



STATEWIDE SUBSTANCE USE RESPONSE WORKING GROUP

SUBCOMMITTEE 2: TREATMENT AND RECOVERY

DRAFT MEETING MINUTES

September 22, 2026 – 11:00 a.m.

Virtual via Zoom

Members Present via Zoom or Telephone

Stephanie Cook; Dr. Jose Maria Partida Corona; John Firestone; Assemblymember Heather Goulding; Guiseppe Mandell; Steve Shell

Members Absent

Assemblymember (Dr.) Rebecca Edgeworth

Attorney General's Office Staff

Not present

Social Entrepreneurs, Inc. (SEI) Support Team

Margaret Del Giudice; Kim Hopkinson

Other Participants via Zoom

Ashlyn A.; Linda Anderson; Jinan Barghouti; Miranda Branson; Heather Kerwin; Megan Martinez; Sabrina Petrel; Maddie Proctor; bquezada [Belkis Quezada]; Miranda; Beth Scott; Morgan Sollano; Joan Waldock; Tina Gerber-Winn

Unless otherwise identified with [], members of the public are listed by their name or number as it appeared on Zoom.

1. Call to Order and Roll Call to Establish Quorum

Steve Shell, Treatment and Recovery Subcommittee Chair, called the meeting to order at 11:02 am. Kim Hopkinson (SEI) called roll and established quorum with six out of seven members present.

Chair Shell reminded members to announce early departure from the meeting to ensure accurate minutes and allow the Chair to confirm quorum. The following guidance was also provided in the Zoom chat: *If a member must depart a meeting prior to adjournment for any reason, the member shall formally announce their departure for the record to ensure accurate minutes and to allow the Chair to confirm that a quorum remains in accordance with Nevada's Open Meeting Law.*

2. Public Comment

Kim Hopkinson read the statement on public comment and provided call-in information. She provided the following guidance regarding use of the chat verbally and posted in the chat: *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.*

Chair Shell invited public comment.

Vice Chair Guiseppe Mandell elevated the growing problem of 7-OH, noting that it is now marketed as an energy drink without any warnings, and that it is a significant problem. Though not on the agenda, he wanted to ensure this was elevated for SURG members.

Hearing or seeing no additional public comment, Chair Shell continued to agenda item #3.

3. Review and Approve Minutes for the May 26th, 2026, Treatment and Recovery Subcommittee Meeting

Chair Shell invited a motion to approve the minutes from May 26th, 2026, Treatment and Recovery Subcommittee meeting, asking members to please state their name and the specific motion they are making throughout the meeting, to help maintain the public record.

- Dr. Jose Maria Partida Corona moved to approve the minutes.
- Member John Firestone seconded the motion.
- The motion passed with no dissent.

With no further discussion, Chair Shell proceeded to agenda item #4.

4. Subcommittee Reorientation

Chair Shell explained that this reorientation happens annually to make sure subcommittee members are clear on expectations around participation.

Kim Hopkinson, SEI, reviewed how attendance is tracked and that members should reach out in advance if they cannot make a meeting. She continued with an overview of the recommendations process, letting subcommittee members know that an updated link to the SurveyMonkey recommendation survey will be shared with members following the meeting. For additional details, please refer to the meeting PowerPoint available on the SURG website at [https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_\(SURG\)/SURG_website](https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/SURG_website) for the September 22, 2026 Treatment and Recovery Subcommittee meeting.

Chair Shell welcomed questions or comments, and seeing or hearing none moved to agenda item #5.

5. Review AB374 Section 10 Requirements and Subpopulations Addressed in Prior Recommendations

Chair Shell introduced this agenda item as one that happens annually in tandem with the previous reorientation agenda item to make sure subcommittee members are clear on the charge of the subcommittee.

Kim Hopkinson noted that the meeting PowerPoint would be posted on the SURG website and distributed to SURG members following the meeting so that members and the public can review slides in more detail, as she would be only briefly going over the information in the interest of time. She then provided an overview of the Treatment and Recovery Subcommittee legislative assignments as well as background on how this assignment came to be, directing members to pages 5-7 and Appendix C of the latest Annual Report for more information (the Annual Report is available on the SURG website).

She then reviewed the number of Treatment and Recovery recommendations aligned with AB374 components and those that impact special populations. She also highlighted that this information is drawn from the SurveyMonkey recommendations submissions.

Chair Shell shared that there was significant interest and traction around the Treatment and Recovery recommendations in the 2025-26 Annual Report, including several notifications that groups are incorporating recommendations into bill draft requests (BDRs). He highlighted the Joint Interim Standing Committee on Health and Human Services, who noted they are moving forward with a BDR prohibiting the pre-authorization of buprenorphine for opioid use disorder, which was a recommendation submitted by Dr. Partida Corona.

Chair Shell moved to agenda item #6.

6. Review of the Carry Forward Treatment and Recovery Recommendations

Chair Shell explained that carry forward recommendations are those that were submitted via SurveyMonkey by subcommittee members during the previous reporting cycle and did not make it into the 2025-26 Annual Report. Noting time constraints during this meeting, Chair Shell indicated that discussion of these recommendations would occur at the November subcommittee meeting and encouraged members to note today any recommendations for which they would like to see a guest speaker or subject matter expert present in the future.

He then turned the agenda item over to Kim Hopkinson, who reminded members that if they have a recommendation they'd like to be considered by the subcommittee, to ensure they submit this via SurveyMonkey prior to the November subcommittee meeting. She reviewed the carry forward recommendations (listed below) to serve as a reminder of activities from the previous reporting cycle and as potential recommendations for the subcommittee to consider for possible inclusion in the next Annual Report.

Carry Forward Recommendation #1 (noted as #6 in the PowerPoint to align with previous numbering prior to the 2025-26 Annual Report):

When medication assisted treatment is initiated in detox, we should recommend continuance of medication assisted treatment for the duration of detox, inpatient treatment, IOP and for one year from time of initiation.

Although it is common practice for patients to be taken off medication assisted treatment straight from detox, there is plenty of evidence showing patients fare better when medication assisted treatment is continued, particularly when treated for one year or longer. Of note, it is common practice in lower acuity care, such as ASAM criteria level one care, to treat patients with medication assisted treatment for months, if not years with said medications. It does not make clinical sense then, to taper patients off medication assisted treatment straight from detox, resulting in much more relapse and repeat admission to inpatient care.

Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026.

Carry Forward Recommendation #2 (noted as #7 in the PowerPoint to align with previous numbering prior to the 2025-26 Annual Report):

Nevada prescription monitoring program should include methadone dosing from any substance use treatment facility, including methadone clinics. Or, Nevada needs to adopt a methadone central registry.

Many patients receiving methadone treatment can become hospitalized or incarcerated. During these hospitalizations and incarcerations, there is often great difficulty in obtaining accurate information regarding a patient's true, current, methadone dose. If these were reported into Nevada Prescription Monitoring Program, it would prevent underdosing or overdosing patients on medication assisted treatment and make for much easier calculations for pain management, should the need arise.

Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026.

Carry Forward Recommendation #3 (noted as #8 in the PowerPoint to align with previous numbering prior to the 2025-26 Annual Report):

Hospital ERs should have a daily call schedule for outpatient follow up regarding substance use disorders, just like what currently exists for primary care. This list can be derived from NVSAM, SNAAP and SAMSHA collaboration which will produce a master list to the hospitals throughout the state. It will not be the hospital's responsibility to create the list, only to dispense it to the appropriate patients.

The establishment of a list with robust information, such as insurances taken, medications provided, services provided, etc., would provide a greater likelihood of patients seeking treatment for their substance use disorders in the ER actually getting long term care for said affliction.

Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026.

Carry Forward Recommendation #4 (noted as #9 in the PowerPoint to align with previous numbering prior to the 2025-26 Annual Report):

A research study should be funded and conducted to investigate the cost savings associated with early intervention for care via street medicine for the unhoused. The goal of such a study is to elucidate the viability of shared savings payment models to facility third party payer support for such street medicine teams, rather than support through grant funding, which is inherently unstable.

Street medicine is the most effective means to address medical issues among the unhoused prior to these medical issues requiring costly hospitalization. By providing proof of savings generated by this approach, third party payers are much more likely to adopt funding of street medicine, making this approach much more nascent.

Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026.

Carry Forward Recommendation #5 (noted as #10 in the PowerPoint to align with previous numbering prior to the 2025-26 Annual Report):

Funding should be made available for addiction specialists to advertise outpatient ASAM criteria level one services in state, particularly if those addiction specialists are board certified, trained in Nevada or both.

Although many patients cannot enter inpatient rehab because of insurance or work/family commitment limitations, these patients often still do well with treatment at a lower level of care, which is much less expensive. However, because many inpatient services also have IOP services and generate income in the tens of thousands per patient treated, they raise the average cost of advertising for all those providing addiction services. If we provide a stipend for advertising to addiction specialists committing to a certain length of stay in our community providing level one care, we can effectively build a deeper bench of addiction specialists, particularly those that are familiar with the resources that already exist in our community if they were trained in Nevada.

Submitted by Jose Maria Partida Corona, MD, FASAM on 3/23/2026.

Chair Shell reminded members that these recommendations would be revisited in November and encouraged members to submit recommendations via SurveyMonkey. He then moved to agenda item #7.

7. Review 2026 Treatment and Recovery Subcommittee and SURG Meeting Topics and Timeline

At Chair Shell's request, Kim Hopkinson provided an overview of the 2026 Treatment and Recovery Subcommittee and SURG meeting topics and timeline. She reminded members to notify SEI more than four days in advance of a meeting if they will be unable to attend, especially for meetings around the holidays, to ensure a quorum during meetings or look for alternate dates. Regarding upcoming meetings, she indicated that topics have not yet been proposed for the November and December

meetings as this is the first meeting of the reporting cycle. The November meeting will focus on the carry forward recommendations as well as any new recommendations submitted before that meeting. She encouraged subcommittee members to email her directly with requests for subject matter experts, and SEI will reach out to schedule them. She continued with a look ahead at the full SURG meeting timeline and anticipated meeting topics, which include the FRN Assessment Prioritization presentation in October that will be a follow-up to Heather Kerwin's presentation during this meeting (agenda item #8). She added that the January meeting will include election of officers, including the SURG Vice Chair. For additional details on meeting dates and topics, please refer to the meeting PowerPoint available on the SURG website at [https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_\(SURG\)/](https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/) for the September 22, 2026 Treatment and Recovery Subcommittee meeting.

Chair Shell invited questions and, hearing none, moved on to agenda item #8.

8. Presentation on Data Highlights and Methods for Scoring and Ranking Fund for Resilient Nevada Recommendations

Chair Shell introduced a video recording of the presentation made by Heather Kerwin, MPH, CPH, Opioid & Infectious Disease Epidemiologist, Office of State Epidemiology, DPBH at the September Recovery Subcommittee meeting. Sections of that recording not relevant to the presentation were edited out by SEI prior to sharing at the Treatment and Recovery meeting.

He explained that Ms. Kerwin would join after the recording for a Q&A period. For presentation details, refer to the *PowerPoint Presentation - 2026 NV Opioid Assessment Overview* and the PDF *2027-2031 Nevada Opioid Assessment Secondary Data Excerpt – DRAFT*, both available as part of this meeting's material on the SURG website at [https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_\(SURG\)/](https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/) for the September 22, 2026 Treatment and Recovery Subcommittee meeting.

Note that the recording was paused twice, once to address an unintentional muting (for which the recording was rewound), as well as to address a question by a subcommittee member which was tabled until Ms. Kerwin was able to join the call.

Ms. Kerwin's presentation included a review of the seven Fund for a Resilient Nevada (FRN) Statewide Opioid Goals, which identify priority areas for Nevada to address with the state's opioid settlement funds. The presentation also contained the criteria used to score the goals as part of the second iteration of the Nevada Opioid Assessment to inform the Opioid Plan and guide funding decisions made over the next 4-year cycle. Ms. Kerwin noted that the focus will be on six of these goals, as Goal 7 regarding the provision of high quality and robust data and accessible, timely reporting is not scored or ranked within this presentation because it relates to the totality of data overall.

Her presentation covered criteria for scoring the Fund for Resilient Nevada statewide opioid goals, the methodology, high-level opioid assessment data highlights, and the next action items, which include a survey for SURG members to complete.

Ms. Kerwin provided a brief overview of the seven Opioid Settlement Goals.

- **Goal 1:** *Ensure Local Programs Have the Capacity to Implement Recommendations Effectively and Sustainably*
- **Goal 2:** *Prevent the Misuse of Opioids*
- **Goal 3:** *Reduce Harm Related to Opioid Use*
- **Goal 4:** *Provide Behavioral Health Treatment*
- **Goal 5:** *Implement Recovery Communities*
- **Goal 6:** *Provide Opioid Prevention and Treatment Consistently across the Criminal Justice and Public Safety Systems*
- **Goal 7:** *Provide High Quality and Robust Data and Accessible, Timely Reporting*

Ms. Kerwin continued to describe the scoring methodology which consisted of a modified Hanlon Method to obtain an average score for each goal based on weighted criteria informed by primary and secondary data. This average is obtained by combining the scores of the goal's indicators and dividing it by the total number of indicators. Indicators are scored using the following weighted criteria: magnitude, trends, severity, key informant/focus group ranking, as well statewide survey questions that asked participants to rank the goals in terms of their importance for addressing opioid use, gaps and needs in the community, and priorities for funding. Ms. Kerwin noted that 179 individuals in Nevada with lived or living experiences, who work in the field or adjacent to it, or who have friends and/or family with lived experience participated in the key informant interviews or focus groups, and over 400 people responded to the statewide survey.

She provided a breakdown of some of the demographics of survey respondents (e.g., race, age, occupation), which included residents from 15 of 17 counties (for more detail, please refer to the presentation PowerPoint). Ms. Kerwin qualified that only individuals 18 or older were eligible to participate in the survey

Ms. Kerwin then presented results of the survey that highlighted the following as the highest priorities: Goal 1: Ensure Local Programs Have the Capacity to Implement Recommendations Effectively and Sustainably (referred to on the presentation slide as 'Community Workforce and Capacity Building'), 2: Prevent the Misuse of Opioids, and 4: Provide Behavioral Health Treatment (referred to on the presentation slide as 'Behavioral Health Services'). Ms. Kerwin emphasized that these results are not intended to be restrictive; a lower ranking of a goal does not mean that it isn't a value to address it through funding or programming, but these results can be used to help provide justifications for funding decisions.

Ms. Kerwin moved onto opioid assessment data highlights. Secondary data consists of national survey data from the following: Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Survey (YRBS), and National Survey on Drug Use and Health (NSDUH), as well as Vital Statistics (birth and death data), hospital discharge data, and Medicaid billing data. Ms. Kerwin explained that secondary data is often more accurate as prevalence estimates of populations impacted and that primary data were more reflective of the summary of perspectives from individuals who participated in interviews, focus groups, or the statewide survey.

There were over 50 indicators for the secondary data. These are indicators—or data points, that relate to opioids and other substances broadly, behavioral health, healthcare access, as well as mortality. Ms. Kerwin and her team sorted out the data by goal. When reviewing the tables, she noted that the indicators have a number in between the parentheses. That is indicating which goal that indicator counts towards. One indicator regarding counties with a Medication Assisted Treatment (MAT) program implemented in county-level jail was greyed out on the slide pending an update from Bill Teel with GROWLER Consulting. Mr. Teel has been working with Nevada communities and county-level jails to build MAT programs and establish wrap-around services for individuals post incarceration. One indicator regarding counties with a Medication Assisted Treatment (MAT) program implemented in county-level jail was greyed out on the slide pending an update from Bill Teel with GROWLER Consulting. Mr. Teel has been working with Nevada communities and county-level jails to build MAT programs and establish wrap-around services for individuals post incarceration.

For additional detail on all data collected for the assessment, including a full list of secondary data indicators and a breakdown of secondary data demographics and county specific estimates, please refer to the *2027-2031 Nevada Opioid Assessment Secondary Data Excerpt – DRAFT* on the SURG website at <https://ag.nv.gov/uploadedFiles/agnv.gov/Content/About/Administration/2027-2030%20Nevada%20Opioid%20Assessment%20-%20remediated.pdf>.

Ms. Kerwin expressed gratitude towards the Nevada Health Authority Office of Analytics for their significant support in collecting the secondary data, much of which was not public. Following her overview of the several secondary data indicators, Ms. Kerwin presented FRN Statewide Opioid Goals 1-6 along with both primary and secondary data highlights associated with each goal. For details, please refer to the presentation PowerPoint.

- **Goal 1: *Ensure Local Programs Have the Capacity to Implement Recommendations Effectively and Sustainably***

Ms. Kerwin reviewed the secondary data highlights. Nevadans live in a Health Resources and Services Administration (HRSA) designated Mental Health

Professional Shortage Area. She also noted that in 2024, less than 3% of Medicaid authorized providers billed for Screening, Brief Intervention, and Referral to Treatment (SBIRT). While reviewing primary data highlights, she noted that people with lived experience (PWLE) emphasized that peer recovery support specialists need stigma and bias training to build a compassionate healthcare workforce. *"It's one thing to create professionals, it's another to create compassionate professionals"*. She also noted that the workforce needs to be able to serve the needs of people who use drugs where they physically are located. Mobile outreach, preventive screenings, and other modalities are important to bring to the people who use substances. She added that screening rarely goes beyond intake-forms with checkboxes, which may not yield honest answers. For all data highlights presented associated with goal 1, please refer to the presentation PowerPoint.

- **Goal 2: Prevent the Misuse of Opioids**

Ms. Kerwin commented that there has been a decrease in opioid prescription rates, however this is not typically where people who use opioids are obtaining them. So, while it is good to see one source of opioids reduced, it is not solving the problem.

Among data presented, Ms. Kerwin highlighted that nearly one in four foster care placements were due to parental drug or alcohol use and further described the increased rates of Adverse Childhood Experiences (ACEs) in Nevada. When highlighting the primary data, she commented that there has not been a standardized, cross-all-grade, youth prevention program since DARE. While substance use prevention coalitions are doing great work delivering evidence-based K-12 programming, a challenge is that students often only receive it once or at different grade levels, and it varies depending on the school district.

- **Goal 3: Reduce Harm Related to Opioid Use**

Ms. Kerwin emphasized that people with lived experience can be the important conduit, or link, to get harm reduction supplies to those who need it the most. This was an overall challenge for rural, frontier, and urban communities.

- **Goal 4: Provide Behavioral Health Treatment**

Ms. Kerwin elevated stigma as a major concern noted by people with lived experience. She summarized responses, stating that people with lived experiences expressed *"not feeling as though they are being treated like a human"*. She concluded by saying compassionate healthcare workers must be a priority when funding mental and behavioral health treatment services.

- **Goal 5: *Implement Recovery Communities Across Nevada***

Continuing with Goal 5, Ms. Kerwin provided additional context to the Key Informant and Focus Group Highlights slide wherein people with lived experience are learning to cope with life's challenges while maintaining recovery and feel as though they need to address various serious problems all at once, like owning a car, paying rent, setting up bank accounts, getting a job, and paying bills. She continued that many described the significant challenge of missing out on their formative years, when you typically learn how to manage these types of things while building resilience slowly, and then having to do all of it at once while maintaining recovery. She noted that PWLE in rural communities preferred in-person providers but noted that this may be a generational reflection, as these individuals were 40 years old or older. However, overall, these individuals made it clear that they wanted to establish trusted rapport with their healthcare service provider.

- **Goal 6: *Provide Opioid Prevention and Treatment Consistently Across the Criminal Justice and Public Safety Systems***

While reviewing primary data highlights, she noted that some people with lived experience indicated that incarceration was the primary reason for initial sobriety because substances were not available, but it was not a great system for sustained recovery. She emphasized that often people cycle in and out of the justice system, offering many touchpoints that could serve as opportunities for intervention. Additionally, she noted that law enforcement could help communicate where to obtain Narcan for individuals who are unaware of where to locate it.

- **Goal 7: *Provide High Quality and Robust Data and Accessible, Timely Reporting***

Ms. Kerwin briefly went over Goal 7 but noted that this goal should be embedded in any programs/projects funded by statewide opioid settlement dollars. She described the need for this to be as standardized as possible to better understand comparisons and trends in collected data.

Closing her presentation, Ms. Kerwin provided an overview of the Recommendation Ranking Survey for SURG members to rank ACRN and SURG recommendations that align with the FRN Statewide Opioid Goals. Recognizing that the SURG recommendations have already been prioritized relative to each other, the survey asks respondents to prioritize these and the ACRN recommendations within the context of each of the FRN Statewide Opioid Goals. She clarified that only opioid-specific SURG recommendations were included, and SURG recommendations addressing substance use more generally were excluded. Ms. Kerwin asked members to allow at least 30 minutes to complete the survey and noted that the survey does not include the current status of each recommendation, so members

were encouraged to draw on their own expertise regarding whether a recommendation is already underway or actively being worked on.

Following the recorded presentation, Chair Shell thanked Ms. Kerwin, who had joined the meeting during the last portion of the recording, and invited questions from subcommittee members.

Dr. Partida Corona asked if the magnitude criterion used in the scoring system was applied to the population as a whole or if it was focused on special populations. Ms. Kerwin explained that the magnitude score is applied to each indicator such that whichever population that indicator is focused on is what that criterion will be applied to. She provided as an example the YRBS indicator, which looks at the high school population. For this indicator the magnitude criterion would be applied only to this population rather than extrapolated out to all Nevadans. Dr. Partida Corona appreciated this distinction as it helps facilitate efforts to focus on particular populations.

Dr. Partida Corona then noted that the secondary data indicators include opioid prescriptions calculated in morphine equivalents and asked how opioids used for medication assisted treatment (MAT) are separated out, noting that the federal government combines these in the same category. Ms. Kerwin responded that she reached out to the Prescription Drug Monitoring Program (PDMP) board to better understand the data and uses the Office of Analytics PDMP dashboard, which doesn't necessarily allow you to deselect buprenorphine, though it does allow for methadone to be excluded. She added that buprenorphine may not be among the PDMP data. She noted that the data set is imperfect but is the best available resource for looking at prescribed opioids per capita. Dr. Partida Corona asked if refining the data system that looks at MAT would be a good recommendation, and Ms. Kerwin affirmed that it would be valuable to be able to look at MAT data separately from other prescription opioids.

Dr. Partida Corona followed up with a question about whether the stigma training discussed under Goal 1 could be geared toward legislators, given their impact on policy. Ms. Kerwin emphasized that stigma training would be beneficial to every individual at any touchpoint and that legislators would be a great group to work with.

Chair Shell encouraged anyone with additional questions to contact Ms. Kerwin at the email address she provided and moved to agenda item #9.

9. Public Comment

Kim Hopkinson read the statement on public comment and provided call-in information. She provided in the chat the following guidance regarding use of the chat: *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.*

Member Stephanie Cook shared that the DPBH Bureau of Behavioral Health, Wellness, and Prevention, which owns the state's naloxone saturation plan, is recruiting a naloxone subject matter expert to help update the plan and expand education and stakeholder engagement. She added that they are investing in an anti-stigma campaign that will address stigma related to access to treatment, medications for opioid use disorder (MOUD), and naloxone. One of the goals is a marketing approach directed at legislators ahead of the upcoming legislative session. She added that she hopes to present on the campaign at a future meeting.

Hearing or seeing no additional public comment, Chair Shell continued to agenda item #10.

10. Adjournment

Chair Shell reminded members that the next full SURG meeting is scheduled for October 14, and the next Treatment and Recovery Subcommittee meeting is scheduled for November 24.

Chair Shell adjourned the meeting at 12:33 pm.

Chat Record:

From Kim Hopkinson to everyone 11:03 AM: If a member must depart a meeting prior to adjournment for any reason, the member shall formally announce their departure for the record to ensure accurate minutes and to allow the Chair to confirm that a quorum remains in accordance with Nevada's Open Meeting Law.

From Kim Hopkinson to everyone 11:05 AM: 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.

From Kim Hopkinson to everyone 12:30 PM: 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.