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

Statewide Substance Use Response Working Group **May 7, 2025**
Prevention Subcommittee Meeting **3:00 p.m.**

Zoom Meeting ID: 825 0031 7472
Call in audio: 1 253-205-0468
No Physical Public Location

Members Present via Zoom or Telephone
Chair Jessica Johnson, Erik Schoen, Angela Nickels

Members Absent
Senator Fabian Doñate and Debi Nadler

Attorney General's Office Staff
Deputy Attorney General Rosalie Bordelove; Dr. Terry Kerns; Deputy Attorney General Joseph Peter Ostunio, Esq.; and Ashley Tackett

Social Entrepreneurs, Inc. Support Team
Kim Hopkinson, PhD, and Laura Hale

Members of the Public
Linda Anderson; Lori Bryan; James Dardis; Kaci Fleetwood; Mark Funkhouser; Ashley Greenwald; Noelle Hardt; Amy Lucas; Josh Luftig, PA-C; Kelly Morgan, MD; Breanne Van Dyne; Brooke Wagner; and Cherylyn Rahr-Wood

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Johnson called the meeting to order at 3:00 pm

2. **Public Comment** *(Discussion Only)*
   Kim Hopkinson read public comment guidance, and Chair Johnson asked for public comment. Seeing or hearing no public comment, Chair Johnson moved to agenda item #3.

3. **Review and Approve Minutes from March 5, 2025 Prevention Subcommittee Meeting** *(For Possible Action)*
   After confirming with DAG Ostunio that individuals not present at the March meeting could participate in approval of the minutes from that meeting, Chair Johnson asked for a motion to approve the minutes from the March 5, 2025, Prevention Subcommittee meeting.
   - Mr. Schoen made the motion to approve.
   - Ms. Nickels seconded the motion.
   - The motion carried unanimously.

4. **Low Barrier Emergency Department Based Naloxone Distribution** *(Discussion Only)*
   Josh Luftig, PA-C – National Implementation Leader – National Bridge Network introduced himself and along with Dr. Kelly Morgan, MD, shared slides for this presentation. He works in an emergency department (ED) in Oakland, CA, and does national work around addiction

care delivered from the ED, including harm reduction and Naloxone Distribution. Neither he nor Dr. Morgan have any conflicts of interest; a lot of their work is funded by the opioid response network.

Dr. Morgan, ED physician in Nevada referenced challenges to the distribution of Naloxone in emergency departments. She has worked with Josh and his team from Bridge on a number of initiatives, including harm reduction which integrates Peer Navigators. Next quarter they are looking to launch buprenorphine for the 911 system as part of a multi-year project to get people the help they need. In Southern Nevada, Dr. Morgan and Dr. Dave Hart have been two of the biggest ED local champions. Challenges include stigma with hospitals not wanting to attract substance use patients to their EDs by having supplies available, but the patients are already there. So, they need to play a much more prominent role in harm reduction. Dr. Morgan worked to get "Halloween – style" candy jars of Naloxone in hallways for anyone to take when they need it. This met with resistance from a lot of hospitals and particularly some of the pharmacy departments that oversee those programs when hospitals don't have dispensing pharmacy licensure. Boxes of Naloxone don't have patients' names on them or other types of identifiers. There were also concerns about not having a nurse administer the medication.

Experience in the ED is that patients who acutely overdose on opiates now are not leaving with Naloxone in hand, and most are not going to a pharmacy to fill a prescription. The stigma around getting Naloxone includes being asked why it's needed, whether they can pay for it, or where is their ID, similar to challenges filling buprenorphine prescriptions. Dr. Morgan's experience is that if they don't provide Naloxone in the ED and patients don't leave with it in hand, they're not going to get it at all unless they're finding it at some other site. Within their EMS (Emergency Management System), they say "Here, take a kit" to make sure people have Naloxone, but somehow that has not trickled into the hospital systems. Dr. Morgan believes this is a significant area for improvement.

This experience sets the stage for opioid-related deaths continuing to go up with a 30% overall increase. Last year was the first year that the national data went down – significantly down – except in five states. Nevada was one of the five that went up, second only to Alaska. Despite their efforts, Fentanyl related overdose increased by 42% in Nevada, and they are seeing more and more encounters related to Fentanyl in the ED. Dr. Morgan shared trends from the Statewide Plan. Synthetic opioid overdoses, other than Methadone, which is mostly Fentanyl, have gone up at astronomical rates. Data on crude overdose death rates were provided by staff at Southern Nevada Health District, showing highest rates in downtown Las Vegas.

In 2023, there were 72,000 hospital encounters, with 52.6% Medicaid patients. Dr. Morgan reiterated that the patients with substance use disorders (SUD) end up in their EDs anyway. Again, it's a prime location to really encourage community distribution of Naloxone.

Mr. Luftig provided a broad look at the Bridge program where they were starting to identify more patients for SUD. Part of the intervention is identifying the opioid use disorder (OUD) specifically and prescribing MAT (medication assisted treatment) and administering

buprenorphine and giving the patients Naloxone in hand to take home. They are not relying on a prescription. Naloxone is an opioid antagonist that blocks and reverses opioids for 30-60 minutes, with no known adverse effects or allergic reactions. There is no potential for abuse, so there's no street value. In fact, there's a negative street value in the sense that they're trying to get it to patients who really should have it on hand, the way that you would give people helmets or fire extinguishers, as a public health intervention, not a controlled substance.

Buprenorphine distribution started in the 90s in the US, through schools, on street corners, and out of syringe exchanges among the lay public. It comes in multiple formulations. Mr. Luftig focused on intranasal spray which was released within the last decade. It has been a game changer because it's relatively inexpensive and very simple to administer this spray, compared to an injection being very complicated. It reverses an overdose by displacing the opioid on the receptors in the brain and has a higher affinity to just push the opioid off and restore breathing.

The problem with prescribing is that only 11% of patients who should have Naloxone are even getting a prescription, and only 1.6% who are at risk for an overdose are having that prescription filled. So, it's a failed intervention to just rely on prescribing if more than 98% of patients are not actually receiving Naloxone, which is lifesaving for them. Nearly 50% of ED visits are substance use related, with higher risk patients more likely to receive care in the ED, as their only healthcare touchpoint. As the only resource with all-hours safe access and acute psychiatric stabilization, they can start people on buprenorphine treatment right there, which is something that most syringe exchanges and most other touch points for Naloxone are unable to do. They can also navigate people to ongoing care, and they are well distributed geographically throughout Nevada, serving over a quarter of a million patients in rural Nevada, in addition to urban areas.

After a non-fatal overdose, patients are at a substantial risk of a repeat overdose, mostly compressed into that first 48 hours. Handing them Naloxone in the ED provides safety in this critical timeframe.

The Bridge model includes low barrier treatment with administration and prescribing of buprenorphine, supporting treatment engagement and retention, and stabilizes their use disorder. Linkages to care and community are also provided along with harm reduction, more than doubling retention and treatment.

Distribution via standing order is permitted in Nevada, as in most states, but low barrier distribution is still not occurring due to a complex regulatory environment including storage and labeling of Naloxone that creates a chilling effect on ED and hospital participation. The FDA has authorized over the counter Naloxone since 2013 which should loosen up the regulations. By reaching out to the Board of Pharmacy, along with California Health and Human Services and the Department of Public Health, Mr. Luftig and other advocates were able to exempt EDs from these regulations. Separate storage from hospital formulary medications and standard operating procedures were put in place to limit related policies to Naloxone.

Multiple methods of distribution include hand distribution from a provider, a nurse, a substance use navigator, or a hospital volunteer. But passive distribution using a stand, a vending machine, or a countertop basket are more effective, with the distribution stand being the powerhouse. These newspaper style distribution stands are not locked and can be indoor and outdoor, and they are virtually indestructible. A guide is available on their website, and training is no longer required because instructive labeling is now required, similar to labeling for ibuprofen or Acetaminophen. In Mr. Luftig's hospital program, they add labels with helpline numbers to support access to treatment, as well. They increased from 7 kits a month to over 500 kits by implementing these types of processes statewide, totaling over 300,000 kits distributed for free over the life of the program.

In Nevada, kits are distributed through federal and state grant programs. The value added by distributing through EDs is incredible, if the state can provide the Naloxone and amend regulations for exemption. Dispensing labeling, maintenance, storage packaging and security can then be implemented. The state Board of Pharmacy is the key authority to engage in this process. Local harm reduction organizations can help expedite the process with distribution stands and other supplies. Template documents are available to healthcare systems and program descriptions can be provided on agency websites.

Chair Johnson thanked Dr. Morgan and Mr. Luftig for this excellent presentation contextualized to Nevada, with lessons learned under the Bridge program. Mr. Schoen added his thanks and his support for getting Naloxone out to as many people as possible. He felt the graph showing the highest risk within the first 48 hours after ED treatment was particularly impactful.

Chair Johnson asked about multiple methods of distribution regarding stigma and how in-hand Naloxone complements that. Mr. Luftig suggested a belt and suspenders approach with saturation for everyone at risk and everyone surrounding those at risk to be able to intervene. In-hand provision is an opportunity for providers to have a conversation with the patient about why it's important to carry Naloxone, and they realize the ED is in their corner with practical solutions for their health and safety. This can build trust to engage in treatment in the future. Automated passive distribution provides a touch point for the entire community to access Naloxone and labeling can connect them back to the ED, with 24/7 availability.

Most of their volume in his program in California is through the distribution stands, with 70 stands around the county. Nevada has pioneered a lot of work around vending machines. While they are more expensive than stands, there may be more buy-in from the institutions for vending machines. Naloxone is an incredibly stable molecule and doesn't require any staff intervention once the machine or stand is filled, although Mr. Luftig does not recommend putting them in direct sunlight in the Nevada desert environment.

Dr. Morgan added that they see a lot of people with OUD who may not come in for an acute overdose or non-fatal overdose, or may not be forthcoming about their use, but the passive distribution provides them the opportunity to leave the facility with Naloxone in hand.

Chair Johnson asked about how this was received and whether there was a difference between urban and rural communities in California. Mr. Luftig said they have 200 hospitals implemented at this point, including academic community hospitals, rural hospitals, and tiny hospitals in the middle of nowhere. In Placerville, it is really the anchor for the entire county. Patients know their life was saved by the kit that came from the ED distribution stand. Naloxone is pretty widely accepted and once you improve access to treatment, it's very compelling to have access to a reversal agent. Some people may object if there is no link to ongoing treatment, but if you pair them, it's a bulletproof program. The program has been celebrated with newspaper articles and interviews, particularly given the prior hopelessness around the opioid crisis. The feedback has been very positive.

Chair Johnson thanked them again, noting that she put in a draft recommendation around community access of Naloxone for the Prevention Subcommittee.

5. Review Progress on Prior SURG Prevention Subcommittee Recommendations
(Discussion Only)

Ms. Hale reviewed slides regarding the timing of recommendations related to the budgeting process or legislation where there is a long lead time. Rather than requesting a budget item for "this biennium," SURG recommendations might target the next biennium so that agencies have a workable timeline as it passes through the executive branch administration process with multiple rounds of approval.

Bill draft requests (BDRs) should be directed to a specific legislator, agency, or board with authority and assigned allocation for submitting BDRs. Otherwise, they may not go very far.

For recommendations related to State Plan Amendments (SPAs) for state Medicaid, those can take from 90 days for cleanup language to two and a half years for things like the recent crisis SPA.

Updates for specific recommendations made by the Prevention Subcommittee were provided to Ms. Hale by Breanne Van Dyne, Section Manager for State Opioid Response under the Bureau of Behavioral Health, Wellness and Prevention (BBHWP), Division of Public and Behavioral Health. Ms. Hale provided a brief overview of the tracker spreadsheet noting that recommendations from the last few years were grouped together by topic area that might cut across subcommittees. Updates from various programs and divisions of DHHS from past years were included in the tracker, along with any legislative updates. The document will be made available to members once it has been completed for all subcommittees and reviewed internally by SEI staff.

Staff from SEI have worked with DHHS programs over the last few years to provide annual updates to SURG recommendations. In response to BBHWP federal grant timeframes, the last updates were provided in October 2024 and there was an agreement to provide future updates in October every year going forward.

Chair Johnson offered huge thanks to SEI staff and suggested members review the tracker document, when available, with four steps in mind ahead of the June meeting:

1. Any questions for staff or for discussion including, for example, whether the cited activity related to a recommendation reflected an increase in funding, or if there was an offsetting cut.
2. Whether or not to keep recommendations active and resubmit them on the survey that Kim Hopkinson sent out.
3. Whether to modify recommendations, based on this information, for further discussion.
4. Whether to delete a recommendation altogether.

6. **Discuss Proposed 2025 Prevention Subcommittee Recommendations** *(Discussion Only)*
Chair Johnson reviewed slides for the 2025 Recommendations Process, reminding members to use the survey link that Dr. Hopkinson sent to them as early as possible to support scheduling presentations. She would love for everyone to submit a recommendation, whether it is new content or related to updates on previous recommendations.

Dr. Hopkinson shared slides with new recommendations submitted for 2025 via the current survey, comprising the following:

- Re-elevating a 2024 recommendation to *Create a bill draft request to allocate a 15 percent set aside of cannabis retail funds to be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts.*
    - Chair Johnson noted that SEI has been working on this recommendation from Ms. Nadler to schedule a proposed presenter with international exposure.
- *Request clarification or guidance from the Nevada Board of Pharmacy on hospital emergency department distribution of naloxone pertaining to the non-pharmacy storage and distribution of naloxone to the community.*
    - Chair Johnson appreciated materials from today's presenters to help with amending the language to be more specific.

Chair Johnson reported confirming speakers for June with the Boys and Girls Club who will talk about statewide programming around prevention under the Fund for Resilient Nevada, and a recently published report.

7. **Update on Multi-Tiered System of Support (MTSS) Project**

Kaci Fleetwood, M.Ed, BCBA, LBA; Ashley Greenwald, PhD., BCBA-D, LBA; and Brooke Wagner, MSC-SC, BCBA, LBA with MTSS, University of Nevada, Reno presented slides for this item.

Ms. Fleetwood noted that MTSS is a statewide project with a variety of funding streams, administered by UNR. Staff are located throughout the state and partners include school districts, local education agencies, and the State Department of Education, to build prevention, intervention and treatment frameworks for both clinical and non-clinical supports.

Community and school-based goals and data are used to help districts select evidence-based practices to meet their needs. Training, coaching, and technical assistance are provided for implementing those practices, with 80% success targeted within three years.

Their work is based in public health, using a 3-tiered continuum of support, including academic, social-emotional, and behavioral. MTSS is defined by core features for universal access, evidence-based interventions, engaging in universal targeted screening. Data-based decision making occurs at the site level, the district level and the state level. Everyone at every level receives the training. For example, substance prevention programming goes to every student in the school or every student in the grade level. Tier 1 is for everyone, Tier 2 goes to youth with similar risk factors, and Tier 3 is individualized support with a treatment plan for more complex needs.

Evidence-based practices with different screeners and assessments are available for substance use targeting within different school districts to identify the most appropriate intervention and treatment plans.

Dr. Greenwald works across many state agencies to help with strategic planning and alignment, considering intersectionality. Whereas Ms. Fleetwood works more in the school districts to help install, scale, sustain, and innovate their MTSS systems. Ms. Wagner is a coaching coordinator to support mid-level management in the districts and to provide training to end-level providers and school administrators.

Ms. Fleetwood shared charts gauging implementation at different levels of fidelity, showing strong correspondence with average daily attendance levels, as well as better outcomes in math and English.

MTSS works with 76% of local education agencies; Storey County recently joined in the past 90 days. Some partners have been involved for over a decade. Nevada Revised Statutes (NRS) violations are also documented throughout the state, including violence, weapons, and substance related indicators, which are their strongest outcomes for MTSS.

Other indicators of bullying, cyberbullying, harassment, and discrimination show similar outcomes. All the data are produced by an external evaluator to avoid biased reporting with the publicly accessible Nevada Report Card.

Schoolwide positive behavior support demonstrates lower use of substance and alcohol, particularly in high schools, with every $1 invested returning fiscal savings of $104.90. Support from the Fund for Resilient Nevada (FRN) allowed greater focus on substance use, but they have been informed that is coming to an end.

Ms. Nickels noted support for the MTSS program within her school district, where engaging students in these conversations saves a lot of headaches from an administrative standpoint.

Mr. Schoen referenced the end of funding in June and asked what MTSS will look like going forward. Ms. Greenwald was unable to answer this question with any certainty. They have had sustainable sources since inception in 2012, so this is the first year without that. They are housed under UNR, but there are extension offices in rural communities and in Las Vegas. Program champions from relationships built over the last decade have been very helpful, but they need to work with state agencies to try to secure funding going forward, which is challenging given the loss of federal funds.

Chair Johnson asked Ms. Fleetwood to talk about the extent of "reach" within particular counties, regarding curriculum selection and what levels of school administration and/or county administration get involved in that process.

Ms. Fleetwood responded that they can scale up to 100% of schools pretty quickly, in two to three years for Carson City, Lyon County, and Humboldt County. Three districts where they are not up to scale are Washoe County, State Public Charter School authority, and Clark County. They are up to about 135 out of 374 schools in Clark County. The MTSS staff work to build district level capacity but with recent teacher turnover and cuts, the MTSS staff lean in a little harder to fulfill that role for their districts. They are also collecting fidelity data among their 200 schools, as well as providing coaching support. Annual initiative inventories on programming and curriculum implementation provide additional information to support targeted guidance. The State Public Charter School authority has the most variability for implementing evidence-based programming.

Chair Johnson shared that her daughter started a *Leader in Me* program that has been really successful, which Ms. Fleetwood confirmed is a Tier 1 program.

Chair Johnson expressed an interest in seeing where there is alignment with expansion of effective, evidence-based prevention programming across the state. Ms. Fleetwood said they would be honored and interested in doing that in a thoughtful and collaborative way and welcomed follow-up conversations.

8. Discuss Report Out for July 9, 2025 SURG Meeting

Chair Johnson reminded members they would be meeting again in June as a subcommittee. For the July 9 full SURG meeting, she will be traveling for a grant site visit meeting in Atlanta, so she asked Vice Chair Schoen if he might be available to present at the July meeting in case her internet connection goes sideways. Vice Chair Schoen confirmed his availability. Chair Johnson will prepare brief statements on the presentations received today, and subsequent discussions.

9. Public Comment

Dr. Hopkinson read public comment guidance, and Chair Johnson asked for public comment. Seeing or hearing no public comment, Chair Johnson moved to agenda item #10.

10. Adjournment

The meeting adjourned at 4:27 pm.

Meeting Chat Log:

From Kaci Fleetwood 4:24 PM

Thank you everyone! Appreciate the invitation to present. Take care.

From Kaci Fleetwood 4:25 PM

In case you would like to reach out, my email is Kacif@unr.edu

From Brooke Wagner 4:25 PM

Thank you for allowing us to come today, I am going to exit and catch a flight to Las Vegas.