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PREVENTION SUBCOMMITTEE

Substance Use Response Group (SURG)

May 7, 2025

3:00 pm

1. CALL TO ORDER AND ROLL CALL TO ESTABLISH QUORUM

Chair Johnson

1. Call to Order and Roll Call to Establish Quorum Cont.

Member	SURG Role	Subcommittee Role
Jessica Johnson	Urban Human Services (Clark County)	Chair
Erik Schoen	SUD Prevention Coalition	Vice Chair
Angela Nickels	Representative of a School District	Member
Debi Nadler	Advocate/Family Member	Member
Senator Fabian Doñate	Senate Majority Appointee	Member

2. PUBLIC COMMENT

Public Comment

- Public comment will be received via Zoom by raising your hand or unmuting yourself when asked for public comment. Public comment shall be limited to three (3) minutes per person (this is a period devoted to comments by the general public, if any, and discussion of those comments). No action may be taken upon a matter raised during a period devoted to comments by the general public until the matter itself has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.020.

- If you are dialing in from a telephone:
  - Dial (253) 205-0468
  - When prompted enter the Meeting ID: 825 0031 7472
  - Please press *6 so the host can prompt you to unmute.

- Members of the public are requested to refrain from commenting outside the designated public comment periods, unless specifically called upon by the Chair.

3. REVIEW AND APPROVE MARCH 5, 2025 PREVENTION SUBCOMMITTEE MEETING MINUTES

Chair Johnson

4. LOW BARRIER EMERGENCY DEPARTMENT BASED NALOXONE DISTRIBUTION

Kelly Morgan, MD and Josh Luftig, PA-C

Emergency Department Bridge Program

Substance Use Response Group (SURG)
Prevention Subcommittee Meeting
May 7, 2025

Josh Luftig, PA-C– National Implementation Leader - National Bridge Network

Kelly Morgan, MD - Emergency Physician, LVFR EMS Medical Director, Local Champion

Disclosures

- *No financial interests impact or may be perceived as having impact on the viewpoints and recommendations.*
- *Our work with emergency departments in Nevada was funded through the Opioid Response Efforts (ORN)* https://opioidresponsenetwork.org

Introduction

The experience of an Emergency Department physician

Introduction

Opioid-related overdose deaths 2019-2020

Across the U.S.

30% overall increase in opioid-related overdose deaths

In Nevada

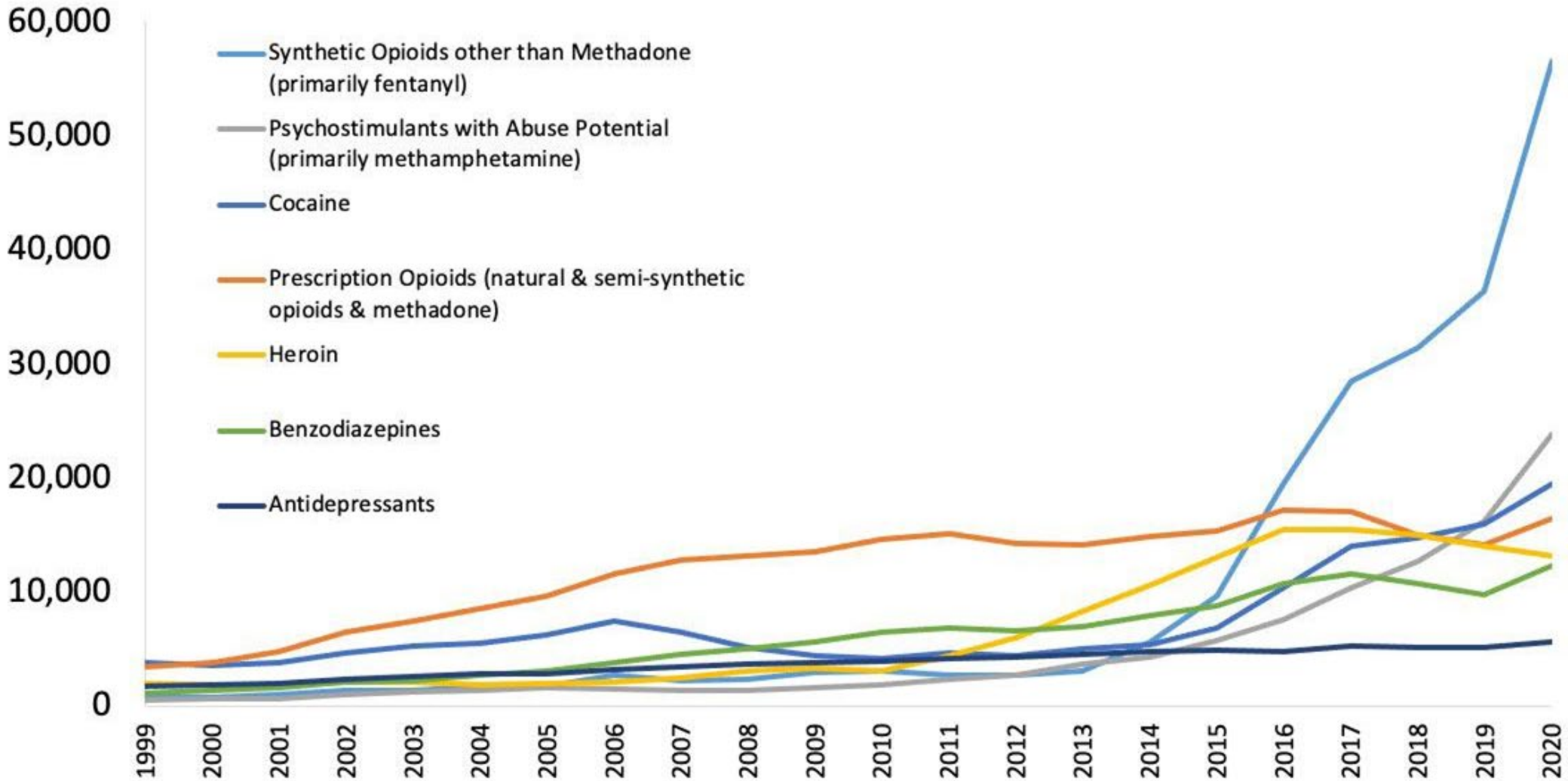
42% increase in opioid-related overdose deaths

227% increase in fentanyl-related overdose deaths

23% increase in opioid-related emergency department (ED) encounters

Source:
Nevada Opioid Needs Assessment and Statewide Plan 2022

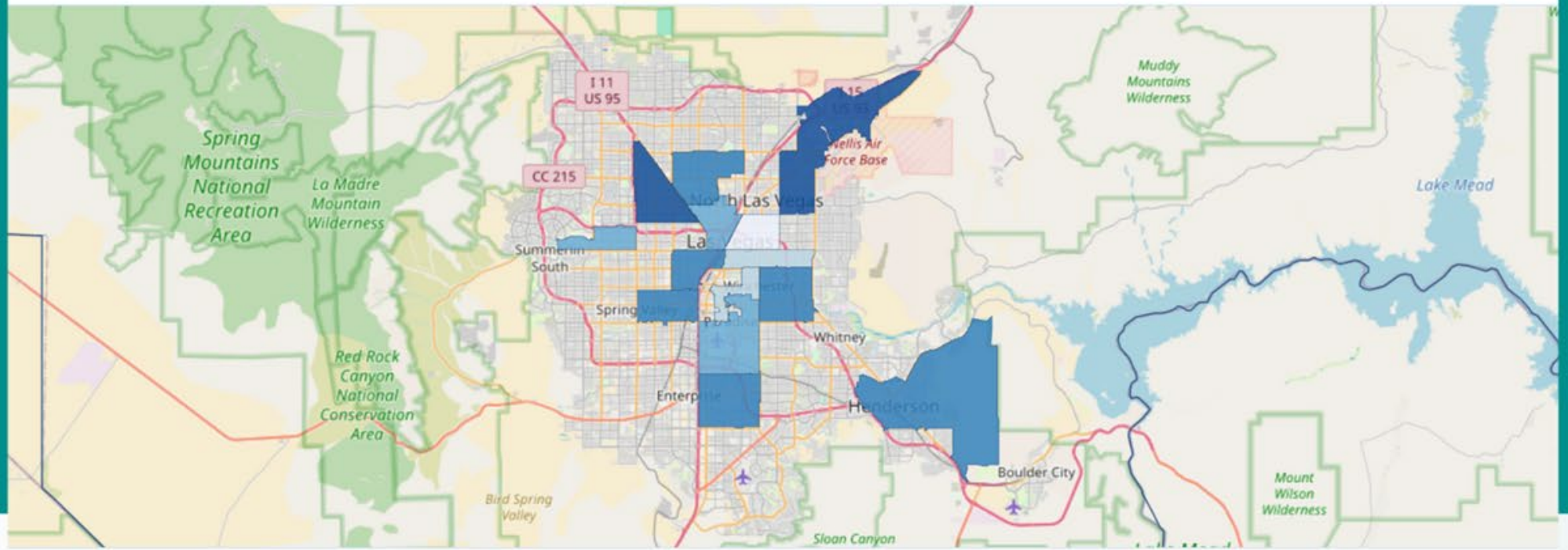
Figure 2. National Drug-Involved Overdose Deaths*, Number Among All Ages, 1999-2020



Nevada Statewide Statistics

Crude Death Rate for Opioid-Involved Overdoses by ZIP Code, 2023

These data present death rates for opioid involved overdoses by ZIP code, showing the ZIP codes where 12 or more deaths occurred in 2023. The ZIP code 89101 has the highest opioid-involved death rate in 2023.



Zip Codes of Highest Crude Opioid Overdose Death Rates

Top Resident ZIP Codes with the Highest Crude Opioid Overdose Death Rate per 100,000 Clark County Residents, 10/2023-08/2024			
ZIP	Count of Deaths	Population	Rate per 100,000
89101	32	41479	77.147
89104	21	36516	57.509
89106	12	30811	38.947
89119	15	47594	31.517
89121	19	67609	28.103
89103	12	45170	26.566
89011	11	41693	26.383
89123	13	58026	22.404
89115	13	73305	17.734

Nevada Statewide Statistics

CURRENT STATUS – SUBSTANCE-RELATED DEPENDENCE (2023)

DATA AS OF 12/31/2023

Data below are displayed by the resident county of the patient visiting the hospital for a drug-related dependence. Rates are calculated per 100k population. There may have been multiple drugs involved in each record, therefore each category is not mutually exclusive. All substances include every drug-related visit not limited to alcohol, opioid, and stimulant. **Learn More**

SELECT A DRUG TYPE

All Substances

SELECT A HOSPITALIZATION TYPE

- (•) Emergency Department
- ( ) Inpatient

SELECT A COUNTY/REGION

- [ ] North
  - [ ] Carson City
  - [ ] Washoe
- [ ] Rural
  - [ ] Churchill
  - [ ] Douglas
  - [ ] Elko
  - [ ] Esmeralda
  - [ ] Eureka
  - [ ] Humboldt
  - [ ] Lander
  - [ ] Lincoln

KEY METRICS

72,618
TOTAL HOSPITAL ENCOUNTERS

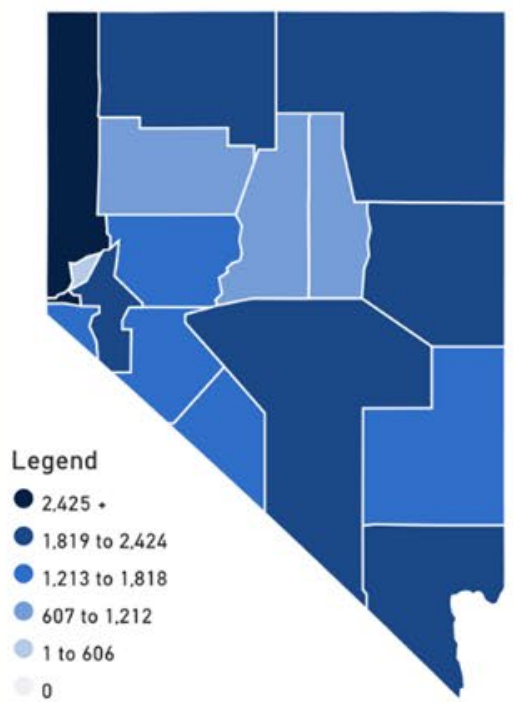
2,189.7
AGE-ADJUSTED RATE

2,219.4
CRUDE RATE

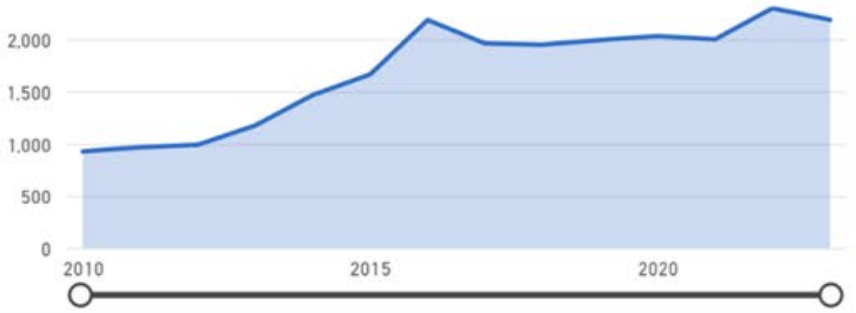
Not Applicable
AVERAGE LENGTH OF STAY (DAYS)

52.6%
PERCENT OF VISITS WITH MEDICAID PAYER

AGE-ADJUSTED RATE BY RESIDENT COUNTY



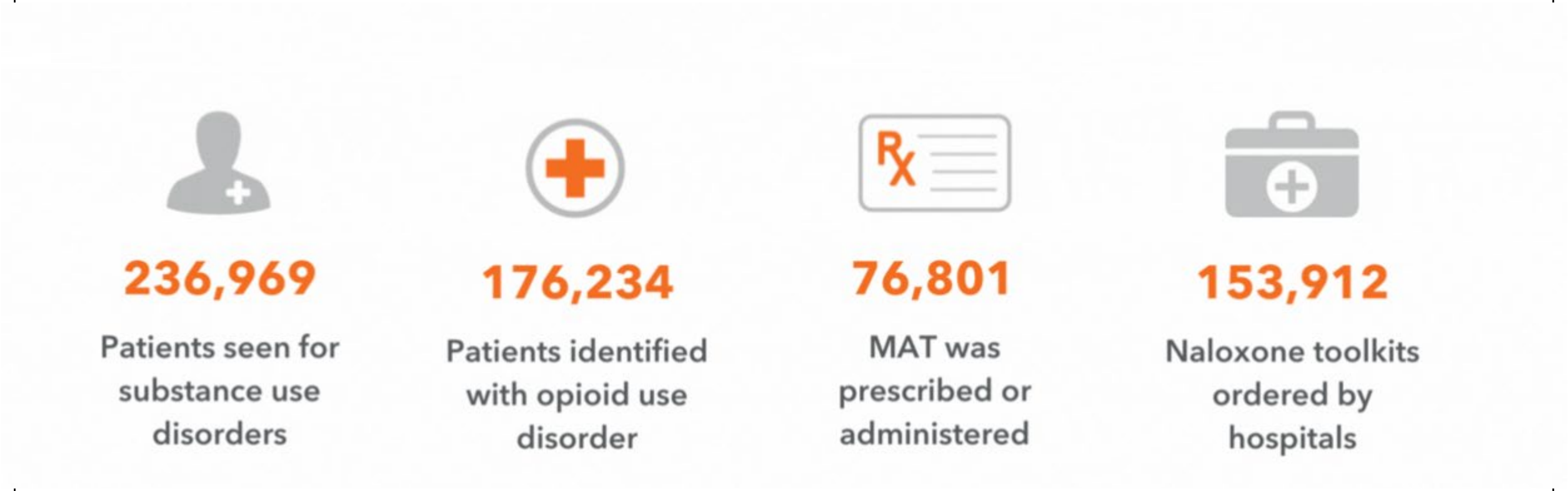
AGE-ADJUSTED RATE BY YEAR



COUNTY	POPULATION	DEPENDENCE	AGE-ADJUSTED RATE	CRUDE RATE
Carson City	59,039	1,707	3,027.5	2,891.3
Churchill	26,634	434	1,703.0	1,629.5
Clark	2,392,158	49,995	2,055.2	2,090.0
Douglas	53,510	666	1,384.0	1,244.6
Elko	56,426	1,296	2,255.3	2,296.8
Esmeralda	1,093	15	1,230.7	1,372.4
Eureka	1,888	14	843.8	741.5
Humboldt	17,862	345	1,939.3	1,931.5
Lander	6,225	48	775.9	771.1
Lincoln	4,984	66	1,327.1	1,324.2
Total	**3,271,898**	**72,618**	**2,189.7**	**2,219.4**

This dashboard is updated annually. For questions or feedback please email data@dhhs.nv.gov.

Bridge Impact: To-Date (250+ hospitals)

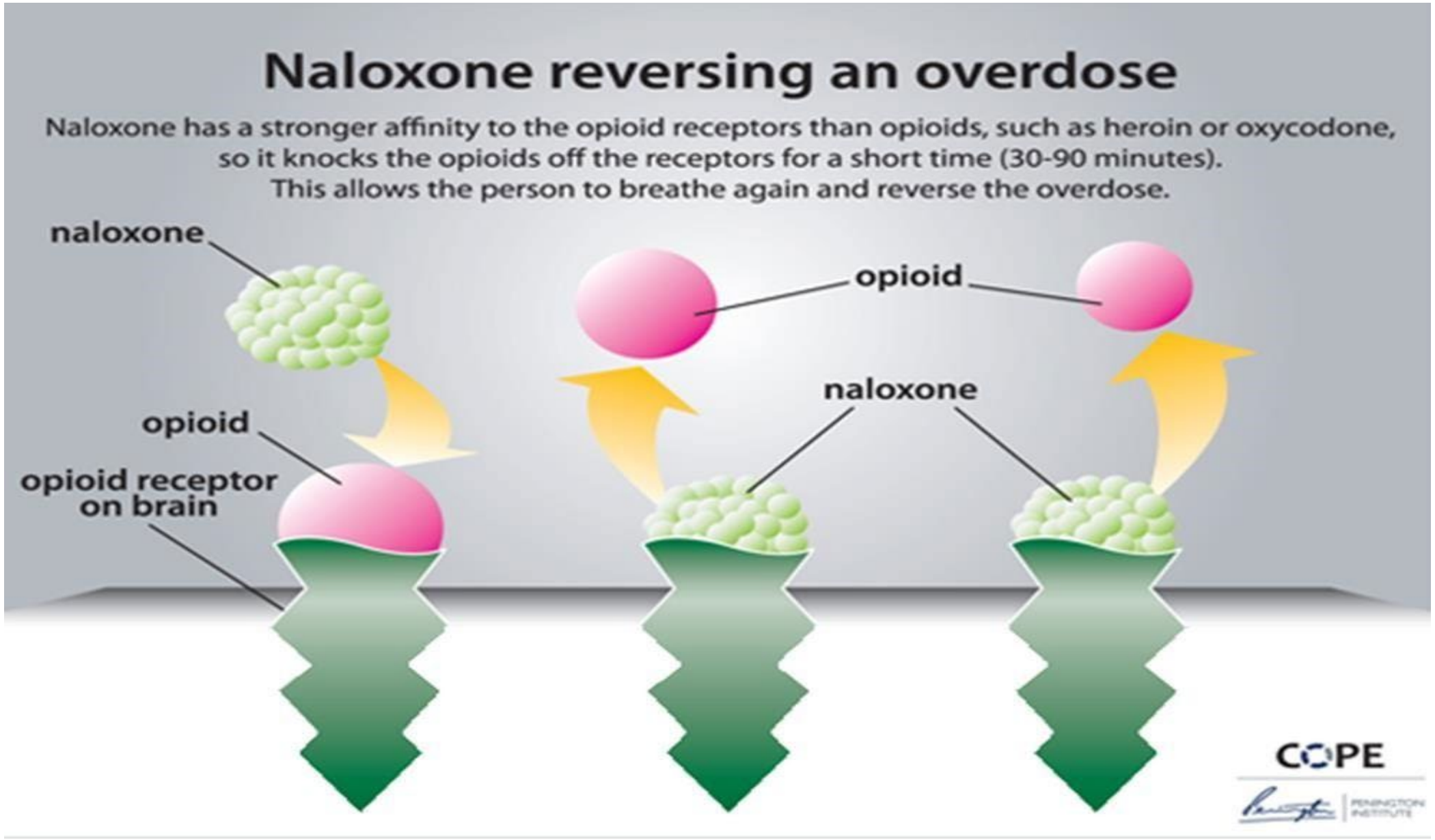


Source: CA Bridge

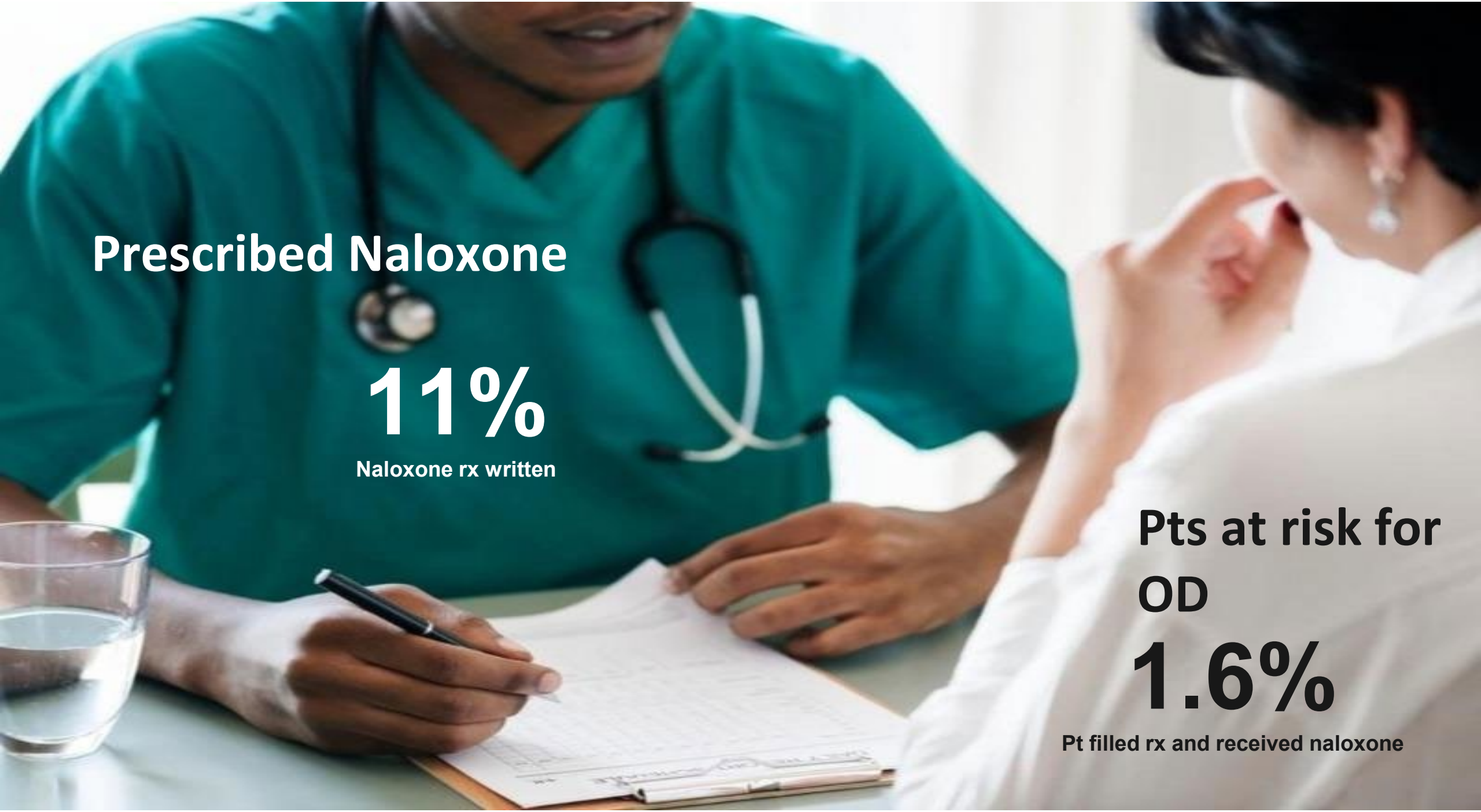
Naloxone

Opioid agonist blocker – Reverses overdose and blocks opioids for 30-60 min

- No known adverse effects, allergic reactions, potential abuse, no street value, not a controlled substance
- Community distribution since 1990's
- Common formulations:
  - Intranasal (nasal spray) – relatively inexpensive, simple to administer
  - Injectable – generally least expensive



http://www.copeaustralia.com.au/wp-content/uploads/FAQsAboutNaloxone.pdf


Prescribed Naloxone
11%
Naloxone rx written
Pts at risk for OD
1.6%
Pt filled rx and received naloxone

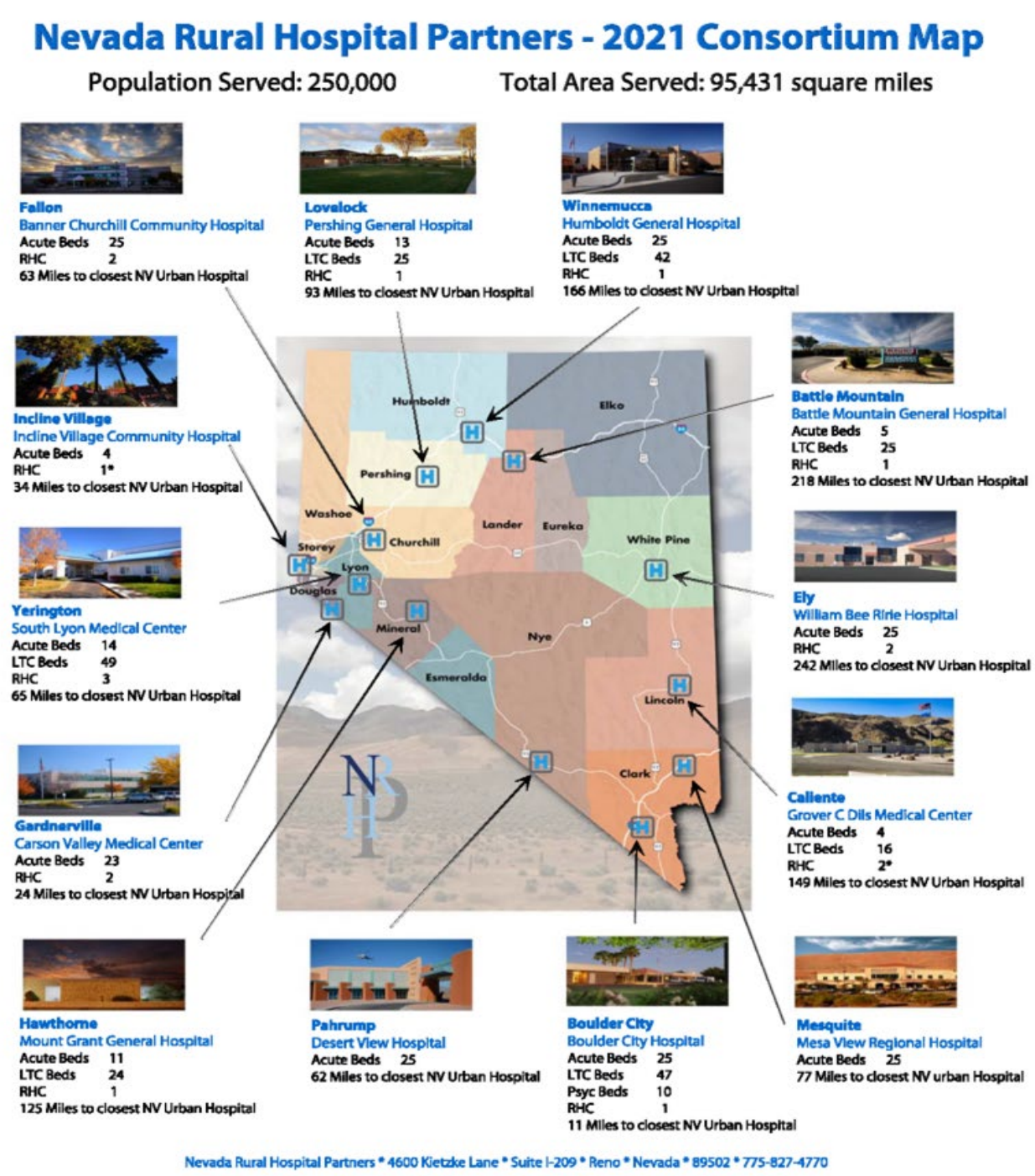
Why naloxone from the Emergency Department (ED)?

The Emergency Department (ED)
The Ultimate Safety Net

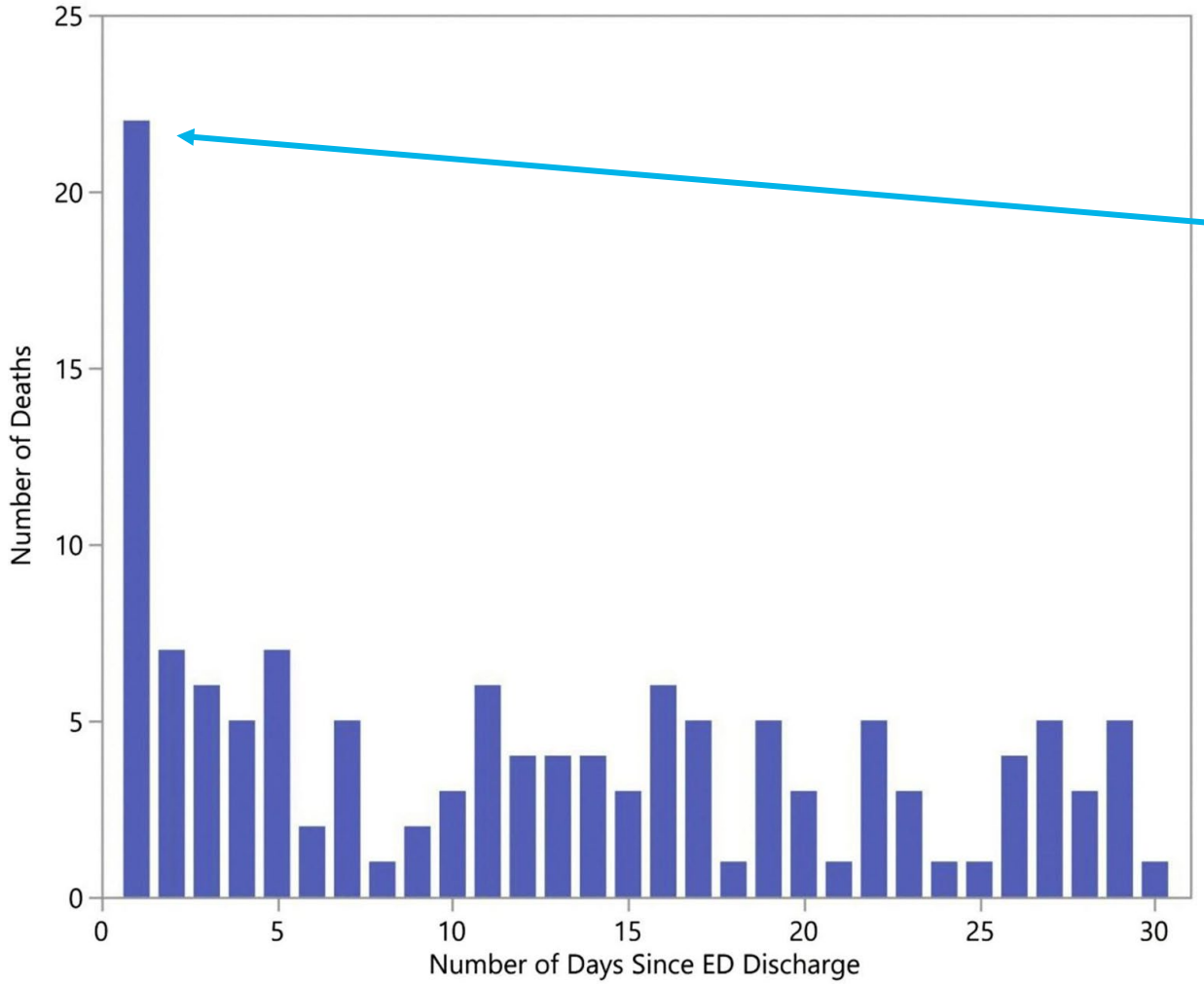
- Nearly 50% of ED visits are substance use related
- Offer all-hours safe access, acute psychiatric stabilization, same-day treatment, and navigation to ongoing care
- Critical link to shelters and community treatment programs

EDs: Well distributed geographically

ED “safety nets” serve 250,000 in rural Nevada



Treatment When it Matters Most



Fatalities spike in the first 2 days after ED treatment for nonfatal overdose

Source: Weiner, Scott, et al.. One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose. Annals of Emergency Medicine. April 2, 2019.

Bridge Model

Revolutionizing the System of Care

Low-Barrier Treatment

Connection to Care and Community

Culture of Harm Reduction

Benefits of the ED Bridge Model

- ED buprenorphine starts – more than **doubles** retention in treatment at 30 days
- Navigators – more than **doubles** patient retention in treatment at 30 days
- Naloxone distribution **decreases** overdose fatality rates
    - An estimated 16% of recipients of ED-distributed naloxone go on to reverse an overdose (NNT = 6.2)

Benefits of the ED Bridge Model

Instead of "revolving door" of "frequent flyers," with little to no intervention, each encounter is an opportunity to re-engage and immediately restart addiction treatment and provide naloxone

Issues impeding ED naloxone distribution

Nevada: Naloxone distribution via standing order is permitted (NRS 453C.100) and a mechanism for EDs to apply for naloxone is in place (Nevada State Opioid Response naloxone distribution project), **but low barrier distribution is not occurring.**

- Complex regulatory environment has a chilling effect on ED/hospital participation
- Without guidance & regulation exemption EDs are forced to follow complicated protocols with minimal impact
- **FDA: Naloxone is over the counter since 2023. Prescriptions and standing order no longer required.**

NRS = Nevada Revised Statutes

What's Working Well / Evidence Based Practice

California example:

- **Board of Pharmacy**, Heath and Human Services, and Dept of Public Health exempted EDs from regulations, provided they stored public distribution naloxone separately from hospital formulary medications and followed specific policies in the form of standard operating procedures (SOP)
- Exemption was posted on Health and Human Services Naloxone Distribution Program website
- Template SOPs were provided to hospitals as guidance

Methods for Distributing Naloxone

- **Direct “In Hand” Distribution**
  - SUN, nurse, clinician, ED tech, security guard, etc
- **Automated Distribution / Passive Distribution**
  - Distribution stand, vending machine, countertop basket

CA BRIDGE

Guide to Naloxone Distribution

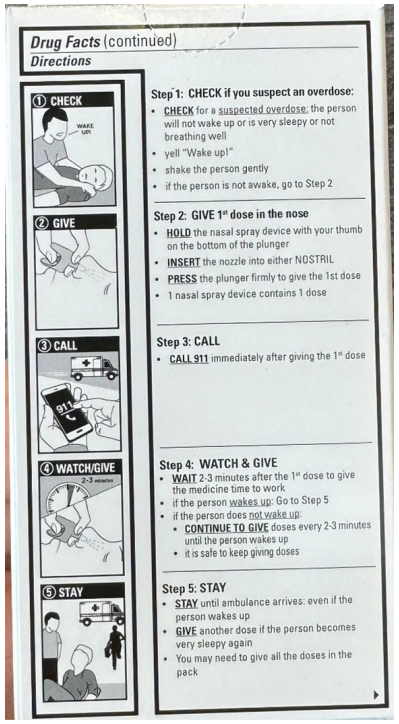
Public Access Naloxone Storage: Distribution Boxes, Vending Machines, and Overdose Emergency Wall Cabinets

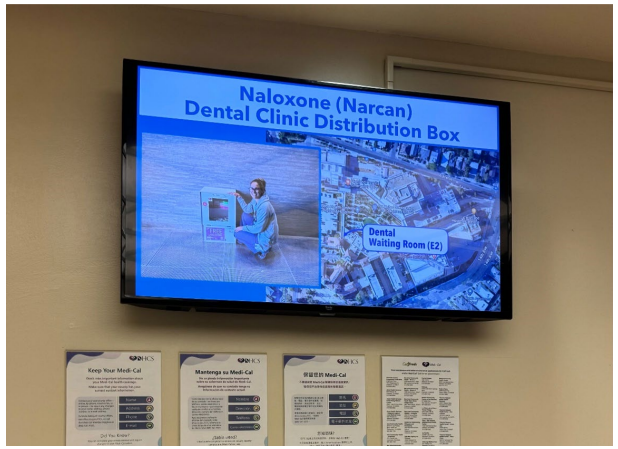
Self-Service Naloxone Access Points	*Overdose Emergency Wall Cabinet*
Public, self-service naloxone access points, such as distribution boxes and vending machines, are a way to expand your program, automate distribution, and preserve recipient anonymity. Fentanyl test strips can also be provided alongside the naloxone kits. These self-service access points can be placed in strategic locations within the healthcare system such as in front of the entrances to the ED, OB/GYN, MAT clinic, and Dental clinic.	Overdose emergency wall cabinets can be placed throughout your healthcare system similar to public access automated emergency defibrillator (AED) cabinets.
	
Click here for an example of a naloxone distribution box for purchase.	Click here for an example of an overdose emergency naloxone wall cabinet for purchase.

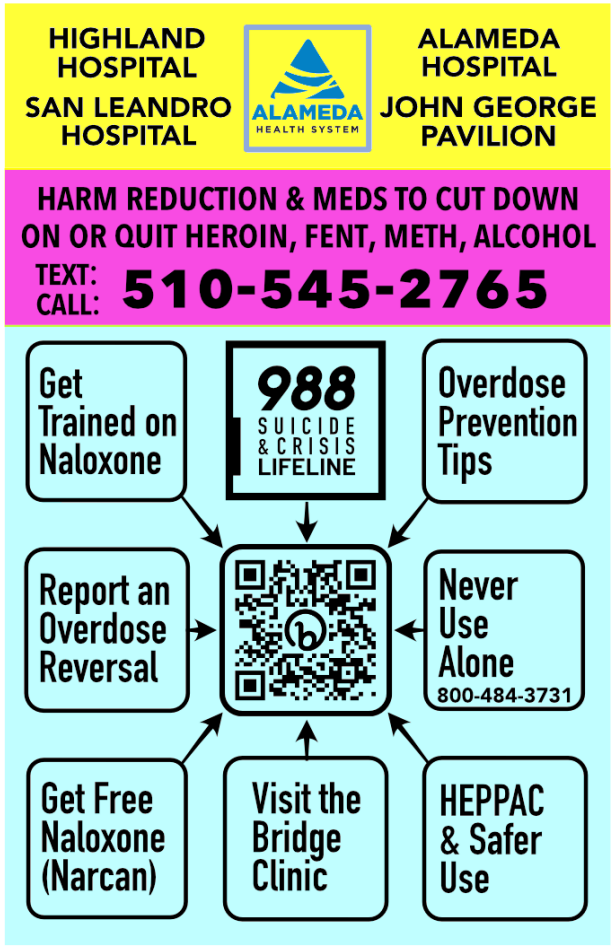
cabridge.org/resource/guide-to-naloxone-distribution

Providing Training

- In person
- On packaging instructions
- QR codes
- Digital displays







Impact

2018

320

rx written

88

rx filled

7

kits in hand / mo

Since 4/2019

65x

65-fold increased distribution rate

6,000+

kits directly distributed

500+

kits in hand / mo

Results: Statewide (California)

2018

0

EDs with high impact naloxone distribution

0

kits for free distribution

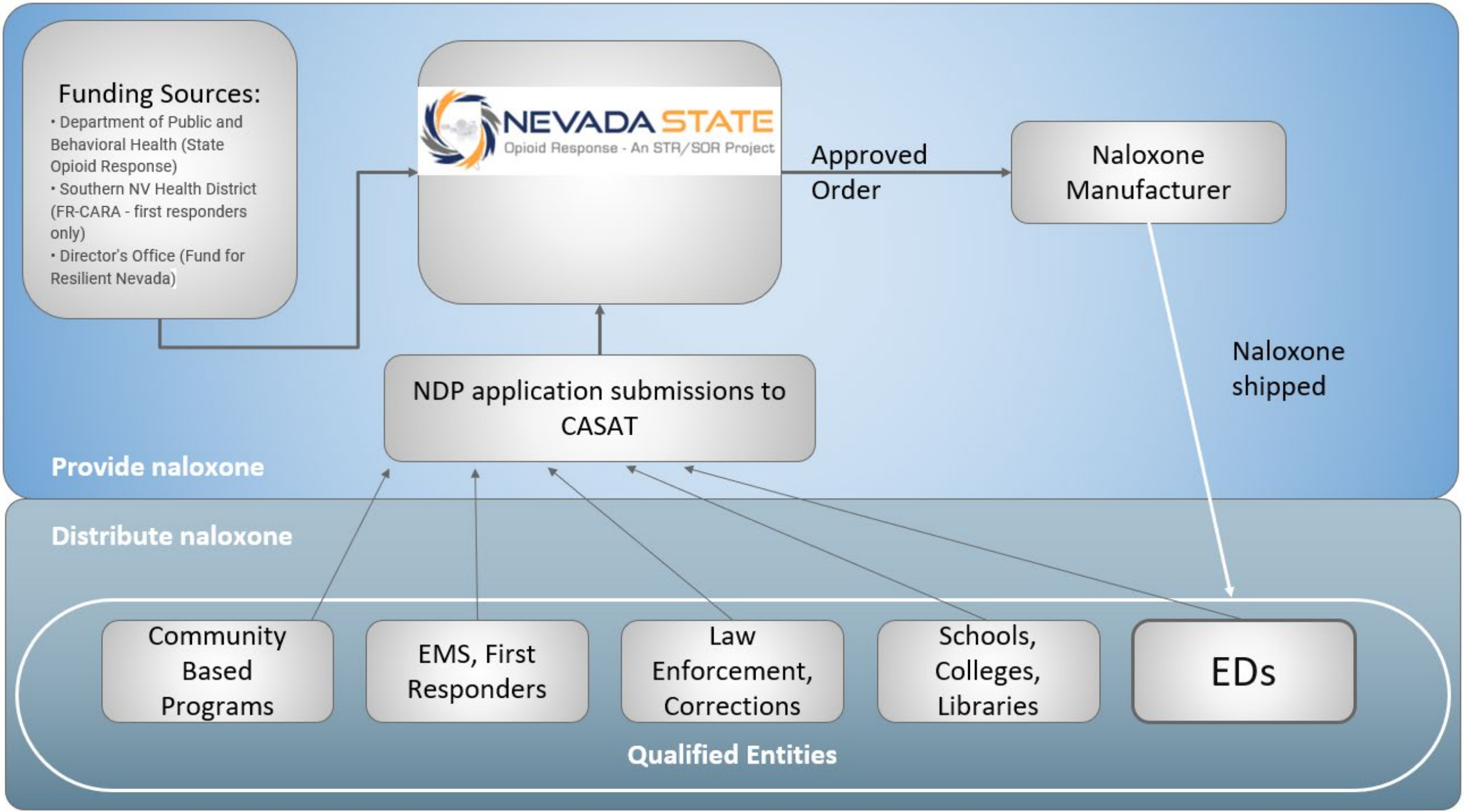
As of Q2 2024

199

EDs distributing naloxone

>300,000

kits for free distribution


Funding Sources:
• Department of Public and Behavioral Health (State Opioid Response)
• Southern NV Health District (FR-CARA - first responders only)
• Director's Office (Fund for Resilient Nevada)
NEVADA STATE
Opioid Response - An STR/SOR Project
Approved Order
Naloxone Manufacturer
Naloxone shipped
NDP application submissions to CASAT
Provide naloxone
Distribute naloxone
Community Based Programs
EMS, First Responders
Law Enforcement, Corrections
Schools, Colleges, Libraries
EDs
Qualified Entities

Which regulations require exemption

- Regulatory domains include medication dispensing, labelling, maintenance, storage, packaging, and security.
- Regulations exempted in CA mapped to similar regulations in NV:
  - NAC 639.742 - 639.900, NRS 639.2801, and NAC 639.5007 - 639.520
  - Details provided in addendum

NAC= Nevada Administrative Code

NRS = Nevada Revised Statutes

Recommendations

Request state regulatory bodies (**Nevada Board of Pharmacy (BOP),** Nevada Department of Health and Human Services (DHHS), Nevada Division of Public and Behavioral Health (DPBH))

- **Permit low barrier distribution from Emergency Departments (ED)**
- **Permit EDs to adopt a naloxone-specific standard operating procedure (SOP) for public naloxone distribution**– separate from and exempt from the regulatory framework surrounding hospital formulary medications used in patient care.
- Distribution stands established in front of and/or inside ED waiting rooms

Draft language provided in the addendum

Recommendations

Template documents be made available to healthcare systems

- Templates such as SOP, log sheets, program description can be provided on an agency website, e.g. BOP, or 3rd party website, e.g. Center for the Application of Substance Abuse Technologies (CASAT)

Draft template documents provided in the addendum

Recommendations

Consider opioid settlement funds and other funding opportunities for

- Naloxone
- Fentanyl test strips
- ED-based peer support navigators
- Training for healthcare providers ED-based initiation of MOUD

REFERENCES

See addendum

Contact Information

Name	**Josh Luftig, PA-C**
Title	National Implementation Leader, Co-Founder – Bridge
Phone	415-342-5630
Email	jluftig@bridgetotreatment.org

Name	**Kelly Morgan MD**
Title	Emergency Physician
Phone	702-885-2460
Email	kellymorganmd@gmail.com

5. REVIEW PROGRESS ON PRIOR SURG PREVENTION SUBCOMMITTEE RECOMMENDATIONS

Laura Hale, Social Entrepreneurs, Inc.

Process Considerations

- There may be a delay between when recommendations are presented in the SURG Annual Report and when they can be actioned. For example,
  - Some recommendations have budget considerations or require bill draft requests (BDRs).
  - The State of Nevada Budget Process begins in the even-numbered year before each legislative session. Budgeting for the SFY2026-27 biennium began in March of 2024, nearly a year before the *2024 SURG Annual Report* was published at the end of January 2025. Budget submission deadlines vary by Department.
  - Bill draft requests will only be developed upon request by a specific person or agency. For the 2025 Legislative session, the deadline for many BDRs was prior to the publication date of the *2024 SURG Annual Report.*[1]

[1] https://www.leg.state.nv.us/Division/Research/Content/items/bill-draft-requests-allowed-by-entity-2025-nevada-regular-legislative-session

Process Considerations

- There may be a delay between when recommendations are presented in the SURG Annual Report and when they can be actioned. For example,
  - Some recommendations require state plan amendments (SPAs).

  Require the state office of Medicaid to develop a state plan amendment to implement changes to support the recommendation requesting rates and billing standards for CHWs and Peers be increased to align with the national average and CMS standard.

  - The timelines for SPAs vary from 90 days to over two years, depending on the scope and depth of the changes.

Process Considerations

- DHHS provides an update on annual recommendations in October of each year.
- Additionally, it has been requested that the SEI support team track the status of recommendations, at a Subcommittee level, on a regular basis. This tracker will be shared with the Prevention Subcommittee following this meeting, and an updated version will be posted to the SURG website with other June meeting materials.

6. DISCUSS PROPOSED 2025 PREVENTION SUBCOMMITTEE RECOMMENDATIONS

Chair Johnson

Recommendations Process

- Subcommittee members submit recommendations via SurveyMonkey.
- The earlier recommendations are submitted, the more time we have to schedule presentations and to refine the recommendation. **Please submit your ideas as early as possible!**
- All subcommittee members are encouraged to submit at least one recommendation.

2025 Proposed Recommendations Submitted

- Elevation of recommendation included in the 2024 Annual Report

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.

2025 Proposed Recommendations Submitted

- New recommendation:

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 community.

7. UPDATE ON MULTI-TIERED SYSTEM OF SUPPORT (MTSS) PROJECT

Kaci Fleetwood, M. Ed, BCBA, LBA; Dr. Ashley Greenwald, Ph.D., BCBA-D, LBA; and Brooke Wagner, MSC-SC, M.Ed, BCBA, LBA

MTSS

MULTI-TIERED SYSTEM OF SUPPORTS

University of Nevada, Reno

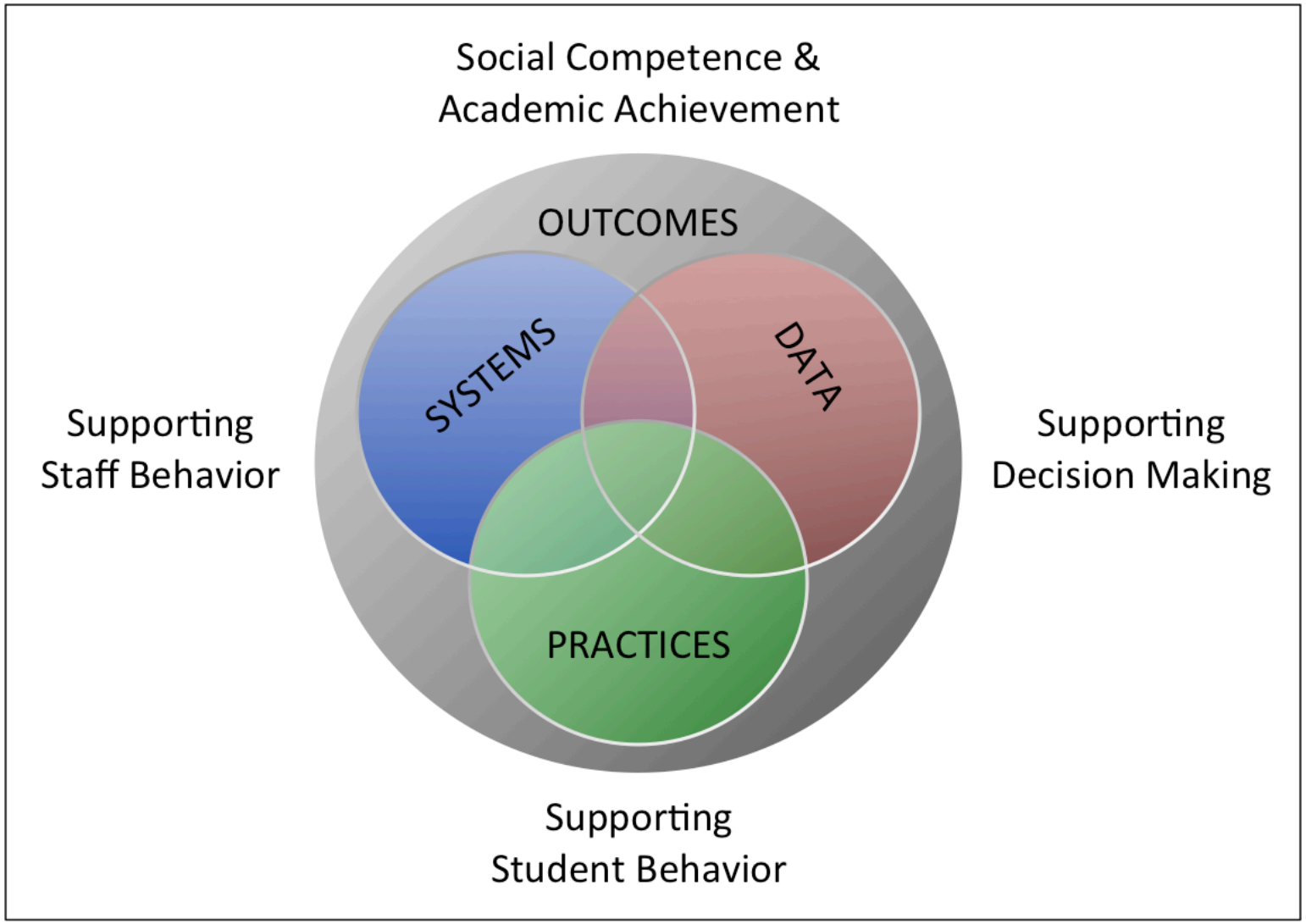
Multi-tiered System of Supports in Nevada

Kaci Fleetwood, M.Ed, BCBA, LBA

Ashley Greenwald, PhD, BCBA-D, LBA

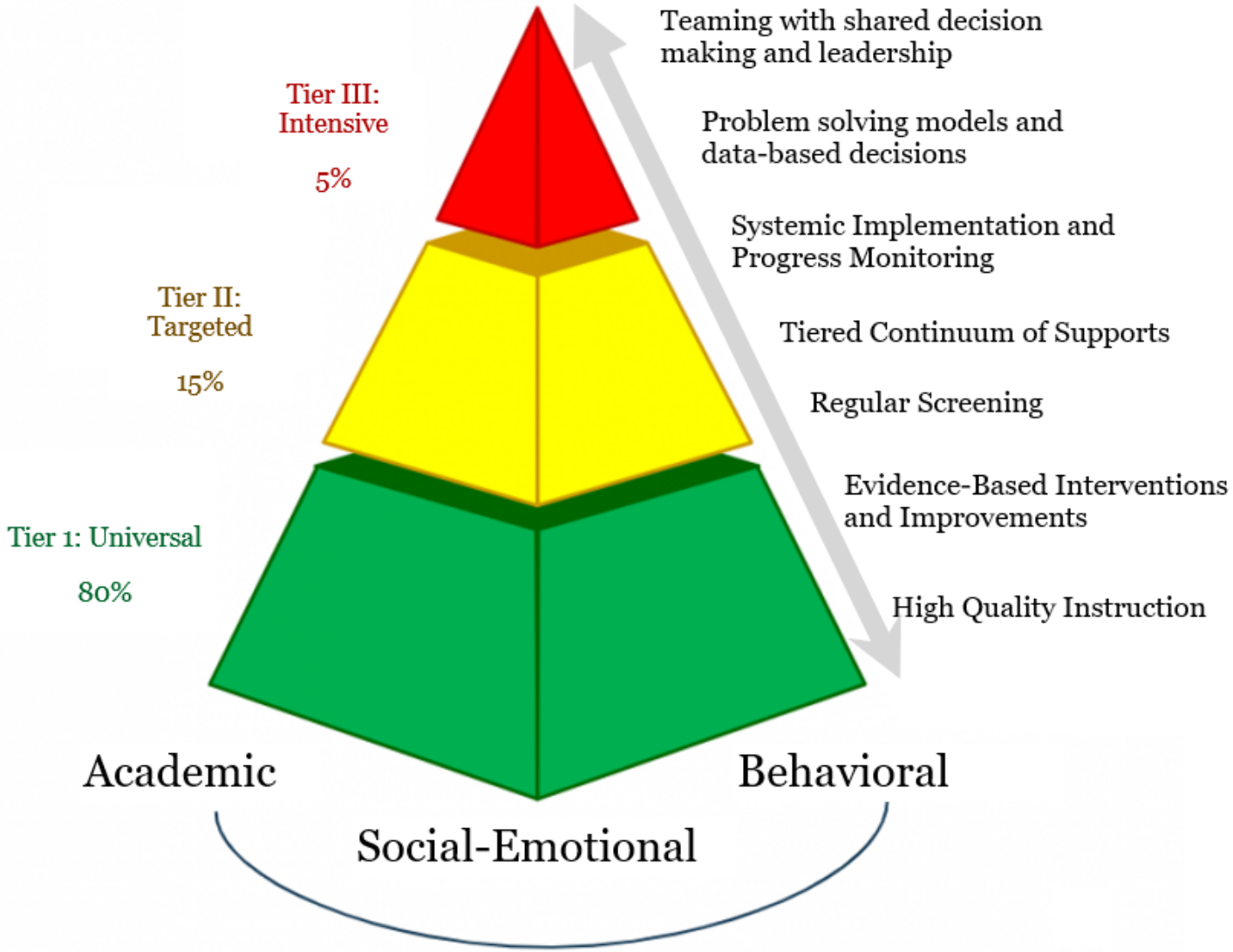
Brooke Wagner, MSC-SC, BCBA, LBA

MTSS is an Operating System



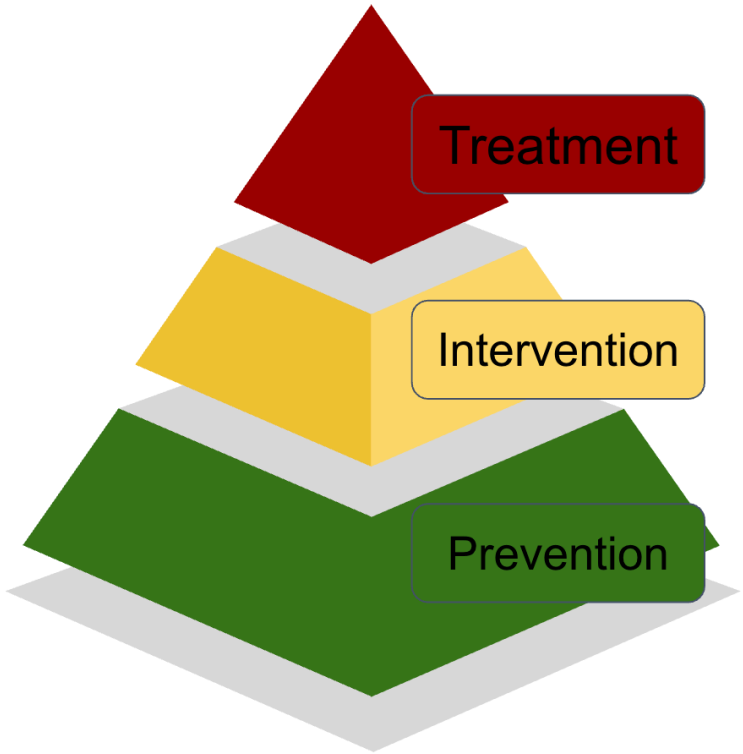
University of Nevada, Reno
MTSS
MULTI-TIERED SYSTEM OF SUPPORTS

Continuum of Support & Core Features



NEVADA MTSS
MULTI-TIERED SYSTEM OF SUPPORTS

School Context



Tier 1 is for everyone

- Universally everyone receives

Tier 2

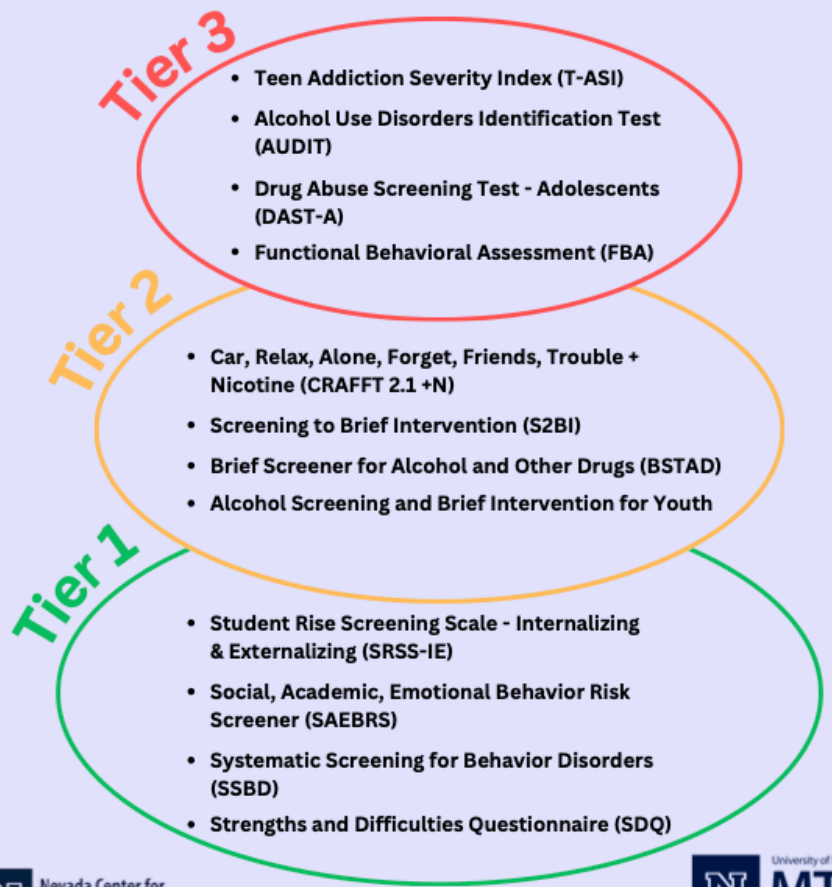
- The “same intervention” is delivered to youth with similar risk factors
- Same data utilized for entry/exit criteria; same skills are monitored

Tier 3

- An individualized support/treatment plan is based on individualized assessment. Treatment goals monitored are individualized.

Substance Misuse

Screening and Assessment Options Across the Tiers

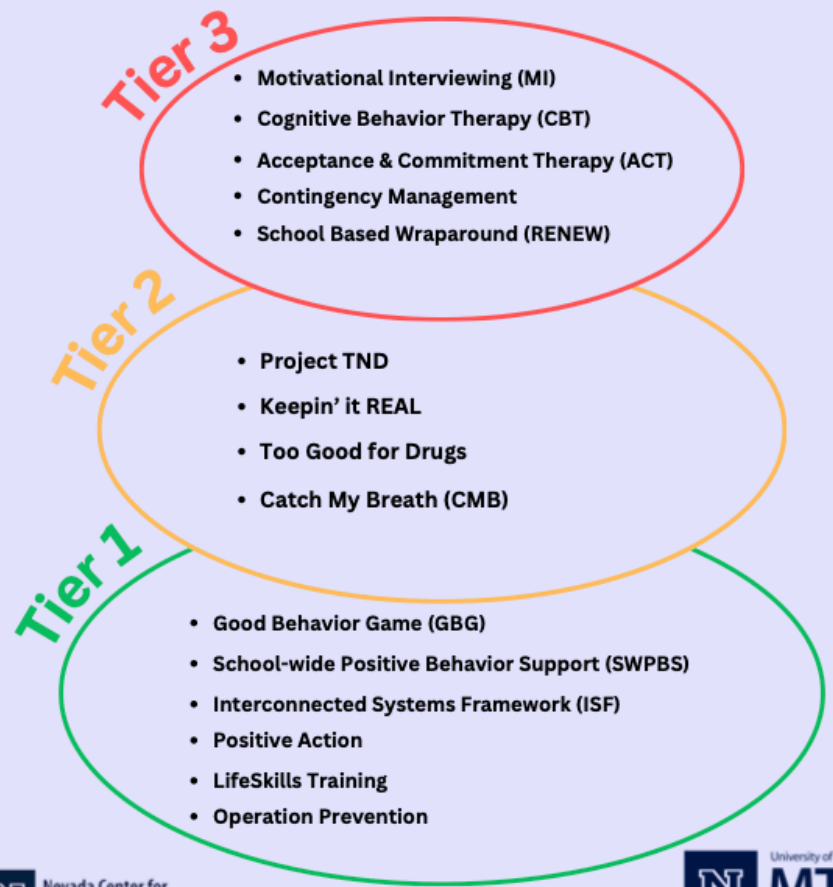


Nevada Center for Excellence in Disabilities

University of Nevada, Reno MTSS MULTI-TIERED SYSTEM OF SUPPORTS

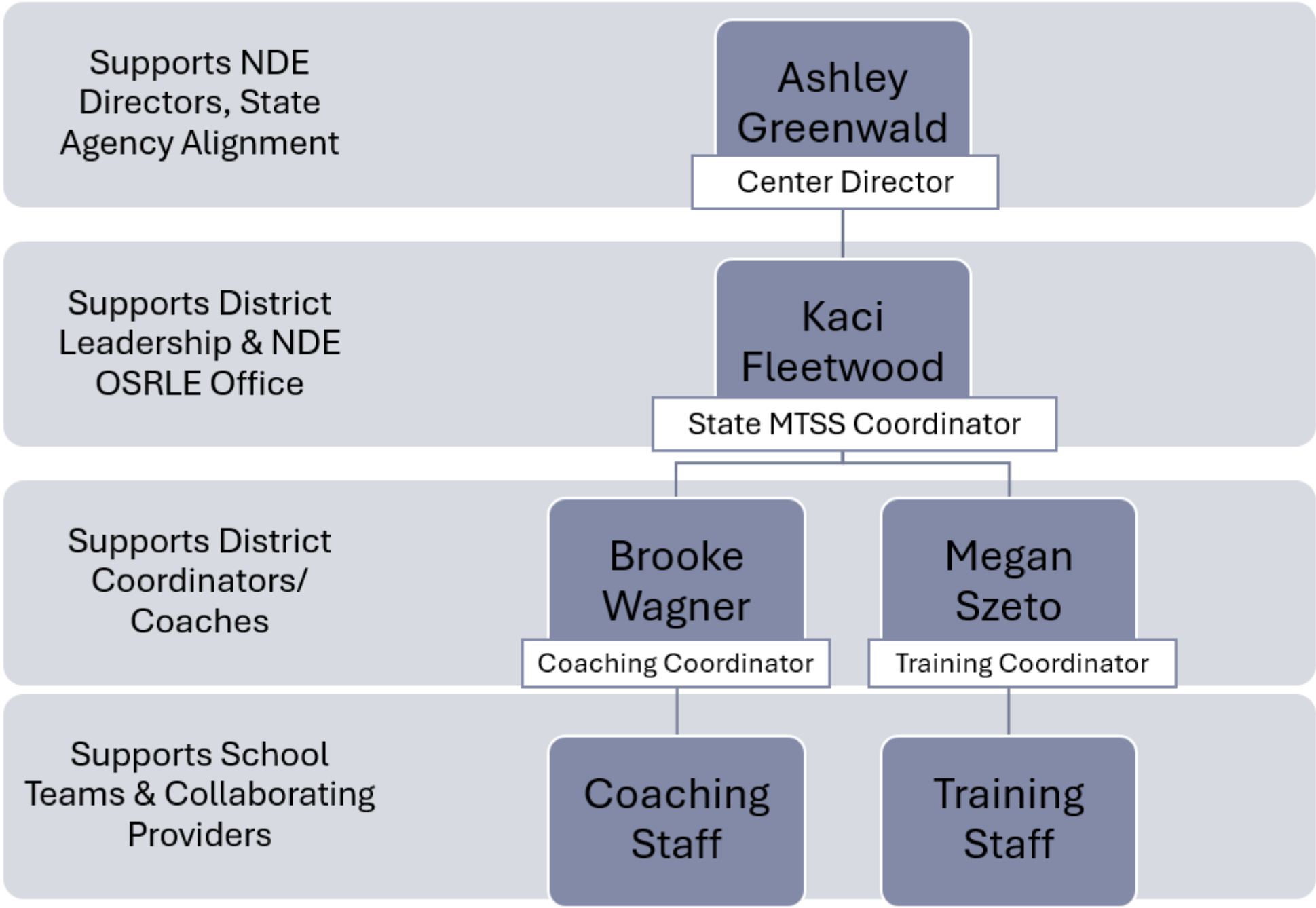
Substance Misuse

Intervention Options Across the Tiers



Nevada Center for Excellence in Disabilities

University of Nevada, Reno MTSS MULTI-TIERED SYSTEM OF SUPPORTS



University of Nevada, Reno
MTSS
MULTI-TIERED SYSTEM OF SUPPORTS

Nevada MTSS

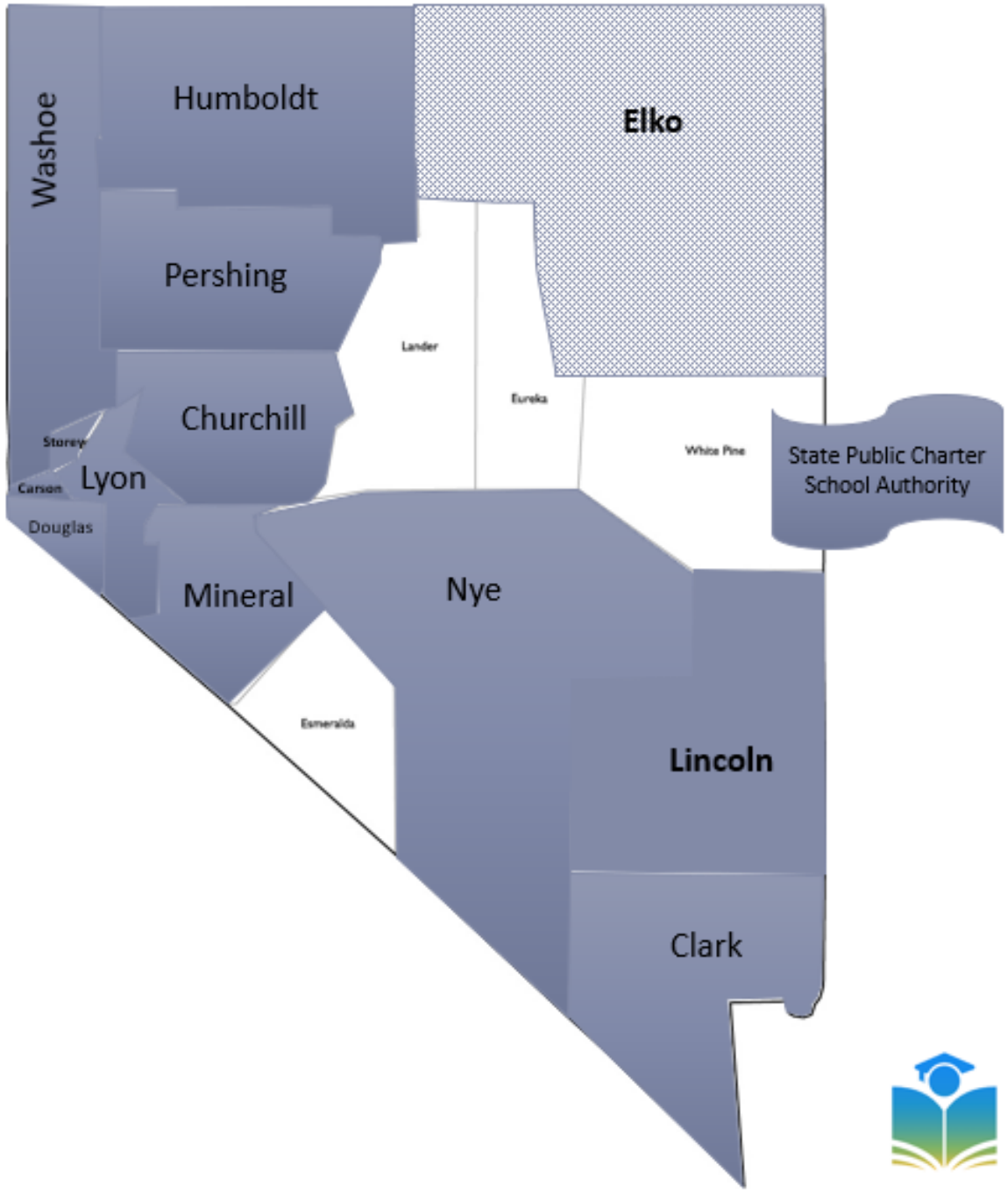
As of October 2024:

13 Local Educational Agencies (76%)

State Public Charter School Authority (41%)

220 Implementing Schools (33%)

Over 200,000 students

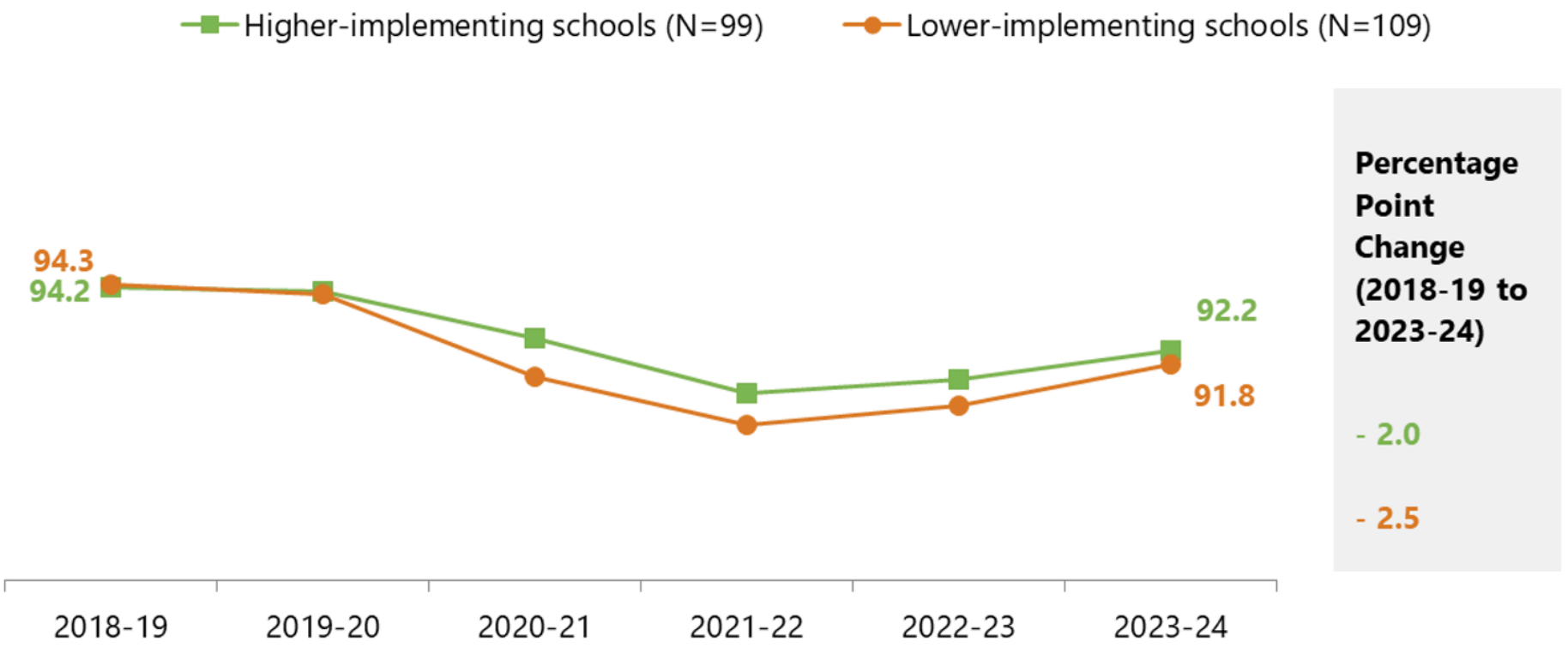


University of Nevada, Reno MTSS MULTI-TIERED SYSTEM OF SUPPORTS

NEVADA Department of Education

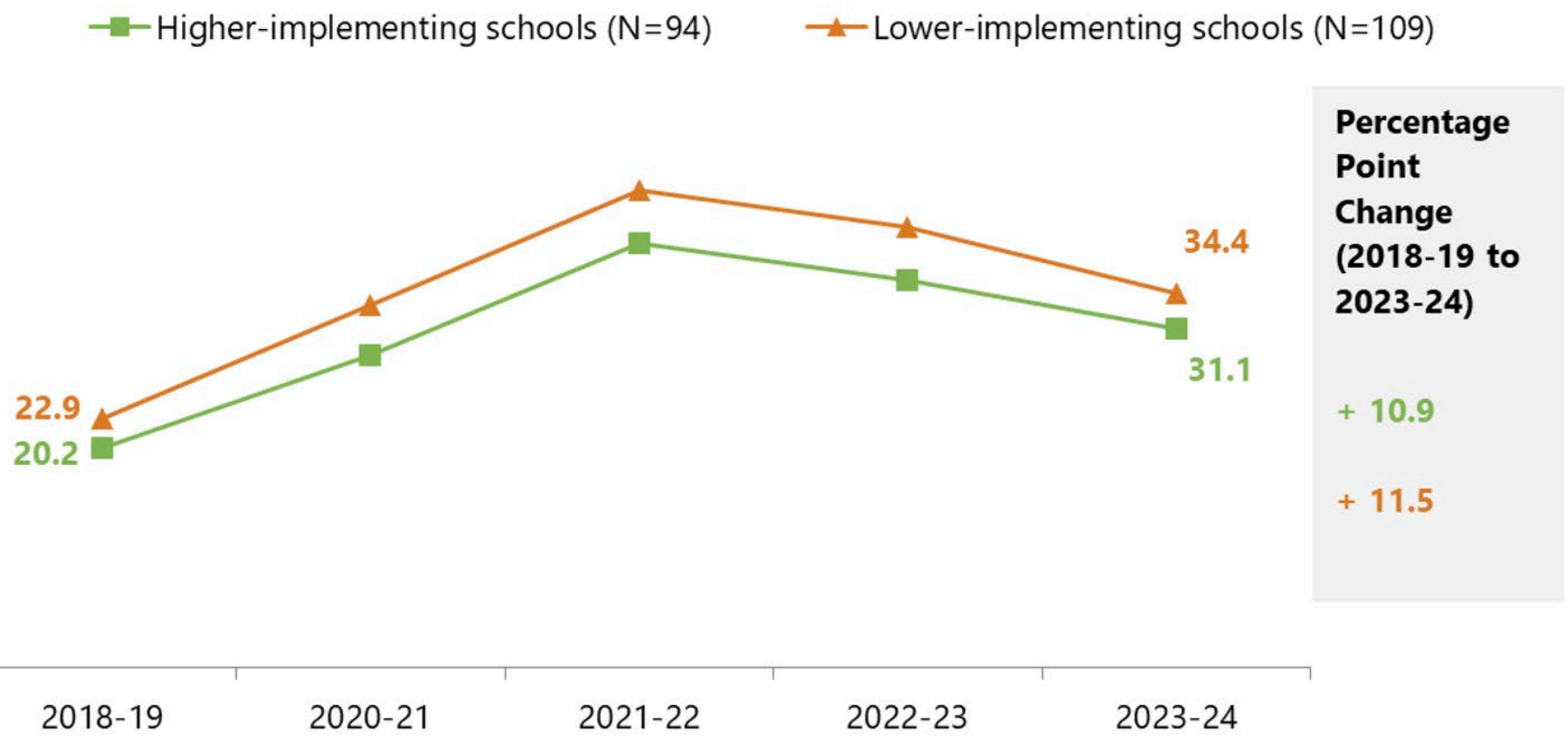
Average Daily Attendance

Figure 20. Trends in Average Daily Attendance (Nevada State Report Card Data)*



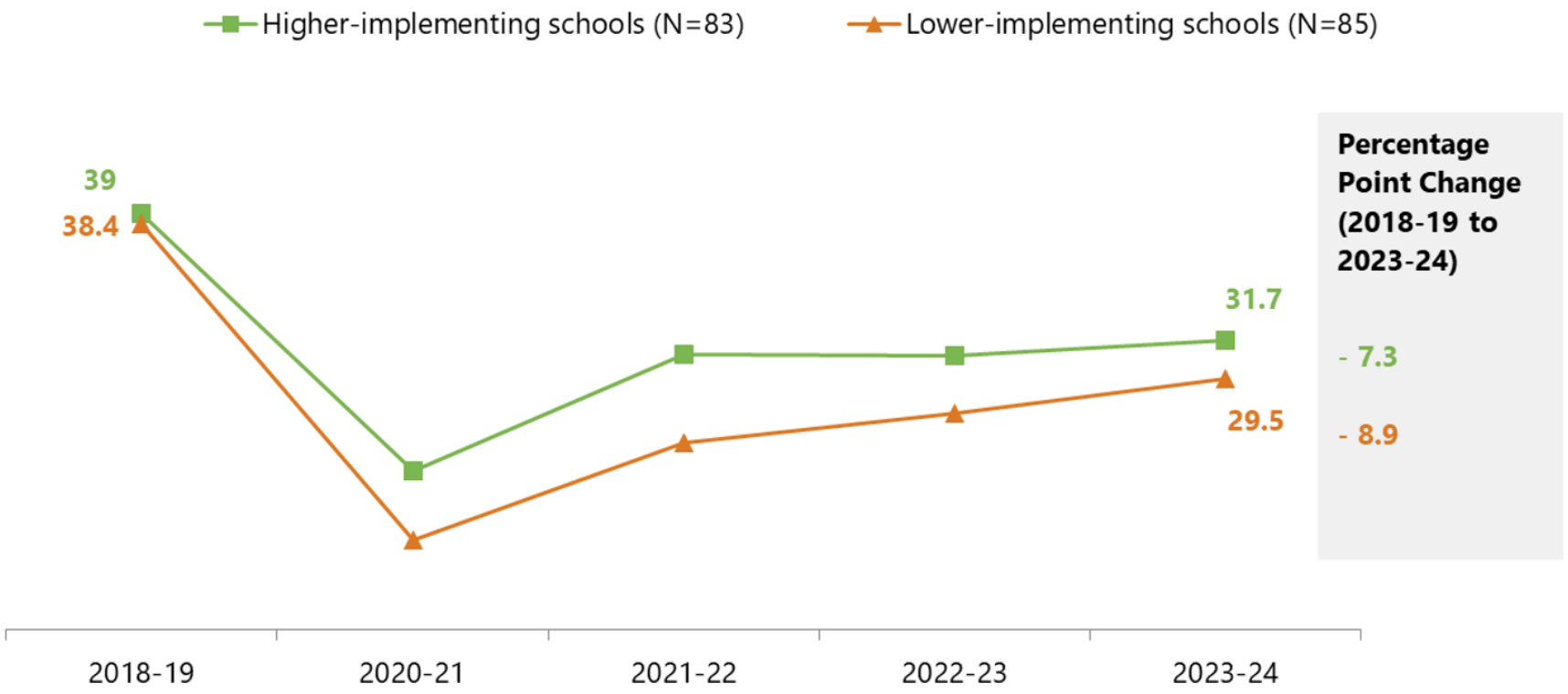
Chronic Absenteeism

Figure 21. Trends in Chronic Absenteeism Rates (Nevada State Report Card Data)*



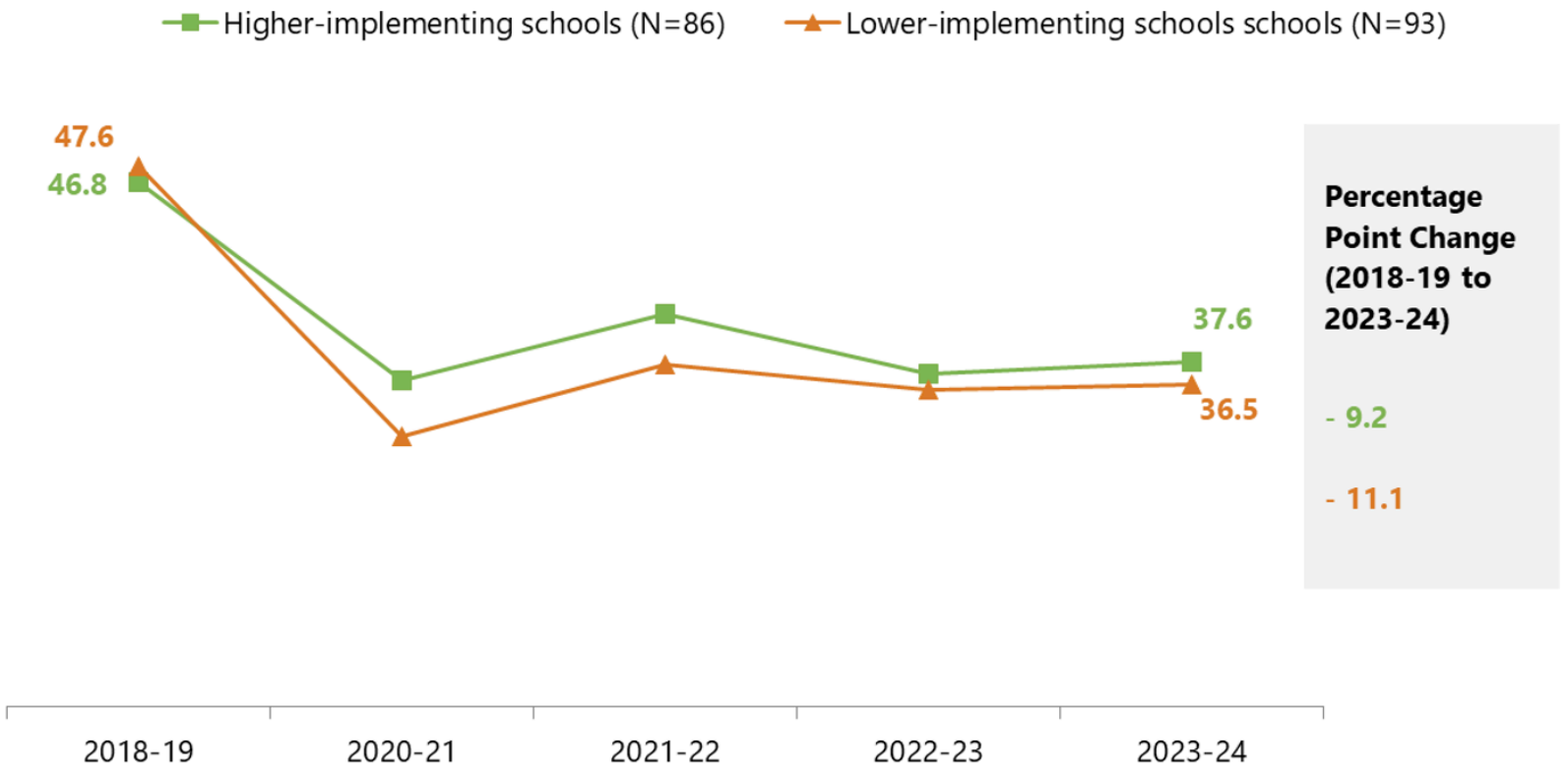
Math Proficiency

Figure 22. Math Proficiency Rates (Nevada State Report Card Data)



ELA Proficiency

Figure 23. ELA Proficiency Rates (Nevada State Report Card Data)

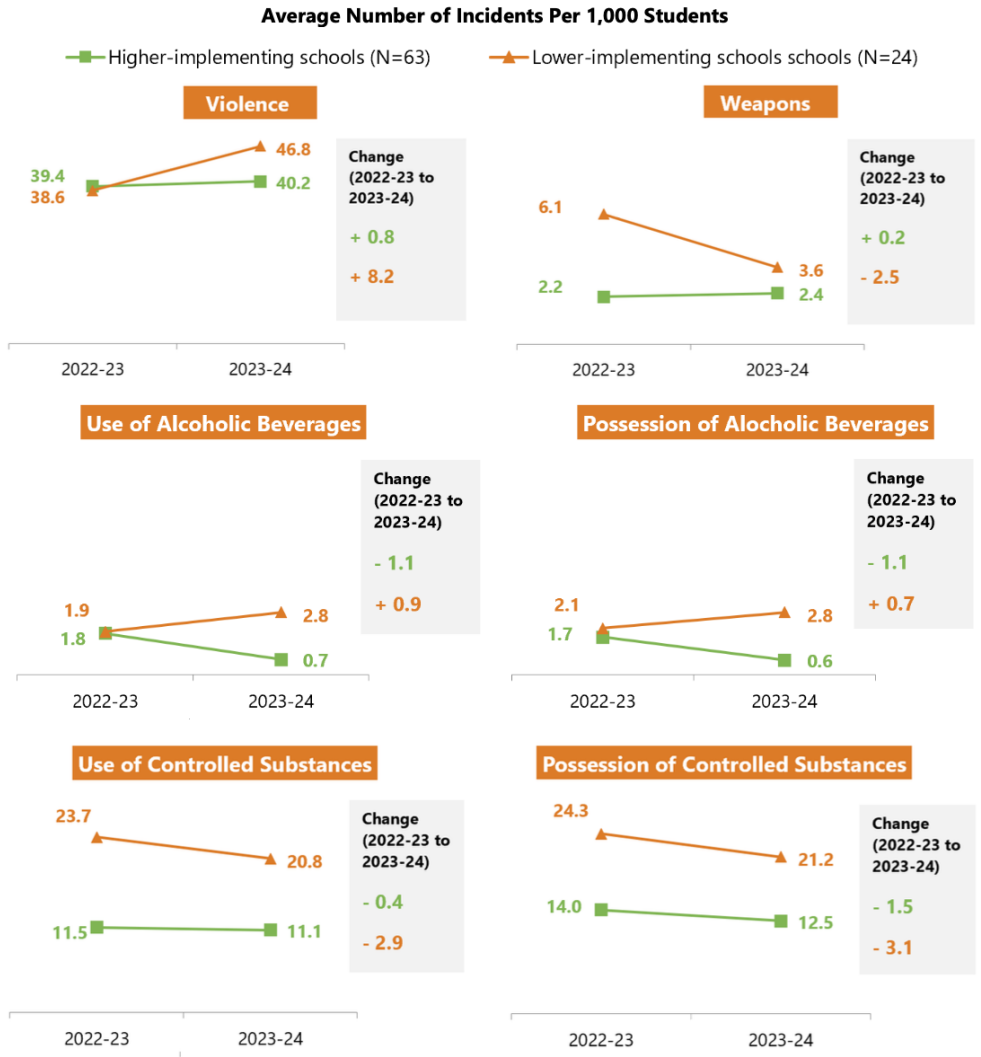


Student Outcome	Did higher-implementing schools outperform lower-implementing schools in 2023-24?	Percentage point difference between higher-implementing and lower-implementing schools in 2023-24	Did higher-implementing schools have better trends than lower-implementing schools?
Average Daily Attendance	**Yes**	**+ 0.4**	**Yes**
Chronic Absenteeism Rate	**Yes**	**- 3.3**	**Yes**
Math Proficiency Rate	**Yes**	**+ 2.2**	**Yes**
ELA Proficiency Rate	**Yes**	**+ 1.1**	**Yes**

Weapons, Violence, Alcohol, and Substances

- In 2023-24, higher-implementing schools outperformed lower-implementing schools on all measures, including the average number of incidents including Weapons, Violence, Use/Possession of Alcoholic Beverages, and Use/Possession of Controlled Substances.

- Furthermore, higher-implementing schools experienced declines in the average number of incidents related to violence and the use and possession of alcoholic beverages, while lower-implementing schools experienced increases.



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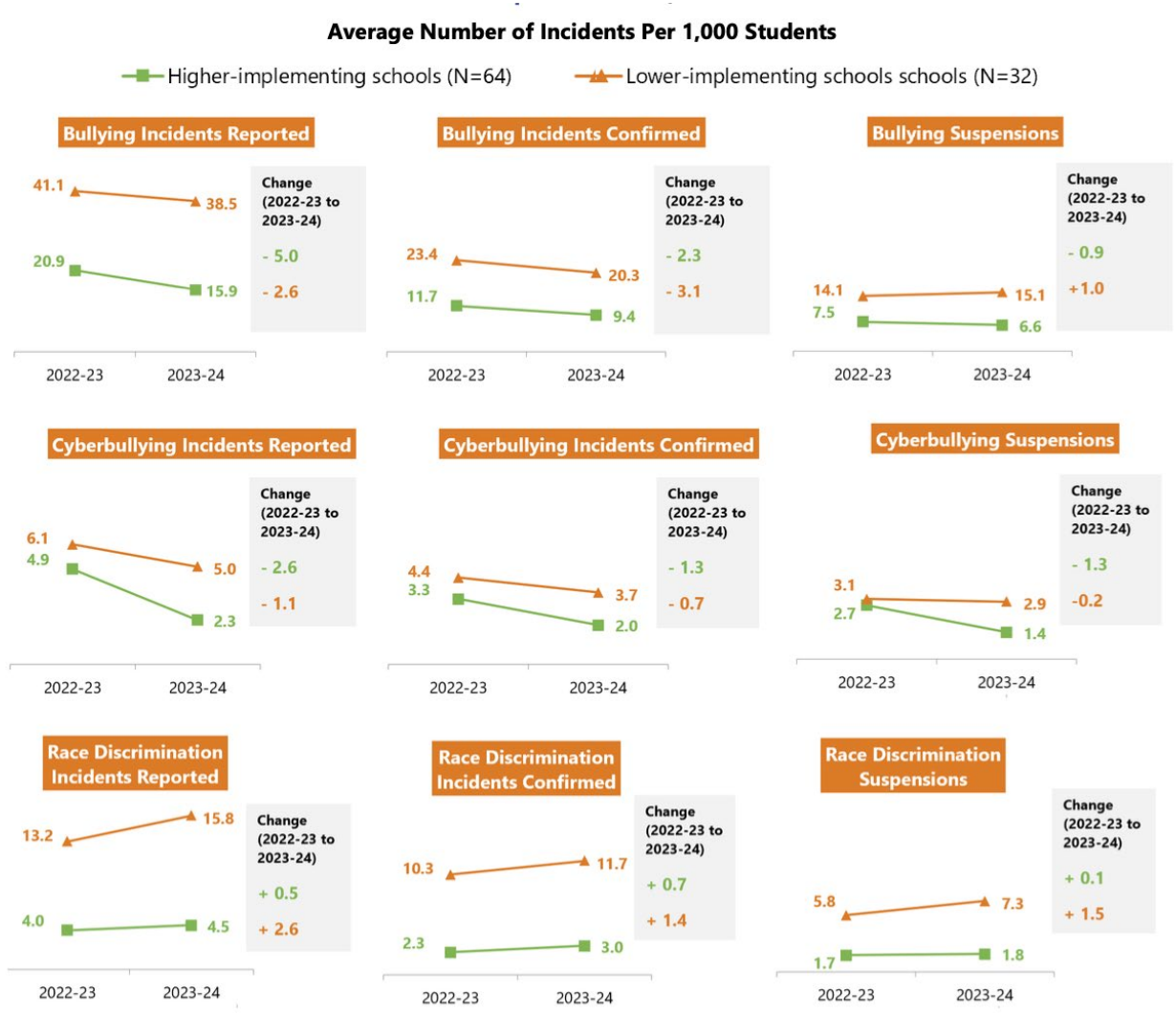
Bullying, Cyberbullying, and Racial Discrimination

- In 2023-24, higher-implementing schools outperformed lower-implementing schools on all bullying, cyberbullying, and race discrimination measures.

- From 2022-23 to 2023-24, higher-implementing schools experienced declines in the number of bullying and cyberbullying incidents reported and confirmed and incidents resulting in suspensions; furthermore, their declines were often larger than those of lower-implementing schools.



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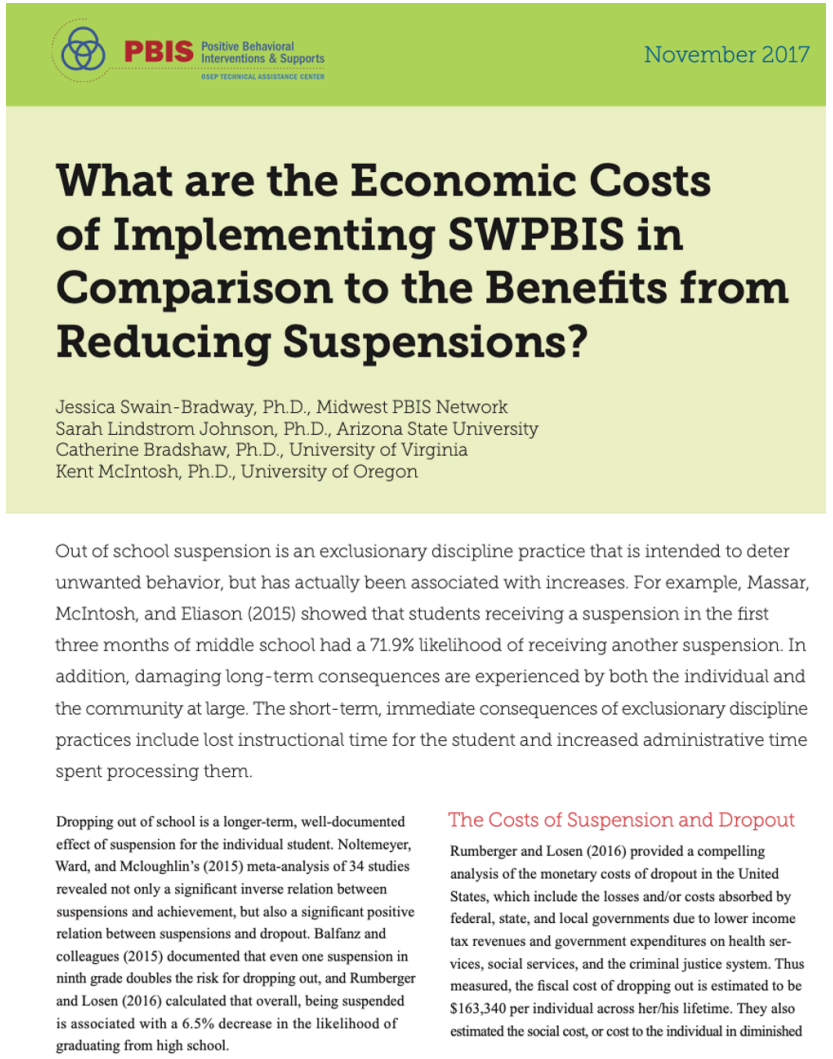
Discipline/Behaviors *Average Number of Incidents Per 1,000 Students*	Did higher-implementing schools outperform lower-implementing schools in 2023-24?	Difference in Rate per 1,000 Students between higher-implementing and lower-implementing schools in 2023-24
Violence	**Yes**	**- 6.6**
Weapons	**Yes**	**- 1.2**
Use of Alcoholic Beverages	**Yes**	**- 2.1**
Possession of Alcoholic Beverages	**Yes**	**- 2.1**
Use of Controlled Substances	**Yes**	**- 9.6**
Possession of Controlled Substances	**Yes**	**- 8.7**
Bullying Incidents Reported	**Yes**	**- 22.7**
Bullying Incidents Confirmed	**Yes**	**- 10.9**
Bullying Suspensions	**Yes**	**- 8.4**
Cyberbullying Incidents Reported	**Yes**	**- 2.7**
Cyberbullying Incidents Confirmed	**Yes**	**- 1.7**
Cyberbullying Suspensions	**Yes**	**- 1.6**
Race Discrimination Incidents Reported	**Yes**	**- 11.3**
Race Discrimination Incidents Confirmed	**Yes**	**- 8.7**
Race Discrimination Suspensions	**Yes**	**- 5.4**

Larger Societal Impact



PBIS Positive Behavioral Interventions & Supports
OSEP TECHNICAL ASSISTANCE CENTER

November 2017

What are the Economic Costs of Implementing SWPBIS in Comparison to the Benefits from Reducing Suspensions?

Jessica Swain-Bradway, Ph.D., Midwest PBIS Network
Sarah Lindstrom Johnson, Ph.D., Arizona State University
Catherine Bradshaw, Ph.D., University of Virginia
Kent McIntosh, Ph.D., University of Oregon

Out of school suspension is an exclusionary discipline practice that is intended to deter unwanted behavior, but has actually been associated with increases. For example, Massar, McIntosh, and Eliason (2015) showed that students receiving a suspension in the first three months of middle school had a 71.9% likelihood of receiving another suspension. In addition, damaging long-term consequences are experienced by both the individual and the community at large. The short-term, immediate consequences of exclusionary discipline practices include lost instructional time for the student and increased administrative time spent processing them.

Dropping out of school is a longer-term, well-documented effect of suspension for the individual student. Noltemeyer, Ward, and Mcloughlin's (2015) meta-analysis of 34 studies revealed not only a significant inverse relation between suspensions and achievement, but also a significant positive relation between suspensions and dropout. Balfanz and colleagues (2015) documented that even one suspension in ninth grade doubles the risk for dropping out, and Rumberger and Losen (2016) calculated that overall, being suspended is associated with a 6.5% decrease in the likelihood of graduating from high school.

The Costs of Suspension and Dropout

Rumberger and Losen (2016) provided a compelling analysis of the monetary costs of dropout in the United States, which include the losses and/or costs absorbed by federal, state, and local governments due to lower income tax revenues and government expenditures on health services, social services, and the criminal justice system. Thus measured, the fiscal cost of dropping out is estimated to be $163,340 per individual across her/his lifetime. They also estimated the social cost, or cost to the individual in diminished

Fiscal Benefits of Investing in School-Wide Tier 1

Every $1 invested resulted in a fiscal savings of **$104.90**

NEVADA MTSS
MULTI-TIERED SYSTEM OF SUPPORTS

Substance- Prevention Related Funding

- We were very grateful to receive FRN funding for SFY 2024 & SFY 2025
  - This allowed us to broaden and scale our prevention efforts
- We have received notice that (As of June 30 2025) we will **no longer have funding** to address substance prevention/intervention/treatment in schools

8. DISCUSS REPORT OUT FOR JULY 9, 2025 SURG MEETING

Chair Johnson

9. PUBLIC COMMENT

Public Comment

- Public comment will be received via Zoom by raising your hand or unmuting yourself when asked for public comment. Public comment shall be limited to three (3) minutes per person (this is a period devoted to comments by the general public, if any, and discussion of those comments). No action may be taken upon a matter raised during a period devoted to comments by the general public until the matter itself has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.020.

- If you are dialing in from a telephone:
  - Dial (253) 205-0468
  - When prompted enter the Meeting ID: 825 0031 7472
  - Please press *6 so the host can prompt you to unmute.

- Members of the public are requested to refrain from commenting outside the designated public comment periods, unless specifically called upon by the Chair.

10. ADJOURNMENT

ADDITIONAL INFORMATION, RESOURCES & UPDATES AVAILABLE AT:

https://ag.nv.gov/About/Administration/Substance_Use_Response_Working_Group_(SURG)/

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