Boards, commissions and decision making bodies whose actions will substantially impact the lives of people with disabilities are formed with no consideration given to the issues and participation of people with disabilities.

47. Only a handful of state and local governmental agencies regularly consult with people with disabilities when planning budgets and services or developing policy, technology or even planning office location. This results in adverse consequences to both agencies and to people with disabilities.

48. Legislative initiatives, when not specifically related to people with disabilities, often do not consider the potential effects to them. Examples are affordable housing, streets, public facilities and general program development, i.e., children's resource, technology and senior centers.

49. Community-based public accommodations and private and non-profit agencies providing social, health and other public services do not consult with people with disabilities in planning thus, are not designed to accommodate people with disabilities. This results in development of costly "separate" systems of service which are unnecessary and drain resources needed for critical disability services such as personal assistance, independent living and respite care.

50. Social workers, admissions staff and discharge planners are not familiar with all available resources and many are not familiar with disability and debilitating illnesses. Ψ

51. Only 51% of Nevadans with disabilities of working age are employed. For many, work is precluded because health care benefits received through Medicaid would be lost and are

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either not available through any private insurance (i.e., personal assistance) or not available through a particular employer plan. State funded services which are available to pickup some of the services needed to work, i.e., personal assistance have long waiting lists.

52. Many substance abuse services are based on twelve step programs or similar programs that require a strong capacity for verbalization. Many mildly and moderately mentally retarded people need to be counseled and trained to address this issue. Additionally, programs must provide accommodations for wheelchair users, deaf and blind and substance abusers and should be trained in working with people with disabilities, especially those with a high incidence, i.e., brain injury.

53. Dental care for people with all disabilities is abysmally inadequate. Most offices are not equipped with the accommodations needed for severe disability. Many dentists won't work with people who are non-verbal, terrified of needles and act out in public. Often for challenging behaviors, i.e., autism, dental care involves general anesthesia. Most often extraction, rather than repair, is the treatment assigned to people with disabilities for cost reasons. Proactive prophylaxis is generally unavailable to people with disabilities although dental disease is a leading cause of new and exacerbated disabilities. A single point of entry is essential to this potentially life threatening and disability exacerbating situation.

54. There is no centralized source, which provides information on all the various services and programs. People with disabilities and families view this as one of the most critical of systemic deficiencies. Study after study in Nevada, in all disability groups, reports this finding. Computerized access programs, which have been established in the past, do not work; there is a dire need for an integrated information and referral system such as that offered by 211 universal access and the United Way Tapestry Systems.

55. The general public is not acquainted with disability, lessening opportunities for volunteerism, inclusion in mainstream events/activities and appropriate action should a family member unexpectedly become disabled.

56. Consumers must often wait hours for Para-transit and must schedule transportation days in advance. Thus they are denied access to mainstream opportunities for socialization and community participation.

57. There is no current initiative for 911 registry of people with the potential need for crisis intervention by local emergency response teams. Such a service could prevent further disabilities and save lives.

58. Disability specific sexual counseling, i.e., sexual dysfunction, sexual aids, etc. is not provided as a matter of course to newly disabled people. Birth control, prevention and awareness of sexually transmitted diseases is rarely provided to people with disabilities, particularly to those with cognitive disabilities, i.e., mental retardation, pervasive developmental disorder including autism and brain injury.

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59. Additional accessible vehicles are needed for travel to workshops, group homes, recreation and opportunities for socialization by very severely disabled people.

60. Many medications needed are not stocked by the VA requiring veteran patients to pay out-of-pocket for medication they can't afford.

61. Severely disabled people are unable to "get out" in the community due to inadequate public transportation, lack of a transportation voucher system or other transportation alternatives. Not nearly enough bus stops or CitiLift services are available in the community and no transportation coverage is available when an unexpected need or emergency arises, or a person's usual form of transport fails for some reason. A Ψ

62. Most families have not been able to access the professional supports and training they need to improve their care of a dependent with disabilities. Families need psychological support, information about disabilities, intervention training for behavior problems, training about the way the service system works, and availability of grievance processes when things are going wrong in the service system. Ψ

63. Meals on Wheels are currently not provided to people with disabilities although there is a documented critical need for these services as evidenced by hundreds of disabled applicants annually.

64. Therapeutic and psychiatric services are not currently being made available in the home although these services may be essential to people unable to ambulate or to travel.

65. Caregivers, including family caregivers, are not currently trained to the unique needs of the individual they will be serving. Both caregivers and consumers agree that this is a critical deficit in provision of personal assistance services.

66. Free or low-cost prescription drugs are only available to people on Medicaid or eligible for services from those Nevada counties providing this service. Many people with disabilities simply go without the drugs they need to maintain their health.

67. Many severely disabled consumers are totally immobile requiring transport by ambulance, yet the VA currently requires they "see" the patient at the VA facility. A report by a licensed physician (one who makes house calls) should be accepted by the VA so that the paid prescriptions are more readily available. The SSI/SSDI process is unclear to many Vets and often these consumers are totally unaware of this potential benefit.

68. Abuse and neglect of residents is reported by advocates, consumers, families and providers to be rampant in Nevada nursing homes and group care facilities. Advocates are threatened with termination of access when they complain about this abusive treatment and neglect to staff. Residents say that they risk retaliation if abuse is reported. Families fear the same retaliation.

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69. Severely disabled people and parents of children with severe disabilities are getting divorced or are deciding against getting married because marriage will result in the loss of Medicaid, family preservation, respite and other assistance. They are forced into these situations by virtue of not being able to afford high costs of care and medications with the level of the two incomes combined.

70. Often, although safeguards and rules are in place which adequately protect the rights of agency clients, in practice, they are not being followed at the local case management level. This may be a result of poor communication between central and local offices or agency to intermediary provider. Whatever the case it results in violation of established rules regarding client rights.

71. When problems arise in accessing or maintaining services to which clients are entitled, those problems are often solved in light of the ferocity of advocacy provided for the individual client. People with disabilities, parents and advocates report that this results in unequal treatment of recipients requiring the same services and avoids addressing issues which critically affect the lives of recipients and families systemically. Ψ

72. Too many group and nursing homes are substandard and frequently maintain poor security, hygiene and meal services and little attention to client rights. Such homes merely warehouse clients. Ψ

73. Supported employment does not have a rate structure that allows it to have a “level playing field” with other types of placements (e.g. small group placement or facility based placement) DHR needs to cooperate with DETR to access technical assistance grants from the federal government to provide training to providers on serving “more challenging” clients. Ψ

74. Law enforcement does not understand disability and must receive additional education about people with disabilities especially those with mental illness, brain injury, autism, MS and mild, mental retardation and those who are deaf. Ψ

75. Staff providing advocacy services are not trained in the issues and aspects of specific disabilities. This is reported to create problems especially for complex disabilities, i.e., traumatic brain injury, autism and other pervasive developmental disabilities. Ψ

76. Medicaid sends out a mandatory form to be filled out by recipients’ landlords, revealing to others (landlord) the recipient’s status for benefits, including Food Stamps. Consumers view this as a breach of confidentiality.

Autism/Pervasive Developmental Disabilities

77. Although training programs for parents are available in working with their children with autism, those programs and the follow-up support required to maintain any gains

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made through parental training are prohibitively expensive. The inability to access appropriate training and maintain training gains can lead to escalation in the negative behavior of children and adults with autism and other pervasive developmental disabilities, harm to parents, siblings and property, family breakup and eventual institutionalization. Ψ

78. In-home support, life skills and personal assistance services for families of people with autism and other pervasive developmental disabilities who want to keep their child at home are not available. Even if funding were provided to allow these services, ADL trainers, personal assistants and respite givers are not trained to work with people with autism and those with pervasive developmental and behavioral disabilities. Ψ

79. There are no undergraduate degree programs in the highly complex autism/pervasive developmental disabilities field, and current pre-service university curricula does not sufficiently prepare educators and professionals to work successfully with this population.

80. Aging caretakers (often single mothers, living alone with middle-aged child), knowing how difficult it is to adequately care for an adult with autism, are often prisoners in their own homes, with little or no relief in sight. They know how easy it would be for untrained staff to be upset at the highly unusual behavior and poor communication skills of their son or daughter, and how easily abuse can occur. They are leery about placement with a provider if they can't really trust the staff with their loved one—especially if there is no one specifically trained and experienced in autism. After aging-out of school, adult sons and daughters with autism typically either sit at home (or need a caretaker) with no programs, or participate in those which poorly serve their unique needs.

81. Companion assistants for people with autism such as those with Aspergers who usually don't need intensive care, but need a support person for some parts of their lives are not available. Without these limited services participation in vocational and/or higher education classes is not possible.

82. As with all other disabilities, the difficulty in recruiting and keeping high quality, direct care staff presents a major barrier for people with pervasive developmental disabilities in maintaining community independence. However, for people with autism, who have a high need for a consistent and predictable environment and caregivers who understand their individual blend of peculiar characteristics, a constant change of direct care staff can be especially disturbing and destabilizing.

83. Very few educators, professionals, providers or caregivers have received any meaningful training in working with the unusual, often severe, behaviors and highly challenging learning styles of people with autism and pervasive developmental disabilities. In addition to limiting opportunities for learning, self-improvement and full participation, this situation has potential for unnecessary escalation of acting out behaviors, aversive, inappropriate management of negative behaviors, overuse of psychotropic drugs, use of physical restraints and abuse and injury to people with autism. Ψ

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84. Typically, ICFs/MR and group homes in Nevada are programmatically and structurally designed for people with mental retardation and not for pervasive developmental disabilities including autism. Most of these do not have staff trained and experienced in autism and are generally at a loss when trying to handle the unusual language, cognitive, behavioral and social deficits of autism. If staff are ignorant of successful ways of dealing with these unique deficits, behavior problems are likely to be dealt with in a punitive manner, which can quickly become severe and dangerous. It is at that point that parents are often called to come get their child or adult because “he doesn’t fit our program.” Ψ

85. Although Medicaid HCBS waiver guidelines provide basically a zero-reject service, if a client is out-of-control, an understaffed agency not skilled in working with severe behaviors can discharge a person who presents a significant challenge. (“He is a danger to himself or others.” “Our program is not set-up to treat his condition.”) It is easier and less expensive to discharge the hard-to-manage clients than to retrain, supervise, monitor, and support staff for people with autism. Ψ

86. Reimbursement rates for group care and day placement are typically low, so providers naturally gravitate to serving clients with less intensive needs than those with autism. When rates are the same for all clients, it makes more business sense for providers to have 1 staff to 4 clients than 1 staff to 1 client, as is needed so often when the diagnosis is autism, pervasive developmental disabilities or brain injury and a highly individualized program is critical. This is especially true for residential programs, where a client’s family can’t as easily be called to come get their son or daughter who is acting up. Ψ

### Homelessness and Disability

87. Programs for seriously mentally ill, physically disabled and brain injured homeless persons are severely lacking in Nevada. While only 2% of the general population is diagnosed with serious mental illness... more than 35% of the homeless population is seriously mentally ill (usually schizophrenia or bipolar disorder). These individuals are repeatedly being arrested for misdemeanor crimes of survival (such as stealing food) and consequently jails are reported to be the most utilized mental health facilities in the state. Mentally ill homeless individuals are consistently brought to emergency rooms. Mobile crisis units, crisis stabilization units and a full program of intensive daily outreach and intensive case management services are needed. Intensive outreach on a daily basis is not available to engage this population and they do not have the ability to access services on their own. Many are dual diagnosed with chemical dependency as well as disabilities. The University of Nevada, Las Vegas, in a recent study of the homeless in Clark County found that 25% of people interviewed had a physical disability. Many of these are veterans, others are now homeless because of a lack of housing and/or services and health care which led to eventual impoverishment. Passage of legislation to fund programs for the homeless mentally ill in other states has had phenomenal outcomes in the areas of reduced hospitalizations, reduced incarcerations, and reduced days homeless. These types of programs have been fiscally successful (380% return on investment) and have been

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expanded in every legislative session. Many homeless people with disabilities can be returned to successful, productive lives as a result of this type of program. Many more can be stabilized and prevented from becoming hospitalized, institutionalized or incarcerated.

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88. Existing homeless programs are not planned for and do not provide accommodations needed by people with disabilities. Such accommodations should include accessibility, interpreter availability, TTYs, etc.

89. Homeless planning does not recognize issues of brain injury at all, leading to inappropriate diagnosis, referral, medication and treatment of their disabilities. Neither does any planning include provision for the broader range of disabilities, i.e., amputees and/or people with physical and neurological disabilities. Additionally, the conditions faced by homeless people such as abuse and lack of nutrition, dental and medical care are creating new disabilities. Prevention and early intervention targeted to this newly emerging disability population will go far in eliminating the need for institutionalization in the future. Other preventive measures which will help to stem the escalating tide of new disabilities are: assault and violence prevention, especially in children, but also in preventing brain injury, is critical to prevention of new disabilities. Recognition and early treatment of mild brain injury should be included in all homelessness planning; availability of prosthetic replacements and proper maintenance is crucial in light of the large numbers of disabled veterans among the homeless population and people whose amputation was caused by poor nutrition and diabetes resulting from homelessness; parental training in recognition of mild brain injury, violence reporting and safety, nutrition and nutritional supplements; mandatory, accessible education and treatment for spousal and child batterers and; single point of entry established for immediate referral of disabled homeless, especially children, for disability prevention, education, intervention and treatment.

90. Nutritional programs including streamlined access to Food Stamps, provision of emergency food, assurance that children are getting enrolled and accessing free breakfast and lunch programs are woefully inadequate or non-existent.

#### Aging and Disability

91. At age 65 people with disabilities on Medicaid move from a status of disabled to one of “frail elderly”. With this change in status their service provision is transferred to the State Division of Aging. Because available programs and services differ in this division from those previously provided under the State Plan people may lose needed services potentially causing them to become institutionalized. This is especially true of personal assistance, which under the State Plan is capped at 55 hours but in the Division of Aging at 28 hours.

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92. Mental health issues of seniors with disabilities, particularly increasing depression, are generally not addressed or are inappropriately addressed by psychologists and mental health practitioners who are not trained in disability. Similarly, changing effects of use of

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alcohol due to increasingly changing medication or onset/progression of disability, i.e., stroke/MS are not being addressed at all. Generally when people with mental illness enter the “aging system”, their previous diagnosis for mental illness, i.e., bipolar disorder, is revised to “organic brain syndrome” and mental health services are no longer provided. Ψ

93. As noted in a previous section, there is no provision for “retirement” of seniors with mental retardation and related conditions who must receive highly intensive supports and reside in a supported living placement. They must be “out of the house” all day in a certified training center (CTC). For seniors this means they cannot stop work, stay home, volunteer, take up arts and/or crafts, etc. They must continue to go to the CTC. No other disability or non-disability group is faced with such a fate in their golden years.

94. People with disabilities in group care paid for by Nevada counties automatically transfer to the federally paid “domicillary care” program at age 65. The base rate for paid group care by Clark County is \$1,000 which may be increased to \$1,277 for higher levels of care such as those required by seniors with disabilities. The federal base rate of \$887 is \$113 lower than the Clark County rate. Although the “domicillary care” rate is subsidized by the state at \$9.09 per day, when maximized the group care or nursing facility will still receive \$113 less than it was previously paid by the county. The senior must negotiate his continuing residence with the facility (which is not required to continue care) or look for a new place to live. Rates paid for this care vary from county to county. Ψ

95 Generally, primary care and geriatric physicians have very little knowledge of rehabilitation medicine and assistive technology. For seniors with disabilities whose disability is most often exacerbated by the aging process, this is a critical, often life threatening problem. Additionally, needed rehabilitation and therapeutic services are not regularly planned for seniors, as they are perceived to be in the final stages of their lives.

96. There is a growing tendency by insurers and health care payors to use age as a means of limiting access to rehabilitation by substituting age-defined criteria for functional needs criteria. The best criteria for deciding whether a senior with disabilities, or any senior for that matter, needs rehabilitation services and technology should be assessments that show whether the person will benefit in terms of functional independence and increased mental capacity.

97. Pain management, therapy, ventilator and assistive technology needs of people with disabilities, particularly those with spinal cord injury and polio survivors increase dramatically with age. Caregivers, gerontologists and payors in the senior services arena are ill equipped to understand the underlying issues and potential resolutions to these problems.

98. Day placement, as noted previously, mainly constitutes work at a CTC for people with mental retardation, often for extremely low wages or below minimum wage. Senior centers

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and their programs are not designed to accommodate seniors with disabilities let alone those with mental retardation. Social outlets and family respite are generally unavailable.

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99. Continuing rehabilitation services and technology for stroke and polio survivors and seniors with MS or brain injury are not planned for and inadequately provided for in all senior service delivery systems. Ψ

100. Very few, if any, geriatric providers are even aware of the effects and service needs of post polio syndrome. The functional abilities that required the greatest effort during rehabilitation, that took the longest, and that depend on the greatest personal determination to ultimately achieve and accomplish are the very same abilities that will be lost first as a person becomes older and weaker, whether from a condition unrelated to the polio or from the late effects of polio.

101. Although communications technology is an integral part of all disability planning and service delivery, it receives little or no attention in planning senior programs and services.

102. Nursing home staff and administrators have little or no understanding of cognitive disabilities and mental illness in seniors and are ill equipped to care for people with these disabilities. If they are accepted, these seniors are often over-medicated for the convenience of staff. Ψ

#### Children with Disabilities

103. Referral of babies from neonatal intensive care units (NICU) to early intervention programs often occurs without parents understanding what is happening, why it is necessary or what their roles are as parents. Additionally, parents are not being given information about organizations and support groups which could help them cope with the experience of having a baby in the NICU. Decisions in these critical stages of early intervention are often left entirely to professionals. Parents need assistance to become knowledgeable about appropriate interventions so that they may participate in the decision-making process.

104. Physicians are not referring children for developmental and early educational services and when they do, they're not referring them early enough in the child's life and/or disability.

The amount of early intervention services a child receives from available state providers is not always commensurate with parent's knowledge of what is needed for the child's development.

105. Parents' observations are not valued to the extent they should be in establishing plans and authorizing hours for these critical services.

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106. Child Find personnel are not as knowledgeable as is warranted about school programs, available services and placements nor are plans well coordinated with school district personnel. Goals written by the Child Find team are often carried by school teams who may have differing opinions and approaches.

107. Child Find and early intervention staff often lack knowledge of the accommodations and assistive technology required by differing disabilities. Therefore appropriate accommodation for unique sensory, cognitive, behavioral and communications needs are not always provided.

108. Goals of the Individual Education Program (IEPs) are not always carried out due to lack of training and a lack of communication and collaboration among school staff responsible for implementing IEP goals.

109. There is a serious lack of communication and collaboration between school related community-based public and private service providers regarding IEP goals.

110. Students with behavioral problems are being placed in segregated schools and out-of-state because neighborhood schools lack the ability to provide necessary supports and services.

111. Children with disabilities, particularly those with severe and/or pervasive disabilities, experience a compounding of the frustrations, fears and confusion experienced by their non-disabled peers in transitioning from elementary to middle and high school settings. They are ill equipped and do not have the supports they need to deal with the increasing expectations of teachers and peers in these settings. Parents report that these kids need strong, consistent support to negotiate new, often large and confusing environments, understand and adhere to more complex rules and disciplines, cope with increasing competition and comparisons among non-disabled peers, avoid discouragement because of new demands on self-motivation and cognitive skills. Additionally, these kids often face exceedingly harsh treatment from non-disabled peers. This unpreparedness, the usual problems of a growing maturation, an increased understanding of their segregation from non-disabled peers, exclusion from extra curricular activities and a reported unwillingness of school officials and teachers to modify curriculum and provide needed accommodations all contribute to the disgraceful 20% dropout rate experienced in the student population

112. Students and parents are not presented enough information on how to access services which will be needed in adult life such as higher education assistance, independent living and assistive technology services, Vocational Rehabilitation, Social Security and other community-based programs.

113. School to adult life transition placement is not occurring in a timely manner and adult service providers are not developing plans early enough in the child's transition process. These deficiencies lead to total collapse in the planning process for graduating students and other school leavers. There are currently more than 11,000 students with disabilities who

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meet the requirements under IDEA for having a transitional plan in place. Although an age is not specified, regulations of the Vocational Rehabilitation agency also require that the State Plan policies assure the development of an Individual Plan for Employment (IEP) by that agency for all disabled students in need of services from that agency “before the student leaves the school setting.” Neither of these requirements is being met or ever has been. Among the many issues faced by transitioning students as reported by them; by their parents and by the professionals who serve them are:

- a lack of understanding by parent as to what should be occurring during transition.
- school staff’s lack of knowledge of available job opportunities and underestimation of the potential of students with disabilities.
- academic curriculum and job goals which are mismatched, pre-employment skills and job awareness doesn’t begin early enough and assistance with these issues by vocational rehabilitation staff occurs sporadically or not at all.
- low acceptance into school-based occupational education programs.
- students not receiving instruction in the community environments to which they will be transitioning.
- Vocational Rehabilitation’s (VR) lack of success in closing the majority of graduating students and school leavers and those they do work with successfully are closed after 90 days whether or not they need additional and/or ongoing services. There is also a critical lack of follow-up services to help students keep jobs.
- job coaching services which are difficult to access and maintain and often interrupted before the job transition is complete. Parents and teachers report that these services are rarely followed-up to provide support in the event of changing employment conditions, problems, or for other services needed to help them keep jobs. More often than not no “career” planning is ever done with these students nor is assistance provided to assist the new ex-student employer to work toward advancement.
- reasonable accommodations needed for students with disabilities to keep their jobs are often not planned in advance or provided as needed.
- because students with severe disabilities are hard to place, there is a lack of job opportunities for them aside from sheltered workshops.
- the loss of medical insurance when disabled students become employed—causes them and their families not to even think about working.
- agencies such as NBS, Employment Security and Job Corps do not understand disabilities, especially psychological and cognitive disabilities, even though they are

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charged with this responsibility under the Work Force Development Act. There is a 90% unemployment rate for people with severe mental illnesses and a 60% rate for other disabilities.

114. Children of all ages are not receiving the services they need in a timely manner, often do not receive all of the services to which they are entitled and parents are not generally aware of their rights, the required timelines for delivery of services to their child or even what services are available.

115 Parents do not receive the training and support they need at any stage of their child's development to access and maintain appropriate services and community linkages for their children. This adds significantly to the emotional stress they universally experience. A centralized (one-stop) assistance program that could help them to access appropriate information and resources, in-home assistance, respite care, and other needed services would lessen stress and frustration considerably.

116. Most programs are not designed to reflect the goals, dreams and expectations of children with disabilities and their families. This is one of the saddest issues experienced by children and parents alike.

117. Services for children and young adults with disabilities such as mental illness, autism, pervasive developmental disability and brain injury or who experience unpredictable behavior are terminated or denied far more often than they should be because of a lack of resources, training and/or understanding of those complex disabilities. These and other specialized services needed by children and young adults with low incidence disabilities/conditions are in extremely short supply and often do not exist in rural areas.

118. Families are often not able to access even those services which are available due to lack of transportation and/or distances, or lack of services in rural communities.

119. Seamless service systems do not exist and programs do not always utilize "Best Practices" for service delivery which reflect child and parent choice.

120. There is a lack of adult role models with disabilities willing to serve as mentors to assist children in areas of self-advocacy and esteem, employment, self determination, social and recreational opportunities.

121. Decisions are often determined by available resources rather than documented need and best practices, i.e., early intervention programs have a waiting list for services, so children are not receiving services within the 45-day established timeline. Services are delivered based on program structure rather than comprehensive need of the child/family. There is a need for flexible funding models such as those "wrap around" programs in Washington and Vermont.

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122. Services to kids with disabilities have not kept pace with population growth and shifts of populations/geographic areas nor are training programs keeping even reasonable pace with the need for providers specialized in the needs of children with varying and often complex disabilities.

123. As is the case with adults and their families, guidance and support in life and benefits planning is non-existent for parents who cannot afford to pay for this service.

124. Child welfare policies, restrictive eligibility, and lack of family and foster family support encourage child abandonment and discourages adoption and/or high quality foster placements.

125. No mechanism exists for planning across agencies/ programs to meet needs for parents/caregivers, i.e., children are being made eligible for Medicaid, but have not had EPSDT (Early Periodic Screening Diagnoses and Treatment) or Healthy Kids screening.

126. There is not a system to track the long-term progress of children and allow parents and professionals to gain from positive outcomes and choices. There are not consistent definitions for disabilities of children or diagnosis across agencies and for differing behavioral and cognitive issues. No one tracks kids with disabilities who need services but do not fit “special education” criteria.

127. Although there is a significant anticipated increase in children diagnosed with Autism and other pervasive developmental disabilities over the next ten years, and many more children will survive a critical brain injury, there is little in the way of service planning to meet these critical and growing need.

Mental Illness

128. When a person with a mental illness is incarcerated, there is a disruption in services and medications may be cut off or changed. When released, the client may not resume services with the same treatment providers, resulting in a discontinuity of services. In many instances, a forensic PACT that would interface with the jails could be a solution to this problem. In other instances, there should be a mechanism in place to assure that the client’s current case manager can interface with the jail system, and facilitate his transition upon discharge. Ψ

129. The mental health crisis unit scheduling system is archaic, revolving around a crisis-unit based system of intake with no computerized internal communication.

130. When prescribing medications, a cost-consciousness should be reinforced in a way that is consistent with professional judgement. Consumers and advocates are concerned that external influence by pharmaceutical companies may result in the wholesale use of the newest, most costly and not necessarily most effective medications. This is observed on a

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national level as well as in Nevada. It is essential to balance optimum patient outcomes with conservation of fiscal resources.

131. The distribution system for prescription drugs in mental health is currently limited to a few private and State-owned and operated pharmacies. A full evaluation of purchase and distribution practices is warranted and is evidenced by medication clinic waitlists.

132. Housing for seriously mentally ill persons over the age of 62 is almost non-existent, since adult homes and nursing homes are reluctant to, and/or legally prevented from, admitting persons with a mental illness; group homes are likewise reluctant to take older mentally ill persons. Ψ

133. Vocational services for the mentally ill are almost non-existent on a statewide level, even though the VR system is required to serve this population, has no waiting lists and returns unspent funds to the federal government nearly every year. Non-VR state funded programs are understaffed, with vital coordination with other agencies not maximized.

The Salvation Army has instituted several vocational programs, but limited funding.

134. The existing fledgling Peer Counselor program for the mentally ill suffers from unstable funding and inadequate commitment of resources, which results in under-utilization of the concept. When used properly, Peer Counselor programs benefit the bottom line. The agency involved gains valuable, committed employees who, because they are still technically in training, work for a lower salary than long-term employees. The Peer Counselors gain training, work experience, self-respect, confidence, an opportunity to contribute and opportunities to move into competitive employment if they so choose.

#### Spinal Cord Injury

135. Disability management and prevention programs are virtually non-existent for people with spinal cord injuries even though: 50% will be re-hospitalized for serious complications; they are 60 times more likely than the general population to die from septicemia or disease of the pulmonary circulation; 35 times more likely to die from pneumonia or influenza; and 5 times more likely to commit suicide. Ψ

136. People with spinal cord injury asked that the need for personal assistance services be repeated in this section even though discussed previously. It is the predominating service in their ability to work, to remain independent and free of institutional care.

#### Brain Injury

137. Nevada is lacking in education, research, and advocacy for the brain injured. Brain injury survivors exit an institution not being educated about their condition and resultant disability. The community, state service providers and the legislature is lacking in awareness of the incidence of brain injury and the life-long horrific consequences of such

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injury, and in prevention and education programs designed to avoid the occurrence of brain injury.

138. Because many brain-injured individuals do not appear to be disabled, there is a constant problem in obtaining services, especially appropriate services.

139. Agencies and the courts do not recognize, nor does private enterprise, that brain injury survivors have special ADA accommodation needs, i.e., help filling out forms and processing paperwork, allowing tape recorders, being accompanied to appointments, adjustments made to lighting, etc. Equal access to services is being denied.

Accommodations are made for apparent physical deficits, but not for cognitive impairments concerned with traumatic brain injury which often involve complex issues, including visual issues, hearing, and many more. This is particularly true when the individual seems visibly "normal", regardless of their decline in functioning, i.e., memory, processing, and recall.

140. There are no long-term brain injury centers focused on brain injury and recovery and there is a need for physicians and psychiatrists with an interest in brain injury who are visionary, aggressive and hopeful for the future of their patients; nurses who are trained in brain injury, who know how to work with brain injured patients and have ability to redirect aberrant behavior rather than fight with and sedate them; therapists, administrators and case managers who are experienced and interested in working with brain injury clients. Ψ

#### Mental Retardation and Related Conditions

141. There is a lack of communication between workplace and home care providers for people with mental retardation, especially dealing with medication changes, physician appointments, transportation, not calling in to work for those clients who are unable to call for themselves, not receiving signed permission slips for outings, emergency information sheets not being filled-in and returned.

142. Many young women (and men) with mental retardation long for affection and often become the target of sexual abuse. Research estimates that over 50% of females with mental retardation will suffer sexual abuse in their lifetime. Programs must be developed to prevent abuse and to address the consequences once it has occurred.

143. A significant minority of adult females with mental retardation will have one or more children. Many are abandoned by the father. If the father does stay involved, he often has an intellect that is not much higher than the mother does. These families will need specialized training and long-term support to address the needs of their children.

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144. In Southern Nevada, there is no position, which is solely responsible for quality assurance for community-based services for people with mental retardation. There appears to be only an “informal” assurance of quality of care and sometimes the more restrictive rules of the ICF programs are mistakenly applied to the community-based services.

#### Blindness

145. There is an acute shortage of mobility and orientation instructors in Nevada and the lack of a “professional community” which might attract them. This means that people of all ages are unable to access the training and coping skills they need to adjust to blindness and live independently and safely in their communities. Long waiting times for training further isolate newly blind individuals who are unable to travel safely in the community.

146. Rapidly increasing numbers of aging blind persons are straining orientation and adjustment (O/A) resources, which are critical to maintaining daily living skills and independence. Ψ

147. Since treating ophthalmologists and retina doctors seldom make blindness service referrals, many newly blind are unaware there are aids and devices or a State agency to assist in coping with vision loss.

148. There are few, if any, mental health professionals trained in dealing with the grieving of vision loss and the adjustment to it.

149. There are no audio-descriptions of emergency information, except for the warning sound, provided on local television stations; consequently, much necessary safety information is inaccessible to this population.

150. Para-transit agencies appear to be ‘screening out’ blind and visually impaired persons for services yet fixed routes are often inaccessible or distant. This reinforces isolation.

#### Deafness and Hard of Hearing

151. There is a critical lack of qualified interpreters throughout Nevada. Health care providers, businesses, nonprofit organizations, employment, housing and the court system are not accessible to deaf people because they do not appropriately provide interpreter services.

152. There is a lack of sensitivity of employers at all levels of employment in working with people who are deaf and hard-of-hearing. This has created a hostile workforce environment for them, thereby, deaf and hard of hearing employees often quit and they rarely get promoted to the next level.

153. Education and training for deaf adults on health care needs, Medicaid, etc. by way of DIRECT teaching is needed but is currently provided only through interpreting services. These interpreters, for the most part, do not possess the skill of conveying information

Ψ = Olmstead Related

accurately at the level of communication these people possess. Many deaf and hard-of-hearing persons have minimal to below minimal language and reading skills. For example, many do not access closed captioning device even though they are available.

154. Live TV captioning is lacking....news programs and emergency news are not adequately captioned or not captioned at all! In order to live in the community like everyone else and be full participants, they must know what's happening.

155. Minority deaf persons and those from other countries have no access to services that are culturally sensitive to their communication needs. There is very little outreach to this population.

156. There is a need for a one-stop service center in the North and in the South with satellites in rural areas to include, but not be limited to, telecommunication services (relay training and TTY distribution, and training classes (healthcare, parenting skills, etc.); interpreting services; advocacy and referrals.

157. Lack of accommodation in the court, health care systems and legal advocacy system among the deaf population is a huge and growing problem.

#### HIV/AIDS

158. People with HIV/AIDS experience all of the issues listed in the physical/neurological, progressive, terminal and cross disability sections of this paper but circumstances are made worse for them as providers do not want to work with them, landlords don't want to rent to them, employers don't want to hire them, insurers don't want to cover them and the general public is afraid of them. Ψ

159. The increasing number of antiretroviral drugs and the rapid evolution of this field of science have introduced extraordinary complexity into HIV/AIDS care. This means that it is more important than ever before that people with HIV disease receive care directed by a physician with extensive HIV/AIDS experience. In geographic areas in which this is not possible, the importance of access to HIV/AIDS expertise through consultations cannot be overstressed.

160. People living with HIV/AIDS are particularly vulnerable to denial of care because of their complex and costly health care needs. Furthermore, appeals processes often have a turnaround time so lengthy that it endangers HIV/AIDS treatment regimens and the health of the person denied care. Ψ

#### Progressive Disability

161. Personal assistance services (PAS) are capped at levels which don't recognize the eventuality of growth in need for services of people with progressive disabilities. While four hours a day may seem a reasonable amount for an average for an unchanging

Ψ = Olmstead Related

disability, this is not the case for the progression or episodic regression of disabilities such as muscular sclerosis. Ψ

162. Service planning for progressive disabilities such as MS must project need for episodic or emergency increase in services and include long range planning for eventual need, e.g., technology, home modification, etc.

**ALS and Other Terminal Disabilities**

163. The majority of private practice neurologists do not confer the diagnosis of ALS. While able to perform diagnostic testing here, families are sent out-of-state for diagnosis. This creates financial hardship. Once the diagnosis is given, the family returns to Nevada with a physician located elsewhere.

164. Veteran's diagnosed with ALS are referred to California for assessment and training in the use of alternative augmentative communication aids. This is not feasible, as many of the patients would need to be transported by ambulance. The result is that the needed equipment is not provided via their VA benefits.

165. The deciding issues of most insurance policies and for Medicaid paid rehab in connection with payment for medical treatment are: whether or not the patient can continue to make rehabilitative gains (defined as increased function in one or more life skills, such as mobility, self-care, communication) and whether or not the care the patient receives is considered "maintenance" or "custodial care." With ALS, there is no possibility of any rehabilitative gain. The provisions of most insurance policies will deny payment for custodial care and, since there is no approved medical treatment for ALS, the care required is deemed custodial in nature.

166. Terminally ill people are not being accepted for skilled nursing facility care due to their inability to "show progress."

167. Terminally ill people are unable to access needed end of life care due to a severe shortage of qualified hospice facilities.

168. Often neurologists will not identify ALS as the primary disability of a consumer thus denying needed early assistance. There are no survivors to ALS, the disease progresses rapidly and at an unspecified pattern. Applications for SSDI should not be denied and sent through an appeal process as is currently the case. By the time the case is resolved, the patient has died.

169. When providers of assistance to people with terminal disabilities request assistance, it is for a consumer that has but months to live. This disallows the luxury of "time" to wade through a maze of bureaucratic paperwork. Many such services need to have a priority code affixed. Ψ

**Ψ = Olmstead Related**

170. Currently many insurance policies require that a person must first be hospitalized for a medical problem that leads to the nursing home admission before being permitted to collect benefits for nursing home care. Additionally, a person must first receive skilled-level nursing home care before they can qualify for lower levels of long-term care. With ALS and other terminal disabilities, it is extremely rare for a patient to be hospitalized for a medical problem that would lead to a nursing home admission and, since there is no effective medical treatment for ALS, patients do not receive skilled-level nursing and, thus cannot qualify for lower levels of long-term care. Ψ

171. There is a critical shortage of counseling/support groups for terminally disabled consumers and their families: patient to patient; caregiver to caregiver; children/grandchildren – accepting death; grief counseling; training: how to handle spousal independence after death (i.e., many spouses were previously not responsible for the household finances; many do not know how to balance a checkbook); preparation for final arrangements and adjusting to being a widow/widower.

172. Respite care is unavailable for people with terminal disabilities. If the caregivers become ill, there are then two patients. There is need for a minimum of two days per week (two hours each for three months) during the final stage of life. Ψ

173. The average cost for consumers with ALS is \$200,000 per year. Many families of these people and others with very severe disabilities such as HIV/AIDS end up in bankruptcy due to a lack of assistance in the end of life stages of the disease.

#### Rural Disability Services

174. There are very few home health or oxygen companies in any of the rural areas and if they exist they may only have one or two providers available.

175. There is a shortage of rural health care and mental health workers in rural Nevada. Higher pay and incentives are needed to attract state social workers, including clinicians and other non-profit and private health care providers to work and live in rural areas.

176. Mobile clinics are desperately needed for those of all ages in rural areas particularly for those with mental illness.

177. Rural people with disabilities tend to have a lower family income, be less educated, and have fewer job opportunities than their urban counterparts. Further, rural areas tend to have inadequate housing for disabled residents, severe shortages of health personnel, an absence of necessary health care facilities, and poor or nonexistent public transportation systems. Although about 30 % of the nation's population live in rural areas, only one % of the federal public transportation dollars go to them. Four basic factors and their interactions have been identified to account for major transportation problems for rural disabled residents: low income, placing serious restrictions on the mobility of disabled individuals; transportation service deficiencies, when transportation is either not available

Ψ = Olmstead Related

or operates too infrequently to be of any relevance; distance from social, health or employment facilities; and inaccessibility of older vehicles (Pre-ADA). Lack of mobility is a serious problem for people with disabilities as it prevents performance of the important roles in the person's life. Not only is the frequency of social interaction curtailed when the person cannot move around freely in the community, but its nature is changed. People who cannot go out and interact with the world are forced to wait for the world to come to them. This creates a social dependency which, added to economic and physical dependency can negatively influence the person's self-esteem and self-concept. Additionally, there is a strong relationship between the availability of accessible transportation and the ability of people with disabilities to live outside institutions. Ψ

178. There are too few accessible/adaptable housing units in rural areas available to meet the need of persons with disabilities; little multi-family housing exists in rural communities, so accessibility provisions in the Fair Housing Amendments Act (applicable only to multi-family housing) have had a minimal impact on the accessibility of rural housing. There are no federal building access requirements for single residential settings; the resources and assistance available in rural communities may not include expertise in accessibility problems. Often this translates into less effective, "make-do" solutions to accessibility problems; the low population density of rural areas means that supported living-type programs, such as "shared attendant care," must draw occupants from a very large geographic area, resulting in some residents being moved great distances from their previous home. Distant relocation is usually a negative factor, which makes group homes inappropriate for most rural areas and; low rural population density results in a scarcity of many of the support services which permit urban or suburban residents to live independently in their own homes. Ψ

179. There are very few specialty providers, therapists and providers who are knowledgeable in diagnosis, treatment and management of disability especially complex disability in any of Nevada's rural areas.

180. Mental health counseling and emergency services are seriously inadequate in the rapidly growing areas of Elko and Nye counties. There are month-long waiting lists for critical counseling services in some areas.

181. Hospice services are particularly limited in the rural areas. Many of the hospice volunteers are physically unable to 'reposition' or 'move' a patient, and, therefore, unable to provide training to the in-home caregivers. The availability of DME (durable medical equipment) is extremely lacking. Ψ

182. People with disabilities and families report that the most prevalent reason their rights are not protected is that they are not fully aware of what those rights are. Bureaucracies and state entitlement rules are confusing, complicated and interpreted differently by

Ψ = Olmstead Related

different people in the same organization. There is no place to go to get a simple clarification that people can count on as being correct.

183. Since people with disabilities and their families in rural areas have such difficulty in getting information about and locating necessary services, there needs to be a single point of entry in each county that is linked to the statewide single point of entry mentioned earlier in this paper.

184. The lack of affordable, accessible respite care has been mentioned in other sections of this paper. However, it deserves to be mentioned again as a critical need in rural Nevada.

185. People with disabilities and their families living in rural Nevada and on Reservations have not been included in the development of policy and service planning conducted by state and local governmental agencies. State and local governmental agencies should assure that the specialized issues of people with disabilities in rural areas are considered and included in all deliberations related to service delivery and policy development by including representatives from rural areas and Tribes on all policymaking boards, councils and committees involved with planning service delivery and policy development for people with disabilities.

**PART VII**

**MINORITIES WITH DISABILITIES – THREE LIVES**

**Mack Nez Johnson, Jr.**

My name is Mack Nez Johnson, Jr. I was born in Reno, Nevada. When I was growing up in Reno, I could never imagine I would be strolling these same streets in a wheelchair. The same curves I wheeled my bicycle off of, I now maneuver my wheelchair down. Every time I get out and about in Reno or any other city, I give thanks to the Creator there are people here watching over my needs. As a person with a disability I have a lot of personal needs to be met with every day. I'm a C-4 quadriplegic paralyzed from the shoulders down. I cannot groom myself, prepare meals, dress or undress myself. As far as all my personal needs are concerned, I'm pretty much dependent on a Personal Assistance Service. Take away that service and you can visit me in a nursing home. It's just not the personal needs I'm concerned about, but to be treated equally, humanely and with respect. That said, it leads me to the topic of racism and discrimination. I am a full-blooded Native American and my family and ancestors have live in Nevada for hundreds of years. By the looks of things, it is as if we're the foreigners here. The federal government and states have not treated my people well. My people are left behind in rural and isolated areas of the state with very little education and knowledge, outside of reservation life. I say to you --- the ones who hold elected offices and those who are concerned, let's make a change. Let us learn from our mistakes. Indian and non-Indian alike, we have wisdom and knowledge that date back to when time began. It's been awhile since I've ridden a bicycle, but I understand you never forget.



1. Concern: Native Americans with disabilities on isolated/rural reservations have limited or no vocational training opportunities. The current system has been totally ineffective.

Solution: Assure Tribal Vocational Rehabilitation is implemented and provide effective outreach and services to all reservations including isolated/rural Tribes.

2. Concern: Many professional throughout the state are unaware of Native American culture and values essential to providing effective programs and services. This can also create stereotyping and communication barriers.

## **Nevada Strategic Plan for People with Disabilities**

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Solution: Provide cultural sensitivity training/classes to professionals (e.g., health care providers, Vocational Rehabilitation counselors, therapists, social workers, etc.) and within college curriculums that educate future professionals.

Conduct a Native American Summit of Indian leaders and people to develop long range planning.

Develop an office specific to multicultural issues that employs individuals of various ethnic heritages that services are intended for.

3. Concern: There is a severe lack of knowledge on reservations as to the needs and potential resources available to assist Native Americans with disabilities.

Solution: Develop outreach coordinator positions for qualified Native Americans with disabilities that provide training and education to individuals on reservations (e.g., social workers, Tribal councils, families, disabled, etc.).

4. Concern: There are inadequate personal assistance services on reservations for the disabled and elderly.

Solution: Develop regional personal assistance service offices managed by Native Americans and employ them as personal care attendants.

5. Concern: Native Americans with disabilities of all ages do not have access to necessary services and programs essential to improving their lives.

Solution: Identify Native American children, youth and adults with disabilities through collaboration with the Tribes, and provide essential programs, education, and recreation to assist in their independence, leadership and quality of life.

Report service outcomes in terms of impact to improved independence and quality of life on an annual basis in all programs serving disability populations.

## **Cecilia Leal-Covey**

My name is Cecilia Leal-Covey. I emigrated from Mexico to the United States 13 years ago. When I was two years old, I got poliomyelitis that paralyzed me from the hip down. I have had my disability for 36 years now; and I don't know any other way to be. I am used to it; however, there are many obstacles I have to overcome daily. Being a Hispanic woman and immigrant in a wheelchair hasn't been easy to deal for me. Sometimes I don't understand and it's difficult for me to define if the difference of treatment is because of my culture, my disability, my gender or because of the country I came from --- or is it all of these things? Still, this is the least thing of my concerns. I cannot waste time thinking, trying to find out the reason why I'm being treated differently. I wouldn't find the answer, and I wouldn't be able to change their minds in a few minutes. The only thing I can do to change people's minds is showing them that a person with a disability is as capable as anyone else.



My day-to-day activities and struggles are examples that can help able-bodied people to understand about disabilities and create a respect that everyone deserves.

I know there are some people out there hidden, homebound, intimidated by society and social issues. They may be dealing with depression, adaptation, and they are scared of the unknown. As a result they react defensively creating barriers between them and other people. But that is why I don't waste my time defining the difference of treatment, I expend my time trying to educate people because I know that they will welcome anyone with disabilities and provide the same or better services that they provided for me. Also to help those who are intimidated and scared, I reach out to them and try to inform them about the services available for us in our community.

Some people call me "token" but, instead of insulting me, or making me feel less, I use the advantage or disadvantage (depending on your point of view) to get into their circle of society and teach them. I admit that sometimes I cry and I vent due to my sadness and frustration in being impotent to change their minds. Instead of torturing myself, I move on and start my objective somewhere else. But, I know the place I leave will provide the best services or will hire a person with disabilities with no doubt. I always brag about people with disabilities and their successes.

Life has been hard for me; don't think I have an easy life with everything given to me...no. Before I came to the U.S.A. I used to be a great student, one of the best sportswomen for the Mexican National Team, but I was also the fastest drinker of bottles of hard liquor, did shoe shines on the streets and begged money to survive. Did I do any substance abuse other than

alcohol? Yeah! Why? Because in my country at that time, people with disabilities were worthless. It was so hard to find jobs. There was no personal attendant care and it was hard to get around with no transportation at all. When I wanted to use the metro, I had to do it crawling down the stairs holding my wheelchair with one hand and balancing myself with the other. Instead of staying at home and crying, I knew I needed to get out and say “hi” to God everyday, every minute.

When I came to the United States, I joined a group of people with disabilities because they were a great example for me and everyone else. I do admire them and thank them for all the changes they made to benefit us. I know other countries are and will learn of what American has done for people with disabilities. I hope my country will give the same opportunities to its people --- the unknown freedom.

I understand there are several issues we need to educate people about, such as employment, education, health, and all the services in general that could help people with disabilities and able-bodied people to enjoy life with happiness and peace, together.

1. Concern: Hispanics with disabilities don't know about the services available for people with disabilities.

Solution: Do outreach with information about available services. Have bilingual material.

2. Concern: Professionals throughout the state are unaware of people with disabilities, their culture and their beliefs.

Solution: Provide cultural sensitivity training to all service providers. Have a program that provides sensitivity training on an ongoing basis. Also, would approach conferences, workshops, camps and any other ways of providing service providers with sensitivity training.

3. Concern: Advocates sometimes misunderstand the meaning of advocacy. Hardship and misunderstanding builds between an advocate and a person with disabilities.

Solution: There is a need for training to help advocates recognize when they are burned out and when misunderstanding is building hardships and anger.

4. Concern: Day-to-day struggles and discrimination can negatively change the life of a person with disabilities, causing isolation, depression, etc.

Solution: There is a need for training for people with disabilities to learn how to deal with their new situation, assertiveness training and how to advocate for oneself without rejection as a result of speaking up.

5. Concern: The community needs to know we are here --- working, shopping being part of the society. Then they will interact with us more often.

Solution: Approach media (television, newspaper, radio, etc.) about people with disabilities to inform the entire community we are there living like anyone else.

## **David Sims**

Living life as a person with a disability is extremely difficult. There are many obstacles to overcome such as depression, rigorous therapy (mental and physical) and just day-to-day living. This is especially so when the disability comes suddenly and unexpectedly.

My name is David Sims and I am a 25-year-old black man who has had to face one other obstacle --- racism. I remember my first months of living in the nursing facility. I was on life support, so I couldn't speak. Whoever I was communicating with had to read my lips. One respiratory therapist who was changing the tubes on the ventilator didn't realize I was coherent. Unaware of this, he was speaking aloud and said, "You people will do anything to live off hard working citizens." I just laid there



and became so angry that he would say something like that! That wasn't the only incident. There were many more. It seemed that most of the people I encountered automatically thought I was shot during a gang fight or drug deal. Was this because I was a young black man? Without them even knowing anything about my background or the cause of my injury, they made assumptions based on skin color. To this day, when people approach me, the first thing they say is, "Was your injury due to gang violence?" It's never, "Were you in a car wreck?"

I have encountered many people since my first days of being disabled. Most of them are very nice; however, a smaller number are bad. These encounters range from caregivers to other people with disabilities. Through my investigation and conversations with other young black males with disabilities, I've learned that discrimination can be on both sides. Because of the constant assumptions based on skin color, the person with the disability may have great anger that causes them to lash out against those who are able-bodied and assist them with their daily lives. These issues make it hard for caregivers to do, even want to do, their job well.

Some individuals with disabilities are upset just because they are disabled. This causes them to be angry with everyone around them and may cause rejection in return. Then, the person with the disability claims he's being discriminated against. However, the real reason may be the person's attitude. Often their anger does not allow them to see the truth in the situation. This is an example of how discrimination and misunderstood motives can affect both patient and caregiver.

My experience has been, whether you are black or white, you will face discrimination in one way or another. It depends upon the individuals you encounter and how you choose to react to one another. I believe if you treat those around you with great respect, then you are most likely to receive respect in return. Having been given the opportunity to share my concerns has been enlightening and informative, as I have spoken to others in situations similar to mine --- in skin color and disability. I would like to reveal these concerns and the possible solutions as they were shared with me recently. I look forward to work to implement change for the better of all those with disabilities.

1. Concern: Disabled African Americans do not have a support group or agency that employs African Americans to assist them with problems/advocacy.

Solution: Build a group of African Americans with disabilities who are knowledgeable about the struggles of African Americans so they can assist their peers in a culturally sensitive manner.

2. Concern: There is a great need for outreach programs to encourage the participation of those in the African American community to assist those with disabilities and advocate for them in the full range of situations that may occur.

Solution: Inform the African American community their support is needed and vital to those with disabilities. Hold public hearings so consumers can voice their opinions on the services being provided, while educating the public on the problems of being a minority with a disability.

3. Concern: Care providers are not always cognizant of cultural differences and how those differences may manifest themselves in a daily care situation and with program services. This makes the disabled African American feel as though he/she is in a situation of double discrimination, i.e., skin color and the disabling condition.

Solution: Provide multi-cultural education classes for care providers.

4. Concern: Personal assistance services may not be provided in a consistent manner due to the nature of the location/neighborhood of the client. Some assistants are reluctant to travel into certain areas, thus denying the client the care he/she deserves.

Solution: Refine the interview process so the care provider is knowledgeable and willing to provide care to whomever may need it regardless of home location.

5. Concern: Many African Americans feel they are receiving services from those who have no clue or understanding of being black and disabled, thereby increasing tensions between both parties.

Solution: Before a service provider, personal assistant, counselor or caseworker is assigned, there should be a face-to-face meeting so there is a greater understanding of the needs and requirements of both parties involved. Then a decision can be made on whether to move forward or not.

## PART VIII

### GOALS AND ACTION PLAN

#### Critical Success Factors

The Nevada Task Force on Disability (NTFD) and its sub-committees identified six key elements crucial to the successful implementation of Nevada's strategic planning objectives. These elements, key to aligning the Nevada system with the principles set forth by the Centers for Medicare and Medicaid (CMS) in complying with the Olmstead Decision and the American with Disabilities Act (ADA), and planning now for the future of children with disabilities include:

- *Involvement of people with disabilities and the families providing their care.*  
For systems and services to work effectively they must be designed to meet the needs of children and adults with disabilities and their families. If not planned with their direct and sustained involvement, services, however well meaning, may fall short of addressing the issues they are intended to resolve or may miss the mark entirely.
- *Early and successive, standardized, comprehensive assessment of individual needs.*  
Beginning at the first sign of potential disability, whether at birth or as a result of a later diagnosis or injury, a comprehensive life-long assessment process must begin. To do otherwise is to risk an erosion of resources previously applied, miss opportunities to build on individual growth potential and expend scarce resources for costly, unnecessarily restrictive services.
- *Availability of community integrated settings.*  
A flexible and comprehensive array of community services and supports allows families, people with disabilities and professionals to make cost effective decisions to appropriately meet their real needs. Lack of options limits choice, decreases prospects for successful and sustained independence, and forces expenditure for services in unnecessarily restrictive settings.
- *Informed Choice.*  
The ability for people to make an informed choice makes it easier to select a preferred service and realign services with changing conditions. The ability to make informed choices invites a trusting partnership between service consumers and providers, and encourages people to take more responsibility for their own growth and independence. Conversely, uninformed, misinformed or under-informed decisions promote distrust, result in an ineffective or inefficient use of resources, and can lead to serious, even catastrophic, consequences for children and adults with disabilities and the families who care for them.
- *Founded on the Principles of Self-Determination:* freedom to choose a meaningful life in the community; authority over a targeted amount of dollars; support to organize resources in ways that are life enhancing and meaningful to the individual with a disability; responsibility for the wise use of public dollars and recognition of the contributions individuals with disabilities can make to their communities; confirmation of the important leadership role that self-advocates must play in a newly re-designed system and support for the self-advocacy movement.

- *Effective, broad-based infrastructures and quality assurance:*  
To build and sustain the infrastructure required to carryout the mission of this planning effort requires information, continued strategic planning, effective data systems, financial investment, capacity building, an informed/organized constituency and continuing research, documentation, and, ongoing evaluation. Without these critical elements the NTFD Plan will face the same end as have many of its predecessors - - - relegation to someone's shelf.

### **Ten-Year Planning Goals**

Following are nine goals and accompanying strategies that resolve barriers identified by the NTFD as presenting the greatest urgency for action. Throughout its deliberations, to view the "system" holistically across all disabilities, service systems and ages, many additional recommendations were developed. The original list of NTFD goals is found in Appendix G. The goals enumerated in Appendix G are no less important than the nine which follow and no less urgent. The overall system for serving Nevadans with disabilities is perceived by the NTFD and its sub-committees to be so "broken" and seriously under-funded that only those recommendations needed for alignment with the ADA/Olmstead principles of the CMS and those most crucial to Nevada children are addressed here.

Strategies requiring financial investment include general estimates of the level of support needed and the recommended source of that support. Several of the sources listed have generally been used as "discretionary." The NTFD believes that while such discretionary funding is crucial to building new community resources, it has also led to further fragmentation of resources which may be better utilized if aligned with those currently existing for critical service.

The strategies also propose modifying Millennium Scholarship requirements enabling students with disabilities to participate in educational and career opportunities. The combination of this strategy with others targeted to education will go far in moving us toward a future where no Nevada child is left behind.

Task Force members have worked hard to identify currently existing resources which might be restructured, collaborations which could save resources, potential means of saving future resources and ways to insure that resources gained are not lost. Every known alternative was explored as a possible funding source before new general revenue dollars were targeted.

Each strategy which has a potential cost was generally reviewed for what those costs might be. Costs provided and the backup detail of how they were projected are meant to give the reader a very general idea of what the costs might be to begin to implement each strategy, where those costs might come from in addition to general revenue and how such strategies might be accomplished. In addition to the overall cost to serve the total consumer base for each strategy (i.e., all people on waiting lists) the cost to serve each person has been broken out in Section VIII. The NTFD is well aware of the current economic climate and

understands that it may not be possible to quickly address the needs of the total population waiting for, or in need of, service.

**A. Stakeholder Partnerships**

People with disabilities and families of children with disabilities know the most about what they need. They are the experts in what does and does not work for them. Their involvement is crucial to effective service design, delivery and expenditure, and is a preeminent guiding principle in complying with Olmstead and ADA tenants.

Additionally, as recognized by the National Council on Disability, the ADA holds great promise for ethnic minority persons with disabilities, but the promise will be realized only if specific efforts are made for outreach, education, and removal of barriers in the minority communities.

People with disabilities who are also members of minority groups face double discrimination and disadvantage in our society. They are more likely to be poor and undereducated; have fewer opportunities than other members of the population; and, are at greater risk of disability and at greater risk of not receiving needed services if they have a disability. The NTFD seeks to involve, solicit the views of and accept the guidance of minority people with disabilities in planning the services that affect their future.

The NTFD recognizes that, although there are many existing state level advisory groups and councils representing people with disabilities, each has a specific program-related mission. The Task Force gently reminds state appointing authorities that these councils must represent all of the more than 375,000 Nevada citizens with disabilities in the cities, inner cities, isolated rural areas, reservations, and those with no home at all.

**GOAL 1: Social policy, program structure, regulation and planning affecting the lives of children and adults with disabilities will fully reflect their views, culture and involvement.**

***Strategies:***

a. Establish a permanent 15-member State Disability Service Coalition comprised of people with disabilities, families of children with disabilities, and members from existing consumer councils and advocacy groups. The coalition will be charged with developing a uniform set of guiding principals and core values for all service development and delivery; ongoing responsibility for monitoring implementation of the Strategic Plan for People with Disabilities; implementing and revising strategies; updating and reporting progress to each session of the legislature in preventing institutionalization; and, returning people from segregated settings and providing an adequate array of community integrated services.

**Nevada Strategic Plan for People with Disabilities**

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**Table 1  
Disability Service Coalition**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Members</u>
2004 – 2005	\$ 7,518			15
2006 – 2007	\$ 7,518			15
2008 – 2009	\$ 7,518			15
2010 – 2011	\$ 7,518			15
<b>Total:</b>	<b>\$30,072</b>			<b>60</b>

Refer to Section IX, 1) Disability Service Coalition

- b. Establish by Executive Order, and renewed by each succeeding Nevada governor, that:
- all state funded managed care programs currently serving or intending to serve children and adults with disabilities include a representative number of knowledgeable adults with disabilities and families of children with disabilities in the design, planning, approval and evaluation of such programs, and include at the minimum, the recommendations of the Health Care Financing Administration (HCFA), now CMS, 2000 Report to Congress;
  - boards, commissions and decision-making bodies whose actions substantially impact the lives of children and adults with disabilities include the participation of informed adults with disabilities and their families;
  - all state agencies will adhere to established principals and core values in providing and operating their programs;
  - all state agencies providing disability services regularly consult with adults with disabilities and families of children with disabilities, including those in rural areas and on reservations, when planning budgets and services or developing policy, technology, location and other issues that will affect them;
  - in formulating policies affecting children and adults with disabilities, state and county agencies consult with and be guided by respect for Indian Tribal self government and sovereignty, and encourage tribes to develop their own policies to achieve mutual objectives; and,
  - the state’s service delivery system for children and adults with disabilities and their families be guided, in all operations, by the core values established by the Governor’s Task Force on Disability and guiding principles established by people with disabilities and their families.
- c. Establish, by legislative resolution, renewed by every succeeding session of the legislature, that general legislative initiatives impacting children and adults with disabilities include consideration of the potential effects such legislation may have on their lives and access to services.

**Nevada Strategic Plan for People with Disabilities**

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d. Develop local agreements to ensure public accommodations and private and non-profit community agencies providing social, recreational, health and other services to the general public consult with children and adults with disabilities and their families in planning processes to avoid development of costly “separate” systems of services.

e. Conduct an Indian Summit and follow-up session of tribal and state governmental leaders to explore and implement mutually effective communication, policy, planning, and service delivery strategies for Native Americans with disabilities residing on reservations. Review progress biennially.

**Table 2  
Indian Summit**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Attendees</u>
2004 – 2005		\$20,000	Council on Developmental Disabilities	120
2006 – 2007				
2008 – 2009		\$20,000	Council on Developmental Disabilities	120
2010 – 2011				
<b>Total:</b>		<b>\$40,000</b>		<b>240</b>

Refer to Section IX, 2) Indian Summit

f. Establish, implement and monitor recommendations of a sunseting statewide task force on minority populations with disabilities to assist in the review and modification of ongoing and prospective planning, service delivery, data collection, research, outreach and evaluation related to children and adults with disabilities.

**Table 3  
Task Force on Minorities**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Members</u>
2004 – 2005		\$22,596	Councils on Developmental Disabilities & Independent Living	17
2006 – 2007				
2008 – 2009				
2010 – 2011				
<b>Total:</b>		<b>\$22,596</b>		<b>17</b>

Refer to Section IX, 3) Task Force on Minorities

## **B. Comprehensive Assessment and Planning**

### *People in Institutional Care:*

Nearly 1,000 children and adults with disabilities currently reside in Nevada's system of skilled, intermediate, and psychiatric care facilities. Another 90 or so live in out-of state residential facilities. In the 2000-01 school year, 158 children with disabilities resided in correctional facilities. Although the numbers of adults with disabilities in correctional facilities is unknown, it is no doubt substantial given the incidence of brain injury, mental illness and pervasive developmental disability in Nevada.

A 30-day snapshot of 1,613 Nevada nursing home residents identified 216 (13%) with potential for discharge within 30 to 90 days. Few, if any, will receive comprehensive, setting-neutral assessments for the services and supports they will require to return to their communities. None of them will participate in the development of a discharge plan linking them, in advance of their departure, to all of the community providers they will need to rely on for the complete array of services, supports, technology, home modifications and advocacy for sustained community independence.

Many people with disabilities in Nevada facilities will never leave because neither they nor the staff providing their assessments are, or will, become aware of the resources available to help them transition. Still others will stay because they have lost everything they had prior to entering the facility, and literally no longer "have a pot to cook in." Many will become sicker and suffer pneumonias and infections during their stay, putting them further at risk for prolonged institutionalization.

Based on testimony taken in its public meetings, the NTFD believes many people are unnecessarily placed in institutional care because pre-admission screenings do not adequately consider the full array of available options. Comprehensive assessments and planning, if implemented wisely and cautiously, can move people back to their communities or prevent them from leaving in the first place. Such assessments also afford the state the opportunity to save millions of dollars spent for unnecessary and/or prolonged institutional care.

### *Nevada Students:*

At least 11,000 students with disabilities will exit special education in the upcoming five-year period by either graduating or aging out of the school system. Most will be unprepared and lack the services required for adulthood in the most appropriate, integrated settings. No one will track what happens to the great majority of these kids. Those who have been tracked are known to have only about a 25% success rate in finding employment through adult service providers. Roughly 20% will receive a regular diploma and every year, 17% to 19% will drop out of school before completion. This dropout rate is three times higher than that of non-disabled students. Few of those who graduate with a regular diploma and none who earned an adjusted certificate will have the opportunity to participate in higher education or in the Nevada Millennium Scholarship Fund. The millions of dollars spent on these kids, the potential they have, and the hard work of their teachers is quickly lost without the transitional assessments and supports they need to move to adult life.

### *New Disabilities:*

The majority of newly disabled children and adults leaving acute care and rehabilitation settings are unprepared to do so. In 2001, Nevada spent millions of dollars for newly injured or disabled people. Most, who return to the community from acute care settings, have no idea where to turn for assistance with their new independent living needs and, as a result, may fail to remain in the community.

Supplemental Security Income (SSI) eligibility determinations for people with new disabilities take an average of 100 days to complete. Reapplications may take up to two years for final resolution. Medicaid approval is tied to SSI eligibility, thus the 100+ days is also applicable to obtaining Medicaid services; and application for Medicaid adds another 10 to 45 days to the process. Many newly disabled people with severe injuries leave acute care with only the option of transferring to an institution because of these delays.

Most hospital staff are unaware of the non-Medicaid services which could be made available to people exiting acute care. This lack of knowledge limits placement options considered in the assessment process. Discharge planning is often reported to be minimal and rarely includes advance planning for assistive technology, home modification or long-term personal assistance.

### *Homelessness:*

Thousands of people with disabilities who are homeless may never gain access to an assessment and planning process unless they become institutionalized. Once they enter such a costly placement, community return is a long and cumbersome process.

### *Newborns:*

The NTFD Children's Sub-committee indicated prevention also begins with assessment. Families of at-risk or disabled newborns and those whose children will develop later disabilities can only assist their children if they know what's wrong, what to do about it, and where to go for help. Infants and toddlers must be planned for as a part of our overall vision for Nevada's future.

**GOAL 2: Service provision to people with disabilities in the most integrated, appropriate settings will be assured through the application and resulting service plans of individualized, setting neutral assessments and expedited service entry.**

### **Strategies:**

a. Develop, implement, and monitor setting neutral assessments (SNA) through a collaborative effort of county social service, facility representative, Nevada Medicaid, Department of Education, Division for Aging, Mental Health and Developmental Services, and Office of Community Based Services staff with an equal representation of knowledgeable advocates, adults with disabilities, and family members of disabled children.

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b. Individually determine, through independent, advocacy-driven application of the SNA by community-based providers, which children and adults currently receiving services in unnecessarily restrictive institutional or group care settings could, with reasonable modifications, receive services in the community.

**Table 4  
Setting Neutral Assessments**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005		\$ 31,250	Title XX	125
2006 – 2007		\$ 31,250	Title XX	125
2008 – 2009		\$ 31,250	Title XX	125
2010 – 2011		\$ 31,250	Title XX	125
<b>Total:</b>		<b>\$125,000</b>		<b>500</b>

Refer to Section IX, 4) Setting Neutral Assessments

c. Provide annual and intermittent training for minimum data set (MDS) coordinators, and other appropriate staff of institutional, acute and group care facilities in the philosophy and use of the setting neutral assessments and “no wrong door” resources.

**Table 5  
MDS Coordinator Training**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Trainings</u>
2004 – 2005		\$15,000	Title XX	50
2006 – 2007		\$ 7,200	Title XX	24
2008 – 2009		\$ 7,200	Title XX	24
2010 – 2011		\$ 7,200	Title XX	24
<b>Total:</b>		<b>\$36,600</b>		<b>122</b>

Refer to Section IX, 5) MDS Coordinator Training

d. Require discharge plans for all people with disabilities being transferred from institutional care and group care which are paid from state resources, include at a minimum, advance provisions for: 1) personal/social adjustment; 2) special evaluations; 3) integrative therapies; 4) life skills training; 5) psychosocial interventions; 6) assistive technology; 7) drug and supply need; 8) medical care; 9) transportation; 10) in-home assistance; 11) environmental modification; 12) family counseling; 13) case management; 14) caregiver training, and; 15) housing.

e. Identify and transfer people in institutional care who can be served in the community, and who do not oppose such transfer, assuring appropriate discharge planning, transitional supports and targeted services coordination in the process.

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**Table 6  
Targeted Service Coordination**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005		\$204,250	Title XX	100
2006 – 2007		\$204,250	Title XX	100
2008 – 2009		\$204,250	Title XX	100
2010 – 2011		\$204,250	Title XX	100
<b>Total:</b>		<b>\$817,000</b>		<b>400</b>

Refer to Section IX, 6) Targeted Service Coordination

f. Develop a rider to Medicaid budgets based on the Texas model. Modify existing policy to allow a “money follows the person” pilot for children and adults assessed to be in unnecessarily restrictive residential environments. Track results for large-scale implementation.

g. Expand Pre-Admission Screening Annual Resident Review (PASARR) to provide all elements of the SNA to children and adults with disabilities prior to entry into any segregated residential setting. Ensure that all available resources are examined for inclusion in a service plan that meets the needs of the person with disabilities in the most integrated, appropriate environment.

h. Establish a community transfer fund to provide subsidies to people re-entering their communities from institutional placements to purchase minimal personal items needed to setup housekeeping, subsidize rents and deposits, assist with the first month of expenses.

**Table 7  
Transfer Subsidy**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005		\$129,440	Title XX	80
2006 – 2007		\$129,440	Title XX	80
2008 – 2009		\$129,440	Title XX	80
2010 – 2011		\$105,170	Title XX	65
<b>Total:</b>		<b>\$493,490</b>		<b>305</b>

Refer to Section IX, 7) Transfer Subsidy

i. Assure all children (age 0-2) referred for early intervention services receive, a multidisciplinary child evaluation and family needs assessment, and an individualized family service plan (IFSP) and have their plans completed within 45 days to comply with federal law. This can be realized by expanding the number of providers certified to perform these evaluations.

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Note: *This can be accomplished by including providers in the community, and those performing Early & Periodic Screening, Diagnosis and Treatment (EPSDT) screens for similarly disabled or developmentally delayed children as eligible to perform these assessments. While it is difficult to accurately assess the cost impact of such a proposal, the potential costs are very high. Currently the state, through the Special Children’s Clinics, First Step and HAPPY programs serve. 1,741 children at an average annual cost of more than \$5,000 per child. There are 591 children (as of June 30, 2002) who have not received an IFSP within 45 days of their referral, and an additional 51 who have received an IFSP, but no services. Finding is referenced on page 61. The expansion of providers would require additional oversight to ensure the quality of the assessments and appropriateness of the services indicated in the plan are maintained. Without this oversight, the costs could be substantially higher.*

j. Examine development of a 1115 Medicaid waiver allowing presumptive eligibility of those with severe, long-term disabilities to assure newly injured people in acute hospital settings are not transferred to unnecessarily restrictive settings

k. Assure all eligible at-risk children and adults quickly receive the assessments and Medicaid services they need through a single eligibility application for SSI and Medicaid.

**Table 8  
Single Eligibility**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$ 160,124	\$ 160,124	Federal Match	50
2006 – 2007	\$ 404,661	\$ 404,661	Federal Match	100
2008 – 2009	\$ 445,626	\$ 445,626	Federal Match	100
2010 – 2011	\$ 490,790	\$ 490,790	Federal Match	100
<b>Total:</b>	<b>\$1,501,201</b>	<b>\$1,501,201</b>		<b>350</b>

Refer to Section IX, 8) Single Eligibility

l. Implement a statewide system of outsourced mobile units for outreach, assessment and referral of children and adults with disabilities who are homeless and in crisis.

**Table 9  
Mobile Outreach**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$ 602,872			21,900
2006 – 2007	\$ 572,872			21,900
2008 – 2009	\$ 572,872			21,900
2010 – 2011	\$ 572,872			21,900
<b>Total:</b>	<b>\$2,321,488</b>			<b>87,600</b>

Refer to Section IX, 9) Mobile Outreach

m. Identify the service needs of out-of-state residential placements and develop in-state capability to return those residents to Nevada.

n. Children who are segregated or at risk for out-of-home or residential placement (mental retardation, seriously emotional disturbances, autism, and multiple disabilities) will receive setting neutral assessments and individualized, integrated services and supports as guided by the Olmstead decision and related CMS guidelines.

**C. Community Capacity**

More than 600 children with disabilities are waiting for medical treatment and therapies vital to their development. In any month, an average of 30 children are waiting for placement in residential care, 450 children and adults for critical psychiatric services, 106 for dental care, and far too many for adoptive homes.

Three hundred and six (306) families have been waiting for months for just a few hours of respite care service, hundreds more wait for interventions to help them manage the out-of-control behaviors of their children with autism, developmental disabilities or brain injury. One hundred and eighteen (118) families of children with disabilities and adults will wait up to two years for the home and environmental modifications which will allow them to access their communities.

An average of 255 adults with disabilities are waitlisted each month for the medications they need to stabilize their mental illness. In August of 2002, 133 adults were waiting for supportive housing and those currently waitlisted for affordable, accessible low-income housing will wait another two to three years. More than 7,000 people with disabilities are at risk of becoming homeless, and at least 3,600 are already homeless.

Upwards of 700 adults with physical disabilities and seniors are waiting for home and community support services through Medicaid waivers and nearly 200 for the service Congress has recognized as the number one service utilized by people to avoid unnecessary institutional care - - personal assistance. To make matters worse, state funds available for personal assistance are often lost by reversion to the state due to unforeseen acute episodes of clients receiving such care.

Because people with disabilities having income in excess of the SSI income limit can only receive Medicaid services if they either accept placement in a nursing home or if a slot becomes vacant on an appropriate Medicaid waiver, many languish in institutions unnecessarily. If the resident's name "comes up" on the waiver waiting list, it must often also concurrently appear on a housing waiting list for community transition to occur. Pots, pans, dishes and furniture, lost in the move to institutional care must often be replaced, and almost always, personal assistance must be available.

Sadly, there is one population desperate to get into, rather than out of skilled facilities. People with terminal disabilities such as ALS cannot access care in a skilled nursing facility

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without first entering an acute environment. These unnecessary acute stays often add to catastrophic costs that must be borne by families or public resources.

**GOAL 3: Children and adults with disabilities of all ages will receive services expeditiously and in the most integrated environments appropriate to their needs.**

**Strategies:**

a. Ensure waiting lists for services critical to community integration and avoidance of segregated service environments are regularly expanded and move at a reasonable pace, not to exceed 90 days, 5 days for medication clinics. Those services are identified as medication clinics and treatment for mental illness, Home and Community Based Services (HCBS) personal assistance, and independent living services.

**Table 10  
Critical Waiting Lists**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$ 9,313,726	\$ 4,226,965	Fed Match/Tobacco Settlement	1,135
2006 – 2007	\$10,163,655	\$ 4,553,167	Fed Match/Tobacco Settlement	1,135
2008 – 2009	\$11,183,139	\$ 4,954,285	Fed Match/Tobacco Settlement	1,135
2010 – 2011	\$12,356,080	\$ 5,395,922	Fed Match/Tobacco Settlement	1,135
<b>Total:</b>	<b>\$43,016,600</b>	<b>\$19,130,339</b>		<b>4,540</b>

Refer to Section IX, 10) Critical Waiting Lists

b. Collaborate with Rural Health Task Force to ensure long-term viability of rural health care facilities for enhancement of rural primary health care model and develop a rural PACT service to people with mental illness.

c. Establish a statewide contract with commercial pharmacies to fill prescriptions for people with mental illness in locations close to where they live.

d. Provide a continuous allotment, through the 10% disability designation of Tobacco Settlement Funds, to ensure families providing primary care to a severely disabled family member receive respite within 90 days of application.

e. Provide access for children with disabilities to medically necessary services, health care, specialized dental care, medications, medical equipment, and assistive technology.

f. Assure that funding is flexible and services and supports meet the individual needs of the child and family.

g. Provide enhanced state unit funding to school districts to reduce the proportion of local district funds needed for special education programs.

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h. Develop interagency agreements among local and state programs to implement one primary service coordination system for families of children with disabilities that includes state-defined criteria for roles and responsibilities, uniform training requirements and minimum provider qualifications.

**Table 11 - Family Respite**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005		\$ 749,837	Tobacco Settlement	440
2006 – 2007		\$1,999,566	Tobacco Settlement	880
2008 – 2009		\$1,999,566	Tobacco Settlement	880
2010 – 2011		\$1,999,566	Tobacco Settlement	880
<b>Total:</b>		<b>\$6,748,535</b>		<b>3,080</b>

Refer to Section IX, 11) Family Respite

i. Monitor and report to each session of the legislature the number of county paid nursing facility residents to ensure that people eligible for Medicaid services by virtue of being institutionalized and having their care paid with 50% county match monies, will be assured equal opportunity for services paid with 100% state funds should they choose to live in the community.

j. Ensure that waiting lists for medically necessary services to children with disabilities move at a reasonable pace and meet all federal and state regulations.

**Table 12 - Children’s Services**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$ 6,699,912			1,284
2006 – 2007	\$ 6,699,912			1,284
2008 – 2009	\$ 6,699,912			1,284
2010 – 2011	\$ 6,699,912			1,284
<b>Total:</b>	<b>\$26,799,648</b>			<b>5,136</b>

Refer to Section IX, 12) Children’s Services

k. Fully implement the provisions of Senate Bill 174, the Nevada Personal Assistance Services Act, for efficacy in avoiding unnecessary entry into, and transfer from, skilled nursing facilities.

**Table 13 - SB 174**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u>#Consumers</u>
2004 – 2005	\$ 5,257,052	\$1,697,686	Title XIX	266
2006 – 2007	\$ 5,340,612	\$1,677,748	Title XIX	266
2008 – 2009	\$ 5,340,612	\$1,677,748	Title XIX	266
2010 – 2011	\$ 5,340,612	\$1,677,748	Title XIX	266

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<b>Total:</b>	\$21,278,888	\$6,730,930		<b>1,064</b>
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Refer to IX, 13) SB 174

l. Draft and support legislation allowing state funds allocated to the personal assistance programs administered by Aging Services and the Office of Community Based Services to be carried over into the next fiscal year.

m. Provide permanent funding for the state’s Positive Behavioral Supports Network at a level that, at a minimum, will support adequate training and service delivery to 1,500 families with children with autism and brain injury, and others in need of such interventions to avoid or return from institutional placement and keep families together and in control of their lives. This can be accomplished using the 10% disability designation of Tobacco Settlement Funds.

**Table 14  
Positive Behavioral Supports**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u>#Consumers</u>
2004 – 2005		\$ 444,000	Tobacco Settlement	210
2006 – 2007		\$ 444,000	Tobacco Settlement	210
2008 – 2009		\$ 444,000	Tobacco Settlement	210
2010 – 2011		\$ 444,000	Tobacco Settlement	210
<b>Total:</b>		<b>\$1,776,000</b>		<b>840</b>

Refer to IX, 14) Positive Behavioral Supports

n. Assure that services provided through Medicaid, Special Education, Independent Living, Maternal and Child Health, Child and Family Services and Vocational Rehabilitation will recognize, plan and fund the positive behavioral supports required by people with behavioral disorders to maintain home, community and educational independence while avoiding institutional placement.

o. Implement NRS Chapter 629, as included in the Nurse Practice Act, through all state programs providing this service insofar as allowable under federal CMS guidelines.

p. Develop methodology for ensuring access to financial assistance and/or subsidies to qualified people with disabilities and families of disabled children who cannot afford the prescription drugs they need in all Nevada counties.

**GOAL 4: Children and adults with unique needs will obtain services in a timely and appropriate manner.**

**Strategies:**

a. Develop policy and provider requirements that seniors with disabilities paid from state and county resources: 1) receive the same level of assessment for independent living needs, utilizing the same functional needs criteria, as do younger children and adults with disabilities, and 2) receive therapeutic services and medication specific to a generally diagnosable mental health condition when they have been previously diagnosed with mental illness rather than labeled with “organic brain syndrome” and left untreated.

b. Develop an inter-local agreement between the Division for Aging Services, the Sanford Center on Aging, and the UNR School of Medicine to assure pre-service professionals in the senior service arena receive training in the underlying issues and potential resolutions to the pain management therapy, ventilator and assistive technology needs of seniors with disabilities, particularly those with spinal cord injury and polio survivors.

c. Promote the use of senior center service delivery systems for seniors with disabilities including those with mental retardation through reasonable changes in programs and facilities.

d. Monitor progress of people with brain injury paid from state resources, whose skills have been lost and will not be regained without immediate rehabilitation, to ensure they receive services consistently and without delay. Report client outcomes, service environments, and costs associated with services for people with brain injury on an annual basis.

*Note: The NTFD was unable to determine if, in fact, there is a cost associated with this strategy and therefore requests cases be tracked and reported over a four-year period.*

e. Identify people with cognitive and pervasive developmental disabilities who need independent guardianship opportunities beyond those offered by the public administrator to insure more individual attention and advocacy.

f. Provide orientation and mobility training needed by people who are blind enabling them to move safely and independently in their communities, and the orientation and adjustment services needed to acquire and maintain daily living and independence by excluding these positions from state hiring freezes, assuring positions are filled expeditiously, and promoting the development of a “professional community” of O & M trainers in Nevada.

g. Provide training within personal assistance programs to ensure people with autism, other pervasive developmental disabilities and brain injury (who have a high need for a consistent and predictable environment) will obtain caregivers who understand and are trained in their individual particular characteristics and needs.

**Table 15  
Personal Assistance Training**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Caregivers</u>
2004 – 2005	\$ 3,200			120
2006 – 2007	\$ 3,200			120
2008 – 2009	\$ 3,200			120
2010 – 2011	\$ 3,200			120
<b>Total:</b>	<b>\$12,800</b>			<b>480</b>

Refer to Section IX, 15) Personal Assistance Training

h. Consistently and objectively consider the unique travel problems, both personal and environmental, faced by blind or visually impaired people when determining eligibility for services through the Para Transit certification process.

i. Fund a statewide interpreter’s (sign language) coordinator and trainer’s office at the state level to ensure interpreters are trained and qualified to do the job effectively and satisfactorily in accordance with NRS 656A.

j. Develop a Medicaid HCBS Cognitive Impairment Waiver to assure delivery of the complex and costly array of behavioral services needed by people with brain injury, autism, and other pervasive developmental disabilities and mental illness for their unique behavioral and independent living needs.

**Table 16  
HCBS Cognitive Impairment Waiver**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$ 476,425	\$ 476,425	Federal Match	25
2006 – 2007	\$1,716,476	\$1,716,476	Federal Match	75
2008 – 2009	\$2,849,791	\$2,849,791	Federal Match	100
2010 – 2011	\$3,131,514	\$3,131,514	Federal Match	100
<b>Total:</b>	<b>\$8,174,206</b>	<b>\$8,174,206</b>		<b>300</b>

Refer to Section IX, 16) HCBS Cognitive Impairment Wavier

k. Continually expand Nevada’s Medicaid Buy-In Program to equitably provide, by 2008, medical insurance coverage or wraparound to all people with disabilities who, by virtue of becoming employed, have established an income above poverty level, but cannot obtain the health care coverage and services required to terminate reliance on public benefits.

l. Expand funding for the Homeless Mentally Ill Outreach initiative (H.O.P.E. –

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Homeless Outreach Pilot Education) program to implement ongoing programs providing intensive outreach and case management services including immediate access to necessary medications and housing.

**Table 17  
Project HOPE**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$4,000,000			400
2006 – 2007	\$4,000,000			400
2008 – 2009	\$4,000,000			400
2010 – 2011	\$4,000,000			400
<b>Total:</b>	<b>\$16,000,000</b>			<b>1,600</b>

Refer to Section IX, 17) Project HOPE

**GOAL 5: Decrease the risk of disability institutionalization in the general disability population by improving and protecting critical health care services.**

**Strategies:**

a. Establish, by Executive Order and legislative resolution, renewed by each succeeding governor and legislative session that, effective July 2003, critical health, mental health, nutrition and personal assistance services to children and adults with disabilities, poor children and frail seniors are exempted from budget cutting during economic downturns.

b. Provide families who act as primary caregivers with the disability education, training and support services needed to effectively provide care to their family member or significant other without undue physical and/or mental hardship.

**Table 18  
Family Caregivers**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Families</u>
2004 – 2005		\$ 11,700	Federal PAS	78
2006 – 2007		\$ 11,700	IL/DD Councils	78
2008 – 2009		\$ 11,700	IL/DD Councils	78
2010 – 2011		\$ 11,700	IL/DD Councils	78
<b>Total:</b>		<b>\$46,800</b>		<b>312</b>

Refer to Section IX, 18) Family Caregivers

c. Develop a statewide single point of entry for affordable, accessible basic health and dental care in all counties and on all reservations, offering specialized disability services through a collaboration of the Nevada Dental School, Federally Qualified Health Centers and Tribal Health Services.

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**Table 19  
Single Entry Health and Dental**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005		\$127,360	DD Council	100
2006 – 2007		\$127,360	DD Council	400
2008 – 2009		\$127,360	FQHCs/Dental School	600
2010 – 2011		\$127,360	FQHCs/Dental School	800
<b>Total:</b>		<b>\$509,440</b>		<b>1,900</b>

Refer to Section IX, 19) Single Entry Health and Dental

d. Ensure that appropriate provider rates for Personal Assistance, Community Training Centers, and Supported Living Arrangements are established and adopted by the Nevada Legislature and implemented for all state programs.

**Table 20  
Provider Rates (PAS)**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$8,185,230	\$6,463,866	Federal Match	5,699
2006 – 2007	\$7,423,450	\$6,044,245	Federal Match	5,699
2008 – 2009	\$7,672,401	\$6,181,378	Federal Match	5,699
2010 – 2011	\$7,946,870	\$6,332,568	Federal Match	5,699
<b>Total:</b>	<b>\$31,227,951</b>	<b>\$25,022,057</b>		

Refer to Section IX, 20) Provider Rates (PAS)

e. Annually monitor and report to the Legislative Committee on Children and Families, progress on Project IMPRV, Self-Improvement Plans, IDEA Parts B and C.

f. Provide, via a Department of Human Resources directive, that no person whose services are paid from state funds is removed to a more restrictive environment without specific documentation that positive behavioral supports have been fully utilized and failed to correct the presenting issues, identifying how they have been used and why additional restriction is required.

g. Establish a “fast-track” system with priority coding for people with terminal disabilities applying for services from publicly-funded programs, particularly when the condition is expected to rapidly deteriorate.

h. Include in a legislative resolution, renewed by each session of the legislature, language supporting Nevada's motorcycle helmet law as a primary resource for preventing additional catastrophic injuries thereby preserving critical funds for services to currently un- and underserved survivors of traumatic brain injury.

- i. Encourage entities within the University of Nevada systems to provide, training for professionals and parents serving children with autism and other behavioral disorders focusing on best practices for intervention, which include cognition, communication, social-emotional, and behavioral supports.
- j. Assure that parents of children with disabilities have the affordable, in-home, individualized support they require to avoid escalation of negative behaviors causing a disruption in family unity, potential injury to family members, and out-of-home placement.
- k. Provide access to crisis supports and services for families who are caring for children with disabilities.

**D. Information and Choice**

Information which is up-to-date, accurate, reliable, easy to access and easily understood is a need expressed in nearly every Nevada study of families and people with disabilities since the early 1990s. Consumers and parents report great frustration in locating the needed services and supports. Many report not knowing where to go to get assistance. Others say they must go to many different agencies to obtain information and referrals (I&R) to meet their needs in a comprehensive manner. Although various I&R systems have been implemented over the years, families and people with disabilities report their usefulness is minimal. Information is often outdated, many people never find out the system exists, call in numbers are hard to remember, and linkages to other services are not well coordinated and often do not exist. Without ready access to reliable, appropriate information, referral and assistance, consumers and families cannot make the best decisions on how their needs can best be met.

In considering a permanent remedy to this common need, the NTFD has determined that a 211 system tied to comprehensive disability information No Wrong Door web access and disability specific call centers provides the solution. 2-1-1 is the national abbreviated dialing code for free access to health and human services I&R. 2-1-1 is an easy-to-remember and universally recognizable number that makes a critical connection between individuals and families in need and the appropriate community-based organizations and government agencies. 2-1-1 makes it possible for people in need to navigate the complex and ever growing maze of human services agencies and programs, and to access a broad range of services with one telephone call. By making services easier to access, 2-1-1 encourages prevention and fosters self-sufficiency.

Access to emergency police and fire services through the "911" telephone number is nearly universal and an indispensable service. However, thousands of individuals and families search daily for emergency financial assistance, food or shelter. For those who want to give back to the community through volunteerism, donations or civic involvement, the situation is only marginally better. I&R personnel have known for years that a universal number would mitigate this problem.

2-1-1 offers Nevadans:

- Streamlined access to existing services by eliminating confusing and frustrating searches;
- An efficient and accurate database and referral system for existing services;
- Independence for vulnerable people (elderly, disabled, non-English speaking, illiterate, those new to their communities, etc.) to help themselves; and,
- Improved information for community planning.

As of June 2002, there are 29 active 2-1-1 centers in 14 states with aggressive statewide planning underway in those states to achieve 100% population coverage as soon as possible. Today, approximately 30,052,066 Americans (over 10%) have access to information by dialing 2-1-1.

Significant work has been done in Nevada to develop I&R capabilities. United Way of Northern Nevada and the Sierra is licensee for a comprehensive web-based database of human services. United Way of Southern Nevada developed a similar database, although their system has not been recently updated. The Crisis Call Center provides comprehensive I&R services throughout Nevada, with a concentration on northern Nevada. United Way of Southern Nevada works closely with HELP of Southern Nevada, and can provide a potential call center resource in the Las Vegas metropolitan area. Given all this, Nevada is poised to develop a 2-1-1 system, with a disability website drop in and call center.

There are nearly 400,000 people in the State of Nevada with disabilities. There is only one state agency that provides any semblance of a single point of entry, Developmental Services under the Division of Mental Health/Developmental Services, and it is disability specific. Public hearings and forums, stakeholder meetings and surveys conducted statewide over the past five years by the Nevada Councils on Developmental Disabilities, Independent Living and Assistive Technology, the Office of Community Based Services, Nevada Rural Health and various non-profit agencies clearly document that people with disabilities and their families are faced with having to navigate through a system of service delivery that resembles the “corn field maze.” The service delivery system in Nevada is fragmented with many service providers not knowing about other providers and the kinds of services they provide, or at best, the information they have is outdated and/or inaccurate. Because of this fragmentation, many people with disabilities and their families have wrong or misconstrued perceptions about services and agencies which results in their unwillingness to seek out those services. Stories from families who have been sent from office to office, clerk to clerk, agency to agency, are well documented within the disability community. Family unity is in jeopardy, the divorce rate among couples with children with disabilities is over 80%, people with disabilities are unnecessarily institutionalized because they can’t readily access services, and many families simply give up and move to other states because they can’t find the services they need here in Nevada.

So much of this, if not all, could be avoided by having an Office of Disability such as the one created for the state of New Jersey by then Governor Christine Todd Whitman. The office would provide a single point of entry and service coordinating assistance, making it easier for people with disabilities and their families to get accurate and up-to-date information about

and access to the services they need. These people simply want the same things in life as others in Nevada: to be productive citizens who contribute to the communities in which they live; to be good family members and to be able to enjoy a full and cohesive family life; to have meaningful employment that provides satisfaction and independence. They also want and deserve to have a stronger voice in the very process that makes policy decisions about the kinds of services that people with disabilities need. Nevada has shown leadership in developing many of its disability-related programs and policies, but too often they have been developed without involving people with disabilities and without coordinating where these services would best meet the needs of the very people they are to serve. An Office of Disability would bring people with disabilities and their families into that decision and policy-making process and give them a stronger, more unified voice to help “de-fragment” and improve the service delivery system in Nevada.

These people deserve the recognition and support of the State, county and local governments to protect their rights and to reach their full potential. To fulfill this responsibility, The NTFD recommends that the staff establish an Office of Disability which is empowered to serve these citizens with disabilities effectively so that comprehensive, consumer-driven programs can be developed and coordinated statewide.

**GOAL 6: Children and adults with disabilities will not be placed at risk of institutionalization while living independently and/or inclusively in their communities for lack of adequate information and support and will easily and appropriately access the services they require.**

**Strategies:**

- a. In collaboration with Nevada counties and United Way organizations, establish and fund a 2-1-1 universal access line with a supplementary No Wrong Door website and community level call centers providing information, referral and resolution assistance in:
  - services available from all state, county, nonprofit, private, faith-based and charitable organizations;
  - life and benefits planning;
  - individual and family support networks;
  - immediate, monitored crisis intervention;
  - transportation schedules, availability and access points;
  - affordable, accessible and supportive housing options;
  - affordable, accessible and supportive living arrangements; and,
  - assistive technology/environmental modification access health care resources.

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Elements of the No Wrong Door (NWD) system include:

- assisting newly disabled people and families in developing long-term care life plans to include all major aspects of their future need for medical care, rehabilitation, financial planning, insurance coverage, and other necessary independent living, financial and legal issues;
- linkages with federally qualified health centers (FQHCs), state and county caseworkers, educators, insurers, non-profit and private providers and tribal health clinics;
- immediately providing NWD resources and entry contacts for Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) and Medicaid services to applicants and other children/adults with a new diagnosis;
- prominently display materials designating NWD resources and information in all health care provider offices, agencies and facilities;
- training and information on the full range of available NWD service options, acceptance criteria, service entry points and the philosophy/economics of independent living to case and social workers, educators and institutional admissions, assessment, and discharge staff providing services to children and adults with disabilities; and,
- procedures designating hospital staff and/or identified community advocates to assist newly injured people in accessing NWD resources and website.

**Table 21  
No Wrong Door**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Calls</u>
2004 – 2005	\$ 480,960	\$ 53,440	Homeland Security	20,000
2006 – 2007	\$ 640,260	\$ 71,140	Homeland Security	104,000
2008 – 2009	\$ 640,260	\$ 71,140	Homeland Security	104,000
2010 – 2011	\$ 640,260	\$ 71,140	Homeland Security	104,000
<b>Total:</b>	<b>\$2,401,740</b>	<b>\$266,860</b>		<b>332,000</b>

Refer to Section IX, 21) No Wrong Door

b. Establish a state Office of Disability Services within the Department of Human Resources at the director’s level based on the New Jersey model. The office shall:

- serve as the single point of entry for children and adults with disabilities seeking assistance and not meeting the requirements for disability-specific programs located in any state government agency;
- serve as the disability liaison to the 2-1-1 access and NWD system to assure a comprehensive I&R system for persons with disabilities and their families, those who serve and advocate for them, and members of the general public. In carrying out this function, the office shall periodically publish a statewide directory of disability services and assure the NWD website is consistently updated to contain accurate, timely, and comprehensive information;

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- operate as the state-level coordinating body among all agencies of state government providing services to people with disabilities and serve as a locus within state government for the interests of people with disabilities and their families;
- serve as the primary liaison to the county offices providing services for people with disabilities, provide technical assistance to the county offices and seek to establish an electronic network which connects to each of the county offices. In addition, the office shall work with counties that do not maintain services for people with disabilities to establish such services and assist the counties in seeking federal, foundation and other grant funding to establish or enhance county services for people with disabilities;
- administer the personal assistance services program established pursuant to the “Personal Assistance Services Act,” (SB 174) and seek to coordinate all other publicly funded programs providing personal assistance or other home-based services to people with disabilities. The office shall also operate such state, federal or foundation funded demonstration programs as may be determined by the Department of Human Resources Director;
- establish a disability housing liaison position to coordinate housing information and availability throughout the state, identify funding opportunities and promote the attraction of new housing options for children and adults with disabilities;
- provide business or property tax credits to all developers of single and multi-family dwellings who build units that include basic wheelchair accessibility as outlined in Fair Housing Standards; and,
- publish, and biennially update, a Review of Community Capacity which: reviews current and projected capacity of Medicaid State Plan services, HCBS waivers, county services and other governmental, and non-profit services across all disabilities; identifies the costs of existing and new community supports; provides a strategy for the expanding and/or restructuring of community services consistent with statement of need; includes waiting list data as a primary basis for planning and reports individual outcomes of service delivery; reports progress in implementing strategic planning goals.

**Table 22  
Office of Disability**

<b>Fiscal Period</b>	<b>General Revenue</b>	<b>Other</b>	<b>Source</b>	<b># Consumers</b>
2004 – 2005	\$4,724,430	\$ 6,661,802	Telephone Surcharge, Federal IL/DD/AT	6,500
2006 – 2007	\$4,724,430	\$ 6,661,802	Telephone Surcharge, Federal IL/DD/AT	6,500
2008 – 2009	\$4,724,430	\$ 6,661,802	Telephone Surcharge, Federal IL/DD/AT	6,500
2010 – 2011	\$4,724,430	\$ 6,661,802	Telephone Surcharge, Federal IL/DD/AT	6,500
<b>Total:</b>	<b>\$18,897,720</b>	<b>\$26,647,208</b>		<b>26,000</b>

Refer to Section IX, 22) Office of Disability

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**GOAL 7: People with disabilities and families of children with disabilities will knowledgeable and appropriately choose and direct the services they receive and receive them at each critical juncture of life.**

**Strategies:**

a. Develop and monitor written information designed to ensure children and adults with disabilities are given accurate eligibility criteria; are fully informed of all available service options in state programs to which they are being admitted, provided a full menu of the scope of services permitted by federal/state guidelines, and given an easily understandable guide to client rights and remedies associated with the program at application to the program; with appropriate assistive technology applied.

b. Document through annual monitoring reports, which include client/family perceptions, that:

- goals of consumer and family service plans and the provider(s) to be used in achieving those goals will be established by the consumer, an advocate or family member of his/her choosing. Professionals may guide, but will not direct, establishment of the plan;
- consumer and family placement/service plans will be driven by what is preferred by the consumer rather than by what is readily available; be provided to the consumer; be followed up for changes in need and functioning levels; reflect the holistic needs of the consumer and his or her family for ancillary services and supports; provide needed information on advocacy alternatives; and contain measurable objectives; and,
- children and adults with disabilities are informed, in advance, of any decisions made about them, will have their perspectives fully included in those decisions and be informed of their appeal right without disruption in service during the appeals process.

c. Provide special education teachers, through grants to non-profit agencies, needed assistance to develop, case-manage and monitor progress of transition plans for 1,000 students aging out of secondary education in a “second step” demonstration project.

**Table 23  
Student Transition**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005		\$ 400,000	Vocational Rehabilitation	250
2006 – 2007		\$1,200,000	Vocational Rehabilitation	750
2008 – 2009		\$1,650,000	Vocational Rehabilitation	1,000
2010 – 2011		\$1,600,000	Vocational Rehabilitation	1,000
<b>Total:</b>		<b>\$4,850,000</b>		<b>3,000</b>

Refer to Section IX, 23) Student Transition

d. Educate parents of all transition age students in the Ticket to Work model through which students/families are able to control their own services.

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e. Assure that the federal mandate of the Vocational Rehabilitation program to assist people with disabilities to prepare for employment is fully utilized and monitored for successful pre-vocational training and educational outcomes.

f. Monitor and report to each session of the legislature matched funding returned to the federal government.

g. Provide all students with disabilities, as part of their junior year, information and guidance with respect to post secondary application procedures, financial aid, accommodations etc. including those available through Vocational Rehabilitation programs.

h. Establish pilot program to provide inclusive post-secondary education opportunities to people with cognitive disabilities.

- Revise post secondary entrance and eligibility requirements to allow students with cognitive disabilities to qualify for post secondary learning opportunities.
- Revise Millennium Scholarship criteria to allow students with cognitive disabilities to earn post secondary certifications while benefiting from campus learning experiences to better prepare them for a life of integration and inclusion.

i. Require, through a Department of Employment, Training and Rehabilitation directive, that closure outcomes of students with disabilities be reported and published annually and include: age at entry into service; services provided; time in service; service outcome stated in terms of competitive employment, completion of higher education, sheltered workshop, wages and benefits received, homemaker/family worker, self-employed, not working or reason for unsuccessful closure; and, number of total closures ages 10 through 19 and percentage successful.

j. Through converting 10% of existing slots, establish a self-determination pilot program in which a minimum of 100 children and adults with disabilities control their own budgets and services with the assistance of fiscal intermediaries and consumer-chosen microboards.

k. Assist 100 families annually in setting up microboards to advise a family member with a disability in making life choices that would enhance their quality of life without jeopardizing their supports.

**Table 24  
Family Microboards**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$21,752			200
2006 – 2007	\$21,752			200
2008 – 2009	\$21,752			200
2010 – 2011	\$21,752			200
<b>Total:</b>	<b>\$87,008</b>			<b>800</b>

Refer to Section IX, 24) Family Microboards

**E. Quality Assurance and Infrastructure**

Throughout the plan, the NTFD and its contractors have noted the lack of a comprehensive, unduplicated, standardized data system as one of the primary barriers to serving children and adults with disabilities in the most integrated settings. Without knowing who needs, wants and can appropriately use, community-based services, the availability of such services and providers is difficult, if not impossible, to ensure.

A data system which can allow people and agencies to talk to each other in the same language, to effectively plan services across disability groups, provide outcome reporting for services provided and identify those in need of additional services, does not exist in Nevada. The development of such a system is crucial to NTFD goals and to effectively serving all people with disabilities.

The NTFD, in developing even the most general costs associated with its strategies noted that additional state revenue sources are essential, but also believes that existing funding to disability services might go much further if restructured to expand the state's potential for outsourced services. Such an outsourcing at the community level combined with improved data system should significantly enhance Nevada's ability to identify and serve a much broader section of the disability population, and do it more effectively.

Members of the NTFD and its sub-committees have experienced first hand, as providers, family members and consumers, the importance of planning for middle income families and individuals who may experience a disability. Services provided to this working population early in the disability process will keep families in tact, help them avoid impoverishment and reliance on public funds.

The support and knowledge of Nevada legislators has proven to be perhaps the most crucial element in the progress of disability policy, service and oversight. The NTFD believes that integrating children and adults with disabilities into the existing oversight responsibilities of relevant Nevada legislative committees will better insure their services and the unity of their families.

A final piece in the assurance of quality and integrated, community-based service delivery is the missing link in Nevada's delivery system. That link is access to independent information and mediation in the pursuit of individual rights. The NTFD would connect this link by building on the mission of existing legal service agencies already working with low-income people and already knowledgeable of the principals of the Americans with Disabilities Act.

**GOAL 8: The state system of service delivery and long-term care will be managed and monitored so services in most integrated settings become the norm throughout Nevada.**

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**Strategies:**

a. Provide through Legislative Resolution renewed by each session of the legislature that:

- budget planning, decision-making and rate setting for one or more disability populations or services does not occur in isolation of the others, e.g., supported living arrangements for people with mental retardation vs. those with brain injury/autism, personal assistance for those with physical disabilities vs. those with mental illness, autism, mental retardation; and,
- legislative budget requests and forecasting recognize and include the needs of people with severe disabilities and their families with incomes above Medicaid limits, but unable to afford the critical personal assistance, respite, health care, environmental modifications and medications needed to avoid family disruption, impoverishment, exacerbation of disability and institutionalization.

b. Develop legislative bill draft requests to:

- Implement a legislative interim study to comprehensively review, evaluate and recommend improvements in state data systems for efficacy in providing consistent cross-agency information and meaningful client specific service outcomes needed for decision-making, planning, budgeting, tracking and monitoring costs and outcomes of disability services provided.

**Table 25  
Data Systems Review**

<b>Fiscal Period</b>	<b>General Revenue</b>	<b>Other</b>	<b>Source</b>	<b># Consumers</b>
2004 – 2005	\$500,000			
2006 – 2007				
2008 – 2009				
2010 – 2011				
<b>Total:</b>	<b>\$500,000</b>			

Refer to Section IX, 25) Data Systems Review

- Conduct an independent study examining the restructuring of state agency service provision to outsource, through a community grants and voucher systems, all direct service, care and case coordination to non-profit and private entities to strengthen and add independence to planning, coordination and quality assurance functions at the state level.

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**Table 26  
Agency Outsourcing**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$500,000			
2006 – 2007				
2008 – 2009				
2010 – 2011				
<b>Total:</b>	<b>\$500,000</b>			

Refer to IX, 26) Agency Outsourcing

c. Review the feasibility of allowing community-based providers to contribute the state’s share of available federal matching funds as a community cash “match” to grants and contracts awarded by the state.

d. Continue the Disability Sub-committee of the Legislative Commission as a permanent, standing committee of the Nevada Legislature.

e. Utilize the State Disability Consortium to develop and implement uniform statewide quality assurance measures in all state programs serving people with disabilities to evaluate and report impact, outcome, and consumer satisfaction; consistently solicit consumer perspectives for program improvements; and, assure service provision in the most integrated setting appropriate to individuals in need. Report biennial outcomes to legislative Committees on Health Care and Children and Families.

**GOAL 9: Provide independent in-state monitoring and mediation of Olmstead and Americans with Disabilities Act compliance.**

**Strategies:**

a. Establish a cabinet level position to coordinate planning across systems, agencies and disability populations, monitor implementation of strategic planning goals; ensure compliance with provisions of Olmstead and the ADA, oversee the development of a comprehensive, cross agency, data system and assure coordination of state and county resources.

**Table 27  
Chief Deputy for Disability Issues**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$241,335			1,200
2006 – 2007	\$236,024			2,400
2008 – 2009	\$236,024			2,400
2010 – 2011	\$236,024			2,400
<b>Total:</b>	<b>\$949,407</b>			<b>8,400</b>

Refer to Section IX, 27) Chief Deputy for Disability Issues

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b. Establish an independent, community-based, Disability Ombudsman within one or more legal services entities qualified to receive legal filing fees under NRS 19.031 with statewide responsibility for mediating “integrated settings issues,” related to provisions of the Olmstead Decision, the Americans with Disabilities Act, the Individuals with Disabilities Education Act (IDEA), which remain unresolved after exhaustion of available remedies.

**Table 28**  
**Disability Ombudsman**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 – 2005	\$264,572			150
2006 – 2007	\$258,572			150
2008 – 2009	\$258,572			150
2010 – 2011	\$258,572			150
<b>Total:</b>	<b>\$1,040,288</b>			<b>600</b>

Refer to Section IX, 28) Disability Ombudsman

c. Support passage of legislation to include ADA accessibility guidelines within the State Building Code.

## **PART IX**

### **NEVADA SERVICE DELIVERY SYSTEM**

#### ***OVERVIEW***

This part of the *Nevada Strategic Plan for People with Disabilities* documents the current service delivery system available in Nevada. Although not comprehensive in content, it does contain descriptions of the bulk of services available. This section is meant to provide the reader with an overview of the state's current capacity for serving Nevada's children and adults with disabilities.

A team of staff worked on this part of the *Plan* but would never have been able to accomplish their work without the assistance, cooperation and input of many others. Without naming those who provided the needed help and support, the team acknowledges those individuals who made a contribution. Apologies are sent to any organizations that may have been missed in the process.

The current system of healthcare delivery for people with disabilities in Nevada is widespread. It encompasses every level of government --- local, state and federal; it reaches from the cities into the rural areas; and, it covers almost every type of need and disability. However, it does not fully meet the needs of those people with disabilities, and while the descriptions contained in this part identify and describe the services available, they also point out areas of unmet need or shortfalls in services.

Part VI covers the following programs/entities in the order listed below (and the Table of Contents will direct the reader to the page number):

- Non-Profit Organizations
- Federal Qualified Health Centers and Rural Health Center Programs
- Indian Tribal Health Centers
- Nevada Counties
- State Government Agencies/Entities
  - Nevada Medicaid
  - Office of Community Based Services
  - Mental health and Developmental Services
  - Children's Services
    - Community Connections
    - Division of Child and Family Services
    - Health Division
    - Department of Education
    - Nevada Check Up
  - Housing Division
  - Department of Transportation
  - Vocational Rehabilitation Division

Aging Services  
Nevada Hospitals  
University and Community College System of Nevada

Each of these agencies/organizations is described in this part of the *Plan*, providing information to the reader, to the greatest extent possible, of the services they provide, who they serve, where they are located, how they are funded, trends and/or issues which directly affect their delivery of services to people with disabilities, and when possible, costs associated with service delivery.

In working with staff of these organizations for development of the descriptions, the team quickly became aware of a common difference among them all. The data collection methods used are almost as varied as the number of organizations. Not only do they have unique data systems, if they have one at all, they often have different definitions for the same or similar terms. Consequently, it is difficult for outsiders to quickly comprehend just what each organization is about and how they serve their customers.

Another obviously missing piece to adequately delivering services to people with disabilities is a comprehensive, statewide information and referral system. Although there are currently some systems that provide a point of reference for users, there is no all-inclusive system that provides information on services available throughout the entire state, or information on all organizations providing those needed services. This type of system would be the single most important change that could be made to the current delivery methods available. However, simply developing such a system will never be adequate. It must also be maintained, staffed, updated on a regular basis, and made available at no cost to users. Such a system of information and referral and its ongoing upkeep cannot be done without cost. But the end results could be immeasurable in the assistance to those individuals seeking much needed information related to their healthcare. Information available via telephone and computer is essential to those people with disabilities in locating the services, providers, agencies and support they require.

## ***NON-PROFIT ORGANIZATIONS***

A survey of non-profit organizations conducted for this study identified 69 organizations in northern Nevada and 44 similar organizations in southern Nevada. Additionally, there are about a dozen other agencies providing services within Nevada that are actually located outside the state. Generally these out-of-state organizations have “hotline” phone numbers where individuals may receive information and referral services only.

Non-profit organizations are a critical partner to Nevada government agencies in that they offer many varied types of services to thousands of people in the disability community. An example of cooperative services is a current joint effort between Washoe County Social Services and the United Way in expansion of United Way’s computerized system *Tapestry* in an effort to provide a “no wrong door system” for information, referral and application for services. Other examples are the Salvation Army’s program for transitional housing provided in cooperation with the state Division of Mental Health and Developmental Services in Las Vegas, and the Nevada Centers for Independent Living partnership with the Office of Community Based Services for home modifications. These non-profit agencies often act as an extension to government programs providing services where government funded programs fall short or fail to meet the needs of the community. Non-profits are run by experienced and knowledgeable people who often employ and consult with members of the disability community, and their family members and friends who want to make a difference in their lives. Therefore, it is important for government agencies tasked with implementing programs that provide for health care, support and/or other needs of the disabled to maintain open communications with those requiring the services and keep them actively involved as programs develop and change.

In completing the non-profits survey one common factor became quickly obvious. Most of the agencies do not collect statistics in a manner which is helpful in determining the numbers of people served, the cost to serve them, the cost associated with the various types of services, the cost associated with the various disabilities which are covered by their services, etc. Consequently, such data has not been included in this report. What we do know is there are many different agencies providing one or more services in nineteen different categories to individuals seeking their assistance. Table 1 lists twenty different disability populations toward which the agencies direct services. The services provided by each agency are listed in Appendix B and include: advocacy/legal representation; counseling/behavioral management, daycare, dental care; education schools/training programs; employment search/vocational training and workshops; healthcare, medical supplies/prescriptions; housing/supported living arrangements/assistance; independent living; information and referral; personal care assistance; recreation/social interaction/sports; rehabilitation; respite care; testing/screening/assessment and evaluation; technology/medical equipment loans and assistance; and therapies (speech, physical and occupational; transportation; volunteerism).

**Table 1  
Numbers of Non-Profit Agencies  
and Services by Disability**

Disability	Northern Nevada		Southern Nevada	
	# Agencies	# Services	# Agencies	# Services
Aids	6	6	4	6
All Disabilities Adults	27	19	15	16
All Disabilities Children	22	13	3	10
Blind/Visually Impaired	4	4	3	9
Brain Injury/Stroke	4	8	4	11
Cancer	5	7	5	8
Deaf/Hearing Impaired	6	4	5	5
Diabetes	3	5	2	1
Developmental Disabilities (Pervasive)	12	14	7	12
Epilepsy	1	2	0	0
Learning Disabilities/A.D.D.	8	12	1	1
Lungs	1	4	1	2
Mental Illness	7	7	4	7
Mental Retardation	9	13	4	4
Multiple Sclerosis	1	5	1	3
Muscular Dystrophy	1	5	2	4
Orthopedic Problems	1	3	1	3
Physical Disabilities/Spinal Cord Injuries	7	8	8	13
Polio	1	4	1	6
SED (Severely Emotionally Disturbed)	4	6	1	3
<b>TOTAL COUNTS</b>	<b>130</b>	<b>149</b>	<b>72</b>	<b>124</b>

The number of agencies in Table 1 reflect a duplicated count when they provide services for more than one disability type. For example, an agency providing services to all children and adults with disabilities will be counted in each of those disability categories. Therefore, the total count of 130 agencies in the north and 72 in the south exceeds the actual agencies providing services in Nevada. The list is not all-inclusive, but is representative of the many and various agencies providing services to people with disabilities. It should be noted, the United Way organizations in Nevada, of which there are three, are not included in the listing of non-profit organizations. Their work, while vital to the support of people with disabilities, is not in the direct provision of services. Rather, United Way funds many of the agencies that provide direct services and provides an important link to all service agencies in their communities.

While approximately 70% of the state's total population resides in Clark County, the numbers above indicate only about 36% of the agencies providing services are located there. A report prepared June 2001 by the National Center for Charitable Statistics, the national

repository of data on the non-profit sector in the U.S., revealed additional and similar information. The report includes 1999 data from the Internal Revenue Service Form 990 Return Transaction File as reported in 2000. The difference in the sum of assets between Clark County and Washoe County appear quite marked. Per the report, "Total assets = total assets at the end of the year, including cash, savings, investments, land, buildings, equipment, inventory, and accounts, pledges, grants, and loans receivable." For tax year 1999 Clark County reported \$907,500,000 in total assets for all charities. On the other hand, for the same year Washoe County reported \$1,471,700,000 in total assets. By comparison, Washoe County, with about 17% of the total population, reported 38% more in assets than those reported by Clark County charities.

*Issues/Trends/Innovations as Reported by the Agency*

There appears to be a dwindling of resources available to non-profit organizations in recent months due to a decline in contributions to charities following the September 11, 2001 attacks on the U.S. Nationally, contributions to non-profit organizations dropped dramatically as the public responded to the needs of residents of New York City and Washington D.C. who were directly impacted by the disaster. As a result, contributions to local and regional non-profit organizations were adversely impacted.

With so many agencies providing services it is likely there is a duplication of effort, services and costs, and that improved coordination would prove helpful for the non-profits and those they serve. In part this could be accomplished by a centralized information and referral system whereby individuals needing service could be briefly assessed and referred to agencies providing services. If the assessment is not feasible, a referral could be made based on the type of disability or service needed. This centralized system could be automated, or be a combined automatic and human operator system.

Additionally, non-profit agencies could certainly benefit from some type of tracking system which would provide common information to account for the numbers of people served, the types of disabilities or problems being provided for, the cost of services by service category, the cost of services by disability/problem, the government programs being supplemented, funding sources, and other information which would provide the executive and legislative branches of government with data needed for decision making. This would also provide government-funding partners with quality information regarding the needs of the community and the effectiveness of their non-profit partnerships.

Finally, if there is nothing currently in place, it would likely be helpful to the non-profit organizations to create a vehicle for communication and coordination of their agencies. Perhaps a council of executive directors or another type of organized group made up of members of the non-profit directors could be formed. There is such a group in northern Nevada, the Human Services Network, that joins the efforts of the Truckee Meadows Human Services Association and the Community Unity Coalition. However, a statewide network or council could benefit the entire community and help strengthen the activities of them all. Coordination and support at the state government level for such a group might be helpful.

***FEDERALLY QUALIFIED HEALTH CENTER  
AND  
RURAL HEALTH CENTER PROGRAMS***

The Family Health Center (FHC) Program was authorized in 1972 as an addition to the Economic Opportunity Act of 1964. Federal Qualified Health Centers (FQHC) were authorized under the 1989 Omnibus Budget Reconciliation Act (OBRA), and the program was expanded under OBRA 1990. The Bureau of Primary Health Care (BPHC) and the Centers for Medicare and Medicaid (CMS) share oversight of the program. FQHCs receive cost-based reimbursement for Medicare and Medicaid patients as a mechanism to increase primary care services to high-risk populations in underserved areas.

The FQHCs must apply for FQHC designation which requires the applicant to conduct a needs assessment of their patient populations, describe other primary care services in the service area, and assure compliance with FQHC governance, financial and clinical requirements. Eligibility requirements for an FQHC are: nonprofit, tax exempt or public status; board of directors, a majority of which must be consumers of the center's health services; provision of a culturally competent, comprehensive array of primary care services to all age groups; operation of a sliding fee scale; acceptance of Medicare; and, provision of services regardless of ability to pay. FQHCs provide the following:

*Health Services for the Homeless* enables public non-profit private grantees, directly or through contracts, to:

- Provide health services at locations accessible to homeless individuals;
- Make emergency health services available at all hours;
- Refer as appropriate to medical facilities for necessary hospital services;
- Refer mentally ill individuals to mental health services, unless the grantee can provide the service;
- Provide outreach to inform homeless individuals of available health services; and,
- Aid the homeless individual in establishing eligibility for or obtaining public assistance.

*Community Health Centers* are entities which, either through staff and supporting resources, or contracts or cooperative agreements with other public or private entities provide all of the services listed under Migrant Health Centers except accident prevention, and infectious and parasitic screening.

*Migrant Health Centers* are entities which, either through staff and supporting resources, or contracts or cooperative agreements with other public or private entities, provide:

- Primary health services;
- Supplementary health services;
- Referral to providers of supplementary health services and payment, as appropriate and feasible, for their provision of such services;
- Environmental health services;

- Infectious and parasitic disease screening and control;
- Accident prevention;
- Linguistically appropriate health education; and
- Patient case management services (outreach, counseling, referral, and follow-up services).

These services are available for migratory agricultural workers, season agricultural workers, and their families, within the area the migrant health center serves. This also includes individuals who previously were migratory workers but are no longer because of age or disability, and members of their family are within the area.<sup>13</sup>

Nevada's two primary FQHCs are described below:

### A. Health Access Washoe County (HAWC)

HAWC is considered a Community Health Center (CHC). HAWC is a non-profit tax-exempt organization based in Reno, Nevada. The Washoe County Medical Society developed it to treat the working uninsured of northern Nevada. HAWC opened in 1995 and is now treating 3,000 to 4,000 patients per month. HAWC offers family practice medicine, women's health care, basic diagnostic laboratory, basic radiology services, family dentistry, pharmacy and health education services and is located in Reno at 1055 South Wells Avenue, Suite 110, Reno, Nevada 89502. HAWC provides the following:

1. *Pharmacy Services* - As a federally funded program, HAWC is able to purchase prescription drugs under the 403B Purchasing Program at significant savings and make those drugs available at competitive prices. Follow-up of prescriptions and billings are also administered through HAWC's Pharmacy.
2. *Women's Health Connection* - HAWC partners with the Nevada State Health Division's Women's Health Connection Program. The Women's Health Connection is a breast and cervical cancer early detection program available to eligible Nevada women at no cost. HAWC houses the program's only case manager and patient navigator, and is a provider of services for eligible women in northern Nevada. Funding for the program is made possible from the Centers for Disease Control and Prevention.
3. *Vaccine for Children Program* - In a collaborative effort with the Nevada State Health Division and the Washoe County District Health Department, HAWC provides childhood immunizations to uninsured and underinsured children regardless of their ability to pay. A \$15 administration fee is charged for those patients who can afford the fee; however, the fee is waived for those patients unable to make payment.

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<sup>13</sup> Rural Health Center Program/Federally Qualified Health Centers Program, Minnesota Department of Health, Internet website: <http://www.health.state.mn.us>.

4. *Regional Diabetes Collaborative* - Nevada's diabetes rate exceeds the national average with over 6% of the population estimated to have diabetes. In 2002, HAWC joined the Bureau of Primary Health Care's Western Regional Diabetes Collaborative. This Collaborative brings together health center teams for about twelve months, under the guidance of national experts, to bring about rapid improvements in diabetic care through a dynamic diabetic care model.
5. *Children's Mental Health Services* - HAWC received funding in 2002 to initiate Children's Mental Health Services in which children and families can receive low-cost, necessary mental health referral and treatment during their primary care visit with a HAWC physician. With this program, pediatric patients are referred immediately to an on-site pediatric mental health specialist for evaluation and treatment needs.

HAWC also has an outreach medical clinic that serves the health needs of northern Nevada homeless. The outreach medical clinic opened in 1998 and has provided approximately 12,000 medical visits for homeless individuals since its inception. In 2001, the HAWC outreach homeless clinic provided over 4,000 medical visits to homeless individuals, 44% of whom were women and 12% were children and teens. The HAWC outreach homeless clinic is located in the Homeless Corridor, an area within Reno consisting of shelters and motels where homeless families and individuals are concentrated.<sup>14</sup> Services offered include: free health visits and medications; laboratory tests; dental referrals; birth control pills; TB, HIV/AIDS, Hepatitis B & C testing; pap smears, breast exams, and colonoscopies; and minor surgical procedures. The clinic is located at 624 East Fourth Street, Reno, NV 89512.

### **B. Nevada Health Centers, Inc. (NVHC)<sup>15</sup>**

NVHC is another federally funded Community Health Center program that has operated primary care medical clinics in rural Nevada for over two decades. It was originally founded in 1977 as the Central Nevada Rural Health Consortium and opened its first clinic in 1978. This was one of the earliest federally funded Community Health Center programs. NVHC is a private, not-for-profit corporation supported by local, state and federal grants and contracts and revenues from patient services. The central administrative office located in Carson City, with a division located in Las Vegas, oversees the clinic network located throughout urban and rural areas in northern and southern Nevada. NVHC provides quality health care and social services to underserved urban areas and remote rural areas.

NVHC also operates a healthcare for the homeless program in Las Vegas called Las Vegas Outreach Clinic. This program includes primary care to the homeless and

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<sup>14</sup> HAWC Brochures to include Main HAWC Facility and Outreach Medical Clinic for the Homeless, John G. Scott, Jr., M.D., President and Michael Rodolico, Ed.D., MPH, Executive Director.

<sup>15</sup> Nevada Health Centers, Inc. Brochure, Steve Hanson, CEO 8-28-02.

provides outreach services into the homeless community. Las Vegas Outreach Clinic is located at 403 West Wilson, Las Vegas, NV 89106.

The NVHC clinic system is based on the full-service, family practice model. Services include: periodic screening for all children and adults; well-child care and vaccination; family planning; nutrition assessment and education; preventive dental assessment; acute/episodic medical care; management of chronic medical problems; emergency/after hours medical service; basic diagnostic laboratory; basic diagnostic x-ray; pharmacy; health education; ambulatory surgical service; primary care services for all insurance companies; and occupational medicine.

NVHC provides the following:

1. *Pharmacy Services* - As a federally funded program, NVHC is able to purchase prescription drugs under the 403B Purchasing Program at significant savings and make those drugs available through clinic dispensaries to patients at competitive prices. The service is coordinated through NVHC's pharmacy, Community Health Pharmacy. Follow-up prescriptions and billings are also administered through their pharmacy.
2. *Mammography Services* - In January 2000, NVHC began operating a mobile mammography van that provides screening service throughout Nevada. January through June, the van is based out of Las Vegas and visits urban and rural areas of the south. July through December, it is based out of Reno and visits urban and rural areas of the north.
3. *Other Community Services* - NVHC works cooperatively with the State Health Division providing space for the division's community health nursing services in the fifteen rural counties. This cooperative arrangement providing community-based nursing services offers the opportunity for a more comprehensive approach to serving the total health care needs of Nevada's rural communities. NVHC endeavors to provide outreach services and community education when and wherever possible

## **Nevada Strategic Plan for People with Disabilities**

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The fifteen clinics located throughout Nevada are as follows:

Administrative Offices  
1801 N. Carson Street, Suite 100  
Carson City, NV 89701  
(775) 887-1590 / (775) 887-7047 FAX

Amargosa Valley Medical Clinic  
845 Farm Road  
HCR 69, Box 401-V  
Amargosa Valley, NV 89020  
(775) 372-5432 / (775) 372-1303 FAX

Austin Medical Clinic  
121 Main Street  
P. O. Box 225  
Austin, NV 89310  
(775) 964-2222 / (775) 964-2232

Carlin Community Health Center  
151 South 8<sup>th</sup> Street  
P. O. Box 400  
Carlin, NV 89822  
(775) 754-2666

Crescent Valley Medical Clinic  
5043 Tenabo Avenue  
Crescent Valley, NV 89821  
(775) 468-1010 / (775) 468-1019 FAX

Cambridge Family Health Center  
3900 Cambridge Ave., #102  
Las Vegas, NV 89109  
(702) 307-5415 / (702) 307-5416 FAX

Sierra Family Health Center  
1000 North Division Street, #203  
Carson City, NV 89703  
(775) 887-5140 / (775) 887-5143 FAX

Martin Luther King Family Health  
Center  
1700 Wheeler Peak  
Las Vegas, NV 89106  
(702) 383-1900 / (702) 319-6147 FAX

Jackpot Community Health Center  
135 Keno Street  
Jackpot, NV 89825  
(775) 755-2500 / (775) 755-2502

Eureka Medical Clinic  
250 South Main Street  
P. O. Box 347  
Eureka, NV 89316  
(775) 237-5313 / (775) 237-5073 FAX

Gerlach Medical Clinic  
350 Short Street  
P. O. Box 40  
Gerlach, NV 89412  
(775) 557-2313 / (775) 557-2140 FAX

Beatty Medical Clinic  
702 Irving Street  
P. O. Box 431  
Beatty, NV 89003  
(775) 553-2208 / (775) 553-2844

Las Vegas Division  
4415 Spring Mountain Road #103  
Las Vegas, NV 89102  
(702) 307-5414

North Las Vegas Family Health Center  
2225 Civic Center Dr. #240  
Las Vegas, NV 89030  
(702) 214-5948 / (702) 214-9439 FAX

Wendover Community Health Center  
925 Wells Avenue  
P.O. Box 3520  
West Wendover, NV 89883-3520  
(775) 664-2220 / (775) 664-2965

**INDIAN HEALTH CENTERS**

There are 26,420 American Indians (AI) and Alaska Natives (AN) residing in Nevada, 15,910 of whom are enrolled tribal members and 7,155 of whom reside on one of Nevada’s 26 reservations. Sixteen reservations have Tribal Health Clinics and/or Service Units providing services to the population shown in Table 2:

**Table 2  
AMERICAN INDIAN AND ALASKA NATIVES IN NEVADA BY COUNTY**

County	All Ages			18 Years and Over	
	Total Population	AI/AN Population	Percent	Number	Percent
Carson City	52,457	1,259	2.4%	897	1.7%
Churchill	23,982	1,146	4.8%	733	3.1%
Clark	1,375,765	10,895	0.8%	7,833	0.6%
Douglas	41,259	692	1.7%	476	1.2%
Elko	45,291	2,400	5.3%	1,575	3.5%
Esmeralda	971	50	5.1%	30	3.1%
Eureka	1,651	26	1.6%	22	1.3%
Humboldt	16,106	647	4.0%	448	2.8%
Lander	5,794	231	4.0%	159	2.7%
Lincoln	4,165	73	1.8%	43	1.0%
Lyon	34,501	844	2.4%	558	1.6%
Mineral	5,071	779	15.4%	502	9.9%
Nye	32,485	636	2.0%	452	1.4%
Pershing	6,693	229	3.4%	158	2.4%
Storey	3,399	49	1.4%	36	1.1%
Washoe	339,486	6,162	1.8%	4,219	1.2%
White Pine	9,181	302	3.3%	211	2.3%
<b>Total:</b>	<b>1,998,257</b>	<b>26,420</b>	<b>1.3%</b>	<b>18,352</b>	<b>0.9%</b>

Source: 2000 Census

The clinics/centers are funded through the Indian Health Service (IHS), which is an agency within the Department of Health and Human Services. IHS is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. IHS is the principal federal health care provider and health advocate for Indian people. The goal of IHS is to raise the health status to the highest possible level. IHS is currently providing health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states.

It is important to note that not all of the services listed are provided by all Tribal Health Clinics and that services provided in most areas are woefully underfunded. Some of the services and programs offered through IHS are: behavioral health programs, cardiology, child health, injury prevention, maternal child health, National Pediatric Height and Weight Program, Clinical Information Resources (CIR), Clinical Support Center (CSC), dental, diabetes program, Elder Care Initiative, Epidemiology Program, health care information, nursing opportunities, National Counsel of Nursing, National Council of Nurse Administrators, nutrition and dietetics training, optometry, pharmacy and women’s health.

**Nevada Reservation Clinics**

Fallon Tribal Clinic  
P. O. Box 1980  
Fallon, NV 89407  
(775) 423-3634  
(775) 423-1453 FAX

Walker River Tribal Health Center  
P. O. Drawer "C"  
Schurz, NV 89427  
(775) 773-2005  
(775) 773-2576 FAX

PHS Indian Health Service  
Drawer A  
Schurz, NV 89427  
(775) 773-2345 or 800-843-5790  
(775) 773-2425 FAX

Washoe Tribal Health Center  
950 Highway 395 South  
Gardnerville, NV 89410  
(775) 883-4137  
(775) 265-3429 FAX

Las Vegas Tribal Health Center  
Number Six Paiute Drive  
Las Vegas, NV 89106  
(702) 382-0784  
(702) 384-5272 FAX

Yerington Health Center  
171 Campbell Lane  
Yerington, NV 89447  
(775) 463-3335  
(775) 463-3390 FAX

Indian Health Center  
P.O. Box 315  
McDermitt, NV 89421  
(775) 532-8522  
(775) 532-8024 FAX

Battle Mountain Health & Human Services  
37 Mountain View Dr. # C  
Battle Mountain, NV 89820  
(775) 635-8200  
(775) 635-2062 FAX

Moapa Health Clinic  
P. O. Box 819  
Moapa, NV 89025  
(702) 865-2700  
(702) 865-2821 FAX

Duckwater Health Department  
P.O. Box 140068  
Duckwater, NV 89314  
(775) 863-0222  
(775) 863-0142 FAX

Pyramid Lake Health Center  
P. O. Box 227  
Nixon, NV 89424  
(775) 574-1018  
(775) 574-1002 FAX

Goshute Health Clinic  
P.O. Box 6104  
Ibapah, UT 84034  
(435) 234-1170  
(435) 234-1162 FAX

Reno/Sparks Tribal Health Center  
34 Reservation Road  
Reno, NV 89502  
(775) 329-5162  
(775) 329-4129 FAX

Newe Medical Clinic  
400 "A" Newe View  
Ely, NV 89301  
(775) 289-2134  
(775) 289-4728 FAX

Duck Valley Health Center  
P.O. Box 130  
Owyhee, NV 89832  
(775) 757-2415  
(775) 757-2066 FAX

Southern Bands Health Center  
55 Shoshone Circle  
Elko, NV 89801  
(775) 738-2252  
(775) 738-5859 FAX

**NEVADA COUNTIES**

Nevada law requires that “To the extent that money may be lawfully appropriated by the board of county commissioners for this purpose...every county shall provide care, support and relief to the poor, indigent, incompetent and those incapacitated by age, disease or accident, lawfully resident therein, when those persons are not supported or relieved by their relatives or guardians, by their own means, or by state hospitals, federal or private institutions or agencies.”

The 2000 Census reported Nevada with a total population of 1,998,257. Nevada’s state demographer estimates an average statewide growth rate of 2.6% per year will result in a population increase to 2,611,454 by the year 2010.

**Table 3  
COUNTY POPULATION INFORMATION**

<b>County</b>	<b>U.S. Census 2000 Total Population</b>	<b>Year 2010 Estimate by the Nevada Demographer</b>	<b>Average Annual Change</b>	<b>Number of Disabled 2000 Census</b>	<b>Estimated* Number of Disabled in 2010</b>
Carson City	52,457	63,515	1.7%	9,564	11,580
Churchill	23,982	36,047	3.3%	4,109	6,176
Clark	1,375,765	1,827,770	2.8%	264,470	351,361
Douglas	41,259	60,712	3.3%	6,624	9,747
Elko	45,291	60,155	1.6%	6,635	8,813
Esmeralda	971	1,666	0.8%	251	431
Eureka	1,651	2,129	0.9%	344	444
Humboldt	16,106	19,978	0.9%	2,300	2,853
Lander	5,794	7,743	1.0%	1,116	1,491
Lincoln	4,165	4,280	0.1%	873	897
Lyon	34,501	48,990	3.3%	7,112	10,099
Mineral	5,071	5,846	-0.9%	1,419	1,636
Nye	32,485	58,517	5.2%	8,598	15,488
Pershing	6,693	10,540	3.2%	986	1,553
Storey	3,399	4,729	2.2%	840	1,169
Washoe	339,486	390,462	1.7%	58,972	67,827
White Pine	9,181	8,375	-2.6%	1,697	1,548
<b>State Total</b>	<b>1,998,257</b>	<b>2,611,454</b>	<b>2.6%</b>	<b>375,910</b>	<b>491,264</b>

Source: U.S. Census 2000 and NV State Demographer website [NSBDC.org/demographer/pubs/estimates](http://NSBDC.org/demographer/pubs/estimates)

\*Estimated Number of Disabled in 2010 is calculated using the percent of difference between the total population in 2000 and the disabled in that year. The same percentage was then applied to the estimated total population in 2010 to find the estimated number of disabled.

Nevada has seventeen counties that provide a varying degree of support and assistance to disabled residents. All counties report they provide services to “indigent persons in need of assistance” and do not collect data on persons with disabilities separate from the general population served. The largest and most populous county is Clark where the highest level of support is provided to its residents, followed by Washoe County, the second most populous, which also provides a high level of support in many areas. The other fifteen counties are smaller in population, have much smaller tax bases and offer considerably less in medical and social support programs. Every county was contacted in an effort to secure the same level of data from each, but each county uses different eligibility criteria for their indigent

clients. In addition, most counties do not separate disabled clients from the general population they serve. This made it difficult to provide comparable data among the seventeen counties. Therefore, county-by-county information is contained in this document, but is not consistent in content.

Under an agreement with Medicaid, all Nevada counties pay costs nursing home patients with monthly income more than 157% of Supplemental Security Income (SSI) and up to 300% of SSI (\$834 to \$1,593). Counties pay half the cost of nursing home care for patients in the 300% County Match program. Medicaid uses the county contributions to leverage federal reimbursements at a dollar-for-dollar rate, which is used to pay the other half of the cost of care. Counties offer financial assistance for other non-Medicaid nursing home residents depending on income, assets and county of residence.

While this plan is focused on persons with disabilities, it is important to note that studies show many homeless individuals are also disabled, but may not be reflected in the data collected by any of the government entities. A 1999 homeless study by the University of Nevada Las Vegas found that 25.1% of the homeless reported having physical disabilities, while another 16.9% said they had been diagnosed with a mental disability. That equates to a total of 42% of the homeless individuals surveyed. These people may or may not be included in counts of people with disabilities, making it an important group to keep in mind as information is reviewed as it relates to disabled individuals only.

**Carson City**

The 2000 Census reported Carson City to have a population of 52,457. Nevada’s state demographer estimates an average growth rate of 1.7% per year will result in a population increase to 63,515 by the year 2010. Carson City does not show persons with disabilities in a separate category from any other group in need of assistance. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 4**  
**Carson City - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	812	7.6%
21-64 Years	5,620	20.2%
65 Years & over	3,132	41.8%

In the area of services, Carson City provides a one-time assistance in any twelve month period for rent, utilities, food vouchers (if the person is ineligible for Food Stamps), emergency one-time physician or dental assistance and three refills on prescriptions. All eligibility for services is based on income guidelines. Additionally, the county pays emergency medical for hospital care only, if income guidelines are met, as well as indigent burial and long-term care backup for senior citizens.

In the service areas of long-term care and medical assistance (including medications), Carson City reports their actual costs for FY00 - FY02, along with projections for FY03 - FY07 as follows:

**Nevada Strategic Plan for People with Disabilities**

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**Table 5  
Carson City Medical Costs/Projections**

	Projected Costs							
	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07
<b>Long Term Care</b>	\$ 1,190,996	\$ 1,093,075	\$ 974,537	\$ 998,901	\$ 1,023,873	\$1,049,470	\$ 1,075,707	\$ 1,102,599
<b>Medical Assistance</b>	\$ 66,159	\$ 63,269	\$ 153,249	\$ 157,080	\$ 161,070	\$ 165,032	\$ 169,158	\$ 173,387

Reported by Carson City Environmental Health Dept. - 8/12/02

**Churchill County**

The 2000 Census reported Churchill County to have a population of 23,982. Nevada’s state demographer estimates an average growth rate of 3.3% per year will result in a population increase to 36,047 by the year 2010. Churchill County does not distinguish between disabled and non-disabled applicants for assistance. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 6  
Churchill County - U.S. Census Data  
Disability Status of Non-Institutionalized**

Age Group	Number Disabled	% of Age Group Population
5-20 Years	408	6.9%
21-64 Years	2,454	19.5%
65 Years & over	1,247	44.8%

Churchill County reports services available to persons with disabilities and all others who meet eligibility criteria in their county as: crisis services; educational services; group home care; limited prescription drug services; and supported employment.

**Clark County**

The 2000 Census reported Clark County to have a population of 1,375,765. Nevada’s state demographer estimates an average growth rate of 2.8% per year will result in a population increase to 1,827,770 by the year 2010. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 7  
Clark County - U.S. Census Data  
Disability Status of Non-Institutionalized**

Age Group	Number Disabled	% of Age Group Population
5-20 Years	23,630	8.0%
21-64 Years	182,423	22.4%
65 Years & over	143,706	40.7%

Clark County Social Service is mandated by Nevada Revised Statutes Chapter 428 to provide financial and medical assistance to indigent residents determined eligible per policy approved by the Clark County Board of Commissioners. Eligibility for services is based on an assessment of individual and family needs, assets and income. Contributing factors include verifiable lack of family support and/or denials for other support programs. County clients receive medical and/or financial assistance and are comprised of working poor, or

**Nevada Strategic Plan for People with Disabilities**

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unemployed populations. A portion of county clients are disabled, who upon application, are found not to be covered by other programs but who meet the county’s eligibility criteria.

In early 2001, the social service satellite office in North Las Vegas was relocated to the Community Resource Center where staff served approximately 25% of the agency’s clients during the last fiscal year. The Henderson office, which served about 5% of the agency’s clients that same year, relocated to Lake Mead Drive. In the first two months of 2002/2003, the Cambridge office, located in the south central portion of Las Vegas, served 20% of the agency’s clients, whereas it served 13% the prior fiscal year (2001/02). Satellite offices ensure that financial and medical services are available to clients who may have limited access to transportation. In addition to permanent satellite facilities, staff members perform outreach at the Salvation Army Safe Haven, MASH Village, and the Economic Opportunity Board. They also make regular trips to Laughlin, Searchlight, Overton, and Mesquite to assist clients in outlying areas of the county. During the past year, Clark County instituted a program to re-certify the eligibility of certain clients by mail. The program improves service accessibility for disabled clients and allows those with stable incomes and living situations to submit information needed to verify eligibility by mail and receive re-certification for county payment of their medical services without the usual face-to-face contact. Up to 150 Medical Assistance Service authorizations are sent each week to individuals participating in the program.

Financial assistance payments accounted for approximately \$2.5 million in fiscal year 2001. As part of that program, the agency provides direct assistance service payments for shelter, burials or cremations, one-time transportation to a person’s place of residence outside Clark County, or local transportation to medical appointments. Arrangements can be made to pay shelter assistance directly to landlords, when appropriate.

Medical Assistance Service provides a wide variety of services including inpatient hospital care, long-term care placement, group care, prescription drugs, durable medical equipment, prosthetics, therapies (oxygen, intravenous, physical, occupational and speech), and homemaker services. In fiscal year 2001, Clark County spent in excess of \$42 million on its Medical Assistance Service program.

**Table 8  
Clark County Social Services Cost of Services – Disabled**

	1999		2000		2001	
	Number Served	Avg Cost Per Person	Number Served	Avg Cost Per Person	Number Served	Avg Cost Per Person
Alternative Health Care	39	\$ 2,181.00	46	\$ 2,350.00	57	\$ 2,650.00
Financial Assistance	719	\$ 2,288.89	752	\$ 2,005.79	932	\$ 2,041.91
Homemaker Home Health Care	199	\$ 2,203.45	185	\$ 2,366.46	187	\$ 2,497.17
Long Term Care	1,268	\$ 7,438.00	1356	\$ 7,910.00	1572	\$ 9,104.00
Medical Assistance	3,023	\$ 6,609.72	3066	\$ 6,173.22	3029	\$ 6,439.56
Transportation Assistance	86	\$ 200.60	95	\$ 216.00	108	\$ 220.00
Volunteers	5	\$ 219.00	7	\$ 315.00	11	\$ 495.00

Survey data provided by Clark County Social Service - 8/5/02

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Clark County also provides medical services in cooperation with other entities. For example, they provide a donation to the Office of Veteran Affairs to assure veterans receive transportation assistance to the VA hospitals out of state. Another example is they provide operation funds, case management services and nursing evaluations for Caminar, a non-profit organization that runs Pedregal House, an HIV/AIDs group living residence.

Clark County Social Service reports the following full range of services: advocacy services; benefits planning; chore services; community transportation and companion services through agency volunteers; crisis services; environmental modifications through agency volunteers or grant funds; group home care; independent living services; laboratory/x-ray; therapies (oxygen, intravenous, physical, occupational and speech); direct medical services through designated primary care or outpatient hospital clinics, prosthetics; assisted living; case management; emergency dental; eye care through an upcoming pilot program; HIV/AIDS program services, child care licensing, Sudden Infant Death Syndrome Support groups, Cobra insurance continuation payments, homemaker services; individual/family counseling; medical transportation; prescription drugs through designated providers; skilled nursing in institutional settings (long-term care); adult group care; adult day care; and burial/cremation services.

Looking forward to the next five years, Clark County projects expenditures needed to serve the disabled community as shown below:

**Table 9  
Clark County Social Service Projected Cost of Services**

	<b>2003 Projected Cost</b>	<b>2004 Projected Cost</b>	<b>2005 Projected Cost</b>	<b>2006 Projected Cost</b>	<b>2007 Projected Cost</b>
Alternative Health Care	\$151,050	\$155,582	\$160,249	\$165,056	\$170,008
Financial Assistance	\$1,941,119	\$1,970,235	\$1,999,789	\$2,029,786	\$2,060,233
Homemaker Home Health Care	\$1,180,361	\$1,192,164	\$1,204,086	\$1,216,127	\$1,228,288
Long Term Care	\$15,170,968	\$15,550,242	\$15,938,998	\$16,337,473	\$16,745,910
Medical Assistance	\$20,090,584	\$20,391,942	\$20,697,822	\$21,008,289	\$21,323,413
Transportation Assistance	\$23,760	\$24,235	\$24,720	\$25,214	\$25,719
Volunteers	\$505	\$515	\$525	\$536	\$547

Survey data provided by Clark County Social Service - 8/5/02

*Issues/Trends/Innovations as Reported by the Agency:*

Clark County faced soaring energy rates in 2001, which created financial hardships for many individuals who looked to the social service agency for help. Meeting this challenge was extremely difficult since the agency has limited funding for utility payments, and these funds are usually in the form of acquired grants.

Following the September 11, 2001 attacks on the U.S. there was a major decline in the Las Vegas economy causing a dramatic increase in assistance requests. Clark County was able to collaborate with a number of other agencies throughout the community to provide emergency assistance to residents.

Clark County has experienced some of the fastest growing populations in the nation for several years. The corresponding increasing demand for services and expanding geographic service areas resulting from the county's incredible population growth continue to challenge the social services agency to develop innovative and progressive programs to meet the needs. This challenge is expected to persist so long as the growth continues and, as noted earlier, Clark County's population is projected to grow at a rate of 2.8% per year until the year 2010.

Clark County has an increasing homeless population, many of whom are disabled. The Social Service Department has recently created a Homeless Outreach Unit, consisting of social workers and an Americorp Vista Volunteer, which works in the community to identify and offer financial and medical services to the homeless in collaboration with other community partners such as shelters, non-profits, and police departments.

The county has also been hard hit with the loss of physicians due to increases in malpractice insurance. The hardest hit seems to be physicians practicing in specialty areas; these are many of the doctors that the disabled need to access.

A new vision program pilot has been proposed which would offer basic vision services to clients who qualify for medical assistance and need vision care. They will receive an eye exam, lenses and basic frames once every other year. Once this new service is established, a future pilot program may be considered for qualifying adult clients in need of dental services.

**Douglas County**

The 2000 Census reported Douglas County to have a population of 41,259. Nevada's state demographer estimates an average growth rate of 3.3% per year will result in a population increase to 60,712 by the year 2010.

Douglas County does not differentiate between the disabled and non-disabled. Rather, they provide services to indigent persons who meet income eligibility criteria. U.S. Census data regarding the county's persons with disabilities is as follows:

**Table 10**  
**Douglas County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	554	6.2%
21-64 Years	3,794	15.9%
65 Years & over	2,276	36.7%

The county reports disabled residents receive assistance with needs for rent, medical and dental services, utility bills, food and clothing vouchers, group home care, long-term care and assisted living care. Cash assistance is not provided in Douglas County.

Additionally, the county provides services through other agencies which benefit/assist persons with disabilities. The following is a full list of services provided in Douglas County: assisted living; community transportation; emergency dental; group home care; homemaker;

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medical transportation; occupational therapy; prescription drugs; skilled nursing; case management; educational services; eye care; home delivered meals; independent living services; mental health services; outpatient hospital/clinics; and respite care.

The county recently purchased a software program to enable them to track clients in various ways, including disabilities. They anticipate having more detailed information when that system is fully operational.

### **Elko County**

The 2000 Census reported Elko County had a population of 45,291. Nevada's state demographer estimates an average growth rate of 1.6% per year will result in a population increase to 60,155 by the year 2010.

Elko County serves persons meeting the criteria for "indigents" and does not collect data on persons with disabilities. U.S. Census data regarding the county's persons with disabilities is as follows:

**Table 11**  
**Elko County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	688	5.5%
21-64 Years	4,696	18.3%
65 Years & over	1,251	46.3%

Elko County reports the following services are available to those they serve, including disabled persons: advocacy services; assisted living; benefits planning; group home care; oxygen; physical therapy; prescription drugs; skilled nursing; crisis services; laboratory/x-ray; personal assistance; physician services; specialized medical equipment; and supplies.

### **Esmeralda County**

The 2000 Census reported Esmeralda County's population to be 971. Nevada's state demographer estimates an average growth rate of 0.8% per year will result in a population increase to 1,666 by the year 2010.

Esmeralda, Nevada's least populous county, does not collect information on persons served with disabilities. U.S. Census data regarding the county's persons with disabilities is as follows:

**Table 12**  
**Esmeralda County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	23	11.3%
21-64 Years	162	28.8%
65 Years & over	66	39.5%

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The county does provide services to all eligible residents in the following areas: chore services; crisis services; homemaker; prescription drugs; community transportation; home delivered meals; and medical transportation; a recent change occurred in the administration of the social services program in Esmeralda County and they are seeking new, additional funding to expand services for their residents.

### **Eureka County**

The 2000 Census reported Eureka County had a population of 1,651. Nevada's state demographer estimates an average growth rate of 0.9% per year will result in a population increase to 2,129 by the year 2010.

Eureka County provides services to applicants for assistance without distinguishing those persons with disabilities. U.S. Census data regarding the county's persons with disabilities is as follows:

**Table 13**  
**Eureka County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	32	7.8%
21-64 Years	233	25.1%
65 Years & over	79	38.2%

For people who meet the eligibility criteria, the county provides services as follows: community transportation; home delivered meals; x-ray services; medication management; oxygen; physician services; skilled nursing services; educational services; independent living services; medical transportation; clinic services; personal assistance; and personal emergency response systems.

### **Humboldt County**

The 2000 Census reported Humboldt County to have a population of 16,106. Nevada's state demographer estimates an average growth rate of 0.9% per year will result in a population increase to 19,978 by the year 2010.

Humboldt County provides services to its indigent residents, without regard to disabilities. U.S. Census data regarding the county's persons with disabilities is as follows:

**Table 14**  
**Humboldt County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	212	4.9%
21-64 Years	1,578	17.2%
65 Years & over	510	43.7%

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The services the county reports providing to eligible individuals are: assisted living; crisis services; interpreter services; medical transportation; mental health services; oxygen; prescription drugs; specialized medical equipment & supplies; community transportation; home delivered meals; laboratory/x-ray; medication management; occupational therapy; outpatient hospital/clinic services; and skilled nursing.

**Lander County**

The 2000 Census reported Lander County to have a population of 5,794. Nevada’s state demographer estimates an average growth rate of 1.0% per year will result in a population increase to 7,743 by the year 2010. Lander County provides assistance to those indigent persons meeting eligibility criteria, without regard to disabilities.

U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 15  
Lander County - U.S. Census Data  
Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	52	3.2%
21-64 Years	895	26.7%
65 Years & over	169	44.4%

Through the various county agencies and social service programs the county provides services to residents, disabled and non-disabled, in the areas of: case management; educational services; laboratory/x-ray; oxygen; prescription drugs; crisis services; interpreter services; outpatient hospital/clinic services; and physician services.

Costs directly associated with all eligible persons provided through social services are reported as follows:

**Table 16  
Lander County Social Services  
Medical Costs**

	<b>1999</b>		<b>2000</b>		<b>2001</b>	
	<b>Number Served</b>	<b>Avg Cost Per Person</b>	<b>Number Served</b>	<b>Avg Cost Per Person</b>	<b>Number Served</b>	<b>Avg Cost Per Person</b>
<b>Long Term Care</b>	8	\$13,651	17	\$10,651	11	\$20,355
<b>Medical Assistance</b>	92	\$267	61	\$235	89	\$251
<b>Med Transportation</b>	16	\$20	152	\$45	116	\$42

Source: Lander County Social Service 08-05-02.

Looking ahead to the next five years, Lander County estimates the costs of these services will be:

**Table 17  
Lander County Social Services  
Medical Cost Projections**

	2003	2004	2005	2006	2007
<b>Long Term Care</b>	\$250,000	\$300,000	\$350,000	\$400,000	\$450,000
<b>Medical Assistance</b>	\$45,000	\$55,000	\$65,000	\$75,000	\$85,000
<b>Med Transportation</b>	\$3,000	\$3,500	\$4,000	\$4,500	\$5,000

Source: Lander County Social Service 08-05-02.

**Lincoln County**

The 2000 Census recorded Lincoln County to have a population of 4,165. Nevada’s state demographer estimates an average growth rate of 0.1% per year will result in a population increase to 4,280 by the year 2010.

Lincoln County, one of Nevada’s smaller populated counties, also provides a small number of services to its residents. Most of the services are designated for seniors and low-income families. However, it is believed there are some persons with disabilities who also benefit from these limited services. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 18  
Lincoln County - U.S. Census Data  
Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	106	11.2%
21-64 Years	430	22.1%
65 Years & over	337	51.3%

Lincoln County provides assistance with community transportation; homemaker services; and home delivered meals, as well as emergency services.

**Lyon County**

The 2000 Census reported Lyon County to have a population of 34,501. Nevada’s state demographer estimates an average growth rate of 3.3% per year will result in a population increase to 48,990 by the year 2010.

Lyon County provides services to residents without regard to disability, however some services require income eligibility per NRS Chapter 428. They recently installed new client tracking software and are hopeful it will provide them the capability to capture and report more detailed data in the future. County staff reports a large number of people seeking assistance are either disabled or pending a disability decision from Social Security, but do not have exact numbers. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 19**  
**Lyon County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	636	7.9%
21-64 Years	4,445	23.4%
65 Years & over	2,031	42.8%

While a number of services are referrals to other programs and agencies that may meet the needs of the individual or families with disabilities, the county does provide some services.

For all residents eligible to receive assistance, Lyon County provides, coordinates, and/or offers assistance for the following services: advocacy; burial/cremation assistance; community transportation; prevention/educational services; emergency food; independent living services; job search assistance; medical transportation; case management; crisis management; senior center services, including: nutrition, Meals on Wheels, education, social and recreational programs; individual/family counseling; prescription drugs; group care; assisted living; and long-term care, including 30-day Medicaid backup.

**Mineral County**

The 2000 Census reported Mineral County to have a population of 5,071. Nevada’s state demographer estimates an average growth rate of –0.9% per year will still result in a population increase to 5,846 by the year 2010.

Mineral County, like other Nevada counties, does not collect data specific to persons with disabilities. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 20**  
**Mineral County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	156	14.3%
21-64 Years	786	29.9%
65 Years & over	477	46.0%

The county reports a number of services are available to all persons who meet eligibility criteria. These services are: advocacy services; day placement; environmental modifications; home delivered meals; independent living services; medical transportation; outpatient hospital/clinics; personal assistance; physical therapy; podiatry; skilled nursing; specialized medical equipment and supplies; benefits planning; day treatment; eye care; homemaker; laboratory/x-ray; mental health services; oxygen; personal emergency response systems; physician services; prescription drugs; and special clinics.

**Nye County**

The 2000 Census reported Nye County to have a population of 32,485. Nevada’s state demographer estimates an average growth rate of 5.2% per year will result in a population increase to 58,517 by the year 2010.

Nye County does not track persons eligible for services based on disabilities. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 21**  
**Nye County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	410	6.4%
21-64 Years	5,779	32.0%
65 Years & over	2,409	40.6%

For individuals who meet eligibility criteria, Nye County provides payment assistance for inpatient hospital or emergency room care. They also provide group home care; homemaker; outpatient hospital/clinics; skilled nursing; home delivered meals; medical transportation; and prescription drugs. Additionally, the county provides one-time rental assistance, emergency food, burial assistance and energy assistance.

**Pershing County**

The 2000 Census reported Pershing County had a population of 6,693. Nevada’s state demographer estimates an average growth rate of 3.2% per year will result in a population increase to 10,540 by the year 2010.

Pershing County reports they provide services to indigent residents without regard to disabilities. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 22**  
**Pershing County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	104	7.4%
21-64 Years	633	21.5%
65 Years & over	249	50.1%

The various services Pershing County provides to eligible individuals are: advocacy services; crisis services; home delivered meals; medical transportation; physician services; prescription drugs; community transportation; emergency dental; homemaker; hospital emergency room services; and personal emergency response systems.

**Storey County**

The 2000 Census reported Storey County had a population of 3,399. Nevada’s state demographer estimates an average growth rate of 2.2% per year will result in a population increase to 4,729 by the year 2010.

Storey County, another of Nevada’s less populated counties, provides very limited services to its residents and assists indigents, without regard to disabilities. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 23**  
**Storey County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	68	10.5%
21-64 Years	548	25.5%
65 Years & over	224	49.3%

The county reports the following services are provided: community transportation; emergency dental; individual/family counseling; crisis services; home delivered meals; and medical transportation.

**Washoe County**

The 2000 Census reported Washoe County had a population of 339,486. Nevada’s state demographer estimates an average growth rate of 1.7% per year will result in a population increase to 390,462 by the year 2010.

The Washoe County Department of Social Services was created to assist those applicants eligible under county programs. The department administers the General Assistance and Health Care Assistance programs in addition to child protective services and the licensing and regulating of childcare providers. The mission of the department is to assist residents who have health care, basic, or safety needs and to provide services as directed by the Board of County Commissioners within the resources allocated for the programs. The Department is “...committed to providing referrals, support, prevention, outreach and relief to persons who are indigent, medically needy or medically at-risk, in a courteous and timely manner.”

In serving the disabled community, the Adult Services Division of the department administers the General Assistance (cash) program and provides for health care needs through its Health Care Assistance Program. The Health Care Assistance Program is funded by Washoe County’s Commissioners through the General Fund, and the Indigent Health Levy.

During FY 2000-01 the Adult Services Division implemented changes to the General Assistance program to make it consistent with eligibility requirements for the Health Care Assistance Program and integrate the eligibility determination process. Further, they collaborated with Washoe Medical Center’s Pharmacy to increase indigent patients’ access to

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medications through the Patient Assistance Program. This allows the utilization of discount programs offered by drug manufacturers for certain drugs for indigent patients. This joint effort resulted in savings of \$540,000 in pharmacy costs for the year.

Washoe County General Assistance:

During the FY 00-01, Washoe County’s General Assistance (GA) program received 5,792 applications, but only 2,665 (46%) were accepted. The total number of people served increased that year to 4,113, of which 948 were disabled, 309 homeless, 1,201 employable, and 1,655 were pending Temporary Assistance to Needy Families (TANF), the state cash assistance program.

**Table 24**  
**Washoe County General Assistance Program**  
**Fiscal Year 2000-01**

Categories	Number Served	% Served	Benefit Paid	% of Costs
Pending TANF	1,655	40%	\$140,748	13%
Employable	1,201	29%	\$223,999	20%
Disabled	948	23%	\$621,486	57%
Homeless	309	8%	\$113,317	10%
<b>Totals</b>	<b>4,113</b>		<b>\$1,099,550</b>	

Source: Washoe County Dept. of Social Services Annual Report FY 2000 - 2001

Although the disabled category represents only 23% of the total number served, it accounted for 57% of the total expenditures for the GA program. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Table 25**  
**Washoe County - U.S. Census Data**  
**Disability Status of Non-Institutionalized**

Age Group	Number Disabled	% of Age Group Population
5-20 Years	5,431	7.2%
21-64 Years	40,199	19.7%
65 Years & over	13,342	38.4%

Washoe County Health Care Assistance:

The Health Care Assistance Program (HCA) saw a 5% decrease in the number of its applications in FY 00-01 to 14,504. Regardless, there was a 1% increase in the number of applications approved for payment, to 9,156.

**Table 26**  
**Washoe County Health Care Assistance Program**  
**Applications & Approvals**

Category	FY 98-99		FY99-00		FY00-01		% of Change FY00 to 01	
	# Apps	Apprvd	# Apps	Apprvd	# Apps	Apprvd	# Apps	Apprvd
Inpatient	2,676	1,056	2,643	1,083	2,437	1,067	-7.79%	1.48%
Outpatient/ER	5,726	3,158	230	212	345	338	50.00%	59.43%
ER Only	n/a	n/a	7,226	2,977	6,639	3,002	8.12%	0.84%
Clinic	4,653	4,522	4,347	4,263	4,386	4,244	0.90%	-0.45%
Group Care	183	183	203	185	178	165	12.32%	10.81%
Nursing Home	131	91	298	134	255	94	14.43%	29.85%
Burials	302	249	294	239	264	246	10.20%	2.93%
<b>TOTAL</b>	<b>13,701</b>	<b>9,234</b>	<b>15,241</b>	<b>9,093</b>	<b>14,504</b>	<b>9,156</b>	<b>-4.84%</b>	<b>0.69%</b>

Source: Washoe County Social Service Annual Report FY2000-2001.  
 Effective FY99-00 Outpatient & ER are reported separately.

Even though the disabled represent a large percentage of those adults served by the department, outside of the numbers served in GA, no data is collected specific to the group. Consequently, assumptions must be made when it comes to associating the cost of medical services directly related to the disabled. Below is a chart reflecting the actual costs associated with direct services by the HCA program, as reported by the department. Actual expenditures in the Washoe County HCA are as follows:

**Table 27**  
**Washoe County Health Care Assistance Program**  
**Fiscal Year 1998-2001**

Category	FY98-99	FY99-00	FY00-01	FY00-01 % of Total
Inpatient	\$2,264,359	\$2,351,043	\$2,234,455	17%
Outpatient/ER	\$2,065,881	\$1,945,010	\$2,171,896	16%
Misc.*	\$502,993	\$627,310	\$507,183	4%
Clinic	\$3,126,791	\$3,590,531	\$3,223,278	24%
Group Care	\$529,388	\$491,327	\$476,792	4%
Nursing Home	\$3,461,825	\$4,087,363	\$4,232,083	32%
Burials	\$156,882	\$156,321	\$151,048	1%
Jail	\$876,000	\$434,735	\$291,920	2%
<b>TOTAL</b>	<b>\$12,984,119</b>	<b>\$13,683,640</b>	<b>\$13,288,655</b>	

Source: Washoe County Dept. of Social Services Annual Report FY 2000 – 2001  
 \* Ambulance and medical misc.

If we accept the assumption expressed above that health care costs are spent at the same ratio as GA payments, then at least 57% of HCA is for disabled, or \$7,574,533 for FY00-01. It is important to remember, however, even though Washoe County administrative staff believe most, if not all, disabled GA recipients receive HCA, they recognize there are many others served who do not receive GA, both disabled and non-disabled.

The following list reflects all the services provided by the county: advocacy services; community transportation; group home care; homemaker; medical transportation;

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occupational therapy; outpatient hospital/clinics; physical therapy; private duty nursing; skilled nursing; specialized medical equipment and supplies; case management; crisis services; home delivered meals; laboratory/x-ray; medication management; other assistive technology; oxygen; prescription drugs; prosthetics; special clinics; and speech therapy.

Washoe County reports the following projections in budget needs for the next five years. It needs to be noted, Financial Assistance is projected for persons with disabilities. The other projections are not limited to persons with disabilities, as the county does not differentiate categories of eligibles in these areas.

**Table 28  
Washoe County  
Fiscal Year 2003-2007 Projections**

<b>Category</b>	<b>FY03</b>	<b>FY04</b>	<b>FY05</b>	<b>FY06</b>	<b>FY07</b>
Financial Assistance*	\$ 842,321	\$ 867,590	\$ 893,618	\$ 920,426	\$ 948,039
Long Term Care	\$4,858,272	\$5,101,186	\$5,356,245	\$ 5,624,057	\$ 5,905,260
Medical Assistance	\$8,902,415	\$9,303,024	\$9,721,660	\$10,159,135	\$10,616,296

\*Financial Assistance relates to persons with disabilities – other categories are for total population  
Source: Washoe County Dept. of Social Services Annual Report FY 2000 - 2001

*Issues/Trends/Innovations as Reported by the Agency:*

Washoe County’s Adult Services Division of the Department of Social Services has established a number of goals which it will be working to accomplish over the next several months. Included is a goal to develop and implement a pilot program for alternatives to long-term care. As reflected in the chart above, the nursing home costs represent 32% of all HCAP expenditures. Seeking alternatives to this type of service is a major challenge, but one which should be beneficial to all concerned.

Another important goal is to review all the Adult Services Division’s forms and procedures to assure compliance with the Americans with Disabilities Act.

Washoe County staff are currently working with United Way in Reno to expand its internet web page to provide an integrated system, *Tapestry*, for taking applications for assistance and immediately sharing it with other participating counties and/or non-profit agencies. The goal is to more quickly serve the applicant while eliminating multiple applications, and help agencies avoid a duplication of effort and services.

**White Pine County**

The 2000 Census reported White Pine County had a population of 9,181. Nevada’s state demographer estimates an average growth rate of -2.6% per year will result in a population decrease to 8,375 by the year 2010. U.S. Census data regarding the county’s persons with disabilities is as follows:

**Nevada Strategic Plan for People with Disabilities**

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**Table 29**  
**White Pine - County U.S. Census Data**  
**Disability Status of Non-Institutionalized**

<b>Age Group</b>	<b>Number Disabled</b>	<b>% of Age Group Population</b>
5-20 Years	144	7.4%
21-64 Years	953	22.3%
65 Years & over	600	50.1%

White Pine County reported providing assistance to persons with disabilities as reflected in the table below:

**Table 30**  
**White Pine County**  
**Assistance to Disabled**  
**FY2000-2001**

<b>Service</b>	<b># Served</b>	<b># Denied</b>
Overdue Utilities	15	
Utility Deposit	13	
Rent	2	
Food Voucher	5	
Shelter	3	
Prescriptions	4	
Medical		1
<b>Totals</b>	<b>42</b>	<b>1</b>

Additionally, the county and separate agencies in the county provide the following services: advocacy services; crisis services; group care home; homemaker; outpatient hospital/clinics; physician services; preventative/restorative dental; case management; emergency dental; home delivered meals; laboratory/x-ray; oxygen; prescription drugs; and specialized medical equipment and supplies.

These services are all income-based. Payments of hospital and doctor bills, for example, are set by statute and are relatively low. A one-person household gross income cannot exceed \$438.00.

**STATE AGENCIES**

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**NEVADA MEDICAID**

Medicaid is a medical assistance program created by Congress in 1965 under Title XIX of the Social Security Act. The state and federal government share costs associated with the Medicaid program. The state Medicaid agency establishes eligible groups, the scope of covered services, appropriate limits on services, payment levels for services, and standards for provider participation.

Eligibility for Medicaid is available to a variety of groups, or categories, of individuals. For example, people who are aged, blind, disabled, and low-income families with children are eligible. Eligibility is also based on income and a person or family's financial resources. The Division of Health Care Financing and Policy (DHCFP) is responsible for the purchasing of Medicaid services, while the responsibility for determining program eligibility resides with the Welfare Division. With just over 200 DHCFP employees statewide, the Medicaid program in Nevada serves 137,144 eligible people<sup>16</sup> at a cost of \$799,022,514 a year,<sup>17</sup> which includes administrative and direct medical services costs.

Medicaid eligible people with disabilities are officially reported in two distinct categories, blind and disabled. Table 31 below reflects the number of new enrollees in the categories for each year listed. It is important to note there may be a number of children within the Temporary Assistance for Needy Families (TANF) Medicaid population (neither blind nor disabled) who are learning disabled or emotionally disturbed that are not classified as disabled and are therefore not counted here. Additionally, there may be other individuals with mental illness who are not classified as disabled and are also not counted here.

**Table 31**  
**Medicaid Enrollees**  
**Disabled and Blind**

	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
New Enrollees Each Year	\$ 3,612	\$ 3,829	\$ 4,058	\$ 4,302
Total Disabled & Blind Recipients	\$16,095	\$17,179	\$18,037	\$20,739
Average Annual Cost Per Person	\$10,383	\$10,671	\$11,247	\$11,551

Source: Counts by Categories Provided by Nevada Medicaid Staff

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<sup>16</sup> Nevada State Welfare's July 2002 Caseload Report

<sup>17</sup> Medicaid's FY02 CMS 64 Quarterly Report

Many medical services are provided for people eligible for Medicaid including:

**Table 32  
Medicaid Services**

Inpatient and outpatient hospital and clinic services*	Physicians' services*
Ambulatory Surgical Centers	Family Planning*
Outpatient Hospital services*	Lab and X-Ray services*
Rural Health Clinics*	Podiatry**
Special Clinics	Dental care
End-Stage Renal Disease Clinics/Services	Ocular services, including eyeglasses
Inpatient and Outpatient Mental Health services	Prescribed drugs
Skilled Nursing and Intermediate Care*	Other Remedial care
Prosthetics, orthotics, medical equipment and supplies	Registered Nurse Practitioners
Home health care,* personal care attendants	Private Duty Nursing
Intermediate care for the mentally retarded	Nurse Mid-Wife*
Therapies including physical, occupational and speech	Audiology
Early Periodic Screening, Diagnosis and Treatment*	Chiropractic**
Home and Community-Based Services (waivers)	Adult Day Health care
Mentally Retarded & Related Conditions	Out-of-State services
Frail Elderly	Medical transportation*
Physical Disabilities	Transplants
Group Home	Emergency services

\*Federally mandated services      \*\*Indicates services paid only as an adjunct to Medicare.  
Source: Medicaid Services Manual

As required by the Social Security Act, Medicaid services are, in effect, continuous for eligible people throughout the State of Nevada. Further, each eligible person may obtain services from any licensed, participating facility, pharmacy, physician, therapist, agency or provider participating with Medicaid. However, those individuals enrolled with a Health Maintenance Organization (HMO) in the Medicaid Managed Care program are assured a primary care physician, but must select providers who are contracted with the HMO.

The Medicaid program provides many community-based services and some specialized programs for people with disabilities that allow them to live in their own homes and/or in community-based settings rather than in nursing homes. Those services include personal care aides, private duty nursing, home health, adult day health care, transitional rehabilitation, assisted living, and other services.

The descriptions of Nevada's Medicaid program provided in this section are focused on services that help to maintain individuals in their own homes and help them avoid institutionalization, and services to those currently institutionalized on a long-term basis. The Medicaid services and programs addressed are:

- A. Home and Community-Based Waivers
- B. Rehabilitation Case Management Services (RECAMS)
- C. Katie Beckett Eligibility Category
- D. Personal Care Assistance
- E. Long Term Care

- F. State Plan Services
- G. Issues/Trends/Innovations

Additionally, several new and innovative programs, service delivery methodologies, and changes to existing programs have been implemented recently by Medicaid or are in development stages. These are addressed in each of the areas listed above, or are described under heading G, entitled *Issues/Trends/Innovations as Reported by the Agency*.

The reader is reminded that this section of the *Nevada Strategic Plan for People with Disabilities* focuses on Medicaid eligible individuals who are identified by the program as blind or disabled. Eligible blind and disabled people equate to approximately 15% of the entire eligible group. In the overall context of the program, this is a relatively small group, although their medical and community support needs are extensive.

It is also important to note that, while this document describes the services utilized by the group of 15% blind and disabled individuals, there are likely many more people in the other 85% of the population receiving care and services who are equally as ill and needy as the blind and disabled. Children diagnosed as severely emotionally disturbed (SED) and mentally ill adults are examples of those individuals who may not be categorized as “disabled.” These Medicaid recipients require and access many important services covered under the Medicaid program, but identification of that information is not possible given the current data system capabilities. Further, many Medicaid recipients in need of services due to mental illness, or children diagnosed as SED, may receive services through the Division of Mental Health and Developmental Services (MHDS), the Division of Child and Family Services (DCFS), or through the Department of Education’s special education program working in conjunction with Medicaid’s school-based services. These agencies and their services are described in other parts of this document.

### **A. Home and Community-Based Waiver Programs and Services**

Medicaid offers additional and specialized services to eligible individuals that are not part of the regular Medicaid program through its Home and Community-Based Waivers. Under Section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to allow non-traditional medical and social services to be provided to individuals who meet institutional levels of care. Waiver services are intended to enable those people who would otherwise require institutional care to remain in their homes, or help them leave an institution and live as independently as possible in the community. Generally, the aggregate cost of waiver services combined with the cost of all other Medicaid services may not exceed the cost of nursing facility services combined with all other Medicaid services. In other words, to be considered cost beneficial, the waiver program must be more cost-effective in terms of in-home vs. institutional services. It should be noted, people in institutional care have a higher income threshold for eligibility, consequently the effect of waivers allows more people who are medically eligible for institutional placement to be covered for all their medical care without being institutionalized.

**Nevada Strategic Plan for People with Disabilities**

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Two waivers are operated by Medicaid to serve people with disabilities. One is for people with mental retardation and related conditions, and the other is for people with physical disabilities, including brain injury. Additionally, the Community Home-Based Initiative Program (CHIP) waiver (addressed below) serves many frail and disabled elderly recipients. The waivers for mental retardation and related conditions as well as the waiver for people with physical disabilities have experienced growth in the last biennium based on legislative support. This expansion has allowed more individuals, many of whom are severely disabled, to remain in a community-based setting. Recruitment difficulties and state hiring freezes have impacted the administering agencies' ability to address growth as budgeted, but individuals continue to be added to the programs at a regular rate.

Services provided in the mental retardation and related conditions waiver and the waiver for people with physical disabilities are shown below:

**Table 33  
Waiver Service Comparisons**

<b>Physical Disabilities Waiver Services</b>	<b>Mentally Retarded &amp; Related Conditions Waiver Services</b>
Case Management	Habilitation
Attendant Care	Residential Habilitation Level A and Level B
Chore Assistance	
Homemaking	Community Day Habilitation
Transportation	Day Habilitation
Personal Emerg. Response Sys.	Pre-Vocational Services
Home Adaptations	Supported Employment
Specialized Medical Equipment	Educational Services
Independent Living Services	In-Home Habilitation Training
Respite Care	Home Adaptations
Assisted Living	Special Medical Equip/Supplies
Dental Services (preventive)	Counseling Services
Home Delivered Meals	Respite
	Supported Living
	Dental Services

Source: Medicaid Waiver Program Specialist 08/02; Updated 9/5/02 MHDS

*1. Physical Disabilities Waiver (PD Waiver)*

Nevada's waiver for people with physical disabilities serves individuals up to age 65. The waiver currently has a waiting list of 6 months to a year and some applicants in nursing facilities have waited even longer due to a lack of accessible, affordable housing or service needs above what can be provided through the waiver. However, housing needs are outside the Medicaid agency's control. Further, in some instances, individuals with service needs greater than what the waiver can support may not be medically appropriate for home and community-based placement.

Medicaid’s Physical Disabilities Waiver program has experienced an increase in the number of new enrollees and total persons served during the past few years. The division administrator reports the number of waiver participants has increased almost two-fold in the last two years, due primarily to the work of the Medicaid staff in requesting increased state funding for slots and their aggressive efforts to fill the slots.

During this same time period, division staff reports they collaborated with Olmstead advocates to devise a way to refine waiting list policies. They adopted a process to screen all individuals inquiring about the waiver prior to placing them on an official waiting list. Prior to this change, individuals were identified on the list but did not always meet the requirements for the program, and many times were on the list “just in case” they needed services in the future. Agency staff now screen individuals for medical and financial eligibility with the end result being a waiting list more accurately reflecting those individuals who truly need the waiver services.

While the numbers reflect vacant slots, it is often the case that as staff work to fill the slots, gather eligibility information, etc., it may take several attempts to find an individual who qualifies under eligibility criteria and is still interested in or needing the waiver services when a slot becomes available.

**Table 34  
Physical Disabilities Waiver  
Enrollees/Slots**

	1998	1999	2000	2001
New Enrollees	19	42	39	123
Number Served	109	131	149	251
Federally Approved Slots	125	145	175	260
Unfilled Slots	16	14	26	9

Source: Medicaid Waiver Program Specialist 08/02

At a recent “snapshot in time” (mid-year 2002), there were 59 people in the referral process waiting for their waiver eligibility to be determined by the Welfare Division and/or Medicaid waiver staff. At the same time, there were an additional 57 people on the waiver waiting list who were already determined to meet waiver eligibility criteria but for whom no slot was available. On the date the “snapshot in time” was done, there were 276 people on the waiver receiving services. Those 276 are added to another 14 who were previously on the waiver in the current year to make a total of 290 people served during the current, 2002, waiver year. In other words, the number of current open cases plus the current year’s closed cases equals the total number of people served in the current waiver year.

Staff report the number of unduplicated slots requested at the federal level is purposely more than what is funded by the state legislature. This is to allow the refilling of waiver slots when they are vacated. If the federally approved slots are not higher than the state funded slots, the division would be unable to refill a vacant slot. When slots do not become vacant at the projected rate, based on expected turnover, the federally approved level will not be met. For this reason, the program has not filled the total number of approved slots by the federal oversight agency.

**Nevada Strategic Plan for People with Disabilities**

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The waiver program has the ability to grow as state funding increases. An example of this is seen in the current year's activity. For 2002 there are 390 federally approved slots for the Physical Disabilities Waiver, but only 265 were funded by the legislature in January 2002. By March 2002 funding increased to include another 30 taking the number to 295, then in July 2002 yet another 30 were funded, resulting in 325 funded slots by that date. Staff anticipate further state funding may be available by October 2002 to allow even more of the federally approved slots to be filled.

As described above, the Physical Disabilities Waiver provides various types of services available to waiver eligible clients in addition to regular Medicaid state plan services. Historical costs for waiver services only are shown below:

**Table 35  
PHYSICAL DISABILITIES WAIVER SERVICES AND COSTS**

Type of Service	1998		1999		2000		2001	
	Num Served	Total Costs						
Case Management	109	\$28,513	131	\$57,143	149	\$61,388	251	\$107,870
Homemaker	43	\$66,862	54	\$87,094	75	\$132,048	82	\$143,271
Personal Emergency Response	0	\$0	9	\$1,532	30	\$8,318	51	\$17,251
Assisted Living	0	\$0	0	\$0	1	\$1,050	6	\$123,375
Environmental Modification	0	\$0	0	\$0	0	\$0	3	\$1,665
Transportation	0	\$0	0	\$0	0	\$0	166	\$95,284
Independent Living Services	0	\$0	0	\$0	0	\$0	1	\$532
Home Delivered Meals	0	\$0	0	\$0	0	\$0	21	\$14,210
Special Medical Equipment	0	\$0	0	\$0	0	\$0	2	\$637
Dental Services	0	\$0	0	\$0	0	\$0	0	\$0
Attendant Care	0	\$0	0	\$0	0	\$0	18	\$240,947
Chore Services	0	\$0	0	\$0	0	\$0	0	\$0

Source: PD Waiver Program Specialist 8/02 – HCFA 372 report

The increase in waiver expenditures reflected above is due primarily to an increase in appropriated funding, services and slots, by the 1999 legislature. Further, Medicaid staff submitted an amendment to this waiver that was approved by the Centers for Medicare and Medicaid Services (CMS) in August of 2000. The amendment expanded the number of services available from three to the thirteen previously listed. This expansion has allowed the program to serve individuals with greater medical and functional needs.

The average time each person remained on the Physical Disabilities Waiver receiving services was:

- 317 days in 1997;
- 301 days in 1998;
- 271 days in 1999; and
- 269 days in 2000.

Even though the length of stay on the waiver has decreased in recent years and the average cost per eligible person continued to rise, the cost savings indicates the program is effectively saving Medicaid millions of dollars overall (see Table 36 below).

**Table 36  
PHYSICAL DISABILITIES WAIVER AVERAGE COSTS**

<b>Year</b>	<b>Number Served</b>	<b>Average Cost To Serve</b>	<b>Cost Neutral Level</b>	<b>Total Cost of Waiver Clients</b>	<b>Total Cost if Institutionalized</b>	<b>*Estimated Cost Savings</b>
1998	109	\$14,461	\$23,510	\$1,576,249	\$2,562,590	\$986,341
1999	131	\$14,494	\$23,867	\$1,898,714	\$3,126,577	\$1,227,863
2000	149	\$17,015	\$38,830	\$2,535,235	\$5,785,670	\$3,250,435
2001	251	\$22,846	\$39,747	\$5,734,346	\$9,976,497	\$4,242,151

\*A change in Medicaid’s Nursing Facility reimbursement methodology was implemented 1/1/02 and will impact future cost savings estimates.  
Source: Medicaid Waiver Program Specialist 08/02

The increase in cost neutral levels between 1999 and 2000 are the result of a change in the methodology used in determining that amount. In 1999 and previous years, the cost neutral level was determined by calculating the average cost of nursing level of care costs for all Medicaid residents, including the elderly. Beginning in 2000 a more representative subset of residents was used (e.g., under age 65, in nursing facility care longer than 90 days, etc.) which resulted in an increase in the cost neutral level because it is a more expensive group of people. This change validated Medicaid waiver staff belief that people in this group were more costly to serve. The increase in cost neutrality resulted in an appropriate expansion of the program’s services and costs.

It is interesting to note that while the cost to serve Physical Disabilities Waiver clients has increased over the years, costs have remained well below the “cost neutral” level in every reported year. And, while “cost savings” cannot be viewed as additional funding available to the program, the savings reflected for those individuals served by Medicaid’s Physical Disabilities Waiver, as opposed to institutionalization, does clearly illustrate the benefits of a community-based service delivery system.

*2. Mental Retardation & Related Conditions Waiver (MR Waiver)*

Nevada has a waiver for people with mental retardation or related conditions. To qualify for waiver services, a diagnosis of mental retardation must be established prior to age 18 or a diagnosis of a condition related to mental retardation must be established prior to age 22. Recipients eligible for the waiver have a choice to stay on it or to transition to the Frail Elderly at Home Waiver when they become age 65. Although Medicaid administers the waiver, it is operated by the Division of Mental Health and Developmental Services (MHDS).

Medicaid’s MR Waiver has experienced a fluctuation in the number of new enrollees over the past several years. In spite of those variances and the number of ongoing cases, the program has never served the full number of federally approved cases/slots. One problem experienced in administering the waiver is that sometimes clients are approved but never use services (e.g., respite). If no services are used, then the person cannot be counted as being on

**Nevada Strategic Plan for People with Disabilities**

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the waiver and the slot they occupied must be reported as vacant per federal requirements. A second factor is that MHDS receives legislatively approved funding for a specific number of placements and must not exceed this legislatively approved funding.

**Table 37  
MR Waiver  
Enrollees/Slots**

	1998	1999	2000	2001
New Enrollees	218	130	291	167
Number Served	589	687	969	1065
Federally Approved Slots	979	1,023	1,064	1,109

Source: Medicaid Waiver Program Specialist report of 08/02

At a recent “snapshot in time” (mid-year 2002), there was a total of 1,012 people being served in the current waiver year. That number combined with the 50 closed cases resulted in a total, on that day, of 1,062 people served by the MR Waiver in the current year. Once a recipient is ready for waiver services, approval is requested by MHDS. MHDS reported on August 19, 2002 there is no waiting list for entry to this waiver. Staff are working to fill the vacant slots with eligible applicants.

Services provided under the MR Waiver are in addition to regular Medicaid state plan services and include habilitation (skill and behavior training) for residential, community, prevocational and educational settings, supported employment services, adaptations to ensure accessibility, specialized medical equipment and supplies, counseling services, respite care, supported living services (such as home assistance), and dental care. Various waiver service types and their associated costs are reflected below:

**Table 38  
MR WAIVER SERVICES AND COSTS**

Type of Service	1998		1999		2000		2001	
	Num Served	Total Costs	Num Served	Total Costs	Num Served	Total Costs	Num Served	Total Costs
Residential Habilitation Level A	71	\$231,163	54	\$220,342	58	\$220,141	54	\$163,293
Residential Habilitation Level B	43	\$616,663	49	\$805,175	49	\$752,026	41	\$472,090
Community Habilitation	277	\$1,026,050	491	\$1,965,765	718	\$3,446,797	824	\$3,887,067
Supported Living	423	\$5,673,701	439	\$6,571,663	667	\$10,156,668	779	\$11,845,979
Counseling	111	\$63,407	163	\$96,811	231	\$158,221	204	\$121,099
Respite	43	\$20,893	124	\$84,745	156	\$109,852	166	\$95,284
Environmental Modification	0	0	0	0	2	\$741	0	0
Adaptive Equipment	0	0	0	0	3	\$894	0	0
Extended Dental	0	0	0	0	1	\$123	0	0

Source: Medicaid Waiver Program Specialist 08/02

The average time each person remained on the MR waiver receiving services varied only slightly from year to year during the period 1998-2001. In 1998 it was 332 days, in 1999 it was 331 days, in 2000 it was 302 days, and in 2001 it was 332 days. Even though the length of stay on the waiver has varied little, and the average cost to serve each person has had relatively small changes during the same time period, the total cost of expenditures for both

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waiver and regular Medicaid state plan costs has increased overall due to the large increase in numbers of people being served by the waiver. From 1998 to 1999 the number increased by 85%, from 1999 to 2000 it jumped another 69%, followed by a 92% increase in 2001, for an overall increase of more than a 180% from 1998 to 2001, going from 589 to 1065 people served.

**Table 39  
MR Waiver Average Costs**

	Number	Average Cost	Cost Neutral	Total Cost of	Total Cost if	Estimated
Year	Served	To Serve	Level	Waiver Clients	Institutionalized	Cost Savings
1997	392	\$21,682	\$88,895	\$8,499,344	\$34,846,840	\$26,347,496
1998	589	\$19,175	\$91,917	\$11,294,075	\$54,139,113	\$42,845,038
1999	687	\$20,582	\$94,877	\$14,139,834	\$65,180,499	\$51,040,665
2000	969	\$22,951	\$97,987	\$22,239,519	\$94,949,403	\$72,709,884
2001	1,065	\$22,097	\$101,199	\$23,533,305	\$107,776,935	\$84,243,630

\*A change in Medicaid's Nursing Facility reimbursement methodology was implemented 1/1/02 and will impact future cost

savings estimates.

Source: Medicaid Waiver Program Specialist Report 08/02

On quick review, this eligible group appears quite costly with more than \$23 million dollars spent in 2001. However, the average cost per person is relatively low at \$22,097. And, the average cost to serve these individuals has remained well below the cost neutral level every year shown. Most dramatic are the differences between the costs to serve the people on the waiver as opposed to institutionalization. The estimated cost savings, while not adding dollars to the available budget, illustrates once again the cost benefits of a community-based service delivery system.

**3. Community Home-Based Initiative Program (CHIP) Waiver**

The Community Home-Based Initiative Program (CHIP) waiver is funded by Medicaid but operated by the Division for Aging Services. Detail on this waiver is included in the Strategic Plan developed by the Senior Services Task Force. Information on the waiver is included here as the frail elderly served by the waiver might also be considered physically disabled.

The purpose of the CHIP waiver is to foster independence and self-reliance and maintain the dignity of frail elderly persons and allow them, to the fullest extent possible, to be an integral part of their families and communities. The program establishes community-based services to enable frail elderly persons to remain in their homes. It ensures that any frail elderly person, who requires the level of care offered in a nursing facility, is able to receive the services enabling him/her to stay in his/her home.

Services are provided to individuals who are age 65 and older; require assistance with one or more activities of daily living such as bathing, dressing, eating, ambulating or transferring; are at risk of being placed in a nursing home within 30 to 60 days; and meet financial requirements.

The services provided by CHIP are:

- |                           |                                     |
|---------------------------|-------------------------------------|
| Case Management           | In-home Attendant Care              |
| Homemaker Service         | Adult Day Care                      |
| Adult Companion Service   | Respite                             |
| Medical Nutrition Therapy | Personal Emergency Response Systems |

On May 1, 2002 the CHIP waiver had the following number of persons waiting for entry to the program:

**Table 40  
CHIP WAIVER  
WAIT LIST INFORMATION  
May 1, 2002**

<b>Number on Wait List</b>	609
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**Average Number of Months on List**

Reno	2
Carson City	3
Las Vegas	8

Source: A Strategic Health Plan, Senior Services  
Task Force 08/02

**B. Rehabilitation Case Management Services (RECAMS)**

Medicaid currently operates the Rehabilitation Case Management Services (RECAMS) program and staff report they serve between 50 and 75 people monthly. It has been in existence for the past eleven years and is based on a legislative initiative to provide long-term services to people who have survived a traumatic brain injury. The RECAMS program offers assessment, extensive rehabilitation, and case management in an effort to prevent institutionalization and to promote the highest level of physical functioning possible after injury and institutional rehabilitation. Recipients are offered intensive life skills training as a means to improve independent functioning. Toward the end of the rehabilitation period, services are offered at day treatment centers and in the recipients' own homes in an attempt to prepare for independent living.

All individuals served through the RECAMS program are entitled to the full range of Medicaid state plan services. The costs directly associated with Transitional Rehabilitation Centers for people eligible for RECAMS is reflected below.

**Table 41  
RECAMS COSTS**

<b>FY98</b>	<b>FY99</b>	<b>FY00</b>	<b>FY01</b>
\$2,774,279	\$2,860,608	\$3,002,975	\$2,772,397

Medicaid Claims History Data (based on payment date)

The Medicaid agency is currently considering transitioning RECAMS to a waiver program. Under federal regulations, services currently offered in RECAMS are more appropriately offered as waiver services rather than state plan services.

**C. Katie Beckett Eligibility Category**

“Katie Beckett” is an optional eligibility category under Medicaid which allows a state to waive the counting of parental income and resources toward eligibility for any child eighteen years of age and under who is eligible for placement in a Medicaid certified hospital, intermediate care facility for the mentally retarded (ICF/MR), or nursing facility. If the child is found eligible under this category, access to all state plan Medicaid services is made available. However, there is a monetary limit to the medical coverage costs reimbursed under Katie Beckett, which must be less than the amount that Medicaid would pay were the child institutionalized.

Children in this category must be age 18 or under, meet disability criteria as determined by the Social Security Administration and Nevada Medicaid, be living at home or in a community setting, require a level of care provided in a hospital, nursing facility, or ICF/MR, have medical costs for home care which are less than in an institution, and meet all eligibility criteria of an institutional case, except for residing in an institution.

Current data on eligible persons and costs for their care under this category of eligibility is not available.

**D. Personal Care Assistance**

The Personal Care Aide (PCA) program, also referred to as the personal assistance program, has been a long-standing service option in Medicaid, meaning it is not federally mandated. Services required for people with disabilities that may be provided under personal care assistance have often been provided under the home health care program in the past. Home health, generally provided through a licensed agency using professional level staff, is for more acutely ill people and is a more costly service. The use of personal care aides/assistants is increasing as they are able to provide the needed services, are more appropriate to the type of care required, and are cost effective. Table 42 below compares the cost of the two programs for a four-year period.

**Table 42  
Nevada Medicaid Personal Care  
Payments for Blind and Disabled  
Fiscal year 1998-2001**

Service Type	1998	1999	2000	2001
	Payments	Payments	Payments	Payments
Home Health	\$6,114,660	\$5,480,454	\$6,387,125	\$ 6,230,822
Personal Care	\$1,463,259	\$1,924,618	\$2,329,477	\$ 3,960,972
Total	\$7,577,919	\$7,405,072	\$8,716,602	\$10,191,794

Medicaid paid claims history from UNLV (based on payment date) 08/02

The Personal Care Aide (PCA) program was revised in January 2001 resulting in the creation of several new service delivery models. PCA Provider Agencies (PA) allow the individual receiving services to do so from an agency designed to hire, train and staff competent attendants who can provide back-up care. PCA Intermediary Service Organizations (ISO) were also created to allow recipients to self-direct their care. The ISO is responsible for recruitment and training of attendants, which offers the recipient the opportunity to select and staff care from the ISO's trained pool. This delivery system is currently being refined to attract more participants by specifically addressing the need for back-up services.

The PCA program uses a functional assessment to authorize hours based on each recipient's medical need. The revision in the program now allows authorization of up to 61 hours per week of care, making the program one of the most generous in the nation. The functional assessment also recognizes the need for light homemaking tasks, such as shopping and laundry. The program's revisions were federally approved last year.

The Medicaid program also offers private duty nursing, as a means to address the continuous care needs of people who wish to remain at home. Many of those services are provided to severely disabled children who would be institutionalized without the service. The critical shortage of trained pediatric nurses and nurses in general combined with the increase in caseload has made it more difficult to staff private duty cases in the past several years, often leaving people without service for long periods of time.

The Disabilities Statistics and Research Center of the University of California, San Francisco (UCSF), recently published a study of national data for people with disabilities who have an unmet need for personal assistance services. The UCSF research was extrapolated to Nevada and assumed Nevada has the same rate of disability as the U.S. as a whole. The Center concluded the rate of individuals in the total population who need help with one or more Activities of Daily Living (ADLs) to be about 2% of the total population. Further, the study concluded that of those who need help, approximately 29% need more help than they are currently receiving. For a population of 1,998,257, this means about 39,965 Nevadans need assistance with one or more ADLs and of those, 11,590 need more help than they are currently receiving.

By applying the UCSF study's conclusions to the Medicaid program, 2% of the 20,739 total Medicaid disabled/blind population eligible in 2001, or 414 people, needed personal care assistance and 29% of those people with disabilities receiving personal care assistance, or 120, needed more help than they received. Medicaid staff reported there were 646 people who actually received personal assistance services in FY01, and another 1,217 in FY02. This number represents all Medicaid eligible people who received personal assistance, not just the disabled.<sup>18</sup>

In spite of the findings of the UCSF study, Table 42 above clearly illustrates Nevada's expansion of services in the area of personal care assistance. From 1998 to 2001, the program increased expenditures by more than 150%. This result comes from an increased

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<sup>18</sup> Medicaid Program Specialist, August 16, 2002 and Medicaid Deputy Administrator, August 30, 2002.

number of individuals served, changes in the service delivery methods described above that improved the availability of caregivers, and an increase in the reimbursement rate.

### **E. Long Term Care**

For the purposes of this document, Medicaid's long term care (LTC) services are those provided in nursing facilities where individuals receive skilled nursing or intermediate care, or in an intermediate care facility for the mentally retarded (ICF/MR). In the Medicaid program, the term nursing facility (NF) means an institution which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services, or health-related care and services to individuals who, because of their mental or physical condition, require care and services above the level of room and board which is available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases. Intermediate care services are those health-related items and services provided to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition or rehabilitation potential, require care and services on a resident basis in a qualifying nursing facility.

Under Medicaid, nursing facility services (including intermediate care) may be covered when:

1) the recipient is pre-screened by designated personnel; 2) inpatient services are authorized by a physician; 3) they are prior authorized as appropriate by the Medical Review Team; 4) they are provided to eligible Medicaid recipients of any age; 5) they are provided in a Medicare/Medicaid certified participating facility; and 6) they are provided under an acceptable plan of care.

An Intermediate Care Facility for the Mentally Retarded (ICF/MR) is defined as one with a primary purpose of providing health or rehabilitative services for individuals who are mentally retarded or who have conditions related to mental retardation. All ICF/MR facilities provide 24 hour a day residential care. Intermediate care services are medical and habilitative services provided to a mentally retarded person or a person with a related condition. The services are certified as needed and provided in an inpatient facility. Training and habilitation services are those intended to aid the intellectual, sensorimotor, and emotional development of an individual. They include instruction in self-help skills, social skills, and independent living activities with the goal, when feasible, of enabling individuals to function in community living situations. Medicaid covers ICF/MR services when 1) they are properly certified/recertified by a physician; 2) are authorized by the Nevada Medicaid Office; 3) are provided to eligible Medicaid recipients; 4) are provided by a Medicaid certified participating facility; and 5) the Interdisciplinary Team has developed an appropriate individual program plan based on its evaluation and reevaluated the plan as required.

**Table 43  
Medicaid Eligibles and LTC  
Payments for Blind and Disabled  
FY99-01**

	1999		2000		2001	
	Number Eligible	Total Cost to Serve	Number Eligible	Total Cost to Serve	Number Eligible	Total Cost to Serve
ICF-MR	271	\$25,162,151	265	\$24,716,754	255	\$26,103,930
Nursing Facilities	413	\$14,370,986	455	\$16,843,495	489	\$18,392,633
<b>Totals</b>	<b>684</b>	<b>\$39,533,137</b>	<b>720</b>	<b>\$41,560,249</b>	<b>744</b>	<b>\$44,496,563</b>

Source: Medicaid paid claims history from UNLV (based on service date)

Nursing facility placements have remained relatively static over the past five years. While the industry has opened new facilities, especially in southern Nevada, the availability of beds to Medicaid recipients has not increased accordingly. The closure of three facilities in northern Nevada in the same time frame has made it difficult to find placement in this area. The vacancy rate for nursing facilities throughout the state is 22.2% per the FY2001 summary utilization report. Even though the aged institutional placements are down slightly, disabled institutional placements continue to rise, up from 634 in April 1996 to 776 in April 2001. While this is far less than the growth from 1991-1998, it still represents a 22% increase for the five-year period.

In January 2002 Medicaid implemented a new reimbursement methodology for nursing facilities located in Nevada. The previous payment structure based on patient level of care was replaced with a case mix reimbursement system where facilities are reimbursed the same rate for each Medicaid recipient, with quarterly adjustments based on the facility's medical acuity. The daily rate includes room and board, nursing services, all supplies, wheelchairs, feeding pumps, IV equipment, etc., with the only exceptions being medications, pre-authorized therapies, lab, x-ray or specialized seating systems. The statewide average is currently \$121 per day for facility reimbursements based on the case mix methodology.

Nursing facilities have been reluctant to accept individuals with behavior problems, including those resulting from brain injury, autism or documented mental health issues. This has led to placement of individuals with long-term care needs in out-of-state facilities.

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**Table 44  
Out-of-State Placements  
Medicaid Aged, Blind & Disabled  
FY99-FY01**

<b>FY99</b>	<b>Nursing Facility Number</b>	<b>Total Cost</b>	<b>ICF/MR Number</b>	<b>Total Cost</b>	<b>Residential Trt Ctrs Number</b>	<b>Total Cost</b>
Aged	29	\$691,962	0	\$0	0	\$0
Disabled	29	\$1,326,726	9	\$438,267	8	\$839,226
Other	0	0	4	\$187,437	26	\$2,537,752
Sub-Total	58	\$2,018,688	13	\$625,704	34	\$3,376,978
<b>FY00</b>						
Aged	25	\$596,989	0	\$0	0	\$0
Disabled	28	\$1,463,872	11	\$563,835	14	\$1,398,829
Other	0	0	4	\$170,820	26	\$2,524,223
Sub-Total	53	\$2,060,861	15	\$734,655	40	\$3,923,052
<b>FY01</b>						
Aged	23	\$575,390	0	\$0	0	\$0
Disabled	31	\$1,538,822	11	\$561,580	11	\$1,183,746
Other	0	0	4	\$163,892	31	\$3,208,222
Sub-Total	54	\$2,114,212	15	\$725,472	42	\$4,391,968

Medicaid paid claims history from UNLV (based on service date)

Medicaid eligible persons are sometimes placed out of state in long-term-care nursing facilities, ICF/MR facilities, and Residential Treatment Centers (RTC) when such services are unavailable in the state. Medicaid staff report that RTC placements are generally not considered long-term. They are included here, however, since many of the placements occur in out-of-state facilities. A great many of the RTC placements are children in foster care, while ICF/MR placements are a mix of state custody individuals and others. In some cases, the ICF/MR adults may initially have been placed out-of-state as children when there was no appropriate placement available in Nevada. The placements have lasted a number of years and the residents have since grown up in those facilities and have come to know them as home. In other cases of ICF/MR placements involving children, they are mostly located in Utah in a facility that provides the medical care and educational opportunities needed. Some of these children are in Nevada's custody through the Division of Child and Family Services, while others were admitted to the facility from the Ely and/or Elko areas. Many families from these geographic areas of Nevada seek medical treatment from the University Medical Center in Salt Lake City and referrals from that treating facility to the Utah ICF/MR facility are routine. Further, year-round travel for families to visit these children in Utah is easier than travel to western Nevada where comparable care facilities are located.

In a June 4, 2002 meeting of Nevada's Legislative Committee on Health Care, the administrator of the Division of Health Care Financing and Policy (DHCFFP), Department of Human Resources (DHR), testified that individuals residing in out-of-state nursing facilities are there primarily because Nevada nursing communities refuse to accept individuals with difficult behavior management problems. Such behaviors are generally the direct result of a dementia-related condition, medical condition, mental illness, mental retardation, or

traumatic brain injury. Nursing facilities in Nevada most often refuse to admit people with severe behavior problems due to their inability to meet the individual’s needs and currently no Nevada nursing facility will accept residents with such problems, regardless of the cause of their conduct. Another influencing factor is the need for specialized staff training and a higher-than-average nursing staff ratio.

Nevada’s nursing facilities were recently offered the opportunity to negotiate higher reimbursements for residents with behavior issues. They refused, noting the increased potential for cited deficiencies and possible sanctions from the federal government and the Bureau of Licensure and Certification. The facility representatives fear deficiency citations for improper use of chemical restraints (medications) and for resident-to-resident abuse. The facilities also claim the nursing shortage limits their ability to extend staffing ratios.

Examples of conditions that result in out-of-state placements include: alcohol dementia, brain injuries, eating disorders, and sexual aggression. Few, if any health care providers in Nevada, receive the training needed to deal effectively with these types of behaviors.

The current Medicaid average reimbursement rate for nursing facilities in Nevada is \$121 per day. In comparison, the program pays an average of \$97 per day for some residents in out-of-state facilities, mostly in the State of Utah. Out-of-state facilities that accept those residents requiring specially trained staff and higher nurse-to-resident ratios are reimbursed as much as \$250 per day for individuals requiring an extremely high level of care.

The DHCFP administrator reiterated earlier testimony that the division’s attempts to persuade Nevada’s long-term-care industry to accept an enhanced Medicaid rate to develop additional spaces to care for residents with behavioral problems have been unsuccessful. However, the division is attempting to identify proactive steps to address this issue, given current budget restraints. Further, the DHR director has instructed proactive steps be taken to return these residents to Nevada.

Medicaid staff continue working with the Division for Aging Services and the Bureau of Licensure to monitor all out-of-state placements.

**F. Medicaid State Plan Services**

As noted previously, through its full state plan services, Medicaid offers benefits providing a wide range of medical care to a variety of eligible people. Individuals become eligible by applying to the Welfare Division for Temporary Assistance for Needy Families (TANF) and/or Medicaid. The number of blind and disabled who are Medicaid eligible has continued to increase each year as illustrated in Table 45.

**Table 45  
Medicaid Eligibles  
Disabled and Blind**

	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Total Disabled & Blind Population	16,095	17,179	18,037	20,739

Source: Medicaid Accounting Staff Report 08/02

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Likewise, costs of medical services for people who are disabled and/or blind have increased each year. These changes are attributed to both increased numbers of persons eligible for services and the cost of medical care in provider reimbursements and added services.

**Table 46  
Nevada Medicaid  
Payments for Blind and Disabled  
Fiscal Years 1998-2001**

	1998		1999		2000		2001	
	Payments	% of Total						
ICF-MR	\$23,904,375	14.07%	\$25,053,481	13.46%	\$24,065,718	12.39%	\$27,137,642	11.14%
Nursing Facilities	\$12,686,954	7.47%	\$13,640,355	7.33%	\$14,801,816	7.62%	\$19,282,904	7.92%
Home Health	\$6,114,660	3.60%	\$5,480,454	2.94%	\$6,387,125	3.29%	6,230,822	2.56%
Personal Care	\$1,463,259	0.86%	\$1,924,618	1.03%	\$2,329,477	1.20%	3,960,972	1.63%
Adult Day Health Care	\$133,941	0.08%	\$185,305	0.10%	\$226,698	0.12%	\$187,857	0.08%
HCB Waiver-MR	\$6,282,754	3.70%	\$7,864,758	4.23%	\$12,375,633	6.37%	\$18,200,752	7.47%
Case Management	\$5,234,896	3.08%	\$6,256,880	3.36%	\$7,690,255	3.96%	\$8,993,636	3.69%
Physical Disabilities Waiver	\$58,357	0.03%	\$68,550	0.04%	\$101,195	0.05%	\$251,430	0.10%
Hospice	\$105,412	0.06%	\$479,476	0.26%	\$537,105	0.28%	\$630,977	0.26%
Other Waivers	\$23,019	0.01%	\$35,703	0.02%	\$41,115	0.02%	\$25,108	0.01%
All other (Medical)	\$113,941,627	67.04%	\$125,107,798	67.23%	\$125,658,959	64.70%	\$158,692,050	65.15%
<b>Totals</b>	\$169,949,254		\$186,097,378		\$194,215,096		\$243,594,150	

Source: Medicaid Paid Claims History from UNLV (based on payment date which may result in a slight variance from other tables).

While payments for ICF/MR services increased over the four years shown, the percent of total payments for this service declined from 14.07% in 1998 to 11.14% in 2001. Further, Nursing Facility payments increased in amount, but the ratio to total dollars spent by Medicaid remained static. Together, these two institutional groups account for more than 19% of Medicaid's total expenditures for blind and disabled recipients in 2001.

Other expenditures which directly serve people in independent or community-based settings, personal care, home health, adult day health care, case management, physical disabilities and MR and other waivers combined account for more than 15.5% of payments for blind and disabled recipients.

As seen earlier, in 2001 there were 1,361 people served in waivers for physical disabilities and MR services. During the same time period, 744 people were served in nursing facilities and ICF/MR facilities. The comparison of costs for serving those individuals is reflected in Table 47.

**Table 47  
Comparison of Costs in FY01  
PD and MR Waiver vs. Long Term Care &  
ICF/MR for Blind & Disabled**

	<b>Number</b>	<b>Total Medicaid</b>	<b>Avg Cost</b>
	<b>Served</b>	<b>Expenditures</b>	<b>Per Person</b>
Physically Disabled Waiver	251	\$5,734,346	\$22,846
MR Waiver	1,065	\$23,533,305	\$22,097
ICF/MR Facilities*	255	\$26,103,930	\$102,368
Nursing Facilities*	489	\$18,392,633	\$37,613

\*Facilities data for both eligibles and payments was selected based on **service** date  
Source: Waiver data from Medicaid Waiver Program Specialist; Facility data from Medicaid Paid Claims History (based on service date) from UNLV .

This table is yet another illustration of the cost benefits of community-based delivery systems.

**G. Issues/Trends/Innovations as Reported by the Agency:**

*1. Policy Updates*

During the past two years, the Medicaid agency has been revising policy coverage in many areas. Policies are updated when new federal directives are received, new treatments for medical conditions are discovered, when improvements in the quality of care and quality of the recipient’s life can be achieved, and through legislative initiatives and advocacy interventions. Federal initiatives regarding the creation and strengthening of community-based care has been heavily endorsed, and much of Medicaid’s policy revision has occurred with this in mind.

*2. Long-Term Residential Options*

Medicaid is exploring viable alternatives for meeting the long-term residential needs of individuals with neurobehavioral impairments following brain injury. Currently, severely impaired individuals have to be placed in out-of-state facilities, while those with mild to moderate impairments vie for the very few options currently available in their communities. A good deal of consideration and research is underway to determine the feasibility of an effective waiver for people with traumatic brain injury in Nevada.

*3. Institution Relocation & Diversion Programs*

Medicaid recently implemented two new projects intended to maintain recipients in the community vs. institutionalization in nursing facilities. These projects include (1) Nursing Facility Relocation, and (2) Hospital Diversion. Both of these projects consider the Medicaid recipient’s desire to remain in, or return to a community living situation as the primary consideration.

The Nursing Facility Relocation project aims to provide Medicaid recipients currently living in nursing facilities the option to relocate to the community. Medicaid completed a pilot project in 2001 using four nursing facilities and the Minimum Data Set (MDS) screening tool developed in the State of Vermont. This then led to the task of personally

canvassing residents of nursing facilities where the lowest payment levels were found. Those residents who are at the highest functioning levels require the lowest payment from Medicaid due to their lower level of care. While completing this process, Medicaid staff instructed NF staff about this project, which resulted in some direct referrals. Compiling of the full data findings is underway and will be useful to Medicaid staff in identifying future residents with the potential for discharge to a community setting. Additionally, the continued interaction and communication with NF staff about newly admitted residents or existing residents who express a desire to live in the community is expected to help in identifying these residents and assisting them in relocating to community settings.

The Hospital Diversion project seeks to assist Medicaid recipients to avoid nursing facility placement at the time of hospital discharge. This project started as a pilot with Washoe Medical Center but has since expanded to include St. Mary's and Northern Nevada Medical Center. Medicaid staff are working toward further expansion to Carson City, but have determined insufficient staff to include Las Vegas, Elko and Fallon at this time. The project includes both the Division for Aging Services (DAS) and the Welfare Division working in conjunction with Medicaid. When a Medicaid application is made to the Welfare Division or a waiver application to DAS, it is sent to Welfare with a special cover sheet indicating it is for the diversion project, resulting in "fast tracking" the process. The intent is to make the applicant eligible for the waiver and divert them from nursing facility placement whenever possible. Barriers to project success at this time are: a need for more waiver slots; a need for more staff to work the project at the Welfare district offices; a need for more case managers for the waivers; a need for more DAS staff to work the waivers; the lack of an assisted living option within Medicaid; the low reimbursement rate for waiver group home providers; and the fact Nevada does not have a presumptive eligibility policy.

#### *4. Staffing Needs*

Medicaid staff members believe recognition of essential service delivery needs and systems revisions as illustrated in this plan will help in efforts to improve available Medicaid services. However, program changes or growth will require the filling of current vacancies and additional staff positions to assure the changes can be put into operation.

#### *5. Ticket to Work*

The Ticket to Work/Work Incentive Improvement Act provided Nevada the option of expanding Medicaid coverage to employed people with disabilities. Nevada was awarded a three year Ticket to Work-Medicaid Infrastructure Grant by the federal agency, Centers for Medicare and Medicaid Services, in the fall of 2000. Utilizing this legislation and grant, the Department of Human Resources has been in the process of designing and now recommending a program to ensure availability of quality health care services to individuals with disabilities when achieving and maintaining competitive employment either by retaining or purchasing Medicaid coverage.

6. *Uninsured Nevadans*

There are a great many uninsured citizens in the State of Nevada, both children and adults. This results in a population of people who are at risk and exist without the coverage needed to assure ongoing medical care. The Annie E. Casey Foundation's *kids count 2000 Data Book*<sup>19</sup> reports, "In 2000 8.4 million American children did not have health insurance. More than 2.2 million of those children were from low-income working families, representing an uninsured rate more than double that of children generally... This gap is noteworthy because uninsured children are less likely to receive medical care for serious injuries and recurring health conditions. Not only do the children suffer needlessly, but their parents also miss more days of work to care for them... the lack of health-care coverage also influences the job choices of low-income parents, who may feel compelled to turn down a better paying job if it doesn't include health-care benefits." The same document, page 114, compares Nevada's demographics to those of the nation. Here it is reported that 20% of Nevada's children were without health insurance in 1999, compared to 14% nationally.

The Great Basin Primary Care Association conducted a study of uninsured Nevadans and found that a total of 388,332 people, adults and children, in the state are uninsured. That represents 18.8% of the total population.<sup>20</sup>

Financial hardships have a negative impact on uninsured families when accidents, illness or injuries occur, whether for children or adults, and often places added burdens on local government agencies where families turn in times of emergent need. Further, medical providers who experience unpaid claims by uninsured patients tend to seek rate increases from insurance companies and government programs.

**H. Medicaid Conclusion**

This section on Nevada's Medicaid program is intended to provide the reader with a concise description of the various services paid by the program on behalf of people with disabilities that either help them avoid institutionalization or assist in their leaving an institution. It was often difficult to focus on the small population of just over 20,000 people with disabilities since the program serves well over 130,000 people. Further, Medicaid offers coverage in a great many medical and community support services, many of which are not addressed in this document. For those reasons, this description may have unintentionally overlooked some special group(s) of people, or particular services the reader expected to see.

The descriptions contained here are intended to document program activities and services offered, account for who receives those services, describe the way in which services are provided, and, when available, list the costs associated with the services. It is hoped the reader has been provided sufficient information on the Medicaid services for people with disabilities that assists in understanding the program's operations.

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<sup>19</sup>*Kids count 2000 Data Book*, page 20, based on U.S. Census Bureau, "Health Insurance Coverage 2000," Table 4 "Children Without Health Insurance for the Entire Year by Age, Race, and Ethnicity: 1999 and 2000."

<sup>20</sup> Great Basin Primary Care Association, website, [www.gbpcanet.net](http://www.gbpcanet.net), *Number of Uninsured Nevadans, Table 1*

***OFFICE OF COMMUNITY BASED SERVICES***

The Office of Community Based Services (OCBS), within the Department of Employment, Training & Rehabilitation (DETR), had a FY 02 budget of \$12.5 million dollars. Under the guidance of several mandated, consumer-directed councils and advisory groups, including the state Independent Living Council, an OCBS staff of 10 operates six federal and five state programs. OCBS services are outsourced and provide:

- administration and flow through for federal and state funds targeted to disability issues;
- needs assessment, trend analysis, and planning and program development designed to build service capacity;
- research, policy analysis, and interagency collaboration in areas of disability related service, legislation and policy issues;
- development of initiatives to attract new funding and technical assistance resources from federal and private sectors;
- leadership training and consultation for Nevada consumers with disabilities and their families;
- information dissemination and service collaboration;
- grants management, program oversight, monitoring and technical assistance to assure quality; and
- coordination of resources to avoid duplication.

Again, service delivery is outsourced, and provided by private and non-profit agencies. This privatization of OCBS services has resulted in the attraction of more than \$35,000,000 in additional resources for the purposes of the OCBS mission *“to provide resources at the community level which promote equal opportunity and life choices for people with disabilities through which they may positively contribute to Nevada society.”*

OCBS grantees provide services to Nevadans of all ages with physical, neurological and sensory disabilities. Generally, the services are provided to people above Medicaid income eligibility levels and require a co-pay by the applicant on a sliding fee basis. Staff provides coordination among its community providers and with sister state agencies providing similar service.

OCBS assists only those people with disabilities whose needs cannot be met through any other governmental source, typically because of ineligibility or because the service is unavailable. In this regard, OCBS “fills the gap” in service provision for those above income levels for other programs or for services not included in the menus of sister agencies. In addition to assisting those who would otherwise “fall between the cracks,” OCBS provides services for unique disability needs, e.g., telecommunication for those with sensory impairments and transitional rehabilitation for traumatic brain injury.

OCBS houses and provides administrative support for the state/federal program of Developmental Disabilities (DD) which receives direction from an Executive Council appointed by the Governor. The program provides conditional grants to community-based entities for start-up and demonstration of models in service delivery and consumer

leadership. All grantees must demonstrate ability to become self-sufficient upon termination of grant funds. DD funds may not be used to provide ongoing services. An example of Developmental Disabilities sponsored initiatives is seed funding for assisted housing designed to complete the continuum of services needed for clients who receive all other necessary services from another entity such as Medicaid.

OCBS programs are:

**A. In-Home Personal Assistance**

This program was established in 1985 by the Nevada Legislature to assure people with disabilities would not be placed at risk of institutionalization. People with disabilities utilize personal assistance at an average cost of \$17.24 per hour. Between 1999 and 2001, 141 people (ongoing and new clients) were assisted at an average cost of \$19,902 each (includes administrative and case management costs). During this same period, 288 persons were denied services due to budget limitations. At current funding levels, 78 clients can be served annually on an ongoing basis at approximately \$19,902 each. Presently there are 166 on the waiting list for program entry. While an eligibility determination takes one day, the time on the waiting list is dismal. It takes an average of 19 months for those in an institution/or at imminent risk of becoming institutionalized to receive service, and the wait is indefinite for all other categories of persons with disabilities. As such, no one has been added to the program in the last five years, except those in the most dire circumstances.

Accounting for a 3.2% annual service cost inflation, 2.6% annual population growth, the projected costs for the next five biennia are:

FY2004-05	\$ 10,573,400
FY2006-07	\$ 11,835,500
FY2008-09	\$ 13,248,300
FY2010-11	\$ 14,849,600
FY2012-13	\$ 16,599,800

**B. The Community Service Center Fund**

In 1999, the legislature provided \$5,000,000 in Tobacco Settlement funds for construction of a supportive services complex for services to people with disabilities. The project seeks to build a comprehensive service continuum in which local community college and nonprofit providers serving people with disabilities are co-located, retaining the integrity and autonomy of their individual programs but sharing space, technology, operating costs, services and, most importantly, their client base. OCBS and a steering committee of legislators/community officials administer the fund.

**C. Independent Living Services**

Between 1999-2001, 350 new enrollees with disabilities were assisted at a cost of \$3,464 each for direct services (excludes administrative and case management costs). During this same time period, 350 potential enrollees were unable to be served, the same exact number that was served. At current funding levels, 56 clients can be served annually at a cost of approximately \$3,728 per enrollee for direct services. This past year, the program had the

benefit of a \$400,000 one-shot appropriation that was used exclusively for services. With this augmentation, the program was able to serve 176 people and report zero growth on its waiting list. Given this, it appears approximately \$656,000 in direct service funding, plus administrative costs, is the ideal funding level for the program.

Presently, there are 8 individuals awaiting an eligibility determination (approx. 20 days) and 118 waiting for services. Statistics indicate the time from eligibility to service is 16 months, with the actual services taking only about 6 months. In the past three years, new enrollees were provided home modifications (average cost \$6,000), vehicle modifications (average cost \$5,000), wheelchair/scooter (average cost \$4,500), and other devices (average cost \$2,000).

Considering a 3.2% annual inflation service cost and a 2.65% population growth, the projected cost of new enrollees in each of the next five biennia is:

FY2004-05	\$ 2,377,101
FY2006-07	\$ 2,660,842
FY2008-09	\$ 2,978,451
FY2010-11	\$ 3,333,970
FY2011-12	\$ 3,731,926

#### **D. Assistive Technology Loan Program**

The Assistive Technology Loan Program enables a person with a disability to borrow money to purchase devices that enable them to live more independently, i.e., wheelchair accessible vans, bathroom modifications, ramps. The loan program can be used for a broad array of devices.

“New applicants” are better defined as requests for new loans. A previously served person can return to the program to request additional loans for needed devices/replacement devices. OCBS has \$1.4 million on deposit with the bank which is used as collateral for the client loans. Nevada State Bank, the current provider, allows \$2 in loans for every \$1 on deposit with the bank. There is no cost for the loans as the clients borrow the money and pay it back with interest. Program administrative costs are borne by the bank partner, and the case management costs associated with helping clients secure the devices they need costs approximately \$80,000 annually and are presently being funded through interest earned and grant support.

For the period 1999-2001, the program processed an average of 12 loans annually. In 2002, 46 loans were processed and this number is expected to increase to 100 in 2003. Loans were secured for home modifications (\$6,000), vehicle modifications (\$5,000), wheelchairs/scooters (\$4,500), other devices (\$2,000). The total cost to service each loan was approximately \$1,600 (includes “all” associated costs). Approximately \$450 of the loan cost is returned in interest paid by the client. In the past three years, everyone requesting services has been served; however, today there is the capacity to service an additional 280 loans due to additional federal funding and an infusion of state tobacco money into the loan program. The average time for an eligibility determination is four days, and the time between eligibility and service is five days.

## **Nevada Strategic Plan for People with Disabilities**

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Assuming 3.2% service cost inflation for administration costs, the projected costs for the next five biennia are shown below. It should be noted the program's capacity is greater than the demand for service, so a population growth factor has not been added into the costs shown below.

FY 2004-05	\$167,700
FY 2006-07	\$185,500
FY 2008-09	\$207,600
FY 2010-11	\$232,400
FY 2012-13	\$260,100

### **E. TTY Distribution Program**

The TTY (also called Telecommunication Device for the Deaf, or TDD) Distribution Program 1) provides free telephone, telecommunication devices and assistive equipment to people with sensory or speech impairments via the Northern and Southern Nevada Centers for Independent Living, and 2) provides training for people to use Relay Nevada. The program is funded through a surcharge on telephone access lines.

In 1999 and 2000 the agency served in excess of 200 individuals annually; in 2001 that number dropped to 88. The drop in service can be attributed to an apparent result of complacency in those offering the services. With continual state population growth, there is no reason to believe the program will not be in high demand. The average cost to serve new enrollees is \$627 each which includes the purchase price of the equipment and cost of client education and program administration.

No people were left unserved in the past three years. The program's capacity is limited only by the staff's ability to manage their workload. The program is mandated by law to provide TTYs to qualifying individuals. It is unknown how many more people could have been served between 1999 and 2001. Presently there is no one waiting for an eligibility determination; the average time to determine eligibility is 2 days and the time between eligibility and service is 2 days.

OCBS offers Relay Nevada. Through an annual contract of approximately \$1.2 million with Sprint, relay services are provided which enable TTY users to communicate with telephone users. A relay operator acts as an intermediary by typing the words of the telephone user and voicing the words of the TTY user. Approximately 450,000 such phone calls are relayed in Nevada each year.

Assuming an approximate 3.2% annual inflation in the cost of administration and equipment, and a 2.6% annual growth in the state's population, the projected cost of the TTY Distribution Program for the next five biennia are:

FY 2004-05	\$273,000
FY 2006-07	\$305,600
FY 2008-09	\$342,100
FY 2010-11	\$382,900
FY 2012-13	\$428,600

**F. Deaf Resource Centers**

Information, advocacy, interpreter referrals and family training for the deaf and hard of hearing are provided via the Southern Center for Independent Living and the Nevada Association of the Deaf. The number of new clients is rapidly expanding annually. In 1999, 71 persons were served, 257 in 2000, and 528 in 2001—a 205% increase in one year alone. The average per-person cost of service is \$208. This per-person cost has dropped precipitously as the number of clients served has increased. Statewide funding for the program has been \$110,000 annually since its inception. The program was able to serve all those seeking services; the program’s capacity is limited only by staff’s ability to manage their workload.

There are currently no persons awaiting an eligibility determination which takes 2 days, and no waiting lists for service. On the average it takes 4 days for service to begin and 1-3 months for service to be completed.

Based on an ideal current funding level of \$110,000 annually and 3.2% annual inflation for the cost of administration, the program costs for the next biennia are:

FY 2004-05	\$241,100
FY 2006-07	\$256,800
FY 2008-09	\$273,500
FY 2010-11	\$291,300
FY 2012-13	\$310,200

**G. Nevada Supportive Housing**

OCBS in cooperation with the Nevada Housing Authority, the federal department of Housing and Urban Development (HUD) and Fannie Mae, provides seed funding for the development of accessible, affordable apartments and access to 24-hour, shared supportive services in Las Vegas, Reno and Carson City. Currently there are four apartment buildings in the state and four to five more in the various stages of planning. Accessible Space, Inc. (ASI), a national company, is the Nevada provider. The current funding package was developed in 1996; however, the program’s inception was in 1991 when OCBS coordinated the various roles of all the funding players. This service model has been successful as it allows people who need intermittent or overnight care to live in their own apartment in the community rather than a nursing facility. It also allows flexibility, independence and security since staff are available on an as-needed basis rather than in scheduled blocks of time. Since the inception of the Nevada Supportive Housing program in 1991, OCBS has provided a total of \$497,850 in funds that has been leveraged into \$28 million, or a 56:1 return on investment.

In 1998 ASI provided housing for 10 new applicants, 36 in 1999 (a 25-unit building was opened), 12 in 2000, and 6 applicants in 2001. The average cost to provide services to the new residents is:

1998	\$89.94 per-person/day
1999	\$91.44 per-person/day
2000	\$91.44 per-person/day
2001	\$102.62 per-person/day

Each resident pays 33% of their income towards the shelter cost. Additionally, shelter costs are paid by 20-year guaranteed rent subsidies from HUD (guarantees made by HUD when apartment units are built). The above figures are the Medicaid daily rate paid on the resident's behalf under the Physical Disabilities Waiver for services only (not shelter).

The program capacity is and has been 94 persons since 1999; however, there are 4 new complexes which have received approval from HUD and will be brought on line as follows: 24 units in Las Vegas in September 2002; 24 units in Reno in June 2003; 22 new units in December 2003 in Henderson; and 19 new units in June 2004 in Las Vegas. Buildings run about a 4% vacancy rate due to resident turnover. Currently ASI is serving 56 people paid by Medicaid at an average cost of \$100.26/day. The total cost depends on the number of people receiving services and the level of care authorized.

There is a current waiting list of 148 people with disabilities. Historically there were 110 people waiting for service in 1998, 95 in 1999, 130 in 2000, and 152 persons waiting in 2001. People are on the housing waiting list for approximately 12-18 months. Because clients are free to choose any provider for supportive services, not all residents choose ASI services; however, if new residents are on Nevada Medicaid there is generally not a wait for ASI's supportive services as they can be arranged while the housing application is being processed.

#### **H. Nevada Community Enrichment Program (NCEP)**

NCEP is a post-acute, non-profit, accredited neurorehabilitation program which offers 1) comprehensive day treatment and 2) residential living to people who have sustained a traumatic brain injury or suffered a neurological impairment, e.g., stroke, aneurysm, tumor, etc. NCEP serves both adolescents and adults by providing varied services (approximately 34 in number), e.g., daily life activities, family education/support, medical management, vocational rehabilitation, etc. NCEP is committed to successfully transitioning people who have sustained a brain injury or malady to community and home re-integration. NCEP receives a grant from the Office of Community Based Services to fund a program which serves a ratio of private-pays, Medicaid pays and those who pay zero for their cost of care. The profits made from the first two categories of clients in essence cover the cost of the population that receives services at no cost.

From 1999-2001, NCEP averaged 69 new enrollees each year of which 1/3 is residential and 2/3 is day treatment enrollees. The average cost to serve a residential client on an annual basis is \$58,590, and \$29,040 for day treatment. NCEP has the capacity to serve 24-28 persons per/day in day treatment---of those, 8 can receive residential treatment services. NCEP staff report there is never a waiting list for a private-pay and Medicaid patients and generally a few slots may be kept open for them should they be needed. Private-pays/Medicaid patients receive services within 3-7 days. There is however a waiting list for the un- or underinsured, that being 34 persons presently. People without funding can remain on a waiting list for 9-18 months depending on the case mix of clients in the NCEP program. Roughly 48 persons are not admitted to the program annually. It is important to note that of the 48 people, 87% choose not to be waitlisted or are lost during the wait list period to institutionalization, move out of state to find more timely service or be nearer to family, or

are simply lost altogether and become untraceable. The staff report most of these people go without services altogether.

The following projections are based on a 4% increase in program costs annually and no increase in the average number of persons served.

<u>Residential Services</u>		<u>Day Treatment</u>	
FY03	\$1,401,459	FY03	\$1,389,246
FY04	\$1,457,510	FY04	\$1,444,814
FY05	\$1,515,815	FY05	\$1,502,636
FY06	\$1,576,466	FY06	\$1,562,712
FY07	\$1,639,509	FY07	\$1,625,226

**I. Consumer Leadership Development**

Consumer leadership opportunities is a collaborative effort between the Nevada Governor’s Council on Developmental Disabilities and the Office of Community Based Services, with financial support from the Independent Living and Assistive Technology programs, to fund the cost of training for people with disabilities and their families. Community Chest, Inc., a non-profit agency, is provided a grant by OCBS to facilitate the trainings. The trainings educate the person with the disability and/or his family to advocate for the disability, and frequently become active in policy and decision-making. By developing knowledgeable leaders, the disability community can become less reliant on (usually non-disabled) policymakers to drive systems change issues. Typically those trained will go on to sit on local and state boards affecting the disabled. Some have been instrumental in helping to establish new programs. One person founded a non-profit organization in Las Vegas called Families for Effective Autism Treatment (FEAT) after receiving training from the leadership grant.

During the past three years, the Consumer Leadership Development Grant provided a total of \$113,182 to fund leadership training opportunities to 445 people at an average cost of \$254 per person. The grant has also brought nationally recognized leaders to Nevada to work on issues like the Americans with Disabilities Act and the Olmstead Supreme Court decision.

No waiting list exists for the program; however, those seeking training are asked to request funding from other sources as well and participate themselves if able to do so.

**J. Issues/Trends/Innovations as Reported by the Agency**

OCBS is the only personal assistance resource for those above Medicaid income eligibility excepting seniors. The In-Home Personal Assistance program has languished for years without funding increases or consideration of the waiting list. Historically, a client has been as likely to die as to be served while on the waiting list for this service although Congress has declared personal assistance to be the number one service utilized by people with disabilities to avoid institutionalization.

The Office of Community Based Services is one of the few public resources available to help families with home and vehicle modifications through its Independent Living Services

## **Nevada Strategic Plan for People with Disabilities**

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program. The need for this assistance is substantial. Additionally, there is an increasing demand for intervention therapy training for families with children who have severe autism. Training to prepare a family to be their child's therapist costs \$3,000-\$5,000. With the training and 40 hours of therapy weekly, the effects of autism can be reversed in 3-6 years and most families are willing to commit to providing the in-home therapy because of the dramatic changes it can yield.

The state agency and its subcontractors have implemented a number of automation processes which have 1) enabled client services to be more efficiently provided, 2) automated communication between the state agency and service provider, and 3) enabled the state staff to provide improved case management.

Presently the Assistive Technology Loan Program is well funded through Tobacco Settlement resources to provide collateral for loans to people with disabilities; however, the program needs to be marketed so more people are aware of its existence. The only funding needed in the foreseeable future is for case management costs.

In the typical advocacy service scenario, a deaf client seeks assistance with a particular issue, assistance is provided and the case is closed. The process of closing a completed case proved confusing and sometimes upsetting to deaf individuals. Hence, the Deaf Resource Centers developed a process whereby completed cases are put into "inactive" status. This allows the program to track case successes and give the client peace of mind knowing their program association has not been discontinued. Additionally, there is a large gap in understanding between the deaf and hearing communities. Deaf culture is sometimes as different from mainstream American culture as any foreign culture. This is difficult for hearing persons/institutions to comprehend when the "only" apparent difference is the sense of hearing. There is also the misconception American Sign Language (ASL) is English put into signs. The construction of ASL is different than any other language and is subtle and complex. It requires a highly skilled interpreter to properly translate in most situations. The program described here helps to build practical and educational bridges between the deaf and hearing communities.

The Nevada Supportive Housing service model is a win-win for the person served, the state, and the provider. People with the most severe disabilities may be served in a least restrictive environment and help support themselves, the state can utilize Medicaid funds to support a portion of the individual's shelter cost, and the provider can continue to build additional apartment buildings as needed. Changes made in the Medicaid state plan in 2001 expanded personal care service options for people with disabilities. Service authorizations are now based on an individual functional assessment. The impact of this change was particularly beneficial to southern Nevada as authorization for services had previously been based on a dollar cap versus individual need. The expansion of the Physical Disabilities Waiver and the addition of the assisted living service package have increased the number of residents eligible for supportive living services. ASI currently provides waiver funded assisted living services to 9 residents. This is an ideal funding option for the type of services ASI provides because many of the residents need supportive services that go beyond the scope of Medicaid's personal assisted living services. For individuals with cognitive impairments, assisted living

services allow staff to assist with household chores, money management, community orientation, and other tasks essential to the success of an independent living situation. The per diem rate is also designed to accommodate the need for 24-hour staffing and a site supervisor. The addition of assisted living services as a Medicaid state plan service would expand the available service options not only for ASI residents, but other people with disabilities as well.

Another hope for the future is that Medicaid will develop a waiver for the traumatic brain injured thereby enabling Nevada Community Enrichment Program (NCEP) to serve more people with coverage and reduce the waiting list for service. OCBS provider, NCEP, reports if a brain-injured person receives rehabilitation and returns to work, s/he can become ineligible for Supplemental Security Income (SSI) even though the person is still living with the consequences of their injury. Further, without SSI benefits, the individual no longer qualifies for Medicaid and the provider (NCEP) does not get paid. In 2001, NCEP provided nearly \$500,000 in care to Medicaid pending individuals who were ultimately found to be ineligible for the program. In the case of a homeless person who is institutionalized, that person is denied rehabilitation by Medicaid for lack of a viable discharge site with another responsible adult in the home. Treatment should be available for the homeless regardless of their living status, and to rectify the matter, the rehabilitation provider should be responsible for where a homeless person should be placed when rehab is completed. NCEP believes the school districts are not addressing the numbers of traumatic brain injured youth attending schools. For example, Clark County has 98 identified students with brain injuries, yet the brain-injured classroom at Bonanza High School was recently closed. Teachers need special skills to teach these students, and the demographics indicate there are a sufficient number of these children. The state's school districts should provide adequate education/services for this population.

## ***MENTAL HEALTH AND DEVELOPMENTAL SERVICES***

The Division of Mental Health and Developmental Services, a division of the Nevada Department of Human Resources, provided services to 25,494<sup>21</sup> Nevadans with mental illness and developmental disabilities in FY02. Eighty-eight percent of the division's population receives mental health services and the remaining 12% receives services for developmental disabilities. The division's mission is to work in partnership with consumers, families, advocacy groups, agencies and diverse communities to provide person-centered services in the least restrictive, most inclusive environment. The services provided maximize each individual's degree of independence, functioning, satisfaction, and self-sufficiency while ensuring individual rights.

MHDS employs 1,155 employees and has a FY02-03 biennial budget of nearly \$278 million. Fifty-two percent of the biennial budget is expended on people with mental illness and 46% on those with developmental disabilities (2% is spent on administration).<sup>22</sup>

### *Mental Health Overview*

Four entities deliver mental health care in the state. Northern Nevada Adult Mental Health Services (NNAMHS), located in the Reno area, has an inpatient psychiatric hospital and provides a variety of outpatient community-based services. The same campus also houses the Lake's Crossing Center, Nevada's facility for mentally disordered criminal offenders. Southern Nevada Adult Mental Health Services (SNAMHS) is located in Las Vegas and has a psychiatric inpatient unit plus outpatient community-based services provided in four community mental health centers. Rural Clinics is responsible for operating a network of 16 community mental health centers in the remainder of the state.

While MHDS provides mental health services to adults, the Division of Child and Family Services, Department of Human Resources, provides mental health services to children residing in Clark and Washoe counties. Children in the remaining areas of the state receive their mental health services from MHDS' system of rural clinics. MHDS provides services to all children who are developmentally delayed.

A full range of community-based services for adults with mental health issues is provided by MHDS. Community-based services include an array of "residential services" as well. The community-based services can be categorized as follows: 1) Medication Clinics, 2) Outpatient Counseling, 3) Program for Assertive Community Treatment (PACT), 4) Psychiatric Emergency Services (PES), 5) Psychosocial Rehabilitation, 6) Personal Service Coordination (case management), 7) Intensive Case Management (southern Nevada only) and 8) Residential Services, which encompasses group homes, supported living arrangements, transitional housing, and residential treatment programs. The aforementioned residential services are all considered non-institutional placements.

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<sup>21</sup> MHDS Program Evaluation Staff August 2002.

<sup>22</sup> MHDS Briefing Document July 27, 2001.

Inpatient services are provided in Clark and Washoe counties at the Southern Nevada Adult Mental Health Services and Northern Nevada Adult Mental Health Services psychiatric hospitals.

### *Developmental Services Overview*

Three regional centers provide services for children and adults with developmental disabilities throughout Nevada. In the Las Vegas area, Desert Regional Center (DRC) offers community services in its main office and 3 branch offices in Henderson, Pahrump and North Las Vegas. In the Reno area, Sierra Regional Center (SRC) provides community services. The Rural Regional Center (RRC), located in Carson City with satellite offices in Elko, Fallon and Winnemucca, offers community services for the rural Nevada counties. The agency's community-based services can be categorized into four areas: 1) service coordination, 2) family support services, 3) job and day training, and 4) residential support (*not considered institutional placement*).

Nevada's inpatient (institutional) services for people with developmental disabilities are provided at two intermediate care facilities for the mentally retarded (ICFs/MR), both state-run facilities. The Desert Developmental Center is located on the DRC campus near the main office in Las Vegas and the Sierra Developmental Center is located on the SRC campus in Reno.

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Both Mental Health and Developmental Services have the goal of serving their clients in community-based living environments (and providing supportive/preventive services for same) to reduce the need for state institutions and congregate living facilities.

For purposes of this document, Mental Health and Developmental Services will be discussed separately below. And, within the context of each, there will be discussion of "community-based" services, and "institutional or inpatient" services. Community services are supportive services provided to persons residing in either their own home or another residential living arrangement commensurate with their level of independence. Institutional residents may also receive some of the enumerated community services. There are a variety of residential settings to accommodate the least restrictive environment for mentally ill or developmentally delayed Nevadans. Inpatient services are provided to those individuals who are severely mentally ill and considered a danger to themselves or others, or those having profound developmental needs.

### **A. Mental Health Services Profiled**

The Center for Mental Health Services estimates 7.2% of the population in Nevada will suffer from a severe mental illness during their life.<sup>23</sup> More recently, a study ranked Nevada as the number one state in the Western United States for prevalence of mental illness, estimating as much as 23.7% of the population in Nevada will have some form of

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<sup>23</sup> Estimation of the 12-month Prevalence of Serious Mental Illness, CMHS Draft, Kessler, et al. 1997.

diagnosable mental disorder during their life.<sup>24</sup> It also estimated approximately 1.8% of Nevadans are currently dysfunctional because of serious mental illness.<sup>25</sup>

Per the division’s *FY00 Biennial Report*, there is an equal split between male and female individuals served. Around 72% of the clients served in southern and rural Nevada are between 21 and 44 years of age. MHDS only serves children at its Rural Clinics, where they comprise 26% of the client base. Approximately one-third of the clients have never married, and more than one-third are unemployed and not looking for work.

**Table 48  
Mental Health  
Nevadans Served FY 1999 - FY2002**

FY1999	% of Dec.	FY2000	% of Inc.	FY2001	% of Inc.	FY 2002	% of Inc.
18,523	-8.71%	19,456	5.04%	20,575	5.75%	22,341	8.58%

Source: FY00 MHDS Biennial Report and MH Program Evaluation Manager on 8/27/02 and 9/12/02

US Census Bureau, Census 2000, figures indicate the disability rate among Nevadans has increased in the past decade from 13% of the population in 1990 to 20% in 2000, and the 20% rate of disability is higher than the national average of 18.8%.<sup>26</sup>

To serve the growing mental health needs of residents in the Silver State, the following “community-based” and “institutional” services are offered:

*1. Community-Based Services*

- a. Medication Clinics: The division’s medication services are provided by a physician or advanced practice nurse with prescriptive privileges to evaluate, prescribe and monitor medications for the treatment of psychiatric disorders. Services may also include pharmaceutical counseling and education provided by a pharmacist. Since medication forms a foundation to treat most mental illnesses, the medication clinics are the division’s largest treatment service.

The tables below show 1) the numbers of people provided medication clinic services in fiscal years 2000-2002 and the historical waiting lists for same, and 2) the service cost and projected population for medication clinic services.

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<sup>24</sup> Needs Assessment in the West: a Report on a Workshop and Subsequent Analysis (WSDSG, 1998).

<sup>25</sup> Ibid.

<sup>26</sup> University of California, San Francisco Nevada Demographic Report, July 2002.

**Table 49  
Mental Health  
Community-Based Services**

Medication Clinics	FY2000		FY2001		FY2002	
	Avg	Avg Mo	Avg	Avg Mo	Avg	Avg Mo
	Served	Wait List	Served	Wait List	Served	Wait List
Southern Nevada	4,380	0	4,804	0	5,462	217
Northern Nevada	1,289	130	1,491	82	1,698	56
Rural Nevada	1,297	53	1,235	66	1,316	68

Source: MHDS CLEO Reports dated 8-22-02.

Table 49 illustrates a 22% increase in the average number served in FY 2002 over FY 2000 at the medication clinics and an 86% growth in the average wait list for medication clinic services.

**Table 50  
Mental Health  
Service Cost & Projected Population**

Medication Clinics	Avg. Mo. Cost Per/Person*	Average Monthly Population		
		FY03	FY04	FY05
Southern Nevada	\$168	5,714	6,125	6,537
Northern Nevada	\$208	1,542	1,882	2,012
Rural Nevada	\$88	1,462	1,533	1,605

Source: CLEO 8/16/02

\*Average monthly cost per person is based on May/June 2002 only.

- b. Outpatient Counseling: Outpatient counseling services provided to individuals include diagnosis and evaluation, counseling, psychotherapy, and behavioral management. These programs focus on developing insight, producing cognitive and/or behavioral change, improving decision-making, and reducing stress. Specialized services are provided to families and couples to facilitate communication between patients and family members. Group counseling sessions include activity therapy as well as psychotherapy to help guide patients through interpersonal conflict and improve positive communication.

Tables 51 and 52 show 1) the numbers of people provided outpatient counseling for fiscal years 2000-2002 and the historical waiting lists for same, and 2) the service cost and projected population for outpatient counseling services.

**Table 51  
Mental Health  
Community-Based Services**

Outpatient Counseling	FY2000		FY2001		FY2002	
	Avg	Avg Mo	Avg	Avg Mo	Avg	Avg Mo
	Served	Wait List	Served	Wait List	Served	Wait List
Southern Nevada	791	28	953	5	1,030	16
Northern Nevada	275	36	366	13	388	38
Rural Nevada	2,869	218	2,915	180	2,912	176

Table 52 illustrates the high numbers of people receiving outpatient counseling services in rural Nevada. Outpatient counseling is the foundation program for rural clients and accounted for 73% of all the statewide outpatient counseling cases in FY00.<sup>27</sup> Though the numbers of persons needing the service has grown in the past three years, the statewide average wait list has shown a decline of 23% FY 2002 over FY 2000.

**Table 52  
Mental Health  
Service Cost & Projected Population**

Outpatient Counseling	Avg.Mo.Cost Per/Person*	Average Monthly Population		
		FY03	FY04	FY05
Southern Nevada	\$26	1,058	1,127	1,197
Northern Nevada	\$66	399	426	453
Rural Nevada	\$118	3,284	3,438	3,592

Source: CLEO 8/16/02 \*Average monthly cost per person is based on May/June 2002 only.

- c. Program for Assertive Community Treatment (PACT): This program provides intensive community-based treatment and rehabilitation services to clients with serious mental illness by using a multidisciplinary mental health team to provide services. PACT's goal is to reduce debilitating symptoms and minimize or prevent recurrent acute episodes of illness. Continuous rather than time-limited service and interventions tailored to each consumer characterize this program. Nationally, the PACT model has shown participants to have longer and more productive community tenure and be better able to manage their impairment upon discharge from the program. PACT was initiated at SNAMHS in 1998 and NNAMHS in 1999. PACT services are unavailable in rural Nevada.

Tables 53 and 54 below show 1) the numbers of people provided PACT services in fiscal years 2000-2002 and the historical waiting lists for same, and 2) the service cost and projected populations for PACT services.

**Table 53  
Mental Health  
Community-Based Services**

PACT	FY2000		FY2001		FY2002	
	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List
	Southern Nevada	69	6	69	3	68
Northern Nevada	46	0	39	0	45	0

Source: MHDS CLEO reports dated 8/22/02

<sup>27</sup> MHDS FY00 Biennial Report, pg. 22.

The average monthly wait list for PACT services in northern Nevada is non-existent.

**Table 54**  
**Mental Health**  
**Service Cost & Projected Population**

PACT	Avg.Mo.Cost Per/Person*	Average Monthly Population		
		FY03	FY04	FY05
Southern Nevada	\$727	72	72	72
Northern Nevada	\$830	72	72	72

Source: CLEO 8/16/02

\*Average monthly cost per person is based on May/June 2002 only.

- d. **Psychiatric Emergency Services (PES):** Psychiatric emergency services, within a 72-hour period, allow clients in crisis to be stabilized and avoid admission to a hospital. The positive effect of this program is shown by the fact approximately 83% of the clients provided PES are stabilized and avoid acute care hospitalization.<sup>28</sup> PES consists of services in either the *Ambulatory Unit* or the *Observation Unit*. The Ambulatory Unit provides crisis assessment and intervention services. The Observation Unit provides services for people requiring extended stays. PES services are unavailable in rural Nevada.

The tables below show the numbers of people provided Psychiatric Ambulatory Services (PAS) and Psychiatric Observation Unit (POU) services in fiscal years 2000-2002 and the historical waiting lists for same. NNAMHS' psychiatric emergency services was implemented in January 2000.

**Table 55**  
**Mental Health**  
**Community-Based Services**

Psychiatric Ambulatory Services (PAS)	FY2000		FY2001		FY2002	
	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List
	Southern Nevada	579	0	603	0	659
Northern Nevada	n/a	n/a	164	0	193	0

Source: MHDS CLEO reports dated 8/22/02

**Table 56**  
**Mental Health**  
**Community-Based Services**

Psychiatric Observation Unit (POU)	FY2000		FY2001		FY2002	
	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List
	Southern Nevada	230	74	238	80	234
Northern Nevada	n/a	n/a	117	0	110	0

Source: MHDS CLEO reports dated 8/22/02

<sup>28</sup> SNAMHS experience for July/August 2002.

PAS services show a marked growth of 47% FY02 over FY00. Likewise, POU shows an increase in services of 49% FY02 over FY00. There are no wait lists for PAS; however, a wait list does occur for POU in Las Vegas and it continues to grow. To better serve the increased demand for services, the number of beds in the POU was increased to 20 in May 2002.

Tables 57 and 58 show the average monthly costs per person for northern and southern Nevada for PAS and POU services.

**Table 57  
Mental Health  
Service Cost & Projected Population**

<b>Psychiatric Amb Services (PAS)</b>	<b>Avg.Mo.Cost Per/Person*</b>	<b>Average Monthly Population</b>		
		<b>FY03</b>	<b>FY04</b>	<b>FY05</b>
Southern Nevada	\$73	783	872	961
Northern Nevada	\$28	175	189	201

Source: CLEO 8/16/02  
\*Average monthly cost per person is based on May/June 2002 only.

**Table 58  
Mental Health  
Service Cost & Projected Population**

<b>Psychiatric Observation Unit</b>	<b>Avg.Mo.Cost Per/Person*</b>	<b>Average Monthly Population</b>		
		<b>FY03</b>	<b>FY04</b>	<b>FY05</b>
Southern Nevada	\$441	317	357	396
Northern Nevada	\$40	113	113	113

Source: CLEO 8/16/02  
\*Average monthly cost per person is based on May/June 2002 only.

- e. Psychosocial Rehabilitation: Psychosocial rehabilitation is targeted to clients in need of an active treatment environment to foster their independence in the community. The goal is to maximize an individual's level of functioning in the community and to prevent acute inpatient care. Services provide consumers with education and training related to employment, social relationships, living situations, leisure, lifestyle and wellness. The outcomes for psychosocial rehabilitation are to teach and reinforce functional, adaptive, independent living, social and vocational skills with an emphasis on preparing for/maintaining employment or other productive activities.

The tables below show 1) the numbers of people provided Psychosocial Rehabilitation services in fiscal years 2000-2002 and the historical waiting lists for same, and 2) the service cost and projected population for psychosocial rehabilitation.

**Table 59**  
**Mental Health**  
**Community-Based Services**

Psychosocial Rehabilitation	FY2000		FY2001		FY2002	
	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List
	Southern Nevada	101	72	95	52	126
Northern Nevada	136	n/a	158	1.5	237	4
Rural Nevada	114	0	95	0	88	0

Source: MHDS CLEO reports dated 8/22/02

Table 59 shows a 28% increase in the average served in FY02 over FY00, and a 31% decrease in the average total wait list for the same period.

**Table 60**  
**Mental Health**  
**Service Cost & Projected Population**

Psychosocial Rehabilitation	Avg. Mo. Cost Per/Person*	Average Monthly Population		
		FY03	FY04	FY05
Southern Nevada	\$178	130	130	130
Northern Nevada	\$106	278	336	393
Rural Nevada	\$391	139	154	169

Source: CLEO 8/16/02

\*\*Average monthly cost per person is based on May/June 2002 only.

- f. Personal Service Coordination (Case Management): Personal service coordinators organize treatment and assist individuals in accessing services and choosing service opportunities based on a treatment plan developed with the client. They assure clients access financial, housing, medical, employment, social, transportation, crisis intervention, public assistance and other essential community resources. Personal service coordinators also help mobilize family, community, and self-help groups on the client's behalf. They provide direct treatment to clients when none is available through referrals or community agencies. Case management services are provided statewide and the figures below do not include the personal service coordination provided by Mojave Mental Health, a university-affiliated provider paid directly by Medicaid.

The tables below show 1) the numbers of people provided personal service coordination services in fiscal years 2000-2002 and the historical waiting lists for same, and 2) the service cost and projected population.

**Table 61**  
**Mental Health**  
**Community-Based Services**

Personal Service Coordination (case management)	FY2000		FY2001		FY2002	
	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List
	Southern Nevada	549	89	565	83	489
Northern Nevada	624	10	568	4	571	3
Rural Nevada	1,254	0	1,273	0	581	9

Source: MHDS CLEO reports dated 8/22/02

Although it appears there is a 32% decrease in the average number of case-managed in FY02 over FY00, a closer study reveals the drop is attributable to significant number of cases being closed in rural Nevada between FY01 and FY02. For that same period of time, rural Nevada experienced a 54% drop in the average of personal service coordination cases.

**Table 62**  
**Mental Health**  
**Service Cost & Projected Population**

Personal Service Coordination	Avg. Mo. Cost Per/Person*	Average Monthly Population		
		FY03	FY04	FY05
Southern Nevada	\$184	630	630	630
Northern Nevada	\$179	630	630	630
Rural Nevada	\$223	491	506	522

Source: CLEO 8/16/02

\*Average monthly cost per person is based on May/June 2002 only.

- g. Intensive Service Coordination: Intensive service coordination provides increased and accelerated care for clients in southern Nevada who are severely mentally ill and are felons. It provides services for those clients having difficulty adjusting to a community placement and needing short-term structured assistance with case management and residential services prior to reintegration. Intensive service coordination includes the traditional case management services and residential services, but the services are provided on a more frequent and structured basis to ward off unnecessary institutionalization. Additionally, traditional case management services such as medication management, financial management and residential services are provided on a more intense basis as well. The program began in southern Nevada in December 1997 and more than quadrupled, growing from 11 initial clients to 50 at the end of FY00.<sup>29</sup>

<sup>29</sup> MHDS FY00 Biennial Report, pg. 20.

Tables 63 and 64 show 1) the numbers of people provided Intensive Case Management services in fiscal years 2000-2002 and the historical waiting lists for same, and 2) the service cost and projected population.

**Table 63  
Mental Health  
Community-Based Services**

Intensive Service Coordination (case management)	FY2000		FY2001		FY2002	
	Avg	Avg Mo	Avg	Avg Mo	Avg	Avg Mo
	Served	Wait List	Served	Wait List	Served	Wait List
Southern Nevada	47	0	46	0	47	12

Source: MHDS CLEO reports dated 8/22/02.

Table 63 indicates this service incurred its first wait lists in FY02.

**Table 64  
Mental Health  
Service Cost & Projected Population**

Intensive Service Coordination	Avg. Mo. Cost Per/Person*	Average Monthly Population		
		FY03	FY04	FY05
Southern Nevada	\$362	60	60	60

Source: CLEO 8/16/02

\*Average monthly cost per person is based on May/June 2002 only.

- h. Residential Services: The following is a list/description of the various residential services provided for persons with mental illness:

*Group Homes aka Adult Group Care Facilities (AGCF):*

These are group residential programs for clients who do not require specialized intensive services. Group homes are located in the community and operated by independent contractors. They provide 24-hour staff providing supervision and training in cooking, cleaning, etc., and individuals usually share a room. It should be noted there is a national trend to decrease the number of congregate living arrangements and increase the opportunity for people to live in their own apartments or individualized living arrangements.

*Supported Living Arrangement (SLA):*

These are apartments or homes for clients who require training and support in daily living. Trainers come to the residence to teach living skills and provide support. One program in this category is Shelter Plus Care (SPC), a federally funded program to help disabled homeless mentally ill people and their families find shelter and subsequently get treatment. Apartments rented through SPC must meet HUD standards.

*Residential Treatment Program (RTP):*

The Residential Treatment Program is available in Clark and Washoe counties. Residential Treatment Programs provide 24-hour staff and individual and group training to teach community living skills. RTPs provide treatment and psychosocial

rehabilitation for patients having difficulty adjusting in a community placement and needing a short-term, structured setting prior to reintegration. As an alternative to hospitalization, the program focuses on increased living skills and reduced hospitalization for those who are frequent users of inpatient care.

*Intensive Supported Living Arrangements:*

These are services that provide intensive support and/or skills training for residents with specialized service needs.

*Respite Care:*

Respite care is provided to clients in community outpatient services. The person must be in crisis but ineligible for hospitalization and need an alternate current living situation for a short time (not to exceed five days).

The tables below show 1) the numbers of people provided residential services in fiscal years 2000-2002 and the historical waiting lists for same, and 2) the service costs and projected populations.

**Table 65**  
**Mental Health**  
**Community-Based Services**

Residential Programs	FY2000		FY2001		FY2002	
	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List	Avg Served	Avg Mo Wait List
	Southern Nevada	413	44	486	103	600
Northern Nevada	152	3	154	4	152	17
Rural Nevada	29	0	39	0	38	5

Source: MHDS CLEO reports dated 8/22/02

In FY02 there was a 33% increase in the numbers of persons receiving residential program assistance over FY00. For the same period of time there was an overall decrease of 31% in the wait list comparing FY02 to FY00.

**Table 66**  
**Mental Health**  
**Service Cost & Projected Population**

Residential Programs	Avg. Mo. Cost Per/Person*	Average Monthly Population		
		FY03	FY04	FY05
Southern Nevada	\$796	678	769	860
Northern Nevada	\$932	161	165	168
Rural Nevada	\$648	58	68	78

Source: CLEO 8/16/02

\*Average monthly cost per person is based on May/June 2002 only.

2. *Institutional Care*

The Dini-Townsend Hospital, part of the Northern Nevada Adult Mental Health Services campus, is staffed for 50 beds (40 inpatient care and 10 observation beds), but is licensed

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for 90 beds (80 inpatient and 10 observation) in northern Nevada. In Clark County, the inpatient hospital is part of Southern Nevada Adult Mental Health Services campus and has 88 beds (68 for inpatient care and 20 observation beds), but is licensed for 103 beds (77 inpatient and 26 observation).

Inpatient care is designed to serve severely mentally ill (SMI) patients who are experiencing an acute phase of their illness. Primary services are oriented toward developing a differential diagnosis, treatment plans to more fully respond to the patient's acute needs, and stabilizing their psychiatric condition. The inpatient stay may be short or long-term. Both facilities focus on consumer recovery and stabilization.

Tables 67 and 68 show 1) the numbers of people provided inpatient care (does not include the Lakes Crossing facility) in fiscal years 2000-2002 and the historical waiting lists for same, and the service cost and projected population.

**Table 67  
Mental Health  
Community-Based Services**

Inpatient (institutional care)	FY2000		FY2001		FY2002	
	Avg	Avg Mo	Avg	Avg Mo	Avg	Avg Mo
	Served	Wait List	Served	Wait List	Served	Wait List
Southern Nevada	67	9	68	7	72	3
Northern Nevada	47	0	39	0	35	0

Source: MHDS CLEO reports dated 8/22/02

The wait list for southern Nevada shown in Table 67 requires further explanation. SNAMHS staff report there are two distinct waiting lists. The first wait list is for the psychiatric observation unit (POU) for persons waiting in hospital emergency rooms or general beds. The second wait list is for those patients in POU who have exceeded their 72-hour stay and await a bed in the SNAMHS inpatient unit, but can't be moved because there are no available beds. However, there continues to be a need for more staff to serve at the licensed capacity, more residential support services, additional intensive service coordinators, more PACT services, and a mobile crisis unit to address the incredible need for such services in southern Nevada.

**Table 68  
Mental Health  
Service Cost & Projected Population**

Inpatient (institutional care)	Avg.Mo.Cost Per/Person*	Average Monthly Population		
		FY03	FY04	FY05
Southern Nevada	\$8,657	65	68	68
Northern Nevada	\$7,122	40	40	40

Source: CLEO 8/16/02

\*Average monthly cost per person is based on May/June 2002 only.

In an April 17, 2002 presentation before the Legislative Sub-committee to Study the State Program for Providing Services to Persons with Disabilities, MHDS staff reported Nevada currently rank 35<sup>th</sup> in actual dollars and per capita expenditures per

the national Association of State Mental Health Program Directors 1999 Survey. That same survey ranked Nevada 47<sup>th</sup> when it comes to the state per capita expenditures for state hospitals. This low ranking reveals Nevada is placing more emphasis and resources on community-based services. Nevada ranks 20<sup>th</sup> in expenditures for community-based programs per the same survey.

3. *Issues/Trends/Innovations as Reported by the Agency*

*Training:* Currently the division relies on an existing staff member who devotes a very small amount of time to training issues. MHDS does not have a statewide training coordinator, nor adequate funds to coordinate training and ensure those needing training get it.

*Accreditation:* There are two primary national accreditation agencies: 1) the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which focuses on inpatient and community mental health agencies, and 2) the Council on Accreditation of Rehabilitation Facilities (CARF), which focuses on rural and forensic facilities. NNAMHS is currently JCAHO accredited and SNAMHS is requesting JCAHO accreditation in July 2003. Rural Clinics will request JACHO or CARF accreditation by July 2006. It is the goal of the MHDS to have all agencies accredited by national accrediting organizations.

*Management of Information:* MHDS has no statewide management information system to electronically transmit medical records, integrate pharmacy services into the medical record and connect staff to the Public Health Alert Network. A Technology Investment Request (TRI) has been submitted to request funds to upgrade the current non-HIPAA compliant Legacy Information System to a Creative Socio-medics Corporation Suite of Avatar applications for patient management, pharmacy and electronic medical records. This new information system would be centralized and all agencies would be connected to a statewide database.

*Consumer Service Assistance:* MHDS is interested in hiring consumers to assist clients as part of the “transitional” mental health services offered. “Consumer service assistants” are consumers or families of consumers hired in state-funded positions. Consumer service assistants perform advocacy and service improvement activities on behalf of the clients in mental health service agencies. Additionally, they provide peer support to clients and basic clarification of agency processes.

*Homeless Program Coordination:* Currently there are insufficient funds and staff to augment programs and provide outreach for those persons who are homeless and have a mental illness. There is a need for additional outreach and an even more critical need for expanding community-based mental health services to account for increased growth in the general population of people who are homeless and suffer from mental illness.

*More Community-Based Health Services:* Although MHDS continues to focus on expanding community-based services there continues to be a need in this area for adults and children who have a serious mental illness (including a co-occurring disorder).

*Senior Mental Health Outreach Services:* Specialized gerontological mental health care has been available to seniors age 60 and over through a grant from the Division for Aging Services. To impact the highest rate of suicide among seniors in the United States and the debilitating effects of serious mental illness among older Nevadans, geriatric mental health specialists conduct comprehensive evaluations, provide counseling, service coordination, and referral services. Major goals of the Senior Mental Health Program are to maximize the ability of older adults to remain independent as long as possible. As the aging population continues to grow, senior mental health services will be an ongoing need.

\* \* \* \*

Mental Health is like any other state government entity in that state population growth, hard economic times and internal staff vacancy and turnover rates impact the quality of services provided. The changes in population composition, increased health care costs, and the need for improved technology continue to be challenges for the future.

## **B. Developmental Services Profiled**

MHDS provides developmental services to people with mental retardation and conditions related to mental retardation. Per the division's *FY00 Biennial Report*, 57% of the recipients are male and 43% female. The people receiving services consist of 25% children (aged 0-17), and 75% adults (aged 18+). Clients are more likely to be in the age group from 21-34 years old (36%). The elderly comprise 3% of the service population age 55 or older. The division provided residential supports to a total of 1,236 people in 2002, of which 89% received non-institutional residential care.<sup>30</sup>

The number of people living in large state institutional care has been stable over several years. This is due in large part to the growth in 1) private intermediate care facilities for the mentally retarded (ICFs/MR) which are community residences with up to 6 residents (*not considered institutional care*), 2) supported living arrangements (SLAs) which provide individualized services in homes/apartments to nearly 80% of the population,<sup>31</sup> and 3) group homes and developmental homes with 4-6 residents. Per MHDS data there has been a 137% increase in community supports (513 to 1,216 people served) between 1996 and the planned FY03 budget year.<sup>32</sup> For that same period, there has been a 22% decrease in institutional beds (172 to 134).<sup>33</sup> In terms of expenditures, there has been a 277% increase in community-based funding between 1996 and 2003 (\$11,644,110 to \$43,890,123).<sup>34</sup>

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<sup>30</sup> Nevada Developmental Services Baseline Report, August 22, 2002.

<sup>31</sup> MHDS Agency Briefing dated July 2001.

<sup>32</sup> Nevada Developmental Services Institutional and Community Residential Supports 1996-2003, Table V dated 4/4/02.

<sup>33</sup> Ibid.

<sup>34</sup> Nevada Developmental Services-Financial Support for Nevada Developmental Services, Table VI, dated 4/4/02.

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In 1996 developmental services were provided to 1,705 Nevadans; today, staff are serving in excess of 3,000 people with developmental disabilities.<sup>35</sup> In addition to the general state population growth of just less than 3%, the developmentally delayed group is growing more than two times faster due in large part to the Parry v. Crawford U.S. District Court decision decided January 15, 1998 to include “related conditions” in the developmentally delayed population. These are individuals who have diagnoses such as epilepsy and cerebral palsy that require assistance similar to what people with mental retardation need. People with related conditions account for 27% of all new cases and now account for 11% of the people in service.<sup>36</sup>

Developmental Services are provided by three regional agencies. The Desert Regional Center is located in Las Vegas and provides services to the southern area of the state. Sierra Regional Center in Sparks provides services to the northern area of the state. Rural Regional Center in Carson City provides services throughout rural Nevada. At the three regional centers, Developmental Services provides the following “community-based services:” 1) service coordination, 2) family support services, 3) job and day training, and 4) residential support.

*1. Community-Based Services*

- a. Service Coordination: All eligible persons are assigned a service coordinator (case manager) at the regional center. Service coordinators assist people in obtaining needed benefits and services. Through person-centered planning, the service coordinator works directly with the person and others, helping the customer articulate their future needs. Jointly, the customer and service coordinator develop service plans that focus on achieving consumer-determined outcomes. Service coordinators visit with the client at least quarterly to assess the efficacy of the plan and if the services are being provided as intended. Plans are updated as needed.

Table 69 shows the numbers of children and adults provided service coordination (case management) services by MHDS for the past three fiscal years.

**Table 69  
Developmental Services Service Coordination**

	Total			Desert Reg. Ctr.			Sierra Reg. Ctr.			Rural Reg. Ctr.		
	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02
Children	645	756	822	424	471	514	137	181	193	84	104	115
Adults	1,992	2,190	2,331	1,292	1,425	1,508	444	494	525	256	271	298
Total	2,637	2,946	3,153	1,716	1,896	2,022	581	675	718	340	375	413

Source: DS Overview 8/5/02

MHDS staff report Nevada has a 1:45 staff to client ratio as of June 2002, which equates to the national average. An improved staff to client ratio would result in better quality services to the clientele. Once qualified for service coordination,

<sup>35</sup> Legislative Commission’s Sub-committee to Study the State Program for Providing Services to Persons with Disabilities 4/17/02 minutes.

<sup>36</sup> Ibid.

which entails gathering client histories and/or providing social/medical testing, services are immediately provided. Staff indicate once a person qualifies, services are typically life-long as the population of people with developmental disabilities is static. Rarely do people leave the program except for moving out of state, death, or the family decides to care for the family member without state intervention.

Table 69 also substantiates the developmentally delayed caseload growth of 7% FY02 over FY01, which is more than double the state's population growth as previously mentioned in this report. Again, the Parry v. Crawford U.S. District Court decision regarding serving persons with "related conditions" shows its impact in these numbers. Per MHDS program staff, 27% of the new cases in FY02 have related conditions, and 47% of the newcomers are children.<sup>37</sup> DS staff project 4,088 persons will need service coordination by the end of 2005.<sup>38</sup>

- b. Family Support Services: Family support services assist families of individuals with developmental disabilities and related conditions to care for their relatives in the family home. All individuals who are eligible for services through the regional centers are eligible to apply for these services. The goal is to prevent costly out-of-home placement by assisting the family in caring for their relative. Any charges for services are determined by using a sliding fee scale. Most consumers who are eligible for Medicaid pay no fees for services. However, it should be noted that the Family Preservation Program defined below is 100% state funded. The following services are provided:

*Respite*: temporary care in/out of family home;

*Purchase of Service (POS) Supplements*: up to \$300 annually can be provided to a family to assist with the additional costs of caring for the relative at home. Examples of services/goods qualifying for payment are services not covered by insurance, car seats, special furnishings, etc.

*Clinical Assessment*: evaluations provided by a social worker, psychologist or nurse necessary to carry out the individual's plan.

*In-home Training*: trainers teach necessary skills to the family enabling them to care for the individual at home.

*Counseling*: family members are provided support and guidance in problem solving the many issues that can accompany caring for the individual at home, e.g., personal independence, social-sexual issues, work issues, etc.

*Family Preservation Program*: monthly financial aid to needy families caring for a profoundly mentally retarded family member in the home. The assistance can be used for a variety of needed services/equipment to facilitate community-based care.

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<sup>37</sup> August 16, 2002 meeting with Sierra Regional Center DS staff.

<sup>38</sup> Ibid.

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**Table 70  
Developmental Services Family Support Services**

	Total			DRC			SRC			RRC		
	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02
Persons in natural home	1,478	1,684	1,768	1,103	1,204	1,240	197	267	295	178	213	233
Total Family Support Services	n/a	n/a	1,077	n/a	n/a	733	n/a	n/a	182	n/a	n/a	162
Family Preservation Prog.	276	304	347	198	214	245	42	51	61	36	39	41
Respite	666	645	777	436	374	458	143	168	189	87	103	130

Source: DS Overview 8/5/02

Comparing Tables 69 and 70, 56% of the 3,153 persons served in FY02 live in their natural homes. Sixty-one percent of the 1,768 persons living in their own home received a family support service(s) of some type. Of the 1,077 family support services, 32% was for Family Preservation Program support and 72% for respite care. Providing increased family support services is an effective way to provide quality care and reduce unnecessary institutionalization for Nevada’s developmentally delayed population.

- c. Jobs and Day Training: All adults eligible for services through the regional centers are eligible for jobs and day training services. These services vary in type and intensity to allow individuals vocational choices. Supports range from pre-vocational and vocational training in supervised, structured settings, to enclaves, which are supervised work groups in community job settings, to supported employment, including activities needed to sustain paid competitive employment. The regional centers contract with private and nonprofit organizations that operate community training centers and other qualified providers offering training choices to the developmentally delayed based on their interests and skill levels.

**Table 71  
Developmental Services Jobs and Day Training**

	Total			Desert Reg. Ctr.			Sierra Reg. Ctr.			Rural Reg. Ctr.		
	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02
<b>Total Jobs &amp; Day Trng</b>	1313	1413	1395	838	958	904	306	303	319	169	152	172
Number in Employment	289	303	516	206	217	406	38	45	65	45	41	45
Number in Enclaves	210	248	268	167	184	209	20	31	40	23	33	29
Percent in Employment	22%	21%	37%	25%	23%	45%	12%	15%	20%	27%	27%	26%

Source: DS Overview 8/5/02

Of the 3,153 persons receiving developmental services in FY02, 44% (1,395 persons) were receiving Jobs and Day Training. Thirty-seven percent of the people receiving jobs and day training services in FY02 are in employment.

- d. Residential Support: As with the aforementioned developmental services, residential supports are available to people who have open cases at the regional centers. The program is designed with the goal of allowing people to live in a home of their choice as self-sufficiently as possible. It goes without saying these are important alternatives to restrictive and costly institutional settings. Residential services are funded by

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using the individual’s own resources (Social Security, job income, etc.) and supplementing these as needed with state and federal funds. The Nevada Medicaid Program funds the costs of many support services if the person is eligible. The state also provides funds to assist the person with living expenses in the community. The community residential options available are:

*Small Private ICFs/MR:* provides 24-hr supervision to persons requiring support, medical care and training; however, the services are less restrictive than those provided in the larger ICFs/MR. These services are provided in community neighborhood residences for up to six people. Small Private ICFs/MR are funded by Medicaid.

*Intensive Supported Living Arrangements (ISLA):* private agencies provide services in community residences for up to four individuals who live in their own homes and contribute to the cost of same. ISLAs were developed as an alternative to ICFs/MR for those who could be supported in this environment.

*Supported Living Arrangements:* individualized living supports that supplement an individual’s resources in their own home to allow maximum community independence. Because this is the least restrictive support option for adults, it is the most preferred option.

*Private Group Homes:* located in community neighborhoods and provided by private organizations, these homes serve up to six persons age 18 or older who need some support and training. There isn’t any staff awake at night and residents may have intermittent periods with no supervision.

*Developmental Homes:* private homes in the community which serve up to four persons who are usually younger/more dependent individuals desiring a more “family-type” setting.

**Table 72  
Developmental Services Residential Supports**

	Total			Desert Reg. Ctr.			Sierra Reg. Ctr.			Rural Reg. Ctr.		
	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02
<b>Total Res. Supports</b>	<b>1,053</b>	<b>1,156</b>	<b>1,236</b>	<b>586</b>	<b>661</b>	<b>702</b>	<b>316</b>	<b>335</b>	<b>354</b>	<b>151</b>	<b>160</b>	<b>180</b>
<b>Community Res. Support</b>	<b>801</b>	<b>898</b>	<b>994</b>	<b>440</b>	<b>513</b>	<b>560</b>	<b>237</b>	<b>252</b>	<b>281</b>	<b>124</b>	<b>133</b>	<b>153</b>
Reg. Supp.Liv.Arrng. (SLA)	476	531	582	241	292	321	149	151	154	86	88	107
Intensive SLA	203	264	305	102	149	162	75	85	112	26	30	31
Intensive Plus SLA	28	36	54	21	21	32	3	8	15	4	7	7
Group Home	47	22	26	42	17	21	0	0	0	5	5	5
Developmental Home	47	45	27	34	34	24	10	8	0	3	3	3
<b>Private (small) ICF/MR</b>	<b>111</b>	<b>111</b>	<b>111</b>	<b>60</b>	<b>60</b>	<b>60</b>	<b>24</b>	<b>24</b>	<b>24</b>	<b>27</b>	<b>27</b>	<b>27</b>
<b>Institutional (state ICF/MR)</b>	<b>141</b>	<b>147</b>	<b>131</b>	<b>86</b>	<b>88</b>	<b>82</b>	<b>55</b>	<b>59</b>	<b>49</b>	<b>0</b>	<b>0</b>	<b>0</b>

Source: DS Overview 8/5/02

As previously stated, private (small) ICFs/MR are not considered as “institutional” settings. Hence, of the 1,236 persons receiving residential supports in FY02, 89% are

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in non-institutional settings and living in the least restrictive setting possible given their limitations. Of interest also is the fact that 95% of all community supports are supported living arrangements.

**Table 73  
Developmental Services Integrated Residential Supports**

	Total			Desert Reg. Ctr.			Sierra Reg. Ctr.			Rural Reg. Ctr.		
	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02	FY00	FY01	FY02
<b>Integrated Res Supports</b>	912	1,009	1,105	500	573	620	261	276	305	151	160	180
<b>% Pers w/Comm Supp</b>	87%	87%	89%	85%	87%	88%	83%	82%	86%	100%	100%	100%
<b>% Comm Supp - SLA</b>	88%	93%	95%	83%	90%	92%	96%	97%	100%	94%	94%	95%

Source: DS Overview 8/5/02

**2. Institutional Care**

State Intermediate Care Facilities for the Mentally Retarded (ICF/MR): The ICF/MRs provide supervision and training to individuals who require intensive support, medical care, treatment, and training. Located at the Sierra Regional Center and the Desert Regional Center, these campus-based homes are licensed to provide services to approximately 134 people. The homes care for four to twelve people. Each facility is staffed by state employees on a 24-hour basis and must follow strict federal and state guidelines. The programs are funded by Medicaid and offer specialized services. This setting is also the most restrictive.

Table 75 provides the numbers of persons receiving institutional care for FY00 through FY02. Between FY00 and FY02, the number of inpatient residents has declined by 10 people representing a 9% decrease. The more notable comparison however is the 22% decrease in state institutional beds (172 to 134) since 1996.<sup>39</sup> As previously stated, the number of persons receiving inpatient care has remained relatively flat for the past seven years in comparison to the growth in community supports, which have increased from 513 in number to 1,236 people served.

**3. Developmental Services Caseload Projections:**

Projected caseloads for the aforementioned four core services provided by MHDS to the developmentally disabled population are illustrated in the following two tables.

**Table 74  
Developmental Services Caseload Projections**

	FY02 Actual	FY03 Budgeted	FY04 Req.	FY05 Req.	FY06 Req.	FY07 Proj.	FY08 Proj.	FY09 Proj.	FY10 Proj.
Service Coordination	3,153	3,236	3,791	4,088	4,385	4,682	4,979	5,276	5,573
Family Support Services	1,077	1,280	1,456	1,552	1,666	1,779	1,892	2,005	2,118
Job and Day Training	1,395	1,588	1,859	2,004	2,193	2,341	2,490	2,638	2,787
Residential Supports**	1,236	1,350	1,608	1,741	1,754	1,873	1,992	2,110	2,229

Source: MHDS

\*\* includes Inpatient Care (ICF/MR facilities)

<sup>39</sup> Nevada Developmental Services Institutional and Community Residential Supports 1996-2003, Table V, dated 4/4/02.

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4. *Developmental Services Cost Comparisons by Services:*

Table 75 provides the cost per client for the categorical services, with the exception of case management, provided by Developmental Services for FY 2001. Previous tables in this report compare the numbers of people served for growth purposes. The purpose of Table 75 is to show the comparison costs for “types” of services.

**Table 75  
Developmental Services Clients Served & Client Costs  
FY 2001**

Service	Area	Clients Served	Total Cost	Cost Per Client
<b>FAMILY SUPPORT SERVICES</b> includes respite, POS, assessments, counseling inhome training, etc.	Rural	117	\$95,290	\$814
	South	568	\$333,110	\$586
	North	143	\$142,539	\$997
	<b>Total</b>	<b>828</b>	<b>\$570,939</b>	<b>\$690</b>
<b>FAMILY PRESERVATION PROGRAM</b>	Rural	36	\$101,236	\$2,812
	South	200	\$519,030	\$2,595
	North	47	\$128,670	\$2,738
	<b>Total</b>	<b>283</b>	<b>\$748,936</b>	<b>\$2,646</b>
<b>JOB AND DAY TRAINING</b>	Rural	175	\$979,102	\$5,595
	South	899	\$5,812,170	\$6,465
	North	341	\$2,477,223	\$7,275
	<b>Total</b>	<b>1,415</b>	<b>\$9,268,495</b>	<b>\$6,552</b>
<b>COMMUNITY RESIDENTIAL PLACEMENT</b>	Rural	143	\$2,955,851	\$20,670
	South	458	\$10,424,290	\$22,760
	North	241	\$5,283,521	\$21,923
	<b>Total</b>	<b>842</b>	<b>\$18,663,662</b>	<b>\$22,166</b>
<b>PRIVATE ICF/MR SMALLS</b>	Rural	27	\$2,967,428	\$109,905
	South	60	\$4,398,177	\$73,303
	North	24	\$1,774,338	\$73,931
	<b>Total</b>	<b>111</b>	<b>\$9,139,943</b>	<b>\$82,342</b>
<b>STATE ICF/MR INPATIENT CARE</b>	North	59	\$7,865,075	\$133,306
	South	88	\$10,912,128	\$124,001
	<b>Total</b>	<b>147</b>	<b>\$18,777,203</b>	<b>\$127,736</b>

Source: DS FY01 Management Allocation Plans, & June 2001 Performance Measurement Indicators

Of particular note is the cost comparison among community residential, the ICF/MR smalls and the inpatient care (institutional) costs. The cost of a community residential and an ICF/MR small combined are still less than the cost of one person in a state institutional ICF/MR facility. Table 75 further confirms the numbers of persons receiving community residential and ICF/MR small services, 953 persons, compared to the 147 individuals in state institutional care in FY01. Any number of comparisons can

be made by study of Table 75; however, in the final analysis, the numbers underscore the benefits of a community-based delivery system. Community-based services are good for the person who is developmentally delayed, his or her family, the community as a whole, and the taxpayer. Community-based services are person-centered and cost effective.

### *5. Issues/Trends/Innovations as Reported by the Agency*

*Related Conditions:* Funding to provide services to persons with “related conditions” such as cerebral palsy and epilepsy is new to the division as a result of a 1998 lawsuit. Though additional legislative monies have been provided to serve this growing population, more will be needed to serve persons with related conditions, which now account for 25% of the new people entering the system.

*Community-Based Service Expansion:* DS has developed a progressive community-based service system and addressed many waiting list needs in recent years. This accomplishment is due in large part to the Medicaid Home and Community-Based Services Waiver for People with Mental Retardation and Related Conditions. Because of the waiver, there has been a decrease in the population at the state’s intermediate care facilities for the mentally retarded. The number of HCBS waiver slots has increased from 180 in 1994 to 1,182 in 2003. Much of the unmet need has been for residential assistance. In the four years ending June 2002, residential assistance alone has increased to 1,236 people being served, up 50% from the four years prior. Expanding current capacity to reach people on the MHDS residential service waiting list continues as a major issue. Two other aims of the community-based strategy include 1) increasing support to families to keep the family unit intact and decrease the need for residential supports---this includes respite care and cash assistance to families, and 2) providing a wider array of employment opportunities.

*Intake and Assessment:* Federal regulations require intake and assessment to be completed for all new applicants within 30 days of application. Once intake and assessment is completed, eligibility for services is determined and, if eligible, the person is assigned to a service coordinator for planning and service delivery. The current approved funding is 10 hours per intake applicant. While typical applicants are served within 30 days, Rural Regional Center applicants often are not due to lack of testing resources on site, no local accessibility to historical records, coordination of testing time and travel time for home visits.

*Service Coordination:* Service coordination (targeted case management) qualifies for federal matching funds and helps access other matching funds through the Home and Community- Based Waiver. Individual caseloads for service coordinators vary. The current ratio is one service coordinator to 45 people served; however, caseloads are consistently higher due to population growth and vacant positions. A factor related to caseload size, which affects small rural offices, is the amount of travel required to meet with the recipients. Additionally, as persons with more complex disabilities are increasingly served in the community, and community quality assurance becomes more important, the average hours per person served will need to increase. A future adjustment

to the 45:1 ratio would augment the number of service coordinators as well as federal revenue.

*Family Support:* Family support includes respite care, small grants to modify the home and limited cash assistance. Because the budget is a fixed set of dollars, as additional recipients are added, the amount of services and dollar allotment to each family are reduced. This has and will continue to result in a progressively smaller allocation to families and soon, waiting lists will occur for service. A review of family needs indicates that in-home habilitation services and help with behavioral consultation are required to keep families intact. At the present time, this need is not adequately funded in the Family Support budget. Additionally, current respite allocations only provide 1-2 days per month. The results from a 2001 Family Support Survey indicate there is a need for additional emergency assistance as well. A service model such as individual budgets provided directly to families so they can purchase their own services and fiscal intermediaries, agencies that assist families with purchasing and paying for services, could address this need.

*Residential Support:* Residential support is provided depending on the level of support needed to maintain the person in the least restrictive, integrated setting possible. With the requirements of the ADA and the Olmstead Decision, homes for people need to be developed in the community. As the population increases, so does the number of people presenting complex needs and challenging behavior. To support people with challenging behavior, additional staff is required in these homes, along with the financial support. Higher community funding rates for selected persons are needed to divert people from institutional care. Additionally, funding for short-term, unanticipated needs would be beneficial to those who live in the community. Fiscal intermediary options should help provide choices to Nevada residents and families in the future.

*Jobs and Day Training Services:* Nevada needs to bring in more supported employment service providers to provide choices of places to work for developmentally delayed residents.

*Quality Enhancement:* Quality assurance staff is responsible for enforcing laws and regulations as well as partnering with service providers. Enforcement and accreditation agencies require strict compliance with health and safety standards. Quality assurance activities assess and encourage the delivery of supports consistent with the preferences and needs of the persons receiving services. Developmental Services has adopted the standards of The Council on Quality and Leadership in Support for People with Disabilities. Quality is defined by the personal outcomes achieved as a result of services. The Sierra Regional Center and Desert Regional Center have received The Council's accreditation; Rural Regional Center has a two-year plan to attain accreditation. The division is not funded for quality assurance. Lacking staff, the regional centers oversight of community programs is insufficient. Staff training is a major area of concern for community providers given the cost, staff turnover, and compliance and accreditation requirements.

*Provider Rates and Infrastructure:* As Nevada becomes more dependent of private providers of service, an ongoing consideration is the adequacy of provider rates. A rates task force has identified a model of periodic rate review and adjustment. Suggested rate simplification in some areas is needed as well. In the area of technology, a coordinated use of same could lead to better use of existing resources and a clearer assessment of future needs for office space, voice mail, computer support, clerical supports and equipment. Appropriate equipment and technology could enhance staff productivity and service quality.

### **C. Conclusion**

This section on Mental Health and Developmental Services is intended to provide the reader with a concise description of the various services provided by the division to those with mental health issues or developmental delays. The document was designed in such a way as to clearly delineate between community-based and institutional services. The goal was to describe the service, who receives it, and who waits to receive it; where the various services are provided within the state; and, to the extent possible, the cost of providing the services on a per person basis. Although there is a great deal of information contained on MHDS, it is hoped the reader finds it enlightening.

## ***CHILDREN'S SERVICES***

The Children and Transition Sub-committee of the Task Force on Strategic Planning for Persons with Disabilities dedicated its work to identifying the needs of children with disabilities. They worked tirelessly to document current services available and identify the unmet needs of these children. Although some other agencies or program areas discussed in other parts of this section address services needed by children, generally they are programs that provide care/services without regard to age. For example, people eligible for Medicaid receive a full complement of state plan services, regardless of age, although there are certain Medicaid services limited to people of particular ages.

The programs described in this section are limited to children, generally people less than nineteen years of age, with some being limited to only the youngest children, those less than three years of age.

The agencies addressed in this section are:

- Community Connections, as it relates to Individuals with Disabilities Education Act, Part C;
- Division of Child and Family Services;
- Division of Health;
- Department of Education, as it relates to Individuals with Disabilities Education Act, Part B; and
- Nevada CheckUp.

## ***COMMUNITY CONNECTIONS***

Community Connections is an organizational unit in the Department of Human Resources, created in 1999 to provide a state-level framework for pass-through dollars to community-based programs. Community Connections provides administrative, fiscal, and program oversight of Family to Family Connection, Family Resource Centers, Children's Trust Fund, the Head Start State Collaboration Grant, Community Services Block Grant, Social Services Block Grant (Title XX), and the IDEA, Part C grant. For the purposes of this document, only the administration of IDEA, Part C grant funds is discussed.

The Individuals with Disabilities Education Act (IDEA), Part C, is a federal grant program administered by the U.S. Department of Education. The purpose of IDEA, Part C is to implement and maintain a statewide system of early intervention services, facilitate the coordination of payment for services, and enhance the state's capacity to provide services to children with developmental delays.

IDEA, Part C serves eligible children ages birth through 2 years. When a child reaches 3 years of age, they are served by IDEA, Part B, administered by the Nevada Department of Education, if deemed eligible. Each state determines eligibility for its program consistent with federal regulations. In Nevada, children are eligible for services if they meet the criteria

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listed for developmental delay. There is no income eligibility criteria, nor geographic barriers to providing service to eligible children. The federal law requires that when a child is referred for early intervention services, a multidisciplinary child evaluation and family needs assessment, and an Individualized Family Service Plan (IFSP) must be completed within 45 calendar days. With the acceptance of federal IDEA funds, early intervention services must be provided as outlined in the federal regulations, regardless of the additional cost to the state.

Nevada defines a developmental delay as a delay for the child's age in the following areas: cognitive development; physical development (including vision and hearing); communication development; social or emotional development; or adaptive development. To qualify for services a child must exhibit a minimum 50 % delay in one area or a minimum 25 % delay in two areas. Children who have a diagnosed condition with a high probability of leading to a delay may also be found eligible. An example is Down Syndrome.

The U.S. Department of Education awards IDEA, Part C grant funds annually to the states. In Nevada the grant enhances state and other funding to provide early intervention services. The program costs more than is received from the federal government and the state must make up the difference.

Community Connections retains about one-half of the grant for administrative, fiscal, and program oversight and sub-grants the remainder to five programs, three operated by the state's Division of Child and Family Services (DCFS) and two by the Health Division. These early intervention programs provide direct evaluation and assessment and early intervention services for children.

Unfortunately, the IDEA, Part C grant allocation does not have the capacity to fully finance early intervention services and there are waiting lists for such services. (Waiting lists are addressed in detail later.)

According to the federal government, approximately 3 percent of children, aged birth through 2 years, have disabilities. Using the U.S. Census, the federal government computed Nevada was serving just 1.03 percent in 2001. Table 76 below shows the number of potentially eligible children in Nevada for IDEA, Part C services.

**Table 76**  
**Early Intervention**  
**Potentially Eligible Children**  
**Based on U.S. Census Data**

Nevada	Population Zero to three	Potentially Eligible
<b>Total</b>	<b>86,767</b>	<b>2,603</b>
Males	44,567	1,337
Females	42,200	1,266

U.S. Census 2000 Data

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An Individualized Family Service Plan (IFSP) is developed with families and professionals to determine programming to enhance each child’s development and promote family self-sufficiency. The following lists services required by IDEA, Part C, but is not all inclusive:

- |   |                                |
|---|--------------------------------|
| Assistive Technology Devices                      | Occupational Therapy           |
| Assistive Technology Services                     | Physical Therapy               |
| Audiology Services                                | Psychological Services         |
| Family Support, Counseling<br>& Home Visits       | Service Coordination           |
| Medical Services for Diagnostics<br>Or Evaluation | Social Work Services           |
| Health Services                                   | Special Instruction            |
| Nursing Services                                  | Speech and Language Therapy    |
| Nutrition Services                                | Transportation & Related Costs |
|   | Vision Services                |

The services used by new enrollees for three years are shown in Table 77.

**Table 77  
Early Intervention  
Services Used by New Enrollees**

Services	FY99	FY00	FY01
Audiology	30	33	23
Assistive Technology	66	40	36
Parent/Family Counseling/Trng	649	640	568
Health Services	0	0	1
Medical Services	0	1	4
Nutrition	79	87	92
Occupational Therapy	220	226	195
Psychological Services	18	31	16
Physical Therapy	239	271	232
Respite Care	10	4	7
Nursing Services	0	0	0
Service Coordination	736	744	640
Special Instruction	732	721	604
Speech/Language Therapy	400	395	287
Social Work Services	1	1	0
Transportation	1	0	0
Vision Services	20	15	22

Source: Project TRAC Database 06/30/02

As noted earlier, while Community Connections coordinates the department’s efforts for IDEA, Part C, responsibility for delivering services falls to two Department of Human Resources divisions, Child and Family Services (DCFS) and Health. Jurisdiction is geographically determined and all programs must provide the same required services. In DCFS, the programs are known as First Step in the south; the Infant Enhancement Program, a northern hospital-based service; and HAPPY in the northern and rural areas. In the Health Division, the program is called Special Children’s Clinics with a program in Las Vegas and one in Reno.

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Numbers of children served by these programs are reflected in Table 78.

**Table 78  
Early Intervention  
Total Children Served  
FY99-02**

Location	1999	2000	2001	2002
First Step	359	379	342	341
HAPPY	167	161	153	171
Special Children's Clinic - Las Vegas	899	978	934	785
Special Children's Clinic – Reno	453	479	410	444
<b>Statewide Totals</b>	<b>1,878</b>	<b>1,997</b>	<b>1,839</b>	<b>1,741</b>

Source: TRAC Database 8/30/02

Program costs associated with Early Intervention services in fiscal year 2002 are shown in Table 79 for the average annual and monthly cost per child in each area.

**Table 79  
Early Intervention  
Program Costs - FY02**

Program	Total Cost	Number Served	Avg Annual Cost P/Child	Avg Monthly Cost P/Child
First Step	\$1,656,121	341	\$4,856.66	\$404.72
HAPPY	\$981,189	171	\$5,737.95	\$478.16
Special Children's Clinics	\$6,446,354	1,229	\$5,245.20	\$437.10
<b>TOTAL</b>	<b>\$9,083,664</b>	<b>1,741</b>	<b>\$5,217.50</b>	<b>\$434.79</b>

Source: Early Intervention Programs/IDEA, Part C 08/02

Funding for Early Intervention services is shared by various federal and state agencies. State general funding is involved to supplement other reimbursements or grants. Additional funding comes from the Medicaid (Title XIX) program, the U.S. Department of Education through its IDEA grant, the Maternal and Child Health (Title V) program, Nevada Check Up, private insurance, and from Child Care and Development funds through the Welfare Division.

Provision of Early Intervention services by the Division of Health and the Division of Child and Family Services is discussed in detail below. Each of the divisions provides services to children with disabilities in various programs. Information on other programs is also included in each division's discussion area.

Rural Respite

Rural respite began as the result of a grant from Community Connections in the Department of Human Resources, under the direction of the Division of Child and Family Services. That funding source has since been exhausted, but there are still respite programs operating in Elko and Fallon as a result of this initial state supported effort. Another respite program has since been formed in the rural areas from funding secured through a grant from Nevada's Tobacco Settlement monies.

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Respite is a high priority service for families of children with special needs, including adoptive and foster families. Respite services are important to families with children with disabilities because they enhance family stability and reduce the likelihood of costly out-of-home placements. In addition, for children already in foster care or an adoption placement, respite services can help prevent a disruption in the placement.

The goal of Rural Respite in Elko and Fallon is to improve access to respite care in rural Nevada by recruiting and training volunteers to increase the number of respite providers. Rural Respite Volunteers recruit teenagers to work together to provide a low cost, center-based respite program for families in rural Nevada to support families with young children with disabilities. The respite program through the Healthy Nevada funds provides vouchers to families to access respite within their homes.

*Issues/Trends/Innovations as Reported by the Agency*

Nevada’s IDEA, Part C lead agency, in conjunction with the Nevada Department of Education (the IDEA, Part B lead agency) recently completed Self-Assessment and Self-Improvement Planning mandated by the U.S. Department of Education, Office of Special Education (OSEP). The process revealed severe areas of non-compliance across numerous indicators in the birth to three Part C program. The purpose of this Continuous Improvement Monitoring Process is to review system change to improve services for children and families. There is real concern that with the current economic climate and population needs, the ability to make significant systems change and to come into compliance is limited. The lack of financial resources and the population growth have created a situation where early intervention programs have become increasingly out of compliance and the past three legislative sessions authorized no budgetary growth for early intervention programs. The state has been the sole provider of early intervention services and, as a result, community providers have no incentive to provide services. The state has not been able to keep up with the population needing services and has not built community capacity to assist and support those efforts.

Data shows that the number of children served yearly in Nevada is decreasing while the number of children waiting for services and the average length of time they are waiting is increasing.

**Table 80  
EARLY INTERVENTION  
NUMBER SERVED & WAIT LIST INFORMATION**

INDICATOR	FY'02 1 <sup>st</sup> Quarter	FY'02 2 <sup>nd</sup> Quarter	FY'02 3 <sup>rd</sup> Quarter	FY'02 4 <sup>th</sup> Quarter
Referred children waiting for services beyond 45 days with no IFSP	196	249	182	591
Children with IFSP waiting for any service	135	58	50	51
Average wait time from referral to IFSP (Federal law requires no more than 45 calendar days)	129.7	128.1	131.6	134.8
TOTAL Children (with IFSP) Served	979	895	826	877

Source: TRAC Database 08/02

This trend bears out that as of December 1, 2000, Nevada was serving 1.13% of the potentially eligible children contrasted with the national recommendation of 3% of the birth to three-child population. Per OSEP, as of December 1, 2001, Nevada's percentage had dropped to 1.03% -- less than 66% of the suggested incidence level.

Nevada, overall, has poor data as a basis for informed decision-making. Data are often not shared across programs and systems. In addition, data has not been collected consistently or accurately across programs making comparisons and projections difficult. Nevada had designated funding for a Birth Defects Registry, which would have assisted with identification and planning, but due to lack of resources, this will be eliminated when funding ends January 31, 2003.

The two largest providers of Early Intervention services are in the Health Division and were built on a medical model, which is a major obstacle in providing services in natural environments, a Part C, IDEA requirement. Early Intervention Services must be provided in the settings where young children without disabilities interact and play, and not in a segregated medical model setting. These Early Intervention programs are beginning to move services within the community and home, but the percentage of change has been low, particularly in Las Vegas. Within the Division of Child and Family Services, the Early Intervention programs were already providing most of the services within natural environments and have not experienced the same level of difficulty with the change.

Current best-practices research indicates that service coordination is pivotal in order for families to experience success within the early intervention system. Service coordination is key to assisting families in identifying both the formal and informal supports and resources needed by family members to promote their child's development. Equally important is how and in what manner supports and resources are provided to enhance the competency of parents and strengthen the family. Beginning March 2003, early intervention programs must provide service coordination training to any new employee.

Per federal regulations, a Part C IDEA child eligible for Part B (school district services) must have an Individualized Educational Program (IEP) in place on their 3<sup>rd</sup> birthday. While a statewide interagency agreement exists between Nevada Department of Education and Nevada Department of Human Resources, local interagency agreements do not exist in all school districts. There is not a consistent or shared data collection system from school district to school district or from department to department, a fact stakeholders believe limits information for decision-making.

### *Successes:*

- Universal Newborn Hearing Screening implemented January 2002.
- Ethnic and cultural groups are accessing Early Intervention services at similar proportions to the state demographics.
- Hospital Intensive Care Nurseries in Nevada work closely with Early Intervention to make timely referrals.

- Collaboration is successful among Early Intervention services, local school districts, Family to Family Connection, Family Resource Centers, Public Health, WIC, Tribal Health Clinics, physicians/pediatricians, Covering Kids Coalition, child care centers, local dairies, etc.

***DIVISION OF CHILD AND FAMILY SERVICES***

The Division of Child and Family Services (DCFS) has more than 900 employees and a budget exceeding \$100 million annually. DCFS was created by legislative action in 1991 and combined child welfare (from the Welfare Division), children’s mental health services (from the Division of Mental Health and Developmental Services) and all of the Youth Services Division (which included youth correctional services and childcare licensing). The new division was created to improve the delivery of services to Nevada children and families. DCFS is organized into seven principal units: three regions including North, South, and Rural; Juvenile Corrections; Fiscal Services; Family Programs Office, and UNITY (the management information system).

IDEA Part C - First Step (Urban and Rural Early Intervention Services) Las Vegas

With four community locations in Las Vegas, First Step provides family-centered services to families with children ages birth through two years with developmental delays. Services are provided in both urban and rural southern Nevada settings. Services include infant and toddler developmental intervention; hospital NICU developmental care and assessment; service coordination; developmental, speech, gross motor, fine motor and feeding assessments; and therapeutic activities such as physical, speech and occupational therapies. Therapeutic treatment/intervention programs are provided primarily in the natural environments of families, such as family homes, child-care centers, and relatives’ homes. Therapeutic treatment/intervention programs are provided individually via home visits and developmental videos or in small groups of two to eight children. The First Step program works collaboratively with Early Childhood Mental Health Services under the Division of Child and Family Services. A family member expressing a desire for mental health or crisis services may be served jointly, with the IFSP coordinated by First Step.

The number of newly enrolled children in the First Step program is reflected in Table 81.

**Table 81  
First Step  
New Enrollees**

	<b>1999</b>	<b>2000</b>	<b>2001</b>
At Risk (at risk of delays)	15	14	1
Hearing Impaired	5	0	0
Deaf/Blind (Dual Sensory)	0	1	0
50% Delay in one area or 25% in at least two	85	57	46
Visually Impaired	0	1	1
Physical or Mental Condition	85	76	86
Records w/o Data	0	2	0
<b>Total</b>	<b>190</b>	<b>151</b>	<b>134</b>

Per TRAC data provided by Community Connections 8/02

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IDEA Part C - Infant Enhancement Program (IEP)

The Infant Enhancement Program provides family-centered services to families with infants in the neonatal intensive care units at St. Mary’s Hospital and Washoe Medical Center in the Reno area. Two extensively trained infant development specialists provide developmental care recommendations, developmental assessments, feeding assessments, training and mentoring to families and medical staff. Each infant and their family are referred to the appropriate community resources upon hospital discharge. This program also provides training and technical assistance to hospital staff in the Las Vegas and Reno areas. Table 82 details the number of children served and the average monthly caseload.

**Table 82  
Northern Nevada Child & Adolescent Services**

<b>Infant Enhancement Program</b>	<b>FY00</b>	<b>FY01</b>	<b>FY02</b>
Total number served	200	212	225
Average monthly caseload	n/a	35	40

DCFS NNCAS update 9/4/02

IDEA Part C - HAPPY Northern and Rural Services

The Home Activity Program for Parents and Youngsters (HAPPY) serves infants and toddlers with developmental delays and their families residing in rural northern and northeastern Nevada counties. Early intervention services are provided in the home, childcare settings, and other identified natural environments. This service delivery area covers approximately 74,000 square miles. HAPPY staff have offices located in Reno and Elko. Developmental specialists and contracted specialists (physical therapists, speech therapists, occupational therapists, pediatricians, nurses, interpreters, behavioral aides, a signing instructor, pediatric neurologist, vision and orientation and mobility specialist, audiologist, and nutritionists) provide evaluations and assessments; and direct and/or consultative early intervention services.

The numbers of new enrollees in the HAPPY program are reflected in Table 83.

**Table 83  
HAPPY  
New Enrollees**

	<b>1999</b>	<b>2000</b>	<b>2001</b>
At Risk (at risk of delays)	0	12	2
Hearing Impaired	1	1	1
Deaf/Blind (Dual Sensory)	0	0	0
50% Delay in one area or 25% in at least two	1	17	46
Visually Impaired	0	0	0
Physical or Mental Condition	21	31	0
Records w/o Data	4	2	27
<b>Total</b>	<b>27</b>	<b>63</b>	<b>76</b>

Per TRAC data provided by Community Connections 8/02

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Children served by the Early Intervention programs located throughout the state must have an Individualized Family Service Plan (IFSP) completed to determine the services needed. Wait lists are not uncommon in these programs. Table 84 provides information on the waiting lists at the end of fiscal year 2002, June 30, 2002.

**Table 84  
Early Intervention Wait List  
End of Year FY02 (6/30/02)**

<b>DCFS</b>			
	<b>First Step</b>	<b>HAPPY</b>	<b>TOTAL</b>
No IFSP – Referred Waiting > 45 Days	12	2	14
IFSP Done – Waiting for any EI Service	26	9	35
<b>TOTAL</b>	<b>38</b>	<b>11</b>	<b>49</b>

Source: TRAC (Nevada's Data System) - 08/02 & Early Intervention Programs

Based on data reported by staff in the Community Connections office, new enrollees for three fiscal years, and the current program capacity in each of the programs is as follows:

**Table 85  
Early Intervention  
New Enrollees & Service Capacity  
DCFS**

<b>Program</b>	<b>FY99</b>	<b>FY00</b>	<b>FY01</b>	<b>Maximum Capacity</b>	<b>Capacity July 2002</b>
First Step	190	151	134	212	153
HAPPY	27	63	76	102	102
<b>TOTAL</b>	<b>217</b>	<b>214</b>	<b>210</b>	<b>314</b>	<b>255</b>

Source: TRAC Database 06/30/02

In addition to the IDEA, Part C services provided, DCFS offers many other types of services to children.

**Mental Health Services:**

Southern Nevada Child and Adolescent Services (SNCAS) and Northern Nevada Child and Adolescent Services (NNCAS), through their mental health service programs, are responsible for providing assistance to children in both outpatient and inpatient settings. SNCAS and NNCAS provide a range of mental health related services to severely disturbed and/or behaviorally disordered children, adolescents, and their families. A continuum of care is available and includes early childhood programming, active case management, outpatient counseling, intensive family oriented community-based treatment homes, and inpatient residential treatment for adolescents. In addition, DCFS provides contracted mental health services, both residential and non-residential, to include rehabilitative skills (individual and group), intensive community-based services, partial care/day treatment, therapeutic foster care, and residential group home care. These services are accessed by children in foster care, youth parole and in the custody of their families. SNCAS and NNCAS strive to provide

quality mental health care and treatment in the least restrictive environment and utilize community-based, family oriented, individualized services developed to address the unique needs of each child and their family.

Inpatient - Northern Region:

The Adolescent Treatment Center (ATC) is a 16 bed residential program for severely emotionally disturbed adolescents. Fourteen of the beds provide services for clients requiring longer term care while the remaining two beds are dedicated to crisis intervention and psychiatric emergency care. The program is designed for both boys and girls, ages 13-17. The unit is staffed 24-hours a day/seven days a week, providing around the clock awake supervision. This facility provides the most restrictive level of direct care services offered within the agency.

Residential services are developed and provided through a multi-disciplinary team of mental health professionals and include:

- 1) Psychiatric evaluation and medication monitoring;
- 2) Individual, group, and family therapy;
- 3) Psychological and educational assessment;
- 4) Special education and day treatment;
- 5) Recreation;
- 6) Nursing care;
- 7) Crisis/emergency evaluation and intervention.

The average length of stay for clients in ATC is 4 to 6 months. For emergency admissions the average stay is 10 days for stabilization. The goal is to move the youth to a less restrictive level of care at the earliest possible date. Youth at the ATC attend school on the premises daily and participate in regular therapy with a team leader/clinician working toward a return to the community.

Family Learning Homes, Achievement Place West, and Half Way House are family-style residential homes for children with more severe emotional or behavioral problems. Professionally trained staff provide 24-hour care in an intensive, community-based treatment program. The child's parents or guardians are involved in parent training and counseling at the same time so the child may be returned to his/her home as soon as possible. Although these homes are similar to ATC in the scope of services and level of treatment provided, the homes are considered to be less restrictive than ATC. Children attend regular school in the community.

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The number of children served in a three-year period in these facilities, with a total of 41 beds, is shown in Table 86:

**Table 86  
Northern Nevada Residential Treatment  
Adolescent Treatment Center & Group Homes**

<b>Adolescent Treatment Ctr</b>	<b>Fiscal Year 2000</b>	<b>Fiscal Year 2001</b>	<b>Fiscal Year 2002</b>
Avg Number on Wait List	4	4	2
Number of Beds	16	16	16
Total Program Cost	\$1,364,089	\$1,415,495	\$1,479,687
<b>Family Learning Homes</b>			
Avg Number on Wait List	6	12	11
Number of Beds	25	25	25
Total Program Cost	\$1,570,933	\$1,574,693	\$1,740,950
<b>Combined</b>			
Number Served	122	110	121
Combined Total Costs	\$2,935,022.00	\$2,990,188.00	\$3,220,637.00
Average Cost to Serve	\$24,057.56	\$27,183.53	\$26,616.83

Source: Dbase: CBS & NNCAS 08/02 & NNCAS Program Cost Budget, 08/30/02

**Inpatient – Southern Region:**

Desert Willow is a 56 bed hospital providing mental health care for severely emotionally disturbed children and adolescents in the most restrictive environment. Twelve beds, dedicated to “Acute Adolescent Care,” are JCAHO accredited for this level, another eight beds, dedicated to “Children’s Acute Care,” are accredited for this level, while the balance, thirty-six beds, are in three non-acute units. Two of the non-acute programs serve adolescents 12-17 years of age (12 beds each). Many of the adolescents referred and admitted have not progressed in multiple, less restrictive living environments, and may also have a history of multiple psychiatric hospitalizations. These adolescents demonstrate varying degrees of behavioral and/or emotional dysfunction. The Specialized Adolescent Treatment Program (SATP) with 12 beds is a trans-disciplinary approach to treating impulse control for sexual offender adolescents between the ages of 12 and 17 years.

All program participants attend an on-site school and have special education provided by the Clark County School District. This allows the patients to participate in educational activities while continuing to receive intensive mental health treatment and work closely with a multi-disciplinary team toward a return to the community.

Residential services are developed and provided through a multi-disciplinary team of mental health professionals and include:

- 1) Psychiatric evaluation and medication monitoring;
- 2) Individual, group, and family therapy;
- 3) Psychological and educational assessment;
- 4) Special education and day treatment;
- 5) Recreation;

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- 6) Nursing care;
- 7) Nutritional Assessment and Counseling;
- 8) Crisis/emergency evaluation and intervention.

In addition, two Residential Treatment Centers, Sedona and Sunrise, are located on the same grounds as Desert Willow. While not as restrictive a setting as Desert Willow, these centers provide family-style residential homes for children with severe emotional or behavioral problems. Professionally trained staff provide 24-hour care in an intensive, community-based treatment program. The child’s parents or guardians are involved in parent training and counseling at the same time so that the child may be returned to his/her home as soon as possible. Although these homes are similar to Desert Willow in the scope of services and treatment, the homes are considered to be less restrictive.

On Campus Treatment Homes, known as Oasis, are seven family-style residential homes with a total of 27 beds providing intensive, highly structured treatment for severely emotionally disturbed children and adolescents, ages 7-17 years. Services include: individual, family and group therapy; case management; and psychological, psychiatric and medical intervention as prescribed.

Table 87 details the numbers of children served and costs associated with their care for the fiscal years 2000-2002.

**Table 87  
Southern Nevada Child & Adolescent Services  
Desert Willow & On Campus Treatment Homes**

	2000			2001		2002		
	Total Beds	Total Served	Cost per Child	Total Served	Cost per Child	Total Served	Cost per Child	Avg Mthly Waitlist
<b>Desert Willow</b>								
Adolescent Acute Res. Trt. Prg.	12	115	\$11,343.55	86	\$19,480.79	81	\$19,507.03	3
Child Acute Res. Trt. Prg.	8	54	\$24,039.12	40	\$35,284.34	42	\$35,792.06	3
RTC1-Sedona	12	49	\$25,834.08	35	\$34,741.90	32	\$52,976.99	2.6
RTC2-Sunrise	12	43	\$29,439.54	34	\$35,762.87	39	\$43,467.79	2.6
Spec. Adolescent Trt. Prg.	12	25	\$50,379.47	33	\$36,744.19	23	\$55,309.58	1
<b>On Campus Treatment Homes</b>	27	57	\$34,589.83	56	\$40,666.73	27	\$75,956.19	13.8
<b>Combined Total</b>	83	343		284		244		

DCFS, SNCAS, Special Report 8/30/02

*Outpatient:*

In the Northern Region, Early Childhood Services (ECS) provides prevention services, crisis in-home intervention and respite care, and outpatient mental health services for children from birth through age 6 (kindergarten) and their families through three program units:

- 1) Project Crisis: provides in-home crisis intervention and respite care;
- 2) Early Childhood Treatment Program: provides outpatient assessment and treatment utilizing individual, group and family treatment modalities as well as extensive community outreach through consultation and training to child care and preschool programs, including Head Start programs; and

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- 3) Day Treatment Program: provides 10 hours of day treatment programming weekly to children ages 3 to 5 who are victims of crime (VOCA federal grant) with adjunctive treatment and case management services to families.

The number of children served by NNCAS for three years is reflected in Table 88.

**Table 88  
Northern Nevada Child & Adolescent Services**

<b>Early Childhood Services</b>	<b>FY00</b>	<b>FY01</b>	<b>FY02</b>
Average number on wait list	73	88	101
Total number served	284	269	288
Average cost to serve	\$2,492.90	\$2,924.70	\$2,585.84

Rpts/MeasInd-FY2002: NNCAS & Program Budget 3281, 08/30/02

In the Southern Region, Early Childhood Services (ECS) provides prevention services, crisis in-home intervention and respite care, outpatient mental health services for children from birth through age 6 (kindergarten) and their families through three program units:

- 1) Crisis Home-Based Services: provides in-home crisis intervention and respite care;
- 2) Early Childhood Counseling Program: provides outpatient assessment and treatment utilizing individual, group and family treatment modalities as well as extensive community outreach through consultation and training to child care and pre-school programs, including Head Start programs; and
- 3) Day Treatment Program: provides 10 hours of day treatment programming weekly to children ages 3 to 5 who have severe emotional or behavior problems in conjunction with a hands on coaching for caregivers who attend at least one day each week.

The number of children served by SNCAS Early Childhood Services (mental health only) for three years of history is reflected in Table 89.

**Table 89  
Southern Nevada Child & Adolescent Services  
Early Childhood Services**

<b>Counseling</b>	<b>FY00</b>	<b>FY01</b>	<b>FY02</b>
Average number on wait list	49	53	64
Total number served	476	400	415
Average cost to serve	\$1,799.28	\$3,201.00	\$2,256.47
<b>Day Treatment</b>			
Average number on wait list	22	15	17
Total number served	162	154	141
Average cost to serve	\$3,598.77	\$3,575.25	\$3,998.69
<b>Crisis</b>			
Average number on wait list	17	27	31
Total number served	249	214	188
Average cost to serve	\$2,540.35	\$3,111.98	\$3,768.40

DCFS, SNCAS, Special Report 8/30/02 – Updated 9/3/02

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The Outpatient Service programs in both the Southern and Northern Regions provide services to youth 6-17 years of age and their families and includes:

- 1) Psychiatric evaluation and medication monitoring;
- 2) Individual, family, and group therapy;
- 3) Case management;
- 4) Psychological and psychosocial assessment and evaluation; and
- 5) Twenty-four hour on-call crisis intervention.

Table 90 details the number of children served, the cost to serve and waiting list information for outpatient services:

**Table 90**  
**Northern Nevada Child & Adolescent Services**

<b>Outpatient Services</b>	<b>FY00</b>	<b>FY01</b>	<b>FY02</b>
Average number on wait list	161	155	200
Total number served	513	578	660
Average cost to serve	\$1,230.84	\$1,212.58	\$1,257.32

Rpts/MeasInd-FY2002: NNCAS & Program Budget 3281, 08/30/02

**Table 91**  
**Southern Nevada Child & Adolescent Services**

<b>Outpatient Services</b>	<b>FY00</b>	<b>FY01</b>	<b>FY02</b>
Average number on wait list	n/a	n/a	40
Total number served	468	364	509
Average cost to serve	\$3,056.09	\$3,620.86	\$3,070.13

DCFS, SNCAS, Special Report 8/30/02

In the Southern Region, the outpatient service program, known as Children’s Clinical Services, provides crisis and outpatient services to youth with multiple and complex needs. Typically, youth served have severe emotional disturbance and are involved in the child welfare, juvenile justice, substance abuse and/or special education systems. They require intensive interventions and the coordination of resources/services is critical to successful outcomes. Services are delivered from five neighborhood care centers and are home and community-based. Most youth are transitioning from out-of-state residential care, at immediate risk of out-of-state placement, transitioning from an acute psychiatric hospital or residential treatment placement or are at risk of immediate disruption from their family’s home. The Southern Region is the recipient of a federal Substance Abuse and Mental Health Services Administration children’s mental health system of care grant that will end on August 31, 2004. This six-year grant funds clinical staff positions, family support positions, and a system of care development totaling over \$7 million.

Implementation Project For AB-1 Mental Health Services – Project Overview

Through Assembly Bill 1 the 2001 Nevada Legislature has integrated the child welfare system and increased treatment support for children within this system. This includes creating funding for 327 behavioral health services slots for children in the ongoing child welfare system who have severe emotional disorders and are currently not served or receiving adequate services. The funding for these services began for 10% of these children

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in April 2002 and then a phase-in of the other children begins in November 2002. For the first phase, it has been decided to identify eight children in the Rural Region, eight in the Washoe jurisdiction, and eight in each of the north and west neighborhood care center regions of the Clark County jurisdiction.

Foster Care, aka Substitute Care – Northern, Southern & Rural Regions

Provided in the Northern, Southern and Rural Regions, foster/substitute care is a family-focused service that provides for the temporary care of children in need of protection. Foster home placement for children, including those with severe disabilities (also called medically fragile) provides temporary or permanent placements including adoption, emancipation, independent living, guardianship, relative placement, or long-term foster care. Services include emergency shelter care, foster family care (including relative placements), group home care, therapeutic foster care, respite care, residential treatment care both in and out-of-state, and independent living services. Additional services to support the child and family include in-home counseling (family preservation/intensive family services), early childhood services, and other outpatient services.

A “higher level of foster care” is available for those children who are severely emotionally disturbed (SED) in both group homes and therapeutic foster homes. Because of the urgency for placement of these children, there is no waiting list. Although numbers and costs can be associated with the SED children in the higher level of foster care, these are not the only children with disabilities in the foster care system. Therefore, counts are not provided here as it would provide only a portion of the entire number of children with disabilities in the foster care program and the cost of expenditures for their care. Rather, Table 92 provides a count of the actual number of children in foster care in FY00 and FY01 and those with various types of special needs.

**Table 92  
Children in Foster Care**

	<b>2000</b>	<b>2001</b>
Males	1687	1598
Females	1524	1390
<b>Total</b>	<b>3,211</b>	<b>2,988</b>
<b>Special Needs</b>		
Emotional/Behavioral	518	493
Unmanageable/Delinquent	92	83
Cognitive Disability	322	263
Drug/Alcohol Abuse	59	44
Medical/Health Prob.	191	180
Pregnant/Parenting	12	15

DCFS Five-Year Comprehensive Child & Family Services Plan 8/01

Likewise, many children with severe emotional disturbances and those with special needs are served through the subsidized adoption program. Numbers on the children with disabilities are also not included here as there are many other children with disabilities who are adopted without a subsidy being provided.

Independent Living Program

DCFS is responsible for the administration of the Title IV-E Program and the Independent Living Program (ILP) under Section 477 of the Social Security Act. The ILP is designed to provide young adults in foster care with opportunities to obtain the skills necessary to attain self-sufficiency and transition from foster care to adulthood.

The people served by the ILP are young adults in the custody of DCFS over the age of fifteen and one-half. The division works to assist young adults in out-of-home care to learn to access support systems available to them, whether they are under agency care or living by themselves in the community, regardless of their family situation or history in foster care.

Nevada foster care youth between the ages of 14 to 18 and former foster care youth up to age 21 who have been discharged from foster care because of age may participate in the ILP. Although 15 ½ has been established as Nevada’s official entry point to begin formal ILP transitional living planning, younger children from the age of 14 are not excluded from services if it can be justified to meet the child’s needs, especially as it relates to educational services. Early ILP planning is encouraged for the younger teen to prepare them for more intensive services offered through ILP.

Children’s Resources Bureau – Northern, Southern & Rural Regions

The Intensive Family Services/Children’s Resources Bureau (IFS/CRB) programs provide home-based specialized clinical assessments and clinical consultations to children entering or in DCFS custody and their families as well as to youth in juvenile probation and parole services for sex offenses. Assessment services are also provided to youth in the custody of Youth Parole and children already in the foster care system. Specialized assessments include juvenile sex offense specific, psychosexual, psychological, mental health, developmental and family functioning, Through contracts with community providers, neuropsychological, sex offense specific, psychiatric assessments are also provided. In the North and South, the Children’s Resource Bureaus have initiated the provision of intensive case management services for identified children within the child welfare population. In the rural region, these services are provided by the Intensive Family Services clinicians who also provide family preservation services. This program is designed to provide clinical support to child welfare and youth probation/parole services.

**Table 93**  
**Children's Resources Bureau**  
**Number of Children Served**

<b>FY 2000</b>	<b>FY 2001</b>	<b>FY 2002</b>
3,182	2,839	2,152

Source: DCFS, So. Region Update 9/4/02

Family Preservation Services

Intensive Family Services/Family Preservation Service programs (IFS/FPS) provide intensive home-based treatment services for children at risk of out-of-home placement due to abuse and neglect. Other services are reunification of children in foster care and adoption

preservation. All children served are under the supervision of Child Protective Services or in the custody of DCFS. Services are provided in the Rural (in four rural communities) and Southern Regions (from five neighborhood care centers). The goals of family preservation service programs are to eliminate unnecessary out-of-home placement of children ensuring their safety in the family home, to strengthen the family to better care for the developmental needs of their children and to improve family functioning. Services are family-focused and include assessment, family therapy, education, and case management.

**Table 94**  
**Family Preservation Services**  
**Number of Children Served**

FY 2000	FY 2001	FY 2002
306	459	207

Source: DCFS, So. Region Update 9/4/02

Juvenile Corrections

The Youth Parole Bureau provides aftercare services to youth, including those with disabilities, released from the Nevada Youth Training Center at Elko, the Caliente Youth Center in Caliente, and youth committed to DCFS custody at the China Spring Youth Camp in Minden. Youth are assigned a counselor at the time of commitment who works with him/her and institutional staff to identify and implement an appropriate treatment plan. The plan is used to facilitate a successful return to the community. Other programs implemented by Youth Parole include:

- Alternative Placement;
- Specialized Treatment;
- Intensive Aftercare;
- Drug Education and Counseling;
- Transitional Community Integration; and
- Drug Testing.

The Youth Training Centers, Nevada Youth Training Center (males) and the Caliente Youth Center (co-ed), provide residential, correctional care for adjudicated delinquent youth. The programs include:

- Education;
- Vocational training;
- Recreation;
- Drug and alcohol abuse counseling; and
- Individual/group counseling.

Table 95 reflects the number of people served for a three-year period.

**Table 95  
Juvenile/Youth Corrections**

	FY00	FY01	FY02
Youth Parole	1,129	1,009	1,088
<b>Institutions</b>			
Caliente Youth Center	455	367	373
Nevada Youth Training Ctr	457	389	444
Summit View	30	119	113
<b>Total in Institutions</b>	942	875	930
<b>Total Served</b>	2,071	1,884	2,018

DCFS, Juvenile Corrections, Special Report 8/30/02

Interstate Compact on the Placement of Children (ICPC)

DCFS provides statewide administration of the Interstate Compact on the Placement of Children (ICPC) program. The compact is a uniform law enacted by all 50 states and establishes procedures for the interstate placement of children and fixes responsibility for those involved in placing the child. The intent of the ICPC is to ensure protection and services to children who are placed across state lines for foster care, adoption, or institutional care.

Through ICPC, the division provides oversight, evaluation, authorization and monitoring of children, including those with disabilities, who are placed out-of-state or who are placed in Nevada by other states. Last year DCFS' ICPC staff received more than 900 requests. Such placements include children with behavioral and other disabilities, e.g., autism, traumatic brain injury, mental illness, etc., for whom appropriate educational and/or treatment placements are not available in Nevada or who have been denied acceptance by Nevada facilities.

***DIVISION OF HEALTH***

The Bureau of Family Health Services employs 124 employees and has a FY02-03 budget of \$37,545,639.<sup>40</sup> The bureau provides a cluster of programs that share the common goal of improving the health of families, mothers, infants, children, and adolescents, including children with special health care needs. The bureau is located within the Health Division of the Department of Human Resources and oversees the following programs to improve child and family health:

- Maternal and Child Health (MCH) services assure access to quality, affordable health services for pregnant women and their children. MCH encompasses Baby Your Baby, Perinatal Substance Abuse Prevention, MCH Prenatal Program, Fetal Alcohol Abuse Prevention, a Newborn Screening Program, and a Newborn Hearing Screening Program.
- Children with Special Health Care Needs (CSHCN) are children ages 0-19 supported by the Maternal and Child Health Block Grant (Title V of the Social Security Act). CSHCN

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<sup>40</sup> Department of Human Resources – Division Briefs, July 2001.

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provides services for children suffering from conditions which lead to a handicap and supervises the administration of those services.

- Special Children’s Clinics provide early intervention, diagnosis, treatment, and follow-up services to families with children who have known or suspected developmental delays.
- The Women, Infants, and Children (WIC) program provides supplemental food, nutrition, education, and referral to families with low income, pregnant and postpartum women, infants and children to age five to improve their nutritional health status.
- Primary Care Development Center provides a primary care system to ensure access to primary health care services.
- The Oral Health Program assures Nevadans achieve optimal oral health.
- Child and Adolescent Services include teen pregnancy and injury prevention initiatives.
- Birth Defects Registry (funding is scheduled to end January 31, 2003).

For the purpose of this document, only Special Children’s Clinics, Children with Special Health Care Needs, and WIC will be reported on.

**Table 96**  
**Summary of Family Health Services**  
**SFY99-00 Budgeted Expenditures by County**  
**2000 State Population 1,998,257**

County	Population	Percent of Population	Expenditure
Carson City	52,457	2.6%	\$1,183,811
Churchill	23,982	1.2%	\$570,111
Clark	1,375,765	68.8%	\$24,603,815
Douglas	41,259	2.1%	\$906,653
Elko	45,291	2.3%	\$978,311
Esmeralda	971	0.0%	\$31,317
Eureka	1,651	0.1%	\$31,317
Humboldt	16,106	0.8%	\$411,453
Lander	5,794	0.3%	\$177,522
Lincoln	4,165	0.2%	\$89,976
Lyon	34,501	1.7%	\$722,723
Mineral	5,071	0.3%	\$146,201
Nye	32,485	1.6%	\$666,677
Pershing	6,693	0.3%	\$165,068
Storey	3,399	0.2%	\$75,092
Washoe	339,486	17.0%	\$6,564,115
White Pine	9,181	0.5%	\$221,477
<b>Total</b>	<b>1,998,257</b>	<b>100.0%</b>	<b>\$37,545,639</b>

Source: Nevada State Health Division Briefing Document

IDEA, Part C

IDEA, Part C funds services to children from birth through age two as described below.

Special Children’s Clinic – Las Vegas (SCC-LV)

Special Children’s Clinic provides family-focused multidisciplinary diagnostic and early intervention services to children ages birth through two years. Diagnostic evaluations are provided in the following areas: social, medical, developmental/psychological, speech and language, audiological, nutrition, physical therapy and occupational therapy. In addition to comprehensive assessments, other early intervention services offered include: service coordination, reassessments and NICU (Neonatal Intensive Care Unit) follow up, infant/toddler intervention, parent/toddler groups, individual and group language therapy, physical therapy, occupational therapy and nutrition treatment. Services are provided in center-based, home-based and community settings.

The number of children newly enrolled for services in the SCC-LV is reflected in Table 97.

**Table 97  
Special Children's Clinic Las Vegas  
New Enrollees**

	1999	2000	2001
At Risk (at risk of delays)	0	0	0
Hearing Impaired	12	8	8
Deaf/Blind (Dual Sensory)	1	3	1
50% Delay in one area or 25% in at least two	66	178	155
Visually Impaired	1	3	4
Physical or Mental Condition	304	321	256
Records w/o Data	0	0	0
<b>Total</b>	<b>384</b>	<b>513</b>	<b>424</b>

Per TRAC Database 06/30/02

Special Children’s Clinic – Reno (SCC-R)

Special Children’s Clinic provides family-focused multidisciplinary diagnostic and early intervention services to children ages birth through two years. The service area encompasses a 50-mile radius around Reno and includes Dayton, Fernley, Gardnerville, Wadsworth, Nixon, Incline Village, Carson City, and Virginia City. Diagnostic evaluations are provided in the following areas: social, medical, developmental and/or psychological, speech and language, audiological, nutrition, physical therapy and occupational therapy. In addition to comprehensive assessments, other early intervention services offered include: service coordination, re-assessments and NICU (Neonatal Intensive Care Unit) follow up, infant/toddler intervention, parent/toddler groups, speech therapy, physical therapy, occupational therapy, and nutrition treatment. Intervention services are primarily provided in home-based and community settings.

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The number of children newly enrolled for services at the SCC-R is reflected in Table 98.

**Table 98  
Special Children's Clinic Reno  
New Enrollees**

	1999	2000	2001
At Risk (at risk of delays)	2	6	2
Hearing Impaired	0	0	1
Deaf/Blind (Dual Sensory)	0	0	0
50% Delay in one area or 25% in at least two	209	162	122
Visually Impaired	0	0	5
Physical or Mental Condition	7	52	67
Records w/o Data	5	22	4
<b>Total</b>	<b>223</b>	<b>242</b>	<b>201</b>

Per TRAC Database 06/30/02

Children served by the Early Intervention programs located throughout the state must have an Individualized Family Service Plan (IFSP) completed to determine the services needed. Wait lists are not uncommon in these programs. Table 99 provides information on the waiting lists at the end of fiscal year 2002.

**Table 99  
Early Intervention Wait List  
End of Year FY02 (6/30/02)  
Health Division**

	SCC-LV	SCC-R	TOTAL
No IFSP – Referred			
Waiting > 45 Days	242	335	577
IFSP Done – Waiting for any EI Service	6	10	16
<b>TOTAL</b>	<b>248</b>	<b>345</b>	<b>593</b>

Source: TRAC Database & Early Intervention Programs

Based on data reported by staff in the Community Connections office, new enrollees for three fiscal years, and the current program capacity in each of the programs is as follows:

**Table 100  
Early Intervention  
New Enrollees & Service Capacity  
Health Division**

Program	FY99	FY00	FY01	Maximum Capacity	Capacity July 2002
Special Children's Clinic-Reno	223	242	201	249	220
Special Children's Clinic-Las Vegas	384	513	424	523	498
<b>TOTAL</b>	<b>607</b>	<b>755</b>	<b>625</b>	<b>772</b>	<b>718</b>

Source: TRAC Database & Early Intervention Programs 07/19/02

Children with Special Health Care Needs

The Health Division's Children with Special Health Care Needs (CSHCN) program offers payment assistance to persons who are pregnant or children with specific disabling and/or chronic medical conditions. To be eligible for help, persons must be a state resident, U.S. citizen or qualified alien, meet established financial criteria, and meet age limits (0-19 for children, no age limit for prenatal care, no age limit for metabolic needs). It should be noted applications are accepted on a child up to the age of 19; however, medical attention can be provided the child through the age of 21 if necessary to correct/ameliorate the condition. Program representatives are available to help in each Nevada county. Once an application is submitted it is reviewed for medical, financial and administrative eligibility. The applicant is advised of the disposition of the application in writing generally within 7-10 days of application--provided all needed verifications are submitted by the parent and other eligibility requirements are met.

All CSHCN services must be prior authorized. Reimbursement for medical bills is paid at the Medicaid rate directly to the doctor, hospital or other medical provider who performed the service. CSHCN has a number of Memorandums of Understanding (MOUs) with various providers in the community to include doctors, pharmacies, x-ray, anesthesia, etc. to provide the necessary services to children. Medical providers must bill any available health insurance before requesting CSHCN dollars. Health Division staff report CSHCN costs have gone down since the recent outreach activity to augment the number of children served by Nevada Check Up. Nevada Check Up provides medical coverage for children at 200% of the federal poverty level. CSHCN raised its income eligibility limit to 250% of federal poverty to serve those ineligible for Nevada Check Up.

Persons are limited to a maximum of \$10,000 annually in assistance with the exception of extenuating circumstances. Some severe, chronic or disabling disorders include, but are not limited to the following: central nervous system defects; cleft palate and craniofacial conditions; convulsive disorders; cystic fibrosis; eye conditions leading to vision loss; genitourinary system anomalies; heart disease; hearing loss; metabolic and endocrine disorders such as diabetes, hypothyroidism, and PKU; orthopedic conditions; reconstructive surgery; respiratory system anomalies; and prenatal care which must begin prior to the third trimester.

Children with Special Health Care Needs services include the following:

*Newborn Screenings:* State law requires newborn screenings on every infant born in Nevada. The hospitals perform the required screenings at birth and send the test to the lab. If a problem is identified, CSHCN follows up with the physician and family to ensure the child in question is receiving necessary medical attention. Effective January 2002, hospitals with over 500 births annually are required to offer the parents of newborns the opportunity for a hearing screening. Hospitals having in excess of 500 births annually represent 95% of all births in the state. Staff estimate 85% of all newborn Nevada children receive the hearing screening.

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*Prenatal Care:* Prenatal care is covered as long as it's initiated prior to the third trimester; however, the program does not pay labor and delivery costs.

*Multi-Disciplinary Clinics:* Specialty clinics are provided by Special Children's Clinic, Las Vegas, and include a Genetics Clinic, Craniofacial Clinic, Metabolic Clinic and Diabetes Clinic at University Medical Center in cooperation with University of Nevada School of Medicine. In Reno, specialty clinics are offered and include a Craniofacial Clinic at University of Nevada, Reno in cooperation with the University of Nevada School of Medicine, Genetics Clinic, Metabolic Clinic, Endocrine Clinic, and Pulmonology Clinic.

*Hospital (Inpatient and Outpatient):* CSHCN provides necessary inpatient and outpatient care as needed for children with special health needs.

*Physician/Medications/Therapies:* The aforementioned are also provided by CSHCN.

*Special Foods and Formulas:* Some children require special formulas as infants or, later in life, foods to prevent health problems and/or keep a chronic medical problem under control. These formulas and foods are very expensive, are never discounted for purchase, and are absolutely necessary to the health of the child. Some of the food costs range between \$5,000-6,000 annually. CSHCN provides this service as well.

CSHCN provides medical help to children, some are disabled and others may not be disabled, but have a chronic disease, congenital defect, etc. A child's medical condition is assigned to one of four categories to determine the extent of services provided by CSHCN. Category 1 is excellent prognosis once served; Category 2 is good prognosis and the prevention of disability or deterioration is anticipated; Category 3 is fair prognosis; and, Category 4 is poor prognosis despite treatment. The following medical conditions/ disabilities are covered: 1) blood cell conditions, 2) cardiovascular conditions, 3) endocrinological conditions, 4) craniofacial anomalies, 5) ear disorders, 6) eye conditions, 7) gastrointestinal disorders, 8) genitourinary disorders, 9) metabolic disorders that are treatable inborn errors of metabolism, 10) neurological disorders, 11) orthopedic conditions, 12) pulmonary conditions, and 13) reconstruction.

**Table 101  
Children with Special Health Care Needs**

<b>Fiscal Year</b>	<b>Unduplicated Number of Children Served</b>	<b>Total Cost</b>	<b>Average Cost Per Child</b>
FY 1999	1,012	\$1,205,996	\$1,192
FY 2000	*733	\$1,211,461	\$1,653
FY 2001	784	\$1,069,806	\$1,365

Source: Report provided by Chief, Family Health Services on 8/27/02

\* The reduction in children served between FY99 and FY00 is due in part to Nevada Check Up outreach efforts.

The tables under Idea, Part C and Table 101 titled Children with Special Health Care Needs (CSHCN) reflect the numbers of children served by Family Health Services in northern and southern Nevada. However, there is yet another population of children served at the specialty clinics offered at the Special Children's Clinics. In FY02 there were approximately

2,000 children statewide served in the multi-disciplinary specialty clinics offered at the Special Children's Clinics in Reno and Las Vegas.<sup>41</sup>

CSHCN is unable to identify the type of service used by enrollees. Likewise, data are unavailable to ascertain the numbers of children the program is unable to serve per year. Presently there are 128 clients awaiting an eligibility determination. The length of time to process an eligibility determination varies and is dependant upon the parent(s) providing all the necessary information needed to make a decision in a timely manner. If the child has applied for Medicaid and Nevada Check Up, a denial from both programs is required; however, presumptive eligibility can be made and services provided while awaiting these denials.

CSHCN currently has 748 outstanding invitations to participate in program services, which were mailed to potential recipients as a result of newborn testing and hearing screening results and other referrals.<sup>42</sup> Children are referred to the program from a number of sources to include the military, private physicians, mental health, hospitals, schools, state agencies, friends/neighbors, juvenile court services and the like.

As of July 1, 2002, the program was serving a total of 417 children. This is a snapshot in time number.<sup>43</sup> There is no limit on the number of persons that can be served each year; however, staff reports CSHCN did once project overspending their budget in April 2000. This is the only time this occurred and the staff simply stopped accepting new applications for that program year and continued to serve their ongoing caseload until July 2000 when they resumed accepting new applications. Staff reports there is no waiting list for services.

#### Special Supplemental Food Program for Women, Infants and Children (WIC)

WIC is a USDA federally funded program operated by the Health Division to provide nutritional food and education to pregnant (or recently pregnant) women, infants and children up to age 5. Households receiving WIC benefits must have moderately low incomes or be receiving Temporary Assistance to Needy Families (TANF), Medicaid or Food Stamps and be determined to have a nutritional risk at a WIC clinic.

To address the subject of wait lists, WIC benefits are provided to persons meeting certain priorities. WIC infants are priorities 1, 2 and 4 depending on risk code, with priority 1 being the highest risk, priority 2 is infant of a mother eligible or would have been eligible for WIC during pregnancy; priority 4 is nutritional risk only. Children are priorities 3 and 5. Priority 3 are high risk children with the following types of problems e.g. metabolic disorders, cleft-craniofacial disorders, feeding disorders, failure to thrive, etc. Priority 5 is strictly nutritional risk based on poor diets. Should a wait list become necessary, priority 5 children will be wait listed after priority 6 postpartum women. It is not anticipated that any wait list, if required in Nevada, would go beyond priority 5.

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<sup>41</sup> Special Children's Clinics FY02 Statistics Reports dated July 2, 2002 and August 23, 2002.

<sup>42</sup> Health Division, Bureau of Family Health Services Data, August 2002

<sup>43</sup> Ibid.

## ***DEPARTMENT OF EDUCATION***

The Individuals with Disabilities Education Act (IDEA), Part B, is a federal program administered nationally by the U.S. Department of Education's Office of Special Education Programs (OSEP), and in Nevada by the state's Department of Education. As part of its responsibilities, OSEP administers the Individuals with Disabilities Education Act (IDEA), intended to ensure that the rights of children and youth with disabilities and their parents are protected. IDEA, Part B regulations govern the Special Education Programs administered by the Nevada Department of Education (NDE).

The Individuals with Disabilities Education Act has a long history. Prior to its implementation in 1975, approximately 1 million children with disabilities were shut out of schools and hundreds of thousands more were denied appropriate services. Since then, many are learning and achieving at levels previously thought impossible. They are graduating from high school, going to college and entering the workforce as productive citizens in unprecedented numbers.

Ninety percent of children with developmental disabilities were previously housed in state institutions. Today, they are no longer in those settings. Compared to their predecessors, three times the number of young people with disabilities are enrolled in colleges or universities, and twice as many of today's 20 year olds with disabilities are working.

On a national level,

- Twice as many children with disabilities drop out of school;
- Dropouts do not return to school, have difficulty finding jobs and often end up in the criminal justice system;
- Girls who drop out often become young unwed mothers—at a much higher rate than their non-disabled peers;
- Over 1 million children, many of whom would have been placed in separate schools and institutions 25 years ago, are being educated in neighborhood schools, saving an average of \$10,000 per child per year;
- Nine percent more children with disabilities graduated from high school between 1984 and 1992;
- Youth served under IDEA are employed twice as often as their predecessors, older Americans with similar disabilities who were not served under the law; and
- Nearly half of all adults with disabilities have successfully completed course-work in colleges and universities.<sup>44</sup>

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<sup>44</sup> OSERS website at [www.ed.gov/offices/OSERS.html](http://www.ed.gov/offices/OSERS.html), *IDEA '97 General Information, Overview*, 8/26/02.

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Under federal and state law, every student with a disability between the ages of 3 and 21 is entitled to receive a free appropriate public education (FAPE). Special education programs in Nevada’s seventeen school districts and in the Nevada Youth Training Center serve students with identified disabilities in one of the twelve categories established in the NRS, Chapter 388. School districts must provide the services necessary to assure FAPE for all students with disabilities, without regard to the adequacy of state revenues to support the associated costs.

Eligibility for special education services is established through conducting a series of assessments, evaluating the results, and determining whether a student meets the criteria established in the Nevada Administrative Code for each of the eligibility categories. Parents, teachers, school psychologists, and other specialists comprise the teams that make eligibility decisions.

On December 1, 2000, there were 38,163 students, ages 3-21, in Nevada who were eligible for and receiving special education services.

**Table 102  
SPECIAL EDUCATION STUDENTS  
BY COUNTY/FACILITY  
December 1, 2000**

<b>County/Facility</b>	<b>Number</b>
Carson City	1,199
Churchill	667
Clark	24,497
Douglas	783
Elko	1,061
Esmeralda	8
Eureka	68
Humboldt	542
Lander	177
Lincoln	72
Lyon	938
Mineral	174
Nye	887
Pershing	189
Storey	96
Washoe	6,532
White Pine	250
Nevada Youth Train Center	23
<b>STATEWIDE TOTALS</b>	<b>38,163</b>

Source: Nevada Department of Education 3/29/01

According to the law, “special education” means “specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability.” The instruction can be provided in many locations including the general education classroom; a resource room; a

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self-contained program; a special school; a hospital or home setting; or a residential school. Regardless of the location, the program must be provided in accordance with an annual Individualized Educational Program (IEP) developed by parents and educators. The law requires that students with disabilities be served in the “least restrictive environment” which means that removal of the student from the regular educational environment must be based on the student’s unique needs and determined through the IEP process.<sup>45</sup>

**Table 103  
PERCENT OF STUDENTS SERVED  
BY PLACEMENTS, BY DISTRICTS  
SCHOOL YEAR 2000-2001**

<b>County/Facility</b>	<b>Regular 80-100% in Reg Ed</b>	<b>Resource 40-79% in Reg Ed</b>	<b>Separate 0-39% in Reg Ed</b>	<b>Public Separate</b>	<b>Private Separate</b>	<b>Public Residential</b>	<b>Private Residential</b>	<b>Home Hospital</b>
Carson City	63.98%	22.99%	12.31%					0.09%
Churchill	62.74%	30.77%	6.50%					
Clark	42.41%	35.36%	19.50%	2.34%		0.02%		0.37%
Douglas	80.69%	17.64%	1.67%					
Elko	61.63%	30.97%	7.30%				0.10%	
Esmeralda	85.71%	14.29%						
Eureka	62.07%	37.93%						
Humboldt	71.61%	27.96%	0.43%					
Lander	56.29%	34.44%	8.61%					0.66%
Lincoln	91.67%	8.33%						
Lyon	66.79%	27.39%	4.73%	0.61%				0.48%
Mineral	56.16%	39.73%	4.11%					
Nye	49.36%	38.01%	11.86%	0.13%				0.64%
Pershing	89.16%	10.24%	0.60%					
Storey	63.04%	33.7%	2.17%					1.09%
Washoe	65.63%	20.6%	11.51%	2.11%		0.05%		0.1%
White Pine	81.22%	16.9%	0.94%				0.47%	0.47%
Nv Youth Train Ctr	100%							
<b>STATEWIDE TOTALS</b>	<b>50.71%</b>	<b>31.33%</b>	<b>15.73%</b>	<b>1.89%</b>	<b>0.00%</b>	<b>0.02%</b>	<b>0.03%</b>	<b>0.30%</b>

Source: Nevada Department of Education 10/1/01

Students are entitled to receive “related services” if those services are necessary to assist the student in benefiting from special education. Related services are defined in federal regulations as “transportation, and such developmental, corrective, and other supportive services required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.”<sup>46</sup>

<sup>45</sup>Special Education In Nevada, NDE Educational Equity Team, February 2001

<sup>46</sup>Special Education In Nevada, NDE Educational Equity Team, February 2001.

The number of students receiving special education services represented approximately 11% of the total school enrollment for the year 2001. Those with learning disabilities, speech/language impairments, and health impairments comprised nearly 79% of Nevada’s students with disabilities; more than half of those students spent more than 80% of their school day in regular classrooms. In a recent five-year period, the number of students enrolled in special education programs statewide increased about 35%, compared to the growth in total school enrollment at about 30%. Special education populations grew at approximately double the rate of general education populations during the early 1990s, primarily due to the state legislature’s mandate in July 1990 that local school districts begin providing services to students at age three.<sup>47</sup>

**Table 104**  
**Students With Disabilities**

<b>Fiscal Year</b>	<b>Number of Students</b>
FY 2001	38,163
FY 2000	35,847
FY 1999	33,294
FY 1998	31,726
FY 1997	29,946

Source: Special Education in Nevada, NDE, Educational Equity Team, 02/01

Between 1997 and 1999, growth rates in special education and general education were nearly identical, approximately 6% in 1997 and 5% in 1999. During the next two years, special education population increased at a slightly higher rate than general education, 6.4% compared to 4.6%.

As Nevada has experienced increased growth in the entire state population, so has it experienced increases in the special education population. A related growth issue is the increase in ethnic minority student populations. The number of Limited English Proficient (LEP) students grew over 500% in a ten-year period. Nevada had 4,456 LEP student in FY1988 and 27,997 in FY1997. In FY1999 there were 34,202 students with Limited English Proficiency served by the local school districts in the state.

The cost of educating students with disabilities is approximately 2.5 times the cost of educating students in the general population. This includes both the general education and specialized program costs for students with disabilities. Costs associated with providing mandated special education and related services include: salaries and benefits, student evaluations, speech therapy, physical therapy, counseling, specialized equipment, regular and specialized and transportation, costs associated with general classroom participation, materials, supplies, and the educational costs not unique to special education, such as utilities, maintenance, and administration.

Federal funding through IDEA is available for supplementing the student’s special education costs. Federal support for special education is generated on a census-based formula. Funds

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<sup>47</sup>State of Nevada, IDEA Part B & Part C, Self Assessment Findings, December 2001.

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are granted to local school districts based partly on a count of special education students taken each year on December 1<sup>st</sup>, and partly on relative poverty rates. While there have been steady gains in the overall allocation, those gains have been so small that the proportion of federal support to state and local support has actually declined.

Special education programs receive a combination of federal, state, and local revenue. The requirements for the programs are set by federal law (IDEA), state law (NRS) and regulations set by the Nevada State Board of Education, and local policies set by the local boards of trustees of the school districts. Due to the individualized nature of the program, the services in school districts vary based on the unique needs of their students with disabilities. Special education students participate in the general education classroom to the maximum extent appropriate and receive supplemental services based on their IEPs. Therefore, costs associated with educating students with disabilities exceed the districts' funds available to operate the basic education program. Table 105 reflects the growing differences between state and local expenditures for special education:

**Table 105**  
**Nevada Expenditures for Special Education**  
**Comparison of Funding Sources**

	<b>FY 1994</b>	<b>FY 1997</b>	<b>FY 2000</b>
State Expenditures	\$40,884,480	\$48,117,392	\$60,007,167
Local Expenditures	\$69,336,336	\$104,903,155	\$143,861,090
<b>Total Expenditures</b>	<b>\$110,220,816</b>	<b>\$153,020,547</b>	<b>\$203,868,257</b>

Source: Special Education in Nevada, NDE, Educational Equity Team, 02/01

Beginning in 1973, state law provided a “unit” funding mechanism for school districts to operate specialized educational programs for students with disabilities. A unit is defined as “an organized unit of special education and related services which includes full-time services of persons licensed by the superintendent of public instruction or other appropriate licensing body, providing a program of instruction in accordance with minimum standards prescribed by the state board.”

In the early 1970s, units were funded in a number and for an amount per unit that approximately equaled the average teacher’s salary and benefits. That meant units could be used for special education salaries and benefits only, and additional expenses were covered by state and local funds in the basic support guarantee, federal funds, and supplemental local funds as necessary. Over time the unit funding has not kept pace with the actual number of units operating or with the growth in teachers’ salaries and benefits. As Table 105 reflects, over the past several bienniums, local school districts have used an increasing amount of local revenue to fund special education programs and services. Table 106 shows the special education unit funding for a recent ten-year period:

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**Table 106  
Nevada Special Education  
Unit Funding**

<b>Fiscal Year</b>	<b>Number Of Units</b>	<b>Funding Per Unit</b>
FY92	1389	\$25,956.00
FY93	1475	\$26,200.00
FY94	1560	\$26,208.00
FY95	1645	\$26,208.00
FY96	1746	\$26,739.76
FY97	1857	\$27,151.22
FY98	1976	\$27,694.00
FY99	2088	\$28,248.00
FY00	2186	\$28,813.00
FY01	2291	\$29,389.00

Source: Special Education in Nevada,  
NDE, Educational Equity Team, 02/01

Although state special education funds are distributed “equitably” among the local school districts, the diminishing level of support creates a vulnerability to legal challenges on the basis of “adequacy.” As Nevada’s schools are preparing students to exit the system, it is imperative they meet the needs of those individuals, particularly the students with disabilities. Table 107 details the numbers of students between the ages of 14 and 21, by category of impairment, exiting the system during the school year 2000-2001:

**Table 107  
Students Exiting Special Education  
During 2000-2001**

<b>County/Facility</b>	<b>Returned to Reg Education</b>	<b>Graduation Standard Diploma</b>	<b>Adjusted Diploma Cert of Attend.</b>	<b>Reached Max Age</b>	<b>Dropped Out</b>	<b>Other (Moved, etc.)</b>	<b>Total</b>
Carson City	11	38	18	0	24	61	<b>152</b>
Churchill	18	11	9	0	0	45	<b>83</b>
Clark	148	319	404	0	652	860	<b>2383</b>
Douglas	6	8	13	0	4	32	<b>63</b>
Elko	9	21	17	0	19	40	<b>106</b>
Esmeralda	0	0	0	0	0	0	<b>0</b>
Eureka	0	2	3	0	0	2	<b>7</b>
Humboldt	3	5	5	0	3	26	<b>42</b>
Lander	5	4	4	0	0	21	<b>34</b>
Lincoln	0	0	1	0	0	0	<b>1</b>
Lyon	9	12	28	0	7	51	<b>107</b>
Mineral	0	1	3	0	1	3	<b>8</b>
Nye	7	16	31	7	23	22	<b>106</b>
Pershing	4	2	3	0	0	4	<b>13</b>
Storey	0	1	3	0	0	0	<b>4</b>
Washoe	8	48	133	0	0	101	<b>290</b>
White Pine	0	4	2	0	0	17	<b>23</b>
Nv Youth Train Ctr	0	0	1	0	0	34	<b>35</b>
<b>STATE TOTALS</b>	<b>228</b>	<b>492</b>	<b>678</b>	<b>7</b>	<b>733</b>	<b>1,319</b>	<b>3,457</b>

Source: Nevada Department of Education Report of 10/01/01

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Parents and students dissatisfied with the actions of the school districts with regard to their assessments, IEPs, education, etc., are entitled to file a complaint that is investigated. The NDE has established a complaint investigation system in compliance with IDEA procedural requirements. Federal and state laws require an investigation be conducted and a decision issued within 60 days of receipt of a complaint alleging a violation of IDEA. During FY1998-2001, 88 complaints were received and decisions rendered within the 60-day time limit.

Parents and students who disagree with the proposal or refusal of the district regarding identification, evaluation, placement and FAPE also have access to due process and appeal procedures in federal law.

Issues/Trends/Innovations as Reported by the Agency

*1. Transitioning from School*

A major issue related to children with disabilities is how they are prepared for transition from school to post-secondary education, work, and community life. As children age and exit the educational system, they must be adequately prepared for the next phase of their lives. Table 108 illustrates the numbers of children in special education in Nevada based on age at the annual count conducted December 1, 2001. These children can be expected to exit the educational system within eight years of the date of the count.

**Table 108  
Special Education Report  
Count of Children by Age & Impairment  
December 1, 2001**

Eligibility/Impairment	Ages								Total
	14	15	16	17	18	19	20	21	
Mentally Retarded	140	152	131	138	120	64	45	23	813
Hearing Impaired	41	33	38	18	20	7	1	0	158
Speech/Language Impaired	49	25	17	14	3	1	0	0	109
Visually Impaired	9	6	11	12	5	2	0	0	45
Emotional Disturbance	197	197	181	131	63	8	2	0	779
Orthopedically Impaired	15	22	16	11	8	5	2	1	80
Health Impairment	143	119	98	72	26	5	1	1	465
Learning Disabled	2,353	2,185	1,876	1,475	645	89	14	8	8,645
Deaf-Blind	0	0	1	0	0	0	0	0	1
Multiple Impairments	51	39	35	41	32	26	28	18	270
Autism	18	19	14	12	8	6	3	0	80
Traumatic Brain Injured	15	17	9	5	2	2	0	0	50
<b>Total</b>	<b>3,031</b>	<b>2,814</b>	<b>2,427</b>	<b>1,929</b>	<b>932</b>	<b>215</b>	<b>96</b>	<b>51</b>	<b>11,495</b>

Source: Nevada Department of Education Report printed 1/31/02

A great deal of progress has been made in the years since children with disabilities were mandated to receive a free and appropriate education. Enormous changes have occurred in the perceptions of educators, rehabilitation professionals and parents regarding the ability of even severely disabled people to live and work in the community. Instead of planning for

lifelong dependence, the outcomes now sought are self-sufficiency, productivity and independent living. Severely disabled students no longer need to automatically be relegated to sheltered work or day activity centers. Thousands of severely disabled people have become competitively employed in independent work sites. As these students finish school and look toward the future, the question becomes what will happen to them after they leave the school system. Several studies indicate the overwhelming majority of these children stay at home or work only in non-integrated settings. Some observations from these studies are:

- a) Vocational and transitional programming begin too late in the disabled student's academic lifetime and do not emphasize job placement as the culminating outcome;
- b) Parents are not being provided opportunities to acquire the skills and knowledge necessary to effectively support and participate in the transitional process;
- c) Transitional planning does not evolve from an interagency assessment of needs and resource commitments; and
- d) Emerging innovations in technology and vocational training are not being incorporated into the transitional process.

There are serious ramifications to these observations:

- Without early, specific planning for vocational transition, students will not receive a quality post-secondary program, nor will they enter the labor force;
- Without strong parental support and involvement, implementation of transitional services will have little or no chance of succeeding;
- Without cooperative planning among agencies for individual transition, inadequate resources and lack of follow through will defeat transitional objectives; and
- Without thorough integration of technology and supported employment, the majority of severely disabled students will never function at the level of their true ability.

Transition from school to the work place requires movement through school instruction, planning for the transition process and placement into meaningful employment or post-secondary education. All available resources must be identified and continually scrutinized for quality, appropriateness and adequacy in advancing established transitional objectives. Such an investigation should result in expansion and restructuring of transitional services to meet real rather than perceived needs of disabled students.<sup>48</sup>

Even the Office of Special Education Programs recognizes the importance for preparing and planning for the transition of children with disabilities from school to the community. One of the IDEA accomplishments of which they are most proud is: "Although less than 1% of the annual expenditures to educate children with disabilities is spent on research and development to improve practice, these dollars have had exponential results. They support

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<sup>48</sup> *Nevada State Transition Plan, 1990-1993, Interagency Planning Strategies to Assure the Effective Transition of All Nevadans with Disabilities from School to Post-Secondary Education, Work and Community Life*, A Cooperative Project of, Nevada Departments of Education and Human Resources, et al.

programs that allow children with disabilities to become independent learners and self-supporting adults.”<sup>49</sup>

## *2. Qualified Staff Needed*

There is a critical need for qualified staff in special education, particularly for positions in specialized fields (e.g., autism) or for positions in rural areas of the state. For the school years 1998-2000, local school districts reported expectations of more than 300 vacancies in special education personnel including teachers, related service providers, school psychologists, and administrators. During the 2000-2001 school year, school districts reported employing approximately 80 special education teachers that were not fully certified.<sup>50</sup>

For those already working in Nevada’s school districts, there is a need to enhance training for general educators who teach students with disabilities in their classrooms. Further, there is a need for training teachers and school administrators in meeting the legal requirements of state and federal law. Access to training, particularly in rural areas and for educators working with students with low-incidence disabilities, remains a challenge.

## *3. Instruction Materials*

Developing instruction materials and services assuring meaningful student participation in general education curriculum is of primary concern to special education instructors. If students with disabilities are expected to learn to the same high standards as other students, they must have the same curricula, goals and opportunities.

## *4. State Standards/Assessments*

Educators, parents, and policymakers are concerned about the appropriateness of state standards and assessments as applied to students with disabilities, particularly if students have had limited access to the general education curriculum. Special education students, as all other students, are required to pass the high school proficiency examinations to obtain a standard high school diploma. However, accommodations may not change the nature, content, or integrity of the test(s). Special education students are eligible for an adjusted diploma if they complete the requirements of their IEPs even if they do not pass the high school proficiency examination. Financial support for post-secondary education through the Millennium Scholarship is only available for students who have passed the high school proficiency exam. This is certainly limiting for special education children who wish to pursue post-secondary education. Additionally, many students earn an adjusted diploma in lieu of a standard diploma, which may limit their options for military service, admission to higher education, and potential job opportunities.

## *5. Accessibility to Technology*

Another high priority is the assurance students with disabilities have access to technology in the schools.

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<sup>49</sup> OSERS website at [www.ed.gov/offices/OSERS.html](http://www.ed.gov/offices/OSERS.html), *IDEA '97 General Information, Overview*, 8/26/02.

<sup>50</sup> *Project IMPRV, Final Report Self-Assessment*, Nevada Department of Education, Part B, Special Education Services, December 2001.

*6. Incompatible Data Systems*

Other than the mandated data, school districts do not each collect identical data regarding special education students and services. This impacts the state’s ability to gather data pertinent to the services delivered to these students. For example, during a survey of districts by the NDE, only four were able to provide the number of students for whom assistive technology services and devices were provided during FY01. Other districts reported, “this data could be collected given sufficient time and resources.”<sup>51</sup>

**NEVADA CHECK UP**

Nevada Check Up is the State Children’s Health Insurance Program, established by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. The Nevada program was established as separate from the Medicaid program and as such, is not an entitlement program. Nevada Check Up provides affordable, comprehensive health insurance to children ages 0 through 18 who are from families at or below 200 percent of the federal poverty level, are uninsured and ineligible for Medicaid. The family pays a quarterly premium of \$10, \$25 or \$50 based on gross annual income; and there are no co-payments or deductibles. Some families with very low incomes may have the premiums waived, and premiums are always waived for Native Americans from federally recognized tribes.

The program, administered by the Division of Health Care Financing & Policy, began on October 1, 1998 in Nevada with an enrollment of 1,603 children. As of August 1, 2002, there were 23,993 enrolled.

**Table 109**  
**Nevada Check Up**  
**Average Number of Enrollees**  
**FY00-02**

<b>2000</b>	<b>2001</b>	<b>2002</b>
8,079	14,985	20,781

Nevada Check Up Program 08/02

The mission of the Nevada Check Up program is to provide health insurance to every eligible child in Nevada. Increasing enrollment of children is a division goal for both Medicaid and Nevada Check Up. Toward that end, the division works with local coalitions that provide education and outreach to assist families in applying for the Nevada Check Up or Nevada Medicaid. The Nevada Covering Kids Coalition, and its local projects, serves as the primary outreach entity for both medical assistance programs. Staff work to develop partnerships with the business community so employees who cannot afford private health insurance premiums may have the alternative of applying for Check Up.

Children receive health care services through contracted managed care plans in Clark and Washoe counties, and on a fee-for-service basis elsewhere in Nevada. Children enrolled in Nevada Check Up receive health care benefits that include:

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<sup>51</sup> Nevada Department of Education, Project IMPRV, December 2001

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Inpatient hospital	Outpatient hospital	Ambulance
X-Ray	Dental	Physician Services
Mental Health	Vision	Prescription Drugs
Chiropractor	Home Health	Hearing Aids
Well Baby/Well Child	Immunizations	Laboratory Services

Program costs are reflected below:

**Table 110  
Nevada Check Up  
Average Annual Cost Per Enrollee  
FY00-02**

2000	2001	2002
\$1,344.32	\$1,320.21	\$1,254.68

Nevada Check Up Program 08/02

For those children who reside outside Clark and Washoe counties, services may be obtained from any Medicaid provider who accepts Nevada Check Up.

Nevada Check Up serves all eligible children without regard to disabilities. Although many enrollees may have disabilities, coverage is based on eligibility criteria noted above and includes children with and without disabilities.

**Children’s Services Conclusion**

This section on Children’s Services is intended to provide a concise description of the various programs and services provided to children with disabilities by the state agencies that focus their activities on children. The section became quite large due to the fact there are so many state agencies which serve children. Whether through IDEA’s education grants, or state custody foster care, whether providing special foods, or clinics helping children with special health care needs, Nevada has a wide number of agencies engaged in helping children with medical, social and community support needs.

The difficulty arose in isolating children with disabilities from the general population of children being assisted. In some of the agencies that task was straight forward, while it was almost impossible in others. Consequently, the descriptions provided document, to the extent possible, the program activities and services offered to children with disabilities, account for who receives those services, describe the way in which services are provided, and, when available, list the costs associated with the services.

The descriptions are intended to document the efforts of the state agencies’ operations of the programs. It is hoped the reader has been provided sufficient information on the services available for children in general, and specifically for children with disabilities, through these Children’s Services programs to assist in understanding the programs and operations.

## ***THE NEVADA HOUSING DIVISION***

The Housing Division, Department of Business and Industry, was created by the Nevada Legislature in 1975 when it was recognized that a shortage of safe, decent, and sanitary housing existed throughout the state for persons and families of low to moderate income. The mission of the division is to assist and encourage the private sector and other government entities in the creation and maintenance of affordable housing throughout the state.

The division's programs include:

### **A. The Single Family Mortgage Purchase Program**

This program provides mortgage loans to qualified buyers at interest rates below the conventional market interest rate, making home ownership affordable to a broader range of Nevadans.

### **B. Multi-Family Project Bond Financing**

The Housing Division is the designated issuer of tax-exempt housing revenue bonds in Nevada. Bond financing for affordable housing projects is a method of financing in which tax exempt and taxable mortgage revenue bonds are utilized to fund permanent mortgages for affordable housing projects.

### **C. The Low-Income Housing Tax Credit Program**

This is a federally regulated state administered program designed to help eliminate the funding gap in the creation of low- and very low-income housing projects. Federal tax credits, awarded on a competitive basis, provide equity financing for affordable housing projects.

### **D. The Investment Partnership Program (HOME)**

HOME is a federally funded, large-scale program for affordable housing which allocates funds by formula to participating jurisdictions (state and local governments which receive funds to operate the program). HOME is designed as a partnership among the federal, state and local governments, and those in the private sector (profits and not-for-profits) which build, own, manage, finance and support low-income housing initiatives.

### **E. The Account for Low-Income Housing (Trust Fund)**

The Trust Fund is a state-funded program for the express purpose of affordable housing. Funds are allocated by formula to participating jurisdictions (state and local governments) to expand the supply of rental housing through new construction and rehabilitation of multi-family projects. The Trust Fund may also be used to provide financing for down payment assistance and homeowner rehabilitation of single family residences, and to provide emergency assistance to families in danger of becoming homeless.

**F. The Emergency Shelter Grant (ESG) Program**

ESG was established in 1989 to improve the quality of existing emergency shelters for the homeless; make available additional emergency shelters, meet the costs of operating emergency shelters; and provide certain essential social services to homeless individuals so these persons have access not only to safe and sanitary shelter, but also to the supportive services and other kinds of assistance they need to improve their situations.

ESG is also intended to restrict the increase in homelessness through the funding of preventive programs and activities.

**G. The Low Income Weatherization Assistance Program (WAP)**

WAP was established in 1977 to assist low income persons in reducing their utility bills by providing energy conservation measures. With the exception of multi-family buildings (5 or more units per building) assistance is provided free of charge and no liens or financial obligations are placed on individuals receiving assistance.

**H. Issues/Trends/Innovations as Reported by the Agency**

Since its inception the Housing Division has financed housing for more than 35,000 Nevadans, many of whom are people with disabilities. The division has worked closely with the Office of Community Based Services and the Council on Developmental Disabilities since 1990, committing \$937,493 in trust funds to housing initiatives designed to provide homeownership and supported living opportunities to 244 low-income people with disabilities.

In late 2001, BBC Research and Consulting (BBC) was contracted by the division to conduct a housing needs assessment of special needs populations in the greater Las Vegas and Reno/Sparks areas. The purpose of the special needs housing study was twofold: 1) to obtain population estimates of people with special needs in Las Vegas and Reno; 2) and to determine the rental housing needs of the special needs populations in these areas. The information provided by the study will be used by the Housing Division to facilitate planning and resource allocation. The study's special needs populations include people with Alzheimer's/dementia, physical and developmental disabilities, mental illness, HIV/AIDS, homeless people age 55 and older, victims of domestic violence, and parolees.

The study covers Clark and Washoe counties and includes Las Vegas, North Las Vegas, Boulder City, Henderson, and unincorporated Clark County, and the cities of Reno, Sparks and unincorporated Washoe County.

***NEVADA DEPARTMENT OF TRANSPORTATION***

The mission of the Nevada Department of Transportation (NDOT) is to efficiently plan, design, construct and maintain a safe and effective transportation system for Nevada's travelers taking into consideration the environment, economic and social needs and intermodal transportation opportunities.

The department is responsible for planning, constructing, operating and maintaining 5,400 miles of highway and nearly 1,000 bridges which comprise the state highway system. Among its programs, NDOT administers the Federal Transit Administration's Section 5310 program for "Elderly and Persons with Disabilities Transportation," Section 5311 "Small Urban and Rural Public Transportation," and the "Job Access Reverse Commute" program which provides public transportation for low-income workers. The aforementioned programs provide services to people with disabilities, including those on tribal reservations.

NDOT and its providers serve all Nevada counties and serve people with disabilities in rural areas including Battle Mountain, Carlin, Eureka, Goldfield, Hawthorne, Lovelock, Mesquite, Tonopah, Wells, the Amargosa Valley, Beatty, Crescent Valley, Gerlach, Imaly, Indian Springs, Mina, and Zephyr Cove.

Through 10 disability sub-recipient providers, NDOT provided 152,426 rides to people with disabilities in 2001 and \$539,383 in disability-specific services. Additionally, NDOT, through its Small Urban and Rural Riders program, provided vehicles and funding to 11 disability service providers and 12 tribal services programs.

Rides provided to people with disabilities in 2002, although not fully counted as of this writing, are projected to exceed 175,000.

NDOT closely collaborates with the Office of Community Based Services, and with the Nevada Centers for Independent Living in designing and providing services to people with disabilities throughout the state. Additionally, people with disabilities serve on the NDOT Statewide Transportation Advisory Committee for Transit.

Future plans for specialized public transportation to people with disabilities include service in Pahrump and to the Duck Valley Indian Reservation. A new and exciting program planned by NDOT called Care Ride is being developed to provide transportation services for people with disabilities, seniors and the general public for dialysis, chemotherapy, and other medical needs.

## ***REHABILITATION DIVISION***

The Rehabilitation Division is one of the divisions within the Department of Employment, Training, and Rehabilitation (DETR). The Rehabilitation Division is comprised of three bureaus. The two bureaus providing direct services to the disabled are the Bureau of Vocational Rehabilitation and the Bureau of Services to the Blind and Visually Impaired.

According to a 1994 Harris poll, there are approximately 43 million Americans with disabilities. Roughly 66% of those who are working age are unemployed. The poll found 60% of those who rate their impairments as “slight” are working, but only 8% of those with “very severe” disabilities are working. To assist the population of unemployed persons with disabilities in joining the workforce, the bureaus provide comprehensive rehabilitation services that go beyond those found in routine job training programs.

### **A. Bureau Vocational Rehabilitation**

The Bureau of Vocational Rehabilitation (BVR) provides vocational rehabilitation services to eligible individuals with disabilities to assist them in preparing for and obtaining meaningful employment. The Vocational Rehabilitation program specializes in services for Nevadans with disabilities, especially those with the most severe disabilities, consistent with their skills, abilities, and informed choice. Services may include testing and assessment, vocational training, medical evaluation and treatment, mobility evaluation and training, life skills training, evaluation for and purchase of assistive technology, vocational evaluation, career exploration, job placement, and supported employment.

To be eligible for BVR services, a person must have a physical or mental impairment that is a substantial barrier to employment, be able to benefit from vocational rehabilitation services in terms of employment, and require vocational services to prepare for, enter, engage in, or retain employment. BVR also assists disabled persons to locate employment by developing and maintaining close relationships with local businesses. BVR enables persons to become tax-paying citizens and reduce their reliance on public assistance programs.

The provided services are an assessment for determining eligibility and vocational rehabilitation needs by qualified personnel; counseling and guidance; referral and other services to secure needed help; job-related services, e.g., job search and placement assistance, job retention services, follow-up, etc.; vocational and other training services, e.g., vocational adjustment services, books, tools, etc.; to the extent financial support is not available from another source, diagnosis and treatment of physical and mental impairments, including corrective surgery, prosthetic devices, eyeglasses, special services, and diagnosis and treatment for mental/emotional impairments; maintenance for additional costs incurred while participating in an assessment of determining eligibility and vocational rehab needs; transportation; on-the-job or other personal assistance services; interpreter services provided by qualified personnel; rehabilitation teaching services for persons who are blind; occupational licenses, tools, equipment, and initial stock and supplies; technical assistance/other consultation services to conduct market analyses, develop business plans and

the like; rehabilitation technology, including telecommunications, sensory and other technological aids; transition services; supported employment services; and specific post-employment services necessary to retain/regain/advance employment. Only those services related to preparing for/obtaining/keeping a job may be provided.

Under the Workforce Investment Act, the division partners with DETR Employment Services, Job Opportunities in Nevada (JOIN), Nevada Business Services, and community-based non-profit agencies to provide employment services to people with disabilities. Under the newly passed federal “Ticket to Work” program, people with disabilities will be allowed to select the provider of their choice for employment services through the implementation of a voucher system.

**B. Bureau of Services to the Blind and Visually Impaired**

The Bureau of Services to the Blind and Visually Impaired (BSBVI) provides comprehensive rehabilitation services to individuals with blindness or severe visual impairments to accommodate disabling conditions and reduce dependency for such individuals whose disabilities present a barrier to employment and/or self-sufficiency. The bureau determines program eligibility of individuals whose vision is not correctable by ordinary eye care.

Services available for eligible individuals may include medical evaluation and treatment, low vision examinations and aids, mobility evaluation and training, life skills training, counseling, vocational evaluation and career exploration, vocational training, job readiness training, and assistance in obtaining employment. The specific services are comparable to the detailed list enumerated under BVR.

The bureau is also the state-licensing agency for the Randolph-Sheppard Act designed to provide training, placement and management services to legally blind persons who operate food service and other types of businesses in public buildings and private sector operations. BSBVI has four distinct service programs to serve Nevadans who are blind or visually impaired: 1) vocational rehabilitation, 2) older blind independent living, 3) life skills training, and 4) the blind business enterprise program.

**C. Service Costs for Ongoing and New Clients**

The Rehabilitation Division provided the following data on ongoing and new enrollees into their programs:

**Table 111  
Rehabilitation Division  
Ongoing & New Enrollees**

State Fiscal Year	General (BVR)		BSBVI		Total Served
	Ongoing Cases	New Enrollees	Ongoing Cases	New Enrollees	
2000	3,461	3,114	251	185	7,011
2001	3,519	2,868	259	268	6,914
2002	3,109	3,125	302	309	6,845

Source: DETR Data 8/02 & 8/27/02

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In SFY02, the two bureaus served a total of 6,845 clients. Of those persons, the Bureau of Vocational Rehabilitation served 6,234 (91%) and 611 (9%) were served by the Bureau of Services to the Blind and Visually Impaired.

**Table 112  
Rehabilitation Division  
Cost to Serve Ongoing & New Enrollees**

	Clients Served FY02	Cost to Serve FY02
General (BVR)	6,234	\$12,699,161
BSBVI	611	\$3,493,133
<b>Total</b>	<b>6,845</b>	<b>*\$16,192,294</b>

Source: DETR Data August 2002  
\* Total FY02 Budget for BVR and BSBVI

The average cost to serve 6,845 clients in SFY02 was \$2,366 per person. Of those 6,845 clients, 3,434 (50%) were new enrollees. As a result, the total estimated cost of serving all new enrollees in FY02 was \$8,124,844 (new enrollees times the average cost to serve). It should be noted the total cost to serve clients includes all operating, personnel and case service costs.

The new enrollees use the services of both bureaus. Both the Bureau of Vocational Rehabilitation and the Bureau of Services to the Blind and Visually Impaired have no waiting list and are not currently under an “order of selection.” Order of selection means the division, under federal regulations and public hearings, has established who will be served first.

Although the bureaus have no waiting lists, people do wait for the following:

**Table 113  
Rehabilitation  
Persons Awaiting Services for SFY03 (as of August 2002)**

Type of Wait Time	General (BVR)	BSBVI	Combined
Eligibility Determination	469	27	496
Plan Development	757	78	835
Service After Plan Developed	10	1	11

Source: DETR Data, August 2002.

The average time it takes to determine one’s eligibility for service is 33 days, which is well below the federal requirement of 60 days. However, once determined eligible, there is an additional wait time for receipt of planned services. In Nevada the average time is 127 days. During this 127 day period, evaluation services, and counseling and guidance are provided to facilitate the development of vocational rehabilitation needs which result in a plan of service. The wait time between eligibility and planned service has increased since the state government hiring freeze was imposed in the fall of 2001.

**D. Transitioning Disabled Youth into Gainful Employment**

A major issue for the bureaus is working with the population of disabled youth ages 14 and up while they are in the educational system to better prepare them for the world of work.

As of December 1, 2001, there were 11,495 children between the ages of 14 and 21 classified as special education students. Of the 11,495 children, 75% are learning disabled and 25% have disabilities requiring more services, e.g. autism, traumatic brain injured, deaf-blind, vision and hearing impaired, etc.<sup>52</sup> Table 108 provides additional detail.

The chart below indicates the numbers of youth served in the past three fiscal years.

**Table 114**  
**Rehabilitation Division**  
**Transition Caseload for Youth**

State Fiscal Year	General BVR	BSBVI	Total
Fiscal Year 2000	665	22	687
Fiscal Year 2001	618	20	638
Fiscal Year 2002	598	17	615

Source: Voc Rehab Data on Trans. Caseload dated 8/28/02

**E. Issues/Trends/Innovations as Reported by the Agency**

The numbers of youth potentially requiring bureau services to prepare for entry into the world of work are identifiable and the division is cognizant of the need to augment the numbers served; however, it would take a state reprioritization of goals to do so. Staff of the two bureaus continues the challenge of providing transition services to as many youth as possible within the confines of their existing resources.

In recent years there have been a number of advancements in technologies to better assist people with disabilities in securing gainful employment. For example, in years past the blind were unable to use computers; now, with “speech input” technology, the blind and visually impaired can operate computers like any sighted member of the work force. As innovative technologies continue to enter the marketplace and become affordable once widely available, more can be done by the bureaus to serve people and avail them of favorable outcomes.

Along this same vein, as medicine and technology continue to advance in the modern age, more people are able to survive catastrophic accidents today than ever before. Likewise, children are able to survive the early stages of life in neo-natal intensive care units where a decade or two ago they would not have survived. Advances in medicine and technology help to serve those with disabilities, and augment the populations of people requiring aid, support and ongoing help with their condition.

Nevada’s economic situation has a bearing on the disabled community just as it does on the marketplace. In good economic times, it’s easier to find employment for persons with disabilities. Conversely, it’s terribly difficult in a poor economy. In line with poor

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<sup>52</sup> Nevada Department of Education Report printed January 31, 2002.

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economies comes a tightening of budgets designed to serve the same population. When no program enhancements/improvements can be injected into state budgets, program services to the disabled community are impacted. In a time of budget cuts, the problem is further exacerbated as the bureaus rely heavily on state dollars used to match available federal dollars to provide services. Department staff report, 22% of the bureaus' budgets are state dollars and 78% are federal. Lessening the ability of the bureaus to leverage federal dollars has a definite impact on service programs and customer service.

As Nevada's population continues to grow, so does the community of persons with disabilities. There's a natural growth associated with population growth and added to that the impact of medicine and technology. These are the challenges of the future for the Bureau of Vocational Rehabilitation and the Bureau of Services to the Blind and Visually Impaired.

***HOSPITALS***

Nevada hospitals provide services ranging from acute medical and long term acute care to home health service, hospice, mental, emotional and spiritual counseling, rehabilitation services, clinics, pharmaceutical, nursing home placement, mental illness inpatient and outpatient, volunteerism, and health information resources. There are eighteen hospitals located throughout northern Nevada and nineteen hospitals located in southern Nevada. For the purpose of the Strategic Plan for People with Disabilities, a survey was conducted with some of the major hospitals to ascertain what, if any medical services are offered at no cost or reduced cost, and any outreach services and educational programs offered for underserved or uninsured people with disabilities in their neighboring communities. Data was collected on the six largest hospitals located in northern Nevada and the five largest hospitals located in southern Nevada.

Summaries of services provided by the targeted hospitals are included in this write-up.

Listed below are the names and addresses of all the hospitals located throughout northern and southern Nevada for informational purposes. This list does not include campuses, clinics, and centers owned and operated by the hospitals. Hospitals marked with an asterisk were surveyed.

**Northern Nevada Hospitals**

Battle Mountain General Hospital  
535 W. Humboldt Street  
Battle Mountain, NV 89820  
(775) 635-2550

BHC West Hills Hospital  
1240 E. Ninth Street  
Reno, NV 89520  
(775) 323-0478

\*Carson Tahoe Hospital  
775 Fleischmann Way  
Carson City, NV 89703

\*Churchill Community Hospital  
801 E. Williams Avenue  
Fallon, NV 89406  
(775) 423-3151

\*Northeastern Nevada Regional Hospital  
(Formerly Elko General Hospital)  
2001 Errecart Boulevard  
Elko, NV 89801  
(775) 738-5151

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Humboldt General Hospital  
118 E. Haskell Street  
Winnemucca, NV 89445  
(775) 623-5222

Incline Village Community Hospital  
880 Alder Street  
Incline Village, NV 89451  
(775) 833-4100

Mount Grant General Hospital  
1<sup>st</sup> and A Streets  
Hawthorne, NV 89415  
(775) 945-2461

Northern Nevada Adult Mental Health Services  
480 Galletti Way  
Sparks, NV 89431  
(775) 688-2001

\*Northern Nevada Medical Center  
2375 E. Prater Way  
Sparks, NV 89434  
(775) 331-7000

Pershing General Hospital  
855 6<sup>th</sup> Street  
Lovelock, NV 89419  
(775) 273-2621

Rehabilitation Hospital of Nevada Reno  
555 Gould Street  
Reno, NV 89502  
(775) 348-5500

South Lyon Medical Center  
213 S. Whitacre  
Yerington, NV 89447  
(775) 463-2301

\*St. Mary's Regional Medical Center  
235 West Sixth Street  
Reno, NV 89520  
(775) 323-2041

Tahoe Pacific Hospital  
2375 E. Prater Way  
Sparks, NV 89434-9645  
(775) 331-1044

\*Washoe Medical Center, Inc.  
75 & 77 Pringle Way  
Reno, NV 89502  
(775) 982-4100

William Bee Ririe Hospital  
1500 Avenue H  
Ely, NV 89301  
(775) 289-3001

Willow Springs Center  
690 Edison Way  
Reno, NV 89502  
(775) 858-3303

### **Southern Nevada Hospitals**

Boulder City Hospital, Inc.  
901 Adams Boulevard  
Boulder City, NV 89005  
(702) 293-4111

Charter Behavioral Health  
System of Nevada  
7000 W. Sprint Mountain Road  
Las Vegas, NV 89117  
(702) 876-4357

Sunrise Hospital & Medical Center  
3186 S. Maryland Parkway  
Las Vegas, NV 89109  
(702) 731-8000

Mountain View Hospital  
3100 North Tenaya  
Las Vegas, NV 89128  
(702) 255-5000

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\*Desert Springs Hospital  
2075 E. Flamingo Road  
Las Vegas, NV 89119  
(702) 369-7610

Grover C. Dils Medical Center  
700 North Springs Street  
Caliente, NV 89008  
(775) 726-3171

Horizon Specialty Hospital Las Vegas  
640 Desert Lane  
Las Vegas, NV 89106  
(702) 382-3155

Integrated Health Services of  
Las Vegas  
2170 E. Harmon Avenue  
Las Vegas, NV 89119  
(702) 794-0100

Lake Mead Hospital Medical Center  
1409 E. Lake Mead Boulevard  
North Las Vegas, NV 89030  
(702) 649-7711

Montevista Hospital  
5900 W. Rochelle Avenue  
Las Vegas, NV 89103  
(702) 364-1111

Nye Regional Medical Center  
825 South Main  
Tonopah, NV 89049  
(775) 482-6233

Health South Rehabilitation Hospital  
of Las Vegas  
1250 S. Valley View Boulevard  
Las Vegas, NV 89102  
(702) 877-8898

\*Saint Rose Dominican Hospital  
102 E. Lake Mead Drive  
Henderson, NV 89015  
(702) 616-5000

Southern Nevada Adult Mental  
Health Services  
6161 W. Charleston Boulevard  
Las Vegas, NV 89146  
(702) 486-6000

\*Summerlin Hospital Medical Center  
657 Town Center Drive  
Las Vegas, NV 89144  
(702) 233-7000

Kindred Hospital  
5110 W. Sahara Avenue  
Las Vegas, NV 89102  
(702) 871-1418

UMC Rancho Rehabilitation Center  
4333 N. Ranch Drive  
Las Vegas, NV 89130  
(702) 656-0470

\*University Medical Center of  
Southern Nevada  
1800 W. Charleston Boulevard  
Las Vegas, NV 89102  
(702) 383-2000

\*Valley Hospital Medical Center  
620 Shadow Lane  
Las Vegas, NV 89106  
(702) 388-4000

*Carson-Tahoe Hospital – Carson City*

The hospital auxiliary determines needs and raises funds for community outreach programs as well as for capital improvements to the hospital. The auxiliary opened the Hospitality House where out-of-town patients' family members may stay to be close to the hospital. The auxiliary also has an ongoing program to provide needy newborns with layette clothing.

*Churchill Community Hospital - Fallon*

The diabetes program, "Choose Control," includes group survival skills, dietary counseling, foot screenings, and a monthly support group. Choose Control is conducted in four classes and as an incentive to attend, the cost of the classes is fully reimbursed if the patient attends all four sessions. The Resource and Wellness Center offers support groups for Gastric Bypass and MS, as well as conducting free blood pressure clinics and elder care classes for the caregivers. The Community Resource Library is available to surrounding communities at no

cost and includes books, videotapes and Internet access on all topics of health and wellness. Volunteers to assist with the use of the Internet are on site. The Lifeline Program allows people with disabilities the opportunity to live in the comfort of their home by providing 24-hours-a-day, 7-days-a-week monitoring by way of an in-home device called a communicator. With the press of a help button, the lifeline monitor will get the needed help immediately. There is a one-time installation fee of \$20 and a monthly fee of \$35 for this service. Community health fairs are held at a low cost for blood work and flu shots, and offered at no cost to seniors.

### *Northeastern Nevada Regional Hospital - Elko*

Formerly named Elko General Hospital, Northeastern Nevada Regional Hospital is a brand new hospital facility. The Elko General Hospital Facility was sold to the Elko School District for just \$1. Northeastern Nevada Regional Hospital provides health education services to the Senior Center and the hospital dieticians conduct seminars on nutrition. The hospital conducts community health fairs and offers blood work and flu shots at reduced costs. "I Can Cope" is a support group sponsored by the hospital through the American Cancer Society.

### *Northern Nevada Medical Center - Sparks*

Northern Nevada Medical Center is the founding member and sponsor of Susan G. Komen Breast Cancer Foundation Northern Nevada Race for the Cure. The hospital offers free and low-cost services to include monthly health fairs throughout the community and at employer work-sites. Prostate cancer, mammography, and osteoporosis screenings are conducted. Free immunizations on National Immunization Day and low-cost flu vaccines are administered. Medical services for women and families in drug and alcohol recovery programs through Lighthouse of the Sierra are offered, as well as medical services and follow-up counseling for sexually abused persons. The hospital also provides first aid stations for the public at many Sparks and Reno community events. Monthly health education seminars are held and sponsored by the hospital. The hospital is also an active partner in the Partners in Education Program, with an at-risk Sparks middle school.

### *Saint Mary's Regional Medical Center (St. Mary's) - Reno*

St. Mary's is making measurable health improvement in the lives of vulnerable, underserved people in the community, through unique programs and services developed as outreach clinics, school-based programs, mobile vans, telephone and cyberspace resources. Programs of St. Mary's Community Outreach include:

- Take Care-A-Van, mobile medical vans that work with the Washoe County School District to identify at-risk children needing medical, dental and vision care. In cooperation with the Dental Society and the Northern Nevada Dental Hygienists, the medical professionals have provided more than 12,000 children with medical and dental health and preventive services, including well-child check-ups, immunizations, vision screening and preventive and restorative dental services. Take Care-A-Van also travels to homeless and transient areas in Reno to provide medical services and dental work. St. Mary's now has 3 medical mobile vans that have provided services to an excess of 16,000 underserved, uninsured, or underinsured children, seniors, and homeless persons.

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- Project New Hope provides no-cost surgery to disadvantaged children through the collaborative efforts of volunteer doctors, nurses, clinical, and non-clinical providers. St. Mary's donates the use of the surgical services and equipment; various vendors donate medical supplies, and community partners donate non-medical goods and services. Project New Hope has performed needed surgeries for more than 70 people that could not afford the cost.
- The Nurse Triage is a tele-health service offered to the community at no cost and staffed by registered nurses 24 hours a day, seven days a week for fast advice and healthcare information.
- St. Mary's Nell J. Redfield Health Center, formerly called Neighborhood Health Center, provides low cost or free medical care to the uninsured and underserved in the southeast area of Reno and focuses on the needs of women and children. The center served in excess of 15,000 patients in 2001.
- Kids Korner, Senior Korner, and Knock and Talk are programs sponsored in conjunction with the county health department and the police department to provide medical and dental services to the uninsured and at-risk underserved children and seniors in the community.
- The Parish Nurse Program provides education, screenings, referral and advocacy on identified issues. It is staffed by registered nurses educated in community assistance.
- Sun Valley Clinic is a joint project with Sun Valley PTA, Washoe County school nurses, and St. Mary's to meet the medical needs of children with no health insurance. The clinic provides immunizations and well-baby check-ups. Common pediatric problems seen in the clinic include ear infections and tonsillitis, which if not treated, can lead to more serious conditions. The clinic served in excess of 3,800 patients. In addition, the Midwife/Well Woman program served 600 new patients.
- Senior programs include health prevention, glaucoma screenings, hearing screenings, and a variety of social activities are sponsored by the hospital for seniors.
- St. Mary's Health and Wellness program offers an array of free or low cost programs, seminars, classes, lectures, women's health screenings, immunizations, flu and pneumonia shots. Courage, Acceptance, Reassurance and Empowerment (CARE) is an ongoing cancer support group.
- The Adolescent Outreach Program extends outreach services to youth and teens by offering tobacco intervention and prevention programs to more than 2,500; reading programs to over 2,000 youth with learning disabilities; truancy and alcohol intervention projects to 400.

### *Washoe Medical Center*

Washoe Medical Center provides many support groups and a wide variety of educational classes open to the public at little or no cost and includes a diabetes program for adults, children, and seniors. Other sponsored support groups are a Stroke Support Group, Breath Easy, Friends for Life, and Quit for Good is a smoking cessation program. Nutrition counseling and education classes are held regularly by dieticians. A support and rehabilitation program called Pursued Lip Pals is offered for people with pulmonary medical problems. Other programs and classes offered are the Congestive Heart Failure Management Program and Change of Heart for people with heart problems, Yes to Life is a weekly sponsored speaker and luncheon program. Total Joint, is a hip and knee replacement class.

Everyday Fitness is pool therapy offered at discount rates, as well as free regular health screenings to members of the Washoe Senior Options.

Washoe Medical offers other health-related classes and programs as follows:

- Washoe Health Resource Center (WHRC) is open to the public weekdays and provides health-oriented books, journals, brochures, health newsletters, magazines, videos and Internet access. WHRC sponsors community and corporate health fairs to include low cost or no-cost flu and pneumonia shots, health screenings, immunizations, and education. Health Hotline is a free telephone resource, open to the community to provide 24-hour access to registered nurses for healthcare advice. Health fairs also focus on heart health screenings, cancer screenings and prevention, and stroke risk factors screening and symptom education. WHRC provides a bilingual computer program called CancerHelp, made possible by a grant from the National Cancer Institute. The database is updated monthly and is easily accessible to help people deal with a cancer diagnosis.
- Washoe Senior Options offers the emergency response system program called Lifeline. The Lifeline program sponsored by Washoe Medical Center provides support in rural communities and include Battle Mountain Lifeline, Duckwater Lifeline, Winnemucca Lions Lifeline, Carson Tahoe Hospital, South Lyon Lifeline, and Eureka Lifeline.
- The Washoe Medical Foundation is a non-profit organization established to develop fundraising projects and coordinates the use of donor money. The foundation provides shoes and a pair of sweatpants to any patient in need. Under the Susan G. Komen Grant, any needy woman with breast cancer can apply for funds for living expenses and food.
- Washoe Pregnancy Center ensures access to early pre-natal care for women who are underinsured or on Medicaid.
- Washoe Medical Center Clinic is a collaborative effort with Washoe County to ensure access to primary medical care in a physician office setting to uninsured or underinsured that qualify for care at the location.
- Washoe Medical Auxiliary provides free infant car seats for every baby born at the hospital.
- The Social Services and Spiritual Care Services Program consist of social workers and chaplains that offer mental and spiritual counseling services to patients, outpatients, and the community. They provide grief support, cancer support and counseling services, and provide information and referral services to indigent patients to proper social service agencies for needed assistance.
- Truckee Meadows Tomorrow is a community-wide effort that identifies the quality of life, and plays a leadership role to sponsor improvement programs in smoking, prenatal care, and the use of seatbelts and infant car seats.

*Desert Springs Hospital – Las Vegas*

Desert Springs Hospital does not have any outreach programs or services for people with disabilities in their neighboring community. The hospital offers a program for senior patients called Senior Advantage. Seniors must apply for membership to receive the services, discounts and benefits offered. Script Save discount prescription card provides lower prescription costs, and discounts are available through Lens Express. Blood pressure screenings are held weekly as well as many social events, seminars, health fairs, and

luncheons. Free private Medicare Information Counseling and Assistance (MICA) is also available.

### *St. Rose Dominican Hospital - Henderson*

St. Rose offers about twenty community outreach programs servicing a broad spectrum of the population with disabilities and at-risk communities. The programs summarized below are not all inclusive:

- Clinic on Wheels (COW) is a bus outfitted with medical equipment that provides free medical and dental health screenings for southern Nevada preschool students. About 1,000 children have been screened and medically served.
- Positive Impact Program, a partnership with the Clark County School District, offers medical and dental care to students who are uninsured or underinsured. More than 1,000 children have been serviced, since the program's inception in 1989.
- Helping Hands of Henderson is a community-based respite care and transportation program staffed with more than fifty volunteers to assist with transportation and errands for the poor, frail elderly and people with disabilities.
- The Transitional Housing Program provides two houses as temporary residence to homeless families so parents can find employment and earn enough to secure permanent housing.
- Baby your Baby is an information and referral service that encourages pregnant women to seek early and continuous prenatal care, regardless of their ability to pay.
- The Parish Nurse Program aims to have preventive health care available in local parishes, including providing medical screenings and educational classes. Parish Nurse also provides follow-up care for patients after they leave the hospital.
- Lifeline is a personal emergency response system that allows the frail and/or people with disabilities to access an operator through a pendant alarm system. This system allows them to continue living in the comfort of their own home and offers a measure of safety in case of injury or an emergency.
- RED (Responsible Early Detection) is a program in collaboration with the Susan G. Komen Foundation that provides diagnostic mammograms to women who are uninsured or underinsured.
- The St. Therese Center, in collaboration with the Diocese of Las Vegas, provides holistic support services to people with AIDS/HIV. St. Rose provides office space, maintenance support and technical support.
- The Henderson Teen Task Force is a community collaboration of various individuals and agencies designed to meet the changing needs of teens by increasing self-esteem through education and addresses the issues of teen pregnancy, substance abuse and violence prevention.
- The hospital serves as the agent for the Family to Family Program, a statewide educational program for families with newborns. This program provides free home visitation by a registered nurse and other educational services throughout an infant's first year of life.

### *Summerlin Hospital Medical Center – Las Vegas*

Other than sponsored support groups, Summerlin Hospital Medical Center does not have any outreach programs or services for people with disabilities in their neighboring community. The hospital provides monthly hospital-sponsored support groups for cancer, leukemia,

lymphoma, multiple myeloma and Hodgkin's disease. Summerlin Hospital also sponsors the Senior Advantage Program.

*Valley Hospital Medical Center – Las Vegas*

Other than sponsored support groups, Valley Hospital Medical Center does not have any outreach programs or services for people with disabilities in their neighboring community. The hospital provides monthly support groups for diabetes and brain tumor. Valley Hospital also sponsors the Senior Advantage Program. Through the Babies are Beautiful program, Valley Hospital offers services to pregnant women, regardless of their ability to pay, to encourage early and continuous prenatal care.

*University Medical Center (UMC) – Las Vegas*

UMC sponsors and participates in several community events to promote health and wellness in the community. Classes offered are on a variety of health-related topics and are open to the public, and most are free. UMC in collaboration with the Clark County Health District sponsors immunization clinics and well-baby checks. UMC offers diabetes education classes at no cost. Other classes offered are CPR, Safesitter, Infant Care and Development, Childbirth education, Child Passenger Safety, Smoking Cessation, and others. The hospital also sponsors the Senior Advantage Program.<sup>53</sup>

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<sup>53</sup> Data Researched through the Internet on hospitals described: [www.hospitalsoup.com](http://www.hospitalsoup.com) (Northern Nevada) Carson Tahoe Hospital, Churchill Community Hospital; Northern Nevada Medical Center; Northeastern Nevada Regional Hospital; Saint Mary's Regional Medical Center, Washoe Medical Center (Southern Nevada) Desert Springs Hospital Medical Center; St. Rose Dominican Hospital, Summerlin Hospital Medical Center, University Medical Center, Valley Hospital Medical Center 9/3 – 9/5/02; Telephone Interviews Conducted with: Linda Loeppky, Resource & Wellness Center, Banner Health System, 9/4/02; Laurie Krueger, Community & Physician Relations Coordinator, Northern Nevada Medical Center, 9/3/02; Diane Elmore, Educational Coordinator Northeastern Nevada Regional hospital 9/4/02; Becky Swanson, Director of Community Relations, St. mary's Regional medical Center, 9/4/02; Jane Torres, Communications Department, Joanne kohls, Manager of Social Srvice & Spiritual Care Services, Washoe Medical hospital; Deanna Heller, Washoe Senior Options, Lori Mitchell, 9/3/02 Washoe Health Resource Center, 9/4/02.

***UNIVERSITY AND COMMUNITY COLLEGE  
SYSTEMS OF NEVADA (UCCSN)***

In the fall of 2001, UCCSN had a total combined enrollment population of 90,080 students in the state universities and community colleges. Nevada's two universities, University of Nevada, Las Vegas (UNLV) and University of Nevada, Reno (UNR), have enjoyed continued growth since their establishments. Both universities have experienced expansion of student enrollments, programs, services, faculty members, and staff. UNLV and UNR combined student enrollment for the fall of 2001 school term was in excess of 37,900 students. Continued annual increases of student population at the universities have prompted an integration of services to students with disabilities to keep pace with the increasing enrollment numbers of disabled students. Nevada's universities recognize and strive to ensure students with disabilities have equal access to full participation, and equalization of opportunities and benefits from all programs offered to non-disabled students. UNLV and UNR have a variety of services and programs as well as cooperative extensions of services that reach out to people with disabilities in their neighboring communities. Services and programs will be described in summary and may not be all inclusive.<sup>54</sup>

Nevada State College (NSC) is the newest four-year public college addition to the UCCSN, located at 1125 Dawson Avenue in Henderson, Nevada. The initial founding class of 2002 – 2003 academic year is budgeted for 500 full-time equivalent (FTE) students and its core curriculum will be aimed at meeting current critical shortages in Nevada of qualified teachers and nurses as well as offering a strong liberal arts program. NSC is not included in this survey.<sup>55</sup>

The fall 2001 enrollment for the community colleges exceeded 52,000 students. In addition to branch campuses located in rural communities, Nevada's community colleges consist of:

Community College of Southern Nevada (CCSN) 3200 East Cheyenne Avenue Las Vegas, NV 89115 (702) 651-4000	Truckee Meadows Community College TMCC) 7000 Dandini Boulevard Reno, NV 89512 (775) 673-7042
Great Basin Community College (GBC) 901 Elm Street Elko, NV 89801 (775) 738-8493	Western Nevada Community College (WNCC) 2201 West Nye Lane Carson City, NV 89703 (775) 887-3000

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<sup>54</sup> Internet Website: [www.unlv.edu](http://www.unlv.edu) "History of UNLV" and [www.unr.edu](http://www.unr.edu) "Content/History", 8-26-02; Student Headcount figures obtained from UCCSN Administration, 9-03-02.

<sup>55</sup> Internet Website: [www.nscnevada.edu](http://www.nscnevada.edu), 8-30-02.

In contrast to UNLV and UNR, services and programs in Nevada's community colleges are lacking and not keeping pace with the population growth of students with disabilities. Community colleges are aware of the special needs and services required for students with disabilities, and all of the community colleges are in compliance with ADA laws.

The primary reason cited for insufficient services to students with disabilities is a lack of resources and funding shortages. Universities may decline entrance to students who cannot obtain passing SAT/ACT scores and any student who does not maintain the required grade point average (GPA). However, community colleges are mandated to have an open door policy and cannot deny entrance to any students with or without disabilities, which includes learning disabilities. Thus, a level of frustration is expressed because the law mandates community colleges to accept students with disabilities; however, the state legislature is not providing the necessary funds for the colleges to offer equal access to full participation, and equalization of opportunities and benefits from all programs offered to non-disabled students.<sup>56</sup> Services and programs are described in summary and may not be all inclusive.

### **University of Nevada Las Vegas (UNLV)**

The fall 2001 enrollment exceeded 23,600 and students with disabilities accounted for approximately 2% or 472 students. The annual average enrollment for the 2002 - 2003 school term is anticipated to be approximately 24,000 students, an increase of over 4 percent. It is estimated students with disabilities will be in excess of 1,700 students. Nearly one-third of the 1,700 are learning disabilities and 9% are ADD or ADHD. It is believed the actual percentage of students with disabilities may be higher, due to the fact students are not required to self-disclose disabilities.<sup>57</sup>

*The Exceptional Children's Services (ECS)* program is a function of the Department of Special Education and has operated for nearly 20 years. ECS provides psycho-educational diagnostic assessments to school age children in Clark County and surrounding areas. ECS prepares professional personnel for advanced graduate students pursuing degrees in School Psychology by utilizing graduate clinicians to work under the direct supervision of university professors. Research projects related to children with severe disabilities and mental retardation are conducted through ECS.<sup>58</sup>

*Disability Services (DS)* offers a wide array of services to students with disabilities. These services include advocacy, adaptive computer lab, equipment check-out, testing accommodations, ASL/RTC Interpreters, note-takers, research and lab assistants, alternate formats textbooks, and resources and links.<sup>59</sup>

*The Student Support Services Program* assists qualified college students with disabilities in overcoming personal concerns, academic deficiencies, and financial difficulties that could

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<sup>56</sup> Interviews conducted and brochures obtained: CCSN, Traci McGee, Disability Specialist; GBC, Phil Smith, Counselor ; TMCC Mitch Glazier, Director of Student Services; and WCC Susan Tanner, Coordinator of Disability Services.

<sup>57</sup> Telephone Interview conducted with Anita Stockbauer, UNLV Director of Disability Services.

<sup>58</sup> List and general information on services for people with disabilities obtained from Thomas B. Pierce, Ph.D., UNLV, Department of Special Education and Internet Website [www.unlv.edu](http://www.unlv.edu), 8-27-02.

<sup>59</sup> Telephone Interview conducted with Anita Stockbauer, UNLV Director of Disability Services; Internet Website [www.unlv.edu](http://www.unlv.edu), 8-27-02.

impair their chances of succeeding in college. The program provides students with disabilities the necessary tools to adjust to the demands of college and campus environments. Services offered include tutoring, advising, and providing workshops that consist of study skills, time management, note-taking and listening skills, reading and outlining textbooks, test taking strategies, report and essay writing, scholastic motivation, improving concentration and stress reduction.<sup>60</sup>

*Consolidated Students of the University of Nevada (CSUN) Preschool* is a high-quality early childhood preschool accredited by the National Association for the Education of Young Children (NYAEC). It is located on the UNLV campus and operated in conjunction with UNLV's College of Education and the university's student government. The preschool accepts all children with or without disabilities, and accepts all disabilities. There are currently 228 children enrolled 12 months to 5 years of age. The Clark County School District (CCSD) has 24 slots for children with disabilities filled during the first half of the year, and 32 slots for children with disabilities filled in the second half of the year. Approximately 65% to 85% preschoolers are children of UNLV students, with the balance belonging to faculty, staff, and the general public. The preschool works cooperatively with the CCSD, First Step Program, and the Special Children's Clinic.<sup>61</sup>

*Nevada Community Personal Assistance Services (PAS) Project* is a grant awarded by the federal government to the state Office of Community Based Services (OCBS) to monitor and evaluate the personal assistance services programs throughout Nevada. The UNLV PAS Project coordinates activities to carry out the mission of the overall project, reviews the system and compares Nevada's system with other states' PAS systems. UNLV PAS, under the guidance of the state's Personal Assistance Council and OCBS, is responsible for developing recommended training models, designing and implementing the PAS website and conducting a PAS Summit.<sup>62</sup>

### *Other Programs/Projects/Services*

- UNLV libraries fulfill the research needs of students with disabilities. UNLV libraries offer a wide spectrum of software, assistive and adaptive technology, and provide service accommodations that include assisting students to retrieve, copy, checkout, and renew library material;
- Greenspun College of Urban Affairs located at UNLV is a full-service, low-cost counseling center providing quality mental health counseling services to Las Vegas residents. Students working on advanced degrees in community counseling, psychology, and school counseling work with clients under the direct supervision of professionally qualified UNLV faculty members. The center offers counseling in anger management, anxiety, child behavior problems, coping skills, depression, and other counseling services. The center also offers Spanish-speaking services on a limited basis.
- The Lili Claire Life Skills Center will be a partnership between UNLV and the Lili Claire Foundation. The facility is currently under construction and the goal is to help people

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<sup>60</sup> Internet Website: [www.unlv.edu](http://www.unlv.edu) "Student Support Services."

<sup>61</sup> Telephone Interview conducted with Catherine Lyons, Director UNLV/CSUN, 8-28-02.

<sup>62</sup> Telephone Interview conducted with Kyle Konold, Project Director of NV PAS, and PAS Grant Material, 8-27-02.

with developmental disabilities pursue career paths and to find and retain work. Eventually the center will become a classroom for UNLV students studying special education.<sup>63</sup>

### **University of Nevada, Reno (UNR)**

In the fall of 2000, UNR's enrollment was approximately 13,100. In the fall of 2001 the number was approximately 14,300, an increase of almost 9 percent, of which 570 were students with disabilities. Four percent of the total student population is students with disabilities. It is anticipated the enrollment for 2002 – 2003 will be approximately 15,260, or a 9 percent increase in the total student enrollment. At these percentages, it is estimated that approximately 621 new students with disabilities will be attending UNR.<sup>64</sup>

*The Disability Resource Center (DRC)* was created to meet the diverse education needs of students with disabilities and ensure students with disabilities have equal access to, participate in, contribute to, and benefit from all university programs. Accommodations include reader services/books on tape, note-taking, alternative testing accommodations, adaptive computer equipment, accommodations counseling, classroom aids, interpreter services, real-time captioning, course substitutes, and Math 019/119 may be taken as a two semester course for the equivalency to Math 120. American Sign Language (ASL) is now accepted as an accredited foreign language. DRC offers a wide range of software and assistive and adaptive technology. UNR also provides accessible housing accommodations for students with disabilities in addition to parking accessibility and parking permits for disabled persons that qualify.<sup>65</sup>

*The Center for Learning and Literacy* focuses on tutoring elementary children with learning disabilities beginning in the first grade through eighth grade. The children who attend the tutorial reading program range from one to two years below grade level in reading, spelling, and writing. The Center offers several specialized reading programs and generally instructs on a one-to-one ratio. Occasionally, students are grouped to take advantage of similar developmental levels.

*The Cooperative Extension* promotes efforts to reduce risks for disease, in particular heart disease and diabetes by offering a variety of health and nutrition outreach programs to the community. Programs include diabetes education to minority, disabled and at-risk populations. Other volunteer outreach programs include the wellness program that is a school-based and work site-based education program to teach about nutrition, diet, food safety, physical activity, stress management, and obesity health risks. The program also teaches nutrition for seniors and low-income mothers as well as teen mothers. The program also offers Spanish-speaking services.

*The Nevada Health Service Corps (NHSC)* is a loan repayment program for health professionals administered by UNSOM (University of Nevada School of Medicine), Office of Rural Health. The purpose of this program is to improve the delivery of primary health

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<sup>63</sup> Website: [www.unlv.edu](http://www.unlv.edu) on "Other Programs, Projects, and Services," 8-27-02.

<sup>64</sup> Telephone Interview with Serge Herzog, Director of Institute Analysis, 8-30-02.

<sup>65</sup> Telephone Interview and brochure obtained from Mary Zabel, UNR, Director of Disability Resource Center, 8-27-02.

services in Nevada's medically underserved areas. NHSC provides funds for physicians, physician assistants, nurse practitioners, and certified nurse midwives to repay loans for educational expenses in return for a period of obligated service in nonprofit clinics. NHSC recipients have served in every rural Nevada County. Applicants must hold a current license to practice in Nevada or be eligible for licensure and must agree to a minimum contractual obligation of 24 months of services.

*University Libraries* provides assistance and instruction, which lead users with disabilities to independent research, regardless of their ability. All UNR libraries have wheelchair accessible tables and NEON computer system workstations, large print readers, wheelchair accessible photocopiers and telephones and with various software and assistive technology.

*The University of Nevada School of Medicine (UNSOM)* has a Psychiatry Residency program that provides comprehensive mental counseling services in acute inpatient and long-term outpatient settings in rural communities. Currently, the medical school provides psychiatric services to approximately 1,500 patients a month, of which approximately 800 are incarcerated patients.

*The Volunteerism in Progress (VIP)* club assists people with disabilities in the community. In 2001 donations included more than 4,600 hours of service and 1,300 pounds of food to a variety of community causes. Students collected more than \$3,200 for the needy in a food drive, holiday parties for youth and a multiple sclerosis fund-raiser. Hundreds of students regularly involve themselves in community service projects and volunteer their time for helping home-bound seniors, hospice volunteering, respite care workers, patient care volunteers, clerical workers, recreation coordinators, fundraising and many other volunteer services.<sup>66</sup>

### **Community College of Southern Nevada (CCSN); Great Basin Community College (GBC); Truckee Meadows Community College (TMCC) and Western Nevada Community College (WNCC)**

Reasonable accommodations are extended to all students with disabilities, to the extent it is not financially or administratively burdensome, and does not alter the nature of programs established for students without disabilities. Community colleges must, therefore, find alternative ways to teach students with disabilities without adversely impacting the school budgets or the nature of programs. Accommodations consist of providing volunteer readers and peer note-takers; tutorial assistance; extra time allowed on assignments or course-load modifications; alternative ways of classroom assignments; closed-captioned and sign language; books on tape; seating accommodations; allowing courses to be tape-recorded; laptop computers are allowed; assistance with printing materials; accessible parking; and study skills management are taught.

General consensus and expressions of concern are that the community colleges are not properly prepared to accommodate the increasing population of students with disabilities. There exists a high need for assistive and adaptive technology; the costs of closed-captioned

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<sup>66</sup>Information of "Other Services" obtained from Internet Website: [www.unr.edu](http://www.unr.edu), 8-29-02.

services are high; and sign language interpreters are costly, as well as scarce. One of the biggest challenges is students with disabilities must have special instruction and aids to have equal opportunities, so alternative methods must be developed that will not adversely impact the financial and established program requirements.

CCSN is a comprehensive education institution within the UCCSN. CCSN serves students in southern Nevada and has campuses in North Las Vegas, the West Charleston Campus in Las Vegas, and the Henderson Campus in Henderson. There are also satellite campuses located throughout southern Nevada serving Clark, Lincoln, Nye and Esmeralda counties. These satellites include the Western Campus, Summerlin Campus, West Sahara Campus and the Boulder City Campus. The fall 2001 school term had a total of 33,364 students enrolled for all campuses. CCSN is the largest school of the UCCSN in terms of student population, including the universities. Each of the campuses has a Disability Resource Center (DRC) that is responsible for the services and programs provided to students with disabilities and are staffed with a full-time disability specialist. Through a federally funded program called TRIO, the DRC offers free services to students with disabilities to include academic assistance, career planning and advising, assistance with financial aid needs such as completing forms and obtaining information on scholarships and grants, personal development, and adjustment to college programs. Other services offered are educational intervention for students with special learning problems. Challenges expressed are a lack of staff and resources to properly provide services for the increasing number of students with disabilities. They note shortage of space for testing accommodations, note takers, and lab and research assistants, and the shortage and high cost of providing ASL interpreters, as well as the high cost of providing closed-captioned services. All of the aforementioned are problems.

### **CCSN SCHOOL OF DENTISTRY**

The Dental School was designed to solve two problems in Nevada: a shortage of dentists and a lack of dental care for poor children, people with disabilities and medically compromised individuals. These three populations experience distressing dental problems. There are several contributing factors, however, financial barriers to treatment are the most serious and common. Many are unable to work and lack income to pay for dental care. There is only one public health clinic that has a dental department. Medicare lacks dental benefits, and only a few dentists generally accept Medicaid patients because of coverage and fee restrictions.

The Community College of Southern Nevada (CCSN), in collaboration with the University of Nevada School of Medicine Dental Residency Program, UNLV School of Dentistry, the Northern Nevada Dental Health Program and the Anthem Blue Cross and Blue Shield Foundation utilize the Community College of Southern Nevada's Miles for Smiles program and community partnership programs to provide free or low cost services to children and people with disabilities throughout the state.

An important feature of the program is the absence of rigid eligibility criteria. Many governmental health and social programs must exclude certain individuals because they earn

marginally too much to qualify for much needed help. The Dental School program is designed to minimize that problem by enabling people to qualify for dental care if they are unable to afford needed treatment because of limited resources linked to factors beyond their control. These factors may include ongoing medical expenses or higher housing costs related to a disability.

The program recruits volunteers from the dental community to volunteer their time and/or facilities to provide care to qualified applicants of the program. Providers may choose to provide these services in their own offices, in designated clinics or on the Miles for Smiles mobile clinic. Staff ensures all volunteer dentists are licensed in the State of Nevada. Those who are licensed will become a part of a provider base available for treatment of patients of this program. While participants of this program will have priority regarding the scheduling of clinical services as determined by the residency program, it is understood that volunteers from this provider base may also be utilized to meet the philanthropic objectives of the Miles for Smiles and Northern Nevada Dental Health programs. Information about the program is distributed to organizations in Nevada that serve such persons after volunteer dentists are recruited. Community caseworkers or health care providers refer patients to the program. Once they qualify they are referred to a volunteer provider to receive their dental work in the private office of the provider.

Staff conduct periodic surveys of both providers and patients to inquire if cases are going as expected and if not, what remedial measures are needed to deal with problems. The program manager will then introduce and coordinate productive solutions to address the problems identified. To date 88 volunteer dentists have been recruited throughout Nevada by this innovative program.

The Dental School plans to establish a number of clinics statewide to treat children and people with disabilities. Several in Clark County are already operating. The clinics will receive reimbursement from several sources, including Medicaid, low-income children's insurance program called Nevada Checkup, and private insurance providers contracting with the dental school for treatment.

GBC located in Elko, is the smallest of the community colleges with a fall student enrollment of approximately 2,680. There are approximately 30 students with disabilities or about 1 % of the population is students with disabilities. GBC also has branch campuses located in the rural communities of Ely and Winnemucca. Although there are a number of disabilities, the greatest number of students requiring assistance are students with learning disabilities. Another large group comes from the gold mining community. GBC has many students referred by Vocational Rehabilitation who have suffered injuries related to heavy industrial accidents. Being in a rural setting, the pool of professional and skilled people is sparse. As with other institutions, GBC is concerned with potential high costs for equipment and services needed to provide for the educational needs of students with disabilities.

TMCC's fall enrollment for 2001 was 10,455 and TMCC anticipates that enrollment will continue to increase throughout the current school term. TMCC has approximately 294 students with disabilities or about 2.8 percent of the total student enrollment. To better assist

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students with disabilities TMCC works cooperatively with UNR in coordinating symposiums. The need for assistive and adaptive technology is of primary concern. Closed-captioned services cost \$80 per hour, which is high for a community college with limited funds. TMCC cites the primary disabilities as developmental disorders followed by learning disabilities. The continued challenge of providing the necessary tools with the limited budget is concerning.

WNCC's fall enrollment for 2001 term was 5,657 of which approximately 200 were students with disabilities, representing 3 percent of the total student enrollment. WNCC works cooperatively with the state Bureau of Vocational Rehabilitation which refers students to the community college. The largest disability segment consists of students with learning disabilities, followed by psychiatric or behavior disabilities and developmental delays. There are students with autism, as well as students with hearing and visual impairments. WNCC has branch campuses located in Minden, Gardnerville, Fallon, Hawthorne and Yerington. In an attempt to provide services to the community, WNCC also holds classes for a general education diploma (GED) and English as a Second Language (ESL) at the Friends In Service Helping (FISH) facility. The class has a deaf student attending the GED class, and WNCC is required to provide an ASL interpreter for this student. Attempting to assist the special needs of students with disabilities in the branch campuses and at the Carson City campus is a challenge, particularly in light of the severely limited budgets.<sup>67</sup>

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<sup>67</sup> Interviews conducted and brochures obtained: GBC, Phil Smith, Counselor ; TMCC Mitch Glazier, Director of student Services; and WNCC Susan Tanner, Coordinator of Disability Services 8-28-02; Information obtained from Internet Website: [WWW.Nevada.edu](http://WWW.Nevada.edu); [www.ccsn.nevada.edu](http://www.ccsn.nevada.edu); [www.gbcn.edu](http://www.gbcn.edu); [www.tmcc.edu](http://www.tmcc.edu); [www.wncc.nevada.edu](http://www.wncc.nevada.edu), 8-30-02

## **PART X**

### **QUALITY ASSURANCE AND ACCOUNTABILITY**

#### **Quality Assurance**

Nevada's system of community services and supports has grown tremendously and will continue to grow exponentially over the next several years. As the system grows, so will its complexity. Along with growth in programs and services, Nevada's infrastructure and information systems must incorporate methods for measuring and continually enhancing quality.

Currently, the methods for evaluating and ensuring quality vary greatly and depend heavily on the nature of the individual's disability, funding structure or coordinating agency. It is essential that Nevada provide its citizenry with the confidence that clear minimums of quality are established and upheld.

What is quality? Quality is pervasive values, standards and attitudes. Quality is dynamic, constantly changing and evolving. It is apparent when quality exists and when it does not. Quality matters. It is what is important. Quality is doing things right. And when things are not done right, making them right quickly. Quality is the willingness to analyze, admit mistakes and make corrections. Quality requires action, not just discussion.

In human services, quality cannot only be viewed as the degree to which a particular function or service is performed. The essential issue in determining quality relates to the satisfaction of the consumer receiving the service. Providing services that aren't based on consumers' expectations leads to conflict, dissension, dissatisfaction, and inefficient use of resources.

Quality is defined by consumers and can occur when:

- ✓ The specific needs, wants, and expectations of the individuals being served correlate to the services provided;
- ✓ A comprehensive and rigorous effort is undertaken to identify the specific individual needs, wants and expectations;
- ✓ There are clear minimums for safety;
- ✓ Evaluation, analysis, and negotiation includes the spectrum of stakeholders to establish quality levels and expectations;
- ✓ Services and programs are designed to provide the service outputs and individual outcomes as determined by stakeholder consensus; and

## **Nevada Strategic Plan for People with Disabilities**

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- ✓ Each critical component and outcome of the service delivery system includes an accepted measurement instrument and agreed-upon levels of performance.

In order to ensure quality in the community for people with disabilities a statewide quality structure should be established. This structure should include the following components:

- ❑ Methods used to conduct ongoing quality measurement, improvement activities and needs assessments;
- ❑ Methods, including service coordination (case management), used to conduct periodic reviews of individual community transition and support plans;
- ❑ Descriptions of availability of advocacy programs to assist individuals with disabilities in the community;
- ❑ Established principles, expectations and standards for all types of community services for people with varying types and levels of disabilities and needs;
- ❑ A system of monitoring and evaluating community services that is independent of those who provide services;
- ❑ Description of how people with disabilities and their families are involved in the monitoring and review of community services;
- ❑ A process to ensure that all monitors of community services are trained and evaluated;
- ❑ A community monitoring process that provides for a specific schedule of monitoring and selection of site to be monitored, including unannounced visits to settings other than private homes;
- ❑ A description of qualifications and standards for paid staff and caregivers who provide services and supports for people with disabilities;
- ❑ Relevant practice guidelines or evidence-based performance measurement tools used to assess the quality of services and supports;
- ❑ An appeals/grievance process that can be accessed by individuals with disabilities if individual rights are violated;
- ❑ Policies and procedures that require the reporting, investigation and resolution of allegations of abuse, neglect, theft, sexual exploitation, serious or unexplained injuries, deaths, and the violation of human or legal rights; and
- ❑ A review of systems that collect, analyze and track data regarding quality of community supports and services.

## **Nevada Strategic Plan for People with Disabilities**

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Part of the continuing work of the Task Force on Disabilities is to develop a plan to implement a statewide quality assurance process. This should be developed by September 2003. Also included in the Goals of the Strategic Plan is the formulation of a statewide, independent, community Disability Ombudsman. The office of the Ombudsman, in conjunction with the Task Force will work to ensure the full implementation of a Quality Assurance Plan.

**PART XI**

**FISCAL IMPACT AND BUDGET DETAIL**

**1) State Disability Service Coalition**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Members</u>
2004 - 2005	\$7,518			15
2006 - 2007	\$7,518			15
2008 - 2009	\$7,518			15
2010 - 2011	\$7,518			15
<b>Total:</b>	\$30,072			

*Cost per member: \$501.20*

Children's Issues Advisory Group (Annual)

2 mtgs per year (1 mtg in Reno, 1 mtg in Las Vegas)

6 members from Las Vegas

6 members from Reno

3 members from Rural (Elko/Fallon)

<u>Per Year</u>		<u>6 people Las Vegas</u>	<u>6 people Reno</u>	<u>3 people Rural</u>
Airfare	@ \$111.50/flight	669	669	335
Hotel	@ \$58.00/night			232
Car Rental	@ \$45.00/day	270	270	
Per diem	@ \$26/day	144	144	156
Parking	@ \$8/day	48	48	24
Mileage	@ \$0.365/mile	110	131	
Elko (576 mi)	Round trip to Reno			420
Fallon (122 mi)	Round trip to Reno			89
<b>Subtotal per year</b>		<hr/> 1,241	<hr/> 1,262	<hr/> 1,256
<b>Total per year</b>		<hr/> <hr/> \$3,759		

**2) Indian Summit**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Attendees</u>
2004 - 2005	\$20,000		Council on DD	120
2006 - 2007				
2008 - 2009	\$20,000		Council on DD	120
2010 - 2011				
<b>Total:</b>	\$40,000			

*Cost per attendee: \$166.67*

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	<u>SFY 2004</u>	<u>SFY 2008</u>
	<u>Cost</u>	<u>Cost</u>
Speakers	\$10,000	\$10,000
Facilities/Reporting	\$5,000	\$5,000
Consumer Stipends	\$5,000	\$5,000
<b>Total</b>	<b>\$20,000</b>	<b>\$20,000</b>

**3) Task Force on Minorities**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Members</u>
2004 - 2005	\$22,596		Council on DD & IL	17
2006 - 2007				
2008 - 2009				
2010 - 2011				
<b>Total:</b>	<b>22,596</b>			

6 meetings total in Reno (4 mtgs in 2004, 2 mtgs in 2005)

17 members (1 member from each county representing the tribe in that county)

		17 people	
		<u>Reno</u>	
Airfare	@ \$111.50/flight	446	(assume 4 will fly)
Hotel	@ \$58.00/night	464	(assume 8 will need overnight accommodations)
Car Rental	@ \$45.00/day	135	(assume 4 will need rental cars)
Per diem	@ \$26/day	316	(8 @ \$26, 9 @ \$12)
Parking	@ \$8/day	32	(4 air travelers)
Mileage	@ \$0.365/mile	2,373	(avg 500 miles RT to Reno, 13 members)
<b>Total per meeting</b>		<b>3,766</b>	

**4) Setting Neutral Assessments**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005		\$31,250	Title XX	125
2006 - 2007		\$31,250	Title XX	125
2008 - 2009		\$31,250	Title XX	125
2010 - 2011		\$31,250	Title XX	125
<b>Total:</b>		<b>\$125,000</b>		

**Cost per consumer: \$250.00**

Each consumer receives a 5 hour assessment @ \$50 per hour

<u># Consumers</u>	<u>Time/Assessment</u>	<u>Cost/Hour</u>	<u>Total Cost</u>
125	5 hrs	\$50.00	\$31,250.00

**Nevada Strategic Plan for People with Disabilities**

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**5) MDS coordinator Training**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Trainings</u>
2004 - 2005		\$15,000	Title XX	50
2006 - 2007		\$7,200	Title XX	24
2008 - 2009		\$7,200	Title XX	24
2010 - 2011		\$7,200	Title XX	24
<b>Total:</b>		\$36,600		

*Cost per training: \$300.00*

Each training takes 4 hours @ \$75.00 per hour

<u># Trainings</u>	<u>Time/Training</u>	<u>Cost/Hour</u>	<u>Total Cost</u>
50	4 hrs	\$75.00	\$15,000.00
24	4 hrs	\$75.00	\$7,200.00

**6) Targeted Service Coordination**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005		\$204,250	Title XX	100
2006 - 2007		\$204,250	Title XX	100
2008 - 2009		\$204,250	Title XX	100
2010 - 2011		\$204,250	Title XX	100
<b>Total:</b>		\$817,000		

*Cost per consumer: \$2,042.50*

Coordination for a total of 5 months

5 hrs/wk for 2 months (for the last month in the facility and the first month out), then 3 hrs/wk for 3 months

@ \$25.00/hr

<u>Hours</u>	<u>Weeks *</u>	<u>Cost/Hour</u>	<u>Total Cost</u>
5	8.6	\$25.00	\$1,075.00
3	12.9	\$25.00	\$967.50
			\$2,042.50

\* Assume 4.3 wks/month

**7) Transfer Subsidy**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005		\$129,440	Title XX	80
2006 - 2007		\$129,440	Title XX	80
2008 - 2009		\$129,440	Title XX	80
2010 - 2011		\$105,170	Title XX	65
<b>Total:</b>		\$493,490		

*Cost per consumer: \$1,618.00*

Median housing cost based on the "Special Needs Housing Study"

(Median housing cost x 2 months + \$150 x 3 months) x # consumers

**Nevada Strategic Plan for People with Disabilities**

	<u>55 years +</u>	<u>Phys Disability</u>	<u>HIV/AIDS</u>
Las Vegas			
Range	\$550	\$300 - \$1,000	\$300 - \$600
Median	\$550	\$650	\$450
# people	58,000	31,200	1,600
Reno			
Range	\$575	\$300 - \$1,000	\$300 - \$600
Median	\$575	\$650	\$450
# people	14,000	5,900	650
Weighted Median:	\$584		

**8) Single Eligibility**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$160,124	\$160,124	Federal Match	50
2006 - 2007	\$404,661	\$404,661	Federal Match	100
2008 - 2009	\$445,626	\$445,626	Federal Match	100
2010 - 2011	\$490,790	\$490,790	Federal Match	100
<b>Total:</b>	\$1,501,201	\$1,501,201		

<i>Cost per consumer: \$8,578.29</i>	<u>State General Fund</u>	<u>Federal Medicaid</u>
	\$4,289.15	\$4,289.14

Assumes 50 new eligible consumers the 1st biennium and 100 per biennium thereafter  
 One time cost for NOMADS system changes \$50,000 and \$5,000 per year thereafter  
 Cost does not include carry over consumers from year to year

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Medical costs	\$265,247	\$799,322	\$881,252	\$971,581
Administrative cost	\$55,000	\$10,000	\$10,000	\$10,000
	\$320,247	\$809,322	\$891,252	\$981,581
@ 50% match				
State General Fund	\$160,124	\$404,661	\$445,626	\$490,790
Federal Medicaid	\$160,124	\$404,661	\$445,626	\$490,790

There are two parts to the costs for instituting this policy. The first part is the medical costs for the individuals who would be covered. The second is for the administrative costs associated with changes to NOMADS and related eligibility systems as well as an interface with the Social Security Administration.

Medical costs - Individuals on SSI are automatically eligible for Medicaid under federal law. Since they are also necessarily low income (in order to qualify for SSI) these individuals would not have financial wherewithal to pay for any expensive medical treatments. It is therefore assumed that either they have other medical insurance or they are going without medical care. For any major expenses, such as a hospital stay, the medical provider would ensure that a Medicaid application was filed. Accordingly, it is estimated that the cost per eligible for the added individuals would be only 25% of the average cost for Medicaid disabled noninstitutional eligibles in the first biennium. This percentage is increased to 35% of costs in subsequent years to account for the potential effect of people dropping other health insurance.

There is no reliable data to determine the number of SSI recipients that are currently on Medicaid. The total number of blind and disabled on SSI was 18,593 in December 2000 and 20,066 in December 2001. For those dates the number of noninstitutional eligibles and those with less than the SSI income were added to get a roughly comparable amount.

**Nevada Strategic Plan for People with Disabilities**

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The Medicaid amounts are taken from the June report of Medicaid eligible recipients. The December 2001 amounts were increased by 4% for noninstitutional and 5% for institutional based on anticipated retroactive eligibility determinations.

It must be noted that this is not an exact correlation. Some individuals may be eligible for Medicaid even though they are not on SSI. The timing of determinations may also be a factor, particularly with regard to the December 2001 amounts.

Nonetheless, based on this comparison it is estimated that the number of SSI recipients that are not on Medicaid is relatively small. For purposes of projecting costs, the amount is estimated at 0.5% of SSI recipients, or 100 individuals.

The cost per eligible per month is based on the FY2000 costs for disabled noninstitutional, increased by 5% per year. (FY2000 costs are used as they represent the last substantially complete year of costs available)

**Administrative costs**

Department staff was unable to provide estimated costs for this change. The principal costs are for one time changes to the NOMADS system and establishing a process for interfacing with SSA. Additionally, there are costs associated with maintaining these individuals in the system, including third party liability data, processing Medicaid cards and related costs. For purposes of this report only the one time costs are estimated at \$50,000 and the ongoing costs are estimated at \$5,000 per year, but if this proposal were to move forward a more complete review of administrative costs would need to be undertaken.

**9) Mobile Outreach**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$602,872			21,900
2006 - 2007	\$572,872			21,900
2008 - 2009	\$572,872			21,900
2010 - 2011	\$572,872			21,900
<b>Total:</b>	\$2,321,488			

**Cost per consumer: \$26.50**

Outreach costs (vehicle will be operated 3 shifts per day)

(8 hrs/day x 5 days for 6 FTE) =	240	hrs
(8 hrs/day x 3 days x 4 FTE) =	96	hrs
	336	total hrs/wk
Total annual hrs	17,472	52 wks
Total annual salary @ \$10/hr	\$174,720	
Benefits	\$52,416	benefits @ 30%
Total annual salary including benefits	\$227,136	
1st yr equip cost (one time)	\$30,000	\$15,000/vehicle for 2 vehicles
Vehicle maintenance @ \$50/day	\$36,500	2 vehicles, 365 days/yr
Vehicle operation @ \$0.95/mile	\$22,800	12,000 miles/yr per van, 2 vans
Total cost of program 1st year	\$316,436	
Total cost each year thereafter	\$286,436	

Both Locations - 6 FTE will work three shifts 5 days per week and 2.4 FTE will provide coverage for their off time.

8.4 FTE @ \$10/hr + benefits @ 30% + vehicle \$15,000 (one time expense) to equip + \$0.95/mile to operate x 12,000 miles/yr + \$50/day for maintenance/insurance, vehicle will operate 24 hrs /day

**Nevada Strategic Plan for People with Disabilities**

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**10) Critical Waiting List**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$9,313,726	\$4,226,965	Fed Medicaid, Tobacco Settlement	1,135
2006 - 2007	\$10,163,655	\$4,553,167	Fed Medicaid, Tobacco Settlement	1,135
2008 - 2009	\$11,183,139	\$4,954,285	Fed Medicaid, Tobacco Settlement	1,135
2010 - 2011	\$12,356,080	\$5,395,922	Fed Medicaid, Tobacco Settlement	1,135
<b>Total:</b>	\$43,016,600	\$19,130,339		

*Cost per consumer: \$13,688.75*

Outpatient Counseling

*Cost per consumer: \$3,253.39*

253 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
South	\$12,411	\$13,683	\$15,085	\$16,632
North	\$74,823	\$82,492	\$90,948	\$100,270
Rural	\$619,585	\$683,093	\$753,110	\$830,303
Total - Gen Fund	\$706,819	\$779,268	\$859,143	\$947,205

Psychosocial Rehabilitation

*Cost per consumer: \$5,439.97*

55 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
South	\$244,278	\$269,316	\$296,921	\$327,356
North	\$12,649	\$13,946	\$15,376	\$16,951
Rural	\$0	\$0	\$0	\$0
Total - Gen Fund	\$256,927	\$283,262	\$312,297	\$344,307

**PACT**

*Cost per consumer: \$21,649.25*

7 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
South	\$130,134	\$143,473	\$158,179	\$174,393
North	\$0	\$0	\$0	\$0
Rural	\$0	\$0	\$0	\$0
Total - Gen Fund	\$130,134	\$143,473	\$158,179	\$174,393

Personal Service Coordination (case management)

*Cost per consumer: \$6,158.03*

**Nevada Strategic Plan for People with Disabilities**

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32 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
South	\$93,320	\$102,885	\$113,431	\$125,057
North	\$16,021	\$17,663	\$19,473	\$21,469
Rural	\$59,876	\$66,013	\$72,780	\$80,240
<b>Total - Gen Fund</b>	<b>\$169,217</b>	<b>\$186,561</b>	<b>\$205,684</b>	<b>\$226,766</b>

Intensive Service Coordination (case management)

**Cost per consumer: \$11,609.17**

13 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
South	\$129,597	\$142,881	\$157,526	\$173,673
North	\$0	\$0	\$0	\$0
Rural	\$0	\$0	\$0	\$0
<b>Total - Gen Fund</b>	<b>\$129,597</b>	<b>\$142,881</b>	<b>\$157,526</b>	<b>\$173,673</b>

Medication Clinic

**Cost per consumer: \$6,586.26**

375 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
South	\$1,222,778	\$1,479,561	\$1,790,269	\$2,166,226
North	\$390,688	\$472,732	\$572,006	\$692,127
Rural	\$200,711	\$242,860	\$293,860	\$355,571
<b>Total - Gen Fund</b>	<b>\$1,814,177</b>	<b>\$2,195,153</b>	<b>\$2,656,135</b>	<b>\$3,213,924</b>

Physically Disabled Waiver

**Cost per consumer: \$52,977.96**

State General Fund

\$26,488.98

Federal Medicaid

\$26,488.98

160 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Program Cost	\$6,960,229	\$7,547,182	\$8,320,768	\$9,173,646
Administration	\$405,000	\$470,453	\$499,103	\$529,498
<b>Total</b>	<b>\$7,365,229</b>	<b>\$8,017,635</b>	<b>\$8,819,871</b>	<b>\$9,703,144</b>
General Fund	\$3,682,615	\$4,008,817	\$4,409,935	\$4,851,572
Federal Medicaid	\$3,682,615	\$4,008,817	\$4,409,935	\$4,851,572

Environmental modifications/controls

**Cost per consumer: \$3,629.00**

Average cost to IL clients in 2002 was \$3,629.00

150 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Program Cost	\$544,350	\$544,350	\$544,350	\$544,350
<b>Total - Tobacco Settle</b>	<b>\$544,350</b>	<b>\$544,350</b>	<b>\$544,350</b>	<b>\$544,350</b>

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<u># Clients/Yr</u>	<u>Avg Cost/Client</u>	<u>Total Cost/Yr</u>
75	\$3,629.00	\$272,175.00

**PAS - OCBS**

*Cost per consumer: \$26,936.00*

90 consumers on the waiting list per biennium

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Program Cost	\$2,424,240	\$2,424,240	\$2,424,240	\$2,424,240
Total - Gen Fund	\$2,424,240	\$2,424,240	\$2,424,240	\$2,424,240

<u># Clients/Yr</u>	<u>Hrs/Yr/Client</u>	<u>Cost/Hour</u>	<u>Total Cost/Yr</u>	<u>Biennium Cost</u>
45	1,456	\$18.50	\$1,212,120.00	\$2,424,240.00

**11) Family Respite**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Families</u>
2004 - 2005		\$788,583	Tobacco Settlement	440
2006 - 2007		\$1,999,566	Tobacco Settlement	880
2008 - 2009		\$1,999,566	Tobacco Settlement	880
2010 - 2011		\$1,999,566	Tobacco Settlement	880
<b>Total:</b>		\$6,787,281		

*Cost per family: \$2,203.66*

Respite projection for first biennium

Accounts manager @ .35 FTE	\$14,000
Family advocate @ .35 FTE	\$15,750
Support staff @ 1.0 FTE	\$32,500
Benefits @ 30%	\$18,675
220 families @ \$80/month for 12 months the first year	\$211,200
440 families @ \$80/month for 12 months the second year	\$422,400
Admin fee @ 8%	\$74,058
<b>TOTAL</b>	<b>\$788,583</b>

Respite projection for 880 families per biennium

Accounts manager @ .35 FTE	\$14,000
Family advocate @ .35 FTE	\$15,750
Support staff @ 1.0 FTE	\$32,500
Benefits @ 30%	\$18,675
880 families @ \$80/month for 12 months	\$844,800
Admin fee @ 8%	\$74,058
<b>TOTAL</b>	<b>\$999,783</b>

**Nevada Strategic Plan for People with Disabilities**

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**12) Children's Services**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$6,699,912			1,284
2006 - 2007	\$6,699,912			1,284
2008 - 2009	\$6,699,912			1,284
2010 - 2011	\$6,699,912			1,284
<b>Total:</b>	\$26,799,648			

*Cost per consumer: \$5,218.00*

Average cost per child per year = \$5,218

<u># Clients/Yr</u>	<u>Annual Cost/Client</u>	<u>Total Cost/Yr</u>	<u>Biennium Cost</u>
642	\$5,218.00	\$3,349,956.00	\$6,699,912.00

**13) SB174 - PAS**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$5,257,052	\$1,697,686	Title XIX	266
2006 - 2007	\$5,340,612	\$1,677,748	Title XIX	266
2008 - 2009	\$5,340,612	\$1,677,748	Title XIX	266
2010 - 2011	\$5,340,612	\$1,677,748	Title XIX	266
<b>Total:</b>	\$21,278,888	\$6,730,930		

*Cost per consumer: \$26,325.02*

	<u># Clients</u>	<u>Hrs/Yr/Client</u>	<u>Cost/Hour</u>	<u>Total Cost/Yr</u>
OCBS Gen Fund	30	1,664	\$18.50	\$923,520 \$923,520
Aging Gen Fund	33 clients @ 4 hrs/day			
		<u>SFY 2004</u>	<u>SFY 2005</u>	
		\$936,307	\$947,915	
Medicaid Gen Fund	70 clients	\$726,919	\$798,871	
Fed Title XIX		\$858,812	\$838,874	

Note: These same 70 Medicaid clients are included in table 10 "Physical Disabled Waiver"

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**14) Positive Behavioral Supports**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005		\$444,000	Tobacco Settlement	210
2006 - 2007		\$444,000	Tobacco Settlement	210
2008 - 2009		\$444,000	Tobacco Settlement	210
2010 - 2011		\$444,000	Tobacco Settlement	210
<b>Total:</b>		\$1,776,000		

*Cost per consumer: \$2,114.29*

Intensive Team Training

\$2,000 per focus person (individual with disability)  
 Minimum 5 support teams trained together  
 Includes 6 days training, 5 individual support team meetings, Admin costs

Consultations

\$2,000 per focus person (individual with disability)  
 10 extended training/planning meetings (approx 2.5hrs)  
 Related prep costs  
 Admin costs

Large group trainings

One day training, maximum 30 participants (\$800/day)  
 Full training day  
 Related prep costs  
 Admin costs

Annual cost

Team training for 75 focus individuals	\$150,000
Consultation for 30 focus individuals	\$60,000
Group trainings, 15 days	\$12,000
	\$222,000

**15) Personal Assistant Training**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Caregivers</u>
2004 - 2005	\$3,200			120
2006 - 2007	\$3,200			120
2008 - 2009	\$3,200			120
2010 - 2011	\$3,200			120
<b>Total:</b>	\$12,800			

*Cost per caregiver: \$26.67*

One day training for group of 30 caregivers (maximum)  
 \$800 per day for training  
 120 caregivers would be trained in 4 days @ a total of \$3,200

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**16) HCBS Cognitive Impairment Waiver**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$476,425	\$476,425	Fed Match	25
2006 - 2007	\$1,716,476	\$1,716,476	Fed Match	75
2008 - 2009	\$2,849,791	\$2,849,791	Fed Match	100
2010 - 2011	\$3,131,514	\$3,131,514	Fed Match	100
<b>Total:</b>	<b>\$8,174,206</b>	<b>\$8,174,206</b>		

*Cost per consumer: \$54,494.71*

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Consumers	25	75	100	100
Program Cost	\$547,850	\$2,962,499	\$5,200,480	\$5,733,529
Administration	\$405,000	\$470,453	\$499,103	\$529,498
<b>Total</b>	<b>\$952,850</b>	<b>\$3,432,952</b>	<b>\$5,699,583</b>	<b>\$6,263,027</b>
General Fund	\$476,425	\$1,716,476	\$2,849,791	\$3,131,514
Federal Medicaid	\$476,425	\$1,716,476	\$2,849,791	\$3,131,514

The costs for a cognitive impairment waiver are estimated to be comparable to the physically disabled waiver on a per client basis. These costs are very rough because they are dependent on many factors including whether the individual put on to the waiver are currently receiving Medicaid for their primary medical costs and what services would be included under the waiver. It is assumed that many of those initially included on the waiver would come from the current RECAMS program for those with traumatic brain injury. The additional cost for these individuals would be limited because many of the service that they would receive are already covered under Medicaid. It is also expected that some individuals placed on the waiver would not currently be on Medicaid, and that for those individuals the costs would be significantly higher as they would be receiving full medical costs as well as the waiver services. These individuals can be among the most costly served by Medicaid.

It is proposed that there be 25 slots opened annually, beginning July 1, 2004. Thereafter an additional 25 slots would be added each July 1 through 2007 when there would be a total of 100 slots available.

Administrative costs are included for development and submission of the waiver to begin on or about October 1, 2003 in order that the waiver can be operational by July 1, 2004.

Please note that these costs do not include the potential impact of any of the rate increases proposed in the strategic plan. Since many of the services covered by this waiver would be impacted by those increases, the costs related to this expansion would rise accordingly.

**17) Project H.O.P.E.**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$4,000,000			400
2006 - 2007	\$4,000,000			400
2008 - 2009	\$4,000,000			400
2010 - 2011	\$4,000,000			400
<b>Total:</b>	<b>\$16,000,000</b>			

*Cost per consumer: \$10,000.00*

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Based on information provided by the project  
 Average cost of \$10,000/person per year. 200 consumers can be served per year.

**18) Family Caregivers**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Trainings</u>
2004 - 2005		\$11,700	Fed PAS	78
2006 - 2007		\$11,700	IL/DD Councils	78
2008 - 2009		\$11,700	IL/DD Councils	78
2010 - 2011		\$11,700	IL/DD Councils	78
<b>Total:</b>		\$46,800		

*Cost per training: \$150.00*

<b>Counties</b>	<u># Trainings per year</u>	<u>Training hrs per session</u>	<u>Total hrs/yr</u>	<u>Cost/Yr @ \$50/hr</u>
Clark	12	3	36	\$1,800
Washoe	12	3	36	\$1,800
Rural *	15	3	45	\$2,250
Total/yr	39		117	\$5,850

\* one training per year per county for 15 rural counties  
 Hrly cost for training = \$50/hr

**19) Single Point Entry - Health/Dental**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005		\$127,360	DD Council	100
2006 - 2007		\$127,360	DD Council	400
2008 - 2009		\$127,360	FQHC/Dental School	600
2010 - 2011		\$127,360	FQHC/Dental School	800
<b>Total:</b>		\$509,440		

*Cost per consumer: \$268.13*

2002 grant amount	\$44,000
Increase by one clerical staff	
Salary	\$16,000
Fringe @ 23%	\$3,680
Total	\$63,680

**20) Provider Rates**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$8,185,230	\$6,463,866	Federal Match	5,699
2006 - 2007	\$7,423,450	\$6,044,245	Federal Match	5,699
2008 - 2009	\$7,672,401	\$6,181,378	Federal Match	5,699
2010 - 2011	\$7,946,870	\$6,332,568	Federal Match	5,699
<b>Total:</b>	\$31,227,951	\$25,022,057		

**Nevada Strategic Plan for People with Disabilities**

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*Cost per consumer: \$2,467,54*

**Personal Assistance Services**

Medicaid provider rate increase to \$18.50/hr

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Clients	579	579	579	579

Average wkly service hours per client were not available, used same hours as OCBS, 22 hrs/wk.

	<u>Cost @ \$17.00/hr</u>	<u>Cost @ \$18.50/hr</u>	<u>Annual Cost Increase</u>
Annual hrs/client = 1,144 (22 hrs/wk x 52 wks)			
579 clients x 1,144 hrs = 662,376 hrs/year	<u>\$11,260,392</u>	<u>\$12,253,956</u>	<u>\$993,564</u>
General Fund			\$496,782
Federal Medicaid			\$496,782

*Inflation not included.*

Aging provider rate increase to \$18.50

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Clients	1,020	1,020	1,020	1,020

Average 28 service hrs/wk per client

	<u>Cost @ \$16.00/hr</u>	<u>Cost @ \$18.50/hr</u>	<u>Annual Cost Increase</u>
Annual hrs/client = 1,456 (28 hrs/wk x 52 wks)			
1,020 clients x 1,456 hrs = 1,485,120 hrs/year	<u>\$23,761,920</u>	<u>\$27,747,720</u>	<u>\$3,712,800</u>
General Fund			\$1,856,400
Federal Medicaid			\$1,856,400

*Inflation not included.*

OCBS provider rate increase to \$18.50

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Clients	100	100	100	100

Average 22 service hrs/wk per client.

	<u>Cost @ \$17.24/hr</u>	<u>Cost @ \$18.50/hr</u>	<u>Annual Cost Increase</u>
Annual hrs/client = 1,144 (22 hrs/wk x 52 wks)			
100 clients x 1,144 hrs = 114,400 hrs/year	<u>\$1,972,256</u>	<u>\$2,116,400</u>	<u>\$144,144</u>
General Fund			\$144,144

*Inflation not included.*

**Community Training Centers (CTC)**

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Clients	3,000	3,000	3,000	3,000
Cost of Increase	<u>\$1,478,200</u>	<u>\$1,125,266</u>	<u>\$1,240,605</u>	<u>\$1,367,768</u>
General Fund	\$1,108,650	\$843,950	\$930,454	\$1,025,826
Federal Medicaid	\$369,550	\$281,316	\$310,151	\$341,942

*Inflation not included.*

Targeted to achieve Rates Task Force recommendation by 2011

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**Supported Living Arrangements (SLA)**

	<u>2004 - 2005</u>	<u>2006 - 2007</u>	<u>2008 - 2009</u>	<u>2010 - 2011</u>
Clients	1,000	1,000	1,000	1,000
Cost of Increase	\$3,469,880	\$2,641,413	\$2,912,158	\$3,210,654
General Fund	\$2,081,928	\$1,584,848	\$1,747,295	\$1,926,392
Federal Medicaid	\$1,387,952	\$1,056,565	\$1,164,863	\$1,284,262

*Inflation not included.*

Targeted to achieve Rates Task Force recommendation by 2011

**21) No Wrong Door**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Calls</u>
2004 - 2005	\$480,960	\$53,440	Homeland Security	20,000
2006 - 2007	\$640,260	\$71,140	Homeland Security	104,000
2008 - 2009	\$640,260	\$71,140	Homeland Security	104,000
2010 - 2011	\$640,260	\$71,140	Homeland Security	104,000
<b>Total:</b>	\$2,401,740	\$266,860		

**Cost per call: \$8.04**

Approximately 20,000 calls for 2004-2005 and 104,000 per biennium thereafter

	<u>SFY 2004</u>	<u>SFY 2005</u>	<u>Each year thereafter</u>
Statewide Coordinator 1 FTE	\$40,000	\$40,000	\$40,000
Support Staff 2 FTE	\$50,000	\$50,000	\$50,000
Fringe @ 23% (Coordinator & Support Staff)	\$20,700	\$20,700	\$20,700
Disability I & R Operators 8.5 FTE *		\$238,000	\$238,000
Steering Committee (incl facility costs, etc)	\$8,000	\$8,000	
Create Business Plan	\$5,000		
Public Awareness	\$5,000	\$5,000	\$5,000
Training Plan	\$20,000		
Certifications	\$2,000	\$2,000	\$2,000
Needs Assessment	\$20,000		
<b>Total</b>	\$170,700	\$363,700	\$355,700

\* Two locations: 3 shifts/day, 1 operator/shift @ \$28,000/operator/year

Service available 7 days/wk, 24 hrs/day

Note: Costs do not include telephone equipment or connection fees

**22) Office of Disabilities**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$4,724,430	\$6,661,802	Fed DD, Fed AT, Fed IL, Telephone Surcharge	6,500
2006 - 2007	\$4,724,430	\$6,661,802	Fed DD, Fed AT, Fed IL, Telephone Surcharge	6,500
2008 - 2009	\$4,724,430	\$6,661,802	Fed DD, Fed AT, Fed IL, Telephone Surcharge	6,500
2010 - 2011	\$4,724,430	\$6,661,802	Fed DD, Fed AT, Fed IL, Telephone Surcharge	6,500
<b>Total:</b>	\$18,897,720	\$26,647,208		

**Nevada Strategic Plan for People with Disabilities**

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*Cost per consumer: \$1,751.73*

See budget detail table

**23) Student Transition**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005		\$400,000	Vocational Rehabilitation	250
2006 - 2007		\$1,200,000	Vocational Rehabilitation	750
2008 - 2009 *		\$1,650,000	Vocational Rehabilitation	1,000
2010 - 2011		\$1,600,000	Vocational Rehabilitation	1,000
<b>Total:</b>		\$4,850,000		

*Cost per consumer: \$1,616.67*

	<u>Hours</u>	<u>Cost/Hour</u>	<u>Number</u>	<u>Cost per</u>
Assessment	5	\$50.00	1	\$250.00
Case Management	3	\$25.00	18	\$1,350.00
<b>Total</b>				<b>\$1,600.00</b>

(\$50/hr x 5 hrs/assessment) + (3 hrs/mo case mgmt x 18 months x \$25/hr) =

\* One time cost, \$50,000, for study in 2008 or 2009

**24) Family Microboards**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$21,752			200
2006 - 2007	\$21,752			200
2008 - 2009	\$21,752			200
2010 - 2011	\$21,752			200
<b>Total:</b>	\$87,008			

*Cost per consumer: \$108.76*

4 training sessions per year, 1 ea. Las Vegas, Reno, Fallon, Elko.

<u># Training Sessions</u>	<u>Cost/Session</u>	<u>Cost/year</u>	<u>Cost/biennium</u>
4	\$2,500	\$10,000	\$20,000

In-State travel for 2 trainers

<u># Trainers</u>	<u>Miles/year</u>	<u>Cost/mile</u>	<u>Cost/year</u>	<u>Cost/biennium</u>
2	1,200	\$0.365	\$876	\$1,752

**25) Data Systems Survey**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005 *	\$500,000			
2006 - 2007				
2008 - 2009				
2010 - 2011				
<b>Total:</b>	\$500,000			

**Nevada Strategic Plan for People with Disabilities**

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\* *One time cost in SFY 2005*

**26) Agency Outsourcing Survey**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005 *	\$500,000			
2006 - 2007				
2008 - 2009				
2010 - 2011				
<b>Total:</b>	\$500,000			

\* *One time cost in SFY 2004*

**27) Chief Deputy for Disability Issues**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$241,335			1,200
2006 - 2007	\$236,024			2,400
2008 - 2009	\$236,024			2,400
2010 - 2011	\$236,024			2,400
<b>Total:</b>	\$949,407			

*Cost per consumer: \$113.02*

<u>Annual cost:</u>	<u>SFY 2004</u>	<u>SFY 2005</u>	<u>Each year thereafter</u>
Salary	\$76,839	\$76,839	\$76,839
Fringe @ 23%	\$17,673	\$17,673	\$17,673
Travel			
Out-of-State	\$7,000	\$7,000	\$7,000
In-State	\$5,000	\$5,000	\$5,000
Operating			
Computer	\$1,606		
Printer	\$774		
Office Equip	\$2,931		
Supplies	\$2,000	\$2,000	\$2,000
Telephone	\$1,500	\$1,500	\$1,500
Postage	\$1,500	\$1,500	\$1,500
Publications	\$1,500	\$1,500	\$1,500
Misc			
Office space, etc.	\$5,000	\$5,000	\$5,000
<b>Total</b>	\$123,323	\$118,012	\$118,012

**28) Disability Ombudsman**

<u>Fiscal Period</u>	<u>General Revenue</u>	<u>Other</u>	<u>Source</u>	<u># Consumers</u>
2004 - 2005	\$264,572			150
2006 - 2007	\$258,572			150
2008 - 2009	\$258,572			150
2010 - 2011	\$258,572			150
<b>Total:</b>	\$1,040,288			

## **Nevada Strategic Plan for People with Disabilities**

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*Cost per consumer: \$1,733.81*

	<u>SFY 2004</u>	SFY 2005	<u>Each year thereafter</u>
Paralegal 1.0 FTE	\$45,000	\$45,000	\$45,000
Attorney 0.1 FTE	\$6,000	\$6,000	\$6,000
Support Staff 1.0 FTE	\$35,000	\$35,000	\$35,000
Fringe 2.1 FTE	\$28,000	\$28,000	\$28,000
Travel	\$2,000	\$2,000	\$2,000
Equipment	\$6,000		
Supplies	\$500	\$500	\$500
Telephone	\$1,000	\$1,000	\$1,000
Office space	\$4,786	\$4,786	\$4,786
Misc (Ins, Dues, etc.)	\$4,000	\$4,000	\$4,000
Consultants	<u>\$3,000</u>	<u>\$3,000</u>	<u>\$3,000</u>
Total	\$135,286	\$129,286	\$129,286

**Nevada Strategic Plan for People with Disabilities**

**Office of Disabilities  
Budget Detail**

	Developmental <u>Disability</u>	Personal Assistance <u>Service</u>	Traumatic Brain <u>Injury</u>	Assistive <u>Technology</u>	Hearing Devices & <u>Relay</u>	Independent <u>Living</u>	Deaf Resources <u>Centers</u>	(Chief) Position <u>Transfer</u>	<u>Total</u>
<b>Revenue</b>									
General Fund Appropriation	120,271	1,559,479	300,000			219,047	110,000	53,418	2,362,215
Telephone Surcharge					1,351,222				1,351,222
Bal Forward (Telephone Surcharge)					941,672				941,672
Federal	408,984			331,442		297,581			1,038,007
	<b>529,255</b>	<b>1,559,479</b>	<b>300,000</b>	<b>331,442</b>	<b>2,292,894</b>	<b>516,628</b>	<b>110,000</b>	<b>53,418</b>	<b>5,693,116</b>
<b>Expenditures</b>									
Personnel *	248,635	30,490	16,814	109,017	56,984	159,259	12,610	53,270	687,079
Travel Out-of-State	2,975			1,931	3,682	0			8,588
Travel In-State	7,079			4,523	5,560	8,454			25,616
Operating	25,621	6,105	2,077	26,992	9,108	11,669	2,035	148	83,755
Client Services						196,173			196,173
Contracts					1,252,100				1,252,100
Grants	241,239	1,522,884	281,109	186,495	134,736	140,236	95,355		2,602,054
Reserve (Telephone surcharge) **					829,910				829,910
Purchasing Assessment	69			204	20	184			477
SWCAP	3,637			2,280	794	653			7,364
	<b>529,255</b>	<b>1,559,479</b>	<b>300,000</b>	<b>331,442</b>	<b>2,292,894</b>	<b>467,911</b>	<b>110,000</b>	<b>53,418</b>	<b>5,693,116</b>

\* Personnel:

- Chief
- Director of Developmental Disability
- Accessible Housing Liaison
- Senior Grants Manager
- Accounting Assistant I
- Long Term Care Coordinator
- Administrative Assistant III
- Independent Living Specialist
- Quality Assurance Specialist
- Administrative Assistant III
- Administrative Assistant I

\*\* Telephone surcharge

Use of telephone surcharge funds is restricted to the Hearing Devices and Relay budget per NRS 707.360

## **PART XII**

### **PUBLIC REVIEW**

#### **PUBLIC HEARING – Las Vegas, Nevada OCTOBER 3, 2002**

A public hearing on the Strategic Plan for People with Disabilities was held at the Nevada Department of Education, Suite 208, 1820 E. Sahara Blvd., Las Vegas, NV 89104 commenced at 10:00 a.m. Dr. Tom Pierce was facilitating and welcomed all present. He asked everyone at the table to introduce themselves. Dr. Pierce gave a brief history of the Strategic Plan, which was mandated under AB513. He told the group of how well the recommendations of the Plan were received by the Legislative Subcommittee on Disability. He then read the nine goals of the Plan and asked for comments on the Strategic Plan.

Donny Loux commented on past programs that had been developed only to have those programs subsequently discontinued because of budget cuts. She explained the goal will exempt services to poor children, people with disabilities and frail elderly from budget cuts. The group agreed that this is one of the most significant things in the Plan.

One witness asked which legislators on the subcommittee were also on the money committees. Donny Loux responded that Assemblywoman Vonne Chowning, Senator Rawson and Senator Townsend were also on those committees. Ms. Loux stated that the Disability Task Force has recommended that Dina Titus' committee continue as a standing committee to monitor the progress of the Plan. She said that for the Plan to be a success continued advocacy will be imperative. Over 280 issues were brought forward to be put in the plan. Many of these were collapsed and there are now 78 recommendations. Not all of these will be addressed in the first session but will be within the ten-year time period. She commented that the Task Force tried to look at all sources of revenue and be as cost effective as possible. Ms. Loux stated that in the past 10% of the Tobacco funding had gone out in small grants for services for the disabled. The Task Force has asked that more than a million dollars be set aside for Respite Care in a voucher model for approximately 1000 families and permanent funding for the Positive Behavioral Support Program to be funded with these dollars. The rest of the 10% Tobacco funds would go for Independent Living Services, which would support home and vehicle modifications, environmental controls and assistive technology. The Task Force also asked that all case management and assessments to keep people from going into nursing homes and out of nursing homes be done by community based providers rather than by state agencies. The Plan also recommends that a transfer fund be developed to assist people coming out of nursing homes since when they enter they usually give up all of their possessions. Other issues such as for children transitioning from school to community have alternative funding methods suggested in the Plan. Dr. Pierce stressed how importance of advocacy will be for success of the plan and keeping the legislators interested.

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Dr. Pierce was asked if the amount of money stated as needed included what the Rates Committee recommends. Dr. Pierce confirmed that the agencies had not prioritized that information. Ms Loux commented that the Legislative Branch and the Executive Branch have both suggested that the Plan become Nevada's Olmstead Plan. She stated that the Task Force, Legislative Branch and Mike Willden's office have accepted a policy of 90 days for waiting lists of critical services.

Another issue raised was that the "money follows the person model". This takes no new funding and is being done successfully in Texas and Indiana. It makes it possible for someone in an institution to be able to get out and have the money that the state has been paying for that person's care to be transferred to services so that he may survive out in the community. According to Ms. Loux it is very important to focus not only on those issues which cost new dollars but also on the strategies that do not take new or additional funding. Many of these are critical to involvement of people with disabilities in policy and decision making.

Another witness commented that he had recently been diagnosed with MS and was concerned about the handicap parking laws. He stated that Clark County Courthouse has only two handicap parking spaces and the City Courthouse has a similar problem. Ms. Loux responded that at Dina Titus' committee meeting this issue was discussed and that the advocate who held the primary information on the Plan goal had not been present to give the committee the information they requested on this recommendation. She said this shows how important participation in such hearings by informed advocates is!

A witness asked if the Plan addressed the issue of expanding the waiver slots. Ms Loux responded that this would be covered under the 90 days waiting list. In order to fulfill that requirement you would have to increase the waiver slots accordingly. The witness stated that she was interpreting the Plan to say that if the state agencies said there was no waiting list no new slots are needed. It is not specific enough. Ms. Loux and other participants agreed with her that the Plan needed to be clearer on this issue.

A witness testified that regarding the waiting list issue in the Nevada Service section on page 166 in the draft document there is information provided on mental health waiting lists. He said that he was very familiar with the needs in Southern Nevada and aware of the needs in Rural Nevada. He stated that he was concerned about how the number on the waiting list was defined. For example, he said that he was aware of many people who were waiting for medication appointments and the wait could be as long as to 4 months. He mentioned out patient counseling; the Plan states that there are 16 people waiting for counseling and therapy. The witness stated that he knows there are many more people waiting than that. Dr. Pierce agreed with the witness and stated that the figures should be rechecked. The discussion proceeded between Ms. Loux, Dr. Pierce and the witness as to how to remedy the problem of inaccurate statistics.

One witness stated that she had attended one of Senator Townsend's meetings and he had stated that all of the statistics had better agree before this Plan is presented to the legislature.

## **Nevada Strategic Plan for People with Disabilities**

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He said he had noticed several waiting list tables where the figures could not possibly be correct. For example, one table said there were only six people on a waiting list for PACT services and yet the Mental Health Division testified at their meeting how much these services were needed and that new funds needed to be found. The witness that works with the mentally ill stated that the figures in the Plan were budget figures and not a true reflection of community need.

A witness that works with children's issues stated that possibly when the Task Force goes to the legislature they could use the issue of inaccurate statistics as positive proof of the need for new and improved data keeping. Dr. Pierce stated that even if the witnesses at the hearing were to testify before the legislature they would still need documentation of need rather than just stating the need. Ms. Loux stated that other members of the Task Force had also expressed concern about the low numbers in the Plan. The witness said the Task Force had no way of obtaining the numbers and had to accept what the agencies gave them.

The next witness stated that he came to commend the Task Force for the work they have done. He said that Nevada is about 10 years behind Massachusetts and California, both who have excellent programs in mental health. He complimented Tony Records on his work and stated that his hands on work in Indiana, Wisconsin and the model Office of Disability in New Jersey have all been great. The witness said that his having lived and worked in two other states gives him a perspective that may be helpful to the Task Force. He referred to cost effective methods and how that influences the legislators. He urged the Task Force to go after all federal matching funds that are available. It is crucial for a state like Nevada to apply for these programs. He said that he worked in Vocational Rehabilitation and that they went after every state dollar they could get. He stated that in Massachusetts some of the funding they used was four to one. Four dollars of federal money for every one dollar of state money appropriated. He also stated that he thought the Task Force should be talking to Senator Reid and Senator Ensign along with the Office of Civil Rights. He commented that the legislature really does not have a choice regarding funding of some of these issues. Otherwise litigation may become a problem. He gave examples of litigation that other states have had to battle with. Ms. Loux commented that our legislators have been very supportive of both the Plan and of ADA issues. She stated that his point was well taken however and that advocates need to go to the legislature and be visible and voice their opinions.

A witness asked how people who are interested will know what happens with the Plan. Ms. Loux replied that if an Office of Disability were created, one of its duties would be to report biannually on the progress of the Plan. It would have information on the goals, what the Legislative Branch recommends and what the Executive Branch accomplished. But she said it was also up to the public and advocates to continually ask these questions.

One of the witnesses suggested that a bulletin be put out every few weeks with the points that are a priority for contact with the legislators, so that all the advocates are on the same wavelength with regard to these subjects. Ms. Loux commented that that is an excellent idea and that Mary Evilsizer and the Center for Independent Living had done that for the Medicaid Buy-In. They made a list of the legislators who were involved, the bills that were

up for vote and the phone numbers and e-mail addresses needed to make contact. The people would contact their legislator once a month and ask how things were progressing and if the legislator needed any support or letters. It really made a difference and as a result the Medicaid Buy-In was approved.

A witness from the Independent Living Program stated that there is a long waiting list of clients waiting for home modifications such as grab bars, ramps and other equipment. He stated that many of their clients are at risk of being institutionalized because their home is an inappropriate environment because of their disability and a lack of funds to improve it. In many cases they are not able to get in or out of their homes for emergency purposes or daily living. When the client applies for services and is told how long the wait will be they try to go elsewhere and end up back at CIL because there isn't anything else out there. He stated that it is very difficult to tell people that they are on a waiting list until 2005. Ms. Loux commented that both the CIL in the North and South closely watched and kept up to date records of their waiting lists and this is one of the reasons the goal regarding using Tobacco Funds for Independent Living was put forward.

A witness asked the person from CIL about the money being sent back from Vocational Rehabilitation. He wanted to know what the CIL thought was the reason for them sending back these funds, approximately \$200,000 this year. The CIL representative responded that he thought that they were sending everyone to the Independent Living Program. He stated that he didn't know if VR just wasn't out there finding jobs for people or what. But for \$200,000 he would certainly find jobs for people like him. He said it upset him to think that they could send that amount of money back when his agency is looking for money for a simple ramp or piece of equipment. The witness stated that he hoped that people in high positions in state government would look into why Vocational Rehabilitation of Nevada was returning money that could be spent on consumers, which is why they are funded. The Independent Living representative stated that he could think of 5 or 6 people right now who may have to go into a nursing home because of a lack of assistance to keep them at home. Once they are in the nursing home it costs the state double what it would have to keep them at home. If the person needs a wheelchair or ramp Medicaid will say you don't need it because you are in the nursing home. The client ends up losing their income and home and will not have the resources to get out of the nursing home again. Since Medicaid will deny them, they apply to the Independent Living Services for the wheelchair or other piece of equipment so that they can return to their home and are told that because of the waiting list and lack of funds the IL program can not help them at this time.

Dr. Pierce reiterated how important it will be to follow what the legislature is doing, to keep in contact with individual legislators and be as active as possible. The legislature has always been very supportive of people with disabilities.

A witness suggested that the terminology on the website regarding the different meetings should be clearer to the lay person. The Task Force, Steering Committee, Senator Dina Titus' meeting, Adult or Housing Committees etc. do not tell the public which meetings they should attend etc. She stated that it is very confusing. Ms. Loux agreed with the witness. Dr.

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Pierce suggested the Ms. Loux's office might put out a list explaining what each meeting is about and who should attend. Ms. Loux stated that was a good idea and could be implemented.

One witness stated that he had reviewed the Plan and could only find one statement about employment for developmentally disabled citizens and that referred to Nevada needing to bring in supported employment providers as work choices for developmentally disabled residents. In the past Nevada has brought in supported employment companies. He stated that he thought the recommendation in the Plan should be for adequate reimbursement for supported employment services because then the market will take care of itself. If there is adequate reimbursement for supported employment services, service providers will come to Nevada, and you don't have to recruit them. He also stated that Vocational Rehabilitation also gave back federal funds when the 3% budget cut occurred and they decided to take \$500,000 of state dollars out of client services which meant that they were going to give back \$2,000,000 of federal funds which actually reduced the services by \$2,500,000. They could have made some arrangements for providers to match those dollars in different ways so those critical services stayed in Nevada.

Another witness testified that Vocational Rehabilitation always gives back much of their federal money or has to quickly give it away at the end of the year.

A witness came forward with a correction to the Plan. She stated that on pg. 123 describing Clark County Social Services. The reporting in the middle paragraph states Independent Living Services and she did not know what the Plan was referring to. She said they have a homemaker service and a volunteer program for seniors who can not get out of the home to grocery shop. Ms. Loux stated that it was reported to the contractors that Social Services has a volunteer program, which provides home modification such as ramps. The witness said they had applied for grant funding through the Tobacco funds to add home modifications to their homemaking services but were denied that funding. The letter stated that if Social Services re-wrote the grant there might be funding available but not as written. She stated that the item listed, as Physician Services did not mean that they would pay for a doctor's visit. They do provide funding for clinic visits. She suggested that Physician Services be taken out of the Plan along with removing Independent Living Services and Cognitive Services, which they do not provide either. She said they do have an Eye Care Program but it is only a pilot program and will last for about six months.

Another witness stated how happy he has been to be able to participate in the activities of creating the Plan. Dr. Pierce acknowledged his comment and reinforced the statement of "now the work begins". He said that the Task Force would need this witness's continued participation even more in the future.

A witness came forward to thank all those who worked so hard on this gem of a document. She stated that she would have further comments after she studied the Plan further. She said she knew that this Plan would make a huge difference in the lives of the disabled and thanked everyone again.

**Nevada Strategic Plan for People with Disabilities**

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There being no further comments the hearing was closed at 2:00 p.m.

Attendees:

Mary Morgan for Lila Holdsworth  
Dr. Tom Pierce  
Jean Peyton  
Bob Hogan  
Gary Shade  
Edie King for Janelle Mulvenon  
Donny Loux  
Michael Stuhff  
Vic Davis  
Anita Puentes  
Mary Jackson

Tom Olin  
Mel Phillips  
Reggie Bennett  
Betty Shade  
Ed Guthrie  
Arlene Harbach  
David Sims  
Jeanie Rhoads  
Karen Taycher  
Tom Allman  
Mary Evilsizer

**PUBLIC HEARING – Reno, Nevada  
OCTOBER 3, 2002**

A public hearing on the Strategic Plan for People with Disabilities was held at the Salvation Army, 1931 Sutro Street, Reno, NV 89512 commenced at 10:00 a.m. Paul Gowins was facilitating and welcomed all present. Mr. Gowins asked for comments on the Governor’s Strategic Plan for People with Disabilities, which was mandated under AB513. He introduced Brian Lahren, Chairman of the Disability Task Force and Ken Vogel, Executive Director of the Developmental Disabilities Council for the State of Nevada.

Mr. Gowins explained that there were copies of the Plan available for review if anyone present had not had a chance to review the document prior to the hearing.

Mr. Lahren introduced Leslie Hamner, Legislative Counsel Bureau, Kitti Barth, Governor’s Committee on Employment of People with Disabilities and Andrea Wicker who was representing John Hunt, a candidate for Attorney General.

The first person to testify stated that she had talked to a staff person from CIL concerning this draft. Her first question was if a disabled person does not have a computer and if the 211 system has not been set up yet on how would they access the services that will be offered? Mr. Gowins stated that the 211 System is a phone system and does not require the use of a computer. He also said that 211 is a telephone line that does not require a computer. Mr. Lahren commented that the 211 System is designed to help agencies coordinate their efforts as well as help the consumer get the information he/she wants without having to call several different numbers. He stated that both Mike Willden and the Governor’s office considered the 211 System a priority. The witness asked Mr. Gowins if a stroke victim would be able to use this system. Mr. Gowins replied that the Plan was not age or disability specific. It is not

designed for just the disabled, or for seniors or for the homeless; anyone could access it. Mr. Lahren explained that the services listed were not income restricted or just for Medicaid eligible people but for all populations. He stated that the Plan mentioned advocates that would visit nursing homes and clients. Her question was who would pay their wages? Mr. Gowins responded that there are already people in non-profit agencies such as the Centers for Independent Living that make regular visits to clients and they might be able to assume some of the responsibility. Mr. Gowins said that in talking with other states such as Texas, the state contracts with the Centers for this purpose. A discussion between Mr. Gowins, Mr. Lahren and the witness continued on how to identify the people in nursing homes who should not be there but out in the community. Mr. Gowins stated that in some states the money follows the person so that the money used for the nursing home could be used to move the person out into the community. But in Nevada the funds are so limited that in some cases neither is possible.

The witness asked why the registry of birth defects is no longer in existence. Mr. Gowins replied that this registry was funded by a grant and the funds are no longer available. The state legislature did not vote to keep this program going. Mr. Lahren stated that this program was vital in predicting what future needs would be and also essential in creating early intervention programs.

The witness asked about crisis calls and if the intention of the Plan was to change that procedure or use what exists. Mr. Gowins and Mr. Lahren both responded that they were not sure but thought that the 211 System would be tied into the Crisis Center and would be a 24-hour service. Call centers for 211 would be established in Northern and Southern Nevada but eventually would extend to the rural areas.

The witness asked about the dental services discussed in the Plan. She wanted to know if it would cover people in nursing homes, people on Medicaid, dentures, re-lining dentures etc. Mr. Gowins stated that specific types of services have not been defined yet. He stated that the need of the disabled population for dental services is clear but providing those services is not an easy issue. He said that there are a few programs actively providing services such as Miles for Smiles and the Donated Dental Services Program but that they are just serving a small percentage of the population. Mr. Lahren stated that many medications create gum disease and dental problems. Medicaid covers dental costs at a Medicaid rate. Dentists in Nevada say that that is not enough and refuse to take more Medicaid patients. So it is a catch 22 situation. The witness stated that she has MS and her medication creates severe dental problems. None of her insurance covers dental fees.

Another witness testified that he was able to get a dentist in Reno to help him with his needs but was advised that he had to keep it confidential because the dentist did not want other dentists in the area to know that he was providing services for free. Mr. Vogel commented that the Director of the Donated Dental Services Program has been able to get 88 dentists statewide to agree to provide services but most of them are in the Las Vegas area and they are only willing to take one patient per year. So far the program has not been able to enlist any dentists in the rural area willing to participate in the Donated Dental Services Program.

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According to the director the program has a waiting list of approximately 125 people needing services statewide.

The first witness asked about the Meals on Wheels service as mentioned in the Plan. Mr. Gowins responded that traditionally Meals on Wheels has been offered to seniors. There is no funding source to extend that service to the disabled although the need is clearly there. The Plan suggests that funding be created to provide this service to those consumers that are unable to prepare their own meals. The witness asked what happens if the person receiving the meals is unable to feed himself. Mr. Gowins stated that that is part of the problem. To schedule the PCA to be there when the food arrives is not always feasible.

Mr. Gowins was asked about a statement in the Plan that referred to services provided at the VA hospitals which included free prescriptions for veterans. Mr. Gowins stated that he gets calls from consumers that can not get their medications because of the cost. In some cases he is able to identify the consumer as a veteran and inform him that he can take his prescription to a VA hospital and get it filled at no cost. But many people are not aware of that.

Mr. Gowins was asked about the Death and Dying portion of the Plan. She wanted to know if the Plan had a provision to protect the rights of a dying person from the family who may be anxious to get through this ordeal and on with their lives. Will there be an advocate for the dying person? Mr. Gowins said that the Plan addressed this issue and will clarify it during the implementation period of the Plan. He explained that the Plan started out with about 260 issues which were collapsed and combined. Out of that approximately 77 priorities were developed. Over the next ten years all 260 issues will hopefully come forward.

Another witness requested that the editing of the Plan include not only mention of the deaf population but also of the hard of hearing. She specifically referred to the heading on page 34 that should read, "Blindness and Deaf and Hard of Hearing. Section 152 and 153 under that heading should include hard of hearing. Mr. Gowins reminded the audience that this Plan is a draft and that this is the purpose of the hearing. He assured the witness that this issue would be brought to the attention of the editors.

A resident of the Frost Yasmer supported living residency commented that his main issue was that personal care attendants want a definite schedule of needs. He also spoke about the need for more legal representation for people with disabilities, stating that most people with disabilities can't afford to hire an attorney to represent them. He stated that his disability is a hidden disability, a seizure disorder. He stated that he does not know when he is going to have a seizure, when he may need someone to pick him up off the floor and put him in bed. It may be a week or a month in between episodes. Most PCA services are not willing to work with a client under those circumstances. He stated that at this time he either gets no services or service all the time, which he does not need or want. He asked if the Plan would address this problem. Mr. Lahren responded that under the Olmstead Act he should be able to live with the least amount of restrictions and the most independent environment that is available. Mr. Gowins said that several people had brought up this issue and the assessment

process should be addressing it. He assured the witness that this would be included in the Plan.

Another resident from Frost Yasmer stated that his issue was with housing. He is living in a supported living environment. He would like the community around him to be knowledgeable about this type of facility so that the residents could be more integrated with the community. He said that the residents feel isolated instead of feeling involved in the community. He said that he has been asked if this is housing for the mentally retarded or a drug rehabilitation house or what. He stated that there should be some community education about what the apartments really are. He also said there is a need for money management services to be provided as part of the support system of assisted living.

One of the witnesses asked about the process for evaluation of progress within the Plan. How will the legislature and the Governor know if there is compliance with the Plan? Mr. Gowins responded that the Plan makes provision for monitoring the progress of the Plan. The Olmstead Act states that the Plan must be “effectively working” to be in compliance with Olmstead. Mr. Lahren stated that the legislative body would be asking for a report at each session on progress of the Plan and would decide on funding accordingly.

An advocate from Carson City stated that there are people who fall between the cracks. They don't qualify for services because of mental instability, homelessness, unemployment or behavioral issues. Even people who are employed may not be able to keep a job without on going job coaching and are in desperate need of services. This witness stated that she has received many calls lately regarding the elderly. They may not have a disability but they need someone to come in once a week to check on them and see what is needed. The same is true of developmentally disabled citizens who may be able to work and live on their own but need some one to keep them on track. Mr. Gowins stated that housing is a major issue within the Plan statewide. He also mentioned that he is part of a DD Council Housing Development Subcommittee that is working on development of a statewide housing initiative for people with disabilities. Mr. Vogel followed this discussion with an announcement of the Housing Summit the DD Council is hosting on October 15th from 10:00 a.m. to 3:00 p.m. at this location.

A witness from the Disability, Advocacy and Law Center complimented all the people who worked so hard on the Plan and commended them for what they have accomplished. He also complimented the legislators who worked with the committees to reach this goal. He stated that his hope was that a monitoring system be developed that will make it easily available to see what has been accomplished at every stage of the plan in the future. He suggested that the goals and objectives be moved closer to the front of the plan so that it is one of the first things you see when looking at the Plan. He said that many people had agreed with him. He also felt that the consumer profiles should be moved forward in the plan since consumer issues are the main theme of the Plan.

There being no other witnesses to testify the hearing was adjourned at 2:00 p.m.

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### Attendees:

Deidre Manley, Frost Yasmer Estates Manager  
Craig Inman, Consumer  
Bill Sharp, Sanford Center on Aging  
Miguel Villalobos, Consumer  
Jack Mayes, NDLAC  
Leslie Hamner, LCB  
David Love, Bethel Housing  
George Mayes, Consumer  
DeeDee Foremaster, Advocate  
Carol Stonefield, Senior Research Analyst  
Maureen Fradianni, CIL  
Laura Sheldon, CIL  
Brian Lahren, WARC  
Ken Vogel, DD Council  
Paul Gowins, CBS  
Andrea Wicker

**PART XIII**

**JUSTIN'S FINAL MESSAGE TO US ALL: "I am with you, I love you. Lead on!"**

Dearly Beloved:

Listen to the heart of this old soldier. As with all of us the time comes when body and mind are battered and weary. But I do not go quietly into the night. I do not give up struggling to be a responsible contributor to the sacred continuum of human life. I do not give up struggling to overcome my weakness, to conform my life – and that part of my life called death – to the values of the human dream.

Death is not a tragedy. It is not an evil from which we must escape. Death is as natural as birth. Like childbirth, death is often a time of fear and pain, but also of profound beauty, of celebration of the mystery and majesty which is life pushing its horizons toward oneness with the truth of mother universe. The days of dying carry a special responsibility. There is a great potential to communicate values in a uniquely powerful way – the person who dies demonstrating for civil rights.

Let my final actions thunder of love, solidarity, and protest – toward empowerment.

I adamantly protest the richest culture in the history of the world, a culture which has the obvious potential to create a golden age of science and democracy dedicated to maximizing the quality of life of every person, but which still squanders the majority of its human and physical capital on modern versions of primitive symbols of power and prestige.

I adamantly protest the richest culture in the history of the world which still incarcerates millions of humans with and without disabilities in barbaric institutions, backrooms and worse, windowless cells of oppressive perceptions, for the lack of the most elementary empowerment supports.

I call for solidarity among all who love justice, all who love life, to create a revolution that will empower every single human being to govern his or her life, to govern the society and to be fully productive of life quality for self and for all.

I do so love all the patriots of this and every nation who have fought and sacrificed to bring us to the threshold of this beautiful human dream. I do so love America the beautiful and our wild, creative, beautiful people. I do so love you, my beautiful colleagues in the disability and civil rights movement.

My relationship with Yoshiko Dart includes, but also transcends, love as the word is normally defined. She is my wife, my partner, my mentor, my leader and my inspiration to believe that the human dream can live. She is the greatest human

being I have ever known.

Yoshiko, beloved colleagues, I am the luckiest man in the world to have been associated with you. Thanks to you, I die free. Thanks to you, I die in the joy of struggle. Thanks to you, I die in the beautiful belief that the revolution of empowerment will go on. I love you so much. I'm with you always. Lead on! Lead on!



**JUSTIN DART, JR.**  
**1931 - 2002**