

Division of Mental Health and Developmental Services  
Substance Abuse Prevention and Treatment Agency (SAPTA)  
Advisory Board (SAB)

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**MINUTES**

**DATE:** September 12, 2012  
**TIME:** 9:30 a.m.  
**LOCATION:** Sierra Regional Center  
605 South 21<sup>st</sup> Street  
Sparks, NV 89431

*Video-Conference*  
  
Desert Regional Center  
1391 S. Jones Blvd.  
Las Vegas, NV 89146

**BOARD MEMBERS PRESENT**

Sparks Site

Diaz Dixon  
Ed Sampson  
Kevin Quint ( Chairperson)  
Lana Robards  
Maurice Lee (Proxy Amy Roukie)  
Michele Watkins  
Nancy Roget (Proxy Michelle Berry)  
Steve Burt

Step 2  
Frontier Community Coalition  
Join Together Northern Nevada  
New Frontier Treatment Center  
WestCare, Inc.  
Central Lyon Youth Connections  
University of Nevada, Reno – CASAT  
Ridge House

Las Vegas Site

Brad Greenstein  
Debra Reed  
Frank Parenti  
Ronald Lawrence

PACT Coalition  
Las Vegas Indian Center  
Bridge Counseling Associates  
Community Counseling Center

**BOARD MEMBERS ABSENT**

Dorothy North  
Tammra Pearce

Vitality Unlimited  
Bristlecone Family Resources

**STATE OF NEVADA STAFF**

Sparks Site

Betsy Fedor  
Charlene Herst  
Chuck Bailey  
Deborah McBride  
Diane Allen  
Margaret Dillon  
Meg Matta (recorder)  
Richard Whitley  
Tracey Green

Health Program Specialist, SAPTA  
Health Program Manager II, SAPTA  
Health Program Specialist II, SAPTA  
Agency Director, SAPTA  
Health Care Quality and Compliance  
Management Analyst II  
Administrative Assistant III, SAPTA  
Administrator, Health & Human Services  
State Health Officer

Las Vegas Site

Steve McLaughlin

Health Program Specialist II

**PUBLIC**

Sparks Site

Art Grossman  
Dani Doehring  
Denise Everett

Step 1  
Step 1  
Quest Counseling

Las Vegas Site

Jeni Martell  
Peggy Sue Black

Community Counseling Center, Las Vegas  
Las Vegas Indian Center

1. **Welcome and Introductions**

Chairman Kevin Quint opened the meeting in due form at 9:40 a.m.

2. **Public Comment**

Kevin Quint shared sad news of the passing away of Sharon Peal who was a former Deputy Director of BETA for many years before moving on to the Department of Education. No further information is available at this time.

3. **Approval of Minutes from the July 11, 2012, Meeting**

Steve Burt moved and Michele Watkins seconded to approve the minutes with three corrections. Motion carried.

4. **At 10:00 am the SAPTA Advisory Board was Adjourned for Public Forum to Take Comments Regarding the Block Grant Application. *The meeting resumed at its conclusion.***

Deborah McBride explained that every year SAPTA is required to conduct a public forum to receive comments and suggestions on the block grant as it is in the process of being written. For 2013, SAPTA is only required to submit two forms: one for planning and one for reporting. The documents are due to SAMHSA October 1<sup>st</sup>. The planning document looks forward, and lists the general information and forms, assurances, certifications, funding agreement, etc. There are also some tables and a lot of numbers. The reporting side is for 2010 compliance and shows how the dollars were spent. These documents are posted for you to review on the BGAS website as well as the SAPTA website.

Steve Burt discovered a problem on pages 5 and 6 that needed correction. Diaz Dixon volunteered to chair a subcommittee to look further at the documents. After some discussion, it was decided that rather than review it as a subcommittee, if any of the committee members had further comment, they could individually let Deborah know via email as soon as possible.

Deborah reported on the Synar Report which is submitted at the same as the Block Grant. It looks at tobacco use by minors, and the retail outlets that allow access to underage users. There are several investigators who visit every retail outlet twice a year. Currently, they have issued 59 citations and 19 finds, and found several retailers who were not in compliance. The retail violation rate has climbed from 1.1% to 3.1%. We must remain below 20%, so overall we are doing a good job.

Deborah McBride opened the floor to further questions and comments. Kevin asked a question regarding the status of combining the SAPTA Block Grant with the Mental Health Block Grant. Deborah explained that originally, the first year was optional. Now it has been changed in the Federal Register to allow further submission of separate Block grants. For the near future, we are leaning in that direction.

Richard Whitley added that nothing prevents us from combining the two agencies, however; and where there is overlap, especially with regard to co-occurring disorders, he would propose writing a joint grant. Historically, there have been two paths of activity on some of the same issues. He would like to see the mental health and substance abuse work in concert where possible. Kevin Quint agreed, adding that behavioral health was now a current issue in substance abuse prevention. Health Care Reform wraps them together in one paradigm, and providers are now looking at issues they did not have to look at previously.

Richard Whitley clarified that on the mental health side, the operation is quite different from the substance abuse side. On the Mental Health side, the state is the primary service provider. It is his belief that they need to move towards the model in substance abuse prevention, and see that new initiatives focus on community-based services. On co-occurring treatment, we should not have two models, a state model and a community model, with little connection to one another. He is open to suggestions on this. He does not want to throw

away opportunity by taking advantage of permissive time-lines from the Feds when we could be taking action now. He encouraged the group to be active in defining and formalizing the direction with new initiatives, and suggested we may wish to consider including Dave Caloiaro in the conversation, who oversees the Block Grant for Mental Health.

Deborah McBride said that in fact, SAPTA has been talking to Mental Health for two years now regarding the mental health prevention piece, which was added by SAMHSA. The discussion has been on how our coalition system can pick up the mental health promotion part of the work, and how SAPTA can assist with that. The discussion has also included co-occurring issues.

Dr. Tracy Green confirmed that from a provider perspective, the majority of the clients seen are co-occurring. Sometimes it is so interwoven, it is difficult to separate the symptoms and provide seamless service. She thinks we are missing some opportunity in the area of co-occurring.

Kevin Quint summarized that it would be a useful conversation to discuss how we can be involved in the Block Grant development; and secondly, in melding the two issues together in some way. He stated that the mental health block grant is smaller than the SAPTA block grant. Most states have different methods of funding mental health and funding substance abuse. Richard Whitley said that the majority of resources that go towards mental health services are state general funds; but he added that this is not a question that is only block grant driven, but a philosophy on how to embrace co-occurring disorder. He thinks that funding for co-occurring disorder should include block grant funding, and state general funding as well. As funding becomes available through salary savings or through new initiatives, it should be anchored to the same, community based model.

Frank Parenti said he likes the idea of sharing and leveraging resources, especially with regard to cases of co-occurring disorders receiving the psychiatric treatment they need. However, although co-occurring was covered under earlier grants, in order to access funding they had to relocate their agency staff to the mental health facility, defeating the ability to treat the co-occurring disorders as they come through the agency doors. He wants to protect the current ability to fund treatment for the co-occurring cases within the community provider system. He hopes that new funding models will not interfere with what they have already established as best practices.

Ron Lawrence added that disintegration of behavioral health services is happening slowly on the community level. In addition to integrating his services with the mental health sites, he has created a co-occurring disorders treatment at his own location. However, there is a Southern Nevada Adult Mental Health site within walking distance of them, and it would be easy to just send their clients there for psychiatric service. He wants to see more integration with the psychiatric part with regard to the ability to get prescriptions and medication. He thinks we need to work a little harder to achieve integration, and look at dual-licensing or other innovative ways to succeed. He can testify to the fact that his on-site co-occurring program is not only working, it is working beautifully.

Dr. Green commented that this is exactly the direction they would like to see across the state, and where possible, the comprehensive service delivery within the community becomes the norm. She stated that the Health Division would like to assist the community providers to achieve the goal of becoming comprehensive and integrated. If a provider type doesn't allow for billing insurance or Medicaid, perhaps a way could be found to link agencies, or use community resources like the psychiatrist down the street, or whatever it takes to provide comprehensive services and not continue with the current segregation.

Kevin said he appreciates this conversation and wants to extend his cooperation to SAPTA wherever possible. If anyone has any further input on the Block Grant, they can email Deborah McBride or Rebecca Vernon Ritter with their individual comments. Rebecca said she needs to see any comments or corrections before the last week in September. There being nothing further on the Block Grant, it was moved by Amy

Roukie to approve the block grant as written, to include all feedback as submitted. Diaz Dixon seconded the motion and the motion carried. Kevin adjourned the Public Forum at 10: 45 a.m. to return to the regular agenda.

5. **Discussion and Approval on the Recommendation from the Nomination Subcommittee Regarding the Continued Membership of the Las Vegas Indian Center on the Advisory Board**

Michelle Berry reported that the subcommittee met to discuss the problem of the Las Vegas Indian Center, a member on the board, missing three consecutive meetings without written notification. The by-laws only allow for three excused absences. LVIC submitted a letter of explanation, and the group decided to keep them on the board under probation for one year. The terms of the probation the committee is recommending is that LVIC must attend at least 50% of the meetings, and for the ones they are unable to attend they must obtain an excused absence and appoint a proxy. Steve Burt moved to approve the Nomination Subcommittee's recommendations, and it was seconded by Amy Roukie. Motion carried.

A follow-up letter will be sent to LVIC to advise of the Board's decision, and to formalize the conditions of the probation.

6. **Discussion, Recommendation, and Approval, of Certification Tools and Sanctions for Prevention, Treatment and Administrative Programs.**

Deborah McBride informed the Board that this was in response to a recommendation from the Legislative Council Bureau (LCB) audit to tighten up the monitoring and certification process on the providers, and to ensure that they are meeting the standards set forth by the NRS and NAC. They also recommended that SAPTA begin use of sanctions when programs are not in compliance. During the coming year, the certification and monitor instruments, as well as all of the SAPTA processes, will be reviewed and re-tooled to tighten procedures. SAPTA's goal is to both meet its requirements by the LCB audit and at the same time improve the process for the providers. SAPTA staff has taken some initial steps in the review process, but would appreciate the committee's ideas and input.

Charlene Herst said the certification instrument is used to compare the program's policies and procedures with the statutes, and is used for all programs seeking certification from the state. During this process, areas are sometimes discovered where the program is not in compliance. The question to the Board is, how should issues of non-compliance be handled, how long should a provider be given to rectify the issues of non-compliance before sanctions are levied, and which of the non-compliance issues are critical enough to require urgent attention. She then directed attention to the prevention certification instrument, which is used to certify coalitions and administrative programs. In a preliminary review by SAPTA staff, the most critical areas of compliance were identified and highlighted. In some cases, corresponding points were increased and/or decreased according to the seriousness of the compliance. The proposal was that non-compliance in any of those critical areas would immediately halt the certification process until corrected. Other issues of non-compliance could be given a little more time to address. The critical issues are highlighted in yellow on the handout. Samples or suggestions of the sanctions that should be imposed were provided.

Charlene asked the committee to think about how to get programs which are out of compliance to cooperate before going so far as to decertify them. Betsy Fedor also said that there may be extenuating circumstances for inability to comply, which SAPTA will certainly take under advisement; but another problem was that although the issues are delineated for the providers, the same issues of non-compliance were found in subsequent site visits. She asked for ideas on what procedures could be implemented that would not pose a burden on the providers but be effective in preventing repeat findings. In the treatment tool, critical items have been identified through a collaborative effort of SAPTA staff and CASAT and are highlighted in yellow. She asked that the Advisory Board look them over and provide feedback.

Michele Watkins asked for clarification on the wording in number 13 on page 3 of the certification instrument for coalition, administrative and prevention providers, where the requirement was that notice be

given to the Division within 30 days of cancellation of the liability insurance. She stated that the way it is currently written, it would seem to indicate that the insurance company should have it written into its policy that it is responsible to provide notification of cancellation to SAPTA. However, Michele found that the insurance company will not provide that notice and it cannot, therefore, be written into their insurance policy. She suggested that this be reworded to clarify that it should be written into the program's policies and procedures, and would be the responsibility of the program (agency or policy holder) to notify the SAPTA of cancellation of insurance.

Charlene added that on number 11 on the same page, the time required to retain all records has changed from 4 years to 6 years.

Deborah McBride reiterated that this is in response to the LCB audit which recommended more accountability. Deborah intends to enlist the input from all the prevention and treatment providers. She said that this is an early discussion on a work in progress – there is a possibility that the two instruments, certification and monitor, be integrated in such a way as to eliminate duplication. A Consolidation sub-committee will be established to meet only once or twice to advise on consolidating the regulatory entities so that providers do not get so many site visits. Kevin suggested that the process be done in parts, for prevention and treatment.

7. **Discussion, Recommendation, and Approval, of Treatment Monitor Instrument**

Betsy Fedor reported that the treatment monitor instrument had been presented at the last Board meeting with feedback to Steve McLaughlin requested. Steve said that no feedback was received. Betsy, therefore, thinks that the monitor instrument for treatment is at a point where it may be ready to be approved, unless the Board wishes to look at it further under committee.

Richard Whitley had comments on the regulatory items for treatment facilities. As background, he informed the members that the goal to move towards integration had come from the Governor's office, and he and Dr. Green have been working on a formal plan to integrate Health and Mental Health. When looked at in that light, the layered regulatory requirements are somewhat redundant in places, and difficult to navigate because of the complexities. He put in a Bill Draft Request (BDR) as a state agency to consolidate the regulatory authorities over treatment providers. He would like to see a workgroup organized to include Marla McDade Williams, Deputy Administrator of Regulatory and Planning, and Diane Allen, to look at all the tools and see how they can be consolidated. Diane pointed out that the Treatment facilities are regulated more closely than hospitals are, and in some cases the various regulators are looking at the same things. Richard said that the goal is not to be a hindrance with these regulations, but to be a helpful facilitator. He recommended a subcommittee be established to make it more efficient and consolidated. This will save money and achieve better compliance. He said that Marla has stated that as many new private sector providers coming into the state, that all providers should be regulated by a uniform standard, not single out funded providers for extra regulation. Richard Whitley asked that if any providers had issues with the regulations, to let him know about it. He was embarrassed that our regulators have not always extended the option of obtaining a variance for some findings. He would like to hear from the providers directly if there is a problem.

Frank Parenti said he would like to see one instrument that takes into consideration the accreditation that some providers get from CARF or JCAHO. Kevin identified the volunteers to be members of the subcommittee: Brad Greenstein, Frank Parenti, Lana Robards, Denise Everett, Dani Doehring and Diaz Dixon. The first meeting will happen internally, but Richard would like to own it administratively in time. He said that since it all hangs on statute, changing the statute is the key to consolidation. Kevin said what he does like about the documents as they exist now is the reference to the NAC and NRC. Diane Allen recalled that the last time the instruments were revised was in 1998; the statutes at that time had not been revised in 20 years. It provided motivation to update them. Also, HCQC bills SAPTA according to the amount of time it takes to perform an audit, and if the process can be shortened, it could decrease fees.

Kevin clarified that the subcommittee's goal would be to revise the various instruments, but also to look at the BDR. Richard would like the entire regulatory overlay, including the block grant requirements, to be reviewed thoroughly. Kevin said that for the Prevention piece, he would like to email the coalitions for feedback. Charlene will put it on the agenda for the upcoming coalition meeting on November 9<sup>th</sup>. Kevin said this will be the first part of the process.

8. **Presentation, Discussion, Recommendations, and Approval, Regarding Instant Drug Testing Policy**

Betsy Fedor provided background on instant drug testing. She said that this has been discussed before and guidelines and forms have been changed very little. HCQC requires providers conducting drug tests to be a licensed lab, which is very expensive. This statute dates back to a time when the tests were complicated, but now it is a simple test that can be purchased at any drug store. Providers need to act in the best interest of their clients - if they have drugs in their system the provider needs to know. Principles of effective treatment require the providers to monitor the drug use of clients; but simple urine tests, even dip tests used only for monitoring, are prohibited except in licensed labs. As a result, a provider that cannot afford to become licensed has to have a probation officer come to the facility to conduct the test for them in order to properly monitor their patients. Richard wants to get to the root of the problem first, and then provide a compliance agreement or a variance, depending on what is the best course of action. Dr. Green is happy to help everyone work through the problems. Please email her at: [tgreen@health.nv.gov](mailto:tgreen@health.nv.gov). She and Diane Allen will meet with the lab people at HCQC. Richard said this issue should be included in the revision of the statute.

9. **Update, Discussion, and Recommendations, Regarding Marijuana Funding**

Deborah McBride reported that SAPTA has paid out \$58,423 to date.

10. **Discussion and Recommendations Regarding Health Care Reform**

Dr. Green will be happy to put together a formal presentation for the next Administrator report. We don't know if the Medicaid expansion is going to be applied for us. We are currently working with the health exchange to look at those in the 400-plus federal poverty level and working on developing an essential benefit package for them. Dr. Green said they have looked at the Health Division budget with and without the Medicaid expansion. At this point, it is about making all the providers as viable as they can be; which means the ability to bill Medicaid. Whether that is accomplished through a partnering, assisting with supervision, implanting Health Division staff into provider facilities, or exercising other options, she wants to be of service. Health Insight has a reasonably priced electronic health record (EHR). It's a sliding scale that would provide a unified data base for us. Medicaid also has a free billing alternative, so neither the EHR nor the Medicaid billing needs to be a costly intervention, which is a huge relief. They met with the University and the Echo Program to provide supervision with clinicians. Echo is a telemedicine option run by the University, currently run as a peer-to-peer program where rural community physicians are able to telecommunicate with a specialist who is either in Reno or Las Vegas. It also can be used in the provision of clinical services where a University-based psychiatrist works with groups in a rural setting. Medicaid is reimbursing for telemedicine. Dr. Green said they are working on a second Medicaid meeting to look further into billing questions and discrepancies. She invited providers to communicate with her – her cell phone is 775-762-6163.

Kevin Quint expressed his relief that the Administration intends to help create an environment where the coalitions and providers can succeed.

11. **Update, Discussion, and Recommendations, Regarding SAPTA Information Technology System**

Chuck updated the Board on several ongoing projects. NHIPPS will not be the solution for electronic records as we move forward with Healthcare Reform. The existing contract for Mitra's consulting on NHIPPS expires March, 2013. We have the option of writing a sole-source contract. We also may be able to convert to the CNVHS code used by the Columbus system in Texas. He and Deborah McBride have also looked into Accord 360 which is a system based on inter-operability of four different types of components covering the

provider, the funder, and insurance. The problem is that these options do not address the needs of the Prevention providers. He is also working on establishing requirements for the new system, whether the contract will be written for a sole source vendor, or go to an open process. Chuck is convinced that there will be more options for billing as time goes on, and his current focus is in making sure we have a plan in place to move forward and continue to support the Prevention component, as well as the Treatment component concerning clinical records. Amy asked about interoperability, and Chuck said that NHIPPS will probably not have that capacity. Currently there are no set of standards for meaningful use. If it becomes a requirement, they will need to open up and RFP process that will extend the timeline. Chuck thought we may want to wait and spend fewer dollars in the short term so that we will be better able to act when there are clear definitions. He asked for this to go to the IT subcommittee to implement ideas, and Kevin will facilitate that.

The data warehouse which is being developed under Prevention SPE dollars is progressing. There is a weekly status meeting for that project, and Chuck suggested that the providers may wish to designate someone from Prevention and from Treatment to sit in on that meeting via WebX. Recently Ernie Hernandez has been sitting in. He is the Health IT Manager and will become the manager over the consolidated group. Chuck asks to be notified of the designees so he can notify them. He says the daily details are too numerous to cover in this meeting, but he welcomes involvement in the weekly decision-making process.

Chuck said that the best project tracking development has grown out of IT changes resulting from the merger of MHDS/Health into Public Health/Behavioral Health. Two key roadblocks remain: one is the security pass through from NHIPPS and the second is contingent on SQL Server 2008 upgrade from the SQL Server 2005.

Regarding outcomes reporting, we will have a Prevention Outcomes Report at the state level for the first time. This is based on the Pre/post tests we began collecting in 2010, and will be included in the 2011 Annual Report. Outcomes measures are mandated by SAMHSA and we have now met that requirement.

Regarding the YRBS, the response rate does not meet CDC requirements. Active consent is a huge barrier. The \$500 per school incentive is budgeted for 44 high schools only.

Frank Parenti brought up that the inability to run utilization reports was an obstacle. Margaret Dillon said she was having problems in the testing environment, but she now has a solution. The paid summary report is in the system as well, so both of those will be tested and move them into production. Also, together with the Data Warehouse developers, we now have exception reports available for use. These reports are useful to review the status of service records or information submitted, and to be sure none were omitted. Providers will now be able to check if they created the billing record for services rendered. An exception report will be developed for grants as well.

Margaret also reiterated that while there are standards for electronic records as they apply to primary care, there are no federal standards or established standards developed yet for behavioral health records. The EHR system previously mentioned by Dr. Green will need to have a behavioral health component, and the challenge for the Technology Subcommittee will be to define the needs. As we look at various systems, we need to be asking if there is a behavioral health component, if it can do an assessment, if there are screening tools, etc. We don't know yet what the expectations will be and we will need to keep an eye on any standards established by the federal government to be certain we are in compliance.

**12. Discussion and Recommendations Regarding Technology Subcommittee**

Kevin stated that this agenda item was just covered in the previous discussion and he will work to get the subcommittee put together.

**13. Discussion and Recommendations Regarding the Legislative Session 2013 Subcommittee**

Kevin said the subcommittee meeting has not met recently and also needs to be re-started. He asked if anyone

had anything to discuss regarding BDRs or legislative issues. He will try to include the issues discussed in today's meeting.

14. **Discussion and Recommendations Regarding New Funding Streams**

Charlene Herst gave an update on the Partnership for Success II Grant. SAPTA is hoping to hear if we have received the grant before the end of September.

15. **Standing Informational Items:**

**Administrator's Report**

Richard expressed his appreciation of the Advisory Board and would like to use this forum for staff on the Mental Health side to come and discuss areas of overlap. He brought up the issue from the last meeting on single patient having multiple reimbursements from different sources, SAPTA being one. He said that people were either insured, uninsured, or under insured. With underinsured, there will be some things which are not covered, and multiple funding streams can be used to cover the expenses. SAPTA needs to have a policy in place that clearly describes this procedure. Dr. Green will be more than happy to review a new policy. Deborah asked for clarification that we would no longer be a payor of last resort, and Richard concurred that SAPTA is not the payor of last resort, even now. This is especially true when a client is Medicaid eligible and also is covered by SAPTA. Kevin commented that the payor of last resort is language that comes from the federal block grant. Richard explained that every federal grant contains language to that effect, but that public dollars are only needed where the single source doesn't cover everything, which implies multiple reimbursements. Other programs have figured out how the system subsidizes other payor resources, so reimbursement is always a mix. It is a good use of the public dollars to subsidize services that are never covered by a single payor. He feels that we need to stay on the current path of training providers to bill Medicaid. Dr. Green reiterated that the same service is not to be paid for by several funding streams, but that the reimbursements are for services that are not covered by other sources. Where applicable, multiple services can be paid by multiple entities. She emphasized that the reimbursements were not to be duplicative. It would be her goal to enhance all providers to be able to bill all resources, not only SAPTA. They should be able to recoup all the dollars available.

Frank Parenti stated that they are working as hard as they can to serve as many people as need help, without nearly enough funds to serve the process. He has appreciated the help of SAPTA staff in negotiating NHIPPS, and will appreciate any help to streamline the process. Richard added that another role the Health Division plays with regards to commercial insurance is that when plans want to expand their coverage area, they have to go through the Board of Health to demonstrate adequacy of their network. As we go forward with the Affordable Care Act, substance abuse treatment is a basic benefit under behavioral health. The better the providers are at getting reimbursements and showing their commercial viability, the better position the Health Division is in to push the commercial plans to demonstrate their adequacy of coverage by utilizing the treatment provider's services. So, the short term goal is to be able to bill Medicaid, but the long term goal is to be able to receive reimbursements from commercial plans. He is also open to putting mental health professionals who work for the state hospitals out into the rural frontier areas to get their mental health services into the community and does not see why we couldn't put clinics on site if the numbers are there. He commented that there is a huge challenge in transforming state provided services to community mental health clinics. He feels Nevada is far behind other states in this area. He offered to extend technical assistance from the Administrative level and from HCQC as well. One of the advantages to having Diane Allen's assistance is to provide guidance on what kind of licensure from CMS, certification and billing would be available. Richard will be happy to bring any other regulatory body to the table to facilitate that discussion.

Regarding Treatment, the budget was submitted as an agency request. The state requires the budget to be submitted within the cap of the previous year's spending. Anything else is an item for special consideration, or needs a demonstration that case load is extended. We did put in for some new initiatives that will go to the community for substance abuse treatment. The detail, until it is approved and becomes the Governor's budget, will remain confidential. But Dr Green, using SAPTA data, was able to move new dollars into

treatment to be used for focused programming surrounding prescription drug use, discharge from ER into substance abuse treatment, and programs related to the Department of Corrections and their discharge into the community of people needing ongoing treatment. It will not be an item for special consideration; but rather a new initiative. He will provide more information as he is able to. Once it becomes public, he would like to get back on to the agenda to share the process.

Regarding co-occurring disorders, he does not feel it is correct to fund COD in separate ways. On the mental health side, it is being funded through three distinct budgets. If the communities are already providing treatment for COD, the state should follow and apply more dollars to it. Mental Health returns more unspent funds to the general fund than any other state agency. The unspent dollars will go away if we don't move forward with an initiative to move the funds to the treatment side. He says it is an important area to focus on.

Dr. Green went on to explain that the initiative would move unspent funds for a one-time funding savings to be used for the immediate year. It is intended to be self sustaining, but not through the direct funds we would have already had. She wants to focus on population exiting from the jails, prison system or detention centers who have mental illness diagnoses, or co-occurring diagnoses with substance abuse, that require transitional housing services as well as the wrap-around services that could occur. They are looking at providing locations for detox, and some in-patient beds (we're hoping to use some licensed beds that are currently not in use in the south) and also provide resources for transitional living beds for the treatment providers to support these clients for a period of time until they are able to find employment or move into the community to live independently. This is focusing on the transitional population coming out of the criminal justice system, providing them with in-patient, detox, and treatment, followed by transitional living, or rent.

Richard Whitley added that this is not a program intended to compete with existing programs. But in putting together the initiative, they have made the margin very wide so that no element of service provision got left out. It's a placeholder so they can come back to the providers for advice on how to design the program. A key issue is homelessness. They hope to bring dollars to address the gaps that exist in the system. It is the goal to turn this over to the communities eventually.

Kevin Quint asked for a structured presentation on the vision for the community-based system. For instance, Kevin wonders what will happen with NNAMHS, SNAMHS and Rural Based Clinics.

Richard Whitley responded that he would be happy to give a presentation. In the restructuring, Richard does have a area for community services that he would like to see the mental health side move towards. He said the Prevention Coalitions are the model of what he thinks that mental health should be striving for. For new funding and new initiatives, he is committed to utilizing the coalitions for prevention. He is also committed to not allowing treatment to eclipse prevention; SAMHSA has finally introduced the concept of prevention within mental health. They are talking about prevention not only for primary prevention but also for early intervention and screening. He sees the coalitions being the vehicle for that goal as well. He sees the opportunity to make changes and improvements. He doesn't want to slap on layers of bureaucracy, but to examine the root causes and provide a quality approach. He extended to everyone the use of data that the Health Division has for use when writing grants. He would also like to hear the provider's unique platforms to understand the unique populations they serve.

Ron wanted to reinforce the need for guidance on obtaining multiple funding streams. This will help with the problems of retaining staff. It will also make it possible to go out into the community with mental health prevention. Dr. Green also knows that getting clients eligible for Medicaid can be tedious, and the Health Division would like to help with that process as well.

Kevin thanked Richard Whitley and Dr. Green for their report.

**Chairperson's Report**

Tabled due to time considerations.

**SAPTA Report**

Deborah's report was covered by the Administrative report. She has nothing further to add.

**Center for the Application of Substance Abuse Technologies (CASAT) Report**

Michelle Berry asked if we are still moving forward with Strategic Planning. If it meets, is it subject to open meeting laws? Yes, let's get a direction for our group. Michelle brought forward the name of Susan Doherty who would be willing to facilitate.

16. **Review Possible Agenda Items and Future Meeting Dates**

Dave Caloiaro on the MHDS Block Grant  
Richard Whitley's design for consolidation  
Sub-Committee reports

Next meeting: November 14<sup>th</sup>. Members asked for a change of venue as the break-ups in the audio made it a strain to hear the other location.

17. **Public Comment**

Denise Everett announced that this is Recovery Month, and the Virginia Lake Walk-a-Thon is an opportunity to show support for recovery.

In Las Vegas, there will be a Recovery Rally, a picnic with bands combined with many fun events, and a Rally Walk.

Lana Robards told of upcoming events in Fallon also to celebrate Recovery Month, a 5K Walk-Run. Also there is a soft ball tournament in honor fallen law enforcement officer; and a large community picnic.

Kevin reported on an event sponsored by JTNN Heroin Committee. MuHA – Music Healing for Addictions, raised awareness for addictions. It was a fun and successful event with a great turnout. Proceeds will go for their public service announcements and parent support.

Denise Everett added that their house opened and brought brochures.

18. **Adjourn**

It was moved and seconded to adjourn, the motion carried and Kevin Quint adjourned the meeting at 1:00 p.m.