MEETING NOTES

Statewide Substance Use Response Working Group
Treatment and Recovery Subcommittee Meeting

Monday April 25, 2022
3:30 p.m. – 4:42 p.m.

Zoom Meeting ID: 861 4580 3592
Call In Audio: 669 900 6833
No Public Location

Members Present via Zoom or Telephone
Chelsi Cheatom, Dr. Lesley Dickson, Jeffrey Iverson, Lisa Lee, and Assemblywoman Claire Thomas

Members Absent
Steve Shell

Department of Health and Human Services Staff
Dr. Stephanie Woodard

Attorney General's Office Staff
Rosalie Bordelove, Terry Kerns, Ashley Tackett

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

Members of the Public via Zoom
Jennifer Atlas (Griffin Company), Abigail Bailey (Division of Health Care Finance and Policy), Jeanette Belz (Belz and Case Government Affairs), on behalf of the Nevada Psychiatric Association; Michelle Berry (CASAT), Marcel Brown, Lea Case (Belz and Case Government Affairs), Kristen Pendergrass (Shatterproof), Marcie Ryba, (Department of Indigent Defense), Lea Tauchen (Abney Tauchen Group)

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Thomas called the meeting to order at 3:30 p.m.

   Ms. Marschall called the roll and announced a quorum, with five members present.

   The Chair read a statement that she *may take agenda items out of order and combine two or more items for consideration or remove any agenda items throughout the duration of this meeting. Reasonable accommodations for accessibility can be made with Vicki Beavers, Executive Assistant for the Attorney General, at (702) 684-1212 or vbeavers@ag.nv.gov.*

2. **Public Comment** (Discussion Only)
   Chair Thomas asked for public comment, with a three-minute limitation per person.

   Marcie Ryba, Executive Director, Department of Indigent Defense Services, which is tasked with oversight and support of indigent defense providers throughout Nevada, read the following statement.

   Historically, little attention has been paid to indigent defense providers in this ongoing conversation of criminal justice reform. However, indigent defense providers are an essential piece of the plan for Nevada to program to effectively combat the opioid epidemic. Public defenders can turn the wave of addiction because they're uniquely situated to provide aid at intercept level 2 on the Sequential

Intercept Model which was developed by the Substance Abuse and Mental Health Services Administration [SAMHSA] GAINS Center. As public defenders are often the first person to be able to have an impact on an individual's opioid addiction after arrest, we hope this subcommittee will consider funding a holistic resource center which will provide the evidence-based practice of holistic defense for indigent defense providers, which is especially needed in the rural counties.

This holistic defense model is based on the idea that to be an effective advocate, public defenders must adopt a broader understanding of the scope of their work. Defenders must not only address the immediate case at hand, but also the collateral legal consequences of criminal justice involvement, such as loss of employment, public housing, custody of children, and immigration status. Underlying life circumstances and non-legal issues often play a role in driving clients into the criminal justice system, and this includes opioid addiction.

A Rand Corporation study on holistic representation found key findings that over a 10-year study holistic representation prevented more than a million days of incarceration. Holistic representation reduced the likelihood of a prison sentence by 16% and actual prison sentence length by 24%. Holistic representation saves taxpayers an estimated $160 million in inmate housing costs alone. And holistic defense can significantly reduce incarceration and save taxpayer dollars without harming public safety.

Our department is willing to assist in any way, and we hope this subcommittee sees us as a partner in this process to address the opioid crisis. Thank you.

3. **Member Introductions** (Information Only)
Chair Thomas introduced Kelly Marschall to ask members to introduce themselves.

Chelsi Cheatom is the Program Manager at TracB Exchange Syringe Service in Las Vegas. She is a Harm Reduction Program representative on the SURG and she is also the Deputy Director of the PACT Coalition working in primary prevention.

Dr. Lesley Dickson is a Physician and Psychiatrist practicing Addiction Psychiatry since 1990, including at the VA Hospital in Lexington, KY. She is Boarded in Psychiatry and retired from the VA a few years ago. She is currently the Director for the Center for Behavioral Health, Group Recovery. They mostly work on opioid use disorder (OUD) and some alcohol addiction, and now amphetamines use disorder.

Jeffrey Iverson is in long-term recovery with abstinence since March 28, 2006. He is the Founder and CEO of the non-profit Freedom House, Las Vegas, a 40-bed treatment facility, as well as a 100-bed transitional housing facility. Individuals in the criminal justice system need inpatient and outpatient services. He is also the Founder and Director of Crossroads of Nevada for inpatient and medical detox services with 120 beds. First responders and Las Vegas Metro drop off patients at those facilities. He tries to use his experience as best he can to develop helpful programs.

Lisa Lee is a Program Specialist with Washoe County Human Services Agency and is also in long-term recovery. She has worked in many roles, including case management, outreach worker, Certified Peer Recovery Support Specialist, and she is also a supervisor, and a Drug and Alcohol Counselor. She is also a doctoral student in public health, doing her dissertation looking at how parental substance use intersects with the child welfare system. She has been involved in harm reduction since the mid-1990s, from a risk reduction standpoint including a broader ethos in standing with marginalized populations and empowering those communities. She has also engaged in a lot of statewide research with people who use drugs.

Ms. Marschall reviewed the slide on Subcommittee Scope, based on sections of the legislation from AB374, and Section 10 in particular.

Chair Thomas reviewed the slide on Member Roles, including meeting attendance and communicating with the Chair. Providing recommendations and reviewing materials in advance of the monthly meetings is required and appreciated. Subject matter experts (SME) will be engaged for these meetings over the next year, extending into February 2023. Presentations will be made to the larger SURG, based on subcommittee progress, with a final report in January.

4. **Review Subcommittee Tracking Tool** (For Possible Action)
Chair Thomas explained that a survey has been developed to support member recommendations. Ms. Marschall noted that members can submit recommendations with the survey or with the spreadsheet and staff from Social Entrepreneurs, Inc (SEI) will compile all the recommendations into a single spreadsheet that will be shared back to the members for the next meeting. Ms. Marschall reviewed the elements of the tracking tool, noting that cross-cutting items may be confusing, so members can skip that as it is not required. Members can also provide links for supporting documentation.

   Ms. Lee asked if there is a deadline for making recommendations. Ms. Marschall described a rolling deadline to get them in for the May meeting, and then report to the larger SURG committee with some prioritization.

5. **Review Baseline Information for Response to Substance Use** (*Information Only)*
Stephanie Woodard, PsyD, Senior Advisor for Behavioral Health, Department of Health and Human Services (DHHS), provided an overview of Substance Use Treatment and Recovery programs administered by the Division of Public and Behavioral Health (DPBH) and the Division of Health Care Finance and Policy (DHCFP).

   Dr. Woodard explained that the goal of these presentations to each subcommittee is to provide baseline information, recognizing that while many members do have SME, other members do not have that same expertise because they are not working specifically in this field. With a shared baseline for what the current state system looks like, they will have an opportunity for discussion and members can lend their expertise to help further the conversation.

   Dr. Woodard presented from the perspective of the DPBH, which receives federal grant funding as well as endowments, foundation dollars or private grants. They also receive state general funds that are used for maintenance of effort, which is required to be eligible for some federal grant funding. For example, DHCFP, also known as state Medicaid, pulls federal match funds depending on different eligibility categories for people enrolled in Medicaid.

   DPBH is also a regulator, as in the case of the Bureau for Health Care Quality and Compliance (HCQH), which licenses healthcare facilities. Other Bureaus provided direct services, including several substance-use disorder treatment programs that receive direct grant funds, as well as fee for service programs. This helps ensure access to safety net services for uninsured or underinsured individuals. Medicaid serves as a primary payer for SUD treatment and recovery services.

   DPBH covers an array of SUD services, including outpatient, residential and transitional living, but Nevada Medicaid is currently limited to covering outpatient and inpatient services, excluding residential treatment services and transitional living.[1]

[1] Some Managed Care Organizations may include contractual coverage of these services.

On the DPBH side there are consistent gaps in coverage for higher levels of care, including residential treatment services, withdrawal management services, and transitional living. From the DHCFP side, the gaps in Nevada Medicaid are related to institutions of mental disease, wherein federal rulings limit state reimbursement. There is no requirement for priority populations from DHCFP, so coverage is dependent on medical necessity; but SAMHSA requires DPBH to ensure adequate and timely access to individuals in priority populations, including pregnant women, pregnant women who use intravenous drugs, and individuals who inject drugs. Federal grants to DPBH also require additional data collection and reporting through the treatment episode data set (TEDS). Because TEDS is limited to providers funded through DPBH, it's a small snapshot of admissions and discharges. Some states require similar data collection from all SUD treatment providers, but Nevada does not. However, Nevada DPBH does include recovery support services, including peer recovery and other recovery support services, but DHCFP is primarily limited to peer recovery support services for data collection.

The Bureau of Behavioral Health Wellness and Prevention (BBHWP) manages most treatment and recovery funding for DPBH. The Substance Abuse Treatment and Prevention Agency (SAPTA) is a program within BBHWP. Its two primary funding streams are SAMHSA and the Substance Abuse Block Grant (SABG). The State Opioid Response (SOR) grant helps fund essential safety net programs and services, with an eye toward sustainability – typically within Medicaid.

Most funds go toward residential treatment, transitional housing, case management, and supporting the development of recovery-oriented systems of care in expanding access to recovery support services for adolescents as well as adults. These funds target gap services that are not available within the state Medicaid Plan. State general funds also support Medicaid infrastructure to expand prevention and treatment for individuals who are involved in the criminal justice system, with reentry and social services. Also, Medicaid expanded services to include SUD treatment, beginning in January 2014 with the advent of the Affordable Care Act.

The two treatment systems require collaboration and coordination between DPBH and DHCFP. Multiple advisory committees provide guidance for behavioral health wellness and prevention, including a statewide prevention strategy to ensure availability and accessibility of treatment and prevention services. Information is gathered from all regions of the state to include in the State Plans for allocation of funds, including the work of the SURG.

Over 160 SAPTA certified SUD treatment providers are enrolled with Medicaid to provide agency-level services. Certification is required for all funded programs through BBHWP, with minimum requirements specific to SUD treatment. Facilities licensed under HCQC include hospitals, detox centers, residential and transitional housing facilities, crisis triage centers and community behavioral health centers. These requirements combine to assure that our treatment providers are meeting best practice standards.

Recommended SME include:

- The Center for Applied Substance Use Technologies (CASAT) which is contracted with the state to provide certification reviews;
- Community-based SUD treatment providers; and
- DHCFP on Medicaid coverage and limitations within the state Medicaid Plan.

Certification services consistent with the American Society of Addiction Medicine (ASAM) include site visits from CASAT for prevention coalitions as well as SUD treatment and recovery programs.

Endorsement using the Dual Diagnosis Capability Toolkits (DDCAT) evaluates the capacity to meet the needs of individuals with co-occurring mental health conditions.

Long ago, treatment was bifurcated between SUD and mental health, but the value of treating co-occurring issues is now recognized. SAPTA certifies a range of programs including opioid treatment, aka methadone clinics, civil protective custody programs where law enforcement ensures people can receive medical treatment, and drug court services. Certification has been developed for Assertive Community Treatment Teams, but it has not yet been implemented. Other programs such as Supported Housing/Tenancy Supports, Crisis Residential and Recovery Housing are in the queue to launch in the next year to 18 months. BehavioralHealthNV is a website established to search by location or service category for adults or adolescents. Certification data provides information, including any issues or concerns.

Integrated opioid treatment and recovery centers (IOTRCs) created the foundation for medication assisted treatment (MAT) with a hub and spoke model in Nevada, including harm reduction, psychiatry, behavioral health services, case management, and a full array of peer recovery supports as well. We recognized the need to build out their capacity as primary providers for OUD stabilization in the community.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT) Act Planning and Implementation grant allowed expansion of SUD treatment with thorough system review, including a Medicaid 1115 demonstration waiver with federal reimbursement for community-based withdrawal management as well as residential treatment. This would address the coverage gap previously noted, and it is currently in review with the Centers for Medicare & Medicaid Services (CMS) at the federal level. Additionally, an alternative payment methodology was developed for office-based opioid treatment, which recognizes that prescribing buprenorphine for opioid use disorder (OUD) looks very different in the injection and stabilization stage compared to the maintenance stage. This is a potential incentive for providers to join Medicaid services and provide MAT in the community.

The SOR grant also focuses on MAT expansion, supporting outpatient treatment and recovery services. The federal government now recognizes that stimulant use disorder often co-occurs with an opioid use disorder, and it is, actually, the primary issue that needs to be addressed in treatment. They are seeing quite a bit of success with treatment of stimulant use disorder. Priorities include tribal treatment and recovery, criminal justice system treatment and recovery, peer recovery support, community preparedness planning for tribal communities, mobile opioid recovery outreach teams, and a primary focus for some programs on neonatal abstinence syndrome prevention.

There has been a big push to distribute naloxone kits, including overdose education. A focus on criminal justice deflection and diversion recognizes that individuals may be better served through treatment than incarceration. Specialty services include housing, pregnant and parenting programs, and a focus on diversity and health for communities that are disproportionately impacted by substance use, providing wrap around treatment and recovery support services. Expansion of criminal justice programs also support MAT services during incarceration and continued maintenance, linking to community-based services upon reentry.

Certified Community Behavioral Health Clinics (CCBHCs) are an essential component of the state's infrastructure for SUD treatment. They include 24/7 crisis intervention, ambulatory withdrawal management and an array of services in the community. The number of CCBHCs has increased from three, to now having nine Medicaid enrolled providers and seven with SAMHSA Direct funding to

establish services in communities. They are considered safety net providers for adults, children, adolescents, and families, regardless of their ability to pay.

Nevada's crisis response system includes a 24/7 crisis call line and crisis care hub, with transparency into the behavioral health system to ensure timely referrals, including deployment of mobile crisis teams, similar with a 911 response. The 988 crisis response is coming on line soon to deploy services in the community with mobile crisis teams. Crisis residential services are also being established with coverage under Nevada Medicaid. There is a need to expand these services under the 1115 demonstration waiver for all Nevadans who need that service, and then the Crisis Stabilization Centers offer a different front door from emergency rooms, for those who have immediate behavioral health care needs, but don't need emergency medical care. They will be open 24/7 to provide 'living room model' services in a warm and welcoming environment that looks very different than an emergency room.

In-home crisis stabilization services recognize support from family, friends or caregivers close by as a better option than outpatient treatment for some individuals. Services distinguish between adult services compared to children, youth and families. They are required to be responsive to both mental health and substance use related crises, ensuring capacity and referral for withdrawal management and MAT. They are strongly rooted in recovery and include peer recovery support throughout the continuum. This may or may not include formal treatment services, honoring individual autonomy to choose their own recovery pathway. People with lived experience are included on the decision-making bodies with SURG and other advisory groups. This leads to the best outcomes in developing systems and services that support individuals, through treatment, harm reduction and sustained recovery.

Recommended Subject Matter Experts:

- Recovery Communities, including Foundation for Recovery;
- Dr. Kelly from Harvard University; and
- Individuals with lived experience.

The recovery-oriented systems of care and support include peer recovery and support services certification, recovery-oriented faith-based communities, alternative peer groups, recovery high schools, recovery friendly workplaces, and recovery communities. Statewide examples include:

- Foundation for Recovery,
- National Alliance on Mental Illness (NAMI),
- There is No Hero in Heroin (TINHIH), and
- Nevada's Recovery and Prevention (NRAP at UNR).

For a very long time, recovery was really considered an add-on to our formal treatment delivery system. Distinct funding for community-based recovery supports is needed to empower recovery services to develop outside of formal treatment services.

Chair Thomas asked Dr. Woodard if the provider service search is interactive for family members to locate treatment in their communities. Dr. Woodard explained it is available and online for the public, but it doesn't currently give you an overview of where care is currently available. It just gives the information necessary to determine the level of services available in a particular area, and if they treat adults or adolescents or both. Also, some quality indicators are available, but you would need to reach out to the individual providers to determine if they are currently accepting new patients.

6. Consider Recommendations for Presentation from Subject Matter Experts for Future Meetings *(For Possible Action)*

Terry Kerns, PhD, Substance Use Law Enforcement Coordinator, Office of the Attorney General provided an overview of recommendations, based on presentations to the Joint Interim Standing Committee on Health and Human Services. This Subcommittee could invite some of those presenters to discuss their recommendations in more detail than what is included on the Tracking Tool. Dr. Kerns also noted the expertise of SURG members, as well as ACRN members, and invited subcommittee members to provide their SME recommendations to her or to SEI, as well to arrange presentations.

Ms. Lee recommended a presentation on overdose prevention sites, from Kailin See with the Washington Heights Corner Project. Dr. Kerns also heard this presentation and agrees that it would bring a depth of information to the committee.

Dr. Dickson offered to present on MAT as well as the Bridge program to get emergency room doctors and staff to refer people into treatment programs. She is working with others to start a pilot program with several hospitals in Clark County. She could also do a presentation on Kratom and getting it listed as a schedule one drug with the Board of Pharmacy. A regulatory hearing had been scheduled, but it was cancelled. It might be better to work on legislation, but there's going to be push back from the industry.

7. May Meeting Date (*Information Only.)*

Chair Thomas noted that the next meeting is scheduled for May 16th at 8:30 a.m.

8. Public Comment

Chair Thomas asked for any public comments and read a statement that they are *limited to three minutes per person. This is a period devoted to comments by the general public, if any, and discussion of those comments. No action may be taken upon any matter raised during a period devoted to comment by the general public, until the matter has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.020*

The meeting was adjourned at 4:42 p.m.

Chat Notes

15:39:15 From Kelly Marschall, SEI (she/her) to Everyone:
vbeavers@ag.nv.gov
15:43:27 From Kelly Marschall, SEI (she/her) to Everyone:
If you are joined by phone and can list your name in the chat, we can record your participation in the minutes
16:29:04 From Kelly Marschall, SEI (she/her) to Everyone:
As a reminder here are the areas in which treatment and recovery workgroup members will address recommendations as found in the legislation and on your original spreadsheets: B: Assess evidence-based strategies, C: Assess Treatment/Recover, D: Criminal Justice System Support, E: Evaluate-Improve Evidence-based Programs, F: Examine Recovery Support Systems, H: Examine Quantitative and Qualitative Data on Risk Factors, I: Develop Law Enforcement and Public Health Strategies, and J: Expand Education and Harm Reduction with particular focus on C, E, F, J (2)