

Thank you Mr. Chairman and members of the committee for the opportunity to speak. My name is David Marlon and I'm the president of Solutions Recovery, a leading alcohol and drug treatment center. We have treated addiction and co-occurring clients in Las Vegas for the last 8 years.

Our co-occurring clients have serious mental illness and a drug dependency. This is the case for at least half of the mentally ill population treated in the State funded system in Southern Nevada.

Before starting Solutions Recovery, I was the Chief Operating Officer at Sierra Health/Health Plan of Nevada and learned to look at health care as a system. With that, we developed knowledge of how to run a successful and cost efficient mental health treatment model.

Our current public mental health system in Southern Nevada is broken. I do not believe that taking patients to an emergency room to be medically cleared to then transport them Rawson Neal (where over 50% of their presented clients do not meet admission criteria) is good clinical or cost effective care. Right now, we have a great opportunity to reform the system. We do not need a "quick fix" of only funding more acute psychiatric and/or Community Triage Center (CTC)/Local Alcoholism Reception Center (LARC) beds without looking for solutions that address systemic problems and long-term system development.

In my opinion, the most pressing need is fixing the ER/Legal 2000 problem with the expansion of CTC/LARC or other detox bed capability and most importantly the development of a PES (psychiatric emergency service) with co-located or contracted crisis stabilization bed capability or a PHF (psychiatric health facility).

(PES) stands for Psychiatric Emergency Services. They are outpatient psychiatric "crisis/urgent walk-in" clinics that are usually combined with a crisis hotline, mobile crisis and police liaison programs. They typically have contracted acute, residential and sub-acute a bed capability. Some of the states with developed PES programs include California, Colorado, Michigan, Wisconsin and Texas.

(PHF) stands for Psychiatric Health Facilities, and are the cornerstone of public behavioral health services in Arizona and California. PHFs are hybrid inpatient/outpatient facilities that provide both outpatient walk-in crisis stabilization and short-term sub-acute psychiatric inpatient services. The sub-acute inpatient services are typically adjacent to or physically proximate to the outpatient clinic. The inpatient component is typically fifteen (15) beds or less, therefore exempt from the IMD exclusion and Medicaid billable.

The next priority should be to develop wraparound service infrastructure to include expansion of case management, co-occurring, mobile crisis services, outpatient transitional services, peer to peer services, transitional housing and the development of

“priority access” into the existing outpatient service system to allow for meaningful triage.

The third priority should be to develop intensive case management services for the “super users”. This means expanding both the current Program of Assertive Community Treatment (PACT) team’s capability as well as developing a secondary level or “bridge” case management capability to allow for transition from intensive case management to a lesser level of case management.

I would also like to express my opinion that the managed Medicaid healthcare providers could to be invited to testify to this committee and discuss recommendations, as they will be major players in the delivery of public behavioral health services.

Lastly, I want to thank you Mr. Chairman and members of the committee for taking the time to help solve this issue. While we all agree on the problem, the solutions are far more complicated and elusive. As a member of our community for the last 25 years, I appreciate everything you are doing. With that, I am happy to answer any questions.