M E E T I N G N O T E S

Statewide Substance Use Response Working Group **May 22, 2023**
Response Subcommittee Meeting **10:00 a.m.**

Zoom Meeting ID: 868 3331 1069
Call in audio: (669) 444-9171
No Public Location

Members Present via Zoom or Telephone
Dr. Terry Kerns
Shayla Holmes
Christine Payson
Dr. Stephanie Woodard
Gina Flores-O'Toole

Members Absent
None

Attorney General's Office Staff
Ashley Tackett and Rosalie Bordelove

Social Entrepreneurs, Inc. Support Team
Crystal Duarte and Madalyn Larson

Members of the Public via Zoom
Eric Hall, Josh Luftig, Kalli Getachew, Linda Anderson, Michelle Berry, Morgan Green, Sarah Windels, Tray Abney, Lea Tauchen, Kelly Morgan

1. Call to Order and Roll Call to Establish Quorum
Chair Kerns called the meeting to order at 10:02 am.

Ms. Duarte called the roll and established a quorum.

2. Public Comment (10:03 am)
Chair Kerns asked for public comment.

Ms. Duarte reminded participants we can only use the chat to communicate technical issues as the chat is included in the public record. She asked members to refrain from texting one another during the meeting.

No other public comment.

3. Review and Approve Minutes from April 19, 2023 Response Subcommittee Meeting (10:05 am)

Chair Kerns asked for a motion to approve the April 19, 2023 Response Subcommittee meeting minutes.

- Vice Chair Holmes made the motion;
- Ms. Payson seconded the motion;
- Dr. Stephanie Woodard abstained.
- The motion passed unanimously.

4. Presentation on Opioid Antagonist Saturation Plan (10:07 am)
Michelle Berry, Senior Manager, and Morgan Green, Project Coordinator, Center for the Application of Substance Abuse Technologies, University of Nevada, Reno

Michelle Berry and Morgan Green's presentation slides are posted online at the SURG webpage under attachments for this meeting.

Ms. Green provided an overall update on where the state is in terms of the opioid antagonist saturation plan from the State Opioid Response (SOR) grant requirement. Between September 30, 2021- September 29,2022 Nevada distributed 27,916 kits. The distribution goals over next two years the next two years are as follows:

Year 1: 40,000 units
Year 2: 55,000 units

Ms. Green specified on the "Current Distribution" slide the total naloxone units distributed does not factor in law enforcement. There is still a discrepancy in what is considered full saturation (115,000 units) and what was possible between September 30, 2021- September 29,2022. The infrastructure, distributing partners, and the ability to distribute large amounts were not in place.

The targeted distribution and communication strategy focuses on locations and populations at highest risk. This includes improving relationships with industry, focusing on entertainment to expand more targeted distribution sites related to risky behavior such as casinos, sporting organizations, cannabis dispensaries, bars and clubs, and the sex industry. Expanding jail-based distribution and relationships with criminal justice agencies outside of the metropolitan areas and initiating emergency room opioid antagonist distribution, possibly in partnership with ED Bridge and Zero Suicide. There is also work going into increasing the availability of Harm Reduction Vending Machines in rural locations. Finally, working with the Attorney General's Office to reduce barriers to access through state legislation.

Ms. Green mentioned the SOR grant is currently the primary funder of opioid antagonist medications in Nevada and we must work on other funding sources for opioid antagonist medications to avoid shortages. In addition, she mentioned Assembly Bill 156 is working on this initiative, to secure multiple funding sources for the purchase of opioid antagonist medications.

Vice Chair Holmes asked Ms. Green if the naloxone distribution sites in Lyon County are correct because the slide says two sites, but Vice Chair Holmes is currently distributing at four sites?

Ms. Green assured Vice Chair Holmes she is right because they are counting these sites as organizations and they don't always communicate with SOR where they are distributing.

Vice Chair Holmes replied to Ms. Green and said they may need to work together to make sure we can get accurate site information.

Ms. Green replied to Vice Chair Holmes saying that would be wonderful to get as accurate site information as we can.

Ms. Payson asked about the spelling of the Nalmefene opioid antagonist medication

Vice Chair Holmes asked Ms. Green if they have had any success with the private partnerships for the vending machines as they are struggling in the rural counties to get buy in?

Ms. Green noted they have been working heavily with bars in Washoe County, specifically as pilot sites, but they haven't worked with them on the vending machine piece. She mentioned there has been heavy distribution through anonymous boxes at a lot of bar locations which has been really effective. Ms. Green noted the bars have been amazing partners and are a lot more open to this idea. They are noticing decreased shame and stigma for reaching out at these locations as well.

Ms. Green mentioned the rural counties have been more challenging to get buy in for the vending machines because of the requirements such as internet connectivity and weather permitting machine locations, which is limiting. They try to place the vending machines in places with other resources such as peer recovery support specialists, so people can feel comfortable seeking help at the same time.

Chair Kerns asked if we are getting naloxone now in the state since the delay? Secondly, Chair Kerns asked if they are tracking data on the naloxone that is getting distributed (i.e. is it getting used, is it expiring)? And, if it is getting used are you getting feedback on how many doses per overdose are being used on average?

Ms. Green said there are some delays in the naloxone orders because of strained resources at the state level, but the program does have naloxone right now. Secondly, they do track naloxone usage – it is a self-report, so we have fewer tracked numbers compared to actual but we do ask when they fill out the questionnaire to get information about overdoses and other information from the re-supply. Ms. Green noted it is taking an average of 4-6 doses right now with fentanyl overdoses.

Chair Kerns noted the naloxone distribution at the Electric Daisy Carnival (EDC) in Las Vegas. She asked Ms. Green if they are distributing both nasal and injection naloxone?

Ms. Green said they are purchasing both (with the help of OD2A). She noted naloxone injection is better for fentanyl overdoses and withdrawal symptoms.

Dr. Woodard asked if we are collecting data from Medicaid to track prescriptions written and filled for naloxone?

Ms. Green said we are not tracking this right now. But, there is a big discrepancy between the number of providers writing prescriptions and patients actually filling the naloxone prescription. Ms. Green mentioned it makes her happy it isn't a provider education issue, but rather getting patients to fill their prescription for naloxone.

Dr. Woodard noted there may be opportunities to have conversations with pharmacies about naloxone distribution and to also work with state Medicaid agency to educate on the importance on filling the naloxone prescription while simultaneously being prescribed opioid medications. In addition, there may be possibilities to work with the state Medicaid agency to create a technical bulletin for provides to provide support and coaching around the importance of patients filling all their prescriptions including naloxone while simultaneously being prescribed pain medications.

Chair Kerns said these are great suggestions and we should pursue these especially if counties don't have a naloxone distribution site, they can work with pharmacies to distribute naloxone.

5. **Presentation on Community Naloxone Access (10:28 am)** *(For Possible Action)*
Kalli Getachew, Emergency Department Nurse, Valley Hospital

Kalli Getachew's presentation slides are posted online at the SURG webpage under attachments for this meeting.

Ms. Getachew noted one of the biggest things she has noticed in the hospital is when patients are discharged with naloxone prescriptions they usually don't fill it.

{This presentation was combined with the bridge presentation}

6. Presentation on Emergency Department Bridge Program (10:32am) (*For Possible Action*)
Sarah Windels, National Program Director – National Bridge Network, Josh Luftig, PA-C – National Implementation Leader – National Bridge Network

Sarah Windels's and Josh Luftig's presentation slides are posted online at the SURG webpage under attachments for this meeting.

Ms. Windels introduced the California Bridge Program – a program that brings all the tools and knowledge needed to work with patients in the emergency departments to provide naloxone and other resources and tools.

Mr. Luftig explained the Bridge program started with four hospitals in 2017 and has increased to 278 hospitals in 2023. This program uses the hospital setting to connect substance use disorder patients with treatment through peer navigators. In addition, Mr. Luftig noted the Bridge program initiates medication assisted treatment (MAT) in the hospital setting.

Mr. Luftig noted the Bridge Model is characterized by low barrier treatment, connection to care and the community, and the culture of harm reduction. Low barrier treatment means having the clinical staff know about buprenorphine and be able to administer and prescribe it immediately in the emergency department. Secondly is connection to care such as having peer navigators right

in the emergency department so they can model behaviors and engage patients in outpatient treatment. Lastly is the culture of harm reduction including distributing naloxone and modeling language and behavior that is non-stigmatized around substance use conditions.

Mr. Luftig explained the issues impending emergency department naloxone distribution in Nevada is heavily related to not having low barrier access to naloxone. Mr. Luftig said it would be easier to have naloxone distribution in places like schools and libraries because of the low barriers and these environments not having to follow complicated protocols.

Chair Kerns thanked Ms. Getachew, Ms. Windels, and Mr. Luftig. She asked if the peer navigators would be the one that would be providing the naloxone as well as offering other types of services? And does that help alleviate the issues with hospital personnel providing medication for people who you are seeing in the emergency departments.

Ms. Getachew said she would be able to provide patients in the emergency department with an overdose kit right then and there. Also, she could give it to other people coming in to the emergency department who are not admitted but would like to have naloxone like family members, friends, or people who are dealing with opioid related substance use. This way would make naloxone much easier to access instead of giving them a prescription for Naloxone which may not get filled for reasons such as stigma or income.

Mr. Luftig seconded what Ms. Getachew said. In addition, Mr. Luftig mentioned previous models required a Pharmacist to be involved which created a bottleneck. This allows any staff member (i.e. clinician, nurse, peer navigator) they can all train in and be engaged in the program to distribute naloxone.

Chair Kerns asked if there are there any components for follow up after buprenorphine engagement?

Mr. Luftig noted they encouraged follow up clinics to have availability access to treatment after the emergency department initiates the care of buprenorphine. Once the emergency department starts a lot of the community follows along. He also talked about mobile integrated health partners through Las Vegas Fire and Rescue being able to engage patients with buprenorphine treatment in the field. Additionally, he added they recommend giving a larger supply for buprenorphine so that the person can stay engaged in treatment until they have their appointment.

Dr. Morgan added that there are efforts underway for community paramedics to help with these services. To figure out how to be used as the initial bridge to get MAT normalized in the Emergency Departments. There are also peer navigators being involved to help this begin to form into a coalition to provide these services. Then community paramedics act as that next step to getting people to stay engaged and work with community partners to ensure communication between community paramedics and Emergency Departments.

Chair Kerns thanked the presenters for the outstanding work they are doing.

7. 2023 Legislative Update (11:01 am) (*For Possible Action***)**

Vice Chair Holmes gave an update on the bills related to the Response subgroup (SB4, SB35, and SB 197). She explained SB4 is a good bill that is heavily related to our Response Subcommittee and the prescriptions that were discussed within the Fund for Healthy Nevada. Vice Chair Holmes noted SB35 has a 5/19/23 Assembly Workshop. She noted SB412 includes MAT in jails and correctional facilities (if money allows) and this has seemed to be snuck in as an amendment in SB35. She added SB197 has died and SB412 is sitting with a waiver with not much going on.

Vice Chair Holmes noted AB132 is moving along but may not be as updated as we have on the screen. She corrected the above statements with AB156 being the bill that would encourage MAT in correctional facilities. She said this bill has not even been read in the Senate yet.

Chair Kerns noted these updates are as of the end of April.

8. Overview of Recommendations Received and Next Steps (11:05 am) (*For Possible Action*)

Chair Kerns said we had 4 recommendations, which are explained in detail in the presentation slides posted online at the SURG webpage under attachments for this meeting.

For Recommendation #3, Dr. Woodard noted California was the first state that passed this waiver of this kind. We are seeing Centers for Medicare and Medicaid Services really stand by this and understand how they can use 115 waivers to do connectivity of care after release into the community.

Chair Kerns added that from SB35 and MAT availability in our frontier counties have a lack of providers being able to actually have and prescribe MAT. Similar to those who are discharged from Emergency Departments and Prisons/Jails are at higher chance of overdosing which is why this is being looked at.

Dr. Woodard talked about Bill Teal (within the Fund for Resilient Nevada) is working on a contract with DHHS to explore MAT in incarcerated settings to evaluate how county-based jails are in relation to readiness in being able to implement MAT/MOUD programs. She mentioned the importance of understanding the obstacles and opportunities to expand care in incarcerated settings. She does not have a timeline on this right now.

For Recommendation #4 Vice Chair Holmes added that University of Nevada, Reno is working on this recommendation currently and have several localities participating. In addition, there is a lot of research showing this recommendation can be helpful for not only opioids but other substances as well for a better community-based response. This is also helpful for providing data to trigger innovation to respond to spikes and things of that nature.

Chair Kerns noted University of Nevada, Las Vegas is also working on this recommendation – so we have some basis in our state for this.

Chair Kerns added one of the other things they are looking at is doing some targeted fentanyl awareness/education for our first responders. She mentioned a few months back, there were some deputies exposed to fentanyl and were treated. She also added she has heard anecdotally officers are pre-dosing themselves with naloxone before they go into do action. So, they are working on getting some education for our first responders.

Dr. Woodard noted she thinks this fits the Joint Task Force priorities and should be heard and contemplated before the Joint Task Force.

Chair Kerns agreed and noted this may be one we'd like to add.

Ms. Duarte said there will be a legislative update at the larger SURG meeting. But it would be great for people to get together to refine the recommendations that are similar (but until we hear final updates from legislative session, we will have to wait on this). If members heard something today that they want to elevate/recommend from the presentation, please submit these recommendations personally.

9. Discussion of Report Out for July SURG Meeting (11:21 am) (*For Possible Action*)

Vice Chair Holmes asked the committee if there is anything they would like to discuss from our four recommendations to report out at the July SURG meeting?

Ms. Duarte noted the next Response meeting will be July 17th at 9am, so it will be after the large SURG meeting on July 12th.

Chair Kerns noted we really need to figure out what is happening with recommendation #1 and #2 from the legislative session before we can come to consensus on what we will do with these recommendations. We may want to add this to our report out to the larger SURG.

10. Public Comment (11:24 am) *(Discussion Only)*

Chair Kerns asked for public comment.

Dr. Morgan backed up the presentations made today and added that the most important recommendation made today was to re-look at the Board of Pharmacy regulations to help better enable naloxone distribution within hospital settings for community harm reduction. She explained she saw patients twice this past weekend who needed Naloxone and weren't ready for treatment yet. Dr. Morgan said she would like to stress the importance of this recommendation to the committee here today. Having easy access to naloxone should be a top priority going forward.

Chair Kerns noted this is not currently a recommendation, but it could be something we want to put as a recommendation. We can look at the Bridge program and figure out the next steps to getting this implemented in our state.

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