MEETING NOTES

Statewide Substance Use Response Working Group Meeting

Wednesday, April 8, 2026
2:00 p.m.

Meeting Locations:

Offices of the Attorney General:
100 North Carson Street
Carson City, NV 89701
Mock Courtroom

McCarran Center - State of Nevada Campus
1 State of Nevada Way, Suite 100
Las Vegas, NV 89119
Conference Room 225/226

Virtual via Zoom

Note: All presentation materials for this meeting are available at the following link: https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/

Members Present via Zoom or Telephone
Robert Banghart (joined at 3:02 p.m.); Dave Briggs (joined at 2:13 p.m.); Chelsi Cheatom; Dr. Jose Maria Partida Corona; Assemblymember Rebecca Edgeworth; Assemblymember Heather Goulding; Peter Handy; Nicole Hicks; Shayla Holmes; Stacey Lance; Kyra Morgan (joined at 2:08 p.m.); Senator Dina Neal (joined at 2:04 p.m.); Wendy Nelsen; Rosa O'Bannon; Christine Payson; Steve Shell

Members Present in Las Vegas
Attorney General Aaron Ford, Guiseppe Mandell, Jessica Johnson, and Bud Schawl

Members Present in Carson
Noël Chounet

Members Absent
Stephanie Cook and Senator Jeff Stone

Attorney General's Office Staff
Terry Kerns; Chief Deputy Attorney General Mark Krueger; Deputy Attorney General Joseph Ostunio; Ashley Tackett; and Teresa Benitez-Thompson

Social Entrepreneurs, Inc. (SEI) Support Team
Kasey Docena; Crystal Duarte; Deanna Lyons; Kim Hopkinson; and Mary O'Leary

Other Participants via Zoom or in person
Linda Anderson; Jess Angel; Ayla Babakitis; Chyna Balzer – Nevada (OD2A-S); Casey Barber; Dave Briggs; Lori Bryan; Lea Cartwright - Cartwright NV Government Affairs; James Dardis – Nevada; Denise Davidson; Mark Funkhouser; Tina Gerber-Winn; Dr. Daniel Gerrity; Shayla Gransbery; Patricia Hanisee; Christine Jones (CJ) Brady; Lisa Kelso; Dr. David Marlon; Abe Meza - Nevada - Substance Use Treatment- Program Coordinator; Anne-Elizabeth Northan; Ferrari Reeder; Jamie Ross; Kimberley Sarandos; Katie M. Snider, Ph.D.; Cynthia Stephenson; Maureen Strohm; Karina Tomco; Samm Warfel NDVS (she/her); Dawn Yohey
Unless otherwise identified, members of the public are listed as their name appeared on Zoom.

1. Call to Order and Roll Call to Establish Quorum

Chair Ford called the meeting to order at 2:00 p.m. Crystal Duarte (SEI) completed the roll and confirmed a quorum.

The Chair shared that if a Member must depart a meeting prior to adjournment for any reason, the Member shall formally announce their departure for the record to ensure accurate minutes and to allow the Chair to confirm that a quorum remains in accordance with Nevada's Open Meeting Law. SEI also noted this in the chat.

The Chair announced that Senator Neal, who is the newest Member of the SURG, was appointed by the Senate Majority Leader.

With that, the Chair moved to agenda item #2.

2. Public Comment

The Chair read public comment guidance and asked for public comments. He noted the comment in the chat that asked Members not to use the chat for anything other than technical assistance requests. Anything in the chat becomes a part of the public record and may not be available to anyone who is calling in. Things that are put in the chat may not be visible to people who call in by phone, so it can create challenges in ensuring everyone receives the same information. Therefore, he kindly reminded everyone to use the chat only for technical assistance requests only.

Guiseppe Mandell thanked everyone for their time, efforts, and being a part of this true civil service. There was no public comment offered in Carson.

Kim Hopkinson (SEI) also noted in the chat: "*Please do not use the chat for items other than technical support, as this becomes part of the public record. The meeting chat functionality is limited to inquiries regarding technical difficulties or to indicate an interest in offering public comment. Exercise caution with links which may appear in any meeting chat as they could be malicious.*"

Seeing or hearing no additional public comment, Chair Ford moved to agenda item #3.

3. Review and Approve Minutes for January 14, 2026, SURG Meeting

Chair Ford asked for a motion to approve the minutes. The Chair indicated that the minutes will be updated to include a meeting location of "virtual via Zoom." Members were asked to please state their name and the specific motion they are making to maintain the public record.

Crystal Duarte (SEI) noted that one version of the meeting notes was sent out noting a Zoom meeting ID that was incorrect, but this has been changed. It now just lists the two public meeting locations, physical locations, and a section stating that the meeting occurred on Zoom. The Chair said that this is the version that should be approved along with any other edits.

- Bud Schawl made the motion to approve the minutes
- Guiseppe Mandell seconded the motion.
- The motion carried unanimously.

Before the presentation began, Crystal Duarte noted that Subcommittee Member Kyra Morgan had their hand raised to indicate that she joined the meeting at 2:08 p.m. Chair Ford moved to agenda item #4.

4. Status Update from the Fund for Resilient Nevada

Dawn Yohey thanked the members and the SURG. She introduced herself as the Clinical Program Planner with the Department of Human Services (DHS), Fund for a Resilient Nevada (FRN), in the Director's Office. She noted that this report to the SURG fulfills the Annual Requirements for NRS 458.490.[1] Ms. Yohey described that her presentation would review the FRN Annual Report, the One Nevada Signatories report to the FRN, as well as the Fund for Resilient Nevada dashboard. She began to describe the statewide funding priorities, which were listed in the PowerPoint slides.

The FRN wanted to highlight certain findings around overdose deaths. Overdose deaths and opioid involvement have continued to increase in Nevada between 2023 and 2024. Some provisional 2024 data indicated that there were 1,253 overdose deaths statewide, representing a continued upward trend, with 792 deaths involving opioids. But the growth rate for synthetic opioids has slowed. The Nevada High Intensity Drug Trafficking Area (HIDTA) continues to identify fentanyl as a high threat due to widespread availability and low cost. However, deaths related to synthetic opioids, including fentanyl, only increased by 7% from 2023 to 2024. Opioids continue to pose a disproportionate risk, for families and children involved in the child welfare system. Overall, methamphetamines, cocaine, and heroin remain high-threat substances.

Following this, Ms. Yohey described several funded programs and gave an overview of their progress reports. One of the programs highlighted was the UNLV wastewater program, which is a partnership between Southern Nevada Water Authority, the Southern Nevada Health District, UNLV Center for Water Intelligence and Community Health, as well as the University of Nevada, Reno. They have built an integrated wastewater monitoring program to detect opioids and other high-risk substances among youth and transitional-aged youth on college campuses. She noted that in Southern Nevada, in 2025, they completed a pilot study manuscript.

The publication includes the study of high-risk substances on university campuses in Southern Nevada, including important lessons learned for future campus-based wastewater monitoring. Detections of opioids and related metabolites and other high-risk substances in campus wastewater illustrate how campus-based wastewater monitoring can capture substance presence and use that may help inform future public health activities. Other upstream monitoring assessments of individual residence halls revealed consistent detection of methadone, as well as its metabolites, in specific dorms throughout the fall semester. Cocaine and related metabolites were also elevated in the same housing. These findings inform new interventions and strategies with student health services, including targeted harm reduction programming, pain management education, naloxone availability, as well as counseling.

These results were shared with the local health department, the mobile crisis intervention team, and the university's student wellness team to create a direct pipeline for wastewater signal to student-facing public health response. They are developing a new dashboard, to provide an interactive visualization of the drug analyte concentrations across monitoring sites and time points. These new efforts are being developed to deploy and monitor additional substances, which have not been detected in dormitories yet.

This program is in year two, and expands to additional Nevada University campuses, incorporating composite sampling and broadening the analyte panel to address emerging threats in the drug supply. This program also aims to extend wastewater-based drug monitoring to all high schools across Nevada, positioning the state among national leaders in campus-based surveillance for youth substance use prevention.

[1] Link to NRS 458.490 - Report by Department of Human Services to Working Group concerning use of certain money: https://www.leg.state.nv.us/nrs/nrs-458.html#NRS458Sec490

Ms. Yohey then shared some photos of the drug analytes from April 2026 and continued to outline another funded program.

The recommendations noted in the report were to maintain the current funding strategies and/or decrease funding efforts, based on sustainability or changes in need. The FRN is going to complete their program evaluations within the next few years to ensure that money is appropriately spent. Additionally, they are currently revising their needs assessment and statewide plan. They are still identifying priorities with the Advisory Committee for a Resilient Nevada (ACRN), their advisory committee, as well as other partners for future funding.

Ms. Yohey stated that the last part of the report details their expenditures through fiscal years 2023-2025. To read the full information provided by Ms. Yohey, please review the PowerPoint slides in the attachments for the SURG meeting. The Chair paused for questions.

Kyra Morgan introduced herself and stated that she was with the Division of Child and Family Services (DCFS). She asked, when looking at wastewater surveillance, if they could compare that to a benchmark. When looking at university housing versus the community, she wanted to know if the level of fentanyl in university wastewater was higher than what is found in the general community setting. Or these were detected at the same levels or lower levels. She was curious if that was indicative of higher use on the university campus than elsewhere.
Ms. Yohey was unsure of the answer at that time but emailed the study author, Daniel Gerrity, PhD, PE, the Principal Research Microbiologist at the Southern Nevada Water Authority, Water Quality R&D, who provided a response.[2] This information was also provided directly to Member Morgan.

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[2] Following the meeting, Dr. Gerrity provided the following response to Member Morgan's question: "…it can be challenging to directly compare wastewater-based concentrations at upstream/high-resolution locations (e.g., university campuses) vs. community-scale samples (e.g., from a wastewater treatment plant). Results from the campus pilot study vs. the corresponding sewershed *[sic]* are discussed in more detail in the FRN-related publication, *Piloting Wastewater-Based Monitoring on a University Campus to Inform Public Health Surveillance and Response for Opioids and Other High-Risk Substances* , available at https://doi.org/10.2166/wh.2026.182. The community-scale/sewershed study was published previously and is available at https://doi.org/10.1016/j.scitotenv.2023.168369.
This is due to several factors, including significant differences in the size of the contributing population, dilution from other flows in the sewer system, and degradation of certain compounds in the sewer system.

In community-scale samples, we expect to see cocaine and/or its metabolites (e.g., benzoylecgonine) in just about every sample collected, so assessing changes in concentration becomes more important for understanding changes in consumption within the community. In the past, this was also true for fentanyl and its major metabolite norfentanyl, at least in certain parts of Southern Nevada. At the campus level, you have a much smaller population that is less likely to be consuming/exposed to certain compounds on a consistent basis. Therefore, detection frequency can be a more reliable indicator than concentration, particularly for compounds that are rare (e.g., heroin and its metabolite acetylmorphine). In other words, any detection, regardless of concentration, might be actionable for the highest risk compounds. Concentration trends may be valuable at the campus level for compounds that we detect more frequently (e.g., methamphetamine). Lastly, the 2025 pilot study was a first step toward understanding and characterizing baseline detection frequencies and concentrations for local campus wastewater. Now that we are in year 2, we may be able to dive deeper into concentration trends (e.g., methamphetamine and cocaine-related compounds), but we'll still be relying mostly on detection frequency for the opioids (e.g., fentanyl/norfentanyl) when we share the data with our public health partners."

The Chair called on Member Chounet. She had a question about the overdose data. She was curious about the delay, since she is new to the Committee. She wanted to know if it was normal to have preliminary data from a year and a half ago project how programs and funding can be established going forward, especially if the data isn't finalized. Ms. Yohey said yes, it's customary. She handed it to Member Morgan for further clarification.

Member Morgan shared that if they look at the mortality data that is kept in the state from vital records, they can report about six months later, because that is how long it takes for autopsy results to populate. If they look at overdoses in the context of hospitalization, those are even quicker. They can look at those at a three-month delay if it is a non-fatal overdose. She believed that Ms. Yohey's was speaking to a data set that is reported to the Centers for Disease Control and Prevention, and where they perform a data quality initiative to reconcile with the medical examiners directly. There is a whole process. She believed the data that comes out of that specific system is the longer delay that Member Chounet was referencing, which is out of the control of the state. Member Chounet thanked her.

Response Subcommittee Chair Kerns believed that the program that Ms. Yohey highlighted with the wastewater was a recommendation that came out of the 2024 SURG Annual Report.

Ms. Yohey moved to the next portion of the presentation and noted that she was not going to mention everything in the slides due to time constraints. She gave a high-level overview of the One Nevada Signatories in the Northern and Southern counties, describing their project names and target populations.

Before proceeding to the FRN Dashboard, she paused for questions. Chair Ford called on Senator Neal.

Senator Dina Neal thanked the Chair. She asked if the FRN was able to receive data representing the actual impact of the dollars. Specifically, what changed after programs have received funding.

The FRN requests that information from the counties to incorporate that data into their yearly report. If any money was spent, they are asked to describe what the outcomes of the services were. Ms. Yohey said that information is not available on the PowerPoint slides, but she does have some of that information, not all of it. Senator Neal requested Ms. Yohey to share what she has available, and Ms. Yohey agreed.[3]

Member Johnson thanked Ms. Yohey for the wonderful presentation. She asked for clarity on the difference between administrative expenses and total expenditures.

Ms. Yohey explained that all of the dollars from any of the recoveries come with an 8% administrative cap, or it depends on bankruptcy, the court order, or the settlement. For the most part, FRN caps everything at 5%, because they don't want to go over a 5% administrative cap—like an indirect (expense). and the actual expenditure is what they spent on the program, and then the administrative expenses must be at or under is the 5% cap. Member Johnson thanked her.

The Chair stated that Ms. Yohey exceeded the time allotted but let her finish. Ms. Yohey quickly walked through the FRN Dashboard[4]. Chair Ford expressed that he liked the transparency and ability to see how much funding has already been received and allocated. He asked if other Members had questions.

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[3] Following the meeting, Ms. Yohey updated the slides to answer Senator Neal's question regarding the impacts of programs that receive FRN funds. These are found in the attachments for the SURG meeting.
[4] Link to the FRN Dashboard: https://app.powerbigov.us/view?r=eyJrIjoiMzg2MDYzYzEtNmQwYy00NjYwLTk1MDgtYzJiY2VjOGVjZmJkIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

Member Johnson referred back to the first part of her presentation, where Ms. Yohey stated that the FRN team is undergoing the follow-up needs assessment. She was curious about the timeline and whether the plan was to complete this needs assessment by the end of this calendar year or fiscal year. She also asked Ms. Yohey to walk Members through the next steps and the ACRN's goals.

Ms. Yohey shared that the needs assessment is due this summer. This effort is supported by Heather Kerwin, their epidemiologist. Additionally, she announced that there is a survey that is about to be distributed for Members to fill out to identify what they believe are needs and priorities, to report what they see in the community. The FRN will take this information as part of their community-based participatory research. Ms. Kerwin has had conversations with community leaders, as well as individuals who have been impacted by substance/opioid use, to figure out what they believe are important measures that the FRN needs to include in the needs assessment. Then the plan will be completed by December of 2026. She stated that she or Ms. Kerwin will distribute that information to the Committee.

Response Subcommittee Chair Kerns said that the survey link has been sent from Heather to us already, so all the SURG Members will receive an email with that link from the SEI Team. Ms. Yohey thanked her for the update and asked Members to fill it out. The more information the FRN receives, the better.

The Chair asked if there were any additional questions. Crystal Duarte said she didn't see questions online or in Las Vegas. But she noted that Member, Dave Briggs, joined the meeting at around 2:13 p.m. She also said that these slides will be made available to the public on the SURG website with the other materials. The Chair thanked her, then Member Chounet had a follow-up question.

Member Chounet loved the dashboard and how interactive it was. She glanced at several different goals in the current fiscal year of 2026. She noticed a trend of a significant budget, but very few dollars spent, despite being almost six months into this fiscal year. She wanted to know why the funding spent has been low so far. Ms. Yohey noted that some contracts were carried out a little bit late, so this may be impacting on some of the spend-down. The FRN has updated this as frequently as possible, but some providers have not turned in their billing. Other larger-amount awards have not been executed yet, also impacting the spend-down.

There were no follow-up questions. The Chair asked if Ms. Yohey wanted to add anything, she declined and thanked everyone. With this, the chair moved to Agenda item #5.

5. Presentation on State Budgeting Process

The Chair introduced Christina Hadwick, the Deputy Director of Fiscal Services at the Department of Human Services (DHS). Ms. Hadwick thanked everyone for the opportunity to present on the budgeting process and overview of our Fund for Healthy Nevada (FHN). She noted that this fund is overseen by the Department of Human Services Director's Office. Much of the funding is allocated to Division of Public and Behavioral Health, ADSD (Aging and Disability Services Division), and some of it is within their Grants Management Unit at the Director's Office. She provided a brief introduction of FHN¸ stating what it does, the statutory authority, where the revenue is generated and how that revenue has declined, which has resulted in reductions to funding programs.

She described in further detail that they receive the Tobacco Master Settlement Agreement Funds (MSA) projections for the current fiscal year from the State Treasurer's Office in August of each year. Then, the revenue is not actually received until April of each year. For budgeting purposes, they historically based revenue projections on a three-year average. However, during the 2025 session, FHN began working with the State Treasurer's Office and discovered that the revenue projections for 2026 and 2027 were decreasing significantly, resulting in 12% cuts in each year of the biennium, with revenue continuing to decline. Their current projections show a cumulative decline of more than 31% from FY24 to FY29.

The FHN has projections from the State Treasurer's Office for their current budget build for 2028-2029, also showing a cumulative decline from FY24 over 31%. Ms. Hadwick noted that FHN keeps a reserve balance in this account equal to the following year's projected revenue for cash flow purposes, since the revenue does not come in until April of each year. So, that impacts the amount of funds that they have available to fund the required programs. Lastly, their administrative expenses are capped at 2% for the State Treasurer's Office, and then 5% for the Department of Human Services.

Ms. Chadwick shared the following funding recommendations:

- *Nevada conducts a statewide community needs assessment every two years.*
- *These assessments identify the most urgent health issues across the state.*
- *Those funding decisions are then guided by those findings and overseen by advisory groups like the Grants Management Advisory Committee (GMAC).*

She noted that the Department of Health Services is currently working on FHN's needs assessment to guide their funding decisions for FY28 and FY29, to be completed by June 30th, 2026. Once completed, they will develop a plan to determine the percentage of available money in the Fund for Healthy Nevada, how much can be allocated out for the purposes in NRS 439.630[5], paragraphs C through H. She proceeded to give an overview of the legislatively approved budget for FY24-25 compared to the legislatively approved budget for FY26-27. She provided visual examples of the programs that are required to fund per NRS, which include wellness, disability services, Senior Rx/Disability, senior independent living, assisted living, and then cessation.

She pointed out the decreases due to funding cuts that happened during the legislative session. Because the revenue is continuing to decline, she anticipated having additional cuts in FY28-29. However, the FHN has not finished our assessment of the FY28-29 budget. To read the full information provided by Ms. Chadwick, please review the PowerPoint slides in the attachments for the SURG meeting, found on the AG's website.

The Chair thanked her for the presentation. The Chair disclosed that about five days ago, his office got notification that the allocation this year from the Tobacco Master Settlement Agreement is about $32.7 million. This payment will come through on the 15th and the 21st, and the Fund for Healthy Nevada will receive 60% of that. If he understood, that's a decrease year over year, so he believed she was correct that a decrease will be shown in expenditures for that reason.

Senator Neal asked what the plan was. As Revenue Chair, that tobacco money is going away because prevention aims to decrease smoking in the community. Senator Neal wanted to know what the plan was to fund those services described in the presentation, if something is being put forward. She was curious if the FHN is going to get in front of the Interim Finance or Health Committees in order to present this budget, the sliding scale, and present how much is needed to maintain these programs, because there isn't another source of funding. Senator Neal believed these were important conversations to bring to the table for debate in 2027.

Ms. Hadwick shared that for FY26-27, the FHN is funded through the Budget and Fund for Healthy Nevada. But there are discussions they need to have for FY28-29. The funding cuts happened during the legislative session in 2025. They had to make quick decisions to make 12% cuts each year across the board.

[5] Link to NRS 439.630: https://www.leg.state.nv.us/nrs/nrs-439.html#NRS439Sec630

This time, they have more time to be thoughtful about it and get in front of those committees if needed. The reserve balance in their fund shows their funding extending to about the next ten years to fund these programs, but again, it is reduced each year. So, if they need to sustain these at higher levels, it would be another funding ask from different sources.

Senator Neal wanted to bring that up because interim committees are happening now. Each committee has a certain number of BDRs, but this is something that they need to get in front of any of the committees, by asking the Chair to get into the IFC (Interim Finance Committee) agenda. That way, there's an awareness for the Members on both sides of the committees who may not have seen this information, because the budget is massive. So, they may not recognize that these are cuts that they will either have to replace or deal with.

Ms. Hadwick thanked her for this and offered her contact information. With no further conversation, the Chair moved to the next presentation.

6. Presentation on Peer Certification

The Chair introduced Anne-Elizabeth Northan. Ms. Northan is the Project Director for the Nevada Certification Board (NCB). She was passionate about workforce development, and she was the previous Executive Director for the Certified Prevention Coalition in Washoe County and is currently a Certified Prevention Specialist. Ms. Northan works for the Center for Substance Abuse Technologies (CASAT) at the School of Public Health at the University of Nevada, Reno (UNR), and they manage the Nevada Certification Board, which has its own 501(c)(3) nonprofit with an independent board of directors. She noted that the presentation broadly describes peer information and additional information about the Nevada Certification Board.

The Nevada Certification Board provides community behavioral health professionals with certification, continuing education resources, and advocacy that validate their competencies to provide ethical, person-focused, and evidence-based services to meet the needs of vulnerable individuals in Nevada. Their credentials are considered community-based professionals, meaning they live and work in the community, have shared lived experience with those they serve, and contribute to community-driven solutions. Community Health Workers (CHW) are frontline public health workers who are trusted members and have a close understanding of the community that they serve. These kinds of trusting relationships enable CHWs to serve as a liaison for individuals between services and the community and improve quality and cultural competency of service delivery. She noted that this credential is specifically called out an NRS 449[6] and that NCB-Certified CHWs are Medicaid reimbursable.

Peer Recovery Support Specialists (PRSS) are individuals with lived experience in recovery from substance use, problem gambling, mental health, or other co-occurring challenges. Oftentimes, communities have a misperception that it is only recovery from substance use, but it is a broader field open to individuals who have lived experiences in a variety of areas related to mental and behavioral health. These professionals use their experience to provide support and hope for individuals to work through their own recovery. Their peer credential is affiliated with the International Credentialing and Reciprocity Consortium (IC&RC); therefore, they have reciprocity with other member boards across the United States. NCB holds the IC&RC membership for peers and prevention specialists, as there can only be one per state. Peers who hold NCB certification are Medicaid reimbursable. She shared other community-based professionals that they certify and provide endorsements for. These are listed below.

[6] Link to NRS 449: https://www.leg.state.nv.us/nrs/nrs-449.html#NRS449Sec0027

Certifications:

- *Community Health Workers (CHW)*
- *Doulas*
- *Peer Recovery Support Specialists (PRSS)*
- *Peer Recovery Support Specialist Supervisors*
- *(PRSS-S)*
- *Prevention Specialists (C-PS)*
- *NEW Family Peer Support Specialist (FPSS)*

Endorsements:

- *PRSS Problem Gambling*
- *PRSS Trauma Informed Care*
- *CHW Early Childhood Endorsement*

Then she outlined national affiliations, special populations, growth highlights, and evidence-based practices that are effectively working. She then discussed the following gaps:

- *National Credentialing Model for CHWs*
    - *IC&RC is beginning to engage in conversations around certifying which would continue to elevate the profession and ensure that the Nevada Certification Board, as the IC&RC Member Board, continues to serve this field with evidence-based best practice credentialing.*
- *National Credentialing Model for Doulas*
    - *There are several national foundational trainings for Doulas and in collaboration with the Doula field, NCB has maintained best-practices for this emerging professional credential. We consistently review research and work with Doulas to implement best-practice credentialing for our state.*
- *Employer Education*

Next, Ms. Northan shared the following recommendations:

- *Ensure Nevada Certification Board as an independent nonprofit continues to have the necessary authority and resourcing as the credentialing body for community-based professionals in Nevada. This continuity will further uplift and enhance certified professions under our purview, respond to community needs, and protect public safety.*
- *Peer workforce requirements to bill for Medicaid include prior convictions restrictions. They recommend reviewing, based on findings, potentially more specific requirements relating to type of conviction, recovery length, and other determining factors.*
- *Prevention Specialists were added to NRS 433*[7] *last session, and we recommend that additional language be added in NRS and/or NAC defining their role and supervision requirements specifically that a Prevention Specialist or Certified Prevention Coalition provide supervision.*
- *Pay parity across community-based certifications.*
- *Continue to enhance Doula profession through credentialing opportunities.*

To read the full information provided by Ms. Northan, please review the PowerPoint slides of the attachments for the SURG meeting, found on the AG's website. As Ms. Northan wrapped her presentation, she provided the references used and her contact information for Members. The Chair thanked her and asked if there were any questions.

[7] Link to NRS 433: https://www.leg.state.nv.us/nrs/NRS-433.html#NRS433Sec6255

Member Mandell had a question about employer education. He thanked her for all the work on the Peer Recovery Support Specialists (PRSS) certifications, as this is what started his career several years ago and is a walking example of how far someone can go being a Peer Recovery Support Specialist. He believes the certifications are important. The question on the employer education and the gaps was whether there were discussions of any type of incentivization for hospitals, employers, or other similar workforces on board.

Ms. Northan said this was a great question as this has been in discussion for a while. Some of the certifications, including peers, have been traditionally paid for through grant funds. As changes take place on the state and federal level, it's important to figure out how to incentivize and ensure that there's funding available for those positions within Medicaid reimbursement and external to Medicaid reimbursement.

There are a lot of opportunities for non-traditional placement within community-based organizations, not with billing capacity. But there are continuous discussions that are happening. He thanked her for the information.

Member Johnson said this was an excellent presentation and thanked her for her time. She echoed Mr. Mandell, saying that she was proud to be one of the first ten people to have a Certified Prevention Specialist credential in Nevada, and gave her kudos to their work. These have been priorities for this SURG in previous years outlined in the recommendations. She was interested in the third bullet point with the recommendations around Prevention Specialists. She wanted to connect with Ms. Northan to be a subject matter expert for the Prevention Subcommittee to help them better understand gaps in relation to this recommendation. She proposed that the Prevention Subcommittee could close that gap with a recommendation. She was also interested in learning more about the peer workforce requirements and where there are barriers to access, and if there's an opportunity for any of the Subcommittees to help address that gap.

Ms. Northan thanked her for the feedback and said she was happy to connect about the Nevada Administrative Code/Nevada Revised Statutes related to prevention with the Subcommittee. She is also learning that workforce requirements have come up in conversations. She believes to have seen it at five years post-conviction, and at ten years post-conviction. It was a broad recommendation because more research needs to be done on understanding barriers related to PRSS workforce requirements to pull in individuals with lived experience. [8]

The Chair asked if there were any other comments or questions. Member Schawl thanked Ms. Northan for this important work. The University Medical Center, particularly the Crisis Stabilization Center, have utilized PRSS extensively. The modification of the prior work experience/prior convictions (recommendation) is important to push. This change could help employ Peer Recovery Support Specialists directly within the medical centers and other areas that would otherwise prohibit bringing individuals in. He said he would be happy to work with her if needed.

[8] Following the meeting, SEI reached out to Ms. Northan for further clarification on this subject. She stated that this was in relation to peers and a recommendation to review background check requirements that exist in Medicaid. In some cases, there is a 5-10 year waiting period post-conviction and there is discussion amongst professionals that this could be reduced, and/or that there should be a scale of review for people with lived experience depending on the severity and nature of the crime. Ultimately, they want peers to come with lived experience, and that experience sometimes involves the justice system. Peers can be certified after two years of "recovery", but sometimes have trouble with employment, so this should be examined.

The Chair said he didn't want to speak for someone but felt confident that one person in the meeting, referencing Senator Neal, is always interested in talking about criminal justice reform issues that can possibly address some of the gaps that were just described. He wouldn't be surprised if she chimed in. "*No pressure, Senator Neal*", he joked.

Crystal Duarte also noted Member, Robert Banghart, joined the meeting at 3:02 p.m. She then pointed out there was a member of the public with their hand raised, and that it was noted that their comments would be reserved for the public comment period.

Member Nelsen gave kudos to Anne-Elizabeth, and shared that her organization has eight people going through the PRSS right now, as well as Community Health Workers. This has changed their workforce dramatically in the frontier area, and said this work is vital and thanked Ms. Northan for their efforts.

The Chair thanked Member Nelsen and reminded the person from the public to wait until public comment. He asked if there were additional questions. Hearing none, he thanked Ms. Northan for her presentation and offered a ten-minute break, and with instructions for Members to come back at 3:20 p.m.

7. Review and Discuss Preliminary Recommendations from Subcommittees (See slides for additional information)
The Chair introduced the agenda item and handed the floor to the Subcommittee Chairs.

Jessica Johnson thanked Chair Ford and the Committee Members. She noted that several new Members recently joined the Prevention Subcommittee and that their insight has fueled excellent discussions. There are two recommendations that they will present today, and shared that there are others currently being workshopped that will be discussed at a higher level. She read the first recommendation aloud:

Request guidance from the Nevada Board of Pharmacy be posted to their website and communicated to pharmacists to clarify regulations pertinent to the distribution of naloxone in hospitals to permit low barrier naloxone distribution from Emergency Departments (EDs) and permit EDs to adopt a naloxone-specific standard operating procedure (SOP) for public naloxone distribution, separate from and exempt from the regulatory framework surrounding hospital formulary medications used in patient care.

The Prevention Subcommittee has exchanged dialogue with the Board of Pharmacy. Hospitals who have reached out to the Board of Pharmacy have been given guidance that naloxone distribution isn't prohibited in any way, but there is a barrier around unclear information. Oftentimes, hospital pharmacists need clarity about who is managing the medication in the hospital. This recommendation would help close that information gap. Prevention Subcommittee Chair Johnson mentioned that their colleagues from the Bridge program in the state of California have relatively standardized language for the Board of Pharmacy.

Chair Ford asked where the information on the language could be found. Member Johnson said she believed the language was included in the background for this recommendation, in the compiled recommendations document that was provided by the SEI team.

The Chair asked if there were any questions and noticed Member Schawl nodding in agreement. Member Schawl agreed that providing the protection of clarity could help pharmacists, and the regulatory environment that hospitals operate under, to have that additional language. It was important for hospitals to be comfortable with this.

Chair Ford asked if people have previously been unsuccessful receiving guidance from the Board of Pharmacy. Member Johnson said that she was told that when hospitals reach out, they have great experiences with the Nevada Board of Pharmacy (BOP) through one-on-one conversations. There have been requests from individuals who are working on expanding naloxone access through hospital systems—an evidence-based process that reduces overdose deaths in many states. This guidance can be used as a reference rather than having to reach out and to talk with the BOP directly. There were no other questions, so they proceeded to the next recommendation. Prevention Recommendation #2 was submitted by prior Subcommittee Member Debi Nadler in 2024, re-elevated for 2025-2026 and is sponsored by Jessica Johnson. It reads:

Create a bill draft request to set aside cannabis wholesale tax to be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts.

For context of this recommendation, The Nevada Tobacco Control and Smoke-Free Coalition presented data on youth cannabis use, and the impacts specifically around vaping. The Coalition provided the Prevention Subcommittee with various recommendations about youth substance use, particularly around cannabis, nicotine, and the utilization of vapes or electronic cigarettes.

Member Johnson said those were the only two recommendations the Prevention Subcommittee had prepared for today but that they were drafting more. They opened the floor for discussion.

Member Johnson wanted to highlight a few of the drafted recommendations that were found in the compiled subcommittee recommendations document that was put together by the SEI team. One of the recommendations was around doubling funding for the state focused on prevention programming for people between the ages 0 to 24. Another one that was submitted by Stacey Lance will be a joint recommendation with the Response Subcommittee and Prevention Subcommittee.
There is an additional elevated recommendation based on conversations with ACRN and other groups related to the specifications of biannual naloxone saturation and distribution plan.

With no further discussions or questions, the Treatment and Recovery recommendations were presented.

Vice Chair Shell thanked Chair Ford and expressed his excitement at sharing the recommendations. He was going to echo what Ms. Johnson said, that there has been a lot of great energy within the Treatment and Recovery Subcommittee with new Members. He was also going to follow the same process of sharing the recommendations that they would like to bring forward for this year's reporting cycle and then give a quick overview of the other drafted ones to conclude. Vice Chair Shell read the first recommendation that was originally submitted by Chelsi Cheatom, now co-sponsored by Stephanie Cook.

A retrospective assessment or/and prospective study would be conducted to assess the outcomes of all patients following discharge from certified withdrawal management facilities within five years of discharge, including trends in the patterns of step down and use of MOUD, to examine potential contributors to overdose and develop best practices for continued care after treatment.

The Treatment and Recovery Subcommittee felt strongly that they are at a critical juncture to drill down on the data in Nevada and understand what contributes to overdoses in the state to lead to better strategic planning efforts. Other states have been doing this. For example, Connecticut has been successful with their studies through the years; they are one of the top states in the country in relation to mental health and substance use. Vice Chair Shell hopes the committee will agree to move this recommendation forward and is open to having conversations if needed.

Member Johnson asked if the committee considered any barriers to data collection for this recommendation. Vice Chair Shell said they have considered who should be involved. With Nevada being such a broad, huge state, he thinks data collection is critical but currently does not have other details to share.

Kyra Morgan reintroduced that she was with the Division of Child and Family Services. She mentioned that the Office of Analytics and the Nevada Health Authority do similar analyses. Sometimes, when DCFS contracts with specialists for evaluations, they go to the Office of Analytics for the data. Member Morgan recommended meeting with Madison Lopey, their Chief Biostatistician, to see what is available, and what resources they could help dedicate to that project.

Vice Chair Shell said he would take note of that great idea and thanked Member Morgan. He asked if there was anything else Members wanted to discuss regarding this recommendation. Response Subcommittee Chair Kerns shared that Chair Ford had to step out for a moment but told the committee to proceed. Vice Chair Shell moved to the second recommendation. He noted that this was a combination of recommendations from both himself and Dr. Jose Maria Partida Corona.

Recommend to the Nevada Department of Human Services that they incentivize the implementation of cohesive addiction consult services.

Hospitals would receive Department funds to hire peer recovery specialists, if they meet the following specific criteria: adoption of delineation of privileges for addiction medicine as a medical specialty, as well as established protocols for the inclusion of midlevel providers and peer recovery navigators.

Vice Chair Shell noted that in previous SURG meetings, there have been discussions about the challenges in emergency rooms around the state, but also the benefits of utilizing Peer Recovery Support Specialists (PRSS). Medicaid can reimburse PRSS, with some limitations, but other payers do not reimburse for the use of PRSS. So, the Treatment and Recovery Subcommittee wants to figure out a way to help hospitals stand up these types of programs. He noted that Dr. Partida Corona has added language that would require hospitals to follow the criteria that would help create a robust addiction consult service all around. The Subcommittee felt that this is a strong recommendation for everyone to consider. He offered space for Dr. Partida Corona to provide additional comments.

Dr. Partida Corona wanted to add the language to not just include peer recovery navigators, but Community Health Workers as well. He believed that Jamie Ross elevated this as well at a Treatment and Recovery Subcommittee meeting, and that this should be taken into consideration.

Vice Chair Shell thanked Dr. Partida Corona and said they could bring this up at the next Subcommittee meeting before presenting it to the full SURG in June. He asked if there were any other questions or comments regarding the Subcommittee's second recommendation.

Member Johnson said this was an exciting recommendation. She believed this fills a gap in the consideration of CHWs (Community Health Workers) regarding opportunities to expand the workforce across the state. She was curious if Vice Chair Shell or Dr. Partida Corona had thought about any supervision training that was presented by Anne-Elizabeth Northan—if that is included in the criteria for hospital trainings and ensuring support.

Vice Chair Shell said they have had some discussion around that. From his personal experience of using peers in an emergency room in Northern Nevada, the supervision piece is critical, and they could take note of that and figure out if there's a way to amend the language when the Subcommittee meets in May. He acknowledged that the supervision piece is critical to this. Member Johnson thanked him.

They moved to the third recommendation, which was originally submitted by prior Member Chelsi Cheatom, now co-sponsored by Member Guiseppe Mandell.

Recommend that state funding be increased for Contingency Management to be used to support people in recovery through rewards for reaching their recovery goals.

Vice Chair Shell noted that this is an evidence-based model that several states have in practice and that the Subcommittee felt that this could help efforts in Nevada. He asked Member Mandell for additional insight.

Member Mandell wanted to keep Member Cheatom, the champion of the recommendation, in mind. This recommendation was regarding reimbursement with clients or patients while they are in treatment or not. He asked that members just keep in mind it is under all the standards of what the law allocates, and no cash value or anything like that.

Vice Chair Shell thanked him and asked other Members for their input. Hearing none, he moved on to the fourth recommendation, out of five in total. The fourth recommendation was submitted by Dr. Partita Corona. The Subcommittee was excited that he submitted this.

Elimination of prior authorizations needed for starting medication assisted therapy with buprenorphine and buprenorphine products of all types for opioid use disorder. This would apply to all payors including Medicaid MCOs (Managed Care Organizations).

Vice Chair Shell described how prior authorizations for various services have been a long-standing issue around the country, so the Subcommittee appreciated Dr. Partida Corona bringing this recommendation forward. He asked if Dr. Partida Corona had anything further to add and noticed Member Cheatom had their hand raised.

Member Cheatom announced that she had to depart from the meeting early. Member Chelsi Cheatom departed at approximately 3:38 p.m. They wanted to continue the conversation but noticed Dr. Partida Corona was frozen on the screen. Vice Chair Shell asked if anyone else wanted to add comments.

Chair Ford wanted to know if there are other states that have already eliminated prior authorization for medicated assisted therapy for buprenorphine. Vice Chair Shell said yes, there are other states that have adopted this. That information is available in the justification materials provided in the compiled subcommittee recommendations attachment. Vice Chair Shell apologized for not knowing off the top of his head. They moved on to Member Chounet.

Member Chounet really appreciated the thoughtfulness and forethought behind the recommendation. She asked if there has been any discussion around expanding this to treatment in general. She has heard of some recent instances of challenges with access to treatment under the new MCOs in Nevada, regarding pre-authorizations. Vice Chair Shell shared that it has been part of the conversation in looking at all treatment settings. They know that prior authorizations create unnecessary delays, no matter the level of care. He offered that the Subcommittee would take a closer look at that when they meet again.

Chair Ford said he will lead the meeting again once Vice Chair Shell has completed sharing all the recommendations. Before they proceeded, Kim Hopkinson noted that Dr. Partida Corona had rejoined the meeting by resolving a technical issue. She wanted to go back in case there was a question directed to him. Dr. Partida Corona apologized and said he was back on.

Vice Chair Shell stated that they were questioned about the fourth recommendation, on whether there are other states that have adopted the same practice of eliminating prior authorizations. Vice Chair Shell knew there were, but he couldn't speak to which states. He thought Dr. Partida Corona was able to address that. Dr. Partida Corona shared that there are a multitude of states who have adopted this practice—California being one of the states. He believed that Nevada is probably in the minority, as far as eliminating prior authorization. Chair Ford thanked him.

Vice Chair Shell moved on to the fifth, and last, recommendation for the current report cycle, which was also submitted by Dr. Partida Corona. He noted that this is also something that other states have incorporated into their practice. He turned to Dr. Partida Corona to share more insight.

Recommend that insurers and payors not impose dosage limitations for buprenorphine when used for Medications for Opioid Use Disorder (MOUD).

Dr. Partida Corona shared that, in short, the reason that he wrote this recommendation was because he believes there is a question of stigmatization when it comes to addiction. When thinking about it, there aren't other situations where you see the state weighing in on the dosage of a medication. Yet, for some reason, there's an imposition of people that are not licensed to practice medicine (he assumes), weighing in on how much of a medication should be given to a patient, trumping the experience and the insight that the physician has in dealing with a patient.

He added that it would be one thing if it was something innocuous, but when talking about underdosing someone that is seeking treatment for opioid use disorder, oftentimes, it makes the difference between those people relapsing and not. When patients relapse—sometimes, patients die. So, it isn't a minor point, this has real world consequences. What he proposed is to remove the state from decisions that are made between patients and physicians.

Member Johnson thanked Dr. Partida Corona for both recommendations. She wondered if he could discuss the opportunity to close these gaps, and the impact that that might have on treating people who are using fentanyl or have fentanyl use disorder. She wanted to know if there was any evidence, or if other states have moved in this direction and have seen the impacts around treatment.

Dr. Partida Corona was glad Member Johnson brought that up. Before the fentanyl epidemic, there was an opioid use epidemic. On average, most patients were given between 8 milligrams and 16 milligrams of buprenorphine. But with fentanyl being much stronger, now there is the lion's share of patients that are ending up on 24 milligrams to maintain their sobriety. This may seem like a huge escalation, but it saves lives. When looking at the number needed to treat for a positive outcome, meaning preventing relapse, it's 2. The number needed to treat is 2 doses above 16 milligrams. It would be 3 doses between 8 and 16 milligrams, and it's 4 below that. So, it is better to dose at a higher level, because the likelihood of retaining these patients in their recovery is higher. Member Johnson thanked him for sharing.

Chair Ford asked if Vice Chair Shell wanted to conclude the agenda item. Vice Chair Shell said that if there was nothing else on recommendation #5, he wanted to share five additional recommendations that the Treatment and Recovery Subcommittee has started to workshop for the next report cycle, in a high-level overview. He began to read the sixth recommendation, submitted by Dr. Partida Corona.

When medication assisted treatment is initiated in detox, we should recommend continuance of medication assisted treatment for the duration of detox, inpatient treatment, IOP (Intensive Outpatient Program) and for one year from time of initiation.

Vice Chair Shell explained that it is a common practice that most patients are taken off those medications after detox, and studies have shown that if patients can stay on that treatment regime for at least one year, it leads to better outcomes. Then he moved to recommendation #7, which was also submitted by Dr. Partida Corona.

Nevada prescription monitoring program should include methadone dosing from any substance use treatment facility, including methadone clinics. Or, Nevada needs to adopt a methadone central registry.

Then Vice Chair Shell read recommendation #8, submitted by Dr. Partida Corona, regarding hospitals: Hospital ERs should have a daily call schedule for outpatient follow up regarding substance use disorders, just like what currently exists for primary care. This list can be derived from the Nevada Society of Addiction Medicine (NVSAM), the State of Nevada Association for Addiction Professionals (SNAAP) and Substance Abuse and Mental Health Services Administration (SAMHSA) collaboration which will produce a master list to the hospitals throughout the state. It will not be the hospital's responsibility to create the list, only to dispense it to the appropriate patients.

Vice Chair Shell stated that the last recommendations were also submitted by Dr. Partida Corona:
(#9) *A research study should be funded and conducted to investigate the cost savings associated with early intervention for care via street medicine for the unhoused. The goal of such a study is to elucidate the viability of shared savings payment models to facility third party payer support for such street medicine teams, rather than support through grant funding, which is inherently unstable.*

(#10) *Funding should be made available for addiction specialists to advertise outpatient ASAM criteria level one services in state, particularly if those addiction specialists are board certified, trained in Nevada or both.*

Vice Chair Shell concluded the high-level overview of Treatment and Recovery recommendations. He shared that those were the new recommendations from Dr. Partida Corona that the Subcommittee is excited to start workshopping and bring forward in a future meeting to be considered for the next report cycle. He asked if there were any other questions from the Chair or Committee Members. Chair Ford didn't see any hands raised and thanked him for the presentation.

Chair Ford turned it to Response Subcommittee Chair Kerns to report on the Response Subcommittee recommendations. Before she started on the recommendations, she highlighted that Member Morgan had questions about wastewater concentrations at university campuses compared to the community wastewater concentrations. Dr. Gerrity, who presented that information to the Response Subcommittee, provided an answer to Member Morgan's question, and said that it will be summarized in the meeting minutes [see footnote above] so it will be available for everyone.

Moving on to the Response Subcommittee recommendations, Response Subcommittee Chair Kerns echoed the comments of fellow subcommittee chairs. The Response Subcommittee has been fortunate to have participation revitalized by new Members that have recently joined. The Subcommittee originally had three recommendations, but it increased to five after consultation with subject matter experts such as the Crime Lab, the Board of Pharmacy (BOP), the medical examiners, and Jermaine Galloway, also known as 'Tall Cop', who is a national expert in the areas that will be discussed in the first three recommendations. It was determined that the Subcommittee should divide what was one recommendation into three recommendations with different action items specific to each substance.

Recommendation #1 was submitted by Member Shayla Holmes:

Recommend that mitragynine, 7-hydroxymitragynine, and mitragynine pseudoindoxyl including: any isomer, ester, ether, salt, or salt of an isomer; any synthetic, semi-synthetic, or chemically modified derivative; and any compound containing mitragynine, 7-hydroxymitragynine, or mytragynine pseudoindoxyl as an active pharmacological ingredient, regardless of whether the substance is naturally derived, synthetically produced, or manufactured through chemical modification be added to the Schedule 1 of NAC 453.510.

Response Subcommittee Chair Kerns noted that there has been a lot of research done on this topic, and that other states have done this as well. She shared that the two other recommendations that related to this originally stated listing these drugs under Schedule 1, but this was changed based on the discussions and advice from subject matter experts. It was elevated to the Subcommittee that anyone could drive around and find these substances, especially Kratom, readily available at vape shops, and convenience stores. The Tall Cop, Jermaine Galloway, has done this. At the various places that sell these products, oftentimes, it is sold as a 'nutritional supplement', and people may not necessarily know what they are purchasing.

It was also highlighted that Kratom can be used for people who are in treatment. If they know they are going to be drug tested, they can still use Kratom products, which often are not tested for, and this can help them with their symptoms and pass their drug test. She asked if Member Holmes wanted to add anything.

She thanked Response Subcommittee Chair Kerns and noted she didn't have anything to add, except that the Board of Pharmacy invited the Subcommittee to speak at their next meeting on April 16th, where they will begin the hearing process to schedule Kratom and its metabolites. So, there is already some progress.

Response Subcommittee Chair Kerns stated that she believed in their consultation, this has been something that has gone forward in legislation previously, but there was no movement on this matter, so they want to try to push this again. She asked if there were questions.

Member Johnson thanked them for their presentation. She was curious if there was any sense of the mortality impact or morbidity impact of this in Nevada. She has seen some national reporting come out on this, but she was wondering if Response Subcommittee Members had a sense of that. Response Subcommittee Chair Kerns stated that Dr. Knight from Washoe County has published research about this and discussed seeing an increase of deaths related to Kratom in our state. She noted that this was referenced in the justification section of the recommendation.

Member Mandell said that he knows those names of the drugs are hard to pronounce. He said 7-OH is what it is known for in smoke shops. Being at the Attorney General's office, Member Mandell wanted to highlight how bad this issue is impacting the treatment industry right now. Elevating this was very important, because right now, not only does a lot of insurance not authorize treatment, but the detox is worse. 7-OH is 7 to 13 times stronger than a lot of the opiates out there. Many insurances (such as Medicaid) won't authorize detox for it. He has had conversations with distributors as well through his own investigation, and they disclosed that once this is outlawed, distributors already have six more products in line with different components. So, being that we're in the Attorney General's office, he wanted to share the dangers of it. He doesn't know what the laws look like to come down on these smoke shops, but it is a major problem, and it has been difficult getting individuals into treatment as well, because they cannot get insurance authorization, because it is not technically an opiate.

Chair Ford said that an interesting part of this conversation for him was that they were essentially, in this Committee, asking the legislature to criminalize something, when they typically do not do this. In fact, last time the Committee tried to do that, the Chair got in trouble with this Committee. So, he found it interesting to hear that Members of the Committee are contemplating that. He asked the legislators on the screen to take note of this as something to revisit at some point.

The Chair asked Crystal Duarte if there were any questions online. Seeing none, they moved to the second recommendation. This was also submitted by Member Shayla Holmes.

Prohibit the sale of phenibut *(β-phenyl-γ-aminobutyric acid), including: any isomer, ester, ether, salt, or salt of an isomer of phenibut; any synthetic, semi-synthetic, or structurally modified derivative; and any compound that acts as a GABA-B receptor agonist or functional equivalent with similar depressant or psychoactive effects to individuals under 21 years of age, aligning with existing cannabis regulations and mandate that all products containing phenibut or its derivatives have standardized labeling, including clear warnings about potential health risks and age restrictions.*
Restrict Sales Locations: *Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities.*
Enhance Enforcement Mechanisms: *Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations.*

Throughout their research and discussions with subject matter experts, Response Subcommittee Chair Kerns highlighted that there are individuals that are seeking these substances that may know what they are getting. However, there are many individuals who get products that are presented to them as 'health supplements' and they are unaware of what they are getting. That was why the Response Subcommittee thought about having it originally, as Schedule I, but changed that to an age restriction instead. She asked if Member Holmes wanted to add anything, Member Holmes declined.

Chair Ford asked what the name was for the current drug they were discussing. He knew the first one was Kratom. Response Subcommittee Chair Kerns was not sure. Crystal Duarte suggested there were probably several street names for it. Member Mandell agreed.

Chair Ford asked for forgiveness, as he is not a doctor, but he needed clarity on if they were talking about bath salts or chocolate mushrooms—he wasn't sure. Member Holmes said that the mushrooms are the next one. Response Subcommittee Chair Kerns agreed. Chair Ford said they were a little over his head. Member Mandell said it can be things like bath salts, and shared that several individuals have died from this, including someone close to him that he had sent to receive treatment. He then listed other kinds of drugs that are sold legally in smoke shops. Chair Ford thanked him.

Kasey Docena (SEI) asked who was primarily speaking from the Vegas office so it could be accurately captured in the notes. Chair Ford apologized and said he asked for street names and Member Mandell provided him with a handful of suggested names. The SEI Team member thanked him.

Member Johnson thanked the Members for the recommendation. She was curious when talking about restricting the sale locations, what their thoughts were about an infrastructure that exists that they could build on, and how this would be limited. Response Subcommittee Chair Kerns asked if Member Holmes wanted to answer. Member Holmes said that this question can help them further define this. They were thinking of licensed establishments (smoke shops or marijuana dispensaries), and the language that outlines where these products can be sold (such as not having them near schools). The problem is that the substances they are specifically targeting, unfortunately, are available at the counter when an individual is trying to buy a candy bar. Currently, there are no restrictions on them, so the hope is to limit that further.

Member Johnson wanted to call attention to a presentation at the interim Subcommittee from the Tobacco Coalition. She believed they were talking about a scanning app that they were using, and a study that was done by the University of Nevada, Reno on the implementation of that. She wanted to turn their attention towards that presentation and think about where some of the gaps are, what technology is already in place, and where there are challenges with implementation in terms of restriction. The Members thanked each other for their insight.

Assemblymember Goulding said she might have missed part of the conversation on the recommendation. She asked if there was any conversation about prohibiting this altogether instead of just under 21. She wondered why under 21 and why it does not rise to the level of prohibiting it generally.

Member Holmes shared that the Response Subcommittee had several presenters originally. The first three recommendations that Response Subcommittee Chair Kerns went over were all in one, and the goal was to prohibit them all and have them all added to Schedule I. But through discussions with subject matter experts that educated Members on the different components, essentially, it was found that each of these substances do not all rise to the same level. There is not as much research on some of these chemicals as there is on Kratom.

Additionally, there are documented deaths from Kratom, which strongly supports their argument, since there are a lot of people that will speak out against Kratom. The pushback is why this has failed to pass in the past. With phenibut and amanita muscaria, it was recommended to start with restrictions only.

Assemblymember Goulding noted that it seems that this product is allowed to be sold because it does not have enough evidence to say that it is *dangerous*. But she was curious if there was any evidence to say that it was *safe*. Member Holmes denied seeing any evidence. In fact, there is evidence that other states have taken stricter regulations, and/or Schedule I for some of these substances. It is about whether this becomes enforced locally, and then what the Board of Pharmacy is willing to do, and how those processes work. That’s why this was split into three recommendations for better success.

Assemblymember Goulding found it troubling that it is difficult to prohibit the sale of something that they don’t know is safe. She felt that the direction of the regulation was interesting.

Member Holmes agreed, and said she believed that Member Mandell, mentioned that these smoke shops and other sellers have a laundry list of other items that are similar to all these chemicals that are legal to sell and have no restrictions on them. Member Holmes shared that, unfortunately, with the way that our current system works, negative things have to happen to be able to restrict and create laws to get things added to Schedule I. It's an unfortunate reversal of how we would prefer it to probably be in an altruistic world. Assemblymember Goulding thanked her for indulging her beginner questions.

Chair Ford said they were great questions—in fact, it may be suggested to offer recommendations #2 and #3 as the alternative to have the legislature consider outright restriction, or at a minimum, limiting the sale to 21. He was thinking out loud here, because there would be a hearing on this, with experts coming in to convince Members of whether it should be limited or outright prohibited, as they're trying to do with Kratom in recommendation number one. So, this was something for everyone to think about. He still believed that they were going to have some opposition from groups that would normally be aligned with you, especially from a harm reduction perspective, and Members should prepare for that. But he does suggest that they might want to consider alternative languages that give the recommendation to restrict at a minimum but consider outright outlawing it.

Member Holmes wanted to add that originally, when she was first trying to figure out how to make this recommendation, they were trying to figure out language that did not have to be so (chemically) specific, but it was extremely challenging as far as considering how to make it where unsafe substances are not readily available until (an individual reaches a certain age). Unfortunately, after talking to different people, it resulted in describing it chemical by chemical at this point in time. So, they are still trying to figure that out, but it is not an easy nut to crack.

Chair Ford noted that it is a good thing that the Legislative Counsel Bureau (LCB) is good at this. When they talked about opioid issues, the result wasn't solely focused on opioids—it was opioids and the derivatives. There were all kinds of verbiage that was used to capture molecular differences that would have moved something out of the definition of the statute, but kept it in there, nonetheless. Chair Ford believed that presenting something like this to the Committee for consideration would give them the ability to craft the language needed to be consistent with how it has been previously executed.

Dr. Partida Corona offered a suggestion for the Committee to consider. Whenever something becomes illegal, it is not that it is removed from the community—basically, *it is putting it in the dark*, *in the black market.* Chair Ford agreed. Dr. Partida Corona offered they should keep this in mind, making something illegal does not eliminate it. This simply provides a revenue source for people that would use it as a nefarious source of funds. A better approach might be just to tax it.

Member Mandell wanted to highlight that, in the past, a drug that was better known as "*Spice*", did go in the black market for a short period of time, but then phased out. It was bought at the smoke shops from individuals who were recovering for a reason, because it was easy, convenient, and legal. However, if it is now becoming illegal, so they may just buy the real thing—hence they get into treatment, and at least they can get into treatment while using that. But they can't get the treatment using "*Spice*".

Chair Ford appreciated the insight. Member Hicks echoed what was said. One of the problems they have in a specialty court, she oversees all the specialty courts in Washoe County, if a substance is not illegal, then they can't tell someone that they can't do it. All they can say is they strongly *discourage* an individual from doing it. If it is not illegal, then at the end, they graduate people from specialty courts who are using Kratom, and in turn, go back out and use it again. They have individuals repeating and coming back into the system, but the hope is to stop them from using substances and help them with recovery once they are successful in graduating. Chair Ford connected her feedback to Member Mandell's comment. Then he turned it over to Dr. Partida Corona.

Dr. Partida Corona asked out of curiosity if that holds true for alcohol as well, if someone is actively drinking. Member Hicks said yes, they can prohibit an individual from drinking, but it is *not illegal.* Since they have more background with alcohol than with Kratom, it is challenging to say, "*Hey, don't use Kratom*". There are a whole host of reasons, because they are not always testing for it—which is a big deal. Alcohol is easier to test for, so they can do this, but it is different than Kratom.

Dr. Partida Corona said that that's fair enough, but his point was that they may want to consider it along those lines, in that it may be legal, but an individual is getting intoxicated with it. So, it should be considered on the same level to achieve good traction in taking care of the situation with addiction. It is all about nuance.

Chair Ford said he appreciated the conversation, but unfortunately it had to end to move to the final recommendations and following agenda items. The Chair wanted to clarify if the recommendations that were discussed are incorporated into the Annual Report Draft, which is due before the next meeting. Response Subcommittee Chair Kerns said the Draft Report will be completed, and is due on August 1st, but will be presented in the June meeting, then finalized in July.

Chair Ford asked if there was time to send these recommendations back for consideration of whether they want to augment the language to "*limit*". Chair Ford suggested this, so the Subcommittee could reconsider whether they wanted to phrase their recommendation differently. He also suggested getting Dr. Partida Corona's position on this. The Chair thinks that he can testify at a hearing that presents a position so legislators can make informed decisions on this matter. But at a minimum, he believed they should consider sending back recommendations #2 and #3 for reconsideration. He read the recommendations. Following that, the connection with the Las Vegas location was temporarily lost.

Kim Hopkinson asked if the connection. Deputy Attorney General Joseph Ostunio agreed that the Vegas Zoom was disconnected. This took place at 4:14 p.m.

Kim Hopkinson asked for the Committee to pause for one moment while she texted the Vegas group to make sure they knew that they had disconnected and thanked everyone for their patience.

Within a few minutes, the Las Vegas location was back online. The Chair restated those recommendations #2 and #3 for the Subcommittee to consider additional language that clarifies that point. Recommendation #3 was about mushrooms essentially. He shared that he knew that there was a lobby to legalize mushrooms all the way around. They came to him as the Attorney General to see if he would advocate for the legalization of it. He shared this so she was aware that she was going to have opposition in that regard. But since this is for individuals under the age of 21, maybe they would be less opposed to an outright ban.

Then they moved to recommendation #4, which was submitted by Response Subcommittee Chair Kerns.

Recommend state agencies under the legislative, judicial, and executive branches involved with deflection and diversion programs have a comprehensive definition of recidivism and desistance, and standardized policies related to measuring and reporting recidivism. Additionally, require that all publicly funded or publicly administered reentry programs define success using clear, behavior-based outcomes and that programs articulate what meaningful behavior change looks like for participants using tools for measuring engagement, goal attainment, and behavioral milestones.

Response Subcommittee Chair Kerns added that the Nevada Department of Corrections is currently the only one in the state with a definition of recidivism. Their definition of recidivism is an individual returning to prison within three years. The Subcommittee recommendation looks at, not only if someone recidivates, but *why*, what programs might have led to behavioral changes. Additionally, it is not just going back to if there were re-arrests or re-engagement with law enforcement; it also looks at excluding things such as a failure to appear, or failing a drug test, and more. In summary, they felt like Nevada has multiple programs to try to reduce recidivism, but are unsure of what works, why it works, and what produces the behavior changes. She asked if there were any questions.

Crystal Duarte noted that Chair Ford had stepped out, and Vice Chair Steve Shell took over in his role.

Member Morgan mentioned that, for the youth side, the Juvenile Justice Oversight Commission does have a standardized definition of recidivism for youth offenders. She offered that they may want to differentiate how this looks when looking at youth versus adults. They may want to investigate the definition that is in place.

Response Subcommittee Chair Kerns said that was a great point, thanked her, and asked if there were any other questions. Response Subcommittee Chair Kerns highlighted that they worked with Washoe County, who has implemented some programs, and are one of the only/first jails that have an opioid treatment program based out of the jail and are also looking at new programs. She believed it was the IGNITE program[9] that was endorsed by the National Sheriffs' Association. The Response Subcommittee will continue to work with them. The IGNITE program will have evaluations of their program as well.

Member Chounet said her comments were about recommendations #2 and #3, she didn't have a chance to comment since there was such a robust conversation. She wanted to put out there that she supports the option to either limit the sales to 21 years and above or the argument for prohibiting the sale outright. Her concern would be around the enforcement of this. Something that is seen in working with tobacco products is that, in the rural areas (where she resides), there is very limited enforcement and compliance checks of tobacco regulations around selling to individuals under 21 years of age. So, she has a concern that, in limiting this to 21 and over, we would not necessarily be impacting the sale to individuals under the age of 21 in the rural areas. The most compliance happens in Washoe and Clark, but there is limited capacity out in the rural areas.

Response Subcommittee Chair Kerns appreciated that and thanked her. She highlighted that in some of the conversations they have had, they analyzed that the mushrooms were bad enough, but it's the *additives* that are also combined with the mushrooms that cause problems. That led to support for clear labeling standards as well. She asked if there were any other questions, then moved on to recommendation #5, which she submitted.

She read the original version of this recommendation first. Then, moved to the following slide, where the following modifications were made to the recommendation to better capture the advice received from the subject matter expert presentations and collaboration with Prevention Coalitions:

Work with prevention coalitions to make available mechanisms for safe disposal of opioid prescriptions (i.e., Deterra Bags) and to provide education to community members (i.e., youth and senior groups). Prevention coalitions will also provide a one-page document with information about opioid overdoses, disposal, and available addiction assistance to be provided with opioid prescriptions. Board of Pharmacy will provide education via their website and work with the Nevada Opioid Center of Excellence for a continued education course.

Response Subcommittee Chair Kerns disclosed a personal experience where she broke her arm and received an opioid prescription after surgery. She said she did not receive nearly as much information; this was the push for trying to get this recommendation out. Then someone else shared their experience with her. They knew they could get naloxone at pharmacies free of charge, so they went to a pharmacy. However, the pharmacy technician declined the individual naloxone. So, this individual went back, talked to the pharmacist, and they said yes, they were able to provide this. This was the educational component that came into this recommendation.

There were no questions or comments for recommendation #5, so she handed it over to Vice Chair Shell. He then moved to agenda item #8.

[9] The IGNITE Program stands for: Inmate Growth Naturally & Intentionally Through Education. Their goal is to enhance the safety of jails, communities, and correctional staff by creating an environment conducive to rehabilitation and personal growth. For more information, visit https://www.sheriffs.org/ignite/

8. Discuss Process for Ranking Recommendations
Vice Chair Shell read the agenda item and turned it back to Response Subcommittee Chair Kerns. She noted that in June, the SURG will review final recommendations from each subcommittee. In the past, the full SURG has taken different approaches to ranking recommendations.

In 2022, the SURG used a weighted ranking process in which Subcommittee Members were asked to independently rank their top five priorities among the recommendations put forward within their Subcommittee with one being the highest and five being the lowest. Final recommendations were included in the report but not listed in priority order. Members then requested that recommendations be ranked by the full SURG, with rankings included in the 2023 report to reflect the relative importance of different recommendations. SEI polled Members within a full SURG meeting for preliminary ranking of recommendations. Each Member ranked their top five recommendations through a live survey link with weighted scores aggregated to generate the top 20 recommendations for the SURG overall.

For the 2024 report, input was provided by all Subcommittees and the full SURG voted to have recommendations ranked by each subcommittee. Each Subcommittee's suggested ranking was then moved forward to the SURG for a final vote. She noted that the current Subcommittee Chairs met in March and would suggest moving forward with the ranking by Subcommittee, as was done in 2024. She asked if there were questions, or if anyone would propose a motion on ranking recommendations for the SURG 2025 Annual Report.

Dr. Partida Corona asked if the point of ranking was to assess priority recommendations to identify which of these to come in front of legislature. Response Subcommittee Chair Kerns noted that some recommendations may come before the legislature if there is a Bill Draft Request (BDR). But if it is a policy change for a different department, that would not necessarily have to go through the legislation. Response Subcommittee Chair Kerns noted that the Interim Committee on Health and Human Services and the Behavioral Health Policy Boards have requested presentations on SURG recommendations. They are also looking for BDRs to support or to receive support. So, ranking recommendations gives them an idea of what the SURG feels is more important than others.

The decision to have it ranked at the Subcommittee level was because it seemed like certain ones rose to the top and others did not, but all Subcommittees had important recommendations.

Member Johnson added that in the first year of this report process, they recognized needing a strategy for how the recommendations were populated in the report. So, she commends this group and the iterations over time of lessons that they have learned, alongside with the guidance from SEI in identifying a strategy for report completion.

Response Subcommittee Chair Kerns thanked her and asked if anyone had any questions. Vice Chair Shell proposed a motion on ranking recommendations for the 2025 Annual Report.

- Jessica Johnson proposed the ranking recommendation as outlined in agenda item #8.
- Bud Schawl seconded the motion.
- The motion carried unanimously.

Response Subcommittee Chair Kerns wanted to elevate that between now and the next Subcommittee meetings, Members will be asked to complete a survey to identify affiliations and potential conflicts of interest. This can also be found on page four of the bylaws; there is a section that speaks to conflicts of interest. She highlighted that in the bylaws; the Chair or their Designee will survey the SURG Members annually to collect information regarding their affiliations outside of the department.

Each Member is responsible for fully disclosing all current affiliations. Conflicts of interest must be declared by Members prior to discussion of any matter that would provide direct financial benefit for that Member or otherwise have the appearance of a conflict of interest. When funding or other decisions are made regarding an organization with which the Member has an affiliation, the Member shall state his intention to abstain from making specific motions or casting a vote before participating in the related discussion. Members are required to disclose and abstain in accordance with the provision of NRS 281A.420. That survey will be coming out soon. She also highlighted that in discussions with the Deputy Attorney General and others on the conflict of interest, they noted that the SURG does not make funding decisions. The SURG makes recommendations on programming and potentially funding, and all the presentations have either been programmatic or evidence-based practices, and not proprietary types of things. Members can still be involved and can still vote, because the SURG does not make final funding decisions. She thanked Vice Chair Shell.

Vice Chair Shell thanked her and asked if there were any other questions. Hearing none, they moved to item #9, which was to review and consider items for the next SURG meeting. He handed it back to Response Subcommittee Chair Kerns.

9. Review and Consider Items for Next Meeting
Response Subcommittee Chair Kerns read the information on the slide:

June 2026
- Review Final, Ranked Recommendations
- Approve 2025-26 Annual Report Template

July 2026
- Approve 2025-26 Annual Report

October 2026
- Presentations from Subject Matter Experts: Crisis Stabilization Centers and Morbidity and Mortality Rates

Response Subcommittee Chair Kerns asked if there was anything anyone wanted to suggest for topics in future meetings. Chair Ford called on Guiseppe Mandell. Member Mandell wanted to hear about the Drug Court programs and their success—particularly Henderson Courts, as they have had a lot of success. He also wanted to know if the rural areas are having any success, such as Boulder City or their Drug Court programs.

Chair Ford thanked Vice Chair Shell and Response Subcommittee Chair Kerns for taking over in his absence. Chair Ford added that on the October 2026 meeting, they are going to have an overview of open meeting law. This is currently pending, but they will probably have this for the new Members.

The Chair emphasized that the new Members have brought new life to the Committee with great ideas that have elevated the discussions. They closed this section and moved onto the last public comment.

10. Public Comment.
Chair Ford read public comment guidance and asked for public comments. Jessica Johnson announced that the Southern Nevada Substance Misuse and Overdose Prevention Summit, is happening in Las Vegas, Thursday, August 13th, from 8:00 a.m. to 5:00 p.m. at the Tuscany Casino Hotel. There is a "Save the Date" announcement on the Southern Nevada Opioid Advisory Council website. She encouraged everyone on the Committee to go, but for anyone interested in learning more or attending, they could find that at snoac.org. As the date gets closer and registrations open, with permission from the Committee, Member Johnson would be happy to send out more information and registration. She thanked everyone.

Chair Ford thanked Ms. Johnson. They moved to virtual comments. Dr. Maureen Strohm congratulated everyone on the extraordinary work that they reviewed this afternoon. She wanted to specifically comment on the Treatment and Recovery Subcommittee recommendations. She strongly supported recommendation #1, in looking at the outcome of patients following discharge. She shared that there is a huge discrepancy in the quality of management, and some of this appears to be driven by insurance companies. She has been told by a couple of different facilities that they are forced to taper individuals off the life-saving treatment of buprenorphine when they come in from an opiate withdrawal. If they do not taper them off, insurance companies claim that they are not withdrawing their patients, and that they are not providing withdrawal management, and refuse to provide payment for detoxification services.

Another comment was about how she appreciated Dr. Partida Corona's recommendation on the support for navigators and wanted to point out that UnitedHealthcare is back with another opportunity to provide navigators at University Medical Center, as well as Sunrise Hospital and Medical Center. Dr. Strohm is looking to find more information on that.

Regarding recommendation #3, state funding for contingency management, the California Experiment[10], which was very successful regarding Contingency Management (CM) improvements in the care of patients with meth use disorder. SAMHSA, the Substance Abuse and Mental Health Services Administration, as a result of that study, raised the limits to $750 per year. Dr. Strohm shared that she has several patients locally who are currently participating in a NIDA (National Institute on Drug Abuse) funded study from back East, where they are working on an app platform to raise that limit up to $1,000. Again, she congratulated everyone for considering Contingency Management as an important piece of the treatment process. She specifically gave praise to Chelsi Cheatom and Guiseppe Mandell.

Regarding the questions of eliminating prior authorization, California has eliminated prior authorization, and she would like to see them add Medicare to the process. She is going through substantial difficulties at Behavioral Health Group (BHG) in accessing certain MOUD injectables for Medicare patients, with the claim on the one hand that the insurance says it is covered, yet when they submit for it, they are mandated to put through a prior authorization that gets declined. She thanked everyone and hoped she fit her comments into the three-minute limit.

Chair Ford thanked her. He asked if there was anyone else that wanted to speak. Seeing or hearing no public comment, Chair Ford moved to agenda item #10.

11. Adjournment

Chair Ford entertained a motion to adjourn the meeting. The meeting was adjourned at 4:39 p.m.

[10] The California Recovery Incentives Program: Took place in California in 2023 as a large-scale effort to implement Contingency Management as a treatment for individuals that experienced stimulant disorders. *Dr. Strohm noted meth use disorder, but a study noted that it also provided treatment for individuals who used cocaine, methamphetamine, and amphetamine.* More information can be found here: *https://www.sciencedirect.com/science/article/pii/S294987592400225X*

Chat Record:
02:04:00 Kim Hopkinson (she/her): If a member must depart a meeting prior to adjournment for any reason, the member shall formally announce their departure for the record to ensure accurate minutes and to allow the Chair to confirm that a quorum remains in accordance with Nevada's Open Meeting Law. Please do not use the chat for items other than technical support, as this becomes part of the public record. The meeting chat functionality is limited to inquiries regarding technical difficulties or to indicate an interest in offering public comment. Exercise caution with links which may appear in any meeting chat as they could be malicious.

03:01:00 Kim Hopkinson (she/her): Members of the public are requested to refrain from commenting outside the designated public comment periods, unless specifically called upon by the Chair. A second period of public comment will be available in agenda item 10. Comments can also be emailed to kdocena@socialent.com. These comments and questions will be recorded in meeting minutes.

3:02:00 Robert Banghart Robert Banghart here

3:39:00 Maureen Strohm added in the chat, "CALIFORNIA HAS ELIMINATED ALL PA FOR MAT AND MOUD"

Ms. Duarte noted in the chat "The Las Vegas meeting room has disconnected" and "We are reconnecting now" 4:15 p.m.