AB387 Task Force
Meeting Minutes
October 21, 2020

Roll: Tina Gerber-Winn, Kathryn Roose, Cara Paoli, Megan Wickland, Ross Armstrong, Charity Sharp, Michelle Sandoval, Jennifer Myers, Dr Linning, Will Jensen.

Absent: Gladys Cook

Agenda:

1. Call to Order
2. Welcome and Introductions
3. Public Comment and Discussion
4. For Possible Action- Meeting Minutes
5. For Possible Action- Action Items
6. For Possible Action- Confirm Next Meeting
7. Public Comment and Discussion
8. Adjourn

1. Call to Order

Chairman Tina Gerber-Winn called the meeting of the AB387 Taskforce to order at 11:15 am, Wednesday, October 21, 2020.

2. Welcome and Introductions

Charity Sharp, Administrative Assistant IV, Central Office.
Jennifer Myers, Clinical Programs, Rural Clinic
Michelle Sandoval Clinical Social Worker with Rural Clinics

3. Public Comment and Discussion

None

4. For Possible Action- Meeting Minutes May 27, 2020.

Tina- One correction with language change from “phase sheet” to “face sheet”.

Dr Linning- Sent a word document with needed corrections; run on sentences etc.

Tina- Does anyone else have any comments on the minutes? Alright, hearing none then I will take a motion to approve with the corrections that have been submitted to Lisa D.

Ross- This is Ross, I move to adopt the amended text.
Will- I will second that.
Tina- So, can we take a vote. All in favor?
Team- I
Tina- Any apposed?

Tina- Let me note the team approved motion.

5. For Possible Action- Action Items

Tina- So, we are ready for the next, I think this one is really for possible action. I believe this is where we are talking about the documents we had submitted. To assign task force meeting and according to our minutes last time, to focus on eligibility and any kind of roadblocks to service access. They needed more data from specific cases. They could recommend ways to improve access to care. And then the other piece was our clinical group, which is Ross, Cara, Dr Linning and myself, with the process. I did

give Michelle, Jennifer and Charity a crash course tutorial. I shared our meeting notes with them and some history of the NRS. They put together our assessment process. I know that you didn't have a lot of time to review the process. But I do believe it captures an eligibility process, a care planning process and then a consulting team. I know we called them something different in the documentation to allow us to access the needs of a child and to create a plan of care. As well as a team to help implement that plan of care including payment. And an assessment piece, or a reporting out piece at the end to the clinical group as well as administration within our department.
I would like to start on the first document which was titled Relinquishment of Custody Prevention Taskforce Procedure. And I just want to say my staff, my loyal team created a title for our working group. Which is certainly able to be modified, based on whatever we want to call the process. I want to say, that as a whole as far as the task force procedure, it notes the bill. And I want to state to whoever does this overview and I think its probably Jennifer, the year that this assembly bill was created. It was 2019, is that correct Ross?

Ross- Yes

Tina- We should probably put the assembly year if we are going to note it and when it was created. Only because this coming year there will be an assembly bill 387 for 2021 legislative session so we know the reference. And so, the staff outlined what the purpose of the bill was and just in general a brief organization of how we came together. A procedure for ourselves as far as definition. Who our teams are to provide care and procedures for how referrals are offered. Asses and plan on behalf of children and their families. And the liberties in a sense that as an organization we have created specific websites. Thank you Kathryn for putting these into ADA compliant format. I thought about that as a process in a draft. But I know if we are going to publish this even as a draft people need to be able to read it with some assisted devices. So, segue essentially back to the fact that a website to collect data. Our assumptions are that we will need at least 1 clinical/case management lead in charge of the process and 1 assistant to help coordinate, take meeting notes and will communicate with the group. Whether it's the family, clinical team or assessing/recommending a plan of care, the implementation team, which is
our division and our department employees who would then have expertise with care. The first part of the procedure really is how to make a referral to the group. Asses priority if we have multiple referrals. Who gets

to go first, in our attention. Particularly if we have more than one referral to have more than one implementation with the same lead. They don't know how many referrals we're going to have but the process will allow us to prioritize if we have several requests. It's indicated in a flow chart who of course is part of our team and individual staff who have the clinical knowledge to assess the records we are going to request. As well as give recommendation with treatment plans. That process could be pretty intensive and then we would have a care plan written up by the case manager, to whoever's assigned to this process and then a lab implementation team to take it from there. With resources to the help the child and his or her family access the resources. It indicated a lot of inclusion in potential team members. I think for the implementation team under number 5 it says, "the team shall include". I think the team "may include". And I would just say that to Jennifer. We had a running list of entities we thought could help us contribute with creating care. DCFS, Department of Clinical Perspective, as well as Child Welfare Perspective, potentially. County Child Welfare entities, someone from the Public Behavioral Health. And Medicaid. Again, depending on the end care needs of the child. This includes you also Will, as an expert for education. Because many times when we have children who have to enter into alternate living situations we still have to provide for their education. We access remedies for children who are is still school aged and enrolled in a school district somewhere. I know there is an obligation to educate them regardless if they might be having medical care provided when they are a resident. Some suggestions passed from the governor's Office of Consumer Health as an advocate to access some insurance benefits, minority health. So, we just had a list. It's not meant to be exhaustive, but it is meant to be inclusive. That was the idea with that. The group implementation team and the lead case manager would really support the family as well as advocate for service. And benefit access and follow up on some of the needs to enroll providers with Medicaid's assistance. Necessity for example. Or to access special use funds that DCFS might have or ABFD as an example. To try and assist a child. For feedback we did include an administrative team. That team would, met quarterly at least, to take feedback of the process. How there working. The number of children that we've assisted. I think that might be helpful in the administrative reporting. I think as time evolves we could get more intensely creative on the depth of the services. The initial path, I think, gives an outline of the intention. To take a referral. How to connect with the family. To collect the details. How to assess that detail and how to make a plan that would be supported by our department. And through a variety of divisions. That was the overall. I think Ross had his hand up.

Well Cara had her hand up to. Sorry I wasn't paying attention so I don't know who raised their hand first.

Ross- Cara was definitely first so I'll just defer to her.

Cara- I was just wondering if there was something that you had sent out that outlined what you are talking about. Just so we have that as a reference. Or if we could present it while your talking just so we can see it up on the screen.

Tina- I apologize. I don't have as much experience with LifeSize. Let me try, I think I can share. Let me get the documents open.

Michelle- I have it open if you want me to share.

Tina- You know what Michelle, I would be glad to defer to you. If you could just show them the first document I just discussed.

Cara- Oh perfect.

Tina- So, there was a long narrative. It was probably 5 pages long. This is the graphic that explains the process in a more compact detail.

Michelle- Yes, I think this really simplifies it quite a bit. As we are talking about the procedure document you were talking about Tina. I think this simple flow chart would really help get a clear picture of what that longer six- page document outlines. So, thank you. I don't know if there's a way to enlarge it. Maybe there's not. Maybe if we could have it sent out to everybody we could take a look at it.

Tina- Kathryn did send out documents yesterday so if you haven't looked. I apologize for not saying that straight out. Kathryn did send them out for us. She sent it out last night at 7:00 pm.

Ross- And you can if you look on your screen where it has the document. On the lower right. You can make the size whatever you want.

Michelle- Oh nice, thank you.

Ross- So my question, in taking a look at it I think that the definition of the Implementation Team and Clinical Team are a little bit off because it's not

the members of the Statutory Task Force that would be sitting on those. It's just members that are appointed by the director office to serve on that particular team. So, the way it's currently written it would have to be members of this team. Which I don't know if it is the most appropriate folks. And then can I just get a little bit of clarity on the difference between the Clinical Team and the Implementation Team. I'm a little confused on the need to have 2 separate teams.

Tina- So, the Clinical Team was, seemed to have representatives chosen by the director if that is the person in charge of the process. To have someone representing Family Services, or Mental Health. Those could be Mental Health as far as Child Welfare. And a provider from Public and Behavioral Health. It could be a psychologist, a clinical social worker, depending on the case. I think it's a shall so basically the clinical team would allow for. I guess we could just say, we would like to have a representative from a certain discipline. But Washoe County didn't want to be part of a process if it wasn't related to their operations. We could just say representation with certain type of background. The people that are helping us develop this process are the Clinical Team. They were to give us representation of how to implement a care plan. This is what is written. Clinical Team would be representative to have the skill set to asses the records that we are going to receive to the family. Develop recommendations for a care plan to address the child's needs.

Michelle- Did Washoe say they didn't want to be involved in something?

Tina- No, I didn't say that. I'm just saying our suggestion in this process was that someone from Washoe County, Child Welfare as well as Clark County Child Welfare should be part of this Clinical Team. As a point of inclusion. As well as DCFS because their another Child Welfare agency. And then the representatives for Behavioral Health Specialist. Somebody who understands the treatment needs or options. Whatever we believe the clinical team should be. The suggestion just included everybody representing a child welfare agency. Then representatives who understood care needs of the particular child, in theory.
Does that make sense?

Michelle- Well I need to expand on what you said. Then the Implementation Team is really, if that care plan can't be carried out that the clinical team reviews and comes up with, then that Implementation Team are really those high level administrative staff who can look at team and options. Look at insurance. And make those changes that are needed

that can't be carried out in the care plan due to some obstacle. That implementation team is kind of that higher level of getting the care plan carried out.

Tina- Representation of a team of clinical experts participating which we assumed would be the Child Welfare Agency. You said the DPBH Medicaid be appointed by the director. The case manager receives the referral and the relative information and then works to develop the clinical team. The recommendations. History or just knowledge. The Clinical Team interviews with the client and comes up with the suggested care plan. Envision any of us being on that team per say, unless we are clinical experts in some kind of service delivery that's relevant to the child's needs. I know that there's resources in every agency and every division that could be scoured to create a clinical team. And it would be specific to the child's reported needs. The Clinical Team would create a plan of care. A suggested care plan which was also part of the documents. The case manager is appointed to proctor this process, would create a care plan on behalf of the clinical team. The child's family, the child representative agreed to that care. That would be the first process that the clinical team would address. Once that's created, if there weren't obvious ways to provide the care as Michelle said we would have an Implementation Team appointed to create the solutions necessary to implement a care plan. That means that the person needs some kind of residential treatment for a specific illness. Persons on Medicaid that don't have a provider that's enrolled. Further development of provider resource. The case manager would work with Medicaid to make that happen. Provider enrollment process that the implementation expert from Medicaid would assist the manager in enrolling the provider necessary to implement the care plan. For example, it would be for recommending a certain type of outpatient service not covered by the child's current health care plan. Would, through the case manager advocate with the governor's office of consumer health to cover the care plan. Care recommendation example; If I couldn't get a certain treatment through my insurance but our clinical team recommended it for the care of the child for recovery then we could advocate with the insurance plan. Create a single source payment for that particular service. Another example; If for some reason there's no such funding for the service and it is relevant to the recovery of the child then we might talk to Aging and Disabilities Services Division for a specialty use of funding they have for certain kind of service delivery. If we located a provider and we didn't have a payment source. So those are just three examples of the implementation team. What they would be working on.

That to would vary depending on the situation of the child and specific roadblocks in care.

Ross- Thank you. That is very helpful. Every child and family is going to get a clinical team to develop the care plan. And then the Implementation Team is developed once there's an identified roadblock. So, I think your right. I think the language and procedures need to all change to "may", instead of "shall be". And the definitions need to change. So that there's just people who have been appointed by the director's office to be on the Implementation Team. Not members of the task force for that purpose. Because right now shall wouldn't make sense necessarily to Clark County unless they wanted to be involved in like Lyon County. And so, I think that helps the Clinical Teams expertise. I would just say to make sure that any of the intake forms by our DCFS care team language. Because I know the word "client" makes some folk erupt in anger. Not me, necessarily but we have some folks who, that that's a really jarring term. So, we're happy to run it through that team for that system of care. Friendly language. And so follow the clinical team and whatever Implementation Team is needed. They would stay involved until there is a solution in place that's sustainable. Is that the idea?

Tina- Absolutely. That again might involve several clinical teams working at one time on several cases if we had urgent issues. If a child couldn't be released from a facility because there was no after care plan as an example. We definitely need to have that plan of care extended so remediation continues for a child's success and support for the family etc. I understand what your saying with the clarification of language. There are suggestions on how to not make it to cumbersome to explain. And we don't have quite honestly, any need to take credit for creating or being noted in the process as long as we all agree to do that. This process is something we want to try. We can readily assess clinical needs for the treatment plan and recommended care plan. Find a case manager and somebody to support the flow of this process with fluidity and timeliness and clarity for being involved and concerned about a child. That is basically what has been designed. And then I definitely wanted to have feedback in an administrative level that is actually doing and helping in a way for critiquing and modifying the process as we go. That was really the administrative teams that we indicated and include Cara and Lisa in that process. We need people who will come to the meetings with authority to make recommendations for the best care provision. Or the best and most convenient solution to get to coverage, money and provider. Whether you are on the clinical team or rotation team. The brain

power for the roadblock so that we can get the best care for the child. Administratively we feel that its best to tell administration to tell the people who are in charge that it is working, or what might be needed to make it work effect.

I'm sorry, I'm not paying attention. There's a guest showing. I'm sorry, go ahead guest.

Ross- I think it's Dr Linning based on what I'm seeing on the screen.

Tina- So Lisa, Dr Linning

Dr. Linning- So, my question in terms of the Implementation Team and the Administrative Team. Are those to be designated people that are available when the need arises and not a scramble of who's going to do it? Because this is kind of a hierarchical decision-making process. It is often been the case that we didn't end up with that decision-maker coming to the table when we needed it. Usually this is a pretty urgent situation. A child that needs some critical care right away and families have ended up relinquishing or ending up at the shelter assuming that that would expedite the process. I want us to make sure we are somehow suggesting who the players will be. Obviously acknowledging that there will be a time where there might need to be a designee. So maybe we also need to consider that. If it's administrator X or their designee making decisions. Because we have just hit that roadblock constantly.

Tina- Appreciate your question. I would suggest for the Clinical Team. If we agree with the composition of who wants to be included in each assessment, or if it's a "shall". For example, if you didn't want to participate, as Ross suggested in discussions about a child in Lyon County, then we wouldn't contact you. Meaning, if I was the case manager, I would not contact you to participate in the clinical team. If you wanted to participate in the collaborative or learning process and you were my contact, I would call you and say we are going to conduct a clinical team meeting to come up with a plan of care. Who would you suggest in the county system. Your discretion and your authority would be who you chose.

Dr Linning- Clinical Teams need to be included. Because they are going to be really specific to the county where the child resides. The services being considered. That team, I agree, needs to be included. But as we move up the hierarchy for decision making both the Implementation Team

and the Administrative Team. Those are the teams that I think need to have some good designation so we don't get players at the table, respectfully acknowledging how busy those people are. It doesn't serve the purpose to set this up if you don't have the buy in that they'll make that happen if it's needed.

Tina- Right. So, to go, jump to the Administrative Team. After soliciting modifications, suggestions, omissions, on the processes that Kathryn sent out on our behalf. That it would be presented to the Division Administrators, Department Director. Their clarification, amendments, again, final process is their buy in. But the Department Director can appoint a Division Administrator to cooperate with the process. I do not believe based on comments that I've received from Division Administrators that they are not interested in being cooperative. The meeting to anoint this would be with the Director and the Division Administrators and our suggestion would be to have Clark and Washoe administrators be included. It is inclusive to take all recommendations. Division Administrators or County Administrators would then be whoever is going to part of our resource. While to develop that knowledge. But I do believe one has some idea of who would be the best and most influential and supportive. I know that their busy but it's also part of their job honestly to help people get into care so hopefully they'll help us. So that would be the first pass and then our suggested Administrative Team schedule is every quarter to report out on what we've been doing. As well as is the process working. What children and families have we helped. What policy is standing in our way to be faster at what we are doing or more successful. The purpose of the Administrative Team, not to ask their permission but to tell them what we need them to hopefully address in policy, guidance and directives to support the process. The Implementation Team is essential if we have roadblocks to care and that, you are right, can be specific to county area or to a division, depending on the needs of the child, with the help of the Division Administrator endorsing this process. The Administrative Team meeting will indicate when things have gone well. Not to rat out anybody. It is not a punitive process but it is a realistic assessment of how it's working. Does that make more sense? Sorry for your long wait Will.

Will- That is just fine. Just a question or a point of clarification. I'm wondering about the inclusivity. I'm wondering if there needs to be intentionality to include, be included on those implementations. We are going to have those, whoever is receiving treatment. Have 180 days for six to eight or nine hours a day. Depending on what is happening at their

school. I'm wondering if this is the appropriate place to shore up this wrap around. Around these little cherub's that need us. Or if maybe that's misguided in this conversation.

Tina- Michelle and or Jennifer, there is a plan of care to talk about educational needs, so would education be appropriate in the Clinical Team? Development of the care plan based upon what Will's saying or Implementation Team or both.

Michelle- Absolutely. Have the Department of Education included in the Implementation Team. It is such an important piece. And the Clinical Team I am sure. Absolutely. When we were thinking about all of this, school social workers, I mean, I think anybody who wants to come to the Clinical Team that is invited. That the case managers and families identify, I think could be a huge resource. But Department of Education is included at the Implementation Team.

Tina- I do think that we need to make that clarification. I do believe for the clinical team and I'm remiss to not consider the school social workers. And that really is not DOE right? Will, it is school district?

Will- Yes, it's the school district but we have an office of safe and respectful learning. My colleague Kristin McGill, who is probably more closely related as your counterpart. But I'm so happy to be here and part of all this, but she oversees and has her thumb on the juice. She's got juice that can help us on this.

Tina- Just to note to the rural clinic then we would add safe and respectful learning. We, as well as our implementation team (unintelligible). Sorry I didn't memorize what you all put together so artfully. I just know we need to make sure that correction is made. I did have several other documents. I know that Michelle included basically the letter that Kathryn sent out to report some of the numbers originally for the children who are affected. Their medical needs and at risk of being relinquished. And then we included the referral form. I believe Ross suggested that we run by the System of Care. We can run everything by the System of Care. Michelle is very involved and has worked on multiple things with (unintelligible). We do have several formats to show the full work as well as the team membership. Michelle, Jennifer and I can go through those again after we review comments. Another form is a release of information. We did put this under a letterhead for the department. According to the law it is the director's office (unintelligible) mimics our release of information through

rural clinics. It is familiar to us. It allows for the collection of behavioral health data and other medical data. It gives informed consent (unintelligible) and we mimicked what we already had approved. If there is other concerns with the content people can just let us know or we can run it through our own process with the attorney general's office to assure it is adequate. As well as the care plan that was suggested with the objectives and the acknowledgment by the client or their guardian the work we are doing together. And process how we run our delivery, our service delivery clinics. Our process is based on our knowledge. Permission to get information. Requesting permission to give information on behalf of the child and their family. And regular case management and communication to coordinate with the family. The Clinical Team, Implementation Team and the Administrative Team to advice how the process is working.

Ross- First let me say this is great. It's like some structure to what's we've talked about a lot on this Task Force. To make sure we are in compliance with open meeting law. The best step next, I think, would be for folks to submit their written edits to Lisa who can then give them to your team. It's one of those things where open meeting law prevents us from using a bunch of good online collaboration tool. We cannot set up a team and all work on one document together. It would be a violation of that. I think that would be the best thing. Then come back with a specific action at our next meeting to adopt it all. To make it very clear that we are getting ready to adopt it. Then have that submitted to the director's office for implementation at that point.

Tina- That is a great suggestion. So, let me see, that was your motion? Was there a motion in there?

Ross- No. Based on the language of the agenda I don't think we can adopt this process today so it would just be, that's my discussion. That would be the best next step. As the chair, you don't need a motion on what we are going to do with our next steps. You can just declare on high that this is how we are going to proceed.

Tina- See, I like that. I really do believe that the frame of this depends on how fast people can digest and review the details. It's not that much, quite frankly, and it is in mind with what we had talked about in multiple meetings. My request would be that people take time. First of all, can everyone acknowledge that they did receive an email from Kathryn Roose, last night about 7:00pm. I think the only one who can't

acknowledge is Gladys. My request to Lisa, can you please contact Gladys Cook and make sure she knows the detail is in her email from Kathryn.

Lisa- Yes

Tina- Then my request is people take time to review and give us edits back by next week. If there isn't any major aversion, that's my request.

Team question (unidentified)- would it be helpful to send out something or do you want us to just work off of what came in yesterday.

Tina- I know Jennifer's picked up on what I suggested but I would just ask that you make your comments. What I did was a brief overview compared to all the details and I want to make sure that those I have working on this consider what your saying. To assure we understand. Please send it to Lisa Dubois.

Dr Linning- So do you want it in some format, like a google doc that all those changes go into or track changes in a word doc or because if your getting multiple versions then it's kind of messy to make sure that your capturing all of it. I'm just curious if there's a preferred method that we can use for the editing process.

Tina- I will defer to Jennifer. I know what I would say but Jennifer, what's easier for you.

Jennifer- I don't know how Michelle feels about this, but I'm ok with everyone sending in (unintelligible) and then we'll sort it out. Thank you for considering that though.

Michelle- Since there are so few of you, if you want to just do the track changes in the word document that have been provided then shoot them to Lisa then we can collect them and make sense of all of it and get them back to you guys for review.

Tina- Thank you for that. I was going to say I print things out and write all over them to figure out what I mean. So, edits in by Friday which I know there is a holiday next week. Then the group will review. My team will review and make corrections. We will schedule another meeting to review what we consider our close to final draft. I don't think there's much more we need to discover or discuss on this item number five.

6. Confirm Next Meeting

Tina- Stating that we can receive the edits by the end of next week, I believe the team is proficient at getting any amendments done the following week. I'd be surprised if it wasn't done sooner than that. So sometime the first week in November. The week of the 9th. There is a holiday in there I believe. My suggestion would be Monday the 9th, Tuesday the 10th at some point or the 13th. Any suggestions at this point.

Will- the 10th in the afternoon would work wonderful.

Ross- The 9th is really bad. The 10th and 13th I can make work.

Cara- I can as well. The 10th is ideal.

Megan- I can't do the 10th in the afternoon but I can do the 10th in the morning. Otherwise I'm open on Thursday the 12th or Friday the 13th.

Dr Linning- the 13th is best for me. Tuesday I could move some things if I needed to.

Will- The 13th works, anytime.

Tina- 10:30 on the 13th, is that late enough for you Cara? Do we have consensus on the 13th of November at 10:30. We have a quorum. Unfortunately, if that doesn't work for Gladys, I guess we'll have to take her written comments. So, we will go ahead and schedule the meeting. I think the Lifesize worked for people. For the most part. I think it's worked great.

7. Next Meeting: November 13, 2020 at 10:30

Megan- Is it possible to have it in TEAMS for our next meeting.

Tina- I will let Lisa answer. I had requested TEAMS, but I think there is a technology issue perhaps.

Lisa- Yes, I think we have a problem with calling in for the public. Kathryn was that where we landed? We didn't have a number. There was

something about trying to do it on TEAMS and I can’t remember right at this moment what that was.

Tina- Thank you Lisa. For TEAMS you do have to have an account with the inclusion of a phone number for the call in and I know the rural clinics didn’t have a call in line. Although we’ve talked about getting one so that must be the problem. Megan there isn’t an ability to call in when in TEAMS so unless everybody has access to TEAMS we can’t use it at this moment.

Megan- Ok, that’s fine. No problem. I’ll figure out how to get Lifesize working for me for next time.

Tina- Ok, thank you so much. So, the only thing we have left. We set the meeting. We will have the agenda review the draft. Finalize the draft.

Tina- I don’t know if there’s any public comment. But it is the time for that. Is there any public comment?
No.
I guess we don’t have any comments.

8. Adjourn