

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

MINUTES

DATE: April 22, 2013
TIME: 9:00am
LOCATION: Substance Abuse Prevention and Treatment Agency
4126 Technology Way, 2nd Floor
MHDS Conference Room
Carson City, NV 89706

Teleconference Number
1-888-363-4735
Access Code: 1602938

BOARD MEMBERS PRESENT

Via Teleconference

Frank Parenti (Chairperson)	Bridge Counseling Associates
Steve Burt	Ridge House
Mark Disselkoen	CASAT
Ester Quilici	Vitality Unlimited

BOARD MEMBERS ABSENT

N/A

STATE OF NEVADA STAFF

Carson City Site:

Chuck Bailey	HPA II, Data, SAPTA
Betsy Fedor	HPS I, Treatment, SAPTA
Inna Botcharov	HPT, Treatment, SAPTA
Lisa Tuttle (recorder)	AA IV, Admin, SAPTA

Las Vegas Site:

Steve McLaughlin (via teleconference)	HPS II, Treatment, SAPTA
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PUBLIC

N/A

1. **Welcome and Introductions**

Chairperson Frank Parenti opened the meeting at 9:03am and introductions were made.

2. **Public Comment**

No public comment.

3. **Discussion and Recommendation for Development of Treatment Standards Manual**

Mark Disselkoe will begin looking at the NAC458 for each compliance statement to establish a starting point to define meanings and how they apply so there is a consistency of perspectives from the provider, the State, SAPTA, and CASAT. The next stage will be to review other standards of practice and best practices. Mark reviewed every standard, and to the best of his ability, came up with what he thought a standard had historically met. He has been dealing with these standards as far back as 15 to 17 years. Mark then sent it to Steve McLaughlin, Scott Boyles, and Michelle Padden for feedback. He received general feedback but still needs to examine Scott's information in depth. The next goal will be to get verbal or written feedback from the committee members.

Mark clarified to Ester Quilici the document he sent was the Certification Standard Definition Draft and said this is where they need to start. At the last meeting, they looked at other states' standards which vary in their levels of information. Some are very similar in stating what the requirements are and what they mean. Some states go beyond that with the minimum standard but also with best practice, which is above minimum standard. The reason this committee was initially formed was to get an understanding on what current standards say due to conflicts of how things are reviewed and perceived. Mark liked what Ester had to say when they spoke three weeks ago about taking this process slow to cover all bases and receive everyone's input and feedback.

Ester believes the importance of going back to basics. Her agency is undergoing audits from insurance companies which are requiring, for example, start and end times, a waiver signed by clients as to whether they want or don't want an after care appointment, and a waiver of liability. Her concern is if they don't pattern reviews or requirements after CARF, JCAHO, Medicaid, or other national certification systems, they will be in the same parallel doing things for one or another. They need to especially look at CARF and meet the standards of the national organization, as well as state organizations. She believes a thorough discussion is needed about the collection of money by states before proceeding or taking on any state organization requirements. Per Steve McLaughlin, they are tied by NRS and NACs and must comply with these specifics. In the state of Wyoming, Mark wrote the substance abuse and mental health standards utilizing joint commission, CARF, and Medicaid so they were congruent across all of those disciplines and accreditations. Within the next year, there will need to be a formal rewrite process of the rules. As they look at other standards that they want to include with the standards of practice, he believes it is also important to focus on the other components. Mark is doing a webinar on Thursday on a CARF preparation for Wyoming with that very thought in mind. Ester commented it's all about having good standards of treatment and being paid by the state, by insurance companies, and by Medicaid to ensure the delivery of treatment. Ester is interested in the CARF webinar and wants to be able to participate in it. Mark, Steve McLaughlin, and Michelle Berry can discuss how they can get that done.

Currently Mark is helping five different programs in Wyoming become CARF accredited due to a linkage with funding. They have to be state certified but they also must be CARF or nationally accredited. Regardless if it is CARF, JCAHO, COA, Medicaid, or private insurance they must have NRS and NAC document compliance and clarification. Frank believes it is impossible to include everything Ester suggested because JCAHO will not recognize CARF certification and the same for COA. It will become a 900 page document. He already went through the certification process with CARF and wrote new policies prior to their coming out with a new book containing new requirements two weeks later. It is a moving target, but at least the State will have Medicaid in place as the next standard. These need to be done one at a time, but it is unknown how they can be all inclusive. This could be a living document, so if rules are rewritten they won't have to start over. Mark has written this instrument three times over the years, and there is always a baseline

with which to begin, build from, and adjust. He is not concerned about having to enhance or revise it based on potential changes in future rules. Steve McLaughlin agreed and stated when looking at substance abuse standards this is a good start. Ester wants something inclusive enough so as not to backtrack. She inquired as to what specifically is needed to be done with the definitions draft. The NAC used to be extremely detailed as to a treatment program, but is now empty. Part of what is being done is checking SAPTA's regulations of what will be required. Mark wants to take this process in steps because of the amount of information, which first is to define what is not in policy. He asked them to initially review the draft definitions where policy is not referenced. These have shrunk; however, there are still several standards that don't reference SAPTA policy and stand alone. He would like to get feedback, make updates, and examine SAPTA policies within the NACs to discuss at the next meeting. Mark paralleled every statement from the certification document out of the NAC. The positive is to do this within the instrument because it's organized by section (personnel, clinical, and levels of service) which is easier to examine rather than in pure NAC form. Not every program runs residential detox, and Ester believes this term must be defined further regarding social model versus modified medical or medically supported. Mark agreed that detox is not generic. Detox in the ASAM manual is broken into different levels of social, medically managed, and clinically managed, and he will add enhancements to the definitions. He did this in Wyoming because it gets into an issue of what they are paying. They cannot see this as generic because there is a large continuum of service under detox.

Because ASAM level 3 is very confusing, they must look at supporting level 3 without breaking down into other levels. At one time the Bureau of Alcohol and Drug Agency (BADA) included level 3.3 as a medium intensity residential program. The ASAM definition of 3.3 is "substance abuse treatment services for people with disabilities" and it shouldn't have belonged in the program description. A level 3.5 is standard residential 30 hours structured activities and 3.1 is transitional residential. A level 3.7 is an acute level of residential services for short term stabilization where medical support is needed 24/7 and doesn't actually have to be on site. He believes going with a standard 3.5 is a good idea unless there is a true transitional bed which would be a 3.1 and the person is in outpatient services in conjunction with that. Ester expressed they have to be very careful what the licenses reflect in order for the insurance companies to pay. SAPTA has moved toward the 3.5 level of service. A while ago, Steve McLaughlin said it was lumped together, which it needs to be separated. There was discussion among the group that it doesn't make sense to do certification for a level which isn't funded. All different levels can be certified, but it doesn't mean they will be funded. Some people meet the requirements of a 3.7. This was limited by Wyoming because of the expense to pay for a 3.7 due to the medical wrap-around services provided. It could help some people to be certified for a 3.5 and a 3.7, especially to charge insurance when a 3.7 is utilized. Mark does ASAM level of service training which explains all the different levels of service, how to deliver them, and what they need. He believes this would be helpful in the future. Nevada is not utilizing 3.3 as intended by ASAM, and they are considering removing this standard. When it started, it served a huge purpose for Steve Burt when he managed the residential facility in Carson City and moved people 3.5, 3.3, and 3.1 based on their interpretation of how many hours of care they should receive on any given day. It was ridiculous the amount of admissions and discharges they were handling on a daily basis within the NHIPPS environment, and that is why it went to the middle. Mark believes level 3.5 is what most people do for residential. When jumping to 4, they are inpatient which is psychiatric substance abuse stabilization. It goes back to the term residential. Dorothy North has often said that when they term their high intensity delivery systems programs as residential, the insurance companies may think they are halfway houses or the services are not what are being delivered and it demeans the service levels they are providing. Residential terminology doesn't apply because systems are becoming more sophisticated.

Mark may send his power point on the levels of service he simplified from the ASAM to Steve McLaughlin for review. Ester believes they need to look at a different terminology rather than residential but she is not clear what ASAM would allow. Changing state regulations may follow if they can make a case to fine tune nomenclature, definitions, and standards of treatment. As Mark reads through the definitions he can add nuances to begin that process. Mark requested feedback from the rough draft he compiled in order to enhance and improve the definitions for the particular standards prior to the next meeting.

Ester inquired as to who is supporting Mark in handling this project. As part of the certification contract CASAT provides technical assistance and guidance. This is part of what Mark does for Nevada now and in the future. The goal is for him to keep this moving and to gather consultation and stakeholder buy-in for opportunities to share it and to help mold it. The goal is to be taken into the Health Division and HCQC to use the standards document to assume the role of surveyor. Resulting from the BDR, it is still to be determined that the residential program, and not necessarily the outpatient program, will be impacted. Mark spoke to Richard, and no matter what happens they will be there to help. This document would be utilized in training and any type of transitions that occur. Mark is already working on the integration of this treatment instrument with HCQC for residential programs. There is another committee working on the reduction of redundancy to ensure a seamless process. Steve McLaughlin is unsure if the BDR was yet passed because he was getting questions about it from Dr. Green. Barry Lovgren spoke at the public hearing, but Mark ultimately does not know what happened with it. Frank reiterated that Barry was saying that the correct standard was out of compliance with the NAC. They clarified it would be all inclusive and encompass everything that hadn't been covered previously. It moved forward and was passed. Basically the BDR discusses facility, and the definition of facility references residential programs, and there is nothing in the BDR about outpatient or prevention. There was mention of evaluation centers and detox techs, so there will have to be some collaboration; however, certification of outpatient programs will still be done by SAPTA.

Frank believes they need to focus on supporting this draft and move forward by putting something in writing to Mark about suggested changes to specific sections. Steve Burt supported the current documentation and to move forward with it as provided to them. Ester has already made suggestions to Mark. Mark encouraged everyone to take time to review it. From a process standpoint, Frank suggested any proposed changes be emailed to Mark and "copied" to the subcommittee members to keep them informed and to have a record of changes, rather than waiting until everything is compiled. Because Frank does not want Mark to be inundated with phone calls, he believes this would be the most efficient process.

There were no recommendations to the information which was reviewed. Ester requested to receive the standards for Utah, New York, Wyoming, and Idaho. Lisa Tuttle will distribute these standards via email to the committee members.

Motion made by Frank Parenti and moved by Steve Burt to have Mark Disselkoen and Steve McLaughlin proceed with clarifying definitions. Seconded by Ester Quilici. All in favor. Motion carried.

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

There was nothing new to add to the agenda specific to what is being done for the SAPTA standards. Currently, they have a copy of what would be called a review instrument. Frank asked if a policy manual would actually be developed which was part of a conversation he originally had with Scott. He understands there is a program operating in access standards but wants to know if there is something clearer. The goal is to get that completed and integrated into the larger policy document. There will be definitions and a review instrument which will work backwards from the definition to the policy. Everyone was in agreement. Ester will contact her two clinical management treatment staff to review this. Mark will also start working on the policies.

The committee set a date for May 28, 2013, at 9:00am, for the next subcommittee meeting. It was discussed to add to the next meeting agenda to approve meeting minutes for the March 11 and April 22 meetings.

5. **Public Comment**

No public comment was made.

6. **Adjourn**

The meeting was adjourned by Frank Parenti at 9:45am.