COMMISSION ON BEHAVIORAL HEALTH
DIVISION OF CHILD AND FAMILY SERVICES
JULY 14, 2017
MINUTES

VIDEO TELECONFERENCE MEETING LOCATIONS:
NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES,
2655 ENTERPRISE ROAD, RENO, NV
AND
DIVISION OF CHILD AND FAMILY SERVICES,
4126 TECHNOLOGY WAY, 3rd FL CONFERENCE ROOM, CARSON CITY, NV
AND
SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES
6171 WEST CHARLESTON BOULEVARD, BUILDING 8
LAS VEGAS, NV

COMMISSIONERS PRESENT AT THE RENO LOCATION:
Pam Johnson

COMMISSIONERS PRESENT AT THE LAS VEGAS LOCATION:
Tabitha Johnson
Viki Kinnikin, Chair
Noelle Lefforge
Lisa Ruiz-Lee
Asma Tahir

COMMISSIONERS ABSENT:
Lisa Durette
Barbara Jackson

STAFF AND GUESTS:
Ryan Gustafson, Division of Child and Family Services
Kathy Mayhew, Division of Child and Family Services
Ann Polakowski, Division of Child and Family Services
Kevin McGrath, Division of Child and Family Services
Kristen Rivas, Division of Child and Family Services
Julie Slabaugh, Deputy Attorney General
Susanne Sliwa, Deputy Attorney General
DuAne Young, Division of Health Care Financing and Policy
Tara Phebus, Nevada Institute for Children's Research and Policy
Misty Allen, Office of Suicide Prevention
Michelle Sandoval (by phone), Division of Public and Behavioral Health Rural Clinics
Lea Cartwright, J.K. Belz & Associates

CALL TO ORDER AND INTRODUCTIONS
Commissioner Kinnikin called the meeting to order at 8:30 A.M. Roll call is reflected above; it was determined that a quorum was present.

PUBLIC COMMENT
Commissioner Kinnikin called for public comment. There was none.

CONSENT AGENDA
APPROVAL OF MINUTES AND AGENCY REPORTS
MOTION: Commissioner Lefforge moved to accept the minutes from the March 16, 2017 meeting.
SECOND: Commissioner Tabitha Johnson.
VOTE: The motion passed unanimously.

MOTION: Commissioner Lefforge moved to accept the agency reports presented for this meeting.
SECOND: Commissioner Tabitha Johnson.
VOTE: The motion passed unanimously.

ADDRESS SUICIDE SAFETY IN TREATMENT ENVIRONMENTS AND RECOMMENDATIONS OF THE USE OF A NATIONAL STANDARDIZED SAFETY CHECKLIST
Tara Phebus presented on this agenda item. She is the Executive Director of the Nevada Institute of Research and Policy at UNLV and Coordinator of the Clark County Death Review Team and she participates on the statewide Executive Committee for the Review of Deaths of Children.

A letter was sent to this Commission making the recommendation about exploring the implementation of a standardized checklist to help insure a safer environment for patients in mental health institutions.

The recommendation came out of a case review that was done of a suicide fatality within a residential treatment center. The discussion was what kind of best practices are in place to ensure safety in policy and the physical environment with the desire to have that information shared with other facilities. The state committee thought it would be best to bring the recommendation to this Commission to explore, or if it wishes to promote some sort of standardized safety checklist.

They identified the Mental Health Environment of Care Checklist that comes out of the VA as a possible idea to be used. It is extensive and was created several years ago. It is not the only list that exists.

Some other work in this area was done in 2014 to pull together administrators from residential treatment facilities for children. They talked about this as an issue and they were concerned

about doing individual case reviews because there were private and state facilities and they were concerned about sharing that information and about any damaging information that might come out of their facilities with an incident review with other folks.

Misty Allen from the Office of Suicide Prevention said they have worked with DCFS in juvenile correctional facilities on something similar. They learned how to make facilities suicide safer. DCFS has reached out to her office to meet the mandate for suicide prevention education and training. She thought this might be a great opportunity to build a training around. Her recommendation is to make this an opportunity to improve safety in facilities and promote education.

Chair Kinnikin asked if the checklist has been presented to other agencies. Ms. Phebus responded that it has not. They wanted to start with the Commission to see what it thinks the next steps for the Executive Committee for the Review of Deaths of Children should be. If the Commission thinks this is a good idea, if the Commission wanted to send a letter of recommendation, or if it has any ideas about other checklists if this one is not sufficient or appropriate.

Kathy Mayhew said the Planning and Evaluation Unit can look into it to see if there are any checklists that are more relevant to youth. Ms. Phebus said it is more about the physical environment.

Commissioner Ruiz Lee said she would assume as part of a JCAHO accreditation there would be standards that would be reflective of this. Are those standards different? Would those standards be different than are in the spreadsheet?

Ms. Mayhew said she could look into this as well.

Commissioner Lefforge said she supports the safety of children in these facilities. She is concerned when there is so much attention on the physical environment. She worries about checklists because she thinks sometimes people go through the checklists and say things are fine, and perhaps resources of attention, time, and surveillance are not met. She does not want to see resources taken away that would help someone’s suffering so that they would not want to engage in these behaviors to begin with. She worries about the veil of safety that can be created around checklists of these types of things.

Ms. Phebus said she thinks this is something that is addressed in this particular tool. In the introduction it talks about the fact that the checklist is not a replacement for good policy and practice in terms of staffing and supervision.

Commissioner Lefforge asked how they envision utilizing the checklist.

Ms. Phebus replied that the Executive Committee for the Review of Deaths of Children did not get that far into it. They thought they would bring it to some other groups more directly involved in it to see if it should be pursued as a mandate or more as a letter of recommendation.

Commissioner Ruiz Lee said she would be interested in what is specific to juvenile facilities and what JCAHO has to say about facilities. It sounds like it might be part of health care quality control – part of a licensing component. Determining where the requirement could sit might be one avenue, and it might be a question for Cody Phinney and her team, but the VA's checklist is a good place to start. If the state can do some additional work to see what else is out there and then we could figure out where we could meet the recommendations.

Chair Kinnikin would like to see how to focus not just on the checklist but on the relationship component of it and how you merge the two.

Commissioner Lefforge is concerned about the history of the project. Ms. Phebus spoke of the resistance to explore and share information with others and raising concerns of client confidentiality. She believes that after an incident, we should have access to what went wrong in a facility. She is a little put off by the checklist because she thinks what should be done is what the Executive Committee on the Review of Deaths of Children wanted to do originally, which is open it up, look at what happened and share information.

Ms. Phebus said the original idea with that was to create a peer review process where facilities could share information similar to what hospitals do with case reviews. There did not seem to be much of an appetite for that in 2014.

Commissioner Ruiz Lee asked who the facilities are that should come to the table and those that did not want to come to the table. Ms. Phebus said in 2014 they were looking at residential treatment facilities for children.

Commissioner Ruiz Lee said these would be the same facilities that are subject to the bi-annual review by the Legislative Council Bureau (LCB) audit on children's facilities. Has anyone had a conversation with the LCB about incorporating some of these components?

Ms. Phebus said that is not something they have done. The list of participants from May of 2014 were Desert Willow, Montevista Hospital, Seven Hills, Spring Mountain Treatment Center, Desert Parkway, the clinical services manager for the Clark County Department of Juvenile Justice Services, a representative from the SAPTA, the state behavioral health deputy, and Dr. Andy Eisen who was a state Assemblyman at the time. She said Commissioner Ruiz Lee's point is a good one.

Commissioner Ruiz Lee said all of those facilities and Child Haven are audited on a regular basis. A thought might be to have the state do its research but interweave that audit process into this conversation. If they know that it is going to be reviewed as part of their audit, it sets the

expectation for performance. The other piece is their licensing. So perhaps there should be a conversation with the licensing folks at least about education. There are a couple of avenues to start the dialog. Ms. Phebus agreed that these are good ideas and she can bring that information back to the Executive Committee and DCFS will do their research on the various tools and differences.

The Commission would like to hear back from the Executive Committee on the Review of Deaths of Children at its next meeting.

PRESENTATION OF INFORMATION ON THE DIVISION OF CHILD AND FAMILY SERVICES (DCFS) MOBILE CRISIS PROGRAM AND TRAININGS

Ryan Gustafson and Ann Polakowski presented:

- Mobile Crisis Response Team (MCRT) has been in operation in Las Vegas for 3.5 years. It is a DCFS program through Southern Nevada Child and Adolescent Services and a counterpart program in the north through Northern Nevada Child and Adolescent Services for about 3 years. Michelle Sandoval is administrating the rural MCRT. It is a partnership with DCFS and the Department of Public and Behavioral Health (DPBH) with funding from the System of Care grant.
- MCRT has fielded over 4,500 calls and responded to 3,000.
- We monitor the diversion rate from hospitals very closely. The goal is to partner with the hospitals so youth do not have to go to the hospitals to begin with. The diversion rate sits at over 80% across the state.
- MCRT has teams of clinicians and case workers who dispatch when we get calls. We like to get out there within an hour.
- We collect data on our peak periods. In Reno, the calls are more from the schools and less from the hospitals than in Las Vegas. We staff the teams around those peak times.
- Las Vegas went 24/7 a few months ago. We are not there yet in Reno.
- The goal is to go in and do a crisis assessment very quickly and to keep youth in the community in a less restrictive setting.
- DCFS is trying to with the SOC grant staff, bolster up our internal training and for the community.
- For the MCRT teams in the south, they do a combination of intensive internal work as well as some external trainings. Clinicians and Psychiatric Case Workers go through Motivational Interviewing, Solution Focused Cognitive Behavioral, Suicide Awareness and Safety Planning, Trauma Informed Care, Wraparound, and TFCBT training online. Internally, the training process is pretty intense and lengthy for new staff. They do Wraparound training. There is also Conflict Prevention and Response Training which is DCFS' internal restraint training. Ryan Gustafson said MCRT does not go hands-on with the clients.
- Every time MCRT does an assessment, that recommendation from that team filters back to the MC supervisory team and they will staff those spaces so we make sure we are

double-checking a recommendation. It always go back to a clinical supervisor. They look at every safety plan that comes through and every treatment plan.

- Every day the team in Las Vegas meets at 2:00 pm, this is to check-in, for stability, and get a sense of community with the team.
- In Las Vegas MCRT runs 7 days/week and we would like to get there in Reno. In Reno we are running an 8 am to 8 pm schedule for now. Ninety-Eight percent of the calls in Reno come within those hours.
- We are trying to be good community partners with MCRT. We have worked with the MCOs that have their own response team or ramping up those services. Some of them use similar assessments but we work closely with them so families do not have to go through assessments multiple times. We do not discriminate against any insurance; if we get a call we will go out.
- We reached out to the Certified Community Behavioral Health Clinics (CCBHC). We are a Designated Collaborating Organization (DCO) with Westcare in Reno and Clark County because they have to have crisis response in place.
- MCRT brochures are included in the meeting packets for today.
- The rural MC response program is not a 24 hour but the hotline for them is 24 hours.
- In Clark County the calls to MC are initiated by hospitals, ERs, parents, school counselors. Rarely get calls from youth, but get return phone calls from youth. They have worked with Metro and given some public service training.
- They have a plan for the next year in terms of outreach and education.
- They leave information on resources for the family and MC can stay open on a family for 30-45 days. They offer a stabilization service if the family is not connected to a provider.
- This is a new program for the state and we have continuing marketing efforts. We are working on it internally. If anyone wants us to present to their agency or organization, let us know. We like to do presentations to community partners.

Commissioner Lefforge asked what MC needs. Mr. Gustafson responded that regularly the biggest issue is staffing resources. There is an internal effort where we are focusing more on our safety net of services and we consider MC is a back-end safety service. If individuals become aware of new promising practices, or evidence-based trainings, we would like to get information on that. We would like to partner with anyone for training opportunities.

Commissioner Lefforge asked what the leading contributors to staffing issues are.
Mr. Gustafson responded that the state is notorious for having staffing issues. There is a high turnover rate as is the case with most public serving agencies. It is a high stress job. We try to be aware of staff's needs and self-care. There is a continual rotation of staff due to their level of stress. The shifts are tricky; it is a hard to work the graveyard shift and weekends.

Ms. Polakowski said MC has created some creative work schedules. If she feels staff is burning out, since she is over the outpatient area, she has the ability to move them to outpatient until they

are ready to come back. She has some creative, out-of-the box kind of people in MC which is helpful.

DISCUSSION AND DECISION TO CONTACT MEDICAID AND INSURANCE COMPANIES ABOUT HEALTH CARE PROVIDER'S ACCESS TO HEALTH CARE INSURANCE PANELS

Commissioner Lefforge reported that at the last Commission meeting, there was public comment from a psychologist about her concern about being told that insurance panels were closed. There was a request for Medicaid to gather more information on this problem. Commissioner Lefforge conducted a survey regarding Psychologists experiences with insurance and panels and she prepared a presentation – Nevada Licensed Psychologists Insurance Paneling Report, which was a handout for the meeting.

Commissioner Lefforge reviewed the handout which included information on:

- Survey respondents. There were 156 licensed psychologists in Nevada who responded.
- Psychologists Who Provide Billable Services – Types of Service.
- Psychologists Who Provide Billable Services – Populations Served. Children are the least served population by Psychologists.
- Have you attempted to become paneled by an insurance provider in Nevada? Why aren't you paneled by an insurance provider in Nevada?
- Reasons for not working with insurance panels.
- Paneled Compared to Not Paneled Providers – Types of Services.
- Paneled Compared to Not paneled Providers – Populations Served.
- Paneling Info by Insurance Provider. If you add the numbers up, there are quite a few Psychologists that have either left those panels or have been unsuccessful in being paneled with the various providers.
- Reason Not Paneled.
- Reasons Panel Closed. Whenever a reason was given that a panel was closed, the reason was "there are too many providers in the area".

Chair Kinnikin asked what happens next. Commissioner Lefforge said she is hearing from the professional community that this is a very frustrating problem. Part of our call is to have some data to bring to the negotiations with a CMS related agency, expecting they could come to the negotiations that they could keep the panel open to providers who want to provide a service.

DuAne Young, Chief over behavioral health, pharmacy, primary care, and hospitals for Medicaid would like to provide some insight regarding the network capacity issues. Medicaid never reaches capacity for fee-for-service. Providers for credentialing who are turned down - it could be because they do not have the full-range of credentials. Also regarding network capacity, when providers are turned down it could be something technical like they did not submit the right paperwork. There are providers who have had issues in their past in terms of activity that is not

completely forthcoming in terms of the standards that CMS holds, and for those reasons they are rejected. You must demonstrate you reach the full integrity of the model you are applying to. There is another issue they are addressing top down regarding network capacity for the MCOs. The MCOs do demonstrate that they have reached capacity for services. We see that behavioral health services are being given out in abundance. What we do have is a serious lack of the full range of services. We have a lot of youth who are receiving services, but they never received an assessment, so how do we know if they are receiving the right services? Medicaid will need to challenge the providers to make sure they are having the full range of services. He thinks it is an over-arching problem that the providers are there but not providing the full range of services.

Commissioner Lefforge said that highlights why the report is concerning. All respondents in her survey are licensed Psychologists that have an active license with the state board. A lot of them do not provide services to children or do psychological testing services. It is a problem if the insurance panels are looking at full, as having a certain number of Psychologists without looking at needing more Psychologists to provide the services. Some of the MCOs Medicaid works with are telling Psychologists that their panels are closed.

Mr. Young said they may very well have met their caseload because they do contract with their larger providers and they may determine a certain agency is large enough to meet the needs. Medicaid can push back and challenge but part of that capitated rate is them saying that if they can show the numbers, then Medicaid can only challenge them on it so much. He can take this report back to the chief over Managed Care to look at some of the reasons. Medicaid is constantly checking that the MCOs have reached network capacity of what they said they would meet in their contract. If they are not meeting what they contracted for, then Medicaid has ways to negotiate.

Chair Kinnikin said one of her concerns is that they might say they are taking clients, but that might be six weeks out.

Mr. Young said they are looking at that problem. There is no mechanism now to check on wait times other than calling and saying what is your wait time. They are trying to figure out how to do that. It is a problem nationally and unfortunately, as the federal regulations tighten, he does not think it is a problem that is going to be easily solved, and the same with rates. We can continue to look at ways we can do the most with the system. He suggested this group could link into the Governor’s Commission on Rural Health. Workforce development is also an issue to look at. How do we solve these problems?

Commissioner Ruiz Lee thanked Commissioner Lefforge for providing the report with concrete data.

Commissioner Lefforge said since the survey is created, if any of the other professions want to use it, we could distribute it, she would just need the email address of other licensed professionals.

Chair Kinnikin said she is concerned that the process is so cumbersome.

Commissioner Lefforge said it concerns her that a small private practice person is taking the same space as a larger office. Why should that be? She thinks we will have to find a way to put more pressure on the private insurance companies because they all have different procedures.

DISCUSSION AND DECISION ABOUT RECOMMENDATIONS FOR THE STRUCTURE OF THE REGIONAL MENTAL HEALTH CONSORTIA'S UPDATES TO THEIR 10-YEAR PLANS

Commissioner Ruiz Lee said she read Dan Musgrove's email regarding this agenda item and she is requesting that the item not be moved to another date. She wanted the Commissioners as a body, to discuss the various types of reports that come to us and contents of those reports and what should be in those reports and what the expectation is that the Commission does with those reports.

When the Subcommittee was preparing the Governor's letter, part of the challenge was in getting the information from the local Consortia so it could be incorporated. They had to wait for the reports. She thought the Commission should talk about where these reports were coming from and how do we get the information. Does it have to be in some sort of a format in order for the Commission to use the information?

There is a difference in the contents of the information in the reports. Washoe County's report is shorter and much more succinct than Clark's. She wanted to discuss what are the reports that should be coming to us, where do they go, how do they come to us, how do we use them? What is statutory mandated contents of those reports? She does not know that everything in statute is in the reports.

We now have this new regional board. There are some report requirements in terms of reporting to the Commission. She believes this is a good opportunity to look at who sends us the reports, what are the report requirements and is there a way we can better understand that and streamline it, definitely rolling into that regional board and how that perhaps adjusts the flowchart of reporting requirements. Her intention was not to disrupt the regional Consortia's reporting or give them busy work.

She does not know if this would require a subcommittee to meet to pull the pieces together with some state program assistance.

Chair Kinnikin said she thinks AB366 is going to shuffle things a little bit. From what she read in the bill, the Consortia are going to report to the Divisional people and they will report to the Commission. She emailed the Governor's office to see if they had appointed anyone to the new regional boards and she has not received an answer. There are a lot of questions regarding the

new board. She thinks discussing what is necessary to be reported and what we do with it may be altered.

Commissioner Ruiz Lee said her actionable item would be that we spend some time mapping everything we know including this new bill. It is not just a layout of the existing statute requirements, but rolling this into it. Maybe this is something that the Attorney General's office can help with. Maybe we start with something as simple as, this is the Commission, these are the bodies that are authorized by the statute, these are the reports that are required and when, and these are the contents. Then we would incorporate this statute modification knowing that the members have not been appointed yet. So we can have a better understanding of what we should be seeing.

The underlyng part she would like to see and support - the reports on the strategic plans are really important because they show where we are experiencing success and where there are delays in service deliveries. The Consortia have been good in advocating for this legislatively, but as a Commission we have not. How do we engage in that dialog? How is the state spending our money, seeing improved outcomes? How do we advocate for that on the same side as the Consortia, as opposed to being a more passive body. Somebody should be asking why we have not had any success in certain areas.

Chair Kinnikin said how finances are spent and how effective they are is part of the Commission's charge.

Commissioner Ruiz Lee added that we want to know how we can do our work more collaboratively. We have to know what the reporting areas are for all these bodies. There is a lot of statute that provides guidance and direction. Some statutes were written or revisited in 2001. Maybe it's time to ask what the reports should contain.

Chair Kinnikin thinks perhaps a flow chart could be a good place to start. She asked Kristen Rivas if it is possible for DCFS staff to compile that for the Commission. This would be a flowchart of the Governor's office on down of who reports to whom, when, and what are the statutes that are connected to that.

Ryan Gustafson said he thinks it is possible to make a flowchart that breaks down the organizational structure from the Governor's office down. We could try to put together a flow chart with the organization structure and the reports due and time frames. It gets trickier if you start to stick language in the flowchart about how reports look. We could start to put a draft together to share.

Chair Kinnikin said that would start the conversation.

Commissioner Ruiz Lee said when the bylaws were re-written for the Commission, there was a page showing the connecting organizations. She thinks it would work to go back to that page,

with that small organization format, and then adding in the new body, and then looking at the reporting mechanisms and requirements. It's not about the format of the report but what is the statutory content of the report, and what obligation does the Commission have.

Commission Lefforge said she believes one of the revisions to the bylaws was the deletion of that organizational chart because it is out of date.

Commissioner Ruiz Lee said maybe they need to go back to revisiting what it should look like so it aligns with statute.

Chair Kinnikin said that would be terrific if that could be developed and used as a conversation starting point and then fine-tune it with the statute requirements with each one and blend in AB366.

MOTION: Commissioner Ruiz Lee made a motion to approve all of the above.
SECOND: Commissioner Tabitha Johnson.

Commissioner Lefforge said they are asking for an organization chart of who reports to the Commission with the associated statutes that determine their reporting and the statutes that dictate the Commission's follow through.

Susanne Sliwa said it would be best to have a motion to modify the prior motion and clarify everything.

MOTION: Commissioner Ruiz Lee made a motion that we go back to the previous version of the bylaws that identified all of the various independent bodies that reported to the Commission. That we update that list with those statutorily created and identify what reporting requirements those independent entities have to the Commission and what the Commission's reporting requirements are and upon receipt of that information and to whom does it go to. Imbedded in the statute there are timelines and deadlines for the reporting requirements. If we could identify those timelines and deadlines that would be excellent.
SEOND: Commissioner Lefforge.
VOTE: Motion was passed unanimously.

Chair Kinnikin said it is important to put this item back on the agenda and continue to have this so the Consortia can have a voice since it effects them directly.

MEDICAID UPDATE AND CHANGES
DuAne Young gave the following update:

- Continuing to work with providers on BST rate. We have not seen that as part of the state plan change yet. They continue to have discussion with providers until they implement that.

- The Certified Community Behavioral Health Clinics (CCBHCs) are up and running and seeing clients. Medicaid is in the trouble-shooting phase but they are off to a good start with the clinics taking clients and offering a full range of services.
- They moved forward to look at some of their internal services, increasing capacities, working with the Governor's Commission on Rural Behavioral Health, working on the workforce Commission, and across DHHS to address provider saturation and standards, the scope of services, what services we offer the most, what services we are lacking, issues related to training for target case management and documentation. They want to make Medicaid more user friendly and get to the root of whether there is a lack of services, lack of access to services. What can we do to promote the services that are not being engaged as much?
- Mr. Young has been running a two-man show. They have new staffer coming on Monday and looking to fill another positions.
- They are working with out of state providers to let them know that assessments need to be completed so they can be paid for services.
- Met with Never Give Up Youth and suggested they contact this Commission to present what they are doing. They opened up a new RTC in Armagosa Valley. They have a business plan to include three facilities in Nevada. Commissioner Ruiz Lee asked about their accreditation. Mr. Young said he could verify this with their enrollment department.

UPDATE ON THE CHILDREN'S SYSTEM OF CARE BEHAVIORAL HEALTH SUBCOMMITTEE

Kevin McGrath reported:

- System of Care (SOC) is currently serving 222 children. They are all entered into the Avatar system. We continue to expand.
- RFI for the rural intensive outpatient program has been selected and we chose Pacific Behavioral for this. SOC is working with them to see if they can get up and running before October 1, 2017.
- Have received all proposals from our current sub grantees for fiscal year 2018 (FY18). Evaluating our budget on salaries, travel, operating expenses. Making some assumptions to see what we will need to spend for FY18.
- Received our site visit protocol from SAMSHA, a document they will use when they come to visit in FY18. SOC is working on getting the documents completely answered and reach out to families in SOC so SAMHSA can meet with them.
- Clinical reviews have begun for our sub grantees. We will begin fiscal reviews. Going out to them a lot and they are coming to us. We talk about sustainability and how we can insure they are providing clinical services appropriately. Learning about we can help them and help sustain within SOC.
- SOC staff has completed a training they developed with Medicaid with Kim Riggs about how to complete PARs for day treatment.

- Began our initial training with National Wraparound Implementation Center for Wraparound Nevada staff and sub grantees. An overview of Wraparound will be presented in Las Vegas on June 21, 2017 and is open to anyone.
- They are doing a lot of trainings which is a big component of our SOC. Recent trainings have been on Trauma Informed Care for Social Workers at the Clark County School District.
- Completed a contract with The Center in Las Vegas to help us establish LGBT training. They will do it with us. Trainings will be done statewide including at rural sites.
- The SOC strategic plan was updated and is on the DCFS website. They added a page on SOC accomplishments.
- Been working with the Department of Welfare and Support Services to get eligibility workers out to the sub grantees to get them signed up with Medicaid. To see if there is a way to fund services for youth outside of the SOC.
- Workgroups.
    - Communications Workgroup has been very active. There is a monthly newsletter. If you do not get it, let him know. Working with IT on developing a website. Working on developing webinars on trainings so especially rural sites can use it as needed. Pamphlets and posters were disseminated. Facebook and Twitter are very active and they post daily. A champions list is being developed, which is people SOC wants to identify as being familiar with SOC, and then can go out to other agencies and stakeholder groups.
    - Special Populations Workgroup is continuing discussions around revising Medicaid funding. They are examining the evidence based practices. They developed a list of those currently being used in Nevada. Have been asked to whittle it down to look at what would be the most cost effective to expand in Nevada and the best way to go about doing it. Did a survey of therapists about what they want. Nevada PEP has surveyed families about what kind of services they want. Out-of-state placements have been decreasing in the state. People are looking at them more closely.
    - Workforce Development Workgroup is working with the AB399 workgroup on a policy on LGBT issues. Working on provider enrollment and a provider agreement form. A training document is being completed. SOC wants to do training in a more focused manner. Getting a list of people who have been trained, what groups they are in and what they were trained in. Working on Wraparound practice standards.

Commissioner Ruiz Lee asked where the webinars will be hosted. Mr. McGrath responded that there have been some changes with Nevada Partnership 4 Training. SOC is working with them to be a part of what they are doing rather than re-invent the wheel. Commissioner Ruiz Lee suggested looking at the QPI website. They do a good job of online webinars.

She is getting a lot of questions about the role of the new CCBHC in terms of service delivery and how that dovetails into a wide variety of mental health programs.

ANNOUNCEMENTS

None

DISCUSSION AND IDENTIFIATION OF FUTURE AGENDA ITEMS

1. Address CCBHC and invite Stephanie Woodard from the Division of Public and Behavioral Health. Mr. Gustafson believes it would be worthwhile to have her come and speak to understand their role in community services.
2. Continue agenda item #7 – Recommendations for the Structure of the Regional Mental Health Consortia's Updates to their 10-Year Plans.
3. Continue contact with Medicaid.
4. Update on SOC.
5. Commissioner Lefforge said she could have an update on agenda item #6 – Discussion and Decision to Contact Medicaid and Insurance Companies about Health Care Provider's Access to Health Care Insurance Panels.

PUBLIC COMMENT

None.

ADJOURNMENT OF PUBLIC SESSION

Chair Kinnikin adjourned the meeting at 10:30 am.