NEVADA LEGISLATURE
JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

(Section 6 of Assembly Bill 443, Chapter 392, *Statutes of Nevada 2021*, at page 2505)

DRAFT MINUTES

February 17, 2022

The second meeting of the Joint Interim Standing Committee on Health and Human Services for the 2021–2022 Interim was held on Thursday, February 17, 2022, at 9 a.m. Pursuant to *Nevada Revised Statutes* (NRS) 218A.820, there was no physical location for this meeting.

The agenda, minutes, meeting materials, and audio or video recording of the meeting are available on the Joint Interim Standing Committee's meeting page. The audio or video recording may also be found at https://www.leg.state.nv.us/Video/. Copies of the audio or video record can be obtained through the Publications Office of the Legislative Counsel Bureau (LCB) (publications@lcb.state.nv.us or 775/684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sarah Peters, Chair
Senator Fabian Doñate, Vice Chair
Senator Joseph (Joe) P. Hardy, M.D.
Senator Dallas Harris
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblyman David Orentlicher, M.D.
Assemblywoman Robin L. Titus, M.D.

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Patrick B. Ashton, Senior Policy Analyst, Research Division
Kristi Robusto, Senior Policy Analyst, Research Division
Crystal Rowe, Research Policy Assistant, Research Division
Julianne King, Research Policy Assistant, Research Division
Eric Robbins, Principal Deputy Legislative Counsel, Legal Division
Cathy Crocket, Senior Program Analyst, Fiscal Analysis Division

Items taken out of sequence during the meeting have been placed in agenda order.

AGENDA ITEM I—CALL TO ORDER

Chair Peters:

Welcome to the second meeting of the Joint Interim Standing Committee on Health and Human Services. Please mark members as present upon their arrival. We have a full agenda today. We are going to talk about substance use, the opioid crisis, and the landscape for treatment and recovery. We will wrap up the day with an overview of the bills that were passed during the 2021 Legislative Session pertaining to this issue.

This particular area can be very personal for folks, and I appreciate that emotions can come up from the discussion of substance use and recovery. This is a heavy issue, and I want to respect what comes up for us in this area. Please let me know if you need to step away at any point to take a breather or turn off your camera if you need to.

Depending on the length of the question-and-answer portion of the first few agenda items, we will plan to take a quick lunch around 1 p.m.

Unfortunately, due to unforeseen circumstances, we will be skipping Agenda Item X today. Dr. Kelly is unavailable due to a family emergency. We send our thoughts and will try to reschedule that important topic. Additionally, we will hear Agenda Item XIV right after Agenda Item V since we have the presenter here for both of those items.

The Zoom meeting has a chat feature; however, this feature is only to be used for technical assistance. Any links or information that you would like to share during your presentation should be stated verbally on the record, or you can follow up with staff if there are additional items you would like to share.

AGENDA ITEM II—PUBLIC COMMENT

Chair Peters:

We will move on to public comment. Public comment will be limited to two minutes per speaker. Staff will time each speaker during public comment to ensure everyone has a fair opportunity to speak. We also ask that you do not repeat what a previous commenter stated. An additional opportunity to make public comment will be available at the end of the meeting. Our Broadcast and Production Services (BPS) staff will interact with those making public comments to facilitate participation. Broadcast and Production Services, please add the first caller with public comment to the meeting.

BPS:

Thank you so much, Chair Peters. If you would like to provide public comment at this time, please press "star nine" on your phone to take your place in the queue.

Caller with the last three digits 918, you are unmuted and may proceed.

Leann D. McAllister, M.B.A., Executive Director, Nevada Chapter of the American Academy of Pediatrics:

My name is Leann McAllister, and I am the executive director of the Nevada Chapter of the American Academy of Pediatrics (Nevada AAP). Thank you for prioritizing discussing substance abuse at today's meeting.

Pediatricians have long been ringing the alarm on the impact of the opioid epidemic on children's health, witnessing its devastating consequences in their clinics and communities.

The Nevada AAP strongly advocates that treatment is prioritized over criminal prosecution. Incarceration and the threat of incarceration do not reduce the incidence of alcohol or drug use and can deter pregnant women who need help from seeking prenatal care. This is also harmful to children; studies have shown that receiving prenatal care significantly reduces the negative effects of substance use during pregnancy, including low birth weight and premature birth.

The Nevada AAP currently has 276 members, most of whom are board-certified pediatricians, both primary and specialty care; members also include pediatric nurse practitioners, physician assistants, pediatric residents, and medical students, all of whom live and work in Nevada and have dedicated their professional lives to the health of all children (Agenda Item II A).

Chair Peters:

Thank you. Please go ahead and add the next caller.

BPS:

Caller with the last three digits 324, you are unmuted and may proceed.

Steven Messinger, Policy Director, Nevada Primary Care Association:

Good morning, Chair Peters, and members of the Committee. My name is Steven Messinger, and I am the policy director for the Nevada Primary Care Association.

We are the state membership association for community health centers, also known as federally qualified health centers (FQHCs). We have been grateful to be the recipient of nearly 1.2 million state-administered grant dollars used to boost capacity to treat substance use disorder in our member clinics located across the state. Our FQHCs are a critical tool for bringing these services to underserved populations and rural communities, and this grant has allowed us to expand their ability to deliver these crucial services.

However, there are steps the Legislature could take to make this effort much more effective. This legislative body could request a bill approving an expansion of available behavioral health provider types to practice in FQHCs and be reimbursed by Medicaid. This list includes licensed alcohol and drug counselors, marriage and family therapists, and certified professional counselors.

As this Committee turns its attention to the efforts to mitigate the opioid crisis and substance use disorders broadly, we urge you to consider expanding the types of addiction specialists and other behavioral health provider types to provide sustainable services to our most underserved populations. Thank you for your time.

Chair Peters:

Thank you for your comments. Are there any other callers on the public line for public comment?

BPS:

Chair, your public line is open and working; however, there are no more callers at this time.

Chair Peters:

Thank you so much.

AGENDA ITEM III—CONSIDERATION OF REGULATIONS PROPOSED OR ADOPTED BY CERTAIN LICENSING BOARDS PURSUANT TO NRS 439B.225

Chair Peters:

We will go ahead and move on to our next agenda item. This agenda item, consideration for regulations proposed or adopted by certain licensing boards, will be presented by our legal counsel Eric Robbins. Mr. Robbins will make some opening remarks and then members may ask questions on these regulations.

This is an informational item only. Staff informed you about the status of the regulatory process on the two regulations that we are considering. If you have a greater interest in participating in the development of these regulations, the process can be found on the LCB website, or you can reach out to our staff for additional assistance.

Committee review is an important process for follow-up on bills that have passed in the last couple of sessions, but we will not be taking any action on these items today. For the regulatory process, I just want to note this Committee neither approves nor denies any of the regulations before you today; instead, each board adopts its own regulations followed by approval from the Legislative Commission. The Committee's consideration of these regulations is only from an advisory perspective. If you need further detail on the regulatory process, please direct those questions to our LCB staff after the meeting. I will go ahead and ask Mr. Robbins to please present these two regulations.

A. LCB FILE R171-20 OF THE BOARD OF MEDICAL EXAMINERS

B. LCB FILE R180-20 OF THE BOARD OF MEDICAL EXAMINERS

Eric Robbins, Principal Deputy Legislative Counsel, Legal Division:

We have two regulations for the review of the Committee today; both are proposed by the Board of Medical Examiners (BME). We have R171-20, which revises various provisions concerning licensure and regulation with regard to the practice of medicine (Agenda Item III A). Then we have R180-20, which revises qualifications for certain applicants for licensure as a physician assistant (Agenda Item III B). We have Sarah Bradley from the BME here to answer any questions from members of the Committee.

Chair Peters:

Thank you so much. Are there any questions on the regulations from the Committee? Go ahead, Assemblywoman Titus.

Assemblywoman Titus:

Thank you. Just a quick question regarding these regulations, Mr. Robbins. Where are they in the process? Are they close to being proposed for passage by the Legislative Commission?

Mr. Robbins:

Regulation 171-20 has not had a workshop or public hearing yet. My understanding is the Board plans to have those this spring. As for R180-20, the Board has had a workshop and public hearing but has not yet formally adopted the regulation; they plan to do that later this spring. Neither of these regulations are at the stage yet where they would be presented to be the Legislative Commission.

Assemblywoman Titus:

Madam Chair, may I ask a question of the representative from the BME?

Chair Peters:

Yes. Please go ahead.

Assemblywoman Titus:

I have been a member of the BME, and I do appreciate all the work that goes into making sure the citizens of the State of Nevada are protected and that we have good medical doctors and physician's assistants. I am concerned about Section 8, subsection 2 of R171-20, where you are removing the requirement that the person who is going to practice medicine in the State of Nevada be a citizen or here in good status. Does it not matter to the state anymore that they are a legal immigrant or here legally? Can you clarify that? Are you going to look somewhere else? Can you explain why you are removing that?

Sarah Bradley, Deputy Executive Director, Board of Medical Examiners:

The reason for the change in Section 8, that you are pointing out, is to be consistent with changes in NRS that were enacted, I want to say, in the 2019 Legislative Session. Because the requirement of citizenship or lawful status was removed from the other license types that are in our NRS, we are doing this to be consistent with those changes in NRS.

Chair Peters:

Thank you, Ms. Bradley. I think Mr. Robbins can speak to that as well.

Mr. Robbins:

To clarify the changes that Ms. Bradley was talking about, NRS 622.238, which was added during the 2019 Legislative Session, provides that "notwithstanding any other provision of Title 54, a regulatory body shall not deny the application of a person for the issuance of a license pursuant to this title based solely on his or her immigration or citizenship status."

Assemblywoman Titus:

Thank you for that. For clarity, I recognize it is taking us sometimes eight years to bring a nurse in—from say the Philippines, where we have gotten a lot of nurses for our hospital—but we still had to have them come in on a legal status. Is that one of the things eliminated? Is to expedite the licensure process? I want to make sure we have good oversight.

Ms. Bradley:

Madam Chair and members of the Committee, the intent here is to make this regulation consistent with the NRS provisions the Legislature has passed and enacted. It is not my intent to make any position on this. We are going to make sure that people have the appropriate education and things like that. Whether they can lawfully work or not, is not a question for the Board—in my view—especially given the direction the Legislature gave us in 2019.

Assemblywoman Titus:

Thank you, Madam Chair, for the questions.

Chair Peters:

Thank you so much. I appreciate the Board is taking those steps to be consistent with what we have decided in the Legislature is important to licensing in Nevada. Senator Hardy, I see your hand up. Do you have a question on one of these regulations?

Senator Hardy:

Thank you, Madam Chair. I have a question on the same regulation [R171-20]. I am aware, for instance, of a person who was a medical doctor (MD) in the Philippines, came to the United States, and is now working as a medical assistant. Are we proposing to allow other nation's physicians, who come here legally, to be licensed as physicians without having to jump through any other hoops as physicians?

Chair Peters:

I believe this only pertains to consideration of citizenship, not to education or those other background pieces that are important to ensuring our licensed physicians are well educated in the areas of importance in Nevada and the United States.

Senator Hardy:

That sounds wonderful, Madam Chair. Are physicians from another country going to be allowed to be physicians in the State of Nevada without having to go to school and repeat their medical education that they got somewhere else?

Mr. Robbins:

Senator Hardy, *[Inaudible]* licensing doctors does not affect any of the other educational qualifications. They would still have to have the educational qualifications prescribed by statute. It just says—what the statute already says—that the Board cannot deny a license based on citizenship status. They still could deny a license based on educational qualifications and, in fact, they would have to deny the license if they do not have the educational qualifications prescribed in statute.

Senator Hardy:

If a person from Canada comes to the United States, a bona fide physician, it is my understanding that we accept Canadian medical schools as qualified education. Do we accept any other countries, or do we preclude any other countries from accepting their medical doctorate degree? Do we have in statute that we only accept medical doctor

degrees from the United States or the residencies from the United States? Where are we with that? Does this appreciably change anything that we do now that will preclude somebody from somewhere else from getting the right to be approved by the BME because they have an MD or a doctor of osteopathic medicine (DO) somewhere? Will they not be allowed to practice here?

Ms. Bradley:

We are already licensing foreign-trained doctors every day. Again, the regulation just speaks to the status to work. The thought is that you can get a license and perhaps then be able to find a job and be able to get your lawful status. We have doctors right now who have obtained degrees from universities in India, Mexico, and all over the country. There is a process in the statutes—and I could get the exact statute for the chair and the members of the Committee—that talks about the foreign approval process. There are certain universities that offer MD degrees that are already vetted and approved; a foreign equivalency review is done. Again, this regulation does not affect that, it is already in place in NRS. I know because I look it up on occasion, and I see files every day. We have many doctors trained in other countries who are practicing in Nevada at the moment.

Senator Hardy:

Is there a list of countries that we accept and a list of countries that we do not accept their medical degrees?

Ms. Bradley:

I am not aware of a list of countries; I am aware of a list of schools. The review is done by an outside entity specified in NRS. We use an acronym that stands for foreign equivalency review. There are many universities that are already preapproved, and others can submit to that review; if the entity deems them equivalent to the approved programs, they would be eligible for licensure in Nevada. I have worked in licensing for 15 years in my career. I have only been at the Board for two years, but this is very common for all professions. I have seen this with every profession for every licensing board I have ever worked with; there is an option for foreign education review, and there are people licensed as long as it is deemed equivalent.

Senator Hardy:

So, there is a list of schools that have been preapproved, and if you go to one of those schools and get a medical doctorate of some kind, you can come here and be approved? Are there any other hoops that they must jump through?

Ms. Bradley:

They must have an approved residency and meet all the requirements that we require of all applicants. Education is just one piece; there is also the residency, an exam requirement, and other things. The entity is a third-party entity; it is not a Nevada entity that rates these schools. I am sure on their website they would have a list; I do not have a list right now. I can provide the chair and the members of the Committee with the statute that talks about this process if you would like, Madam Chair.

Chair Peters:

Thank you, Ms. Bradley. I would appreciate that. Since this is not directly related to the piece of regulation that we are looking at under this item, I am going to ask that any additional questions, Senator Hardy, are directed to Ms. Bradley or to staff offline and that follow-up can occur there. This seems like a really important issue that you are impassioned about. I know from personal experience, having gone from an engineering school in Nevada to an engineering school in Australia, that they are not always considered equivalent. It is important to know where you stand with education requirements.

Senator Hardy:

Madam Chair, if I may, not to belabor, but if we are doing this with other countries, then we need to open the doors to Nevada and recruit from other places as well as recognize that they have opportunities to come here. I would love to have the list of medical schools and would love to have the public know this. That is one of the challenges I have with this particular regulation—I think we put the cart before the horse. We are going to, in essence, approve something that the public has not seen yet, which is not the tradition that we have had in the Legislature.

Chair Peters:

I just want step in about what our role is here. Our role is to provide input into the process; it is not to make decisions. We are not approving, and we are not suggesting the approval by the Legislative Commission either. We are just reviewing these as they pertain to the legislation that has passed in previous sessions. There is a public input process, and as an elected official, you are more than welcome to reach out to these boards and entities for proposing these regulations to provide your input at that process. You are right, the public does get an additional input process where they will have *[Inaudible]* these regulations from our website today and are able to then follow up through that public input process as those meetings are set up through the spring and summer. Additionally, I agree that we should be looking at how to encourage folks to come to Nevada because our health care industry could use that boost in the number of providers. I would encourage you to take that up with the Governor's Office of Economic Development (GOED) or one of the economic development groups that reaches out to other countries and works with them on bringing people into Nevada and encouraging those industries.

I am going to move on from this topic if there are no additional questions on the other side of the regulation. Thank you so much, Mr. Robbins.

[Subsequent to the meeting, Ms. Bradley provided the statutory provisions that allow the Board to license individuals who have obtained education in other countries. Those provisions included NRS 630.170, 630.195, and 630.265.]

AGENDA ITEM IV—REMARKS FROM THE ATTORNEY GENERAL

Chair Peters:

We are going to move on to Agenda Item IV. We have the honor today of hearing from the Honorable Aaron Ford, our attorney general. He will be providing a brief introduction on some of the work their office has been doing on the opioid epidemic.

Aaron D. Ford, Attorney General, Office of the Attorney General:

Good morning, Chair Peters, and members of the Committee. I would like to begin by thanking you all for the opportunity to provide some opening remarks for today's Interim Standing Committee on Health and Human Services.

In Nevada, we have seen significant legislation passed in a remarkable, coordinated effort undertaken to address the opioid and drug epidemic in our state. Before the pandemic, these efforts had begun to bear fruit. We have seen decreases in the number of opioids prescribed, and more importantly, both nonfatal and fatal overdoses.

Unfortunately, with the *[Inaudible]* began to see unprecedented increases in nonfatal and fatal overdoses, most of which were related to the illicit use of opioids. According to the Department of Health and Human Services (DHHS), Office of Analytics, Nevada saw a larger number of opioid overdose deaths in 2020, at 484, than the previous peak in 2011 at 460. Nevada was not the only state to see high overdose numbers. In fact, according to the Centers for Disease Control and Prevention (CDC), there were over 100,000 overdose deaths in the United States between April 2020 and April 2021. Many of these deaths, as I have alluded to, can be traced back to illicit use such as fentanyl, a disturbingly common drug with a potency more than 100 times that of heroin. Often people do not realize that the drugs that they have procured are laced with fentanyl, and deadly results occur when they take too much unknowingly.

Every death caused by the drug epidemic is a tragedy, and every overdose must be seen as a reason to continue our work. One death, one overdose is one too many. One area in which Nevada has made improvements is in our substance use surveillance activities. These activities, as we will discuss further, allow us to understand what is going on in our communities, how to better address this issue, and hopefully, how to prevent overdoses and death from substance misuse. Today you will hear about the surveillance systems currently in place in Nevada that inform us of fatal and nonfatal overdoses.

Steps to better aid us in our fight against the opioid epidemic were also taken in the 2021 Legislative Session with the passage of both AB 374 and Senate Bill 390. I am going to speak a little bit about the focus of what these bills created and their importance in fighting the opioid epidemic. Assembly Bill 374 created the statewide Substance Use Response Working Group (the SURG). I chair that group. Senate Bill 390 created the Advisory Committee for a Resilient Nevada (ACRN) and the Fund for a Resilient Nevada. The SURG and ACRN provide recommendations for the use of money from the Fund for a Resilient Nevada.

The majority of the money that goes into the Fund for a Resilient Nevada originates from opioid litigation settlement funds recovered by my office. As you know, my office secured a $45 million settlement from McKinsey & Company in 2021. The money from that settlement was transferred to the Fund for a Resilient Nevada. Earlier this year, I announced that my office has also secured over $280 million in additional settlements with manufacturer and distributor defendants. Millions will be transferred to the Fund from those recoveries this year as well. I cannot praise those enough who have worked on opioid litigation and negotiated these settlements to assist in battling the substance use crisis currently afflicting Nevadans. I also cannot praise enough the efforts of the employees of DHHS who have also worked so hard, and continue to work so hard, in their efforts to fight this epidemic.

The task of creating a needs assessment and state plan to use this money, in a coordinated and strategic effort to fight this crisis, is how Nevada is going to win this fight and save

lives. The staff of DHHS has also worked so hard to support my office's litigation and has provided terabytes of data through discovery, and I wanted to be sure to recognize and thank them for their great work.

Again, thank you all for allowing me to provide these opening remarks. I would like to extend my personal gratitude for your efforts to help all Nevadans affected by this drug crisis. With that Chair Peters, I turn the mic back, and thank you so much for the opportunity to be here this morning.

Chair Peters:

Thank you so much, Attorney General Ford. We appreciate you taking time out of your day to come and speak with us about this important issue. We look forward to hearing more about how things are going in those programs, where Nevada stands today, and how we can help.

Attorney General Ford:

Thank you so much.

AGENDA ITEM V—SUBSTANCE USE OVERDOSE SURVEILLANCE DATA: TRENDS, GAPS, AND POLICY CONSIDERATIONS TO IMPROVE DATA SURVEILLANCE IN NEVADA

Chair Peters:

We are going to move on to Agenda Item V, our substance overdose surveillance data presentation. We are going to be looking at trends, gaps, and policy considerations to improve data surveillance. We have quite a few folks here to present, but I believe that Kyra Morgan, our state biostatistician, will be kicking us off. It looks like you have your presentation on the screen, so please proceed when you are ready.

Kyra Morgan, State Biostatistician, Office of Analytics, DHHS:

Thank you and good morning, everyone. I am going to kick off this presentation with a data update to highlight substance use in Nevada and talk about where we have been and where we are currently (Agenda Item V). First, I wanted to set the stage with some national and regional comparisons. According to the Substance Abuse and Mental Health Services Administration, the prevalence of last year's substance use disorder in Nevada was 9.5 percent, and the prevalence of last year's alcohol use disorder in Nevada was 6.2 percent.

I want to touch on the data sources that we are using. We have three resources available at the top of this screen and most of the data in my presentation were pulled directly from those resources. They are publicly available and updated regularly. The first is the *Bureau of Behavioral Health Wellness and Prevention 2020 Epidemiologic Profile*, which comes out every two years. We also have an Opioid Surveillance Dashboard and a Methamphetamine and Stimulant Surveillance Dashboard that are updated regularly. There are also some data sources listed here, which I am not going to get into in the interest of time.

I want to go through these definitions because they are going to be important as I go through the data on the following slides. I am going to talk about alcohol- and drug-related emergency department encounters. Those are visits where alcohol and drug use or abuse is

listed as part of the diagnosis, but it is not necessarily an acute life-threatening overdose type of a situation. Same thing with alcohol- and drug-related inpatient admissions. Those are impatient stays where alcohol or drug use or abuse is listed as part of the diagnosis, but not necessarily in a life-threatening way. Then we are going to get into a little bit of information on poisonings, where the primary reason for the visit is an overdose, and the patient record has specific billing codes for overdose or poisoning. I will touch on drug-and alcohol-related deaths. These are defined as a death where a contributing factor to the cause of death included drugs or alcohol.

This information is from our behavioral risk factor surveillance survey. It asks, during the past 30 days, how many days did you use marijuana, hashish, other illegal drugs or prescription drugs without a doctor's order just to "feel good" or "get high." Obviously, you can see significant increases in marijuana use spanning the entire time period, with a significant jump in 2017, when marijuana became legal recreationally. In 2020, about one in five Nevadans surveyed indicated they had used marijuana in the past 30 days. We also see a significant increase, although the magnitude is much lower, related to illegal drugs; that is the orange line. You see, respectively, a significant increase between 2019 and 2020 even though the magnitude is significantly lower.

This slide looks at emergency department encounters. I will try to just give a brief interpretation of each of these graphs as I realize there is a lot to interpret in one presentation. This looks at alcohol and drug trends in an emergency department setting again, nonoverdose encounters. You will notice between 2012 and 2014, we saw alcohol presenting more commonly than drug use and abuse. Since 2014, that has switched, and we have seen more drug use and abuse in our emergency department than alcohol. To put a general magnitude of disease burden on this, in any given quarter of 2021, we saw approximately 8,600 alcohol and 9,300 drug-related visits to Nevada emergency rooms. Also worth noting, the stark increases in drug-related visits between 2012 and 2016, then a bit of decline, and in general, just stability since then. Whereas alcohol visits have started to increase again over the past several years.

This is drilling down into that drug category. It is the same exact metric, but we are looking at the specific type of drugs that were present in those individuals. One thing I want to make sure everyone is clear on, these groups are not mutually exclusive. In other words, an individual might present to the emergency department that they use or abuse multiple types of drugs, so an individual could be counted multiple times across this graphic. I want to draw your attention to the trend related to methamphetamines, which is the dark orange line that you see increasing most significantly. The grey dotted line is marijuana; we saw significant increases, and it has been declining since 2017. Then opioids, the blue line, increased until about 2017 and have decreased since then.

This is the inpatient setting, but same data. These are people who were admitted overnight, at least to the hospital. It is really the same story; alcohol and drug use were on par until 2014 and then drug use started to grow more significantly than alcohol use. I also want to express using caution when interpreting 2020 and 2021. The reason is, we know the Coronavirus Disease of 2019 (COVID-19) pandemic has changed utilization patterns in our hospital setting. A lot of practices have been put in place to reserve room for patients that really need it, and we have seen this across the board; utilization was down in 2020 and 2021. I am not comfortable assuming that the declines we see here are related to a reduced burden in the community. It is more likely that it is based on utilization patterns and is probably an effect of the COVID-19 pandemic. When looking at increased impatient admissions, there were approximately 5,300 alcohol- and 8,400 drug-related admissions to Nevada hospitals in any given quarter of 2021.

Again, this just drills down into that drug category to try to explain which drugs are being most frequently used by these individuals in the hospital. Marijuana is most frequent and has significantly grown overtime. The second line is probably the most concerning; that is methamphetamine with a significant growth over the span of the graph. Then you will see the blue line, opioids, was growing and then it leveled off and started to decline. Cocaine has been relatively stable, which is the green line near the bottom of the graph.

I threw in one slide here on poisonings. I know that my colleagues presenting later are going to go into more detail related to regional poisonings in both Clark County and Washoe County. I also realize these graphs are messy and hard to look at, but I think they are important to include because it is a stark contrast to what we saw when we were looking at a situation that was not an actual overdose but was just a presentation of drug use and abuse. When we looked specifically at these acute life-threatening drug-related poisonings, opioids are still accounting for the vast majority of those, which is the blue line. On the left-hand side, you are looking at the emergency department. You can see a significant increase in 2020 and 2021 related to opioids, excluding heroin, and even more significant growth in the orange line, which is your heroin-related emergency department overdoses. Also, a significant growth in marijuana and methamphetamine has been more consistent as it relates to these poisonings. The right-hand graph is messy, and I apologize for that. If you ignore, for lack of a better word, 2020 and 2021 knowing that those years are anomalous, and you look specifically at the time from 2016 to 2019, you see an extreme growth in methamphetamine-related inpatient admissions for poisonings, and then significant improvement related to opioids and heroin. I think that is indicative of a lot of the policy changes that you are going to hear throughout the presentations today.

This slide looks at alcohol and drug related deaths. Specifically, the top half of this slide focuses on alcohol-related deaths. You will see a significant increase from 2019 to 2020. I want you to know that the 2021 data is still preliminary. We will probably see those numbers come in a little higher when we have those reports in our system. The drug-related deaths graph, the second graph on your screen, shows consistent increase in drug-related deaths from about 2015 to 2021. I want to highlight about 1,400 drug-related deaths in 2020 and just over 1,500 drug deaths in 2021. It is consistent year over year, with growth averaging 14 percent over the last two years.

This is my last slide; it looks at unintentional or undetermined overdose deaths by the specific substances that were present. I want to draw your attention to methamphetamines, which were involved in the highest number of unintentional overdose deaths in both 2019 and 2020 and observed a significant increase year over year of 44 percent. I also want to draw your attention to benzodiazepine, which is in the middle of your screen. The overdose deaths related to benzodiazepine increased by 91 percent year over year. Fentanyl and fentanyl metabolites, which is a little bit lower on your screen, increased by 223 percent from 2019 to 2020. Then, lastly, prescription opioids, excluding methadone, increased by 67 percent from 2019 to 2020.

That concludes my high-level presentation, and I would defer to the Committee and the chair if you would like to take questions now or power through the rest of the presenters.

Chair Peters:

For the sake of time, we should let the presenters get through their presentations and then we can take questions. Mr. Delise, please go ahead.

Brandon Delise, Epidemiologist, Office of Epidemiology and Disease Surveillance, Southern Nevada Health District (SNHD):

Thank you and good morning. I have been an epidemiologist here since 2018, and I lead efforts to monitor development improved surveillance within the fields of drug overdose and emergency medical services (EMS). Thank you all for attending this presentation (Agenda Item V). Monitoring drug overdose indicators is important to inform community prevention and response activities. In the next five minutes, I will provide a high-level overview of overdose death data and nonfatal overdose data in Clark County.

Using the health districts' electronic death registry system, we can look at the overdose death rate for all intents among Clark County residents by drug class from 2015 to 2021. The figure to the right lists the different types of opioids and benzodiazepines. If we look at all opioid deaths, represented in green, what we see is a general decrease from 2015 to 2019, and then from 2019 to 2020, we see a sharp increase in opioid deaths. I also want to bring to your attention to what is happening with the light purple line, which represents synthetic opioid deaths; that category does include fentanyl. Since 2015, we have witnessed an increase all the way through 2021, with the largest increase occurring from 2019 to 2020. The preliminary rates of fatal overdose involving synthetic opioids, again which does include fentanyl, in 2021 was higher than ever before. Fatal overdoses involving fentanyl impacts younger individuals. The median age at death in 2021 was 32 years for fentanyl overdose and 49 years for nonfentanyl overdose. Additionally, the rate of fatal overdose involving all opioids and heroin reached its highest in 2020.

Just like the previous slide, we can look at overdose death rates for all intents among Clark County residents by drug class from 2015 to 2021. But instead of all opioids and benzodiazepines, this figure lists psychostimulants, which includes methamphetamine, represented in grey, and cocaine, represented in yellow. The rate of fatal overdose involving psychostimulants reached its highest in 2021. From 2015 to 2021, fatal overdoses involving psychostimulants increased by 144 percent. Additionally, the median age at death in 2021 was 46 years for a fatal overdose involving psychostimulants, which contrasts to what we talked about in the last slide.

Moving on to the next data source, we will now look at nonfatal opioid overdoses in Clark County in 2021 via EMS data linked with hospital discharge data. The median age for a nonfatal opioid overdose in 2021 for men was 42 years and for women it was 49 years. Looking at the figure to the right, the highest frequencies of nonfatal opioid overdoses in 2021 occurred in April and in May. The top zip codes in Clark County with the highest frequency of nonfatal opioid overdose events in 2021 include 89101, 89119, 89109, 89121, and 89102. All the zip codes I have just mentioned are in the central Las Vegas valley, including the downtown and the strip areas.

Just like the last slide, we are still looking at nonfatal opioid overdoses in Clark County in 2021; however, we are now looking at all the data in the form of a heat map. This is a heat map of nonfatal opioid overdoses throughout the entirety of 2021. As we can see, the red areas of the heat map include the downtown and the strip areas, which is where we see the most frequencies occurring.

Moving on to the last data source that I will be discussing, our emergency department discharge data. Emergency department data, along with the previous data sources discussed, can provide critical information to this rapidly shifting crisis. The figure to the left displays the number of emergency department visits due to poisoning by any opioid in Clark County from 2016 to 2020. From 2019 to 2020, emergency department visits due to

poisoning by any opioid increased markedly. The median age for the emergency department business due to opioid poisoning in 2020 was 38 years for men and then 41 years for women.

The implications of the data I have provided over the past five minutes support evidence-based prevention and response efforts focused on polysubstance use, and these efforts must be adapted to address the changing drug overdose epidemic. That is all the information that I wanted to share. I do appreciate everyone's attention. Thank you.

Chair Peters:

Thank you so much, Mr. Delise. I appreciate that context. I was wondering during the overview that Ms. Morgan shared, how much of an impact was split between our urban areas and our rural areas, so that was helpful. Next, we have Shawn Thomas. Please proceed when you are ready.

Shawn Thomas, M.P.H., Opioid Epidemiologist and Public Health Diversity Surveillance Coordinator, Overdose Data to Action, Trudy Larson MD Institute for Health Impact and Equity, School of Public Health, University of Nevada, Reno (UNR):

Good morning, Chair Peters, and members of the Committee. Today, I will talk briefly about recent drug overdose trends in Washoe County (Agenda Item V).

Drug overdose deaths have been on the rise in Washoe County throughout the past decade and have only continued to increase, following suit with what Kyra showed earlier with drug-related deaths statewide. The figure here shows the rates of drug-related and opioid-related overdose deaths among residents in Washoe County by year for the past three years. Please note that 2021 is still preliminary and is subject to change; however, it does appear that opioid-related overdose deaths may match or even exceed those from 2020.

This slide, and all those that proceed it, use data from the EMS platform ImageTrend which collects data from EMS, fire, trauma, and emergency preparedness. We use the system to identify suspected nonfatal opioid overdose, which is pictured by month in 2021. As you can see from Figure 2, it has fluctuated throughout the year, reaching a high during the summer months. One thing to note is, due to updates to records over time, the most recent months may not be entirely complete. Additionally, I want to mention that in approximately 15 percent of incidents, the patient is treated or released against medical advice, which is an issue because the EMS personnel believed the person required further treatment, but the patient was unwilling to continue.

Figure 3 shows the incidents by zip code in both a table and a zoomed in graphic of Washoe County. The top five zip codes with the highest number of suspected nonfatal opioid overdose-related incidents were 89502, 89512, 89431, 89501, and 89509. They are mostly concentrated in downtown Reno and branch out to northeast Reno, Hidden Valley, Southwest Reno, and Sparks.

Figure 4 shows incidents by age group. The 25 to 34 age group had the highest percentage of incidents as well as the highest rate of incidents, while the 35 to 44 age group had the second highest percentage. I want to mention that two-thirds of incidents were among males.

Figure 5 shows the percentage of incidents by race/ethnicity. While the chart shows that 44 percent of incidents were among white non-Hispanic, the race/ethnicity with the highest rate were those identified as being black non-Hispanic. Another thing to note is that one-third of incidents did not record race or ethnicity, so race/ethnicity data may be underestimated.

I just want to wrap up with a key couple of takeaways. Drug-related and opioid-related overdose deaths have continued to increase in Washoe County, with opioid-related overdose deaths rates expected to exceed 2020 rates. There were 375 suspected nonfatal opioid overdose incidents in Washoe County in 2021. Rates of suspected opioid overdoses were highest among black non-Hispanic people between the ages of 25 to 34. Although drug overdoses are most common among people identifying as white, people of color have been seeing the highest rates of suspected overdose and are disproportionately impacted. Again, I want to mention the zip codes with the highest number of nonfatal opioid overdoses are concentrated more near the downtown region. That is all I have, thank you.

Chair Peters:

Thank you, Mr. Thomas. I believe we have Dr. Kerns up next; go ahead and proceed when you are ready.

Terry L. Kerns, Ph.D., Substance Abuse/Law Enforcement Coordinator, Office of the Attorney General:

Good morning, Chair, and Committee members. The Overdose Mapping Application Program (ODMAP) is a program that was originally developed by the Washington D.C./Baltimore High Intensity Drug Trafficking Area and is offered free to agencies who are interested in using this program (Agenda Item V). The ODMAP program provides near real time suspected overdose surveillance data to support public safety and public health efforts in mobilizing an immediate response to a sudden increase or spike in overdose events. Near real time is defined as within 24 to 72 hours from the suspected events. Suspected overdoses mean the information is not fully vetted as you would find with information, such as toxicology results or autopsy results, from the medical examiner or corner's offices. In trying to get that 24- to 72-hour data, you do lose some of the fidelity, but it is a starting point or provides a red flag that there may be something that needs to be addressed further within your community. In our state, the majority of suspected overdose data is from the EMS electronic medical records. The ODMAP data includes three data points. Those three data points are: the location; was the event a fatal or nonfatal overdose; and was naloxone—which is a drug that is used to counteract the effects of an opioid overdose—given and, if so, was a single dose or multiple doses given. In some other states across the United States, such as in New Jersey, they have legislation in which law enforcement enters the information on overdoses. In that, ODMAP has a feature where case data can be entered, but because a majority of the overdose information in our state is from EMS data, we currently are not using that. An example would be if law enforcement was on scene and knew that it was a pressed pill or knew that it was heroin, they could enter that information, which we are not always getting currently.

I am going to show you some of the screenshots directly from ODMAP. This shows you information on suspected overdoses in our state from January 1, 2022, to February 8, 2022. As you can see, the number of suspected overdoses pops up. There were 631; the number of suspected fatal overdoses is 19, and the number of times naloxone was provided is 234. The dots on the screen are color coded, and they show the general location where the

suspected overdoses occurred. They are color coded for fatal or nonfatal and whether naloxone was given as a single dose, multiple doses, or no naloxone.

The ability to provide, graphically, the data on overdoses. We can look at overdoses by type and the color coding I talked about regarding nonfatal, no naloxone, and so on. We can look at the day of week, the hour of day, suspected overdoses that occurred per day, and suspected overdoses that occurred per month. We can look at county and state line charts to see if we are having, for example, a rash of overdoses that have occurred just across two counties where you may not have realized that otherwise. That is how we can look at the data from some of these graphs. This shows an example if we pull up the day of week that the overdoses occurred.

As I mentioned, ODMAP is a starting point. There is additional work that would need to be done to determine if a spike in overdoses did actually occur, which brings me to the next point. Through the state opioid response (SOR) grants, each county developed a community overdose spike response plan. The plan will look different for each county, but it is typically a collaboration of public health, law enforcement, fire, EMS, community coalitions, and others as determined by each of the counties. A couple of our counties have taken it to the point of exercising their community overdose spike response plans.

As mentioned before, the more real time and the limited data that is collected in ODMAP, we do not have as accurate of information, but it is meant to signal that there could be something happening, and a county should look at their community response plan to determine who should be doing what. For example, if there is a spike in a county, law enforcement will want to try to get those drugs causing the overdose off the streets, or public health and the community coalitions may want to start targeted outreach and harm reduction efforts such as naloxone distribution. This is just a brief overview of ODMAP, and I will now turn the presentation over to Elise Monroy.

Chair Peters:

Thank you so much, Dr. Kerns. Please go ahead, Ms. Monroy.

Elyse Monroy, Program Manager, Overdose Data to Action, Trudy Larson MD Institute for Health Impact and Equity, School of Public Health, UNR:

Thank you, Chair. I am here to provide a wrap-up of data presentations and to discuss some of the existing surveillance gaps (Agenda Item V).

From these presentations, we can see that emergency department encounters from drug poisonings continue to rise. In 2021, deaths by methamphetamine, fentanyl, benzodiazepines, and prescription opioids surged. We also see that people of color and youth are being disproportionately impacted by use and overdose, and polysubstance use and exposure continue to complicate prevention and intervention efforts in the state. On a positive note, we can see, from Terry's slides and the attorney general's comments, in recent years Nevada has developed the ability to collect near real time information on suspected overdose instances, as well as developed communication and response mechanisms to notify communities of red flags or to notify them that they may be at potential risk for overdose spike or cluster events. While public health in Nevada can get information about suspected events quickly, we do not have a system that allows for timely confirmation of substances that are causing harm in communities.

At present, Nevada can report on suspected nonfatal overdose and drug use encounters to the emergency department and to EMS, and this is what is used to inform the states overdose morbidity. Then, we wait for the postmortem toxicology to confirm the substances that are causing harm and increasing the state's mortality rates. Nevada needs a surveillance system that is both timely and confirmatory to best inform public health prevention and intervention initiatives. In order to get to a system that is both timely and confirmatory, there are a couple of gaps in public health's ability to do biosurveillance of the substances that are causing harm.

Currently, Nevada depends on a limited set of data to inform the state's level of risk. This presents challenges for implementing appropriate and timely prevention and intervention programs. At this time, Nevada gets confirmatory toxicology data about what is in the drug supply from the postmortem exam. This is reported in alignment with CDC guidelines with a 6-to-9-month lab. By the time public health has reported on their data or law enforcement has reported on their data, the drug supply and overdose landscape will have inevitably changed. Waiting for mortality data to tell us what is actively killing people is not a good public health strategy.

How do we get to a system that is both quick and confirmatory? First, we need to start by increasing the quantity and the quality of biosurveillance that is done on the drug supply. To do this, we can go upstream from the postmortem toxicology, and this can be done through antemortem testing or drug seizure testing or toxicology. Antemortem testing is testing that is done before death; an example of this would be DUI panels or blood or urine screens done in a hospital.

The Minnesota Overdose to Action (OD2A) program has a pilot where they are actually using excess urine drug screens pulled from patients that come in on a suspected overdose. That surveillance sample specimen is then sent to the state public health lab for identification of fentanyl. A drug lab in a neighboring state has reported to the Nevada OD2A program that they are using their DUI data to inform their prevention efforts. The lab reported that they have been stunned by the number of people who are driving under the influence of fentanyl.

Another example of an upstream touch point to assess what is in drug supply would be testing on syringes returned to syringe service points. The Washington D.C. crime lab is actually doing this type of testing and reporting the information to inform public health. In all of these instances, the data that is collected as a result of these tests is being shared with stakeholders and public health to inform community risk.

Another example of upstream testing would be wastewater monitoring. Innovative work has been done in Nevada on wastewater testing for COVID-19, but other states have been using wastewater testing to monitor and inform what is in the drug supply.

Finally, data and information gleaned from seized drug testing is another way that public health programs in other states are informing their work.

The OD2A program is currently working on a needs assessment to understand the state's capacity for testing and biosurveillance of the drug supply to inform risk. In our preliminary findings, we have identified a few critical issues that may be impacting Nevada's ability to drive to a quick and confirmatory surveillance system.

First, Nevada is one of only two states with no statewide crime lab. Nevada has three labs that serve each region, but each of these labs works independently so testing panels and

analysis is not always standardized. This means the lab may be using and reporting out on different testing protocols. In 2020, the Nevada Office of Traffic Safety, Department of Public Safety, actually published a gap analysis on the state's current forensic toxicology labs. The report noted inconsistent testing panels and thresholds across the three labs in the state was a significant gap. Specifically, the report notes the three labs use different testing panels and test for different numbers of drugs ranging from one lab testing for 30 drugs, while we have another lap that is testing for 60 drugs. The report also noted that there is a difference in the cutoff values used to distinguish positive and negative results, and this cutoff inconsistency also impacts interpretation of results. While standardizing analysis with these forensic labs will help to ensure fair treatment of all drivers and ensure the state knows which drugs are causing impairment for forensic purposes, it can also help to better inform public health prevention and intervention efforts.

Next, Nevada's existing crime labs are forensic in nature. Through our needs assessment research and work with labs, we understand that the role forensic labs play in the current system is to use science for the purpose of criminal proceedings, not for public health surveillance and not to inform community risk. Currently, there are a limited number of data sharing agreements in place between crime labs, law enforcement, and public health or prevention partners. We know that some of our local prevention and overdose spike response stakeholders enjoy informal information sharing relationships with their local law enforcement, but these agreements are largely relationship and personnel driven and this is inconsistent with building a sustainable system.

Finally, through our work on the needs assessment, we have heard that many of the drugs seized in Nevada are actually not even tested. Seized drugs are tested if and when a case goes to trial. We have heard that this could be a result of not enough lab capacity and/or funding. If seized drugs are tested in Nevada, that data is sent to the national forensic lab information system or NFLIS. The NFLIS data is reported quarterly. While our program has not had a chance to take a deep dive into how local crime labs are funded, we did find that forensic testing is at least in part supported through county general fund. *Nevada Revised Statutes* 453.575 requires court fees to be levied to pay for controlled substance analysis. If a county can only recoup the cost of analysis when court fees are levied, that may result in limited testing resources.

Some recommendations to address these critical issues include developing a statewide crime lab that allows for standardized forensic testing, as well as a statewide lab that has the capacity to do a surveillance sample testing to inform public health risk. Next, the state should look to developing standardized data sharing agreements and mechanisms statewide. Finally, examine the funding formulas or mechanisms that may be impacting testing capacity in Nevada.

It is not inevitable that deaths by opioid, fentanyl, and stimulants have continued to rise. Implementation of harm reduction strategies and public health interventions can be done to curb deaths. However, these strategies should be informed by timely confirmatory data, and if public health in Nevada has to continue to rely on a surveillance system depending on death data to tell us what is killing people, the state may struggle to get ahead of these deaths. That concludes this panel's presentation. Are there any questions?

Chair Peters:

Thank you so much, Ms. Monroy. I believe we have a couple of questions from the Committee. Senator Hardy and Assemblyman Orentlicher both have questions, and I have some follow-up as well. I want to let the Committee know, I have about ten minutes

scheduled for questions. Obviously, this is an important issue, so we may go over that a little bit. I would encourage you, if you are interested in this topic, to take down the names of these presenters today, reach out to staff for their contact information if you do not have it, and get in contact with them over the interim to talk about these issues and what we can do. We also have an opportunity to look at some of these recommendations as potential bill draft requests (BDRs) that come from this Committee, but we will do that at a later date. I am going to and start with Senator Hardy. Please go ahead with your question.

Senator Hardy:

Thank you, Madam Chair. I was interested in what Ms. Morgan was talking about. When we read the newspaper, we keep reading about the school age kids who are not in school and how we are seeing an increase in mental health issues and drug use. I did not see the differentiation of that group and was wondering what we are doing with that particular group. Are we not seeing that kind of drug and alcohol use in our school age kids, or is it just something that is not as pronounced? Thank you, Madam Chair.

Ms. Morgan:

I might also refer to Dr. Woodard, who is also on the call. I did not prepare data, unfortunately, at an age level, because I had a 10-minute time crunch. I could not fit everything in there that I wanted, but I can surely follow up with that age break out. I believe we have seen increases most specifically in teenage years and early adulthood. The last time I looked it was up, I think, through age 30, where we saw the most significant increases. I can follow up with the Committee with specific numbers. Dr. Woodward, or maybe Ms. Monroy, if you can address what we are doing for targeted intervention.

Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, Division of Public and Behavioral Health (DPBH), DHHS:

We have actually seen a pretty significant increase in indicators that suggest the amount of youth behavioral health has increased. This includes both substance use, as well as mental health conditions. As Ms. Morgan was mentioning, the core group is typically adolescents as well as young adults, and we can certainly provide some additional data for this group if that is needed.

Chair Peters:

That would be appreciated, Dr. Woodard; thank you so much. If you would not mind working with staff on getting us that information, we can pass that around to the Committee. Assemblyman Orentlicher, please go ahead with your question.

Assemblyman Orentlicher:

Thank you, Madam Chair, and thank you presenters. This day is very illuminating, and I appreciate you presenting to us. It was helpful when you gave us the absolute amount and then the relative amounts that some populations have higher proportionate drug use. Do you have an urban/rural comparison? Obviously, there are going to be many more cases in Clark and Washoe, but for the rurals, are they proportionately more, less, or the same? Do you have that information?

Ms. Morgan:

We have that information; I just do not have it in this presentation, but I will add that to my follow-up for the group. Just a reminder, we have most of that online so I will be able to pull that together quickly as a follow-up to this.

Chair Peters:

Thank you so much. Dr. Titus has a question as well; please go ahead.

Assemblywoman Titus:

Thank you, Madam Chair. I thank you for the presentation, and this is scary data. I have been on the HHS Committee now four terms and the Interim Committee four terms. For a while, we were making a difference and the numbers were going down; this data is pretty alarming that they are going back up again. I need some clarification; you can send it to all of us afterwards. You briefly mentioned Narcan and that on the ODMAP, you can chart whether Narcan was given and how many times. I would be interested in seeing a breakdown; I quickly did some math, and it looked like on the one chart there were probably 520 deaths prevented because Narcan was used. Both Dr. Hardy and I have supported having Narcan in schools, allowing our police force to use it, and allowing it in businesses. I just wonder if you have any breakdown of where Narcan is being used and the actual number of prescriptions. If you have any of that information, could you send that to us?

Ms. Monroy:

This is Elyse Monroy with the OD2A program. I believe the SOR grant collects that information, so I will coordinate with the SOR program on following up with the Committee.

Assemblywoman Titus:

I would really like to know if it is being given in a store or how often the police give it versus EMS, because EMS should be giving it. We really expanded access to that; we put it in bags and prescribed medication.

I also really appreciate you bringing up the state crime lab. I have met with many sheriffs, because I represent multiple counties, and they all say they would like to have the crime lab.

I am also concerned about other issues the sheriffs are seeing. In my last four sessions, we have restricted doctors from prescribing; we have reigned in folks from writing too many narcotics; really regulated our prescriptions; and the attorney general sued the bad pharmaceutical companies because they created these drugs that got everybody addicted. But what I am hearing is that we are still having more drugs, despite those efforts. The sheriffs I have met with said they are seeing almost a fourfold increase in illegal drugs in the rural counties. It is their belief that is because of open borders and more drugs are coming into our state from other countries. Is anybody addressing where the drugs are coming from?

Ms. Monroy:

I would think the High Intensity Drug Trafficking Areas (HIDTA) program may be addressing that later. From a public health perspective, we get limited data from law enforcement

related to drug seizures. Like I mentioned, local prevention and spike response agencies have really great informal information sharing relationships with their local law enforcement. I know that we worked closely with Douglas County on its spike response, and its law enforcement works real closely with their coalition, but it is very relationship driven. We do not have a lot of information about what the drug supply looks like in Nevada. To my point, in order for us to get ahead of what is in the drug supply and to inform prevention and intervention efforts, we have to know what is in the drug supply. Unfortunately, we currently have to wait until we have death data to tell us what people are dying from. An effort to increase awareness about what is in the drug supply and what substances are causing harm could help public health to do more informed strategy.

Assemblywoman Titus:

I really think communication across all departments is so important, so thank you for what you are doing, and thank you, Madam Chair, for the question.

Chair Peters:

Thank you, Dr. Titus and Ms. Monroy. I do not see any other questions from the Committee. I have a couple of questions, but I will take most of mine offline. The one that I would like to ask is to Ms. Morgan. You had some indicators collected for diagnoses of folks who come in with drugs in their system. I wanted to know whether we are collecting information on whether that diagnosis is for behavioral, mental, or physical problems when they are presented in the hospital and in that EMS data. Do you have any breakdown of that as percentages of the cases we are seeing in the diagnoses as they pertain to drug use?

Ms. Morgan:

That is a really interesting and great question. The slides I prepared for this meeting are very high-level, so those are truly anyone in an emergency department setting, who, during that encounter, it was indicated in their bill that they either had drug use or abuse. It was not limited in any way to behavioral health or mental health diagnosis, but we can pull that information by looking at other diagnosis codes on those billing claims. I can follow up with that information for the Committee.

Chair Peters:

That would be great; thank you so much. I think that would really help us understand what kind of limitations are in those emergency rooms and where we can focus some energy for that piece.

AGENDA ITEM VI—OVERVIEW OF OPIOID AND STIMULANT PRESCRIBING PATTERNS IN NEVADA

Chair Peters:

We are going to go back to our regularly scheduled agenda items. We are going to move on to Agenda Item VI, which is an overview of opioid and stimulant prescribing patterns in Nevada. I hope this information answers some of the questions that were asked during the previous presentation. I am going to pass it off to the presenters and we will wait until after the presentation to ask questions. Please proceed when you are ready.

Darla Zarley, PharmD, Grant and Project Analyst, Prescription Monitoring Program (PMP), State Board of Pharmacy:

Thank you, Chair Peters, and members of the Committee. First, I want to provide you with an overview of the Nevada PMP (Agenda Item VI). It was established in 1997 and coadministered by the State Board of Pharmacy and the Nevada Division of Investigation. The program is currently housed at the State Board of Pharmacy. It was originally designed to identify potential "doctor shoppers;" however, the role has expanded to help identify inappropriate prescribing and prescription forgeries. It is a computerized program to track all controlled substance prescriptions dispensed to patients in Nevada. Pharmacies and dispensing practitioners transmit their prescription data to us on a daily basis. The PMP is a very important tool to assist practitioners in making a clinical decision on whether or not to prescribe the controlled substance to a patient.

There are two major bills that have been passed to fight the opioid epidemic, AB 474 in the 2017 Session and AB 239 in the 2019 Session.

One goal of AB 474 was to prioritize patient safety and inform patients of the risk of taking an opioid. It was designed to create an open dialogue between the patient and the provider to ensure prescribing a controlled substance is medically necessary and appropriate. Another goal was to prevent addiction and misuse of controlled substances. This was accomplished by requiring a prescriber to check the patient's PMP prior to prescribing a prescription and every 90 days thereafter if they are going to continue that course of treatment. It also established guidelines for writing an initial controlled substance prescription. The initial prescription may not exceed a 14-day supply or daily 90 morphine milligram equivalents (MME) for an opioid naive patient. Informed consent was required from the patient between the patient and the provider. It required a patient medication agreement and a patient risk assessment if the treatment was going to last more than 30 days. It required risk of abuse assessment if the treatment was greater than 90 days.

Assembly Bill 239, which was passed in the 2019 Legislative Session, provided further clarification and guidance on AB 474. The patient risk assessment was limited to the relevant medical history of the patient's pain, not the entire patient history. The initial prescribing guidelines were allowed to exceed a 14-day supply or daily 90 MME, if the practitioner deemed that it was medically necessary. There were also some concerns from practitioners that hospice patients were not getting treatment in a timely fashion. There was an exemption made for hospice, palliative care, oncology, and sickle cell prescriptions. The practitioners were not required to check the PMP prior to prescribing; however, they were required to check the PMP as soon as possible and at least 90 days thereafter if they were going to continue the course of treatment. They were not required to perform a patient risk assessment, enter into a patient medication agreement, or adhere to the initial base supply or daily MME. It also defined in statute, course of treatment and acute pain.

What you see here is the number of patient queries run by doctors from 2014 to 2021. This shows there is an increase usage of the PMP, which is essential in assisting practitioners with prescribing appropriately and preventing misuse and abuse of controlled substances. Now I am going to turn turn it over to Kyra to go over prescribing patterns.

Ms. Morgan:

I am going to touch briefly on opioid prescribing patterns, and then Dr. Beth Slamowitz, our senior policy advisor on pharmacy, is going to chime in on prescribing policies within fee-for-service Medicaid (Agenda Item VI).

Here we are looking at a couple of maps showing prescribing patterns per capita. You can see national comparisons, as well as how that progress has been made overtime. In 2020, Nevada providers wrote 47.4 opioid prescriptions for every 100 people, compared to an average U.S. rate about 43.4 prescriptions. Although Nevada is still slightly higher than the national average, we have observed a decline from 73 opioid prescriptions for every 100 persons in 2017, which is a 35 percent decrease. These maps are actually very interesting and go back in time to 2008. You can watch them dynamically change as the opioid pandemic has progressed. That is all available at the link here, which is sourced as the U.S. Opioid Dispensing Rate Maps, Drug Overdose, CDC Injury Center.

I also wanted to take this time to let the Committee know that we maintain all the data I am about to go over, and it is also public facing on a dashboard that is updated monthly—the Nevada Prescription Drug Monitoring Program dashboard—in case anyone is interested in monitoring this after the meeting.

Here is a chart looking at the opioid prescription counts and rates, per 100, by month, from 2017 to 2021. Obviously, you see significant decline over that period in the magnitude of 44 percent. We also see significant decline in the number of individuals who are coprescribed opioids and benzodiazepines during the same month; it decreased even more significantly by 68 percent in Nevada.

Here I am looking at opioid prescription counts and rates by days supply or how many days were supplied in those prescriptions. I included some detailed data from 2017 and 2021 that you can reference. I wanted to make some high-level conclusions—that is, we have seen opioid prescribing rates decrease across all the supply volumes over this time frame. More specifically, for prescriptions with less than 30-days' supply, we observed a 52 percent decrease; we saw a 36 percent decrease in prescriptions with a 30-to-90-day supply; and then a 55 percent decrease in prescriptions with more than 90-days' supply.

We can also look at this using the MME. Potency can be compared across the spectrum of opioid drugs using a conversion factor to an MME. Essentially, by converting different opioids to the standard unit of measure, a prescriber is more able to assess the patient's potential risk for overdose related to dosing. Nevada observed decreasing trends across all MMEs from January 2017 to December 2021. The largest declines were observed in patients receiving the highest level of MME. Patients who received greater than 90 MMEs per month decreased by 53 percent; the number of patients who received 50 to 90 MMEs per month decreased by 49 percent; and patients who received less than 50 MMEs per month decreased by 28 percent.

I have one more slide for reference. It gives details at a county level for those who are interested, but I am not going to go over this in great detail. With that, I will send it over to Dr. Slamowitz to talk about Nevada Medicaid opioid prescribing policies.

Beth Slamowitz, PharmD, Senior Policy Advisor on Pharmacy, DHHS:

Chair Peters, and members of the Committee. I am going to do a high-level overview of current prescribing policies within fee-for-service Medicaid (Agenda Item VI).

The first bullet point there, for reference, Chapter 1200 of the Medicaid Services Manual (MSM), sets the guidelines and limitations regarding coverage for prescription drugs for Medicaid. The link is there in case anyone is interested in exploring further.

A few of the high-level policies that are currently effective for fee-for-service Medicaid include limitations on early refills for controlled substances. Currently, 90 percent of the controlled substance has to be used before a refill will be authorized. We also have policies on transdermal fentanyl and long-acting narcotics. Both of those locations within the MSM chapter are identified for further review. Lastly, we have a policy on opioids, opioid containing cough preparations, and opioids prescribed to under age 18.

I wanted to point out that when this policy was put in place, we were anticipating the passage of AB 474, but we put in requirements that were a little more restrictive than what AB 474 passed. The limitations on the Medicaid fee-for-service policy are for prescriptions at 60 MME or less per day, as well as for a 7-day initial prescription versus the 14 and 90 MME that exist within NRS for AB 474. Prior authorization is not required for under age 18, if the initial prescription is for three days or less. There is an exceptions policy to allow for the treatment of cancer-related pain, postsurgery that has greater than the three-month recovery time, palliative care, long-term care, HIV and AIDS, or in consultation with a pain specialist. The opioid containing cough prescription also has an age limitation of 18 years or older. We also implemented a codeine and tramadol for children policy, and a reference for that policy is indicated on slide 15.

Lastly, I wanted to mention that when the opioid policy was implemented in May 2017, prior to the passage of AB 474, there were roughly just over 19,000 opioid prescription claims per month that we saw. The average prescription claims per month in 2021 were just over 11,000, so we have seen a decrease on average of about 6 percent year over year. That concludes my one slide presentation. I am going to stop there and see if there are any questions from the Committee.

Chair Peters:

Thank you so much, I appreciate your presentations today. Senator Hardy has a question.

Senator Hardy:

Thank you, Madam Chair. As I look at the graphs, we have done a wonderful job decreasing the amount of prescription opioids and benzodiazepines; we are doing what we can. As I look at the graphs of opioid overdose deaths, it seems to be more heroin and fentanyl that are not prescriptions. Have we decreased overdose deaths at the same time we decreased the prescription opioid amounts given?

Ms. Morgan:

We decreased opioid overdose deaths up to a point, and then we saw those unfortunately start to climb again in 2020 and 2021.

Senator Hardy:

Have we had fewer deaths now than we did before?

Ms. Morgan:

Let me follow up with some detailed information on that so I can make sure I am comparing the same time frames.

Chair Peters:

We have a couple more presenters on this issue, so they may answer some of your questions. We are going to hold off on questions until we are done with the presentation.

Sarah A. Friedman, Ph.D., Assistant Professor, School of Public Health, UNR:

Thank you, Chair Peters. I will be sharing preliminary results from a funded research study on the effect of AB 474 on opioid prescriptions among Medicaid pain patients (Agenda Item VI). We studied noncancer primary care patients aged 18 to 64, who used Medicaid between 2016 and 2019 in Nevada or Colorado. The slides that follow focus on the Nevada data, but data from Colorado are included in the appendix of this presentation for your reference.

This next slide shows the outcomes that we studied as well as the subset of patients among which we studied; each outcome is in blue text. For example, we examined days' supply among patients with acute conditions. I will note that several of our outcomes are based on the current CDC opioid prescribing guidelines, rather than AB 474, because our research was interested in whether the law increased receipt of guideline concordant care. The outcomes not mandated by the law include the 50 MME threshold, the seven-day supply threshold—although as Dr. Slamowitz just mentioned, that was required by the Nevada Medicaid policy—immediate release preparations, urine drug testing, and use of alternative pain therapies, including physical therapy.

Our results were largely in accordance with the findings *[Inaudible]* for the outcomes we both looked at. We observed decreases in the proportion of patients with opioid prescriptions over both 50 and 98 MME, as well as decreases in days' supply over seven. We also observed desired decreases in coprescribed opioids and benzodiazepines and desired increases in urine drug testing and physical therapy. The slight but statistically significant decreases in immediate release preparations that we observed went against the CDC guidelines.

The next two slides help us see the magnitudes of the changes in two of our outcomes of interest. This slide shows the trend in initial prescriptions with an MME over 50. The average proportion of patient months with this outcome after the law decreased 10 percentage points, from 19 percent to 9 percent. We saw substantial decreases both in the months immediately after the law and throughout the rest of 2018. Our adjusted analysis where we controlled for patient characteristics, time, and state found strikingly similar results. The proportion of opioid naive patients getting prescriptions over this threshold would have been substantially higher, about 20 percent in January 2019, if the law had not been passed. Compared to what it was, given that it was passed, this was about 9 percent.

Another notable finding was in coprescribing opioids and benzodiazepines. The average proportion with this outcome after the law decreased seven percentage points from 21 percent to 14 percent. There was not a significant change in this outcome in the months immediately following the law, but after the law, the time trend decreased at a faster rate. Our adjusted analysis found that the proportion of patients with coprescribed medications would have been substantially higher, about 17 percent in January 2019, if the law had not been passed. Compared to what it was, it was about 13 percent.

On the next slide, we have collected some related evidence from other states. Finding results that are generally consistent with what we found here in Nevada, seeing decreases in dosages and days' supply. I will not go through this slide in detail, but I will leave it here for your reference.

Finally, my contact information is on the next slide. We have also learned that this Committee may be interested in prescription stimulants, which we have not looked at in this study, but going forward, we would be interested in investigating trends and stimulants in the Medicaid claims data if that would be of interest. Thank you so much for your attention.

Chair Peters:

Thank you so much, Dr. Friedman, and all of the presenters today. I am going to go back to questions. Senator Hardy, do you have a follow up on your question related to decreasing deaths?

Senator Hardy:

Thank you, Madam Chair. The question is, have we actually decreased the number, rate, or average number of deaths by opioids? My theory is we have done a great job decreasing the prescriptions of opioids, but we have people turning to fentanyl from the corner virtual store. I think we have seen heroin and fentanyl go up at the same time we have seen prescription rates go down. Are we saving more people, or are we putting them on the street corner getting a riskier form of fentanyl or opioid, and therefore, still having a rate of death that may or may not be improved?

Ms. Morgan:

I would like to follow up with a detailed response on that. I am looking at our opioid dashboard now; I have some numbers in front of me, but I think it would do the Committee more justice if I could provide something a little more thoughtful as a follow-up to this meeting.

Chair Peters:

Thank you so much for offering to follow up; please work with staff on making sure we get that out to the Committee. That is a good point, Dr. Hardy. Dr. Orentlicher is the next Committee member with a question. Please go ahead.

Assemblyman Orentlicher:

Thank you, Madam Chair. I also have an unintended consequences question. My guess is that the decrease in prescribing is good, and we are eliminating inappropriate prescribing. I know at the time these bills were passed, there were concerns by practitioners that it would make it harder to prescribe appropriately. You did mention there has been increased use of physical therapy, which suggests to me that we are seeing a good transition from opioid prescribing to more appropriate therapies, but are we seeing any unintended consequences in terms of inadequate use of opioids?

Dr. Friedman:

Thank you for your question. Although we were not able to always look for appropriateness of care for every patient claim we examined, it was encouraging to see an increased use of physical therapy for patients with joint pain. We also looked at the use of nonopioid pharmaceuticals and did not see the desired increase in that outcome, which was less encouraging.

Chair Peters:

Thank you so much for that information, Dr. Friedman. Are there any other questions from the Committee? I do not see any other questions; thank you all for the presentation today.

AGENDA ITEM VII—THE DRUG LANDSCAPE: HIGH INTENSITY DRUG TRAFFICKING AREAS WITHIN NEVADA, TRENDS, AND PUBLIC HEALTH IMPLICATIONS

Chair Peters:

Our next agenda item is Agenda Item VII. We have Keith Carter here with Nevada HIDTA for his presentation. Mr. Carter, please proceed when you are ready.

Keith Carter, Director, Nevada High Intensity Drug Trafficking Areas:

Good morning. I would like to thank the Committee for inviting me here today to talk about the HIDTA program and what we do. Since it is the first time that I have been here as the director of the statewide program, I would like to give you a brief overview of the HIDTA program. I want to thank Terry Kerns, who also discussed one of our premier programs, ODMAPs, which was developed through HIDTA several years ago and has now gone nationwide.

The HIDTA program is a comprehensive overarching program that has been in the State of Nevada since 2001. We are primarily a law enforcement program; however, in the last few years we have partnered with the CDC and have created what is called the overdose response strategy. It is a nationwide strategy to address overdoses and partner law enforcement with public health. Many of the presenters at today's meeting are very familiar to me. They are people that my program and personnel deal with frequently, and it has been a collaboration that has really helped. I think law enforcement realizes that we could be doing more to help our public health situation.

Today, I have been asked to talk about our drug threats, and I am going to take it from a different view than what we have heard today. Also, it can be complicated to really understand what the drug threats are in our state. There is a lot of information to decipher, and it depends on your needs and how deep you want to look through that information. The best example I can give of that is, in law enforcement, you have to consider that primarily law enforcement deals with preliminary information. They respond to a situation, they take action, they move very quickly, and then move on to the next situation. Sometimes the information that law enforcement collects is subject to change as it is merged with long-term data research. That is one of the areas where we rely on our public health partners, to do that long-term research. A lot of the information you heard today we utilize to develop a total threat picture. Over and above that, the information that we collect we use in developing the drug threats to our community. I am going to go through some of those so you understand that we really take a very wide spectrum of information.

First is investigative data. We look at our investigations and ask what are the investigators really investigating, and often that information is in real time. Over a period of time, we may see some of that change. We also survey annually about 2,000 law enforcement personnel in our state. We want to know what they are seeing on the streets, what changes they have seen, and really what is happening now. We take an extensive view of drug seizures, overdose investigations, as well as overdose trends, information from public

health, and information from our border. The border information is important to us because of our proximity to Mexico; it is a barometer of what we may see on the street.

Today I am going to give you what I call a 30,000-foot view. I am not going to spend a lot of time on a lot of data, because you have already heard most of that. The other aspect I will focus on is illegal and illegitimate drugs. That is the area we deal with and what I am going to talk about today.

Several of the previous presenters talked about drug use, and one of the things we hear a lot is polydrug. I think it is important that the community understands that we do see more polydrug users today than we have in the past. By that, I mean, if you look at the overdose data from some of my colleagues, you will see where many people who die from overdoses have multiple drugs. In the past, we had drug users who primarily used cocaine or heroin, but today that has changed quite a bit. That complicates what we do—it complicates our prevention, it complicates our investigations, and it complicates our ability to reduce the supply. I am going to look at all those illegal and illegitimate drugs and what we call a threat order.

In our state, methamphetamine (meth) is by far the worst drug that we have on our streets. It has been for many years, and it has cost more lives than any other drug. If you look at Clark County in 2001—because it is a good batch of numbers and we get the information quickly—there were almost 900 overdoses and over 500 of those were caused by meth. We see meth in a very pure form in the streets; it is very inexpensive, and it is readily available across our entire state. In 2021, in the State of Nevada, over 500 pounds of methamphetamine were seized by law enforcement. It is seized in powder and pills; the user smokes meth, snorts meth, and we find it in pill form.

I want to talk a little bit about the history of meth. That may help some of the questions on overdoses and if we have made a difference. In the 1990s, methamphetamine labs were pervasive; they were all over the state. In Clark County, a methamphetamine lab was discovered every day for several years until our Legislature made some changes in our laws that have been very effective. Today, we find very few methamphetamine labs. But what has happened is we have more methamphetamine today than when it was being manufactured in our own state, and it is a higher quality than when it was manufactured here. Is it an intended consequence? It may have been, we just do not know since there are too many factors involved. When you look at what has occurred in Mexico, all of our meth is manufactured in Mexico and brought to our state. There has been a significant change there, so it is hard to answer that question. Meth is 100 percent man-made, which complicates our ability to reduce the supply. It is different than other drugs that are grown on plants, and I will talk about some of those in a little bit.

The next drug in our threat orders is fentanyl. We consider fentanyl a very significant threat to our citizens. The difference with fentanyl and meth is that fentanyl, in terms of illicit drugs on the streets, is relatively new and began in 2014 and 2015 for our state. Now, it is essentially everywhere, unfortunately. As several of the presenters have discussed, fentanyl is a very potent drug. Most of the illicit, illegitimate drug is manufactured in Mexico and transported to our state in powder form, but primarily in pill form. The pills that we see primarily resemble an oxy 30 pill and to a person who is not an expert, it is very difficult to determine the difference. We have seen an increase in fentanyl deaths since the beginning of fentanyl on our streets. We know there are some drug users who seek out fentanyl and want to use fentanyl, but there are those who use the drug, and it is probably unintentional. When it comes to fentanyl, we find drug users are not your typical drug addicts, which adds to our complication in dealing with the situation. We know from investigating overdose

deaths of fentanyl, that some of these deaths are instant and there is no opportunity to use Narcan. We also know that finding fentanyl and interdicting fentanyl for law enforcement is very difficult. The typical pills are easy to hide; they do not have much odor, which complicates the entire situation. Last year in Clark County alone, there were well over 100,000 pills seized by law enforcement. It is on the streets and very easy to get. A pill of fentanyl ranges from about $25 to $65, depending on the drug trafficker. We find that our drug traffickers are also polydrug dealers. It is rare to find someone who is only trafficking fentanyl; normally they have methamphetamine, fentanyl, and a lot of times heroin.

We would classify heroin as our next threat. The use of heroin is relatively stable, and it has not gone down. The price of heroin has remained stable and available on the streets. In Nevada, we see what is called black tar heroin, which is a brown heroin, not the typical white heroin that you might see in the Hollywood movies. Heroin is manufactured from a plant, and it also comes into our state from South America and Mexico.

Cocaine is next on our list. Many people believe cocaine is a designer drug—a drug that is not addictive, that they can use cocaine on a Saturday and go to work on Monday. We have, obviously, a number of overdose deaths from cocaine. Cocaine is very high-priced and remains high-priced. What is of concern is that we have found cocaine mixed with other drugs, including fentanyl and methamphetamine. The age range of cocaine runs the gamut from 18 to 65.

Next, I will group pharmaceutical drugs together, from a law enforcement perspective. I agree that our state has done a fantastic job of changing the availability of pharmaceutical drugs. Whether there are unintended consequences, it is complicated to answer that question, especially when our borders are more open than in the past and our border patrol has the ability to search about 5 percent of the vehicles that cross our border. We still see some pharmaceutical drugs on the streets. We also see some pharmaceutical drugs mixed in with the illicit drugs. We do not know exactly when that happens. It could not happen during the manufacturing process, but it could happen during the transportation, or it could happen at the dealer level. There are some new trends that we have run across, although at this point, we do not call them emerging threats because there are few, which I alluded to earlier, such as the mixing of stimulant drugs with depressants or the mixing of some illicit drugs with marijuana, fentanyl, cocaine, or meth. We have even found those together in pill form. It leads us to believe that some of that is occurring at the manufacturing and transportation process. More information and more work on that is needed, but it is a concern for us when it comes to those who are using drugs. That is all that I have.

Chair Peters:

Thank you so much for that presentation, Director Carter. Are there any questions from the Committee on this issue? Please go ahead, Dr. Titus.

Assemblywoman Titus:

Thank you for that information. I have also been hearing about the concern of these drugs being brought in. I am curious about the statement about methamphetamines. For years methamphetamine use has gone down, and you mentioned it is not a designer drug. As a doctor, I have seen many meth addicts and not only what it does to you mentally but what it does to you physically. I am very disappointed to hear about the dramatic increase of meth being brought here. You mentioned only 5 percent of the cars coming across the borders are checked. Is that what has traditionally happened? Do you have any more data on that?

Mr. Carter:

That is the information we have about what is happening today, and for us, what is most important, is what is happening right now. I would certainly be able to provide you with more information.

Assemblywoman Titus:

In rural Nevada, methamphetamine labs are a tremendous problem. Folks think it is a good place to come out and hide, so it has been an issue for us out in the rural areas. In my little community of Smith Valley, which you think would be protected from any of that, we have had multiple meth labs. They rent a little storage container, like nobody is paying attention, and will produce their product. We have seen some improvement, so it is very discouraging to hear about the dramatic increase.

Mr. Carter:

Methamphetamine has really been our number one drug threat, I would say easily, for the last seven years. The difference we have right now is the availability and the cost is very low, yet the purity of the drug is the highest we have ever seen.

Assemblywoman Titus:

Thank you for that because something that has not been mentioned is the cost of these drugs. I think that perhaps fentanyl has gone up in cost because they are not getting it via prescription, and they are having to buy it. That is a good insight and I have not thought about that correlation. Thank you, Madam Chair, for the question.

Chair Peters:

Thank you for that and the clarification. Are there any other questions from the Committee? I am not seeing any other questions. Thank you, Director Carter for the presentation.

AGENDA ITEM VIII—MEDICATION ASSISTED TREATMENT OPTIONS FOR SUBSTANCE USE DISORDERS AND AN UPDATE ON SENATE BILL 390 (2021), WHICH ESTABLISHES A MENTAL HEALTH CRISIS HOTLINE AND PROVIDES FOR THE DISTRIBUTION OF PROCEEDS FROM CERTAIN OPIOID LITIGATION

Chair Peters:

We will move on to Agenda Item VIII. This is a really interesting area, and I am looking forward to hearing about the progress. We are looking at medication-assisted treatment (MAT) options for substance use disorders and an update on SB 390. This bill establishes a mental health crisis hotline and provides for the distribution of proceeds from certain opioid litigation. We have Dr. Kamyar to begin and Dr. Woodard and Dr. Capurro to follow. Please go ahead and proceed when you are ready.

Farzad Kamyar, M.D., M.B.A., Director of Collaborative Care, High Risk Pregnancy Center:

Thank you, Madam Chair, and Committee members for having us today to present on this topic, MAT options for substance use disorders (Agenda Item VIII A-1). I am a physician specialized in psychiatry and addiction medicine. I am the director of collaborative care at

the High Risk Pregnancy Center, where we have The MOTHER Project, which is a program specifically designed to treat pregnant and postpartum patients with opioid use disorder.

Everyone has been talking about how substance use is an issue, and it is a problem. Some more statistics here—in 2020, 40 million people in the nation had a substance use disorder, close to 15 percent, which is significant. We are setting records every year. In 2020, there were more than 90,000 drug overdose deaths, which was a record. I would not be surprised if 2021 was even higher than that when that data comes in. Unfortunately, because of this landscape, overdose is now the leading cause of accidental death among adults and amongst the patient population we work with. An overdose is the leading cause of death for reproductive age women in the United States, and that is all causes, more than cancer, more than heart disease, et cetera.

What is addiction and substance use disorder? I think it is important to frame this because it leads into how we should be approaching treatment. The American Society of Addiction Medicine's (ASAM) definition in 2019 says addiction is a chronic disease, much like others, such as diabetes or hypertension. They define it as a "treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences." There is no mention of it being this choice, a moral weakness, or a failure, which is fantastic because it medicalizes addiction and substance use.

It is important to understand what changes are occurring; a lot of it has to do with the brain, but dopamine specifically. What we are seeing is in the way that humans work; life-sustaining activities release dopamine, also known as the reward neurotransmitter. We are familiar with this as in "Hey, this kind of makes us feel good." It was designed to have us replicate life-sustaining activities. You will see in the chart on the left, things such as food and sex, what we call natural rewards, that bring some pleasure. Ideally, for the continuation of the human species, these are the things we want to continue doing. If you look at the graph on the right, we get into trouble with dopamine when we are exposed to substances. What is notable here is the amount of increase that happens with various substances compared to natural rewards. Amphetamine goes from a baseline of 100 to almost 1,100; it increases the amount of dopamine 10 times what food would.

Repetitive exposure to these vastly increased amounts of dopamine lead to physiological changes. These physiological changes mimic the physiological changes that happen in other chronic diseases. In the chart on the left, you will notice there is a comparison for someone who has heart disease. We are looking at metabolism here, with red being the areas of metabolism and the blues being little metabolism. In the healthy heart, the heart is contracting, but in a diseased heart, not so much. It is similar in the brain; in a healthy brain you have metabolism going on, and with someone who has been using or abusing cocaine, not so much. The right side of the slide is looking at dopamine and how it functions and transporters that are available. It is notable here that in the healthy brain they do exist, but in someone who has been using methamphetamine, it is like they are gone.

Fortunately, in the realm of chronic diseases, we like to think that for things like asthma, hypertension, and diabetes there are effective treatments, and we are lucky we have made advances and there are effective treatments for addiction/substance use. They cannot effectively be cured with the modalities and treatments that we have now, but they can be managed with a combination of medications, when they are available for that substance, with behavioral therapy as the most effective. So much so, that when you put these effective treatments in place, the "relapse" rates or return to substance use are comparable to the relapse rates in other chronic diseases, such as diabetes and hypertension. Trying to

normalize that notion—you might have heard this before—that those with addiction are always relapsing, they go into treatment and then they fall out of treatment, et cetera.

This notion of MAT is where you can use medications that are effective to treat that patient. It is very important that medications, when available, are the standard of care. Not only have they been found to be safe and effective, but we are labeling them as lifesaving treatments. These are lifesaving medications in the same way that insulin is lifesaving for someone who has diabetes. The definition of MAT is the use of U.S. Food and Drug Administration (FDA) approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Again, touching on how effective this is, when someone is effectively in treatment beforehand, when they are using illicit substances like heroin, the risk of morbidity and mortality is astronomical. When they are effectively in treatment with MATs, it reduces that risk of morbidity and mortality almost sixfold, comparable to the baseline for the regular population.

There is no maximum recommended duration of MAT; treatment may continue indefinitely. This is where we view treatment differently—this notion of parity where we are required to treat mental health and substance use disorders the same exact way, so they should be the same as we view and treat other physical issues. I will tell you that is not where we are, and there is a lot of work that is needed to make that a reality. In the same way that someone might be insulin dependent for the rest of their lives, we should not have this bias or stigma associated with someone who is in MAT for an opioid use disorder. What do medications do ultimately? They are effective for treating withdrawal, having people stay in treatment, and preventing relapse or return to substance use. Things that are all good and very positive.

Currently, MATs are available and FDA-approved for three different substances: (1) alcohol and the corresponding treatments—disulfiram, acamprosate, naltrexone; (2) nicotine—you might be familiar with nicotine replacement, like patches, and some newer medications, like Chantix and Wellbutrin; and (3) opioids, which are a big deal and causing a lot of morbidity and mortality. We are fortunate to have three approved FDA medications currently approved—buprenorphine, methadone, and naltrexone.

You will notice when we talked about MAT, we talked about adding other things like behavioral therapies, and that is where the additional treatment options come in, such as therapy/counseling, social work/case management, peer support, mutual self-help groups, et cetera. A lot of times addressing these social determinants of health is becoming really important because without addressing those, it is really difficult to get people to be in treatment.

There are multiple levels of care. Level one is the lowest intensive treatment, and it is office-based. This is the traditional treatment, such as in a clinician's office, maybe once a month. Then there is intensive outpatient, where the designation is nine or more hours a week, but again, that is in an outpatient setting. Residential treatment is more intense and is usually in a designated space; patients might stay there overnight. The highest level is inpatient, which is traditionally an institution or a facility specifically to treat something.

Unfortunately, we just had the discussion on methamphetamine, or stimulants, that are causing a lot of morbidity and mortality. We do not currently have a medication option for methamphetamine. Again, unfortunate at this time, but ideally with future therapy innovations, we will have something that is as effective as it is for other substances like alcohol, nicotine, and opioids.

Bias and stigma play a role, and I thought it was important to mention when we talk about parity and how we view treatments. Bias is the conscious and unconscious things that affect us; it is this opinion that influences our judgments. Another word that we use often times when it comes to substance use is this notion of stigma—a set of negative and often unfair beliefs that a society or group of people have about something.

It is important to talk about bias and stigma because it is very likely that patients suffering from addiction or substance use disorder might be those that are ultimately facing the most amount of bias or stigma from health care in general, members of the regular population, family, friends, et cetera. Within the world of health care, multiple studies have demonstrated bias and stigma associated with substance use, and it is to the detriment of being able to identify these patients and have them access care and treatment. This is something that we are trying to become more aware of and eliminate in our approach to care.

One of the studies was from the Recovery Research Institute. Participants were asked how they felt about two people who were "actively using drugs and alcohol." One was referred to as a "substance abuser" and another was referred to as "having a substance use disorder." This more positive, person-first language that we do recommend is on the right in the blue, versus the stigmatizing language on the left, "substance abuser." They found the substance abuser was less likely to benefit from treatments; they are more likely to benefit from punishments because it was a result of their own fault, and they should be able to have control over their substance use without help. That is where the biases and stigma come in; our traditional views on those with addiction and substance use disorders. I will mention that 50 percent of these participants were in health care, so we are not immune to this. That is the end of my section, and I will hand it off to my colleagues, Dr. Capurro and Dr. Woodard.

Dr. Woodard:

We will be talking about MAT for opioid use disorder and the opportunities we are seeing in Nevada for programming as well as policy (Agenda Item VIII A-1).

Increasing access to high-quality MAT has been a core strategy in Nevada for addressing the opioid crisis for several years. This includes using federal funds from our state-targeted response grant, as well as our SOR grants, to increase capacity and enhance competencies for providers; expand service arrays, including MAT in federally qualified health centers; developing Nevada's hub-and-spoke system; and supporting navigation to care for high-risk populations, including those who are involved in the criminal justice system as well as pregnant and parenting women.

We have received the SUPPORT Act Planning Grant, which is the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment grant. This grant was awarded to the Division of Health Care Finance and Policy (DHCFP), DHHS, from the Centers of Medicare and Medicaid Services (CMS). There has been an enormous amount of work that has been accomplished through that planning grant, so much so, that we have also received a demonstration grant that Dr. Capurro will be discussing. Then, we will provide an overview of policy considerations that relate to MAP, including workforce development, alternative payment strategies, and parity across payers for collaborative care for the treatment of opioid use disorder.

This is a snapshot of what the current treatment landscape looks like in Nevada. We have 369 prescribers who are waivered to prescribe buprenorphine; however, not all these

prescribers are prescribing. We have done a couple of different surveys over the last several years to understand, of those who are waivered, how many are prescribing, and for those who are prescribing, how many are prescribing up to capacity. We are consistently learning that while we have waivered prescribers, very few are prescribing up to capacity, if they are prescribing at all. This is an important point because we know we can work with prescribers to incentivize them and help to understand some of the barriers from expanding services to the patients they serve.

We also have 14 opioid treatment programs (OTP) in Nevada, which are situated primarily in our urban areas. These are considered traditional methadone clinics; however, many of these clinics have expanded to offering other FDA-approved medications for opioid use disorder. We have an OTP in the Washoe County Detention Center; this is Nevada's first and only jail-based OTP. These programs are licensed and certified by the state and are overseen by our state opioid treatment authority.

Essentially, when we look at both the OTPs as well as our buprenorphine waivered prescribers, we find that we have capacity within the system, primarily in the urban areas, but we lack a connection to high-quality integrated services across different systems. Our rural and frontier communities still struggle with limited access to all behavioral health services, including MAT, and require different solutions to increase the access. Parity, coverage, and affordability continue to limit access to evidence-based treatment.

Addressing solutions include developing integrated treatment networks, and many states have implemented what we call a hub-and-spoke system, which I will talk about a little bit later. Understand that a hub-and-spoke system is a system of care where providers are working together collaboratively to support and manage the care of individuals with opioid use disorder.

With leveraging telemedicine, changes to some federal regulations during the COVID-19 pandemic have allowed for a greater use of telemedicine, including initial evaluations. We can reduce barriers to access, especially for those who have a lack of geographic access, by introducing telemedicine as a facilitator for accessing care and increasing access within primary care providers, office space settings, and also hospitals and emergency rooms.

One issue as it relates to stigma and bias, as Dr. Kamyar was talking about, is really finding ways that we can reduce chances that individuals are denied care because they are on MAT. We have seen this as an evolution within our court system, as well as within our state-funded providers who are not able to deny access to care to individuals who are currently on MAT. I will turn it over to Dr. Capurro who will be talking about the experience of the DHCFP with the SUPPORT Act Planning Grant.

Antonina Capurro, D.M.D., M.P.H., M.B.A., Deputy Administrator, DHCFP, DHHS:

Thank you, Dr. Woodard. Under the SUPPORT Act, CMS developed a planning and demonstration grant aimed at increasing the capacity of Medicaid providers to deliver substance use disorder and opioid use disorder treatment and recovery services. This has been crucial to our work. In 2019, as Dr. Woodard mentioned, Nevada was one of 15 states awarded the 24-month SUPPORT Act Planning Grant. In September 2021, Nevada was one of only five states that was selected for the 36-month SUPPORT Act Demonstration Grant. Through that demonstration grant, Nevada has also received enhanced federal reimbursement for substitute disorder treatment and recovery services, which is key to our ability to implement our areas of focus. As part of the SUPPORT Act Planning Grant, the Infrastructure Assessment Report (IAR), which is pictured there on the left-hand side, was

created as an extensive study of Nevada's substance use disorder treatment landscape. It identified barriers and challenges to increase provider capacity and also included recommendations for policy and best practices to enhance and expand substance use disorder treatment services across the state.

The SUPPORT Act core team created a five-year strategic plan to ensure the development and long-term sustainability of provider capacity in order to meet the needs of Nevada Medicaid beneficiaries. They selected specific areas of focus that include: (1) engaging the provider community to assess capacity and qualifications and their willingness to provide these services; (2) developing a comprehensive MAT policy and MSM chapter updates; and (3) providing an alternative payment methodology for MAT services. Our focus included developing and disseminating a comprehensive perinatal care practice standard and increasing substance use disorder provider capacity through education, communication, and collaboration.

In response to the SUPPORT Act, Nevada has developed a comprehensive MAT strategy. The policy documents the process of treatment, the use of buprenorphine medications, and qualifications of providers. We were able to adapt the ASAM criteria for the Medicaid MAT policy and update our Chapter 3800 of the MSM, which includes a MAT policy that was approved in June 2020. Our MAT billing guide was published the following month in July 2020.

We have also done a lot of work around the implementation of the screening, brief intervention, and referral for treatment (SBIRT) codes. Those were activated in March 2020 for a number of medical providers listed here. The SBIRT toolkit was developed, and training was provided to Nevada's largest female reproductive health practice. Using the success of that toolkit as a guide, similar SBIRT training was included in the Health Workforce Grant Application from the Health Resources and Services Administration (HRSA), recently completed by the state, to expand SBIRT workforce support to dental professionals. The Division continues to monitor SBIRT trends and has engaged with each of the managed care plans to discuss implementation and possible promotion of SBIRT during monthly meetings with each of those plans.

We have done a lot of work around prior authorization requirements. Prior authorization requirements have been aligned with other behavioral health provider types, and prior authorization barriers for substance use disorder treatment have been removed and minimized.

As mentioned, Nevada's MAT policy, Chapter 3800 of the MSM, went into effect in June 2020; the SBIRT reimbursement codes were implemented in March 2020; and the SUPPORT Act Planning Grant began in 2019. As indicated by this graph, it is having a significant impact on the state. The chart illustrates that with more focus and awareness there has been an associated upward trend in the treatment for opioid use disorder. The work in these trends is paramount.

As noted by the Kaiser Family Foundation, Medicaid covers 38 percent of nonelderly adults with an opioid use disorder, making it the largest source of coverage for individuals undergoing Medicaid-assisted treatment. In January 2021, Nevada Medicaid administered a survey to providers to assess current barriers and challenges with MAT prescribing, addressing social determinants of health, and any challenges with technology-supported informational exchanges. The survey was completed by 343 providers, and they included a wide range of provider types, as well as settings. The vast majority of those were self-reported experiences. We found that 65 percent noted a limited number of

organizations to which referrals could be made. Twenty three percent of the respondents currently prescribed MAT, but 16 percent who did not currently prescribe, did not know if the organization had that capability. Of the 80 percent who were currently prescribing, 73 percent were not prescribing to capacity. There is still a great deal of workforce needs indicated here.

The survey also identified barriers to prescribing MAT and that was foundational to developing a strategic plan. The barriers that are noted here from the survey largely represent topics that are also described nationally as challenges. Some of these include reimbursement limitations, limited availability of referral networks to provide comprehensive patient-centered care coordination, the need for educational training to increase the understanding of MAT delivery, administrative barriers, and addressing stigma. These issues create barriers to successful treatment of patients with opioid use disorder and substance use disorder and have been the focus of the state's work. In just a moment, I will discuss an alternative payment model that is being designed to resolve the underutilization of MAT services, the barriers to care coordination, reimbursement, and these administrative barriers that were identified.

The survey also gathered information on provider incentives. They found that 39 percent of respondents were very willing to participate in providing MAT, if there was a comprehensive alternative payment model, and 45 percent of respondents were somewhat willing. We are hoping to use these people who responded in the alternative payment methodologies that we are building. Respondents indicated, as you can see here, that some of the incentives that would be helpful included bonus payments for waivered providers, educational incentives, as well as student loan repayment programs.

As mentioned, one of the solutions to the barriers identified in the state survey, is the Patient-Centered Opioid Addiction Treatment (P-COAT) payment model (Agenda Item VIII A-2). It is an alternative payment method that is designed to improve outcomes and reduce spending for opioid addiction by overcoming the barriers in the current payment system for successful outpatient care.

Some of the specific goals around the P-COAT model include: creating a reimbursement structure that will support the full range of services provided to treat opioid use disorder; expanding the network of providers and tapping into some of those willing to provide treatment; encouraging a coordination of service delivery; reducing inefficiencies and unnecessary expensive treatment; and utilizing evidence-based care practices that lead to improved outcomes. Some of those improved outcomes would consist of: (1) increasing the proportion of successful treatment for individuals with an opioid addiction; (2) reducing spending on potential avoidable emergency room visits and hospitalizations; and (3) reducing deaths caused by opioid overdose and complications of opioid use. The payments would be issued monthly and would be bundled as a set of MAT services using the ASAM guidance. The P-COAT model as an alternative payment model also features a performance-based adjustment for bundled rates. The P-COAT model is a priority and a budget concept that the Division is planning to put forward for the next budget building cycle. Dr. Woodard, I will hand it back to you.

Dr. Woodard:

Thank you, Dr. Capurro. I also wanted to talk about some of the work that is being done in this state. This is going to highlight one of a variety of studies where researchers are working in communities with individuals who use drugs and are in recovery, to better understand, from their perspective, the barriers and facilitators for accessing both harm

reduction and treatment and recovery services. This qualitative research helps to bring vital information and the voices of individuals with live experience into our consideration when we are developing, designing, and implementing new programs within the state.

As an example, a study that was conducted by Swigart and Lee this past year, interviewed 35 individuals between the ages of 25 and 62; 16 of those individuals were currently using opioids, and another 19 had used them in the past. Some of their key findings include highlighting a need for greater access to harm reduction services, as well as outreach and peer supports, and greater integration, cohesion, and interconnection between those supports and services for treatment and recovery. This is incredibly important especially when we talk about coordinated care and collaborative care models, recognizing a multitude of programs may be working to support one individual at a time, and it is ensuring those programs are able to communicate with one another to collectively support the individual in treatment and recovery services. There must be comprehensive communication around what services are available, as well as the populations of focus for those services and any affiliated costs, and increasing opportunities for individuals who both use drugs, as well as those who are in treatment and recovery to connect to purpose and community. We know that purpose and community are really two hallmarks of successful recovery programs. When these can be fostered within individuals, there is a greater likelihood they are able to continue their recovery trajectory. There must be increased communication and information dissemination on educating what is MAT, how it works, and where and how can they access those services.

Key findings from this research are the policy recommendations, including recognizing that the criminal justice system has a role in encouraging individuals with opioid use disorder to engage with MAT; integrating peers as well as support for social determinants of health into their services and harm reduction strategies; and efforts to destigmatize treatment and reduce some of the criminalization and punitive practices towards individuals who have an opioid use disorder.

The hub-and-spoke model of care has been optimized by many states across the United States and is a core best practice treatment model for coordinating the treatment for individuals with opioid use disorder. States have used federal grants to upstart some of the hub-and-spoke essential practices, as well as infrastructure. Nevada has done some of that work, as well, through our SOR grants and state-targeted response grants. The way this works is the hub is a site that can initiate treatment, stabilize patients, and provide ongoing consultation to, what we would consider, our scope or satellite site, and offer access to all three FDA-approved medications for the treatment of opioid use disorder, including methadone.

The spokes are called office-based opioid treatment providers, and these can be in a multitude of different kinds of treatment systems, including FQHCs, critical access hospitals, primary care clinics, obstetric/gynecologist (OB/GYN) clinics, and even pediatrics. The office-based opioid treatment providers can work with a multidisciplinary staff, such as nurses and care managers, to provide ongoing care for individuals with opioid use disorder who tend to have more stable and less severe opioid use disorder, or for those who have been successful in maintaining for some time. They connect patients to wraparound services, as well as support for social determinants of health, and offer an array of outpatient behavioral health services, including counseling and case management.

We continue to talk about collaborative care, and we see collaborative care is the linchpin that helps to keep this hub-and-spoke model intact. The hub is really the core of where the majority of services can be initiated. As individuals become more stable, less severe, and on

more of a maintenance therapy, moving them out into the spokes, or office-based opioid treatment providers, can be very helpful in ensuring that we continue to have open doors of access while not overburdening some of our opioid office-based opioid treatment providers with trying to address individuals with high severity of needs in more complex disorders.

Some of the programming and policy considerations that have been elevated during the course of our work over the last several years and highlighted with the work through DHCFP and the SUPPORT Act grant include: (1) ensuring harm reduction strategies are available to all communities to support individuals with opioid use disorder; (2) encouraging greater implementation of screening, brief intervention, and referral to treatment across all primary health systems; and (3) integrating harm reduction, peer support, navigation to treatment, and recovery services into mobile crisis teams, recognizing these teams will be going out into communities, meeting individuals, and providing additional services and support to them. We have already started to include overdose education and naloxone distribution as part of some of the mobile crisis teams deployed in the community, as well as ensuring that there is a no barrier, timely access for individuals who are seeking treatment and recovery supports, regardless of their ability to pay. This can be done through crisis stabilization centers, implementing a full hub-and-spoke system, and encouraging access to recovery supports throughout our community. Additionally, there has been work in collaboration with the Nevada Hospital Association to establish a Bridge MAT program with emergency rooms. As we heard earlier this morning, identifying data of individuals who are coming in and being served in our emergency rooms with nonfatal overdoses and recognizing those are opportunities to engage individuals in care and initiate them on MAT and bridging care to a provider in the community who can then continue that care onward. Also, optimizing technology—such as a health information exchange, the Prescription Drug Monitoring Program, and registries—to ensure timely access to medical information is essential to facilitate collaborative care management. We must encourage those waivered prescribers to prescribe through offering incentives and opportunities to continue developing their competencies.

Finally, recognizing withdrawal management is not a complete episode of care; follow-up and referral are essential for continued support and care. I will speak more about this in my next presentation on the sequential intercept model. Especially for individuals who are put through withdrawal management while they are incarcerated, recognizing that in and of itself is not a complete episode of care. Individuals, who are not connected with care following incarceration, are at an increased risk for overdose as well as death by overdose. We must make sure there is a linkage as individuals are reentering into the community. Pregnant women with opioid use disorder can be safely cared for during pregnancy, and neonatal abstinence syndrome can be reduced in both incidence and severity with proper care planning. Individuals in incarcerated settings, who need access to withdrawal management, need the opportunity to have induction for MAT while they are incarcerated to bridge to a community provider. Individuals who are involved in the criminal justice in court systems should also be provided access to harm reduction strategies, as well as treatment and recovery services including MAT.

The decision to begin and maintain MAT needs to be held collaboratively between the individual and the provider. Medication selection should be made based on the individual's preference and provider recommendations, so that we do not have outside entities, such as courts, unilaterally determining what medication is most appropriate for a patient. Also, it is important to recognize that individuals with lived experience must be engaged in the programming design considerations as we develop and implement programs across our state. It has been said many times already—but I will say it again—parity in coverage and participation in a statewide hub-and-spoke model across all payers with limitations on fail

first treatment, options for prior authorization, and coverage limits needs to be considered as we are looking to build out a statewide system where individuals who need access to opioid use disorder treatment have that access, regardless of their ability to pay and regardless of their insurance carrier. We must use and promote telehealth as a modality for providing MAT services to seek options to ensure continued access to telehealth MAT, especially considering the modifications that have been made to some of those policies under the public health emergency.

Chair Peters, I can pause here if you would like to open it up to questions from the Committee as it relates to the presentation on MAT, or if you would prefer, I can go into the summary of the update on SB 390.

Chair Peters:

Let us pause here for some questions on the MAT discussion. I have a few questions, and it looks like we have some questions from members. We will start with Dr. Hardy. Please go ahead.

Senator Hardy:

Thank you, Madam Chair. Have we seen the benefit to opening up the waivers to people who have not had full 8 or 24 hours? Have we seen people bite on that opportunity yet?

Dr. Woodard:

We have heard, at least anecdotally, that we have more prescribers who are willing to prescribe now that they have waived some of the training and education requirements. We have not fully understood yet the impact that has had on access to treatment specifically in Nevada.

Senator Hardy:

Thank you, Madam Chair.

Chair Peters:

Thank you. Assemblywoman Gorelow is next on my list.

Assemblywoman Gorelow:

Thank you, Chair Peters. I have a question for Dr. Kamyar. You describe yourself as a collaborative care psychiatrist. Could you talk a little bit more about what that is?

Dr. Kamyar:

Absolutely. The collaborative care model, which Dr. Woodard mentioned, is what I foresee as being the wave of the future when it comes to providing mental health services for the United States. Fundamentally, we have a huge mental health issue that is largely untreated at this time. As a primary care provider, if I identify someone with depression and send that person for mental health care, that is a traditional model. Then, this person now needs to set up an appointment, find availability, find a provider, coordinate with insurance, et cetera. We find that not only does that not happen, about one in two patients does not even show up for the referral to see the clinician, and then of those that do, a very small percentage continue care with the clinician. Then there is the added complexity that we do

not even have enough providers. If everyone today who had some sort of mental health issue decided to go see a behavioral health specialist, it would overwhelm the system and it would probably come crashing down. We have seen where the first appointment is six months out.

Collaborative care brings the prescribing and treatment care to the primary care provider. In our case, we have maternal fetal medicine/perinatologists in the realm of OB/GYNs. Our clinicians are the ones who are treating the high-risk pregnancy for these patients. They are also the ones who are seeing these patients for their opioid use disorder, providing them with prescriptions for these medications, and doing follow-up. One of the cornerstones of a collaborative care program is what we call a care manager; this is where the specialist in behavioral health comes in. That person does all sorts of stuff, such as figuring out how treatment is going, what follow-up is needed, whether the treatment is effective, et cetera. In this sort of triangle, you have the patient, the primary care, and the care manager, and then over here there is the behavioral health specialist, let us say a psychiatrist for example. That is the role I provide at the High Risk Pregnancy Center. I basically work with the care manager, and that person is the conduit to the primary care provider/perinatologist to inform them about taking care of these patients in a way that they normally would never do.

You could ask Dr. Woodward about how many perinatologists are providing buprenorphine for patients in the United States. You can then go to OB/GYNs and then primary care providers, and that number starts to dwindle when you go up the specialties. Effectively, we have numerous perinatologists who are now prescribing buprenorphine for these patients who normally would not be getting care. We will say pregnancy and postpartum is sort of this targeted patient population, our priority patient population.

That is, fundamentally, how the program operates. Collaborative care is very evidence-based. There are numerous studies, over 80 but probably close to 100, that show it improves access to care, lowers the cost to deliver care, but fundamentally improves outcomes and is much better than traditional care. Patient and provider satisfaction is through the roof compared to traditional care models. It is the way of the future, but the reimbursement and the motivating factors for implementation are not quite there yet.

Assemblywoman Gorelow:

I was going to ask about the Medicaid reimbursement. I know we had mentioned in the discussion that it was a barrier. Are your services currently being reimbursed, and, do you collaborate with the OB as well?

Dr. Kamyar:

Currently, they are not being reimbursed; CMS has defined collaborative care codes specifically to implement this model. I believe Nevada is working on it because we have been involved in those discussions, but currently it is not reimbursed here in Nevada. I think we are unique and probably the only program that uses the collaborative care model. We have been fortunate to be grant-funded as opposed to previous years when it was being floated by the High Risk Pregnancy Center. It keeps patients and babies or neonatal fetuses alive, so it was important to offer.

Assemblywoman Gorelow:

Thank you very much.

Chair Peters:

Thank you. Keep us posted on how that collaboration is going with Medicaid, and if there is anything you need from us, please let us know. Dr. Orentlicher is next with a question. Please go ahead.

Assemblyman Orentlicher:

Thank you, Madam Chair. Dr. Woodard, I want to pick up on the points you discussed about the use of medically assisted therapy in the judicial system. I remember hearing a presentation a few years ago about what seemed like a pretty substantial resistance, and a surprising resistance even, in drug courts to using medically assisted therapy. Is that getting any better? What can we do to get these drug court judges to be more comfortable? It seems like some of the stigma and bias factors we heard about were relevant.

Dr. Woodard:

I think we have seen some pretty remarkable progress through our judicial system as it relates to access to MAT. Some of the best practices that have come out through the national judicial court systems, who provide training and technical assistance to judges and courts, have been quite progressive in helping courts and judges understand the utilization of MAT and how it can enhance some of the outcomes for their drug court specifically. We see some courts bifurcating between drug court and a specific MAT court, recognizing that some individuals with opioid use disorder are going to benefit from differentiated treatment. Where we do see some challenges is ensuring that individuals who are entering into any specialty court, for either mental health or substance use disorder services, have adequate comprehensive evaluations on the front end, to determine where there are co-occurring or comorbid behavioral health conditions and offering opportunities for comprehensive treatment while they are engaged in care. We know there are many people, a majority of individuals actually, who engage in care through drug courts who also have co-occurring mental health conditions. While we are mandating individuals to treatment through those court systems, we want to make sure they have access to care to treat all the disorders they are coming with, which will ultimately benefit the individual and enhance outcomes, both in the short-term and in the long-term for those individuals to meet and then maintain recovery ongoing.

Chair Peters:

Thank you for the question and for that information, Dr. Woodard. Dr. Titus, please go ahead with your question.

Assemblywoman Titus:

Thank you and this is great information; I appreciate that. Dr. Woodard, you referenced the prison population and how they are being treated for substance abuse or drug abuse and making sure they receive a warm handoff to a health care provider to continue treatment after the release. What percent of our incarcerated Nevadans are receiving treatment for their drug addiction, not just the MAT system but counseling and other treatments? Are all our incarcerated people who have been identified as either having substance abuse or drug addiction being offered treatment? Are we able to reach everybody?

Dr. Woodard:

Dr. Titus, that is an excellent question. What I can say, absent concrete data, is no. We do not necessarily have access to adequate treatment for individuals with mental health or substance use disorders within our criminal justice system, whether they are incarcerated in jails or in prison. Certainly, there have been efforts to increase access to those services. I think the barrier is determining if something like MAT is an essential service that everyone who has an opioid use disorder has the right to access while incarcerated. There is a different interpretation around whether it is considered an essential service for an individual who is incarcerated. I think there are additional policy considerations to look into.

Assemblywoman Titus:

Thank you for that. I have concerns that we are making sure that those who have been identified as having a substance use disorder get treatment and then a warm handoff once they are released to avoid an increase in overdose. I would love to see some follow-up and actual numbers on how much we are lacking and the percent of our prison population that is offered treatment.

My next question is regarding Medicaid. One of the things we heard last session was to make sure individuals did not immediately lose their Medicaid eligibility once they were incarcerated and to avoid a delay in getting back on Medicaid when they were released. Has that been helpful at all? Has that been implemented?

Dr. Capurro:

I do not have specific information on that, but I am happy to do some research and provide that for the Committee.

Assemblywoman Titus:

Thank you. There was mention about a delay in getting appointments and treatment. I would not want to see additional delays in treatment while someone is waiting for authorization after being released. I just want to make sure these changes we passed have started and are being effective. Thank you, Madam Chair.

Chair Peters:

Thank you for the great questions. I think many of us on this Committee are interested in the workforce model issue and how many more we need in place to where everything is covered, and that goes across the board.

I know Dr. Kamyar has to leave shortly, so I have one final question related to the MAT, and then we can move on to the presentation on SB 390. My question is about the treatment protocols for somebody who has a long-term MAT. Can you talk about the standards for that model and who is providing that longer term of care for folks?

Dr. Kamyar:

Traditionally, it should be no different than other forms of treatment for chronic diseases. Depending on the medication the patient might be on, the location of that treatment might differ. For example, let us use buprenorphine, which can be prescribed in an office setting for opioid use disorder. I foresee that for a patient, much like when they see us, it is just like going to see the doctor for their regular checkup and regular medication. Ideally, when

we have eliminated bias and stigma or destigmatize, we view this as a chronic disease, and we implement treatment as such. It should be no different, especially if the patient is at a place where they are living the life that they want to live, but they are in sustained recovery. To them, the community, and everyone involved, it is just like they are getting their high blood pressure medication. They take it and go on with their lives.

Chair Peters:

I agree with that model, theoretically. I am just curious how many folks are actually doing that in their facilities, what long-term treatment looks like, how we hand folks off when retirements happen, or when facilities are purchased by other facilities and what is needed for that continuity of care. I think that might be a longer-term discussion to have.

I appreciate your input; this is amazing work and effort to destigmatize this conversation. I know from serving on the Regional Behavioral Health Policy Board in Washoe County, this is an area we are looking at to ensure we are supporting the folks who are providing those MATs for our community and providing the resources they need.

Thank you so much for your presentations. Dr. Woodard, if you would like to please go ahead with your presentation on SB 390.

Dr. Woodard:

Senate Bill 390, as many of you will recall from last session, was a bill that was carried by the Senate Committee on Health and Human Services and has two primary components (Agenda Item VIII A-1). The first portion of SB 390 helps to establish an account, which we call the Crisis Response Account, and a surcharge for telecommunications is deposited into that account. The first part of SB 390 is primarily focused on a crisis call center. The goal is to prepare us to be ready for 988, which is the three-digit telephone number for the National Suicide Prevention Lifeline. That will be going live nationally, regardless of whether states are ready for it or not, starting July 16, 2022. Nevada has been working on its Crisis Response System for the last several years, and we were in a really good place to begin doing this work.

Senate Bill 390 is going to allow us to have some revenue generated from the surcharge and deposited into the Crisis Response Account that will support the ongoing call center and care traffic control; allow for ongoing operations, now and into the future; as well as provide additional funding to support mobile crisis teams and crisis stabilization centers. The goal is to ensure that mobile crisis and crisis stabilization centers are able to treat anyone and everyone, regardless of their ability to pay, and recognize that they are part of the critical infrastructure needed in our communities to really affect the change needed within crisis services.

The first part of SB 390 is 988 and the Crisis Response Account. The Crisis Response Account has been developed and the regulations to establish the fee are underway. We are hoping to get those approved through the State Board of Health, DPBH, DHHS, sometime this spring.

The second portion of the legislation has to do with the Fund for a Resilient Nevada. This is the opioid settlement litigation funding that is coming into the state. One important point to make is these are only the funds the state will be receiving and not the funds that will be allocated through what is called the One Nevada Agreement to counties and cities. The One Nevada agreement was a negotiated agreement through the Attorney General's Office

with cities and counties across the state, who are also engaged in their own opioid litigation. We recognize that large settlements may come to the state that need to be allocated appropriately, according to this negotiated agreement, to cities and counties that are also participating in that litigation, with the remainder of those funds. Then, approximately 43 percent of those funds are going into the Fund for a Resilient Nevada.

The Fund for a Resilient Nevada has been established. The Fund sits within DHHS and was the recipient of about $28 million from the first settlement award that the state received last spring. Those funds are being used currently to support the development of the state needs assessment. That needs assessment is a critical component of us being able to understand what the needs of the state are and how that will then inform the state plan. The state plan will be used to help allocate funding to specific activities within the state, and then around July, we anticipate having those dollars ready for distribution for the priorities that are identified in the state plan. We were also required, through SB 390, to establish the Advisory Committee for a Resilient Nevada. This committee was established through appointments from the Attorney General's Office, the director of DHHS, as well as the Office of Minority Health and Equity, DHHS. The representatives on the committee have been meeting since October and have been meeting monthly. They have been helping to shape and inform the conduction of the state needs assessment, and we are anticipating that needs assessment should be completed within the next month or so.

Chair, I will leave it open if anybody has any questions about SB 390 and where we are related to implementation.

Chair Peters:

Thank you so much for the update. Are there any questions from the Committee? I am not seeing any questions.

AGENDA ITEM IX—SEQUENTIAL INTERCEPT MODEL: INTERSECTION BETWEEN CRIMINAL JUSTICE AND BEHAVIORAL HEALTH

Chair Peters:

We are going to and move on to the next item, which is presented by Dr. Woodard. Agenda Item IX is on the sequential intercept model. Dr. Woodard, please begin when you are ready.

Dr. Woodard:

Thank you. The next presentation is, in large part, a continuation of the discussion we recently had around MAT. I will be presenting on the sequential intercept model and the intersection between criminal justice and behavioral health (Agenda Item IX).

The sequential intercept model was developed as a way to identify where there are intercepts, or opportunities, for individuals who are either at risk, becoming involved, or have become formally involved in the criminal justice system to be able to screen, assess, and facilitate access to recovery support services, as well as treatment for individuals who have a substance use disorder. This model can also be applied to mental health conditions, but for the purposes of the meeting today, I will be keeping my comments and review of specific programs solely focused on substance use disorders recognizing co-occurring disorders within those communities.

In a brief overview of the sequential intercept model, we look at it as a continuum with Intercept 0 being community services including a crisis continuum. Intercept 1 opportunities are prebooking for individuals to be diverted or deflected away from the criminal justice system and into treatment. Intercept 2 occurs when individuals have been booked and are currently being processed through initial detention in initial court hearings. Intercept 3 is for those individuals who are formerly incarcerated in a jail or prison, as well as individuals who are sentenced to specialty courts. Intercept 4 focuses on reentry, so as individuals are exiting jail or prison, services and support, as well as those warm handoffs, are essential in ensuring continuity of care. Intercept 5, which we consider community corrections, focuses on the role of parole and probation to support individuals in the community.

We see intercepts as opportunities. There has been an entire body of research on optimizing these intercepts, to either deflect or divert, individuals away from the criminal justice system, or optimizing their involvement within the criminal justice system and supporting their engagement in treatment and recovery support services. Some of the results are outcomes that have come from that. We have found through that research, it reduces ongoing substance use, as well as recidivism and unnecessary incarceration. It does end up, ultimately, reducing the risk to public safety because it helps individuals get into treatment and connect with the recovery support they need. It reduces overall costs of incarceration. It can be used to address racial disparities, especially those that result in over incarceration of individuals from racial and ethnic minority groups. It has a positive impact by reducing overdoses and suicides, increasing treatment outcomes, and reducing burden overall on public safety and judicial systems to address behavioral health needs.

An important part of legislation was AB 236 (2019), which made significant changes related to the eligibility for and programs available to individuals in the criminal justice system with either serious mental illness or substance use disorder. This bill fundamentally changed the way that behavioral health services can be utilized, not only for those who are incarcerated but also for the purposes of jail diversion. There has been quite a bit of work done in Nevada to support the sequential intercept model. We recognize that individuals with substance use disorders and mental health conditions, who have high treatment needs, really benefit from being engaged in care versus being incarcerated.

Assembly Bill 236, as well as the sequential intercept model, can take the risk, needs, and responsivity model into consideration. When we talk about diversion or deflection from the criminal justice system for individuals with behavioral health conditions, we also want to make sure we can uphold public safety and identify the treatment needs, so we can provide, what we would consider, adequate dosages of treatment for the individual.

A model has been developed and implemented in Nevada for the last several years, and it is called the risk, needs, and responsivity model. When we apply this model, we look at the risk or likelihood that an individual may reoffend and try to identify the propensity for criminogenic behavior. This falls into a category of low, medium, or high. For individuals who are in drug court, we actually see the greatest return on investment when we identify those who have both a high need for treatment as well as a high risk for recidivism. Those courts do well when they can identify that population and serve that population within drug court. Risk is really focusing on the potential risk for recidivism or to reoffend.

I will provide a brief overview of the risk, needs, responsivity model. We use this model to help identify the risk for recidivism or the propensity to reoffend, as well as an individual's actual needs and how those needs might be best met as it relates to treatment and then responsivity. Responsivity is considered all of the different factors that can contribute to an individual being able to benefit from treatment and interventions. This includes their needs

and motivations, as well as learning styles, but other variables can also be considered. Variables such as learning disabilities, language, and the ability to access treatment in the language of preference for that individual can all impact responsivity. We apply this model to help identify those individuals who may best benefit from programs for deflection and diversion, as well as those who have high treatment needs that can be treated within the criminal justice system including incarceration.

Intercept 0 is community services. We differentiate between deflection and diversion by essentially saying that deflection can occur when there is no offense that has occurred. Putting charges or arrest aside, we really want to make sure that individuals can benefit from deflection, prior to having a risk for interfacing with the criminal justice system. This Intercept 0 optimizes community crisis services. Law enforcement can assist with a warm handoff to local crisis care services, and ultimately the goal is to connect people with treatment or services instead of arresting them or charging them with a crime.

Examples of deflection services in Nevada include: (1) crisis call centers, 911, as well as 988, which is our national suicide prevention lifeline; the entire continuum of services as it relates to crisis care; (2) our crisis response teams (in Las Vegas we have a crisis response team which is a coresponder model with behavioral health and EMS); (3) mobile crisis teams and mobile outreach safety teams; and (4) crisis intervention training for law enforcement. This also includes harm reduction strategies such as overdose education and naloxone leave behind programs. We have a leave behind program in the Washoe County Sheriff's Office. When law enforcement is on the streets and they encounter individuals that may be at risk because of opioid use, they can provide overdose education and leave behind the naloxone for them. It also includes homeless outreach teams as well as what has yet to be launched, but is part of AB 236, which is the behavioral health field response grant. This would provide funding to coresponder models with law enforcement and behavioral health coresponding to individuals in the community who are experiencing crisis.

Nevada's crisis system is a continuation of the overview of SB 390. We have been working over the last several years to develop the Crisis Response System within Nevada and specifically as it relates to 988. The vision of the Crisis Response System and 988 will serve as the foundation of Nevada's behavioral health safety net. We will reduce behavioral health crises, strive to attain zero suicides in our state, and provide a pathway to recovery and well-being. You can see the mission on the slide as well.

When we talk about a coordinated crisis continuum, we are talking about three primary rungs on a ladder, but we recognize there are many different rungs or steps between these primary rungs. The first is the crisis center, ensuring that individuals have someone to talk to. We anticipate by year three of implementing 988, that we will have upwards of 99,000 individuals within Nevada potentially contacting the crisis call center through 988 to access someone on the other line to help address their issues. We know from our own data, as well as nationally, approximately 80 to 90 percent of individuals who call a crisis line can have their issues resolved to a point where they may not need immediate follow-up, and the crisis call center could also connect them to follow-up care.

For the percentage of individuals who need immediate assistance, we have mobile crisis teams that go into the community and respond to an individual where they are, to address the crisis they are experiencing. We must also ensure that we have crisis receiving and stabilization centers. The Nevada Legislature passed legislation during the 2019 and 2021 Sessions to establish crisis stabilization centers statewide. These centers offer a warm and welcoming environment for individuals who are experiencing crisis but need a short, less than 24-hour stay and more observation. Recognizing that having a place to be able to

assess and refer individuals can also unburden some of our emergency rooms. Some of the essential crisis principles and practices include initiatives such as zero suicide.

As I mentioned, 988 is going live on July 16, 2022. We are working with our primary and secondary 911 dispatch lines to make sure we have connectivity. At the very least, a low-tech way for calls to be transferred between 911 and 988, depending on the severity of the needs of those calls.

The foundation for crisis care is 988. We recognize that when it comes to a community response, law enforcement will still have the ability to deploy within the community as the call comes into 911. There is also the need for a differential response for calls that are coming to 988. Recognizing it is more than just a call center, individuals can go into a community to work with people in crisis where they are, as well as having crisis facilities as an alternative door to emergency rooms and jails, so individuals who are in crisis can be diverted from jails and into crisis centers.

Crisis response partnerships include 911; about 10 to 15 percent of the calls to 911 nationally are estimated to be more crisis- or mental health-related. We are recognizing that not only will the calls for 988 continue through the National Suicide Prevention Lifeline, but there are a portion of those 10 to 15 percent of 911 calls that could successfully be diverted over to 988. An array of interventions will then be offered by 988 that are not necessarily public safety driven and help to set forth a cascade of care that is much more specific to the behavioral health issues that they are struggling with.

Some deflection programs that are discussed in AB 236 include law enforcement officer training to ensure that law enforcement officers have access to things like crisis intervention training, as well as how to identify individuals in a behavioral health crisis and how to adequately intervene. Also, the reinvestment of dollars resulting from cost aversions through AB 236 can be invested in a behavioral health response grant program for the responder model for law enforcement and behavioral health to respond into communities.

Intercept 1 and diversion are before individuals are arrested or before they are booked, but often after they have committed a crime or had some involvement with law enforcement. These examples in Nevada include the law enforcement intervention for mental health and addiction (LIMA) program in Clark County, mobile crisis teams, mobile outreach safety teams, crisis response teams, civil protective custody and protective custody for individuals who are under the influence of either alcohol or a controlled substance, crisis stabilization centers, crisis triage centers, and the behavioral health field response grant.

This is a snapshot of our mobile outreach safety teams and the number of individuals they are interfacing with on a monthly basis. This is a snapshot from our Behavioral Health Chart Pack, which is generated out of the Office of Analytics, DHHS. These are available online to the public, as a public facing link, on the Office of Analytics. You can see here that we have mobile outreach safety teams that are interfacing with individuals across the regions in our state, including Clark and Washoe Counties and our rural regions. Mobile outreach safety teams are really a coresponder model, again, pairing law enforcement with behavioral health to deploy into communities as a result of a call coming into 911 dispatch. These teams are not intended to be able to deploy as a result of a call coming in from 988, in order for an individual to be served in the community.

One example of a diversion in our communities is the LIMA program. The program is a partnership between Clark County Eighth Judicial District and Las Vegas Metropolitan Police Department, funded by DPBH, DHHS. Essentially, law enforcement is now empowered in

Las Vegas Metro; when they are on the street encountering individuals in the community, they can divert them into treatment instead of arresting them. The services that are provided through this program include: withdrawal management, treatment services across the automated care management (ACM) continuum, collaborative case management, weekly meetings with their case manager, connection to transitional housing and/or permanent housing, assistance in securing vital documents, and assisting with a positive support system including peer supports. The programs that are utilized by LIMA are all Substance Abuse Prevention and Treatment Agency (SAPTA) certified.

Intercept 2 can occur during initial detention or through court hearings. This helps when they identify individuals who are coming into jails who have a higher need for treatment than a risk for recidivism and a threat to community and public safety. There are opportunities to divert out of the programs and into treatment. These include our forensic assessment services and triage teams (FASTT). While an individual is awaiting trial, pretrial community supervision allows them to be supervised in the community instead of being retained in an incarcerated setting. Some of the presentencing investigation reports provide a comprehensive view of an individual for the judges to consider prior to making their determinations on sentencing. More detailed examples of the forensic assessment services triage teams are the FASTT programs in jails in Douglas, Lyon, and Churchill Counties as well as Carson City. These are partnerships between local jails and community behavioral health providers, again, funded through DPBH. These participants are referred to services based on their needs, and the services can include substance abuse and mental health treatment, collaborative case management, and connection to temporary or transitional housing as they are reentering into the communities.

Intercept 3 is court- or jail-based care. This happens after the individual has been booked into jail. These programs can also defer individuals into community-based services through jail-based assessments and follow-up for those warm handoffs into the community, as well as through court processes and programs. Examples of these include jail-based withdrawal management programs, opioid treatment programs, and affiliation. I mentioned earlier, the Washoe County Detention Center has started its own opioid treatment program, but there are other jails that have opioid treatment programs in the community, push-in services into the jails to ensure that individuals have access to treatment for opioid use disorder while incarcerated. Jails are also doing a lot as it relates to behavioral health treatment programming by ensuring that programming is available while individuals are incarcerated; providing medication management, including medication management for psychiatric issues; and utilizing specialty courts, including MAT specific specialty courts, drug court, youth offender courts, family drug courts, as well as veterans' courts.

As I mentioned before and will touch on briefly, the Washoe County Detention Center started an opioid treatment program. Through this program, individuals, as they are coming into the jail, are screened for opioid use and risk for withdrawal to determine if they may have an opioid use disorder. Medication assisted treatment can be initiated for withdrawal symptoms, and medication maintenance is also provided as a course of treatment. Then there is a bridge to the community for that warm handoff for referrals for continuity of care for maintenance, treatment, and recovery support services.

Intercept 4 is reentry. As individuals are reentering into the community following incarceration either through jail or prison, this involves the linkage and referral to community-based services and supports. It also helps to support eligibility determinations and benefit enrollment to ensure people have access to insurance, housing, food, and employment opportunities upon reentry. Examples in Nevada include Temporary Assistance for Needy Families (TANF); Women, Infants, Children (WIC); Supplemental Nutrition

Assistance Programs (SNAP); and Medicaid benefits. Specifically, as individuals are reentering into the community, we have a reentry court through the Eighth Judicial District, residential treatment programs, and transitional living programs for individuals who previously have been incarcerated.

An example is the Eighth Judicial District reentry court. This is a partnership between the Department of Corrections, the Eighth Judicial District, as well as some grant funding. They have developed a reentry court to reduce the occurrences in overdose and relapse as individuals are reentering into the community following release from prison. This is actually a collaborative program that started as the court system noticed a large number of individuals reentering after incarceration through our Department of Corrections were relapsing very quickly, most often before they were able to actually engage with parole. It created a lot of issues, not the least of which was several overdose deaths as a result of the relapse that was occurring post reentry. We got together and they have developed this wonderful reentry court. They are having some amazing success, and individuals who are involved in the court have access to MAT, as well as an array of treatment services, collaborative care management, connection to housing, assistance with securing vital documents, and assistance with establishing a positive support system including peers.

Finally, Intercept 5 are community correction programs that help to integrate criminal justice supervision through parole and probation, with additional treatment and recovery services. The goal of these programs is to support reentry into the community and reduce risk for recidivism.

Assembly Bill 236 actually did a lot of work on the portions of reentry. Several provisions regarding parole and probation include training requirements for individuals and parole and probation on evidence-based practices; requirements for the petition of early discharge of a person who is on parole; requirements for reentry programming and coordination with state agencies, starting before the individual is moving into the community so adequate time can be allocated to ensure a warm handoff; and also ensuring that the consumption of alcohol or a positive drug test cannot be the sole reason for revocation of supervision. Many individuals that we had seen were being remanded back to prison because there was a relapse. Under AB 236, now it is seen as a relapse in opportunity to reengage that individual into treatment planning and an opportunity to reevaluate what might be needed or was missing before to help that individual continue on their recovery trajectory.

To put all of this together, the sequential intercept model offers many different pathways to treatment. This includes the collaboration between law enforcement and the criminal justice system, as well as the treatment system. The way these systems can work best together, is recognizing when an individual has a behavioral health condition that could benefit from treatment. We must ensure there is identification screening and assessment, as well as referral and placement into treatment; continuous monitoring and reporting of those programs that are working in conjunction with the criminal justice system to provide treatment and recovery services; and available recovery supports to those who need them. This is done through systems, communication, collaboration, and case management. Chair Peters, that concludes my formal presentation, and I am available for questions.

Chair Peters:

Are there questions from the Committee? I do not see any questions; we will reach out to you, Dr. Woodard, if we have other questions that come up on this particular issue area. Thank you so much for your time and effort; we really appreciate you being here with us and your expertise in area.

AGENDA ITEM X—RECOVERY FROM SUBSTANCE USE DISORDERS AND RECOVERY-ORIENTED SYSTEMS OF CARE

(This item was removed from the agenda.)

[John F. Kelly, Ph.D., A.B.P.P., Elizabeth R. Spallin Professor of Psychiatry in Addiction Medicine, Harvard Medical School, and Director, Recovery Research Institute, Massachusetts General Hospital, was unable to appear before the Joint Interim Standing Committee on Health and Human Services. Chair Peters indicated Dr. Kelly would provide this presentation at a subsequent meeting.]

AGENDA ITEM XI—OVERVIEW OF STRATEGIES TO REDUCE THE HARM CAUSED BY SUBSTANCE USE

Chair Peters:

We are going to move into Agenda Item number XI. This is an overview of strategies to reduce the harm caused by substance use. There are quite a few presenters; please proceed when you are ready.

Jessica Johnson, Senior Health Educator, SNHD:

Good afternoon, Chair Peters, and Committee members. I am the first in a series of presenters today on harm reduction options. I will be providing an overview and definitions (Agenda Item XI).

Earlier today, you heard some sobering statistics from our colleagues collecting and analyzing data; this is a brief reminder, on the screen, of the sobering story we are seeing in Clark County reflected statewide. As a country and as a state, we are painfully aware of the magnitude and cost of substance use and associated harms to our citizens and our society. These are our family members, our friends, this is us.

In desperate times such as these, it is imperative that we cast aside old thinking, acknowledge underlying stigmas, and commit ourselves to a public health-oriented "all evidence-based strategies forward" approach. *[lost connection].*

Karla Wagner, Ph.D., Associate Professor, School of Public Health, UNR:

Chair Peters, this is Karla Wagner for the record. I am on the docket to present here, and I have Jessica's slides if you need me to step in.

Chair Peters:

Go ahead and if we get her back, we can swap out again. Let us keep going if we can.

Dr. Wagner:

I think what Ms. Johnson was saying is, in this moment, we have an opportunity to hear from people engaged in the boots on the ground work that is saving the lives of people in Nevada and across the country who use drugs. Harm reduction work is work that has been done for many years. It has a history in this country long before it became a term that came into popular vernacular.

Over the next few slides, we are going to take the opportunity to get everybody on the same page when we say "harm reduction," and then there are several of us on the panel that are going to talk about specific aspects of harm reduction programing and what opportunities we have.

Harm reduction is a term that is used in many ways. To get everybody connected in terms of what we are talking about today, we are talking about a spectrum, or a continuum, of practical strategies to reduce the harms associated with substance use. Harm reduction happens on a continuum from safer drug use techniques, to reducing or managing use, all the way to abstinence or stopping to use drugs for some people. It is focused on promoting the dignity and well-being of people who use drugs. It is more than a set of practical strategies though; it is a framework for grassroots and social activism. It is a movement to understand structural inequalities, and we focus on harm reduction in upstream determinants of health, things like poverty, racism, homophobia, and classism that drive health-related outcomes among people who use drugs.

A common way of talking about harm reduction is we say that harm reduction promotes low threshold services, and it is a way to meet people where they are at. We mean that both literally and figuratively. That means meeting people where they are in the community and taking services to them. It also means meeting people where they are at in their drug use and their life by working with them to engender the kind of change they value and can see as reasonable next steps for themselves, not imposing change on people. There is a link here to the National Harm Reduction Coalition website. They have a really nice set of informational slides about the history of harm reduction and how we do this work.

There are six principles that form the foundation of what it means to do harm reduction work. There is essentially no gold standard for harm reduction programs. They are usually grounded in a by-the-community, for-the-community approach. We often say that harm reduction work is work that is done mostly by people who use drugs, for people who use drugs. The first principle that undergirds the work that we do is health and dignity, acknowledging that drug use is complex and exists on a spectrum of use and safety. In this principle, we establish the quality of individual and community life and well-being as the criteria for successful interventions. Second is participant-centered services calling for nonjudgmental, noncoercive provision of services and resources to people who use drugs and the communities in which they live. Third is participant involvement, by which we mean ensuring that participants and communities impacted by drugs and the interventions that we promote, are at the table in the creation or discussion of programs and policies that are designed to serve them. The fourth principle is participant autonomy, by which we mean affirming that participants are the primary agents of change. We seek to empower participants, to share information, and support each other in strategies that meet their actual conditions by giving them the resources to do so. Fifth, we address sociocultural factors recognizing that the realities of various structures and systems of social inequality affect both peoples' vulnerability and capacity to use drugs and to reduce drug-related harms. Finally, harm reduction is founded on principles of pragmatism and realism. We do not attempt to minimize or ignore the real and tragic harm or danger associated with drug use, but we do acknowledge there are practical strategies that we can engage in to mitigate those harms. I will hand this back to Ms. Johnson.

Ms. Johnson:

My apologies to the Chair and committee. Thank you for stepping in Dr. Wagner; teamwork makes the dream work. Excellent coverage of the principles.

The scientific literature is clear on the benefits of harm reduction and harm reduction programs. There have been over seven governmental reports, across nearly 40 years of research, that cite the direct benefits of harm reduction programs. These include the prevention of blood-borne infections; stopping overdose and reducing substance use for those engaged in syringe service programs; support of public safety, particularly through the reduction of the presence of discarded syringes in the community and needle stick injuries among first responders; cost effective interventions, reducing health care costs such as preventing HIV, viral hepatitis, endocarditis, and other infections; and stigma reduction, providing an affirming space to combat stigma.

Harm reduction efforts began in the United States in the late 1980s with syringe services in response to the HIV epidemic and have expanded in recent years within Nevada. Some of the key legislative efforts, as you have heard highlighted throughout the day.

Harm reduction cannot thrive if we also do not address drug-related stigma. Stigma remains one of the largest and most persistent drivers of negative outcomes for those struggling with addiction. Stigma impacts an individual's ability to participate in the various systems—social, economic, health care access, et cetera—which further erodes someone's self-worth, increases social isolation, reduces access to care, exacerbates the issue, and increases the risk of overdose death. The statistics on this slide are from a national survey conducted by Shatterproof and The Hartford and demonstrate the pervasive stigma that continues among the public and health care professionals when looking towards improving the efficacy of harm reduction.

As a state, we must continue to come together around meaningful solutions, including the treatment, recovery supports, and harm reduction to end the overdose epidemic and save the lives of Nevadans. My references are on the next slide. I will turn this over to the next presenter if the Chair does not wish to take questions at this time. Thank you and thank you, Dr. Wagner.

Chair Peters:

Thank you so much. I will go ahead and have everyone present and then we will take questions at the end. Ms. Berry is next, if you would like to begin.

Michelle Berry, M.B.A., Nevada State Opioid Response, Senior Project Manager, Center for the Application of Substance Abuse Technologies, School of Public Health, UNR:

Thank you for having me today. I am housed at the Center for the Application of Substance Abuse Technologies, which is in the School of Public Health at UNR. We manage the SOR grant on behalf of DPBH. The program aims to address the opioid crisis by increasing access to MAT for opioid use disorder, reducing the unmet treatment need, and reducing opioid overdose related deaths through prevention, treatment, and recovery efforts. We look at implementing prevention, treatment, and recovery support services that are also aimed towards stimulant use and misuse and it includes cocaine and methamphetamine. For the purposes of the presentation today, I will be going over our overdose education and naloxone on distribution efforts (Agenda Item XI).

The state opioid response covers all of the target areas that were identified in 2016 as priority areas for Nevada. These include prescriber education and guidelines, treatment options and third-party payers, criminal justice interventions, data collection, and intelligence sharing.

Those priority areas are highlighted through eight major goals of SOR, and we have heard a little bit about the SOR grant. These are the three different time frames, and the dollar amounts that have been awarded to the state for the reduction in opioid use. We started this initiative in 2017; we were renewed for funding in 2018 and then another iteration in 2020.

Dr. Woodard went over, earlier today, the development of a hub-and-spoke model and what that looks like for service delivery. That is what we try to really focus on and develop during the state-targeted response years. Then we moved forward to the state opioid response, the additional provision of getting organizations ready to provide MAT in outpatient setting. Now in SOR II, we have encompassed stimulant use disorder and expanded our focus to funding residential, transitional living, and withdrawal management services.

Our overdose education and naloxone distribution efforts started in 2018. As of February 2022, we have 26 partnering agencies, forming 42 naloxone distribution sites across the state. The majority of the naloxone that has been distributed across the state came from two places: one being the SOR grant and the other being the first respondent care grant that SNHD had for several years. They took the lead on distributing naloxone through Clark County, and then the SOR grant distributed to the rest of the state. With their funding ending, we are providing the naloxone to SNHD to then provide to their communities-based providers.

As of September 2021, we have assembled and distributed 23,139 doses of naloxone and 21,830 kits; 1,391 reversals have been reported and 6,871 kits have been distributed to law enforcement/first responder agencies. One of the questions from this morning was who these kits were distributed to. Recipients are individuals who use drugs, clients in substance use disorder treatment, first responders, and community distributors. I will provide those numbers to the Committee. We do have a virtual dispensary that outlines where the sites are for individuals who are seeking naloxone; it is real time and can be found on the website: www.nvopioidresponse.org.

Ms. Johnson will speak to the Clark County overdose plan for the distribution of fentanyl test strips. For SOR, we are looking at the distribution of fentanyl test strips going live in March 2020, first targeting harm reduction organizations and needle exchange programs. We will then target organizations that engage in street outreach and work directly with high-risk populations, followed by law enforcement and first responders, and then our existing naloxone distribution sites that will also be distributing the fentanyl test strips within the naloxone kits. Ms. Johnson, do you want to speak briefly about your fentanyl test strip plan?

Ms. Johnson:

Clark County's OD2A grant received permission from the CDC to utilize dollars for fentanyl test strip distribution. We have developed a training for community partners distributing test strips. To date, 32 people from 6 agencies have completed the training process. Since the launch in December 2021, SNHD has four certified local distribution sites throughout the county and approximately 2,400 strips are out at these distribution sites for clients to receive training and pick up.

Ms. Berry:

I wanted to mention, the SOR grant also looks at other harm reduction efforts through our media campaigns including stigma reduction; trying to normalize the use of naloxone;

zero suicide efforts, which Dr. Woodard spoke briefly about earlier; screening, brief intervention, and referral to treatment; and working with organizations for neonatal abstinence syndrome focus projects. That concludes my part of the presentation; I can turn it over to my next colleague.

Chair Peters:

Thank you so much. It looks like we have Dr. Christina Parreira. It looks like we are having technical difficulties. Is it possible that we can skip through this section and then come back to her when she arrives?

Dr. Wagner:

Chair Peters, this is Karla Wagner again. I have her slides and can give it a go. I am not as familiar with this, but my colleagues can jump in.

Chair Peters:

Thank you, Dr. Wagner. Please go ahead.

Dr. Wagner:

Christina Parreira works at Trac-B Exchange, which is one of the two brick-and-mortar syringe exchange or syringe service programs that we have in Nevada. These next few slides are describing some of their efforts (Agenda Item XI). Ms. Johnson may want to jump in here at several points just to flush out some of the robustness and the harm reduction services that Trac-B is offering in southern Nevada.

Syringe service programs are one of the foundational strategies that we employ in a harm reduction way of thinking to address drug-related harms. Syringe service programs provide people who inject drugs with sterile injection supplies; we know and now have 30 years of evidence to demonstrate it can reduce the spread of HIV, hepatitis C, and other blood borne pathogens. People who inject drugs are also at risk for soft tissue infections or abscesses and other less common infections, like endocarditis infections of the heart, that can be transmitted through injection with nonsterile equipment. Syringe service programs ensure that people have clean, new syringes for every injection. They also work to ensure safe disposal of used syringes by giving people a place to return their used syringes.

Chair Peters:

It looks like we have Dr. Parreira back.

Christina Parreira, Ph.D., Health Educator, Trac-B Exchange:

I am sorry; my computer crashed, and I finally got back on. My name is Christine Parreira. I am a health educator at Trac-B Exchange, which is the first syringe service program in Las Vegas. We offer a lot of services other than that though, such as: (1) naloxone, which we have talked about at length for overdose reversal; (2) fentanyl test strips, so people can test their substances and see if they are laced with fentanyl; (3) and safer sex supplies—condoms, lube, dental dams, plan B pills. Also, a lot of syringe service programs, including ours, offer HIV and hepatitis C testing and linkage to care, for free, to people who test positive. These programs are extremely cost effective. The lifetime cost of treating HIV is approximately $380,000, where as a syringe cost two cents.

The great thing is that individuals who go through these programs often end up engaging in treatment and being connected with community resources simply because they are around providers that they normally would not be around. For example, if you are going to Walmart to buy your syringes, you are going in and out. However, if you are going to a syringe service program, there are counselors, peer recovery sports specialists, and pamphlets that talk about treatment services. People are actually getting connected with some of these resources and services to be able to get them from using into recovery if they so choose.

Trac-B exchange services is southern Nevada's first and only syringe exchange, which opened in 2017. We offer syringe exchange, and safe disposal is a big part of what we do to reduce needle stick injuries. We offer naloxone medication and training, fentanyl test strips, HIV and hepatitis C testing, and linkage to care. We have seven public health vending machines in Las Vegas and one in Hawthorne. We are the first in the country to implement these public health vending machines, but it is starting to catch on in other places. We also offer MAT—Suboxone, Sublocade, Vivitrol. In our peer recovery support services, our peers all have at least two years in recovery, and they all have lived experience. I also do some of the peer work, and we help people with anything from housing to getting into treatment to getting IDs, basically anything we can help with to get them on the road to recovery. We have counselors, and everybody who is in the MAT program has to get counseling at least once a month. Then, we extend our services to rural Nevada; as I am sure we all know, there is not a lot out there. I am actually one of the people who goes to some of the jails, such as the Lincoln County Detention Center in Pioche, to help people get on MAT when they come in and then get them hooked up with treatment, if that is something that they are looking for.

This is some data from Trac-B Exchange from 2021. We put out 728,878 syringes, and our return rate is really fantastic; we took in 570,404. For Narcan, 7,099 doses were given out. We then track people who come in for refills—what they did with it, if they lost it, whether they used it, or whether the police took it—197 refills were due to be used, and of those, 189 of the overdoses survived, 2 passed away, and 6 outcomes were unknown. In 2021, we had 1,172 new clients who signed up for the syringe exchange and 11,328 returning clients. We had 519 HIV tests conducted, with 505 being negative and 14 positive; 130 hepatitis C tests were conducted, and 101 were negative and 29 were positive.

Here is a picture of one of our public health vending machines. They are discrete. We have them in methadone clinics, and we have one on the way to the Washoe County jail. These are nice for people who might be embarrassed to go to a syringe exchange. They can go up, and put in their unique identifier ID; they do not have to talk to anyone, and they can get their stuff and leave. It is a novel approach to an old problem, and it makes it very convenient for people. All people need to sign up is an ID. They can get access to any of our eight locations across Nevada; seven of those are in Clark County and one is in a rural area, Hawthorne. All of the contents are free to our clients. They include syringes, Narcan, hygiene kits, pregnancy tests, safer sex materials, sharps containers, and first aid kits. What is nice about these, is we do tailor them to the community. We have run into some communities, where we are still trying to get a machine, and they say that are not comfortable with the syringes, so we do not have to include the syringes. We completely tailor these machines to what the communities say they need and with what they are comfortable.

Next, we have vending machine data from 2021. Total transactions were 8,282, and we put out 167,110 clean syringes. We do not have data on the syringes we took back because next to each vending machine there is a large sharps container and people just throw them in there, so that is hard to track. For naloxone, we gave out 514 kits, which breaks down to

1,542 doses. We gave out 429 safer sex kits, which breaks down to 2,574 condoms; 773 first aid kits; 500 hygiene kits; 237 pregnancy tests; and 110 sharps containers. That is our vending machine data for 2021. With that, I will wrap up my portion, and thank you so much.

Chair Peters:

I wanted to take a point of privilege to suggest, that in engineering, when we are trying to collect data on something that is a little abstract to collect, we use weight data. If you take the weight of the empty container and then the weight after it is filled, you can make an estimate of how many have received.

Please go ahead, Dr. Wagner.

Dr. Wagner:

This begins my official presentation (Agenda Item XI). My name is Karla Wagner. I am an associate professor at the School of Public Health at UNR. I am here, not representing the university, but speaking about best practices, current research, and some emergent issues in the field as we think about harm reduction solutions.

I have a large portfolio of research funded by the CDC and the National Institutes of Health, much of which is involved with many of the programs that you have been hearing about today. We have a study that examines the impact of the peer recovery support services that are offered in emergency departments as part of the SOR and state-targeted response grants that Ms. Berry just told you about. We have new research funded by the CDC that is looking at the intersection of opioid use and methamphetamine use; it is a multisite study between Nevada and New Mexico.

I also have two Ph.D. students who are working on very relevant and timely programs that we have also heard about today. One is studying the deployment of the harm reduction vending machines that Dr. Parriera just told you about, to look at the impact, the reach, and who is using them. Another is looking at the interest in buprenorphine prescribing among Nevada physicians and doing some early work to look at the implementation of the emergency department bridge buprenorphine program that Dr. Woodard told you about earlier where emergency department physicians are initiating people on buprenorphine in the emergency department before they leave.

First, I am going to share a little bit about the history of and best practices for overdose education and naloxone distribution. You may know that overdose education and naloxone distribution have a very long history in the United States. We only started talking about this in Nevada in about 2014, and across the United States in about 2010. The first U.S. program distributing naloxone directly to people who use drugs was started in 1996 in Chicago. This program has a long history and there is quite a bit of data. At this point, it is quite commonly accepted that distributing naloxone to people who use drugs must be part of our national strategy to address opioid overdose morbidity and mortality. A new article that just came out in *The Lancet Public Health* suggests that even despite this long history, no states in the United States are distributing enough naloxone to reach the targets that would signal an effective public health intervention. In this case, they were modeling naloxone used at 80 percent of witnessed overdoses.

You just heard some data about the thousands of kits we have distributed in Nevada, and we are very proud of that. We are also very proud of the naloxone expansion law and our

911 Good Samaritan law that allowed us to do this on such a large scale. But what the science is telling us, is that we are not getting enough kits out there and we are not getting them to the people who need them, not just in Nevada, but nationally, too.

Another thing that I want to point out about overdose education and naloxone distribution, is that it is an educational and comprehensive training program. When we teach people about overdose, we teach them how to recognize and respond to an overdose using naloxone. We also teach them how to prevent an overdose. Naloxone distribution, however, is not a substitute for medical care and medical follow-up. The best practice is to train people to call 911 to seek medical care when they have witnessed an overdose. This is important because as naloxone distribution has been adopted as part of our national strategy, part of what has happened is that the burden of recognizing and responding to overdoses has shifted to the communities of people who use drugs. It has shifted away from the emergency medical and first responders and towards people who use drugs. It is important to recognize that because people who have experienced an opioid overdose can benefit from follow-up medical care, not only because of linkage to services, but also because they might be experiencing medical complications that really need a professional medical response.

Another challenge we are recognizing in the national research literature is the conflict between the directive to call 911 when you witness an overdose and the concerns that people who are responding to overdoses have in terms of the law enforcement response that might be generated by that call to 911. Specifically, I believe every state in the nation has a 911 Good Samaritan law that is designed to provide protections for people responding to an overdose against charges related to drug possession, paraphernalia possession, and some other minor offenses. It is not clear that those protections are sufficient, and it is not clear that people who are in the community trust that the law will be implemented in a way that protects them. There is some conflict between the public health imperative that people respond to overdoses of naloxone and call 911 and the criminal justice response that people fear when they are doing so.

Another challenge that I want to point out is related to naloxone distribution. There has been a tremendous increase in the number of doses that have been distributed over the last many years. During that time, we have faced many supply disruptions on the manufacturing side. We also encounter funding hiccups depending on where the money is coming from to buy the naloxone as well as pipeline challenges in terms of getting the naloxone into the right hands. What I want to highlight here, is, that when this happens, the people who end up without naloxone are typically the most vulnerable. When we have supply disruptions or funding problems, the folks who are not getting the naloxone are those most vulnerable to the consequences related to that. This is something that we need to pay attention to moving forward.

One more challenge, based on things I was hearing this morning, as you are all aware, is the increases across the nation in stimulant-related deaths and deaths related to the coinvolvement of stimulants and opioids and opioids including fentanyl. Naloxone can be effective in response to a fentanyl-related overdose, but it often takes multiple doses. But it cannot be effective in response to a stimulant-related overdose. In Nevada, we have a long history of a high prevalence of methamphetamine and methamphetamine-related morbidity and mortality, and naloxone distribution is not the fix for that.

I wanted to spend a little bit more time on this issue of places where public health and criminal justice efforts have an opportunity to harmonize. One of the things we know about 911 Good Samaritan laws is they were enacted to reduce the perceived consequences of

calling 911 to seek medical care for somebody who is dying of an overdose. They do that by providing protection for things like possession of drugs for personal use or possession of paraphernalia, low-level charges. We know from the last decade of research with people who use drugs that they are afraid of many more things than what is protected by the law. For example, possession with intent to distribute is not protected; people are afraid of losing their housing if the police or ambulance show up to their house, and people are afraid of involvement of Child Protective Services. There are a lot of things that people worry about that serve as a barrier to calling for help that are not protected by a typical Good Samaritan law.

One of the things that is emerging in the field is this issue of drug-induced homicide laws. We have one in Nevada, and several other states have drug-induced homicide laws. These laws punish people for furnishing a substance that caused the unintentional death of the person who consumed it. The consequences are quite high; it is punishable as second-degree murder with a sentence of 25 years or life in prison in Nevada. These kinds of laws are in direct conflict with the public health effort to get people to call 911. For many years there have been calls to harmonize law enforcement and public health goals as a way to reduce overdose deaths, HIV transmission, and other harms. When the criminal justice codes and public health codes are in conflict, typically the fear of criminal justice consequences is what influences behavior rather than concern about health risks. What we know from several years of research is that negative interactions or fear of law enforcement leads to more syringe sharing and leads to not calling 911 for an overdose. I have done research on this topic both in Nevada and elsewhere, and this is a persistent concern among people who use drugs and an opportunity for improving our public health response. Now I will hand you over to Ms. Lee.

Lisa Lee, M.A., CPRSS, DrPH Student, Walden University Program Specialist, Human Services Agency, Washoe County:

Good afternoon, everyone. I am a person in long-term recovery from opioid use disorder and a program specialist for Washoe County Human Services Agency. Thank you for your time and the opportunity to speak with you today. I am here to provide information about overdose and disease prevention sites and background on the bill which was presented last session (Agenda Item XI). The information presented here in no way reflects the views of my employer.

I would like to begin by thanking the many individuals who contributed to the development of Bill Draft Request (BDR) 40–978 which became AB 345 in the 81st Legislative Session, especially Assemblyman Orentlicher, who sponsored this piece of legislation, Dr. Karla Wagner, Robert Harding, Lea Moser, Megan Comlossy, Dr. Joanne Csete, Dr. Alex Kral, and all other members of the working group.

In my previous position before coming to the county, I was with Trac-B Exchange and launched a fentanyl test strip pilot in Washoe County. What prompted this collection of data, was that during naloxone distribution efforts, folks were reporting that they were using four to five individual naloxone units to reverse one overdose. This all happened very suddenly about last March and prompted the fentanyl test strip pilot in northern Nevada. It was launched from April 4 through May 16, 2021, right before I joined Washoe County Human Services Agency. The data indicated a 93 percent fentanyl positivity rate in heroin and a 67 percent positivity rate in methamphetamine.

In my personal life, I have lost 11 folks in the last 12 months, including two family members, to either fatal drug poisoning or drug-related harm. Unfortunately, these personal

losses are reflected in the most recently available surveillance data. Problematic substance use, reoccurrence abuse, and drug poisonings have definitely been exacerbated during the pandemic. As you saw earlier, and I will not go over these slides because this is much older data than what you have heard this morning, Nevada has experienced an uptick in fatal drug poisonings. Our data in Nevada nears national trends of increasing overdose fatalities during the pandemic. During which, an estimated 100,306 people died in the United States for the reporting period from May 2020 through April 2021. Just to put the human perspective back in it, that is over 100,000 people who will no longer sit with their friends and family during the holidays.

Nevada has done a great job and has a multilayer policy and funding priority strategy in place to combat the opioid crisis. The Nevada DBPH, as you heard, has funded MAT extension statewide, as well as naloxone and fentanyl test strip distribution. Further, Nevada legalized syringe service programs in 2013, prescription drug monitoring programs, the Good Samaritan Drug Overdose Act, and layperson naloxone access in 2015. In 2021, Nevada legalized drug-checking supplies, such as fentanyl test strips, adding to the overdose prevention toolkit.

However, pointing back to the last legislative session, we still do not have overdose prevention sites (OPS). I just want to confirm that when we say OPS, this is synonymous with what is referred to as a safe injection facility, safe consumption facility, or an overdose prevention center. These are all synonymous, and I have heard a bunch of different terms to refer to the same thing. These are interventions that are well supported in the literature that go back many decades. Some of the highlights that research on OPS has found include the following outcomes: people share syringes and other safe injection equipment a lot less; they lower blood borne transmission rates, such as HIV and hepatitis C; there is a positive correlation with linking people to services, including substance abuse treatments; they also encourage safe syringe disposal, which means less syringes discarded in public places; there are less cases of public injection, so people are not injecting in public or semipublic locations; they lower fatal overdoses and drug-related injuries, such as soft tissue infections like abscesses, endocarditis, et cetera. A recently published paper also found that there was no increase in neighborhood crime. They do not encourage drug naïve individuals to initiate use, and overall, they decrease the burden to emergency care like emergency departments and EMS services. There are a few suggestions for reading if you are interested in learning more on this topic.

Overdose prevention sites are an essential public health strategy designed to reduce fatal drug poisoning, reduce drug-related harms, reduce the burden on emergency services, and positively impact the lives of people with a substance use disorder. They can be either mobile or fixed sites, where people who use drugs can use substances that they bring on site under the supervision of training staff and with access to safe injection supplies. While this may sound radical, the first OPS opened in Switzerland in 1986. There are over 120 sites globally; there is even a Google map that maps the locations of these sanctioned facilities.

The first sanctioned OPS in North America was Insite, which opened in 2003 in Vancouver, British Columbia. Insite operates in partnership with Vancouver Coastal Health, which reported over 3.6 million visits from 2003 to 2019. During that time, there were 6,440 overdose reversals with zero fatalities and almost 50,000 visits to clinical treatment. Insight has a supervised consumption space on the bottom floor, a substance use treatment facility on the second floor, and a transitional living ward dedicated to recovery housing and transitional living on the third floor.

There were no legally sanctioned OPS in the United States due to prohibitive clauses within the controlled substances act. However, on November 30, 2021, the first OPS opened in New York City. It has been reported that as of January 23, 2022, less than two months in operation, there were 4,974 visits, by just over 580 unique individuals, and they had already reversed 114 overdoses. There is ample evidence that supports the effectiveness of OPS in reducing individual and community level drug-related harms.

Early last year, a working group assembled to discuss legislation that Assemblyman Orentlicher, an attorney, medical doctor, and health law professor was interested in sponsoring. The stakeholder group and existing statute helped to form the language in what we came BDR 40–978/AB 345. The bill was set to die in committee and was amended from the original language about an overdose and disease prevention site pilot that would authorize local health authorities in a community with over 100,000 residents. It pivoted and legalized drug-checking supplies, such as fentanyl test strips. As you heard, our state has been able to get those out to individuals and organizations. The original language would provide opportunities for Washoe and Clark Counties, through their county commissions, to pilot OPS that could operate as fixed or mobile sites and be operated by a nonprofit, health district, or academic institute. The sites would offer supervision under trained staff who would provide sterile consumption equipment, the ability to reverse overdoses should they occur, and education and referrals to treatment. The local health districts would provide oversight, and it would be anticipated that the sites would be well studied by academic researchers.

The language from BDR 40–978/AB 345 builds upon existing legal architecture in Nevada, including hypodermic device decriminalization and authorization syringe services programs. If anybody is curious in looking at these laws further, they are NRS 439.987 and 439.991. Layperson naloxone distribution and administration is NRS 453C.110 and 453C.120 and the Good Samaritan Overdose Act is NRS 453C.100.

Looking at the language in the original version of AB 345, the legislation would enable a pilot site in those counties with over 100,000 residents, which after two years of data and a preliminary review, would allow for other pilot sites in additional counties in Nevada, should they want those. Then after four years and a formal program evaluation, the pilot site could transition into a permanent site.

I would like to take a minute here because I think this is really important to discuss. A few years ago, under the Trump Administration, the U.S. Department of Justice filed a civil suit to stop Safehouse, which was the proposed OPS in Philadelphia, from opening. Safehouse appealed to the Supreme Court and in a very important Third Circuit Court ruling, they did stop Safehouse from opening citing "the crack house statute" from the Controlled Substances Act. However, as recently as last week, the U.S. Department of Justice did signal that it is reconsidering its stance on OPS.

I will now turn it over to my colleague Dr. Wagner.

Dr. Wagner:

I want to say one thing related to what Ms. Lee was just telling you about the federal position on the OPS. There are only a handful of people in the United States doing research on these sites at the moment, but the research they are doing is quite robust. Researchers are potentially getting some signals that there is a change in the way the feds are thinking about these things and there is some openness to considering the data. I think that is very encouraging.

I am going to present a little bit of data locally (Agenda Item XI). When Assemblyman Orentlicher approached us to start having conversations about what OPS legislation could look like, Ms. Lee and I seized the opportunity to do some data collection, both in Reno and Las Vegas, with people who use drugs to get their perspectives on what they would think about a place like this. It is a priority of our research group to center the perspectives of those for whom interventions are delivered.

In May 2021, we did a series of qualitative interviews with people who use drugs. We recruited mostly through convenience sampling and street-based outreach. We asked them essentially: have you ever heard of an OPS and what would you think about it, how would you like it to run, what do you see as the benefits, what are your concerns, and if we were to consider something like this in your community, how would you like it to be done?

This is a quick table that shows the demographics of the folks we were talking to. Some important highlights include that about 60 percent were unstably housed and reporting living in a park, street, abandoned house, or their vehicle, but about a quarter were living in their own house or apartment. They were about 36 years old, a little more than one-half were male, one-quarter were Hispanic, and just over 50 percent were white.

We identified three big overarching themes in the stories that people were telling us. We asked them: what do you think about an OPS, how would you use it, what would be the benefits, and what would be your concerns? People's opinions fell into three groups. They talked about benefits to self, benefits to others, and more broadly about benefits to the community. Some of these things align with things I was talking about earlier, in terms of opportunities to harmonize public health and criminal justice strategies. One of the biggest benefits that people perceived to their own selves from having an OPS in their communities, was someplace they could go to use drugs in a clinically supervised environment and they would not be at risk of criminal charges for carrying syringes. I do not know if I mentioned this on the slide where it was noted, but we are still hearing reports in Nevada of people being charged for carrying syringes, even though they should be protected under the paraphernalia law. We also saw benefits in terms of having another opportunity to access sterile supplies, to get help with other medical concerns like vein health, and to access referrals to appropriate services and care.

On the right side are quotes, the numbers are participant ID's, and the "Reno" is that these interviews were done in Reno. This is people actually talking about what benefits they would see to themselves. I want to draw your attention to the top one because it illustrates some of the themes I was talking about earlier. This person said,

> I have people ask to come over here to my house to fix or get high. I do not want to let people do that, but I let people do it here because I do not want them to do it in the street. That is problematic. I had one person overdose on me, which was frightening. Other people have requested to fix or get high here and I tell them no. I always feel bad. I just cannot risk it. It is probably how I got hepatitis; I was letting people fix at my place.

What you are hearing here is a person who has their own place, who is looking out for their friends and community members by allowing their friends to come over and use drugs in their house, so that he can keep an eye on them. He can be there to respond if somebody overdoses, but that is a big burden on him, it is an emotional burden, and it does put him at risk for some very serious criminal justice sanctions. To this person, opening a site where he could send his friends, where they could get medical care, get linked to services, and not be

in his home would be an enormous benefit that he sees not only to himself, but also to his friends for whom he is providing this informal service.

Many people did not think they would use the site themselves, but saw how this could benefit other people, keep people from having to do this stuff in public, it says in that first quote. It would be helpful; people were talking about self-managing their mental health system. In the second quote on the right-hand side,

> It would definitely be helpful, because sometimes that is why we use, is to get rid of depression and anxiety. Maybe that particular person might not need heroin. They might need an antidepressant or something and it would be a window to a door, for them to be able to walk into a space that would meet them where they are, allow them to do what they need to do, and provide the opportunity to link to clinical behavioral health care.

There are unique issues to women who are using drugs, women who are living on the street, and women who are seeking services. Being a woman using drugs can increase vulnerability in certain ways. One of the things that people talked about was running a space where there would be women's nights so that women could come together and be protected from some of the things they face but also have opportunities to link to services and care.

Finally, people talked about benefits to the broader community. When we asked people about the benefit of opening a space like this, they talked about the ability to reduce drug use in public spaces, reduce discarded syringes, reduce crime, and reduce stress on EMS and emergency responders. In the quotes to the right,

> I see a lot of benefits. It would save the county money on overdoses because people could be treated there. When their immune system is not as robust and they are susceptible to endocarditis … ," which is the heart infection that I was talking about earlier, "… I mean it would save the county a huge amount of money in hospital bills, I am sure. Because indigent people requiring emergency services, and transportation, and things of that nature would be receiving care inside.

The next person said,

> It is reducing public exposure to some of the most tragic kind of results of drug use. The biggest thing for me personally, is that you would not walk up on somebody who had died or who was dying. And if they were just able to go to this place that would happen less. The only place for that horrible stuff to happen is out on the street in public. Where are we going to go? We do not have a spot to go, it happens where it happens.

Providing people with a space to come inside, to be with other people, and to be supervised not only reduces the chances of overdose death but also reduces public exposure. I want to point out one data point from the international research on these sites—many overdoses happen in these OPS, but not a single person has died from an overdose that they had experienced at an OPS. The take home there is people might still be consuming drugs in such a way that depresses their respiration and sends them into an overdose, but because there is supervision and there are medical personnel on site, nobody has died in an OPS.

I get to wrap this up by talking a little bit about the slides of gaps, but I think about this more in terms of opportunities as we think about how to move things forward in the state

and in the nation. As we have talked about, I think a fantastic opportunity that we have to consider is whether there is a space for OPS in Nevada and how we could implement those in a way that could really address some of the drug-related harms that we continue to experience. The data is out there, and it is strong. There are many potential benefits of these sites including cost savings, reducing burden on the hospital system, and decreasing fatalities.

Nevada, at the moment, only has two syringe service programs: Trac-B Exchange, that you heard from earlier, and Change Point through Northern Nevada Hopes, up here in the north. Even through Trac-B is expanding their services through harm reduction vending machines, this is not enough to meet the needs of the state.

One of the opportunities that we see moving forward is to make sure that when embracing these principles of harm reduction, people who use drugs are engaged in the decision-making process as subject matter experts. When we are thinking about policies, programs, and services to address drug-related harms, we need to be thinking about how to get the people, for whom those services are intended, in the room and at the table and amplify those voices. We can also think about that in terms of funding allocation. It is not always the case that funding for programs ends up with the grassroots organizations who have the expertise and are doing the work. Making sure those grassroots groups are also getting to the table is an important opportunity moving forward.

Housing first initiatives is a bullet point here because as you all know, in Nevada and in many places, housing affordability and housing stability is a major problem. The link between housing stability and drug overdose death and drug-related harms is really tight; they are intimately connected. Ensuring housing stability is a step towards reducing drug overdoses and reducing drug-related harms.

Finally, for a lot of today you have heard some really fantastic data. We have many surveillance systems set up in this state that are tracking drug-related harms in terms of morbidity and mortality. I would like to suggest that one of the opportunities we have is to complement those surveillance efforts with more granular analysis of the circumstances of death. We are counting deaths in our mortality and morbidity reports. If we looked more closely at the circumstances surrounding death, of what was going on in those cases, I think we could get a better handle on where to place our resources and where to place our interventions.

You also heard a lot today about upstream interventions. You must be doing all of it and investigating a death record is too late, but it could tell us where to intervene so it does not happen again. I would emphasize that best practices in terms of harm reduction research suggests that even in our surveillance efforts, we incorporate the on-the-ground perspectives of people who are using drugs. With that, I will end, and we can take questions.

Chair Peters:

Thank you so much. There is so much information out there. I would entertain questions from the Committee. I have Senator Doñate first. Please go ahead.

Senator Doñate:

Thank you so much, Chair Peters. And of course, thank you, Dr. Wagner and Ms. Lee, for your presentations today. I find it interesting because it is at the forefront of public health

innovation. Dr. Wagner, would you be able to detail the feedback you have gained from law enforcement regarding these sites and what is the substance of the conversation you had with them in terms of implementation since the 81st Session ended? I think that would be helpful for context for us.

Dr. Wagner:

Thank you for that question. I can tell you a little bit about what is happening in terms of how we are talking about these things. There might be other people in the room who could do a better job answering your questions specifically about conversations we had in the state. You are asking about OPS, right?

Senator Doñate:

Correct.

Dr. Wagner:

This is another place where we have an opportunity to better harmonize criminal justice-related concerns and public health-related concerns. As Ms. Lee pointed out, there are statutes at the federal level that make this difficult and those are criminal justice-related statutes. Addressing the "crack house statute," which prohibits the intentional operation of a brick-and-mortar establishment where people knowingly use drugs, is an opportunity because on the law enforcement side they are asked to enforce that standard. On the public health side, we are saying that public health value outweighs the enforced need. The other concern, and the thing that needs to get resolved, is there has to be some kind of buffer space around a place like this.

One of the big concerns that people had when we asked them about using an OPS was how they would get to and from the space if every law enforcement officer in the community knows they are going to this space to use drugs, they know they will be carrying drugs, and they are going to stop them on their way in or out. These are opportunities where we are going to have to have some difficult conversations, but I think the idea that we are all moving in the same direction in terms of minimizing deaths needs to be our central focus. I think Ms. Lee has some follow-up.

Ms. Lee:

Senator Doñate, thank you for the question. I myself have not had conversations with law enforcement since the 81st Session. Primarily because I wanted to hear what the people who use drugs, for which these sites are intended, have to say and what their concerns are because they are the ones who are dying. I definitely want to be mindful that if these spaces were to exist, they would be spaces in which the people who are intended to be there, would actually come there. I am not sure about law enforcement, but as Dr. Wagner mentioned, that was a concern that came up time and time again.

Another concern which I find most interesting, coming from the child welfare perspective, is that there were mothers who talked about their current practices of substance use now. When you think about child safety, permanency, and well-being, they are legitimate concerns. They talked about how spaces like this would eliminate having any kind of paraphernalia or drugs within their homes because they would bring it to the site, use there, and never have that stuff around their children. The other concern they expressed living with, was the fear of overdosing in the home and having their child find them, what that would be like, and not having the courage to have the conversation with their child around

how to use naloxone, which is a very uncomfortable conversation. I think those are legitimate concerns and were the things I picked up on from the child welfare perspective. I wanted to bring that up in this forum.

Chair Peters:

Thank you so much for that insight, Ms. Lee and Dr. Wagner. We really appreciate the work you have put in on this particular issue. I would encourage folks who were interested in this topic to reach out and work with Assemblyman Orentlicher, as he has continued interest in this particular area, and we can see what we can do as we go into the next Legislative Session. Assemblywoman Titus, do you have a comment or a question?

Assemblywoman Titus:

Thank you very much, this is very interesting. As someone who was opposed to that particular bill for a number of reasons, I am married to a retired sheriff, so you can imagine the conversations we had in our home regarding this particular bill. Again, it is all well intended and Dr. Orentlicher brought in some international folks. I think part of the concern was the newness of it. How do you know the outcomes if you do not have one to do research on?

You commented that folks said they would not have drugs in their house. My concern was, at the time, they are still getting these drugs somewhere. There are supply chain problems for everything else, but there does not seem to be a supply chain issue for illegal drugs. These are not prescribed drugs from a provider, such as myself. They are bought illegally on the street; you do not know who they came from or what they may be laced with. There is still no monitoring of what drugs they are taking and still the potential for overdose. They are still going to get these drugs, they are still going to be in their homes, and they are going to take them to this facility.

I certainly hear and appreciate what you are trying to do for the people who are the users, but there is still a pyramid effect for this whole other concern. I am happy to continue the conversation next cycle around regarding some of the things that I heard you testify on and the concerns that many of us have regarding these types of facilities. I just want to go on record with that comment.

Chair Peters:

Highlighting these concerns from the last session is important, especially in the interim so we can work through some of those if this bill is going to make it back into the legislative session. I saw both Dr. Wagner and Ms. Lee raise their hand in response.

Ms. Lee:

Dr. Titus, as you were speaking about that, the first thing that came to my mind was this is an opportunity for additional surveillance to see what people are taking. It was suggested much earlier in the day about checking syringes, and Trac-B is doing that by using technology in Las Vegas. This would provide an additional opportunity to really see what kind of contaminants are being used. Certainly, fentanyl is one of many, and we are also seeing one that is part benzodiazepine intended for animals that is being found in some parts of the country. I cannot remember the exact drug, but I will get back to you with that, Dr. Titus. There are other contaminants and this offers an additional space in which to really get that ground-level surveillance.

Dr. Wagner:

Dr. Titus, what you are saying is exactly right—there is no quality control in terms of drugs bought on the street. People do not know what they are getting and that is exactly the argument for a space where people can use under medical supervision, because you do not know and we cannot control that side of it, but we can control this.

Chair Peters:

Thank you so much, I do not see any other questions from the committee. I would like to thank you both for your continued work in this area and the presentation on this issue. We hope to hear from you again as we move through this and vet out more of this issue area.

AGENDA ITEM XII—BEHAVIORAL AND MENTAL HEALTH INSURANCE PAYMENT PARITY: THE NATIONAL LANDSCAPE

Chair Peters:

We are going to move on to our next agenda item, which is Agenda Item XII, the behavioral and mental health insurance payment parity and the national landscape. Today we have Tim Clement with us; he is the director of legislative development from the American Psychiatric Association. Please go ahead when you are ready.

Tim Clement, M.P.H., Director of Legislative Development, American Psychiatric Association:

Thank you very much, Chair Peters. My name is Tim Clement, and I am going to give a presentation today about mental health parity (Agenda Item XII). Do not let the phrase detract from the fact it is about mental health and substance use disorder parity; it is just as much about substance use disorders as it is about mental health. Also, because there was a request, I am going to throw in a little bit of information about telehealth at the very end.

What is mental health parity? As I said, substance use disorder is just as much a part of it. It is a very simple concept; it is the insurance coverage for mental health and addiction treatment should be no more restrictive than coverage for other medical care. It does not mean that treatment must be the same; it is just the insurance practices for mental health and addiction cannot be more restrictive than what they are for other medical care.

That is a simple concept, so why are there state and federal laws about parity? Historically, insurance coverage for mental health and addiction was much more restrictive than coverage for other medical care. It was very common to see more expensive co-pays and coinsurance for mental health and addiction care, as well as separate deductibles for mental health care, medical care, medical mental health care, and substance use disorder care. Those deductibles for mental health and addiction would be much higher and harder to reach than they were for medical. There are hard limits on inpatient stays—20 visits per year—then you are on your own, and 30 visits per year for outpatient care, and that is all you get.

In the late 1990s and early 2000s, states started passing state "parity" laws. However, many of these laws were well below the standard of actual parity; they still made it explicitly legal to have more restrictive mental health and addiction coverage. In fact, some of these state laws actually codified more restrictive insurance coverage for mental health and addiction. These laws, generally, would establish a minimum number of inpatient days

and outpatient visits. You would get at least 45 days in an inpatient facility and at least 60 outpatient visits, and they vary greatly by state. They established annual and lifetime dollar minimums, providing at least $5,000 worth of care coverage for each year. They would establish a list of serious mental illnesses that must be covered, and other conditions were considered optional. That was the landscape for a good 20 plus years, states passing a patchwork of laws. States cannot do anything about large employer-sponsored plans that are not regulated by state regulators. States could do a little bit, and they have been, but it was a patchwork.

In 2008, President George W. Bush signed the Mental Health Parity and Addiction Equity Act into law. This is what we call the Federal Parity Law, sponsored by Patrick J. Kennedy (D-RI). So, there was a dynastic Republican family signing the law and a dynastic Democratic family sponsoring the law; it was very bipartisan throughout. The federal law supersedes most of those state mental health addiction coverage laws. For example, many state laws, not Nevada, still have some provisions on the books that codify more restrictive care; those no longer have effect because of the federal law. The Federal Parity Law sets the floor; anything that is lower than what is in the federal law is superseded. However, states can go beyond the federal law or help improve its implementation, like you did in Nevada last year with AB 181 (2021), and we will talk a little bit more about what states have been doing.

There are still problems though; the concept is simple but the Federal Parity Law is very complex. It sets the rules for insurers' managed care practices and is incredibly complex partly because the health care law is complex. Because of the complexity of the law, there have been problems with compliance, and most of those relate to the insurers' managed care practices, how they manage the benefits, prior authorization, other utilization review such as concurrent review, retrospective review, step therapy, formular design, provider network design, and reimbursement rate setting. The law does not require that reimbursement rates have to be the same, but how you go about setting those reimbursement rates has to be comparable and no more stringent.

In 2017, thanks to grant funding from the federal government and the Trump Administration, a number of state insurance departments began looking into ensuring compliance with the Federal Parity Law. About 20 states received this federal grant money and started digging into it. Basically, every examination found that insurers were not compliant with law as it related to managed-care practices. There is a saying among state insurance regulators—if you look, you will find problems. It is not because of malfeasance; they have struggled with the complexity and might not have taken it quite as seriously as they needed to until recent years when there has been a great deal of action. When federal regulators looked at the U.S Department of Labor, they found problems, too.

Beginning in 2018, states started to pass legislation that required greater transparency and accountability from insurers in terms of compliance. They required insurers to do these compliance analyses, demonstrating compliance with the federal law, and submit them to state regulators. You see here, we are up to 17 states with Nevada joining the party last year. We will expect to see several more this year. The format of those 17 state laws are the same in all 17 states. After they saw this happen, Congress took action too.

In December 2020, Congress amended the Federal Parity Law by adding language that was identical to all those state laws. This ended clearing the deck in all 50 states. Now, every state, every insurer, and every group health plan in the United States, including those that states cannot regulate, have to do these analyses. They must make them available to federal and state regulators upon request, and the amendments also required the federal

regulators to request a certain number of analyses every year. Nevada passed AB 181 in 2021 because the state legislation needs to formalize this process to make sure that these analyses are actually submitted and looked at by state regulators.

In five years, how did we go from zero states having the federal government-required transparency, to every insurer and every group health plan in the United States having to be transparent in this uniform fashion? As you know, many people are dying every day from overdoses and suicides, and that statistic there is wrong. The CDC just issued updated overdose data—up to 410 Americans die every day from an overdose or suicide. When I first started saying that in 2016, it was 245 Americans die every day, so we have gotten worse by about 155 people in the last six years. It was a terrible crisis six years ago and it has gotten much worse. Things are really bad, and a lot of it has to do with fentanyl.

Another reason why laws have passed so fast is usually when you have health insurance and you are really sick, insurance covers the treatment you need to survive and get better. When you have an opioid use disorder, you are sick and you might die or overdose; you are revived with naloxone, go to inpatient treatment, and the provider says you need to be there for another three, four, five, six days. If the insurer says they are not going to cover that, it contradicts the recommendations of the medical health care professionals, which is commonplace in behavioral health care. For other medical conditions, when you are sick and you are going to potentially die, insurance covers the treatment you need to get better. When it comes to mental health and addiction, often that does not seem to be the case.

Another reason these laws have passed so fast is the federal law is fundamentally comparative. How could an insurer know that it complies with this law unless it was doing comparative analysis? There is no way you could know whether you comply with this law without doing comparative analyses. State legislatures and Congress found this argument very persuasive and that is why it happened.

There is a lot of stuff that has happened at the state level over the last four years and a lot of stuff happened in Congress. The amendments to the law also required the federal agencies to submit a report to Congress every year about what they find when they look at these analyses. They just released their first report a few weeks ago. It focused on what they found in the comparative analyses they reviewed, and not a single health plan or insurer was able to submit sufficient information initially. These are the same analyses that will be coming into the Division of Insurance (DOI), Department of Business and Industry (B&I), and Medicaid here in Nevada this year. Just keep that in mind when we think about those reports that are going to come in here to Nevada. When they gave them to the federal government, all of them were not good enough initially. Then when they asked for more information and received that information, they found all kinds of violations. It was a really bad report. You have my contact information; if you email me, I can send you the report. It is worth a read. The report shows that there is still a lot of work to do. The reason a lot of these laws passed, is because we had a feeling that there was not full compliance in the law and now it has been confirmed. It is true, we have problems. A lot of that work has to happen at both the legislative level and the regulatory level.

Some states are now pursuing legislation similar to AB 181. Something I think is the most important about what states are doing, and this falls outside of the legislative arena, is 32 states have joined the parity working group at the National Association of Insurance Commissioners (NAIC) since 2020. I just checked a few minutes ago and now it is 33 states; another state just joined. This group is made up of state insurance regulators who meet regularly and share best practices about what they are doing on parity. Some states have been doing really good on parity, like Illinois, Texas, Pennsylvania, and

Oklahoma. These states have a lot of good things to tell their regulator colleagues. The NAIC meets three times a year in person, and it is a great opportunity to be part of this parity working group. Nevada's DOI has not yet joined this working group, and I think this would be a fabulous opportunity to learn a lot from these regulators because they really want to share what they know with their colleagues.

From the legislative angle, some states are providing funding for insurance departments to designate a full-time parity specialist. In Arizona, they have Dr. Lynette Hennigan who has been hired and on the job for a year and a half. When Arizona passed its parity legislation in 2020, they funded a full-time person for a number of years to be on top of parity. For a department to do what is necessary for parity compliance and implementation, you probably need to have that full-time person. Otherwise, it is so complicated; if you have other things to worry about, such as auto insurance, flood, casualty, and homeowners, you are probably not going to get on top of this complicated law, which is why it is a smart thing to fund a full-time person. Also, there is congressional legislation that would send grant funding to states to add staff to do some of this work. I am not sure on the status of that, but there is something else out there.

What else are states doing on mental health coverage? A few states passed legislation in 2021 that requires insurers to rely on nonprofit specialty society criteria when determining whether mental health or addiction care is medically necessary. For example, in California, Illinois, and Oregon, if you make substance use disorder a medical necessity determination for level of care placement, you have to follow the criteria of the American Society of Addiction Medicine. You cannot use your own in-house criteria that you designed to suppress costs. The reason this is happening is because a major court case, the *Whit v. United Behavioral Health*, found that a major insurer was making decisions about mental health and substance use disorder care on in-house criteria that was specifically designed to suppress costs. For instance, when the behavior health medical team wanted to adopt the American Society of Addiction Medicine criteria, they were overruled by the corporate office because of the presumed cost. Following the best that medicine and science has to offer was not what United Behavioral Health wanted to do; they wanted to keep costs down at a certain level and that leads to poor care and more people dying. This is something the few states I mentioned have done. Georgia is also pursuing a lighter version this year. This is a pretty comprehensive piece of legislation. It is model legislation that was created by the Kennedy Forum, which is run by former Congressman Patrick J. Kennedy, who was also the sponsor of the Mental Health Parity and Addiction Equity Act, the current Federal Parity Law.

I am going to wrap up with a little bit on telehealth insurance coverage. This is not about the delivery; this is about the insurance coverage. This is a separate issue, but it is somewhat related because a lot of telehealth happens in the behavioral health realm. Telehealth insurance coverage legislation is not a new thing; this is something that has been going on for many years. Before the pandemic, the main issues pursued were: (1) that insurers cover telehealth; (2) the reimbursement would be at the same rate as in person; and (3) efforts to cover what is called asynchronous telehealth, which means the patient is not there when the telehealth occurs. For example, a patient comes into a primary care physician's office, the primary care physician asks, maybe, depression-screening questions, writes down his answers or records the encounter, stores it, and then sends it to a psychiatrist who looks at it later and then renders a determination or diagnosis.

If you want to know more about telehealth, the Center for Connected Health Policy is a great resource. You will see what is happening all over the country when it comes to telehealth, not just coverage, but all kinds of other things related to telehealth.

During the pandemic and beyond, in March of 2020, telehealth came to the forefront of everyone's minds, and everyone was familiar with telehealth by the spring of 2020. Legislative efforts to expand telehealth focused on the previous goals that we just talked about, but also coverage of audio-only telehealth under certain circumstances. You want to see that patient, but sometimes it is not possible because of broadband, or it might not be medically advisable to do symptoms of psychosis. Prohibiting insurers from requiring that only a certain technology platform or vendor be used can be very disruptive to care because if you have multiple insurers with different platforms and vendors, it is going to take a lot of money for providers to get those things up and running. Another goal is prohibiting utilization review that is in place for telehealth. They do not do it in person, so you have to do prior authorization for telehealth visits, but you do not have to do prior authorization for that same visit if you were in person. Allowing more flexibility where the patient and provider can be located during the telehealth site, which is known as the originating site and the distant site, is another goal.

The American Psychiatrist Association actually created model legislation on insurance coverage of telehealth. It is something I worked on with our telehealth committee, and we put together the model legislation that addresses the issues described previously and a few other bells and whistles. You can go to that link if you want to find out more. Two good case studies in enacting this legislation are Georgia and Oklahoma. In 2021, Georgia passed House Bill 307, which has most of what is in that model legislation, and so did Oklahoma with SB 674. It shows that the model legislation definitely has some opportunities.

With that, I am going to post my contact information. If you have any questions or want to go into great detail about anything I went over, please send me an email.

Chair Peters:

Thank you so much. It is nice to see that there is some bipartisan effort across the country. I am looking forward to seeing what we come up with in Nevada. Are there any questions from the committee? I have questions that came up, but mine are directed more for our DOI. We really appreciate your time today. I would like to see that report you were talking about, so I will have staff reach out to you if we cannot find it online.

AGENDA ITEM XIII—OVERVIEW OF AND POLICY CONSIDERATIONS RELATED TO ASSEMBLY BILL 181 (2021), WHICH REQUIRES CERTAIN HEALTH INSURERS TO DEMONSTRATE MENTAL HEALTH PAYMENT PARITY AND ADDICTION EQUITY COMPLIANCE

Chair Peters:

We are going to move on to our next agenda item. Agenda Item XIII is the overview of and policy considerations related to AB 181, referenced in the last presentation. This bill requires certain health insurance insurers to demonstrate mental health payment parity and addiction equity compliance. We have Nick Stosic, Deputy Commissioner with the DOI, to tell us about this bill and how things are going.

Nick J. Stosic, Deputy Commissioner, Division of Insurance, Department of Business and Industry:

Thank you. Chair Peters, and members of the Committee, I appreciate the opportunity to be here. You will also see the name of Jeremy Gladstone, who is effectively our subject matter expert on network adequacy and mental health parity. Unfortunately, he has to leave the

office at 2:30, so I will do the best I can to answer questions, but if there are any I cannot answer, we will be sure and get back to you as quickly as we can. Also, I appreciate Mr. Clement's presentation, and being the last presentation today, you will be glad to know I will be able to cut out some of my slides because he covered some of the subjects that I would have been covering (Agenda Item XIII). Also, just to give you an update, since he mentioned us in his presentation, although we are not a member of the mental health parity working group with the NAIC, our staff does participate in every one of those committee meetings. We are up on the subject, but we are just not an official member of that committee at this point.

I was asked today to present on AB 181, and as Mr. Clement mentioned, it was passed in 2021. Part of the language of that bill is directly related to H.R. 6983 (110th Congress), or the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which is also known as MHPAEA. Again, Mr. Clement gave you a pretty good overview on what that particular bill covered.

Assembly Bill 181 amends NRS 687B.404 to require the commissioner of insurance to perform a data request, on or before July 1st of each year, from insurers or organizations that provide health care to solicit information necessary to evaluate the compliance with the Mental Health Parity Act. The information needs to be provided to the Division by October 1st of each year, and then by the end of the year, the commissioner is required to summarize and provide a report to the Patient Protection Commission, the governor, and the director of the LCB by December 31st of each year. Assembly Bill 181 was effective on January 1, 2022, so our first date of call will occur prior to this July, and our report compiling the information will be submitted by the end of this year.

This particular slide I can pretty much pass. It talks about the Consolidated Appropriations Act of 2021 that Mr. Clement addressed and the requirements for carriers to provide a comparative analysis on the nonquantitative treatment limitations. This particular bill was effective on February 10, 2021, so the insurers had their first go-round of producing those reports, as Mr. Clements mentioned, and we are looking forward to, again, receiving the reports this coming year.

Assembly Bill 181 allows for insurers or other organizations to file a copy of the federal report, in lieu of the data that the commissioner is asking for. However, the bill does allow the commissioner to request supplemental information, beyond this report, to determine whether the insurer or other organization is in compliance with federal law. I assume this first year will be interesting for us to see what type of information is provided, and based on that, I would assume that in future years we will probably be asking for more additional information that they will have to file.

Up until now, the determined compliance with federal mental health parity laws, the Nevada DOI conducts annual reviews of health benefit plans sold in our state. The Division reviews plan documents and plan designs, including coverages, drug formularies, network designs, and other aspects of the plan. As part of this review, we look for red flags, which may indicate noncompliance with MHPAEA. Every carrier is required to attest to any differences they have with annual or lifetime limits, whether their contracts provide any mental health or substance abuse treatment limitations, the availability of their plan information, and their internal claims appeals and external review processes. That is what they currently are required to do.

When we go forward and get to see the comparative analysis, they will be giving additional information on things like prior authorization requirements; concurrent reviews for

in-network and out-of-network inpatient and outpatient services; and standards for provider admissions to participate in the networks, including reimbursement rates, formulary designs for prescription drugs, and step therapy protocols. We will obviously be getting a lot more information this year than we have been receiving in the past.

One thing I wanted to share with you, Chair Peters, and the rest of the Committee members, is the DOI was recently awarded federal funds under the Cycle II State Flexibility Grant. We will be using those funds to contract out the research and development of procedures and tools that can be used by our Division staff to conduct MHPAEA compliance reviews and ensure a consistent and thorough review is done on all health insurance products. We intend to use these federal funds to conduct an assessment of the Division's current procedures and tools, research what other states are doing to address MHPAEA compliance, and develop procedures and tools that can be used to do a more rigorous review for MHPAEA. It will be going out to bid this year, so I am assuming later in this year we will start to access those grant funds and begin this review.

Lastly, I wanted to review two Nevada statutes that still are not in compliance with the current federal MHPAEA law. Mr. Clement addressed the issue that sometimes obsolete limits are put in Nevada law. Actually, in NRS 689A.046 and 689C.167, we currently have limits that, for example, have a $1,500 per calendar year for the treatment of withdrawal from drugs and alcohol, $9,000 for inpatient treatment, and $2,500 for outpatient counseling. Again, separate from federal law, these are the requirements that technically a carrier would be able to follow and be in compliance with state law.

The drug and alcohol treatment limits were added to NRS during the 1985 Session, so it has been quite a while. The Committee may want to consider removing these limits from those two statutes and point to federal law to ensure that carriers are in compliance with MHPAEA. Making this type of change would not create a new mandated benefit for the state, since it would be altering state law to match federal. With that, that is the end of my remarks, and I am more than happy to answer any questions to the best of my ability.

Chair Peters:

Thank you so much. I am really grateful for the update, I was really invested in this piece of legislation last session, so it is nice to know it is being applied. I am looking forward to our first comparative analysis.

I had a couple of questions. The first one has to do with becoming a part of the NAIC parity working group. You said the Division participates, but not as a member. What does it take to become a member and is there something we can do to support that?

Mr. Stosic:

Chair Peters, becoming a member is probably just a matter of requesting to do so. There are about 200 different NAIC committees, and we are members of about 50 committees right now. We spread our membership around; the very important committees that we are not members of, we still attend every meeting so we are still involved in the discussions. If you would like, we would be happy to go forward and get formal membership, but I can assure you that we are attending all the meetings and we are notified anytime a meeting is being held.

Chair Peters:

Of course, I would like for you to do what is best for Nevada, whether that is attending meetings or obtaining a formal membership. If there are benefits to being on that working group, such as the sharing of information to make sure we are doing a comparative analysis that is whole, that would be great. Just keep us posted and let us know if there is anything we can do. I was also wondering if there was a membership fee.

Mr. Stosic:

There is not a membership fee. The working group is working on potential legislation, et cetera, so being a member of the working group makes you more active as opposed to somebody who is listening in. It is an actual working group that is trying to develop potentially different models for the MHPAEA.

Chair Peters:

That leads into one of my next questions, which is related to the potential position funding that Mr. Clement mentioned. There is grant funding that some folks are specifically using for this comparative analysis and data collection position. I was wondering whether you have applied for that grant, and if not, is there a reason?

Mr. Stosic:

When I mentioned that we had been given the Cycle II State Flexibility Grants, the position is a part of that grant. We are going to contract out the process on researching development procedures and tools from MHPAEA. We have been awarded that grant and again the funds are going to be specific to this particular subject.

Chair Peters:

So, you are contracting out that service to do the initial determination of what your process is going to look like? I imagine you will come back to us with maybe needing more staff or more authority. Do you think you will come back to us with some of those recommendations?

Mr. Stosic:

Chair Peters, I really expect, once we see what we find from this particular grant, and once we go through the first year of receiving these comparative analysis and seeing how it evolved and the amount of work, we are going to have a much better understanding if it is something that current staff can handle or if we would need an additional position in order to do an adequate job. I do not envision that it would be a year-round, full-time position. I think we will have more information down the road on what we are going to need in terms of staffing.

Chair Peters:

Keep us posted on that please. I have one question and hopefully it is a quick response. One of the points mentioned by Mr. Clement was the federal bill from February 2021 that authorized states to request information from all payer types, including the self-funded plan. I am curious if you believe that you have the authority to ask for that information, despite the fact that we cannot regulate it, or if that is something that we would have to consider through legislation.

Mr. Stosic:

That is one of those questions, Chair, that I would have to look into. Generally, since we have no regulatory authority over providers, I would say typically that is not something we would be able to do. If it is granted under federal law, that also does not necessarily give the states that regulatory authority. That is an issue we are more than happy to research and find out more about what is contained.

Chair Peters:

I would appreciate that along with some follow-up. Not that we want to regulate them, but it is important that when we do a comparative analysis, that we are comparing across the board. In my mind, having parity and consistency of care or that continuity of care is really important, whether you are bouncing between Medicaid and the Public Employees' Benefit Plan or the Silver State Health Plan and a private plan. We want to make sure that our comparative analysis is consistent across the board, especially for mental health care and behavioral health care. Let me know what you find on that.

Any other questions from the Committee before we move on to our last item on the agenda? Seeing none. Thank you so much, Mr. Stosic; we appreciate your time here today and your efforts on this bill implementation. We look forward to your report in December.

AGENDA ITEM XIV—UPDATE ON ASSEMBLY BILL 374 (2021), WHICH ESTABLISHES THE STATEWIDE SUBSTANCE USE RESPONSE WORKING GROUP

(This item was taken out of order.)

Chair Peters:

We are going to go ahead and move on to our next agenda item which we are taking out of order because we have Dr. Terry Kerns with us right now. We are going move on to Agenda Item XIV, which is an update on AB 374 from the 2021 Legislative Session. This establishes the Statewide Substance Use Response Working Group. Dr. Kern, please go ahead whenever you are ready.

Dr. Kerns:

Thank you. I wanted to talk to you today about AB 374, which establishes the SURG, which you heard about from Attorney General Ford. If you look at the bottom of this slide you can see the references on where to find AB 374 on the NELIS website. You can also find information on the SURG on the attorney general's website; go to the website, scroll down to committees and boards, and then that will take you to where you scroll over to the Substitute Use Response Working Group (Agenda Item XIV A-1).

One thing that is significant about AB 374, is this bill deals with all substances and substance use disorders as opposed to just focusing on opioids and opioid use disorders. As you have heard, and we will hear more, polysubstance use and misuse and other substance use and misuse are at high levels in the U.S. and in our state.

There were 18 members that were appointed to the SURG that include legislators, people who work in the field of substance use disorders, people who work with prevention and harm reduction programs, people who use drugs or family members of those who use

drugs, law enforcement, representatives of urban, rural, and frontier counties, and representatives from our school.

The membership is:

- Chelsi Cheatom, program manager with Trac-B Exchange, which is our safe syringe program; represents a program for representing harm reduction caused by substance misuse;
- Barbara Collins, principal for the Mission High School in the Clark County School District; represents the school district;
- Leslie Dixon, M.D., F.A.C.L.P., L.F.A.P.A., medical director for the Center for Behavioral Health; provider of health care with expertise in medicine for the treatment of substance use disorders;
- Senator Fabian Doñate, Senate District 10, state Majority Leader appointee;
- Attorney General Aaron D. Ford, from the Attorney General's Office;
- Shayla Holmes, director of Lyon County Human Services; a representative of a local government entity that provides or overseas a provision of human services in a county whose population is less than 100,000;
- Jeffrey B. Iverson, director of Shine a Light Foundation of Freedom House; one person who is in recovery from substance use disorder;
- Jessica Johnson, senior health educator from Southern Nevada Health District; a representative of local government that provides or overseas the provision of human services in the county whose population is 700,000 or more;
- Lisa Lee, human services program specialist of Washoe County Human Services Agency; representative of local government that provides or overseas provision of human services in the county of a population of 100,000 or more but less than 700,000;
- Debi Nadler, cofounder of Moms Against Drugs; one advocate for persons who have substance use disorder or family members of such;
- Christine Payson, representative from the Nevada Sheriffs' and Chiefs' Association; law enforcement representative;
- Eric Schoen, executive director of Community Chest, Inc.; one representative of a substance use disorder prevention coalition;
- Steve Shell, vice president of Behavioral Health, Renown Health; a representative of a hospital;
- Assemblywoman Clara (Claire) Thomas, Assembly District 17; Nevada Assembly Speaker appointee;
- Dani Thomas, executive director of the Ridge House; one person who provides services related to the treatment of substance use disorders;
- Assemblywoman Jill Tolles, Assembly District 25, the Nevada Assembly Minority Leader appointee; and
- Stephanie Woodard, Psy.D., senior advisor on behavioral health, DPBH, DHHS; DHHS director appointee.

Assembly Bill 374 does a lot. There are 16 items labeled A through Q in the legislation that the SURG is to address. Straight from the legislation, this bill requires the SURG to comprehensively review various aspects of substance misuse and substance use disorders and programs and activities to combat substance misuse and substance use disorders in our state. The activities include assessing, studying, examining, evaluating, and then making recommendations concerning substance use and misuse based on these findings.

The SURG works in conjunction with SB 390's ACRN, which you already heard about and will hear more on later. Recommendations from the SURG and the ACRN assist with how funds

from the Fund for a Resilient Nevada are directed. As you heard from Attorney General Ford, a major source of funds for the Fund for a Resilient Nevada comes from the opioid litigation settlement.

Part of the requirement of AB 374, is for the SURG to produce an annual report, which was provided as part of the attachments for the Committee meeting today and can also be found on the attorney general's website (Agenda Item XIV A-2). The report for this year outlines the appointment of the 18 members and discusses the first and only meeting that was held in 2021 on November 16. Much of that first meeting was laying out the form and structure of the SURG to include electing Attorney General Ford as chair and Assemblywoman Tolles as vice chair, adopting the bylaws, and setting up the priorities for 2022. This included setting up meetings in 2022 and being briefed on the state needs assessment, the state plan, and state and local funding of programs to address substance misuse and substance use disorders that will all be provided for DHHS.

The formation of subcommittees based on their priorities discussed in the November 2021 meeting were outlined. The framework for the three subcommittees that are being formed are: (1) prevention; (2) treatment and recovery; and (3) response. The 16 items that were laid out in AB 374 to be addressed by the SURG were used as guidelines for these three subcommittees. There were some items that are overarching and will be addressed by all subcommittees such as special populations.

Special populations defined in AB 374 include:

- Group one: veterans, elderly persons, and youth;
- Group two: persons who are incarcerated, persons who have committed nonviolent crimes primarily driven by a substance use disorder, and other persons involved in the criminal justice or the juvenile justice system;
- Group three: pregnant women and parents of dependent children;
- Group four: lesbian, gay, bisexual, transgender, and questioning persons;
- Group five: persons who use intravenous drugs;
- Group six: children who are involved with the child welfare system; and
- Group seven: other populations disproportionately impacted by substance use disorders.

Another overarching item that will be addressed by each of the three subcommittees is data and information sharing. The SURG will meet quarterly in 2022, and the subcommittees will meet monthly and then report back to the larger SURG. I invite everyone to read the 2021 SURG annual report; it provides a much more in-depth review of the SURG's 2021 activities and the priorities for 2022. This will conclude my overview and I welcome any questions.

Chair Peters:

Thank you so much, Dr. Kerns. Are there any questions from the Committee? I am not seeing any questions from the members. You said there has been one meeting so far. Do you have any additional meetings scheduled?

Dr. Kerns:

There was one meeting on November 16, 2021, and a meeting on January 19, 2022. We have another meeting scheduled on March 9, 2022, and then we will look to June to schedule the next one.

Chair Peters:

We look forward to updates on how things are going and the recommendations that come from those meetings. Thank you.

AGENDA ITEM XV—PUBLIC COMMENT

Chair Peters:

The last item on the agenda is public comment. We are going to take a short break to allow people to call in under public comment; again, the information for calling in is on the agenda today.

Broadcast and Production Services, will you please add the first person with public comment to the meeting?

BPS:

Thank you so much, Chair Peters. Your public comment line is open and working; however, we have no callers at this time.

Chair Peters:

Great. Thank you so much.

Chair Peters:

I want to mention that our next meeting will be held on March 24, 2021, at 9:00 a.m. Before we adjourn the meeting, are there any other comments from the members?

Assemblywoman Titus:

Madam Chair, I just wanted to tell you it was a great, thorough presentation. I appreciate you putting all this together with the various opinions and all that you have covered. Well done, thank you.

Chair Peters:

Thank you for that feedback. I really want to thank staff; they worked really hard with DHHS to come up with some great solutions, options, and folks to come and present today. I think we are heading in the right direction on these issues related to behavioral and mental health care in Nevada.

AGENDA ITEM XVI—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 3:01 p.m.

Respectfully submitted,

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Crystal Rowe
Research Policy Assistant

_____

Patrick B. Ashton
Senior Policy Analyst

APPROVED BY:

_____

Assemblywoman Sarah Peters, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II A	Leann D. McAllister, M.B.A., Executive Director, Nevada Chapter of the American Academy of Pediatrics	Written Remarks
Agenda Item II B	Steven Messinger, Policy Director, Nevada Primary Care Association	Written Remarks
Agenda Item III A	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, Legislative Counsel Bureau (LCB)	LCB File R171-20 of the Board of Medical Examiners
Agenda Item III B	Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, LCB	LCB File R180-20 of the Board of Medical Examiners
Agenda Item V	Brandon Delise, Epidemiologist, Office of Epidemiology and Disease Surveillance, Southern Nevada Health District (SNHD); Terry L. Kerns, Ph.D., Substance Abuse/Law Enforcement Coordinator, Office of the Attorney General; Elyse Monroy, Program Manager, Overdose Data to Action, Trudy Larson MD Institute for Health Impact and Equity, School of Public Health, University of Nevada, Reno (UNR); Kyra Morgan, State Biostatistician, Office of Analytics, Department of Health and Human Services (DHHS); and Shawn Thomas, M.P.H., Opioid Epidemiologist and Public Health Diversity Surveillance Coordinator, Overdose Data to Action, Trudy Larson MD Institute for Health Impact and Equity, School of Public Health, UNR	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item VI	Sarah A. Friedman, Ph.D., Assistant Professor, School of Public Health, UNR; Kyra Morgan, State Biostatistician, Office of Analytics, DHHS; Beth Slamowitz, PharmD, Senior Policy Advisor on Pharmacy, DHHS; and Darla Zarley, PharmD, Grant and Project Analyst, State Board of Pharmacy	PowerPoint Presentation
Agenda Item VIII A-1	Antonina Capurro, D.M.D., M.P.H., M.B.A., Deputy Administrator, Division of Health Care Financing and Policy (DHCFP), DHHS; Farzad Kamyar, M.D., M.B.A., Director of Collaborative Care, High Risk Pregnancy Center; and Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, Division of Public and Behavioral Health (DPBH), DHHS	PowerPoint Presentation
Agenda Item VIII A-2	Antonina Capurro, D.M.D., M.P.H., M.B.A., Deputy Administrator, DHCFP, DHHS	Fact Sheet
Agenda Item IX	Stephanie Woodard, Psy.D., Senior Advisor on Behavioral Health, DPBH, DHHS	PowerPoint Presentation
Agenda Item XI	Michelle Berry, M.B.A., Nevada State Opioid Response, Senior Project Manager, Center for the Application of Substance Abuse Technologies, School of Public Health, UNR; Jessica Johnson, Senior Health Educator, SNHD; Lisa Lee, M.A., CPRSS, DrPH Student, Walden University Program Specialist, Human Services Agency, Washoe	PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
	County; Christina Parreira, Ph.D., Health Educator, Trac-B Exchange; and Karla Wagner, Ph.D., Associate Professor, School of Public Health, UNR	
Agenda Item XII	Tim Clement, M.P.H., Director of Legislative Development, American Psychiatric Association	PowerPoint Presentation
Agenda Item XIII	Nick J. Stosic, Deputy Commissioner, Division of Insurance, Department of Business and Industry	PowerPoint Presentation
Agenda Item XIV A-1	Terry L. Kerns, Ph.D., Substance Abuse/Law Enforcement Coordinator, Office of the Attorney General	Handout
Agenda Item XIV A-2	Terry L. Kerns, Ph.D., Substance Abuse/Law Enforcement Coordinator, Office of the Attorney General	Report

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