MEETING NOTES

Statewide Substance Use Response Working Group
Treatment and Recovery Subcommittee Meeting

November 18, 2025
3:00 p.m.

Zoom Meeting ID: 894 8937 5298
No Physical Public Location

Members Present via Zoom or Telephone
Chelsi Cheatom, Stephanie Cook, Dr. Lesley Dickson, Guiseppe Mandell, and Steve Shell

Members Absent
Assm. Heather Goulding and Assm. Rebecca Edgeworth (Excused for Special Legislative Session)

Office of the Attorney General
Dr. Terry Kerns, DAG Joseph Peter Ostunio, and Ashley Tackett

Social Entrepreneurs, Inc. Support Team
Laura Hale and Kelly Marschall

Members of the Public via Zoom
Linda Anderson, Jess Angel, Lori B., Jamie Bartlett (CASAT Learning), Jennifer Bevacqua (Safe Babies Nevada), Haylee Butler, Tina Gerber-Winn (NV Public Health Foundation), Heather Kerwin, Maddy Larson, Candace Lewis Vaughn, Stefaine Maplethorpe, Jamie Ross, and Sabrina Schnur

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Shell called the meeting to order at 3:01 p.m. Ms. Marschall called the roll and established a quorum.

2. **Public Comment**
   There were no public comments.

3. **Review and Approve Meeting Minutes from August 19, 2025, Treatment and Recovery Subcommittee Meeting**
   - Dr. Dickson made the motion to approve the minutes.
   - Ms. Cheatom seconded the motion.
   - The motion carried unanimously.

4. **Introduction of New Subcommittee Members**
   Chair Shell said he was very excited to have some new members joining this subcommittee, but sad to see others go. He invited all the members present to introduce themselves with brief background information:

- Chelsi Cheatom said she represented harm reduction based on her prior work with Trac-B Syringe Exchange program in Las Vegas established in 2016, which she still supports. She now works for the PACT Coalition for Safe and Drug Free Communities and will be transferring to the Prevention and Harm Reduction Subcommittee, based on her expertise, and will continue as a member of the full SURG. She said it had been great serving on this subcommittee, where they are doing wonderful things with good recommendations. She is available if anyone has questions about her previous work related to harm reduction.
- Stephanie Cook serves as the State Opioid Treatment Authority within the Bureau of Behavioral Health, Wellness, and Prevention (BBHWP) where she is also the Deputy Bureau Chief, overseeing substance use programs which account for most of the state program expenditures as the single state agency for substance use services. Her background with substance use treatment dates back to 2016 and she is excited to work with the subcommittee members.
- Dr. Dickson has been an Addiction Psychiatrist for many, many years and will be resigning from the SURG at the end of this year, following her retirement last August from the Center for Behavioral Health Group. She will be relocating to San Diego sometime next year and she will miss serving on this Subcommittee and on the SURG.
- Chair Shell noted that Assm. Rebecca Edgeworth was recently appointed to the SURG by the Assembly Minority Leader, and Assm. Heather Goulding was appointed some months ago by the Assembly Speaker. Both agreed to serve on this subcommittee when not in session.
- Mr. Mandell is in long-term recovery from an opioid addiction and had worked in law enforcement prior to being homeless. He also lost a brother to fentanyl four years ago which drove him to do this work as a community engagement specialist for Vogue Recovery Services. They help navigate people getting into treatment and he is excited to be part of it. He got syringes from Ms. Cheatom when she worked at Trac-B back in the day, well before treatment. He also said he had been learning from Dr. Dickson for a long time and he looked forward to working with everyone.
- Chair Shell said he is not originally from Nevada, but he has lived here for 16 years, although he will probably never lose his accent. He commuted to Las Vegas from Reno for several years and opened Desert Parkway Behavioral Hospital where he was the CEO for a few years. Then he opened Reno Behavioral Health Care Hospital where he served as CEO. From there, he went to Renown Health to serve as Vice President of Behavioral Health. About 18 months ago, he started the nonprofit Behavioral Health Association of Nevada, a coalition of Behavioral Health Professionals and allies around the state.

Chair Shell expressed his appreciation for all the members and gave special thanks to Ms. Cheatom and Dr. Dickson for all their contributions and accomplishments. They have a lot of great ideas for Treatment and Recovery, and he looks forward to working with all the members.

5. **Follow-up Discussion Related to Proposed Recommendations and July Presentation: "A retrospective assessment or/and prospective study would be conducted to assess the outcomes of patients following discharge from detoxification and examine mortality and overdose."**
Ms. Marschall shared slides posted for this meeting and noted that all the detail from previous presentations is available on the SURG website and can also be displayed for discussion purposes.

Ms. Cheatom referenced the studies that were included with the submission of this recommendation **[a retrospective assessment or/and prospective study would be conducted to assess the outcomes of patients following discharge from detoxification and examine mortality and overdose]** and reviewed with the subcommittee members at their August meeting. There is a lot of information about ways to reduce people's risk of opioid overdose, including harm reduction information, as well. The takeaway she saw from the MOUD article provided is that medically managed opioid withdrawal saves lives after 60 days, compared to detox with a 90% rate of relapse within a year. So, one suggestion is to have people start MOUD after they leave detox. Her takeaway from the cohort analysis in Massachusetts is that people who have undergone MOUD, residential treatment, or a combination of the two reduced their mortality rate compared to those who did not receive any treatment after they left detox.

A fourth study Ms. Cheatom cited focused on recipients of OUD treatments prior to fatal overdoses in comparison to no treatment, and that was a study done in Connecticut between 2016 and 2017. Exposure to methadone or buprenorphine after detox reduced the relative risk of overdose by 38% for methadone and 34% for buprenorphine. Multiple studies show that when people are leaving medically managed detox, being on some sort of medication for OUD helps to reduce the risk of an overdose and possible death, which is why she believes a retrospective study would be the best use of this recommendation for Nevada.

Mr. Mandell asked about the timeframe for how long people were on MOUD and if they ever came off it. Ms. Cheatom again cited the study that MOUD saves lives, especially when used over 60 days, with 60% risk reduction and 10% risk reduction for each additional 60 days. She doesn't know specific timeframes for follow up on outcomes. Others may have ideas about looking at death and treatment data.

Mr. Mandell said he appreciated Ms. Cheatom's hard work, noting the importance of the amount of time people are on MOUD. Ms. Cheatom reviewed the study where the follow up period was limited to only 12 months and required the presence of an OUD diagnosis in Medicaid claims.

Ms. Cheatom further clarified that she had not looked at private insurance because the best available source was Medicaid claims. Mr. Mandell encouraged looking for a study of long-term outcomes and whether people got off MAT (medically assisted treatment). Ms. Cheatom offered to look for that as well and will forward anything she finds to Ms. Marshall. Subcommittee members could create their own time limit if they move forward with this recommendation.

Dr. Dickson referenced a suicide study in Minnesota looking at people who went to an emergency room after a suicide attempt and how many survivors subsequently go to treatment or make another suicide attempt. There may also be a way to follow up with people who go to a clinic versus how many are referred. She said there is a terrible rate of return. They could track whether people make an appointment; whether they keep the appointment; and whether they return for evaluation. Staff would need to get permission to call the patients to follow up. Funding for a study could possibly come from the Fund for Resilient Nevada through a Request for Proposals (RFP).

Ms. Cheatom thought this was a good idea to inform a prospective study, if they could get permission to follow up after detox treatment or do a retrospective with available data and expanded timeframe as Mr. Mandell mentioned. Dr. Dickson suggested finding graduate students to write it up as a grant for IRB (Institutional Review Board) approval. It's a long-term process to get off the ground, but it's good to have enthusiastic researchers who want data and publications, and funds to pay for them. She was unsure which University programs might have such candidates.

Ms. Cook reported that the state is currently doing a lot of this work for state level implementation, including working on a dashboard to track who is on MOUD, and the services they are seeking before and after. They review the data and related gaps for when services are accessed and better ways to access services including residential treatment, prison system services, and other access data points. Medicaid data is the largest source and will now be combined with PEBP (Public Employee Benefits Plan) data under the Nevada Health Authority, and the state health exchange. When the state looks at access to MOUD and reducing overdoses, they're looking at it from a treatment standpoint and getting people the treatment they need.

Mr. Mandell said he was so glad that Ms. Cook and Ms. Cheatom were on the call. He noted that one of the problems in the state is tracking data and numbers, and if information was limited to only Medicaid, Affordable Care Act, or HealthLink data, it may not properly show the right numbers as many, or even the majority of, overdoses are commercially insured patients. He noted that one gap, even in Medicaid data, is that it may not show accurate numbers or success rates for different treatment modalities. Mr. Mandell also highlighted that a retroactive approach is probably the quickest way to do a study where lives could be saved right now, and suggested that there are people with lived experience who would be willing to participate in order to save lives.

Chair Shell said he was excited about Ms. Cook's comments. He asked Ms. Cheatom for her advice about whether this recommendation should stay with this subcommittee or follow her to the Prevention Subcommittee. Ms. Cheatom said it should stay with Treatment and Recovery. She was also very happy to hear from Ms. Cook regarding the study they are conducting.

Chair Shell recommended moving this recommendation forward, noting they didn't need to take further action at this point, other than to continue to vet it for submission in August 2026.

Ms. Marschall asked if there was a member who would co-sponsor the recommendation to help move it forward. Chair Shell called for a motion:

- Ms. Cook made the motion to serve as co-sponsor for this recommendation.
- Mr. Mandell seconded the motion.
- The motion carried unanimously.

Chair Shell moved discussion to the next recommendation, which he submitted on 6/17/25:

Hospital emergency rooms continue to struggle with a high volume of patients who present with substance misuse and often with co- occurring mental health conditions. A high percentage of these individuals have multiple visits to the ERs for various reasons that are associated with their substance misuse. The ER teams do their best to evaluate, treat and connect to community services, but many of their team members lack the expertise to effectively manage substance misuse and do not have lived experience like peer recovery support specialists. Evidence has shown that connecting individuals with substance misuse to a peer while in the ER leads to better outcomes as the peer can help navigate a transfer to treatment options in the community as well as maintain communication with the individual for a period of time to encourage recovery. Hospitals would be more motivated to establish peer support teams if financial assistance is provided on a long-term basis.

Chair Shell provided additional information this recommendation. He has worked with PRSS (Peer Recovery Support Specialists) teams in the ER who were grant-funded, and while they have made great advances with Medicaid reimbursement, a lot of payers do not reimburse for peer support. The Renown Team was disbanded when grant funds ran out, but emergency rooms truly need support from PRSS. Dr. Kelly Morgan, Emergency Medicine Specialist for Valley Hospital and Medical Director of Las Vegas Fire & Rescue previously presented to SURG Subcommittees and may be willing to present again. Dr. Dickson recalled a previous request for presentation from Patrick Kelly, CEO, Nevada Hospital Association, on this subject. Ms. Marshall had reached out to Mr. Kelly but was unable to confirm a presentation for today's meeting; she will follow up with both Dr. Morgan and Mr. Kelly.

Mr. Mandell said he works directly with peer navigators and all the ERs, including Valley Hospital and West Henderson Hospital. He gets a lot of referrals from these programs and has contact information. Ms. Cheatom added that Valley Hospital is also helping with PRSS on-boarding and could also speak about this; she will send information to Ms. Marschall.

Ms. Cook noted that they are struggling with this in Northern Nevada and she has people looking at some of those hospitals. Chair Shell added that Trac-B had great data from when they were in the Renown ERs, so that could be considered for Northern Nevada.

6. **Update on and Discuss Previous Treatment and Recovery Subcommittee Recommendations**

Chair Shell provided an overview of these recommendations from 2024, noting the options for the subcommittee to make changes for resubmission if members want to do so. No action is needed today, but he wanted members to keep this in mind.

1. Legislation should be considered to amend the Nevada Revised Statutes pertaining to the Nevada Bureau of Health Care Quality and Compliance's employment guidelines for hospitals, including behavioral health hospitals, to hire certified peer recovery support specialists who have felony backgrounds and are within three years of their last felony conviction. It is recommended that individuals who were convicted of drug offenses or other offenses that do not involve violent acts or sexual exploitation be considered for employment as certified peer recovery support specialists in hospitals.
2. Support BDR 95 to ensure opioid antagonists must be available on all campuses under our Nevada System for Higher Education, including in Student unions, Health centers, all levels of the dormitories, Residential Advisor's domiciles, sports facilities, and libraries and include training of the administration of opioid antagonists which can take place during online Freshman orientations much like we already disseminate information about Title IX, during orientation week, training could be offered throughout the year by various clubs and programs within each institution's design.
3. Support access and linkage for treatment of trauma for people with substance use disorder (SUD) or those who have overdosed and for surviving family members after an overdose fatality. Support training for healthcare professionals to identify and address trauma.
4. Direct the Division of Public and Behavioral Health to identify a funding mechanism for hospitals and providers to enhance the "Bridge Program" for Emergency Departments by incorporating Peer Recovery Support Specialists into their treatment models. Support the use of Peer Support Navigators via telehealth to increase access to treatment and support for individuals identified in Emergency Departments.

Chair Shell invited Maddy Larson to provide an update on the second recommendation (BDR 95/AB394 was passed and approved by the governor). Ms. Larson thanked Chair Shell and all members for their support and reported that the corresponding Nevada Revised Statutes (NRS 396) are being implemented. She noted how helpful it was to point out to legislators that this was part of the SURG Recommendations and the Annual Report.

Naloxone access is being implemented separately across all eight NSHE (Nevada System of Higher Education) campuses to ensure autonomy for multiple storage places and training opportunities. By presenting this during the interim session, they were able to get a ton of stakeholder engagement. Assm. Tracy Brown-May is a champion for opioid harm mitigation, and she was the primary sponsor for this bill. They also worked with the Government Affairs team, Northern and Southern Police Commands, the Board of Regents, the Chancellor, and Stephanie Cook with DPBH. She thanked Ms. Cook for having so many meetings with her last year to move this forward. It passed both the Assembly and Senate unanimously, with one revision to add Senators Titus, Rogich, and Buck as joint sponsors.

The NSHE response plan includes the original resilience policy to call 911, administer naloxone, and emphasizes compassionate response and rescue breathing, with steps for emergency coordinators to stock the naloxone and document the process. This will help shift the narrative around opioid use and drug use in general to keep people safe and keep people alive. There is also a clause to protect students against disciplinary action for obtaining the naloxone or using it in good faith. This is based on input from Dr. Karla Wagner's research team because students were scared to administer or to be seen taking naloxone.

Ms. Larson works with each NSHE institution to support implementation and get them the naloxone they need. She is also working with community coalitions throughout Nevada to get naloxone to additional locations so they can cross county borders if needed. Finally, they are working to get the procedure into the University Administrative Manual with all the red-tape legal language.

UNR is a pioneer in training and distribution points. UNLV is offering free naloxone through the Student Rec Center and also offers fentanyl test strips. TMCC offers naloxone through the Counseling Center and includes faculty and staff training. Western Nevada College serves Carson City and the Quad Counties and is also doing training within their emergency response teams, faculty and custodial personnel, and they're also opening up their AED CPR first aid training to all their faculty and staff on campus, which includes naloxone training. Ms. Larson is also working with the Carson City Coalition to get them naloxone. Desert Research Institute is not a regular setting, but they are part of Nevada's Recovery Friendly Workplace Initiative, and they have multiple boxes set up around their campuses that they restock as needed.

Ms. Larson is still working on coordinating with College of Southern Nevada, Great Basin College, and Nevada State University, so if anyone has contacts that they can provide to her, that would be helpful.

Chair Shell thanked Ms. Larson for all her efforts and offered his congratulations on the successful implementation work.

Chair Shell noted that Recommendation #1 from 2024 was still sitting out there with stumbling blocks for a lot of hospitals who are excluded from hiring PRSS who have a felony within the last five years, and he feels strongly that it should be lowered to three years, as long as there was no conviction for violent acts or sexual exploitation.

Ms. Cheatom reviewed Recommendation #3 which is still a work-in-progress that Chair Shell said could be incorporated with new recommendations going forward.

Chair Shell noted that Recommendation #4 is similar to his recommendation this year for linking Peer Support in Emergency Departments, not necessarily for the Bridge Program.

7. **Discuss Proposed 2025 Treatment and Recovery Subcommittee Recommendations**
   Chair Shell explained that these recommendations were previously discussed. Subcommittee members had no further discussion regarding these two recommendations.

- A retrospective assessment or/ and prospective study would be conducted to assess the outcomes of patients following discharge from detoxification and examine mortality and overdose.
- Hospital emergency rooms in Nevada continue to lack evidence-based peer support teams that can provide a vital service to their patients who present with substance misuse. Many of these patients have multiple visits to the ERs due to not being adequately connected to community services for treatment or not having ongoing support to maintain their recovery. Hospitals lack the financial resources necessary to cover the expenses for peer support teams whose services are not reimbursed by most insurance companies. It is recommended that hospitals be incentivized through an expenditure of opioid settlement funds to establish peer support teams in their ERs.

8. Discuss Upcoming Presentations and Topics

Ms. Marschall reviewed notes for upcoming presenters and topics including the following:

- Patrick Kelly, Nevada Hospital Association with possible follow-up from Valley Hospital or the West Henderson Hospital on the use of peers, related costs, and any follow-up process.
- Regarding outreach to Dr. Morgan, Chair Shell suggested holding off until the members synthesize the relevant recommendations and possibly find somebody from the Valley system who can speak to the cost and benefits of the team.
    - If members have suggestions for people who can talk about the cost-benefit of using peers, please forward information to Ms. Marschall for follow up.

Ms. Marschall said she is happy to follow up with any other suggestions or ideas for other presenters or topics. She announced that she will be stepping down from supporting the SURG on December 31st, and someone else from SEI will staff this subcommittee, along with Ms. Hale moving forward.

Chair Shell thanked Kelly for everything she had done for Treatment and Recovery and wished her the best. He noted her superstar capacity for keeping them organized and moving forward. Ms. Marschall noted that she will continue with SEI on a very part-time basis. It's a measure of the efficiency and functionality of the SURG that she has no concern stepping down. The SURG is a strong and beneficial committee for the state of Nevada. She is proud to have helped stand it up and support it.

9. Discuss Report out for January 14, 2026 SURG Meeting

Chair Shell will report on recommendations and new members at the January 2026 SURG meeting and summarize related discussions from today's meeting. Ms. Marschall suggested it would be helpful to let people know about Maddy Larson's update to track implementation of previous recommendations. Also, note reconsideration of previous recommendations as there may be some viability of integration for PRSS or to reelevate support for people experiencing trauma recommendations.

10. Public Comment

Ms. Cook asked if the SURG would present information to the HHS Committee during the legislative interim period. Dr. Kerns said that she has presented with the Attorney General to

the Committee in the past. It's always been when they have the actual report and recommendations completed. Ms. Cook supported sharing that information in the interim.

11. Adjournment

Chair Shell adjourned the meeting at 4:09 p.m.

Chat File

00:42:19 Jess Angel: It is important to pull together some data from Nevada as these studies are not local to this state and that can alter the outcomes of research

00:53:35 Jess Angel: hospitals do not want peer support specialists in Nevada because of the low reimbursement rate from Medicaid...once the state raises the reimbursement rate things will change...right now Nevada is the lowest rate w/Medicaid at $7ish a unit and other states are paying upwards to $20/unit!