Substance Abuse Prevention and Treatment Agency Advisory Board Bimonthly Meeting

MINUTES

DATE: **August 8, 2018**
TIME: **9:00 a.m.**

	Meeting	*Videoconference*
LOCATION:	**4126 Technology Way** **2nd Floor, Conf. Room 201** **Carson City, NV 89706**	**4220 S. Maryland Parkway** **Building D, Suite 810** **Las Vegas, Nevada 89119**

TELECONFERENCE: **(888) 363-4735 / Access Code: 3818294**

BOARD MEMBERS PRESENT

Michelle Berry, Center for the Application of Substance Abuse Technology (CASAT)
Mari Hutchinson, Step 2
Jennifer DeLett-Snyder, Join Together Northern Nevada
Lana Robards, Co-Chair, New Frontier
Andrea Zeller, Churchill Community Coalition
Patrick Bozarth, Community Counseling Center
Jolene Dalluhn, Quest Counseling
David Robeck, Co-Chair, Bridge Counseling Associates
Tammra Pearce, Bristlecone Family Resources
Wendy Nelsen, Frontier Community Coalition
Leo Magridician, WestCare
Jasmine Troop, HELP of Southern Nevada
Ester Quilici, Vitality Unlimited

BOARD MEMBERS ABSENT

Denise Everett, Ridge House
Jamie Ross, PACT Coalition

STAFF & GUESTS PRESENT

Meg Matta, Substance Abuse Prevention and Treatment Agency (SAPTA)
Kendra Furlong, SAPTA
Marco Erickson, SAPTA
J'Amie Frederick, SAPTA
Judy Dumonte, SAPTA
Auralie Jensen, SAPTA
Joan Waldock, SAPTA
Stephanie Borene, University of Nevada, Las Vegas
Michelle Padden, CASAT
Linda Lang, Nevada Statewide Coalition Partnership
Dan Ficalora, Bridge Counseling Associates
Ashanti Lewis, Ferrari Public Affairs
Bill Kirby, SAPTA
Jessica Hoff SAPTA
Sara Weaver, SAPTA
Laurie Gleason, SAPTA
Raul Martinez, SAPTA
Roxanne DeCarlo, The Empowerment Center
Diane Anderson, CARE Coalition
Amanda Henderson, WestCare
Dinita Smith, Adelson Clinic
Jennifer Lee, CARE Coalition

DRAFT

1. Roll Call, Introductions, and Announcements
   Roll was called. Ms. Robards determined a quorum was present.

2. Public Comment
   Ms. DeLett-Snyder pointed out that non-members engaged in the discussions and voted on motions at the last meeting. She asked the co-chairs to inform non-members of Board protocols.

3. Approval of Minutes from June 13, 2018 Meeting
   Ms. Quilici moved to approve the minutes. Ms. Troop seconded the motion. The motion passed.

4. Standing Informational Items
   - Co-Chair's Report
     Mr. Robeck said he, Ms. Lang, Ms. Quilici, and Ms. Dottye Dexter participated in a meeting for medical directors of Certified Community Behavioral Health Clinics (CCBHCs) at which Ms. Quilici and Ms. Dexter made a presentation about their agency in Elko.
   - Substance Abuse Prevention and Treatment Agency (SAPTA) Report
     Ms. Weaver gave an update on the new tracking system. She reported some providers submitted emails to SAPTA Pay but did not receive return notification emails. She said the Internet Technology (IT) Department was working on it. She asked providers to contact her so she could check the tracking system to ensure their emails were received.
     Ms. DeLett-Snyder said her bookkeeper attempted to submit something and was notified she was locked out. The system generated an email that said an email about how to change the password would follow, but that follow-up email was not sent. Ms. DeLett-Snyder said her bookkeeper did not have a problem submitting RFRs last month. Ms. Weaver asked Ms. DeLett-Snyder to have her bookkeeper forward the email to her for follow up. Ms. Weaver reminded her there were two parts to submitting an RFR—the first, logging into the Secure File Transfer Protocol (SFTP) site, appeared to be the problem in this case. She said she would refer the bookkeeper to the Health Help Desk in order to reset the password. She reminded providers that the second part of the RFR procedure was to have the agency send SAPTA an email using the subject line convention outlined in the procedure.
     Ms. Jensen said reporting to the HAvBED emergency system had improved. She reminded providers the information needed to be updated daily. She noted that even if there were no changes, the report must be updated daily so that the report of number of beds and vacancy rates would be accurate. She added that the emergency placements phone—(775) 400-0790—was available and manned all day, every day. She said a staff member would reply to voicemails within four hours on weekdays and within eight hours on weekends. Ms. Furlong pointed out that the number was listed on the SAPTA website. Ms. Jensen noted that Nevada's 2-1-1 system would give the number to those seeking services.
     Mr. Erickson introduced Laurie Gleason as the Management Analyst III.
     - Strategic Plan Update
       Mr. Erickson stated that focusing on compliance with federal guidelines was a goal in the Strategic Plan. He noted relationships with SAPTA partners were improving as analysts have been onsite more often. He said SAPTA was working on quality improvement with evaluations and policy trainings. He said SAPTA's annual treatment site visit with federal officers (feds) took place recently and that good things were said about the improvement they saw in Nevada behavioral health services.
       Ms. Zeller asked if the federal report was available. Mr. Erickson replied there would be no written report. He explained the feds were preparing SAPTA for next February's audit.

He said SAPTA would do more monitors, and new Division policies were being written to reflect federal mandates. He pointed out SAPTA staff wrote policies being adopted Division-wide for consistency. Mr. Robeck stated the Advisory Board had not seen the changes. He asked if the Board would be asked to advise on changes before they were implemented. Mr. Erickson said some changes were in Division policies, not specific to SAPTA. He added changes would be published on the website. Mr. Robeck pointed out agencies could not be held accountable to policies revisions they have not been informed about.

- Case Vignettes

  Mr. Erickson said the purpose of the vignettes was to give agencies and SAPTA the opportunity to ask what they would do in certain circumstances, what could have been done better, and how to work with the system—since sometimes the problem was with the system, not with an individual agency. He asked agency representatives to think about how they would respond if they were the State. Mr. Robeck commented it was important to take a serious look at these. Ms. Quilici asked if they could discuss the scenario about health care coverage. She thought the other scenario was out of the control of the agency involved. She commented it seemed as if agencies were pushed to take a client whether or not they were credentialed with the client's insurance company.

  Ms. Robards referred to Scenario 2, about a 25-year-old female who was incarcerated. There were problems working with the jail to have her released or transported through the Inmate Assistance Program (IAP) to a treatment facility. She pointed out that it was difficult to get through the gatekeepers at the jail, even if everything was in position to place a client immediately—if the client was not released, she would not get to the facility. Sometimes courts do not communicate well with IAP, so there could be a time delay. Under the new SAPTA preauthorization process, an assessment must be done first—instead of admitting someone on an emergency basis and doing the assessment internally, preauthorization must be done up front. It might not be done in the jail. Mr. Robeck said Bridge received jail referrals, but there usually were no transportation problem. He noted the State's alternative solution was typical of Nevada—putting clients first often required thinking outside the box. Agencies should be doing that.

  Ms. Robards suggested they strategize how agencies could help facilitate jail referrals to get clients into programs more quickly. Ms. Jensen asked about the assessments that were needed prior to client admission. Ms. Robards said they were required unless the client needed emergency placement for detoxification (detox) services. Ms. Jensen said she thought the Mobile Outreach Safety Teams (MOST) went into jails to do assessments. Ms. Robards replied that independent evaluators did assessments at the Washoe County jail. She pointed out that it took time to get those assessments to facilities. Ms. Pearce added that independent evaluators do not assess to the level facilities need in order to admit a client—information agencies need was often missing. She said it was an ordeal for them to try to do an assessment at the jail. Ms. Robards said this was part of the new admission process for the pilot program her agency was part of. If the evaluator did not use the American Society of Addiction Medicine (ASAM), the facility would have to determine what the evaluator meant. She stated it could become an issue in the preauthorization process. She would not allow her counselors to interpret someone else's assessment. When clients get to her facility, her team must do another assessment to preauthorize admission. At that point, they do not know if the client will be accepted into the program. Ms. Padden said the process was revised so that if a facility received an assessment that did not meet the standard, initial preauthorization was for 14 days if the

Diagnostic and Statistical Manual for Mental Disorders (DSM) was adequate. Preauthorization for 14 days was allowed in order to give agencies time to do an ASAM evaluation so the clinician could be confident where to place the client in the program. Some authorizations are under the ASAM component saying, "To Be Determined" within the initial 14 days. Clients can be admitted; agencies then have 14 days to meet and assess them. Ms. Robards said the Advisory Board was discussing how agencies could speed up the process. Ms. DeLett-Snyder said Washoe County approved certain people and paid for their evaluations. She suggested treatment agencies work with the county and tell them what they need. She thought the county would listen and tell evaluators they need to provide what the facilities require. She concluded that if the county paid for the evaluations, facilities should be getting what they needed. Mr. Robeck said he wished he could be confident about the screenings or assessments provided for him. He said Bridge New Frontier, and Vitality do comprehensive assessments, because they are held to higher standards as CCBHCs. He pointed out that residential treatment facilities have a limited number of beds they manage, so they should not be mandated to give up a bed without preapproving the client themselves. He would hate to see residential providers forced to accept somebody else's screening or assessment. As an outpatient provider, Bridge does comprehensive evaluations of clients. Ms. Robards said the preauthorization was for residential facilities where bed capacity was an issue. She stated New Frontier had 28 beds and people wrapped around the building trying to be admitted.

In Scenario 2, there were extenuating factors taken into consideration. While the scenario was not unique, the resolution was. Mr. Erickson said it was clear the agencies collaborated. The outcome for the client was fairly well done. The client in Scenario 1 sat in a jail for days without knowing what was going on .The client and the family would have been frustrated with the treatment system. He thought it was good for the Advisory Board to analyze and think about how systems, data, and people could work together. He hoped that, in the future, providers would work with the IAP to make it easier for the next client. Ms. Robards said that was their goal for all of their clients.

Ms. Quilici asked Mr. Erickson if SAPTA wanted facilities to waive coverage. Mr. Erickson said the point of Scenario 1 was to understand what happened—there were major problems. The first issue was that a block grant recipient should know the priority populations. SAPTA could make a judgment call to approve care, whether the insurance allowed it or not. SAPTA was not called for an approval in this case. Agency A could have accepted the client, rather than telling her she did not have the correct insurance. SAPTA should not be the barrier to treatment. He said he did not want agencies to have to take a client and not be paid. Ms. Quilici thought any residential program would at least get the room and board situation addressed. She said it would be great to get full coverage for the stay, but something could be eked out for the priority population—the system was committed to that.

Mr. Robeck pointed out he wanted to hold Mr. Erickson accountable when he said SAPTA would be responsive. At the last meeting, the Board discussed SAPTA's unresponsiveness to emails. Today they heard that it could take four to eight hours to get a response from the person holding the duty phone. It did not appear to him that the duty phone would have handled this scenario. Getting a state agency involved when other agencies were providing services would not have been a solution. Mr. Erickson said contacting SAPTA during business hours on a normal day would have gotten the information to an analyst who had the ability to do something about it. Ms. Quilici pointed out that Health Plan of Nevada and SilverSummit were dumping clients on the State because they did not cover

residential services in the continuum of care and that was an issue that needed to be addressed. She added the fee-for-service and Amerigroup covered the continuum of care. This would be a complication for a treatment center and yet it seemed that the treatment center was at fault when no one addressed the problem with the Managed Care Organizations (MCOs). The MCOs refer clients, but do not pay for services. Mr. Robeck said he understood that intravenous (IV) drug users were priority clients in Nevada, meaning certified agencies were supposed to see them and worry about payment later. Ms. Quilici said her issue was tangential, not about the priority population. She said her agency took pregnant females, IV-using pregnant females, and the priority populations. She told the other agencies that if they had a problem, they could call Vitality; if they did not get the correct response, they could call her directly. Ms. Furlong said the capacity and waitlist policy stated that a pregnant woman with an MCO could be accepted by any certified agency and SAPTA would cover her for the first 14 days while coordination of care took place. It could be that the policy needed to include any priority population with MCOs so Scenario 1 did not happen again. For at least the first 14 days, facilities would receive payment from SAPTA until SAPTA figured out what to do with the client. That way, the client would not end up in an emergency room. Ms. Robards pointed out that the client needed emergency detox services. She had a hard time understanding how four different facilities could have been involved without accepting her into their drop-in emergency detox programs. She commented that the diversion program staff did not contact the right agencies. She noted that her program accepted clients 24/7, so time of day would not matter. She thought all of her sister agencies had adopted the same policies that were foisted on them over the years through the additional funding. Ms. Furlong said the written policies stated that for a client with insurance an agency was not enrolled with, SAPTA would not cover and the client should be referred back into their network. If that was one of the barriers that caused this client to be bounced around, SAPTA must come up with an alternative solution so that this did not happen again. She suggested making SAPTA funds the safety net for the first two weeks so a client could receive emergency care. Ms. Robards said in her case, SAPTA was the safety net provider because her facility had 28 beds. Under the federal Institutions for Mental Disease (IMD) rule, Nevada Medicaid and MCOs could not pay for residential services, including emergency detox, at a facility with 16 or more beds. At her facility, if a client comes to her door, she knows she has a pay source. Mr. Robeck said MCOs played a big role in this, particularly in Washoe and Clark Counties. They determined which agencies they work with and how they are going to proceed yet may not have a client reassessed to their standards or put into the right situation. "Emergency detox" does not mean a client should wait two or three days for an appointment. It does not necessarily mean a client should receive outpatient medically assisted treatment (MAT). It does not mean they should be rejected because the insurance is not accepted. He expressed disappointment that more requirements were not placed when negotiating those contracts because Health Plan of Nevada covers about 50 percent of all Medicaid clients in Nevada. The State should take a serious look at them and hold them accountable and require they do certain things. For instance, CCBHCs are required to take all clients—regardless of ability to pay—for any of the array of services provided whether their insurance program pays for them or not. The MCOs should have that same requirement. There are standards of being a community partner that MCOs are not held accountable to. Mr. Erickson praised the police department's involvement in the scenario—they spent eight hours with the client. He pointed out that the woman was homeless. If he were the client, he would not

trust the system at all. He explained that it was important to think about what the State should do in these situations, as some things are violations of block grant rules. If a federal project officer talked to this client, the system of care would look bad. He said he was in an exit interview with the HIV agency recently. Their federal team had been on site. He learned that the feds went to agencies and spoke privately to clients receiving services. Ms. Robards pointed out as the pass-through and regulatory agency, SAPTA needed to be aware there were 399 other female IV-using heroin addicts out there that probably got into a treatment center because of the process that is in place. She understands the need to fix what was broken, but said they need to recognize that providers work hard trying to speed up the process. She said sometimes providers hit a wall—the problem could be the referral source, the jail, the courts, or the clients. Mr. Erickson suggested that it would be helpful for agencies to share their success stories.

- Upcoming Funding, Ideas for Funding Formula, and Potential Rate Increases

  Ms. Furlong stated that SAPTA was developing a funding formula for fee-for-service block grant dollars for treatment. She said they were attempting to fund what Medicaid or other insurances did not—residential services, transitional housing, and detox. She said she determined through HAvBED the maximum capacity for each provider. If SAPTA funded every available bed for all levels of care for 365 days, they would need more than $19 million. If SAPTA increased the rates, the need would be more than $26 million. She said there was not enough money in the block grant for that. She asked what the Board's priorities were and if they wanted to give preferential treatment to residential providers. She asked what they should do about outpatient services when they could not even fund all the beds in the state, adding that Nevada needed more beds to meet the need. They looked at the past three to five years to determine how much money was spent on outpatient and residential services and what the vacancy rates were. The vacancy rates were difficult to determine because capacity reporting was not tracked well. With HAvBED, they determined the average vacancy rate for the last year and applied it to the current beds to see what that did to the dollars.

  Ms. Dalluhn said only funding residential placements was funding the deep end—the clients with severe problems. If outpatient and intensive outpatient services were provided, residential stays could be averted. She said her agency lost some block grant funding this year because they were unable to spend the funds on clients eligible for SAPTA funding, which meant they had to apply for other grants because the outpatient clients could not be covered by SAPTA. She understood the need to fund residential placements, but did not think all of the money should be put there because residential treatment was more costly and more limited. Using the continuum of care, outpatient and intensive outpatient services were good for everybody—it was good for the clients; it saved money in the healthcare industry; and it was much more accessible. Ms. Furlong explained that SAPTA did not want to eliminate paying for outpatient services, but most health insurances cover those. They needed to determine who was eligible for coverage and why—because they could not afford their co-payments, their deductibles were too high, or they were part of the undocumented population. They have talked about financial hardship programs and whether or not that was something to consider. She asked providers for ideas in developing a formula that was fair and distributed the dollars appropriately to where the dollars need to go.

  Ms. Quilici suggested they form a subcommittee to discuss the topic. She added that decreasing payments to detox was counter to what was happening in the detox setting. She said detox was more complicated, costing more to do. She thought Medicaid would

provide more funding so that SAPTA could retarget the money they have to the continuum of care—detox and residential treatment. Ms. Robards commented that this was a large discussion, better done in a subcommittee. Feedback should come from all different types of facilities—outpatient, residential, and transitional. She saw recently that SAPTA would no longer fund pending-eligible Medicaid clients. There are many restrictions on what can be funded for outpatient services. Undocumented people are the only ones left that SAPTA will fund for outpatient services. Ms. Furlong said SAPTA was writing the eligibility policy. Input would be valuable in determining that policy. She said SAPTA has had a continual problem with needs increasing without funding increases. She said they talked about increasing rates in October. If they are increased, services will decrease in communities. The other option is to keep funding the same and provide more services. Ms. Pearce agreed there were many issues to be considered. While agencies have had flat funding, salaries have had to go up and credentialing has been stiffer with some of the MCOs. She would not want to see outpatient services excluded. She agreed that a subcommittee would be in order. Mr. Robeck feared that a wrong decision would become a barrier to treatment. He thought the Board should be involved in making this policy. Ms. Robards pointed out that the agencies have been discussing a rate increase for more than two years.

Ms. DeLett-Snyder asked if there was money in the Opioid STR Grant—Category 2 medication-assisted treatment exchanges, residential and transitional housing—that could help treatment in a way that made sense. Ms. Furlong said SAPTA already used some of those funds for direct treatment. She said they were trying to pull funds from wherever they could. They are involved in conversations with counties and social services to use marijuana dollars, which required a Division of Child and Family Services (DCFS) referral. She thought the money was not being reimbursed the way that was anticipated. She said Judy Dumonte, the women's services network representative, was coordinating with the county to try to direct that money back into treatment so that agencies did not just get referrals, but would also be paid for the services performed. Ms. DeLett-Snyder asked if the counties had other priority areas for the marijuana money they receive. Ms. Furlong said these were treatment dollars the state was giving the county. Many counties create referrals, then tell agencies to bill SAPTA for the services. SAPTA provided them the dollars to pay for the services. She wondered where the dollars were going if counties were not paying for the services. Ms. Dalluhn said Quest Counseling was one of the treatment centers that used to get marijuana dollars. The Human Services Agency told them the money now went to the Crossroads Program and other similar ones. Her agency has not received a referral in three years. Ms. Furlong said the dollars have now been assigned to Ms. Dumonte and can be used for women and adolescents. They will improve their effort to make sure dollars were used more appropriately.

Ms. Zeller said that DCFS in Churchill County worked with a wellness center that offered mostly counseling for treatment. Her coalition funds the county to support the DCFS referrals, but New Frontier does not receive anything. She expressed concern about having the money utilized in the whole county, rather than just certain DCFS partners. Ms. Robards said each county was different. If the money was given to a county and a county developed its own infrastructure like the community health workers, resource liaisons, or those kinds of things some of that money may be funneled to them. When the rest of the community was not involved in the process, most agencies did not know those dollars existed. Ms. Furlong said those discussions would be opened because the State

needed more attention there, adding that was a reason Judy is looking at what has been done and how to improve things.

Ms. Robards announced that the volunteers for the Funding Subcommittee were Tammra Pearce, Ester Quilici, David Robeck, Jolene Dalluhn, Jasmine Troop, Mari Hutchinson, Leo Magridician, Lana Robards, Jennifer DeLett-Snyder, and Kendra Furlong. Ms. Robards invited all of the Board members to participate in the discussion. Ms. Quilici volunteered to chair the subcommittee. Ms. Furlong suggested the subcommittee move quickly as the formula needed to be developed so SAPTA could readdress the way block grant dollars were being distributed for the upcoming year.

Ms. Furlong reported the Request for Qualifications (RFQ) done internally expires in 2020. The RFQ was put out by State Purchasing. All providers were encouraged to apply for it—once providers are in the vendor pool, they qualify for provider agreements. When the internal RFQ expires, it will not be renewed; SAPTA will pull from State Purchasing's vendor pool. It is not mandatory to be added to the vendor pool, but SAPTA will pull vendors from that pool. Ms. Robards asked if they should enroll under S107 or S167. She said she enrolled for both. She has a blanket contract from the State that says she has been accepted. She found the application process confusing. DCFS, Vocational Rehabilitation, Youth Parole, and SAPTA go under State Purchasing, but there is no definition given of who is 107 or 167. Ms. Weaver said she would contact the contract unit to get clarification and send Ms. Robards the information she received

Mr. Erickson said the prevention portion of the block grant involved a different set of money. For that, his team will develop its own internal formulas. Ms. Robards pointed out that many prevention people did not know what funding was available. She thought it would be helpful for prevention providers to participate in the discussions in order to get more information. Ms. Robards reminded the Board that it was important to know where the money was going. She said she understood that their discussion would be about treatment dollars, but there was a time when the Board did not even know who received the Opioid STR funding and who to call or refer to. Opening the discussions to all providers, particularly all members of the Board, would be helpful. Ms. Weaver commented that in order to determine quorum, a list of members of the subcommittee would be needed. Ms. Furlong said the subcommittee could come up with a temporary solution for this year and could move forward with other decisions. Ms. Quilici asked for the timeline. Mr. Erickson replied that the new grant cycle would begin October 1. He recommended they use the current system for the current grants, then make adjustments later if they are needed. They would not want to delay the grants that start October 1. Ms. Furlong clarified that Mr. Erickson recommended flat-funding everyone, then moving forward with future solutions. Mr. Erickson said that would eliminate a delay of funds. Ms. Gleason recommended the discussions start next week. Mr. Martinez said he would send out a doodle poll for meeting dates. Mr. Robeck said he would co-chair with Ms. Quilici. Ms. DeLett-Snyder was added to the Funding Subcommittee.

The Request for Applications (RFA) for Assertive Community Treatment Teams (ACT) went out. Applications are due by August 21. A technical assistance webinar was scheduled for August 14, with questions for that due by August 9. Six awards, totaling $1.8 million, will be made. The CCBHC expansion RFA went out July 6. Ms. Robards said 14 facilities applied and 10 were accepted for interviews. She pointed out that CCBHCs would not be applying for the ACT money.

Ms. DeLett-Snyder asked if SAPTA knew when the Nevada Web Infrastructure for Treatment Services (WITS) would be starting. Mr. Erickson replied there had been some

delays. Ms. Lang reported the pilot had to be completed before anyone else started using it. It has been delayed until September. Mr. Erickson said they wanted to be sure they were doing it right and that all the partners were involved.

- Center for the Application of Substance Abuse Technologies (CASAT) Report
  Ms. Berry said there was nothing to report for CASAT.
  - Opioid State Targeted Response (STR) Grant
    Ms. Berry reported they were working on the three Integrated Opioid Treatment and Recovery Centers (IOTRCs)—Center for Behavioral Health, Vitality, and The Life Change Center. Center for Behavioral Health and The Life Change Center have started expanding their mobile crisis units into emergency departments, working with Carson-Tahoe in Carson City and with North Vista; University Medical Center and Renown have made verbal agreements to begin working with the mobile recovery teams. They also started the expansion of naloxone distribution statewide. She added that the need assessment for the STR was published and available. They began notifying awardees who will receive dollars for the Year 2 release of funds.
    Between February 2018 and April 2018, 2,500 individuals accessed treatment through the Integrated Opioid Treatment and Recovery Centers. 101 individuals received peer support services; 300 naloxone kits were distributed; 1 opioid overdose was reported; and 2 mobile recovery outreach teams were established. As of a week ago, the IOTRCs distributed 850 naloxone kits through law enforcement; 1,700 kits across 40 agencies have been distributed. Coalitions have held 10 training events at which 130 kits were distributed to stakeholders and community members attending the events. Southern Nevada Health District's first responders shared grant distributes naloxone to organizations and individuals in Clark County. They have facilitated 21 trainings and distributed about 1,400 kits across the county. They onboarded two community-based organization distribution sites for naloxone. For Year 2, they will try to expand into clinical outpatient treatment and recovery services for SAPTA-certified providers; Medication-Assisted Treatment (MAT) expansion of SAPTA-certified providers; travel treatment and recovery criminal justice; community para-medicine, neonatal abstinence syndrome, recovery support services, and community preparedness planning. They completed a carryover request for STR that has not yet been approved. She said she was working on the State Opioid Response (SOR) submission which was due August 15 that would bring an additional $7.1 million to the state for working with individuals with opioid use disorder. Some of the money in the SOR was set aside for fee-for-service and some for expansion of services that MCOs will be providing. That will start in September, so will overlap with SOR and STR. She stated that Terry Kerns has been working with several law enforcement organizations to get them online with overdose maps. Las Vegas Fire and Rescue have recently signed a user agreement to begin putting information into the system. Ms. Berry said Ms. Kerns indicated that the Public Service Announcement (PSA) for the Good Samaritan law in both English and Spanish would run for four months. Ms. Kerns is working with coroners' offices regarding best practice guidelines. Ms. Berry reported they are having conversations about using some STR dollars to train law enforcement in Las Vegas. She stated that Project Echo offered a training primarily for practitioners of ongoing clinics, a MAT clinic that would help providers onboard medication-assisted treatment in their clinic settings; a clinic concerning the reduction of opiates and alternative pain management; and a clinic for working with pregnant women diagnosed with opioid use disorder. Participation in the clinics is free. She said they have received reports from their IOTRCs about the information requested when they provided

the overdose educational naloxone distribution. The information will be published within the next month. A training is coming up in Reno and one in Las Vegas for alternatives to pain management in emergency department settings. Those will be held November 13 in Reno and November 14 in Las Vegas. As soon as registration opens, information will be sent to physicians throughout the state. She said they were working on a project with the Nevada Department of Corrections, the Washoe County Sheriff's Office, and the Law Enforcement Assisted Diversion (LEAD) in Clark County.

Mr. Robeck said applications were still outstanding for the STR grant. He has heard for a few weeks that awardees were being notified. Ms. Berry replied they have obligated all of the Year 2 funds and are waiting to see if they receive a carryover. They do not want to over-obligate themselves, so are waiting until they receive notice of the carryover before notifying agencies of awards. Mr. Robeck asked if there was funding when the RFA was released, or if it was released with an expectation of funding for the future. Ms. Berry replied there were additional dollars obligated to this for fee-for-service that were not previously put into the budget—those were the dollars being obligated.

Ms. DeLett-Snyder verified that the SOR grant was for $7 million. She asked if it included money for treatment. Ms. Berry replied that the majority of the money was obligated to go into direct service, fee-for-service, and expansion of services through the MCOs. Ms. DeLett-Snyder pointed the funds could help what was discussed earlier. She asked which community-based organizations provided naloxone. Ms. Berry replied they were Ridge House and Living Free. Ms. DeLett-Snyder asked what other options there were for expanding it. Ms. Berry said they were contacting community pharmacies and additional community-based organizations about their interest in becoming distribution sites.

- Medicaid Report

  There was no Medicaid report as no one from Medicaid attended the meeting. Mr. Robeck said this topic was on the agenda because there were things being proposed—the biggest being prior authorizations—that would impact agencies accepting Medicaid. Depending on the number of clients seen, the impact could be large. He said individual clinicians in southern Nevada were concerned about the extra work on prior authorizations they would need to do in order to work with current clients. He expressed concern about its impact on mental health in Nevada. He said he understood the purpose behind the change—there has been a lot of fraud—but these agencies are already extra-supervised and SAPTA-certified. He said he would like to see those Medicaid providers not having to fall under this because they have been encouraged by SAPTA to increase the number of Medicaid clients to take the burden off the block grant funding. They have done that and now may be facing a bigger problem that will require them to hire more employees to only do prior authorizations because of the increased workload. This will directly and indirectly affect the people on the Board and will become a serious obstacle to treatment as agencies and clinicians stop doing Medicaid treatment and abandon their clients. He concluded that it was a big issue in southern Nevada. Ms. Dalluhn commented it was a big issue in the north, as well. She said many agencies worry about how they will be taxed by this issue. Her agency is a Provider Type 17, so she has done Prior Authorization Requests (PARs) for years; this would be new for Provider Type 14 agencies. She stated that it required a great deal of administrative time to complete all the PARs. Mr. Robeck pointed out that preauthorization had not been waived for CCBHCs. He said his agency served 1,000 unduplicated clients at any given time, which would be a lot of PAR activity. Ms. Dalluhn thought CCBHCs did not have to do a prior authorization for each client. Ms. Robards said that was true. Mr. Robeck said the new policy may apply to them, too. He asked if SAPTA staff could move the conversation on to Medicaid. Ms. Robards said she thought the new

policy only affected Provider Types 14 and 82. She did not know if it would affect 17-215 or 17-188. She said she did not see anything in the new policy that would change Provider Type 17 yet. Mr. Robeck said it could result in agencies' no longer accepting Medicaid, which would put an extra burden on the agencies that accept it. It would be a challenge for clients who needed help. The CCBHCs could not even get an answer from Medicaid on whether the policy will or will not impact them. Mr. Erickson said SAPTA would look into it.

5. Make Recommendations of Talking Points to Highlight the Block Grant Priorities

Mr. Erickson said the federal project officer helped them prepare for the coming audit team. Nevada has not had an audit in several years. He explained that the team consisted of 12 people. The officer recommended that every agency, provider, and employee at agencies be alerted to the fact that they are block grant recipients. She suggested giving them talking points about the block grant. He said the federal team will have a list of all SAPTA providers and randomly call agencies to ask about priority populations and the block grant. Usually administrators have had the information, but all staff members should have the answers right in front of them. He asked if the Board would approve the talking points.

Ms. Quilici pointed out she was told the Synar Amendment required all facilities to be smoke-free, but the amendment relates to youth access to tobacco. She asked why treatment centers were mandated to go smoke-free and why the Synar Amendment was used as the reason. Ms. Furlong said she worked with Kyle. Devine and Mark Disselkoen to uncover the policy that required facilities be smoke-free, but did not find anything specific—other than it was said in the past. She said SAPTA would not hold facilities to the standard when there was no written policy. Mr. Erickson said other states have had federal project officers comment if sites did not have smoke-free zone signs. He said he would ask Nevada's project officers for policy on that. Ms. Robards said she was told there was a federal mandate requiring recipients of block grant funding to be smoke- or tobacco-free facilities. She said her assurances have changed over the years as they have signed on to get block grant funding. She thought SAPTA's regulations through Substance Abuse and Mental Health Services Administration (SAMHSA) and the Substance Abuse Prevention and Treatment Block Grant (SABG) funding had changed over the years. She thought it was possible that the language changed also. Ms. Quilici pointed out that it was a good health measure. She said the policy shook things up when it was implemented—facilities did not want to be the tobacco police, focusing on other drugs. She added her agency was caffeine-free, too.

Ms. Dalluhn said she thought the talking points were helpful for directors to pass on to their staffs. She had not considered talking to them about the points. Mr. Erickson said he hoped the Board would approve what was written or would recommend changes. They could send the document out on ListServ with guidance on how to use it. He pointed out while the audit would be in February, the feds could call agencies any time between now and then. Ms. DeLett-Snyder asked if they would call prevention agencies to ask what they knew about treatment or what they knew about prevention in the block grant. Mr. Erickson said it was unknown, which was why they created the document. Mr. Robeck said it looked as if it followed a template of questions the feds might ask. Mr. Erickson said the document went over the priorities and purposes of the block grant. Mr. Robeck thought it was too much information to give to his front office workers. As a result, he stated he was hesitant to approve it. Mr. Erickson said he thought if the feds made a phone call, they would focus on the priority populations. Mr. Robeck said the information was something agency staffs should be aware of and he appreciated SAPTA's providing it. Ms. Robards stated that organizations have developed training processes for every position, including for the intake staff fielding calls. She said she would compare this information with their current written process and make sure that all of the bullet points were covered in existing policy and then stand responsible for her team. Mr. Robeck asked if it there was an advantage to the state if the Board supported this. Mr. Erickson said the purpose was to let the Board know before it was sent it out to them. Mr. Robeck saw no reason for the Board to vote on it. He added that there was no benefit to SAPTA to

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take a vote. The Board agreed to table the vote. Mr. Erickson pointed out that subrecipients of grants would also need to be educated on these points. Anybody receiving funds at any level was required to follow all the federal guidelines.

6. Make Recommendations of Agenda Items for the Next Meeting on October 10, 2018
   Ms. Quilici suggested that agencies contact legislators to let them know the political support needed. She pointed out that even Nevada's national representatives did not know much about CCBHCs, which she believes are the wave of the future. Ms. Robards asked Ms. Quilici to talk about the discussions with the National Council for Behavioral Health and their efforts to lobby on behalf of behavioral health. Ms. Quilici said she spoke with them this morning as Mr. Robeck, Ms. Robards, and she develop an approach through the National Council. Mr. Erickson said the regional policy boards were collaborating as each was allowed one bill before the state legislature. Ms. Quilici suggested an update. Mr. Robeck said he and Ms. Robards were open to calls regarding agenda items.
7. Public Comment
   Ms. Quilici noted that Nevada created a system of CCBHCs, with each one being different but offering the same nine core services and providing badly needed service. She said the meeting in Washington, D.C., included agencies with over $100 million in budgets and huge staffs. And yet, the Nevada CCBHCs got the job done. She appreciated the system, and the public-private support they got in order to do this. The State collaborated and continues to do that. Nevada has the only two CCBHCs in the United States that are in rural frontier areas. Mr. Robeck, in Las Vegas, was able to do so much without a huge staff and budget.
   Ms. Nelsen announced that Pauline Salla resigned from Frontier Community Coalition's board. Jeff Munk will return to the position.

8. Adjourn
   The meeting adjourned at 11:24 a.m.

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