Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Multidisciplinary Prevention Advisory Committee (MPAC) Meeting
Meeting Minutes
Wednesday, December 02, 2020
1:00 pm – Adjournment

Note: Agenda items may be taken out of order, combined for consideration, and or removed from the agenda at the chairperson's discretion

1. Roll Call (1:07)
   Members Present: Jamie Ross (Co-Chair), Linda Lang (Co-Chair), Alyssa O'Hair, Brian Iriye, Elliot Wade, Helen Troupe, Isela Anguiano, Jennifer DeLett-Snyder, Keith Carter, Rosa O'Bannon, Sara Beers, Sofia Cano-Allison, Stephanie Asteriadis-Pyle, Terry Kerns, Trey Delap
   Members Absent: Heidi Gustafson
   To all of our guests today, we will make sure we hear from only the members and all other comments will be taken during the public comment periods.

2. No Public comment

3. Ms. Lang: Under the members list, instead of Rosa O'Bannon it lists Alyssa O'Bannon, so I would like that changed to Rosa O'Bannon. Ms. Ross: it appears that Stephanie Asteriadis-Pyle is not hyphenated, and it is requested that be corrected.
   Mr. Delap Motions to approve the minutes with the two corrections.
   Ms. DeLett-Snyder: seconds the motion
   Approved: Ms. Lang, Ms. Ross, Ms. Asteriadis-Pyle, Ms. Heidi Gustafson, Ms. DeLett-Snyder, Ms. Rosa O'Bannon, Ms. Beers, Ms. Kerns, Ms. Anguiano, M. Cano-Allison, Mr. Delap, Dr. Iriye, Ms. Troupe, Dr. Wade.
   Opposed: None
   Abstention: Alyssa O'Hair

4. Ms. Kerns motions to approve the November 18, 2019 minutes.
   Ms. Asteriadis-Pyle seconds
   Approved: Ms. Lang, Ms. Ross, Ms. Asteriadis-Pyle, Ms. Gustafson, Ms. DeLett-Snyder, Ms. O'Bannon, Ms. Beers, Ms. Kerns, Ms. Anguiano, Ms. Cano-Allison, Mr. Delap, Ms. Troupe
   Opposed: None
   Abstention: Dr. Iriye, Dr. Wade

5. Ms. Ross: Carol O'Hare has resigned due to health issues. With the last round of member addition, we added 2 more members than the 15-minimum required bringing it to 17 members. This was done in order to not have to immediately re-open and fill the vacancy. This is notice that Carol O'Hare has resigned we have 16 members and still fulfil the required 15 members.

6. Ms. Lang provides the reason for today's presentation are to help with additional information to supplement the Epidemiology Profile, and to help inform and guide the MPAC. Mr. Carter: is the state director for the National High Intensity Drug Trafficking Area (HIDTA) Program operated out of the white house under Office of National Drug Control (ONDC) – drug czar. HIDTA has been around for 27 years and in Nevada for 20 years. There are 33 HIDTA teams throughout the US including Puerto Rico and the Virgin Islands. HIDTA focuses on information, intelligence, prevention and enforcement and has partnered with CDC on several initiatives. I will review current information and how we arrive at our conclusion. It is important to understand that is there always going to be information and intelligence gaps. We try to identify those gaps. We look at seizure data throughout the state, overdose data, investigation trends, boarder data/seizers (being relatively close to the boarder), drug prices on the street, and neighboring states (California, Arizona, Oregon, and Utah) data. For reporting, we focus on Washoe and Clark counties as they show the overall trend in Nevada. Looking at drug overdoses, the Data/research shows that methamphetamine leads to overdoses and is concerning because Naloxone does not work well with methamphetamine overdoses. The second leading cause of overdoes is Heroin, and the third is fentanyl. What concerns HIDTA is that fentanyl overdoses was very low to non-existent in 2015. This is important because of the influx of fentanyl crossing the border. Why? Because there is an increase in manufacturing in Mexico and is cheaper/easier to make than methamphetamine. A $32,000 "investment" in a kilo of Fentanyl when broken down to street value is worth $20 million which is the highest return rate for all illegal drugs. The street level drugs – China white, perks, oxy, candies, wheels, M30s – are a combination of acetaminophen and fentanyl; caffeine and fentanyl; caffeine, meth, and fentanyl; and fentanyl and gabapentin (uncontrolled) which are made with a pill press in garages or even out in the middle in the wilderness. Another area of concern, that started in 2019 and continues into 2020 is the increase in the use of cocaine. More is flowing into the US from S. America and Mexico. There is Low perception of harm and is considered a party drug with little to no side effect when using on the weekends. Cocaine is the secondary cause of overdose. The Majority of overdoes which we have examined is caused by what we call poly-drug. They usually have more than one poly-drug – combination of poly-drug and alcohol. Since Covid, the most concerning issue in the last 9 months is multi-person overdoses – when more than one person at a particular location overdose – usually pill based and among younger people who are overdosing together. Another area is the use Narcan. In 2019 in Clark County, there were about 33 instances of Narcan use by first responders about a third of the cases were overdose related. Although we do not know with certainty as that information is not available. A problem with Narcan is that someone must be available to administer Narcan. When we compare Washoe and Clark counties, we see the same information/pattern coming out of the two counties with one exception – black market marijuana. This is due to gap/loophole to marijuana law. Questions? Ms. Kerns: I have talked to people who are/have distributed Narcan

who would not distribute to people who identified as stimulate users. Because we are seeing a lot of poly-drug use, they have changed the way they distribute Narcan due to it being laced with other drugs or they are using multiple drugs and there is no harm/adverse effect to using Narcan. I also believe there is not much information being collected in poly-use. Mr. Carter: I believe Narcan should be distributed to everyone as users may be expecting to buy one drug but will be getting something different. Ms. Lang: Thank you for presenting the information as it follows what we, the MPAC, are trying to do. You gave us the consequences (overdose deaths), then backed it up (why is it happening) – telling us about the drug seizures, investigative trends, and the border data, and trickled it down to some of what is contributing - mentioning Covid. Finally, you started talking about what we should be getting into next: this is happening, this is why, and looking at the prevention models that can address the issues. You gave me a good picture of what is happening the last couple of years. Questions or discussion. Dr. Wade: the data makes sense as other states have been distributing Narcan to everyone as fentanyl and heroin are being added to make substances/methamphetamine stronger and more addicting. Ms. Ross: I agree with you Dr. Wade. In Clark county there is an effort to get Narcan into local jails and to people who are recently discharged. Ms. Kerns: Southern Nevada Health District is working on getting Narcan into the jails to people who self-identify as substance use disorder upon their release. Dr. Wade: the opiate use in the Vegas and the Southern Nevada are much higher at least when self-reporting when they come into custody. Washoe County is the only jail that has an official MAT program. The program is specifically for Buprenorphine and Vivitrol. At Clark County Detention Center, Narcan is being distributed in the packet as they leave but it may be limited to HIV and drug use patients. Ms. Ross: Terry or Keith is there an update to ODMAP? Ms. Kern: we are trying to go statewide; we have a grant for ODMAP although it is not for every county. We continue to work with state EMS through a prior CDC grant. All the EMS agencies in the state go through an automatic program interface, their data is automatically uploaded to the state EMS database it is not just overdose, respiratory illnesses, infectious diseases, and other reportable information. We are working with state EMS, a subgrantee, to get an interface with the state EMS database into ODMAP. Ms. DeLett-Snyder: The mixing of Fentanyl and Gabapentin would it make it more sedating? Why would they do that instead of mixing it with a stimulant? Is Gabapentin cheap? Mr. Carter: I would be guessing and one thing to remember is that it is not scientific. Some of the substance found in the home-made pills make you think why would that be in there. As far a Gabapentin, it is easily available in the US. My thinking is that if it is available in the US there are massive quantities in Mexico and those using it have no idea what it is and what it does. Dr. Elliot Wade: Physiologically deep into withdraw dopamine receptors are so low that that are literally trying to get anything and everything to drive the dopamine up and not feel like crap. Often, we see people don't care what they use or using anything that drives up dopamine. Mr. Cater: In July Clark County started an overdose response team that is going out for overdose rather than

reaching out after it has occurred. Having said that, it is a small team, and they are overrun with work, so it is very limited. Mr. Delap: I am concerned with the dissemination information on Narcan/Naloxone to the lay public including politicians. An issue we have had in the last session a member of the assembly health committee asked what happens if you are allergic? There is a lack of awareness that this is a critical intervention. This information is valuable, and we need to practice telling other people. With Naloxone being distributed, is it bringing down overdoses? Overdoses are continuing but they are not opiate rather they are poly-substance. Is it still best practice promote the distribution of Naloxone even if the target isn't opioid overdose, but just an overdose? Dr. Wade Elliot: I would rather Narcan be given rather than someone thinking my friend only does this type of drug and it not work is another thing. In the City of N. Las Vegas there is upwards of 51% of people using opioid. In Washoe it is more like 9%. Ms. Kerns: The protocol for state EMS if you come across someone who is unconscious Naloxone is one of the tools in the toolbox to use. Also, an analogy I use is that it is it is similar to CPR in that the sooner you receive it the better chances of survival. Another analogy is that people are afraid/concerned about giving CPR because they may break their ribs. As a lifesaving tool, it does not matter if you break ribs/administer Naloxone the chance of saving their lives is greater.

7. Ms. Ross: Rosa O'Bannon is the coordinator for the Safe and Drug Free Schools within the Clark County School district (CCSD). Ms. O'Bannon: I am a department of 1 which serves a student population of over 320,000. We over see small grants and have a small budget for education for students and families. The program is the only one to require parents and students to attend the program. The main goal is to educate on substance abuse/use. Parents are often the last to admit there is a problem and yet they are the main providers with alcohol accessible and if they are recreational marijuana uses that is also readily available. The program is referral based with referrals made by school administrators. When a student is identified as in possession of drugs, under the influence, or in possession with intent to sell on school grounds, school events, or school sporting events, they are referred to the program. CCSD regulation 5141.1 requires schools to provide educational opportunity for students and parents. Previously, students would be either expelled or sent to behavioral school. AB 168 asks schools to provide intervention to deter and educate students and parents. Referrals have gone from 1600 in 2016-17 to 3,400 in 2018-19 more than doubling. Approximately 85% of the referrals have been for marijuana. The program accepts students from age 9 to 18 (second/third grade to seniors in high school). Elementary school referrals have seen a significant increase going from single digit to double digits. Elementary students would come to school with the intent to sell as a way to make money. In the program, a survey is conducted asking if they have ever used and have used in the last 30 days on 13 different common substances used with alcohol and marijuana being among the first two question. As referrals are most often for marijuana, most of the students in the program disclose they are using multiple drugs. In the program, we let the parents know they are not alone, and it is a

problem in the community and in the school as well. We educate parents on the accessibility of drugs within the home and to find ways to have the parent engage in the student's education and behavior while in school. Parents are shown the informal survey and it is then they are open to the idea it could be their child as 98% of students in the program are using marijuana and alcohol. Going back to 2016-17 participation was less than 20 students with session sizes of up to 40 people. Our session now has about 40-50 students with a size of over of 100 participants. Exit interviews are also done which show that the students are receptive. The perception of harm with use of marijuana students were asked if it would affect them in reaching their goal only 79% agreed. Prior to 2017 there were a lot of students using spice, and the most recent trend is with marijuana vaping and vaping tools. The focus from the department is shifting also educate the administrators and health teacher about vaping. The health teachers are responsible for drug education. They – health teachers – felt that the information within their curriculum was outdated. We have partnered with the American Lung Association, and we have partnered with community resources. We do not capture pills. If it is not in a package, we – nurses and administrators – cannot identify any kind pill. In the informal intake survey, more than 30% of students admitted to using some type of pill. We also provide prevention education participating in the All-Star Prevention Program for the past 6 years. The program is ongoing in 12 -15 middle schools. The focus is on risky behaviors and identifying the protective factors, so they can focus on their goals. Feedback from the administrators/teacher is that they see the awareness and a focus on goals. We have also partnered with the DEA to offer the opioid summit where we had participants from high school and middle school. 2020's in person summit was cancelled although a virtual summit was well attended. Questions? Ms. Kerns: Department of Public and Behavioral Health was looking to hire a statewide coordinator for the dept of ed to standardize curriculum and activities throughout the state. Has that position been filled and if so, how is it affecting what you are doing? Ms. O'Bannon: I have heard about it, no one has reached out to me. Ms. Lang: a person has been hired and is reaching out now. Ms. Palmer: Dana Walburn has presented to all the prevention directors and they have her email and phone number – Jamie or Linda can send it out. Dana Walburn is the Nevada Statewide School Behavioral Health Coordinator. She has been trying to communicate and connect with different people. Department of Child and Family Services and Department of Education, and Department of Public and Behavioral Health. We recently meet with her and she asked who else she can connect with and this is a great opportunity to share her information. Ms. Lang: Jamie or I will type her information into the comment box. Any other questions? Ms. O'Bannon: With Narcan in mind, I have tried to do some training and to bring that professional development, and it seems there is a lot of hesitation on which department or which individual would want to be charged to training or asking their staff to be trained because there are a lot of regulations on touching/not touching. The only staff that carries Narcan are the school police and only a core set of the school police carry Narcan. Mr. Delap: On the topic of Narcan in school, the bill

almost passed, and that was in part why it did not pass – not every school has a nurse and once you train/empower teachers they now liable to act. The bill will be reintroduced in the next legislative session by Assembly Woman Cohen. I will ask this committee, if they hear people who do not get it, that you make sure they do.

8. Presentation: Dr. Brian Iriye

Dr. Iriye: will discuss changes in prevention in a different way - Prevention in neonatal abstinence syndrome (NAS) by changes in treatment of pregnant women and prevention in maternal overdose by changes in policy and therapies. Opioid is expanding in the general population as well as pregnant population with use being highest the Medicaid population with over 21%. There is a big problem with Opioid during pregnancy, but there is also a problem with other illicit drugs during pregnancy. A study with the Tennessee Medicaid population reveals that 28% of woman use at least one opioid prescription medication during pregnancy. That population represent 65% of women that have neonatal abstinence syndrome in their kids. In 2000 NAS represented 1.2 per 1000 births; in 2016 is it 8.8 per 1000 births. These births often have kids in the hospital for minimum 14 to 21 days with an average cost of $8,000 to $10,000per day. In 2016, every 16 minutes, an infant in the US was born with NAS. From 2009 to 2016 the immediate cost of hospitalizations across the US went from ~$732 million to over $2 billion. The most recent significant data is that if a child is exposed opioid and gets NAS there is a decrease in head circumference of 1 centimeter. There are not many medications that cause a decrease of 2 to 3 millimeter of head circumference. Although, there is not a direct correlation between head circumference and brain volume, even though other disorders such as alcohol spectrum disorders that use head circumference as a proxy for central nervous system damage. In the long term, the damage is seen in test scores of 7th graders, born with NAS, who test lower in tests of aptitude than 5th graders. Another problem is with what happens with the mothers - mortality. Pregnancy associated maternal mortality are deaths for up to a year after birth. Across the US, 8-15% of all maternal pregnancy associated deaths are maternal overdose deaths. Part of the problem is that new mothers have more stresses - a new child to take care of, change in living situation, and more appointments they must attend. Overall, we spend more time with the treatment of infants than in prevention and treatment with mothers. Treatment and response in pregnancy is a little antiquated, in my opinion, and is fraught with dogmatic discussion that have been invalidated by recent data. Health care providers, organizational governments payers have been slow to change or provide incentives for treatment. Also, there is a stigma of women using during pregnancy and do not want to self-disclose due to that stigma. Some issues we are seeing are poor identification of people (lack of screening), lack of payment for appropriate responses (collaborative care codes are not paid for by Medicaid), problems in types of treatment people are receiving – they are not getting preconception counseling (preventative before pregnancy), the majority of older treatment therapies like methadone are very effective yet are probably less effective other types of treatments like Buprenorphine during pregnancy, and there a dogma with new therapies that are superior for care

like shared decision making and withdrawal in some of the patience during pregnancy. Three general problems we see most is that methadone by most providers is thought of as the only method of treatment for pregnant women. Another problem we see is the thought that dosing should be increased during pregnancy because of a 60% blood volume increase – from 5 to 8 liters. The thinking behind this is because the medication will be diluted due to the increase in blood volume. Weening in patients is counter indicative which is not true when the patients are selected properly. Over the past 10 years it has been shown that woman treated with buprenorphine rather than methadone there is a much lower rate of NAS, there is a lower dose rate in those who do have NAS, a decrease in hospital stays, and a lower treatment duration. All of this has been for over 10 years. You want to ween people to what would have less of a long-term problem among infants when mothers are treated with buprenorphine (alternative modalities). A program out of Tennessee slowly weened pregnant women off certain medication – under very close supervision – with success. The dogma was to increase not decease doses from two case reports from the 70's. Since then, five papers spanning 24 years with no fetal deaths. One study had four groups - incarcerated patients (acute detox), inpatient detox with intense outpatient behavioral follow up, inpatient detox without behavior health follow-up, and slow outpatient buprenorphine detoxification with intense behavioral health follow up – had 301 participants with no second or third trimester fetal demise. If detox in association with behavioral health, you had only 20% risk of relapse and detox without behavioral health there is a 70% risk of relapse. Behavioral Health is key and important to policy. In 2017, the SMFN (Society for Maternal-Fetal Medicine)/American College of OBGYN (ACOG) have concluded that if woman does not accept treatment with an opioid antagonist medically supervised withdrawal can be considered under the care of a physician with experience in prenatal addiction with informed consent. Back to the postpartum issue, most pregnancy coverage stops after 60 days from delivery. Most of the material overdose deaths occur between 7 and 12 months after delivery. Expansion for care up to a year after postpartum and has been supported by ACOG and SMFM. Another thing that needs to change is how we treat women during pregnancy/postpartum who have pain (pain relief for cesarian) and increased stresses. Across the US, the average person from a cesarian delivery get prescribed 40 opioid pills with an average use 20 to 25 and an estimated 20 million pills left to be misused/abused with 1 out of 300 women becomes possibly addicted. A few studies have shown that Acetaminophen/ibuprofen given around the clock have better pain control and don't require any opioids or maybe one or two bridges pills, but nothing upon discharge. Screening, brief intervention, and referral to treatment (SBIRT) is not being done because of the stigma. In Nevada, a panel was created and put together what is called the Behavior Change Wheel. It is a book that help you implement change in policy and educational means. Medicaid is now paying for SBIRT hopefully leading more screening and treatment. In summary, opioid use in pregnant women is underestimated, there is a larger cost due to hospitalization and NICU (neonatal intensive care unit) and other long-term disabilities. Buprenorphine in reproductive age women probably works better than methadone because of the decrease in NAS. I

think it is important to know about NAS that the smaller head circumference and the long-term effects. People should know that treatment during pregnancy is not bad, it is great in organized situations and motivated patients with intense behavioral treatment. Ms. Lang: This is exactly the information we are looking for that we can't get out of documents we have been receiving. Are there any questions? I look forward to getting your strategies as we move forward. Mr. Delap: SBIRT is that billable? Has Nevada received funding? Dr. Iriye: SBIRT is a questionnaire if you have positives to the questionnaire, you do a brief intervention and refer to treatment. SBIRT is now being paid for by the state.

9. Discuss Disclosure Statements
Mr. Trevino: I have not received the disclosure statement from 4 members. A deadline was set which passed a time ago. I have sent out emails including the document that needs to be signed. Ms. Lang: Please sent that out to the 4 member and CC Jaimie and me. You know the four members.

10. Discuss/Set meeting time/date and agenda items for next meeting.
Ms. Lang: Ben scheduled the Combined meeting for January 6th, however the chairs of the groups have moved it to January 28th from 9 am – 1 pm. It is a long meeting with each of us doing speaking for an hour. The Epi-profile will be coming out soon. Ms. Ross: The Epi-Profile will be released at the next Epi workgroup which will be on December 14th. Contact Ben, Linda or Myself if you don't have the agenda.

11. New Conferencing Meeting Format
Mr. Trevino: a month ago we were advised that the state is moving away from Zoom and WebEx. We thought we had a little more time to prepare and implement the new changes. Going forward we are exclusively using the Teams app. It will be sometime, hopefully not long, before I get my own call-in number. That is the reason for the discrepancy in start time on the agenda. Ms. Palmer: For the disclosure statement Item 9, there was a set deadline, and it is a requirement to be member, that will need to be addressed. When you do send out the communication, keep Linda and Jamie on email the communication and include me. I apologize for the time frame. That was time for the state and IT to get set up. I know Ben has been diligent in sending out a couple of communications informing everyone. Going forward we will make sure the agenda has all the acronyms will be spelled out and anything where someone is presenting will have their name, title, where they are from and purpose of the presentation.

12. Public Comment
Ms. Palmer: I looked at the calendar for the December 14th Statewide Epidemiology Workgroup. It does say a 12:30 start time which is for the IT component. Ben will send out a new calendar reflecting the start time. My Team has spoken with Damaris the SAMHSA representative and let her know about the annual meeting. She may be attending. Ms. Lang: After the combined meeting, I would like to continue to have one

or two presentation like the ones we just had. It is more beneficial that just the data.

13. Adjourned at 3:12pm