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

Statewide Substance Use Response Working Group **August 06, 2024**
Response Subcommittee Meeting **11:00 a.m.**

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

Members Present via Zoom or Telephone
Shayla Holmes
Dr. Terry Kerns
Nancy Lindler
Christine Payson

Members absent
None

Attorney General's Office Staff
Rosalie Bordelove and Ashley Tackett

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

Members of the Public via Zoom
"Aacero," Tray Abney, Linda Anderson, Jordan Baez, Jessi Bailey, Brandon Beckman, Alexia Benshoof, Jason Benshoof, Natalie Bladis, Chris Burroughs, Jennifer Duncan, Dan Gerrity, Rachel Isherwood, Nadine Keinhoefer, Elyse Monroy, Ed Oh, Chyna J. Parker, Ken Pfeil, Sabrina Schnur, Teresa Thompson, Marcus Thornton, and Pauline Whelan

1. Call to Order and Roll Call to Establish Quorum
Chair Kerns called the meeting to order at 11:02 am.

Ms. Duarte called the roll and established a quorum.

Chair Kerns noted Senator Jeff Stone will join this subcommittee as a member of the Senate appointed by the Senate Minority Leader.

2. Public Comment (11:04 am) *(Discussion Only)*
Chair Kerns asked for public comment and read the public comment guidance.

Chair Kerns congratulated Vice Chair Holmes on obtaining her Doctor of Public Administration degree.

3. Review and Approve Minutes from June 04, 2024 Response Subcommittee Meeting (11:06 am) *(For Possible Action)*

Chair Kerns noted that on page 7, the 9th paragraph down she would like to change "Advisory Committee for a Resilient Nevada" to the Fund for a Resilient Nevada (FRN).

Chair Kerns asked for a motion to approve the June 04, 2024 Response Subcommittee meeting minutes as amended.

- Dr. Holmes made the motion;
- Ms. Payson seconded the motion;
- The motion passed unanimously.

4. Update on Wastewater Surveillance of High-Risk Substances in Nevada (11:08 am) *(For Possible Action)*
Daniel Gerrity, Ph.D., P.E., Principal Research Scientist, Southern Nevada Water Authority, and Edwin Oh, Ph.D., Associate Professor, Neurogenetics and Precision Medicine Lab, University of Nevada Las Vegas

Dr. Gerrity noted that he would be providing an update on wastewater-based epidemiology (WBE) relevant to the 2023 SURG Annual Report recommendation, "*Recommend the Nevada System of Higher Education (NSHE) conduct a feasibility study to understand the true cost of implementing wastewater-based epidemiology (WBE) in Nevada and its ability to support community response plans. Funding for this study may be available through the Fund for a Resilient Nevada*." Comments offered by SURG members at the time the recommendation was made were that 1) true outcomes and capacity were unknown, 2) the recommendation was included as "not urgent" but with potential to improve understanding of population level characteristics, and 3) there was potential to fill knowledge gaps related to racial and health equity (e.g. rural areas). He and others have a paper coming out that looks at rural and other demographic factors in relation to WBE.

Dr. Gerrity gave a summary of the application of WBE in Southern Nevada. His team took samples every two weeks for one year from eight different sewer sheds. They found 17 trace organic compounds and 22 high-risk substances. Trace organic compounds include ibuprofen, sucralose and other common things people consume. High risk substances include illicit substances and their metabolites, these can include cocaine, norfentanyl, tramadol, and other substances. They have published a paper on this topic.

Dr. Gerrity explained the first of three high risk substance use case studies. The objective of this study was to assess the long-term trends in community-scale high risk substance use. They wanted to evaluate shifting trends and policy effectiveness in relation to high-risk substance use. They scaled this by utilizing centralized wastewater treatment facilities. The found consumption increasing overtime and in relation to special events in Las Vegas. For example, a baseline weekend (without a special event) compared to a Super Bowl weekend, the consumption of cocaine increased by 100 percent.

They can also use this information to estimate how much overall fentanyl consumption is in an area. In 2023, there was about 50 kilograms (kg) of fentanyl in Southern Nevada. Additionally, they looked at data that was released by the Drug Enforcement Agency (DEA), which seized about 80 million fentanyl laced counterfeit pills in 2023. The study estimated that about half of those pills contained fentanyl at concentrations/amounts greater than, or equal to, 2 milligrams (mg), which is estimated to be the fatal dose for Fentanyl. If we take that number, and we apply

it to our wastewater data set, we can say that there's been about 25 million fentanyl laced counterfeit pills that were consumed just in Southern Nevada, from the 2022 to 2023 monitoring period. We can establish baselines from this usage data and we can better understand what that means in terms of consumption of these particular compounds.

The second case study looked at concerning spikes in high-risk substance use. The policy and public health implications for this information is to be able to identify times and locations for targeted interventions. The scale of this data is from centralized wastewater treatment facilities (or collection systems). From this data they are studying the concentrations of the metabolite of fentanyl in the sewer sheds and comparing it to overdose data. Sewer shed 2 had the lowest overdose rate of 80 per 100,000 people and sewer shed 3 had the highest overdose rate of 337 per 100,000 people. He also noted an increase of norfentanyl concentrations after October 2022, which match the overdose rates.

The objective of the third case study was to conduct high-resolution wastewater surveillance. The policy/heath implication for the results of this study were to mobilize facility-specific interventions (i.e. awareness of spikes and naloxone distribution). The scale of this study was within a collection system of manholes at different dates in 2023. From this study, Dr. Gerrity noted Methylenedioxymethamphetamine (commonly known as MDMA or ecstasy) use was elevated during a popular festival in Las Vegas, the Electric Daisy Carnival (EDC). The levels of MDMA were 100 times higher at the treatment plant and 10,000 times higher at the EDC manhole. Additionally, there were MDMA/norfentanyl elevations and spikes at bars. The study also found a link between norfentanyl use and MDMA, indicating people may be taking MDMA laced with fentanyl in Southern Nevada. There was also a link between fentanyl and unsheltered populations. Finally, they detected xylazine in one hospital sample in Southern Nevada, indicating it might not be as prevalent in Southern Nevada.

Dr. Gerrity noted that from this work, Dr. Oh recently submitted a proposal to the Fund for a Resilient Nevada. The proposal focuses on Goal 7 – Provide high quality and robust data and accessible, timely reporting. The requested funding for the project is $750,000 per year for three years. The target population is youth aged 13-17 and transitional age youth 18-24 years old. Funding would support manhole sampling at urban and rural high schools and college/university campuses in Nevada and sampling at specific to bars/nightclubs. Public health actions potentially resulting from this work include: awareness/outreach programs, naloxone deployment to necessary areas, and fentanyl test strip deployment to bars/nightclubs where there is high usage. He noted that this program is based on a similar program in New Mexico. The New Mexico program found none of the samples that they collected contained heroin or its metabolites, but about 10 percent of samples contained fentanyl and or its metabolite, norfentanyl, and about 60 to 70 percent of samples contained cocaine or its metabolites. This study gave researchers the ability to understand high risk substance use and consumption patterns and respond.

Dr. Oh added that the information presented to the subcommittee today is from the sewer shed or facility level and represents jurisdictions like the City of Las Vegas, Henderson, and Boulder City. Using wastewater values of the 39 analytes presented on slide nine of Dr. Gerrity's presentation, we are able to overlay that with zip code level information about these various jurisdictions to make predictions on what type of urban or rural characteristics might be present there. What we found was a striking positive correlation with what I think we already know –

that you are what you eat, or what you consume. The levels of the analytes found closely matched the characteristics of different areas, whether you're in the Anthem jurisdiction or in different parts of Henderson. And so, in the initial publication, there was proof of principle that we can track these 39 analytes over time, over 12 months, across different locations and we can overlay information at the zip code level of whether an area is urban or rural. We are hopeful that moving forward that if this can be done at the macro level and at the city level, it can definitely be done at the dormitory level or high school level. With that information we would have near real time ability to track use and then provide an intervention specific to the needs of that community.

Dr. Gerrity noted that the remaining slides contain information on the citations for the publications of the papers that resulted from these studies as well as the New Mexico program. Dr. Gerrity also noted an executive order in Virginia to develop a wastewater surveillance program for high risk substances across the state. He said there are countless other examples throughout the country right now trying to use wastewater surveillance to expand beyond Covid-19 to things like cocaine and fentanyl, and so forth, to track high risk substance use throughout a community.

Dr. Holmes noted that this work can help us respond to overdose potential. She thinks that this kind of data will give us better information on where to target interventions and to what populations may need heavier naloxone distribution. She asked what the realistic amount of time is between collection and publication of the data. Is it days, hours, weeks?

Dr. Gerrity said that with the analysis it could be within one to two days that the data could be generated. They would collect sample data within one to two days and then getting it to the public, might take longer in terms of uploading it to a dashboard and making sure that the formatting is all right, things like that. But in terms of getting it to people who might take action, it could be happening within that one to two-day period.

Dr. Holmes asked if they have any instances where they have partnered with law enforcement on this work? And if there is anything that they would be able to pull from this data to aid with understanding drug distribution and drug trafficking? Is there any sort of correlation to the law enforcement level, or are they totally focused on the public health side?

Dr. Gerrity said at this point in time they are completely focused on the public health side. Because this work began from Covid-19, there wasn't need for law enforcement but now that we are researching high-risk substances, there have been a lot of concerns brought up about being public health focused compared to law enforcement focused. He said he understands these concerns, however, there really hasn't been any law enforcement involved as of now, because these efforts have been entirely focused on the public health response. This work is expanding throughout the state to benefit other communities, but law enforcement has not been present throughout this work.

Chair Kerns asked about how flexible Dr. Gerrity's team is to add different substances to the number of analytes they are checking for within their research?

Dr. Gerrity said this work is not only in the high-risk substance context but also researches quality of drinking water amongst other things—ultimately, he said they are always looking for

the next contaminant. He noted that UNLV and the College of Southern Nevada will be doing the surveillance part of this research and at the Southern Nevada Water Authority, they will be focused on methodology development. He noted that as new compounds are identified or start becoming more of an issue in certain parts of the country, they can expand their methods to address those new compounds and add them on. Xylazine is a good example where it wasn't part of the original list but now this is something we are including because of the recent trends.

Chair Kerns asked if they have a working relationship with the health department or if there is a memorandum of understanding (MOU) in place with them?

Dr. Gerrity said yes there is a working relationship with the health department. He noted that it really started off as an informal relationship between Dr. Oh at UNLV and the water treatment authority and then Southern Nevada Health District became involved. We all eventually got funding through the Southern Nevada Health District to expand that program so then that became more of a formal relationship. He said that if they are going to develop an MOU, it would formalize the agreement and ensure that groups are getting the data in the timeframe they need.

Chair Kerns thanked Dr. Oh and Dr. Gerrity for their presentation.

5. **Mobile Overdose Response and Nevada's Crisis Response System (11:30 am) (***For Possible Action)*
Rachel Isherwood, BSW, CCM, Crisis Response System Program Manager, Bureau of Behavioral Health, Wellness, and Prevention, Nevada Division of Public and Behavioral Health

Ms. Isherwood noted she would be going over a couple key components of the crisis response system and its role with diversion and deflection, within criminal justice system. She said she will be going over the purpose of the crisis response system as well as the importance of mobile crisis for diversion and deflection, the role of follow up services, such as response for non-fatal overdose.

She explained that the diagram on slide 19 is what crisis response would look like in a perfect world. She said the Substance Abuse and Mental Health Services Administration (SAMHSA) has described three pillars for crisis response. The first pillar is providing someone to talk to, which is the 988 Suicide and Crisis Lifeline. The second pillar is someone to respond in real time, which are the mobile crisis teams. The third pillar is providing a safe place for help, which are the crisis stabilization centers. In this process, someone would call 988 if they are in crisis and receive behavioral health help. If they cannot be de-escalated, they can elect to have someone come to them in person, which is the mobile crisis response team. If someone still is not able to have their crisis alleviated, they can elect to be transported to a safe place for help, which will be the crisis stabilization centers. After any step of that process someone can elect to have follow up services provided to them, and that will be automatically flagged for a return call to that person or for an appointment for follow up services.

Ms. Isherwood noted a few data points that they have found from different articles and jurisdictions implementing the crisis response System. In Arizona, 80 percent of crises were resolved over the phone and the remaining 20 percent that were not resolved needed a mobile

team to be dispatched to them in person. Of those 20 percent, 70 percent were resolved in the field and didn't need additional services in the crisis response system.

Nevada currently has Crisis Support Services of Nevada serving as the 988 call center. The state is in negotiations with a vendor to work on the crisis response system in Nevada further, but Ms. Isherwood could not say more because she is under a non-disclosure agreement. Ms. Isherwood also noted that they are currently developing their mobile crisis response teams in Nevada. Their goal is to have certification standards for mobile crisis teams that will be dispatched from the 988 call center. She mentioned that the current landscape for our state is varying in mobile crisis response program models and that we have virtual crisis care for individuals who live in the rural areas. Additionally, they have a children's crisis response team. In Northern Nevada, she said that Renown is going to be opening up their community crisis center and there will also be one opening up in Southern Nevada as well.

On slide 20, Ms. Isherwood explained the way the crisis response system functions versus the criminal justice system without a crisis response system. On the side representing the criminal justice system, she gave an example of someone with a need for emotional or behavioral health support committing an offense which results in an incarceration. During incarceration or following release, that person may not be receiving the appropriate behavioral health resources to alleviate the problems they are facing, which may cause them to re-offend. She said this is where the crisis response system can come in to be able to support that person and get them the care they need to be successful. She noted an article that found an effective crisis response system can decrease inpatient admission spending by 79 percent. With this, police were able to divert people from being in hospitals trying to obtain behavioral healthcare, or whatever caused them the crisis in the first place. They can use this system, and savings, to get people connected to care so they are not incarcerated or re-offending. The same study also noted that an effective crisis response system resulted in follow up care for 44 percent of individuals who would have otherwise been incarcerated—this saved jail expenses upwards of 3 million dollars.

Finally, Ms. Isherwood noted that naloxone distribution is not a component of the crisis response system, but they could look at possible remedies for this to support the naloxone saturation plan.

Dr. Holmes asked about Ms. Isherwood's thoughts on the co-responder model within the crisis response system? She also asked what this looks like nationally. Additionally, she was curious about what is the most effective way for law enforcement to be involved?

Ms. Isherwood said that there is a lot of stigma with law enforcement and that the number one search in Googled related to 988, is if the police will show up after calling, so this is a concern. It is a question of how to balance this system with the law enforcement system to help people in the most effective way possible while fighting back against stigma. SAMHSA does not include having a law enforcement co-responder model. However, they are aware that there are communities that do heavily rely on law enforcement, and that in many there is a good relationship, such as the relationships in rural counties in Nevada. Ms. Isherwood said they are not looking at doing one size fits all approach. There will be standards and certifications, but we understand that the rural areas are fiercely independent, and we are going to do the best we can to support them. The state is trying to get to a certification standard, so that they can have a level of fidelity met within this system.

Dr. Holmes appreciated her response. She mentioned that her program is considering ways in which they can reduce the presence of law enforcement by shifting toward a civil standby model. This looks like having law enforcement nearby in case someone does escalate but not on the scene right away and could respond when necessary. They are also looking to re-brand some of their law enforcement vehicles to try and reduce stigma. She noted that in rural areas it is important to remember how long it takes to respond to someone in crisis and that this should be kept in mind when developing systems.

Chair Kerns asked if there are any mobile crisis teams being funded through telephone taxes?

Ms. Isherwood noted that we are too early to know things about that specifically. However, she did mention that there is a 988-telephone tax surcharge fee but it has not been spent at all for mobile crisis. She said the majority of this funding will go towards the request for proposal (RFP).

Chair Kerns asked if all teams in this crisis response program will need to be certified to become official mobile crisis response teams under the program?

Ms. Isherwood said yes, if they are going to be dispatched from 988, then that is the goal they are working toward.

Chair Kerns asked how law enforcement will be certified?

Ms. Isherwood said this is still being determined. However, from their research they have determined that there is a Medicaid reimbursement rate for law enforcement on mobile crisis response teams. It is too early to know exactly how this will look.

Chair Kerns thanked Ms. Isherwood for her presentation and responses to questions.

6. Virginia's Framework for Addiction Analysis and Community Transformation (FAACT) (11:51 am) (*For Possible Action)*
Ken Pfeil, Commonwealth Chief Data Officer, Marcus Thornton, Deputy Chief Data Officer, and Chris Burroughs, Director of Data Protection and Governance, Office of Data Governance and Analytics (ODGA)

Ken Pfeil introduced himself as the Chief Data Officer for the Commonwealth of Virginia and he introduced Marcus Thornton as the Deputy Chief Data Officer for Virginia and who would be providing the subcommittee with an overview of FAACT.

The primary thing ODGA does is facilitate data sharing across the commonwealth. Additionally, they help agencies implement data governance strategies, partner with various institution types (executive branch agencies, university institutions, and others), develop data sharing agreements, and develop innovative data analysis and intelligence methodologies and best practices to promote data driven policy making, decision making, research and analysis.

Mr. Thornton said ODGA developed a standard MOU for agencies to utilize for the data sharing process. He said this was important because this means agencies don't have to create a new

established agreement with one another. This allowed the Commonwealth to create a secure and safe data sharing apparatus for agencies to utilize.

Mr. Thornton provided a background of FAACT – the framework for Addiction Analysis and Community Transformation. FAACT was created in 2018 by an Executive Order. Through partnership with the Department of Criminal Justice data was collected from various organizations and a shared platform was created for this data to be disseminated. The FAACT platform was enabled by the Data Collection and Dissemination Practices Act, which was established in 2018. This act was the catalyst to create the data sharing platform and create the cabinet level position for the Chief Data Dfficer and establish what became FAACT. So now we have a platform where we can produce a lot of reports, dashboards, and visualizations surrounding the opioid epidemic and specifically fentanyl.

Mr. Thornton explained the FAACT system has a few key capabilities: 1) comprehensive data governance, 2) secure data sharing, 3) self-service agreements, and 4) predictive capability. Mr. Thornton noted the most important thing people are getting out of FAACT is the data visualizations and the ability to know where fentanyl deaths are happening specifically and in what areas. He also mentioned doing predictive analytics using acritical intelligence – to predict where a fentanyl death may occur. They may be able to predict with some level of certainty where deaths may happen and what groups would be most impacted.

Mr. Thornton noted this data platform has been very successful in Virginia. There has also been more law enforcement collaboration, as well as a naloxone kit distribution push to prevent overdoses.

Ms. Burroughs, the Director of Data Protection and Governance at ODGA, provided a demonstration of the FAACT system. This system has tiles for each partnered organization, as well as an integrated harm reduction dashboard. She mentioned that on this specific dashboard there are metrics from a variety of different agencies who upload data to it. There are metrics related to substance cases, substance arrests, and substance related emergencies in in a specific year. She also brought up the Emergency Medical System overview dashboard that reports substance use incident responses for various counties throughout Virginia. These dashboards are used by various agencies and the Governor’s office to understand response data, what substances are being used, arrests, and demographics.

Chair Kerns asked if the executive order came first or the work behind the scenes of getting the agencies together to make this data sharing dashboard a reality?

Mr. Thornton said the order came first. He explained the timeline – in 2017 the Chief Data Officer position was created in Virginia and in 2018 the Dissemination Act was passed by legislation so that they could do data sharing, which then created OGDA in 2021. At the crux of everything was the fentanyl crisis which is what sparked the creation of ODGA.

Mr. Thornton went over the common questions about FAACT. He said most of the questions are about how ODGA was established, how the platform was established, and what happens to the data. For example, the data that goes into FAACT is all federated—there's not any sort of Personally Identifiable information (PII) that is going to be displayed in FAACT, so we protect all PII information. Additionally, anyone can make a request to access the platform. He said

mostly everyone can get access because it is a public platform. The ODGA are the ones to facilitate the data sharing apparatus. Additionally, Mr. Thornton said there are more sensitive data sets that have other platforms, they are not in FAACT.

Mr. Thornton ended with the importance of having multiple agencies come together to not only contribute to the data, but to help manage the data through defining characteristics of the meta data they collect.

Chair Kerns asked Mr. Thornton if he has any words of wisdom as we move through this data process in Nevada?

Mr. Thornton replied and said to not worry about the data that you can't get and only worry about the data that you can, and that you have to start with and go from there. He said the system will gradually build itself up—you have to start somewhere to get a solid foundation for a data system. He said in their experience they worried a lot about the data they couldn't get instead of focusing on what was right in front of them.

Dr. Holmes asked if they can track specific people who have had multiple touches throughout the system using PII data? She said not to share this publicly but more so to see if someone is "ping ponging" through the system and to tell the story that way?

Mr. Thornton said they do have this ability and then to de-identify individuals. He said they have something called a universal entity index. He said it is a repository of all individuals in the Commonwealth and as they get more data about that individual, they will replace the PII data with a unique identifier so that specific details are not linked to a person. He said this is how they are able to track specific people but do so in a sensitive way.

Dr. Holmes said this could help with conversation the subcommittee has had about recidivism as well.

Elyse Monroy, a member of the public on the Zoom call, was granted permission from Chair Kerns to ask a question. Ms. Monroy asked if the FAACT system can support longitudinal analyses for any of their fatality reviews in Virginia? Additionally, she asked if they have a template MOU for data sharing they could share publicly?

Mr. Thornton said yes, there is a publicly available data sharing MOU on their website that anyone can use. Additionally, he said they do track fatality review data through different dashboards. He said there are a lot of different statistics related to this—crime, suicide, or infant deaths. Basically, he said there is a lot of detail this can go into, so people have to be thoughtful when thinking about fatality reviews.

Ms. Burroughs shared the Medical Examiners (ME) dashboard from when someone dies. But she said there is a technical lessons to be learned from this because a Medical Examiner may have different conclusions after they do their own review compared to when someone is initially diagnosed with cause of death. Additionally, the ME takes a little longer to confirm a fentanyl death. This dashboard has a breakdown of locality, county, substance type, and more stratifications.

Chair Kerns asked about the funding for FAACT.

Mr. Thornton noted that the state has allocated various amounts of funding to support FAACT to different agencies participating. The funding has also been held in the Virginia Information Technology Agency (VIDA), who ODGA partners with closely.

Chair Kerns thanked ODGA for their presentation.

7. Overview of Recommendations Received and Next Steps (12:22 pm) (*For Possible Action)*
Recommendation #1 – *Recommend a Bill Draft Request (BDR) to have recidivism defined in Nevada Revised Statues (NRS)*

Chair Kerns said this is something the subcommittee needs to work on. She said the subcommittee still needs to address some of the topics such as, is there a timeframe, are there specific infractions that would be considered or not? It will also be important to look at some of the programs already being implemented (i.e. Forensic Assessment Triage Team - FASTT) as well as some of the other diversion and deflection programs to get a consensus from those groups. Chair Kerns noted that currently the definition is different from county to county and what we want to do is to be able to look across counties because people travel across counties. Chair Kerns said she will work with Cherylyn Rahr-Wood and Dr. Katie Snyder on this recommendation to get more information.

Recommendation #2 – *Recommend research into implementation of statewide Data Sharing Agreements with the Chief Data Officer of the State of Nevada and implementation of a cross-sector database housing multiple points of data across prevention, treatment, recovery, and criminal justice*.

Dr. Holmes said her aim with this recommendation was to recommend something that would mimic the build out of FAACT and start the foundational process of a FAACT for data sharing in Nevada. She said that based on her research, the best way to get started with this would be to start collecting the data that currently exists and seeing how it can grow from there within a data dashboard. She said that is the basis for this this recommendation, and we just heard from the presenters on how we can do this, but she said we still need to hear from Nevada personnel.

Chair Kerns added that the Office of Analytics out of the State of Nevada Department of Health and Human Services has put together an opioid dashboard, but she doesn't think it is as extensive as FAACT.

Dr. Holmes agreed and mentioned the wastewater-based epidemiology data could be housed in something like this.

Chair Kerns added there is still work to be done on this recommendation.

Chair Kerns then went over the recommendations for considerations from the prior Annual Reports.

From 2022:

- (For consideration) *Resolve the conflict between the Good Samaritan Drug Overdose Act and Drug Induced Homicide Law; immediate action may include recommending community level education using best practice guidelines, as well as education for law enforcement personnel.*

From 2023:

- *1) (Unranked) Recommend to the DHHS (Office of Analytics/or the appropriate entity) to create a data dashboard or other type of regularly updated report on alcohol outlet, tobacco outlet, and cannabis outlet density.*
- *2) (Unranked) Recommend the Nevada System of Higher Education (NSHE) conduct a feasibility study to understand the true cost of implementing waste water-based epidemiology (WBE) in Nevada and its ability to support community response plans. Funding for this study may be available through the Fund for a Resilient Nevada.*
- *3) (Revised from 2022 and removed from 2023 Annual Report Rankings for further consideration in 2024) Review the operations and lessons learned from Clark County's Overdose Fatality Review Task Force when that body's report is released in December 2024 and take this into account when supporting legislation to establish regional Overdose Fatality Review (OFR) Committees allowing flexibility as to the makeup and practice and for the OFR to remain at the county or regional level, as needed, to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies in accordance with established best practices such as the Bureau of Justice Assistance's Overdose Fatality Review: A Practitioner's Guide to Implementation (See Also Overdose Fatality Review for Additional Resources)*

Chair Kerns noted for the 2022 recommendation, "*Resolve the conflict between the Good Samaritan Drug Overdose Act and Drug Induced Homicide Law; immediate action may include recommending community level education using best practice guidelines, as well as education for law enforcement personnel,*" staff from the Nevada Opioid Center for Excellence (NOCE) will be coming to talk about the webinar hosted on this subject in June.

Dr. Holmes noted that she agrees that education is a part of this but that people with lived and living experience are not comfortable calling 911 in response to an overdose with the way the law is currently written. Dr. Holmes feels that this cannot be checked off with more education, but rather we need to think about this further and talk to people this directly affects to make sure they are comfortable and not fearful of calling for help.

Chair Kerns said this is an excellent point and that we need to continue to follow this and suggest some language in the future.

Ms. Duarte noted for this recommendation, "*Recommend to the DHHS (Office of Analytics/or the appropriate entity) to create a data dashboard or other type of regularly updated report on alcohol outlet, tobacco outlet, and cannabis outlet density*" did not come out of the Response subcommittee.

Chair Kerns said this may have come from the Prevention subcommittee. However, she mentioned that this is something that could be included in the data dashboard framework similar to FAACT for Nevada.

Dr. Holmes said that a lot of the conversations we have had can fit nicely into a FAACT like data dashboard.

Chair Kerns asked Dr. Holmes if there is already available data on alcohol, tobacco and cannabis density?

Dr. Holmes said she isn't sure but can go look back at other places where this data might be, potentially on the Secretary of State's website.

Ms. Duarte said she can look back at Prevention and re-watch one of the presentations to see what is included under this recommendation.

Chair Kerns explained the next 2023 recommendation, "*Recommend the Nevada System of Higher Education (NSHE) conduct a feasibility study to understand the true cost of implementing waste water-based epidemiology (WBE) in Nevada and its ability to support community response plans. Funding for this study may be available through the Fund for a Resilient Nevada.*"

Chair Kerns said there is proof of concept for this.

Dr. Holmes said she would like to continue to track this. She said it will be important to understand the true costs of this and the actual use of the data, such as with looking at smaller communities (i.e., high schools/universities) is a great pilot program for this.

Chair Kerns agreed. She said it sounds like Dr. Gerrity and Dr. Oh have already been working with Southern Nevada Health District.

Dr. Gerrity said it is more informal for the high-risk substance topic as opposed to the infectious disease topic. He said that as they develop the data, they would share it with the Health District. It would be a lot more formalized so that they could take action and be more confident using the data with the experience they have now.

Chair Kerns thanked Dr. Gerrity for that information.

Chair Kerns went over the final 2023 recommendation for consideration, "*(Revised from 2022 and removed from 2023 Annual Report Rankings for further consideration in 2024) Review the operations and lessons learned from Clark County's Overdose Fatality Review Task Force when that body's report is released in December 2024 and take this into account when supporting legislation to establish regional Overdose Fatality Review (OFR) Committees allowing flexibility as to the makeup and practice and for the OFR to remain at the county or regional level, as needed, to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies in accordance with established best practices such as the Bureau of Justice Assistance's Overdose Fatality Review: A Practitioner's Guide to Implementation (See Also Overdose Fatality Review for Additional Resources).*"

Chair Kerns said at one of the next meetings we are going to have a presentation from the Clark County Opioid Task Force.

Chair Kerns also noted Senator Stone may be submitting a recommendation around pharmacy take back boxes, but we will wait to see until the next meeting.

8. Approach to Recommendation Ranking Process (12:40 pm) (*For Possible Action)*

Chair Kerns said it is likely this year that we will have less recommendations than we have had in the past. For the actual ranking of the recommendations, Chair Kerns explained the options under the various processes: 1) keep the process the same as it was last year, 2) have each subcommittee rank their recommendations and then bring them to the SURG, 3) present them to the SURG and not rank any of them. She noted that part of the reason we are going through this discussion is because the Response subcommittee recommendations usually are unranked or ranked lower.

Ms. Payson said she likes the process of them being unranked. She asked if each subcommittee is allowed a certain amount of recommendations?

Chair Kerns said yes, that's something that we can certainly recommend. She mentioned that a consideration is that the harm reduction recommendations come from all subcommittees, and then there are also sometimes cross cutting recommendations. If we follow the process from last year, cross-cutting recommendations get remanded back to one subcommittee, and then that subcommittee reworks the recommendation to include language from both, and then they take ownership of that one. Chair Kerns said she likes this idea of un-ranking the recommendations.

Ms. Payson said that if it was her preference she would like to allow each subcommittee a certain number of recommendations.

Chair Kerns asked the subcommittee members if they would be okay with the recommendations not being ranked and potentially suggesting a total of 5-6 recommendations from each subcommittee?

Ms. Lindler said this is acceptable. She said it was hard to rank them last year when she didn't have all of the information, so keeping it at the subcommittee level would be helpful.

Ms. Duarte clarified that for the full SURG to go forward with a recommendation or slate of recommendations there would be a vote in December. She wanted to clarify that even without ranking, there will be a vote and possible discussion on each recommendation as there has been in the past.

Chair Kerns wanted to clarify this process in explaining that if we have 12-15 recommendations, would they need to vote on those as a subcommittee? She said the only part that must be considered is that if someone has a strong objection against a recommendation that they wouldn't support, then they would vote nay, and does it then get included or not. In the past, recommendations in which there as not consensus, still were included.

Ms. Duarte confirmed this is correct.

Chair Kerns said this would most likely happen when the recommendations are presented at the larger SURG meeting.

Chair Kerns added a final point for the next larger SURG meeting. To add more members to the subcommittee, we do not have to submit a BDR, Attorney General Ford will do this.

9. Upcoming Response Subcommittee Meetings (12:51 pm) (*For Possible Action)*

Chair Kerns explained the plan for the upcoming meetings. In September, the subcommittee will refine recommendations, get an update from the Nevada Opioid Center of Excellence, get an update on jail medication for opioid use disorder, and talk through workforce. In November, the subcommittee will finalize recommendations with feedback from the SURG and get an update from the Clark County Opioid Task Force. The next Response subcommittee meetings will be on September 18th and November 5th from 11am-12:30pm.

Dr. Holmes said she is going to extend her calendar to 1pm for the upcoming meetings.

10. Public Comment (12:53 pm) *(Discussion Only)*
Chair Kerns asked for public comment and read the public comment guidance.

No public comment was provided.

11. Adjournment
The meeting was adjourned at 12:54 pm.