Agenda Item 1. (Call to Order)
In-person: Ross Armstrong. Megan Wickland. Gladys cook, Tina Gerber- Winn. Elisa Cafferata. Dana Popovich On the phone: Lisa Linning. Cara Paoli. Will Jensen.

Tina Gerber- Winn

Did you want to introduce yourself?

Dana Popovich

Yeah. I'm Dana Popovich. Hi.

Public Comment:
Agenda Item 2. (Introductions)

Tina Gerber- Winn

She is the support for our meeting.

Agenda Item 3. (Public Comment)
So with item number three is public comment and discussion. So do we have anybody on the phone who wanted to offer public comment?
Agenda Item 4. (Review of the Purpose of AB387 Task Force)

Tina Gerber- Winn

So then I'll skip to number four, which is a review. The purpose of our task force. So I wanted to make sure everyone got a chance to introduce themselves more fully. And I know a lot of people who work for the department have met each other in other forms. I think it's important for people to talk about where they might fit into this scheme or what they can offer to the group as we make plans to comply with this law. So this law was developed in the 2019 legislative session and it is designed for our group to create a program to prevent relinquishment of children to custody to certain agencies that provide child welfare.

Tina Gerber- Winn

So in the state that is the division of Child and Family Services, Washoe County and Clark County. So they would all be entities who would be able to take custody of certain children and children who might be relinquished voluntarily so they can be placed into care. So DCFS and I know Ross could please speak to this better, but the NRS 433b.290 to NRS 433b.339 says that children with emotional disturbances can be treated by the division.

That the division can coordinate with private providers for their care. That could include family therapy, classes for patients, Individual therapy, evaluations, services during the day, short term residential assistance, transitional homes, and court-ordered commitment. The law requires DCFS to provide services in the most responsive manner, assuming when possible at a local level. So the law allows for some assistance with care, but it is devised to ensure families aren't feeling the need to relinquish a child to allow them to get access to that care.

So there was a report that was created based on current child welfare establishments, meaning DCFS, Washoe County, and Clark County as to instances when children were relinquished to child welfare and some duplicated accounts related to that and some stats. So I hope we can talk about that later. But really, the task force that we're on is tasked with several things. We're supposed to conduct a review and arrange for the provision of services for children who fall under this statute.

We're supposed to be working to increase the availability of such services like the ones I mentioned. So it can be therapy, it could be inpatient, placement, day treatment, short term residential. The other thing is we are to provide outreach and education concerning the program that we're going to create. So people know it exists, create

regulations as to how services may be paid, especially if situations occur when families relinquish because they can't afford to pay for care, as well as establishing clinical teams, which would provide reviews of cases for children at risk due to a lack of treatment and then stabilized them while we locate long term services.

So we have to decide what that looks like, how we find children who are going to review the services we're going to suggest are provided how they'll be paid for. And then there is an annual report that's due to the department on relinquishment, which is what we had sent out with the agenda and then an annual report to the LCB on how effective we are in our program. So a lot of ground to cover today. We need to figure out through our clinical team how to review each case of a child who's been admitted to a mental health facility, who's not subject to abuse and neglect and is at risk of relinquishment because of a lack of service access and how we're going to develop these plans of care.

So that's a heavy lift, but it's very important to figure out roles. Responsibilities our working groups, how we want to tackle it. I think each representative was noted by the director to be a strong candidate, to represent your business lines, your areas of expertise within your divisions to contribute to this effort. So it's not expected that each one of you will know how to answer all these questions. But it would be beneficial for you to be able to refer to your agency or your division and figure out who might be able to answer and problem solve.

So that is the introduction to the work we have to do. I think hopefully today we can figure out if we're going to set a schedule if we're going to have other ways to address this work separate from this meeting. Well, this will be a status check of what we're doing outside of this group. So we're gonna have to move and shake outside of our regular meetings to come up with strategies for the work we're doing. So that's an introduction to what we've been tasked to do under the statute and why you've been chosen to participate.

I kind of feel like this is mission impossible. And I don't know, there's a tape that's burning somewhere, but we'll figure it out. So that's why I would like about that since we reviewed what our group is, I don't know if we can go around and more thoroughly introduce what you would contribute or what you think you're here for. Based on the group. Goals. So I'll let Elisa start, I'll just go around the circle.

Elisa Cafferata

So I'm always to Elisa Cafferata. I'm the deputy administrator for Field Operations Support at the Division of Welfare and Supportive Services. My units include child care, child support, enforcement investigation recovery program and evaluation. Those things. I'm not the big three, which are TANF and SNAP and Medicaid eligibility, which is also done out of welfare. But I can connect with those, I think when it comes to funding streams to assist in helping to keep kids out of these placements.

TANF and SNAP are possibilities. They're not super speedy sometimes, but they could be possibilities for stabilizing these families. Child care, particularly if we have targeted reimbursements that are available for families that have children with special needs can be of help. When I went back and look at the statute, our division is not on the list of appointments. I'm just a bonus person. So those are some of mine we can go through more specifics.

Tina Gerber- Winn

Very good. Did you want to say anything Gladys?

Gladys Cook

OK. So my name is Gladys and I work with Division of Health Care, Finance and Policy that I oversee that School Health Services Program. And what that program does is bring services to the schools for children who are Medicaid eligible. Currently, right now, we provide services to children who only have an IEP: individualized education program in place with the expansion that we're doing. It will be eligible for general populations to children who are under a 504, an IEP, and the general population.

If that child is Medicaid eligible and the schools can bring the services that are already approved under a Medicaid plan, under a spot, they can receive those at a school, we will be able to pay for that. So reading what this task force is, because of the placement and the severity of these children, the mental health they need, most likely I don't see that those children, based on the severity I don't think they will be able to attend school.

It sounds like they need more intense services. However, what I can do is I can bring in some of those questions and disseminate the information to our other team. For example, we have a behavioral health unit that I can certainly take back some of those questions that we may have. That's the best way I can assist

Tina Gerber- Winn

That would be very helpful. Thank you.

Megan Wickland

My name is Megan Wickland. I represent the Aging and Disability Services Division. I am the Quality Assurance Program Manager for Developmental Services and oversee the QA teams at each of the regional centers. It's our quality assurance team that certifies the providers and we do have children that we serve that are in foster placement and we certainly do serve children that have a dual diagnosis of intellectual disability or developmental disability, along with emotional disturbance or mental health diagnosis.

You know, we can assist with that. If there's a foster family or provider to provide those services.

Tina Gerber- Winn

OK. I'm going to make Ross go last. Cara, did you want to introduce yourself? And what tools you're bringing to our group?

Cara Paoli

I'm Cara Paoli. I work for Washoe County Human Services Agency and we are part of putting together the report to talk about how many kids have come into care and our part of what we're looking at here and trying to get the correct information to keep a relinquishment from happening and trying to provide support and services to the family. I know that's something we struggle with because time is of the essence.

And usually, when families are coming to us, they're already pretty exhausted and frustrated. So it's difficult to keep them engaged. So I'm interested in trying to come up with some strategies and some resources for these families and to figure out how we could try to catch them early and provide the preventative services, as opposed to this crisis-driven response that we tend to care because the parents are already so far along in the process.

Tina Gerber- Winn

So as a follow- up question to describe, Washoe County does not provide direct medical care such as mental health treatment through the county.
You would have to refer families to available resources in your community.

Cara Paoli

Well, we do have a clinical team here and they provide assessments for kids that come into our services or even families that we're providing prevention, support, type services. But their role is very short-lived. It's kind of a brief strategic type of work. Then we try to help them get transitioned in with a more of an ongoing mental health provider or sometimes it's services through developmental services and getting them connected there. So it just kind of depends on what the situation is.

But yes, we do have clinicians here, but they can't provide long term services.

Tina Gerber- Winn

OK. That's what I thought. I just wanted you to say it out loud. In case people didn't know what was available based on each county. It's very different from what they can do. So, Lisa, did you want to introduce yourself full description?

Lisa Linning

Essentially I am the manager of clinical services and also of the foster care program there at Clark County Child Welfare Family Services. So I am the person who oversees all of our contracted mental health services, we have a small clinical team compared to the size of the agency. We have about fifteen clinicians here. So we do some crisis response to Child Haven our emergency shelter in coordination of referrals. I have some of my clinical teams are the ones who provide the parent coaching for advanced foster care programs, which, helps to stabilize some of our most intensive kids in specialized foster care. Others on my team are overseeing any of the RTC placements, that two placements according to mental health court and then really managing most of the referrals. We don't do any direct therapy services within our department. We have contracts that are set up specifically to ensure that our kids get a referral to a provider in the community, which then gives them that continuity of care once they leave our services that they don't have to shift necessarily to somebody different.

We partner a lot with it, the DCFS here locally with early childhood services or with DRC if we've had a child that needs to be considered for their eligibility or their ongoing services. So most of our mental health-specific are referrals to community providers.

Tina Gerber- Winn

Thank you. OK. So, Ross, do you want to go for it?

Ross Armstrong

Sure Ross Armstrong, Administrator for DCFS as kind of a two-pronged role in terms of we provide the direct child welfare services for the counties other than Washoe and Clark. We also have the Family Programs Office, which is the kind of the policy shop for the state for lack of a better word, like a child welfare authority type of thing in terms of helping to coordinate how the three different entities getting some consistency and making sure we're meeting all those federal standards and technical assistance as those agencies need help as directly related to this particular task force, I did work with the sponsor on some amendments that allowed us some time and put some data reporting requirements before putting together the clinical teams so that we could use that data to inform that decision. And so there's kind of questions about where maybe the sponsor was thinking of. I can try to speak on her behalf in terms of the conversations we had with her or, you know, reach out to her and say which way do you want us to go.

But so just I think in terms of setting some good clarity when we're talking about relinquishment and the purpose of the task force, it's not to necessarily address all youth in foster care with mental health needs. Relinquishment very specifically means that the parents have given up their legal rights to the child. The child is free for adoption. There's no longer a legal relationship between that parent and that child. So that's the legal term of relinquishment.

We had the bill amended to include voluntary placement into a child welfare agency, which is listed on the data chart as NRS 432b.360. So there is a statutory provision where a parent can voluntarily place their child into the custody of DCFS for purposes of services, which is unlike the involuntary placement of children, say if we go out and determine there's abuse in the child's not safe and take the kids. So that's the universe we're talking about as there's no abuse or neglect, but there's a struggle there in the family they've either decided to completely legally give up their child or temporarily place the child in the custody of the child welfare service.

Tina Gerber- Winn

Thank you. Anything else?

Ross Armstrong

No, I think it was interesting to see the numbers and kind of the breakdown of the numbers. I'm excited to kind of come up with a system. So it's not just by onesies. I think Cara was the one who talked about the crisis mode of what are going to do to help this family. And there's not a real clear path. So,

Tina Gerber- Winn

OK, so this is Tina. For the record, I am an agency manager with Public and Behavioral Health. So I oversee rural clinics, rural clinics. It is the mental health service provider in rural and Frontier, Nevada.

So we serve all of the area minus Mesquite and Laughlin, which are managed out of SNAMHS southern Nevada adult mental health services our 16 clinics, provide mental health counseling, psychiatric services, and medication, rehabilitative mental health services as well as case management. So one of the things that we partner with DCFS on is to create a mobile crisis response for children in the rural areas. It's not available 24/7, but it is seven days a week. Notoriety is that there a national synopsis of mental health services for children to talk about even the fact that we have a crisis response and it is by Telehealth, the diversion rate to hospitalization is about 86 percent.

Part of what works for that service is the follow-up, not just the mitigation of a crisis, but to have follow up contact with families and help them find service providers. We have found service providers for the children that we've screened or assessed. A lot of the services are via Telehealth. The key issue is really to connect families with service providers who affordably are under their insurance benefits so that they can continue to keep their children in care.

I know that probably if we did follow up on some of the families, the success we feel initially may not be there ongoing. But I think if you're in mental health treatment, it is stop and start kind of thing until you figure out what works for you. Hopefully, families working together can sustain that. So that's why I'm here because we do have people who could be available for the clinical team reviews or even just to fashion a service plan for families when we get to that point about how we structure an intervention to help a family stay together. I think case management or follow up and knowing the lingo to access services is essential for anyone to be successful and teaching parents that, there's a lot of community groups that do that well. But I do think that we see people in crisis. It's overwhelming. We have to teach them in a manner that allows them to learn and then use those tools ongoing.

So that's why I'm interested in the clinical teams and how we as a group would create a response to the community. I do believe rural clinics, we have done a lot with our quality reviews. I understand there are many deficiencies, but one of the things that we try and address is hard to treat individuals where places were failing or not feeling as competent to serve clients. We schedule MDT or multidisciplinary team meetings. We've called in ADSD for seniors, called in ADSD for people with intellectual disabilities, called in DCFS for kids who need wraparound services. We had a child out in Elko who needed to be placed in a long term facility, but he turned 18 and there was a whole bunch of nuances to that and as a teen, we worked to get him placed. It took four months. So I think to realistically set our plan in-game for people, sometimes it's going to take us a while. But the commitment to whoever we screen through our clinical teams will be something I hope we can add to our thought process and whoever we choose to be committed to our work.

I think strong, powerful people in the room that can either answer questions or find people to answer questions, as I said. So I think that's a pretty clear consideration for what we have ahead of us. And I do appreciate what Ross said about talking to the bill's sponsor. I did exchange e-mails with her and didn't have a chance to talk to her yet. So I can let her know what we've decided today and if she thinks there's things we're missing, then we can circle back at the next meeting. So I think that's enough for a number four and

Agenda Item 5. (For Possible Action)

Tina Gerber- Winn

number five for possible action. I would hope that if we review the report together and I'm going to ask for a volunteer to explain it to us a little more thoroughly, and then if we wanted to make any kind of question or follow up item to see if there's more clarification we need or if there's anything else we want to do with the report. I'm not

suggesting there is follow up needed, but I want us to give it the opportunity. In case we wanted more information. So I'm not sure who wants to explain this report to us. I know that Cara and Lisa worked on it and one of Ross's staff. So I'm not sure who wants to go.

Ross Armstrong

This is Ross. I can walk through, so I think the first page is just an explainer of what the bill required that the different child welfare agencies wanted to capture the issue in some cases beyond necessarily the letter of the statute. Some breakdowns may not necessarily be what's in the statute but are also that similar thing, which essentially parents giving up some or all of their rights just for the pure basis of wanting access to services. If you take a look at the data on page two of that report, you can see it broken down by region, Washoe County, Clark County, and the rural region. There was some my understanding there was some conversation that the different entities, the different regions use that 432b.360 very differently. That would be an area that I think would be interesting to take a look at why-

Tina Gerber- Winn

And not to interrupt you. But that's the voluntary relinquishment?

Ross Armstrong

Correct. That's a temporary placement temp. So, yeah, it's not the full-blown relinquishment, but the temporary placement in the agency. Then you see refusal of custody financial. That would be interesting to dig into the refusal of custody, not willing and I think, Dr. Linning or Cara can probably speak to this. But my hunch is that they're at an out-of-state RTC or they are at desert willow and the parent is refusing to pick up the child, even though they're ready for discharge because they can't handle the behaviors at home. Guardianship is where they've not necessarily given them up to the state, but to some other entity and then adopted if they've done a full-blown relinquishment of their parental rights, then they are free for adoption.

I would say and it's not on here, but one of the things where we wanted to make sure is that what I have seen in the past in terms of the most common relinquishment of parental rights is a kid who has been in the system involuntarily because there was abuse or neglect. The parent hasn't been able to get their act together. But there is an agreement to do an open adoption. And so the parent relinquishes so the kid can be adopted by a specific person and there's some sort of open adoption agreement where there can be contact.

So these relinquishments are just in terms of, I can't handle the youth. Then there's the current status of relinquished children. On the top chart number, eight is more of a data point that's going to be important to watch as we set up whatever our response will be to see that those numbers hopefully increase and the numbers of completed relinquishment go down. So they are required there was a pretty quick turnaround on this first set of data. They worked together on it and then there's an annual submission of data to the director after that. I think it is possible, for example, that refusal, of custody, not willing, is the biggest chunk there. I think that if we need or desire any data to get drilled down in terms of age, gender, whatever we might want on some of these particular ones, we can certainly request that from the Family Programs Office and they'll help coordinate that.

Tina Gerber- Winn

So Lisa and or Cara, did you have anything to the description?

Cara Paoli

This is Cara, I think that was a good description of what this entails.

Lisa Linning

I had the same thought.

Tina Gerber- Winn

I'm curious, do people know what prevented relinquishment? What structure of intervention or conversation was had to prevent a relinquishment?

Cara Paoli

I could speak for Washoe County. So we have that couple of program assistance here that are kind of our contact that go to, one for post-adoption potential disruption and the other work for families when they request assistance and they need guidance or there are others on our clinical team that do that as well. But we keep kind of our go-to if they're not requesting clinical assessment or evaluation or services that it needs some guidance and some assistance maybe. But even knowing which facilities to reach out to, those kinds of things. So when he gets involved, he kind of assesses where things are at and we try to push services right away, either clinical services or whatever it is that they're requesting. If we have a referral to a community provider, you know, we try to help make that connection and we'll schedule meetings to sit down and talk about what the issues are and what it would take to try to keep that child and the family intact. So that's kind of what it looks like. And I can't say we have a policy or actual procedure because it's different, you know, situation by situation. But that's kind of what it looks like. Usually, there are clinicians involved and division directors, and sometimes they'll come into voluntary services to see so we have a more formal process than caseworker involvement there. But it does depends case by case.

Tina Gerber- Winn

Thank you for that.

Lisa Linning

This is Dr. Linning, ours is somewhat similar. The piece that I will say I mean, just even from the sheer numbers of kids that we have here in our region, you know, it's hard for us to know how many of these situations are even ready to happen or that do somehow get prevented because they don't necessarily come to our attention in the clinical department. And so, protective capacity of some kind is taken. The piece that I will say is that because my clinical team oversees all of the RTC placement there, the acute setting, the organization and the facilities that we work with pretty regularly if they have a kid from Nevada at their facility and they don't see DFS listed, they sometimes will touch base with us and say, hey, you know, they're careful over confidentiality, but they'll say, hey, we've got this child and we're not sure who's helping with them. And we're now not able to get a hold of the parents or something. So sometimes they will tip us off that something is going awry. The parents struggling or there is a challenge. Then my clinical team will help them know who they can contact and make contact with the parents sometimes if that's what's needed. That is sometimes the only way that the kids that haven't come into our custody even come to our radar.

I think that's the piece that is going to be a little bit challenging for us as a team is to figure out how we identify where some of these kids are so that they don't necessarily come into the system because I think there's probably a lot of preventative work that can be done if we know who they are.

Tina Gerber- Winn

Right. Agreed. I was thinking, as you're talking, there is probably a lot of information sharing. This is Tina, by the way, to prevent things and we're not counting them. Is it safe to say the children who we represent in this report, their families come to our attention because they're in the highest level of distress? I mean, that's my assumption, but I don't know.

Lisa Linning

I would say that put them on the radar in many cases, whether it's a school that identifies they're in distress or some other sort. But again, I think there are probably several kids that we don't know about, for instance. I'll just mention Dr. Shannon had to get off the phone. She got an emergency with one of our children. But I can just reference that for her at DRC. I was at DRC for a number of years, and it was so often the case that we might have a child in our

developmental services getting case management and support. And then because of the mental health care, a lot of times the parent would then say, look, I can't pick them up from an acute setting anymore I'm just exhausted, they are a risk to my other kids. And so sometimes that was an area where a child being served in another agency, like ADSD, might be getting services and then things escalate from the mental health side so significantly that the parent kind of throws up their hands and says, hey, I just need to get them on Medicaid or I need to get them that next level of care because maybe they have culinary insurance that it only covers so much or, you know, like a number of things like Cara was saying it's families how that covers. But that was often the case is that they would have metro workers or hospital workers say, well, just refuse to come and take your child out from the hospital. They'll end up having to go to Child Haven. But then that will get them into care. So, of course, we want to prevent anything like that.

Cara Paoli

So I agree. Back to your point, Doctor Linning about not knowing how many we prevent. That's true because our caseworkers are probably doing that on a fairly regular basis. So that data is going to be kind of difficult to capture.

Tina Gerber- Winn

So one suggestion that I heard Ross say is there might be a few areas where we want to look at it. And I'm not sure if we do at this point or not. But refusal of custody, not willing. There's seventy-five children in Clark, eleven in Washoe, there's a term when they don't pick kids up from treatment. Someone sent me a report and I can't remember the name, but that's we need to get into all that lingo. Is it beneficial for us to figure that out? I think for eligibility reasons. That's why Elisa is here. There's a reason why they couldn't cover benefits or they're not qualified for another type of service program. I don't know. That's going to be what we look into anyway when we review a few cases. So I guess we could wait to see if we need more specifics. I wondered which cases are we going to review? Do we want to do a retrospective review on a case to figure out what happened?

Ross Armstrong

Yeah, I mean, my initial thought would be is what was interesting to me, when you take a look at interesting slash, sad when you take a look at some of that, maybe the timing. But at least for rural and Washoe and about half the ones from Clark. You know, those that have been relinquished on a refusal to custody match the numbers that are still in foster care. So they've been relinquished and it's not like they've been adopted or we've found a solution. They're still hanging out in foster care. I think it would be interesting if we requested the Family Programs Office to provide age data for those top three numbers are the reason. So age data for those top three under the under section A. And then specifically for section three, the refusal of custody, not willing, to get a list of the diagnoses of those children to see if there's a pattern there. If there's a particular diagnosis, we're not able to meet. I think that would help with some next steps and then perhaps request from the different jurisdictions two or three cases and maybe it's like one from the rural region and two from Washoe and four from Clark. But the ones that those child welfare agencies perhaps struggled the most with or think there should have been an easy solution, but there wasn't. Those might be the ones we review.

Tina Gerber- Winn

So the motion I heard there was that we would go back to. Would it be Kathryn?

Ross Armstrong

Correct.

Tina Gerber- Winn

So we would go back to Kathryn Roose from DCFS to ask for clarification, age data for those children under NRS 432b.36 refusal of custody financial and refusal of custody not willing, as well as a request from each jurisdiction meaning DCFS, Clark County, and Washoe County to provide two or three case examples for our review. And

obviously, that would be identifiable information for us to review and analyze. So that was the motion and I did, my paraphrasing. I hope that was correct so I need a second.

Elisa Cafferata

I'll second.

Tina Gerber- Winn

So I have a second from Elisa, is there any discussion to clarify what we're asking for or any other comments?

Tina Gerber- Winn

OK. So we will vote, all in favor say "I".

Tina Gerber- Winn

OK, so the motion passed, so Dana and I will work on how we're going to ask people for that.

Will Jensen

I was on mute. I apologize. I got confused on the phone call- in this is Will Jensen, hi.

Tina Gerber- Winn

Oh, hi. Nice to meet you on the phone.

Will Jensen

Nice to meet you. I'm so sorry to be late.

Tina Gerber- Winn

Oh, that's OK. We introduced ourselves and the purpose of our group. I hope you're picking up the gist. And if not?-

Will Jensen

Yeah. I've been on for quite a few minutes, so I felt comfortable voting on that motion. I had heard most of that.

Tina Gerber- Winn

OK. So then we at least will do the drill down. So that's good. We got our action for that item and we'll get some more data to consider. I would hope we can try and get it sooner before we meet. And we'll talk about that. So people that have a chance to review and add some comments or concerns.

Agenda Item 6. (Developmental Steps)

Tina Gerber- Winn

So we'll move on to the next item, which is pretty big. Our next steps and I don't know people how we want to address this, but we have to figure out and maybe this is a bad strategy. And I'm certainly welcome to any suggestions on how we're going to figure out our program design. Maybe I should have just said that. How do we figure out our program design to conduct the reviews to increase available mental health services? Our plan for outreach and education, so I'm assuming we can do that after we figure out a program if we're going to have any regulations and then our clinical team development. I'm just trying to figure out what makes the most sense to people where to start.

Cara Paoli

Tina, this is Cara. And the other thing we talked about when the group first met before we got this far along was coming up with that common definition so we're all operating from the same place. Then there's going to be some need out of UNITY to be able to track this consistently. That was another thing we talked about. So I don't know, maybe Ross. I don't know where that fits in with everything else on the agenda.

Ross Armstrong

Yeah. I mean, I think certainly in terms of that outreach and education plan, I mean, if there's changes that need to happen in UNITY so this can be more easily tracked. We can certainly invite them to a future meeting to discuss that. I think getting that additional data will be helpful in terms of what the cases look like in those case reviews that may need to occur before we attack these particular four items.

Cara Paoli

Yeah, that would be helpful. We talked, for instance, about when you went through with their relinquishment and kind of the coding that is on that sheet you reviewed and we talked about how we would code that through UNITY. There's a couple of different codes that we could potentially use. But I think that's something that we will need to decide so we're all doing that consistently the same when we're tracking going forward. And those for removal reasons and those kinds of things. There's a couple different ones that I think the county and state people need to decide on so that is consistent.

Tina Gerber- Winn

For clarification-

Ross Armstrong

How staff input these instances.

Tina Gerber- Winn

The common definition in the data system is one thing from somebody who wants to identify a potential candidate for this service. How would we go about that? Is that a discussion that we have today, just to put in words what we look for, what we would see as the common person or child who we would refer to our program for review or assistance? I still don't I don't know enough about the intake process or all the programs. And I don't want to get into all of the nuances of child welfare at all. But to segway a child into the right arms is what we're talking about. So how would that work? Is that too large of a question?

Ross Armstrong

I think maybe that is something that when we ask for those case reviews, when we ask the counties to provide the counties in DCFS to provide the cases for us to review, perhaps we send a list of questions like, is there a particular point in the life of this case you wish you would have had this, in my mind, is always like the red phone like I need this placement team to convene, all the agencies involved need to agree to send decision-makers to that team and there needs to be, you know, execution of a plan and in my mind, that's where the regulation development because I've been trying to think about how exactly you would do regulations around this particular issue. And I think a lot of it would be around this is how you trigger the multi-division team. This is how this stuff gets paid for. And there's a time limit on coming up with a solution.

Tina Gerber- Winn

OK. That sparks we can talk about it for hours, but I know we don't have that much time. What are the things that strike me in what you said was who's our client? And it is probably anybody who has a child who doesn't know what

to do with that child. That's what it's going to be. And the triage to that would be how do we make sure they get connected to the right person? I don't want people to think about what we want to do is rule out the people who are going to help because there's somebody else who should be helping them already in our minds. I think that's why people end up in the situation where they're at with social work and its escalated to the point where it's beyond their control. So that's why I was really curious about the eligibility piece. I guess I agree with you in the sense that if we review the cases, we'll know what the parents. Hopefully, we'll get some idea of what the parents of the child tried to do before they got to that point of being relinquished or not picked up from a facility. Hopefully, we'll have some of that information in a case record to decide. Like you said, where it went wrong. It's really hard to figure out where to bite it first. I think one of the things, too, is our team has to come up with a treatment plan to serve a child until we figure out a permanent care arrangement. That was what is stated here. So do we need to do an eligibility evaluation of the cases to figure out if they would have been eligible for something else, whether it's a home and community-based service, a Medicaid standalone service, whatever that is I don't know? And then and/or an eligibility program through welfare.

Cara Paoli

I think the issue is the severity of need. I'll just speak from my experience that the kids that we're identifying here, our kids are very complex behaviorally and several have multiple diagnoses that fall into behavioral health and also developmental disability. So there's the back and forth of what system do they belong in? Are they rehabilitated or debilitated? If so, to me, it's not a mystery how they come to us because it's almost every time exhausted parents that just can't handle it anymore. After all, they either think the services we're offering are insufficient or that it's not able to provide the amount of respite that they need to make it work within the home. So and you're right, if we go back and analyze the case I'm thinking of is you're asking for a case analysis is one that we're involved in and the children's mental health through NNCAS. It's somebody right now who's the child in an RTC in the Midwest and not doing well. So, I mean, I think we can get an understanding, but I don't know if any of us feel like we need to dissect that piece. So I'll just put that out.

Lisa Linning

I agree with Cara. I mean, every single case that I can think of that I would identify as some of the most severe have both a developmental piece and mental health piece that we can continue to connect with, how to sufficiently provide them services. And then, you know, again, the experience I had within the regional center system is you might get some of those supportive things in place. But if the family doesn't have Medicaid or they don't have sufficient insurance to provide a more intensive or higher level of care, they just don't have access to it. And so a lot of times that's when a family has relinquished to try and get them on paid-for service Medicaid so that they can go to, you know, an RTC to see if that's what's needed or just some more intensive services. I agree. I mean, I don't need to fill out cases to know that those are most intensive. I know. You know, those are the ones that we need the most help with that we continue to disconnect with. And this is

Megan Wickland

Speaking to that as well. Those are our hardest children that have that dual diagnosis. You know, we're trying to provide the supports that we can to the family, but oftentimes they are at a loss at their wit's end and trying to they oftentimes don't qualify for some of the mental health services because of their diagnosis with developmental services and so it's a gap. I think that we have in our service system that we need to fill.

Tina Gerber- Winn

What have you done in cases where there is a harder to reach a solution? What in ADSD do you do to implore others or make opportunities available for service access?

Megan Wickland

Well, I think, you know, it's situation. You know, it's case by case. I mean, there's times where we're trying to prevent children going to an out of state, residential treatment center because they don't typically qualify for the ones in the state oftentimes and just trying to provide those supports in the home where we can. But sometimes they

do end up going to an RTC because there just isn't that outpatient services available to the family. There's only so much we can do up to a certain point and when they need that more intensive service. It's kind of a last resort for them.

Cara Paoli

And Megan, can I add something that we talked about in the System of Care, that pilot project that Kathy Cavakis, kind of wrote an assessment of what the takeaways were from that group meeting?

Megan Wickland

Yes, please.

Cara Paoli

And we can share that with this group, too, it might shed some light. But Developmental Services and correct me if I'm wrong Megan, don't you have to become eligible for those services? So there's nothing offered for an immediate response to families who have children that may or may not be eligible. You have to already be in that service system to get the help? So if there's a youth that may have a developmental disability, but they've never applied to the Regional Center, they're not going to be able to get services. through the Regional Center.

Megan Wickland

Right, they have to meet our eligibility criteria and be already in our system to access services. We're not crisis response, crisis prevention. I mean, we do what we can in providing clinical supports and contracting with behavioral providers and the community to come in and support the family. But yes, they do have to be in our service system.

Cara Paoli

Yes, so that's a gap in our state services, I would say, is that there is no immediate response, like a mobile crisis for that population necessarily. I know like DCFS with their mobile crisis will do assessments. But then what I've seen is they will then say, well, they have an IDD or a developmental disorder. So we really can't assist this family so they step out the majority of the time so that the gap in service that maybe this group can address. Because that puts the family at high risk of relinquishing custody because they feel like they can't access the service.

Lisa Linning

So and then the other piece of it for those of us in child welfare, we might get a call from a family to our intake hotline. From a family or a relative saying that we need help. Going through what we need. But again, unless there's abuse and neglect It's not in our jurisdiction to even do anything. They can't even take the call. So again, this is another one of those little pieces where the law has certain components of jurisdiction. There's policies that then sort of prevent. And then, here again, this is where, you know, coming together to figure out what that safety matter, what that next referral vehicle is for a family that hasn't fit neatly into somebody's eligibility criteria and it so often is the family with that a child with IDD issues. So, that's just another piece that sort of doesn't allow a door to be opened to them. And we don't want them in our child welfare system if there hasn't been abuse and neglect. We all want to be responsive in some way to help a family get the help they need. So I'm just pointing out that that's another juncture of not having access to support.

Tina Gerber- Winn

OK, I think that's part of why Medicaid would be participatory and I know not every person on Medicaid, but case management is what we're talking about in my mind, just from the descriptions that you have to be in a system of care to get case management. But the people that we're talking about aren't in a system of care. And so they don't have an advocate or a case manager potentially. So I guess we'll find that out in the reviews. I do think the mechanism to address some of not meeting my category and we talked about this with a system of care is that for

every requirement, there is a way to create an exception. There's financial implications for an exception, but there's also a process to do it. So, for example, at Medicaid, you can do a single-source agreement with a provider who might not otherwise enroll as a Medicaid provider because they don't want the hassle, but they might want to serve that one person. So then they'll create their eligibility demands or criterion, including wage rate, length of stay kind of dialogue to allow for assistance to that one person for that issue. So that's what Medicaid does. Other health insurance potentially would be influenced by that, I suppose, depending on their requirements or risk to a child. And that is something that perhaps the group would look at as we evolve to influence coverage. I'm not wanting to get into solutions, but I think my hope is when we look at the cases and they're presented, we look at opportunities to push the limit of what our requirements are stated without bending them to the point of breaking. So if you can consider that, because I think many times those one-offs are not that tremendously off to not allow for someone to get that help. And prospectively for talking right now, 100 people, no one's bank would be broken, I don't think for that. So that would just be my request. And we look at those cases to figure out what might have solved the issue or at least improved it. I think case management straight out of the gate or an advocate who's a case manager who doesn't take no or represent a division's limitations. I think that's what always happens, is we tell people what we can do or what we won't do. But I know people get second that and I'm probably not explaining it very well. But it's really hard to get out of the defense of your system when you're representing it. So I think WIll, I don't know what Department of Education does, as far as I know in the past the Department of Ed. has an obligation to educate children, whether they're in the state or out of the state. I'm not sure what your thoughts are so far about reviewing cases and what you've been involved with.

Will Jensen

So a little bit of that broke up. I heard a little bit. The question was, you didn't know where the Department of Education was beyond educating and then I didn't hear any more.

Tina Gerber- Winn

Well, I know you have an obligation to educate students, whether they're in-state or not, depending on certain requirements for the state law. So I'm not sure how you see fit in this group. What is your role, do you think, based on what we've talked about so far?

Will Jensen

Well, that's certainly been a question that I've had. I've been listening and just trying to track it all. And I can already tell that there are some barriers to the acronyms that we use. I don't always clearly understand some of the initials that you're using. And so I'm not 100 percent sure how I'm going to fit in, but I'm certainly going to bring all of this back to my team to see how we can help. I heard the discussion regarding tracking kids and knowing different things about kids and where they're at. And I think that we certainly have a place there. I mean, if we don't do anything else, we certainly track. We track kids. And of course, we do a lot more than that. I think that I'm going to have to feel my way through this and hopefully find a place where we can do this multi-agency collaboration but I'm not 100 percent sure today.

Tina Gerber- Winn

OK. That's fair enough. So we'll remember to talk out the words and hopefully remember what the acronyms stand for. I often forget them.

Will Jensen

Yeah, it's at every meeting that I have as well by people who and I have to do that for them as well. So now I understand.

Tina Gerber- Winn

OK. So I think our next step is to hinge on the case reviews and then come up with our comments about different ways where you think we would review the needs of children for behavioral health strategies that we've used or

could have used to get them the help that we've tried with other people successfully. I think those two things would be best. And then if you wanted to figure out what type of professional you think would be on our review team based on your reviews, we're all in administrative positions with some inkling about direct service that might be fresh or not so fresh. So I think depending on that, you could be considering who you would want for a review team. Once we fill one in. Just on a side note, I think that there are recommendations and different ways to improve everything, including providing training, figuring out how to support families with education, working with providers on how to extend their scope of service in a respectful way that allows them to make money, but also allows access to care. And case management still sticks in my head like I said it three or four times. So I don't think we need to vote because we already decided we wanted to look at cases and we agreed today that to come up with a strategy to address how to get the work done is premature until we have a little bit more information to work with. So that's fair enough. Then we don't need to talk much more about it other than just commit to reviewing the cases and be ready to talk about them when we meet again. And we'll just talk without acronyms and in confidentiality about the children we're trying to discuss.

Cara Paoli

I'm wondering if we need to have a timeline, because when is this group supposed to have our work completed?

Tina Gerber- Winn

Well, I think it's never-ending.

Ross Armstrong

There's a specific date. I think that the clinical groups are supposed to be up and running. My gut says October of this year.

Elisa Cafferata

You have to do a report. That's due on or before July 1st of this year.

Tina Gerber- Winn

I'm looking right now, I'm not ignoring you, Cara. I'm just trying to figure out what it says when we have to.

Cara Paoli

That's fine. The other piece is at child welfare we have deadlines. We have a report due on July 1st that we submit to the task force. That is a laundry list of things that are listed in the bill and then we have another due date next January. So going back to figuring out how we're going to have a common definition and how we're going to track the data consistently statewide, maybe we need a subcommittee of county people and state people that can figure that out because that part's not going away. I don't know if this task force cares about that piece. But the county people do. And the state people. Does this task force need to designate who that group would be? Can we figure out what we're going to need on our own separate from this group? What should look like Ross?

Ross Armstrong

I think that Tina, as the chair, can give assignments out to specific individuals. I'm trying to think of the best way to do this without open meeting law in terms of like every subcommittee has to then follow. So I think if you're assigned to report back on that progress for the next meeting and if you reach out to Kathryn about getting a workgroup together on it, then you can. I will make sure that Kathryn helps facilitate that group at your request Cara.

Cara Paoli

Oh, great. Thank you.

Ross Armstrong

Yeah. I would be happy to be assigned to come back to the next one and maybe it won't be ready at the next one. But to come back and kind of take the lead in terms of what regulation development might look like. Because it gets all super boring lawyer type of stuff. I also think it could be helpful at some point. And again, maybe not immediately, but to get just kind of a briefing on what the Family First Prevention Services Act is going to do in terms of opening up some resources for placement prevention. It's not the cure-all that a lot of folks initially thought it might be, but there are some good contours there that might help might help these families or at least help maybe the less intense of these families so that we can focus on the most intense with our clinical teams.

Cara Paoli

Yeah, I agree with that idea.

Tina Gerber- Winn

So based on those conversations, do we need to take any action or can I just assign?

Ross Armstrong

You can just assign people.

Tina Gerber- Winn

So based on your comments Cara, I would assign you the responsibility to come up with the common definition and clarification of the reporting requirements. Is that a clear enough assignment based on what you've stated we needed?

Cara Paoli

And that I need to work with Kathryn from DCFS to get that accomplished?

Tina Gerber- Winn

Correct.

Cara Paoli

Yep.

Tina Gerber- Winn

And then the other item was Ross is assigned to guide our group about regulations to enforce or support our work. I'm trying to look here today to see where it says that we have to have our teams in October.

Ross Armstrong

It'll be whatever section talks about the teams and then you look at the very end for the effective date. So Section 5, by July 1st, 2021. So Section 5 is effective based on the bill upon passage and approval for the preparation and administrative tasks. But those clinical teams have to be established by July 1st of next year and operating it doesn't mean we can't be operating before then. But that's our deadline.

Tina Gerber- Winn

OK. So that's good to know.

Cara Paoli

And Ross I want to make sure that I have the most recent copy of the bill but section 7.5 under number two has a date of July 1st, 2020 for DHHS to submit to the director of the Legislative Council Bureau, a report summarizing information. Do I have that most recent version of this?

Ross Armstrong

Yes.

Megan Wickland

It looks like it was existing language.

Ross Armstrong

Yeah, I have to go back to the NRS 432 to see, because that was not new language that the bill created. So that's some other report, I think. I'll take a look at that. But I know that we set some staggered dates and Kathryn had some confusion on that, too so we're going to double-check with the deputy attorney generals on the dates that reports are due.

Tina Gerber- Winn

So from what I heard you say if I assign myself a task and I can talk to whoever I want.

Ross Armstrong

So here's the deal. I'm going to put on my retired DAG (Deputy Attorney General) hat. You can talk to anybody you want as long as they're not in this room or on the phone. So if we get to a point where we develop a rolling quorum or just a quorum and we're talking about stuff that this task force may take action on. Then that needs to be an open meeting. So if like let's say you're driving home today and you go, oh, you know what we talked about like the age breakdown in the data and the diagnoses and asking for cases. What would be good is this other thing. The safest thing to do is to just send all that information to Dana as the staff member, and then she can get with the chair and she can help facilitate communication without necessarily having to trigger the open meeting. But you can go back and talk to your rural clinic's team and all that, that rule about having those rolling conversations about these items and not creating a quorum only applies to the people formally appointed.

Tina Gerber- Winn

OK. I'm confused about what some of the systems of care look like. So my question would be, for example, to Megan and say, what assessments do you use? What questions do you ask? Is that not a good start, a way to address it? It needs to come here and we talk about it.

Ross Armstrong

I mean, if you have questions that you need answers to that's on the committee. Send them to Dana.

Tina Gerber- Winn

OK, I just am anxious about the progress time. But we have until July. But I know we have kids who need us to figure it out sooner than that.

Ross Armstrong

And generally, information gathering is not covered in open meetings it's a carve-out. It's just requesting that information and then like discussing where should we go? That gets a little trickier. And if it's one on one and you're not going to then like take that information to the next person and then to the next person to the next, then you're fine.

Elisa Cafferata

Could you send an email to Dana and whomever saying, could you bring this information? You can provide this information and that way it's happening and there's not a second staff?

Tina Gerber- Winn

OK. We could do it that way. I'm just anxious because I think people get nervous about what they should offer up. I think any possibility you should offer up as far as something for us to consider. So I'm just saying that out loud. That would be my request is if you don't do it now. I think everybody in this room has had opportunities to think. I wish we did this in my agency, but we don't. And those are the ideas, I think, that will help us figure out another alternative perhaps for assessment or questioning. So I think about diagnostics. If someone has the wrong diagnosis, they're blocked from getting care. And if that diagnosis is wrong, then we've cut them off from a resource. But we as a group potentially could have someone re-evaluate a child and clear off a diagnosis that stands in the way of access to care. And I think those are the things I want us to think about.

Tina Gerber- Winn

So next steps that we assigned, our regulations and Cara is going to work on the clarification of our population or titling, what do we call it? So I think we close out this item.

Agenda Item 7. (Selection of Vice-Chair)

Tina Gerber- Winn

Seven for possible action. Do we need a vice-chair? I don't know how these work if somebody else wants to take over if I'm not here. The discussion for future agenda items is next. But the reality is, I think we need to decide the frequency of our meetings so we can talk about that in eight. But I don't know if we need a vice-chair or who fronts the meeting in case something happens and I'm not going to be here for whatever reason.

Ross Armstrong

I think it is a small enough group that if you're unable to make it, you can just designate someone to chair that particular meeting. I think in larger public bodies where you have lots of political jockeying and if somebody wants to be the vice-chair versus a committee chair over there, I think that's more important. I don't see a need.

Tina Gerber- Winn

OK. So then if everyone agrees and there is nobody. As long as everyone understands it, you might not expect me to call you. And I will. I'm not even joking. I might just pick somebody, I think. OK. So everybody realizes that I might call you. I won't do that if I can avoid it at all possible to be in charge of the meeting. OK. So we'll move on to the next one then because we don't need to vote. Do we need to vote on that?

Ross Armstrong

No, only action, that was inaction.

Agenda Item 8. (Discussion and Identification of Future Agenda Items)

Tina Gerber- Winn

OK, so I passively agreed to be in charge. All right. So then future discussion identify a future agenda items. I think the frequency of our meetings needs to be decided. I want people to say they will attend or they will make sure their

information is here regardless of whether you attend. So if we want to say month to month, I know there's some anxiety with other people who have reports and want to draw conclusions that will help with other operational concerns. So I found a month seems like it passes fast and six weeks is adequate, but it doesn't matter with our frequency, we'll end up slammed at the very end to kind of put stuff together. So any suggestions on the frequency of our meetings?

Dana Popovich

I would suggest six weeks just because of the open meeting law. So we have a little bit more of a buffer to make sure we get all of our agenda items and that we're out in a timely manner.

Tina Gerber- Winn

OK, so what do people think about that? Six weeks.

Lisa Linning

I would just suggest that we not wait quite that long while we're getting started because July is going to be here tomorrow. So, maybe we meet in a month then we have the definition ready that we've got some additional tasks assigned that people can start working on because I think we are just kind of just throwing away time.

Cara Paoli

That makes sense to me. Tina, are you planning to send information on my case presentation, the review that we're going to be doing? Are we going to send information out to everybody? Or is each person going to kind of present on what that looks like or what do you want that to look like?

Tina Gerber- Winn

So my mind is review form. We do one for an MDT meeting that talks about the history of the person in our system of care it could be when they entered their living situation, diagnosis, treatments being offered, episodes in and out of care. If you have tracks of that. I don't know if you would have all those things. I'm thinking of an MDT meeting form that we use to prep so we can talk about a case. It's a summary and you might send your records related to it or so we can review the records versus your impression of the records.

Tina Gerber- Winn

So a summary sheet and then related documentation to those topic areas. I mean, I can send out or MDT form if people agree that's what they would use as a starting point to frame information presentation.

Cara Paoli

That sounds good to at least get it kind of cohesive.

Tina Gerber- Winn

OK. So do we have to take action on all these things? I'm a novice at this.

Ross Armstrong

I think that, if you get the form to Dana, then she can get three child welfare agencies and say, this is the information we need on...

Tina Gerber- Winn

Right. And then ancillary backup documentation. OK. So that's how we would present the cases. So I can send that to Dana the form that we have for the MDT and she can send it out to you. How long will it take to prep those cases?

Cara Paoli

I'm thinking. You know, part of what's going to be valuable, looking at kind of the initial point of contact and then kind of how I progressed into a relinquishment more than anything. So I'm wondering, because we're trying to figure out, at what point did they decide to relinquish. So I'm wondering if maybe we need to provide a bullet point timeline and then a little summary that might be valuable to this group.

Elisa Cafferata

I have a question. I was trying to reread the statute this afternoon but I was having a hard time, my impression from reading this statute was there's sort of two groups here. One is this group of folks sitting here who are kind of making policy and programmatic recommendations. And then there's a clinical review team which is reviewing cases. And we're not the ones reviewing cases per se. We need somebody to kind of glean out from that as we looked at these 10 cases and here's what happens. Once you hit diagnosis three, you know, then you just so don't fit in the system that it's impossible for the parents to navigate or something. Like, I do not feel personally that I could sit here and listen to a bunch of presentations of cases and go, oh, here's a problem because I don't know enough about any of these systems. I will be sitting here going, that's fascinating and horrible. Somebody should do something. So that's my confusion. I don't know if there's a way to get those teams that have those because we're supposed to appoint or you're supposed to appoint I think a clinical review team.

Ross Armstrong

Director Whitley is supposed to appoint

Tina Gerber- Winn

So that team is supposed to go through every one of these cases and come up with a care plan for 90 days. I mean, that's like intervene in actual service. I don't feel like I have maybe the rest of you feel like you have that expertise. So I'm just a little confused about the different pieces.

Cara Paoli

Let me interject as well some of the situations that we may be talking about. They have no mental health history. Some of them haven't even been diagnosed. So it's more the fact that the parents are running into roadblocks. I don't know at school or at treatment centers or wherever they are. They would have to tell us where they feel they're running into roadblocks.

Lisa Linning

So to me, the main thing that we're trying to get out at this point isn't so much about a mental health review but what are the barriers that are getting parents to the point where they're throwing their hands up?

Ross Armstrong

Maybe we'll tweak it because it would be a little bit different than the MDT one. So maybe we'll get that and kind of massage that with our child welfare staff. So I think the idea of bringing in some cases was more to be like how does this happen. So it would be less of a focus on the clinical staff. I mean, I think it can be helpful, especially the difference between the mental health or a DD diagnosis or the combo. But I think we can tailor the information we request from the child welfare agencies to be focused on like how does this happen? Right. And that would be helpful to us.

Tina Gerber- Winn

We don't have to follow the MDT format. I just wanted to give some idea of what people could think about that impacts access to care. And it doesn't have to be medical care per se, although most of these situations are related to that.

Lisa Linning

I'm just trying to get to the heart of what we're trying to do.

Tina Gerber- Winn

And I think what I'm hearing developmentally is each person here is at a different phase and seeing how they could fit into that because it's a complex solution. It's a large problem that it's going to take multiple types of service systems to address. That's why everyone's here and seeing how your system impacts a child. Consider How does this impact what did our policies could what could have prevented? Whether it's outside your range or not. I get that's a feeling people have. But you also have colleagues that you could ask questions of to say, what would we do? How would we run it? I've often gotten questions about how does your agency run? And I go, hey, just a second. And then I later I go ask someone and then I have that information. I think the strong suit you have and what the director usually does when he picks people is seeing the capabilities you have to solve problems outside of your typical realm. So that is your task, regardless of whether you feel confident in that. That's what our tasks are. So I don't know all the answers and I'm not sure that anyone can. But we kind of want to know who are we trying to help. So these case reviews will give us an idea of the people we're trying to help. If nothing else, then spark who we are going to pull back. So I agree with you. Then we have to decide who's gonna be on the teams. And each agency might have to or division contribute to the teams because I can tell you they don't exist. Otherwise, we wouldn't have this conversation. So that's the thought process. OK. Then I have an eligibility specialist or someone who knows how to access medical benefits for pharmacy coverage, which we have people like that. That might be part of our clinical team. So again, for the next meeting. So we're saying it's something we have to continually commit to attendance, finish our assignments. And this is probably things you've heard before and that we set the frequency at a pace more initially intense and then we can wane as we get skilled and we have our clinical teams situated and our data understood. So we said six weeks? Can you do four?

Dana Popovich

Yeah.

Tina Gerber- Winn

If we send out an email to everyone and people answer to Dana when you're available. I don't know if it's fair, but I said follow Ross's schedule because she can see it. I don't know if that's fair.

Ross Armstrong

So that'll be the week of March 23rd for folks. Okay.

Tina Gerber- Winn

So let's decide.

Ross Armstrong

And Mondays out for me and Friday is rough.

Megan Wickland

We just want to do Wednesday again.

Ross Armstrong

I mean I can do Wednesday. That works at 3:00.

Tina Gerber- Winn

So March 25th, 3:00 p.m. OK. Then we'll do the same scenario of call- in and face to face. So it sounds like our agenda items for sure would be the reviews. I mean, we'll have our introductions, review of cases. What other items do we need to put on the agenda? The update on the reporting. Is that going to be plausible to give a status report on, the work that Cara is leading to clarify the name or?

Cara Paoli

I don't know if we'll have anything done by then because we'll probably take a little time to get everybody scheduled.

Ross Armstrong

I think if it's an in-fill item, then at least if Cara you're running into struggles and haven't had a chance to tell me, you can tell me in the meeting and I can get people in line.

Tina Gerber- Winn

What do you want to call your agenda item Cara, you said common definition. Do you want to be known as that?

Cara Paoli

I would say definition and data collection.

Tina Gerber- Winn

OK. And Dana and I will decide on the order for entertainment and cohesive discussion. And then, Ross, would you talk about regulations? Is that too soon?

Ross Armstrong

I mean, I can talk about the regulatory framework. I don't think we'll be ready for regulations probably until summertime in terms of what we would want to put in them.

Tina Gerber- Winn

I agree. We can't do anything with regulations anyway until then.

Ross Armstrong

Yes. And really, I deeply appreciate the ability to do regulations when they're statutes. As I just initially think about it, I would think anything we could put in regulation could easily just be a directive from Richard. In the meantime, while we're working on actual regulations.

Megan Wickland

OK. And I just have a question. So when can we expect to get the file reviews for us to review? I don't know how in-depth they are, how intense it's going to be like.

Ross Armstrong

I think if we said, you know, hey, send us some information on one or two. These are the top 10 things we want to know, which is I think Cara hit it. We're not talking about what happened after relinquishment and all that stuff. It's that front end of the case. I mean, I think if we say give us one or two good samples of how this happens, that would be doable within four weeks.

Tina Gerber- Winn

Yes. I think Megan's asking to see them before. Correct?

Megan Wickland

Are we supposed to review them before? That was what I was hearing. Are you reviewing them here as a group?

Tina Gerber- Winn

Well, conceptually, I thought if people had a chance to really look at them before the group and then someone could present them and then we could ask some questions. So even if a week before the meeting,

Elisa Cafferata

Before would be helpful but then it raises a question to me of, you know, open meeting. Is this confidential information?

Ross Armstrong

We will ask the DAGs to see if we can do it.

Tina Gerber- Winn

We'll just do it in the meeting.

Elisa Cafferata

Even in the meeting, it's public, you cant reveal confidential child welfare information, just because you're doing in person.

Tina Gerber- Winn

Well, we're not talking about releasing confidential information.

Ross Armstrong

There may be a way to go into the executive session or I will check with the DAGs to make sure that we're doing that right. Because the Dag's may just end up saying you're safer to not have any of the actual information yourself, but have Washoe and Clark and the rural region show up and say, in case, A, this is what happened, in case B, this is what happened.

Lisa Linning

I mean, it's common that material gets sent out before meeting so that people have them available. So the issue is that we don't discuss it amongst each other until the meeting.

Elisa Cafferata

The other issue is if there's personally identifiable information, we can't. Discuss it in a public meeting. If there's confidential information if there's health information like we have to figure out a way to identify.

Lisa Linning

You can't share that anyway with a group like this.

Megan Wickland

So that is my question is that if we're trying to identify if the diagnosis is an issue, so if we're talking about individuals that qualify for developmental services and also have a dual diagnosis. So are we saying that we can't say Child A has a diagnosis of intellectual disability and emotional disturbance?

Lisa Linning

As long as you don't name them or even their actual initials, which would be impossible to really, truly track down. I mean, it's common with sharing clinical records for kids you don't identify any name, date of birth, you know, anything that's so specific that somebody could figure out who it is, but the general parameters. You know, parent tried to get service, say and it wasn't available and dot dot dot. I mean, you can give a general age as long as you don't give a date of birth.

Elisa Cafferata

Right. But again, that's sharing it with another agency that's not discussing it in a public meeting, which is what we are contemplating. I mean, I think there is a way to make sure we're doing it the right way because that's a little above and beyond what any of us normally do.

Tina Gerber- Winn

So what I heard Ross say is we will consult with the DAG's, then we'll give instructions to the group if they're going to present any information at the meeting as to how that would occur.

Megan Wickland

Or what's even sent outright? Because if it's open meeting law, the case stuff is going to go out.

Ross Armstrong

So we'll get clarity on that. And then Dana, as the assigned staff person will then take what the DAG's say and then work with the child welfare agencies to get the correct information in the right format.

Tina Gerber- Winn

OK, so my request to the child welfare agencies is to put a list or give information to Dana on what you think needs to be presented so we can get the list. That is by the A.G. that it's adequate. I can send out the MDT list as an example of what we've discussed. But that doesn't mean that's what you have to present. And then we'll get the approved list from the Aegean. What how we present that in a public meeting. OK. So I think based on that, we're going to have a couple of items that will take us an hour and a half to review and then come to a conclusion. So I don't think there's anything else we need to add to our agenda besides a support group to make sure we're not overwhelmed. I feel that way.

Agenda Item 9. (Public Comment and Discussion)

Tina Gerber- Winn

So go to the next discussion point, which is public comment. And we do have a public person here. I don't know if people want to make any comments at this point. But now is the time.

Leeah Cartwright

My name is Leeah Cartwright. I'm here on behalf of the Nevada Psychiatric Association. I appreciate what you are doing. This is a huge processing task. And if we can be a resource at all, we do have a child psychiatrist members in our association that we do tend to focus more on the adult side. I'm happy to reach out if that's something you need from a physician's perspective. Otherwise, I'll be kind of hanging out with you through this whole process.

Tina Gerber- Winn

Thank you very much. Were there other public comments?

Agenda Item 10. (Adjourn)

Tina Gerber- Winn

OK, so I think we're ready to adjourn, so we will send emails and we'll have contact on the 23rd of March. OK. Thank you.