STATE OF NEVADA SUBSTANCE ABUSE WORKING GROUP

MINUTES OF MEETING

December 8, 2016 – 9:00AM
(Minutes approved at the 2/8/17 Meeting)

Location of Meeting:
Office of the Attorney General
Mock Courtroom
100 N. Carson Street
Carson City, NV 89701

Videoconference to:

Office of the Attorney General
Grant Sawyer Building
555 E. Washington Ave., Room 4500
Las Vegas, NV 89101

1. Call to order and roll call of working group members.
Assistant Attorney General Wes Duncan called meeting to order. Secretary, Marissa Houk, called roll.

Members present:
Adam P. Laxalt, Attorney General – Chair
Wesley Duncan, First Assistant Attorney General – Vice Chair
Mark Jackson, Douglas County District Attorney
Linda Lang, Executive Director, Nevada Statewide Coalition Partnership
S. Paul Edwards, General Counsel, Nevada Board of Pharmacy
Dr. Stephanie Woodard, Department of Health and Human Services
Chuck Calloway, Las Vegas Metro Police Department (LVMPD)
Pat Hickey, Executive Director of the Charter School Association of Nevada
Dr. Miriam Adelson, Adelson Clinic
Jeff Menicucci, Board Counsel

Members Absent:
Dr. Larry Pinson, Executive Secretary, Nevada State Board of Pharmacy
Richard Whitley, Director, Department of Health and Human Services

Others Present:
Michele Smaltz, Executive Assistant to Attorney General Adam Laxalt
Marissa Houk, Legal Secretary ll, Office of the Attorney General
Stacy Ward, Drug Abuse Prevention Coordinator, Street Enforcement Team
Elyse Monroy, Policy Analyst, Office of Governor Brian Sandoval
Jim Wright, Director, Department of Public Safety
Yenh Long
Jeanette Belz
Jennifer Snyder
Catherine O'Mara
Kathleen Conaboy
Shelly Capurro
Lea Tauchen
Chelsey Parvin

2. Public Comment.

No public comment from Carson City or Las Vegas.

3. Discussion and possible action on approval of October 5, 2016, meeting minutes. Attachment A. (FOR POSSIBLE ACTION).

David Marlon moved to approve the Minutes of Meeting as written. Chuck Calloway seconds the motion. Motion passes unanimously.

4. Presentation regarding the "Effect of Non-Scheduled Urine Drug Tests among All Students in a Private High School." Dr. Miriam Adelson/Las Vegas. Attachment B. (DISCUSSION ONLY)

Dr. Miriam Adelson's presentation and slide show focused on the effect of random drug screens on a population of adolescents attending a private high school. Dr. Adelson's presentation began by tracing brain development from adolescence to maturation in adulthood. Dr. Adelson provided statistical information showing that the earlier teens use any substance, the greater the risk for addiction. Further information showed that most illicit drug use begins in the teenage years and that prevention and intervention in adolescents can be most effective for curbing lifelong abuse. Drug screens can be an effective tool in identifying students who have started using drugs needing to be referred to a drug-counselor, identifying existing drug addictions, and to deter students from taking drugs. Currently, most drug-testing in the United States is "for cause" and few schools have started or intend to start random drug-testing. Dr. Adelson stated that if they concentrate on this age, drug abuse can be reduced in America. If a positive result is shown, the student is retested and prescriptions verified.

Chuck Calloway asked Dr. Adelson how the self-reporting did not match the results of the urinalysis tests. Dr. Adelson answered that an example could be that a child reported smoking one puff of marijuana and the test showed as negative or someone could lie and say that they hadn't ingested drugs when they actually had.

5. Presentation on Fentanyl abuse. Dr. John DiMuro, Nevada State Medical Officer/Carson City. Attachment C. (DISCUSSION ONLY)

Dr. John DiMuro is dual certified in anesthesiology and pain medicine and uses Fentanyl in his practice every day and that it is a misunderstood drug. Anyone who has had a surgery has probably been given a dose of Fentanyl and as a result, does not remember their surgery. Fentanyl is a Schedule 2 opioid analgesic with a high abuse potential but when used appropriately can be a very effective anesthetic. It is the most potent opioid used in general practice in the United States, most commonly in the operating room. Ideally, it should be given by anesthesiologists or registered nurse anesthetists due to potency and its rapid onset. Dr. DiMuro continued his presentation with an explanation of drug Schedules. He explained that Heroin is a classic Schedule 1 and that Schedules 2 through 5 are most commonly used for pain. Fentanyl is a small step below heroin. Morphine, Demerol, and Dilaudid are drugs typically seen in the operating room.

Dr. DiMuro explained the various ways of administering Fentanyl: it can be mass produced and supplied as a powder, liquid, transdermal gel patch, lollipop, mucosal patch, or a nasal spray. Two major characteristics of Fentanyl are its potency and rapid onset of action. It can be a hundred times more potent than morphine; 20-50 times more potent than heroin; and it is very cardiovascularly stable, meaning it keeps the heart pumping and functioning instead of depressing function. It can be used as an

intravenous anesthetic, to treat cancer pain, as a skin patch pain reliever, as a sedative for medical procedures, and for illicit drug use. Some side effects associated with opiate use include decreased respirations, sedation, urinary retention, nausea, dry mouth, constipation, decreased blood pressure and heart rate, drug-drug synergy, and addiction or rapid tolerance.

Dr. Dimuro explained that there are several aspects that together, make up the "Fentanyl problem." Originally, the drug was marketed and used to treat malignant pain. Today, it is being marketed and used to treat non-malignant pain. There is a dispute among doctors as to how it should be properly used. Fentanyl patches are easy to misuse and patients may give them to family members instead of using the patches themselves. Powder forms may be purchased overseas and placed into other illicit drugs to add a synergistic effect to the high. Fentanyl saturates body fat and withdrawal effects can be delayed, especially in patients with higher amounts of body fat. Dr. DiMuro reported that anesthesiologists have the highest addiction rate in the field, and Fentanyl is the drug of choice.

Dr. DiMuro suggested several possible corrective actions including capping prescriptions at a 365 per year supply called the "Prescribed 365 Initiative," point-of-service tests, outreach education, enhancements to the Prescription Drug Monitoring Program (PDMP), access for first responders to the PDMP, Board reviews of high-prescribing doctors, greater access to recovery programs and Vivitrol.

Pat Hickey asked what the desirability of the drug is? Dr. DiMuro answered that it is an intense, euphoric high. Linda Lang asked Dr. DiMuro to expand on Naloxone and Narcan and explain the differences to Fentanyl as a rescue drug. He explained that Narcan reverses the opiate attachment to the receptor and that patients who have been using Fentanyl for a long period of time will require a higher dose of Narcan, which may only be a temporary solution. Paul Edwards asked Dr. DiMuro if Karafan is related to Fentanyl and if so, to provide information on their relation. Dr. DiMuro explained that Karafan is basically a Fentanyl on steroids that is even more potent. The problem with Fentanyl analogs is that they are very difficult to test for. Others analogues include Carfentanyl, Sufentanil, Alfentanil, and Remifentanil.

Dr. Stephanie Woodard asked Dr. DiMuro to discuss the differences between point-of-service tests and typical toxicology screenings. Dr. DiMuro explained that a standard toxicology screen involves the urine being sent out to a laboratory to be tested. A point-of-service test involves a pee cup with reactive strips that instantly provides in-office results. These tests are more cost effective and give providers immediate test results. Lang asked for clarification on the Prescribed 365 Initiative. Dr. DiMuro explained that the idea is for the number of prescriptions prescribed to a patient not to exceed the amount that they can take within a year. The PDMP could be a tool to prescribers in determining appropriate prescriptions for their patients. The PDMP could also be used to determine prescribers that over-prescribe to their patients. Hickey asked if insurers would cover drug screen costs. Dr. DiMuro explained that an incentive to the insurance companies would be the low cost of the point-of-service tests at around $20.00, as opposed to the more expensive laboratory tests that could be in excess of $3,000. Prescribers would not be required to use point-of-services tests over lab tests, but would have the option between the two tests.

It is noted that Attorney General Adam Laxalt arrived in Las Vegas.

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6. Discussion and presentation on alternative methods of pain management. Dr. Dan Burkhead/Las Vegas (DISCUSSION ONLY)

Dr. Dan Burkhead is an anesthesiologist board certified in fellowship training in pain management and has been in practice for seventeen years. His presentation focused on alternatives to opiates for the treatment and management of pain. Dr. Burkhead explained that other doctors refer patients to him and other pain management clinics. Their goal is to locate the source of pain and treat it to help patients with non-malignant pain stop or reduce the use of opiates. Medicaid, Medicare, and insurance companies have made dramatic reductions on how they will approve intervention treatments and physical therapy, meaning the patients and physicians are often limited by coverage and out-of-pocket expenses. Some alternatives in pain treatment include anti-seizure medications for neurological pain and sciatica; anti-depressants; oral steroids; and Tramadol.

Three generalized categories that have shown success in the treatment of pain are conservative measures, injection treatments, and surgery. One type of injection is the Selective Nerve Route Block to treat pain caused by herniated discs. This is accomplished by injecting a steroid through a needle into the tissue surrounding the nerve under X-ray guidance stopping the pain. Dr. Burkhead explained that this type of injection treatment has shown to be successful but Medicare limits the amount of Nerve Route coverage to two. This leaves untreated sources of pain after the procedure affecting the over-all quality of care available to the patient.

Another type of injection treatment involves treating the Facet Joints where pain is a result of joint deterioration. A needle can be placed directly into the joint and a steroid injected. Another procedure involves short circuiting the nerves that carry pain to the joint allowing the patient pain relief for up to a year. Another procedure to treat compression fractures is Kyphoplasty. This procedure involves a tiny straw being inserted and cement being injected into the vertebrae stabilizing it. Doctors are again limited by coverage with this procedure. Another type of treatment is Spinal Cord Stimulators. Two leads are inserted into the epidural space behind the spinal cord providing low voltage stimulation to the spinal cord fooling the nerves into thinking there is a vibratory sensation as opposed to a pain sensation. This has shown to be very successful, but is limited by coverage and expense. Other less used or discontinued practices for treating pain includes Percutaneous Discectomy or Disc Decompression, and Thermography procedures.

If a patient goes through conservative treatment and injection treatment without success, the next option would be surgery, however, spinal surgery is limited by coverage and cost. Dr. Burkhead explained that the health and best-interest of the patient is increasingly being affected by the care covered for the patient. A movement in Oregon is trying to stop all intervention treatments and spinal injection procedures because they have a small pool of evidence showing injections to be ineffective. Dr. Burkhead says there is more evidence showing that these injection treatments do work and believes that removing an option of pain treatment will negatively affect patients. Doctors are being pressured to stop prescribing opiates to their patients but are simultaneously being increasingly limited in what alternative treatments are covered for these patients.

Dr. DiMuro stated that he has spoken with the International Spine Injection Society and the Chief Medical Officer in Oregon about the movement in the state and believes the issue comes from the abuse and misuse of injection treatments by fellow anesthesiologists. He stated he is supportive of trying to address the issue of misuse with these professionals, but does not want to see injection treatments stopped all together. Dr. Burkhead agreed that addressing the problem physicians specifically would be a better method.

Dr. Adelson asked Dr. Burkhead if he tells his patients a head of time if he knows

he is unable to treat all of their sources of pain. Dr. DiMuro stated that he has heard some patients will sign advanced beneficiaries but most do not because of the concern of Medicare investigating this practice as fraud. Dr. Adelson asked Dr. Burkhead how long he has been in medicine. Dr. DiMuro answered approximately seventeen years. Dr. Adelson asked Dr. DiMuro how he has seen changes in the field. Dr. DiMuro answered that, especially in the last six years, there have been many restrictions and limitations put on the doctor.

7. Discussion and possible action on coordinating emergency medical services and law enforcement in emergency treatment of certain drug overdoses. Richard Whitley, Director, Department of Health and Human Services, Medicaid Division; and, Jim Wright, Director, Department of Public Safety, Emergency Management Services/Homeland Security/Carson City. (FOR POSSIBLE ACTION)

Jim Wright discussed the importance information sharing between emergency medical personnel (EMS) and law enforcement, and the barriers that need to be broken in order for the information to be shared effectively. Throughout counties in the state, there is little sharing between EMS and law enforcement. One of the first barriers is HIPPA. Wright expressed that there is no desire to violate an individual's rights, but the information could, in the right context, be lifesaving. He provided an example of how it could be effective: if law enforcement is aware that a large shipment of heroin has arrived in a community and that information is shared with the volunteer fire department in the area, the first responders are more likely to be prepared for a potential overdose of heroin.

Attorney General Laxalt asked for clarification as to the "gap" between EMS and law enforcement and what specific information may be shared. Wright explained that the most important information would be what specific substance is the cause of the overdoses. One obstacle is that information-flow could be hindered by the amount of time it takes for labs to return test results showing the substance causing an overdose.

Dr. Woodard reported that she reached out to the Centers for Disease Control and Prevention (CDC) to better understand how information could be shared between EMS and law enforcement for a coordinated response. An example of successful information sharing was found in New Jersey where a synthetic Fentanyl had shown up in the community. Police and first responders were first on the scene to provide a reversal to those overdoses. They were able to alert the Public Health Official of the substance and the additional Naloxone it required to counter-act the overdose, potentially saving lives. States with information sharing usually have a Public Health Coordinator and a law enforcement Coordinator to facilitate the coordinated response.

Attorney General Laxalt expressed interest in a half-day summit to put together an information sharing agreement between EMS and law enforcement. Jackson commented that many representatives from EMS and law enforcement attend a meeting addressing Legal 2000 and that it may be appropriate to use that venue. He also expressed the importance of EMS and law enforcement sharing information with the Public Health Official to inform the public.

Dr. DiMuro explained that PDMP can be a tool to law enforcement when responding to a suspected overdose. Washoe County Detention Facility currently has a mobile data terminal that could be utilized to access protected information. Enhancing the PDMP would make information sharing more effective. Jackson agreed that better access to PDMP would be beneficial and that there should be a plan in place to address

synthetic drugs.

Calloway stated that during the last legislative session a bill was proposed to allow law enforcement to access the PDMP. The Pharmaceutical Board previously allowed access but discontinued after they were advised it could cause legal problems. The bill passed but was written to only allow access to detectives assigned to investigate prescription medication cases. Further, he does not believe it is mandatory for doctors to participate in the PDMP. Senate bill 459, passed during the last legislative session, indicates a prescriber is supposed to check PDMP before writing a new prescription or making changes to an existing one. Lack of evidence of a crime can hinder law enforcement's ability to do follow up after a suspected overdose.

Dr. Adelson commented that there is a methadone clinic in Las Vegas and that the PDMP can be misleading. Discussion was held among the group members about drug-testing and the PDMP. Edwards commented that there are two lawsuits he is aware of involving unlawful access to the PDMP program. If legislation needs to be changed, this group should try to make those changes. Attorney General Laxalt asked if there are any current bills that are close enough in language regarding the PDMP and limited exceptions for first responders where additional access can be added. The draft-language is to be brought back in February, 2017 so that it can be reviewed and ready for legislation.

Wright closed his presentation with comments regarding the importance of sharing information between EMS and law enforcement statewide.

8. Presentation on Recovery High Schools for Nevada. David Marlon, Chief Executive Officer, Solutions Recovery/Las Vegas. (DISCUSSION ONLY)

David Marlon stated that Solutions Recovery is a drug and alcohol treatment center in Las Vegas with four-hundred (400) beds. Marlon reported that there is an effort to bring a recovery high school to Las Vegas. This school would provide an environment for students in recovery to receive an education in a drug-free environment. Currently there are thirty-two (32) recovery high schools in the country with another hundred pending. The Clark County School District has identified potential sites for this school. Dr. Adelson stated that she had previously tried to offer her idea to public schools but there wasn't any response. After the efforts failed, she does not believe this will be successful. Marlon stated that Solutions has also had a limited response to treatments for individuals under 18.

9. Presentation on Roseman's Adolescent Drug Use Study. David Marlon, Chief Executive Officer, Solutions Recovery/Las Vegas. (DISCUSSION ONLY)

Marlon explained that the results from this survey are obtained from a 45 minute survey from six schools and will be available for the next meeting.

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10. Brief update on fact-finding legislative visit to Colorado regarding recreational marijuana. David Marlon, Chief Executive Officer, Solutions Recovery/Las Vegas. (DISCUSSION ONLY)

Marlon stated that this agenda item may be mute with the passing of question two. Attorney General Laxalt commented that he would like to put forward a proposal

from the Working Group on the language regarding Question 2 should proceed. Formation of a smaller working group was discussed and this working group would be in contact with Colorado as to some of the problems they faced.

Calloway reported that the Las Vegas Metro Police Department (LVMPD) put together a recreational advisory board regarding marijuana and would like participation from throughout the state. The advisory board's first priority will be advising law enforcement as to how these changes affect daily practice and what can no longer be enforced. The bill has some vague language that is unclear to law enforcement. The Legislative Council Bureau is to advise LVMPD with short term direction. Attorney General Laxalt commented that many of the answers to these questions may not be addressed until this next session.

11. Discussion on possible regulatory and legislative proposals for the 79th (2017) Session of the Nevada Legislature after passage of the Nevada Marijuana Legalization Initiative, Question 2. The Honorable Pat Hickey. (DISCUSSION ONLY)

Hickey referenced the Memorandum from Smart Approaches to Marijuana (Attachment D) and commented that this may become Nevada's "marijuana session." According to the Memorandum, public health and safety advocates should hold the majority of seats on any advisory committee. Taxation is coming up with regulations under guidance from administration.

Attorney General Laxalt requested formation of a sub-committee focusing on marijuana and discussed having Wes Duncan draft a letter on behalf of the Working Group to the Legislation to address important points and concerns. Duncan will draft a "letter of concerns" on behalf of this group for circulation to other sub-committee members.

12. Update on proposed meeting dates for 2017:

* Weds., February 8th – 10:00
* Weds., March 29th – 10:00
* Weds., June 21st – 10:00
* Weds., October 11th – 10:00

It is noted that no action was taken on this agenda item.

13. Public comment. (Discussion Only) Action may not be taken on any matter brought up under public comment until scheduled on an agenda for action at a later meeting.

No public comment from Las Vegas or Carson City.

14. Adjournment.

Meeting adjourned by Attorney General Laxalt at approximately 11:00 a.m.

Minutes submitted January 27, 2017 by Marissa Houk, Legal Secretary II, Office of the Attorney General.