

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

MINUTES

DATE: January 29, 2013
TIME: 9:30am
LOCATION: Sierra Regional Center (SRC)
605 South 21st Street, Room 124
Sparks, NV 89431

Video-Conference
Desert Regional Center (DRC)
1391 S. Jones Blvd., Room 129
Las Vegas, NV 89146

Teleconference Number
1-888-363-4734
Access Code: 1602938

BOARD MEMBERS PRESENT

Sparks Site

Michelle Berry – Acting as Chair
and Proxy for Nancy Roget (Vice Chair)
Diaz Dixon
Ed Sampson
Steve Burt
Lana Henderson-Robards
Michele Watkins
Suzanne Thompson – Proxy for Tammra Pearce

University of Nevada – CASAT

Step 2
Frontier Community Coalition
The Ridge House
New Frontier Treatment Center
Central Lyon Youth Connections
Bristlecone Family Resources

Las Vegas Site

Frank Parenti
Ronald Lawrence
Amy Roukie – Proxy for Maurice Lee
Jamie Ross – Proxy for Brad Greenstein

Bridge Counseling Associates
Community Counseling Center
WestCare, Inc.
PACT Coalition

Elko (via teleconference)

Ester Quilici – Proxy for Dorothy North

Vitality Unlimited

BOARD MEMBERS ABSENT

Kevin Quint (Chair)
Debra Reed

Join Together Northern Nevada
Las Vegas Indian Center

STATE OF NEVADA STAFF

Sparks Site

Betsy Fedor Health Program Specialist, SAPTA
Charlene Herst Health Program Manager II, SAPTA
Chuck Bailey Health Program Specialist II, SAPTA
Deborah McBride Agency Director, SAPTA
Gaylene Nevers Health Program Specialist I, SAPTA
Lisa Tuttle (recorder) Administrative Assistant IV, SAPTA
Dave Caloiaro Clinical Program Director, MHDS
Becky Vernon-Ritter Grants and Projects Analyst II, SAPTA
Inna Botcharov Health Program Trainee, SAPTA
David Sater IT Specialist, MHDS

Las Vegas Site

Steve McLaughlin Health Program Specialist II, SAPTA
Kim Davis Administrative Assistant II, SAPTA

PUBLIC

Barry Lovgren (via teleconference for
initial public comment)

1. **Welcome and Introductions**

Acting Chairperson Michelle Berry for Kevin Quint opened the meeting in due form at 9:35am.

2. **Public Comment**

Barry Lovgren presented his testimony before the SAPTA Advisory Board regarding a letter he sent in October 2012 regarding the sliding fee scale. A copy is attached.

Ester Quilici requested he fax his testimony to the Board. Mr. Lovgren offered to email it to the Board members, but did not have email addresses. Michelle Berry suggested he email his testimony directly to Lisa Tuttle at SAPTA, and in turn she will email it to the Board members. No further questions or comments were made.

Michelle Berry stated that since this is not an action item no further discussion can be made. However, it will be added to the next SAPTA Advisory Board meeting agenda.

3. **Approval of Minutes from the November 14, 2012, Meeting**

Michelle asked for a motion to the minutes of the November 14 meeting. Motion to approve the minutes by Diaz Dixon and seconded by Steve Burt. All in favor. Motion carried.

4. **Demonstration of Data Warehouse Online Analytical Processing Reporting**

David Sater of MHDS began the presentation on the Mountain Bluebird Data Warehouse system. It's an overview of what has been worked on over the past year to debut new functionality within NHIPPS. As part of the SPE Grant the goal was to build an infrastructure not only for prevention information but link it to other data sources, such as NHIPPS treatment data, Avatar, mental health, co-occurring disorders, developmental services, health, etc., which would make it more valuable.

David explained the different systems, which are information silos. The challenge is that there are barriers when trying to report information across the silos. Three strategies to overcome this are: (1) integration between the systems which are expensive and time consuming, (2) service-oriented architecture which is only for real time transactions, and (3) data warehouse.

He proceeded to the WebEx demonstration on the overhead screen and explained why the data warehouse was chosen. This was an introduction to the system, and a power point presentation will be made available when it is completed.

Michelle Berry asked if they would be able to analyze the data themselves versus other organizations or is it just unique to a particular organization? Currently the permissions allow information accessible within their own coalition and their subrecipients, even if it spans across multiple coalitions. Michelle asked how treatment providers are doing as a whole versus how their particular organization is doing. David said they will be able to do both. As of now the plan is to use the permissions that are currently in NHIPPS. When logging in as a treatment provider they will see all locations for their providers in the data warehouse. He will demonstrate the capabilities of expanding outside that level. Michelle asked if this expanded capability is solely for the SAPTA level. David explained the general public and stakeholders will be able to view the State's data in aggregate only and not be able to see specific client records.

Diaz would like to see data from other agencies to compare how well they match up to each other. Chuck Bailey from SAPTA addressed there may be privacy policy issues specific to the treatment side to protect client identity and services. There will need to be an infrastructure in place to deliver these reports, as where individual providers will be able to see their detailed records. What is aggregate and appropriate for freedom of information requests would be different. Legislators and the public still have a right to see how their money is being used in the aggregate. Diaz is not interested at looking at an individual's record, but at information that can show different providers' strengths and areas of concerns. He is looking for the larger numbers that are utilized in most of the grants that are written. It is important information from the SAPTA

level, but it is also a resource and valuable tool for providers to use. Michelle said it is important to your board of directors on where an agency ranks in comparison to other organizations. Per Chuck, transparency is a corner stone for building accountability and efficiency. Security issues need to be resolved in order to move forward. David stated the cube demo will answer many of these questions. Frank Parenti has already taken this demo in more detail and commented on the depth of information that can be pulled and what can be done is amazing. He assured Diaz that what he was looking to do can be accomplished. Per Chuck, this will provide the infrastructure to bring it onto a web portal to see it easily on line. The dashboards and performance measures are still a work in process.

David proceeded to show slides on the time tracking system for contractors hired by SAPTA which are in quarter hour increments and how this project was accomplished. He then skipped to slide 17 to demonstrate the deliverables. The first cube built was a prevention cube for the session activity detail records for direct service providers. The next cube scheduled is the coalition event record. There are other valuable reports Chuck is currently managing that are on the "to do" list. He continued the demonstration with the Test User report that displayed pie charts of age groups, ethnicity, race, and gender. It is a complicated and valuable report which shows core program name, location name, record type, program completion, start date and end date, county, number of people served. The data team will be a resource for training and information in order to effectively use the system.

Lastly, David showed a massive report which included all data for this type of information. Michele Watkins asked if pre-post data was available; however, currently there is not. David suggested Michele inform Chuck of prioritizing this. The coalition event record is currently being established and should be released within the next few weeks. It would be up to the providers to let them know what they want implemented next. David pointed out these web-based reports will be delivered through NHIPPS. SAPTA is also building a web portal with dashboards for online score cards. The current plan is to have a series of excel spreadsheets and workbooks within the portal.

Gaylene demonstrated a brief summary on measuring prevention data (live data). David stated that agencies will be able to go onto this portal and see preconfigured spreadsheets. However, if anyone has questions on data that is not already preconfigured, this is the way to create your own analysis by opening excel and connecting to the data warehouse. (They experimented with the demographics of the system per request of the meeting attendees.) Research has shown when it comes to pivot tables and OLAP that not everybody will be able to ask the right questions and to get answers. It requires some background and understanding of the way the data is structured. Steve Burt believes you need advanced excel training to get to this level of functioning.

This program is meant to be user friendly. The goal is to be able to analyze your own data in a faster time frame, rather than having to call the data team. Chuck mentioned this will be useful from a grant writing perspective, as to acquire information as needed. However, the data team will be available to provide assistance and write initial reports. David specified the reports in NHIPPS are available now from the live system. The cubes should be ready within the next few weeks. The only cube available now is the session activity detail which is a prevention cube. Previously, there was discussion about an encounter-based reimbursement cube and utilization cube, so there are many possibilities. Chuck will be able to help with determining and managing the highest priorities.

8. **Update, Discussion, Recommendations Regarding the 2014 Joint Block Grant Application**

Dave Caloiaro, Director of Administrative Programs and Planning for MHDS, presented an update of the Joint Block Grant from the Mental Health perspective. This is the first Joint Block Grant effort with SAPTA. Historically, the Mental Health Block Grant has funded positions in the Mental Health agencies: Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), and Rural Services that include 16 rural clinics throughout the state. The grant has funded positions such as service coordinators, case managers, and psychologists.

A big program for Mental Health is the Consumer Assistance Program. There are 12 statewide peer supporters or consumer assistants. It is his understanding that the Mental Health side hasn't had as many requirements as the SAPTA Block Grant. Mental Health cannot use the grant for inpatient services, payments to families or clients, or use of physical building restructuring. Another difference is that SAPTA percentages of funding go to certain groups, for example, pregnant women with substance abuse disorders. Also, SAPTA does not have a requirement for a planning council; however, the Mental Health side does.

Moving from the historic mental health side gives him and his staff a wonderful opportunity to jointly work on mental health, substance abuse, and co-occurring disorders issues. The Joint Block Grant is due April 1, 2013, to the Feds; however, the internal due date is March 28, 2013. Similarly, on the SAPTA side of the block grant there are several sections they are working on. There is a quality team of about 10 people from SAPTA and Mental Health working on sections such as the affordable health insurance exchange, program integrity, recovery, prevention, and primary behavioral health integration activities.

A meeting will be held this Friday, February 1, 2013, jointly between Mental Health and SAPTA to discuss priorities. This joint team meets every other week and progress is being made. He thanked his cohorts at SAPTA for their collaboration in this effort. Amongst those is Becky Vernon-Ritter, who is keeping everyone on task and is reviewing documentation and material. It is his understanding a rough final draft will be presented at the next SAPTA Advisory Board meeting in March, as well as being presented to the Mental Health Planning Advisory Council (MHPAC) meeting on March 7, 2013. This draft will need to be reviewed within a two week period in order to be finalized and submitted.

Dave also spoke about the transformation of the current MHPAC structure required by the Federal Block Grant, which consists of at least 50% mental health consumers and/or their families and 50% state employees representing different agencies (e.g., Mental Health, Division of Child and Family Services, SAPTA, Department of Corrections, Department of Housing, and Department of Employment, Training, and Rehabilitation). A transformation from a mental health to a behavior health planning advisory council would add additional representatives from substance abuse, providers, and consumers. A Governor's Executive Order was just obtained to do so, and this will be presented at their next meeting in March. New bylaws will be drafted presuming the council will approve this transformation. Part of the transformation will go from 17 members currently to 23. He is working on the application for technical assistance from the Federal government that is due in a few weeks. Also involved is the contractor Human Potential through the Substance Abuse and Mental Health Services Administration (SAMHSA). If Nevada is chosen as one of eight states selected to participate, they will help us in this transformation through most of this year. If Nevada is not chosen, they have a good pool of partners, providers, and consumers, as well as the MHPAC. There were no questions or comments made.

5. **Update, Discussion, and Recommendations for SAPTA Treatment Standards**

Per Steve McLaughlin, SAPTA has started the process of gathering information from other states to create a manual that identifies treatment standards for the State of Nevada. He suggested forming a subcommittee with representatives from CASAT and SAPTA to create treatment standards of cohesiveness in Nevada. If a manual is adopted, there will be less confusion from other entities looking at the programs, and it will also help with training purposes. A majority of other states have extensive manuals, but he doesn't feel Nevada will need to be too extensive. He believes it will help with efficiency and effectiveness.

Frank asked what happened to the requirement of demonstrating evidence-based practices to maintain funding which was presented and agreed upon about eight years ago. CASAT is going to be doing CPT. It would make it easier from a treatment perspective to know which evidence-based practice is being used. He questioned who actually was going to certify the agency as competent in evidence-based practices. Originally CASAT was going to do this, but didn't. Per Steve McLaughlin, this is a way for standardization. Although the NRS and NAC's for treatment planning for best practices are in place, he feels that together as a treatment community it would be more effective to create a best practices manual as a baseline that the entire state would use. Frank stated at one time this was done when they were supposed to get secondary

certifications but fell through. He suggested incorporating those instead of having to go through the cost and time. He asked what came to fruition with the evidence-based piece, but Deborah did not know the history. He stated it was about eight years ago and processed through CASAT when they were meeting fairly regularly to decide which evidence-based practices to pursue. He believed it was part of the RFA and was included in the peer review. In Steve McLaughlin's review, there were about 25 states or more than half that recommended and recognized an evidence-based practice. Usually only one or two is what they contract using as their baseline for evidence-based practices. It could be decided as a group which evidence-based practices to use for Nevada. All the programs need to be involved in this. Deborah will review prior minutes and RFA's to find some history on this. Initially it was contingency management, and then the discussion was CPT. Frank's part was important for engagement.

Steve Burt discussed the topic of treatment standards. This is set up with certification monitors because ultimately SAPTA is responsible for certifying the programs and CASAT is responsible for monitoring those regulations. Michelle believes other states that CASAT monitors have treatment standards in their statutes, rather than manuals in place. Steve Burt expressed that a certification manual would make it easier for new and existing programs to monitor and what to be aware of before they come out. There would be a section to discuss evidence-based practices but believes the discussion here is about how to write a progress note, how to do treatment plans, whether or not to discuss the diagnosis at the end versus the beginning of treatment, and all those things that surface during the certification review. It seems to change from time to time based on the opinion of the reviewer, so it is never known how it should be handled. Steve McLaughlin had a discussion with Mark Disselkoe about that. Wyoming has a treatment standard manual and Utah has one that is a joint venture between the programs and the SSA's office. It is a great idea and goes beyond what evidence-based practice is, such as progress noting, treatment planning, etc. This would give a better understanding to programs and certification visits of what to look for. Frank stated that if agencies do not get their certification packet, there can be some confusion on what to do.

A subcommittee will be formed to discuss this in greater detail. Michelle asked for volunteers to help Steve McLaughlin in this effort. Ester Quilici from Vitality Unlimited, Steve Burt from The Ridge House, Frank Parenti from Bridge Counseling, and Mark Disselkoe from CASAT volunteered. Frank will chair the subcommittee.

Michelle stated she would be available on the subcommittee for CASAT if necessary.

6. Update, Discussion, Approval of Annual Treatment Certification Fee Procedures

Steve McLaughlin, Mark Disselkoe, and Frank Parenti are currently working on the consolidation; however, they have not yet been able to discuss annual treatment fees. The consolidation part needs to be identified first before discussing this. Some of their ideas are listed in earlier 2011 Advisory Board minutes. Michelle recommended this issue be tabled for now.

7. Report, Discussion, and Recommendations from the Consolidation Subcommittee

Frank Parenti, Steve McLaughlin, and Mark Disselkoe were on a conference call as a follow up to the Consolidation Subcommittee meeting held December 17, 2012. Progress is being made on potential ideas. One suggestion might be also to move all certifications for SAPTA, CASAT, and HCQC into one date to limit duplication. It is unsure whether HCQC could take over some part of the residential piece and have a clinical component with staff that is trained to implement this. Steve and Mark are working hard to gather information without diminishing the quality of the review process. Mark is working with Paul Shubert at HCQC as a result of a BDR that identifies the duplication licensure certification and the detox technicians to identify how to make it work. Mark is also working with another staff member regarding the alignment of dates to make certification easier for programs. Michelle asked if Mark would give an update to the Board at the next meeting. Frank is just waiting on the next Consolidation Subcommittee to be scheduled.

Meeting called for a break at 11:10am.

Meeting called back to order at 11:25am.

9. **Discussion, Recommendation, and Approval for Peer Review Process**

Per Michelle Berry this item is being skipped.

10. **Report, Discussion, and Recommendations on Performance Measures from Other States**

Steve McLaughlin discussed the background of performance-based contracting. It is part of a fee for service model. Discussions are being held in other areas which may affect us. In the grant, there are specific performance measures to meet in order to access a higher level of funding. Currently he has gathered information from the participating states, but has not been able to distribute. Pennsylvania has a very comprehensive behavioral health performance-based contract system for their funding. Nevada is not yet ready to move into that type of model. Steve will distribute the other states' packets for review prior to discussion at the March Advisory Board meeting.

11. **Report, Discussion, and Possible Action on SAPTA Health Care Reform Readiness Survey**

Steve McLaughlin received 100 percent feedback from the providers and thanked them for their participation on the Health Care Reform Readiness Survey that was distributed last month, which was a version of a readiness survey that NIATx did. This was done to gauge program readiness for health care reform. Good data and specific information was gathered from the survey. Steve does not have the statistics yet, but does have some points for discussion. Overall about six providers are billing Medicaid (possibly more since this survey was conducted). It identifies that most bill for provider type 14 – mental health outpatient. Washoe County Sheriff's Office and China Springs Youth Camp cannot bill Medicaid because they are considered correctional facilities. Many programs have had training for the billing process and are prepared or moving toward billing Medicaid. There is still some work to be done in order to begin billing Medicaid. SAPTA's role will be to try and prepare the programs for functionality in Medicaid, especially Medicaid Expansion and health care reform. Some programs already have an NPI number and about ten programs do not. The SAPTA staff will be available to provide technical assistance to the programs, and Steve can also verify what type of training Medicaid could provide.

Since there were no further questions or comments, Michelle requested that Steve share the results of the survey with the group to review in greater detail for question and discussion at the next meeting.

12. **Approval of SAPTA Policies and Procedures for Possible Action**

Deborah McBride introduced some of SAPTA's policies and procedures that the LCB asked to be put in place as a result of the LCB audit and their recommendations. After the audit of these policies, LCB was pleased with what SAPTA put together and the action that was taken. Deborah brought these policies and procedures before the Advisory Board for review and discussion. These do not yet have numbers assigned yet. Michelle asked Ester if she received a copy of all of these via email, which she stated she did.

Policy #1 Sanctions

This policy shows the steps needed if documents are not received in order to finish audits or monitors. These steps must be written to stay in compliance with LCB requirements.

The sanctions shall include, but are not limited to:

- written warning to correct the deficiency
- mandated technical assistance
- withholding a payment or reimbursement until the correction is completed
- defunding for current subgrant for additional services
- prohibition from future subgrant awards from SAPTA or other state health agencies

This process is a graduated sanction to work with providers to obtain the necessary documentation in order to be compliant. Becky Vernon-Ritter will be sending emails to request any needed items. The LCB auditors pointed out that SAPTA did not have anything established in writing about clear steps to take should there be problems.

The process is shown on the second page for receiving the email warning when something is missing in order to finish the report. It was asked by Ester where the appeals process is. Deborah said it is separate and believes it is in the administrative manual. Steve Burt suggested adding verbiage to the policy that ties in the appeals process so it can be easily referenced. Deborah will add it.

Policy #4 Audit Report Policy

This policy includes general information about types of audit reports. It has information from the subgrant assurances on who needs to have an audit and why. It goes through different steps from the assurances, such as the letter of engagement and the signed final audit report. It also has more detail about how reminders to subgrantees will be sent, due date time periods of notification, how it needs to be signed, etc. Again, Becky will be contacting everyone as a reminder. Much of this process remains the same, but it had to be formalized in writing for consistency for the programs.

Ester asked the question of who in SAPTA reads the audits. Deborah explained the review process begins with Becky, then is routed to the program analyst, treatment team supervisor, fiscal, Deborah, and Division level.

Policy #6 Audit Reports – Agreed Upon Procedure

This policy was written last spring, and it was inserted and referenced within the subgrant to formalize the process. Becky has distributed this to those with limited scope audits as a guide. Ester asked what would be an acceptable level for correction of administrative compliance issues. SAPTA put together a risk assessment to determine this by a rating system. This will be discussed in Policy #10 which shows the scores and frequency.

Policy #7 Fiscal Monitor Process – A Guide for Coalitions for Oversight of Subrecipients

This policy goes through all the steps and talks about the law behind it, the OMB circulars, and the CFRs. Becky did a good job in putting this together. This is a guide to help monitoring for the coalitions' subrecipients. Again, this was put into writing to formalize the policies and procedures. Becky has been doing monitoring for the coalitions and has been informing them that this is a work in progress, and they will be receiving this document once it is reviewed in this meeting. Once they receive it and begin using its applications, the document may change based on their experiences, or due to something originally omitted or added incorrectly. Currently this is a good guide for them to follow when monitoring their subrecipients. There are a few new coalitions that will begin using this guide as a tool in hopes that their monitoring will be an easy process. There may be changes, but nothing significant. Email Becky or Deborah with any questions.

Policy #8 Fiscal Monitoring – General Information

This talks about the monitoring process, how often they occur, selection process, and document review. Deborah reiterated these are things already being done, but need to be formalized. The policy discusses the onsite monitor and what happens at the end. Jamie Ross from PACT said there were discrepancies between Policy #7 and #8. Policy #7 specifies that the fiscal monitor for coalitions and their subrecipients need to be done annually. It states on the bottom of Page 1 "on an annual basis 100% of the programs must be monitored." However, Policy #8 specifies treatment programs and direct service providers for prevention have to be done every other year. It states on Page 1 "treatment programs and direct service providers for prevention on a biannual basis." Deborah said one is for prevention and one is for treatment. Jamie's meaning of Policy #8 relates to her coalition subgrantees. To avoid any confusion, Becky suggested separating the verbiage between the treatment programs and direct service providers for prevention. Deborah confirmed that will be changed.

Ester inquired about the review of timesheets. Becky reviews timesheets to ensure the programs have a methodology of distinguishing the allocation process. For example the SAPTA grant is expensed out for only that specific amount of time a staff member is working on the grant. Many people have an allocation based upon what is in their budget (for instance 20%). Some programs enter their actual time worked onto timesheets with their funding source across the top and the days of the week down the side. Timesheets were checked to see their type of methodology used and to also verify signatures are in place. Ester was surprised by this and questioned when doing performance-based fee for service if timesheets are not being accounted. Becky said this is in the policy because treatment isn't the only program SAPTA funds. They also fund coalitions and prevention programs which are not fee for service. She doesn't yet know what this will look like for treatment for encounter-based or fee for service.

Everything done prior to the last monitoring report went to fee for service. It has not yet been determined whether or not SAPTA will be looking at timesheets if they are fee for service and meeting performance objectives. Becky will try to give the agencies plenty of notice prior to coming out so they will be prepared. Fiscally, she will need technical assistance since she doesn't know what she will be facing. Once the information has been decided on, it will be disseminated to the treatment programs for their knowledge. Ester suggested they talk at a later time because she was still confused and wants to be prepared. Becky reassured Ester that information in these documents still relate to the prevention programs and coalitions, so it will still be part of the policy. Becky will try to give at least 30 days notice prior to her treatment visits and will bring the draft of the monitor tool.

Policy #10 Fiscal Monitoring – Risk Assessment

SAPTA had to devise a way to make an assessment on providers based on monitors' results and some way to score it. After speaking with the auditors, based on their suggestions this is what was compiled to make it as fair as possible. Steve Burt asked if the SAMSHA grant required SAPTA to annually monitor them fiscally. Betsy Fedor specified this occurs every two years. It doesn't seem sufficient to go out every three years. As challenging as the fiscal and program monitors are, having multiple agencies coming out and auditing them becomes the difficulty. It is unreasonable to him because so much can change in one year, and the programs would not be done any favors by this. Diaz recommended that it doesn't have to be a greater frequency. If programs are doing wrong either maliciously or accidentally, corrective action needs to be taken and caught sooner before greater mistakes are made. Steve Burt commented it is challenging when there are 16 agencies coming out to monitor. They've been working on this challenge by bringing the HCQC and SAPTA requirements together under a larger umbrella. For those who have to do A133's each year, it would be beneficial if it were somehow tied together. Becky suggested if going with the low-medium risk every two years and omitting the three years would be more reasonable. Steve Burt agreed that every two years would likely be safe if including the requirements of the audits from everywhere. Deborah wanted to recognize those programs consistently doing a good job.

Comments were made that programs are reprimanded if there is a change in executive management, and it is a risk factor that they have no control over. Turnover of a board chair or president is good; however, a program can be deducted points because of this. For example, if a program is in good standing for up to 10 years and they had to fire their CFO or CEO, no longer should there be a big gap. Instead, because they are now under new executive management, they should be monitored the following year to ensure things are in place. An agency would definitely need examination if they argue about their finances becoming known or how they are handled. Agencies should be open and honest with how their funds are allocated. The A133 explicitly outlines how agencies are to use monies, and the agencies must provide their proof of usage as outlined by the grant.

Michelle asked why the award amount was a risk factor. As Deborah explained, an agency is more at risk when receiving a higher amount of money than one that receives a lesser amount. Sometimes a program will grow too fast internally which can be a contributing factor. Michelle asked if verbiage can be added in lieu of the grant amount, such as do they have the infrastructure in place to receive their award. Otherwise it sounds as if they are being punished because of the award amount received. Diaz agreed that is a good point. He

sees it as a red flag when a program wants to receive money first and then determine how to provide the services that match up. Deborah does not feel comfortable removing the amount. There is more risk for failure in tracking money for those who receive high allotments. However, she can add some verbiage about infrastructure. Michelle and Diaz discussed that points should be given back to the organizations for appropriate infrastructure. Charlene Herst stated that these risk factors originally came from the Director's office and had been used by prevention for quite some time. These risk factors have become valuable for some of these issues, but she agrees that numbers should be decreased if infrastructure can meet the increased dollars. Steve Burt gave an example that contrarily if a program with a \$6,000,000 budget received a grant from SAPTA for \$150,000 there is increased risk because they may not have the infrastructure to monitor the SAPTA grant as it should be. There are legitimate arguments.

Ester's concern was if an agency proves they can meet standards from clean opinions on A133 audits, they should not be subjected to this other review. Deborah explained there is mention in the scoring items about audit findings which is taken into consideration. Steve Burt wants to be transparent with monitors. It is more than a collaborative relationship for everyone to improve when scores and demerit points are assigned. Charlene asked about changing the name from risk assessment to something else. With every effort to make this a quantitative process, Steve still feels it is qualitative and subjective. Deborah asked for other ideas or suggestions. SAPTA was criticized about not having something like this in place, and they've tried to make it as fair as possible.

Steve Burt discussed the probabilities of faked audits coming to SAPTA, and risk assessment is their strategy to prevent such a thing from occurring. However, what is there was a different strategy of prevention other than risk assessment. Diaz said SAPTA can make it mandatory that audits be mailed directly to the agency and the board director from the CPA's office. Deborah had asked auditors about this policy but she was told it would be mailed to the program only. Diaz stressed that his auditor mails it directly to the address of his board president. Becky said this risk assessment will be used for determining the frequencies of monitoring, and a risk assessment tool should be created to be based on who is monitored and when per LCB. Steve believes that is opinion. If SAPTA monitors annually and a thorough job is assessed, he is not so sure following the LCB's recommendations word for word is exactly the strategy that needed to taken. When SAPTA is fully staffed, the right thing to do is go out annually for fiscal monitoring. Charlene said that staffing is the key.

SAPTA is trying to help those programs with clean fiscal monitors reduce the frequency of their monitoring. Having connections with and getting information from other agencies doing fiscal monitors help SAPTA determine whether to start going back annually. Another option that may be helpful would be to add one or two questions on the compliance monitor to determine if another fiscal monitor needs to be done. Per Steve McLaughlin, on the treatment monitor there are about 11 fiscal questions in Section C that could help make this determination. If a fiscal monitor was completed within a 12 month period then those questions would not have to be answered, but if it was completed after the 12 month period the entire section would have to be completed. For treatment and prevention a three-year, low-risk monitor could be managed because the program analyst would be reviewing it. Those fiscal questions were added to help the provider prepare for a fiscal monitor.

Lana had a scenario that if a program was awarded \$700,000 for more than five years and had clean A133s, they would be docked 30 points based on their grant amount and not based on their prior performance. There should be something to offset this when doing a regular fiscal monitor. Deborah suggested adding something positive that would act as a balance. The low risk is set high enough that if a program has a large grant and is reduced 30 points, they are still within low risk and would be monitored every two or three years. Programs with large grants are taken into consideration; it doesn't mean they will automatically fall into the next category. If Becky does a fiscal monitor and the last two or three have had no errors or action items to report, that demonstrates to her that they have the infrastructure to handle their internal controls adequately and reduce risk. Deborah said it is taken into consideration any previous findings that were corrected within the timelines and deduct maybe 10 points rather than a higher number. Item #6 had no findings – instead of 0 points, Becky suggested adding 15 or 30 points to balance it. It would also be good to re-evaluate the staff

turnover section. If a turnover occurred for a director or key personnel position, it means that someone new must be knowledgeable in running their program in order to stay in compliance.

Michele Watkins specifically does not know what the standards are in the evaluation. Deborah said SAPTA will work on this further and bring it back to the next meeting. She asked the Board if this is what they suggest. Policy #10 will be coming back for review. Becky thanked everyone for their input which was very helpful. If there are any more comments or suggestions they may email Deborah. Ester would like three years. She would like it discussed again before it goes back to two. Michelle Berry reiterated that Policy #10 will be re-evaluated again at the next meeting, along with the frequency. To answer Ester's question, the preliminary risk assessments will be done by the SAPTA Prevention and Treatment team supervisors. Ester suggested that someone sign it so they know who has done the assessment. Deborah believed they can. Fiscal will also be looking at them. On the bottom of the second page there is a section for people to initial off. The consensus of the board was to leave on the three year period for now, but leave it on the agenda and re-evaluate.

Policy for Funding Allocation for Substance Abuse Prevention Services

This policy for prevention has already been in effect, but the new item added is on the bottom of page two, Distribution of Funds for Special Projects. This has been put in writing to formalize the policy. At times, there are extra dollars to use toward special projects because SAPTA has an established savings and sometimes money hasn't been spent from the previous year which is carried over. No questions or comments were made.

Michelle Berry asked for a motion to adopt Policies 1, 4, 6, 7, 8, and the Policy for Funding Allocation with changes made to Policy #1 referencing how to make appeals and Policy #7 for the frequency for coalitions versus treatment to make it consistent with Policy #6.

Moved by Steve Burt to approve Policy #1 with added reference to #7 incorrect, Policies #4 and #6, Policy #7 clarifying the frequency for coalitions versus treatment sentence, Policy #8, and Policy for Funding Allocation for Substance Abuse Prevention Services. Seconded by Diaz Dixon. All in favor. Motion carried.

Michelle Berry asked for a motion to review Policy #10 at the next meeting with the input provided to SAPTA. Ester Quilici moved the motion to review Policy #10 at the next SAB meeting and Steve Burt seconded. All in favor. Motion carried.

13. **Standing Item – Discussion and Recommendations Regarding Health Care Reform**

Michelle Berry has no new information. Frank will be moving forward with training for BH Business through NIATx, SASS, and SAMHSA, which is a four-month model training initiative. CASAT and AADAPTS will also conduct follow up training for Medicaid eligibility after it concludes. Michelle suggested contacting Frank for further information, if needed. No questions or comments were made.

14. **Standing Item – Discussion and Recommendations Regarding New Funding Streams**

Steve McLaughlin said he was not able to yet read the Recovery Support to Scale, which is an opportunity through SAMHSA. He will read it to see if there is any action needed to be taken. No questions or comments were made.

15. **Standing Item – Discussion and Recommendations Regarding Legislative Subcommittee**

This subcommittee has not met during these past few months. Per Michelle, this subcommittee will tentatively plan to meet in March.

16. **Standing Informational Items:**

Administrator's Report

There was no update on this report.

Chairperson's Report

There was no update on this report.

SAPTA Report

SAPTA Staffing: Deborah McBride reiterated that SAPTA has lost its fiscal team which moved to the Health Division's central office. However, there is now a person from Health that has been assigned to help SAPTA with its fiscal services. Kathy Meek, who assists in the daily fiscal processes, is still part of the SAPTA team. Gregg Leiss was the Administrative Services Officer (ASO), but has taken a position with another agency. Marianne Lockyer has been assigned to other tasks, as well as Lavonne Peralta. SAPTA is very tight on staffing. SAPTA has, however, acquired a new treatment person two weeks ago. She introduced Inna Botcharov as the new Health Program Trainee. Interviews are also being conducted for the other vacant treatment position which will be located in the Las Vegas office. Diaz Dixon is concerned with the amount of knowledge being lost within SAPTA, which Deborah agreed. She commented on losing two valuable staff members, Margaret Dillon and Layne Wilhem. Steve Burt acknowledged that SAPTA will have to rely more heavily upon this group where the knowledge remains.

Medicaid Training: The Medicaid training was cancelled due to Dr. Tracey Green having to go out of town. They are hoping to reschedule soon.

Sequestration: There is no new news to report on Sequestration. Deborah will pass along any new information as it comes.

Budget Items: The Governor's recommended budget was presented to the Legislature. Because the Governor opted for the Medicaid expansion, some of the monies for treatment will now be going to Medicaid because providers will be billing Medicaid rather than SAPTA for those persons and services provided that are Medicaid eligible. Monies moved to Medicaid from the general fund will be \$3,066,776 in the first year and \$3,367,440 in the second year. Per Deborah, the Notice of Grant Award hasn't been received from the Federal government, so the funding amount is unknown. They hope to have it in within the next week. It should be fairly flat from indications being received.

Deborah suggested following the Legislature by attending meetings and/or budget hearings, or listening in via web casts. Steve Burt asked how Deborah felt about this issue, which she responded that SAPTA will support the Governor's recommended budget. Lana Robards expressed her concerns that funds being received for substance abuse treatment, co-occurring, wait list, etc., will in many instances be excluded due to the way Medicaid is coding substance abuse. Her understanding is they are rolling substance abuse money into Medicaid as a way not to pay current substance abuse providers. They have excluded certain types of providers and populations of people collecting Medicaid. She had listened to some testimony from beginning to end and felt there was some disillusionment occurring. Reading the budget was difficult to understand. From Diaz's perspective, a few years down the road the translation will be lost. It does not look like a good way to handle this. He does not expect any SAPTA employees to make any comment on this. Deborah recommended they attend the Medicaid training when it is rescheduled. Dr. Green and Brandi Johnson (formerly with Medicaid) will be there to answer their questions and concerns. They are working closely with Medicaid and are looking at what changes need to be made to the Medicaid State Plan. This would be a good opportunity to express their concerns. She also suggested expressing their concerns to the legislators, if they so choose.

There were not many changes to the other SAPTA items in the Governor's budget. No reductions were made to prevention; however, there is a reduction in the Marijuana for Medical Use funds which were known to be coming. The budget has allocated \$500,000 but SAPTA was told by Health Division it will be less than that. If revenue increases the funding can be adjusted. Generally, everything remained the same. There are some position reclassifications still within the SAPTA budget. Also in the budget are two new positions: (1) Quality Assurance position for treatment to help with monitoring, fee for service, and reimbursement and (2) Management Analyst III position to oversee fiscal monitoring, audits, the Accounting Assistant position, and handle fiscal projects. This position will report to directly to Deborah.

The Liquor tax is projected to slightly increase.

Information on the Agency Request Budget and the Governor's Recommended Budget are posted under Budget Administration. There are also items for special consideration which are not part of the budget. If there are monies left at the end of the Legislative Session, it can be used toward special projects. One project is for training within the emergency room departments in the north and south to refer senior citizens and adolescents to treatment if needed. Another project is to help with the transitioning of released prisoners. To review these projects in more detail, refer to Budget 3161.

Steve McLaughlin reported on several items. He asked that work amendment forms first go to their analysts for review. Continuation applications will go out in the next few weeks. Frank commented he is on his fifth scope of work change. The reimbursement record itself is a treatment plan, progress note, or assessment.

Charlene Herst thanked everyone in the prevention and treatment programs for submitting all their AB242s in a timely manner. There are new procedures in place, so everything must be submitted earlier than in past quarters. The AB242s are routed to MHDS, Health Division, Directors office, and then LCB by a certain date. Deborah stated this may change at the end of this state fiscal year unless they decide to continue this bill. It is scheduled to sunset, so there will be at least two more. Everyone on the treatment side will receive emails from either Charlene or Kim.

The State Epidemiology Workgroup and Multidisciplinary Prevention Advisory Committee have developed an evidence-based workgroup which will start developing standards and evaluating other states' standards, especially cultural adaptations or programs and make them evidence based. Oregon, Maine, and several other states have already done this, and we are looking at their protocols. The first meeting was held a few weeks ago and the second meeting is coming up soon to set those protocols in place. There is a good team from both the SEW and the MPAC, and some researchers will also be invited to join us.

There are several surveys forthcoming that SAPTA is helping to fund. One is the Youth Behavioral Risk Surveillance Survey which was not approved by CDC because of the lack of numbers. In this year, 2013, another survey is going into the field. SAPTA was given money to ensure that schools comply. Because the data is given back to them, which is a good incentive, it also awards those schools and classrooms for participating. SAPTA is also doing all the Native American schools. There isn't enough data obtained on adolescents anyway, but specifically from Native American youth. The issues are known, but there is only preliminary data.

The University of Nevada is doing a transgender study, and SAPTA is working with the HIV program in the Health Division to fund that study. The University of Nevada already has the protocols set in place for this study. SAPTA is also doing work with the Maternal and Child Health program in the Health Division on a statewide media campaign that will hopefully draw more pregnant women into prevention and treatment services. No questions or comments were made.

Chuck Bailey gave an update of the results from the responses he received from some of the agencies. Initially, the vote was six to four; however, since he sent out the notice of results two more votes were received, making it six to six unofficially. Chuck encouraged everyone to email him with any specific

concerns. At this point, a plan of action is still being decided on how to move forward. He believes there will be issues which will need to be resolved with the changes that are implemented, no matter what the choice. From a system design standpoint, the changes will be easier if the plan with the six to four votes is implemented. Denise supported this plan in which she wrote a strong argument for. This would be a last chance to weigh in so that SAPTA may reconsider what to do going forward based on responses he received since sending out the initial summation. There will be some hurdles to overcome no matter what changes are implemented. The treatment providers will be updated.

SAPTA is exploring the possibility of using other data systems for treatment, such as the upgraded my Avatar system, to see what it offers and if it is better than what is currently being used. The agencies will be kept up to date and will be involved in the review process.

Deborah asked Lisa Tuttle to talk about the status of the SAPTA Advisory Board Disclosure Statements for FY13. At this point, Lisa received three Disclosure forms back. She brought extra copies and suggested if they haven't done so already to sign and return them to her after the meeting. If not, they may email or fax them by the end of the week. Ester requested another copy be sent to her.

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

Michelle Berry discussed clinical supervision. She has been working with the new executive director from the Nevada State Board of Examiners (BOE) of Alcohol, Drug, and Gambling Counselors. In November, a new way to train clinical supervisors was brought before the Board. It was adopted by the BOE and is currently being implemented. Basically, a licensed clinical supervisor approved by the BOE must complete the new training series in order to retain their clinical supervision status, along with anyone who wants to become a clinical supervisor. This information is located on BOE website. A person wanting to become a clinical supervisor will still submit their regular application to the BOE, and then will be sent to Michelle. She will then instruct them to take a 14-unit, self-paced, online course. From there, they will participate in a two day, face to face training and then two, 2 hour webinars. If a person wanted to finish quickly, they would take the online class now, the face to face class in March, and the webinars in April. Otherwise, it is 16 hours for current clinical supervisors. They would sign up for the two day face to face class and take two, 2 hour webinars in order to be in good standing with the BOE. It is open to anyone who is a clinical supervisor in good standing with the BOE, but if anyone outside of that list signs up they will be rejected because there are so many clinicians who are on this list.

There are eight potential classes to take throughout the next year, so there are plenty of opportunities. If anyone has any questions or concerns, Michelle suggested contacting the BOE. She will be happy to assist anyone with registering for classes. Ron Lawrence pointed out that many clinicians that are supervisors for drug and alcohol counselors are also supervisors through the BOE for social work and also through the American Association of Marriage and Family Therapists. That should count for something, since they are required to take supervision training through their own board every year. It is getting to the point that the burdens placed on them are absolutely not worth doing supervision. He wanted them to consider that it's coming to a point supervisors will be spending their entire time in training when they need to be in the field. He is a certified supervisor under the offices of the American Association of Marriage and Family Therapists and did 92 hours of training to get to that status. Frank agreed it was a good point. When he spoke at the BOE meeting on that issue he referenced the fact there was more than just a 10 hour CEU requirement for the same training they provided for the last 10 years. He doesn't deny people need more training; however, if they already have extensive training it should be taken into consideration in lieu of what needs to be done in the specific substance abuse piece. Steve Burt said the Board will take that into consideration. This is in the early stages. Ultimately, they've discovered the failure rate at the oral presentations has been increasing. While this has been under examination, they have noticed this is a colossal failure on the part of those supervisors who are sending those interns before the Board to give an oral presentation of a level never seen before, and the people are just not passing. This is an effort to hold the supervisors accountable, get them

under control, and to certainly approve supervisors through the other Boards that meet these requirements set forth because those are the CEUs approved by the BOE, as well. This is an effort to clean up the supervision of alcohol and drug counselors.

Michelle thanked Ron for his comment, and she will discuss it with the Board. Michelle asked anyone with questions to contact her.

17. **Review Possible Agenda Items**

- Sliding Fee Scale
- Performance Measures
- Health Care Reform Readiness Survey (Steve will distribute)
- Policy #10: Fiscal Monitoring – Risk Assessment

If there is anything else to add, email Deborah or Kim before the next meeting.

18. **Public Comment**

No public comment was made.

19. **Adjourn**

The motion was made by Lana Henderson-Robards and seconded by Ester Quilici to adjourn the meeting. The meeting was adjourned by Michelle Berry at 12:50 p.m.

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Testimony before the SAPTA Advisory Board
January 29, 2013

In October I sent the Board a letter about three problems with SAPTA's protocols for Sliding Fee Scale billing.

First, the SAPTA Sliding Fee Scale makes it impossible for treatment programs to comply with the fifth assurance given to SAPTA in the Notice of Subgrant Award for treatment programs, the assurance that they will bill according to a sliding fee scale "Based on the federal poverty level (FPL up to 400%) or local median income level."

But they must use the SAPTA Sliding Fee Scale, and it's not based on either. It's based on \$39,887, and that isn't the Federal Poverty Level for any size household, nor is it the median income for any county in Nevada. The SAPTA Sliding Fee Scale makes compliance with the subgrant condition of award impossible. The last legislative audit of SAPTA shows that the legislature thinks that compliance with subgrant conditions of award matters.

Second, while treatment is very affordable for clients who qualify for SAPTA-funded treatment under the SAPTA Sliding Fee Scale, scale, it's more difficult for a family to qualify than a solitary individual, and it gets increasingly difficult as family size increases. A solitary individual with income of 366% of Federal Poverty Level qualifies for SAPTA-funded treatment, while a person in a family of eight with income of only 107% doesn't.

Third, the Sliding Fee Scale policy regulates the collection practices of funded treatment programs only by prohibiting denial of treatment due to inability to pay. SAPTA informed me a couple of years ago that this isn't true, that a treatment program must offer an affordable payment plan to a client in arrears and can't summarily sue or refer the client to collections. Such a requirement would establish client fiscal responsibility while protecting the client and her family from undue hardship. Such a requirement doesn't exist.

SAPTA's protocols place every funded treatment program in noncompliance with subgrant condition of award. They exclude families from affordable SAPTA-funded treatment with increasing severity as household size increases. They allow summarily suing or referring to collections a client who falls into arrears.

A pregnant teenager in a family of eight with household income only slightly above the poverty level isn't eligible for SAPTA-funded treatment. The program can charge whatever its full fee-for-service rate is for those who aren't SAPTA clients. When her family inevitably falls into arrears, SAPTA protocols allows them to be summarily sued or referred to collections and only require that the unaffordable treatment continues to be offered. This isn't opinion. This is fact.

If the draft minutes of your last meeting are accurate, it doesn't appear that the Board sees any of this as a problem. I'm hoping you'll reconsider.

While you're at it, you may want to consider another problem that I didn't address because it would have become obvious to the funded treatment programs on the Board when they tried to implement SAPTA's Sliding Fee Scale protocols: They don't work. The Worksheet doesn't match the Sliding Fee Scale. For example, under the Worksheet clients with income above \$500 have a share-of-cost, while under the Sliding Fee Scale it's only clients with income above \$1400. For another example, according to the Worksheet an individual with an income of \$20,000 has a share of cost of 35%, but it's 30% according to the Sliding Fee Scale. Programs using the SAPTA Sliding Fee Scale Worksheet and Agreement haven't been billing many clients according to the SAPTA Sliding Fee Scale. If you think the SAPTA Sliding Fee Scale is appropriate, I should think that you'd at least want clients to be billed according to it.