MEETING NOTES

Statewide Substance Use Response Working Group **June 3, 2025**
Response Subcommittee Meeting **11:00 am**

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

Members Present via Zoom or Telephone
Dr. Shayla Holmes, Dr. Terry Kerns, Christine Payson

Members Absent
Assemblymember Ken Gray (excused due to Legislative Session), Senator Jeff Stone (excused due to Legislative Session), Nancy Lindler

Office of the Attorney General
Joseph Peter Ostunio (Deputy Attorney General), Ashley Tackett

Social Entrepreneurs, Inc. (SEI) Support Team
Crystal Duarte, Mary O'Leary

Members of the Public via Zoom
Alex Tanchek, Cherylyn Rahr-Wood, Dr. Dan Gerrity, Dr. Ed Oh, Dr. Kelly Morgan, Linda Anderson, Lori Follett, Mark Disselkoen, Shannon Lepe

1. **Call to Order and Roll Call to Establish Quorum**
   Chair Kerns called the meeting to order at 11:06 a.m. Ms. Duarte called the roll and established a quorum, noting that all members serving in the Nevada Legislature through the 2025 session are removed from quorum requirements for the duration of the session.

2. **Public Comment**
   Chair Kerns read the statement on public comment and provided call-in information. There were no public comments, and Chair Kerns continued to agenda item #3.

3. **Review and Approve Minutes from the May 14, 2025, Response Subcommittee Meeting**
   - Shayla Holmes made the motion to approve.
   - Christine Payson seconded the motion.
   - The motion carried unanimously.

   Chair Kerns proceeded to agenda item #4.

4. **Presentation on Emergency Bridge Program**

Chair Kerns introduced Dr. Kelly Morgan to present on the Emergency Bridge Program. She noted the overlap between the subject matter and past recommendations made by SURG subcommittees:

- 2024 Treatment and Recovery Recommendation: To direct the Division of Public and Behavioral Health to identify a funding mechanism for hospitals and providers to enhance the Bridge Program for emergency departments by incorporating peer recovery support specialists into their treatment models, support the use of peer support navigators via telehealth to increase access to treatment, and support for individuals identified in emergency departments.
- 2022 and 2023 Treatment and Recovery Recommendation #1 and Prevention Recommendation #8C: To expand access to MAT and recovery support for substance use disorder, limit barriers to individuals seeking treatment regardless of the ability to pay, and encourage the use of hub and spoke systems as well as recovery support, including use and promotion of telehealth, considering the modifications that have been made under the emergency policies and pursuing innovative programs, such as establishing Bridge Medication Assisted Treatment (MAT) programs in emergency departments.

Chair Kerns also noted that the Response Subcommittee learned about the Bridge Program in July of 2023, and currently the Prevention Subcommittee is working on a recommendation regarding low barrier naloxone distribution in emergency departments. With that introduction, Chair Kerns handed the floor over to Dr. Morgan.

Dr. Morgan thanked Chair Kerns for the opportunity to present. She began by grounding the conversation in statewide data. Dr. Morgan highlighted that substance use is deeply embedded in hospital operations: one in every 11 emergency department visits involves a patient with an SUD, and nearly 12% of hospitalized patients have recognized or unrecognized substance use issues. These patients tend to have longer hospital stays, higher readmission rates, and often leave against medical advice—driving up healthcare costs.

Dr. Morgan noted stigma within hospital systems as a persistent and major barrier to treatment. Sharing a personal anecdote about a colleague who lost her son to an overdose, Morgan noted that grounding the discussion in personal stories has helped shift providers' perceptions. Another barrier that Dr. Morgan shared is the disconnect that still continues between hospitals and outpatient follow up. The list of providers continues to change every other week, and who takes what insurance is a massive barrier to getting patients from the emergency department to areas of care. A lot of times the information that we're giving patients is not up to date. The last barrier Dr. Morgan mentioned is the lack of understanding about the process and the need to get more people within the system on board.

Dr. Morgan continued her presentation, detailing the Bridge Model's core components of focusing on clinical champions, the integration of PRSS, and the need for system-level buy-in. She emphasized that clinical champions are crucial to driving adoption of the Bridge Model, yet hospitals often lack funding to support these roles. Dr. Morgan remarked that she is among the very few emergency physicians funded to work on this initiative, and even then, only through the PACT Coalition acting as a pass through. Hospitals do not currently

reimburse for substance use champions in the way they do for Sepsis, Stroke, or STEMI coordinators. She urged the group to consider advocating for the establishment of value-based reimbursement metrics tied to SUD care, stating, “You’re not going to get buy-in from hospitals or providers unless you put money behind it.”

Dr. Morgan listed some other recommendations included encouraging hospitals to offer addiction medicine as a formal consult service with credentialed privileges, similar to toxicology or other specialty services. She noted that no hospitals in Southern Nevada currently offer this. Expanding access to addiction consults would not only improve care but also build comfort and competency among providers managing patients on medications like methadone or buprenorphine during inpatient stays.

Dr. Morgan also raised concerns about recent legislation—specifically SB 378, which includes a provision (Section 18.3) that could allow for the unsealing of criminal records for individuals billing Medicaid. She warned that this could jeopardize sustainability for peer navigator roles, given that many PRSS have lived experience with the justice system. She recommended that a carveout be considered to protect peer workforce development and Medicaid reimbursement.

Dr. Morgen then went on to cover peer recovery support implementation, including both in-person and telehealth models. A 24/7 warm handoff line went live in March 2025, currently staffed by Foundation for Recovery and partners. In-person navigators are embedded at Valley Hospital four days a week. A key challenge has been documenting services delivered by navigators, especially when they are not hospital employees. To address this, Dr. Morgan’s team is working on a solution that uses EMS software to document navigator encounters, allowing these notes to be pushed into hospital electronic health records—an important step for both continuity of care and reimbursement tracking.

Dr. Morgan moved her presentation forward, emphasizing the need to normalize MAT prescribing within emergency departments. Despite federal efforts to increase prescriber education (including new DEA training requirements), many ED providers remain hesitant to prescribe buprenorphine. Some prescribe only 3-7-day supplies, despite knowing patients may not access follow-up care in time due to transportation, ID, or insurance barriers. Dr. Morgan proposed developing a 3-day buprenorphine blister pack, given to patients at discharge—an approach modeled after ED distribution of Paxlovid during the COVID-19 pandemic. Although hospitals are not dispensing pharmacies, she argued there is precedent and a clear public health rationale for making buprenorphine directly available to overdose survivors at the point of care. This would require at some sort of messaging from the Board of Pharmacy that an exemption can exist specifically for buprenorphine.

Dr. Morgan noted that the Emergency Bridge Program is also expanding into EMS systems. Starting in Q3, Henderson Fire and Las Vegas Fire will launch an EMS-administered buprenorphine trial for overdose patients in the field—marking the first oral opioid medication to be carried on rigs. This shift, according to Dr. Morgan, will increase pressure on EDs to continue MAT initiated in pre-hospital settings and represents a significant

breakthrough in coordinated care. “It’s the stick and the carrot,” she said. “They can choose to get on board, or EMS is going to bring patients already started on treatment.”

Then, Dr. Morgan presented data demonstrating the financial return on investment: peer navigator engagement—costing roughly $343 per patient—has been shown to save hospitals nearly $18,000 per patient through reduced ICU stays, decreased readmissions, and improved care transitions. Despite this, administrative hurdles remain high. She reported it took 11 months to navigate hospital red tape to get a PRSS on-site—even with funding and staff already in place. Furthermore, Dr. Morgan shared that she has personally cash-flowed the current SOR-funded work for eight months without receiving a reimbursement or signed contract until four months into the project period. She strongly recommended the state or local jurisdictions establish funding streams to directly support infrastructure building and implementation, rather than relying on slower federal grant reimbursements.

In closing, Morgan underscored the importance of top-down and bottom-up engagement. She noted that the Emergency Bridge Program has made clear progress—but remains at a critical juncture in terms of scaling infrastructure, securing sustainable funding, and ensuring alignment across emergency care, EMS, and outpatient treatment systems.

Following Dr. Morgan’s presentation, Chair Kerns expressed appreciation for both the clarity of her explanations and the significance of the work. Dr. Shayla Holmes commended Dr. Morgan for taking a deeply complex issue within the medical system and presenting it in such a way that someone without a clinical background could understand and even communicate about it.

Dr. Holmes then raised a question about the limitations related to hospital-based medication distribution. Dr. Morgan clarified that the issue is largely regulatory, not legislative. Hospitals are typically licensed to administer medications within the facility but are not permitted to dispense medications to patients for home use, unless they are licensed as dispensing pharmacies like Walgreens or CVS. However, during the COVID-19 pandemic, an exemption was granted that allowed hospitals to distribute Paxlovid directly to patients. Dr. Morgan suggested that a similar exemption could be issued by the Board of Pharmacy for buprenorphine, given the clear public health emergency posed by rising overdose rates and the unique barriers SUD patients face—such as lack of ID, transportation, and ability to pay. Dr. Holmes agreed that the issue could be supported with a recommendation and expressed interest in exploring different avenues that could be taken.

Chair Kerns then turned the discussion to state-level overdose trends. She noted that while most states have experienced decreases in overdose deaths, Nevada and one other state have seen increases, with Nevada’s overdose rate rising by just over 3%. In terms of decreases, Chair Kerns observed that broader access to naloxone as well as a dip in the amount of people going to emergency departments, potentially complicating data collection. However, she emphasized that the issue remains a public health emergency and asked whether the practices Dr. Morgan described—such as EMS-administered buprenorphine—are being implemented elsewhere.

Dr. Morgan confirmed that similar models are being adopted in other regions. She pointed to Hennepin County, Contra Costa County, and Newark as examples where buprenorphine has been successfully rolled out to paramedics. In some cases, specially trained community paramedics are delivering bridge dosing and follow-up. Initially, she hoped to replicate these models using community paramedics in Nevada, but local shortages in both paramedics and providers made this unfeasible. "Really, this should just be a medication everybody has," she said, noting how easily other medications, like IV Tylenol, had been introduced with minimal pushback. She noted stigma as the biggest barrier, pointing out that discomfort with addiction and a lack of knowledge about treatment pathways continue to hinder provider engagement.

Chair Kerns then referenced a previous presentation to the Treatment and Recovery Subcommittee by a local addiction medicine fellow, Dr. Jose Partida Corona, who had advocated for hospitals to include addiction medicine in their credentialed privileges and called attention to outdated reimbursement rates that have not been adjusted since the 1980s. Dr. Morgan confirmed this and emphasized the need to increase access to specialized consultations for complex patients and to ensure support for emergency providers managing individuals on long-term buprenorphine or methadone.

Before closing, Dr. Morgan offered an additional recommendation not included in her presentation slides. She urged the committee to consider advocating for methadone dosing to be included in the PMP Aware system, which tracks controlled substance prescriptions. Dr. Morgan explained that its absence from the database complicates emergency care. Because buprenorphine can be dangerous when administered too soon after methadone—typically within a 72-hour window—ED providers must verify dosing before initiating MAT. Yet many methadone clinics are only open during limited weekday hours, and pharmacists may refuse to fill prescriptions without verification. "It becomes a barrier in the emergency department," she explained. "If we can't confirm methadone use or dosing, we can't safely treat the patient."

Chair Kerns agreed that this sounded like another Board of Pharmacy conversation. With no further questions from committee members, she thanked Dr. Morgan for her extensive contributions and recommendations. Dr. Morgan closed by thanking the group for their time.

With that, Chair Kerns proceeded to agenda item #5.

5. **Presentation on Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) Access in Certified Community Behavioral Health Clinics (CBHCs)**
   Dr. Kerns introduced the agenda item and turned it over to Mr. Mark Disselkoen and Ms. Lori Follett for a presentation on Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) Access in Certified Community Behavioral Health Clinics (CBHCs). Ms. Follett and Mr. Disselkoen thanked the group for the opportunity.

   Ms. Follett started off the presentation, explaining that while the group had expressed particular interest in substance use treatment within the CCBHC model, the broader delivery framework was essential context. She reviewed the CCBHC program's history, noting that Nevada was one of the first states selected for the federal demonstration project launched by

SAMHSA in 2016. The state later transitioned the program into its Medicaid State Plan, which allows it to continue beyond the original demonstration period. That transition was formalized in May 2023, following an 18-month approval process with CMS.

Ms. Follet clarified that CCBHCs were designed to address longstanding gaps in access to mental health and addiction services by providing integrated, evidence-based care with sustainable financing. Clinics must meet rigorous requirements related to timeliness, quality reporting, staffing, and coordination with systems such as criminal justice and education. Nevada currently has 10 full CCBHCs and five access sites. Access sites are satellite locations offering up to four core services, with the ability to refer patients to a main site for comprehensive care. This model has proven especially effective in rural areas. For example, Rural Nevada Counseling uses access sites in Dayton, Fernley, and Yerington to expand its footprint beyond Silver Springs.

To qualify as a CCBHC, an organization must be a non-profit or a governmental or tribal health entity. They are reimbursed using a daily prospective payment system (PPS) rate, which currently averages around $220 per day. Unlike fee-for-service billing, which reimburses by procedure code, the PPS rate provides a lump sum for delivering any qualifying service in a day. CCBHCs can also earn up to 15% in annual quality incentive payments, provided they meet performance metrics.

All CCBHCs must be certified by SAPTA (now called Behavioral Health Certification for Excellence in Nevada, or "Be Seen"), meet national standards, and provide a required bundle of nine core services. These include crisis services, treatment planning, screening and assessment, outpatient mental health and SUD treatment, case management, primary care screening, peer and family supports, psychiatric rehab, and care for veterans. Assertive community treatment is also included in CCBHCs.

At this point, Ms. Follett turned the presentation over to Mr. Disselkoen, who provided further detail on MAT access and expectations within the CCBHC model. He noted that all CCBHCs are required to provide MAT either directly or through formal agreements with external providers. Most CCBHCs employ at least one psychiatric APRN who can prescribe buprenorphine and naltrexone. Methadone, however, can only be prescribed at a licensed opioid treatment program (OTP), often referred to by the outdated term “narcotic treatment program.”

Mr. Disselkoen explained that while no current CCBHCs are licensed as methadone clinics, they all have established coordination agreements with nearby OTPs. These agreements ensure continuity of care and meet SAMHSA's MAT access standards. He noted that all MAT-related providers must comply with multiple layers of oversight, including DEA licensure, pharmacy board approval, joint accreditation, and state-level certification through both Healthcare Quality and Compliance (HCQC) and SAPTA.

To support MAT and withdrawal management, CCBHCs are certified at American Society of Addiction Medicine (ASAM) Level 1, which ensures that patients initiating or continuing MAT receive appropriate support and monitoring. Mr. Disselkoen also reviewed the

pharmacology of MAT medications—methadone (full agonist), buprenorphine (partial agonist), and naltrexone (antagonist)—and emphasized that all CCBHCs have free access to naloxone through State Opioid Response (SOR) funding.

Mr. Disselkoen also shared a resource managed by CASAT: an interactive online treatment finder, which lists all certified SUD and MAT providers across Nevada. This includes detailed information about both Northern and Southern Nevada methadone clinics, as well as facilities like Seven Hills Behavioral Institute, which provides maintenance and withdrawal support but not induction.

Returning to the broader CCBHC model, Ms. Follett emphasized that many of today's CCBHCs previously operated as SUD providers and bring deep experience in addiction treatment. She explained that CCBHCs undergo intensive annual reviews involving teams from Medicaid, the Division of Public and Behavioral Health, HCQC, and CASAT. These site visits assess documentation, care coordination agreements, treatment planning, and adherence to the CCBHC model.

Following the presentation, Chair Kerns thanked Ms. Follet and Mr. Disselkoen and opened the floor for questions from subcommittee members.

Dr. Holmes asked whether all CCBHCs must offer all nine core services at their primary site and whether delivering just one of those services per day qualifies them for the full daily rate. Ms. Follett and Mr. Disselkoen confirmed both points and added that while workforce shortages can temporarily disrupt service availability, the state works closely with providers to ensure gaps are addressed through contracting or quality improvement plans. Mr. Disselkoen clarified that if a CCBHC persistently fails to provide the required services, the state can move to decertify the provider—a step that has occurred in the past.

Then, Ms. Christine Payson asked about methadone clinic availability in Clark County. Mr. Disselkoen confirmed that a slide did include Southern Nevada clinics and that Clark County has more OTPs than any other region in the state.

Chair Kerns closed the discussion by asking about expansion potential for rural areas and how managed care might affect access. Ms. Follett explained that there is currently no cap on the number of CCBHCs in Nevada, and the state is actively seeking to expand in rural and frontier counties. The access site model has made that more feasible, especially in communities where establishing a full clinic would be financially unsustainable. Regarding Medicaid managed care organizations (MCOs), Ms. Follett clarified that state contracts require MCOs to reimburse CCBHCs at least the full PPS rate. They could pay more, but not less. This arrangement helps reduce fiscal complexity for both providers and the state.

Chair Kerns expressed appreciation once more. No further questions were raised by subcommittee members. She then formally closed the item and transitioned to agenda item #6.

6. Update on Wastewater Surveillance of High-Risk Substances in Nevada

Chair Kerns introduced the agenda item, introducing Dr. Daniel Gerrity and Dr. Edwin Oh to present an update on wastewater surveillance of high-risk substances in Nevada.

Dr. Gerrity began by contextualizing the surveillance data with statewide and national trends in opioid overdose deaths. He noted that Clark County has experienced significant increases in opioid-related mortality, particularly from 2022 to 2023. These public health trends closely aligned with changes in the wastewater data, specifically a sharp rise in the detection of norfentanyl, a metabolite of fentanyl. Prior to October 2022, only a single wastewater sample across Southern Nevada contained norfentanyl at detectable levels. However, beginning in October 2022, nearly every sample showed a positive detection, suggesting a distinct shift in local drug use patterns. This finding directly paralleled a statewide rise in opioid-related overdose deaths during the same period.

Dr. Gerrity also shared data from a national wastewater surveillance effort funded by the National Institute on Drug Abuse (NIDA) and implemented by Biobot Analytics. This dataset compared national and Southern Nevada norfentanyl concentrations and showed that, much like the overdose data, Southern Nevada experienced a pronounced spike in 2023 followed by a steep decline in the summer of 2024. Unfortunately, the Biobot program ended at that point, leaving open questions about whether that trend has continued.

Dr. Gerrity outlined that the Southern Nevada Water Authority (SNWA) team collects wastewater samples every two weeks using a combination of methods. At centralized treatment facilities, they use autosamplers that continuously collect wastewater over a 24-hour period, offering a broad representation of substance use. For upstream sampling in the collection system—such as within neighborhoods, universities, or specific sites like event venues—they use a mix of manual grab samples and portable composite samplers that can be deployed in manholes. This allows the team to localize and compare substance use patterns across different geographic and demographic segments.

A localized study was conducted on the Nevada State University campus. Dr. Gerrity explained how sampling locations were strategically chosen to isolate flows from academic buildings, student housing, and mixed-use areas of campus. Notably, no fentanyl, norfentanyl, or xylazine has been detected in samples from the university. However, heroin and its metabolite acetylmorphine were detected in student housing samples on multiple occasions, and those detections were verified in downstream samples. The use of composite samplers in this context proved valuable. In one case, a grab sample failed to detect acetylmorphine, but a 24-hour composite sample collected simultaneously did detect it—highlighting the benefit of longer sampling windows for more accurate surveillance. Dr. Gerrity emphasized that results from each sampling round are shared within days with public health partners, including Nevada State's Student Wellness Center, the City of Henderson's Mobile Crisis Intervention Team, and the Southern Nevada Health District.

Dr. Gerrity concluded the presentation with findings from a wastewater surveillance study conducted during the 2024 Electric Daisy Carnival (EDC). Using samples collected at a manhole near the Las Vegas Motor Speedway—the site of the festival—researchers observed an enormous spike in MDMA (ecstasy) concentrations in wastewater during the event. On

Sunday (reflecting Saturday's activity), levels of MDMA in wastewater were nearly a million times higher than typical concentrations. Norfentanyl was also detected at the Speedway site, with the first hits appearing Saturday and continuing through the weekend. These patterns matched those seen in 2023, indicating consistency year-over-year in substance use during large public events. Dr. Gerrity noted that the 2025 data matches this pattern as well. He emphasized that this type of data helps illuminate not only population-level behavior but also the specific presence of high-risk substances like fentanyl during mass gatherings.

Chair Kerns thanked Dr. Gerrity for his presentation. She opened the floor to committee members to ask questions. Hearing none, Chair Kerns clarified with Dr. Gerrity that their team meets with their partner agencies after they have the data so that it can assist with their partners targeted harm reduction activities. Dr. Gerrity confirmed this. They interpret the data, send out a summary, and leave the response up to their partners.

No additional questions were raised by committee members. In closing, Chair Kerns thanked Dr. Gerrity again for his time. Dr. Gerrity expressed appreciation for the committee's continued support.

With that, Chair Kerns moved the meeting forward to agenda item #7.

7. **Discuss Proposed 2025 Response Subcommittee Recommendations**
Chair Kerns opened the discussion by noting there have been two recommendations submitted so far. Chair Kerns opened the floor to Dr. Holmes to go over the recommendation that she submitted.

Recommendation #1 (submitted by Dr. Shayla Holmes): *Prohibit the sale of all psychoactive substances, including hemp-derived cannabinoids and psychoactive mushrooms, to individuals under 21 years of age, aligning with existing cannabis regulations.*

Implement Clear Labeling Standards: Mandate that all products containing psychoactive compounds have standardized labeling, including clear warnings about potential health risks and age restrictions.

Restrict Sales Locations: Limit the sale of these substances to licensed establishments that can verify the age of purchasers and prohibit sales near schools and other youth-centered facilities.

Enhance Enforcement Mechanisms: Provide regulatory agencies with authority and resources to monitor compliance, conduct inspections, and enforce penalties for violations.

Dr. Holmes noted that her recommendation addressed a growing public health concern: the over-the-counter sale of psychoactive substances—particularly those that mimic illegal drugs but have been chemically modified to remain technically legal. These products, she explained, often bypass regulatory oversight by slightly altering their molecular structure,

allowing them to avoid legal classification while still delivering potent and sometimes more dangerous effects than their illegal counterparts.

Dr. Holmes emphasized that many of these substances are readily available at convenience stores, gas stations, and similar retail outlets with no age restrictions, making them easily accessible to youth. She cited the work of national prevention advocate "Tall Cop", whose presentations have long raised awareness about emerging drug trends and the deceptive marketing of these substances.

The goal, she explained, is not necessarily to ban adult access to legal substances, but to close regulatory loopholes that allow youth to purchase dangerous, unregulated products that often appear benign or are marketed as "mood enhancers." "We have an obligation," she said, "to attempt to protect our youth from access."

Chair Kerns supported the spirit of the recommendation, referencing feedback from Nevada's Youth Risk Behavior Survey (YRBS). The survey team had to revise a question about illegal drug use because students correctly noted that many substances, while harmful, were technically legal for adults. "That gets to the point of what you're doing," Chair Kerns said, reinforcing the importance of clarifying laws around youth access.

Chair Kerns then briefly introduced her own recommendation.

Recommendation #2 (submitted by Dr. Terry Kerns): *Revise this recommendation to also include desistance: Recommend state agencies under the legislative, judicial, and executive branches involved with deflection and diversion programs have a comprehensive definition of recidivism, and policies related to measuring and reporting recidivism.*

Chair Kerns explained that this recommendation focuses on improving how Nevada measures the outcomes of deflection and diversion programs—initiatives designed to redirect individuals away from the criminal justice system and into treatment or support services. Her proposal calls on state agencies across the legislative, executive, and judicial branches to adopt a comprehensive and consistent definition of recidivism and related reporting policies.

Additionally, Chair Kerns recommended incorporating the concept of "desistance", which focuses not just on avoiding re-arrest or conviction but on the longer-term process of moving away from criminal behavior and antisocial activities. She learned about this concept from the Washoe County Sheriff's Office, which has begun exploring desistance as a more holistic measure of success in reentry programs.

Chair Kerns noted that due to time constraints both recommendations were offered for discussion only, with no formal action taken. Members were encouraged to review the full proposal document provided by staff and to anticipate further conversation and refinement at upcoming meetings.

Chair Kerns then proceeded to agenda item #8.

8. Review 2025 Response Subcommittee Topics

Chair Kerns opened the discussion by listing upcoming meeting topics, which include: a presentation on the behavioral health workforce led by Dr. Hunt; continued exploration of recidivism definitions in collaboration with the Washoe County Sheriff's Office; and a session on drug and alcohol prevention, education, and enforcement featuring Officer Jermaine Galloway, widely known as "Tall Cop", whom Dr. Holmes had referenced during the previous agenda item.

The subcommittee is scheduled to meet on August 5, September 2, and November 4, each from 11:00 AM to 12:30 PM. Additionally, Chair Kerns noted that Assembly Bill 19 (AB 19)—which was originally introduced to expand membership of the SURG—has been amended to include adjustments to the group's reporting timelines. These changes are designed to better align with state budget development cycles and legislative deadlines, following feedback from lawmakers who found the current process misaligned with the policy calendar.

Under the new provisions, the 2025 Annual Report, due in January 2026, would focus primarily on documenting the process for developing recommendations. Beginning in August 2026, and every August thereafter, the report will include the finalized recommendations. This new schedule allows more time for recommendations to be crafted, vetted, and positioned for potential policy action.

Chair Kerns noted that some recommendations from the previous cycle were not able to secure bill draft request (BDR) sponsors, in part due to tight timelines. The amendment to AB 19 is intended to resolve that challenge by better syncing SURG's work with the state's legislative calendar. She informed members that the amended bill had passed both legislative chambers and was awaiting the Governor's signature.

In light of this shift, Chair Kerns raised a logistical question about the committee's meeting frequency: With more time to develop recommendations, might the group consider moving from monthly to bimonthly meetings? She asked Ms. Duarte to poll the group on their preferences. Ms. Duarte agreed to send out a survey and added that she would coordinate with other SURG subcommittees to ensure consistency across the broader initiative. While the groups do not need to follow identical schedules, Ms. Duarte emphasized the importance of maintaining aligned momentum across all subcommittees.

Chair Kerns closed the item by noting the significance of this structural change to SURG's operations and opened the floor for questions or comments. With no members indicating interest in further discussion, Chair Kerns proceeded to the next agenda item.

9. Public Comment

Chair Kerns opened the floor for public comment after reading the statement on public comment and call-in information.

Chair Kerns acknowledged Ms. Cherylyn Rahr-Wood for public comment.

Ms. Cherylyn Rahr-Wood began by expressing appreciation for the meeting and its presenters. “Always very beneficial, always great presenters,” she said, commending the quality and relevance of the discussions. She particularly thanked the two most recent presenters for their contributions on wastewater surveillance and CCBHCs.

Ms. Rahr-Wood also provided a timely legislative update, noting that Assembly Bill 60 (AB 60)—a bill to codify Certified Peer Support Specialists (CPSS)—was currently awaiting the Governor’s signature. Once the bill is signed, the state will move forward with developing the regulations and definitions that will shape the CPSS role moving forward. “We’ll be looking for people to step forward when we start writing those regs and codes,” she said.

Additionally, Ms. Rahr-Wood announced that the Northern Regional Behavioral Health Policy Board would meet on Thursday at 2:00 PM, with a focus on reviewing pending legislation still sitting on the Governor’s desk. The meeting would include a high-level discussion and report-out on those bills, offering stakeholders another opportunity to stay informed and involved.

She closed by voicing her support for the two recommendations discussed earlier in the meeting.

Chair Kerns thanked Ms. Rahr-Wood for her comments and acknowledged the value of the Northern Board meetings, encouraging others to attend.

Chair Kerns asked if there were any additional public comments. Hearing none, she officially closed the public comment period, moving the meeting forward to agenda item #10.

10. Adjournment.

Chair Kerns adjourned the meeting at 12:42 p.m. and thanked subcommittee members and all those in attendance.

Chat Log:

(n/a)