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

Statewide Substance Use Response Working Group **August 21, 2023**
Response Subcommittee Meeting **9:00 a.m.**

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

Members Present via Zoom or Telephone
Dr. Terry Kerns
Shayla Holmes
Christine Payson
Gina Flores-O'Toole

Members Absent
Dr. Stephanie Woodard

Attorney General's Office Staff
Ashley Tackett and Rosalie Bordelove

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

Members of the Public via Zoom
Dan Gerrity, Abe Meza, Alissa Engler, Darla Zarley, Vanessa Diaz, A.J. Delap, Alex Tanchek, Edwin Oh, Elyse Monroy, G. Goodlander, Hines J, Jennifer Atlas, Lavatta Palm, Lea Case, Linda Anderson, Mary-Sarah Kinner, Morgan Biaselli, Teresa Benitez-Thompson *Members of the public are listed with the names displayed on their Zoom account.*

1. Call to Order and Roll Call to Establish Quorum
Chair Kerns called the meeting to order at 9:01 am.

Ms. Duarte called the roll and established a quorum with four out of five members present.

2. Public Comment (9:03 am) *(Discussion Only)*
Chair Kerns asked for public comment.

Ms. Duarte read the public comment guidance.

There was no public comment.

3. Review and Approve Minutes from May 22, 2023 Response Subcommittee Meeting (9:04 am) *(For Possible Action)*
Chair Kerns asked for a motion to approve the May 22, 2023 Response Subcommittee meeting minutes.

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

4. Presentation on Emergency Department Peer Support Program (9:05 am) *(For Possible Action)*

Ms. Palm explained the background of the Emergency Department (ED) Peer Support Program at University Medical Center (UMC) in Las Vegas. Individuals come into the ED with a substance use related illness and the team will facilitate getting them into treatment.

Ms. Palm noted in July of 2023 the program saw its highest number of there was the highest number of patients. She also mentioned they will follow up with patients to continue to help patients who may have returned to use or were not ready for treatment when they were in the ED initially.

Dr. Kerns asked if the peers are being reimbursed for these services.

Ms. Palm responded with that this program is grant funded and is not reimbursed through Medicaid. Peers are paid through the grant.

Dr. Kerns asked if this program could be expanded throughout the state of Nevada.

Ms. Palm said funding is always a challenge with these programs. If they are able to secure funding for this program in other places throughout the state they would love to expand.

Dr. Kerns asked about wait times for patients.

Ms. Palm said there could be a 30 minute to 1 ½ hour wait, so she believes this is a long wait time due to the nature of the population. This is usually the insurance wait time because there has to be an insurance screening to see if the patient will be covered.

Dr. Kerns asked if beds are typically open for patients.

Ms. Palm said yes, we have a pretty high success rate for this. Occasionally, there are a few patients we can't get into treatment, but we make sure they have a safe place to go while they are getting started into their treatment journey.

Dr. Kerns asked if OpenBeds is being used out of UMC in Las Vegas and Renown in Reno.

Ms. Palm said their team has used OpenBeds but they usually utilize their connections in the community because they are already established. We make sure the client is okay with the facility they are trying to refer them to.

Dr. Kerns thanked Ms. Palm for her presentation.

5. **Presentation from Board of Pharmacy (9:15 am)** *(For Possible Action)*

Ms. Zarley introduced herself and gave a brief explanation about substance use disorder (SUD) laws in Nevada that pertain to pharmacists/prescribing.

Ms. Zarley explained Senate Bill (SB) 459 which prevents punitive actions against health professionals and any person who administers naloxone or calls 911 to assist someone who may be overdosing on opiates. See slide 18 for more detailed information about SB 459.

Ms. Zarley explained regulations related to buprenorphine in the Emergency Department which authorizes practitioners to dispense a controlled substance for the treatment of opioid use disorder without a Dispensing Registration. See slide 19 for more detailed information

Ms. Zarley presented on Assembly Bill (AB) 156 which allows a pharmacist to:

- Assess a patient to determine whether the patient has an opioid use disorder and whether medication-assisted treatment (MAT) would be appropriate for the patient and;
- Prescribe and dispense a drug for medication-assisted treatment;
- Counsel and provide information to the patient on OUD treatment options including MAT.

See slide 20 for more detailed information.

Ms. Zarley noted the most recent development of the removal of the X-Waiver for practitioners to prescribe buprenorphine. She expanded on more information for DEA registrants to be aware of the many components of prescribing buprenorphine and noted that the elimination of the X-waiver will increase the number of practitioners eligible to prescribe buprenorphine thereby increasing access to buprenorphine for those in need. See slides 21-22 for more information.

Dr. Kerns asked about SB 459 and if there was an education component statewide about the Good Samaritan Law.

Ms. Zarley said she did not know about this.

Dr. Kerns asked if the Board of Pharmacy has had any feedback from the Good Samaritan Law.

Ms. Zarley said they have not received any feedback on that.

Dr. Kerns asked about the data waiver elimination and if there has been a change in practitioners prescribing buprenorphine.

Ms. Zarley said there has been an uptick in buprenorphine prescribing overall but she hasn't looked at the data since the X Waiver was eliminated but could do so. She noted that part of the challenge is getting prescriptions filled at the pharmacy level.

Dr. Kerns asked what the limitations were in pharmacies and if there was anything the subcommittee could do in this regard.

Ms. Zarley said the limitation is the availability of buprenorphine. Most pharmacies have buprenorphine but don't have enough. She wasn't sure what the DEA has set for manufacturing of buprenorphine but didn't think it was limited and wasn't sure about a recommendation that could be made.

Dr. Kerns asked if there is a difference in urban and rural counties in Nevada.

Ms. Zarley said availability of buprenorphine is a problem across all of Nevada.

Dr. Kerns thanked Ms. Zarley for her presentation.

6. Presentation on Wastewater Surveillance of Illicit Drugs in Southern Nevada (9:25 am) (*For Possible Action*)

Dr. Gerrity introduced himself and his colleague, Dr. Oh, who he collaborated on this project with.

Dr. Gerrity explained water-based surveillance and epidemiology and how it works. He described the various sampling methods (e.g., sewer manholes and lift stations, wastewater treatment plants). He noted that within clinical settings, they can make individual conclusions but with wastewater surveillance they can make broader conclusions on a larger community level about public health issues. Wastewater surveillance allows people to do the normal things they are doing (i.e., using the restroom) to answer various public health related questions such as the level of Sars-CoV-2, other illnesses, and illicit substance use.

Dr. Gerrity explained that wastewater surveillance allows for a passive view of the community and can fill data gaps that traditional public health surveillance cannot capture or due to issues related to waning urgency, stigmatization, and legal implications. See slide 30 for more information.

Dr. Gerrity's study looked at 39 different components, not all related to high risk substances but a large amount are. They can observe concentrations of substances in sewer sheds throughout Clark County, which allows them to get an idea of a spatial difference throughout the county. He also explained the dots/outliers on specific dates of substances in a certain location. Additionally, he explained the time between sampling and how they can observe the changes in fentanyl use (and other substances). This allows for trends or changes in trends to be easily recognized and see the overall consumption. This can also be directly related to law enforcement initiatives and what is happening at the same time as higher consumption of substances. See slides 32-35 for more information.

Dr. Gerrity explained how norfentanyl has been found in Las Vegas bar locations and that knowing about this through wastewater surveillance can provide public health opportunities to intervene. Also, there was one sample that detected xylazine in the hospital setting in Clark County.

Dr. Gerrity said we need to now correlate this data with public health work. He recommended we look at the gaps in public health and how Wastewater Surveillance can fill these gaps, for example they need to know what substances are most important to test for. Please see the slide slides 36-37 for gaps and recommendations offered by Dr. Gerrity.

Ms. Holmes asked who is doing the sampling every two weeks? And, how much of an additional burden is this to the team doing sampling?

Dr. Gerrity said this is definitely outside of what the team normally does, but they do have the capability to do this work, so they started looking at it from a research capacity to show a proof of concept that this works. Their hope is that this program will be expanded to fill public health gaps – it's a matter of finding the right people to expand this program and get it stabilized.

Ms. Holmes asked about the frequency of how often wastewater folks go out to manholes to test.

Dr. Gerrity said they don't have to go out to a bunch of different man holes throughout the day. They have identified strategic locations within high risk communities to make this test more manageable. Rural communities will be a lot more resource restricted; it is even challenging to make sure wastewater systems are working correctly, nonetheless have a program like this on top of their additional responsibilities in rural areas due to the constrained resources.

Ms. Holmes asked if Dr. Gerrity believes this is something to be supported in communities with adequate resources.

Dr. Gerrity said yes, absolutely. They need a point of contact who knows public health who needs this information we are collecting to make this data actionable within the community.

Dr. Kerns asked if there is a delineation between illicit and high-risk substances within data collection.

Dr. Gerrity said yes – they aren't all illicit because fentanyl has clinical use in Emergency Departments, for example.

Dr. Kerns asked if there are any other places that are using this data for public health purposes that he knows of.

Dr. Gerrity said Marin County, California also detected xylazine in the wastewater surveillance they have collected. The high-risk substance application of wastewater surveillance is not as frequently used, but there are 500+ systems that are using wastewater surveillance for Covid-19. He believes there is an opportunity to expand existing programs to answer these questions related to high risk substances.

Ms. Holmes asked if we can identify a baseline of high-risk substances to see spikes over periods of time. What is the accuracy of the time of data collection – is that a reflection of the last 72 hours? How long are compounds active?

Dr. Gerrity said what is reflected in the data is whatever is happening right then and there when the data is collected. Wastewater data can be generated in one to two days. The sample is collected and reflects that specific point in time. The part that is not developed yet is pharmaceutical use and these datasets need to be connected. This goes back to connecting the right people who can use this data most optimally.

Dr. Kerns asked if there is a database for suspected overdoses to compare wastewater surveillance data?

Dr. Gerrity said if someone has an overdose you might not actually see this in the wastewater system because people won't be excreting in those wastewater systems, but it could be used to predict overdoses.

Dr. Kerns thanked Dr. Gerrity for his presentation.

7. Crosswalk of Good Samaritan and Drug Induced Homicide Laws (9:51 am) (*For Possible Action*)

Ms. Benitez-Thompson introduced herself and noted that the subcommittee has a recommendation under review related to the Good Samaritan (NRS 453.C.150) and Drug Induced Homicide (NRS 453.333) Laws in Nevada and how they compared to other state laws, including Delaware and Rhode Island.

Ms. Engler introduced herself and gave a brief explanation of the provisions of the laws they are comparing as well as the immunity under these laws. The Good Samaritan Law outlines immunity for certain offenses when someone provides medical assistance in the case of an overdose. The circumstances to qualify for immunity under the Good Samaritan Law are limited to:

- Misdemeanor drug paraphernalia
- Possession not for the purpose of sale (amounts less than trafficking levels and with other evidence indicative it is for personal use); as an example, if police arrive and see that there is a scale or other paraphernalia they may see that as other
- Under the influence
- Violation of restraining order
- Cannot be considered violating parole and probation terms if you call for assistance

These are the limited factors. There is prosecutorial discretion and allow a judge to consider mitigation evidence. If you are charged with a crime but did call for assistance, that can be taken into consideration for sentencing.

The biggest concern is how the Drug Induced Homicide Law plays into the Good Samaritan Law. The Drug Induced Homicide Law is if there is evidence that a person supplied a drug that is the proximate cause of a person's death, they could be charged with murder. Supplied can mean:

- Selling
- Giving

- Trading
- Or otherwise making the drug available to an individual

This law is very broad and could open up anyone to being charged if there is evidence that someone supplied a drug that caused a death.

Ms. Engler also explained she talked with the Las Vegas District Attorney's (DA) Office and they said they would only charge in instances where there was evidence the person was selling the drugs rather giving it to a friend/family member. She explained that prosecuting agencies have distraction and may treat the law differently in rural and even other urban counties. The Clark County DA has taken a more conservative stance as to when they actually charge and they do so as second degree rather than first degree murder to lower the penalty range.

Ms. Benitez-Thompson asked for questions.

Dr. Kerns asked if this has been charged frequently or were there just a few cases.

Ms. Engler said when she spoke with the Clark County DAs office, they said there were cases presented to them where a decision was made not to charge and to focus solely on those who are actually suppliers with evidence of selling drugs. It has been charged in Clark County in this context and focused area. She doesn't have an exact number of Drug Induced Homicide cases.

Dr. Kerns said that a potential recommendation was an ad campaign about the Good Samaritan law to clear up misinformation. Her concern is that there are still people who are afraid to call.

Ms. Engler talked through the requirements to have immunity under the Good Samaritan law. It could include:

- Reporting a drug or alcohol overdose to an emergency service
- Providing care to a person or
- Delivering someone to an emergency room.

There are a wide range of options for immunity under this law. For a public awareness campaign, it could include these things to let people know that they can provide aid with the assurance that they wouldn't have to remain with someone. You could also include the immunity factors listed above (e.g., under the influence at the time of the call).

Ms. Engler also pointed out that law enforcement isn't typically responding to overdose calls unless it results in a death. She said there is probably a fear that is unrealistic because law enforcement wants to save people rather than incriminate them.

Dr. Kerns asked about the other state laws.

Ms. Benitez-Thompson said these laws were similar. They really want to encourage people to act quickly and ask for help when they need it.

Ms. Holmes asked about clarification on the two laws that aren't necessarily linked – Good Samaritan Law provides immunity and the Drug Induced Homicide Law allows for prosecution

in certain instances. Is it correct that the Good Samaritan Law does not protect someone from the Drug Induced Homicide law?

Ms. Engler said yes, exactly – the key factor is the evidence portion. If friends are using together and someone overdoses for the Drug Induced Homicide Law to be used, prosecutors would still have to show evidence that the friend supplied the drug that caused the overdose. As a prosecutor, she wants more evidence rather than just being present to charge someone with Drug Induced Homicide. She wants clear evidence of the sale to be comfortable charging someone with that. If the evidence is there for a Drug Induced Homicide then they can be charged with that as well. It's correct that the two laws are not linked.

Dr. Kerns thanked Ms. Engler and Ms. Benitez-Thompson for their presentation and discussion.

8. 2022 Response Recommendations Review and Discussion (10:09am) (*For Possible Action*)

Ms. Holmes stated the purpose of this is to identify additional workshopping of recommendations and to get someone to champion resubmitting recommendations.

See slide 42 and this document that outlines the status of the Response Subcommittee 2022 recommendations.

Ms. Benitez-Thompson explained SB 35 and the various conversations of stakeholders that worked toward the fentanyl milligram change to 28mg as a low level and 100g as a high level. She noted there is also a requirement for prisons and jails to set up and establish Medication Assisted Treatment programs written into SB 35, as well as ensuring the Good Samaritan Law s as they were already standing carried through to these new changes for fentanyl level trafficking.

Ms. Benitez-Thompson explained another bill that allocated funds to purchase quantitative drug testing equipment. As well as conducting a study to do around quantitative analysis over qualitative analysis. The Judiciary Committee will be seeking to understand how quantitative testing could be use din the state.

Ms. Holmes asked if the committee thinks we can check this off since SB 35 passed in the legislative session?

Ms. Payson stated we can take this as a win although the threshold isn't as low as we would like it to be but it does differentiate between levels.

Dr. Kerns added that they can check it off, but it would be of interest to follow because of the laboratory testing and study that will be conducted from this legislation. She noted that this is different from Nevada Emergency Medical Services purchasing Mass Spectrometers for public health purposes with two going to each county.

Ms. Holmes proposed maybe the subcommittee should consider a more data-focused recommendation based on this. A data focused recommendation may follow this legislation to see if the data is representative of what we were expecting from SB 35.

She said they need someone to champion these recommendations and put them back into the survey to allow them to be reflected in the 2023 recommendations.

Dr. Kerns thought there was a recommendation on data collection. Law enforcement data will be different from mass spectrometer data and even wastewater data so there could be a recommendation to look at all of these components.

Ms. Holmes said she submitted the wastewater recommendation but we need to find funding for that. Her local law enforcement agency cannot test everything. Testing for fentanyl is an additional test. They can only test for what they think the substance is, she noted this is a cost saving measure. There may be room to increase funding across jurisdictions to support testing.

Ms. Payson agreed we cannot test everything. She talked about a conference she went to that explained a law out of California (SB 864), to incorporate fentanyl in a regular toxicology screen, not necessarily screening for what is seized, and that in Nevada we might be able to incorporate this.

Ms. Holmes suggested there may need to be two separate recommendations to distinguish data from law enforcement and public health. She asked Christine if it was a law that restricts testing of substances or if it is funding. Ms. Payson replied that it is related to funding.

Ms. Holmes said she can make a broader recommendation to incorporate data collection and wastewater.

Dr. Kerns added that in California it is now hospitals that are doing toxicology screens on people who had overdosed and including fentanyl so they could get real time results.

Ms. Payson said she can send more information.

Ms. Holmes mentioned the benefits of a presentation on how hospitals identify an overdose for different substances. Where do these different substances get titled and labeled and how can we make recommendations on this?

Dr. Kerns responded that overdoses present very differently for each substance. Toxicology screening would help rule in or rule out an overdose.

Ms. Holmes went over recommendation number 5 and noted that it looks like the crisis team is a new part of the Bureau. She asked if the committee still believes it is a priority? She thinks this is still important. See this document for Response Subcommittee recommendations.

Dr. Kerns agrees that we should still follow this recommendation because there are things going on in the state but more work needs to be done. She said she can try and work on recommendation 5.

Ms. Duarte explained the process for resubmitting the recommendation with revisions and if there are no changes then someone can email her to push the recommendation through.

Gina Flores-O'Toole left the meeting.

Ms. Holmes asked the committee to review recommendations 10 and 17 and make revisions and resubmit. She said that this is imperative to get 2022 recommendations, so they don't die.

9. 2023 Response Recommendations Process Discussion (10:32 am) (*For Possible Action*)

Dr. Kerns explained the process of how we would like to present our recommendations to the larger SURG with more objective components and come prepared to address impact, capacity and feasibility, urgency, and how the recommendation advances racial and health equity. The overall SURG will take the recommendations and weight them. We will also be looking at 2022 recommendations. Come prepared to discuss the recommendations at the next Response Subcommittee meeting. Then we need to present to the larger SURG in October.

Dr. Kerns noted the next Response Subcommittee meeting will be September 18th at 9am.

10. Public Comment (10:34 am) *(Discussion Only)*

Chair Kerns asked for public comment.

Ms. Duarte read the public comment guidance.

11. Adjournment
The meeting was adjourned at 10:35 a.m.