COMMISSION ON BEHAVIORAL HEALTH

DIVISION OF CHILD AND FAMILY SERVICES

JANUARY 13, 2022

DRAFT MEETING MINUTES

This meeting used Microsoft TEAMS technology for video and audio capability.

COMMISSIONERS PRESENT:

1) Arvin Operario
2) Braden Schrag
3) Daniel Ficalora
4) Jasmine Troop
5) Lisa Durette
6) Lisa Ruiz-Lee

COMMISSIONERS NOT PRESENT:

7) Billie Miller
8) Gregory Giron
9) Natasha Mosby

STAFF AND GUESTS:

1. Adina Archibold-Bugett, Desert Winds Hospital
2. Alex Tanchek, Silver State Government Relations
3. Carin Hennessey, Nevada Medicaid
4. Char Frost, Nevada PEP
5. Cindy Pitlock, Division of Child & Family Services (DCFS)
6. Dan Musgrove, Clark County Children's Mental Health Consortium
7. Gwendolyn Greene, DCFS
8. Dr. Jacqueline Wade, DCFS
9. Don Butterfield, Reno Behavioral Healthcare Hospital and Commissioners
10. Dr. David Gennis, Reno Behavioral Healthcare Hospital and Commissioners
11. Jennifer Ahn, Nevada Early Intervention Services
12. Jennifer Atlas, The Griffin Company Government Affairs
13. Jennifer M. Spencer, Office of the Attorney General
15. Jessica Flood Abrass, Northern Regional Behavioral Health Coordinator
16. Joelle McNutt, Nevada Board of Examiners for Marriage Family Therapists and Clinical Professional Counselors
16. Joseph P. Filippi, DPBH

17. Karen Taycher, Nevada PEP
18. Kary Wilder, DCFS
19. Kathryn Martin, DCFS
20. Dr. Megan Freeman, Department of Health & Human Services
21. Michelle Sandoval, Division of Public & Behavioral Health
22. Mitchell Moen, Division of Health Care Financing & Policy
23. Salwa Philips, DCFS
25. Sherri Brozina
26. Stephanie Dotson, DCFS
26. Susanne M. Sliwa, Office of the Attorney General
27. Susie Miller, DCFS
28. Tray Abney, Reno-Sparks Chamber of Commerce
29. Valerie Balen, Belz & Case Government Affairs
30. Kary Wilder, DCFS
31. William Wyss, DCFS
31. Yeni Medina, Autism Treatment Assistance Program

1. Call to Order and Introduction. *Dr. Lisa Durette, Commission on Behavioral Health Chair,* called the meeting to order at 9:02 a.m. *Kathryn Martin, Division of Child & Family Services (DCFS),* conducted roll call and quorum with established with six members present.

2. Public Comment. *Commissioners/Public*

There was no public comment.

3. For Possible Action. Approval of the September 9, 2021, Meeting Minutes – *Lisa Durette, Chair*

MOTION: Approve September 9, 2021, Commission on Behavioral Health with DCFS Meeting Minutes
BY: Braden Schrag
SECOND: Arvin Operario
VOTE: Motion passed unanimously with no opposition or abstention.

4. For Information Only. Reno Behavioral Healthcare Hospital Presentation of their Management of Seclusion and Restraint and How they Address Patterns to Mitigate Repeat Offenses. Discussion, Formulation and Approval of any Plan of Action Needed – *Dr. David Gennis, Executive Director of Clinical Services and Don Butterfield, COO, Reno Behavioral Healthcare Hospital and Commissioners*

Dr. Durette clarified that in previous reviews of seclusion and restraint information, there were concerns about patterns of use at Reno Behavioral Health where it is difficult to determine in cases of multiple restraint incidents of one child, how treatment plans are updated and changed to prevent future events.

Don Butterfield introduced an overview of the Reno Behavioral Health (RBH). The facility opened in 2018 and sees patients of all ages and treats both mental health and substance abuse,

with both inpatient and outpatient programs. Several youth programs are offered; 21 beds are designated for inpatient services, with another 21 beds opening in the future. Finding enough qualified staff is a challenge (nurses, clinicians and therapists). A 21-bed residential treatment program also exists, which is a lower level of care with a general length of stay of up to 90 days. Currently there are 42 beds specifically for youth, with a total of 63 beds coming online. Partial outpatient intensive hospitalization is also available. RBH is the only hospital in Northern Nevada that provides partial hospitalization level of care.

Mr. Butterfield reported that with the high volume of patients, there are occasions where seclusion and restraints are engaged strictly by policy and always as a last resort. Patients have a right not to have seclusion and restraints for means of discipline, retaliation or convenience. Seclusion and restraint is only used for the patient's safety or the safety of others, and only if there is a risk of imminent harm. The hospital is committed to reduce seclusion and restraints and train staff to recognize early intervention situations (to recognize potentially troublesome behaviors is key to de-escalate a situation before it happens). The number of seclusion and restraint incidents has been slowly reducing by about one-third since September 2021, with plans to continue work in this area.

Mr. Butterfield introduced RBH Executive Director of Clinical Services, Dr. David Gennis, who oversees all clinical staff and specializes in youth programming. Dr. Gennis has been with Signature Healthcare for about one year and has been working to reduce seclusion and restraint numbers and improve training for mental health technicians (MHTs) to provide them with a conceptual/theoretical lens in how they provide and deliver patient care. They have started training MHTs in the conceptualization of stages of change and how to interact with patients in terms of where they're coming into the hospital in admission regarding their readiness and motivation for change. Due to varied lived and educational experiences of MHTs, Dr. Gennis felt it was significant to provide them with a philosophical lens of how to provide patient care in the hospital. Stages of change provides team members with a wheel of key markers to identify a patient's stage of change readiness in order to provide better outcomes in terms of interactions and conversations with the patient. Additionally, it provides team members with recommended worker skillsets to provide optimum patient care. Dr. Gennis linked this training with the six guiding principles of trauma informed care delivery and is providing weekly supervision needed to be less reactive and more proactive in providing high quality patient care. MHTs are the key cornerstone staff providing care during 12-hour shifts on the floor and they have the most patient contact. This was a paradigm shift at the hospital to being able to identify a proactive approach to identify patient cues that might inform team members that a patient is about to be triggered so they can respond with a more trauma-informed approach. They have been working on this shift as a team over the last twelve months and Dr. Gennis feels it has significantly reduced the number of seclusion of restraints. All team members are also trained in crisis intervention, which is the Signature Healthcare model of choice and focuses on verbal de-escalation. A new highlighted objective is that if it takes 30-45 minutes to de-escalate a patient, then that is the new expectation, where previously there was more of an urgency when a patient was starting to become aggressive, the team will go to a doctor's order for medication. Dr. Gennis reported they are having good outcomes as a result of this paradigm shift.

Dr. Durrett expressed that the Commission is looking forward to seeing a positive impact from the changes that RBH is putting in place.

5. For Information Only. Division of Child & Family Services – *Dr. Cindy Pitlock, Interim Administrator, Division of Child & Family Services (DCFS)*

Dr. Pitlock gave an update on the momentum and challenges over the past six months. DCFS has about a 31% staff vacancy rate, and they are getting creative in offering flex hours, part-time, hybrid models, and telecommuting to attract clinicians in the industry who want to work three-quarter time to maintain clinical practice. The goal is to retool culture and think differently about how employees want to work and offer those options instead of trying to hire to fit rigid job situations. A staffing agency is being utilized to open beds at Desert Willow with safe, effective programming rolling out in 4-bed increments. An additional 14 contract positions are being hired through a temp company (13 MHTs and one RN) and by contracting back a retired RN, 15 new staff will be acquired in 2-3 weeks.

DCFS now has a new out-of-state dashboard showing 63 youth in out of state placements.

DCFS has been working with Clark County and the Interim Financing Committee to lease Oasis Building 13 for an interim care facility. A contractor has been selected to get an additional 6-bed capacity and is in the process of getting the programming in place. DCFS is looking at potentially relocating DCFS staff to the Oasis Campus to provide more direct access to patient services in buildings 9, 10 and 11. Jennifer Ouellette, new DCFS Deputy Administrator, and Jeffrey Haag, Deputy, Aging & Disability Services Division, toured the campus and are developing options for programs and hybrid models to relocate people so the buildings can be utilized for more direct services. The group plans to meet with the County and the Consortium to identify the appropriate services to match community need.

There is an increased number of female youth in statewide detention waiting for admission to juvenile facilities. A six-bed female pilot program is being planned at the Nevada Youth Training Center (NYTC) or Clark County to relieve that bottleneck and provide a full array of services. Caliente is a very hard-to-recruit area, so other easier-to-hire areas are being considered, based on community need. Recruitment of female staff in the Juvenile Justice facilities is a challenge so the ability to pivot services will develop a flexible staffing model based upon the type of need. This project in early stages and work is in progress with facility supervisors and deputies to get services in place for female youth in desperate need.

The Mobile Crisis Response Team (MCRT) has been increased by an additional six contractors, which solidifies that boots-on-the-ground approach and the step-down concept of youth returning home from residential placements needing intensive placements and coordination of services.

Desert Winds in Las Vegas is currently accepting Medicaid patients. They have 13 staffed residential treatment beds and 15 youth. Acute services will begin in February, based upon staffing. Admission criteria is: 1. They do not serve youth with an IQ under 70, 2. They do not treat autism. 3. They review sexually reactive youth on an individual basis and are currently serving youth ages 12+.

While there are challenges in staffing and other issues, these are definitely some wins over the last four months to provide services to youth. Dr. Pitlock thanked the group for the welcome and their efforts to advocate for DCFS youth programs.

Commissioner Schrag commended Dr. Pitlock for her hard work in moving forward to solve challenges in a difficult time. Commissioner Operario also gave kudos for the advancement of the Mobile Crisis Response Team program and requested future updates on MCRT progress.

6. For Information Only. Aging & Disability Services Division (ADSD) Update – *Yeni Medina, Autism Treatment Assistance Program (ATAP) and Jennifer Ahn, Nevada Early Intervention Services (NEIS)*

Yeni Medina, Autism Treatment Assistance Program, provided a caseload report that the ATAP program received 77 new applications, currently has 873 active children (with an average age of nine years old), with 140 inactive children (waitlisted children). Average time on the waitlist was 100 days. They continue to see growth in the field of professional and para-professional applied behavioral analysis. ATAP is currently working with 28 Applied Behavioral Analysis (ABA) providers in Southern Nevada and 17 ABA providers in Northern Nevada. Recruitment efforts to expand the provider network continue. They are going out into the community to educate families on the program in hopes of additional referrals and applications. ATAP continues to work with providers on additional models and options for parent training for those families that are waiting for one-on-service for children and who'd like to receive more education and support on how they can address behaviors in their home while they wait for a provider.

Dr. Jennifer Ahn, Nevada Early Intervention Services, reported the focus of the NEIS program is support the developmental needs of children 0-3. They are part of a national effort to train and coach staff and cohorts on the socio-emotional needs and development of young children and are involved in the Pyramid Program Model (National Center for Pyramid Model Innovation). The goal is to be able to identify social and emotional needs working with parents and families in a more collaborative and friendly way on challenging behaviors. NEIS is partnering with DCFS on the Child Abuse Prevention and Treatment Act (CAPTA) program to regularly screen young children for developmental needs. They conduct the DCFS agency questionnaire with parents to identify developmental delays for referral to NEIS services. NEIS has an ongoing autism clinic which performs evaluations and diagnostics, helping families to get an early diagnosis and referrals for therapy and services and supports. Dr. Ahn manages the autism clinic and ensures a cross-over with ATAP services.

Dr. Durette asked where Applied Behavioral Analysis (ABA) services are available quickly. Dr, Ahn said there is a challenge with many agencies having waitlists and problems with families getting insurance approvals. Ms. Medina commented that families also experience challenges with availability for services during after-school hours, which creates a big demand for services at those times of day. This creates challenges for staffing and younger children with availability in morning hours tend to receive services quicker.

Commissioner Ficalora asked about the barriers to getting more ABA providers in Nevada. Ms. Medina responded that recruitment and growing the field of professionals and the number of staff available for high-demand hour services is a challenge.
Some community providers are offering training to recruit people interested in working in the field. There is no state effort to recruit technicians presently.

7. For Information Only. Presentation of the Pediatric Mental Health Care Access Program Grant – *Stephanie Dotson, Nevada Pediatric Psychiatry Solutions*

Stephanie Dotson gave a presentation on the Nevada Pediatric Psychiatry Solutions Program which is supported by the Health Resources and Services Administration (HRSA). The program provides psychiatric mental health consultation, care coordination, training, and education. Community engagement and outreach activities occurred in Washoe, Pahrump, Fernley, Fallon, Elko, Smith Valley, Armargosa Valley, Carson City, Beatty, Yerington and other communities. Sixteen providers are currently registered and the program has received one consultation request and six care coordination requests. Training and education opportunities included 130 clinicians trained (DC: 0-5), 70 other trainings, 3 Issue Briefs and 11 Telegrams. Ms. Dotson encouraged everyone to contact her directly for more information.

Commissioner Schrag asked Ms. Dotson to provide context and information about staffing, recruitment selection criteria, training and if there was duplication coordination with other State groups. Ms. Dotson answered that program consultants are all DCFS employees; psychiatric case workers, early childhood/youth therapists and psychologists, as well as a psychiatrist who is available as needed. During this development phase, there are no full-time staff outside of the team dedicated to the program and as the program is built up and the number of support requests increase, they are hoping to expand. Internal staff training was done on telehealth consultation and utilizing telehealth services for children, youth and providers. Coordination with other efforts in the State is planned and the hope is to continue work with Dr. Duette's current consultation program.

Dr. Durette described the mental health block grant funded psychiatric consultation program which is a pediatric psychiatric access line and a state-wide child and adolescent child psychology 'curb-style' consultation program. The line is open Monday-Friday, 9am to 5pm, to any statewide doctor, pediatrician or APRN with a patient in their office who is struggling with a mental health issue or behavioral health disorder. They are staffed 40 hours per week with child psychiatrists who are available to give immediate triage help or consult during scheduled appointments. Commissioner Mosby and the UNLV Psychiatry fellows are part of the program. Chicanos Por La Causa is the organization holding the grant and has a certified community health behavioral center in rural and Northern Nevada. The pediatric access line is available statewide with two care coordinators stationed in Clark County and one care coordinator in the Carson City area. Dr. Durette is the Program Director and in addition to the UNLV Fellows, there is also a contracted child and adolescent psychiatrist.

The program has enrolled 178 primary care clinicians statewide and has done 135 consultations. Dr. Durette posted a link to the mental health block grant funded program in the chat. As an extension of the program, onsite coordinated care is provided by the integrated behavioral healthcare scholars at the Department of Pediatrics main clinic through a warm hand off by the UNLV Fellows. UNLV marriage and family interns are coming on board, which grows the integrated services workforce and expands free services to the community.

Commissioner Troop commended the work being done on these critically needed programs.

8. For Information Only. Medicaid Update and Changes – *Division of Health Care Financing & Policy*

Karen Hennessy, Program Specialist, Behavioral Health Unit at Nevada Medicaid, filled in for Sarah Dearborn and provided staffing updates which included two new management analysts; April Sears, (who will focus on certified community behavioral health clinics (CCBHCs) and supporting data collection) and Mitchell Moen (who will focus on the Mobile Crisis planning grant team).

State Plan Amendment (SPA) 21-008 related to the CHIP SPA is currently on pause through the Centers for Medicare and Medicaid Services (CMS) requesting additional information. The State is working through remaining questions around crisis intervention services. Nevada sent responses back to CMS on December 7th and is waiting for feedback.

On State Plan 21-0009 related to the removal of bio feedback and neurotherapy services for the treatment of a mental health diagnosis, CMS has determined that the bio feedback and neurotherapy provisions of the SPA will be considered as a maintenance of effort violation, under Section 9817 of the American Rescue Plan Act and would put Nevada's 9817 Enhanced Home and Community-based Services funding at risk. The SPA is currently on pause at CMS through a request for additional information and the State and CMS are determining the next steps for those services.

Related to State Plan Amendment 21-0011, as a result of SB96, Medicaid submitted a State Plan Amendment in October 2021 for the approval of increased residential behavioral treatment service rates to $52.00/hr. which CMS approved on January 13th with an effective date of January 1, 2022. There will be changes needed to the Medicaid Management Information System (MMIS) system and claims will be recycled once the system changes take effect (Web Announcement #2673).

With the approval of SB156, proposed revisions have started to Nevada Medicaid Services Manual, Chapter 400 Mental Health and Alcohol and Substance Abuse Services and the Medicaid State Plan Attachment 4.19-B to ensure crisis stabilization services provided at hospitals with a crisis stabilization center endorsement are covered and reimbursed services under Nevada Medicaid. The goal of this legislation is to add a place to go as a critical element in the crisis continuum of care to support an array of crisis services critical in caring for individuals experiencing behavioral health crisis. New proposed policy documentation will include scope of services for crisis stabilization centers, their primary objective requirements, best practices, provider responsibilities, and admission criteria. The crisis stabilization centers' best outcomes will be for patients getting better immediate care and more positive crisis behavioral health care responses. The State Plan Amendment language will address the rate methodology utilized for a daily rate of service and providers will be reimbursed at a daily default rate. After an individual and complete fiscal year of providing services, a provider will be able to complete a cost report of which an individual rate can be calculated. There was a public workshop held on December 13th for the crisis stabilization centers and the upcoming public hearing for stabilization centers will be held on February 2, 2022. A public notice of the hearing is posted on the Division of Health Care and Financing public website under Healthcare Notices.

State Plan 1915(b) Waiver and 1915(c) Waiver with corresponding authority for community-based crisis intervention services may receive an 85% Federal Medical Assistance Percentage for Medicaid (FMAP) for expenditures on qualifying community-based mobile crisis intervention services for the first 12 quarters, within the five-year period beginning April 22nd during which the State meets with the conditions of the 85% FMAP. Work on the development of the grant planning based on this information is underway. CMS issued a state health provision letter providing guidance on new Medicaid options for community-based mobile crisis intervention services created by the American Rescue Plan Act of 2021. Work is in progress to go through the additional information and outline open questions in a letter to CMS. A monthly core team and a smaller biweekly work team have been established. The current focus is on engaging subject matter experts and developing provider standards for these programs based somewhat on what is existing in Nevada already.

Support Act Planning Grant Update – The Waiver 1115, Substance Abuse Order, Institution for Mental Disease IMD Waiver Application titled, "Nevada's Treatment of Opioid Use Disorders and Substance Abuse Disorders Transformation Project", was submitted to CMS November 15, 2021. Nevada is awaiting communication of completeness from CMS.

Support Act 1003 Support Act Planning Grant – A Nevada Substance Abuse Databook is being developed which will monitor future substance abuse trends, utilization and capacity. A review has been completed of the strategic plan and sustainability plan to identify strategies that can be leveraged along with updates on the status of tasks that have been started and completed. These two documents will be posted on the Support Act webpage on the DHCFP website, under Programs.

Work is underway on legislation for SB154 (which makes changes to Medicaid coverage for certain treatments administered at institutions for mental health disease), SB156 (which revises provisions for services provided at crisis intervention centers), and SB69 (which revises provisions related to behavioral health certification of peer support providers).

Specialized foster care meetings are being held biweekly, beginning in January 2022, with county child welfare, juvenile justice agencies and the DCFS to utilize 1915(i) services for intensive in-home supports, services and crisis stabilization services. There are currently ten specialized foster care agencies enrolled under Provider Type 86 (four providers in Washoe County and six providers in Clark County). Two providers have reported performing and actually billing these services.

The Provider Type 14 Billing Guide has been updated and posted which will hopefully be an additional, useful resource for providers. If there are questions, contact the Behavioral Health Unit at behavioralhealth@dhcfp.nv.gov.

Everyone is encouraged to sign up for the Medicaid listserv. Ms. Hennessy will post the link in the Chat.

Commissioner Ruiz-Lee asked about the development and processes of State Legislation related to IMD Waiver (SB154). Ms. Hennessy stated she will find out and report back. Commissioner Ruiz-Lee referred to a previous request that was made on several occasions to receive a copy of the supporting documentation on how the Waiver was constructed and how the contents of that

request were made to CMS. The previous request was made at meetings with Ross Armstrong and an answer has not been received. Dr. Cindy Pitlock said she was not familiar with the issue and will follow up with Dr. Durette to make sure that the question is answered. Ms. Priestly explained the concern is that they understood the Safe Model was leveraged for the submission of the documents and that the model is not really intended for that purpose.

Commissioner Ficalora asked for more information about intent of crisis stabilization centers; if they are attached to hospitals and what the centers would look like. Ms. Hennessy explained they are working with existing community services and trying to help those providers enroll as crisis stabilization centers to provide a place to go in the continuum of 988 and Mobile Crisis Response. Serene Pack, Behavioral Health Unit, has been working on the policy and can answer specific questions. Documents detailing center requirements can be found in the Public Notice for the Public Hearing on February 2nd which includes the proposed policy. There is a point for public comment during the public hearing.

Mitchell Moen stated he would like to talk with Commissioners with available time and resources to share. Dr. Durette suggested Mr. Moen send email to Kathryn Martin and Joseph Filippi to make arrangements.

9. For Information Only. Update on System of Care (SOC) Grant – *William Wyss, DCFS*

William Wyss, SOC Grant Project Director, is new to Nevada and his role is to implement the third year of the grant which ends in September 2023. Key updates included the launch of a self-directed respite program this month in partnership with Nevada PEP. This is an exciting project to support youth and families and they are exploring sustainability with Medicaid funding. They are also working with a national consultant to research what other states are doing. Partnering with PEP is very important because family and youth engagement are a key component of the SOC work. They are also partnering with PEP to have flex funds available for youth and families to help with social and emotional domains. They are funding a Subaward with Community Chest in collaboration with Lyon County to launch multidimensional therapy and case management across Lyon County starting in January. They are looking at community-based services to help keep youth in their homes, schools and communities. Community Chest will also be providing this therapy with community health workers in Mineral County. A project is being developed with the Nye Community Coalition to support ongoing training and direct community clinical services to support youth and families. National Cultural and Linguistic Services in Healthcare training is being completed, which is designed to advance healthcare equity through quality and help eliminate healthcare disparities. Cultural responsiveness is a key SOC guiding principle. Collaboration is underway with Clark County Juvenile Justice to provide care coordination training and technical assistance on a focused model of intermediate care coordination. This is another example of agency collaboration which is the underlying focus of the SOC architecture. A study is being conducted to better understand how SOC core values are reflected in workplaces and environments of community-based services in Southern Nevada to improve outcomes for children, youth and families. They continue to find opportunities to hold community listening sessions in rural communities (safe and permissible events, based on the current state of the COVID pandemic) to listen, partner and build pathways for impacting expanded access to children's mental health services and support. Building healthy communities through partnership, innovation and hope for all children and youth is the SOC vision for children's services and support.

10. For Possible Action. Discussion and Approval of the Division of Child & Family Services Children's Mental Health Policy – *Dr. Gwendolyn Greene, Division of Child & Family Services Client Rights and Responsibilities: Seclusion and Restraint of Children and Youth Policy CRR-1*

Dr. Greene provided an update on requested changes from the Commission in regard to the policy. Previously there was concern expressed by Commissioners on the verbiage and terminology used in the document, primarily about the requirement for a physician or physician-designated practitioners providing face-to-face evaluation of a seclusion and restraint (S&R) recipient within one hour of an S&R order being given. Commissioners expressed concern about including that in the Policy as there might not be times when it's possible to acquire a resource to come in and provide that level of care. Dr. Green reported that piece was extracted from the policy as it was very specific to psychiatric residential treatment (PRTF) organizations, and not necessarily relative to other parties that would be guided by the policy. While this was extracted from the policy, it will be addressed specifically within the PRTF standard operating procedures, so they have that requirement for Commission on Accreditation of Rehabilitation Facilities Accreditation (CARF).

The next concern was in regard to Bullet Item H - Chemical Restraints, Page 12. The Policy initially made reference that medications which are inclusive of a child or youth's regular medical regime are not considered chemical restraints, even if their purpose is to control ongoing behavior. Dr. Durette previously said there had been modifications to the verbiage and definition of a PRN as per NRS433.5456. As a result, the NRS terminology was reviewed, and the item was revised as recommended. The original Bullet Item Number 4 was removed, and Bullet Item Number 5 was modified to reflect that that use of a chemical restraint is specifically prohibited in all DCFS PRTF facilities, including PRTF North, PRTF Enterprise and PRTF Oasis (with the exception of PRN medications that have been medically prescribed as part of the pharmacological regimen). With the addition and modifications of the bullet points, the policy now addresses the fact that PRNs can also be considered a chemical restraint, but because those PRNs are prescribed as part of the youth's pharmacological regimen, they do not necessarily meet the full standard requirement for what a chemical seclusion and restraint is considered per NRS Statute.

MOTION: To approve the Seclusion and Restraint of Children and Youth Policy CRR-1 as submitted.
BY: Braden Schrag
SECOND: Jasmine Troop
VOTE: The motion was approved with no abstentions or opposition.

11. For Possible Action. Discussion and Approval of Appointment Recommendations to the Governor for a New Commission Chairperson – *Committee*

MOTION: To approve Commissioner Braden Schrag as the New Commission and Behavioral Health Chairperson.
BY: Dr. Lisa Durette
SECOND: Lisa Ruiz-Lee and Jasmine Troup
VOTE: The motion was approved with one abstention from Commissioner Ficalora and no opposition.

12. For Information Only. Announcements – *Lisa Durette, Chair*

There were no announcements.

13. For Information Only. Discussion and Identification of Future Agenda Items – *Lisa Durette, Chair*

- The Governor's letter (To be scheduled for the April 7, 2022 meeting.)
- Dr. Stephanie Woodard is to present an update of the Behavioral Health Pack (BH pack). It got tabled at another meeting so it is to be decided if she is to present at the DPBH meeting or the DCFS meeting.

14. Public Comment. *No action may be taken upon a matter raised during a period devoted to comments by the general public until the matter itself has been specifically included on an agenda as an item upon which action may be taken.*

Char Frost referred to the report given by Dr. Cindy Pitlock earlier in the meeting and commented that although beds have been added back in the Las Vegas community, there is still a lack of access for youth with dual diagnosis (mental health and intellectual and developmental disabilities-IDD). The gap needs to be filled, and Ms. Frost advocated for sustainable, community-based services for the higher level of need across these populations, such as intensive in-home supports which are now available to a small piece of the population (but not all) and respite to assist youth and their families while working to prevent more costly out-of-home placements.

15. Adjournment. – *Lisa Durette, Chair*

Chair Durette adjourned the meeting at 10:31 am. The committee members will take a 5-minute break and come back to the Executive Closed Session Meeting under a separate link.

NEXT PUBLIC MEETING –April 7, 2022