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NEVADA DEPARTMENT of
HEALTH and HUMAN SERVICES

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2016 Statewide Community Needs Assessment

Conducted on behalf of the Grants Management Advisory Committee by the DHHS Office of Community Partnerships and Grants

Brian Sandoval, Governor
Richard Whitley, Director

Fund for a Healthy Nevada

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In accordance with Nevada Revised Statute (NRS) 439.630(6), the Grants Management Advisory Committee (GMAC) is required to solicit public input regarding community needs in even-numbered years and use the information to recommend future funding priorities for the Fund for a Healthy Nevada (FHN). The Office of Community Partnerships and Grants (formerly known as the Grants Management Unit) in the Director's Office of the Department of Health and Human Services (DHHS-DO CPG) provides staff support to the GMAC and conducted a statewide needs assessment on its behalf.

Under NRS 439.630(6), the Commission on Aging (CoA) and the Commission on Services for Persons with Disabilities (CSPD) are also required to assess needs and make recommendations regarding use of the FHN. These two commissions are affiliated with the Aging and Disability Services Division (ADSD).

All three advisory bodies must submit recommendations to the DHHS Director by June 30, 2016, for consideration in the budgeting process for State Fiscal Years (SFY) 2018 and 2019. In addition to the recommendations tendered by the three bodies, the Director must (1) ensure that money expended from the FHN is not used to supplant existing methods of funding available to public agencies and (2) consider how the funds may be used to maximize federal and other resources [NRS 439.630(1)(j) and (k)].

The 2016 Statewide Community Needs Assessment is the third conducted by the CPG on behalf of the GMAC. The first occurred in 2012 after the 2011 Legislature amended NRS 439.630 to (1) eliminate specific funding allocations for program areas listed in the FHN and (2) broaden the original provision for Children's Health to include programs that "improve the health and well-being of residents of this State." This category is now referred to as Wellness. The second needs assessment was conducted in 2014.

The GMAC's scope of work as an advisory body includes **FHN Wellness [NRS 439.630(1)(g)], FHN Services for Persons with Disabilities [NRS 439.630(1)(h)]** and **FHN Tobacco Use Prevention and Cessation [NRS 439.630(1)(f)]**. However, the GMAC's vision is that the results of the assessment will be utilized in overall budget development for the Department and the State, as expressed in a letter from the GMAC to the DHHS Director on December 22, 2015 (see appendices).

2016 Methodology

The first two needs assessments conducted under revised NRS 439.630 approached the process from a "ground zero" perspective. In the 2012 assessment, survey respondents were asked to check one or more priority items on a list of basic needs. Two years later, the first question on the survey gave respondents unrestricted freedom to name the one service they would fund if only one could be supported by FHN dollars. In both assessments, public forum participants were given blank post-it notes on which to write the top three priorities for themselves and/or their communities.

Rather than begin at "ground zero" once more, the 2016 assessment was designed to (1) build upon the information collected during those first two assessments, (2) consider findings published in other needs assessments, strategic plans and State plans, and (3) integrate service statistics reported by several key community providers. The data from these sources was presented in a myriad of unique and creative ways, but sufficient similarities existed to transform the information into a reasonable picture of the needs of residents around the state. The CPG shared the results of its Phase One research and analysis at the March 10, 2016 GMAC meeting. In order of preliminary priority, the top 12 needs are listed below.

- Health / Mental Health Care
- Hunger / Food Security
- Transportation
- Employment
- Dental Care
- Housing
- Support for Persons with Disabilities and their Caregivers
- Emergency Assistance
- Substance Abuse
- Education
- Protective Services
- Help Finding Information

During Phase Two of the process, providers and consumers across the state had the opportunity to validate or rebut the preliminary findings. In March and April, a total of 1,311 people participated – including 1,263 through surveys and 48 at forums in Carson City, Reno, Elko, Las Vegas and North Las Vegas. The most significant findings are as follows.

- Participants **validated** the need for all 12 of the cited services. In fact, several survey participants declined to rank the services, saying that all are equally important.
- Participants **validated** the prioritization of:
  - Health / Mental Health Care, which ranked No. 1 across all data sources on both the preliminary and final lists, and
  - Hunger / Food Security, which ranked second on the preliminary list and third on the final list.
- Survey respondents and public forum participants **rebutted** the ranking of several other priorities.
  - Transportation and Dental Care each garnered a much lower priority than the preliminary data indicated, and
  - Housing, Emergency Services, Education, and Protective Services all emerged as notably higher priorities than the preliminary data indicated.

Priorities ↓ Ranking →	Preliminary Ranking	Survey Providers *(760 - 61%)*	Survey Consumers *(441 - 35%)*	Public Forum Participants *(48 - 4%)*	Average Weighted Ranking**
Health / Mental Health Care	1	1	1	1	**1.00**
Housing	6	2	3	2	**2.35**
Hunger / Food Security	2	3	2	7	**2.81**
Emergency Services	8	4	4	6	**4.08**
Education	10	5	5	5	**5.00**
Employment	4	6	6	10	**6.16**
Protective Services	11	7	7	11	**7.16**
Dental Care	5	8	8	8	**8.00**
Support for Persons with Disabilities and their Caregivers	7	9	9	12	**9.12**
Substance Abuse Services	9	10	10	3	**9.72**
Transportation	3	11	11	4	**10.72**
Help Finding Information	12	12	12	9	**11.88**

*1,263 surveys were received; 1,201 responded to the prioritization question.

**The weight of the average ranking corresponds to the percent of respondents in each of the three groups.

- When survey respondents were asked whether any service was missing from the preliminary priorities, no new needs supplanted those already on the list. A total of 463 respondents answered this question, but only 126 actually identified new categories and only three of these new categories were cited by 10 or more participants.
  - Child Care – affordability and availability – 21 respondents.
  - Youth Services – activities, mentoring, transitional services for youth aging out of the foster care system or released from incarceration, homeless services and social workers in the schools – 15 respondents.
  - Immigration Services – general support for this population, legal assistance, advocacy, outreach, homeless services and youth services – 12 respondents.
- It was also noted by several public forum participants that the lack of available, affordable child care creates a barrier to resolving other problems such as employment and education.

<u>Variations Based on Demographics and Geography</u>

Analysis of the demographic data attached to the online and paper surveys did not indicate a substantial difference in perspective between providers and consumers or among the three major geographical areas of the state. As the table on Page 3 indicates, providers and consumers ranked the services almost identically. Only Housing and Hunger / Food Security landed in reverse order. Likewise, the table below illustrates that only Employment, Dental Care and Support for Persons with Disabilities and their Caregivers emerged with notably different rankings according to geography. All other categories are similarly ranked; plus or minus one step.

Priorities ↓ Ranking →	Statewide	Clark County	Washoe County	Rural Counties
Health / Mental Health	1	1	1	1
Housing	2	2	2	2
Hunger / Food Security	3	3	3	3
Emergency Services	4	4	4	4
Education	5	5	6	6
Employment	6	6	7	5
Protective Services	7	8	8	7
Dental Care	8	9	5	8
Support for Persons with Disabilities and their Caregivers	9	7	9	10
Substance Abuse Services	10	11	10	9
Transportation	11	10	11	11
Help Finding Information	12	12	12	12

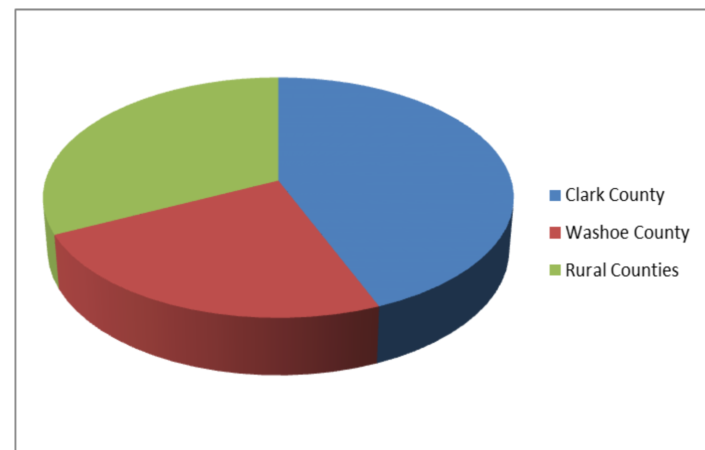
The most obvious variation in results is seen when comparing survey responses to public forum feedback. The table on Page 3 captures a striking difference in priority ranking; with the exception of the top two priorities – Health / Mental Health Care and Hunger / Food Security. (Breakout information for each forum is located on Page 16 in the Appendices section.)

Participant Demographics

The CPG's methodology for the 2016 Needs Assessment included targeted outreach intended to draw input not only from all geographic areas but from all populations in the state. Participants included both providers and users of services. No one was asked to self-identify ethnicity, and demographics were not collected from forum participants. However, the tables below and on the following page provide certain insights about those who responded to the online and paper survey.

Numbers → Area ↓	Population	Percent of Population	Number of Responses	Percent of Responses
Clark County	2,069,450	72.8%	530	43.9%
Washoe County	436,797	15.4%	290	24.0%
Rural Counties	337,054	11.9%	388	32.1%

Population data is from the Nevada State Demographer's 2014 Estimates. Percent of Population exceeds 100% due to rounding.



Consumer Identity	Response Percent	Response Count
Senior Citizen (age 55+)	45.5%	172
Family with children ages 5 – 12 years	22.2%	84
Adult with a disability	19.8%	75
Family with children ages 13 – 18 years	16.9%	64
Family with children with special needs	14.3%	54
Family with children ages 0 – 4 years	11.6%	44
Someone who provides care for a senior citizen	11.1%	42
Someone who provides care for an individual with a disability	10.6%	40
Someone who provides care for a child with special needs	9.5%	36
Veteran with a disability	7.9%	30
Child or youth with a disability	5.3%	20
Other	15.9%	60
	answered question	**378**
	skipped question	**69**

Provider Identity	Response Percent	Response Count
Senior Citizen (age 55+)	35.2%	203
Family with children ages 5 – 12 years	26.7%	154
Family with children ages 13 – 18 years	24.3%	140
Family with children ages 0 – 4 years	21.0%	121
Someone who provides care for a senior citizen	15.1%	87
Someone who provides care for an individual with a disability	13.0%	75
Adult with a disability	8.9%	51
Someone who provides care for a child with special needs	8.9%	51
Family with children with special needs	8.5%	49
Veteran with a disability	5.4%	31
Child or youth with a disability	4.5%	26
Other	26.0%	150
	answered question	**576**
	skipped question	**187**

Those who responded to the demographics question were instructed to check all categories that applied to their circumstances. As a result, the percentages in the tables above exceed 100%. Not surprisingly, self-descriptions entered under “Other” were diverse.

- Of the 60 consumers who marked “Other,”
    - One-third (20) described themselves as adults (either single or married) with no children; and
    - The remaining 40 included an assortment of parents with grown children, caregivers, volunteers, students and professionals.
- Of the 150 providers who marked “Other,”
    - 48 described themselves as adults (either single or married) or families with no children;
    - 44 providers entered their specific profession (primarily social service providers and health care workers);
    - 18 identified themselves as adults with grown children;
    - Five were taking care of both children and elderly parents; and

- The remaining 35 entered a variety of loosely-knit responses including grandparents, single parents and expectant parents.

Service Category Details

Comments submitted by online and paper survey respondents and shared by participants at public forums were used to drill down into the specific needs embedded in each broad service category. The table below highlights the most common themes.

Category	Specific Needs and Issues
Health / Mental Health Care	○ Mental Health – accessibility, affordability, integration of care, supportive services ○ Health Access – provider shortage, affordability, insurance issues ○ Tobacco Use Prevention and Cessation – deserves FHN funding
Housing	○ Affordable Housing – shortage of Section 8 housing, shortage of affordable housing in general ○ Prevention of Homelessness – help with deposits, rent, relocation costs, home repair ○ Homeless Services – shelters for all populations, emergency and transitional housing
Hunger / Food Security	○ Holistic Service Approach – solving the root causes of hunger ○ Braided Services – consumers must utilize multiple services to meet their need (pantries, SNAP, WIC) ○ Nutrition – access to healthy foods, nutrition education, community gardens, partnerships with growers
Emergency Services	○ Financial Assistance – rent, utilities, preventive help, excessive bureaucracy to obtain help ○ Document Assistance – help obtaining identification, birth certificates ○ After-Hours Help – emergencies happen 24/7
Education	○ Life Skills Training – parent education, budgeting and financial management, nutrition education ○ Alternative Education – charter schools, on-the-job training, vocational education, GEDs ○ Public and Higher Education – more funding in general, tuition assistance, expanded pre-Kindergarten
Employment	○ Wages – minimum wage is not a living wage ○ Jobs – employment assistance programs exist but there is a shortage of jobs, especially middle income ○ Barriers to Employment – substance abuse, re-entry after incarceration, lack of education

Category	Specific Needs and Issues
Protective Services	○ Gaps – protective services not available for persons with disabilities ages 18 to 59 ○ Services for Victims – crisis intervention, shelters, recovery resources, therapy, hotlines, personal safety ○ Focus on Special Populations – seniors, victims of human trafficking, domestic violence victims
Dental Care	○ Access – shortage of providers, affordability ○ Coverage – Medicaid, Medicare and private insurance offer limited dental benefits ○ Support for Existing Services – mobile dental care, low-cost health clinics
Support for Persons with Disabilities and their Caregivers	○ Specific Populations – more services for brain injury, blindness, autism, intellectual disabilities ○ One-Stop Shop – create center with comprehensive services for persons with developmental disabilities ○ Support for Existing Services – respite, positive behavior support, independent living
Substance Abuse Services	○ Prevention – substance abuse creates barriers to solving problems in all other service categories ○ Access – shortage of providers and inpatient facilities, affordability, inadequate insurance coverage ○ Treatment – length of covered treatment falls short of best practices, lack of transitional support
Transportation	○ Paratransit – limited routes, not available in all areas, long wait times ○ Public Transportation – limited routes, no routes between cities, limited funds for bus passes ○ Special Populations – children who need after-school care, special needs children, parents with strollers
Help Finding Information	○ Advocacy – people need individualized help understanding and navigating the service system ○ Nevada 2-1-1 – needs marketing and outreach, resource updates, bilingual texting, warm hand-offs ○ Family Resource Centers – need to consider extended hours (e.g., evenings or weekends)

Current FHN Services with GMAC Oversight

Health and Mental Health Care

Health / Mental Health Care was the No. 1 need identified in the 2014 Needs Assessment. Two years later, it continues to cling firmly to the top spot. In the 2016 surveys and in public forums, more input was collected about this need than any other. With due respect, this section contains additional detail about the subcategories of need and the history of health-related FHN funding.

As noted on Page 4, 463 people responded to the survey question designed to identify services that were missing from the preliminary needs list. Of these, 154 (33.3%) entered services that actually belonged in the Health / Mental Health Care category.

- With 60 comments (41.9%), **mental health** was the most cited need by a distinctly wide margin. Respondents observed that:
    - Mental and physical health are intertwined, requiring integrated care;
    - There are insufficient mental health providers and inpatient facilities in the state, particularly in the rural counties;
    - Affordability of care is an issue; and
    - Services like advocacy, case management and supportive housing are needed to ensure stability.

- The next most commonly cited need focused on **health access** in general (36 respondents; 23.4%). Respondents observed that:
    - There is a statewide shortage of health care providers, especially in rural counties;
    - The shortage includes not only primary care physicians but specialists and public health nurses;
    - Many providers will not accept Medicaid and Medicare due to low reimbursement rates and complicated billing requirements or will accept only a limited number of patients with these payers;
    - The cost of insurance, deductibles and co-pays makes health care unaffordable for many Nevadans; and
    - There is a need for advocates and/or case managers to help people understand and navigate the complexities of their health insurance and the health care system.

- **Tobacco use prevention and cessation** was the third most commonly cited need (33 respondents; 21.4%). Respondents observed that:
    - FHN dollars are generated by the Tobacco Master Settlement Agreement (MSA) and should, therefore, be used to address this issue.

Public forum participants reinforced many of the same observations made by survey respondents. Additional areas of concern for both groups included reproductive health, prenatal care, prevention of chronic disease, alternative medicine, and breaking down gender and cultural barriers to health care. However, none of these additional concerns rose to the level of the first three.

Historically, prior to rollout of the Affordable Care Act (ACA) and Medicaid Expansion, FHN dollars were used to support children's health and health access programs. Examples included outreach to increase client participation in Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) program, advocacy to help individuals and families access health benefits and connect with primary care physicians, and case management to help parents minimize their child's asthma symptoms. Today, many of the programs

previously offered by FHN grantees are part of the services insurance carriers are required to provide and/or have been added to the array of available Medicaid benefits. To avoid duplication, the only FHN dollars now directed to health care support under-funded programs like state-sponsored mental health care, suicide prevention and immunization. Even those programs are under scrutiny to determine whether any of their services are reimbursable through insurance.

Tobacco use prevention and cessation is a program area specifically named in the FHN statute [NRS 439.630(1)(f)]. Originally, 15% of FHN funds were set aside to support these activities. In SFY10, this amounted to about $2.7 million. Removal of the statutory program allocations and the concurrent economic recession resulted in substantial changes to FHN spending from SFY11 forward. No money was directed to tobacco use prevention and cessation from SFY11 through SFY13. With the economy showing improvement, the Legislature restored $1 million per year to tobacco programs from SFY14 through SFY17. Tobacco cessation is now a covered service under most health plans; an important consideration in determining future funding levels.

Hunger / Food Security

As identified in all three needs assessments conducted by the CPG on behalf of the GMAC, Hunger / Food Security is a persistent problem in Nevada. It is the most basic of human needs and affects people of all ages, abilities, ethnic backgrounds and geographic locations. Inadequate access to sufficient amounts of nutritious food trumps virtually all other needs and is a fundamental barrier to stability and self-sufficiency.

The 2016 Needs Assessment did not turn up any new ideas for addressing hunger in Nevada. Rather, public forum participants and survey respondents reiterated the same issues that have previously supported high prioritization of food security.

- A holistic approach to service delivery is critical to resolving the root causes of hunger in a household.
- To get through any given month, individuals and families in need must access multiple sources of assistance such as Supplemental Nutrition Assistance (SNAP), Women Infants and Children (WIC), and food baskets from pantries. No one resource is sufficient.
- The nutritional value of supplemental food needs to be elevated. Food pantries have a difficult time providing healthy food for people on special diets. School breakfasts and lunches should meet high nutritional standards.
- Nutrition education is needed including budgeting, recipes and how poor nutrition affects health.
- Community gardens and partnerships with local growers need to be encouraged.

Prior to the economic recession, a small portion of FHN Children's Health (now known as FHN Wellness) grants touched on hunger through nutrition education programs, weekend food back-packs and after-school snacks. It was not until SFY13 that a concerted effort was made to solicit and fund programs that were strategically designed to reduce hunger. The triggers for this effort were the 2012 Statewide Community Needs Assessment, which identified food security as a critical priority, and Governor Brian Sandoval's decision to tag hunger as a Core Function of Government. On the heels of these two developments, an interagency steering committee was formed to write Nevada's Plan for Action around food security. Later, a gubernatorial Council on Food Security was created to implement the plan.

Multiple state agencies and community partners are using the plan to guide anti-hunger activities. FHN Wellness dollars factor into the initiative primarily through grants that support several One-Stop Shops (Goals 2e and 2f in the Feed section of Nevada's Plan for Action). In SFY15, $2,055,732 in FHN dollars provided 48,476 unduplicated individuals with food to meet their immediate needs and support to solve the root causes of hunger in their households. In SFY16, $2.25 million is directed toward this same purpose.

The nature of data collection and analysis typically lags by two or more years, but early indications of progress do exist. According to the Food Research and Action Center (FRAC), Nevada was one of the 15 worst states in reaching eligible SNAP participants as of SFY13. However, also according to FRAC, between January 2015 and January 2016 Nevada increased SNAP participation by 7.3% and showed the most improvement of any other state. Two other benchmarks in Nevada's Plan for Action that are on watch are low and very low food security rates. As of 2014, the United States Department of Agriculture (USDA) reports that:

- Low or very low food security in Nevada was at 15.2 percent, only a 0.01 percent improvement between 2011 and 2014 and above the national average of 14.3 percent; and
- Very low food security in Nevada was at 6.3 percent, a 0.03 percent increase between 2011 and 2014 and above the national average of 5.6 percent.

Support for Persons with Disabilities and their Caregivers

The FHN statute includes a provision specifically for respite care, independent living and positive behavior support. Originally, 10% of the funds were used to support these services. In SFY10, that amounted to about $2 million. Following the statutory change that removed the required allocations, coupled with the negative impact of the economic recession, the average from SFY11 through SFY15 dropped to about $1.27 million. In the current biennium, $1.59 million is designated for these services.

The 2016 Needs Assessment ranked Support for Persons with Disabilities and their Caregivers in the bottom third, but public forum participants explained that support and funding for this category is already available. Therefore, they viewed the category as a problem solved rather than a problem to be solved.

The unanswered question is whether adequate funding is in place for this purpose. In response to the SFY16-17 grant solicitation, the CPG received more than $2.8 million in requests from providers of disability support services. This exceeded the amount available by more than $1.21 million. Only 12 out of 21 applicants received funding, and three of those accepted a fraction of what they had requested. Among them was a successful paratransit program that was offered 35% of its prior award even though its proposal scored relatively high at 85 out of 100. About $2.15 million would have been required to fully fund all respite and independent living proposals that achieved a score of 70 or above, and also to fund the one qualified positive behavior support applicant.

Help Finding Information

Help Finding Information is the last service category on the 2016 priority list. As with Support for Persons with Disabilities and their Caregivers, the most likely reason for the low ranking is that resources already exist and are well-utilized by consumers.

- Nevada 2-1-1 is utilized by more than 10,000 people per month;
- Family Resource Centers (FRCs) made more than 161,000 referrals to community services in SFY15;
- Differential Response (DR), a child welfare program provided through certain FRCs, helped more than 1,400 families in SFY15;
- The Office of Consumer Health Assistance (OCHA) handled 19,500 calls last year; and
- Aging and Disability Resource Centers (ADRCs) handled more than 10,000 inquiries in SFY15.

<u>Nevada 2-1-1</u>

Per NRS 232.359 adopted by the 2005 Legislature, the DHHS must establish and maintain a health and human services information and referral line. This statute, along with Executive Orders signed by three Nevada governors, is responsible for the creation of the single most widely used source of information in the state – Nevada 2-1-1. Initially launched and operated by a dedicated team of community partners, the system is now managed by the DHHS-DO CPG through a contract with Financial Guidance Center in Las Vegas.

Prior to SFY14, financial support for Nevada 2-1-1 was a patchwork of allocations from various funding streams including the FHN Disability, the FHN Children's Health (now known as Wellness), Social Services Block Grant (SSBG-Title XX), the Children's Trust Fund (CTF) and the State General Fund. Allocations were not based on a formula but were dependent on availability of funds. By SFY14, State General Fund support had been withdrawn due to serious economic challenges in Nevada, and the DHHS opted to consolidate 2-1-1 funding in the FHN Wellness category. In SFY14 and SFY15, $500,000 per year was allocated. In SFY16 and SFY17, the annual support increased to $700,000.

A comprehensive strategic planning process currently underway indicates that this level of support is inadequate based on the universally high expectations for the program (i.e., assessing all needs of callers, maintaining an accurate database, obtaining national accreditation and serving as a non-emergency responder during disasters). A shortage estimate was not available by the release date of this report, but it will likely be in excess of $300,000. Staff and stakeholders are working to identify alternative revenue sources and negotiate agreements.

Family Resource Centers and Differential Response

Family Resource Centers (FRCs) and the Differential Response (DR) program were not specifically cited as priorities in the needs assessment. However, both are supported by FHN dollars and both offer services that fall under multiple priority areas including Help Finding Information. Most notably, FRCs and the DR program serve as a resource for families who need help finding information, accessing services that address immediate crises, and long-term support to achieve stability and self-sufficiency.

FRCs were established in 1995 by NRS 430A. In accordance with that statute, the state is divided into 18 Service Areas with 21 FRCs. Residential zip codes determine the catchment areas. At minimum, each FRC provides information, referrals, and case management but many go beyond these basic requirements and provide valuable family support services such as parent education, peer mentoring and food pantries. In SFY15, the FRCs collectively served 33,320 unduplicated adults and made 161,543 referrals to community agencies.

Eight of these FRCs, plus one county-funded community agency, participate in the collaborative partnership that brings DR to at-risk families. The CPG was the lead partner in developing and administering the program from its inception in 2006 until January 2016 when the Division of Child and Family Services (DCFS) took the reins. The hallmark of this early intervention and child abuse prevention program is assessment and connection to supportive resources. When a low-priority case is reported to DCFS or the child

welfare agency in Clark or Washoe County, the DR workers on staff at the FRCs are often called upon to respond. In SFY15, a statewide total of 1,421 new cases were referred to DR.

Until SFY13, State General Fund supported both the FRCs and the DR program. The economic recession resulted in the loss of that resource and financial support for the programs was transferred to FHN Wellness.

- $1.3 million per year in FHN dollars supported the statewide network of FRCs in SFY14 and SFY15. The annual allocation increased to about $1.42 million in SFY16 and SFY17.
- About $1.35 million per year in FHN dollars supported the DR program in SFY14 and SFY15 (augmented by $50,000 per year in private foundation money). The allocation did not change appreciably in SFY16 and SFY17.

Next Steps

A special purpose GMAC subcommittee will meet on Thursday, May 5, 2016 to review the contents of this report. Any questions that cannot be answered by CPG staff during the meeting will be researched over the following two weeks. The committee will meet again on Tuesday, May 24, 2016 for follow-up discussion and adoption of recommendations for FHN funding priorities. The full GMAC will hear the subcommittee recommendations on Thursday, June 9, 2016, deliberate and then take a final vote on the recommendations to be submitted to the DHHS Director. As described on Page 1 of this document, the DHHS Director will consider the GMAC recommendations along with recommendations from the Commission on Services for Persons with Disabilities (CSPD) and the Commission on Aging (CoA). The Director will report back to the GMAC, CSPD and CoA no later than September 30, 2016.

Acknowledgements

The DHHS-DO CPG wishes to thank the community partners who hosted and/or helped to coordinate public forums in communities across the state. Thanks also go to all those who completed online surveys, submitted paper surveys and/or participated in public forums. Without this input, the GMAC could not meet its statutory mandate to conduct an assessment. More importantly, the DHHS-DO CPG could not achieve its vision, mission and goals.

"Our vision is to be a valued partner in strengthening the ability of communities to respond to human service needs."

"Our mission is to help families and individuals in Nevada reach their highest level of self-sufficiency by supporting the community agencies that serve them through engagement, advocacy and resource development."

Appendices

- Public Forum Locations and Results
- Grants Management Advisory Committee – Priority Recommendations for State Fiscal Years 2014-2015 and 2016-2017
- SFY16-17 Fund for a Healthy Nevada Distribution
- Correspondence Between the GMAC and the DHHS Director's Office

Public Forum Locations and Results

Public forums for the 2016 Statewide Community Needs Assessment were held in Carson City and Elko on Thursday, April 17, in Reno on Thursday, April 14, in Las Vegas on Friday, April 15, and in North Las Vegas on Friday, April 22. Turnout was not as robust as in 2012 or 2014 despite outreach to stakeholders. However, those who did participate engaged in valuable discussions about the specific needs within each identified service category. The chart below provides the priority ranking determined at each public forum as well as the overall ranking in the Totals column.

Priority ↓ Forum →	**Carson City** *6 Providers* *0 Consumers*	**Elko** *7 Providers* *2 Consumers*	**Las Vegas** *7 Providers* *1 Consumer*	**North Las Vegas** *6 Providers* *1 Consumer*	**Reno** *16 Providers* *2 Consumers*	**Totals**
Health / Mental Health Care	3	11	4	5	11	**34**
Housing	4	1	4	1	10	**20**
Substance Abuse	3	4	2	4	2	**15**
Transportation	1	6	4	1	1	**13**
Education	1	2	2	3	4	**12**
Emergency Services	3	0	1	0	7	**11**
Hunger	2	0	0	0	8	**10**
Dental Care	0	0	2	4	2	**8**
Help Finding Information	0	0	1	1	6	**8**
Employment	0	0	4	2	1	**7**
Protective Services	1	3	0	0	2	**6**
Support for Persons with Disabilities and their Caregivers	0	0	0	0	0	**0**

Grants Management Advisory Committee

Fund for a Healthy Nevada
Priority Recommendations for State Fiscal Years 2014-2015 and 2016-2017

SFY14-15 GMAC Recommendations

After a review of the 2012 Statewide Community Needs Assessment, oral presentations from the Commission on Aging (CoA) and the Commission on Services for Persons with Disabilities (CSPD) regarding the results of their assessments, and extensive discussion through both an Ad Hoc Subcommittee and the June 14, 2012, Grants Management Advisory Committee (GMAC) meeting, the committee reached the consensus that the priorities for SFY14-15 should be limited to four primary areas of focus. The following recommendations were made.

Primary Priorities

- Food Insecurity with objectives to meet short/immediate, medium and long term needs.
- Health Care with an emphasis on dental care, mental health, tobacco control, alcohol and obesity related conditions, suicide and childhood immunization.
- Family Supports with a focus on children, seniors and other vulnerable populations.
- Help Finding information to include 2-1-1, education and outreach, and information and referral.

Secondary Priorities

- Transportation
- Help Finding Employment
- Housing
- Education
- Utilities

In addition, the following **strategies** were recommended to encourage systemic change.

- The secondary priorities should be addressed as components in grant-funded projects as appropriate. For example, if a proposed project is centered on access to health care but transportation to appointments is a barrier, then the grant applicant would need to address this need. This approach recognizes the interconnectedness of service.

- Collaboration should be expanded to include new public/private partnerships.
- All grant-funded projects should be required to do outreach and marketing for 2-1-1, as well as education and outreach in general.
- Family Resource Centers (FRC) are already in place and should be considered as a service delivery method.
- Project sustainability must be addressed in all proposals.
- Projects need to identify and maximize the benefits available through under-utilized resources, both private and public, e.g., the Supplemental Nutrition Assistance Program (SNAP).
- Consider programs currently supported by funding streams that fall within the GMAC's scope of work. Are the services provided by these programs effective, impacting the community and do they fit the priorities identified by the GMAC?

SFY16-17 GMAC Recommendations

During a GMAC meeting on June 20, 2014, a quorum of nine members voted unanimously to accept the four major service categories identified as priorities in the 2014 Statewide Community Needs Assessment report compiled by the DHHS GMU.

- **Health / Mental Health** *(e.g., tobacco use prevention and cessation, access, cost, immunization, general wellness)*
- **Family Support** *(e.g., Family Resource Centers, Differential Response, information and assistance, child care)*
- **Food Security** *(e.g., food pantries and food banks, access to nutritious food, nutrition education, SNAP)*
- **Support for Persons with Disabilities and their Caregivers** *(e.g., respite, independent living, positive behavior support)*

Although the 2014 Statewide Community Needs Assessment ranked the categories in the order listed above, the GMAC specifically voted to accept the categories in no particular order.

SFY16-17 Fund for a Healthy Nevada Distribution

Use Category	SFY16 Budget	SFY17 Budget
439.630 (c) - Seniors:		
- Administrative costs (ADSD - 3156)	157,116	(157,116)
- Senior Rx (ADSD - 3156)	2,542,884	(2,542,884)
439.630 (d) - Senior Independent Living (ADSD)		
- Administrative costs (ADSD - 3140)	247,684	247,684
- Senior Independent Living (ADSD - 3140)	5,763,970	5,763,970
439.630 (e) - Assisted Living (ADSD - 3140)	200,000	200,000
439.630 (f) - Cessation (DPBH - 3220)	1,000,000	1,000,000
439.630 (g) - Wellness:		
- Administrative costs (DO - 3195)	421,311	426,137
- Suicide Prevention (DPBH through DO - 3195)	400,000	400,000
- Hunger (DO - 3195)	2,300,001	2,300,001
- Immunization (DPBH through DO - 3195)	400,000	300,000
- 2-1-1 Support (DO - 3195)	700,000	700,000
- Differential Response (DO - 3195)	1,420,000	1,420,000
- Family Resource Centers (DO - 3195)	1,437,334	1,437,334
- OCHA Ombudsmen (DO - 3204)	180,000	180,000
- SNAMHS - PACT (DPBH- 3161)	150,000	-
- SNAMHS - Home Visiting Program (DPBH - 3161)	150,000	-
- NNAMHS - Home Visiting Program (DPBH - 3162)	83,308	-
- Lakes Crossing Additional Beds/Staffing (DPBH - 3645)	1,562,221	1,562,221
- So NV MOST Program (DPBH - 3161)	459,513	459,513
- So NV Community Triage Center (DPBH - 3161)	200,000	100,000
- So NV Mental Health Court (DPBH - 3161)	500,000	250,000
- No NV Mobile Crisis Unit (DCFS - 3281)	124,999	124,999
- So NV Mobile Crisis Unit (DCFS - 3646)	375,001	375,001
- No NV Mobile Crisis Unit - Expansion (DCFS - 3281)	635,199	635,199
- So NV Mobile Crisis Unit - Expansion (DCFS - 3646)	1,316,541	1,316,541
439.630 (h) - Disability Services:		
- Administrative costs (DO - 3195)	61,713	61,364
- Respite (DO - 3195)	675,000	675,000
- Positive Behavior Support (DO - 3195)	340,000	340,000
- Independent Living Grants (DO - 3195)	579,672	579,672
- Traumatic Brain Injury (ADSD - 3266)	400,000	320,000
- Alzheimer's Taskforce Support (ADSD - 3151)	49,582	49,582
- Taxi Assistance Program (ADSD - 3151)	170,000	-
- Autism Taskforce Support (ADSD - 3266)	51,864	51,864
- Autism (ADSD - 3266)	2,500,000	2,500,000
- Family Preservation (ADSD - 3166)	1,200,000	1,200,000
439.630 (i) - Disability Rx (ADSD)		
- Administrative costs (ADSD - 3156)	19,419	19,419
- Disability Rx (ADSD - 3156)	605,581	605,581
Treasurer's Administrative Costs - (FHN - 1090)	62,344	62,344
Total Expenditures:	29,442,257	28,363,426

Correspondence Between the GMAC and the DHHS Director's Office

December 23, 2015

Richard Whitley, Director
Nevada Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

During the December 10, 2015, meeting of the Grants Management Advisory Committee (GMAC), staff of the Grants Management Unit (GMU) presented a plan for the 2016 Statewide Community Needs Assessment. As you know, per Nevada Revised Statute (NRS) 439.630, this assessment is conducted in even-numbered years in order to establish funding priorities for the Fund for a Healthy Nevada (FHN).

The GMAC voted to approve the GMU's plan for the assessment and, in language added to that motion, the GMAC also voted to encourage you to utilize the results of the assessment beyond the confines of the FHN.

Assessments conducted in 2012 and 2014 produced useful information about service gaps that cannot be addressed by the FHN. Some are not even within the scope of authority of the Department of Health and Human Services (DHHS). For example, both the 2012 and 2014 assessments fleshed out a variety of needs in the areas of housing, employment, education, youth enrichment and safety.

Capitalizing on the assessment is not exactly a new idea. The concluding paragraph of the 2012 report noted that: "Although the gathering of input from the public was intended for use in the determination of the allocation of the FHN, it has become apparent from the extensive input from the community that the results of this assessment may have a more far reaching impact in the development of grant awards from other funding streams. The priorities identified in this report may also be of assistance in the development of future budget recommendations for the DHHS as a whole, working toward the reduction of information silos and the increased collaboration in strategic planning."

As the GMU begins to conduct the 2016 Statewide Community Needs Assessment, members of the GMAC want to encourage you to utilize the process and the findings in the broad manner characterized in the 2012 report. While statutory compliance is important, our work should not stop there. Advisory committee members, administrators, legislators and other leaders should tap into every available resource to ensure that the needs of Nevadans are identified and addressed. This is the best way to make the most effective use of limited dollars while building strong communities and a strong state. Thank you for your consideration of our recommendation.

Sincerely,

Jeff Fontaine

Jeff Fontaine, Chairperson
Grants Management Advisory Committee

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIRECTOR'S OFFICE

4126 Technology Way, Suite 100
Carson City, Nevada 89706
Telephone (775) 684-4000 • Fax (775) 684-4010
http://dhhs.nv.gov

December 31, 2015

Jeff Fontaine, Chairperson
Grants Management Advisory Committee
c/o Nevada Association of Counties
304 S. Minnesota Street
Carson City, NV 89701

Dear Mr. Fontaine:

Thank you for the letter you recently sent to Department of Health and Human Services (DHHS) Director Richard Whitley on behalf of the Grants Management Advisory Committee (GMAC). He appreciates your committee's perspective on the utilization of data collected through the 2016 Statewide Community Needs Assessment and asked me to respond.

As DHHS Director, Mr. Whitley's vision is to eliminate the silos that exist in the State system and encourage agencies to partner in ways that reduce duplication of effort and maximize resources. Your recommendation to more broadly apply the information collected for the development of the Fund for a Healthy Nevada (FHN) spending plan is very much aligned with that vision. Statutory compliance may be the driving force behind the needs assessment, but the data can most certainly serve a larger purpose.

This approach makes sense not only from a progressive standpoint but also as a practical matter. FHN dollars are often co-mingled with other funding sources to support projects. A good example of this is under the purview of the GMAC. FHN and Social Services Block Grant (SSBG/Title XX) money are combined to finance Hunger One-Stop Shops. Using the FHN needs assessment data to build a budget that recognizes how various funding sources are intertwined can only strengthen the overall effort.

Again, thank you for conveying the GMAC's perspective about the 2016 Statewide Community Needs Assessment. It was a valuable message and will help us enter into the New Year with high ideals.

Sincerely,

Dena Schmidt
DHHS Deputy Director of Programs