

COMMISSION ON MENTAL HEALTH AND DEVELOPMENTAL SERVICES

MARCH 16, 2012

MINUTES

VIDEO TELECONFERENCE MEETING LOCATIONS:
NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES
2655 ENTERPRIZE ROAD, RENO, NV

AND

MHDS CENTRAL OFFICE, 4126 TECHNOLOGY WAY, 2ND FLOOR CONFERENCE
ROOM, CARSON CITY, NV

AND

DESERT REGIONAL CENTER, 1391 SOUTH JONES BOULEVARD
TRAINING ROOM, LAS VEGAS, NV

COMMISSIONERS PRESENT AT THE RENO LOCATION:

Kevin Quint, Chair
Pamela Johnson

COMMISSIONERS PRESENT AT THE LAS VEGAS LOCATION:

Julie Beasley, Ph.D
Marcia Cohen
Valerie Kinnikin
Andrew Eisen, M. D.

COMMISSIONERS ABSENT:

Barbara Jackson
Capa Casale
TJ Rosenberg

CALL TO ORDER

Chair Quint called the meeting to order at 8:45 A.M. Roll call is reflected above; it was determined that a quorum was present. Chair Quint announced that the new packets were sent in individual 3 ring binders that we are all to keep and in the future will get inserts applicable to each meeting.

PUBLIC COMMENTS

Barry Lovgren, private citizen attending in the Carson City location has some corrections to suggest for the minutes of the September 19th, 2011 meeting that we have on the agenda to approve today. He also has comments to make on agenda item #10 (policies) and item #17 (Future Agenda Items). Mr. Lovgren stated he would comment on the items 10 and 17 when they come up.

With regard to the minutes in reference to the public hearing to solicit comments to R029-10; Revisions to NAC 458, the minutes state “Mr. Lovgren added that fees and rules of practice should not be in regulation but outlined in policy. Dr. Cook responded that the MHDS Commission approves agency policies; but does not approve the rules of practice.”

Mr. Lovgren states that this mistakes both Dr. Cook and himself and it misrepresents the relationship between agency policies and rules of practice. Agency policies are not separate from rules of practice and agency rules of practice include its policies. The MHDS policies we are going to be asked to review in item number 10 are MHDS rules of practice. What I had said and what Dr. Cook had said is I had recommended that NAC 458 obtain a provision that the billing and collection practices of funded treatment programs be specified in the SAPTA policy subject to the approval of the commission. Dr. Cook said that the commission does not have statutory authority to approve SAPTA policies. Ms. Slabaugh concurred with Dr. Cook. I would like the minutes to be revised to reflect that.

The second correction is, the minutes state “Mr. Lovgren expressed concern with background checks of detox techs and that the only requirement is a high school diploma.”

That is not correct. I hadn't said that I was concerned that only a high school diploma was required. I said I was concerned that there was no education requirement at all for certification of detox techs. I would like the minutes revised to state that.

The next public comment was from Elaine Cunningham from the foundation “Follow the Dream” Cunningham Advocacy Group. “My issues today are mostly with Seclusions and Denial of Rights. I have personal experience with these things and am a survivor of this system and will not take the time to discuss all the details of my personal experience but I leave my phone number with you if anyone would like to discuss this with me. What I will speak about is that rights are being denied to clients because of hospital policies. Rawson Neal Hospital is so busy that the doctors do not have the time to take a personal interest in the clients like they should. The 72-hour hold becomes a standard amount of hold time and not an “up to 72 hour” hold. Also, the staff assumes that a person is a danger to themselves or others without justification. The worst part is the medical staff lean on hospital policy and make assumptions that put people on legal holds unnecessarily. I have a client that had a major panic attack and needed a sedative; they put him on a legal 2000 and kept him for 5 days before he went to POU at Rawson-Neal. Why?”

When I talked to his wife, I found out that all he needed was a sedative and a place to sleep and that could have been done in 24 hours. Instead of that happening his help turned into needless intervention and days of wasted time waiting. Due Process may as well not exist in the ER's the way it stands right now. I realize it is legislative and sounds good on paper but when you get into the situation, due process doesn't exist. They try to work directly with the client who is usually deeply in psychosis and totally confused and that is not a credible witness to exercise the 72-hour hold. It would only take the staff a few minutes to talk to someone else (family member) or another person familiar with the situation that could give a better account of what was happening and why the client seeks help. The doctors at Rawson Neal are overworked and they make mistakes. Also, it takes three to five days before a bed is available at Rawson Neal. In short, people are being held on Legal 2000 holds for no reason other than hospital procedure. Someone has to do something to assist with this situation. As a state, we get low grades (D-) and we need to improve. These situations are not being cited as Denials of Rights, because it is hospital policy like clients not being able to hold onto their possessions. That is more for staff convenience than patient safety. They are denied food, drink, cell phones. I disagree with not letting them have these things, like cell phones. The client can call family and not ask to use the phones in the facility. There seems to be no due process in the system anymore.

Chair Quint asked Ms. Cunningham what she would like from the Commission.

She answered that she would like an ombudsman set up for Mental Health patients, because when these people ask for their rights, they get denied. Denials of Rights are not being filed when these types of things are happening. It is instead considered acceptable hospital policy as it has gone on for so long. I have even offered to bring in food and drink and been denied because of drugs. Since this is what I do anyway, I would like to be the ombudsman. These people need me to be a voice for them. They are isolated and need comfort and security.

Chair Quint explained that no action could be taken at this time, but stated he would see if the Commission would consider putting this on as an agenda item for the future.

Chair Quint thanked Ms. Cunningham for her comments.

CONSENT AGENDA APPROVAL OF SEPTEMBER 16, 2011 MINUTES

We had public comment asking to revise the minutes from September 16, 2011. Dr. Eisen also requested that he be listed on the September 16, 2011 meeting as present.

MOTION: Dr. Eisen made a motion to table the approval of the minutes until the MHDS Administration reviews the tape from the September 16th meeting and also list Dr. Eisen as present. Commissioner Kinnikin seconded. The motion carried unanimously.

AGENCY DIRECTORS REPORTS

Commissioner Beasley stated that she was surprised going through the reports to see no waiting lists. She asked about DRC stating they have 84 in the Autism caseload number and no waiting list.

Deputy Administrator, Jane Gruner responded that the Autism Program was moved to Aging Services so there is no waiting list because we no longer have the program. We agreed to continue with the individuals that are currently in the program until the program is complete when they are ten years old, but will not have a waiting list.

Commissioner Eisen asked who oversees their waiting list and the program and Jane Gruner responded that the Commission on Autism oversees the program and Tina Gerber-Winn is the Deputy Administrator of the state agency, Aging and Disability Services.

Richard Whitley addressed the commission telling them they could request a report from Aging and Disability Services with caseload numbers and the waiting list numbers. He also stated that there are also services for Autism being provided through the Health Division, Early Intervention for children birth to three.

MOTION: Commissioner Beasley moved to approve the Agency Director Reports, Commissioner Kinnikin seconded. Motion carried unanimously.

DISCUSSION OF THE LAKES CROSSING MEDICAL PROTOCOL AND DISCUSSION OF A POSSIBLE SYSTEM TO DEAL WITH A CLIENT'S MEDICAL ISSUES.

Chair Quint gave an introduction to preface Dr. Neighbors' presentation of this issue by saying he had met with Dr. Neighbors prior to this meeting and stated how serious and important this issue is. Last time Dr. Neighbors gave a general summary of this issue, but Chair Quint has asked her to come back and continue presentation today with more specific information.

Dr. Neighbors began by recalling at the September meeting where Dr. Eisen asked for more specific examples of the impact the change in the medical status of Lakes Crossing Center clients is having on the Lakes Crossing Center staff.

When she presented numbers, she asked that we keep in mind that they are a small agency so even if the numbers are small, these medical incidents have a large impact on their staff. Secondly, Lakes Crossing Center belongs to the NASMHPD forensic national division and our state is not alone in having this problem. Other states are having similar difficulties with an aging and increasingly ill population, physically ill in addition to having mental illness resulting in another kind of co-occurring disorder issue.

What we are seeing is a much more diverse range of medical diagnoses and people coming to us that require intense medical care. For LCC that is a significant issue because unless the court is willing to discharge them to a medical facility, LCC is responsible for their care. That creates unanticipated costs and an excessive demand on staff to provide a wide range of medical care as well as providing mental health care.

With regard to transports for clients having to go to a medical facility, staff did a snapshot from December 2010 to November of 2011 and identified that during that time there were 60 medical transports, 5 a month where a client had to be taken to some type of medical facility for a procedure. That does not include transports normally done for bringing clients that are incompetent to Las Vegas, back to their county of origin after we have determined that they cannot be restored. There are probably between 2 and 4 of those a month as well as transports not uncommonly out of state to place people who have dementia diagnoses or brain trauma or things that do not qualify them to be in our civil psychiatric hospitals here. In addition to the 60 scheduled medical appointments, there were 34 appointments that were unscheduled, mostly to the Emergency Room for acute cardiac or respiratory incident or injuries. In those situations where we had to have a client admitted to the hospital, it would require one of our officers to stay in the medical setting with the client for security reasons. Nurses at \$50.00 an hour and staff to accompany the client are time and money we have not planned for.

A big part of this problem is who pays for all of this relatively sophisticated intense medical care that these people need. Approval from the counties is asked for prior to the transports, but not always approved.

About 44% of the scheduled appointments are dental, 21% are imaging and the remaining 35% are other various types of medical contacts. So in terms of staffing, each one of these medical events takes an officer off the floor. Our mental health technicians are also peace officers so they also are fairly expensive staff to use in this way. This makes it harder and harder for us to meet our policies for minimum staffing without incurring overtime. We have gone 114 positions to 88 positions; that is about a 20% reduction. We are now operating with a much smaller staff to take care of all these extra demands. Then, when they return, we may have to staff giving 1 on 1 or 2 on 1 care for that person just to keep him safe. Recovering from surgery or medical procedures and out in the open with the rest of the population requires special staff attention.

Scheduled appointments are not as big a disruption as the unexpected ones. For example, we had a client having surgery due to a diagnosis of cancer that required hospitalization for four weeks and 1 on 1 care back at the facility for several more weeks. It costs about \$5,000 a week to provide an officer for the hospital stay and that does not include overtime. So, just having the officer well exceeded \$25,000. Dr. Neighbors gave a few more samples of medical events concluding that these situations really interfere with our main mission which is to restore these people to competency.

Lakes Crossing Center has exceeded its \$42,000 overtime allotment by three or four times. Dr. Neighbors estimates that at least 65% of this is due to the staff having to take care of the needs of people with significant medical problems and hospitalizations.

Other medical experience challenges include diabetes, metabolic syndrome, cardiac problems, chronic pain and seizures. Dementia, a larger for Lakes both in that people cannot be restored to competency but also in finding placements for them.

We are also looking at the issue of increasing long-term commitments. It is just in the last five or six years that we are getting long terms commitments because the laws have changed to allow it.

In terms of solutions, we have talked about working a different way with the Criminal Justice system. We need to meet with the courts to discuss what the best way is to see these people through the criminal justice system. Especially people with dementia where it can be determined very early in the process, and we could avoid them spending long periods of time in the jail system or the Lakes Crossing Center facility. It would save everyone a lot of money to get a placement right after being arrested or at least begin the placement process much earlier than it is now.

There are also some legal and statutory concerns that could be addressed. Jane Gruner has been working on helping to get things changed so that incarcerated people may get Medicaid. In addition to that, there is a lot on confusion about who the responsible parties are for these medical costs. It would be good to clarify that with the counties and define their responsibility.

We have also discussed staffing extensively to increase nursing staff and possibly to pooling nursing resources. We have talked about using administrative staff rather than officers or medical staff for all of our care. We have talked about using mental health technicians rather than nursing staff for some of the care. Changes being considered would be to allocate our available resources more efficiently.

We would be really happy to hear any other solutions that anybody has to offer. Dr. Neighbors invited questions.

Dr. Eisen asked that we attempt to determine a dollar amount that we are spending in this inefficient method versus a different mechanism established to either bring the people to a centralized place for medical care or even for the medical to come to them. He also said we need to see if some of the trips to the Emergency Room could be avoided and handled for lower costs some other way. Dr. Eisen further asked, in reference to the counties not always paying or approving, if we could better define their responsibility and work on improving our ability to collect funds from them. He asked who in the county makes the decision to cover the medical expenses.

Dr. Neighbors responded that it is done in the Social Services department of the counties and it varies from county to county.

Julie Slabaugh clarified there is statute in NRS Chapter 433 that covers all state facilities and what it says is that any medical care or treatment that the facility cannot provide in there, is paid for by client, but if the client is indigent it is paid for by the county of origin. That would be most of our clients. There is nothing in the statute about how we force the county to pay. Currently they are paying for some of the costs or procedures, but not wanting to pay for the doctor services, some being specialists. We had a recent client with multiple sclerosis that required a specialist. So then what happens is we do not pay, and the county does not pay and the doctors end up writing it off and not being eager to treat these people.

Chair Quint commented that in his opinion it seems Lakes Crossing is the end of the line for many and they end up housing people that do not exactly fit anywhere else.

Dr. Neighbors agreed particularly with clients with dementia because there is no place in this state for clients to go who have gotten charged with a crime.

Commissioner Pam Johnson commented that the Department of Corrections is experiencing the same thing. Their aging population is younger than in the community, but yet the dementia and aging problems are increasing. We empathize and have the same medical situations, but we have physicians coming in to see the inmates. We are mandated by federal and state law to provide the care.

Richard Whitley spoke to agree with Dr. Eisen that it would be helpful to get a dollar amount to reflect these medical excursions and also agrees that the focus should be on strengthening the enforcement of county responsibility. Mr. Whitley said that maybe county social services should be contacted much earlier in the process. On the onset of the client coming to Lakes Crossing Center we should alert social services and let them know the medical condition that they will be held responsible for while that client is in Lakes Crossing Center.

The other option that we have is the opportunity to put forth a bill draft on behalf of the agency to fix the law so it does support us to enforce county responsibility rather than to continue with the deficit.

Dr. Green agreed with Dr. Eisen about his comments about sending clients to the Emergency Room. One of the things that Dr. Green has been looking at is the whole medical clearance piece and why it is always happening in the Emergency Room. It does not need to happen in the Emergency Room. We need to look at other sites and resources not only for medical clearance to be done in other places but also primary care for non-emergency medical issues that could be provided at a much reduced cost.

Also as we move toward accountable care with pay sources we are going to have more leverage with some of these specialty providers and maybe not top dollar reimbursement but some reimbursement.

Another key issue we are also looking at with EMS and Dr. Neighbors is alternative certified transportation systems. There are ways other states are transporting not only forensic clients, but other mental health clients and Dr. Green would be happy to give updates as to what our options might be.

Dr. Neighbor mentioned that we have heard about how the Affordable Health Care Act will effect the incarcerated. That could affect how we plan ahead.

Dr. Eisen suggested talking with the Department of Corrections and perhaps pooling to with them share resources to bring clients to a common place or bringing medical care in to them. We could avoid unnecessary trips to the Emergency Rooms. We could talk about pooling resources for transportation also.

Commissioner Cohen shared her experience in a past Director of Nursing position in a geriatric facility, 20 years ago where they set up their own medical clinic within their own facility. It was relatively inexpensive. They had specialists come in a bill their services directly to the pay source designated and they did not mind coming in as they saw many people in one day. This set up avoided using all the staff needed to transport and accompanies clients. This was a model used for other clinics in the state of Illinois at the time.

She also asked if Lakes Crossing nurses were medical or primarily psychiatric nurses. Dr. Neighbors answered that they were mostly psychiatric nurses but had other types of medical training and she is sending them for different types of medical training on an ongoing basis.

Mr. Whitley suggested that we try to determine the root cause. Is it policy or resource, enforcement of policy or all of that? We determine that by gathering the data and analyzing cost and policy and the answer could reveal itself.

Commissioner Beasley suggested we work this issue into our Governor's letter in relation to cutting the funds and crowded Emergency Rooms and the other related issues.

Dr. Neighbors asked that Commission support legislative efforts to address this issue in the upcoming session.

Chair Quint concluded this discussion by say he would like this topic to be on the agenda again where the commission can discuss a suggested plan of action and with more cost and policy information provided to us by Dr. Neighbors and Richard Whitley.

HEARING OF PROPOSED REGULATION DEFINING AND DESCRIBING CLIENT “CONSUMER” RELATED TO RECEIVING MENTAL HEALTH SERVICES IN NEVADA

Chair Quint introduced Cody Phinney, the newly appointed Director of Northern Nevada Adult Mental Health Services to present the proposed regulation change.

This proposed regulation is to bring the Division into compliance with SB44 from the previous legislative session which required us to draft a regulation change defining who qualifies for mental health services. This proposed regulation establishes those criteria to qualify someone for services. In general it states if there is a diagnosis from a DSM and they are not eligible to receive services from some other provider or that the co-pays and costs required by that other provider are not prohibitively high. In addition to that, the regulation uses the term consumer rather than patient or client when used in regulation or law.

Chair Quint has if there were questions.

Barry Lovgren made a public comment. Does this referral to consumers refer to SAPTA and Developmental consumers as well as mental health consumers?

Julie Slabaugh stated legislatively it is intended for Mental Health Clients. SAPTA does not provide direct services. Susanne Sliwa agreed it applies to NRS Chapter 433 which is mental health. It appears in the Mental Health Chapter of regulations.

There was a discussion to clarify the sliding fee scale, agency policy, and statute and those processes. It was determined that agency policy will address the eligibility through their sliding fee scale policy.

Commissioner Kinnikin moved that we approve the proposed change to regulation. Commissioner Johnson seconded that motion. Motion carried with Dr. Eisen abstaining.

DISCUSSION OF HEALTH CARE REFORM

Richard Whitley defined “primary care” explaining that it is physical health, mental health, substance abuse treatment and prevention. Dr. Green explained that when a person enters the system in a medical home as a single point of entry, all aspects of care could be addressed from that starting point. If this first point is not a medical hospital a person could enter in a behavioral health setting and receive all aspects of needed services with that point of entry. What we are looking at is the development of a state behavioral health “home”. That would consist of the majority of care being behavioral health whereas in the medial hospitals the majority of care would be medical. Richard Whitley and Dr. Green will provide us with updates as information on the Affordable Health Care Act and Health Reform unfold.

Dr. Green is on the Medicaid Advisory Committee where health reform is being discussed and how it affects Medicaid eligible consumers, their needs and state services. This board has medical professionals, state and county representatives and from that some work groups. The committee is similar to this MHDS Commission and their meetings are public meetings.

LOCAL GOVERNING BOARDS (LGB) UPDATE

Chair Quint asked for updates and Commissioner Kinnikin spoke for SNAMHS LGB saying they talked about the shuffles that are going on with Administration people and other status quo reports from different departments.

Chair Quint said that the Lakes Crossing Center presentation today came from an LGB meeting. Chair Quint also said he is hoping that we can bring some of the review response from the Commission of the Restraints and Seclusions and Denial of Rights and talk about the findings with these boards that include directors, managers and some of the staff.

PRESENTATION OF NEVADA ADMINISTRATIVE RULE MANUAL

Chair Quint turned this agenda item over to Julie Slabaugh, Senior DAG. This topic of administrative rulemaking came up at the last commission meeting in September and there was confusion as to how regulations are adopted in Nevada, how the the NAC interacts with the NRS and how they work with agency policies. You all have a copy of booklet, the Administrative Rulemaking procedural guide in your packets that is put out by the Attorney General's office regarding the steps that are necessary to go through to get a regulation into the Nevada Administrative Code.

There are two levels of law in Nevada. The first is the NRS (Nevada Revised Statutes) which are statutes adopted by the legislature every two years. Those are the primary law of Nevada.

The second, Nevada Administrative Code also has the full force and effect of law, but it is not done by the actual legislature. The final approval is done by the Legislative Commission. That is a commission of legislators that meet in the interim between regular sessions. They will adopt a regulation and once that happens, it will go into the Nevada Administrative code.

The regulation that was approved at this meeting today will now go to the Legislative Commission. They will have public comment and decide to adopt or reject it. Once adopted, it is codified in the Nevada Administrative Code.

Because the legislature only meets every two years, the Administrative Code enables the state government to function in between legislative sessions and allows the agencies to create more detailed rules and laws governing what they do without going to the

legislature at the regular session. The NRS tends to be more general, the Administrative Code more detailed and then agency policy even more detailed.

Julie explained the layers and different process time of the NRS, the NAC and how agencies can spell out specific issues like the sliding fee scale in agency policy as eligibility criteria changes. The NRS and the NAC have to be consistent and cannot conflict.

Julie referred to the summary provided in our Rulemaking guidelines and as a good outline for how the process works. She explained the public workshop and a public hearing and the approval which we did together at today's meeting.

Chair Quint said this would be put on as a future agenda item to discuss.

It was suggested by Richard Whitley that there could be information given to the commission when a change to a regulation is being considered. Julie Slabaugh said we could even have a standard agenda item to discuss regulation changes being considered or in process. The commission will put this issue on the agenda for a future meeting.

PRESENTATION OF UPDATE ON DEVELOPMENTAL SERVICES

Jane Gruner gave an update for developmental services on health care reform is that we have a home and community based waiver and waivers are not included in the 2014 beginning of healthcare reform. In 2016 they will decide how they will handle waivers. For now it will remain the same that the state will have to option to have a home and community based waiver to support developmental services.

Developmental Services recently received a small Olmstead grant that between mental health and developmental services will be used to work with the Division of Child and Family Services to work on children that are out of state and the transition of bringing those children back into the state and also transitioning children to adulthood. Jane will continue to update the commission on these issues as they progress.

We also have a new collaboration that is being developed right now with Early Intervention Services for a "one entry" access to services. This project will benefit the entire service arena, especially parents to improve continuity of services.

Last Jane Gruner gave an update on the transfer of fiscal responsibility of services for children from the state to the counties. We now have contracts with all the counties, except one to pay the state to deliver services. The biggest potential issue will be that it will no longer be equal access. Some counties may decide not to provide certain services for children. We are working with individual counties to develop what that protocol is for each individual service for each individual county. Resources vary from county to county.

Eventually Washoe and Clark could take over providing the services because they already have a clinical staff but that is not certain. In the smaller counties, that is less likely.

An update for Developmental Services will remain a standing agenda item.

UPDATE ON THE MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

Tami McKnight introduced herself as a fairly new Program Planner with the Division of Mental Health and Developmental Services central office. She is here to give an update on the Mental Health Planning and Advisory Council.

The council is proud to announce that in January there was a new chair elected to the Mental Health Planning and Advisory Council, Corrie Herrera, who resides in Elko and has also been a part of coalitions in that area. With healthcare reform, we are looking forward to working with the coalitions with Mental Health, Developmental Services and SAPTA as well.

May is Mental Health Month and we have requested a Proclamation from the Governor's office declaring this special recognition as he has done for us for the past several years. The council is working with NAMI (National Alliance for Mental Illness) who is sponsoring a walk including participation from both state mental health and private mental health professionals. The council is considering mental health month buttons, preparing pamphlets with mental health awareness information and reviewing what we are allowed to spend out of the grant for this event.

Tami updated the commission on the different sub committees currently active in the MHPAC including reinstatement of the rural monitoring committee which assesses mental health needs in the rural areas. This committee has been on hold due to the lack of travel funds due to budget cuts.

Another sub committee is the consumer and family advocacy sub committee. This committee is formed in connection with the legislative session and will be set up later this year.

The next sub committee is the nominating sub committee. With Cody Phinney's new appointment to the Director of NNAMHS, the Acting Director of Program Planning, Dave Caloiaro is being asked to sit on this committee and his application has been to the Governor. There are four other applications pending.

DISCUSSION OF THE IMPACT ON THE COMMISSION WITH THE LOST OF STAFF AND HOW THE COMMISSION WILL FUNCTION AND HOW TO MOVE FORWARD.

Support people have been identified to include Karen Hayes from the MHDS central office for the support of this group and at the DCFS meeting yesterday; we were informed of the support people for that group.

FOR POSSIBLE ACTION; SECLUSION & RESTRAINT PROCESS PROPOSAL

The next item on the agenda was review of a document, “Process for Reviewing MHDS Client Denial of Rights” originally created by Kevin Crowe to assist the Commission to improve the process for the review of Seclusion and Restraint and Denial of Rights documents.

The group looked at the Seclusion and Restraint Report in the first section of the Executive Session packets that can be discussed during this public portion of our meeting. We will review this report and see if it presents data that will help up to review the incidents.

Dr. Eisen referred to the “multiple” markings in the columns and asked how these could be sorted out. Dr. Eisen suggested that we structure the report to identify and clarify the categories by separating the “multiples” on a different line. The idea is to determine how many interventions and the type of incident we have, not how many clients. We want to know how many times staff is needed to attend to each of these interventions.

Jane Gruner responded that we will work on changing the report to meet the request.

The group then looked at the documents outlining the process and Dr. Eisen requested we strike the “This Simply results in too many documents.” from item 2. Dr. Eisen said we should not be reviewing these just to review them, but reviewing them so we can provide feedback from our review.

Dr. Eisen made a motion to approve the Process for reviewing document deleting the one sentence and add “reviewing random sampling of documents” at an estimate of 10%.

Dr. Beasley seconded the motion. The motion carried.

Chair Quint went back to possible action Item 10:

APPROVAL OF MHDS POLICIES

Chair Quint called on Cody Phinney to present the policies:

- Policy A-5.1 is an update for Instructions for Guidelines for Investigations

This just updates the language for reviewing internal investigations.

Barry Lovgren, private citizen commented the policy seems to include complaints received by SAPTA. If it does, the investigation procedure included in the SAPTA

Administrative Manual needs to be deleted and if it does not include complaints made to SAPTA, I think the policy should make that explicit.

Julie explained that this is a division policy and that each agency has their own agency policies. Not every day to day incident rises to a division investigation. If the event at the agency is serious enough to have a division investigation ordered determined by a consultation between the agency director and the administrator or deputy administrator, then these investigation guidelines apply. SAPTA needs their own policy for their agency. The guidelines are for best practice of investigations in general, but not dictating specific steps or mandating the directives. They are guidelines.

Private citizen, Barry Lovgren commented that if we have to have this discussion questioning who the policy applies to, then it must not be clearly stated.

MOTION: Dr. Eisen made a motion to table approving this policy until it is updated to clarify the scope of who follows the policy. Commissioner Cohen seconded the motion. The motion carried.

The next policy:

- A-5 .7 MHDS Medicaid Provider Enrollment and Quality Assurance (New) new to be established

This is a procedure that we developed to meet our obligations with an agreement that we have with MEDICAID to ensure that their provider enrollment requirements are met for MHDS employees and you will see that the scope is specified to the mental health services of the division.

MOTION: Commissioner Beasley moved to approve this policy. Commissioner Cohen seconded the motion. The motion carried.

Final policy:

- 3.010 Fiscal and Management Review

Cody states that MHDS is asking for approval to delete this policy since it has been replaced by other processes.

MOTION: Dr. Eisen made the motion to delete this policy. Commissioner Cohen seconded the motion. Motion carried.

MHDS UPDATE CORE FUNCTIONS REGULATORY REVIEW

Richard Whitley announced that the Executive Branch Governor's budget instructions were rolled out yesterday. One of the new concepts for going forward is performance based budgeting. In the past, we have used workload as a fundamental to build a state

budget. How that affects Mental Health, workload equals caseload and that is an important factor, but in performance based budgeting the focus is on quality and outcome. Although this is a challenge to government, it is really exciting for us to embrace as an agency.

Also with the instructions, all agencies were told to anticipate a flat budget. There is not going to be new money. Agencies are now digesting those instructions. In the future when we give updates on the Affordable Health Care Act, we give an update on our budget building process at the same time as they will interact with each other.

In terms of Core Functions, Mental Health is under Health as a Core Function and the timeline for agencies to develop their budgets is to have them done by August. They then will be reviewed, analyzed and probably kicked back for changes and then go to the legislature for presentation during the session.

Having a public health population based approach to analyze data to identify opportunities for improvement and determine where the gaps exist will be very helpful in this performance based approach. Ultimately the services have to be delivered by individuals but with this public health approach, we not only will look at the numbers we need to serve but also examine the quality of services and establish priorities.

Dr. Eisen presented some concern over us already trying to work with less and less money and how that can threaten efficiency and performance. He expressed being concerned against being penalized for having less funding and the same needs and the same quality expected.

Agenda Items:

Vacancies on the MHDS Commission

Director's Report from Aging Services reporting Autism Numbers

Elaine Cunningham Present more information about her request

Approve September 16th minutes after reviewed for Mr. Lovgren's issues with them

Election for MHDS Commission Officers

Health Care Reform Richard Whitley

Regulation Changes Update

Governor's Letter

Requested by Barry Lovgren: Regulation of Detox Technician's

Requested by Barry Lovgren: Clarify Power and Duties of the MHDS Commission related to SAPTA.

Chair Quint responded he will discuss with Attorney General whether we want this item on the agenda for our next meeting.

Meeting Adjourned.

Respectfully submitted,

Karen Hayes
Recording Transcriber

