MULTIDISCIPLINARY PREVENTION ADVISORY COMMITTEE (MPAC)
DRAFT MINUTES

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DATE: June 15, 2017
TIME: 1:00 p.m.
LOCATION: Div. of Public and Behavioral Health
4126 Technology Way
Second Floor Conference Room
Carson City, Nevada 89706

Video-Conference
Southern Nevada Adult Mental Health Services
6161 W. Charleston Blvd.
Building 1, East Hall Conference Room
Las Vegas, Nevada 89146

Teleconference: Dial: (775) 887-5619, Passcode: 2000#, Pin: 1215
****Unless speaking, please mute telephone.***

MPAC Committee Members Present

Cesar Melgarejo	Office of the Governor
Carol O'Hare	Nevada Council on Problem Gambling
Dena Schmidt, Chair	Department of Health and Human Services
Cody Phinney	Administrator, Public and Behavioral Health
Dr. Kori Singleton	Primary Care Physician
Karla Wagner	University of Nevada, Reno
Linda Lang	Nevada Statewide Coalition Partnership
Stephanie Asteriadis Pyle, Vice Chair	Nevada Prevention Resource Center, UNR
Scott Shick	Chief Juvenile Probation Officer, Douglas County
Cheryl Bricker	Partnership of Community Resources
Keith Carter	Nevada High Intensity Drug Trafficking Area Program

MPAC Committee Members Absent

Heidi Gustafson	Foundation for Recovery
Joseph Joshua Livernois	Northern Nevada HOPES
Dr. Mel Pohl	Las Vegas Recovery Center
Patrick Bozarth	Community Counseling Center of Southern Nevada
Kristen Rivas	CPP- Children, Youth & Family
Justice Michael Douglas	Supreme Court of Nevada

Others Present

Helen See	The Life Change Center
Dani Tillman	The Life Change Center
Lea Cartwright	Nevada Psychiatric Association
Dr. Lesley Dixon	Nevada Psychiatric Association
Barry Lovgren	Private Citizen
Jamie Ross	PACT Coalition
Jennifer Snyder	JTNN

Staff Present

Sara Weaver	Administrative Assistant
James Kuzhippala	Division of Public and Behavioral Health
Bill Kirby	Substance Abuse Prevention and Treatment Agency
Stephanie Woodard	Psychologist
Kyle Devine	Bureau of Behavioral Health, Wellness, and Prevention

1. **Welcome and Introductions**
Dena Schmidt called meeting to order at 1:00 p.m. Ms. Schmidt mentioned that Justice Michael Douglas would like to be included, but not as an official voting member.

2. **Public Comment**
Mr. Lovgren expressed thanks to the Division, and especially Mr. Kuzhippala, for the great work done on the Statewide Epidemiological Profile.

3. **Approval of the December 15, 2016, Meeting Minutes**
Ms. Lang motioned to approve the minutes with changes. Mr. Shick seconded the motion. The minutes were approved unanimously.

4. **Evidence-Based Practice Update**
Ms. Phinney stated that Mr. Erickson could not attend today's meeting; she requested this item be tabled until the next meeting.

5. **Legislation Update**
Ms. Phinney stated the most exciting legislation they worked on was the opioid treatment bill, Assembly Bill (AB) 474, which was passed. She reported that AB 474 provides prescribing protocols for those who prescribe controlled substances. She stated it requires a check of the Prescription Drug Monitoring Program (PDMP) before all initial prescriptions, regardless of length; previously, if the prescriptions were under seven days a PDMP check was not required. She added they had looked at evidence-based practices relating to prescribing guidelines. She mentioned that the Centers for Disease Control (CDC) had put out guidelines, and that several states have moved forward on developing guidelines or protocols for prescribing controlled substances and that they had evaluated those, then worked closely with the medical boards and association to finely tune the prescribing protocols. She stated the only limit they put on prescriptions is the initial prescription for an individual not currently receiving an opioid. In that case, the prescription can be no greater than 90 milligram equivalents (MME) per day, and the prescription cannot be for longer than 14 days. She mentioned that exceeds what many states allow, which is a 3 to 5 day limit for the initial prescription. Providers were concerned about the 3 to 5 day limit, feeling the 14 days was more appropriate. They included that—prior to an initial prescription—an individual must have a physical exam; be evaluated for risk; and sign written informed consent regarding risk/benefit, alternative therapies that are available, safe storage of medication, and the like. She stated the bill included other activities providers will need to engage in and document, including medication agreements for those receiving controlled substances prescriptions for longer than 30 days.

Ms. Lang commented that she worked with AB 459 in the last session, then saw how this bill was handled. She stated she was encouraged by the nearly unanimous support AB 474 received this session, largely due to those who helped write the bill and then when she looks at where they started in 2007 and at what the indicators are nationally, she can see how the west coast is becoming a model for what has been adopted in a quick manner.

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Ms. Woodard replied there has been a lot of innovation, part of which is the Prescribe 365 policy. She added it includes enhancements to the PDMP, so that individuals need to have on their prescriptions the number of days they are prescribed medication to ensure that people are not receiving more than a year's worth of medication in 365 days. She mentioned that one of the key indicators of improper or over prescribing is the number of days the individual is being prescribed the medication.

6. Appointment of a Nominating Committee for the Chairmanship

Ms. Schmidt stated the purpose of this item is to consider a new chair and vice chair which, according to bylaws, requires the appointment of a nominating committee. Those who volunteered for the committee were:

- Linda Lang
- Cheryl Bricker
- Dena Schmidt
- Stephanie Asteriadis Pyle

7. State Targeted Response to the Opioid Crisis Grant Update

Ms. Woodard reported that Nevada received a $5.6 million formula grant from Substance Abuse and Mental Health Services Administration (SAMHSA) in May. The formula was based on unmet need and burden of disease, including opioid overdose, and that all states were allowed to apply. Originally the grant was to be for $5.6 million for each of two years; but in order for the Department of Health and Human Services (HHS) to immediately release money to states, they made the second year of funding contingent on the evidence dollars were used effectively. She added that Nevada may be required to reapply for a second year of funding. The funds are to be used to innovate and build systems; they do not want this to be used to fund systems that already exist, but are broken, or that need enhancement. She stated the Region 9 SAMHSA coordinator has already pulled together the region to have detailed discussions about what other states are doing. She reported that Nevada is one of about 20 states building out a hub and spoke model, a model originally developed in Vermont. She added they also looked at Ken Stoller's stepped care model and would like to develop a hybrid of the two. She explained that once they received the notice of grant award, they began contacting their opioid treatment providers and their federally-qualified health centers (FQHCs) to finely tune what the hub and spoke model will look like in Nevada. She pointed out that 20 percent of the grant must go toward prevention and 80 percent toward treatment. She noted there is not a lot of co-prescribing of naloxone with providers, so they intend to provide academic detailing, a prescriber-to-prescriber consultation format working with prescribers to talk about the co-prescription of naloxone for individuals at risk of overdose including those being maintained on opioid therapy. She stated they will also use Project ECHO to give provider education on alternative pain management strategies—nonpharmacological pain management strategies—and on the treatment side, for prescriber consultation for medication-assisted treatment (MAT). She mentioned they often heard from prescribers who have waivers but have not started treating patients and those who would be interested that this would build competency in prescribing MAT in a way they can feel

confident about. Several other states have already launched similar programs using Project ECHO.

In building the hub and spoke model, Ms. Woodard stated they are working closely with Medicaid and managed care organizations (MCOs) to ensure that whatever they build is sustainable long term, making sure they can leverage Medicaid funding as much as possible because they need to make sure they have spent their dollars wisely in building a system that can stand on its own. She stated they are developing mobile recovery outreach teams as a spoke for the hubs which provide outreach to individuals at risk for opioid overdose and to those who have experienced an overdose. She shared they have reviewed the data and it suggests that if an individual has experienced an overdose and has been treated in an emergency room (ER) or inpatient unit, the risk for subsequent overdose and the risk for mortality related to overdose increases substantially.

Ms. Woodard reported they are developing a position for a screening, brief intervention, and referral to treatment (SBIRT) coordinator. She stated there have been efforts statewide—especially through University of Nevada, Las Vegas (UNLV) and University of Nevada, Reno (UNR)—to train providers on SBIRT technology. The biggest issue has been moving beyond training to providing support for implementation to practice. She pointed out that Massachusetts has had SBIRT coordinators that do on-the-ground work with providers and clinics to begin to develop how they will implement SBIRT into their workflows and support them in doing so, helping them determine their readiness to implement SBIRT and providing them support for implementation. She stated that many do not know how to infuse SBIRT into their workflow. She explained that a provider would go to a training, get the information, learn how to use the technology, but implementation to practice is several more steps, including ensuring the clinic or practice has readiness.

Ms. Woodard stated that because there is such an emphasis in the grant on ensuring outcomes, they will build evaluation into all of their scopes of work so that they can track progress toward their goals. AB 474 also set aside money to prescriber training positions so they will be working with boards and associations to make sure that information is going out, especially because of the prescribing protocols that need to be in place to be sure there is a mechanism to train constituents to fulfill the obligations under the bill.

Ms. Schmidt asked if transitional housing is considered part of treatment. Ms. Woodard replied that it is not. She added the services are outpatient and for individuals with opioid use disorder. Ms. Bricker stated that the SAPTA Advisory Board was told the hub would include employment, housing, food, and that kind of thing. She asked how that would work with this grant. Ms. Woodard replied the hubs will be funded to build their networks, so there will be outreach with community-based organizations to ensure there are formal agreements so they can coordinate those services. She added they are evaluating where they are today and where they want the system to go—what they want the system to look like at the end, which is why the partnership with Medicaid is so important. She stated they are trying to take existing provider types under Medicaid and existing services that are reimbursed under Medicaid and map those into what the hubs will be required to provide. They already know what services

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the hubs are supposed to provide, but some of them are nonreimbursable. She further added that all the federal agencies under HHS are at the table to work with states because they see that sustainability is absolutely important. Since HHS is infusing money into the states, they want to be sure they are getting something for that money. She stated Centers for Medicare and Medicaid Services (CMS) is partnering with SAMHSA, Health Resources and Services Administration (HRSA), and National Institutes of Health (NIH). She explained that NIH is putting dollars out to research outcome related to activities through the Opioid STR grant. She stated they are looking at what is currently reimbursable, what they know needs to be included in the hubs, and will be working with Medicaid to develop mechanisms to prepare for funding in order to build a bundled program for the services we know are essential for long-term recovery supports.

Ms. Lang asked if the hub would be an existing entity, a new entity, the certified community behavioral health clinics (CCBHCs), a treatment facility, a methadone facility, or something else. Ms. Woodard replied that the hubs are opioid treatment programs—traditional methadone clinics—looking to expand so that all MATs are available to those making use of the hubs. She explained the stepped-care model recognizes that office-based opioid treatment providers in a group practice, private practice, or an FQHC, may be willing to prescribe buprenorphine or vivitrol but not have the staff or the resources to provide the intensive care coordination, case management, urine drug screens, supervised pill counts—the things they would want to be able to do to safely and conscientiously continue to prescribe and mitigate risk for those patients. Those individuals may be evaluated through the hub who will be kept at the hub only because they can be provided the wraparound services and because those individuals would be too high-risk to be managed by an office-based opioid treatment provider. She added that there are individuals who are of mild to moderate risk whose care will be coordinated at the hub, but whose prescribing will take place with an office-based opioid treatment provider. She concluded that all of that will be done through a care coordination model so that individuals will receive their urine drug screens, pill counts, case management, any of the vocational supports, and behavioral health treatment.

Ms. Lang asked how many of those are existing. She noted there are multiple locations in Las Vegas, The Life Change Center in Reno, a center in Carson City, and that she did not think that Douglas County has a methadone clinic. She asked about the rural partners. Ms. Woodard replied that is why they are reaching out to FQHCs, knowing that an opioid treatment program is not going to spring up in Elko or in Douglas County any time soon, but they do need to have care available to them and coordinated. She stated they are looking at building from the spokes in, rather than from the hub out. They would do that by using the FQHCs as spokes to build the capacity to provide some medication-assisted treatment. She added that other states have used pharmacies in their rural communities to dispense methadone. She stated that, based on data they collected as well as data from SAMHSA, SAMHSA has recommended target areas for them to focus on: Washoe and Clark Counties, Elko, and the Quad-County [Carson City, Douglas County, Lyon County, Churchill, and Storey County] area. She noted there was also a hotspot in Nye County. She added they will also put an emphasis on Native Americans, who are disproportionately represented in much of their data.

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Ms. Schmidt mentioned they were approved in this budget cycle in Fund for a Healthy Nevada (FHN) tobacco dollars to do an incubator program for FQHCs—to either expand service or to expand access. She explained that a rural FQHC that needed one-shot funding could have up to $250,000 over a two-year period to expand services, either adding a new service or service to a new population. She added they will be releasing that request for information (RFI) the first week of July. She reiterated that if an FQHC needed that funding to get the capacity to meet the need of the Opioid STR grant, these funds will be available.

Ms. Woodard reported they must provide a very specific needs assessment by July 31, so they are going beyond their traditional test data from funded providers in order to get data specific to managed care organizations and Medicaid. She mentioned that when they only go to their funded providers, they only have a small slice of the treatment. They are gathering information the Office of Public Health Informatics and Epidemiology (OPHIE) already has that relates to prevention and treatment put together in their surveillance package for the opioid epidemic. She stated that they must have a well-developed strategic plan by the end of August that moves beyond the current strategic plan, infusing all the data they have pulled.

Ms. Schmidt asked if the managed care organizations are on board with this. Ms. Woodard replied she has met with the MCOs and invited them to participate in designing the hub and spoke model because it is the model they will need to adopt as other models will be obsolete.

Ms. Lang asked if the purchase of naloxone was put into the grant and how it will be distributed. She pointed out that employers, treatment centers, as well as people on the streets have been asking about it. Ms. Woodard replied that naloxone was earmarked for purchase and that she met with the Office of the Attorney General last week and was told there are settlement funds to nearly match the funding for naloxone. The Attorney General's Office has reached out to all the law enforcement agencies statewide so that they will be pooling funding to get the naloxone out. She stated they needed clarification from the Attorney General's Office concerning Senate Bill (SB) 459, regarding community-based organizations being able to store and distribute naloxone. She stated they have settled the mechanism for the Board of Pharmacy; now they to work on this to make sure they distribute naloxone in a way that meets the rules. Nevada Rural Opioid Overdose Reversal (NROOR) Program out of UNR will be expanded from serving the current five rural communities, adding the other communities that have been identified through the grant: Clark, Washoe, and Elko Counties. She reported that NROOR will be working with emergency medical services to purchase, distribute, and educate on naloxone. She added they are trying to figure out how to get naloxone out to the community-based organizations because the mobile recovery outreach teams will also be conduits ensuring that naloxone and education about its appropriate use gets out into communities at risk. Ms. Lang added they had worked with the Board of Pharmacy to come up with this plan for patients and for caregivers and that the Board of Pharmacy and Dr. DiMuro have signed off on it. Ms. Woodard reported that distribution of the kits themselves and ensuring that they know who can purchase them and under what conditions they need to be stored has yet to be established. Ms. Lang asked if the State of

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Nevada is going to keep track of where the kits go so that someone could track back to sue someone in the future.

Ms. Woodard stated they would ultimately love to target individuals already known to be at risk—those who have de-toxed in jail—making sure outreach is done at the jails, doing overdose education and naloxone distribution there. She added the mobile recovery outreach teams will be doing the same in ERs. They will look at de-tox facilities and community-based treatment providers, casting a very wide net to make sure that individuals who need access will be granted access.

Ms. Wagner pointed out that there is 20 years' worth of expertise in the procedures, protocols, and policies for naloxone distribution and a lot of that information, including examples of standing orders, is compiled on a single website called Prescribe to Prevent.org. She added the hard work has already been done, including the kinds of different orders that a medical director or a state medical officer might write are available there. She continued that there are two parts of the law that SB 459 established. One allows pharmacies to prescribe; the other refers to community-based distribution, with community-based organizations distributing under a standing order. Ms. Woodard stated the second is the part that they are seeking to resolve with the Attorney General's Office. It was suggested that finalization of that be made an agenda item for the next meeting.

8. Review and Make Recommendations for the Statewide Epidemiological Profile

Ms. Phinney stated the Division is eager to have this group's thoughts and opinions on the profile as it begins writing block grant applications which have to be approved. She added that part of the mission of MPAC is the approval of this required report and the recommendations that come from it for its priorities for those grant applications that are critical for them.

Mr. Kuzhippala mentioned the report was a collaborative effort involving OPHIE, the Statewide Epidemiology Workgroup (SEW), the SEW subgroup, MPHAC, and members of the community. He thanked everyone involved in the development of the profile.

Mr. Kuzhippala explained they tried to target the topics most useful for their own use, but also for individuals in the community who use this for their grants. They looked at demographics, mental health substance misuse treatment information—not just to the state-funded facilities, but also state-level information because the state treats only a small portion of individuals in Nevada. He stated they looked at the line level hospital and ER visits, new patient admissions, behavioral health deaths, syndromic surveillance, adult and youth behavioral risk factors, perceived risk indicators, a few school success indicators, and special or priority populations data.

Mr. Kuzhippala noted the data sources and limitations, stating they looked at survey data that was available nationally, rather than data from just in the Division. That included data from the National Survey on Drug Use and Health, the National College Health Assessment, the

Monitoring the Future Survey, and the United States Census Bureau. He stated they tried to give a broad view of Nevada's population distribution by age group and by race/ethnicity, the population change from 2010 to 2015, and the median household income.

Mr. Kuzhippala reported that when they looked at mental health treatment centers, they first looked at the ones that were state-funded and the most frequently utilized programs in Nevada, the most common mental health diagnoses, and utilization by city of residence. He explained that in Table 2 [page 13], they looked at the demographic distribution of those who were treated by generic demographics, such as sex, age, race/ethnicity, and education status. He said they then looked at the state as a whole, looking at mental health treatment/counseling among adults for individuals who received treatment that required it and individuals who did not receive the mental health treatment or counseling that they needed. He said this gives a snapshot of the need for treatment and counseling. He stated that in looking at the hospital data, they looked at mental and substance use indicators between 2009 and 2014, observing how ER visits have changed over time. He drew their attention to Figure 7 [page 14] that showed 5,000 to 20,000 visits in 2009 and that anxiety-related ER visits in 2014 have increased greatly. He commented that two factors that could account for the increase in anxiety admissions are better diagnosing or better access to care. A discussion arose over whether this reflects a misuse of ERs or whether people are waiting until they hit a critical point. Ms. Woodard replied that it was probably both, adding that when there are no crisis services available in a community people will go to the ER regardless of the severity of the crisis.

Mr. Kuzhippala moved on to Table 3 [page 18], where behavioral health related ER visits were broken down by gender, by condition, and suicide attempt by method. He stated the SEW workgroup asked to look specifically at schizophrenia diagnoses for ER visits, so that information is given. Ms. Woodard commented that it makes sense to have "unspecified schizophrenia" at the top of the chart because it is similar to the issue they have run into with opioids—dependence/abuse poisoning—the diagnosis can be arbitrary when there are no trained behavioral health clinicians in the ER, unless someone comes in and tells the staff they have a specific type of schizophrenia, the specificity of the diagnosis is questionable.

Mr. Kuzhippala reported on the substance related ER visits [Table 5, page 20], which shows an increase from 2009 to 2014. He pointed out that visits are broken out by general demographics [Table 6, page 25], then Figure 10 [page 21] shows the suicide-related ER visits, which have remained somewhat consistent over time. He stated they were asked to look at payer distribution to compare Nevada residents to out-of-state residents who go to ERs in Nevada [Figure 11, page 22]. He reported that all of the same indicators were pulled for the hospital inpatient admissions, with the addition of average length of stay for the specific mental health and substance abuse indicators. He asked if there were any additions or recommendations from the council. [There were none.]

Mr. Kuzhippala moved on to the section of the profile dealing with substance abuse treatment. He reported they first looked at the primary substances noted at admission to Nevada state-funded treatment centers, then looked at the state as a whole. He explained they used

national-level data to make comparisons to show where Nevada has been over the last few years, and that whenever national data was available they tried to include it in order to have a tool to see how they are doing. Figures 17 through 20 [pages 32-33] show illicit drug use and nonmedical use of pain relievers among adolescents and treatment for alcohol use and treatment for illicit drug use among individuals aged 12 or older. He stated they were requested to look at the coalition level, so they included some health disparities-related activities [Table 11, page 34]. He mentioned that if there are other indicators the coalitions would like to see, they could be included in this table. He added they created individual coalition-level reports that are available on the open publications page and that there is a link to that on the last page of the report. He remarked that if there were any additions to the state-level report, they can be added. An attendee mentioned that she has difficulty getting data out of OPHIE. Mr. Kuzhippala replied that they knew the publications page can be difficult to use.

Mr. Kuzhippala reported that, when they look at mental and substance abuse-related deaths, they first look at suicides by specific methods [Figure 21, page 35], then look at the rates they see for behavioral health-related deaths from 2010 to 2014 [Figures 22 and 23, page 36], then break out substance-related deaths by individual demographics [Table 12, page 37].

Mr. Kuzhippala moved on to syndromic surveillance, which used data from BioSense regarding chief complaints. He commented they tried to pull information out of it, by breaking in down by demographics [Table 13, page 38] and the number of behavioral health-related chief complaints in Nevada facilities for 2015 [Table 14, page 38]. He pointed out they were lacking data from Eureka, Storey, Mineral, and Esmeralda Counties. He reported that, in terms of perceived risk, they used data almost solely at the National Surveys on Drug Use and Health, with one indicator being from the Behavioral Risk Factors Surveillance System (BRFSS). He pointed out that Figures 24 through 27 [pages 39-40] show what people in Nevada perceive as the risk of alcohol, marijuana, and cigarette use, and if people who received treatment for mental illness can live normal lives. He mentioned that if a national-level indicator was available, they tried to include it.

Mr. Kuzhippala reported that the data for adult behavioral risk factors came primarily from BRFSS, with some indicators from the National College Health Assessment. He stated they looked at illegal substance use [Figure 28, page 41], alcohol use [Figures 29-31, pages 42-43]; feeling depressed [Figure 32, page 41]; feeling that everything was an effort or feeling worthless, or feeling restless or fidgety [Figure 33, page 44]; the number of days and individual experienced poor health that prevented them from doing usual activities [Figure 34, page 44]; and individuals taking medication or receiving treatment for any type of mental condition or emotional problem. He clarified that the data is limited to the specific questions asked on the surveys.

Mr. Kuzhippala pointed out they also looked at youth behavior risk factors, comparing data from the state level with data from the national level [Figures 36-45, pages 46- 51]. He mentioned there are high school indicators for most questions on the Youth Risk Behavior

Surveillance System (YRBSS). He added that Nevada also does a middle school survey, but not enough states participate in that to do a national comparison [Figures 46-53, pages 51-55].

Ms. Woodard asked about Table 19, page 60, regarding opioid-related indicators for Nevada residents, wondering if the numbers reported were per 100,000. Mr. Kuzhippala replied it is per 100,000 and that he would make a note to clarify that.

Mr. Kuzhippala explained that, in terms of school success, they looked at the number of habitual truants [Figure 54, page 56] and high school graduation percentages 2010 to 2014 [Figure 55, page 56]. Regarding special populations, he reported that they looked at self-reported prenatal substance abuse birth rates [Figure 56, page 57] and at birth defect prevalence rates in Nevada, 2010 through 2014 [Table 15, page 58]. They also looked at the lesbian, gay, bisexual community [Tables 16 and 17, page 59] and the American Indian/Alaskan Native populations [Table 18, page 60]. He reiterated that they were open to changes.

Ms. Phinney asked if there was data they wanted to see that was not included. Ms. Lang mentioned that a complete needs assessment must to be done by the end of July for the grant and wondered if this would suffice. Ms. Phinney replied that this epidemiological profile is one of the requirements for the grant. Ms. Lang thanked Ms. Phinney for the coalition-level reports. She mentioned they have put them on their websites and that people are using them at the local level. She asked if Ms. Phinney's bosses will allow her the time to add 2017 YRBS data to keep this current. Mr. Kuzhippala replied that they have 2015 information for a few of the data sets, but the biggest limitation before was creating the report from scratch. He added that now that they have a template developed, it can simply be updated. Ms. Bricker agreed, stating she is able to update data sets in her community prevention plan as information becomes available. She added that her behavioral health task force has been able to use the coalition reports this way.

Ms. Wagner asked if the "T" in LGT, in Table 16, page 59, referred to transgender. Mr. Kuzhippala relied that was correct. Ms. Wagner asked if that could be replaced as there are two constructs being conflated there and potentially two really different groups of people or some of the same people. Mr. Kuzhippala replied that this was pulled directly from the YRBSS report published on the UNR website and that he can ask if they can have the information pulled out separately. Ms. Wagner pointed out that gender orientation and sexual orientation are different. Ms. Phinney asked if her point was that in some places it says "LGB" and in others it says "LGT." Mr. Kuzhippala replied that the YRBS portion below that was "Lesbian, Gay, Bisexual." Regarding Table 16, he stated he can talk internally to have that broken out separately.

Mr. Devine stated there are two actions that need to take place. One is to accept the report, the other is to receive the committee's input on priorities based on the report. Ms. Phinney stated the committee has heard some of the priorities the Division is working on regarding the opioid initiative; the CCBHC initiative that is important for integrating behavioral health services with primary care health services; and the implementation and measurement of

SBIRT and other evidence-based practices. She stated input regarding broad-based categories to guide them as they work on the block grant application would be extremely helpful so they know they are meeting the needs of the representation on the committee and that they are on the right track. Mr. Devine added they need to gear toward the prevention side of things to prioritize the next year's plan in prevention. He pointed out that alcohol and methamphetamines are still big issues. Ms. Lang interjected that the data cannot show everything, but an area of focus might be what happens after the legalization of marijuana. In other states that have legalized marijuana, there has been an increase in youth trend rates, with alcohol usage going up as well. She pointed out they need to be proactive, instead of waiting for the data to show up, and that the data in this report shows the perception of risk deteriorating. She stated that she thought education of youth regarding marijuana needed to be at the forefront in prevention. She also stated there will be an increase in ER visits for tourists. She mentioned that alcohol needs to remain a constant focus. Ms. Phinney replied they might be able to borrow some of the work done by the task force with their recommendations. She affirmed the fact that legalization of marijuana is an excellent point and should be included. Mr. Devine agreed that the data is a little old and that it would behoove the committee to look not only at the data, but also at what they know from working day-to-day, then to propose priorities. He mentioned that the number of alcohol-related ER visits is going up while, at the same time, there is an increase in anxiety disorders. He stated he will follow up with Mr. Kuzhippala on some of the associations and other questions this report brings up. He reiterated that the looking for MPAC's guidance and suggestions as to what the priorities could be through the next year.

Ms. Bricker stated the opioid situation is not high in her community right now, but they have done a lot of education to prevent it becoming a problem—primary prevention is. She mentioned that when methamphetamines became a problem, they had to just deal with it; in the case of opioids, they did not have to do that because they developed a plan to educate their community and their doctors. She pointed out that even if data is low in a particular area, it does not mean a problem will not come by the time they get grant money. She added she is using some of her meth money to deal with marijuana use as the high school is flooded with kids using marijuana. She stated students may not be self-reporting their use, although maybe the YRBSS done at the end of the school year may reflect it. She said there is a perception that because it is legal, it is safe. Ms. Phinney stated they have seen success with drinking and driving and wondered how to build on that success with driving under the influence of marijuana or an opioid or another drug. Ms. Lang mentioned they need to look at mental health and substance abuse, being careful when going into primary prevention dollars. She added that they ought to think in silos regarding prevention, noting some of the most successful prevention efforts right now are the Mobile Outreach Safety (MOST) and the Forensic Assessment Service Triage (FAST) teams. She noted the people served by those teams are not going to ERs or using up social services, they are on their medications, they are not in jails, and they are linked with a social worker who is doing prevention to make sure they do not go back. She stated she would call that prevention. Ms. Phinney called it secondary prevention. She suggested if they have the data to show that people go to ERs for anxiety, if those patients could receive a crisis service instead of a prescription for Valium, it

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could be considered a preventative measure as well as a cost-saving measure. Mr. Devine asked them to give him recommendations.

Mr. Melgarejo asked if veterans and those in the military could be identified as a special population. Mr. Kuzhippala replied they can look at some of the survey data collected at the national level. He added the biggest issue in looking at the veteran population is there needs to be a variable that differentiates between an individual who is a veteran and one who is not, which is not information that is regularly collected in most data sets. He said they can look at what indicators are collected and include that. Mr. Melgarejo mentioned they were working on something on a veteran's subcommittee group that would be helped by that information.

Ms. Lang suggested that heroin needs to continue being considered as the coroner's office reports that heroin-related deaths are going up. She stated the problem with prescription drugs is not over and that daily marijuana use will lead to mental health problems.

The committee reviewed that their priority recommendations would concern: marijuana, crisis intervention for all substances from a preventative perspective, continuing with current prescription drug and heroin efforts, alcohol and combinations of alcohol and prescription drugs or alcohol and marijuana usage, pregnant women and drugs or alcohol. Ms. Lang noted that the federal dollars for enforcing underage drinking are now gone after 17 years, so the state will need to continue that. Ms. Snyder pointed out that fatalities from impaired driving as a result of alcohol and marijuana use have increased. She suggested talking about driving under the influence of prescription drugs, alcohol, and marijuana. She mentioned that Washoe County has begun funding a "party car" program in which code enforcement and law enforcement go out to high school- and college-age parties. When they find students under the age of 21 using alcohol or marijuana, those students are referred to a treatment center for an intervention.

There was also a recommendation that, if the data is available, veterans' data be added to the profile and that the change Ms. Wagner suggested be made. Mr. Melgarejo moved to make the recommendations that were discussed. Ms. Bricker seconded the motion. The motion passed unanimously among those members present.

9. Public Comment

Ms. Bricker asked what is happening with the fifth year of the Partnership for Success (PFS) grant, what the process will be, and how it connects with what MPAC is doing. She added that coalitions have heard they will receive reduced funding. Mr. Devine replied that the funding would be available for the fifth year, but the funds will be offset by what was not spent in the first year of that grant. He stated they do not have the final numbers yet, which is why they cannot give the information out to the coalitions. He assumed they would receive a reduced amount. He reported that the state epidemiological work group is supposed to present a profile paper of recommendations as has been discussed here; this group establishes priorities that drive the grant and what they do with their block grant and other matching grants. He added that they do not know when they will receive funds or how much they will receive. Ms. Bricker stated she had thought MPAC had to vote on these priorities before the

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Division would find out about the money and that she is worried about time. Ms. Lang reported that some members of MPAC want to continue what they are doing—working with the coalitions and doing trainings—and wondered if MPAC needed to vote that the final year of PFS continues. She reminded the committee that the first year they were told there would be a sixth year of this grant, so they did not have to worry about spending the first year of the grant. She added that the administration believed that. She stated the grant was only five months long and that agencies did not spend the funds—they could not because of what they were told. She continued that there was a change in administration and the new director had to write a continuation application because it was due the next day. She said that, in one of the years, they lost because the application was not submitted. She stated they are not just talking about year one of the grant, they are talking about cumulative years of reduction in money; they recognize funds will be reduced and limited; and it is too bad it will be offset by the first year when they have come so far since then. She noted that the current funded coalitions need to know so that they can plan.

Mr. Devine replied the way the process has been working, MPAC sets the priorities. As long as MPAC sets the priorities, then they can move forward with the grants. He added that, as long as what was passed in this meeting does not have a major impact on what was done the previous year, they are good. If there are major differences in priorities, they will have to look at that to see what they can do. He pointed out that they are dealing with a new federal administration that does not allow SAMHSA to carry forward any dollars—if dollars are not spent, they are gone. They will no longer be doing offsets or no-cost extensions. Ms. Schmidt stated the priorities MPAC accepted align with the current activities under the PFS grant so there will be no impact.

Ms. Lang stated she thought they had just gone through the priorities for the block grant applications. The priorities for the continuation cannot be as broad as the ones for PFS. Ms. Phinney added she sees these as two separate things. She noted that changing the PFS priorities was not an agenda item, so that her understanding is that those priorities stay the same until MPAC agendizes changes and takes action on them. Mr. Devine gave additional background. He reported that their project officer for the PFS told them that the process over the past few years may not have been utilized the way they would have liked. The SEW looks at the data, they bring the data to MPAC, MPAC prepares the priorities, and those priorities are incorporated into fifth year of the PFS implementation. He stated their project officer told them they were good up until the fourth year; in the fifth year, the process had to change. He was told that maintaining the prescription drug and opioid piece and using dollars to address the marijuana issue could only be done if MPAC set those as priorities. He added that the priorities set in this meeting should not impact that fifth year. He stated he would go back and check the priorities against the guidance they have received, then get back to them as to what will be allowable in the fifth year. Ms. Bricker expressed concern about the process. Mr. Devine stated that that he viewed this as a continuation of subgrants. He mentioned that if scope of work needed to be tweaked in order to accommodate some of the priorities, that can be done. Ms. Lang expressed thanks that Mr. Devine told them this is viewed as a continuation and that the PFS money could be used for marijuana as seven years ago, when this was set up, it was to be used regarding alcohol or prescription drugs. She reported that

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Nevada elected to not use the money for alcohol, so that it had to be used for prescription drugs. Mr. Devine stated that he would commit to going back to all the grant guidance and the federal regulations to see what is possible with the recommended policies. Ms. Snyder pointed out that the priorities they established today do not relate back to the December meeting and previous meetings. She stated the information about PFS was discussed more than six months ago, and that PFS priorities are separate from block grants. Mr. Devine stated that it makes sense that the priorities are different, but the MPAC is setting the priorities for the PFS as well, based on the epidemiologic profile. They are using the profile to make sure the priorities are coordinated. Ms. Snyder replied that the priorities were discussed six months ago and that she would hate to see everything change when the group and the SEW discussed and wrote their continuation. Ms. Phinney suggested that they have a separate discussion with Mr. Devine about this.

10. Adjournment

The meeting was adjourned at 2:38 p.m.

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