MEETING NOTES

Statewide Substance Use Response Working Group Meeting

Wednesday, April 9, 2025
2:00 p.m.

Meeting Locations: Offices of the Attorney General:
Carson Mock Courtroom, 100 N. Carson St., Carson City, NV
1 State of Nevada Way Building, AGO Suite #100, Conference Room 224, Las Vegas, NV

Zoom Webinar ID: 841 1615 6896

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
Chelsi Cheatom, Senator Dorothy Edwards, Assemblymember Heather Goulding, Assemblymember Ken Gray (left at 3:58 for another meeting), Dr. Shayla Holmes, Nancy Lindler, Debi Nadler, Angela Nickels, Christine Payson, Erik Schoen, Steve Shell, and Dr. Beth Slamowitz

Members Present in Las Vegas
Dr. Lesley Dickson and Jessica Johnson

Members Absent
Attorney General Aaron Ford, Jeffrey Iverson

Members of the Legislature Excused
Senator Fabian Doñate and Senator Jeff Stone

Attorney General's Office Staff
Dr. Terry Kerns, Chief Deputy Attorney General Mark Krueger, Deputy Attorney General Joseph Ostuñio, Ashley Tackett, and Teresa Benitez-Thompson

Social Entrepreneurs, Inc. (SEI) Support Team
Crystal Duarte, Laura Hale, Kim Hopkinson, and Kelly Marschall

Other Participants via Zoom or in person
Linda Anderson, Lauren Beal, Allison Cladianos, Denise Davidson, Mark Funkhouser, Morgan Green, Valerie Haskin, Abe Meza, Chyna Parker, Cherylyn Rahr-Wood, Shauntee Rosales-Tamik, Katie M. Snider, Shannon, Maureen Strohm, Marcie Trier, Breanne Van Dyne, Candace Lewis Vaughn, Karla Wagner, Joan Waldock, Quinnie Winbush (wrong meeting), Cherylyn Wood, and Dawn Yohey

1. **Call to Order and Roll Call to Establish Quorum**
   Vice Chair Shell called the meeting to order at 2:01 p.m., noting that he would need to sign off at 3:25 p.m., at which time he would turn the meeting over to Ms. Johnson to chair for the remainder of the meeting. Ms. Duarte called the roll and confirmed a quorum.

2. **Public Comment**
   Ms. Winbush identified she was in the wrong meeting and signed off.

   Ms. Nadler appreciated the wonderful work of all the SURG members, but she expressed her continued grief and that of other bereaved parents in Las Vegas. She continues to be concerned about the lack of

attention to families who have lost kids to opioids, but they don't receive any help to pay for memorials and other needs. She feels their kids are treated as numbers, noting that there would be no settlement if not for the loss of these children, which is so unfair. She was paying $300 a month for counseling, but she can't afford it anymore. She was denied disability, but she has trouble saying the alphabet and has not slept well for five years. All the other families feel this way, with moms raising their grandchildren, but support for them is missing from this lawsuit. The anniversary of her son's death is coming up and she sees all the lawsuits across the country, and asks, please, to humanize him and others, as she would not wish this on anyone.

Giuseppe Mandell, Desert Hope, said he felt Ms. Nadler's pain and suggested she reach out to him to work out a program of support.

3. **Review and Approve Minutes for January 13, 2025, SURG Meeting**
   Vice Chair Shell asked for a motion to approve the minutes.

   - Ms. Nadler made the motion to approve the minutes.
   - Dr. Holmes seconded the motion.
   - The motion carried unanimously.

Note: Items 8, 11, and 13 were taken out of order to ensure a quorum for possible action items.

4. **Compassionate Overdose Response**
   Karla Wagner, Ph.D., University of Nevada, Reno School of Public Health, shared her slide deck with disclosures, information sources, and links. She briefly reviewed opioid overdose deaths in the United States, specifically the role of fentanyl, and reminded everybody what we know about what works, and emerging issues related to synthetic opioids, opioid withdrawal, and the emergence of new opioid antagonist products on the market.

   Dr. Wagner provided a link https://www.sciencedirect.com/science/article/pii/S0955395924002718 for the paper resulting from a 2-day working group about how the scientific community and the harm reduction community think we should be moving forward.

   Dr. Wagner reviewed consensus among the 40 experts participating in this working group to consider the standard dose of naloxone as one injection of intramuscular or one spray of 4 milligram intranasal spray, and to be cautious about the introduction of newer, higher dose and longer acting products with the potential to exacerbate withdrawal symptoms and create barriers to accessing emergency care.

   Drug deaths increased in Nevada and throughout the country from 2015-2022, largely due to fentanyl, but psychostimulant abuse was even higher, with mostly methamphetamine in Nevada.

   Fentanyl and its analogs are more potent than morphine or heroin, so less of the drug is needed for the same effect. It is used routinely in clinical settings to treat pain, where respiration can be monitored and supported. They also know that respiratory depression can be reversed with opioid antagonists like naloxone.

   There is a common myth that simply touching or being in the same room with fentanyl can cause an overdose, but the rate of absorption of fentanyl powder through the skin is so miniscule that it does not present a risk. Another myth is that all drugs people get from the unregulated marketplace have fentanyl in them, but that is also not true. A study of samples from across the country found fentanyl in less than 20% of the stimulant samples tested. Their research also showed that people who use drugs deliberately

use fentanyl, quite often and quite safely. Other people are being accidentally exposed, but Dr. Wagner's research in Nevada found that most people are very aware of the potential and do a lot to mitigate their own risk of overdose. A final myth that naloxone can't be used to reverse respiratory depression from fentanyl is also simply not true. Opioid antagonists like naloxone can reverse fentanyl overdoses.

Naloxone was first used by the Chicago Recovery Alliance by Dan Bigg in 1996. Training people to prevent opioid overdoses by avoiding mixing drugs, and using less after periods of abstinence, such as incarceration, has been available ever since. Recognizing the symptom of interrupted respiration or depressed respiration like blue lips or nails calls for support by calling 911, supporting rescue breathing, and administering naloxone until help arrives. This is the protocol Dr. Wagner has been using since 2006.

Training in rescue breathing has diminished over time, with increased distribution of naloxone, but no matter what kind of opioids are used, including fentanyl, the appropriate response must support respiration. Synthetic drugs like fentanyl or xylazine might complicate the presentation and might make it less likely that somebody wakes up and starts talking before they start breathing. So, we need to pay attention to breathing.

Historically naloxone was only available in one cc vials of intramuscular naloxone to inject into a muscle. Later, intranasal doses of 4 mg were available over the counter. An updated table shows how newer formulations measure up to standard dose equivalents, including a newer 8 mg nasal spray and a 5 mg injectable, which is equivalent to about 12 and a half vials of the standard 1 mg injectable dose. nalmefene is a new antagonist that is used clinically, with no data for community-based settings. It is significantly longer-acting than naloxone, at 6 to 10 hours, compared to about an hour and a half for naloxone.

Studies with New York police officers comparing administration of 4 mg and 8 mg naloxone showed no difference in terms of survival, combativeness, when the people using drugs woke up, or whether they refused transport to the hospital. The only difference they saw was withdrawal symptoms; the recipients of the higher dose product had 2.5 times higher risk of experiencing withdrawal symptoms, including vomiting compared to the people who got the lower dose product. This study implied that higher doses did not provide any additional benefit. A similar study from a harm reduction organization in Pittsburgh showed that increased prevalence of fentanyl use from 2013 – 2016 did not result in an increased number of naloxone doses needed to reverse overdose.

A recent study from Southern Nevada Health District[1] included naloxone administration from uniformed first responders and laypeople, along with local EMS data, which showed 15 out of 15 people who received one dose of naloxone in 2021 survived, with similarly high survival rates through 2022 and 2023. Another sample from 2024 showed a 100% survival rate with 29 out of 29 people who received one dose of naloxone. The study also showed that more doses of naloxone don't necessarily mean a higher survival rate.

In cases where 3-5 doses of naloxone were administered, responders indicated that they didn't wait the minimum amount of time between doses but were rapidly administering multiple doses and not giving naloxone enough time to work. Another table reviewed dosage levels ranging from .5 mg to 4 mg, with 55% of cases receiving 2 mg, with a finding that most overdoses are reversed with standard dosage, and one or two administrations. Although people are talking about needing more doses and higher potency, this may be confounded by not waiting long enough between doses. One study using law enforcement body camera footage showed on average the officers only waited 53 seconds between doses, which may

[1] Data was provided courtesy of Brandon Delise, Senior Epidemiologist, Southern Nevada Health District, originally presented in 2024 via webinar hosted by the Nevada Opioid Center for Excellence.

be amplified in a life-threatening situation. The recommendation is to wait 2-5 minutes between doses and support respiration, giving the medicine enough time to work, similar to waiting a while for Advil to relieve a headache.

In cases where xylazine is used with fentanyl, the patient may not wake up and start talking, even though their breathing is restored. The naloxone is treating the opioid part of the overdose, but not the xylazine. The focus needs to be on restored breathing, even if they don't wake up. A common myth is that more doses will speed up the reversal process, but overmedication with naloxone might cause more serious and painful withdrawal symptoms. Consequently, the recommendation is to give the lowest dose of naloxone needed to restore breathing, minimize painful withdrawal symptoms, and discourage people from using drugs alone. Too much naloxone and related pain can cause anxiety and increase the use of drugs and related risks.

Dr. Wagner summarized as follows: 1) Effective opioid overdose response must restore breathing; 2) Precipitated opioid withdrawal from too much opioid antagonist is a serious concern and can cause harms; and 3) Best practice is to administer the lowest dose of naloxone needed to restore respiration and avoid withdrawal.[2]

Ms. Nadler said this was one of the best presentations she has seen in a long time, thanking Dr. Wagner for breaking it down. In her experience many people are talking about their children dying from marijuana laced with fentanyl, while others say that if you smoke it with marijuana, you can't overdose. She asked Dr. Wagner to address this.

Dr. Wagner noted that people who inject heroin have moved toward smoking fentanyl because they can manage it better and it reduces their risk for overdose, but she questioned the idea that smoking fentanyl with marijuana avoids overdose. She didn't have data on the prevalence of fentanyl in marijuana but said she could do a little more research on it. Following the meeting, Dr. Wagner provided links with additional information to address this.[3]

Ms. Johnson asked about pharmaceutical companies representing some of the drugs Dr. Wagner mentioned, and directly approaching public safety groups, law enforcement, and local officials to share their research related to a type of brain injury from not breathing for too long.

Dr. Wagner clarified this as hypoxic brain injury with limited oxygen for too long. Others may have specific data on this, but her data is that a higher dose or longer acting product doesn't reverse an overdose or restore breathing faster, which is needed to avoid hypoxia. Dr. Kerns confirmed her agreement with this.

Ms. Johnson also asked if there is a risk associated with nalmefene taking a longer time to leave the receptors of the brain. Dr. Wagner cited colleagues in Mexico familiar with nalmefene as a longer acting opioid antagonist, which blocks receptors longer and may extend withdrawal symptoms. Naloxone lasts 60 to 90 minutes, which is manageable, whereas nalmefene could extend withdrawal to 6 to 10 hours. That extended period with painful withdrawal symptoms is a huge deterrent to people seeking help. For

[2] AB394 was amended to replace 4 mg opioid antagonist with "lowest effective" dosage in emergency response plans for the University of Nevada.

[3] *Clearing the Haze: Marijuana and Fentanyl.* Partnership to End Addiction. Retrieved April 18, 2025 from https://drugfree.org/article/marijuana-and-fentanyl/.
Myth-Busting Fentanyl in Cannabis. MATTERS: Medication for Addiction Treatment and Electronic Referrals. Retrieved April 18, 2025 from https://mattersnetwork.org/fentanyl-in-cannabis/

the harm prevention community, the unknown benefit and potential harm does not support use of nalmefene over naloxone.

Dr. Kerns asked a question about teaching CPR with compressions only and not rescue breathing, because it was focused on heart attacks where rescue breathing wasn't any more effective. Is there any effort to include teaching rescue breathing in CPR courses in the case of overdose? Dr. Wagner noted the importance of this issue that has been raised with the American Medical Association (AMA). She added that people are a little bit squeamish about giving rescue breathing, so confidence building and capacity building are needed to convince people to do it. She noted further that naloxone administration and rescue breathing are also integrated into the 911 dispatch protocols.

Assemblymember Gray thanked Dr. Wagner for raising the issue of agitation from too much naloxone. He knew of responders in the field having to hold people down due to anxiety, so he's glad the dosing is getting better. He clarified the term of *anoxic brain injury* (ABI) that is a total lack of oxygen within the bloodstream as opposed to hypoxia, which is a slow reduction in oxygen. The damage actually occurs when there's no oxygen. He's also concerned that they're not recommending mouth-to-mouth rescue breathing, which is needed for overdose, unlike in the case of cardiac arrest where the blood is not pumping; there are two separate protocols.

Dr. Wagner agreed with this and noted that many people in the field will support respiration and ventilation, without administering naloxone if they know they can keep somebody breathing and transport them.

Vice Chair Shell thanked Dr. Wagner, again, for this important presentation which SURG members had requested.

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

Chief Deputy Attorney General Mark Krueger, Office of the Attorney General provided a brief overview of the status of settlement activity. The Purdue bankruptcy is getting closer to settlement with a new plan for another possible settlement with the Sackler family. They hope to see final documents come through in another month or so. The Kroger settlement was finalized with payments to the Administration Settlement Trust, for distribution in April through the One Nevada agreement.

Chief Krueger reminded members of the dashboard where members can see what funds have come in and see where state expenditures are. They are also in the process of creating an online reporting mechanism for the counties and local governments to report on their use of funds.

Chief Krueger also reported Pharmacy Benefit Manager (PBM) litigation was remanded from federal court back to a state court, so discovery should be starting, although defendants have appealed to the 9th Circuit for a stay.

Ms. Nadler asked about how funds are distributed and what kinds of activities are being funded. She had some idea of funds going to different levels of government administration, including Medicaid.

Chief Krueger characterized the Medicaid Match[4] as a way of determining certain funds that can be misleading. The settlements coming through the One Nevada Agreement are maximized because the

[4] The term "Medicaid Match" refers to the Federal Medical Assistance Percentage (FMAP) for the level of matching funds states receive from the federal government. Various factors are considered in determining how much federal support is awarded to a state, including the level of state Medicaid funding and the level of need for federal funding.

multiple signatories agree to the terms, which increases the amount coming to the State of Nevada, Fund for Resilient Nevada, with remaining allocations to local governments. The portion that is *based on the "Medicaid Match"* is only allocated to the counties.

Ms. Nadler noted funds going to issues other than the opioid epidemic in some states. She asked if Nevada funds are going to issues other than the opioid epidemic.

Chief Krueger explained that the money is allocated only for opioid abatement. The majority of the settlements have a cap – especially the bankruptcies – on what can be used for administrative expenses, with different lists of approved uses, all of which are on the Fund for a Resilient Nevada website. Anyone can look at each settlement and how it is being used. Any use other than what is directed in the settlement would be in violation of the national agreements.

Ms. Nadler thanked Chief Krueger for setting up the dashboard and asked if it includes "all three pieces of the pie." (Chief Krueger temporarily lost connection.) Vice Chair Shell noted that the next presentation would include information on the programs funded in Nevada by the opioid settlement.

Vice Chair Shell stated that he would need to sign off in a moment, and the remainder of the meeting would be chaired by Jessica Johnson.

6. **Presentation of Fund for a Resilient Nevada 2024 Annual Report**

Dawn Yohey, Clinical Program Planner, Nevada Department of Health and Human Services, Director's Office, assisting with the oversight of the Fund for Resilient Nevada presented a review of the dashboard before moving on to the Annual Report, based on SURG member requests.

Ms. Yohey emphasized the goal of transparency through the dashboard, with everything linked back to the Nevada Opioid Needs Assessment as well as the Statewide Plan. The link for the Annual Report will also be updated, and allowable uses of the fund are included on the dashboard. The tabs for the dashboard include the following: Overview, Financial Overview, and a separate tab for each of seven goals based on the Statewide Plan. Budget, Dollars Allocated, and Dollars Spent are provided for each specific goal, along with identification of vendors and budget categories.

Ms. Yohey presented slides with information from the FRN Annual Report, starting with a chart of the One Nevada Agreement and the percentages allocated to different signatories, including state and local governments. High level goals 1-6 were reviewed with reference to specific studies completed last year under Goal 7, to provide high quality and robust data.

Specific studies are linked within the Annual Report and can also be found directly online:

- Health Outcomes of Infants with Gestational Exposure to Substances in Nevada (2018-2020)
- Substance Use and Criminality in Nevada: A 2016-2023 Analysis

The Annual Report also includes funded programs and projects, including goals, objectives, how they relate to opioid abatement, and some of their outcomes.

Ms. Yohey noted that the report is very lengthy, but she recommends members spend time reviewing it and bringing any questions back to her. All the programs in the report were funded in calendar year 2024, but they will start seeing more of the fiscal year 2025 awards in the dashboard, for which they can also

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The opioid settlement funds use a state's FMAP rate, also known as "Medicaid Match" in determining components of that state's award. The opioid settlement funds do not actually go into the state's Medicaid budget.

forward questions. As programs are approved for FY2026 and FY2027, those will also be included in the dashboard.

Ms. Nadler asked a question regarding goal #4 on mobile units, and whether the dashboard shows where those units are in Clark County. Ms. Yohey explained that the units were purchased by the FRN program and DHHS also took over the staff funding to have the project administered under a single entity, with three separate units in southern Nevada, Carson City, and rural areas.

Ms. Nadler also asked a question about goal #7 and the Poison Control Hotline. Ms. Yohey explained this was based on a subject matter expert report that was delivered when the litigation was still going on. They fund a small portion of that based on the number of opioid calls received; she will send Ms. Nadler the details. Ms. Nadler reported having been charged $75 for a call to them a couple of months ago.

Acting Chair Johnson asked a question about high quality data with handheld mass spectrometers under goal #7. Would their team be receiving data on the outcomes from the items that are scanned with those? Ms. Yohey confirmed that this is the goal. Their partners at the Division of Emergency Management helped purchase them and get them out to communities, as this was a little better fit with the Department of Public Safety, with their Internal Investigations Unit for narcotics, so they just had to switch vendors.

Ms. Yohey moved onto the One Nevada Agreement section of the report to review how the counties are spending their dollars. DHHS does not oversee the county expenditures, but they coordinate to support appropriate expenditures, which are broken down by region in the report as highlighted by Ms. Yohey.

Ms. Payson asked for more details on expenditures on the drug court and furniture, which Ms. Yohey agreed to get for her.

Ms. Nadler said she didn't see anything on prevention in Clark County, other than fentanyl awareness in Henderson. Ms. Yohey said she pulled information from a spreadsheet, but she can go back and check. She also noted that Clark County is working on a lot of the capital projects with their opioid dollars to build opioid treatment centers. Ms. Nadler reported not finding anything on prevention in Clark County on the website, although she sees that Reno has prevention. Ms. Yohey indicated the state might be able to coordinate with Clark County to help with prevention there.

Ms. Yohey added that they are working to include the annual reporting mechanism on the dashboard, with outcome measures and scopes of work.

Ms. Johnson commended Ms. Yohey for the work in pulling together the report, and she appreciated all the time, effort, and energy of their team, noting the exceptional value.

Acting Chair Johnson called for a 9-minute break asking members to return at 4 pm. Assemblymember Ken Gray advised that he was signing off to get to another meeting.

7. Presentation on Legislative Bills from Behavioral Health Policy Boards

Dorothy Edwards, Washoe Regional Behavioral Health Policy Coordinator, presented slides on Senate Bill 47 for behavioral health insurance parity and how to address various gaps in relation to the Federal Mental Health Parity and Addiction Equity Act. She provided an overview of a proposed study to include network adequacy, reimbursement rates, denial of coverage, emergency care, and utilization – all of which impact access to behavioral health care.

The study would address unique challenges in Nevada, including rural – urban disparities, workforce shortages, and limited insurer pools which could be addressed through innovative policies to improve care, quality, reduce costs, and enhance outcomes. Workforce issues were identified as a driver of gaps in coverage. These untreated behavioral health conditions result in an economic burden for the state.

Although data is currently collected by multiple entities, including the Division of Insurance, DHHS, and Medicaid, this bill would require collection of additional data to fill the gaps to support comparison with other states and to level the playing field. They recognize the limited resources for completing this work, but they have some good proposals to address this, and friendly amendments to the bill were underway. Ms. Edwards is available to answer questions if people want to reach out to her via email or they can watch the hearings linked to the bill on the legislative website.

Valerie Haskin, MA, MPH, Rural Regional Behavioral Health Coordinator presented slides on Senate Bill 68 for Social Worker Interstate Licensure Compact, which also augments requirements for behavioral health licensing boards' annual data reports. Licensed professionals in good standing within member states would be enabled to apply for multi-state licensure, which would help address Nevada's provider shortage with both in-person and telehealth services. Many states have passed this type of legislation, with many more under pending legislation.

Components of SB68 related to annual data reporting would include the reasons for application denial or changes in the number of annual applications over prior year data. This will help to improve communication, consistent reporting, and improved understanding of system changes.

The fiscal note shows up to $561K revenue per biennia, with no expected costs. However, they were told by the committee chair there were no plans to hear any compact bills, so this bill is "dead as a doornail." However, similar bills have moved on the Assembly side. Ms. Haskin thought interstate compact bills on the whole may be a problem, rather than this specific bill.

Mark Funkhouser, Southern Regional Behavioral Health Policy Coordinator presented slides on Assembly Bill 31 on Nonemergency Secure Behavioral Health Transport to pay providers both ways (to and from health care facilities) via Medicaid reimbursement. This bill authorizes the Director to apply for any federal authority necessary to increase by (1) at least 15% the rate of reimbursement for rural/frontier counties; and (2) at least 10% for all other behavioral health transport (Medicaid) services. This would free up law enforcement and EMS from transportation duties.

Key factors addressed by the legislation include inadequate reimbursement and vehicle restrictions; law enforcement and EMS are the doorway to behavioral health care in Nevada; serious gaps exist in rural and tribal regions due to limited transportation and lack of available services; and rural hospitals and jails are not equipped [to provide behavioral health services] and struggle with long waits.

Additional factors include cost burden to local government, law enforcement, and EMS; loss of local services while staff are in transport; increased staff burnout and turnover; and increased risk to individuals needing services in these areas.

AB31 was heard by the Assembly Health and Human Services Committee and then went to a subcommittee. Mr. Funkhouser said the fiscal note will result in some resistance, given federal funding challenges, but advocates include Assemblyman Gregory Hafen, Minority Floor Leader.

Cherylyn Rahr-Wood, MSW, Northern Regional Behavioral Health Policy Coordinator presented slides on Assembly Bill 60 describing multiple benefits of this legislation including standardized qualifications, creating a framework for accountability, encouraging workforce growth, alignment with public health

objectives, legitimizing prevention efforts, and return on investment by preventing substance use and related costs.

In reviewing the language in the bill, advocates suggested the definition of Certified Prevention Specialist as an official profession could possibly be added in the next legislative session.

Ms. Rahr-Wood noted secondary purposes for AB60 included the following: Coalition work is driven by evidence-based programs and initiatives; regular review and consistency in prevention efforts will help maintain effectiveness; the prevention board develops regulations and policies; coalitions collaborate on writing regulations and code to align with and follow both Nevada and federal labor laws and codes.

A fiscal note for $3400 has been removed as it related to Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS) training, which does not fit the proposed activity for this bill. Ms. Rahr-Wood's Board Chair is Shayla Holmes who can also help if SURG members have questions going forward.

Ms. Nadler asked if SB47 had language for mental health specialists in schools. Ms. Edwards said the bill does not include that reference, but she would take this suggestion back to their legislative team, as the kind of thing they want to hear. Ms. Nadler said she would email her to follow up.

Dr. Dickson said it was very unfortunate that they were not able to move forward with SB68 for the Social Work Compact because the Medical Board has been using the interstate compact for physicians for years and it has been incredibly helpful in getting doctors licensed in Nevada. If there is a similar bill in the Assembly, maybe they could get one of the people from the Medical Board to comment on it.

Ms. Haskin referenced AB163, sponsored by Assemblyman Hafen, which has passed out of committee and also calls for an interstate compact for licensed or clinical professional counselors. Another interstate compact bill on the Senate side, SB34 did not meet the deadline either, but they are watching for other bills to be agendized and will keep trying.

Acting Chair Johnson asked Ms. Haskin about core functions, specifically about social work for licensed professionals in this context, and what the requirements would be in addition to understanding the laws and resources, and how the individual interacts with their environment, where resources might be different for different states.

Ms. Hasken clarified that Social Workers are not behavioral health providers, but if they come to Nevada to practice that would be a huge benefit. Things like case management are very different in Elko versus Las Vegas or even Winnemucca, where resources and navigation could be different. That service should be provided within the community itself. A lot of bills propose extended use of Social Workers, particularly school of social work must be licensed through the state board and then get an endorsement through the Nevada Commission on Professional Standards in Education. It would expedite the process if the person was moving to a community in Nevada to do Social Work. It might be more appropriate for a telehealth modality if the person lived outside of Nevada. Licensed Clinical Social Workers (LCSWs) are well poised to be advocates for local response teams because they understand multiple layers of impact such as social determinants of health.

8. **Update for Assembly Bill 19 regarding SURG Membership** (Taken out of order to accommodate quorum) Terry Kerns, Ph.D., Office of the Attorney General reviewed highlights of the bill to increase SURG membership including a member of the general public, someone from Fire/EMS, someone from the Division of Child and Family Services or foster kinship, someone from the state Public Defenders Office or the Department of Indigent Defense Services, and a representative from the Nevada District Attorneys

Association. Dr. Kerns explained updates to the proposed bill including new representation for Public Defenders, and the Department of Health and Human Services (DHHS).

The Chief of Staff for the Office of the Attorney General, Teresa Benitez-Thompson, reached out to stakeholders who suggested the Clark County Public Defenders be added to the SURG and suggested that group could provide input at the local level to Clark County on their use of substance use dollars. Ms. Benitez-Thompson would also reach out to DHHS to support two representatives from the Divisions or programs of their choosing, rather than three. For the representative of the general public, they would give priority to someone who is from a bilingual household that has been affected by substance use.

Dr. Kerns also noted that one of the committee members expressed concern about increasing the size of the SURG in terms of managing that many members. Dr. Kerns explained that the subcommittee structure helps to manage the different requirements under Section 10, items a-q, of AB374, which authorized the creation of the SURG. She felt this alleviated their concerns.

9. Legislative Update

Dr. Kerns referenced potential cuts to Medicaid, noting that Covid funding has already been pulled back which will affect what is being reviewed under the budget. The Office of National Drug Policy provided guidance from the White House on six drug policy priorities.

1. Reduce the Number of Overdose Fatalities, with a Focus on fentanyl
2. Secure the Global Supply Chain Against Drug Trafficking
3. Stop the Flow of Drugs Across our Borders and into Our Communities
4. Prevent Drug Use Before It Starts
5. Provide Treatment That Leads to Long-Term Recovery
6. Innovate in Research and Data to Support Drug Control Strategies

10. Results of Annual SURG Member Survey

Crystal Duarte, Social Entrepreneurs, Inc., reviewed slides with the purpose, process, and results of the survey. Elements of the Recommendation Process that worked well and should be retained include the following:

• The process used this past year for the formulation of the recommendations worked very well. I suggest keeping this process in place."
• I was most impressed with the process of having the subcommittees submit recommendations that were then reviewed by the full SURG. That allowed for more time for each subcommittee to carefully consider ideas and make recommendations for their respective focus areas.
• Scoring, priority recommendations was easy to follow and complete.

One suggestion for improvement was:

- The process is too organized preventing some open discussion among the committee members on specific, pre-chosen topics.

A few suggestions were made for sharing the Annual Report with the following entities:

- NV State Legislators during Session and during Interim Sessions a written formal report should be prepared for the Legislature and Governor.
- Legislative committees
- Behavioral Health Association of Nevada

Ms. Duarte believed that Ms. Payson had also shared the report with the Nevada Sheriffs' and Chiefs' Association.

Additional comments/feedback or questions included a request for a money chart with a breakdown of the distribution of funds and follow-up on what bills have passed during legislative sessions relating to the drug epidemic.[5] The presentation from Ms. Yohey under agenda item #6 was scheduled to address this request, with a thorough overview of both the dashboard and the Annual Report.

11. Subcommittee Updates (Taken out of order to accommodate quorum)

Jessica Johnson, Subcommittee Chair, Prevention, provided an overview of their March 5th meeting, which included the crosswalk tables prepared by SEI to show focus populations and how previous recommendations fit within the requirements of AB374 and to help identify possible areas for focus in 2025. Members discussed planning for their approach, and possible refinement of existing priorities, in addition to identifying any new priorities. They will seek a presentation on cannabis prevention, and possibly another on compassionate overdose response, and follow up on the ACRN (Advisory Committee for a Resilient Nevada) presentation. She appreciated SEI staff for scheduling some of these items on today's agenda.

Dr. Terry Kerns, Subcommittee Chair, Response, shared highlights from their March 4th meeting, which reviewed policy assignments, target populations, and plans for the upcoming year. They also appreciated the SEI tables on previous recommendations in relation to mandated activities and populations to address. They will also be looking at results of previous recommendations, via legislation and program implementation. They discussed interdiction of drugs, compassionate overdose response, and will look at substance use trends from the Clark County Regional Opioid Task Force, medication assisted treatment (MAT) in rural jails, updates on Crisis Response Centers in Washoe and Clark counties, and updates from DHHS on the status and progress of recommendations, along with legislative updates and the opioid settlement.

Steve Shell, Subcommittee Chair, Treatment and Recovery, echoed comments from Dr. Kerns and Ms. Johnson, noting that members were most interested in looking at the status of previous recommendations.

12. Update on Annual Report Dissemination

Dr. Kerns confirmed distribution of the Annual Report to the Governor, to the Legislative Council Bureau for dissemination to all the legislators, also to the DHHS Director, the Division of Public and Behavioral Health, and to the Fund for a Resilient Nevada within DHHS, the Advisory Commission on the Administration of Justice, each of the Regional Behavioral Health Boards, the Prevention Coalition members, and the Attorney General's Office also did a press release.

13. Review and Consider Items for Next Meeting (Taken out of order to accommodate quorum)

Ms. Marschall shared slides with proposed presentations:

- Legislative Session Recap (July)
- Division of Public and Behavioral Health Strategic Plan (July)
- Clark County Regional Opioid Task Force (July)
- Current Trends in Substance Use (July)
- Medication for Opioid Use Disorder (MOUD) in Rural Jails Project Update (July)
- Updates on Crisis Response Centers in Washoe and Clark Counties (July)
- Updates from the Department of Health and Human Services (October)
- Recommendations Presentation, Review, and Feedback (October)
- Finalization of Recommendations (December)

[5] Status reports for legislative bills related to the drug epidemic are provided to the SURG at one or more meetings each year.

• Finalization and Approval of Annual Report (January)

*Opioid Settlement Updates are provided at each meeting, as available

Ms. Nadler asked if the Opioid Settlement Updates could be presented in layman's terms instead of the chart, to provide more accountability. She wants to know how much money went where, how it was used, and whether it was effective. Vice Chair Shell acknowledged Ms. Nadler's concern.

Ms. Nadler also referenced a new drug that hit Arizona, Texas, and some of the East Coast, called Para Fluoro (PFF), known as "China White", which previously referred to heroin, and is 25% more potent than fentanyl. She suggested adding this to the list for future study.

Assemblyman Gray would like to see a presentation on medication assisted treatment (MAT) which he understands blocks some of the receptor cells. He believes there is a lot of potential there.

Ms. Nadler asked if the Good Samaritan law and doing billboards focusing on that is on the list and whether Dr. Kerns is working on that.

Dr. Kerns confirmed that they are looking at the Good Samaritan law versus drug induced homicide, as presented by University of Nevada, Reno, CASAT with educational components, to law enforcement and other members. Also, there have been educational campaigns under the Fund for Resilient Nevada (FRN) and through CASAT. She will send information to Ms. Nadler.

14. Public Comment

Ms. Rahr-Wood asked about sharing the list of bills that staff are tracking for the SURG. Dr. Kerns directed her to the SURG website under today's meeting. She could also send the address via email.

Mr. Mandell with Optima Healing and Recovery thanked members of the SURG and appreciated everything he learned today. As a person with lived experience, one thing that would not deter him from treatment is a couple more hours with overdose or withdrawal, what deters from treatment is the lack of access to get into treatment, and the lack of funding in the budget to be able to access treatment, while going through withdrawals, when you have that moment of clarity. He thanked members for their hard work trying to address this issue. He would like to collaborate with Dr. Wagner to review some of the data. In the field they are seeing stimulant users coming in for treatment are testing positive for fentanyl and opiates unknowingly and a lot of the ODs he has experienced of late – including his own brother, 3 years ago – it was not knowingly, along with a stimulant substance. Granted, he appreciated all the hard work and the great way that (Dr. Wagner) presented it, but he would love to collaborate on where some of that data is coming from because "our data on the ground level is a little bit different."

15. Adjournment

Acting Chair Johnson adjourned the meeting at 4:50 p.m.

Chat Record

01:05:08 Debi Nadler: I'm here if you called my name
01:07:28 Kim Hopkinson (she/her): Please do not utilize chat for anything other than technical issues because the content is not necessarily available to the general public, which is a requirement of the open meeting law.
02:14:07 Maureen Strohm: I recently recertified for CPR/BLS. BOTH compressions and rescue breathing were included AND OD management.
02:14:50 Maureen Strohm: Also, I wonder if longer acting antagonists would interfere with initation of buprenorphine after OD as many states are doing now in the field

02:16:38 Crystal Duarte (she/her): Please do not utilize chat for anything other than technical issues because the content is not necessarily available to the general public, which is a requirement of the open meeting law.
03:48:38 Kim Hopkinson (she/her):Please do not utilize chat for anything other than technical issues because the content is not necessarily available to the general public, which is a requirement of the open meeting law.