AB 387 Task Force to Prevent Relinquishment of Children with Mental Illness or Emotional Disturbances to Child Welfare Agencies

Meeting Minutes

March 25, 2020

Meeting location: Via Teleconference

1. Call to Order: Tina Gerber- Winn, Chair of the AB 387 Task Force called the meeting to order on March 25, 2020 at 3:00 pm.

2. Roll Call:

Present: Tina Gerber- Winn, Ross Armstrong, Elisa Cafferata, Megan Wickland, Cara Paoli, Lisa Linning, Cara Paoli, Izaac Rowe (Deputy Attorney General), and Jennifer Spencer (Deputy Attorney General)
Absent: Will Jensen

Welcome and Introductions: Tina Gerber- Winn

Welcome to everybody. Odd circumstances I know, we have an hour and a half for a meeting. If we get through early, I'm sure there are other things people have to attend to. Hopefully, we can get to our items and then come up with some decisions for our next meeting.

3. Public Comment and Discussion:

Tina Gerber- Winn

So on number three, we had any public comment and discussion.

Lisa Linning

I just have to let you know that I have a mandatory call at 4:00, so if there's anything we need like quorum decision making if we can do those things earlier and I apologize for having to leave early.

4. Discussion about Case Reviews:

Tina Gerber- Winn

That's understandable. Thank you for the heads up. So I wasn't sure if we were going to review cases, but I believe we were going to receive some instruction. We had three members who were going to give us just a basic rundown of a few cases with examples so was that Jennifer, who was going to give us some preliminary instruction on the presentation?

Ross Armstrong

At the last meeting, we had a pretty good discussion about the public meeting. So we don't want to have individual information. So what we did is we just wanted to invite the attorney general's office to consult with us on the best way of reviewing cases for a future meeting. We weren't able to get kind of a format back in time to then have people submit make cases. And so it's just the opportunity to let the DAG's know kind of what your vision of that review would be as chair and address any of the issues in terms of what should be presented and just understanding for all the members that all the documents presented and used by this task force are and need to be public record.

So we just wanted some high-level information to the specific, perhaps the medical condition of the child not and maybe the family's economic status for insurance coverage to see what resources they had available, what other types of services they may have tried to access prior to requesting assistance from the child welfare agency. So that was a high level of what we wanted to know about the cases that were presented. Just to give us an idea of where we needed to figure out solutions or assessments for any referrals we might receive later to evaluate.

Izaac Rowe
Based on what you've just told me, I think if you put a high level where you're talking about the basics without actually identifying an individual or individual family, I think you'd be fine with that at a public forum such as this. I think as long as you don't go into exact details, which doesn't sound like you are. It sounds like you are going into a high level then I think you'd be okay. Jennifer, do you concur?

Jennifer Spencer
Yes, I do agree with that. In reading the AB387, section three, this is the task force. And so presenting the information at the public meeting, it would just need to be redacted with confidential information because under 432b.290 and there's also confidentiality statutes and the 433 statutes as well with the private information. I did notice under Section 5 of 387 it discusses appointing a clinical team to actually do the specific review of each case. And so I think that that can be done under that section. However, presenting the information in a public meeting would need to be generalized information that does not have the confidential information or the identifying information of the subjects.

Tina Gerber- Winn
So that makes sense. Thank you. Once we have our clinical team they won't be subject to everybody listening to their discussions and evaluation of a case. It will be much easier for them. We just want to make sure we collect enough information to give them enough detail to work with. OK, well, thank you for that. We had wanted a case from each child welfare entity, so I'm not sure if people had a chance to prep and consider the case or not.

Ross Armstrong
I know that DCFS doesn't because we were waiting for the opinion from the A.G.'s office. We didn't have time to put one together with the correct items that I felt. I'm not sure if Clark or Washoe do based on the information we just got from the news from the A.G.'s that Jennifer and Isaac presented, if you'd like, we

could certainly have Dana create a template so that we can send that out to the child welfare agencies and get it back. But I know DCFS is not prepared with a case today.

Lisa Linning
For DFS Clark County, we're still scrambling to try and meet the needs of having our staff work remotely and then ensure that the kids that are currently in our custody are prepared. I mean, I can give generalities. I'm the person who kind of oversees those cases, but, you know, not a particular case in particular. So whatever direction we want to go, I can certainly describe a scenario that's played out many times if we want to do that today.

Tina Gerber- Winn
I think that would be helpful because I honestly don't think that we're ever going to have a calm moment and we can talk about our next or next meetings and being realistic about the work we can get done outside of the meeting. So I'm fine with that. If you want to just give us some general ideas of the things you think interfere with care for children and what things we should consider about trying to address when we're service planning.

Lisa Linning
Sure. So there are a couple of scenarios that play out pretty frequently for us. So sometimes we get notified by, say, an out-of-state provider of a child that's a Nevada resident because we have certain facilities that are approved, Nevada Medicaid providers, and because we have so many children that end up needing a high level of care, we have a pretty good working relationship with, several of the out-of-state placement facilities. And so, they'll often, being careful of confidentiality, contact us and say, hey, you know, this kid from Nevada. But, the parent brought them here. But now we can't get a hold of the parent. We don't know what to do or the child's ready for discharge. Nobody is helping, is this child possibly one of yours? So sometimes we get scenarios like that where once a little bit of digging happens on the side of the facility. And if it potentially is a child that has been referred to us, comes to our attention, that the parents, because they've run out of insurance a lot of times if there's a parent placement that occurs and they have culinary insurance, just as an example is pretty common that time runs out before the child is meeting the clinical recommendations for discharge. And so, they'll be left with not being able to complete the treatment protocol and then the parent at a loss of now, what do I do? It has been, you know, information out there that if the parent refuses to pick up the child, then child welfare will be referred and can then come in and help or help the child get onto Nevada Medicaid if we take custody. So that's one of the scenarios. It doesn't usually play out like that until the child is discharged. So they've not met their treatment recommendations, come back to the state, parent refuses to pick them up. So then they end up going to Child Haven unless we're able to intercede in some way. So again, at that time, they go through the process of considering whether they need to be brought into protective custody. Most of the time the parent is protective. But then we become aware that they're at a loss because the child has been dangerous or they don't feel like they can meet their needs or, you know, many of those things. And so then my clinical team is then trying to help the family navigate a scenario where they don't have an insurance option or the private funding to support an additional higher level of care or treatment. So then case by case, we problem-solve with trying to give the family resources or help them understand what are some paths they can go down connecting them with agencies like if the child has, like Autism Spectrum Disorder or something like that, where they might be able to get a referral to ADSD to then get service coordination and some of those things so we'll help try and connect them with resources.

Lisa Linning
But at that point, the families back in crisis because the child's then come back to the state and potentially not stable. And just they might end up back in an acute setting during this time. So, yeah, that's kind of some of the scenario that we've had played out quite a few times. I mean, a lot of times it is because there's been some disconnect between the child either never having access to coverage like Medicaid fee for service that then gives them access to both mental health and potentially other kinds of supportive services they need or the family just feeling so overwhelmed that they need someone to help with assistance with the child. But if they've demonstrated they're trying to be protective, then that's a situation where we wouldn't bring them into our custody.

Lisa Linning
So unless another agency can take them in and help them get the resources they need in place. Then again, you've got a parent that's sort of left with feeling overwhelmed, potentially the child isn't safe in their home due to whatever their mental health concerns are, maybe being combat ever, a threat to other younger kids in the home. So those are kind of two of the ways that we often become aware of kids that have fallen through the cracks with having access to care.

Tina Gerber- Winn
Thank you. So, Cara, did you have any other information you wanted to present?

Cara Paoli
Sure. Yeah. I was just going to say I could certainly present, I had a couple of kids in mind that I think are pretty typical and it may overlap with what Dr. Linning just presented, which I think we have a lot of similar scenarios. But the one you said I'm thinking of was also involved with DFCS through children's mental health families earning homes. So it was a youth that had been adopted and was at risk of disruption, a seven-year-old little boy who had been in and out of treatment since I want to say age five. But he was in the learning homes and was having some trouble behaviorally, obviously, and the learning homes were having difficulty, too, because the parents were very involved and didn't always believe in kind of their treatment philosophy that was being used. So she was very vocal and was trying to bring in other providers and it presented some systemic issues with the agency based on kind of using a particular model of care. And they had objections to some of it so that youth was then at risk of losing that programming. And there was a lot of talk about coming back into child welfare custody. So there were a lot of communications back and forth about what should happen. An attorney got involved for the parents. There were a few meetings that were held and the decision was made to look into RTC placement for this young man, which, as you all know, those are few and far between for seven-year-olds. So an RTC was located, the youth ended up being driven to that RTC by his adoptive parents. And he was, I want to say, in that facility for about six weeks. The parents had daily involvement, had a lot of issues with their programming. There were some incidents between this young man and some other kids in the facility that parents felt were very concerning. The facility ended up wanting him to be discharged, not because he met his treatment goals, but because of the discontent of the family.

Cara Paoli

So once again, the youth was at risk of coming back into child welfare due to parents frustration and the treatment facilities, pretty rapid discharge of this young man. So he ended up being accepted into treatment at Willow Springs, where he is currently and I think we're all concerned as to, you know if the same dynamic is going to present itself again. This family is also concerned that he may never be able to come back home because of the parent's profession as a child care provider and her concern that it may put the kids that she cares for at-risk and she's not certain she's able to do that. I think that puts a question into all of our minds with what's in store for this young man, will you ever have permanency? Will he ever get to go home? So that's one real specific scenario that involves several parts of our treatment programming in the community and Child welfare. There's a question of whether or not this young man has autism. So could potentially touch ADSD. So it's one of those situations where he stands out with his behavioral needs and the parents don't feel like they can have him at home without no intensive services. Many of the services we've offered through wrap-around in Nevada and other in-home support, they've rejected because she is so busy with her day job and doesn't feel that she could participate with all of that programming. So again, I think, you know, we talked about this at our last meeting, how important it will be to have prevention services in place that could rapidly go out and work with families. And then in this scenario, I'm not sure that the family would take advantage of those. So, it kind of puts us in a position that at least in child welfare, would we pursue child neglect given that they adopted this young man and now they're saying that he can never leave home permanently. He just turned eight. But, 10 more years that we need to decide what's best for him. And in my mind, living in treatment facilities and kids cottage congregate care is not best for a child. It presents a lot of issues and things that we may have to talk about more in our meeting. So that's one case. But I think Dr. Linning did a good job of really outlining what we typically look at with kids.

Cara Paoli
We have another child right now that is an ADSD client at Sierra Regional Center, who has been a client there, I believe, for several years, and he's in Washoe County probation. And Dr. H called a meeting last week to discuss what we're going to do because they don't want him in detention. After all, he's struggling there. It's not a good environment for a youth with developmental disabilities. He's not sleeping. He's yelling all night long. The Regional Center said we have no resource for him as far as a home in the community here. They're not serving kids 18 and under in that capacity, they said they've exhausted all of their resources that they've offered to this family. He does not meet their financial eligibility because of the parent's income level. So, now this young man is going to struggle in that regard too. So, again, he's at risk of coming into child welfare because nobody knows what to do. The agency director is reaching out to Susie Miller with DCFS to set up a staff meeting to talk about him and what the options may be as far as possibly maybe Adolescent Treatment Center or Oasis Program or Desert Willow. So, it's kind of that typical scenario as a kid escalates. There's just not programming that's been identified. That could be an immediate response. And Mom's frustrated and worried and not wanting him to come home. So there are lots of case examples we could share. And I think we'll be able to identify commonalities with all them that we present and bring forward.

Tina Gerber- Winn
Thank you for that. What I heard you talking about in both of those situations was parents' education about treatment as well as knowing which referrals and how to get to those referrals because parents aren't always able to do that on their own. Also not agreeing with the treatment modality. And then it sounds like there are some problems with securing the diagnosis in some of the cases might be helpful, like making sure it's the right diagnosis or we're not missing something. I'm assuming that medical history was

received from the family, not that you've asked for it yourself, or tested children with your own resources. Is that accurate?

Cara Paoli
It can be a factor in this particular scenario with this last kid. I was presenting. He's already been found eligible. So he has had all the testing and the school records and everything that he does meet criteria for developmental disability services through the Regional Center. So in this particular scenario, it's not an issue, but that does come up a lot of times with kids who haven't been assessed recently and maybe their behavior is escalating or something new is coming forward and it's difficult to get them into a psychiatrist timely. So those issues do come up.

Tina Gerber- Winn
I think we have a lot to work out. I'm sure we could talk about the individual needs of each case, but the themes seemed to be pretty relevant regardless of whether at Clark County or Washoe County or I'm assuming, Ross with DCFS and the cases that we see in the rural areas.

Lisa Linning
Just to highlight, I would say that overwhelmingly the number of situations that end up kind of feeling like they don't have the resources needed or parents coming to the attention of anyone of the agencies in an overwhelmed state and having tried and failed to get resources for their child. I would say the cases that the kids and families that we're having the most challenge for having some kind of intellectual or developmental disability, almost always. We can identify resources for most of whatever else is going on but that is predominantly one of the most challenging elements to get the right services in place because they can be more extensive. So often the kids need residential care support. You know, the families in many cases do what they can over and over, tried and tried. And now the kid gets bigger. They're becoming without sufficient treatment, they might be becoming more aggressive. So then there are risks and other family members. So I would just want to make sure that to highlight that, if I went to case after case after case, the ones that are most challenging for the families and then for us to help them navigate what they need, there's some component of intellectual or developmental disability quite often.

5. Common Definition/ Data Collection (Cara Paoli):
Tina Gerber- Winn
Okay. Thank you. So I think we did our review of cases. We have some high-level themes. We can move to the common definitions and data collection. And this was Cara's item.

Cara Paoli
So with Katherine Roose's assistant, scheduled a meeting on Wednesday, March 18th. And we had some people from Unity and Jason Benshoof was able to be on the call and several from DCSF. We talked about kind of what the need is. I think everybody was clear on what we need to do. But Jason needed to check into some things with Unity before we can move forward. So he had kind of a list of things to do. Then we were going to invite a couple of other people for our next call so we could get clear with

everybody that needed to be involved with what our next steps are. So we're at this point waiting to hear back from Jason to see where we stand. And then once we hear back from him, we're going to schedule another meeting to get our criteria set up in the common definition.

6. Regulatory Framework (Ross Armstrong):

Tina Gerber- Winn

Very good. Great. Thank you. So we're still a work in progress, which is not a surprise. So, Ross, will you give us some information about the regulatory framework?

Ross Armstrong

Sure, just to let Cara know that at our DCFS leadership meeting this week, Jason, I think has what he needs and was just working with Katherine trying to get everyone together. So that should be happening pretty soon. I think he came up with a couple of different options and then what is the feedback of the program folks, and what's the best path to go forward. So I think they will get that scheduled. So I agreed to talk about the regulatory framework. The bill allows the department to adopt regulations and real basically, we can regulate, the language authorizing the department to adopt regulations is pretty broad. It says any regulations that are necessary to execute the bill, it does note that if there are regulations related to cost that the parent needs to pay for the extent that the parent can pay for the services. So in taking a look at the bill, there are some main pieces. And so I think this is just something to always be keeping in mind in terms of towards the end of this task force's work, what we want is a good understanding of the structure for these clinical teams to review cases and then just to make sure that there's a good process all around that. So what I've done is I've gone through the statutory language and identified areas that this group might want to write some of the regulations around. So kind of the first section of Section 5 of the bill talks about establishing the clinical teams, that they're to review cases, it's very specific about who would qualify to have their case reviewed, which the youth would have to have been admitted to a hospital or health facility, that they've not been subject to abuse or neglect and that they're at risk of relinquishment, involuntary placement.

Ross Armstrong

So just in terms of thinking about the regulations that this task force might recommend for the process of identifying those that make that. Is there a particular division or department or program within all of HHS that should be the referral area for that? How do we get consent since they aren't child welfare cases yet? We would want to make sure to get all the appropriate consents and information sharing and confidentiality agreements for that clinical team. They are not subject to abuse and neglect is pretty clear. I don't know that we would need some regulatory definition work around there. But the third one, at risk of relinquishment or voluntary placement, we could put in some specific parameters depending on how broad or narrow we would want that category to be. So we know which cases qualify for this clinical team. The next big chunk is that there has to be a plan of care and the plan of care has to include the necessary services to prevent relinquishment or voluntary placement. So we could regulate the further plan requirements, in terms of what needs to be in that plan. And we could regulate participation from specific divisions or other programs in the development of that plan. For those are things that we may want to consider for regulatory work. Then the bill requires that clinical team and that plan of care to arrange for stabilization services if need be. So the bill contemplates figuring out a payment structure.
And so for all of that, you could regulate kind of who's a payer of last resort, you know, who becomes

responsible for figuring out the cost, by regulation, we could say that the Division of Health Care, Finance and Policies takes the lead on determining the appropriate fiscal structure, even if that's a mix of Medicaid or non-Medicaid sources. But put that division in charge of that piece of it. I think it just in working with the bill sponsor, the idea of putting this clinical team at the department level instead of one particular division is it that the department has the authority then to direct all the players to the table instead of it being like a division to division or, a county agency to a state division ask. That it's the responsibility of the department to make sure that these items get done.

Ross Armstrong
There is also in section six and this might be where Cara's team, in terms of the definition, we could do some regulatory workaround further defining the report requirements from the child welfare agencies, I think it's pretty good. But if there are some items that we would want to make sure they're in there every time and some accountability on the information to be provided, then we can regulate around that. So that's kind of an overview of what I've identified so far in terms of areas for the regulatory scheme. And so I certainly would take some feedback now and go back to the drawing board and bring perhaps like a fill in the blank type structure for our next meeting to start to work and think about what kind of regulations we would want to go through the process of. I will double-check this with our team of DAGS, but I think that the director can adopt the regs, It doesn't have to go to the Board of Health. So that process will be we will draft basically the draft regs as the task force and then we have a public hearing. We may get some great feedback about the changes. We changed a little bit and then we send it off to the Legislative Council Bureau. They make sure it's all consistent with legal language that would need to be placed in there. And then we have a public hearing. So public workshop first, then a hearing and then be submitted then to the director of the department for his or her adoption. It's just a signature. There's no like board or anything for this particular set of regulatory items. And so that's what the process would look like. If you can get it done in a six-month process, that's usually pretty quick for regulations unless it's an emergency set of regulations. So I'm happy to answer any questions about what we can and cannot regulate to the best of my ability today.

Tina Gerber- Winn
Realistically, some of the attention on getting the regs done, it tends to get disturbed when we have the legislative session. So do you see us having to do that at the same time as the legislature?

Ross Armstrong
Rules in the Nevada Administrative Procedures Act, where we can't adopt regulations or adopt permanent regulations during a specific timeframe. So essentially, we would need to get them done and get final approval by the end of this calendar year or be put on pause during the legislative session next year. So that's kind of a time out zone around the legislative session for permanent regulations. And I think in most cases, it doesn't make sense to do a temporary regulation during the legislative session because the law could change. And then you have to go through the whole process again for a permanent regulation. So, all the things that I talked about could also just be adopted policies by the department. It wouldn't have the same enforcement level. So that could certainly be something if we're unable to kind of figure out exactly what we need those regulations to just adopt policies and procedures until the time came where it was, It will be after the next session to do the regulatory piece, less probably the least amount of authority for policy and procedure to dictate would be the fiscal pieces, but all the other items could be primarily done through policy procedure if we want to before solidifying that regulatory framework.

Tina Gerber- Winn
That makes sense. I'm just curious too, about the financial piece of it. I'm not even sure we haven't talked about how we come up with some idea how much treatment might cost because it seems like some people aren't even finding the treatments that they need for children. So how do we know how much it costs?
Just a thought as I'm trying to figure out the access to care piece.

Cara Paoli
Yeah, I think that will be okay because it'll be depending on if it's outpatient or residential. There's already set costs and then if DHFP gets involved, I think that's a great idea that they would be in charge of that whole piece. And normally the only issue is if the family has insurance. That's where it gets complicated.

Gladys Cook
We are already in house. One way that we can certainly help is to provide you with diagnosis codes or a service code. I can certainly take it back to the team then I can come back and give you some numbers of what you might need. Somebody mentioned something about third party liabilities. The way it works with Medicaid, is in terms of how we pay with third party liability if there is Medicaid, basically, last resort of pair so the private insurance will come in first and then we come in second. I can tell you, I mean, based on that, what the rate would be on that, because it is dependent on that private insurance and how much they can pay. Does that make sense?

Elisa Cafferata
So the agenda item we're on is the regulatory framework, which is what regulations do we need to set up the clinical team. I think we're getting a little ahead of ourselves if we're trying to figure out how to pay for things. So my question to Ross is I know that the last legislative session they created a Maternal Mortality Review Team, which is somewhat similar or analogous to what we're doing with our clinical team and that it's a bunch of people who are coming together to review medical cases, confidential information, and part of what they have to do is deal with the privacy issues and the professional liability issues. Is there a way for us to find out where they are and their regulatory process? Can we kind of copy along?

Ross Armstrong
I can certainly ask them about that. I'm not 100 percent familiar with that bill. Was it more like a domestic violence death or a child death review team or were they coming up with teams that case plan for individual families?

Elisa Cafferata
It's similar to the Infant Mortality Review but they are looking at not only mortality but also severe morbidity. So close calls as well as death. And they are making recommendations, maybe less for

individual families, but more for policies. So we may need specific regulations dealing with how do you come out of a review like that and make a recommendation to an individual family. But some of the other pieces, I think would be the same.

Ross Armstrong
I will check in with that.

Elisa Cafferata
I can send you the bill.

Ross Armstrong
Great, that would be wonderful.

Tina Gerber- Winn
I think that I'll run that through Public and Behavioral Health. But I can figure that out. And that's a good suggestion to see what regulations this group might be forming. OK, so we got things to consider as far as regulations, including payment structure, any kind of plan of care documentation, that type of thing. OK. Thank you for that, so part of the follow up with that, would be to follow up with the Maternal Mortality Team to see where they're at with their structure.

7. Report from Workgroups and Vote on Action if Necessary:
Tina Gerber- Winn
So I think we're ready for any possible action. That would be workgroups, we talked about having workgroups. But I think for a little bit, we still have Cara doing the definition of the cases and we'll have the framework to consider after we do some research. So I don't know if we're ready for workgroups yet, but I think it certainly could be something we would have on the agenda for next time.
Agenda Item 8. Discuss Next Meeting Agenda:
Cara Paoli
I'm wondering if we can get a timeline for ideally how we hope this will go, like with what Ross outlined with kind of the process that we will be following with public hearing, LCB taking a review, public workshops, public hearings. Is there any way we could draw up a tentative calendar of when those things would happen? If we're going to make it happen before the legislative session starts? I think that would help guide our process. Also, I would be interested in discussing some of the barriers we've run into when there is dual insurance involved with some of these kids because I think that has been a barrier to families accessing treatment in the past. I know it's not on the agenda today. So if we could figure out how we can have some discussion around that. And I think Gladys brought up a good point that Medicaid is the payer of last resort. So it's going to take some problem-solving around how that could be handled if that is the barrier for family.

Tina Gerber- Winn
So are you thinking the secondary pair is Medicaid?

Cara Paoli Correct.

Tina Gerber- Winn
OK. So, Gladys, do you have someone on your team to talk about how that works? That would be a Medicaid coverage.

Gladys Cook
I can reach out within our agency to see if we have an expert on third party liability and see if they can come and attend the next meeting and then we can discuss that.

Tina Gerber- Winn
OK. so we have PPO issues or our third-party liability and then the timeline for regulation adoption, an update with Maternal Mortality Team. Then we'll have a data update from the group just to see about the definitions and actions. Are there other things people want to consider discussing?

Tina Gerber- Winn
OK. Why don't we leave it at that? If there were other things that we need to consider. You can always e-mail Dana. Before we finalize what we're going to cover on our next agenda, do we have other comments or discussion? OK. So I think we could leave it at that, it's been a rough couple of weeks, so I don't have much else to say other than I know that everybody's working hard to take care of their clientele and figure out how to keep their staff safe too, I appreciate that. We need to figure out the date when we're going to meet again. Can people tolerate considering future date? Do we want to go for a month?

Megan Wickland
I think a month should be doable.

Cara Paoli
I think that it would depend on the timeline we come up with and how quickly we're going to need to work and how frequently we'll be needing to meet.

Tina Gerber- Winn
So we want the timeline first and then, I mean, we don't have to set a date. Now, I'm just worried it takes a while for Dana to get everyone together. Can we set a tentative date and then decide whether we can set it aside?

Cara Paoli
I'm good with meeting. I'm just thinking we're going to need to meet more frequently if we're going to beat the session. I'm up for a meeting in a month. That's fine.

Tina Gerber- Winn
OK. The 22nd would be a Wednesday afternoon of April. That would put people at three.

Gladys Cook
OK. Sorry, that doesn't work for me.

Dana Popovich
What about April 29th at 3?

Tina Gerber- Winn
That's fine for me. So we'll try it for then. So we have a couple of deliverables and we'll have an update. And if you think of other things that you would want to consider, send it to Dana. Dana, do we have minutes from our last meeting?

Dana Popovich
Yeah. They're posted on their DCFS website underneath Meetings and Agendas so they're up and ready.

Tina Gerber- Winn Very good.

Cara Paoli
Do we need to approve those as a group? Is that part of what we need to do in every meeting room or not necessary?

Ross Armstrong

Yeah, we should, we cannot unless it's properly agenda-ized because it's considered an action to be approved. So a draft has to be available within 30 days of the meeting and then we should be approving them as they're available.

Agenda Item 9. Public Comment and Discussion:
Tina Gerber- Winn
So we can add the last meeting minutes and this one to the next agenda to approve. Okay. Is there anything else? Okay. Going once. Going twice.

10. Adjourn:
Tina Gerber- Winn
Adjourn. Thank you so much for your time today. Good luck. Take care.