MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-First Session
March 26, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:34 p.m. on Friday, March 26, 2021, Online. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblyman Andy Matthews (excused)
Assemblywoman Clara Thomas (excused)

GUEST LEGISLATORS PRESENT:

Assemblyman Glen Leavitt, Assembly District No. 23

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Abigail Lee, Committee Manager
Joan Waldock, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Joanne Csete, Ph.D., M.P.H., Associate Professor, Mailman School of Public Health, Columbia University
Alex Kral, Ph.D., Distinguished Fellow, RTI International
Lisa Lee, Private Citizen, Reno, Nevada
Robert Harding, Private Citizen, Reno, Nevada
Tick Segerblom, Private Citizen, Las Vegas, Nevada
Jim Hoffman, Member, Legislative Committee, Nevada Attorneys for Criminal Justice
Erika Minaberry, Private Citizen, Reno, Nevada
Danielle Barrineau, Private Citizen, Reno, Nevada
Darcy Patterson, Private Citizen, Reno, Nevada
Holly Welborn, Policy Director, American Civil Liberties Union of Nevada
Bradley Mayer, representing Southern Nevada Health District
Chuck Callaway, Police Director, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department
Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District
Lindsey Kinsinger, Manager, Office of Public Health Investigations and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Services

Chair Nguyen:
[Roll was called. Committee rules and protocol were explained.] I will now open the hearing on Assembly Bill 345.

Assembly Bill 345: Revises provisions relating to substance use disorders. (BDR 40-978)

Assemblyman David Orentlicher, Assembly District No. 20:
Assembly District No. 20 is in Las Vegas and Henderson. I am grateful for the opportunity to present Assembly Bill 345. I am joined by experts Dr. Joanne Csete and Dr. Alex Kral, who will talk about the research, and others from the community who know a lot about opioid abuse and how we can deal with it.

Assembly Bill 345 is designed to reduce harm and save lives in Nevada [page 1, Exhibit C]. I have had much help in development from Joanne Csete and from Megan Comlossy of the Legislative Counsel Bureau. The seeds for this bill were planted three years ago when our Health Law Program at University of Nevada, Las Vegas (UNLV) hosted a conference on the opioid epidemic in Nevada and in the United States. We invited Professor Csete to speak about the experience in other countries with addressing similar problems. When she talked about overdose prevention sites, it blew me away. The data are amazing about how effective they are in preventing overdose deaths and transmission of communicable diseases. When I heard that presentation, I thought we needed this in Nevada. I am glad I can present that to you today.

I had help from Lisa Lee, Karla Wagner, Lea Moser, and Robert Harding, who are experts here in Nevada, and other members of our working group for Bill Draft Request 40-978. Jason Griffin also helped on this.

This bill is designed to reduce harm from the problem of opioid use [page 2]. One definition of "harm reduction" says it ". . . is a set of practical strategies . . . aimed at reducing negative consequences associated with drug use." We could do harm reduction in other settings, not only with drug use, but this is a common area where you can have a behavior that you cannot control entirely. Sometimes you do not want to control it entirely, sometimes you do. If drug use is going to exist, you at least want to minimize the harm that is caused. This is a balancing act because you want to reduce the harm, but not go too far. Here are some examples: not driving if you plan on drinking alcohol, but having a designated driver come with you; consuming nicotine in the form of gum or patches instead of smoking cigarettes—at least you are not doing the harm to your lungs from the cigarette smoke; distributing sterile injection devices to reduce the spread of HIV or hepatitis C, which is common in the United States and in Nevada. These examples all relate to drug use, but here is another example in another setting—seat belts and airbags in motor vehicles. We hope we do not have automobile accidents, but we cannot eliminate them entirely so at least we reduce the harm for people who are wearing seat belts and having airbags.

The opioid problem has been a serious one, especially during the pandemic, in the United States and in Nevada. In 2019, almost 50,000 people in the United States died from opioid-involved overdoses [page 3]. This past November, the National Drug Helpline placed Nevada on "red alert" status because of the increase in death from overdoses. We have seen this problem exacerbated by COVID-19. Here is a chart that shows the increase in opioid problems from 2019 to 2020. It shows Nevada in dark red, which means we have seen more than a 50 percent increase. A few months ago, the American Medical Association put out a statement, urging governors and state legislatures to take action and implement harm reduction strategies.

This bill has two components to save more lives [page 4]. One is to authorize an overdose prevention site pilot; the other is to make sure doctors are giving naloxone prescriptions to patients who are at higher risk for overdose. These two together will provide more harm reduction from opioid abuse in Nevada.

I will turn now to my copresenters, Joanne Csete and Alex Kral, to talk about what we know about overdose prevention sites.

Joanne Csete, Ph.D., M.P.H., Associate Professor, Mailman School of Public Health, Columbia University:

I congratulate the Assembly for opening a discussion on this important bill. In the mid-1980s, HIV linked to drug injection was exploding in western Europe [Exhibit D]. The Swiss, among other authorities, decided they needed to do something innovative to try to stop the harm that was coming from the enormous increase they were seeing in drug-related HIV [page 2]. In the shadow of their own Parliament in Bern, they created a space where people

could come inject drugs with medical personnel around them. This would ensure the people had clean injection equipment, and, if there was overdose, there would be medical people to help reduce the harm of it. Since then, these services have multiplied, as shown, in western and central Europe. There are also 37 of them in Canada and 3 in Australia. In Canada, there was only one supervised consumption facility, which was open from 2003 until 2016 when Canada realized it had the same kind of dramatic increase in overdoses as we have experienced in the U.S. Those sites, then, multiplied across the country.

Because of these decades of experience we have with this service and thanks to the enterprising work of many researchers—especially those at the University of British Columbia in Vancouver—we have a robust body of evidence to look at the outcomes associated with this intervention [page 3]. Obviously, these services were created to reduce overdoses. Most of them boast many thousands of overdose episodes without a single associated death or brain injury. This is because people have health help nearby. Needle sharing goes down, reducing HIV transmission. The better services have good systems of referral to other kinds of health and social support. These include, in many cases, access to various forms of treatments for drug dependence. The service in Vancouver that has been well studied has a drug treatment facility on the premises.

The sites lead to a decrease in the unsafe disposal of syringes. Most of these places have been able to demonstrate a decrease in open drug scenes and public disorder. I know of no evidence in the peer-reviewed literature of any increase in crime in the neighborhoods where these services exist, along with no increase in the initiation of drug use, which is often a fear expressed.

The last point is one that is frequently overlooked but is important to the cost-effectiveness of these services. We are looking at people who come inside these services instead of being on the street where, if there is a difficulty or overdose, ambulances with emergency medical technicians will need to come and people will be taken to hospitals. That has declined dramatically in places like Vancouver. When I visited the neighborhood in question before the service opened, I constantly saw ambulances going back and forth to hospitals. Now they do not need to.

Despite this evidence, when the conservative government was elected in Canada in 2006, it decided to close the facility in Vancouver. That was challenged by some people who used drugs. The case went all the way to the Supreme Court of Canada. The Supreme Court, in a unanimous decision, showed that it was very much convinced by the kind of evidence I have just talked about [page 4]. Without any kind of negative evidence it could see, lives were being saved. So, Insite continued and was a model for the many services that now exist across Canada.

I wanted to show you a picture from a visit I made to Berlin, Germany [page 5]. The Germans have gone beyond the first model of a stationary overdose prevention site to having mobile ones. On the right, you see the inside of a supervised consumption bus. The political viability of these facilities is that they now have a long history, thousands and thousands of

overdose episodes with no deaths on their premises. In Germany, as would be the case in the Netherlands and a number of other places we could look at, these services exist in part of a range of harm reduction services [page 6]. You can see I have explained some of the drop-in centers, fixed and mobile consumption spaces. There are also first aid centers where people with soft tissue infections can get those treated. There is free HIV and hepatitis testing. There is even a place where people can bring pets. The symbols are well known in Berlin. People know the routes of the mobile services. This shows a range of harm reduction approaches.

You know that fentanyl is the culprit in much of the overdose mortality in North America. As fentanyl markets expand their reach to Europe as well, some of the services are starting to do things like testing the drugs that come into their centers for the presence of fentanyl or fentanyl derivatives [page 7]. As shown by the Harm Reduction Coalition in New York, people can decide whether they want to take their drug, take it more slowly, or modify their behavior accordingly.

It is obvious that the European Union has never seen the level of overdose mortality we are now suffering within the U.S. [page 8]. I think there are three main reasons for that. First, they are committed to investing in a broad range of overdose prevention services and other harm reduction services that are supported by government money, not just by nongovernmental organizations (NGOs) as they are here. They are sustainable and considered to be part of primary care. Second, with nationalized or quasi-nationalized health systems, you would not see the same kind of out-of-control, unscientific, aggressive, and deceptive marketing of opioid medicines that caught us up here and was in many ways an engine for the dramatic increase we see in the graph. Third, and perhaps most important, in most of these countries minor drug offenses and nonviolent drug offenses are decriminalized or people do not go to jail for them, so there is greater opportunity to steer them to a range of health and social services.

I gave you a few links to summaries of some of the research we have [page 9]. In the more recent one by Armbrecht and others, you will be able to see more recent peer-reviewed literature. The second one on the list was done for Philadelphia, Pennsylvania, when they started considering having a supervised injection or overdose facility. The third is the evidence that went to the Canadian Supreme Court from the pilot years of the Insite facility in Vancouver.

Alex Kral, Ph.D., Distinguished Fellow, RTI International:
I am an epidemiologist and have been studying drug use here in the United States since 1993. In the United States, there are about 71,000 overdose deaths, 2,400 new infections of HIV, and 38,000 new infections of hepatitis C per year [page 2, Exhibit E]. Infective endocarditis, a heart disease, is also up, with about 20,000 cases a few years ago, and soft tissue infections are at about 500,000 a year. The health complications associated with injection drug use in the United States are quite broad.

In the United States, there are no legally sanctioned overdose prevention programs [page 3]. There is one unsanctioned site that we have evaluated. It has been open for six years. It entails, much like you saw in the previous presentation, two separate rooms—one for injection, one for post-injection. They have six stainless steel tables with mirrors and a table for assisted injection. A staff person is present in the room at all times who can help to save somebody or counsel them as needed.

We published a paper in the *New England Journal of Medicine* last July [page 4]. It looked at all the overdoses at that site. During the six years of operation, there were over 10,000 injections. Thirty-three people overdosed, and none of them died. They were all saved by the people who worked at the site. It is also important to note there were no ambulance calls required. That is a big issue as well because of the resources related to having an ambulance respond to overdoses.

We also did a study looking at crime in the neighborhood [page 5]. The left graph shows ten years of data, the five years before and after the site opened. The green depicts the neighborhood within 500 meters of the site; the blue on the left and the red on the right are control neighborhoods in the same city that are similar neighborhoods without a safe consumption site. Based on police reports, crime went down after implementation of the site in the 500 meters around the site. In the blue control neighborhoods, things are stable. There was good news in terms of crime around the site.

We published a study in a peer-reviewed journal two years ago that showed if you implement the same type of site they had in Vancouver in a city in the United States, it would save the city $3.5 million a year. There would be savings in overdoses; in ambulances not being used; and reduction in HIV, hepatitis C, abscesses, and those kinds of things. This is why the American Medical Association voted to approve overdose prevention programs in 2017 [page 6]. This is something that is completely sanctioned by the American Medical Association and many state medical associations.

Yours is not the only state considering such a bill. There are similar bills being deliberated in many states close to Nevada [page 7]. The mayors of many cities have declared they want to implement these overdose prevention sites.

Assemblyman Orentlicher:
As we heard, the American Medical Association and the American Public Health Association endorsed the concept of overdose prevention sites [page 6, Exhibit C]. Now I will go through an overview of what the bill does. This bill would not create an overdose prevention program; it would enable pilot programs. Washoe County and Clark County would have authority to open one pilot program each. If those go well, other counties would be given the option. These could be done either in a brick-and-mortar fixed site or with a mobile site. They would be operated by the health authority, an academic institution—University of Nevada, Las Vegas (UNLV) or University of Nevada, Reno (UNR) School of Medicine—a nonprofit organization, or a combination of any of those three.

How would these work? They are controlled environments with on-site, trained personnel. They can connect the users to education and with referrals for treatment. There would be oversight by state or local health authorities to make sure these are carefully regulated.

The bill provides a number of safeguards for the community [page 7]. Before opening a pilot site, the entity would have to consult with law enforcement, health authorities, and the public. They would have to ensure there was safe and proper disposal of used injection equipment. One of the virtues we have seen is that, instead of needles and syringes being left out in parks, on sidewalks, and in streets, they are disposed of properly in these facilities. There would be oversight by local health authorities, county commissions, and the State Board of Health.

There are safeguards for the participants [page 8]. These will be staffed by trained personnel. There will be distribution of sterile needles and syringes so users are not transmitting communicable diseases. Participants will be monitored in the treatment and posttreatment rooms. First aid will be administered on-site if it is necessary. There will be consultation and referral for treatment for mental health conditions or substance use disorders. Sections 9 and 10 have confidentiality provisions for the participants and protection from any legal consequences for both participants and the staff at the program.

This legislation would enable pilot sites, one each in Washoe and Clark Counties, for four years [page 9]. After two years, if the preliminary review indicates that things are going well, as we would expect, based on the data from other countries and the unsanctioned site in the United States, it would be possible for the Board of Health to authorize pilot programs in other counties. They would review the number of participants, see whether there were overdoses, and see if there were referrals, to gauge how they are operating. After four years for any pilot site, there would be a formal review to decide if they could transition to a permanent site. If it all went well in Washoe and Clark Counties after one year, they could be authorized to expand beyond the one site. That is the main part of the bill.

The second part of the bill is in section 12 that deals with another harm reduction policy, naloxone coprescribing [page 10]. People who are being prescribed opioids and are at risk for overdoses would be prescribed naloxone along with the opioid prescription, so the patient can have naloxone on hand in case of an overdose. Ten states have legislation or regulations on this. Eight states require the prescription be provided; two states require the prescription be offered. What we see in those states is it leads to increases in pharmacy dispensing of naloxone. We do not have enough data yet to know if that method of expanding access to naloxone compares with programs like we have in Nevada for nonpharmacy community distribution of naloxone.

The provisions in A.B. 345 are modeled after Rhode Island regulations. What we brought in from the Rhode Island regulations is that if a physician is prescribing for patients at a higher risk for opioid overdose, the physician would provide a naloxone prescription. The categories of patients who would be considered higher risk are these: if they are taking more than 50 morphine milligram equivalents per day, if they are taking an opioid and

a benzodiazepine, or if they have a history of opioid overdose or opioid use disorder. In our conceptual amendment, we removed previous section 12, subsection 3, and section 12, subsection 4 [Exhibit F]. There is a new section 12.3 to clean up some problems we had with the original language. If you are looking at the people who would get this prescription, it is important to be looking at the conceptual amendment. It seemed like Rhode Island had a good model, but the data are not as clear as with the overdose prevention site, so we welcome suggestions on refining the criteria. We might be leaving some people out that should be in; there may be some people in who do not need to be.

I would like to thank Natalie Johns and Areli Alarcon from my office for their excellent help in preparing this presentation. If you would like to cosponsor this bill, I would be happy to add you on by an amendment.

Chair Nguyen:
There are quite a few questions from members regarding this policy conversation about your bill.

Assemblywoman Titus:
Thank you, Assemblyman Orentlicher, for bringing up this discussion and this bill. I think it is a good policy discussion to have. I am glad you mentioned section 12. That was one of the first things I was going to bring up, especially section 12, subsection 3, where you describe not being able to prescribe Narcan or a reversal drug or opioids if the patient is being prescribed benzodiazepine. I know you are not a practitioner, but as a practitioner I would say it would be important the practitioners themselves make that decision. I am anxious to see what that looks like in your amendment. I will follow up with my questions on that once I see the amendment.

The Centers for Disease Control and Prevention (CDC) recently released a graph on overdoses. We know the opioid epidemic came in three waves. In 1999, the prescription opioid overdoses became a problem. In 2010, it was the heroin overdoses. The third wave was fentanyl overdoses. Over the last several sessions, we have successfully tried to curb that. We were an early state to adopt Narcan prescriptions and allow Narcan to be dispensed to family members. Providers like me who prescribe these are accountable for how they do this. We have also entertained needle exchange programs. I am curious to know how many states actually passed this legislation. Do we have the number?

Alex Kral:
No states have passed this legislation. A bill passed through both health committees and public safety committees in other states, but none of the bills has passed so far.

Assemblywoman Titus:
The first program started in the 1980s in Switzerland, so this is not a new idea. I graduated from medical school in 1981; we were dealing with the HIV epidemic, including issues about needle sharing. Since that time, we have progressed in thinking about not sharing needles. I am curious about statistics on the drugs. Who supplies the drugs? What drugs are

participants allowed to use? Do they bring in their own? Is this a volunteer program? Who controls the dose of heroin? Do participants tell those at the center how much they plan to take? Who controls the actual process, and where do the drugs come from?

Joanne Csete:
Dr. Kral, did you want to talk about the site you studied?

Alex Kral:
There are no drugs provided at the site, so people must bring and use their own drugs. They will typically let the attendant know what type of drug they are using. That is essentially it. They are then free to use as much or as little of those drugs as they want to use. If they use too much and overdose, the attendants are there to help save them. There are no drugs given out at the site; they are pre-obtained.

Assemblywoman Titus:
You bring in your own drugs, such as heroin, which is still illegal under federal and state law. What is the role of government in this? Conceptually, it is nice to be in a safe area. I know there is no increased crime in the area, and overdoses are prevented. Do you see folks coming in just to push the envelope? They can get a new supply of their heroin, not know how strong it is, go to a safe site to inject it, get their high, and know they are safe if they overdose. Is this more enabling than preventative?

Alex Kral:
The number of overdoses at these sites is actually lower than the rate of overdose in the community. That indicates to us that people are not taking more risks in these environments than they are out in the community.

Assemblywoman Titus:
You said there has been a decrease in number of deaths in the area around these sites because Narcan is available. Was the Narcan already available in these areas? In Nevada, Narcan is available. Is that a unique situation?

Alex Kral:
The difference here is that, if you use drugs while you are alone, you can have all the naloxone you want, but you cannot use it on yourself because you have overdosed. The point of these sites is to ensure there is someone there, a professional who knows how to use the naloxone or oxygen they have available. That is the main intervention—to make sure there is somebody there in case of overdose.

Assemblywoman Titus:
I would like to bring this back to the state of Nevada. The studies we have seen show a lowered rate of overdose except for during this pandemic, which is the outlier. We have seen an increase in overdoses in this last year. It is a significant tragedy. Do you know how many Nevada overdoses have been from heroin or from other injectable drugs?

Assemblyman Orentlicher:
I do not have that information. We have some Nevada experts on the call who may know. Let us bear in mind that we get recurring waves. This is not an outlier. The waves seem to be inevitable. The extent of data we have is impressive. There is no reason to think that Nevada would be any different from what we have seen in the all these other locations that have benefitted from these sites.

Assemblywoman Titus:
Would the use of these sites be restricted to Nevada residents? Would you have to show an ID, a health insurance card, or some sort of health care information in case there is an overdose, the overdose had to be reversed, and the person needed to be hospitalized? How much information gathering will be required?

Assemblyman Orentlicher:
We had not thought about that. I would be happy to talk to you about it to see if that should be part of the legislation. I would be interested in hearing whether it is an issue for the unsanctioned site.

Assemblywoman Titus:
My concern is if medical care is sought after an overdose. Do participants have to sign a waiver at the door? How do we, as health care providers, take care of them if they need care? Having worked thousands of hours in emergency rooms and having dealt with overdoses, I am curious about how the process would work and how it would affect those providing care these folks might need. I have other questions but can reach out to Assemblyman Orentlicher off-line.

Chair Nguyen:
I see Ms. Lisa Lee is on the line. She may have Nevada-specific data.

Lisa Lee, Private Citizen, Reno, Nevada:
Data is slow to catch up to us. The most current data on the opioid dashboard is from 2019. Pre-pandemic data in Nevada show about 400 people have fatal overdoses each year. A good share of those are due to polysubstance use of opioids and a benzodiazepine, which is important to note with the coprescribing of naloxone in section 12. I asked the medical examiner in Washoe County for the quarterly report. I try to stay on top of that because I do outreach with people who use drugs, so I want to make sure that I can warn people if there is a bad batch. I have fentanyl test strips that I will be taking out when doing outreach and data collection in northern Nevada. In addition, I wanted to say that there is data collection planned. We are going through the IRB [institutional review board] process currently with Dr. Karla Wagner. The study will be collecting data with people who use drugs to talk about what is happening on the ground as well as acceptability of the overdose prevention sites going forward.

Chair Nguyen:
If there is additional information, please provide it to Assemblyman Orentlicher. He can get it to Committee staff for distribution.

Assemblyman Hafen:
I have several questions but will touch on two different sections of the bill. Section 9 refers to the confidential nature of the information being collected. Do you think that language will stand up to a Freedom of Information Act (FOIA) request? Do you think the information will not be released to individuals who request it?

Assemblyman Orentlicher:
I will check to make sure.

Chair Nguyen:
It looks as if Ms. Lee would like to respond.

Lisa Lee:
Robert Harding is on the call. He can answer that question.

Robert Harding, Private Citizen, Reno, Nevada:
The language used for section 9 is pulled from previous legislation that authorized the syringe access programs in 2013. There have not been any challenges with those records since then, so I do not foresee any problems using it in the future.

Chair Nguyen:
Thank you, Mr. Harding. Are there any follow-up questions?

Assemblyman Hafen:
My concern is these actions are still considered criminal. I would not want the information to be released. I had a question about section 7, subsection 1. It states that these sites will be operated by a health authority, higher education, a nonprofit organization, or any combination thereof. It does not seem to be specific to Nevada higher education or Nevada health authorities. Is this limited to the Nevada System of Higher Education and Nevada health authorities? If so, have they provided any feedback?

Assemblyman Orentlicher:
Our assumption was they would be. I have had conversations with people at UNLV School of Medicine. The person I spoke with said they would be interested in participating in a project like this. Our intent was Nevada entities would operate the program.

Lisa Lee:
We currently have a large stakeholder group that includes people from the Southern Nevada Health District, the Washoe County Health District, and the Office of the County Manager for Washoe County. It also includes associate professors from UNR. We are in constant

conversations about these issues. It all depends on what happens with A.B. 345 going forward, but they all are voices at the table in this larger stakeholder group.

Assemblywoman Peters:
In this Committee, we have talked quite a bit about the societal stigmas attached to behavioral and mental health and the impact that has on access to treatment, the type of treatment you can receive, and the burden of carrying those issues in your life. Would you talk about how this plan works to destigmatize mental and behavioral health related to addiction and other issues?

Chair Nguyen:
I see that one of the people on the line to answer questions has his hand raised. I will go to him.

Tick Segerblom, Private Citizen, Las Vegas, Nevada:
I was trying to reply to the previous question. Clark County is eager to go forward with this program. I have served on the Southern Nevada Health District Board and the Clark County Commission. There are places in my district that are ready to go. All we need is a little help.

Chair Nguyen:
We have someone else who can answer Assemblywoman Peters' question.

Joanne Csete:
There is a lot of qualitative literature about these places. If you talk to people who use drugs and these facilities, they often say those are the only places where they have been able to get nonjudgmental care. For many, it is also the only way to integrate them into any other kind of health or social service system. These are often the door people will go through when they do not want to go elsewhere because they fear stigma, judgment, and discrimination. The best of these facilities have served to be places where people can feel that they do what they need to do without being stigmatized and judged.

Lisa Lee:
I am a woman in long-term recovery from opioid use disorder. While I have not had the privilege of using one of these overdose prevention sites, I can safely say I probably would not have lived with hepatitis C for 21 years if these sites had existed. I can safely say that many of my friends would still be alive at this point. Stigma is a real thing that ends in people not getting care they need. I can tell you that, because of stigma, I did not go for medical care and lanced my own abscesses while experiencing homelessness and being an injection drug user. I constantly endangered my life. There are people around us with necrotizing fasciitis and whatnot that are a direct result of prohibitive policies and keeping people who use drugs in the shadows and without care. I think spaces like this are deeply meaningful.

The opioid crisis has been in the American mass purview for a limited time, but I have been having an opioid crisis for decades. I think of places like this, and I know that a lot of people

would still be here, a lot of people would not live with stigmatizing blood-borne infections, there would be limitations of soft tissue infections left untreated that end up turning septic or go into endocarditis. Stigma is a real thing that kills people. I am glad you brought that up.

Robert Harding:
To reinforce what was just said, there are two forms of stigma. There is external stigma—the stigmas placed on a person. There is also internal stigma, which is when we take those stigmas and start to feel them deeply within our souls and think of them as a person. Having harm reduction services that support people who use drugs and providing that space and that environment helps break down and change the internal stigma, which can be just as deadly as the external.

Chair Nguyen:
Members, if you have questions, please send me a message so I can get you in the queue. We need to get to testimony in support, opposition, and neutral for this bill, and we have one more bill to hear.

I am excited you have so much data to analyze; unfortunately, it is from outside the United States, from countries with different health care systems and different public health care systems, and they have had prolonged education campaigns to destigmatize this. How do you take some of that data and have it play into the success we might have in our health care model?

Joanne Csete:
Of course, the history is different with the nationalized or quasi-nationalized health systems making an enormous difference. The criminal law is different. I think, however, that the actual interventions that go with these services or that could be linked to an overdose prevention site have a certain universality from which we can extrapolate from the decades of experience that is already out there, because overdoses suffered in Europe are not different from the ones here. The other data that is very useful is the cost data. There have been some good costing studies. It is rare to get good costing of any kind of intervention that deals with marginalized populations there. I think the data could be very useful for policy makers here.

Chair Nguyen:
A majority of the countries that have these types of programs available have also decriminalized drug possession. How does that work here? This is still a felony charge in Nevada. How does that work in this legislation? I would not want to see facilities set up, and police officers are waiting outside to arrest people going in or out.

Joanne Csete:
Canadian controlled substance laws are similar to ours. The sites there operate on an exception to the Controlled Drugs and Substances Act that enables people to not be prosecuted for what goes on in the facilities. It is a matter of community liaison work to be sure the police are not standing outside to arrest people as soon as they come out. That is not happening in places where possession has been decriminalized. Basically, there has to be an

exception to whatever drug control laws there are. Even in western Europe, excluding Portugal and a few other places, there has been a longer history of decriminalization but the drugs are still illegal. The law allows for an exception to the drug control criminal framework.

Alex Kral:
The only country that decriminalized drugs is Portugal. None of the others have decriminalized drugs. Norway is about to, but that does not span the data we have from the past few years in Norway. It is much like syringe exchange programs. You need public safety and public health to work hand-in-hand for these programs to work. We have been doing syringe access successfully in many states in the United States for decades now. I do not see a reason why you could not also do that with respect to this particular intervention.

Chair Nguyen:
I have some concerns in addition to the question that was asked by Assemblyman Hafen. I would not want people to be able to do a FOIA request to get the names and addresses of people in the sites and then use that information to further criminalize people who are trying to get help. I do not remember seeing that in the language of the bill, but I think it should probably be considered as part of the legislation.

Assemblyman Hafen:
In the bill language I do not see any age limitation on this program. It does not preclude minors. The Legislative Counsel's Digest implies there is an age restriction—that a person must be at least 18 years old or older. What was your intent?

Assemblyman Orentlicher:
I would have to think about that. I invite our other presenters to share thoughts about drawing age distinctions.

Chair Nguyen:
I will ask Mr. Harding to answer the question so we can move on.

Robert Harding:
I would encourage the Committee to be cautious about requiring IDs or documents. People living on the streets and living without shelter often end up without those. This program would be most beneficial to those individuals because they do not have clean, sterile spaces to use their supply of drugs. Requiring they have some sort of ID or documentation when they come in creates a big barrier. I want to reinforce that the language I brought in section 9 from the syringe services program addressed the anonymity of the program to protect the clients from any FOIA requests and to keep that barrier low.

Chair Nguyen:
Ms. Lee, did you have a response to the juvenile question?

Lisa Lee:
I believe when we put together the original draft language our intention was these would be for people aged 18 years and older.

Chair Nguyen:
Do other countries with programs like this have age limits, or do they target adults?

Joanne Csete:
In some of the facilities, the staff is trained to refer people under age 18 to other kinds of services, but some of them require no proof of age or any identity documents. The ones in Denmark have been widely visited. People who used drugs were part of the design from the beginning. They serve everyone; they do not try to distinguish by age.

Chair Nguyen:
I appreciate your presentation. There are lots of questions and lots of comments. We could probably be here all day discussing this. I would encourage members to reach out to Assemblyman Orentlicher. I am sure he would be happy and willing to provide contact information for some of the presenters. I will open testimony in support, opposition, and neutral of Assembly Bill 345.

Tick Segerblom:
I am not appearing on behalf of the County Commission or the Clark County Board of Health. This bill is fantastic and greatly needed. As you know, the war on drugs is over; we lost. Oregon just decriminalized all drugs. I think that is the way the nation is headed. Now we have to deal with the issue of how to make sure the people who use drugs do not kill themselves and provide services so, hopefully, they can get off of them. My district includes the Flamingo Wash which runs next to UNLV. There are huge numbers of drug users in that Wash. They come out of the Wash and into the neighborhoods. There are syringes everywhere. We have started a syringe exchange program. The next step will be this, where people can come to a secure facility.

With respect to drugs being illegal, I will remind you that possession of marijuana is a C felony under federal law. You will be dealing with bills about places you can go to smoke marijuana. If you can go smoke marijuana, I do not see why you could not also go to a place, bring your fentanyl or whatever you have, and use that at a site. I do not want to oppose the bill, but I think one site in Las Vegas is not enough. I would say, have the pilot programs, but do not limit the number.

Chair Nguyen:
I would encourage you to continue to work with the bill's sponsor about any concerns you have regarding the current language of the bill. We can begin testimony in support of the bill.

Jim Hoffman, Member, Legislative Committee, Nevada Attorneys for Criminal Justice:
Nevada Attorneys for Criminal Justice (NACJ) supports A.B. 345. Chair Nguyen had a question about FOIA requests and criminalization. As I read the bill, section 10 states that a person cannot be prosecuted, arrested, charged, et cetera, for either working at the place or for consuming or possessing drugs in connection with it. There is a basic level of protection there.

Studies have shown that safe injection sites reduce the amount of outdoor drug use, prevent overdoses and transmission of disease, and provide wraparound access to addiction counseling. Nevada has spent the past 40 years trying mass incarceration as a response to drug use. That strategy has failed to stop drug use or the harm it poses to society. Safe injection sites would be a new tool to address the harm in a beneficial way. For that reason, the NACJ supports the bill.

Erika Minaberry, Private Citizen, Reno, Nevada:
I am privileged to have been in recovery for the last 15 years, but 15 years ago I almost died from an infection that was left untreated. I consider myself lucky because a lot of my friends did not make it to that point; they were never given the opportunity to recover, and they had very brilliant brains. If they were able to recover, they would have been able to do amazing things for this community. I believe by passing this bill, lives will be saved, and the community will be enriched.

Danielle Barrineau, Private Citizen, Reno, Nevada:
I wanted to talk a little bit about my past. At the beginning of my drug use, I was kidnapped and sold for sex. If that girl had known about a place like an overdose prevention site, how amazing it would have been. I cannot tell you how many times I tried to escape, and my kidnapper would find me and beat me and torture me. I really did not have a way out. I did not know what to do. If there was a place where I could go use safely, with all the resources that are available for human sex trafficking victims, how soon could I have been saved? How much less trauma would I have had to suffer if not for a place like that? On top of all the facts that have been presented, I wanted to say that for girls who are suffering out there—who cannot speak, do not know where to go, and cannot tell the truth to their pimp or sex trafficker about going to use and get some syringes—this is a great option, and it should be supported.

Chair Nguyen:
Thank you for sharing your story.

Darcy Patterson, Private Citizen, Reno, Nevada:
I am grateful for this opportunity to share my support for A.B. 345. My daughter Kirsten Yamaoka died from a heroin overdose here in Reno, Nevada. She was 21, and it was her birthday. Personally, and as an advocate, there are several reasons I support this bill. With the creation of programs for the prevention of overdoses and disease, those with substance use disorder can come to a nonbiased place that will prevent their admission to our hospitals for infection, overdose, and transmission of diseases such as hepatitis C and HIV.

The ability to administer opioid antagonists such as Narcan can mean another life saved. If a person who has substance use disorder does not remain alive, there is no hope for recovery. This seems elementary, but it is a huge part of how we can guide those to treatment and give education regarding substance use disorder.

In Nevada, we have at least one death from overdose every day. Let us create programs in our community that foster harm reduction and reduce the stigma of substance use disorder, and create and provide a safe place to use substances, with policies put in place for the safety of those who have substance use disorder and the staff of such programs. If this bill had been enacted years prior, there would have been a possibility that my daughter would have been in the presence of someone who legally could have reversed her overdose, therefore saving her life, finding treatment, living recovery, and becoming a contributing member of our community. Please support A.B. 345.

Holly Welborn, Policy Director, American Civil Liberties Union of Nevada:
I am testifying in support of A.B. 345. Among the most disastrous costs of the failed war on drugs are its detrimental consequences for public health. Assemblyman Orentlicher is joining the chorus of lawmakers who are moving the state away from the criminalization policies that destroy our communities and people's lives. Assembly Bill 345 is the right solution to this crisis. Prevention sites offer the promise of reduced overdose fatalities, increase access to health services, and promote overall benefit to public safety. We thank Assemblyman Orentlicher for bringing this legislation and encourage the Committee's support.

Chair Nguyen:
Thank you. We can go to our next caller in support. [There was no one.] We will go to callers in opposition to this bill. [There were none.] Are there callers in neutral?

Bradley Mayer, representing Southern Nevada Health District:
Southern Nevada Health District has been at the table as this bill was being crafted. For the purposes of providing information and context, I have some things to share. The rate of drug overdoses is increasing in Clark County. It has risen from 19.2 per 100,000 people in 2011 to 21.2 per 100,000 in 2020. Most of those overdoses were unintentional. The primary driver can be attributed to the increasing presence of fentanyl in the drug supply. Fentanyl overdoses are concentrated more in a younger population, with an average age of 29 years old versus 49 years old for overdoses not involving fentanyl. In addition to the overdose issue, Nevada received a determination of need from the CDC in 2017 that found the state was at risk for significant increases in hepatitis and HIV infections from intravenous drug use. Around the world, these overdose prevention sites have evolved as a harm reduction strategy, one of several responses designed to address public health concerns associated with illicit drug use. As far as we understand it, no one has died at an overdose prevention site. Studies have been done in other countries that found that the presence of these sites has been associated with decreases in infectious diseases over time—such as in Spain, where new HIV infections were cut in half and in Canada where I suggest that overdose prevention sites prevent about 80 new HIV cases annually. Vancouver, British Columbia, operates one of

these sites. At that site between 2003 and 2006, 46 percent of participants entered a drug treatment program. It is important to acknowledge there are currently no sanctioned overdose prevention sites operating in the United States. As it pertains to the provisions of this bill that involve or relate to the Southern Nevada Health District, we do not have any issues with how this bill is currently written.

Chair Nguyen:
Is there anyone else in neutral? [There was no one.] At this time, I will turn this over for closing remarks.

Assemblyman Orentlicher:
Thank you, Chair, and all my copresenters. As you heard, we have an opportunity to implement a well-tested, well-vetted intervention that will reduce harm, save lives, and bring marginalized people back to our community to the services they need. There are a lot of proposed interventions that we hope will work. We do not have much data, but it is hard to imagine having more data than we have to support this. The fact that the American Medical Association, the American Public Health Association, and other expert organizations have endorsed this should make us confident that this is the right thing to do.

Thank you for the hearing and the suggestions. We will continue to work to ensure we get everything right. Please let me know about other ways we can improve the bill.

[Exhibit G, Exhibit H, and Exhibit I were submitted but not discussed.]

Chair Nguyen:
I will close the hearing on Assembly Bill 345 and open the hearing on Assembly Bill 260.

Assembly Bill 260: Provides for the confidentiality of contact tracing information. (BDR 40-747)

Assemblyman Glen Leavitt, Assembly District No. 23:
Assembly District No. 23 is in the southern part of Clark County. I am here to present Assembly Bill 260 for your consideration. All of you know that since June 2020, contact tracing has been an important strategy for slowing the spread of COVID-19. On June 1, 2020, Governor Steve Sisolak released the Nevada COVID-19 Disease Outbreak Management Strategy and Concept of Operations in coordination with the Department of Public Safety, the Nevada National Guard, and the Department of Health and Human Services. This Concept of Operations identified contact tracing as a key strategy for preventing the further spread of infectious diseases like COVID-19.

It is not clear that the Health Insurance Portability and Accountability Act (HIPAA) privacy rules apply to groups conducting contact tracing. Iliana Peters, former Acting Deputy Director for HIPAA at the U.S. Department of Health and Human Services, Office for Civil Rights, said in August that certain entities conducting contact tracing are not currently required to maintain confidentiality. There was and still is a recognition by Nevada public

health departments of the need to protect the privacy of those diagnosed with COVID-19, saying the individuals who were at risk [unintelligible] not be told the identity of the patient who may be exposed to them. I applaud these efforts to maintain patient privacy at a time when the public health is of utmost importance; however, we can certainly do more to ensure these attempts are successful, including codifying into law specific provisions that protect patient privacy as it relates to contact tracing.

Sections 2 through 4 of the bill define contact tracing and COVID-19. Section 5 prohibits a government entity or persons from disclosing information obtained through contact tracing. It also prohibits a law enforcement agency from conducting contact tracing and prohibits a court from disclosing information related to contact tracing from a government entity or person. Additionally, no later than 30 days, a person who conducts contact tracing on behalf of a government entity must delete, dispose of, or remove such information. Section 6 authorizes that a government entity that conducts contact tracing may disclose the information if a person gives consent, the information is needed to conduct the contact tracing, the information is needed to save a person's life, the information is needed to protect the public health, the information is needed for an investigation after a person has given consent, or the information is highly material to an investigation. It also allows for a representative to consent on behalf of a person for a minor or a person who lacks the capacity to provide informed consent. Lastly, it requires a government entity to keep a written record of that disclosure.

Section 7 requires government agencies that may disclose information may not include personally identifiable information. Section 8 requires the Board of Health to establish regulations to protect the confidentiality of information obtained by individuals. Section 9 authorizes the Division of Public and Behavioral Health within the Department of Health and Human Services (DHHS) to conduct investigations of alleged violations.

That was the initial bill. We have received some friendly conceptual amendments [Exhibit J]. The DHHS inquired about the 30-day limit for keeping data as they are mandated to keep their data for one year. In section 5, subsection 5, the period of 30 days will be amended to one year. They also want to be able to do a further investigation of contact tracing for those held in jail or prison. Section 5, subsection 2, will be amended to allow law enforcement to conduct contact tracing when the individual is currently being held in jail or prison.

Chair Nguyen:
Are there any questions from members?

Assemblywoman Peters:
I am confused about how this differs from what is already occurring for contact tracing. Would you please talk about the need for this in the long term, rather than having it be driven by policy?

Assemblyman Leavitt:
It is difficult to answer that question because everything is unknown with COVID-19. We hope everything will be under control, and we will not have to worry about it in the future. We hope, but we do not know. Putting protections in place now is a step forward in what we are doing even though we are remedying the situation as it currently exists. The reason for the bill is contact tracing does not currently fall under HIPAA. That is the need for this issue. It did not come about because of the newness of COVID-19.

Assemblywoman Peters:
My other question has to do with limiting this bill to COVID-19. Would it make sense to expand this to other pandemic-style scenarios in case we have something like another outbreak?

Assemblyman Leavitt:
I am happy to look into that and expand this beyond just COVID-19 for other diseases that do not currently fall under HIPAA. The goal of the bill is so we do not have people being arrested or forced to stay in their houses because of information regarding their current COVID-19 status.

Chair Nguyen:
Are there any other questions? [There were none.] Is there anyone on the line in support? [There was no one.] Is there anyone in opposition?

Bradley Mayer, representing Southern Nevada Health District:
We met with Assemblyman Leavitt and appreciate the intent of what he is trying to bring forth. We do not want to be in a place where we are opposing this bill and hope to work with him to address some of our concerns. As you will hear from my colleague in Washoe County, there are some issues about the time limits for holding data, beginning with section 5, subsection 4. They would jeopardize current funding streams that have specific requirements that must be met regarding this data. Also, it disrupts the accepted framework for conducting case investigations and contact tracing.

As Assemblyman Leavitt mentioned, we also have the issue of section 5, subsection 2, asking that provision be deleted, as currently law enforcement does contact tracing among inmates. We agree on that, but we need to work with Assemblyman Leavitt on the timelines that exist so something is workable for the health districts relating to those issues. We support the general concept of what is trying to be accomplished here, we just need to do some more work.

Chuck Callaway, Police Director, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department:
Generally, we are in support of the bill. We share the same concern that was voiced by the previous caller about section 5, subsection 2. We believe that needs to be clarified. Our agency does contact tracing on employees. If we had an officer who was involved in training or was in a briefing and had COVID-19, we have an obligation as an employer to ensure that

other workers were not infected. That involves our risk management section doing contact tracing among our employees. As was stated, there could be issues with the Clark County Detention Center and the inmate population with contact tracing. We would like the opportunity to have that section clarified.

Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District:
I wanted to thank the bill's sponsor for working with us. We are almost there. I appreciate the proposed amendments; however, we still have a problem with section 5, subsection 5, where it limits the storage of data for one year. I know it sounds interesting that our requirements are different than DHHS's, but we have to store data longer for research and measurements that we send to the Centers for Disease Control and other places for funding mechanisms. Without changing that time limitation, we could be subject to losing funds. We have about $25 million in funding streams now through 2023 for contact investigation. I think we can get there on this bill.

Chair Nguyen:
May we go to our next caller in opposition? [There was no one.] Do we have any callers in neutral?

Lindsey Kinsinger, Manager, Office of Public Health Investigations and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Services:
We are testifying in neutral. As some of the counties expressed, we would welcome the opportunity to work with Assemblyman Leavitt to provide more clarity. Right now, we do treat contact tracing and disease investigation data and information for COVID-19 with HIPAA protections. I will assure you that information is not being given out unless there is a subpoena or law enforcement is involved. We will work with you. We support the idea of the bill and would look forward to helping you rewrite the data policy.

Chair Nguyen:
Is there anyone else in neutral? [There was no one.] I will turn this back over to you, Assemblyman Leavitt, for any closing statements.

Assemblyman Leavitt:
It looks as if we are making progress on this. I apologize that I did not get the amendments exactly right. We are still working on them. I will get those to the Committee. I do not think any of the issues proposed would be too difficult to overcome. I will continue to work with the Southern Nevada Health District, Washoe County Health District, and the other stakeholders who voiced concerns to get the language right so we can move this from being a great concept to being a great bill. This concludes my presentation. I believe this is an important piece of legislation to keep individuals' information private. I will continue to work with the stakeholders to ensure we find common ground. The working product we pass to the Committee in the future will be solid.

Chair Nguyen:
I will close the hearing on Assembly Bill 260. We will move to public comment. Do we have anyone on the line in public comment? [There was no one.] Are there any comments from members? [There were none.] We will have a busy next couple of weeks. We have quite a few bills that have come in these last few weeks. Plan on being here on Monday, Wednesday, and Friday. We might have another evening meeting if we need to schedule that to hear these bills before the deadline for first committee passage. We are adjourned [at 3:13 p.m.].

RESPECTFULLY SUBMITTED:

_____
Joan Waldock
Committee Secretary

APPROVED BY:

_____
Assemblywoman Rochelle T. Nguyen, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "AB 345," presented and submitted by Assemblyman David Orentlicher, Assembly District No. 20.

Exhibit D is a copy of a PowerPoint presentation titled "Overdose Prevention (supervised consumption) sites: an evidence-based response," dated March 26, 2021, presented and submitted by Joanne Csete, Ph.D., M.P.H., Associate professor, Mailman School of Public Health, Columbia University.

Exhibit E is a copy of a PowerPoint presentation titled "Nevada Assembly Bill 345 Overdose Prevention Programs," presented and submitted by Alex Kral, Ph.D., Distinguished Fellow, RTI International.

Exhibit F is a proposed conceptual amendment to Assembly Bill 345, presented and submitted by Assemblyman David Orentlicher, Assembly District No. 20.

Exhibit G is a packet of letters, submitted by various individuals, in support of Assembly Bill 345.

Exhibit H is a copyrighted issue brief published by the Foundation for AIDS Research, titled "The Case for Supervised Consumption Services," dated June 2017, submitted by Robert Harding, Private Citizen, Reno, Nevada.

Exhibit I is a copyrighted article published by Elsevier titled "Impact of an unsanctioned safe consumption site on criminal activity, 2010-2019," dated December 2020, submitted by Robert Harding, Private Citizen, Reno, Nevada.

Exhibit J is a proposed conceptual amendment to Assembly Bill 260, presented and submitted by Assemblyman Glen Leavitt, Assembly District No. 23.