MEETING NOTES

Statewide Substance Use Response Working Group Meeting

Tuesday June 7, 2022

9:00 a.m.

Meeting Locations: Offices of the Attorney General

- Carson Mock Courtroom, 100 N. Carson St., Carson City
- 3315 Conference Room, Grant Sawyer Building, 555 E. Washington Blvd., Las Vegas

Zoom Webinar ID: 959 7311 4867

Members Present in Las Vegas

Attorney General Aaron Ford, Dr. Leslie Dickson, and Assemblywoman Claire Thomas

Members Present in Carson City

Shayla Holmes, Erik Schoen, and Assemblywoman Jill Tolles

Members Present via Zoom or Telephone

Chelsi Cheatom, Senator Fabian Doñate, Gina Flores O'Toole, Jessica Johnson, Lisa Lee, Christine Payson, Steve Shell, and Dr. Stephanie Woodard

Members Absent

Barbara Collins, Jeffrey Iverson, Debi Nadler, and Senator Heidi Seevers-Gansert

Mercer Staff via Zoom

Dr. Courtney Cantrell

Attorney General's Office Staff

Rosalie Bordelove, Dr. Terry Kerns, and Mark Krueger

Social Entrepreneurs, Inc. Support Team

Crystal Duarte, Laura Hale, Kelly Marschall, Sarah Marschall, and Emma Rodriguez

Members of the Public via Zoom and Las Vegas

Tray Abney (Abney Tauchen Group), Sarah Adler (Belz & Case Government Affairs), Jeanette Belz (Belz & Case Government Affairs), Vanessa Dunn (Belz & Case Government Affairs), Joe Engle (TINHIH), Rhonda Fairchild (Behavioral Health Group), Mary-Sarah Kinner (Washoe County Sheriff's Office), Linda Lang (Nevada Statewide Coalition Partnership), Marla McDade Williams (DHHS), Kristen Pendergrass (Shatterproof), Jamie Ross (Drug Free Las Vegas), John S., Kimberly Sarandos (Join Together Northern Nevada), Tyler Shaw (FRPA), Lea Tauchen (Abney Tauchen Group), Joan Waldock (DHHS), Daria Winslow (Partnership Douglas County), and Dawn Yohey (DHHS)

1. **Call to Order and Roll Call to Establish Quorum**

   Chair Ford called the meeting to order at 8:00 a.m. Emma Rodriguez called the roll and announced that a quorum was established.

2. **Public Comment**

   Linda Lang, Nevada Statewide Coalition Partnership, thanked the Statewide Substance Use Response Group (SURG) Prevention Subcommittee for allowing the coalitions to provide a list of strategies and to present at their last meeting on some things that are very important to the field of prevention. She said it was much appreciated, and she thought it was a great conversation that she hopes will be taken into consideration moving forward.

   Kimberly Sarandos, Program Manager, Join Together Northern Nevada, read the following statement:

   Thank you for your consideration of prevention efforts in Nevada, and for your recognition of the outstanding work of the prevention coalitions in our state. I am here today to emphasize and recognize the importance of Adverse Childhood Experiences (ACES) to prevention work in the state of Nevada and particularly to Washoe County.

   The 2019 Youth Risk Behavior Surveillance System (YRBS) ACES special report suggests that the prevalence of each of the measured ACEs among high school students in Washoe County are higher or similar to the state overall, with the exception of high school students who have ever seen or heard adults in their home slap, kick, punch, or beat each other up which is considerably higher for Nevada. In Washoe County, 34.7% of high school students ever lived with someone who was depressed, mentally ill, or suicidal, and 32.2% of high school students ever lived with someone who was a problem drinker, alcoholic or abused street or prescription drugs. Both metrics are higher than Nevada.

   The state of Nevada ranks higher in ACES than the national average in almost every category and we believe that prevention is tied directly to the mitigation of these traumatic experiences. We embed trauma informed instruction in our activities and are sensitive to stigma in our work. Coalitions work in the trenches with students and family in our communities and know through data and anecdotal experiences that family bonds, meaningful conversation, sense of community and evidence-based programing are key to lifting our children up and helping them to live a successful, holistic life.

   Pediatrician Nadine Burke Harris engaged in a Ted Talk about trauma and pediatric disorders such as ADD, ADHD, Obesity, etc. regarding ACEs data, and she encapsulates prevention perfectly. She says, "One of the things they teach you in public health school is that if you are a doctor and you see 100 kids drinking from the same well and 98% develop a sickness, you can go ahead and write that prescription for dose after dose after dose of antibiotics or you can walk over to the well and say 'what in the world is in this water'. Prevention coalitions in Nevada look into the well; on a daily basis we ask ourselves what is in here and how can we help from the source?

   I know that when my staff makes a connection with a child, or JTNN provides training to counselors on ACES strategies, or we have a conversation with a parent who is at their wits end we are crawling into that hole, and we are reaching for traumatized people to help them out at the very beginning of the continuum of care. I can say with certainty that trauma informed services and ACEs mitigation are a hand out of the darkness. Prevention Coalitions in Nevada and our many community partners engage in structured, meaningful, data driven work that provides a hand out of the darkness and increases community capacity to be that hand for all walks of life.

   Thank you for your time.

3. **Review and Approve Minutes for March 9, 2022 SURG Meeting**

   Chair Ford requested a motion to approve the minutes.

   - Dr. Dickson made a motion to approve;
   - Ms. Flores-O'Toole seconded the motion;
   - The motion passed unanimously.

4. Update on Opioid Litigation, Settlement Funds, and Distribution

Chair Ford noted the timeliness of this agenda item, in relation to recent news articles, and he affirmed the importance of open discussion to answer any questions, concerns or complaints.

Chief Deputy Attorney General (DAG) Mark Krueger, Consumer Counsel for Board of Consumer Protection, Office of the Attorney General, reviewed slides[1] and reported recent movement on the settlements with Johnson and Johnson ($53,508,792.64) and a separate settlement ($231,679,409.03) with the three big distributors: Mckesson, Cardinal Health, and AmerisourceBergen, for a combined total of $285,188,201.67. All of it must go to abating the epidemic that the SURG members and others are working on in Nevada.

An initial payment of approximately $50 million was received from Johnson and Johnson, with a subsequent payment in April 2025 for the remainder. The distributor settlement will be paid out with 18 payments over a little less than 18 years, with the first two payments for a combined total of $20,000,298 coming in June and July 2022.

The One Nevada agreement combined all the litigating cities and all 17 counties to allocate funds through settlements or bankruptcy, with a couple of bankruptcies that are still being wrapped up. This will encourage working together to fight the epidemic, requiring that funds be used for abatement purposes, coordinating efforts statewide. All signatories will provide annual reports to ensure the money is being used for the correct purpose.

Lead litigator costs of $16,538,249.51 were taken off the top, before allocation of funds, as a generally accepted practice.

Chair Ford clarified that these costs are separate from attorney fees, including for discovery, reviewing documents with terabytes of information. Typically, the Attorney General's Office would incur these costs and would have to go to the Board of Examiners for approval, but they do not have the staff to manage the volume for these settlements, so they secured the services of a very reputable firm through an open contracting process. All costs are associated with getting the $45 million from McKinsey, and the $50 million plus from Johnson and Johnson, and the $285 million from the distributors. This information is available to the public through this meeting and will be reflected in the minutes.

Chair Ford offered to clarify any questions people have, again noting that attorney fees are separate – they are not $16 million and will not be $10 million under the Johnson and Johnson settlement.

Mr. Krueger added that their offices are working very hard to keep the costs down. The $16 million for costs is a large number, but this is a huge case, and Nevada's costs have been lower than some of the other states that are similarly situated. At one time, they hired 91 attorneys to help review and redact information collected from the state, mostly at $55 per hour, with four reviewers at approximately $95 per hour.

Chair Ford emphasized that $55 is a very low hourly rate for an attorney, compared to the $400 per hour rate he charged when he was in private practice.

Mr. Krueger reiterated the terabytes of information reviewed, working out to millions and millions of pages.

Mr. Krueger went on to review the Fund for a Resilient Nevada (FRN) created by SB390 to allocate funds to the state for damages. It goes through the One Nevada Agreement allocation and then is managed by the Department of Health and Human Services (DHHS), to be used only for abatement of the opioid epidemic. The Needs Assessment and State Plan required under SB390 identify programs and services needed throughout the state to abate the opioid epidemic and will set new priorities every three years. Cities and counties may also do needs assessments, but it is not required. Most counties are working with the Nevada Association of Counties (NACO) to coordinate these efforts with DHHS.

[1] Mr. Krueger's slides are embedded with the full slide deck for this meeting, which are available online at: https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/

Assemblywoman Thomas asked how funds are distributed to local governments. Dr. Kerns also asked about the timeline for the county needs assessment. Mr. Krueger referenced a report to the Attorney General's Office on the use of funds that is part of an annual report. The state report is due at the end of June or early July, but there is no timeline for counties. He reiterated that DHHS is coordinating with counties.

Mr. Krueger explained that attorney fees of $5 million will not be taken out from the first McKinsey payment, so that as much of these funds as possible can go toward addressing the problem as early as possible. Those fees will be incorporated in the second payment. Then there will be costs between $7 million and $10 million on the first Johnson and Johnson payment. For the distributors' payment, there are no costs coming out, but there are still fees for approximately $3.5 million for the first payment, and approximately $3.7 million for the second payment. The total initial estimated deposit to the FRN in July 2022 would be $44,772,121.14 with slight adjustments up at the end of June.

Vice Chair Tolles thanked Mr. Krueger and reviewed some of the figures for clarification. Mr. Krueger reviewed figures at the top of slide #14 (#21 in full slide deck), reiterating set-costs to move the litigation forward, the total allocated amounts, then attorney fees that come out of that, then estimated additional allocations. In the second part of the spreadsheet, there are no hard costs, but there are fees. The total amount on the bottom is $285,188,201.67. You can see when payments are expected and the amount that should be made.

Vice Chair Tolles had additional questions about where all the funds are going. Mr. Krueger clarified that slide #14 (#21 in full slide deck) shows total monies coming in, whereas they also need to look at allocations under the One Nevada agreement, with allocations to all the counties, in addition to the state. They needed the counties, the cities, and the state to all work together to agree to the settlement. The cities and counties were tiered in to determine the maximum amount of dollars; without those cities and counties, the dollar amount would have gone down. The One Nevada agreement allowed them to get the maximum settlement. The allocation agreement then allocates that money further.

Chair Ford compared this process to going to the Interim Finance Committee of the legislature to ask for funds necessary to complete the work to get the settlement. He said they have to spend money to make money, as far as the $10 million in costs go, which the state would have had to pay for, irrespective of outside counsel.

Vice Chair Tolles asked if they would see this pattern continue where they only deposit a third of what was allocated or is it just that costs and fees are more with the first payment. Chair Ford said his experience has been that you have more costs up front, gearing up with discovery, reviewing documents, and taking depositions. Those costs will transition to new types of costs, such as experts to review data and testify, but they usually are not as high.

Mr. Krueger referenced slide #16 (#23 in full slide deck) representing allocations after the One Nevada agreement, which gives 43.86% of each recovery to the state, after costs are removed. Then a percentage of the money gets allocated to the cities and the counties, per the agreement available online at: https://ag.nv.gov/Hot_Topics/Opioid_Epidemic/.

Most of the signatories' fees are around 25%, so Nevada at 19% is already under the rate for most local governments. However, the MDL (multidistrict litigation) Judge in Ohio ordered that as part of the settlements, but he has no authority over states or local government. So, he can only order local governments to cap those fees at 15%. All the states, collectively, got a certain percentage of the settlements. Nevada's settlement agreement is one of the most robust, with 43.86% going to the state for a net allocation to the FRN of $97 million. The one caveat is that SB390 did permit an 8% administrative fee for managing the funds, but it may not be that high.

Vice Chair Tolles expressed appreciation for Mr. Krueger's detailed explanation which addressed her concerns, and she also expressed her appreciation of Chair Ford's explanation of costs versus fees.

Chair Ford reiterated the importance of the One Nevada agreement with the state, cities, and counties to get the higher settlement. Other states have requested guidance from Nevada. The original allocation from the McKinsey settlement was $6.5 million; Attorney General Ford was the only one among the states and territories who said "no." Through separate negotiation, they got $45 million, with the help of outside counsel. Chair Ford is happy to

address questions, and he stands behind the work his office has done and what Mr. Krueger has accomplished, bringing in over $320 million. They will continue to work as hard as they can to bring that money in and ensure that it goes toward opioid abatement, rather than to the state general funds.

Dr. Dickson asked what kind of oversight there is for county and local government. Chair Ford reiterated that they can create Needs Assessment Plans and work with the state to do comparable efforts. Mr. Krueger recalled that all the signatories to the One Nevada agreement are required to report on their expenditures, annually. They also must comply with the underlying settlement. Dr. Dickson asked for specific names of who is responsible at the county level. Mr. Krueger referred to NACO and DHHS working with the counties. Some counties have health departments, others have points of contact to help manage the funds. They are encouraged to work together and collaborate within geographic areas.

Ms. Lee referenced the millions of people who have been affected personally by this crisis, including those who lost their lives. The victim impact statements during the bankruptcy hearing included hours of testimony. She hasn't seen a lot of discussion around allocations for victims of this crisis. She wondered if anyone has an answer.

Chair Ford said he appreciates that others on the SURG committee have similar questions, but his office is responsible for litigating the settlements to go to the FRN. The SURG could make recommendations to consider giving money to the victims, but it is not in the purview of the Attorney General's Office to say funds will go to a specific victim in a specific amount. It is not like a class-action lawsuit. This is a state action that brings money to the state to determine how to spend it. The state is looking at social services costs and health costs, but the SURG could make a recommendation to them.

Mr. Krueger has gotten similar questions, and he did hear the testimony of victims at the bankruptcy hearing. There are all kinds of entities and people who have been impacted by the opioid epidemic. The state has incurred costs in trying to abate this epidemic; so too have local governments and individuals. The Attorney General's Office is required to represent the state and to make recoveries on behalf of the state, just like actions by the counties and cities. Some of the programs that will be funded with this money will help individuals, but it doesn't pay back individuals for their costs. The programs and services are needed for abatement. The actual settlement, with distributors and Johnson and Johnson, included the multidistrict litigation where private lawsuits and class actions ended up. So, there is some consideration being given to those private causes of action for recovery of costs. Other amounts go to states and counties.

Chair Ford gave a made-up example of suing "Acme Corporation" for widgets that were defective, as part of a multi-state action. They could break down how many widgets were sold, and which Nevadans purchased them. In that type of lawsuit, money received would be given to individuals. This opioid lawsuit relates to state damages; how much we had to expend as a state to assist individuals who were encumbered by the opioid crisis. These are qualitatively different types of lawsuits.

Ms. Johnson thanked Chair Ford and Mr. Krueger for the presentation and asked how locals and counties know how much funding they will receive.

Mr. Krueger said there is an individual slide for every signatory to explain what they will be receiving. He is waiting for the actual costs at the end of June to finalize the actual dollar amounts, pursuant to the Nevada One agreement. Chair Ford gave an example of "Acme County" getting a specific percentage, after costs, based on the agreement.

Ms. Johnson thanked them for the explanation and appreciated the timeline for when the amounts might be available. Mr. Schoen had the same question and appreciated the response. Mr. Krueger reiterated the final slides would be available in July.

Chair Ford thanked Mr. Krueger for his presentation and reiterated the importance of this discussion and the transparency of the process for getting funds for the state. Mr. Krueger added that SURG members should be proud of this process, getting a lot of funds coming into the state for abatement. They aren't done with the process,

but they still have a lot of defendants left and hope to continue to bring in settlement funds. Vice Chair Tolles added her thanks to Mr. Krueger for his presentation and his work.

5. Review Timeline and Process for SURG Meetings and Recommendations.

Vice Chair Tolles reviewed benchmarks to reach the deadline for a report by January 31st. The next three months are crucial for participation and active engagement of all SURG members. The expertise of the members needs to be incorporated into this work and the final product. This is an ongoing committee under the statutes, to continue with recommendations as the issue evolves and impacts lives with new challenges, such as fentanyl. Some recommendations will come after the first set of recommendations in January, to do a deeper dive and evaluate how to better coordinate between agencies or among state, local and federal jurisdictions, continuing to research best practices. So, the committee will prioritize recommendations from each subcommittee for the first report in January.

Vice Chair Tolles reviewed the work to date, with establishment of subcommittees in March, followed by meetings and presentations from subject matter experts (SMEs) in April and May. Initial recommendations from SMEs and subcommittee members were documented for Subcommittee Chairs to report out.

Over the next two months subcommittees will hear from additional SMEs, with discussion and consideration of priorities to potentially bring forward to the state, to the Governor and to the legislature. Then the full SURG will meet in September to discuss recommendations to be refined, rejected, accepted, or amended. Additional refinements can be made through subcommittees in October and November, coming back to the full SURG in December for the last round.

The report will be drafted by the team of consultants and staff for review and approval in January.

Chair Ford thanked Vice Chair Tolles and explained that state agencies have an earlier deadline for submitting bill draft requests for the legislative session, but maybe they could submit a general placeholder pertaining to substance use and abuse.

Dr. Woodard confirmed that DHHS also has the latitude to include a recommendation in their allotment of bill draft requests, and she noted that the Interim Committee on Health is also very interested in what the SURG might identify as key potential legislative policies to move forward.

Chair Tolles explained that the first four bill draft requests from legislators are due by August 1st, but the second allocation for the Assembly is due by December 10th, with one more available within the first week of the legislative session, which would be February 13th.

Chair Ford acknowledged these options for later submissions, but he didn't want to put legislators on the SURG committee on the spot to commit to allocating their bill draft requests for the SURG recommendations.

Ms. Lee asked about the intersection between the SURG and the Advisory Committee for a Resilient Nevada (ACRN) for sharing information or making recommendations.

Dr. Woodard explained they were careful in the legislation to ensure intersection between the SURG and the ACRN, but the SURG is more global whereas the ACRN is focused on providing recommendations to the DHHS on allocation of funds, specifically for the FRN, whereas the SURG is much broader and more global. There is an opportunity for them to communicate and share information, including updates on the Needs Assessment and State Plan, including some recommendations, later in this meeting agenda.

Dr. Kerns said she attends both SURG and ACRN meetings and there are often cross-references for members to review meeting materials and testimony. There could also be a joint meeting if that would help in terms of sharing information and understanding their respective tasks. She said that it is not the case that the ACRN is looking at funding and the SURG is looking at policy.

Dr. Woodard clarified that the ACRN makes recommendations to the DHHS, along with other entities they are statutorily required to consult with. She has also been attending both the SURG and the ACRN meetings, and she is working with Dr. Kerns to bridge the communication between the two groups with updates. Recommendations for funding can also impact policy. For example, the definition of paraphernalia included policy changes to get funding out into the community, after the last legislative session.

Dr. Kerns referenced amending prior legislation and Chair Ford clarified that you would still need a bill draft request.

Chair Ford called a recess at 10:22 a.m. and called the meeting back to order at 10:30.

6. Update from SUG Subcommittees: 1) Prevention; 2) Treatment and Recovery; and 3) Response

Senator Doñate introduced himself representing Senate District 10 and serving as Chair of the Prevention Subcommittee. He recognized members of the subcommittee, noting their subject matter expertise. He reviewed the slides documenting the work of the subcommittee meetings in April and May with presentations from Dr. Woodard, Dr. Grigsby (UNLV Department of Social Behavioral Health), and Linda Lang and Jamie Ross from the Nevada Prevention Coalition.

Senator Doñate referenced primary, secondary, and tertiary prevention to structure upcoming meetings for policy discussion and proposals, including health literacy, reporting mechanisms and data infrastructure, grant funding, screening and integration of behavioral health, and payment mechanisms. A lot of programs nationwide are geared toward primary prevention, but not as much is being done in secondary prevention, so that is an avenue for innovative work. Tertiary prevention includes harm reduction and naloxone distribution. Senator Doñate referred members to the slides for details of recommendations submitted to date, including workforce development, social determinants of health, and childhood development.

Assemblywoman Thomas also recognized the subject matter expertise of her subcommittee members and participation from members of the public. Presenters for April and May included Dr. Woodard, Dr. Kerns and Dr. Dixon on Medication Assisted Treatment (MAT). She referred to the slides for upcoming presentations and recommendations from members of the subcommittee, as well as from the Interim Standing Committee on Health and Human Services (IHC).[2] She asked members to independently rank their preliminary top five recommendations, to see where there is consensus on priorities among members, noting they will continue to add recommendations moving forward.

Assemblywoman Thomas reported three recommendations around increasing access to MAT; one is to engage people with lived experience in program design and another relates to providing linkages to care referrals and follow up for special populations. Other recommendations include workforce, addressing children and youth treatment recovery services, promoting parity in behavioral health coverage, and using the hub and spoke model. The final weighted recommendations focus on strategies to prevent and treat black, indigenous, and people of color (BIPOC) at risk for fatal overdoses; and working to expand certifications to increase the workforce for treatment and recovery. Additional recommendations were identified from the IHC. They look forward to hearing more presentations and bringing top recommendations to the next SURG meeting in September.

Assemblywoman Tolles is grateful for the input of subcommittee members and their expertise, as well as other subject matter experts. They also received an overview from Dr. Woodard in April, along with an overview of the work of the Nevada Department of Sentencing Policy from Executive Director Victoria Gonzales. In May they had presentations from Law Enforcement Agencies on the kinds of issues they're seeing and preliminary recommendations to address those concerns. Their next steps will look at local jurisdictions' response to substance use issues, hearing from city and county representatives working on innovative programs, discussing economic and public health impacts. In August they will do a deep dive on theories regarding at-risk populations and the child welfare system. They will also review the conflict between the Good Samaritan laws and drug induced homicide laws. Their recommendations will be finalized for September.

[2] Joint Interim Standing Committee on Health and Human Services
https://www.leg.state.nv.us/App/InterimCommittee/REL/Interim2021/Committee/1914/Overview

Assemblywoman Tolles reminded SURG members they can look at all the recommendations along with resource links, other evidence-based programs, or sample legislation. Members can add their comments to support discussion for the later meetings, with a chance to identify any questions or concerns. That homework will make the process more efficient. The recommendations submitted have not yet been discussed, but they include some from the Interim Standing Committee on Health and Human Services, as well as other presentations. They want to make sure they're not doing too much crossover. One particular recommendation would adjust penalties for trafficking fentanyl where current statutes start with anything up to 14 grams, which has a potential to kill 6995 people; then from 14 to 28 grams has a one to four-year penalty, but has the potential to kill 13,998 people; then from 28 to 42 grams has a penalty of one to ten years, potentially killing almost 21,000 people; then from 42 to 700 grams has up to 15 years penalty, with the potential to kill 50,000 people.

Chair Ford asked Vice Chair Tolles if they are contemplating specific recommendations for how to adjust the penalties. Vice Chair Tolles confirmed that intent, but they haven't made final recommendation decisions. They will be discussing appropriate adjustments based on information they receive.

Assemblywoman Thomas asked if that requires a bill draft request to amend. Chair Ford confirmed that it does, noting that he has heard this request from many law-enforcement and non-law enforcement entities, so he is very interested in these recommendations to adjust the filters down.

Vice Chair Tolles reviewed additional recommendations from member Shayla Holmes including crisis outreach response teams to availability of lockdown. She is glad they are reviewing recommendations across the subcommittees and would like the consultants to help identify areas of overlap so that they can coordinate and avoid duplication before September. She looks forward to seeing what everyone comes up with.

Chair Ford emphasized how busy the subcommittee members are, doing great work. He also gave kudos to Dr. Kerns who is attending meetings everywhere.

7. **Review Statewide Needs Assessment for the Advisory Committee for Resilient Nevada**

Courtney Cantrell, PsyD, Mercer presented slides on the updated Needs Assessment and the gaps they have identified so far, along with the scoring methodology for recommendations to include in the report. The structure has changes since their last presentation: Section 1 is on background; Section 2 describes the methodology for the Needs Assessment; Section 3 addresses the opioid impact in Nevada with statistics and breakdowns of who is impacted, who is overdosing, what other drugs are involved, the availability of opioids and other drugs, and the impact on behavioral and physical health. Section 4 goes through the current system, addressing opioids, including primary, secondary, and tertiary prevention, and harm-reduction, and the various treatment and recovery places in Nevada and social determinants of health. Then they end the report with recommendations.

They reorganized the report after presenting to the ACRN, to identify gaps for each section, where they have identified some level of need, but not necessarily things that are missing completely.

Dr. Cantrell reviewed data gaps:

> The Prescription Drug Monitoring Program (PDMP) has some robust tools, but additional demographic information could help identify those in need of some intervention on a geographical or cultural basis, with outreach related to data on prescription monitoring. It's hard to identify who's pregnant from the data, but focused efforts could help. Health outcomes in substance use services is a really big area that a lot of states struggle with; Nevada could use more data on people who are being treated for opioid use disorder (OUD) to know what's working or not working. Identifying specific substances involved in suicides would be good to know, and then additional information on people who are using opioids such as their co-morbid physical disorders or their co-occurring mental health disorders. More detailed breakdowns and data reports that address race and ethnicity, housing status, veteran status, pregnancy status, LGBTQ+ status, and any immigration status would be helpful. A lot of these are incredibly hard data to pull, but the state should consider them to try to find ways of incorporating this data into their reporting to better identify health disparities, and tailor efforts towards addressing them.

The next section Dr. Cantrell reviewed was prevention gaps:

Although there is a lot going on with public education at the county level, more is needed because kids are still reporting high and early use of substances, including prescription opioids. There is partial implementation of the Zero Suicide initiative, but full implementation is recommended to incorporate from prevention all the way through after care for suicide. While prescription drug disposal is robust in some areas, it is needed in other areas. Education on treatment options is needed, especially for those without housing and in rural areas. Education is needed for high school students to talk with their health care provider about pain management and prescription drugs. A lot of people with lived experience are still reporting challenges with stigma, having difficulty obtaining and keeping housing and jobs, and having anxiety over seeking help. This is especially true for veterans, tribal members, and people in rural areas where everybody knows everybody else.

Another area for prevention is provider and prescriber education to address expectations of chronic pain and how to cope with it, including utilization and referral for pain management options like physical therapy or chiropractic care. Some negative attitudes from health care providers have been reported by people with health conditions and a history of opioid use, which can distract from their current health condition. Programs like Project ECHO (Project Extension for Community Health Outcomes) help build competency with more information and understanding around pain management issues and opioid prescribing.

Every state has a lot of treatment gaps and limited resources, including insufficient healthcare workforce that existed prior to the pandemic-related workforce tightening. National data show significant disparities across treatment areas for ethnic minority youth, but the data are limited for Nevada. Peer support is wonderful, but it's missing through the entire treatment continuum. There's also a need for more community-based and accessible resources for people released from the criminal justice system. Providers certified for evidence-based treatment of co-occurring disorders are needed, especially for youth with high anxiety and an opioid use disorder that feed off each other. More screening, identification and referral to treatment is needed, based on very low numbers of Medicaid claims.

Outpatient treatment gaps include medication assisted treatment (MAT) and office based opioid treatment (OBOT) that are needed in primary care settings, along with referral to therapy, especially in rural areas. Follow up mental health treatment is needed both during and after MAT, with a strong relationship between mental health disorders and substance use disorders. Formal collaborative care is needed for individuals at risk for suicide.

Withdrawal management, inpatient and residential, are higher levels of treatment. Information for Nevada suggests community support during detox is lacking, but it's necessary. There's also a need for more short-term and long-term rehabilitation beds, especially for youth, which is common in a lot of states. Given the level of exposure among youth, there is really a need for more of those treatment facilities because you don't want them mixed in with adults and different treatment is needed. Again, services are more limited in rural and frontier areas of Nevada, and the cost of transportation is an issue.

The crisis system in Nevada is progressing with 988 mobile crisis response, crisis stabilization units and zero suicide, rather than sending people to the emergency department with no follow up. However, there are still gaps and more services are needed.

Discharge recovery support is needed to address a risky period for people who have just finished treatment. More funding and insurance coverage is needed for long term care and recovery, with residential programs to support sober living before people go back out into the community independently. Some surveys show inadequate discharge planning, with limited communication and coordination between levels of care, particularly for those released from the criminal justice system. A lot of overdoses happen when someone with OUD before they went to jail or to prison returns to the community after having been off opioids. They don't realize their tolerance has gone down, so exposure is a greater risk. More 12-step groups are needed in rural areas, along with educational support, parenting support, and health insurance education about recovery.

Harm reduction and social determinants of health are important for saving lives. When people are still using, we still want to give them enough chances at life to get into recovery in the future, and provide supports like housing, transportation, food and safety that a lot of us take for granted, but greatly affect health care and health outcomes. It's really hard to recover if you don't have these basic needs met. Innovative programs for needle exchange, vending machines, and naloxone distribution and education are especially needed in rural areas, with greater availability.

Dr. Cantrell explained that Mercer developed a scoring methodology for over 90 recommendations identified working with ACRN and the state. Each recommendation is rated based on impact, urgency, feasibility and whether it's one of three legislative targets: overdose prevention; addressing disparities in access to healthcare; and prevention of substance use among youth. The recommendations can be sorted by any of these factors, as well as by the total score. In addition, they will be categorized by allowable expenditure categories in the legislation that is also in a Johns Hopkins guide.

Dr. Cantrell was scheduled for another public presentation to the ACRN on June 8th, planning a deeper dive into the scoring methodology with the 90 recommendations. The Needs Assessment was still being refined and finalized over the next few weeks, with the recommendations appended to the report. The Statewide Plan will also have those recommendations prioritized with additional elements from the state.

Ms. Lee referenced the gap of inadequate data for pregnant[people with OUD, noting that pregnancy status is captured upon admission or discharge, but not in between. They do collect data on a ton of other factors. There are limited family-friendly options for treatment and recovery centers. It becomes a nightmare, especially if child welfare is involved, and reunification plans don't always go well. This is a huge gap in Washoe County. To disrupt intergenerational cycles, they really need to talk about family friendly recovery environments.

Assemblywoman Thomas asked about the status of the 988 roll-out in Nevada, noting that she heard other entities are experiencing a backlog.

Dr. Woodard explained Nevada has had a statewide crisis call center for many years, so they are converting from the ten-digit telephone number for the national suicide prevention lifeline to the three-digit 988 line. Additional funding for the existing program came available in April to supplement current staffing to take calls and provide follow up in case management. They are also finalizing a request for proposals (RFP) to identify a statewide program to take over a more robust call center function and provide a crisis care hub to identify available services within the crisis system and to deploy mobile crisis teams for crisis stabilization. They feel relatively well-prepared to bolster staffing for crisis support services while continuing to build out the entire crisis continuum of care.

Dr. Kerns referenced readiness and acceptability of different programs in different communities, such as vending machines that may work better in Las Vegas or Reno than other areas. Providers might know about prescribing medication for OUD in emergency rooms, but they may not be ready for it.

Dr. Cantrell described the recommendations as coming from a 30,000-foot level, with some specificity, but not necessarily at the regional or county level. They give enough flexibility to identify where to implement programs and counties can also apply for funds, so there is potential for local funding and progress with their coalitions.

8. Review and Consider Items for September 22, 2022, SURG Meeting

Vice Chair Tolles referenced the timeline, noting that the purpose of the September meeting will be to discuss and take possible action on subcommittee recommendations, to accept, amend or reject for the time being. She anticipates this being a lengthy process to go through each recommendation, to consider them and refine them into a rough draft.

Chair Ford indicated that he might not be able to attend on September 22nd. Vice Chair Tolles recommended finding another date that works for Chair Ford.

9. Public Comment

Rhonda Fairchild, Behavioral Health Group, thanked all the subcommittees for their hard work and thanked staff in the Attorney General's Office for their transparency with online materials for people who can't attend. She said

that September 29th is usually the last day of the grant year and then they start over in October. She asked if this funding would be available for grant year 2023 or 2024.

Chair Ford referred Ms. Fairchild to offline resources.

The meeting was adjourned at 11:27 a.m.

Zoom Chat Record

- **Kimberley Sarandos**
  i Do
- **Steve**03:06:39
  I apologize I have to leave now. Great meeting!