DRAFT MEETING NOTES

Statewide Substance Use Response Working Group **February 24, 2026**
Treatment and Recovery Subcommittee Meeting **11 a.m.**

Zoom Meeting ID: 865 8016 1096
No Physical Public Location

Members Present via Zoom or Telephone
Dave Briggs (11:05 a.m. - 12:13 p.m.), Guiseppe Mandell, Dr. Jose Partida Corona, and Steve Shell

Members Absent
Stephanie Cook, Assm. Heather Goulding, and Assm. Rebecca Edgeworth

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

Social Entrepreneurs, Inc. Support Team
Laura Hale, Kim Hopkinson, and Mary O'Leary

Members of the Public via Zoom
Ashlyn A., Tray Abney, Jess Angel, Lauren Beal, Charlie can't rap…, Lea Cartwright-Cartwright NV Government Affairs, Cade Grogan (Ferrari Reeder), Madalyn Larson, Sabrina Petrel, bquezada, Beth Scott, Marcie Trier, Arisa Tongco, and Joan Waldock

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Shell called the meeting to order at 11:02 a.m. Kim Hopkinson called the roll and noted a quorum at 11:05 a.m.

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

3. **Review and Approve Minutes from November 18, 2025, Treatment and Recovery Subcommittee Meeting**
   - Dr. Partida Corona made the motion to approve the minutes.
   - Mr. Mandell seconded the motion.
   - The motion carried unanimously.

4. **2026 Timeline Reorientation and Review of Recommendations Submission Process**
   Kim Hopkinson reviewed slides containing overview of Subcommittee Meeting Topics and Timeline, noting that June 2026 is when final recommendations for this reporting cycle need to be completed. March will be the last subcommittee meeting for discussion of preliminary recommendations for inclusion in this year's reporting cycle. This could include subject matter expert presentations as well as final discussion of preliminary recommendations.

Then, in April, those recommendations will be reviewed by the full SURG. The May Subcommittee meeting will include review of SURG feedback and finalization and ranking of preliminary recommendations for another review with the full SURG in June. If additional recommendations arise after the March meeting, they might be finalized in the next reporting cycle.

Chair Shell explained this year's timeline may feel tight for new members because of the change in reporting cycle. Mr. Briggs and Mr. Mandell appreciated the explanation as new members. Mr. Mandell also appreciated any coaching for submitting recommendations. Dr. Partida Corona noted that additional recommendations are coming through Nevada's Site of Addiction Medicine, including eliminating prior authorization requirements for buprenorphine and medication-assisted treatment (MAT), due to the narrow window for treatment. They will also recommend that Medicaid refrain from stipulating particular dosages, such as limiting to 15 milligrams a day, especially for patients coming off fentanyl, who require about 24 milligrams to maintain their recovery, noting that this should be a decision made with/by the physician or provider. He added that no such stipulation is made for Oxycontin, a substance which kind of got us into this mess.

Chair Shell appreciated these comments and noted there would be opportunity for further discussion under a later agenda item.

Kim Hopkinson explained that recommendations can be introduced and workshopped by the subcommittee during this meeting, with more details based on completion of a survey with required fields of information to help with implementation. A survey link is provided to members to submit recommendations; it is helpful but not required to complete each of the survey questions, but an asterisk (*) can be entered where full information is not available. SEI team members can assist members with gathering information or connecting with subject matter experts (SME). The final version of the completed survey will be included in the annual report.

Dr. Partida Corona asked when the survey was sent out. Kim replied that she sent out the link in the prior week and offered to resend it following this meeting.

5. **Discuss and Draft Proposed Treatment and Recovery Subcommittee Recommendations**
Chair Shell referenced the three recommendations already submitted. (Additional information on these recommendations is available under the attachments for this meeting on the SURG Website.[1])

Recommendation #1: Submitted by Chelsea Cheatom on 8/20/2025
Recommendation Description: 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.

[1] To visit the SURG website, use the following link: https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/.

Chair Shell explained that Ms. Cheatom has moved to the SURG Prevention Subcommittee, but Stephanie Cook volunteered to cosponsor this recommendation and carry it forward. Data was collected from a study in Connecticut that was presented to this subcommittee and can be provided to new members if they are interested.

Dr. Partida Corona expressed interest in the timeframe for the study noting that recovery is not about only looking a year out, but making sure people succeed in the longer term with studies three years out to include relapses, and different types of therapy including MAT and 12-step programs with the biopsychosocial model.

Mr. Mandell agreed with this and added the importance of looking at more than just Medicaid population because the commercially insured population goes beyond detox to include residential treatment, although it might be a difficult problem to solve with HIPAA requirements, and IOP (intensive outpatient programs), PHP (partial hospitalization programs), and success rates. They have had success with the Henderson Drug Courts program where if someone is in custody for two weeks, insurance doesn't authorize it, so Henderson Courts have a separate fund to pay for longer term treatment they know is successful. In his lived experience, "spin-dry detox" versus residential detox makes a difference for sustaining recovery. They could look out three years or longer if participants are willing. His brother died after nine years in recovery due to relapse.

Dr. Partida Corona thought it would be tough to go seven years out or beyond because a lot of medical records are not retained after that. He agreed with Mr. Mandell that court mandated treatment should be reviewed as a separate category of treatment.

Mr. Mandell agreed with this and added that the commercially insured population, which he knows would have to be volunteer participants in a study, are important to study because it's a different kind of treatment that is more long-term with more success. He works with a lot of unions, as well as working with the courts where they work with patients before they get on Medicaid.

Chair Shell asked members to share possible edits to the recommendation.

Dr. Partida Corona suggested a five-year study to include people involved in AA meetings, counseling – cognitive behavioral therapy in particular, MAT, etc.

Mr. Mandell didn't know how they would get the data, but possibly through working with drug-court programs.

Dr. Partida Corona noted that people bounce in and out of insurance, and between Medicaid and commercial coverage. Mr. Mandell suggested they look at the initial point of treatment. He noted that Medicaid doesn't really pay for the full residential spectrum, whereas commercial insurance does, so it would be important to compare success rates.

Mr. Briggs said this made sense to him as well, given the challenges to track data over longer periods, five years is a happy medium.

Mr. Mandell said he has well over five years (in recovery) and would be happy to submit his data; he thinks a lot of other people would do that as well.

Chair Shell noted the importance of identifying funding sources for recommendations, such as general funds or the Fund for Resilient Nevada (FRN). Mr. Mandell referenced possible restrictions with government funding and would like to include private funding, if available, or maybe work with a non-profit and try to alleviate red tape.

Dr. Partida Corona suggested working with the Fellowship[2] and possibly the UNLV School of Public Health. He offered to talk with Dr. Strohm who is the Director for the Fellowship. Chair Shell liked this idea, noting that there is another fellowship program launching in Northern Nevada. Maybe there could be an implementation process working with UNR and UNLV. Dr. Partida Corona agreed this could be a great collaboration between the fellowships.

Mr. Mandell referenced a text from Dr. Edgeworth who apologized for not being able to attend the meeting. She is with Toro University, and Mr. Mandell said they should keep her in mind.

Kim Hopkinson confirmed the ability to review notes and the recording to incorporate these ideas into the recommendation for review at the March meeting.

Recommendation #2: Submitted by Steve Shell on 6/17/2025 and updated for Subcommittee review prior to the February 2026 meeting.
Recommendation Description: Recommend to Nevada Department of Human Services that they financially support the implementation of hospital emergency room-based peer recovery support teams. This could be via dedicated general funds made available to hospitals, or by encouraging applications for use of Fund for Resilient Nevada monies.

Chair Shell reviewed this recommendation that he submitted last summer to support these teams in hospital emergency rooms. Based on his own experience with grant-funded support teams in the ER being unsustainable after funding ran out, he believes the state needs to find a way to incentivize hospitals. Medicaid coverage is great, but lots of other payers do not reimburse for this, and there is also the uninsured population, so hospitals are reluctant to stand up teams without being able to recover their costs. He noted that the recommendation was updated to recommend state general funds be made available or hospitals could apply for FRN dollars, which a couple health systems are in the process of doing.

Mr. Mandell said that Valley Health System is doing this right now and there has been a lot of positive feedback, and health professionals could help to advocate for more of this, possibly including a workforce development program.

[2] Addiction Medicine Fellowship at HCA Healthcare Sunrise Health.

Dr. Partida Corona has seen insurance companies taking the initiative in some cases, but it’s not effective for peer recovery navigators to go to different hospitals because there isn’t familiarity or rapport with the specific ER doctors; it must be folks who are embedded in the actual hospital. He also thought about having an addiction service with peer recovery navigators who would have privileges in those hospitals. They would be viewed as specialists rather than hospitalists to direct special care and get reimbursed by insurance. Historically, they would consult psychiatrists, but many are not specifically trained for handling addiction. A system of treatment would include peer recovery navigators and certified nurses. Dr. Partida Corona suggested that hospitals would need to delineate privileges for addiction specialists to support this billing.

Chair Shell agreed that the concept for an embedded team should be added to this recommendation. Dr. Partida Corona reiterated that the team would go beyond just a peer recovery navigator and would need to include the delineation of privileges, which would require approval from a hospital committee. The privileges would include both mid-levels with addiction training and certified addiction specialists. Current recruitment does not include the necessary training for addiction. This would open the door to work in the hospital under their specialty.

Chair Shell supported this stipulation for delineation of privileges to qualify for either general funds or FRN dollars, to support implementation of the team. At this point in the meeting, Kim Hopkinson reminded members of the public to please hold their comments until the public comment period at the end of the agenda, and asked that comments be made verbally, rather than in the chat, which is not as accessible to meeting attendees calling in via phone only.

Recommendation #3: Submitted by Chelsi Cheatom on 9/25/25
Recommendation Description: Contingency management can be used to support people in recovery through rewards for reaching their recovery goals. Increasing funding to support contingency management could help more providers offer this important support program to patients.

Chair Shell noted that SEI staff are supporting workshopping of this recommendation and hope to engage a presenter for next month, as Ms. Cheatom, who has transferred to the Prevention Subcommittee, is unable to attend. Kim Hopkinson shared associated research information from the next slide as a resource for members until a presentation could be arranged. She noted that this information is also available in the attachment section for this meeting if people are not able to get the links off the shared PPT.

Mr. Mandell referenced an online company that does something like this with monetary rewards. He also referred to strict laws about paying for people who are in place for treatment and suggested Dave Marlon as a possible resource for a future presentation.

Dr. Partida Corona asked how familiar the courts are with contingency management. Mr. Mandell wasn’t sure, but he thinks they give small things like gift cards. He suggested the subcommittee could request a presentation from Scott Kaiser with the Henderson Court on

how these programs are implemented. Dr. Partida Corona recalled that some people serving jail time are let out during the week to work to maintain their family's income. He suggested this would be better managed by the courts than through clinics. Mr. Mandell reiterated there are very strict rules for these programs.

Chair Shell agreed that Dr. Marlon could be a good resource for a future presentation, and he opened the floor to members for any additional recommendations they would like to explore at this time. These recommendations were documented live on the screen by SEI staff.

Mr. Mandell highlighted smaller courts, such as the Henderson Drug Court, to figure out a way to get them funding, which helps the individuals and goes back into the business community. He asked for help in drafting the recommendation. He elaborated that the $25,000 funds given to the Henderson Court last year are not sufficient and noted that private funding is not available due to regulations.

Chair Shell asked for clarification as to whether the current court system is already maxed out, so fewer individuals can benefit from diversion into drug courts. Mr. Mandell confirmed this, noting reliance on state and/or grant funds. Ms. O'Leary offered to assist Mr. Mandell with the survey and/or a meeting with staff to submit this recommendation.

Mr. Mandell further confirmed to Chair Shell that the recommendation would be for the state to allocate more funding to the counties, possibly through the FRN. He suggested $100,000 a year, which is nothing when they're talking about treatment. He suggested this could come from either general funds or FRN dollars. Mr. Mandell added that insurance won't authorize funds for people who are in custody, and rates are low and slow when they do pay. Dr. Partida Corona agreed this was a good idea.

Dr. Partida Corona said that a recommendation related to the elimination of prior authorization for MAT under Medicaid would also be helpful, because there is a narrow window of opportunity to help someone enter recovery. Covered medications should include buprenorphine, at least. He also noted that injectables, which are more expensive, are already covered.

Another recommendation from Dr. Partida Corona is to keep Medicaid from determining dosage for buprenorphine, because that's what people go to medical school for. The commercial payers usually follow whatever Medicaid and Medicare do, so it should always be the purview of the physician because they deal with the consequences for patient relapses.

Mr. Mandell extended this to all treatment in general where insurance companies dictate what type of treatment patients should get, rather than the MD.

Chair Shell recommended amending guidelines for authorization, with Nevada Health Authority working with all those other payers for implementation.

Dr. Partida Corona suggested another recommendation that once patients start on MAT, they should not be tapered off before entering regular inpatient services. There is a false

equivalence from fentanyl to buprenorphine, but MAT is indicated for long-term recovery and should not be tapered while the patient is still in the throes of addiction in the nascent part of their recovery.

Mr. Mandell said he didn't know of many rehab facilities that forcefully taper patients off MAT; he believes it is more patient-centered at that point. He has modified his own stance on this issue because fentanyl is killing so many people. In his own experience, he would not have wanted a fast taper only to withdraw again from Suboxone later. He is not aware of difficulty getting authorization to stay on MAT longer, although some patients don't want to stay on too long.

Dr. Partida Corona said it's one thing to get off MAT upon discharge from the inpatient setting, and another thing completely tapering them between detox and the inpatient setting in the space of a few days. With discharge, it's more likely a month.

Mr. Mandell said he didn't see an issue with the insurance authorizations or treatments. He does see issues with sober living facilities that don't want to accept people on MAT. That could be a discussion with Dr. Kaplan, who oversees a few treatment centers.

Dr. Partida Corona highlighted Mr. Mandell's point about barring people on MAT from sober living facilities. Because they are private entities, it's hard to make requirements.

Mr. Mandell said that most of them don't receive funding in Nevada, and the ones that do may not be as successful. Most of them (owners) are in recovery and they don't do it to get rich, but patients must pay for it. Dr. Partida Corona said if they do receive funding, they should accept folks who are on MAT. Mr. Mandell noted the expertise of people who have been doing this for decades and expressed concern about taking those houses away. He preferred getting input from that community on any changes.

Chair Shell appreciated the discussion and asked members to work with SEI staff on these recommendations ahead of the next meeting.

6. **Discuss Topics of Interest from the Subcommittee**
   Chair Shell referenced public comment from a November 2025 meeting of the Prevention Subcommittee regarding difficulties accessing MAT prescriptions in rural areas of Nevada. He suggested adding this to the agenda for the upcoming March meeting.

7. **Public Comment**
   Jess Angel commented on peer support in hospitals as referenced in the second recommendation. She recently came to Nevada from Alaska where they had a variance process for people with barrier background crimes to work in health care or social work settings, but Nevada does not have such a process. A lot of people in peer support cannot pass a background check, which would be a barrier for getting them into hospitals. In Alaska, if people have passed their probationary period with sobriety and treatment, they could get character references as part of their application packet, to support employment where it was truly needed.

Lauren Beal referenced the conversation about sober living homes, and the lack of framework or guidance has created spaces where people have reoccurrence, so they are no longer serving their purpose of being a sober home. There is room for this committee to think through what sober homes should have in them and people on the committee who are experts on the topic could continue to think through this, particularly as they are seeing concerning things happening.

Marcie Trier, LCADC, LCPC introduced herself as a suicide crisis responder from DCFS for all the hospitals across Las Vegas for the past six years for children's mobile crisis. The idea of PRSS is very good, however, some of the barriers for people under age 21 are the issues of confidentiality and HIPAA, trying to get clearance. Also, PRSS are very specially trained in suicide because there is a correlation between substance abuse, addiction, and suicide, and overdose. Doctors may be leery of staff going into the hospitals and patients may be tentative as well, if they don't have a specific role. While the idea of PRSS is really good, it is so important in recovery or in the immediate stages of overdose to have that special training to understand suicide and addiction in addition to the experiential knowledge that peers have.

Beth Scott asked that Medicaid be invited to any discussions about barriers to implementing peers into emergency rooms, as they are currently working on PRSS services and could help figure things out. They need to know what the barriers are and to work with members to get the language right around MAT under Medicaid, as an umbrella for medications and therapy. She asked Dr. Partida Corona if he was talking about medications for opioid use disorder in reference to MAT during detox and not being tapered.[3]

8. Adjournment

Chair Shell adjourned the meeting at 12:35 p.m.

Chat File

00:18:46 **Kim Hopkinson (she/her): Please do not use the chat for items other than technical support, as this becomes part of the public record. The meeting chat functionality is limited to inquiries regarding technical difficulties or to indicate an interest in offering public comment. Exercise caution with links which may appear in any meeting chat as they could be malicious.**

00:58:44 Jess Angel: There are many who are PRSS who can not pass a background check- the state of NV needs to work on a "variance" process to by pass this. we had this in Alaska and it worked great

01:06:17 Jess Angel: Thank you, I will share during public comment

[3] Public comment is not generally intended for discussion. However, Dr. Partida Corona did confirm Ms. Scott's understanding, noting his specific reference was to buprenorphine.

01:40:16 Mary O'Leary (she/her): Please do not use the chat for items other than technical support, as this becomes part of the public record. The meeting chat functionality is limited to inquiries regarding technical difficulties or to indicate an interest in offering public comment. Exercise caution with links which may appear in any meeting chat as they could be malicious.

01:41:59 jmpcorona: Miss Angel, please contact me so we can see what a variance might look like: jmpcorona@partidacorona.com.

01:42:18 Jess Angel: Reacted to "Miss Angel, please c..." with a blue heart emoji

01:43:48 jmpcorona: Miss Beal, agree with you. That conversation definitely needs to happen. Please email me so we may come up with a good middle ground. jmpcorona@partidacorona.com

01:46:47 jmpcorona: Miss Scott, please e-mail me so that we can figure out what can be done regarding MAT.