MINUTES

of the

Mental Health Planning Advisory Council

meeting on

Wednesday, January 5, 2011

held at

Health Division
4150 Technology Way, Suite 153
Carson City, Nevada 89706

1. CALL TO ORDER, ROLL CALL, INTRODUCTIONS

Patricia called the meeting to order at 9:13 am at the request of Rene, the Chair. Roger did verbal roll call. Tanya passed the sign-in sheet around the room in north and completed the sign-in sheet for LV.

Members Present:

- Ash, Alisha – Consumer/Youth (via video conference in Las Vegas)
- Daniels, Steve – DOC
- Ford, Lisa – DOE (via video conference in Las Vegas) morning only
- Herrera, Corrie – Family Member
- Jackson, Barbara – Consumer
- Lawrence, Coleen – DHCFP
- Merrill, Mechelle – DETR
- Norris, Rene – Chair, Family Member (via video conference in Las Vegas) morning only
- Parra, Debra – Housing
- Peterman, Patricia – Vice Chair, Family Member
- Phinney, Cody – MHDS
- Pinder, Denice – Family Member
- Polakowski, Ann – DCFS (via video conference in Las Vegas)
- Snead, Lydia – Family Member
- Thomas, Alyce – Consumer, Past Chair (via video conference in Las Vegas) morning only
- Wilhelm, Layne – SAPTA
- Willingham, Bryce – Consumer (via video conference in Las Vegas)

Members Absent:

- Bousquet, Judy – Consumer
- Ford, Lisa – afternoon only
- Norris, Rene – afternoon only
- Thomas, Alyce – afternoon only

Staff and guests:

- Benitez, Tanya – MHDS/MHPAC Admin. Asst.
- Caloiaro, Dave – MHDS
- Cook, Harold, Dr. – MHDS
- Duarte, Chuck – DHCFP
- Hefner, Marty – MHDS
- Merrifield, Patricia - DCFS
- Mowbray, Roger – Grant Writer

2. REVIEW AND APPROVE MINUTES FROM PRIOR MHPAC QUARTERLY MEETING ON 10/5/10

Patricia asked if all had reviewed the minutes from the meeting on 10/5/2010. Patricia asked for questions and/or comments.
Lisa Ford present via Las Vegas. Mechelle Merrill was present representing Howard Castle.

Layne motioned to approve the minutes as amended. Lydia seconded the motion.

UNANIMOUS VOICE VOTE: MOTION CARRIED

3. MHDS PRE-ADMISSION SCREENING AND RESIDENT REVIEW PROGRAM (PASRR)

Patricia turned the floor to Dave. Dave asked if all have the handout. PASRR is federally mandated. PASRR was enacted by OBRA by the Congress in 1987. It has been one of the more complex programs throughout the nation because all 50 states have to offer PASRR and its rules and regulations are very comprehensive.

Until about the 1950's maybe 1960's, nursing facilities were generally mom and pop operations with very little federal oversight. Around the 1970's there were nursing home corporations starting to emerge and acquiring or developing large number of nursing facilities. Unfortunately, the facilities were not equipped to deal with and provide appropriate services for persons with mental illness. Then in the 1980's there were a number of people who were released from prisons, and they ended up on the streets homeless, or many had no where else to go and they ended up in nursing facilities. Not only were the nursing facilities not equipped to

care for them, but many of the patients were violent and they would assault staff members and other residents. There were a variety of complaints/lawsuits. The federal government stepped in to address this, and that's when Congress enacted PASRR.

PASRR requires three key partners in a state, the State Medicaid Authority, the State Mental Health Authority, and the State Developmental Services Authority; the federal government uses the term mental retardation. In many states the mental health authorities are separate from the intellectual authorities. In Nevada, it is under MHDS. It requires the three entities to work together to evaluate and make sure that persons with mental illness and developmental disability and/or a related condition are first identified as such and then if they are appropriate to go into a nursing facility, and if the nursing facility can meet their needs.

There are several PASRR participants. The individual is at the center. The Centers for Medicare and Medicaid Services (CMS), and they oversee the federal PASRR program. Then there is Medicaid, which is a very key player. All 50 states Medicaid's are ultimately responsible for PASRR. Health Care Quality & Compliance (HCQC), this is within the Health Division. Mental Health & Developmental Services (MHDS). The Nursing facilities, where the PASRR residents are located and then Magellan Medicaid Administration (MMA), formally known as First Health, they are the PASRR contractor or vender. They are the ones who do the screenings to determine if someone does have a mental illness/mental retardation and if so do they qualify for a nursing facility and if not an alternative placement is identified for recommended as a result. Magellan also determines if person require PASRR specialized services.

Hospitals are responsible secondarily in the PASSR process. Even though persons with PASRR determinations do not apply in hospitals, approximately 75 - 80% of the 1000's of PASRR screenings that are done on Nevada residents each year are done in a hospital setting. Hospitals have some responsibilities to make sure that their clients are screened, that their discharge planning assumes or believes that a nursing facility would be appropriate. The nursing facility is where PASRR primarily pertains to. A nursing facility has to know the persons level and they have to know if the person identified needs PASRR specialized services. The nursing facility has to be aware of this, agrees to admit the resident, and must agree to meet these plans. The person first and foremost has to meet an appropriate level of care to be placed in a nursing facility. The mental health is important however if they do not meet a nursing facility level of care, then PASRR is not going to pertain in a nursing facility, but may recommend an alternative setting.

There are two types of PASRR levels. Level I & II. Everybody in the US that is referred into a Medicaid/Medicare certified nursing facility has to be truly at a PASRR I level. Level I: In Nevada a vendor (Magellan) is used. They receive a referral. The purpose of a level I screening is to determine whether a person has a

mental illness, mental retardation condition and if they do that their needs can be safely and appropriately met in a nursing facility. If not, then in an alternative setting. About 10% of all level I's are I-A, which means they have evidence of a mental illness or developmental disability. I-A means they can not be admitted to a nursing facility until a level II, which is the final determination screening, is done. A I-B determination, also approximately 10%, means that the person is appropriate to be admitted into the nursing facilities, but they have a cognitive disability, and they can go into a nursing facility. A I-C, which is the vast majority of people, shows that on the level I screening there is no evidence of mental illness, mental retardation, or related condition and the person can be admitted into the nursing facility. At this level MHDS is not involved. This is strictly a Medicaid (Magellan) function.

If the person receives a level I-A, then they are referred for a level II screening. A level II-A, Magellan will have one of their staff go and do a face to face screening assessment. The only exception is in rural communities where it is also done by mail, medical record review, and telephone. The level II is the final determination. A level II-A means the person does have and verifies the mental illness or developmental disability; however the person's needs are such that they can not be met in a nursing facility. Generally it would be a step higher and either a psychiatric hospital or some sort of clinical intervention that is outside a nursing facility. A hospital can not admit the person to a nursing facility and if they do there can be penalties. A level II-B means that the person does have the verification of mental illness or developmental disability and the person can be admitted into the nursing facility as long as they receive specialized services. The II-B determination is the most prevalent one, approximately 90%. II-A's are about 5%. The last designation is a II-C and that means the person does have mental illness or related condition. They can be admitted to a nursing facility; however, they do not need the more intensive specialized services. Dave went over some examples for PASRR II-B. If it is Medicaid reimbursable and the facility follows the Medicaid guidelines on procuring the service, Medicaid will accept the charge. In many cases MHDS provides the services, particularly on the developmental services side. Many times the clients in PASRR who have mental illness, many become clients for MHDS for the very first time through PASRR. Most of them do not have a previous record. However, for persons with MR/DD who require PASRR services, many have a service record with the DS agencies.

Denice said she has never heard of this before and asked for an example of where the nursing facility would be. Dave said Renown Skilled Nursing Facility; also Life Care Center of Reno has several PASRR II-B residents. This is a nursing facility, so most but not all of the residents are elderly. They do have some clients that are a little younger. Most of the PASRR residents would be middle age and up. Cody said the first qualification is that they have such severe medical problems that they qualify for the nursing facility. When Dave is speaking of the majority of clients, he is speaking specifically to this group of clients in PASRR.

Dave said from a mental health stand point, the more common PASRR specialized services are psychotropic medications where they require not only a Physician follow up, Pharmacy reviews – generally those are quarterly. They look at the notes, they look to make sure the nurses are administering correctly. Psychotherapy may be another where the client goes out if they can or someone goes to the facility and schedules a group of clients. Monitoring and advocacy is a very unique service to Nevada. This is where MHDS has six regional PASRR coordinators and they go and provide this service as well. Psychosocial testing, if they feel that someone may have a dual diagnosis or if they want to rule something out, then they may be referred. Some of the services may be a one time and others are ongoing. Not all of the residents go into a nursing facility. Some may die in the hospital, some may be diverted to a lower level of care, or their families may step in and take care of them.

Dave has six regional PASRR Coordinators. There are two each in the north, south, and rural areas of Nevada. In those areas there is always one that handles the residents with mental health needs and the other handles the clients with intellectual disabilities. If they have a client who is dual, they will generally assign the PASRR Coordinator who handles the intellectual disabilities because in most cases that person was their client before. They want to keep the continuity of care going including following them in the nursing facility. The regional coordinator has several duties. They first and foremost perform quarterly reviews of residents with mental illness, mental retardation or intellectual disability in a nursing facility that has been identified as a PASRR 2B client. He said there are approximately 140 statewide MHDS PASRR clients, most of which are in Las Vegas. Some of the coordinators have as high as 50 and some have as few as four or five. It depends on the area. Their main job is to make sure that by the federal definition that the facility is either providing or arranging for the provision of specialized services. If the facility is providing or arranging that, they have very strict documentation requirements they do. If the facility is not doing that, then those issues are brought up because of the condition of the resident being in the nursing facility, first and foremost they have to meet medical necessity. Secondly if they have a diagnosis of mental illness, that need has to be cared for as well. They are also a member on the person's treatment team as well if possible. Those with smaller caseloads, it is more feasible. They make every effort to be a part of the nursing facilities treatment team.

Dave is the statewide PASRR Program Manager. He conducts biannual PASRR compliance reviews. He takes what the federal mandates are and he does the review in three parts. He reviews the PASRR vendor, because the federal regulation states that it is the mental health authority that would have to do the level II screening determinations and assign specialized services. Nevada does not do that, they follow up on them, so if the state does not do them as they would be required to do, there is a federal provision that allows for what is called a delegation of authority. The vendor or quality improvement organization has to assure that they meet the qualifications that are outlined in the federal regulations,

one of which is they no are not a nursing facility or do they have any ownership or any other ties with the facility and that they will do other things. Working in collaboration with Medicaid, MHDS has an interagency agreement that allows this to be contracted out and Magellan manages it. However, when Dave does the reviews, he takes 50 or 75 cases at random and makes sure that he agrees with the determination or that he would have come up with the same determination as Magellan did. In most cases it is the case. The vendor has to look at specific information and documentation before they render their final determination. The second and third parts are similar in he goes to the nursing facilities. He reviews the charts; he reviews the work that his staff does to assure that they are compliant with their responsibilities. The biannual review is a large one. This is to assure the Federal Government that this is being done. He has a 200 page report of the most recent review that was done in June 2010. They attempt to be as thorough as possible. Even though the review is a compliance review and is federally mandated, he believes that compliance reviewers need to be educators. They find that there is a turn over not only in nursing facility administrators, but the directors of social services, who are responsible for PASRR. Very rarely two years later, when he returns is it the same person as the prior visit. They try to use this as educational opportunities. If they know the information up front, then maybe nursing facility staff will be more proactive and there is less chance for errors.

He went through some best practices in nursing facilities. One of the items is education. He wants to make sure that the PASRR specialized services are integrated into the nursing facilities plan of care. Years ago, they did not do that. Many know what PASRR is, but they do not understand it. It can be very complex, but there is some leeway with the states interpretation and how they run the programs within the state. Some of the accomplishments of PASRR in Nevada, is they have been recognized by CMS as having one of the most progressive and top notch programs in the United States. They have worked very hard at that and they still have work to do with it. PASRR is emerging and there are other responsibilities. There is a move to also identify PASRR outside of the nursing facility, making sure that people who do not need to be in a nursing care facility are reviewed. Dave has been asked to be on a nationwide PASRR Board of Directors with ten other states. They have quarterly meetings and then they have one large annual educational conference. MHDS performed with Medicaid in 2008 a self evaluation. They were one of a handful of states that volunteered before CMS started coming out to do very formal intense compliance reviews. CMS allowed the states to do their own evaluation. They received a set of guidelines. Nevada was one of the few states that were asked to present at a conference specifically on this.

PASRR will continue to work with Medicaid and Magellan. Up until about three years ago, MHDS, Medicaid and at the time First Health provided annual CEU offered trainings to hospitals, nursing facilities, PASRR providers, etc. It was a great way not only to educate people, but to give CEU's. Due to funding issues,

they have not been able to continue. Medicaid still with Magellan hosts annual conferences, but there is only about an hour dedicated to nursing facilities in general. They attempt to put in a piece on PASRR. Hopefully when funding allows it in the future, they will be able to resume PASRR trainings. They will continue to do the bi-annual compliance reviews. They will continue with their quarterly statewide committee for PASRR, which includes Medicaid, Magellan, Dave, and the six regional coordinators. Another thing they will continue to do is to show one way they are complying with the Olmstead Act. MHDS works closely with Medicaid and its Facility Outreach and Community Integration Services (FOCIS) unit, to move clients from Nursing Facilities to community placements, if appropriate. Since the program has been developed approximately 300 people have been diverted from having to be institutionalized. Medicaid is to be commended for doing such good work with its FOCIS program.

Dave thanked the Council for helping to fund the PASRR program. Without the support of the Council, they would not be able to do what they have done. Not only run the program day to day, but also be able to comply with their federal mandates. The Council's support is very much appreciated.

Dave asked for questions or comments. Rene asked if a person in a nursing facility has a mental illness II-B, they can get services from MHDS. Does the resident have to be brought to MHDS, or do they have to go to a MHDS facility. Dave said it depends. For mental health services, they can be brought to a MHDS facility. A lot of it depends on the transportation. Medicaid will only pay for the transportation only if the services being rendered A) is a Medicaid benefit and B) if prior authorization is necessary or some sort of service management that has to follow the Medicaid guidelines. If those criteria are met, generally speaking transportation would be provided. In some cases, MHDS provides it. In a lot of cases private providers will provide it. Medicaid will only cover it, if the client is Medicaid eligible and service guidelines are met. Most people in a nursing facility are Medicaid eligible but if they are not Medicaid eligible this will not pertain to them. It really varies on who provides the service and who pays for it. Rene said she works in a nursing facility and has seen some information in the charts and wanted to know how they can help. Dave said it is usually the Director of Social Services that is responsible for PASRR in the nursing facilities. It should be in the care plans. They have made great improvements with education in the reviews over the last few years. It forces them to recognize that the person has the mental health needs, but that they are to either provide or arrange for it. Coleen said the services can be delivered at the nursing facility. They can arrange for example a Psychologist to go to the nursing facility and provide services there. Rene asked if there is anywhere that staff can get training on how to more effectively interact with those who are mentally ill. Dave said there is. He is on a workgroup committee provided through the University of Nevada by Dr. Jane Fischer. She runs the Nevada Enrichment program as well. She is actually doing and looking for nursing facilities and group care providers and they are willing to provide if the nursing facility will open up for the day and allow staff to attend.

The primary focus is people with Dementia and Alzheimer's who may or may not have a mental illness. Specific to MHDS they do training, but it is more focused specifically to PASRR and the nursing facilities responsibilities rather than interventions with clients.

Corrie asked in regard to Olmstead, does MHDS make the final determination. Dave said the final decision could happen two ways. It would be Magellan's decision while they are in a hospital. If they are admitted to a nursing facility, Magellan has already done their portion, so it would be one of the regional PASRR coordinators who feels the resident can be discharged in 90 days based on their medical condition, their PASRR needs, and first and foremost the availability of resources in the community.

Patricia thanked Dave on behalf of the Council and turned the floor back to Rene. Patricia said other guests had also arrived, so if they would introduce themselves.

4. BUDGET UPDATE

- **MHDS**

Dr. Harold Cook said there will be changes in the Mental Health Block Grant. They are already seeing changes. The changes will affect what this Council does; it will affect how mental health services are delivered in the state. It will affect to a large extent how the money for the Block Grant is dispersed. At this point, a lot of the money goes to state employees to fund positions. He does not know if it will continue. It may have to change and that will have a huge impact on MHDS. These are things they need to be paying attention to. The issue they have at this point is that the Federal Government is being very cagey in rolling out what these changes are going to be and it is unclear what dynamics are driving this. It does seem to be the case that the office of Management and Budget at the Federal level is dictating to SAMSHA how this is going to work. There are a lot of cost control issues with respect to the Mental Health Block Grant and the SAPTA Block Grant. All of this is happening behind closed doors. His fear is that some point within the next year or two, the Federal Government is going to say mental health has to change everything they are doing and go to plan B and they have 30 days to do it. Healthcare Reform will also have a huge impact on how MHDS does things. There are two probabilities that they need to look at. One is mental health services within the state, will probably have to focus a lot more on preventative items instead of just treatment. The other is the Block Grant will probably have to work on covering the gaps that health insurance and Medicaid will no longer provide for.

The other thing the Council needs to be aware of is to some extent they are talking about in terms of budgets is a zero sum gain. If Medicaid needs more money, MHDS may get less. If MHDS has a compelling case to make for receiving more then another agency may get less. They have according to the economic forum

5.38 billion dollars in state funds to spends over the coming biennium. Agency request budgets which were submitted in September 2010, total approximately 8.2 billion dollars. There have been ongoing discussion and adjustments to the agency request budget, which he will cover. The agency request budget is not what they will hear from Governor Sandoval on January 24, 2011, when he presents the State of the State address.

Dr. Cook suggested going to the State website, Division of Budget and Planning, and look at the agency request budget. The entire state budget request is there, and it is very large. The MHDS budget is part of that and it is about 50 or 60 pages of the entire budget. Governor Gibbons mandated last summer that all State Agencies submit a budget with 10% cuts in general funds. The 10% is from the 2009 budget. In real practical terms, that means that MHDS had to cut 45.5 million dollars in general funds. In addition to that, MHDS lost 6.5 million in Temporary Aide to Needy Families (TANF). This is a program that is run out of the Division of Welfare and Social Services. They have been providing this TANF money to MHDS for years, but they now need it to provide aide to families for housing, food, etc. MHDS has been using it to fund autism programs for children. As a result of the 6.5 million reduction in TANF funding, the agency request budget will eliminate all autism specific services.

The same thing is happening with tobacco settlement funding. Tobacco settlements funding is a result of a law suit by states against tobacco companies approximately 10 years ago. The reason for the lawsuit was smoking is really bad for your health. Because it is bad for health it is bad for Medicaid, because State Medicaid programs pick up a lot of medical expenses for treating tobacco caused illnesses. All of the States received money from the tobacco companies. The state can use that money in any way they want. The State of Nevada used it for medical services. For a number of years MHDS has received approximately one million dollars a year. This has been used to provide senior outreach programs in the north and south. They provide service coordination and counseling services for senior citizens in Clark and Washoe County. The tobacco settlement money is getting less because fewer people are smoking and because the need for more basic type services (food, housing, etc) has increased due to the economic problems the state has experienced. The money has been redirected to that and the MHDS senior services outreach program will be eliminated.

Without touching the general fund MHDS is losing the autism and senior outreach programs. The other things that are being affected by the 44.5 million dollars in the general fund cuts, in mental health alone, there are 135 positions being eliminated. 75 of those are in the south, 40 in the north, and 20 rural. The PACT team in Clark County is being reduced by 50%. They are reducing bed capacity at Lake's Crossing Center (LCC) from 70 to 66. They are reducing supportive living arrangements throughout the state. They have already closed one mental health clinic in Washoe County, the Linden State Clinic. They opened it in 2007/2008. They are eliminating all of the psychosocial rehabilitation. They are

reducing outpatient counseling, depending on the region, it can be anywhere from 25 to 50%. The Mental Health Court is being eliminated in Clark County and being reduced by 50% in Washoe County. In Washoe County, the mobile outreach team is being eliminated. In Southern Nevada, the consumer assistance program is being reduced. Service coordination is being reduced in Rural Mental Health. In addition, they will be changing Rural Services quite a lot. The clinics that are in the south, Pahrump, Laughlin, Moapa, Mesquite, and Caliente will be moved into the Southern Nevada Adult Mental Health Services budget. That will reduce the number of clinics in Rural Mental Health by six and leave only the clinics in Central and Northern Nevada. They are consolidating rural mental health and rural developmental services into one agency. The affects of that will be the elimination of a couple of administrative positions and a consolidation of management into one agency. By consolidating these two services, they will be able to mix and match the staffing and perhaps provide more comprehensive services. Dr. Cook gave an example. The hope is this will provide more efficient and effective services with reduced staffing. In SAPTA there will be reductions in co-occurring treatment, pilot programs. They will be eliminating one Administrative Service Officer (ASO) position, and they will reduce prevention funding by 4.5%. There are a number of vacant positions that they will not fill.

These are the cuts, they do not sound wonderful. There are some things they did avoid. They were able to preserve some mental health court. They did not have to close any clinics in the south, and initially it looked like they would have to close clinics in the south. Rene said the southern clinics will be going under the SNAMHS budget, she asked how it will affect the children. Dr. Cook said there will be no changes in services; this is only a change in who runs the program. The reason they did this, is it make more sense management wise to have the program managed from Las Vegas with all the management resources they have there rather than from Carson City. He said an issue came up in Mesquite this past summer that required management intervention. They were already in the process of transferring management over to SNAMHS. Had the management intervention been necessary from Carson City, it would have taken two day to arrange the transportation and to get someone down there. He was able to make a phone call; the person got in his car and was in Mesquite in two hours. Coleen said they are all in the same position trying to find what little ray of hope. She said they had a situation Elko and Medicaid thought MHDS was already set up and they had a situation in Elko and they did not realize the travel time from Carson City. She believes this consolidation will help. Dr. Cook said it is throughout the rural areas. It will take a while to get there. They have staff that needs to be reoriented.

Dr. Cook said the agency request budget is just the beginning of the budget process. With Governor Sandoval there have been ongoing adjustments to the budget and those will be made public on January 24, 2011.

A parallel process to state budgeting is Priority of Government Services (POGS). They are working on and developing this. This has an impact on how they structure their budgets. The process forces them to define the activities they are engaged in, for example: outpatient counseling, outpatient psychiatric services, psychosocial rehabilitation, inpatient hospitalization, residential support. They define what those are. MHDS has some 70 activities that they have defined. Then they prioritize each of the activities. There are three priorities, high, medium, and low. High priority activities are those that are mandated in Constitution (the State or Federal Constitution) or have some sort of Federal law or mandate behind them. Things like the Olmstead decision in 1998 have a huge impact on the priorities for residential support and inpatient hospitals. The Nevada Constitution has a clause in it that states the State shall maintain an institution for the insane, blind, deaf, and dumb. The State has to maintain an institution; how they define institution is another matter. With mental health services in general, there are very few of those types of mandates as opposed to other services. Medicaid has a lot of services that are mandatory, that if the State of Nevada is going to do Medicaid, they have to provide those services. Chuck has very limited options in terms of where to cut. Mental Health Services are not quite as protected. They have some services that seem to be defined in State law that they have to provide. However, State law can be changed. State law only provides a medium priority for services. Some of the services Dr. Cook has discussed as being cut are being cut because they are low priority. The mobile outreach team in Washoe County, there is nothing in State law that makes MHDS do this program. There is nothing in the Constitution do this program, therefore it is low priority. Psychosocial Rehabilitation is another case, there is nothing in State or Federal law that states it has to be done. This makes it low priority and it gets cut. Many medium priority programs were reduced.

Dr. Cook said he understands it sounds harsh. In each case where they have had to cut a program or a position, it is wrenching. Everyone up the chain of command understands this in not what they want to be doing. They are going to be hurting people, eliminating jobs, eliminating services that people need. At this level, they do not have another option. Down the road these cuts will cost the State more money. In reducing the autism services, the children will grow up without the services that will make them less dependent on state services.

Dr. Cook asked for questions. None were asked. He said advocacy starts here. He said he has spoken throughout the State at Townhall meetings, and he has instructed people to contact their elected representatives if they are not ok with what is being done, because that is who will have the final say over what happens with this budget.

- **DCFS**

Patty Merrifield said a lot of what she has to say echo's what Chuck and Dr. Cook has said. The 10% reduction does not get to the State revenue. They were all mandated to present budgets with 10% reductions.

In Children's Mental Health and DCFS, they are less than 10% because as people saw what 10% looked like, they were one that benefited from some deeper cuts in their own division and some at the department level. They took a pretty heavy hit during the special session in February. They lost 10% of their positions. They ended up closing one of five treatment homes in Reno. And the rest were positions. They are really slim on fiscal, administrative support, and they lost some early childhood outpatient, wraparound. What is coming in the 10% reductions? They are closing the second office in Reno. Like MHDS, DCFS was able to expand children's services in 2007 and they will be closing that. They are impacted by the reductions in the ARRA stimulus funding. The State match for Medicaid does not come from the Medicaid budget, but the state budget. In Children's Mental Health and DCFS about 80% of their revenues are dependent on the 14% of Federal cut. They were able to figure out how to get more Medicaid dollars by taking their Wraparound in Nevada (WIN) statewide. They have a separate budget. The administrative support for the WIN program has come from their agency SNACS and NNACS budgets. By moving WIN to the NNACS and SNACS budgets, they saved 300,000 in the state budget. Other cuts they received during the special session were contract funds, they contract for mental health rehab services, for children who are uninsured. They also took cuts to the placement prevention funds, which are spent for housing, rent, deposits, utilities, etc., for families that are at high risk of losing their homes or paying rent and utilities.

Something that is not in their budget, but will affect children's mental health services is DCFS pays the room and board for all treatment homes for all children in treatment homes across the state. Medicaid gets medical authorization from Magellan for their mental health rehab services provided in the treatment homes. The room and board for foster care is funded through Title IV funds which are federal or state matched. Foster Care and Child Welfare Fund will continue. The room and board for all children that are in parental custody, that includes children on probation, on parole, etc., the funding for that was TANF funding. Like MHDS, DCFS lost their TANF funding. They have reallocated some positions. The other program being cut is on of their early childhood day treatment centers. The maximum daily capacity is 12.

An unknown for DCFS is in the last session they were funded under capital improvement to build a new children's acute hospital in Las Vegas because there are regulations that state they are not able to have prevention treatment and acute care under the same roof. The architecture plans are done. As far as she is aware, the capital improvement funds are still there. The legislature will have to decide the time table for the build, and will they start late winter or early spring or will they wait. They did not add staffing the hospital or the utilities that would need to

be on if they build. They will need to determine where the money to run the hospital will come from if it is built.

What is interesting is in the last year, the rates for acute hospitalization for children have dropped. Most private and state hospitals have empty beds, which a year ago and before they had children waiting in emergency rooms. The vast majority of children they serve at Desert Willow Treatment Center are uninsured. Patty asked for questions. The full text of the Governor's budget should be online on January 25, 2011. Roger said the cuts that Patty mentioned are detailed in the Implementation Report.

- **MEDICAID**

Rene gave the floor to Chuck Duarte, the Administrator of Nevada Medicaid. The Division of Health Care Finance Policy (DHCFP) is responsible for the administration of Medicaid. They also administer the Nevada Check Up program, which is the State's Children's Health Insurance Program. He does not have any hand outs today. The Governor's recommended budget is confidential until the State of the State address. He is going to talk about some concepts and issues they are dealing with. Some of the key issues they are attempting to address through the budget. Obviously revenue shortfall is a big deal. They also have other issues including a reduction in federal revenue as a result of the ending of the American Recovery and Reinvestment Act, which subsidized Medicaid at a higher federal matching rate for almost 24 months. The caseload growth has been one of the fastest growing on a percentage basis if not the fastest growing in the nation. And Health Care Reform and its implications on the Medicaid budget and also potential implications for the Council to think about as they move forward with planning activities.

The revenue shortfall is a huge issue for all departments in Health and Human Services. Medicaid makes up slightly over half of the State General Fund appropriated to the department during any fiscal period. It remains about the same although they are growing as share of the State General Revenue for the department because of caseload growths. When looking at the department Medicaid looks rather large, not from a staffing point of view, but from a spending point of view. For DHCFP, their personnel budget makes up 1% of their budget. There total administrative expense is 5.5% and that includes what they pay the Welfare Division to do, eligibility work, what they pay Magellan to do, claims administration and medical oversight, what they pay a host of other vendors to do. Compare that to insurance companies, which run 18 to 20% for their administrative overhead. They seem to be pretty lean in comparison to commercial entities.

When they look at where they spend their money and where they have to make cuts. The majority of it is going to come from medical expense, what they pay providers for services. About 96% of their budget goes to private sector

providers. The rest goes to unidentified providers or to public entities, school districts, sister agencies like MHDS. Those dollars are used as general revenue by these private entities, hospitals, physician's offices, mental health providers, pharmacies. It is revenue for them and jobs for them. Medicaid is for the most part a private entity. It is privatized to a tremendous extent through contracts of providers and administrative entities. Whatever they do to affect the budget will affect the private sector and patient care. Chuck and the Director have been very clear that what they do with the Medicaid budget will have an effect on lives and livelihoods. They understand that this means jobs in the private and public sector and it will mean patient care. The other thing to keep in mind is who they spend their money on.

When Medicaid spending in broken down on a pie chart and split it into the different entities. They see that Medicaid is like three programs in one. First they are an insurance company for low income families who can not afford insurance, primarily mothers and children. They make up 70% of the caseload and it is growing, but about 35% of their spending. Then the other part of their program is they are a supplement for the Medicare program. They serve approximately 25,000 who have both Medicare and Medicaid and they serve thousands more who are Medicare patients that are low income for whom they pay premium co-pays and deductibles. So they are a Medicare supplemental program for low income seniors and disabled people. The third thing is a program for the disabled. Long-term disabled people who have been determined by the Federal Government to be disabled and have supplemental security income (SSI). The statistics of people who are on SSI is approximately 50% have a mental health diagnosis along with very serious medical conditions. Medicaid spends 70% of their budget on the aged and disabled and 30% on mothers and children. The caseload is 70% mothers and children and 30% aged and disabled. Whatever Medicaid does it will have an affect on the aged and disabled, because that is where the money is spent. It will affect mothers and children too.

At this point they are covering approximately 280,000 people. If they include Nevada Check Up then it is about 300,000 Nevadans and rapidly growing over the last two years. It is projected to grow even faster. This is predominately in the category of mothers and children. These are families who are losing employment, who are either a one paycheck household or no paycheck household, who have lost Cobra coverage and may have lost their unemployment insurance benefits by this time and so they are applying in droves. They will probably continue to apply until 2014. As of this date, they are projecting that by the end of June 2013, they will have 312,000 Medicaid recipients. They are going to grow from approximately 280,000 to 312,000 recipients on average. That is a fairly rapid caseload growth. They are expecting to see a slight decline in state fiscal year (SFY) 2013 at the end of the fiscal year. They are also seeing rapid growth in the aged and disabled sections.

Medicaid has some constraints on what they can do. These are issues imposed as a result of two pieces of federal legislation. One is the Recovery Act (American Recovery Reinvestment Act (ARRA)). That imposed some maintenance of eligibility criteria on States. As a result of getting additional federal funds through ARRA, they had to maintain eligibility. This was continued under the Affordable Care Act, the Health Care Reform Law. So over the next nine years, they are prohibited from affecting children, and for adults through 2014. They are prohibited from doing anything that affects people's eligibility for Medicaid. States deal with Medicaid deal with budget reductions in several ways. One is eligibility. They can not look at that because federal law prohibits them. Two they reduce provider reimbursements, three they impose service restrictions – limitations particularly on adults, because for children they have to provide whatever is medically necessary. The fourth thing they do is eliminate services. Medicaid consists of two types of services, one set are mandatory, those are items like hospital care and physicians services. Hospital services include a great deal of the mental health rehab services for adults. The other is optional. Pharmacy is an optional service.

When looking at what is available to state budgets in terms of dealing with Medicaid, there are really only three things they can do. Cut reimbursement, put controls on utilization and the third is eliminating optional services. Chuck said Governor Sandoval has already said he is not interested in cutting optional services. So they have two things left, service restrictions and rate reductions. Looking at what will yield the largest amount of savings potential. Service limitations can yield some savings and they will be consistently looking at those. There are not necessarily a large number of those in the budget. There are some that continue from this fiscal period forward, but they do not have a host of new service limitations. What is left, provider rate reductions. Because of where they are in terms of federal judicial regions, there have been some decisions made in the ninth federal circuit in the courts there that could put some restrictions on the levels of cuts they can do to provider rates. They are moving forward with provider rate reductions at this time in the arena of 15-25%. There is potential for litigation and they may need to re-evaluate what is cut. If they are unable to do provider rate cuts, they still have to cut the budget and the only thing left is eliminating optional services. The option they are looking at most heavily are provider rate reductions.

This is how they will deal with the revenue shortfall, how they will deal with caseload growth and the cost that comes with caseload growth. The people affected are those that utilize the services, and most of the services are utilized by the aged and disabled. Particularly in and out patient hospital care, special services, etc. In the past, they have made every effort to try to preserve primary care physician service reimbursements. If they move forward they will probably be affecting specialty physician rates, more so than primary care physician rates.

Coleen asked Chuck to address optional versus mandatory eligibility groups. Chuck said they have two categories, one is mandatory and the other is optional. For the most part they cover what they call categorical eligibles; those are individuals they have to cover under federal law. There are a few small eligibility categories they cover that are optional. Disabled children who would otherwise be in a hospital or nursing facility, there is a program called Katie Beckett named after a young girl who lived in a nursing facility for many years. They also cover who age out of foster care up to age 21. They cover women up to 200% of the federal poverty level who are diagnosed with breast or cervical cancer or precancerous conditions. These are very small groups and would not be much savings, but they can not affect those due to the maintenance of eligibility requirements in the Affordable Care Act.

Another issue is the shortfall they project as a result of the termination of the enhanced federal match that comes with American Reinvestment and Recovery Act. They estimate they will probably need somewhere in the area of 216 million dollars in general funds to fill the hole left by the loss of federal funds. That is in addition to covering caseload growth and a part of the revenue shortfall.

These are very serious issues, very large numbers. It will affect jobs, lives, and livelihood. In terms of Medicaid's effect on the health care industry in Nevada, because the majority of the money is in private sector entities, it will affect private sector entities and most of those services go to the aged and disabled. Over the last three years they have made every effort to try and preserve services as long and as much as possible. It is no longer possible for them to say people will not be affected.

Patricia asked if the providers will have to treat people or will they be able to refuse Medicaid. Chuck said they can say they will not take Medicaid, however if they take Medicare, then they will find if an individual is dual eligible, the patient will lose benefits if they see a provider who does not take Medicaid but takes Medicare. Chuck said they will pay for the co-pays, deductibles, coinsurance that Medicare requires the patient to cover. If they are dual, this will be covered, but if a provider is going to do just Medicare, then the provider will have to make sure they have the patient sign a statement understanding that they will be responsible for their own co-pays and deductibles. A large number of people with disabilities including mental health disabilities have both Medicaid and Medicare. Corrie asked if the Medicaid supplement will end for those who are on Medicare. Chuck said no, it is a federal requirement that Medicaid act as a Medicare supplement program. Lydia said she has worked with families who have applied for SSI and Medicaid, and they have been denied the Medicaid services due to the application of SSI. Is there any reason behind that and how can they help them? Chuck said in Nevada the determination of Medicaid eligibility is dependent on the SSI determination. They have looked at other alternatives. They have been asked to consider different types of eligibility for single adults who are disabled but can not get SSI. There are options available; one of them is called the

Medically Needy Program. Any individual can qualify for Medicaid by spending down their income. They basically count their medical expenses against their income to determine if they can make the income eligibility requirements for the program. About 30% of the spending is on the medical needy. Lydia asked if in the earlier scenario they would need to reapply for Medicaid for the person who is turning 18. Chuck said yes. He said to apply for the SSI first and once he is determined SSI eligible, then apply for Medicaid. It usually takes less than a month. There are also new provisions in the SSI laws. They are called compassionate care provisions in the SSI laws that Congress passed. He believes there is a host of mental illnesses that are listed. There are specific diagnoses that if someone presents with medical documentation of that diagnoses, they are eligible for SSI. Rene asked if this includes children. Chuck said it is harder for children who have a Serious Emotional Disturbance (SED) to get SSI. What he has been told by physicians who make those determinations is they are very reluctant to label a child permanently disabled with a mental illness. They will classify a child as SED, but by classifying them with SED the child does not meet criteria for SSI.

Chuck said there has been a lot of discussion in the press about Nevada's choice to sue the Federal Government over the Healthcare Reform Law. Governor Gibbons and now Governor Sandoval has said the Federal Law is the Law until it is not the Law, so unless it is repealed they will continue to move forward aggressively with implementation.

They have some budget items to implement the Healthcare Reform. In the IT projects, which are extremely necessary for them to implement a very important provision of the Healthcare Reform Law which takes effect January 1, 2014, that is the development of what is called the Health Insurance Exchange (HIE). The exchange is essentially a market place that will offer individuals qualified health coverage. Insurance polices essentially that have to meet certain criteria. The exchange will be a market place for individuals as well as small businesses who want to shop for health insurance. Federal law also dictates that the exchange policies offered have to meet certain criteria. They call them bronze, silver, and gold standards, which defines certain levels of benefits. Also within the law, there are certain minimum benefits that must be covered and they do include mental health services. What mental health services are covered is still an open issue and whether they will cover rehab services is also an open issue. The parity law that passed several years ago was weak in a lot of regards because it did not apply to a lot of different insurance companies. A lot of companies did not have to offer mental health benefits. His understanding of the Affordable Care Act is that if they are a qualified health plan, they will need to offer mental health benefits and they have to meet certain parity provisions. It is very complicated. There are certain actuarial studies that have to be done to show that they meet the standards for inclusion in a qualified health plan offered through these health insurance exchanges. Certain plans do not have to have mental health benefits. A lot of self insured employer plans do not have to meet those criteria.

The exchange will be the market place to purchase insurance. They are estimating between 3 & 400,000 Nevadans will buy insurance through a Nevada Exchange. There are a lot of policy issues associated with the exchange. They will be moving forward with planning activities and recommendations. In terms of Medicaid's role, they will be expanding in 2014, to cover individuals up to 138% of the federal poverty level. Contrast that with who they cover now. Now they cover people up to about 30-32% of the federal poverty level. This is a big jump in eligibility. They are expecting approximately 150,000 new lives to come on to Medicaid as a result of the increase in poverty level. Medicaid will be a large part in the expansion in closing the gap on the uninsured besides offering the exchange coverage to individuals and small businesses. By expanding Medicaid and offering affordable insurance on the exchanges to people who can not get it otherwise will close that uninsured gap. People who are below 400% of the federal poverty level will get subsidies and tax credits through the exchange if they purchase insurance. There are incentives for individuals to purchase through the exchange and they will be on a tax basis as well a subsidy and credit basis. Corrie asked if he believes the exchange will affect Medicaid. Chuck said if the person is below 138% of the poverty and they apply through the exchange, they will be put on Medicaid. Rene asked how much is 138%? Chuck said approximately 41,000 for a family of four in today's dollars.

Medicaid will be expanding tremendously as a result of this. There will be additional state costs. They have actually already started planning and developing technology activities to deal with what will be needed in 2014. They have a one million dollar Health Insurance Exchange Grant. He has two dedicated staff working on it as well most of the other managers and chiefs

Chuck said he wanted to leave the Council with something to think about in regard to their planning activities. One is parity, help define parity. Those rules will be established at a federal level of what parity really means in the law. The second this is if the majority of services will be provided through the exchange for individuals who are currently uninsured, how else can State, County, and Federal Grant dollars to pay for services that may not be covered through the Health Insurance Exchange plans. What else is out there? He believes there will be a lot of rehab services that people have gotten used to receiving for their children, family members that probably will not be paid for under Exchange Coverage. He believes they can count on Exchange Coverage paying for Psychology services, Mental Health services, and Mental Health medications. He does not believe Psychosocial will be a part of it, he may be wrong.

There is a line defining coverage for qualified plans, called habilitation. No one knows what it refers to. It does not apply to Medicaid; it applies to qualified benefit plans that are offered through the exchange. Due to advocacy that went on during the Congressional hearings, they think it means services for children with autism, but they are not sure. All of this needs to be defined and this is

where advocacy comes in at the Federal level. This will be a whole new world and looking at health coverage through a completely different lens after 2014. The way the State is structured in regard to delivery of services may change dramatically. He believes there are efforts under way to look at Federal Grants after 2014 and possibly cutting them. There are discussions that if services are going to be provided through the HIE programs, then they do not need the federal grant programs to pay for the under insured or the indigent. Hopefully that is not the case and States will be able to preserve federal grant funding and other funding they have to continue to provide services that may not be covered through health insurance programs offered on exchanges.

Chuck asked for questions. Patricia asked if the healthcare reform will have an affect on providers having to provide services for Medicaid. Chuck said it will not change. State policy can not affect Federal policy. Roger said at the Council's last meeting there was a conversation at one of the last meetings in regard to Medicaid payment for consumer supported services or peer services. He wanted to know if this would be one of the optional services that would be cut. Chuck said Governor Sandoval has already commented that at this point, optional services are not to be cut. Peer support was not cut in their agency request budget. Coleen said in the August meeting they were discussing utilizing the grant funds. There was mention of how Oklahoma was looking at how other states was using grant funds and peer support was one of them. As their funds become tighter, they have to look at how they are utilizing funds for the grant a service such as peer support that is not highly utilizing expenditures; they have to look at the importance of optional services versus mandatory. The group does need to look at how other states are using the funding of the grant and look at the priority of the services at the exchanges. They may not be offering some of the rehab services in comparison to standardized insurance plans. Chuck said the other thing to keep in mind is that Medicaid is unique among medical coverage plan. Medicaid is unique in paying for mental health rehab services. Insurance companies do not pay for rehab services. They have medicalized a social program. This has been good over the last decade or so. At the federal level there is a lot of activity going on in the office of the Inspector General at HHS, CMS. They have been directed to look at a lot of mental health services from the stand point of making sure that they are medically necessary. They have had issues with providers, particularly with children. Essentially this is the direction where Federal and State Government is going. They will be looking to make sure they cover medical services. Medicaid is a medical coverage program. What is being seen at this time is ongoing restrictions with respect to what Medicaid dollars can pay for in respect to social services. It is probably important to start thinking about this issue as a part of the new dynamic under Healthcare Reform and parity, but also as to where the money is going. Using other dollars that are not necessarily Medicaid medical dollars for coverage of other essential services. Lydia asked if a person should file for Medicaid prior to turning 18 or after. Chuck said he is not sure that being 18 is important, what would be important is if

the person has SSI. If the person already has SSI, then get the application in for Medicaid as soon as possible.

The Council thanked Chuck for his presentation.

5. LEGISLATIVE UPDATE

- **MHDS**

Rene gave the floor to Marty. Marty verified everyone had the handouts. This is a pre-session update on how things are looking so far. There are approximately 30 new members to the Senate/Assembly, that is just a little under half Senators and Assemblymen are going to be new. Approximately seven of the 30 have previously served in one of the other bodies. A lot of new faces will be there to attempt to address the issues. Advocacy will be a real key especially to a lot of the new people who are unfamiliar with MHDS. The new members have altered the majorities in the houses a little. There is no longer a veto proof majority in either house. There will be an increased need for cooperation among both parties if they want to be able to pass things through or override certain things that they feel are necessities. Marty pointed out the list of members with contact information.

As of December 10, 2010, there were 619 pieces of legislation that had been drafted. That number has gone up since then. 160 bills were pre-filed right after he submitted the packet for the meeting. These bills are the BDR's being tracked by the MHDS. The pre-filed bills are already available for public comment and viewing. These bills will also be first to be referred to committee and have hearings held on them the first week of session. On February 7, 2011, when the session starts, they will refer these bills to the committees and when the committees meet in the second or third day, they will start hearing these bills. Of the bills that have been pre-filed so far, he will be watching AB16 – Physicians employed by the Department of Correction for being available to be called in to work during periods in which they are not regularly scheduled to work, AB31 – Revises and exemption from the provisions governing contractors, AB37 – Revises provisions relating to the hours of operation of state offices, AB48 – Revises provisions governing children's mental health consortia, AB50 – Revises provisions relating to the licensure of medical and related health facilities, AB51 – Revises provisions relating to certain providers of emergency medical services, AB54 – Authorizes the establishment of a medical district in certain counties, AB61 – Creates a permanent entity to study issues relating to substance abuse in this State, SB10 – Requires approval for the establishment of certain services by a

health facility in larger counties, SB23 – Clarifies the entity responsible for carrying out certain duties relating to the adoption of a child with special needs, SB43 – Makes various changes relating to electronic health records, SB44 is one of MHDS's bills – Requires the Division of Mental Health and Developmental Services of the Department of Health and Human Services to adopt certain regulations. They are taking a look at the bill to see how it has come out so far, but especially the changes in various places in statute where it says client, it changes it to consumer, just to bring it in line with the modern terminology used. It also encourages the Division to adopt regulations of when the consumer may receive services. SB61 – Makes various changes relating to social work. If there are any questions in regard to these bills or if there is something the Council believes they should be watching, let Marty or Roger know and he will add it to his list.

The party caucuses in the Assembly and Senate met after the elections and made assignments for leadership and committee assignments. The most news worthy out of that is that Senator Raggio is no longer the Senates Minority Leader. He has been replaced by Senator Mike McGinness. Senator Raggio has also declined to serve on Senate Finance. He is probably the longest serving Legislator in terms of serving on Senate Finance and how the budget works and how the State Government gets financed. Attachment C which was titled attachment B in error shows the new committee chairmen and makeup of committees.

The legislature as a who will be looking at revenue and taxes as a whole. The pre-filed bill list that was handed out has a number of bills that deal with at some point or other raising revenue, altering tax formula that has to do with the state budget. Education and Health and Human Services are going to be two very large items discussed and how they will be apportioned out. With this last year being the census, the reapportionment will be how they will divide the population and readjust new Senate and Assembly Districts. Whether they will add districts and it will affect the Federal Congressional seats district. This will be a very contentious issue especially with the narrow margins of Democrats versus Republicans in the Assembly and the Senate.

Important issues to MHDS are preservation of services, what the budget will look like and what they will preserve for consumers. Use of consultants and contracts, there was an audit that came out that was a critical review of how they use consultants and how they manage their contracts division wide. The legislature will take a closer look at this to make sure that they are making the most effective use out of the consultants and the contracts that they employ. Potential closure of rural area facilities, consolidation of agencies and functions will also be looked at.

The session is set to start on February 7, 2011. This will be a fast moving session. The pre-filed bills will probably be added to over the next month, so the first week is going to be very busy. MHDS will be watching testimonies. Marty will

continue to make the information available through Roger. If the Council would like, Marty will make a mid session update available.

Marty asked for questions. None were asked.

- **DCFS**

Patty said they went through the Bill Draft Request (BDR) yesterday during the training. It is very difficult to figure out at this point what the proposed bill means because they have a phrase as to what the bills are. All children services are going to be cut and some services are delivered by the county. People have probably seen some things in the newspaper about what the Counties think. The indications in the paper are the Counties are going to be picking up the services. She believes the possible impact for children's mental health as the session goes forward are people saying some of these services are more important. It has happened in the past. In lean times unfortunately, they look at other programs and budgets and say they are not doing it as well. She believes they are going to hear that people want more and they believe they can get more by closing something else. They will not see it with sister state agencies within the department, but they will see it with local Governments. Legislatively they are just starting to track the bills.

Patty said the Joint Money Committees will meet before the session starts. She is not sure if they will be video broadcasted. It is an opportunity to hear an overview of the Governor's recommended budget. Roger said they will be video conferenced as soon as they become available, he will continue to post the meetings as he did last year for the meetings that are relevant to mental health issues.

- **COMMISSION**

Neither Kevin Quint nor Dr. Crowe was present.

6. CMHS REVIEW REPORT

Rene gave the floor to Cody. Cody said they have a visit from the Federal Government on June 8-10, 2010. They reviewed the use of the block grant funds and Nevada's programs. The Federal Government produced this document and then sent it to MHDS and DCFS for accuracy. There were no findings, which mean that there were not any requirements to make corrections. They did provide some assistance on the maintenance of effort calculation. It has been extremely complicated, and partly because it is fundamentally complicated and partly because of changes in personnel. Cody asked Roger for additional comments. Roger said on the Executive Summary page IV, item number five, under technical assistance. Rene and Patricia requested technical assistance for the Council. Some of that was received yesterday, during the training. Item B, they received

some of that in August, but they can continue to work on that. Reviewing the block grant application and procuring public comment will be discussed under item ten. Cody said the division has also received some technical assistance particularly on a request for information (RFI) for psychiatric services that is being conducted in Southern Nevada. Coleen asked if they worked on QFC's and if Cody can work with her on it. Cody asked for questions. None were asked.

7. BLOCK GRANT DEFENSE UPDATE

Roger said for the first time they did the Block Grant Defense via video conference. Generally the Federal Government has required the States to attend the regional meetings where they have about an hour and a half to explain the Block Grant Application and the reviewers will have questions and comments.

As a result of this review there were no additional findings or questions on the Block Grant Application. The Block Grant Application update has been mentioned by both Chuck Duarte and Dr. Cook that the Block Grant is going to be changing significantly for a number of reasons in the next year. Since he requested this agenda item, there have been significant changes and they will cover that in item ten.

Roger asked if it would be possible to break for lunch and then do the Implementation Report after lunch as it leads into the Block Grant Application.

Rene will not be able to come back after lunch. Patricia will chair the meeting after lunch.

Roger asked for questions. None were asked.

The Council adjourned for lunch at 12:00 pm.

8. IMPLEMENTATION REPORT

The meeting reconvened at 1:22 pm.

Patricia gave the floor to Roger. Roger said it is a requirement for every State to complete a report on how the plan from the previous year was implemented. This report speaks to the results from July 1, 20009 to June 30, 2010. The first page is page number 14. There are three pages of block grant budgeted versus expended analysis for state fiscal year (SFY) 2010. This shows in fairly great detail the amounts of money budgeted and expended. There were approximately 60,000 budgeted and not expended. This is primarily due to the restrictions on travel. Then there is money allocated for adult mental health services and for the most part they were fairly close to what was budgeted with the exception of Rural Clinics. On page 15, there is a line item for outpatient mental health staff salaries. Approximately $130,000 more than what was budgeted was allocated. This was

an effort by the MHDS fiscal staff to plug a hole is staff salaries in rural clinics because of the cutbacks that occurred. They used money that was not spent elsewhere to pay for those salaries in the rural areas. The total amount for adult services spent was approximately 1.7 million.

DCFS had approximately 60,000 left. The total amount not spent was approximately 25,000. The money was not lost, because the way the money is granted, there is two years in which to spend it. The fiscal staff is always making sure that the oldest money is spent first. The money will not have to be returned to the Federal Government.

Steve asked if the Block Grant completely finances the MHDS programs. Roger said this is a portion of funding that goes to these programs. In some cases it is 100%. NNAMHS and SNAMHS have specific salaries that are funded. Cody said it is the one position not the entire program that is funded. Patricia said on page 16 under DCFS, there is a sub-grant for the system of care for Nevada PEP. She did not realize they had any sub-grantees. Roger said that one is a sub sub-grant because that is something that DCFS has been allocating that amount to Nevada PEP for the system of care support. Roger said on page 24, there is the description that came from DCFS the purpose of the sub-funding. Patricia asked if DCFS does the oversight on the sub-grant. Roger said this amount is including in the approximate 1.8 million that is budgeted to DCFS. Corrie asked if this includes rural outreach. Lydia said there were rural service providers during the system of care training they did in Las Vegas three years ago. They are certified as a trainer in the rural areas. Corrie asked if she would need to contact DCFS. Roger asked Ann if she can get clarification on what Nevada PEP does with the amount of money and report back. Ann verified they are asking what services are being provided, service delivery in relation to the grant, and are they in the rural areas. Corrie asked about the Consortia operating support. Roger said it should be 3800.00. He will verify.

Earlier when Patty was talking about the reductions that DCFS faced during the special session. On page 20 there is a complete listing of the 37 positions that were eliminated.

Page 28 is a summary of the adult performance indicators and how MHDS performed on the goals that were established for the fiscal year. When they prepared the plan for 2010, they new there were going to be significant reductions. In prior years, the goals in all of the performance indicators had always been fairly optimistic assuming that growth is what they are attempting to achieve. When they prepared this report, they set the goals lower in anticipation of reduced funding and therefore an inability to meet the goals that were obtained in the prior year. In spite of the reductions, they almost met the actuals from 2009. This is a reoccurring theme on both pages. The exception is 1.2 – client perception of care, the goal was maintained. They were able to meet the goal.

On page 29, some of the goals are to limit the decrease in the number of adults receiving supportive housing services to no more than 5%. The column on the far right states whether the goal was met, and the only one that was not is the next to the last goal. Adults receiving medication treatment, the goal was to limit the decrease of the number of adults receiving medication treatment to no more than 5%, and the goal was missed by less than 1%. This is the only goal on the adult side that was not met.

Barbara asked if these are from the yearly surveys they do statewide. Roger said yes. Definitely 1.2, 1.3, 1.4, 3.3, and possibly 3.4 are from the survey. Barbara said this brings out the importance of the surveys. Denice questioned the percentage on 2.2. Roger said he will double check the percentage. On 2.2 the number should be 1,384. On page 34, it has the correct number. The next few pages are the format in which this information gets reported.

Page 50 and 51 is the summary of the performance indicated on the children's side. All of the targets were met. There was a similar strategy as used with MHDS. In fact, DCFS was able to increase the number of children served. Lydia asked where the information comes from for 1.7 on page 51. Ann said the information comes from Avatar. Corrie asked if they are being asked about this when they go into the shelter. Patricia asked how the data is gathered. Cody asked if it is during the assessment. Ann confirmed it is entered during the assessment, when they are entered into services. Denice asked if this is a reflection of the number of children who are not receiving services that should be. Ann said there are probably a significant number of children who are homeless or living in shelters that need to be in services. Roger directed everyone to the back of the book, where the page numbers start over. On page 24 and 25, this is URS table. On table 15, the first line, go across and the homeless shelters is 4. This is where the four came from for the 2010 actual. There are other, 883 and not available 594. Lydia said she has worked with families in the shelter and the children were SED. Roger said on the adult side this is also an issue. There is a percentage of people they are not getting the data on.

Roger asked if there were other questions on the performance indicators. None were asked.

After page 67, the page numbers start over. These are the URS table. They are very detailed. Many are generated from Avatar. The challenge they face is he gets a report from MHDS that covers all of the information on those age groups only for the people served at rural clinics because MHDS is responsible for those age groups in the rural areas. Then he adds the information from all of the children served in Washoe and Clark County. The National Research Institute, which is a branch of the National Association of Mental Health Administrators is contracted to compile and review all of the information from the URS tables. They look for inconsistencies and changes of more than 20% year to year. They had five items this year that they had to respond to. Roger said they do not ask

the types of questions asked earlier. Lydia said she knows there are a lot more children out there than providers think, because they are not seeing those children. Denice asked if the total 31,938 is the total of MHDS and DCFS clients. Roger confirmed. Roger said below that number is a box checked unduplicated, which means if a person is seen at more than one location, they are only counted once. Denice asked if that number is ever divided into the total amount received. She said she would look it up. Roger said this table had to be continued on the next page.

Roger asked for other questions. None were asked.

9. LUNCH

Meeting adjourned for lunch at 12:00 pm. Meeting reconvened at 1:22 pm.

10. BLOCK GRAND APPLICATION UPDATE

Roger said when he originally asked for this to be put on the agenda; he was going to discuss items that were for unmet service needs. Since this has been sent out, MHDS has received direction and information from the Federal Government that could substantially change the Block Grant Application process.

Currently the Block Grant Application that has been discussed in these meetings has been for the Community Mental Health Services (CMHS) Block Grant for 3.7 million. The proposed changes are to eventually combine the process for the mental health block grant with the application process for the substance abuse prevention and treatment block grant which is in the 25 million dollar range. Both of the grants come under the Substance Abuse Mental Health Services Administration (SAMHSA) at the Federal level. They are in the process of combining both grants because of the prevalence of co-occurring disorders of substance abuse and mental health are very high. The purposes of the changes are: the need for greater accountability of how block grants are spent, to establish consistency with the Affordable Care Act (ACA) and SAMHSA strategic initiatives, and there are eight of those. Roger will send those out as a separate document. They are also looking to establish a uniform framework for both block grants, and to make a transition into the year 2014 when the health care reform will be fully implemented. Corrie asked if these will become one grant application. Cody said it appears that is the direction they are moving in. They have given sections for which it will be a consolidated application and the option of doing a consolidated application. Barbara asked if it will affect the money they receive. Roger said he is not sure how to answer. He believes the block grant dollars will be used for different things. The four items that have been noted are: Treatment and support services for individuals with insurance; treatment and support services not covered by Medicaid, Medicare or private insurance. Coleen said she believes this is the point that she and Chuck were attempting to stress earlier. There are services that Medicaid may not be able to cover in the future

and the block grant has to look at those items. There are other block grants that Medicaid deals with that are not as large as this block grant. There are other block grants that may go away. They have been told what they do today will be different tomorrow and the state agencies have to look at what they are doing today and how it will be very different tomorrow with the health care reform. Roger continued on with the last two items; Universal, selective and targeted prevention activities sand services, and to collect performance and outcome data to determine the ongoing effectiveness of prevention and recovery services.

Roger said as of now the block grant is due September 1st of each year for the full fiscal year. The next due date is going to be October 1st, which is the date that has always been for the substance abuse block grant. They will have an extra month to prepare the joint block grant; however it is going to be for a fourteen month period, for the period of October 1, 2011 and ending June 30, 2013. Patricia asked if they were converting from a federal fiscal to a state fiscal year. Roger said they are. Cody said they are also going from a one year to a two year. Roger said they will submit a joint application and they are waiting for additional guidance. This is based on the guidance that the state has received thus far. It will be for a two year period and will be due every April. It will be due in odd numbered years, which is always a legislative year, and a very awkward time for Nevada to have to have a report due April 1st when the legislative session will not be done for another couple of months.

The common goals that the Fed's have laid out in very broad terms are in a word; health, home, purpose, and community is what they are attempting to achieve through these changes. There is a list of the 14 populations that the Fed's expect or want to have addressed in the plan for both substance abuse and mental health going forward. There is quite a bit of diversity. It starts with community populations for prevention activity and they add hard to reach communities, which Nevada understands as the rural areas. They have the traditional mental health populations, children with SED and their families and adults with SMI. Then they become more specific with individuals with mental and substance abuse disorders who are homeless or in the criminal justice system, etc. They get very specific. There are 14 populations that need to be addressed in the plan.

The plan must also address prevention of substance abuse and mental illness and promotion of emotional health, prevention being the key word. Patricia asked if they are just talking about prevention of co-occurring disorders or substance abuse and mental health together. She was not aware mental illness could be prevented. Cody said it is both co-occurring disorders and addressing building emotionally healthy communities at the adolescent level and even in early childhood, addressing some of the things that can be done on a public health basis to prevent mental illness. Some mental illness is biologically based. They will not be able to prevent every mental illness, but on a public health scene, can they build communities that support people in being resilient and in minimizing the impact of mental illness. Corrie said she works with a number of children with

post traumatic stress disorder (PTSD) which can be prevented by educating parents. Patricia said as a parent, she does not want the perception of the public to think that all mental illnesses can be prevented. Cody agreed. Roger said the other three items may address the situation. Roger went through the other three items Bi-directional integration of behavioral health and primary care services, provision of services for individuals with co-occurring mental and substance use disorder, and provision of recovery support services for individuals with metal and substance use disorders. Patricia said if they can get them to their most stable point in life regardless so they can contribute to society and live, that is what they are looking for, so they can live in a specific environment with whatever they have and receive effective treatment but not be over treated. Roger said the document he pulled the slides from is actually 20 pages long. He read the section on prevention. "The current available science was articulated in 2009 by the BOCYF and its report entitled preventing mental, emotional, and behavioral disorders among young people. This report describes risk and protective factors that can be lessened or developed by utilizing multiple institutions and multiple messages in community intervention sustained over time to build emotional health in young children and help prevent substance abuse, depressions, conduct disorders, and other behavioral health issues among adolescents. Because about 50% of adult mental illnesses manifest before age 14 and about 75% before age 25, implications of ignoring this converging sign is significant. Nearly 5,000 deaths are attributed to underage drinking each year." Corrie asked Roger to clarify bi-directional integration. Roger said he believes they are discussing having mental health services available at primary care facilities and medical services available at mental health facilities. Steven said a lot of mental health is biological and most of it is not preventable. The effects of it can be lessened by recognizing it and getting the treatment. One of the treatments that exist is psychopharmacology, where they medicate the person and send them out the door. He believes it is more appropriate to deal with the serious mental illness with the use of psychopharmacology and therapy. Roger said they are not saying that all mental health illness can be prevented. They try for prevention on what they can and if that is not doable then they integrate the behavioral health with primary care and then look at provisional services for co-occurring and then finally provision and recovery support services with individuals with mental and/or substance abuse disorders. Coleen said she believes it is a general statement. She said for example, they would prevent the environment that would lead to PTSD, but they would not be able to prevent Bi-polar. Cody said most of what MHDS and the prisons see is probably more in the SMI category, which is less preventable. A lot of what is coming out now is aimed at a more population based, where if they were to add up the cost of depression (for example) to the economy of Nevada, there is a large impact. It is not so much to MHDS, but they are really turning this toward a public health model. For example the model of public health to address obesity, with public education campaigns, etc. It probably will not be able to address SMI. Steve said if they improve the environment, it may improve the impact mental illness has. Coleen said she looks at a more generalized program of public outreach over larger community

programs. Cody said the model in SAPTA is prevention and treatment and they are somewhat separated. She asked for clarification from Layne. Layne said the whole process is the continuum of care and that is where the federal government lets them add on the recovery support services and community based services. They know they can take an individual, send them away to an institution, and then return them to the community and they fall apart, because they do not have the continuum. Prevention can play on the front end and the back end of the continuum. When they come from treatment back into a small community there may only be prevention resources available, and they get those under this required support. Steve asked what treatment. Layne said substance abuse or mental health. If they have a biological condition, they can not change the disorder, but they can minimize the response to the individual returning to the community but the support into the community to maintain some quality of life there without re-institutionalizing. It is more cost effective to keep them from being institutionalized. Steve said his understanding of treatment, is that they ignore mental health issues. Layne said traditionally that is before when they had drawn the line. The researchers have established that a large percentage of the mental health individuals have a substance abuse disorder. A percentage of the substance abuse individuals have a mental health disorder. This is why they are beginning to blend services with the co-occurring pilot projects that they have and the widening of the use of their substance abuse quadrant to fund the programs in the last five years. Co-occurring disorder treatment is one door out of the five directional access and now they want to bring primary care into the picture. They attach all on the individual because they are all interrelated. Steve asked if they are making a program that will receive funding from the Council responsible for treating mental health and substance abuse.

Roger said on page three the Planning Council involvement, they are very specific. The Fed's expect the Council to have meaningful input of stakeholders in the development of the plan is critical; States are encouraged to expand the MHPAC to include prevention and substance abuse stakeholders. Nevada is ahead by having Layne on the Council because that is not one of the required state agencies for the Council. When the block grant is submitted, they expect states to describe the involvement of persons who are: service recipients and/or in recovery, families or individuals with substance use and mental disorders, providers of services and supports, and persons with co-existing disabilities. They have outlined four steps in the development of the plan. The first step is underway as of last Monday. There is a workgroup that Dr. Cook and Diane Comeaux have asked to come up with a work plan as to how these two block grant applications are going to be combined. They met and the first step of the plan will be to assess the strengths and needs of the service system to address to the specific populations. Then identify the unmet service needs and critical gaps within the current system. They put a line between that and step three because that really needs to take place fairly quickly. Then step three is prioritize state planning activities. They need to rate them low, medium, or high as with the POG's that were mentioned earlier. Then step four is to develop goals, strategies

and performance indicators. All of the performance indicators that were discussed in the implementation report, there is some indication that they may expect those to continue to be reported on; however, it is likely that they will have a new set related to the other proposed activities.

Roger said at the next meeting, the Council will be given the opportunity to review and comment on the assessment of the strengths and needs of the system and the identification of the unmet service needs and critical gaps. He would like to prioritize the state planning activity as well, to be able to give some feedback to the Administrators of both MHDS and DCFS as to what the Council views as its priority. Roger wants to have the information to the Council well before the meeting with the expectation that the Council members come to the meeting prepared to have a discussion and make specific recommendations as to what is accurate, what is missing from the plan, and what the Council sees as the critical gaps, and giving the meaningful input that the Fed's are expecting.

Roger asked for questions and/or comments. Ann asked if this discussion will be happening in April. Roger said a few things have to take place first. The work plan involves the identification of a number of stakeholders in regard to the four items the plan must address on the bottom of page two. Each of the four items have slightly different stakeholders and entities that need to be involved in the assessment of the strengths and unmet service needs. There are some things that have to take place, that they thought could be achieved by April or May. Layne said in March they are supposed to get some more information from the Federal Government on the process and what the requirements are, some more details in how to outline all of this. Then they need to put it together by the end of April or first of May, so they can look at it for any revisions or technical assistance from the Fed's if they are headed in the right direction before they continue. In June they start putting the actual block grant together, what data they need to gather, what narratives do they need, what goals are still in there, etc. Ann asked if the people writing the block grant are asking for the Council's input prior to the writing of the grant, they are asking for the Council's input after they have developed a draft. Roger said the group ultimately responsible for preparing block grant is to provide at least some baseline information on the first two planning steps, so that the Council is not faced with a blank slate to comment on. Corrie asked if they will be identifying additional stakeholders. Layne said on four of the categories, they did. The first step is that they need to put the proposal in front of Dr. Cook and Diane Comeaux, then they seek out knowledge from specific stakeholders, and draw in the information, and then they have a format to submit to the Federal Project Officer asking if this is the direction they are going, and then they get further information in March. Then they can start formulizing how they are going to construct this document. Patricia asked if the Council will receive an update on the progress. Cody said she believes it is very likely that some will be asked to participate; however, not until they receive the go ahead from the Administrators.

- **UNMET NEEDS**

11. TRAVEL/CONFERENCE UPDATES

Roger said the travel budget is very limited. At the beginning of the year the once per year meeting face to face, and supporting travel for members to come to one of the two meeting sites. Then there was money that was budgeted for the Block Grant Defense and that was unnecessary because they participated via video conference. The only outstanding issue is the annual Block Grant Conference and given the changes, they have no idea if that is going to take place or when it will take place. Patricia said they also have the rural monitoring that is funded. Roger agreed and said it is because rural monitoring is one of the three functions of the Council. Barbara asked if there will be a consumer representative at the annual conference. Roger said the Fed's have always paid for the Chair of the Council, the Adult Planner, Child Planner, and IT person. The state sometimes pays for one or two more to go.

Lydia said during yesterdays training, she felt they were separate from what was happening in Las Vegas, and she wanted to know how they can change that and make it more effective. Cody asked her to reflect the information on the evaluation if they had not already done so. She also asked them to email the information to her and she will reflect that to the Administration here. There is a great deal of pressure for travel to be limited. Lydia said she just did not feel that she learned anything from yesterdays training. Corrie said there was a lot of conversation that she missed yesterday and it separates them. Ann said they are having the reverse affect today.

Roger asked for questions.

12. COMMITTEE UPDATES

- **ACCESS TO CHILD/ADOLESCENT SERVICES**

Patricia said she is the chair; however, she was out and had Layne fill in for her. Layne said as reflected in the minutes they have reached a dead end. With the two unknowns, the budget and the changes to the block grant, the effect on the funding from the state to the communities to counties, they have a lot of unknowns so they ceased proceeding any further because they felt they were parallel with DCFS children's mental health plan. Ann confirmed and asked if they can open for discussion.

Ann asked what the Council thinks in terms of what they have heard over the last couple of days. Is this a direction that this Committee should be taking, is the direction the Council had in mind. Lydia asked if this is the group that Kathy Hughes and she were on the fact sheets. Roger said that group sun-setted and this

and the Clubhouse Committee were the two selected by the Council. Ann said she believes they have heard a lot in the last couple of days about how they will have to tow the line in advocacy. Patricia asked if perhaps this committee needs to change its goals from what was initially established to something more along the lines of an advocacy nature. Ann said she is asking what the Council wants them to do with the Committee because as of now the Committee is inactive. Layne said the Committee was tasked with increasing access to children's mental health services and substance abuse services in Nevada. They identified three goals, then they asked if these parallel with what the Commission has in mind. This was parallel; they reviewed the ten year plan the Commission has, so they thought they would support their endeavors. He believes what Ann is looking at is they may need to reinstate another type Committee and let this one be rescinded so they have some work to do. Ann concurred. Corrie asked if they suggested a Committee to work on legislative issues. Ann said there are a number of people on the Council who are not able to advocate but there are many members who can. How do they still look at child and adolescent services when they know it is an issue? Coleen said for those who are new, the state employees can not advocate. When Ann states there are some who can not do that, it would be the state employees. Cody asked if it would be useful if the Committee focused on communicating with the Commission on the plan and following it. Ann said she believes it would be. A year ago, they discussed the large issue of getting access to services for children and adolescents. They attempted to tackle it one way, and she believes it is a smart decision to put that on hold. Coleen said the environment has changed, and now they are entering the legislative session and she believes what Ann is saying is now that the environment has changed, the players have changed. And as Chuck and Dr. Cook said, if they do not like what they hearing from them as State Government, then they need to advocate. The State employees can not advocate; however, they can help partner to utilize resources together. Cody said per the discussion yesterday, it may be useful to have a smaller group from the Council that is communicating about the Children's Mental Health Plan and the particular legislative issue. The consumer and family members of this group would be the ideal people to do that. Ann said she believes that if they do not have a body to draft letters, and discuss the issue, they will lose their chance of doing that as a Council. Patricia asked if she would like to have the Committee to meet to determine what can be done, discuss their options now that the legislative session is here and they have received the training on advocacy and see if they can redirect their focus onto a way of actively advocating for children receiving the appropriate mental health care and substance abuse care in the legislature. Patricia asked who is on the Access to Child/Adolescent Services Committee. Roger said Rene, Patricia, Cody, Ann, Lydia, Alyce, and Layne. He said according to the bylaws on Committees and they say "except for the Nominating Committee and the Executive Committee the Chair in consultation with the Council shall appoint all Chairs and members of all Committees established by the Council. Only members of the Council are eligible for appointments to Committees." Roger said as an action item, so they can take action, if there are members that are interested in joining the Committee

and exploring the options. Corrie said she is on the Clubhouse Committee; she would like to be a part of an advocacy committee. Lydia said her one concern is right now she does not work in the system and so she does not have a voice for the children they are advocating for. She is a family member and she knows the battles she has faced. Barbara said if they are talking about getting advocacy, this Committee needs to extend to other groups and they need to partnership with those people when they are talking about legislature. If they have a Legislative Committee, they can be working on this and not waiting until the last minute. They can be in touch with the organization that works with mental illness. She is asking them to reach out to the organizations. Patricia asked for the Council's suggestion. Corrie asked if she would have to give up the Clubhouse. Roger said no, she can be on both Committees. Denice verified they are discussing a Committee that will investigate and report back to the Council. Patricia said she believes they were attempting to duplicate what DCFS has in place. What they heard is that children's needs are not being met in Nevada and there needs to be improvement and the only way to do that is through advocacy and perhaps this Committee should change its mission to move toward advocacy through contacts, some sort of outreach program, contacts within the provider arena and school districts etc. Layne said DCFS has submitted a bill to the Legislature and at this point they need advocacy. If they reformulate the Committee with non state personnel, they can take it up and support that continuation. Patricia asked if the state personnel are allowed to give guidance. Layne said they would be able to take a non voting role. Corrie said their role would be to advocate, write letters, contact legislators, testify if necessary, contact local media, do outreach to different entities. Cody said the Committee would need to get together and decide and they would need to review the BDR and the plan that has been proposed and who else may be comfortable wit supporting it. Ann said they may not have time to come back. Coleen said how it should work out is educate them. They would now be the voice and educators. An idea may be to come up with one power point presentation and that presentation is the vehicle they would use for the entire legislative session. They will not recreate a presentation every time. Hand out the power point. They are all together as one voice. The Committee will meet prior to the opening of the Legislative Session. Corrie said if time is limited, she can assist. Ann said the state workers would be non voting members.

Lydia motioned that the Access to Child/Adolescent Services meet to redefine their mission with the formal members being Corrie Herrera, Rene Norris, Patricia Peterman, Alyce Thomas, Lydia Snead, with Cody Phinney, Ann Polakowski, Mechelle Merrill, and Layne Wilhelm serving as non voting advisory members. Denice seconded the motion

UNANIMOUS VOICE VOTE: MOTION CARRIED

Denice asked to be invited to the meeting. Corrie asked if Denice could be a proxy. Discussion ensued. Patricia said they would take this to the Executive Committee for discussion.

- **CLUBHOUSE**

  Roger spoke on Judy's behalf. Roger read the email from Judy. "Due to many changes and cut back of funds and possible job loss within SNAMHS of some of the key players in getting Adams House off the ground we are reaching out to HOPE of Nevada, NAMI, DBSA all of whom have an interest in establishing a client directed self-help center/club house. HOPE of Nevada is working on a format of Making Recovery the Goal. I am half way through reading their draft. There is a conference call set up for Thursday, January 13 from 1:00 – 3:00 pm between Myra, Cheryl, Sue Gaines and any and all people that wish to join. The topic for discussion is can we find common ground to work together to establish a drop-in-center in Sothern Nevada. If we can find a way to work together in this huge project I will request an agenda item for the next meeting that will request our commitment to Adams House be broadened and readjusted to support the new agenda."

- **MENTAL HEALTH MONTH**

  Deferred to the next meeting.

- **NOMINATING**

  Roger spoke for Rene. They met twice in December to review candidates for a consumer position. They have two candidates that are well qualified. The Committee selected Britanie; she was the one that did the DVD. The second candidate that the Committee was impressed with is Gayle. The recommendation of the Nominating Committee is the Council recommend to the Governor's Office that Britanie be appointed, and in the event that the Governor's Office does not appoint her, then move forward with appointing Gayle. This will eliminate the Council having to wait. Lydia said it has happened in the past where the Council has nominated someone and the Governor's Office has rejected the applicant.

  Lydia motioned to send Britanie to the Governor's Office and Gayle be sent if Britanie is not accepted. Alisha seconded the motion.

  UNANIMOUS VOICE VOTE: MOTION CARRIED

- **RURAL MONITORING**

  Roger said the Committee did not have the opportunity to complete it in time for the October meeting. He directed them to page 19. Roger went through the unmet needs and the findings of the Rural Monitoring Committee. At the bottom of page 19 it goes into the recommendations made. Roger asked if all had reviewed. Lydia clarified that there was a Nevada PEP representative there. Ann said at that time, they said they were covering Mesquite as part of their

assignment. Roger asked for questions. Corrie asked how far Mesquite from Las Vegas. It is approximately 90 miles. Corrie asked if there is such a shortage of practicing psychiatrists, don't they have some that travel from Las Vegas to Mesquite. Corrie said in Elko they are 300 miles. Ann said they heard that there was comment about travel and the Psychiatrist wanting to be paid for travel. Cody said there is an issue with the contracting and paying contractors for travel time. They are no longer able to pay contractors for the time they spend travelling, and so if that is not the duty location, they can spend the two hours driving out there or they can spend two hours seeing clients in Las Vegas. Patricia asked for questions.

Barbara motioned to accept the report. Lydia seconded the motion

UNANIMOUS VOICE VOTE: MOTION CARRIED

Roger said the Committee will be doing a visit to Laughlin next week.
Ann asked if they have a finalized schedule. Roger said he has just finalized it. They will rendezvous at the state motor pool. It is still unclear as to whether they have been able to generate family members.

- **CEMETERY**

Cody said as many are aware the historic cemetery at Northern Nevada Adult Mental Health Services (NNAMHS) has been refurbished. She took a tour and it looks very nice. They are having a rededication ceremony to dedicate the monument that has been placed there on Friday, January 21, 2011 from 2:00pm – 4:00 pm. She said she would like to publicly thank Tanya; she has been instrumental in arranging it. She requested that the Council appoint one or two members to be present at the rededication ceremony. Lydia and Patricia volunteered to be there.

13. PUBLIC COMMENT

Patricia said she just learned that Senator Raggio has resigned and will no longer be in the legislature.

Patricia asked for public comment. None was made.

14. SET DATE FOR QUARTERLY MEETINGS FOR THE 2011 CALENDAR YEAR

2/15 @ 9:30 am – 12pm regarding legislative activity.
5/17 @ 9:00 am – 4:00 pm
8/16 @ 9:00 am – 4:00 pm Reno
10/18 @ 9:00 – 4:00 pm

Lydia motioned to accept the dates for the meetings. Barbara seconded the meeting.

UNANIMOUS VOICE VOTE: MOTION CARRIED

15. ADJOURNMENT

Barbara motioned to adjourn. Cody seconded the motion.

UNANIMOUS VOICE VOTE: MOTION CARRIED

Meeting adjourned at 3:53 pm