

**COMMISSION ON BEHAVIORAL HEALTH
DIVISION OF CHILD AND FAMILY SERVICES
SEPTEMBER 13, 2018
DRAFT 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:

Denise Everett (by phone)
Barbara Jackson

COMMISSIONERS PRESENT AT THE LAS VEGAS LOCATION:

Lisa Durette (by phone)
Tabitha Johnson
Noelle Lefforge
Natasha Mosby
Melvin Pohl
Lisa Ruiz-Lee (by phone)

COMMISSIONERS ABSENT:

Debra Scott
Asma Tahir

STAFF AND GUESTS:

Ross Armstrong, Division of Child and Family Services
Cara Paoli, Division of Child and Family Services
Kevin McGrath, Division of Child and Family Services
Kathryn Martin Waldman, Division of Child and Family Services
Tracey Bowles, Division of Child and Family Services
Kristen Rivas, Division of Child and Family Services
Tiffany Ontiveros, Division of Child and Family Services
Stephanie Woodard, Division of Public and Behavioral Health
Susanne Sliwa, Deputy Attorney General
Krystal Castro, Division of Public and Behavioral Health
Charlene Frost, Nevada PEP
Yeni Medina, Aging and Disability Services Department/Autism Treatment Assistance Program
Jennifer Tseu, Aging and Disability Services/Nevada Early Intervention Services

Joelle Gutman, Rural Behavioral Health Care Policy Board
Jennifer McKeirnon, UNR MSW Intern
Jill Morano, Clark County Department of Family Services
Patrick Barkley, Clark County Department of Family Services
Lea Cartwright, Nevada Psychiatric Association
Ariana Saunders, Clark County Social Services

1. CALL TO ORDER AND INTRODUCTIONS

Chair Lefforge called the meeting to order at 8:30 A.M. Roll call is reflected above; it was determined that a quorum was present.

2. PUBLIC COMMENT

Chair Lefforge called for public comment. There was none.

3. CONSENT AGENDA

APPROVAL OF MINUTES AND AGENCY REPORTS

MOTION: Commissioner Pohl moved to accept the minutes from the July 13, 2018 meeting.

SECOND: Commissioner Johnson.

VOTE: The motion passed unanimously.

MOTION: Commissioner Pohl made a motion to approve the agency reports.

SECOND: Commissioner Mosby.

VOTE: The motion passed unanimously.

4. UPDATE AND PRESENTATION ON THE INTEGRATION OF CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHC) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

Stephanie Woodard reported:

- There are three CCBHCs remaining. We started with five clinics. Westcare in both the north and south locations were de-certified. The three remaining are strong and doing well. They are New Frontier in Fallon, Vitality Unlimited in Elko, and Bridge Counseling in Las Vegas.
- The CCBHC demonstration program runs from July 2017 through June 2019. After that we are going to need a different way to sustain the CCBHCs. In anticipation of that, an additional six CCBHCs are being brought on board with cohort two - Northern Nevada Hopes is an FQHC, Quest Counseling in rural Nevada, Carson Community Counseling Center and Rural Nevada Counseling, which will be in Carson City and Lyon County. There will be an expansion with Bridge Counseling at another site, and then another FQHC – First Med. Vitality Unlimited in Elko was the recipient of a \$2 million expansion grant through SAMSHA to expand their CCBHC services to Carson City and Lyon County.

- **HOW ARE THEY SUPPOSED TO WORK TOGETHER AND HOW DOES THIS MODEL WORK WITHIN NEVADA'S SYSTEM OF CARE IN TERMS OF COLLABORATION AND PARTNERSHIP?**

The collaboration between CCBHCs and FQHCs should be relatively strong. In certification criteria they are required to have formal care coordination agreements with several different entities in their communities. We will work with Centers for Medicare and Medicaid Services (CMS) closely over the next few months to determine the viability of continuing the CCBHC demonstration beyond 2019 through a 5-year demonstration waiver through CMS.

(Question) Commissioner Durette - There are few to no psychiatrists and no child psychiatrists involved in any of those projects. How is specialty care being provided?

(Answer) Dr. Woodard would have to go back and speak to each CCBHC. They work closely with the organizations available in their community to determine what resources are necessary. The lack of psychiatrists specifically in the rural areas has prompted them to contract with APRNs for much of the psychiatric care necessary for their patients.

(Q) What is the role of an FQHC in the role of general and specialty mental health care?

(A) There are only a couple of FQHCs in the state that are doing behavioral health integration and many of them are doing that as an ancillary service outside of what their standards are. FQHCs are not required to provide any type of behavioral health service.

(Q) We have huge mental health needs in the state which require psychiatry. How can we insure that folks in state are getting appropriate care?

(A): The issue is to know who the care source is for those services. There are different levels of FQHCs based on national standards. DPBH does not certify the FQHCs. That is all predicated on whether they meet specific criteria. There are issues related to the payor source and networks.

- **UPDATE ON NEVADA'S CRISIS TRIAGE CENTER (CTC) MODEL AND WHAT IS HAPPENING IN THE COMMUNITY DUE TO THE LOSS OF THESE SERVICES AND HOW ARE WE MOVING FORWARD?**

Each CCBHC to meet certification criteria is required to provide crisis services including 24/7 crisis services and mobile crisis care. We are looking at an expansion of the CTC model. We have been providing information to the counties regarding funding match for uncompensated care. Washoe County has an RFP that is currently out and soliciting for applications. It is the obligation of the counties to identify who they want to select. Each county is using a different process. In statute, CTCs were supposed to be able to do both psychiatric triage and be the place where law enforcement and first responders could drop individuals off who were suspected of having some crisis need. Those CTCs are licensed to provide medical clearance. If the CTCs were implemented in the way they were intended, the length of stay would be relatively short (23 hours and less), and they would be able to provide the medical clearance to help circumvent individuals from having to go to the emergency room.

(Q) Commissioner Pohl asked where the patient goes after 23 hours in this model?

(A) There has been a lot of work nationally related to crisis services. There are levels of care within the array of crisis services that could and should be available in the community. The CTC is not supposed to be the only crisis service available. It is supposed to be a place where individuals can be evaluated to determine a Legal 2000. If they need a higher level of care then

that should be facilitated and if a lower level of care is needed, then to be able to connect them with same day or next day services for an entry into behavioral health care if needed. We found in discussions around Legal 2000 process that the majority of individuals initiated on legal hold do not necessarily qualify for that hold upon further evaluation. Many who do not qualify are released from that hold within that initial 23 hours. That first 23 hours is an opportunity to stabilize someone on an out-patient basis. The CTC is supposed to triage an individual and figure out what level of care is most appropriate for them.

5. UPDATE ON THE REGIONAL BEHAVIORAL HEALTH POLICY BOARDS

The Boards will present at the meeting tomorrow with DPBH.

6. FOLLOW-UP ON ISSUES WITH DESERT WILLOW TREATMENT CENTER (DWTC)

- **WHAT IS BEING DONE TO GET SOMEONE TO OPERATE THE INOPERABLE UNITS AT DWTC?**

Cara Paoli reported that things are further along than when she reported last time. We have met with First Med and are trying to narrow down items that will be added to the Master Service Agreement. We are in the process of drafting that and it will then be up to First Med to decide if the terms of the agreement are workable for them to provide RTC and PHP services.

- **WHAT IS BEING DONE TO ADDRESS REDUCED STAFF ISSUES AT DWTC?**

There is a handout that outlines the wait list we had with almost a year's worth of data. We are at a point where our wait list is not very high. We have contract agencies if we have a youth who needs immediate acute placement. We can see the clients served in the last 1.5 years and our census. We are motivated to work with our private providers to come in and expand services. At this point in time we are not in a position to increase state staff.

Chair Lefforge asked if there is timeline on operating the inoperable units? Ms. Paoli replied that we hope to have our draft done by next week, so they can review it and decide. If not, we would sit down and negotiate that.

(Q) Commissioner Ruiz Lee asked if the draft that is being prepared is specific to the facility requirements, or program requirements, or combination of both.

(A) It is a combination of both. We talked about how we could get them in as quickly as possible. There are issues if we both come in and operated under our own licenses, a firewall would be required and would be a major project. We are not going in that direction. We are going in the direction where a provider could come in under our license initially and start services right away to expand those units for residential treatment.

(Q) Under the program requirements, where do you think the staffing model is going to go?

(A) They would be required to meet the same standards as the state in our accreditation and licensing requirements.

(Q) Were you able to get an idea of the number of youths who have been placed out of state over this time period that not as many youths could be taken?

(A) We keep track of how many youths go out of state and it is always around 200. We hope we could divert some of those out of state placements if we are able to increase the bed units. We are

working through the SOC trying to get more community service array expansion so there are more in-home services to prevent youths from going out of state. It is a huge effort. We have met with some of our community providers to push the in-home counseling model especially for those youths and families that are identified for our wraparound in Nevada program.

- **DECISION ON WHETHER THE COMMISSION WISHES TO FOLLOW-UP ON THIS ITEM WITH A LETTER OR DOCUMENT AND FORMULATION OF THAT DOCUMENT.**

Chair Lefforge asked if there is any request of action at this point on this item? Commissioner Ruiz Lee said this might be an item we want to trail as an agenda item into the next meeting. If there is not movement before the next legislative session it is going to be a conversation during the legislative session in terms of commitment made. It would be time at that point for us to decide if we want to send a letter to the committee that could potentially hear the item in terms of recommendations or observations. Chair Lefforge said we will want to hear more about this at our next meeting.

7. PRESENTATION ON THE DIVISION OF CHILD AND FAMILY SERVICES (DCFS) INITIATIVE TOWARDS MOVING FORWARD IN COLLABORATION WITH THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH (DPBH) TO BECOME THE CHILDREN'S MENTAL HEALTH SINGLE STATE AUTHORITY.

Cara Paoli referred to a handout called "Delegated State Authority for Children's Mental Health in Nevada" and discussed the best way to ensure that issues specific to children's mental health are well represented in Nevada and prioritized. DPBH and Medicaid recognize that the needs are different than adults and have been working with us as far as the strategic plan through the System of Care (SOC). We are working with them on a statewide community living behavioral health plan, which is considered the OLMSTEAD Plan for mental and behavioral health in Nevada. That plan mirrors our SOC strategic plan goals. It includes a plan for children's mental health to move toward becoming a certified agency for Children's Mental Health in Nevada. We will meet with our DAG and DPBH about some regulations.

The white paper talks about the fact that there is only one single state authority for mental health in every state, and paper gives information about how that is set up and operated through the federal government. It also gives information about how we plan to proceed so that Children's Mental Health issues can continue to be recognized within that entity.

(Q) Commissioner Durette. Much like we have an adult general psychiatrist serving as state mental psychiatric director, what is the plan for the state doing the same for child psychiatrist with respect to DCFS - in a leadership position similar to Dr. Ravin?

(A) Dr. Woodard replied that Dr. Ravin is the Chief Psychiatrist but there has been a separation within DPBH between clinical services and the state mental health authority. That occurred in February or March of this year. The reason for that is because there is an inherent conflict between the role of direct clinical services, and the role of the state mental health authority. As only one of three states that is still the direct provider of behavioral health services, it was necessary to pull those two roles out. Dr. Ravin is the lead psychiatrist for all the hospitals

operated by the state for adult behavioral health as well as out-patient services but is not necessarily the lead psychiatrist for the state mental health authority.

(Q) Who is?

(A) Currently we do not have a psychiatrist that oversees the state mental health authority.

(Q) With children being such a vulnerable population, would it behoove us to have somebody that did not serve in the direct clinical care role but has oversight of consultation of children's mental services at the state level?

(A) Ms. Paoli replied that is something we could look at. Right now, there are a lot of possibilities depending on how things go in the legislative session.

8. PRESENTATION BY CLARK COUNTY DEPARTMENT OF FAMILY SERVICES (CCDFS) IN CLARK COUNTY, NEVADA.

- **HOW MANY CHILDREN AND FAMILIES WERE SERVED IN THE LAST STATE FISCAL YEAR AND HOW MANY ARE BEING SERVED CURRENTLY?**
- **IS THERE CURRENTLY A WAITING LIST FOR ANY OF YOUR SERVICES?**

Jill Marano, one of the assistant directors for CCDFS and Patrick Barkley, Acting Manager over child medical services were in attendance. Ms. Marano distributed a statistical overview report handout about medical services and mental health services. It gives a snapshot of where we are with some of our general numbers for child welfare services. We have been consistent for a few years on numbers of Child Protective Services investigations and the number of children in foster care. We have had close to a 20% increase into our hotline. It has not necessarily correlated to an increase in investigations, we think it is more a general awareness - "If you see something, say something". Erring on the side of caution.

The number of children in placement is roughly 3,400, which is consistent. This is a slow increase in numbers of children in foster care. We are looking at combating that in several approaches/programs. What can we do to stop children from entering, and what can we do to get children to permanency as soon as possible?

- **HOW ARE MEDICAL PLACEMENTS ARRANGED AND MONITORED FOR CHILDREN AND CHILDREN IN FOSTER CARE IN CLARK COUNTY?**

Chair Lefforge said a concern in the community is specific to medical placement. How is that determined and whether they are appropriate? Would a child be in a medical placement if the homes were primarily psychological?

Mr. Barkley oversees the placement unit and the medical unit. For the medical placement, with foster parents we are taking some that are skilled and taking care of medical children, and there are other foster parents that need additional training to take care of those children to the level they require. If it is a complex child needing immediate care, they have community providers; like skilled nursing homes to care for the child, and then they transition the child into a home. They are in a safe placement and then they can wrap the medical services. They have a medical nursing unit that goes out to the foster homes. They go to all their medical appointments with

them and act as a medical interpreter. They educate and monitor the child's well-being. They also have a nurse who goes into the home and monitors the child's well-being.

(Q) Who has oversight of insuring they are only there as long as they need to be there?

(A) The nursing department that goes out there bi-monthly to monitor the child's needs.

(Q) Where would the authority be if someone was concerned about these placements who oversees this?

(A) We have case workers and nurses in the home. They monitor over the specialist visits. There are many safety nets for these children. The more complex the case, the more people are involved.

(Q) Is there anyone with oversight outside of the system?

(A) If there is a caregiver complaint, it goes to licensing and all team leaders would look at it together. We figure out what kind of supports are needed.

(Q) How long would a child be in that care?

(A) It depends on what the ability of the caregiver and the needs of the child.

- **WHAT ARE THE CHALLENGES THE DEPARTMENT IS HAVING AND HOW CAN THE COMMISSION ASSIST WITH THESE CHALLENGES?**

Ms. Marano reported one thing they are struggling with is the lack of foster homes. They launched a new recruitment campaign. They have roughly 80 children on campus which is higher than they want. A significant number of them are under six years of age. That is bad for those young children to have staffed care. She brought some brochures that can be distributed by attendees. They have about 600 foster homes and need about 1000.

9. AGING AND DISABILITY SERVICES DEPARTMENT ADSD UPDATE

Jennifer Tseu reported on Nevada Early Intervention Services (NEIS)

A brochure was distributed that covers NEIS' eligibility criteria and the System Point of Entry (SPOE). It includes contact information for the program. As of September 4, 2018, the number of children served in NEIS is 1,811, and served by community providers is 1,796 for a total of 3,607. There were 713 referrals to the program.

Yeni Medina reported on the Autism Treatment Assistance Program (ATAP)

Ms. Medina reviewed a handout which shows the August monthly caseload, caseload growth, referrals to date, case mix breakdown by plan type, waiting children by age, active children by age, by area, wait time, insurance coverage availability, and interventionist to registered behavioral health technicians.

(Q) Chair Lefforge asked what needs to happen to get the wait list of services down?

(A) A lot of it is provider availability. They are working on attracting providers from out of state to open offices here. Part of the problem is the high need for appointments after school, and the hardest time to find a provider. Most children require an Applied Behavior Analysis provider. The reimbursement rate for some providers is a problem. There was a discussion about the types of insurance used to pay for the services.

10. MEDICAID UPDATE AND CHANGES

- **UPDATE ON MEDICAID'S NETWORK OF PROVIDERS IMPACT FROM STATE RATE CHANGES**
- **OTHER UPDATES**

No one was present to give a report

11. ASSEMBLY BILL 457 (LICENSING BOARDS) COMMISSION RESPONSIBILITIES:

- **LICENSING APPEALS**
- **REVIEW BOARD REGULATIONS**

Chair Lefforge believes the Board of Psychological Examiners meeting is today and they are taking public comment. She does not believe there is any more for the Commission to do now.

12. DISCUSSION AND DETERMINATION REGARDING SECLUSION AND RESTRAINT EMERGENCY PROCEDURES FOR CHILDREN AND YOUTH DENIAL OF RIGHTS FORMS QUALITY ASSURANCE PROCESS.

- **AGGREGATE REPORT OF COMMISSIONER'S COMMENTS FOR THE PAST YEAR**

Kristen Rivas reviewed the handouts:

1. Report shows signatures required for the DCFS and non-DCFS facilities.
2. Updated Seclusion and Restraint Review and Tracking Process.
3. Summaries of forms received for different timeframes broken down by facility. Report of follow-up we did with facilities.
4. Summary of incidents.
5. Summary of Commissioner Comments regarding forms by facility and topic. Letters have gone out to the facilities with the Commissioner's comments.

Ms. Paoli reported that DWTC is going toward all computerized reports. That is an effort that is in place. The process will probably be the same as before. They have a whole process for signatures. Just the appearance will look different.

The aggregate data was presented as requested by the Commission, so they could determine if they would like to invite any facilities to a meeting. The Planning and Evaluation Unit keeps a database of all the data from the Seclusion and Restraint reports. That data is not currently on the DCFS website.

- **DETERMINE AGENCY TO BE INVITED TO THE NEXT COMMISSION ON BEHAVIORAL HEALTH MEETING**

There were no suggestions of a facility to be invited to a Commission meeting. An issue in the past has been whether we are receiving reports. We were successful in our follow-up with Desert Parkway. It seems odd that some of the hospitals did not submit reports recently.

It was agreed that DCFS will put agenda item numbers on handouts in the future.

- **DETERMINE WHETHER TO INITIATE A TIME LIMIT FOR FORM REVIEW**

There was lengthy discussion about whether to initiate a time limit for form review. We had a facility who had a Director of Nursing who left, and we received over 1,600 forms that were over three years old. We have a criteria policy the Commissioners put forth and we follow, is this something that you want to add to that criteria if it is received over a certain amount of time?

MOTION: Commissioner Pohl made a motion to not review Seclusion and Restraint reports if they are over one year old.

SECOND: Commissioner Johnson.

There was discussion before the vote was taken:

- Ms. Rivas asked if we get the reports and they are over one year old what does the Commission want us to do? Commissioner Pohl recommended that we would probably send the older reports back with a notification that it is too late to be reviewed and not within policy. Ms. Rivas said DCFS can keep track of how many have been received.
- Ross Armstrong said we should consult with our DAG to be sure this is consistent with statute. Ms. Rivas had talked to Julie Slabaugh about it, and she said to ask the Commission what they wanted to do.
- Ms. Paoli hopes that will not serve as a deterrent to submitting reports because it is too late. The comments are valuable even if it is not right away. Chair Lefforge agrees and ideally, we would be receiving them as they are admitting them.
- Chair Lefforge recommended that one option is that we could amend the motion to just apply to the set of 1600. Ms. Rivas said the Commission has already reviewed most of the 1600. However, Desert Parkway had not been submitting any, so there is a second incident and they have a box of old ones. That is another reason we brought it up.
- Chair Lefforge thinks it is still a good idea for Commissioners not to be reviewing them if they are incredibly old. We need to do more to push for them to be submitted in a timely manner and follow-up like we did recently.
- Mr. Armstrong stated that there is a general provision with any licensing that you follow the law of the state of Nevada, so if the Commission found there was a constant abuser of that, then the Commission could make an official report/complaint to HCQC which would investigate that in compliance with their complaint office and it would be prioritized high.
- Chair Lefforge said if we keep track of the reports we were unable to review because they are too old, then we could put in a complaint to the HCQC on an agency.

VOTE: Motion passed unanimously.

We want to be vigilant about who is non-compliant, so we can follow-up on it. Chair Lefforge asked Ms. Rivas to notify the agencies of this policy change, so they can have some pressure to submit. Ms. Rivas will draft a letter for Chair Lefforge.

13. APPROVE DCFS POLICIES

Tiffany Ontiveros gave a brief review of the three policies presented to the Commission.

- **ADHERENCE TO SYSTEM OF CARE CORE VALUES AND GUIDING PRINCIPLES**

This was approved at the last meeting, pending a change on page two. The change was made.

- **CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)**

The Commission suggested SOC get some Technical Assistance from Substance Abuse and Mental Health Services Administration (SAMSHA) regarding interpreters. SOC did that and SAMSHA provided them with some resources. The state of Nevada has a contract with Language Link for interpretation services. There was concern about the interpreters not having a behavioral health background. Language Link's interpreters are required to have "active knowledge of technical and non-technical medical and social services-related terminology in both English and the target language". With that, Ms. Ontiveros does not think there would be any change to the policy.

A section of the policy on page 4 regarding DCFS staff ensuring linguistically relevant services was discussed. Chair Lefforge said she would not want staff who are bi-lingual to not be able to utilize that language with children, but when they are doing specialized services, probably someone who is trained to translate that specific term is needed. She does not want to forbid people from using languages that are going to facilitate communication, but her fear is that people are pulled into situations where they are not qualified to interpret because they happen to be around and speak that language. She would like this concern handled by this policy. She will defer to SOC to figure out how this should read given that. Kevin McGrath suggested it could be written to say "any psychological or psychiatric services that are provided, Language Link would be used in those cases. For administrative or minor tasks, staff could be used to do the interpretation".

Ms. Ontiveros reviewed some of the other updates she made to the policy.

Commissioner Johnson asked about sign language and/or oral interpreters being used.

Is sign language provided by Language Link? She requested some language be put in about certification of those folks.

Ms. Paoli said that would be the best practice, but it is very costly, and we might not have that in the budget. There are only two certified people in the state and you are competing with every other agency. She wants DCFS to write policy that is realistic, so we can serve people with disabilities as soon as possible.

MOTION: Commissioner Pohl made a motion to approve this policy.

SECOND: Commissioner Mosby.

VOTE: Motion passed unanimously.

14. UPDATE ON THE CHILDREN'S SYSTEM OF CARE BEHAVIORAL HEALTH SUBCOMMITTEE AND SYSTEM OF CARE GRANT.

Kevin McGrath reported:

- The Building Bridges Initiative (BBI) training will be on 10/23/18 in Las Vegas. Working to get more participation from private providers. There is a possibility we could get a training again in Reno.
- Working on an intensive in-home services model to be done by Medicaid providers. Will be sustainable. Finalizing paperwork.
- Working on what is the Nevada SOC after the grant ends. What that means in terms of population served, capacity, and the values and principles that will be maintained. Versions will be rolled out to workgroups and stakeholders.
- Regarding the SAMSHA site visit in July, we should receive the official site visit report by Monday and we will incorporate it in our action plans to address it.
- The SOC Subcommittee had a presentation from Reno Behavioral Health Hospital. Had a presentation on Family First Prevention Act and discussed what is the SOC document. Discussed the intensive in-home services program we are trying to establish.
- Communications Workgroup. Discussed what is the social media and other kinds of communications tools to use to get the message about what the Nevada SOC is. Talked about the contacts with tribal communities to make sure they are involved in SOC, and other diverse groups we want to reach out to.
- Special Populations. Had presentation from Kathy Mayhew on Together Facing the Challenge program and how it applies to special populations in Nevada. Worked on recommendations from the youth site visit.
- Workforce Development. Working on a workforce capacity information survey. Discussing a tier case management model. Working with stakeholders for their ideas on best way to diversify our workforce.

15. NOMINATE AND APPROVE APPOINTMENT OF A COMMISSIONER TO REPRESENT THE COMMISSION ON BEHAVIORAL HEALTH ON THE NEVADA CHILDREN'S BEHAVIORAL HEALTH CONSORTIUM. PAM JOHNSON WAS THE REPRESENTATIVE AND IS NO LONGER ON THE COMMISSION.

No one volunteered. This item will be carried forward.

VOTE TO INCLUDE A YOUTH MOVE REPRESENTATIVE AS A VOTING MEMBER ON THE CHILDREN'S SOC BEHAVIORAL HEALTH SUBCOMMITTEE

Mr. McGrath explained that SOC wants to have more youth representation on the Subcommittee. Charlene Frost, Roslyn Timmerman's supervisor said Ms. Timmerman would like to serve on the Subcommittee as the representative for youth.

MOTION: Commissioner Durette made a motion to have a Youth Move member be a member on the SOC Subcommittee.

SECOND: Commissioner Johnson.

VOTE: Motion passed unanimously

VOTE ON DISCRETION TO DISSOLVE THE CHILDREN'S SOC BEHAVIORAL HEALTH SUBCOMMITTEE SPECIAL POPULATIONS WORKGROUP AND TRANSITION INTO TASK FORCE TO ADDRESS YOUTH WITH CO-OCCURRING MENTAL HEALTH AND INTELLECTUAL/DEVELOPMENTAL DISABILITIES, WITH OVERSIGHT FROM THIS COMMISSION

Mr. McGrath explained that SOC has had a lot of input from the stakeholders about the directions SOC needs to move in terms of addressing our special populations. We focused on reducing out of state placements and working with children with behavioral health and intellectual/developmental disabilities. We agreed we have gotten to the point where our stakeholders have given us all the feedback they can. Now we need to get the state leaders in the room and start taking that input and move it towards policy that will affect those special populations.

Ms. Paoli reported that the Deputy Administrators over DPBH and ADSD are meeting in a week to talk more about this idea and we have drafted a Memorandum of Understanding (MOU) to give our administrator to review to make sure we are including everything we hope to accomplish.

MOTION: Commissioner Everett made a motion to dissolve the Special Populations Workgroup and transition into a Task Force.

SECOND: Commissioner Pohl.

VOTE: The vote passed unanimously.

16. ANNOUNCEMENTS

There were no announcements.

17. DISCUSSION AND IDENTIFICATION OF FUTURE AGENDA ITEMS

- Commissioner Johnson requested that a representative of the Clark County School District be invited to discuss mental health concerns in the schools. Kristen Rivas will facilitate that. Commissioner Mosby would like to know what the role of clinical social workers in the school are.
- Changes in the network of providers next time for Alexis Tucey.

18. PUBLIC COMMENT

None.

19. ADJOURNMENT OF PUBLIC SESSION

Chair Lefforge adjourned the meeting at 10:20 am.