

COMMISSION ON MENTAL HEALTH AND DEVELOPMENTAL SERVICES
SEPTEMBER 21, 2012
MINUTES

VIDEO CONFERENCED MEETING LOCATIONS
SIERRA REGIONAL CENTER
605 SOUTH 21ST ST.
SPARKS, NV
AND
MHDS CENTRAL OFFICE, 4126 TECHNOLOGY WAY, 2ND FLOOR CONFERENCE
ROOM, CARSON CITY

COMMISSIONERS PRESENT AT THE RENO LOCATION:

Kevin Quint, Chair
Capa Casale
Pamela Johnson

COMMISSIONERS PRESENT AT THE LAS VEGAS LOCATION:

Andrew Eisen, M.D.
Marcia Cohen
Valerie Kinnikin

COMMISSIONERS ABSENT:

TJ Rosenberg
Barbara Jackson

CALL TO ORDER

Chair Quint called the meeting to order at 9:45 am. Roll call is reflected above. It was determined that a quorum was present. Introductions were made at all three locations.

PUBLIC COMMENTS

Barry Lovgren will refrain from public comment until items 10 and 13 come up.

CONSENT AGENDA

APPROVAL OF MINUTES FROM MAY 25, 2012 MEETING
APPROVAL OF DIRECTOR'S REPORTS

MOTION: Commissioner Casale moved to approve the consent agenda as a whole and Commissioner Kinnikin seconded the motion. Motion carried.

REVIEW THE MENTAL HEALTH AND DEVELOPMENTAL SERVICES BYLAWS

One change in the bylaws is they currently state that there will be in person meetings of the commission and due to budget cuts and availability of video conferencing, this needs to be changed or deleted.

There was a discussion about the role of the commission pertaining to oversight and exactly what that means. Chair Quint suggested we appoint a two person subcommittee to go over the bylaws and come back to the next meeting with suggested changes\updates. The notice required regarding absences needs to be clarified.

There was some discussion about the quorum and the difficulty presented with the current vacancies. The vacancies will be discussed later in this meeting, item #8.

Commissioner Cohen volunteered to work with Chair Quint on the review of the bylaws.

MOTION: Commissioner Johnson moved that the bylaws be sent to the subcommittee, Chair Quint and Commissioner Cohen to review and present changes at the next commission meeting. Commissioner Casale seconded the motion. Motion carried.

DISCUSS ADDITIONAL SUPPORT FOR THE COMMISSION TO REPLACE THE RESEARCHER POSITION

Last fall we lost our researcher, Dr. Crowe due to the new legislation referencing contracting retired or current state employees. Dave Caloiaro, Director of Program Planning in the central office will give us an update on replacing Dr. Crowe.

Dave Caloiaro reported there were letters of interest sent out to possible contractors and after reviewing the responders a contractor was selected and Dave is in the process of developing that contract and the scope of work for the position. Some of the key scope of work activities will be

- Children's mental health state plan
- Mental Health Commission orientation
- Establishing and maintaining relationships with community and state stakeholders
- Analyzing projects requested by the commission
- Acting as a legislative link during the upcoming legislative session

Currently, we are working with some of the contract requirements, liability insurance, etc. This process will take a few months and we are hoping to present this contract at the December Board of Examiners meetings and hoping that person could start no later than January 1st.

UPDATE AND DISCUSSION ON HEALTHCARE REFORM

Richard Whitley and Dr. Green are here to talk about Healthcare reform and also how all the upcoming changes will affect the role of the Mental Health Commission.

Richard began with an integration update. He reported that we have submitted our state budgets and a bill draft to integrate Mental Health, Public Health and Aging and Disability Services. From the Health side, we have Early Intervention Services to include services for children birth to age three with disabilities and developmental delays. The proposal is to integrate Early Intervention and Developmental Services so we can better serve children and adults across the life span with developmental delays. It will also give us opportunities to combine resources between the two for assessments and specialty clinics and other specialty services. Those two programs would merge with Aging and Disability Services.

In the area of public health and mental health, Dr. Green and I have put forward a budget and a BDR to integrate the two agencies. There are others states engaging in the same type of integration, including California. Looking at the benefits from a payer source with the Affordable Care Act, behavioral health

services including addiction services are part of the basic benefit package. In Nevada, the state is the largest direct service provider of behavioral health services. On the public health side, we take primarily a population base approach where we work on developing systems of care rather than direct service of that care. Another area we have been working on with Dr. Neighbors is the overlap with criminal justice system.

Another benefit with this integration, it allows us to utilize data from public health system and use the principles of epidemiology and our biostatisticians to analyze the data of the people who have been receiving services in our mental health system who are also in the criminal justice system. We have done this with jails, both Carson and Washoe County. We just recently reached an agreement with Clark County Detention Center to get their data base and also done some matching with the Department of Corrections and the Department of Parole and Probation. What we have been able to show is that at least 20% of the population actually has been in state mental health services. We are able to analyze this information to determine if there would be intervention points where we could possibly prevent incarceration or hospitalizations. We are able to analyze this information and find areas where our current system is failing. Criminal Justice is an area where we can make changes to improve and Dr. Green has looked at the emergency room utilization data and medical clearance data to see how we can improve there.

We have many people in the mental health system that through a mental health crisis are treated in the emergency room, it is determined they have primary health issues as well. Or, our mental health clients are using emergency rooms for primary health visits.

We are looking at how we can best serve the consumer by linking programs and services that can be interchanged between Criminal Justice, Mental Health, Public Health, state clinics and inpatient units, private hospitals, urgent care clinics and emergency rooms to improve services as well as use all of our resources more efficiently.

So we will present the budget to reflect this integration or programs as well as a BDR to initiate and define the integration.

Commissioner Kinnikin in the South asked if this integration is to lay the ground work for Health Home systems. Richard Whitley responded that it supports that system. We have some issues in our state with lack of providers in some areas to serve the current eligible population as well as Medicaid providers. Part of what we hope for with the integration is to deliver some of those services through the medical home concept. The shortage of providers is a complicated issue involving licensing, rates, training programs, internships and avenues to steer students to the Nevada workforce rather than leaving the state. The whole healthcare system, not just behavioral health and mental health need to find ways to recruit healthcare professionals and fill the gaps in services.

Dave Caloiaro also added comments that Medicaid has a pilot program where they are hoping to get at least three health homes that would take care of folks in their fee for service eligible Medicaid clients. The clients would have at least one chronic condition and they are considering persons with behavioral health, mental health and substance abuse issues as well as hypertension, diabetes, kidney disease, etc. They also have an initiative involving management organizations for these homes, Clear Management Organizations (CMO's).

In response to this discussion, Chair Quint commented that in view of the huge upcoming changes with Developmental Services going to Aging Services and Mental Health integrating with Public Health and how will all of this change affect this commission.

Dr. Tracey Green added to this discussion stating that several other states are in the process or have already done this type of integration of agencies with the focus being on total care for the consumer. What it allows us to focus on a service delivery model where the whole person is addressed to include all of their health needs. Dr. Green mentioned the conference in Las Vegas this coming Monday and Tuesday, PERSA (Health) and SAMSHA (Substance Abuse Mental Health) are combining to offer this two day conference.

They will be sharing with us what other states are doing and Chuck Duarte from Medicaid will be there talking about the Medicaid initiatives that Dave Caloiaro was just talking about as well as some of the changes Medicaid is facing with the Affordable Health Care Act. They will have the director of the Silver State Insurance Exchange speak also and some speakers from other states share their integration plans.

Chair Quint responded that Commissioner Kinnikin will be attending that conference and we can put it on the agenda for her to report back to us next meeting in November.

Dr. Green summarized by saying we are looking at all of our data on current health and mental health services in the criminal justice systems, the hospitals, emergency rooms, medical clearance procedures in all these settings and just trying to integrate and implement some change that would make us utilize our resources more efficiently and take better care of the consumers.

Chair Quint reinstated a need for the mental health commission to be informed along the way as to how all of this will change the role of this commission.

Richard Whitley replied addressing the issue of how the commission is reviewing the Restraint and Seclusions and suggested we look at this procedure and talk about ways to improve and streamline the use of the commission's time and effort.

Right now the process is strictly "review" and the commission discusses their responses to the review in the closed meeting with the other commission members and then they are returned to the agency of origin. Do we want to enhance this process? Should we consider having the agencies do a review prior to the commission review? What are the statutory and regulatory requirements? Richard was not suggesting a change but instead suggesting putting it on the agenda to discuss the current process, the review and the outcome.

Chair Quint encourages all the commissioners to think about this discussion, not just the review of restraints, but the role of the commission in lieu of all the current and future changes of the agencies that the commission serves.

LOCAL GOVERNING BOARDS

SNAMHS did not have anything to report from their August meeting.

Lakes Crossing Center, LGB, the current issue was again, LCC clients with medical issues that LCC is not prepared to handle at the facility and having to be transported for medical appointments, hospitalizations, emergency or urgent care visits. All of these events result in unplanned and in appropriate staff use, and expenses not in the facility budget. We will mention this issue in our letter to the Governor.

The other issues that keeps surfacing with LCC and NNAMHS AND SNAMHS is the difficulty to recruit the general psychiatry workforce. There is a huge problem with both recruiting them and retaining them.

Dr. Green said that there are things we are working on things to attract physicians to this state. The entire state has received certification as an “at risk” or needs area, so we now have loan repayment and some of the other benefits associated with that. We have also implemented Dr. Ravin at SNAMHS as part of his position being the statewide residency and graduate education supervisor. He is working with our medical school and with the American Psychiatric Association to look at recruitment and attracting physicians to our area as well as enhancing our programs for our residents. He will be working with Dr. Neighbors as well to look at our forensic rotation and some of the areas where we have our greatest needs. We also have over 20 J-1 Visa positions in our state, which include outside of the United States graduates, medical doctors who can come to our state on a VISA for three years. We are also trying to enhance that program. We are also expanding our services to include nurse practitioners. Our pay rate has always been an issue and that is going to continue to be a problem trying to complete private service. We are also working on partnerships with the private sector to enhance our ability to provide services. We are definitely looking at recruitment with collaboration to best use all of the area resources for the consumer.

Dr. Eisen asked some questions about the J-1 Visa program and Richard Whitley explained and there was discussion about the program, the education requirements and how the participants are selected. Dr. Eisen also asked, what percentage of the graduates in the residency psychiatry programs in the state, are staying in the state to practice.

Dr. Green answered. I do not have percentages, but recently there were two at SNAMHS residents that chose to stay at SNAMHS as either state staff or contract staff after their residency. We have more residents doing that in the South than the North, but the South does have a larger program.

Cody Phinney, Director of Northern Nevada Adult Mental Health Services, added that Dr. Ravin has met with the Northern portion of the residency program and they have recently amended their contracts so we had some 4th year residents that we had not had before. We are making progress on having things be more standardized.

Chelsey Szklany, also agreed that compensation is a problem across the board for all mental health positions. SNAMHS is also losing people to private sector as well as state employees leaving the agency for promotions in other state agencies due to not getting step increases or cost of living raises.

VACANCIES ON THE MHDS COMMISSION

We have to write a letter to T. J. Rosenberg to let her know she is no longer a commission member due to attendance requirement violations. We have to send it to her last known address. Both Chair Quint and Karen Hayes tried to reach her and she no longer is at the work number given to us. Chair Quint will send out the letter.

On Julie Beasley’s vacancy, the Governor’s office has the three names and has not let us know who was selected. Karen Hayes did call for the status update a few days before this meeting.

Karen also reported that she has sent a letter to the President of the Psychiatric Association but has not received a reply for the replacement for Dr. Barron.

There was a discussion about how difficult it is to get a quorum for these meetings, when we have vacancies like this.

ELECTION OF MHDS COMMISSION OFFICERS

Commissioner Casale reported that she met with Chair Quint as a subcommittee and as a nomination committee. It was determined that Dr. Eisen would be nominated to be Vice Chairman and he has accepted the nomination. Chair Quint as agreed to continue to be the Chair. Chair Quint also invited the remaining commissioners to please let him know if they would like to hold office for this commission in the future so we can be better prepared when the time comes.

MOTION: Commissioner Casale made a motion to elect Dr. Eisen as Vice Chair of this commission and re-instate Kevin Quint as Chair of this commission. Commission Johnson seconded. Motion carried.

APPROVAL OF MHDS POLICIES

Dave presented the policies and reminded us that the policies are instigated and reviewed by subject matter experts and then they go to a MHDS statewide policy committee headed up by Joann Flanagan in the MHDS central office prior to coming to the MHDS commission for approval.

- SP-1.2 Serving Consumers with Co-Occurring Mental Health and Substance Abuse Disorder
- IMRT 5.15 HIPAA Complaint Communication
- F-1.3 Developmental Services Billing/Collection Procedures
- CRR-3.1 Consumer Death and Disposition of Deceased Consumer Property
- HR-2.4 Training Policy
- A-4.7 Media Contacts/Events
- A-1.1. Policy Development and Review Process

Dave Caloiaro explained each of the policies.

Chair Quint then asked for comment and reminded the commission that they could vote to approve all of them at once, some of them or one at a time.

Barry Lovgren, representing the general public has comments on the first policy, SP-1.2 Serving Consumers with Co-Occurring Mental Health and Substance Abuse Disorder. Mr. Lovgren's comments began with him saying, "my compliments to whoever drafted this revision". The policy that it replaces was more theory and this revision actually does things. When I read it, it sounds like it makes treatment for co-occurring disorders available in every MHDS mental health center. That is magnificent.

My next comment, which is a question, refers to the very last page. Who can provide treatment for co-occurring disorders? It states, qualified mental health associates and mental health technicians who receive training and have knowledge of co-occurring disorders. Is this acceptable to the Board of Examiners for Drug, Alcohol and Gambling Counselors and if this policy would be acceptable with the licensing for counselors.

I think that needs to be clarified, but I am delighted that this is treatment to now be included in the mental health clinics.

Dr. Eisen explained that the authority for staff to provide treatment is covered in other policies and certifications. This policy just states that we are providing the treatment at our clinics and does not need to identify further who will be providing the treatment.

Commissioner pointed out a typo on IMRT 5.15 and Dave Caloiaro will get that corrected.

Commissioner Cohen began a discussion about the statement referring to staff informing law enforcement of an event requiring law enforcement or the coroner and staff closest to the event being able to provide information to them. It is suggested to insert agency provide “all necessary” information to the appropriate law enforcement interest.

HR-2.4 Training Policy - There was discussion about how this training is provided and it was concluded that the course numbers be excluded so the training could be done in house. Dave will see that this is done.

A-1.1 Barry Lovgren commented that he was told a couple of years ago that this policy does not apply to any SAPTA policy and second he has been told that this MHDS Commission does not hold any authority over an SAPTA policy. Since that time he has determined that this is not quite true. This policy is not in compliance with NRS 433 that moved SAPTA under MHDS if this does not apply to SAPTA policy in general or the care and treatment of people with co-occurring disorders. I am asking if there is someone here that can explain the scope of this policy in regard to SAPTA.

Deborah McBride did clarify that SAPTA does develop policies but not necessarily in the same format as MHDS. Barry Lovgren again asked, are SAPTA policies regulated by the MHDS policy A-1.1.

Steve McLaughlin joined the discussion to try to clear up confusion between MHDS and SAPTA policies. MHDS provides direct service SAPTA does not. The MHDS policies are established to cover direct services and the SAPTA policies are related to the services given by the community providers.

Chair Quint reviewed the changes to the policies:

IMRT 5.15 - Correct the typo on page 4

CRR-3.1 - the words “all necessary” regarding information given to law enforcement.

HR-2.4 - page two , section 3, all references to class numbers will be taken out.

MOTION: Commissioner Casale moved to approve the policies with the changes. Commissioner Johnson seconded the motion. Motion carried.

PRESENTATION FROM DEVELOPMENTAL SERVICES

Barbara Legier, newly appointed Director of Sierra Regional Center and Rural Regional Center is the presenter. Developmental Services is going through a merge between Sierra Regional Center and Rural Regional Center. The process is just underway, so they are going through organizational charts, work performance standards and policies to identify differences and inconsistencies. The goal is to make the business practices uniform with SRC, RRC and DRC in preparation for the merge with Aging Services.

Chair Quint requested a presentation to inform the MHDS Commission about this merge and Barbara Legier agreed to find someone to come to a future meeting to present more information to this group about the merge and Chair Quint asked for this for the November meeting.

UPDATE ON CO-OCCURRING DISORDERS

Steve McLaughlin, Treatment Supervisor for SAPTA is the presenter. Steve will be coming to the meetings in the future to do this update. New initiatives are underway for the progress of addressing co-occurring disorders, especially in adolescent population which is a top priority for Steve. Chair Quint

brought up the Committee for Co-Occurring Disorders approved by the legislature is now facing sunset. We need to talk about what this group can do to assist in this area if that committee does sunset. We can talk about this during this agenda item in future meetings as it will be a regular agenda item.

SAPTA DIVISION CRITERIA – FOR PROGRAMS TREATING SUBSTANCE RELATED DISORDERS CO-OCCURRING ENDORSEMENT

This Appendix C-14 is part of the Administrative Manual in SAPTA and this endorsement for SAPTA Treatment Providers was originally developed in 2007 when SAPTA began the Co-Occurring Disorders pilot project and it was again updated in June of 2012. It is a tool for our providers to use in treating people with co-occurring disorders. This endorsement was provided to the SAPTA Advisory Board and no comments or changes were received. It was also discussed with the Governor's Committee on Co-Occurring Disorders and again no comments or changes requested. We made some changes to it to give more foundation for programs that are treating co-occurring disorders and also to help them develop a good COD program. As we move into the health reform, this will provide a tool and guidance for providers to use. These guidelines for our providers follow the principles that were provided to SAPTA in specific guidelines in a publication from SAMHSA and also leading professors that are experts in the field.

We have compared what we are doing in Nevada with what they are doing in other states and these guidelines are consistent those in other states. Connecticut was one of the original pilot programs and they use these guidelines also.

This is a very thorough document, including integrated treatment and program guidelines, service levels, quality assurance. It is a working document so as we go through with health reform, it could and will change to stay with health reform.

In response to a question from Commissioner Kinnikin regarding how this document will work with DSM IV. Steve McLaughlin answered that they will be looking at DSM IV and updating the guidelines to fall in with that information.

Barry Lovgren commented that this is a very significant revision of the previous criteria for certifying programs providing specialty treatment for co-occurring disorders. Barry commented that this is a very good revision. However, there are two concerns with the content that need to be addressed as they could have serious consequences, but I will hold those to the end.

My main problem is with the process. There had been problems with SAPTA certifying programs in categories for which there were no division criteria for that certification. That problem has been resolved with the adoption of revised division criteria for certification of treatment programs with one exception and the exception is this document in front of you. What you have here is the division criteria of which SAPTA decides whether a program is to be issued certification for the specialty treatment of Co-Occurring Disorders. That certification is available to programs that meet Level 1 and Level 2.1 outpatient and intensive outpatient criteria. If they meet that criteria and the criteria in these guidelines, they are then eligible for the specialty certification and thus they are eligible for SAPTA funding. Although, there are programs that are not funded that carry this certification. I have communicated to Ms. McBride and to Mr. Whitley that the problem with issuing certification that are not certified according to division criteria would be resolved upon this revision being reviewed and approved and adopted by Mr. Whitley and the recommendation by the SAPTA Advisory Board. These things have not been done. The regulation required that there be an open meeting of the SAPTA Advisory Board for which that action was taken. Instead of being done at an open meeting, this was distributed to the SAPTA Advisory Board and they were told to get any comments back to SAPTA administration in the next couple of weeks. There still has been no action taken by the SAPTA Advisory Board on this document. In addition, this is a division

policy for the care and treatment of persons with Co-Occurring disorders. This Commission is not only authorized to accept this policy, it is mandated by NRS 433 to set policy for the care and treatment of persons with Co-Occurring disorders. This is not being presented to you as a policy to be set. It is being presented to you as something done by SAPTA for your information. That is not appropriate. This is on the agenda as an action item.

The next two things are in the content. They are simple and easy to fix. I need to point out that this is already on the SAPTA website as existing SAPTA division policy and in SAPTA's Administrative manual without going through the Advisory Board or being set by this MHDS commission. Its effective date is July, 2007. Establishing requirements did not exist until June, 2012. The way this is written, it is a retroactive policy going back to July of 2007. I am sure that is not the intent. All you would have to do is eliminate effective date July 2007. That really needs to be eliminated. Otherwise, it causes a great deal of problems trying to go back and apply this policy to every program that has been certified and funded.

The other problem with it is on the very last page. You need to remember that these criteria are for programs that may or may not be funded. One of the criteria is that the program must have the ability to address, track and achieve the outcome measures, including the national outcome measures. That is criteria that can only be met by funded programs. Only funded programs are capable of participating in the national outcome measures. This needs to be deleted from the criteria or if not at least specify that it only applies to funded treatment programs. This also speaks to the problem of the certification and inspection process. I have only looked at one certified and inspected program, cannot remember the name of it, but it was an unfunded program. It was a start up program and did not have clinical records yet. So, as a consequence, the inspector had (very appropriately) put "not applicable" regarding clinical records requirements because it was a start up program. But when it came to this requirement, which was impossible for them to meet because it was not funded. Compliance with this standard is not possible.

I am asking for this action. Return this document to the SAPTA advisory board for review and approval at an open meeting. I would also ask that you require the policy development policy that we were just talking be applicable to this policy. I am asking this commission to direct MHDS to do two things: A) Implement the review and approval policy with reference to this criteria and B) Return the criteria to the SAPTA Advisory Board to obtain compliance with NAC 458.11A prior to these criteria getting resubmitted to this commission.

Chair Quint asked for comments.

Richard Whitley then asked "Did this go before the SAPTA Advisory Committee and was it approved?" Deborah McBride answered that it did go to the SAPTA Advisory Board on July 11th and it was approved. Richard then asked, "Did it go as an action item?" Deborah McBride replied, "Yes, it was an action item."

Barry Lovgren then stated he would have to check. He said he reviewed the agenda and the minutes for that meeting. He asked Chair Quint if this was done at that meeting and Chair Quint said he would have to check. Chair Quint remembers being asked for comments and feedback to go back to SAPTA but not the review and approval.

Chair Quint then asked for advice from our DAG, Susanne Sliwa. what order and what process do we need to do with this document. Susanne Sliwa said that she was not sure, but suggested we table this item and do some research to determine what the path this document should take. Susanne Sliwa said in looking at it that it does not look like division policy and it needs to be determined if he needs to follow the procedure for policies.

At this point, Chair Quint proposed to adjourn the meeting and table the remaining items. Looking at them, there is not anyone to report from Aging Services on Autism Services. The commission did discuss the Governor's letter and it is still in progress and there are items for the next agenda contained in these minutes. There is no more public comment.

The regular meeting was adjourned.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Karen Hayes".

Karen Hayes
Recording Secretary

