Division of Public and Behavioral Health
Substance Abuse Prevention and Treatment Agency (SAPTA)
Advisory Board

MINUTES

DATE: October 11, 2017
TIME: 9:00 a.m.

LOCATION:

Meeting	Videoconference	
4126 Technology Way	**6161 W. Charleston Blvd**	**1010 Ruby Vista Dr.**
2nd Floor Conference Room 201	**West Hall Conf. Room**	**Suite 103**
Carson City, NV 89706	**Las Vegas, NV 89146**	**Elko, NV 89801**

BOARD MEMBERS PRESENT

Michelle Berry, Interim Chair	Center for the Application of Substance Abuse Technology
Diaz Dixon	Step 2
Jennifer DeLett-Snyder	Join Together Northern Nevada
Tammra Pearce	Bristlecone
Lana Robards	New Frontier
Pauline Salla-Smith	Frontier Community Coalition
Jamie Ross	PACT Coalition
David Robeck	Bridge Counseling
Ester Quilici	Vitality Unlimited
Jolene Dalluhn	Quest Counseling
Denise Everett	Ridge House
Kim Moore	HELP of Southern Nevada

BOARD MEMBERS ABSENT

Michele Watkins	Central Lyon Youth Connections
Richard Jimenez	WestCare
Ron Lawrence	Community Counseling Center

OTHERS PRESENT

Mark Disselkoen, CASAT	Michelle Padden, CASAT
John Firestone, The Life Change Center	Dani Tillman, The Life Change Center
Barbara Caskey, Vitality Unlimited	Christopher Croft, Tahoe Youth and Family Services
Dona Dmitrovic, Foundation for Recovery	Lea Cartwright, Nevada Psychiatric Association
Jennifer Conrad, FEi Systems, Inc.	Chris Lanham, FEi Systems, Inc.
Richard Brown, The Empowerment Center	Josh Coello, HPN BHO

SAPTA/STATE STAFF PRESENT

Kyle Devine	Marco Erickson
Deborah Aquino	Bill Kirby
Jessica Hoff	J'Amie Frederick
Raul Martinez	Joan Waldock

1. Introductions, Announcements, and Roll Call
   Ms. Berry opened the meeting at 9:02 a.m. She found that a quorum was present.

2. Public Comment
   Mr. Robeck referred to the devastating shooting in Las Vegas. He wanted to thank all of the behavioral health agencies in southern Nevada, state and county officials, and leaders in the government for their response, saying they did tremendous things in the community. Ms. Berry echoed his sentiments, thanking everyone for coming together and making an impact by providing services. There was no further public comment.

3. Approval of Minutes from the August 9, 2017, Meeting
   Ms. DeLett-Snyder pointed out that she had discussed attendance with Ms. Salla-Smith and that Ms. Salla-Smith had not been contacted, but the minutes reflect she was. She said she had not received anything from Substance Abuse Prevention and Treatment Agency (SAPTA) indicating that she was facing removal from the Board. Ms. Salla-Smith said she was contacted about other committees she was a part of, but not by the SAPTA Advisory Board (SAB). She apologized for having missed meetings. Mr. Devine asked that the minutes reflect the fact that Ms. Salla-Smith had not been contacted regarding removal from the Board.
   Ms. DeLett-Snyder also pointed out that the Board had discussed term limits for Board members, as found in paragraph 2 of page 4. She asked if the decision would need to be made by the Bylaws Subcommittee, not by the Advisory Board. Ms. Berry replied that changes to the bylaws must be recommended by the Bylaws Subcommittee. Ms. DeLett-Snyder read from the bylaws: "The term of office for the chairperson and vice chairperson is two years. There shall be no term limits." She pointed out that bylaw was last revised in 2006. Ms. Berry agreed that this issue would have to go to the Bylaws Subcommittee for further review and recommendation. Ms. DeLett-Snyder suggested adding this to the next meeting's agenda.
   Ms. Dalluhn pointed out that on page 7 of the minutes, it stated that Mr. Devine was committed to drafting his plan of expectations for the group and would ask SAB for its plan, and the two could be pulled together to make SAB what it needs to be. It was said that would happen at this meeting, but she did not see it on the agenda. Mr. Devine said that it was an oversight for which he apologized. Ms. Berry added it to a list of agenda items for the next meeting.
   Ms. Robards made a motion to approve the minutes from the previous meeting with the notations discussed. Ms. Dalluhn seconded the motion. The motion passed. Ms. Quilici and Ms. Salla-Smith said they were not present at that meeting, so abstained from voting.

4. Standing Informational Items:
   - Chair's Report (Michelle Berry)
     Ms. Berry reported that she is currently the vice chair of the Board, serving as its interim chair. She said that elections for officers will be held at the first meeting of the new year.

   - SAPTA Report (Kyle Devine, Marco Erickson)
     Mr. Devine had planned on presenting a full accounting of funding from 2016, 2017, and what was budgeted for 2018 and 2019. He reported that there were issues with the report, and that he would get it out to them by the next day.

     - Funding Allocation Update
       Mr. Devine stated that the report would show slight reductions in funding for treatment, but also a slight bump in funding for prevention from dollars that were not added in last year. He suggested they note that for 2018-2019 the budget allocations cover 15 months, including the state general fund that would usually be used July-September and the block grant funding that goes October-September.

The allocation reflects the total amount awarded. He reminded the Board that the Bureau of Behavioral Health, Wellness, and Prevention was working on awarding all of those dollars at one time in order to avoid some of the confusion that arises at the end of the fiscal year. He pointed out that the Bureau would be doing fiscal monitors this year. He explained that if the monitors uncovered issues, the Bureau would provide technical assistance, but if the issues continued in the following years, other courses of action might be taken. He reported that two monitors had been done and that the major finding was on the Bureau. The monitors revealed that the Bureau had not provided adequate written guidance. It has been noted and will be corrected throughout the year. He stated that the Bureau cannot hold providers accountable for anything not clearly communicated. He also stated that if they found systemic issues or issues that they corrected, there would be adjustments to funding throughout the year based on the corrections. He said they had been making corrections at the end of the year to make sure funds were spent and that people had services. This would change that so that corrections would be made earlier in the year as monitors were being done. He announced that they would be requiring a spending plan that would lay out how monthly expenses matched with the budget they provided. He stated the spending plan was an estimate that would be used for planning purposes—if they found things out of whack, they could communicate before things became an issue at the end of the year. He explained that the purpose was to avoid the end-of-the-year scrambles for making adjustments as deadlines loomed. He said they would send out the list and it would be on their website. For the sake of transparency, everyone would know what the allocations were and what was spent in the past.

Ms. Dalluhn stated that her agency, Quest Counseling, was monitored in August. While she had an exchange of emails with Laurie Gleason about the final report, Ms. Gleason told her that she had sent the report to Mr. Devine on October 3. They have not received it yet. She wondered when they could expect it. Mr. Devine said it was approved, and that he would follow up to see where it was. He mentioned that in the past reports were not sent out, but that was no longer the case. He added that if an agency did not receive any reports by the date specified, they could contact him directly.

- Capacity Management and Waitlist Policy

Mr. Devine pointed out the two policies were so closely related that they should be a single policy. The final policy will be effective November 1 and can be viewed here. The main change he noted was that the Bureau was going to become more active in monitoring both capacity and waitlist. He continued that, per federal regulations, if a client in a priority group—a pregnant woman or a person injecting drugs—was going to be put on waitlist, the Bureau had to be notified directly. He stated that in the past, that information was submitted into an information system, but that has changed so that current policy required a phone call to the Bureau so that staff could work to make sure people are getting the services they need. He added there was a federal requirement for all persons injecting drugs. For programs that provide services—if capacity exceeds 90%, the Bureau must be notified. He further added that the Bureau was extending that to all services so that it would be aware of what was going on in Nevada communities. He explained that the purpose was to make sure the Bureau coordinated services and that services would be available to those who need them. Mr. Devine pointed out that he delayed implementing the policy until November 1 so that he could be sure that the internal capacity and protocols were in place to do what needed to be done. He stated that was now in place and the policy would go out with a management memo that gave the specific phone numbers to call in order to remain compliant with the policy. He said issues regarding the policy should be referred to

him. Ms. Berry pointed out a few spelling errors. Mr. Devine said they would be corrected before the policy was sent out.

Ms. Berry read that an organization was supposed to contact the Bureau for approval to place a client on a waitlist. She asked what the turnaround time would be for approval. Mr. Devine replied that for pregnant women and priority groups, approval would be immediate. He said he would allow 24 hours for a response to the provider to make sure the services were coordinated. He added that federal regulations allowed 48 hours from the point of request to when the client should be receiving services. In order to comply with that, he said they would be implementing a duty phone—a cell phone that would be used by staff so that there was always someone available to take a call. Ms. Quilici asked if there would be immediate help, or if the line would be in use Monday through Friday, 8-5. Mr. Devine clarified that it would be used during normal business hours. If there was an emergency on a weekend, a provider could call that line as well. He said that would be explained in the management memo accompanying the policy. Ms. Berry asked who would manage the process. Mr. Devine replied that it would be managed by Kendra Furlong, as she was the supervisor of staff manning the duty phone. If there were problems at that level, Mr. Erickson could be contacted. If problems were not resolved at that level, a provider could call Mr. Devine.

Ms. Berry asked who would update the HAvBED system. Mr. Devine replied that each individual provider is required to input data daily. He added that the system works only if there is accurate information from all funded providers. He explained the system provided a snapshot of available beds, but agencies needed to call to confirm. Mr. Devine stated that all funded programs should have received training and asked that any agency that had not received training contact him.

Ms. Robards pointed out that her agency has had a lot of parenting fathers who are substances abusers. Referring to page two, priority populations, she asked if those fathers would fall into category (e) "all others," since (d) refers only to females. Mr. Devine stated that parenting fathers have been neglected in policy in the past. Ms. Robards suggested changing the word "females" in (d) to "parents." She pointed out that, based on what was in force before, an emphasis had been made on child welfare cases, specifically when children had been removed from the home and the family was working on reunification. Ms. Robards said her agency treated parenting fathers as a priority population anyway. Mr. Devine assured her that would not be a problem. Mr. Dixon said his agency received a lot of phone calls from men who are parenting fathers. He stated this was a population that needed to be helped. Mr. Robeck stated that, as a single father, he found it significant that the policy specifically referred to women. He asked if the wording could be changed in the near future because it seemed to be a big issue if both Ms. Robards and Mr. Dixon spoke up about it. Mr. Devine said that he would commit to changing the wording before the policy was sent out with the management memo.

- Recent Changes with Prevention Dollars and Training

Mr. Erickson stated that some great things had been done with prevention. He said one of those was bringing Community Anti-Drug Coalitions of Nevada (CADCA) to Nevada. CADCA is well known for building coalition capacities by focusing on building a prevention model for the local community. They provided a three-day training with the coalitions which he thought had been well-received. He said that to follow up on the training, SAPTA was encouraging communities to step up their game in building their personal logic models, working with every sector of their communities to discover what the community needed. Communities would need to determine their

priorities and inform the State what those were so the State could fund coalitions based on the community's needs instead of telling communities what services to provide. The State would help with technical assistance for local conditions. He explained the training looked at local conditions for prevention and put energy into building that and that they would be pushing this harder than they had in the past.

Mr. Erickson reported that with block grant dollars, they were able to partner with some State agencies that were experts in their fields—with Chronic Disease Prevention and Health Promotion for tobacco and with Maternal, Child, and Adolescent Health to do a lot of the work for women's services. He added they would continue to work on building capacity in the state, even with the loss of a couple of coalitions—the money allocated to them was used to increase the allocations of those coalitions remaining.

Ms. Robards pointed out that some members of the Board were involved in prevention programs through their own organizations under their primary prevention certification but were not participating with coalitions. She asked if they could be included when training opportunities arose that would benefit them. Mr. Erickson said that they strongly recommended that all players, including the health districts, be at the table so there is not a duplication of services when the community plan was being developed. Funding opportunities would be available, but they should go through the coalitions to collaborate. Ms. Robards said she had been asking to have those involved in primary prevention certification be included in training opportunities for prevention and/or treatment. She pointed out that some of the awards her organization received are in between—such as the Parent-Child Assistance Program (PCAP), which is more prevention than it is treatment.

Ms. Aquino informed the group that a sustainability training was coming up that would be appropriate. Mr. Erickson said they were encouraging everyone to put a sustainability plan in their planning process so that they could see long-term how they could shift funds and continue to set new priorities for communities as they work on something. Mr. Devine said that whenever the Bureau put on a training, he would make sure information was sent out to all funded certified providers.

Mr. Erickson stated another thing added this year was evaluation—reports that would tell the story of what was going on Nevada so that it could be shared. Ms. Robards thought that prevention had always done evaluations. Mr. Disselkoen said that had been through the University of Nevada, Reno. The group agreed that Pacific Institute for Research and Evaluation (PIRE) had done them.

Ms. Berry asked if they were looking at evaluation of the coalition model as a whole. Mr. Devine explained that they are looking at evaluation as a whole, but also at individual evaluation processes for each objective that coalitions have. Without the feedback mechanism, the story could not be told. He said they wanted to better tell the story to the federal government, the legislature, and to community members so the coalitions or agencies could see what was working or what was not working, and could make adjustments. Mr. Erickson said it would also help in writing block grant applications by providing a record of where the prevention coalitions have gone and would provide a history to tell. Ms. Berry asked how often reports would be generated. Mr. Devine answered that the Bureau would require quarterly reports based on the scopes of work on activities. Evaluation reports would be completed based on the deadline of the objective being evaluated; a full report would be required at the end of the year. Ms. Berry asked that they share the findings with the Advisory Board. Mr. Devine added that the findings would be reported to the Statewide Epidemiology Workgroup (SEW), the Behavioral Health Planning and Advisory Council (BHPAC), and the Multidisciplinary Prevention Advisory Committee (MPAC). He admitted this was an area where the Bureau had been negligent—receiving reports without providing

feedback on them. Ms. Dalluhn stated that as a subgrantee of a coalition, her organization already did a quarterly report and wondered if that would change. Mr. Erickson replied they were in the process of building the evaluation report and that it could change throughout the year. Mr. Devine said that it would be between the subgrantee and the coalition—it would be the coalition's responsibility to get the information from subrecipients in a format that made sense to them. The Bureau would get the information from the coalition. Mr. Erickson said that the Web Infrastructure for Treatment Services (WITS) had a place where a lot of that could be done.

Mr. Devine reported that there had been some confusion about Medication-Assisted Treatment (MAT) services for pregnant women. He stated that the Bureau and the Division were working diligently to write technical bulletins and to establish policies to make sure that everyone was clear on the requirements for MAT services. He mentioned that some pregnant women in some programs were expected to be abstinent from all substances. He pointed out that with MAT, that could cause problems to a fetus and that he expected to correct the information and to get it out to all providers. Ms. Robards asked if there could be more training on MAT, as there are multiple schools of thought on practice. She said that even MAT clinics and primary care physicians differed, making it difficult to develop a structure for her organization. She said that she has looked for trainings on opioids and on marijuana and has not found many available. Ms. Berry said that CASAT would set up more trainings for what Ms. Robards needed. Mr. Disselkoen said he did the trainings on MATs and did not know why there had not been a training in a while. He said he updated the material based on new information about requirements. Ms. Robards said she did not think there was enough information available. Ms. Berry pointed out that CASAT filmed Mr. Disselkoen's recent training, so a video would be available in a few weeks. Ms. Robards announced that there would be a training for American Society of Addiction Medicine (ASAM) sponsored by New Frontier at the Convention Center on the October 18. She said the event would result in Continuing Education Units (CEUs). Ms. DeLett-Snyder mentioned that a MAT training on Project ECHO through UNR School of Medicine was available at least once a month. Ms. Berry said that through the State Targeted Response to the Opioid Crisis (STR) Grant, ECHO offered a MAT clinic every other week and a pain management clinic every other week, but that the MAT clinic was geared toward prescribers in overcoming anxiety they might have or questions they had about prescribing.

- CASAT Report (Michelle Berry)

  Ms. Berry reported that there were some new online classes for SAPTA training: Nevada law, crossing professional boundaries, and multicultural awareness. CASAT will be adding a class about the MAT hub and spoke model that should be available by the end of the month. All are available for continuing education hours. She mentioned they were developing a new online clinical supervision course, available at the end of the year. It will be eligible for the certified alcohol and drug counselor (CADC) seeking clinical supervision licensure. She also announced that the Spring 2018 calendar will be on the website by December 2017. She stated the Northern Nevada Behavioral Health Association, formerly Nevada Adapts, holds monthly coalition meetings and that information and notes are posted on the Nevada Behavioral Health Association (NBHA) website. Their next board meeting, at which officers will be elected, is scheduled for November 2, from 10 a.m. until noon. There will be a feed from Reno to Las Vegas and Elko. She stated that Joe Maguire would be coming from Colorado to teach on marijuana policy in the workplace November 13 in Reno and November 14 in Las Vegas. For peer support specialist certification, the grandfathering period opened September 1 and will run

until December 1. All of the information about the certification process has been made available on the NBHA website under the Peer Recovery and Support Certification tab. So far, they have received about 15 applications. Foundation for Recovery is hosting an informational webinar session about the certification process and to answer questions folks might have about applying for peer certification. Regarding prevention certification—so far, they have received about 40 applications for prevention certification specialists, which is going through the same grandfathering period. The application can be found on the NBHA website. She noted that CASAT would be hosting a suicide prevention conference October 12-14 in Reno at Truckee Meadows Committee College and that there was no fee to register. CEUs can be earned. The next Nevada Peer Leadership Advisory Council meeting is October 23, from 10 to 11 a.m.

Mr. Disselkoen added that he would be doing an ASAM training and a Diagnostic and Statistical Manual (DSM) on November 8 in Las Vegas and on November 9 in Reno. ASAM training will be held in the morning, DSM in the afternoon. He reported they had 7 or 8 active applications from private providers seeking certification.

Ms. Berry stated that the Nevada Prevention Resource Center (NPRC), the clearinghouse for CASAT, would no longer have a physical location. Everything available through NPRC should be available online. Currently, Resource Ordering and Reporting (ROAR) is unavailable for accessing materials, but should be up and running soon. She said that everything it does would have a public-facing interface and would be available for free for users. Ms. DeLett-Snyder asked if print materials would be available or if everything would be downloadable. Ms. Berry replied that all materials would be downloadable. Ms. DeLett-Snyder asked if NPRC would be getting rid of the materials they had. Ms. Berry thought those were available. Ms. Berry said NPRC would still be staffed, but it would not be a storefront. Ms. Quilici asked what was available. Ms. Berry replied that they could still access ROAR, but could no longer order from it so that if there was something on ROAR an agency wanted, NPRC could send it to them.

5. Approval of the Division Criteria (Mark Disselkoen)

Mr. Disselkoen said he was representing SAPTA, the Opioid STR Core Group, and the Opioid STR Certification Sustainability Workgroup.

- Medication-Assisted Treatment Programs to Comply with Nevada Administrative Code (NAC) 458

  Mr. Disselkoen gave an overview of NAC 458.118 as it related to Division criteria. He said NAC 458 gave the certification standard for program and that Division criteria were additional requirements beyond what was specifically written in NAC 458. He noted that the luxury of Division criteria is that criteria could be changed more easily than regulations. He reported that NAC 458.118 described how to revise, add, and change Division criteria and that *Nevada Revised Statutes* (NRS) 458.025 gave the statutory authority to do this. He said the Division could only certify and fund programs in accordance with Division criteria. He explained that a program must be certified in order to receive funding. He added that the Division could amend the criteria if:

  - SAPTA staff submitted a written amendment
  - An amendment was placed on the agenda of the SAPTA Advisory Board
  - If the Advisory Board approved the criteria, SAPTA would recommend that the Administrator approve the criteria
  - If the Administrator approved the criteria, it would be presented to the Commission of Behavioral Health for review and approval
  - If the Commission approved it, changes would be published in the *Administrative Manual* of the Division, posted on the Internet, provided to each certified alcohol and

drug abuse program operating in this State for prevention or treatment of substance-related disorders

Mr. Disselkoen reported that SAPTA, Health Care Quality and Compliance (HCQC), and Medicaid staff—Shannon Sprout and Duane Young—helped with developing the criteria (found here). He stated the criteria were developed in response to federal funding related to the opioid epidemic in America and in Nevada and that a Request for Application (RFA) was recently put out focusing on this funding. He said the RFA mirrored the criteria in many aspects, with the criteria providing more detail related to additional requirements. Ms. Berry pointed out that Mr. Disselkoen was speaking about the RFA for the Integrated Opioid Treatment and Recovery Center, not the RFA for funding for the overall STR Grant. Mr. Disselkoen continued that extensive research was completed looking at centers of excellence and hub and spoke models related to MAT services. He said they reviewed work done by Johns Hopkins University and the states of Vermont and Rhode Island—states recognized as leaders in MAT services. Ms. Berry explained that they looked at the Vermont hub and spoke model and the co-op model developed by Dr. Ken Stoller.

Mr. Disselkoen continued his report by explaining new criteria were necessary because:

- The funding has a limited timeframe and is specific to staffing, programs, and training activities.
- Medicaid is developing a bundled rate for these types of services, so there will be a reimbursement mechanism going forward.
- Certification will provide oversight in the near-term but, more importantly, in the long-term.

Ms. Berry explained that because a new funding mechanism and bundled rate were being developed, new certification criteria needed to be developed specific to integrated opioid treatment and recovery centers. She added that, in order for these centers to be accessing the new rate, they would have to hold the certification. Mr. Disselkoen added that people who were awarded needed to be certified as Level 1 Ambulatory Withdrawal Management Outpatient and have a co-occurring disorders (COD) endorsement. Long-term, once the criteria are approved, those centers would need to be certified under them.

Mr. Disselkoen went over the options for certification. Option 1, he explained, was the traditional opioid treatment programs (OTP) that are already licensed by HCQC and certified by SAPTA. Traditional OTPs are programs that dispense methadone. Option 2 was for programs that were not traditional OTP programs but they would be required to provide at least two of the three Federal Drug Administration (FDA)-approved medications for opioid use disorder. They would also be required to coordinate services with an OTP. He noted that beyond Options 1 and 2, programs certified under those options must also provide specific additional services and meet applicable requirements. Most of the information contained in the list of additional services came from Vermont's model. He added that the certification would be for funded programs, but non-funded programs could also seek it. Ms. Berry added that a non-funded program would need to provide all of the services outlined. Mr. Disselkoen noted that there would not be very many programs that would actually do this. He added that if a criterion does not quite work, it could be updated.

- All Certified Providers to Report Treatment Episode Date Set (TEDS) Data to SAPTA to Comply with NAC 458

  Mr. Disselkoen noted this criterion was treatment-specific. He said this criterion (found here) stated that certified treatment programs—private, public, or funded—were required to report TEDS to SAPTA monthly in a format determined by the Division. He added that currently only funded treatment programs provided TEDS data. He noted that 75% of certified treatment programs were not funded, so there is a large number of programs not providing data and that the absence of that data affected the ability of the State to make good decisions. He added that the benefit for private programs in being certified was that they would get court referrals,

third-party payer referrals, and Medicaid provider type 17 access. Mr. Devine clarified the purpose of the change—currently, SAPTA lacked a good picture for treatment in Nevada; requiring all certified providers to send in data would give the State the full picture, allowing for the State to do a much better job of planning future funding and programs and capacity-building.

- All Treatment Providers to Treat Clients Who Are Utilizing Medication Assisted Treatment (MAT) to Comply with NAC 458
  Mr. Disselkoen said the final criterion being reviewed (available here)was based on access to care barriers. He explained that treatment providers must allow access to treatment services for individuals being treated with FDA-approved medication. He added the Americans with Disabilities Act (ADA) covered the issue to some degree, but they decided to provide more clarity on the matter. The criterion states that certified treatment programs—private, public, or funded—cannot deny treatment services to clients who are on stable medication maintenance for the treatment of an opioid use disorder including FDA-approved medications. He drew attention to the caveat "stable medication maintenance." He expressed that he thought it would be obvious that if a client was not medically stable, a program would not have to accept him but would be required to coordinate to make sure the needed medical services are provided. Ms. Disselkoen mentioned that he thought most programs were already doing this. He noted they were using American Society of Addiction Medicine (ASAM) Third Edition criteria to determine severity—indicators include significant withdrawal risk potential and biomedical conditions. He added that a client at high severity would need to have services coordinated through a hospital.

Ms. Dalluhn made a motion to approve the criteria regarding medication-assisted treatment programs complying with NAC 458. Ms. Robards seconded it. The motion passed [Mr. Diaz was absent for the vote.]
Ms. Berry said she would entertain a motion for all certified providers to report treatment episode data set data to SAPTA in order to comply with NAC 458. Ms. Everett so moved. Ms. Pearce seconded the motion. The motion passed. [Mr. Diaz was absent for the vote.]
Ms. Berry said she would entertain a motion for all treatment providers to treat clients who are utilizing medication assisted treatment in order to comply with NAC 458. Ms. Dalluhn so moved. Ms. Robards seconded the motion. The motion passed. [Mr. Diaz was absent for the vote.]
Mr. Disselkoen thanked Mr. Devine and Don Sampson from HCQC for providing feedback for the Division criteria.

6. Discuss and Approve Utilization Management (UM) Subcommittee Recommendations for the Utilization Management Policy (Mark Disselkoen)
   Mr. Disselkoen reported that in August, the Board asked to have a subcommittee review utilization management policy (found here) relating to residential treatment programs. The subcommittee met a couple of times. The recommendations he brought forward came out of the September 21 meeting. He explained that a policy is different from Division criteria. The recommendations are to be made to SAPTA so that they can finalize and put into place the policy, but the policy does not have to be approved by the SAPTA Advisory Board. Mr. Devine specified that this would be a Bureau policy. The policy changes are as follows:

   1. Recommend that the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 not be required as part of policy.
   2. Recommend clearly defining "Auditing File Protocol." The committee recommends electronic reviews rather than onsite reviews.

3. Recommend clearly describing peer to peer review related to appeals of denied services, including utilizing different peers from other communities when reviewing an appeal. A peer defined here is as an appropriately certified/licensed clinician in a residential program from another community from where the appeal is being made.
4. Recommend that a treatment plan not be required as part of the policy.
5. Recommend that initial approval for Level 3.1 be 60 days.
6. Recommend that the initial approval for Level 3.5 be 21 days.
7. Recommend piloting the UM process using a step-by-step procedure beginning with Level 3.5 and continuing with Level 3.1 once the pilot is successful.
8. Recommend checking and correcting the reference in NAC 439.345 related to appeals of denied requested services at assessment and for continued services. NAC 439.345 does not address an appeals process, it is basically notice of proposed disciplinary action.
9. Recommend the claims generated for weekend admissions be processed by noon the next business day after that weekend.
10. Recommend developing a flowchart showing how claims are processed from initial preauthorization through approval and subsequent continued services requests.
11. Provide information on how claims will be electronically processed. SAPTA may contract with somebody to do the UM process if there is not sufficient SAPTA staff to do that. Mr. Disselkoen, Mr. Devine, and Ms. Furlong will look at a mechanism to assure that claims are processed in a timely manner.

Ms. Quilici moved to accept the UM policy. Mr. Robeck seconded the motion. The motion passed [Mr. Diaz was absent for the vote.] Mr. Disselkoen noted that the policy would be updated with the recommendations. Mr. Devine stated that the Division policy book would be updated and available January 1, 2018. Ms. Berry said it would be sent to folks, except for the criteria that must be reviewed and approved by the Behavioral Health Commission in January.

7. Vendor FEi Systems, Inc. Will Present the Project Overview and Information for the Web Infrastructure for Treatment Services (WITS) System

Ms. Berry stated that the State Targeted Response (STR) Grant for the opioid crisis was $5.6 million each year for two years. Part of the funding was set aside to bring on board a new data warehouse and electronic health records (EHRs) system. The State has opted to bring in WITS. Some members of the Board have already been to informational sessions at which this was presented. She emphasized that Mr. Devine and his team had done a good job on this. Those who are already working with a different electronic health records system do not have to adopt this as the materials and information will interface.

Mr. Robeck asked if the State had already purchased the system. Mr. Devine replied that it had—mainly for data collection for the STR, treatment, and Treatment Episodic Data Set (TEDS). He explained that the Bureau would not mandate that anyone change from an existing EHR, although there is an EHR component to WITS. He stated there may be some who would want to switch over to WITS. He said the State was working with WITS on a solution that allowed all data to be uploaded through a data portal out of existing EHRs. Mr. Robeck stated that he watched about three of the four hours of the WITS presentation and thought it sounded like the three agencies selected for the integrated opioid piece would be mandated to change. Mr. Devine replied that once those organizations were selected the Bureau would look at their resources and capabilities, and the agencies would either be able to use WITS or the reporting mechanism being put in place. Mr. Robeck had been concerned about extra cost if his agency was selected to be one of the integrated agencies. Ms. Conrad from FEi said a decision would be made once they knew who the vendors would be and what their capabilities were.

Ms. Conrad's overview can be found here. She said they held a four-hour meeting the previous day and talked a lot about schedules. She said that today she would talk about what those were, what

there were trying to do, and what they were not trying to do. She introduced Chris Lanham, the account manager working with Nevada and providers throughout the process. She said she would give an idea of what the system does, but would focus primarily on what Nevada was trying to do and some of the priorities that the State has for this platform—which is not only an EHR, but is a lot of other things. She said she would finish with how they see the various providers, coalitions, and everyone else involved as that is an important part of the process. She applauded Nevada for involving people in the process. She said that FEi is a health services company. Almost all of what they do concerns behavioral health. She stated they work with more than 33 states and some larger counties, helping with a variety of systems used by providers. She explained that providers feed in information that is used by states and counties for reporting. FEi also manages several systems that Nevada is required to interact with for the Substance Abuse and Mental Health Services Administration (SAMHSA), such as the block grant reporting system. They also send data for TEDS and National Outcomes Measures (NOMs) for 18 or 19 states and counties. She said they try to use that information as well as information from other states to create a collaborative environment in which states and providers can talk to other states and other providers. She added that their federal experience helped states be prepared to respond to changes coming from SAMHSA.

Ms. Conrad provided a PowerPoint presentation that can be found here. She said WITS started out as a system funded by SAMHSA to collect TEDS and NOMs data. It has grown to include areas that touch substance abuse and mental health—corrections information used for reporting; behavioral health providers' data and resulting reports; and State reporting across the board. She reported that WITS was Health Insurance Portability and Accountability Act (HIPAA) Code of Regulations (CFR) 42-compliant, with appropriate levels of data privacy, security, and confidentiality for personal health information. She stated that what the reporting agencies need will be there and be accessible, even by those just sending information into the warehouse. The warehouse has a reporting model that providers and the State can use. She pointed out that the information agencies are required to gather could be used to track what was being spent by Medicaid or out of the state block funding for a single client. The State could then evaluate if that was reasonable, and if there were evidence-based programs that did better. Some states use data from the system and other federal data sets to convince state legislatures to promote and fund statewide programs—criminal justice reentry and crisis programs—that they might not have gotten without access to that data. She said the point was not just to collect data for its own sake but to use the data to better treatment options and programs offered, hitting areas where there might be a gap.

Ms. Conrad stated that Nevada's first goal in using WITS was data collection and reporting to support the STR Grant. The second was to have an integrated, web-based system that gathered information for TEDS, NOMS, and statewide prevention. She said they wanted the information along with cost information in one place for reporting. They also wanted to have access to the data in a meaningful way. WITS would provide electronic health records for providers who do not already have a system or who want to switch. She reminded the Board that FEi takes privacy and confidentiality seriously—their security officer makes sure they understand what is coming in terms of threats for any system they host. She said she and Mr. Lanham would put together a test site for Nevada when they get back to their office, turning on many of the features they think providers would want in order to try out the system. She cautioned that the site would not be Nevada-specific regarding business rules. She reported an approximate timeline—Phase 1 with the pilot providers should start in April. Phase 2 would overlap; it might be on TEDS data collection into a data warehouse and on treatment options for those who want to use the system. Phase 3 may be billing and prevention—Medicaid billing directly from the system and direct billing for block grant services and prevention. Mr. Devine pointed out that this was a very aggressive timeline of about a year to 18 months. Ms. Conrad stated FEi wanted interested agencies to see how this would work and what it looked like so they could answer questions upfront. She said they would be doing extensive implementation planning—involving stakeholders, focus groups, and hands-on training.

She concluded by pointing out that any communication with providers would be done at the direction of the State.

Ms. Dalluhn asked if there would be a cost to providers for using the system. Mr. Devine replied that the system would be licensed to the State, allowing the State to connect anyone in Nevada to the system. He added there should be little to no cost to providers who want to use it. Mr. Devine explained that he would have to check to see what the Legislature did when the Avatar system rolled out in order to determine what SAPTA would need to do. Ms. Conrad added there was no "seat fee" for the system—they charge for the services they provide. In Oregon, a provider agency paid for a customized interface with a lab agency that became available to everybody on the system. Ms. Everett asked if this system would do everything the EHR Award does. Ms. Conrad replied that WITS could be a full-fledged EHR. She did not know enough about Award to know if WITS did everything Award does. Ms. Everett asked if WITS could do billing. Ms. Conrad said it could. Mr. Robeck said that he learned yesterday that everything having to do with EHRs would still have to be built just as it had to be built with Award. Ms. Conrad replied that everything an agency does with EHR is in WITS today. The State has funded making the Medicaid A-37 work with Nevada's Medicaid billing. She did not think there would be many things lacking that other EHRs provide. Mr. Devine added that it would help SAPTA meet some of federal requirements, but if components did not work for providers, it would not be worth it to do this. He made the commitment that SAPTA would do whatever it needed to do to make sure the system worked for all providers, not just for the State. He said that using WITS would be a business decision each provider needed to make. He added that many using Avatar might like this system better. He stated he was aware that providers have invested a lot into their current EHR systems. That is the reason he would not mandate switching to this system, but would make it available to those who chose to use it.

Mr. Robeck stated it sounded as if there was a lot of build out to do. He chose to go with Award because Foothold said they could do many of the things WITS does. Once he bought the system, he was told he had to pay to have features built out. He said he hoped they would see that WITS has those things built out. Ms. Conrad said the best way to evaluate the system was to have someone from FEi demonstrate it for him so that he could see. She said there were around 18,000 clinicians across the country using clinical features in WITS as their EHRs. She added that he would need to be the judge of what he needed. She said if FEi understands the business need, they would be able to show how WITS could do the same as his current EHR or they would tell him that WITS could not do what he needed. She added that they wanted to make the process as painless as possible. Mr. Devine said the State would cover all licensing and maintenance fees. If the State had to man a help desk for the system, there could be a cost to providers. Ms. Berry pointed out that provider input would be solicited every step of the way. Mr. Devine suggested that he would like input on implementation, workflow, and processes—even from those who do not plan to switch over. Input should make the system work better for everybody. In addition, he noted that focus groups would be available to all providers, not just those who decided to use the system. Ms. Tillman asked if WITS included a dosing and medication management system. Ms. Conrad said currently it did not. Ms. Tillman pointed out that Nevada was focusing on the STR Grant, so it seemed to her that MAT should be part of the system. Ms. Conrad explained that WITS had pieces of it, but did not communicate with a dosing machine.

Ms. Ross asked how much the WITS system cost the State. Ms. Berry said the cost to the State was $1.4 million. Mr. Devine explained that the development of the system would be $1.4 million and that he could get the cost information out to them as it was public information. Ms. Berry added that $1.4 million was set aside through the STR Grant for onboarding the program. Mr. Devine said there would be an annual maintenance fee the State would likely cover out of the block grant. Ms. Berry said the first year of maintenance would be covered through the STR Grant and continued maintenance would be covered through the block grant. Ms. DeLett-Snyder asked if the amount from the block grant would be split between treatment and prevention. Mr. Devine said it would be handled administratively. Ms. DeLett-Snyder thought she had seen a document that said the

maintenance cost would be about $400,000 per year. Both Mr. Devine and Ms. Conrad thought that seemed higher than what they remembered. Mr. Devine said he would check on the cost and get that information out to members of the Board.

8. Discuss and Approve the Recommendation from the Nomination Subcommittee to Postpone Nominations to Fill Vacancies Until the Bylaws are Re-examined

Ms. DeLett-Snyder reported that the Nomination Subcommittee met and found conflicting language in the bylaws, noting that the bylaws said that an organization needed to be receiving state funding—it does not say SAPTA funding—in order to be on the Board. The next section stated that an organization needed to be receiving SAPTA funding. The subcommittee requested that the bylaws subcommittee meet to change that. She said the Nomination Subcommittee reviewed the names of all of the organizations currently receiving SAPTA funding. Since the Las Vegas Indian Center is no longer funded, the subcommittee asked if they could be removed from membership as they no longer qualified. She said the subcommittee did not move any further because they thought the bylaws needed to be reviewed before they determined whether or not to nominate anyone for membership. She recommended that the bylaws subcommittee meet to look at the bylaws, make recommendations, and discuss whether any infrastructure changes were necessary.

Ms. Berry asked members of the Bylaws Subcommittee to identify themselves. The following said they would be willing to be Bylaws Subcommittee members: Ms. Berry, Ms. Robards, Ms. Quilici, Mr. Robeck, Mr. Disselkoen, Ms. DeLett-Snyder, Ms. Ross, and Ms. Pearce. Ms. Berry said that she and Ms. DeLett Snyder would serve as co-chairs. Ms. DeLett-Snyder suggested that the Nomination Subcommittee meet before the December SAB meeting. Ms. Berry invited anyone who wanted to be part of the Nomination Subcommittee to email their names to Ms. DeLett-Snyder. Ms. Dalluhn requested to be placed on the Nomination Subcommittee. Ms. DeLett-Snyder asked if the schedule for 2018 meetings had been determined. Mr. Martinez said he would send it out the next week. The first meeting should be the second Wednesday of February.

Ms. Berry asked if any members had agenda items they would like to be included in the next meeting besides what was already discussed. Ms. Dalluhn asked about the meeting with Amy Roukie that was mentioned in the last meeting. Mr. Devine said that Ms. Roukie has been busy with the transition, so the meeting has not taken place yet. He said he would continue working on it.

9. Public Comment

There was no public comment.

10. Adjourn

Ms. Quilici moved to adjourn the meeting. Ms. Dalluhn seconded the motion. The motion passed. [Mr. Diaz was absent for the vote.] The meeting was adjourned at 11:04 a.m.