MINUTES

DATE: March 11, 2013 Teleconference Number

TIME: 9:00am 1-888-363-4735

LOCATION: Substance Abuse Prevention and Treatment Agency Access Code: 1602938

4126 Technology Way, 2nd Floor MHDS Conference Room Carson City, NV 89706

BOARD MEMBERS PRESENT

Via Teleconference

Frank Parenti (Chairperson) Bridge Counseling Associates

Steve Burt Ridge House
Mark Disselkoen CASAT

BOARD MEMBERS ABSENT

Ester Quilici Vitality Unlimited

STATE OF NEVADA STAFF

Carson City Site:

Chuck Bailey

Betsy Fedor

Inna Botcharov

Lisa Tuttle (recorder)

HPA II, Data, SAPTA

HPS I, Treatment, SAPTA

HPT, Treatment, SAPTA

AA IV, SAPTA

Las Vegas Site:

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

PUBLIC

Stuart Gordon Family Counseling

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1. Welcome and Introductions

Chairperson Frank Parenti opened the meeting at 9:00am.

2. **Public Comment**

No public comment was made.

3. Discussion and Recommendation for Development of Treatment Standards Manual

Mark Disselkoen stated that the intent of the subcommittee and the meeting was to create an interpretation of the standards NAC458 to ensure continuity during the review process and also to compare what other states have put together for standards of practice. Standards of practice may sometimes go well beyond the rules. After examining the two examples of the New York State's oasis clinical guidance and Utah's guidance, New York's was more specific at determining rules interpretation, specifically progress notes, treatment plans, and utilization of ASAM. However, it was somewhat generic. Utah was more global, but seemed more generic and didn't have much interpretation on rules. Mark has been working with Scott Boyles and is giving him a historical perspective on these rules. They have done some work on putting together standards, but when they examined these two examples, they were unsure if that was the right direction. They want something more than just standard interpretation.

Steve McLaughlin commented on the two examples of Utah and New York having contrasting styles. He had other states' examples but wasn't able to distribute them prior to this meeting. Pennsylvania's manual has approximately 300 pages and are particular to standardization, regulation, and best practices. Going into health care reform in 2014, he believes it is important to have a standards manual in place which will include a quality assurance piece. It is essential to ensure all programs are following a standardized practice to identify what can be improved upon as a state and as agencies. He commented that Mark is on the right track. Steve Burt's assessment of the documents is the same as Mark's assessment in that New York is direct and to the point. This is what they want when Scott comes out to different agencies and speaks to them about what a progress note should look like. If CASAT and SAPTA agree upon a progress note format, then there is a standard by which to assess them. The problem with New York is that it isn't ASAM driven. Utah's standard is global but is ASAM driven. There is no point to review Pennsylvania's standard if the progress notes, discharge summaries, etc., are not ASAM driven. Steve McLaughlin believes they are ASAM driven but are very long. He agrees that needs to be accomplished. New York is different on two levels. Its legislature passed a quality assurance bill that added new regulations to its version of NACs and NRSs to ensure programs follow regulations for best practices for substance abuse services. New York's certification level is a bit different. It is a multifaceted system with state run substance programs, as well. They may not all be state workers or fully-funded state programs, but some program employees are tied to state employment, which ensures state employees are keeping in line. New York offers a good starting template for progress notes for how they should read. Steve pointed out that Nevada does not have to adopt either one of the two standards examples, but wanted to show what was out there. When Mark was doing certification for BADA, intent statements were added under each standard which basically indicated what it meant. At some point that was omitted. He is unsure if that should be added back into the instrument or if a document should be developed and organized at a minimum, such as the instrument by area, and write an interpretation under each standard for SAPTA, SAPTA Advisory Board, and Treatment Standards Subcommittee to review for feedback as a three-pronged approach.

Frank believes the word "interpretation" started this entire topic of conversation. If interpretation can be labeled as a definition, certification review would be exact so individual's interpretations would not differ. An example of this happened when Steve first began the process of making changes to one of the documents relating to insurance. He reiterated this is why specific definitions should be added to each category. Years ago they were originally mandated to implement evidence-based practice, but it took too long to decide what the evidence-based practice would be. It was then based on determining whether or not to implement the evidence-based practice correctly. It should be simple. On page 31 of the Utah document, it shows this in terms of the crosswalk for ASAM for what is present to justify each level of care. They want a more concrete definition to meet objectives.

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When first reading the certification instruments, Steve was unsure how the points system was determined. If someone were to put 15 out of 50, for example, he would not know how the 15 points was determined. This must be laid out in more detail on how it would be concluded. It is the person's perception doing the certification of what it's supposed to be and not an actual score. There is a standard practice on determining scores. Everyone has been trained but it's not always communicated. Scoring is consistently done. It is not up to interpretation if going back to the DSM as it exists now in terms of an abuse or dependence diagnosis. It either is or it isn't something in those categories that causes to meet that criteria. Frank believes that is what providers are seeking. It was discussed this is why state standards must be developed as a cohesive group. In many ways the standards have not been updated since 2003 or 2004, but they were only updated to reflect Health Division language. They were not really worked on so that created some of the issues going back 15 years.

Mark's recommendation is to rewrite them. He wrote Wyoming's substance abuse and mental health standards which were streamlined and made clearer. Every rule needs to be measureable and speak to quality of service and safety, and if it doesn't it probably should not be in the rules. It worked great. A Wyoming committee wrote the standards, which included providers, state employees, and consumers. The group consisted of 15 people, and it took 18 months to complete and formalize them. After January 1, with the changing landscape of the field the support team should try somehow to do that per Steve McLaughlin. They were written in a co-occurring model in the substance use and mental health rules. Wyoming has mental health rules, whereas in Nevada, there is no specific set of mental health rules. Frank asked should there be rules if Nevada is getting certified for co-occurring treatment. There should be, but Mark was specifying for the SPMI population rules. Steve McLaughlin stated they may soon have to examine a set of mental health rules to move toward the community settings. Idaho also has mental health rules, so there are good examples of states with similar geography and rural-type frontier settings. Mark will send the draft copy of Wyoming's mental health and substance abuse standards to everyone.

Steve Burt's global perspective is he is not as interested in marrying the regulations with the interpretations for the purposes of certification instrument. He is looking for a global instrument they can give to new agencies and to agencies that are not necessarily interested in becoming certified. He wants to present them with the standards of practice that will be developed by SAPTA, so they become the "go to" agency for how treatment should work in the state. There are regulations to back it up, and eventually the regulations will need to be rewritten to match. Although not perfectly appropriate, New York's manual is simple and shows how to write a progress note. Utah is tied to its regulations which makes it no better than what Nevada has, but states such as Wyoming and Idaho have done this through CASAT. Steve suggested moving in this direction because the knowledge base is the same through CASAT. Mark believes it should be a combination. It needs to be a standard definition but also more global that says this is good treatment. This should be the starting point, then later adapt regulations and write drafts. It was suggested to put definitions in draft form, as well as other elements, to include beyond what the NAC defines. The certification also filters into the annual monitor tool that is used where it asks if a program has a certification recommendation from the following fiscal year. They want to make sure all programs are treated fairly on the question based on an actual standard. The entire point is for everyone to be on the same page so it makes sense, and it also helps with training for new programs. After finishing the substance abuse rules for Wyoming, Mark traveled within the state to train on the rules and their definitions. Once the Nevada document is complete, regional trainings with the providers must be done. The first step will be for Mark to work on standard definitions for group discussion and make necessary corrections. It was suggested to review other state manuals to see what might be needed beyond standard definitions and to hold another meeting to discuss what else needs to be focused on the draft. Next will be to review beyond the NAC to eventually have a standard manual that addresses both. They suggested going through the instrument section by section, and it was agreed to add to the draft as they go and make changes as needed.

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Mark said it is important to look at standards and be careful not to interject – rule on the side of less stringent than more stringent. One's personal opinion may cloud the process when looking at standards more stringently. In the past, Mark took this perspective. Through the years others leaned toward more stringent. A standard should not be read into it more that it should. He is working with Scott on this type of philosophy, which he has shown good progress. If proved too complicated for the client or the clinician to understand what is happening, it is better to stop and start over. Everyone agreed this is the direction they want to take and should move forward.

Motion made by Frank Parenti to have Mark Disselkoen and Steve McLaughlin go forward with working on definitions. Moved by Steve Burt. All in favor. Motion carried.

Mark will work on getting a draft completed by mid week of March 18, 2013.

4. Review Possible Agenda Items and Future Meeting Dates

The agenda items will remain the same as discussed at this meeting. Motion made by Frank Parenti to review documents drafted by Mark Disselkoen and Steve McLaughlin. Moved by Steve Burt. All in favor. Motion carried. The subcommittee discussed holding another meeting in April 2013.

5. **Public Comment**

No public comment was made. Frank thanked Mark Disselkoen and Steve McLaughlin for being proactive in this effort. He appreciated Steve Burt's comments of the standards to be available to those who are not funded.

6. Adjourn

The meeting was adjourned by Frank Parenti at 9:30am.