# Biennial Report of the

# Advisory Committee for a Resilient Nevada (ACRN)

# 2022

## Department of Health and Human Services

## Report Date June 30, 2022

*For submission to the Director of the Department of Health and Human Services.*

*On or before June 30 of each even-numbered year, the Advisory Committee shall submit to the Director of the Department a report of recommendations concerning the statewide needs assessment and state plan.*

# Advisory Committee for a Resilient Nevada

## Working Group Members

| Appointments | NRS 433 Requirements for ACRN |
|---|---|
| **Barlow, Jessica** | One member who resides in a county other than Clark or Washoe County; and has experience having a substance use disorder or having a family member who has a substance use disorder. |
| **Collins-Jefferson, Brittney, LCSW, LCADC-I** | One member who represents a faith-based organization that specializes in recovery from substance use disorder. |
| **Grady, Lilnetra** | One member that represents a program for substance use disorders that is operated by a non-profit organization and certified pursuant to NRS 458.025. |
| **Gustafson, Ryan** | One member who is the director of an agency which provides child welfare services or his or her designee. |
| **Kamyar, Dr. Farzad MD, MBA** | One member who is a physician certified in the field of addiction medicine by the American Board of Addiction Medicine or its successor organization. |
| **Loper, Karissa, MPH,** *Vice Chair* | One member who possesses knowledge, skills, and experience in public health. |
| **Loudon, Katherine E.** | One member who possesses knowledge, skills, and experience with the education of pupils in kindergarten through 12th grade. |
| **Dr. Karla Wagner** | One member who represents a program to prevent overdoses or otherwise reduce the harm caused by the use of substances. |
| **Maria, Cecilia** | One member that resides in Clark County and has experience having a substance use disorder or having a family member who has a substance use disorder. |
| **Monroy, Elyse** | One person who possesses knowledge, skills, and experience in the surveillance of overdoses. |
| **Patterson, Darcy** | One member who resides in Washoe County; and has experience having a substance use disorder or having a family member who has a substance us disorder. |
| **Salla, Pauline** | One member who possesses knowledge, skills, and experience working with youth in the juvenile justice system. |
| **Sanchez, David** *Chair* | One member who has survived an opioid overdose. |
| **Saunders, Ariana** | One member who represents an organization that specializes in housing. |
| **Sheehan, Cornelius** | One member who possesses knowledge, skills, and experience working with persons in the criminal justice system. |
| **Sherwood, Laura** | One member who represents a program that specializes in prevention of substance use by youth. |
| **Winbush, Quinnie** | One member who represents a non-profit community-oriented organization that specializes in peer-led recovery from substance use disorder. |

## Non-Member Roles

| Name | Affiliation |
|---|---|
| Henna Rasul | Office of Attorney General, Senior Deputy Attorney General |
| Stephanie Woodard, PsyD | Department of Health and Human Services Senior Advisor on Behavioral Health |
| Dawn Yohey | Department of Health and Human Services/ Clinical Program Planner |
| Joan Waldock | Department of Health and Human Services/ Administrative Assistant |
| Beth Slamowitz, PharmD | Department of Health and Human Services/Senior Policy Advisor on Pharmacy |

Administrative Support Provided by Mercer Health Partners

# Contents

# Introduction and Background

## Context

The Advisory Committee for a Resilient Nevada (ACRN) was established in compliance with the passage of Senate Bill (SB) 390 to be codified in *Nevada Revised Statutes* (NRS) 433 by the 2021 State Legislature 81st session to obtain advice and counsel from persons and entities who possess knowledge and experience related to the prevention of opioid misuse, opioid-related deaths, and injury, as well as addiction and opioid use disorders within the State of Nevada. The goal is to effectively address risks, impacts, and harms of the opioid crisis in the State through the Fund for a Resilient Nevada.

Details of the bill and its requirements and documentation of activities of the ACRN are available at the following site: ACRN Home (nv.gov).

## Roles and Responsibilities

The composition of the ACRN is dictated in statutes. Appointment of members were by the Attorney General, and the Department of Health and Human Services (DHHS), which includes appointments from the Office of Minority Health and Equity. Staff biographies are attached as appendix 1.

Representatives include appointees with broad knowledge, skills, and experience in areas such as juvenile justice, criminal justice, the surveillance of overdoses, public health, child welfare, treatment, faith-based communities, addiction medicine, peer recovery, prevention, harm reduction, housing, and primary education.

Representatives also include appointees representing Washoe County, Clark County, and Rural Nevada with lived experience with substance use disorders, including family members.

Appointments were made final in October 2021. Term dates are October 1, 2021 through September 30, 2023. Members are eligible to serve through 2025. The first meeting was convened on October 5, 2021. The ACRN has met six times in compliance with Nevada's Open Meeting Law. They have had presentations and guidance on their roles/responsibilities in relation to the legislation, processes, health equity lens and choice points, needs assessment which included gaps and the objective tool. Each meeting has included opportunity for comment from the public. ACRN bylaws are included in appendix 2.

The ACRN will advise the Department of Health and Human Services in the development and conduction of the needs assessment, establishing priorities, and establishment of the state plan.

## Legislative Language

The legislation (Sec. 7.9-9) requires specific reporting for and by the ACRN.

On or before June 30 (of each even-numbered year), the ACRN shall submit to the Director of the Department a report concerning:

1. The statewide needs assessment including, without limitation, the establishment of priorities as it relates to information and analyses described below. Priorities must include, without limitation, priorities related to the prevention of overdoses, addressing disparities in access to health care, and the prevention of substance use among youth.

    a) Be evidence-based and use information from damages reports created by experts as part of the litigation

b) Include an analysis of the impacts of opioid use and opioid use disorder on this State that uses quantitative and qualitative data concerning this State and the regions, counties and Native American tribes in this State to determine the risk factors that contribute to opioid use, the use of substances and the rates of opioid use disorder, other substance use disorders and co-occurring disorders among residents of this State.

c) Focus on health equity and identifying disparities across all racial and ethnic populations, geographic regions and special populations in this State.

d) Take into account the resources of state, regional, local and Tribal agencies and nonprofit organizations, including, without limitation, any money recovered or anticipated to be recovered by county, local or Tribal governmental agencies through judgments or settlements resulting from litigation concerning the manufacture, distribution, sale or marketing of opioids, and the programs currently existing in each geographic region of this State to address opioid use disorder and other substance use disorders.

And;

2. Recommendations pursuant to the statewide plan to allocate money from the Fund

Department and the Office shall consider:

a) The recommendations provided by the Advisory Committee in the report; and

b) The recommendations of state, regional, local and Tribal governmental entities in this State whose work relates to opioid use disorders and other substance use disorders.

The Advisory Committee shall consider health equity and identify relevant disparities among racial and ethnic populations, geographic regions, and special populations in this State; and the need to prevent overdoses, address disparities in access to health care, and prevent substance use among youth.

When developing recommendations concerning the establishment of priorities the Advisory Committee shall use an objective method to define the potential positive and negative impacts of a priority on the health of the affected communities with an emphasis on disproportionate impacts to any population targeted by the priority.

Before finalizing a report of recommendations, the Advisory Committee must hold at least one public meeting to solicit comments from the public concerning the recommendations and make any revisions to the recommendations determined, as a result of the public comment received, to be necessary.

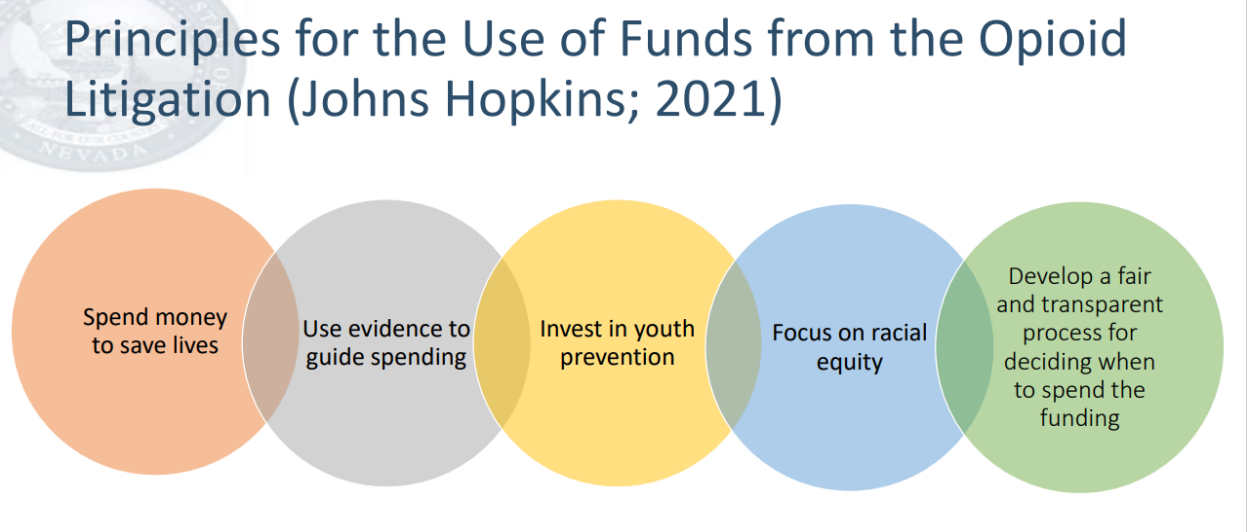
The statewide plan to allocate money from the Fund includes an analysis of the impacts of opioid use and opioid use disorder on this State that uses quantitative and qualitative data concerning this State and the regions, counties, and Native American tribes in this State to determine the risk factors that contribute to opioid use, the use of substances and the rates of opioid use disorder, other substance use disorders, and co-occurring disorders among residents of this State.

There is a focus on health equity and identifying disparities across all racial and ethnic populations, geographic regions, and special populations in this State.

Also, taken into account, were the resources of state, regional, local, and Tribal agencies and nonprofit organizations including, without limitation, any money recovered or anticipated to be recovered by county, local, or Tribal governmental agencies through judgments or settlements resulting from litigation concerning the manufacture, distribution, sale or marketing of opioids, and the programs currently existing in each geographic region of this State to address opioid use disorder and other substance use disorders.

## John Hopkins Principles for the Use of Funds for the Opioid Litigation

The following principles guided prioritization: [Principles for the Use of Funds from the Opioid Litigation (jhsph.edu)]




Principle #1: Spend money to save lives

As best practice, money deposited in the fund stays in the fund and is used to combat the epidemic with no more than 8% of these deposited funds used for administrative costs. Funding can only be used to supplement and not supplant existing projects. This will also ensure additive dollars to funding and expanding projects. Reports concerning all findings, recommendations, and funding under this bill must be created by the Department of Health and Human Services and ACRN and delivered to the Legislature, Governor, Attorney General, and other agencies, as well as the public. Regarding grant to regional, county, local, and Tribal consideration must be given to recovering in their own litigation and reimbursement may be required if there are recoveries.

Principle #2: Use evidence to guide spending

1. Expanding access to evidence-based prevention of substance use disorders (SUDs), early intervention for persons at risk of a substance use disorder, treatment for substance use disorders and support for persons in recovery from substance use disorders;
2. Programs to reduce the incidence and severity of neonatal abstinence syndrome;
3. Prevention of adverse childhood experiences (ACEs) and early intervention for children who have undergone adverse childhood experiences and the families of such children;
4. Services to reduce the harm caused by substance use;
5. Prevention and treatment of infectious diseases in persons with substance use disorders;

6. Services for children and other persons in a behavioral health crisis and the families of such persons;
7. Housing for persons who have or are in recovery from substance use disorders;
8. Campaigns to educate and increase awareness of the public concerning substance use and substance use disorders;
9. Programs for persons involved in the criminal justice or juvenile justice system and the families of such persons, including, without limitation, programs that are administered by courts;
10. The evaluation of existing programs relating to substance use and substance use disorders;
11. Development of the workforce of providers of services relating to substance use and substance use disorders;
12. The collection and analysis of data relating to substance use and substance use disorders;
13. Capital projects relating to substance use and substance use disorders, including, without limitation, construction, purchasing and remodeling; and
14. Implementing the hotline for persons who are considering suicide or otherwise in a behavioral health crisis and providing services to persons who access that hotline in accordance with SB 390.

Needs assessment is created by using the damages report in the opioid litigation, qualitative and quantitative data, and evidence-based practices.

Principle #3: Invest in youth prevention

According to Johns Hopkins, it is imperative to support children, youth, and families by making long-term investments in effective programs and strategies for community change. Primary prevention efforts are designed to stop use before it starts and can interrupt the pathways to addiction and overdose. Youth prevention is noted in several sections of the bill as a required priority. Another highlight is prevention and intervention of ACEs, and strengthening protective factors and reducing risk factors for youth substance use. This includes primary, secondary, and tertiary prevention efforts with evidence-based programming. Evaluations of program must be completed as well to ensure effectiveness.

Principle #4: Focus on racial equity

Advisory Committee for a Resilient Nevada was developed to ensure community members are involved in the entire process and members are from diverse backgrounds. The Department, in consultation with the Committee, must create a needs assessment including community outreach, to determine how to create a state plan for combatting the opioids epidemic and setting priorities for funding in the state plan. This is created using community-based participatory research methods to conduct outreach to groups impacted by opioids, including individuals who use drugs, and through outreach to governmental agencies who interact with groups impacted such as public safety, corrections, courts, juvenile justice agencies, etc. Legislation requires addressing disparities and disproportional impacts on communities be included as a priority in the state plan.

Principle #5: Develop a fair and transparent process for deciding when to spend the funding

The role of the Committee includes advising the DHHS on the needs assessment, prioritization, and state plan for the allocation of funding. All Committee meetings are public meetings and offer opportunities for public input which includes the needs assessment, prioritization, and state plan development, and will also include input and feedback from the community. Reports concerning all findings, recommendations,

and funding under this bill must be created by the Department and the Advisory Committee and delivered to the Legislature, Governor, Attorney General, and other agencies as well as the public.

# Needs Assessment

The State of Nevada contracted with Mercer Health through a master service agreement in order to complete the legislatively required needs assessment to identify gaps and rank recommendations.

## Gaps

Based on reports received throughout the state the following gaps were identified:

**Overdoses (Infers Gaps)**

- Significant increases, especially 2019-2020
- Increases in males, especially Hispanic
- Ages 18-24 and 55-64
- Fentanyl deaths increased 227% since 2019
- 25% of opioid-related deaths involved stimulants
- Mostly ingestion, but snorting is increasing

**Data**

- Limited data available for other drugs co-prescribed with opioids
- Need more drugs tracked by Prescription Drug Monitoring Program (PDMP)
- Demographic data for prescribing (prescribers or recipients)
- Fatal and non-fatal details on overdose for special populations
- More data on pregnant women and opioid use
- Limited data available for children in welfare system
- Race/ethnicity data for individuals receiving SUD services and overall health outcomes
- Various data sets follow their own protocols, criteria and standards, which makes it difficult to compare across data sets and draw firm conclusions
- Lack of standardized reporting
- Different sources collect and calculate different process and outcome metrics
- Data to help identify contributing factors to the opioid crisis
- Gap areas: racial breakdown, special populations such as those without permanent housing, veterans, pregnant women, and those identifying as LGBTQ+
- Data on unauthorized immigrants or others not connected to the current treatment or surveillance systems
- Data on co-occurring mental health and substance use disorders, especially specific diagnoses among those using opioids; demographics of these people
- Data on the use of evidence-based practices (EBPs), especially for polysubstance use and co-occurring mental health (MH) disorders and physical health conditions
- Data on the specific substances involved in suicides
- Data on non-Medicaid screening efforts
- Physical health data for those using opioids

**Prevention**

- Opioid dispensing—higher than national average
- Full implementation of the Zero Suicide initiative

- Lack of capacity for community-based prevention programs across all counties
- School-based prevention programs [Coping and Support Training (CAST); especially Washoe]
- Prescription drug disposal (CAST: Southern and Rural regions)
- Public Education/Stigma
- School system, parents, law enforcement
- Limited public perception supporting prevention (in Clark County)
- Lack of education on addictive potential of opioids and alternative therapies for chronic pain and chronic illness, especially reported in rural areas.
- Education on treatment options
- Education for family members on treatment
- Lack of education among high school students around substance use disorders, awareness of the opioid epidemic and naloxone use, and attitudes about discussing these topics with healthcare providers
- University of Nevada, Las Vegas (UNLV) reported stigma and emotional toll
- Difficulty obtaining and keeping housing and employment
- Anxiety over seeking help, especially among veterans and Tribal members
- Encampment outreach
- Provider education
- More education and monitoring
- Participation in Project Extension for Community Health Outcomes
- How to educate patients on pain management expectations
- Utilization of/referral to other pain management options
- People with lived experience reported avoiding healthcare because of negative treatment from health care providers (HCPs)
- Pre-treatment screening and care plans that include alternative pain management
- Screening
- Insufficient screening for SUDs especially in Medicaid managed care and in rural areas

**Treatment**

- Generally -- treatment in rural areas
- Treatment availability was the most significant and immediate need according to the June 2019 system-wide assessment using the CAST
- National data suggests significant disparities for ethnic/minority youth
- Expansion of peer support throughout treatment
- While overdoses for Blacks in 2020 were 14% and for Hispanics were 19%, Whites were 64% and 2.5% were Asian, in comparison Medicaid data shows that of those Medicaid members receiving opioid use disorder (OUD) services, 84% were White, 9% Black, 1% American Indian/Alaska Native (AI/AN), and 15% Hispanic; in 2018, a report noted that within Medicaid, the racial breakdown was 33% were Latino, 21% African American, and 36% Caucasian (GUINN Center.org "Nevada's Medicaid Population"); this is not an ideal comparison because it is from different sources, but it points to equity issues; national study found Alcoholics Anonymous (AA) and Latino youth report less information care and Treatment Episode Data Set (TEDS) data found that minority adults are less likely to seek treatment
- Lack of community-based accessible resources post-release from the justice system
- Treatment access for pregnant women (providers willing to prescribe, stigma)
- Drug courts and treatment and housing services are not available statewide

- National studies identified a gap for youth in the juvenile justice system
- Co-Occurring
- Providers certified for treating co-occurring disorders, especially for youth
- Mental health treatment (ranked almost last in the nation for access for youth)

**Outpatient:**

- Psychiatrists and psychologists specializing in SUD psychotherapy
- Opioid treatment programs (OTPs) in rural areas
- Office-based opioid treatment
- Outpatient detoxification, licensed drug and alcohol counselors, in two regions
- Most OTPs reported adequate capacity, indicating that identification and referral to treatment as well as barriers to seeking treatment
- Medication-assisted treatment (MAT) in rural areas and on reservations
- Office-based opioid treatment (OBOT) not prescribing up to capacity (reimbursement, lack of time, lack of referrals)
- UNLV-MH treatment during and after MAT
- MAT and other treatment interventions in justice facilities is lacking in many areas
- Outpatient detoxification (CAST)
- Critical need for treatment for youth with co-occurring
- Limited EBP treatment protocols for those using multiple substances and for those with co-occurring mental health and physical health disorders
- Mental health treatment (both for those with and without SUD)
- Lack of formal collaborative care for those at risk for suicide
- Withdrawal management and residential services
- Requirement to detox prior to treatment in current environment
- Mostly in urban areas, lacking in rural
- Short-term rehabilitation (< 30 days) and long-term rehabilitation (30+ days) statewide
- Withdrawal management and residential services are not eligible for Medicaid services for ages 18-64 without the proposed 1115 SUD Demonstration Waiver
- Crisis
- Significant increases in opioid-related ED visits and hospitalization for Nevada Medicaid Beneficiaries (8x increase between 2010-2017)
- Gaps in mobile crisis, especially outside of central Las Vegas
- Gaps in other crisis services according to the NV Crisis Care Response System: Assets and Gaps report
- Crisis stabilization units
- Lacks a statewide, consistent, comprehensive 24/7/365 crisis system encompassing mobile crisis and crisis stabilization
- Follow-up after crisis

**Discharge/Recovery Support**

- Funding/insurance for lack long-term care for recovery (UNLV)
- Limited duration of treatment
- Better discharge planning and communication between levels of care, incorporating social determinants of health (SDOH) elements
- Better coordination of services

- Need programs for the justice system post-release, including Medicaid access
- CAST: Religious or spiritual advisors/faith-based orgs, 12-step groups in more rural areas
- Statewide: educational support, parenting education, health insurance
- Education on maintaining recovery
- Recovery centers (UNLV)

**Harm Reduction**

- Needle exchanges (CAST) statewide
- Limited hours of operation
- Education on the use of naloxone in the community
- Lack of education on harm reduction resources and methods
- Safe places to use
- Opportunity to take advantage of harm reduction in rural areas without other community members knowing about the opioid use

**Workforce**

- 11 providers per 1,000 (national average is 32 per 1,000); concentrated in urban areas
- 11 counties are Healthcare Professional Shortage Areas

**Social Determinants of Health**

- Income lower and unemployment and poverty higher for those living in Tribal lands
- Housing vouchers for those without housing statewide (CAST)
- Affordable housing (especially Northern and Southern regions, Clark County and Washoe
- Transportation, not only to treatment, but for the community
- Employment for those receiving treatment (CAST)
- 'Volunteer and vocational opportunities
- Lack of internet access (UNLV)
- Food insecurity
- Financial difficulties

Key areas with data gaps include the inclusion of race/ethnicity data and indicators of membership in special populations in all opioid-related data. Special populations include: veterans; homeless population; pregnant women; youth, lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual (LGBTQ+); juvenile justice; and children in the child welfare system. Specific to prescription data, more demographic data as well as data on prescriptions other than opioids and benzodiazepines are needed.

Based on the gaps above and the Johns Hopkins Principle #2, the ACRN was able to compile a list of recommendations to be sent through an objective tool for ranking.

## Scoring Matrix/Objective Tool

Mercer used a Likert rating scale to assign a value to each of the recommendations included within this report. The priority rating reflects Mercer's evaluation of the potential impact of the recommendation, as well as urgency and feasibility. Recommendation topics that were prioritized in legislation for purposes of this needs assessment are identified through a Target rating.

## Scoring Definitions

Scoring of impact, urgency, and feasibility were facilitated by reviewing the factors listed under each area below. The ratings for the factors were averaged within each category to produce an average rating for impact, urgency, and feasibility. They were each rated on the basis of whether the recommendation fulfilled one of three legislative priorities, with either a zero (not responsive to legislative priorities) or a three (responsive to at least one legislative priority). The ACRN was given a copy of all ratings, with a total score comprised of the sum of the impact, urgency, and feasibility ratings with the target rating added to indication legislative priorities.

## Impact

Impact was assigned based on a review of the following factors:

1. *The number of lives that would benefit or be impacted*

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Low | | Moderate | | High |

Low = Impacts a small proportion of the population of Nevada residents

High = Impacts almost the entire population with minimal to no exclusions

2. *The magnitude of the individual impact (i.e., improves well-being versus saving lives)*

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Low | | Moderate | | High |

Low = Minimal impact to health/safety/daily life

High = Saves lives or provides major improvement in quality of life or services

3. *The relative impact to health equity for special populations or underserved groups*

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Low | | Moderate | | High |

Low = Recommendation would be detrimental to health equity or result in disparities

High = Recommendation is focused on alleviating disparities/promoting equity

## Urgency

Urgency was assigned based on the need for timely implementation of the recommendation according to the following factors:

1. *Availability of alternatives*

1 2 3 4 5

Low Moderate High

Low = Program or service already exists for the vast majority of those who need it

High = Program or service does not exist/is not being accessed by those who need it

2. *Negative consequence or risk of a delay in implementation*

1 2 3 4 5

Low Moderate High

Low = Minimal risk to the health/safety of the intended population

High = Imminent risk to health/safety of the intended population; target population left vulnerable to negative outcomes

## Feasibility

Feasibility was assigned based on:

1. *Current infrastructure*

1 2 3 4 5

Low Moderate High

Low = Infrastructure does not currently exist

High = Existing infrastructure can support recommendation implementation

2. *Ease of implementation (effort)*

1 2 3 4 5

Low Moderate High

Low = Significant effort required, complex barriers or hurdles exist (e.g., complicated policy/regulatory changes, heavy State staff involvement), difficult to implement

High = Minimal effort required for implementation, easy to implement

3. *Availability of resources for implementation (staff, community, and relative financial resources)*


Low = High one-time cost and/or ongoing investment necessary with unknown resources for sustainability

High = Low one-time cost and/or small impact to current funding streams

### Target

Target was assigned based on identification as one of three legislative priorities from Senate Bill 390, which are consistent with Johns Hopkins Guiding Principles for the use of opioid settlement funds.[1]

1. *Prevention of overdoses*
2. *Addressing disparities in access to health care*
3. *Prevention of substance use among youth*

| Legislative Target Area | Score |
|---|---|
| Yes | 3 |
| No | 0 |

Recommendations are scored for both system- and individual-level priorities, and in some cases a single recommendation can be categorized as both system and individua level. When both categories applied to a recommendation, the scoring and justification were applied separately for the system and individual aspects of the recommendation. When prioritizing recommendations with both a system- and individual-level scores, it is reasonable that the recommendation could be prioritized twice depending on whether the resulting program is targeted to individuals or to the system.

## Ranked and Prioritized Recommendations

Based on the rankings for the recommendations provided by the needs assessment and individual members of the ACRN, they voted and approved to include the following in this report to the Director, listed in legislative categories. Not all recommendations have been ranked through the objective tool at this time, but they will be ranked in the future. This committee would like to make note that these are still considered priorities.

[1] Johns Hopkins School of Public Health, *Principles for the use of Funds from the Opioid Litigation*, 2021.

| Recommendation | Gap | Legislative | Rating Total |
|---|---|---|---|
| Expand Mobile Crisis and ensure that the service is of consistently high quality, leverages federal matching funds, and is available for individuals not covered under Medicaid. Mobile crisis is an important alternative in substance-related crisis situations where the service can offer effective interventions and follow-up that includes referral and connection to post-crisis treatment. The ACRN recommends the opioid settlement funds be allocated to expanding Mobile Crisis services and ensuring the service is of consistently high quality, leverages federal matching funds, and is available for individuals not covered by Medicaid. | Treatment | Crisis Services | **10.7** |
| Support crisis stabilization units across the State that can serve Nevada residents and offer critical diversion from emergency departments (EDs) and jails for those with OUD. The ACRN recommends the opioid settlement funds be allocated to implementing and/or supporting crisis stabilization units across the state that can serve Nevada residents and offer critical diversion from emergency rooms and jails. | Treatment | Crisis Services | **10.5** |
| Ensure adequate funding of the state 988 crisis line such that mobile crisis can be connected by GPS and dispatched by the crisis line. The ACRN recommends the opioid settlement funds be allocated to enhance the state's 988 crisis line with GPS capabilities, so a person calling from a cell phone can be easily located and a mobile crisis unit can be quickly dispatched to help the person in crisis. | Treatment | Crisis Services | **11.5** |
| Implement Mobile Crisis Teams with harm reduction training and naloxone leave behind | Treatment | Crisis Services | **Not Yet Rated** |
| Improve and standardize forensic toxicology testing and data. There are additional ways the State could get toxicology information to inform public health and public safety agencies about | Data | Data | **9.8** |

| | | | |
|---|---|---|---|
| what is in the drug supply, and what the potential risk for an overdose may be. These methods include testing of seized drugs, through a lab or by field test, testing of syringes, wastewater testing, and urinalysis of people who have experienced a nonfatal overdose. | | | |
| Develop a statewide forensic toxicology lab that can support surveillance sample testing and other types of toxicology testing that may increase the amount of information used to inform community awareness of overdose risk, including substances involved in suicides. | Data | Data | **9.2** |
| Expand surveillance testing. This will require a new funding formula for forensic toxicology, as well as better leveraging of federal funds. | Data | Data | **6.8** |
| Share standardized data between public safety agencies and those monitoring local overdose spike response plans. This will support local partners so they may act quickly when needed. The ACRN recommends the opioid settlement funds be allocated to increasing the reporting and analytical capacities within the DHHS Office of Analytics to support sharing standardized data between public safety agencies and those monitoring local overdose spike response plans, so local officials may act quickly when needed. | Data | Data | **12.0** |

| | | | |
|---|---|---|---|
| Establish Nevada all-payer claims database (APCD). The State is currently making progress on this recommendation. The database is intended to and should include claims for all medical, dental, and pharmacy benefits. The advisory committee that will make recommendations on the analysis and reporting of the data should ensure that key data elements are maintained through the de-identification process to ensure the data remain meaningful. Critical needs include the ability to stratify by special population characteristics (race/ethnicity, geography, LGBTQ+ status, pregnancy, etc.), and enough detail to identify physical and behavioral health comorbidities. - The ACRN recommends the opioid settlement funds be allocated to establish a statewide all-payer claims database (APCD) that includes claims for all medical, dental, and pharmacy benefits with enough detail to identify physical and behavioral health comorbidities and de-identified demographic factors important for the meaningful analysis of health disparities, including but not limited to race/ethnicity, geography, sexual/gender orientation, pregnancy, etc. | Data | Data | **14.7** |
| Increase availability and access to real-time substance use disorder (SUD) and opioid use disorder (OUD) reports. The State of Nevada has multiple sources that could provide real-time data. The health information exchange (HIE), electronic health record (EHR) systems, birth registries, the Prescription Drug Monitoring Program (PDMP), and OpenBeds should be evaluated for interoperability-based use cases that will provide the needed data for analysis. Non-claims-based data sources should also be utilized to ensure the capture of all necessary data. | Data | Data | **7.8** |

| | | | |
|---|---|---|---|
| Increase data sharing using the HIE. Promote the use of HealtHIE Nevada chart provider portal at no cost to providers. Funding should be provided to providers in need of system updates or changes to allow for participation. This will increase the ability to share data across behavioral and physical health providers. | Data | Data | **8.8** |
| Provide reports or analytics from the PDMP that allow the State to identify demographic characteristics of those prescribed controlled substances for prevention of future overdoses. - Provide reports or analytics from the PDMP that allow the State to identify demographic characteristics of those prescribed controlled substances for prevention of future overdoses. The ACRN recommends the opioid settlement funds be allocated to increasing the reporting and analytical capacities within the DHHS Office of Analytics, so the State can produce reports from the Prescription Drug Monitoring Program (PDMP) that identify demographic characteristics of those prescribed controlled substances for prevention of future overdoses. | Secondary Prevention | Data | **12.8** |
| Partner with surrounding states to share PDMP data. State leadership should work with neighboring states to establish a way to share PDMP data across state lines. Nevada has PDMP partnerships with 34 states and shares data with four of the bordering five states' PDMPs. California does not share data with Nevada, creating a significant barrier for monitoring and harm reduction efforts along the Nevada-California border. | Primary Prevention | Data | **9.0** |
| Development of an overdose fatality review committee(s) | System Needs | Data | **Not Yet Rated** |
| Programs to monitor prescribing practices, co-occurring prescriptions, indications for prescriptions, all controlled substances including methadone from OTPs with subsequent education, enforcement, etc. based on data [COLLECTION AND ANALYSIS OF DATA] | Data | Data | **Not Yet Rated** |

| | | | |
|---|---|---|---|
| Purchase and distribute handheld drug testing equipment (mass spectrometers) to allow for rapid testing of substances | System Needs | Data | **Not Yet Rated** |
| Establish a "bad batch" communications program to alert communities to prevent mass casualty events | System Needs | Data | **Not Yet Rated** |
| Support the API connection for EMS/Image Trend for data collection and reporting through ODMAP | System Needs | Data | **Not Yet Rated** |
| Increase reporting of Treatment Episode Data Set for all certified providers | System Needs | Data | **Not Yet Rated** |
| Promote careers in behavioral health through early education. Workforce development can begin as early as high school to engage students, especially in rural and frontier communities, to pursue a career in behavioral health. Possible resources could include ambassador programs, virtual mentoring, student training, scholarships, and mentorship. | Primary Prevention | Develop Workforce | **8.8** |
| Develop special medical school programs. Work with medical schools to offer specialized residencies or free or subsidized tuition for students who enter into the behavioral health field and serve in rural and frontier communities or with underserved populations for a specified number of years. The ACRN recommends the opioid settlement funds be allocated to Nevada's medical schools to offer specialized residencies or free or subsidized tuition for students who enter into the behavioral health field and serve in rural and frontier communities or with underserved populations for a specified number of years. | Primary Prevention | Develop Workforce | **11.5** |
| Increase prescriber training in graduate school. Training would be more effective if mandated as a part of graduate school education. Medical school curriculum should include education around buprenorphine, naloxone, and methadone, in addition to training of safe opioid prescribing and pain management practices. The ACRN recommends the opioid settlement funds be allocated to Nevada's medical schools to design and | Primary Prevention | Develop Workforce | **11.8** |

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| implement an opioid prescriber training curriculum, including education about buprenorphine, naloxone, and methadone, in addition to training on safe opioid prescribing and non-prescription pain management practices. | | | |
| Improve upon evidence-based SUD and OUD treatment and recovery support training and resources for providers. Enhance trainings to include culturally tailored and linguistically appropriate services in an effort to decrease health disparities and evaluate current services to determine any possible expansions. Trainings may also include tools to determine the level of risk for relapse. - The ACRN recommends the opioid settlement funds be allocated to improving/enhancing evidence-based substance use disorder and opioid use disorder (SUD/OUD) treatment and recovery support trainings for providers to include culturally tailored and linguistically appropriate services in an effort to decrease health disparities. | Treatment | Develop Workforce | **13.0** |
| Increase provider training and education on the effective use of telehealth. The State currently supports telehealth utilization and billing. Providers may require training as increased flexibility due to COVID-19 has led to an increase in the use of telehealth and a need for training on how to use this modality to deliver treatment. Utilization of federal resources such as the American Medical Association's provider playbook can assist in these efforts. In addition, use of telehealth can assist in expanding services to rural and frontier areas, provide greater access to specialists such as eating disorder specialists, and assist individuals in finding providers with similar cultural backgrounds. The ACRN recommends the opioid settlement funds be allocated to designing and implementing trainings for providers on the effective use of | Treatment | Develop Workforce | **12.0** |

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| telehealth, including how to code and bill for a telehealth visit. | | | |
| Create a primary care integration toolkit. Include the elements of an Integrated Care Training Program. Training in the integration of physical and behavioral health can not only help to identify substance use and potential misuse earlier, but it can address other problems, such as mental health issues, before they contribute to substance use. A toolkit should consider the unique landscape of rural, frontier, and Tribal communities in the development of tools. Integrated care allows for better screening, rapid intervention, and referral to treatment for opioid misuse for the general population. The toolkit should also include a focus on social determinants of health (SDOH) and can be tailored for opioid issues in special populations, such as adolescents and transition-age youth or pregnant and postpartum women, and underserved individuals such as people of color. - The ACRN recommends the opioid settlement funds be allocated to the development of a substance use disorder education and recognition toolkit for primary care providers. The toolkit should include the elements of an Integrated Care Training Program, a focus on the social determinants of health and have sections which appropriately consider the unique landscape of rural, frontier, and Tribal communities. | Primary Prevention | Develop Workforce | **13.7** |
| Address stigma among providers of all types. Enhanced educational and training practices with strategies to influence provider attitudes and reduce stigma can increase provider willingness to offer SUD treatment and recovery services. Anti-stigma training can also benefit primary care, dental, and emergency department providers by promoting more compassion when interacting with people with SUD and in recovery. | Secondary Prevention | Develop Workforce | **8.7** |

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| Evaluate provider enrollment process to ensure the process of becoming a Medicaid provider is not deterring providers from enrollment. The State should evaluate current enrollment procedures, using available data including provider stakeholder group input to determine where there are opportunities to improve the provider enrollment process, encouraging more providers to join the Medicaid program. The ACRN recommends the opioid settlement funds be allocated to evaluating the current Medicaid provider enrollment process, using available data and stakeholder engagement, to ensure the process itself is not deterring providers from enrolling and therefore acting as a barrier to increasing the number of providers who accept Medicaid. | Treatment | Develop Workforce | **9.8** |
| Accurately identify capacity of SUD and OUD treatment providers. Due to the fact that many providers such as Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatment (OBOT) are not delivering services to capacity, a review of available data sources such as Medicaid claims and information from the Office of Analytics, Primary Care Association and other entities can be used to determine the current provider network array and determine where there are gaps, especially in the fee-for-service system. Developing a provider gap and needs assessment will allow the State to target specific areas and provider types as part of the effort to provide as full a continuum of care as possible. Managed care contracts should include provider adequacy requirements for MAT. Information should include the patient capacity of providers. The gaps analysis should include culturally relevant indicators, such as the availability of Tribal providers and distance of underserved populations from existing providers. The ACRN recommends the opioid settlement funds be allocated to developing a statewide provider gap/needs assessment, | Treatment | Develop Workforce | **12.7** |

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| using a diversity, equity, and inclusion (DEI) framing, to determine the current provider network array and what is missing, especially in the fee-for-service system. | | | |
| Capture data on workforce through the licensure renewal processes. Licensure renewal is another opportunity to capture workforce information from the State's 26 health licensing boards. There are opportunities to efficiently collect standardized, longitudinal employment, demographic, and practice data on any health profession licensed by the State of Nevada. Such information can be used to capture existing and calculate projected clinical full-time equivalent (FTE) capacity needed to meet the demand for SUD. Combined with the data from the gap analysis, the information collected can help the State's strategic allocation of resources. | Treatment | Develop Workforce | **8.8** |
| Increase availability of peer recovery support services. Peer supports are a valuable component of treatment, harm reduction, and recovery systems. Consider expanding internship programs, offering scholarships to pursue peer support certification, and promoting 24/7 peer-staffed call centers. | Treatment | Develop Workforce | **8.7** |
| Expand drug court treatment availability as well as treatment protocols to include treatment for multiple substances, including stimulants. Although some efforts have been made, such as the expansion of individuals able to be served by the Las Vegas-based 8th Judicial MAT Re-Entry Court to include those with a stimulant disorder, interventions for those who use multiple substances should be available statewide. | Treatment | Develop Workforce | **9.3** |
| Provide funding to northern rural areas in addition to central rural. We need that stability to have our homegrown clinicians stay in our community and the licensing boards to work with rural areas. | System Needs | Develop Workforce | **Not Yet Rated** |

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| Increase education on the safe use and storage of opioids. Statewide campaign should be developed to provide consistent education and standardized guidance on the use and storage of opioids, such as the Office of Suicide Prevention's Safe Storage Efforts. This campaign should also include resources for safe disposal of opioids, which should include engaging law enforcement, the State, and pharmacies to develop easily accessible safe disposal resources. The ACRN recommends the opioid settlement funds be allocated to launching a statewide educational campaign to provide consistent and standardized guidance on the safe use and storage of opioids, including safe disposal in partnership with DHHS, law enforcement, and pharmacies. | Primary Prevention | Education/Awareness Campaign | **14.2** |
| Implement family-based prevention strategies, especially for transition-age youth and young adults. The ACRN recommends the opioid settlement funds be allocated to researching and implementing family-based prevention strategies, especially for transition-age youth and young adults. | Primary Prevention | Education/Awareness Campaign | **12.5** |
| Implement an education campaign on the addictive potential of opioids and alternative therapies for chronic pain and chronic illness, especially in rural areas, that is tailored to geography and underserved populations. - The ACRN recommends the opioid settlement funds be allocated to designing and launching a statewide education campaign on the addictive potential of opioids and alternative therapies for addressing chronic pain and chronic illness that is tailored for different populations, including underserved populations living in a rural/frontier county. | Secondary Prevention | Education/Awareness Campaign | **13.8** |

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| Implement marketing and communications campaigns to combat stigma in the general public. Campaigns should be tailored to address stigma toward different groups, such as pregnant women, criminal justice-involved people, and youth, and can be delivered in a variety of ways, from online/social media videos to curricula in school health classes, to target different audiences. People with lived experience and those in the target audience can be of assistance in tailoring material to have a meaningful impact. In addition, utilizing success stories from individuals in recovery can be a powerful part of a marketing campaign. | Secondary Prevention | Education/Awareness Campaign | **8.5** |
| Expand educational efforts in the schools to promote early intervention and reduce stigma. Curricula such as Mental Health First Aid can be an effective method of assisting youth in identifying the signs of suicidality in their peers in a way that reduces stigma and increases knowledge of how to promote intervention. Continued training on the signs and interventions of suicide and substance use in the school system for parents, law enforcement, and other community partners will assist in reducing stigma and assist in identifying individuals at risk, allowing for potential earlier intervention and decreased risk for lethality. The ACRN recommends the opioid settlement funds be allocated to expanding educational efforts in schools to promote early intervention and reduce stigma. | Secondary Prevention | Education/Awareness Campaign | **12.8** |

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| Utilize an education and awareness campaign focused on identification of the need for treatment and treatment options, targeted to people using opioids and their families. The campaign should be tailored for different populations in order to promote health equity. Populations targeted should include those without housing. - The ACRN recommends the opioid settlement funds be allocated to designing and launching an education and awareness campaign focused on how to identify the need for treatment and different treatment options targeted to people using opioids and their families. The campaign should be designed using a health equity framework tailored for different populations, including Nevadans experiencing homelessness. | Secondary Prevention | Education/Awareness Campaign | **14.2** |
| The ACRN recommends the opioid settlement funds be allocated to designing and launching a statewide educational campaign to decrease stigma and enhance understanding of recovery targeted at employers and landlords. | Secondary Prevention | Education/Awareness Campaign | **14.2** |
| Increase education for middle- and high-school students around SUDs, awareness of the opioid epidemic, naloxone use, and how to discuss these topics with health care providers. | Primary Prevention | Education/Awareness Campaign | **7.7** |
| Train providers and pharmacists on how to educate patients about pain management expectations and the risk of opioids. Provide tools and patient education materials for statewide use as well as materials tailored for underserved populations. - The ACRN recommends the opioid settlement funds be allocated to training programs for providers and pharmacists on how to educate patients about pain management expectations and the risk of using opioids. | Secondary Prevention | Education/Awareness Campaign | **13.2** |
| Public messaging campaign on the prevention and impact of ACEs | System Needs | Education/Awareness Campaign | **Not Yet Rated** |

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| Create a position to coordinate opioid initiatives across divisions in the Office of Strategies and Initiatives. This position would allow one person to work across the divisions to make sure work is coordinated and gets done and does not get de-prioritized over time, ensuring centralized management of initiatives. This helps solve the issues with pockets of initiatives and pilots occurring but none to scale because no one person is overseeing projects. | System Needs | Evaluate Programs | **8.5** |
| Evaluate outcomes from efforts to support SUD treatment for the criminal justice-involved population. Monitor outcomes of criminal justice-involved individuals. This may include individuals who are inducted onto MAT prior to discharge, or other interventions such as drug courts for individuals with polysubstance conditions and working with probation and parole officers to support the needs of individuals in treatment and recovery to determine best practices for improvements in outcomes in this population. | Health Equity | Evaluate Programs | **10.3** |
| Programs treating SUDs [all American Society of Addiction Medicine (ASAM) levels of care] be evaluated for best practices, standards of care, implemented practices, patient outcomes, data metrics on numerous fronts (agencies, MCOs, etc.) to be held to a certain standard keeping in mind that currently Substance Abuse Prevention and Treatment Agency (SAPTA) certification, IOTRC, CCBHC, etc. designations do not guarantee the above. Ideally, parity in this respect across physical and mental health [for example a pregnant patient who presents for delivery should receive all of the above for the patient and newborn which would include labor and delivery, pediatrician, neonatal intensive care (NICU), etc. as well in evaluation. Another would be the same for infectious disease specialists/departments]. [EVALUATION OF EXISTING PROGRAMS] | System Needs | Evaluate Programs | **Not Yet Rated** |

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| Parity between criminal justice system treatment and regular treatment as much as possible. Same treatments should be available, before, during, and after. [PROGRAMS FOR PERSONS INVOLVED IN THE CRIMINAL JUSTICE OR JUVENILE JUSTICE SYSTEM] | Treatment | Evaluate Programs | **Not Yet Rated** |
| Anonymous school survey to principals and staff to identify specific drug trends/issues in their particular schools, for the purposes of additional training/resources for their students and parents. | Secondary Prevention | Evaluate Programs | **Not Yet Rated** |
| Implement initiatives prior to release from prison that provide information on and connection to post-release treatment and housing, as well as education on the risks of overdose after periods of abstinence. - The ACRN recommends the opioid settlement funds be allocated to designing and launching education campaigns for people who are incarcerated, prior to their release, to provide information about and connections to post-release treatment, housing, and employment, as well as education on the risks of overdose after periods of abstinence. | Tertiary Prevention/Harm Reduction | Housing | **13.3** |
| Address housing needs as a SDOH. Nevada may utilize tenancy supports as an intervention to allow individuals to maintain housing as they go through the recovery process. In addition, development of sober housing resources and affordable housing through partners such as the Public Housing Authority can assist individuals in recovery in finding and maintaining affordable housing to enable ongoing recovery. | Recovery Supports/SDOH | Housing | **9.0** |
| Housing and recovery supports for homeless youth with OUD | Treatment | Housing | **Not Yet Rated** |
| Establish policies and funding to support evidence-based recovery housing using National Association for Recovery Residences (NARR) criteria | System Needs | Housing | **Not Yet Rated** |

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| Work with parole and probation officers to educate them on the need for treatment and recovery and assist individuals returning to the community to have increased support in achieving and maintaining sobriety in the community. Treatment planning for these individuals should also include housing and employment interventions to ensure resources are in place to support the individual in the community. - The ACRN recommends the opioid settlement funds be allocated to designing and launching education campaigns targeted to parole and probation officers about the need for treatment and recovery and how they can assist individuals returning to the community with increased support to achieve and maintain sobriety. | Recovery Supports/SDOH | Justice Programs | **12.8** |
| Expand MAT into adult correctional and juvenile justice facilities. Expand current pilot efforts to provide MAT services within correctional facilities prior to release to help remove lapses in treatment. This would require collaboration and engagement effort with counterparts in the state and local criminal justice systems. The ACRN recommends the opioid settlement funds be allocated to expanding partnerships with the criminal justice system to implement MAT in adult correctional and juvenile justice facilities prior to release to help prevent lapses in treatment. | Health Equity | Justice Programs | **12.7** |
| Implement Safe Baby Courts for families impacted by substance use | Treatment | Justice Programs | **Not Yet Rated** |
| Victim/affected by compensation. The experts can weigh in here on best practices in regards to implementation, who, what, when, where, etc. Possible example to follow could be October 1. [VICTIM COMPENSATION] | Other | Other | **Not Yet Rated** |
| Implement Trauma Informed and Responsive Schools | Secondary Prevention | Prevent ACEs | **Not Yet Rated** |
| Implement Zero to Three programming to support families impacted by substance use | Treatment | Prevent ACEs | **Not Yet Rated** |

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| Implement Child Welfare best practices for supporting families impacted by substance use | System Needs | Prevent ACEs | **Not Yet Rated** |
| Create an Office of Strategic Initiatives as recommended by the DHHS task force to coordinate activities across DHHS for programs supporting families impacted by parental substance use | System Needs | Prevent ACEs | **Not Yet Rated** |
| Train providers and organizations on EBPs for mitigating harm from exposure to ACEs/resiliency training | System needs | Prevent ACE's | **Not Yet Rated** |
| Continue the use of comprehensive preventive services rooted in harm reduction principles. Harm reduction can be an effective way of decreasing risk in multiple areas, from overdose to reduction of HIV and other diseases. It allows for education and intervention with active users who may be in the early stages of change and assists with linkage to treatment. Efforts should include community members, organizations, volunteers, professionals, and other stakeholders to become engaged members of the harm reduction and prevention workforce. Planning, implementation, and monitoring should meaningfully involve people with lived experience. - The ACRN recommends the opioid settlement funds be allocated to implementing comprehensive preventive services rooted in harm reduction principles. Planning, implementation, and monitoring should meaningfully involve people with lived experience. | Tertiary Prevention/Harm Reduction | Reduce Harm | **12.8** |
| Maintain distribution of naloxone kits. Although naloxone is available and public education on the benefits and use have increased, the funding for current efforts is primarily driven by grants and subsidies and a long-term sustainability plan is needed to ensure continued access is available. It is also essential to ensure that further educational efforts are targeted at special populations and groups experiencing disproportionate overdoses. - The ACRN recommends the opioid settlement funds be allocated to | Tertiary Prevention/Harm Reduction | Reduce Harm | **13.8** |

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| increasing/sustaining access to and distribution of naloxone kits. | | | |
| Support an increase in needle exchanges across the State. Many nonprofit organizations provide needle-exchange services, but more sites are needed in locations where those using them feel safe and anonymous. In addition, sites could expand services to include distribution of naloxone and to provide education regarding recovery and treatment as well as public health services. In areas that are currently not receptive to initiating needle exchange programs, increased education needs to be provided to help the community recognize and accept the importance of these programs and the long-term impacts for not only the communities but those with OUD. - The ACRN recommends the opioid settlement funds be allocated to increasing the number of needle-exchange programs across the state and expanding their service array to include distribution of naloxone and education about recovery and treatment options. | Tertiary Prevention/Harm Reduction | Reduce Harm | **11.7** |
| Family support groups bridging to care. - Family navigation and support to care/continued care | System Needs | Reduce Harm | **Not Yet Rated** |
| Require the use of evidence-based practices to address and treat polysubstance use in all treatment protocols and expand statewide access to interventions for polysubstance users (including through drug court) | System Needs | Reduce Harm | **Not Yet Rated** |
| Prioritize naloxone distribution to people at highest risk for overdose death. Require a more systematic data collection effort to drive allocation of resources towards the people and communities with high death rates, as well as innovative efforts to | System Needs | Reduce Harm | **Not Yet Rated** |

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| connect with people at highest risk (e.g., people who are housed, living alone, or living in settings where drug use is hidden) | | | |
| Establish a dedicated funding source to resource the establishment of supervised drug consumption sites. | System Needs | Reduce Harm | **Not Yet Rated** |
| Establish a disease investigation model for nonfatal overdoses to identify and mitigate risk. | Tertiary Prevention/Harm Reduction | Reduce Harm | **Not Yet Rated** |
| Expand access to harm reduction products through the purchase and distribution of vending machines statewide. | Tertiary Prevention/Harm Reduction | Reduce Harm | **Not Yet Rated** |
| Develop no-barrier access to overdose prevention/harm reduction service including naloxone and fentanyl testing | Primary Prevention | Reduce Harm | **Not Yet Rated** |
| Evaluate the outcomes from the Association of State and Territorial Health Officials Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative and State Opioid Response grant projects for pregnant and postpartum women and their infants and implement lessons learned. Ensure that outcome data is detailed and stratified by important demographic characteristics in order to detect and address health disparities. Review of the outcomes from these projects will allow Nevada to analyze lessons learned and apply successes for future initiatives addressing SUD in additional identified special populations. - The ACRN recommends the opioid settlement funds be allocated to evaluate the outcomes and lessons learned from the Association of State and Territorial Health Officials Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative and State Opioid Response projects for pregnant and postpartum women and their infants and apply successful strategies in future initiatives addressing SUD in additional identified special populations. | Health Equity | Reduce Neonatal Abstinence Syndrome | **11.3** |

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| Ensure that all delivery hospitals and health care systems taking care of reproductive age, pregnant, and postpartum patients, utilize currently available programing for pregnant patients that prioritize best practices for patient, family/caregivers, and neonate/infant [i.e. Screening, Brief Intervention and Referral to Treatment (SBIRT), outpatient care, inpatient care, delivery, reproductive planning, care coordination, Comprehensive Addiction Recovery Act (CARA) plan of care, treatment, NAS, etc.] [REDUCE severity of neonatal abstinence syndrome] | Treatment | Reduce Neonatal Abstinence Syndrome | |
| Increase education, adoption, support for buprenorphine first line for reproductive/birthing/pregnant, etc. patients with OUD [REDUCE SEVERITY OF NEONATAL ABSITENCE SYNDROM] | Treatment | Reduce Neonatal Abstinence Syndrome | **Not Yet Rated** |
| Incentivize and implement SBIRT in OB/GYN settings | Secondary Prevention | Reduce Neonatal Abstinence Syndrome | **Not Yet Rated** |
| Establish community health worker (CHW)/Peer Navigator program for pregnant and parenting persons with OUD | Treatment | Reduce Neonatal Abstinence Syndrome | **Not Yet Rated** |
| Promote NAS prevention programs through home visiting and parenting programs for pregnant and parenting persons with OUD | Treatment | Reduce Neonatal Abstinence Syndrome | **Not Yet Rated** |
| Promote Eat, Sleep Console for mother/baby dyads for treating withdrawal | Treatment | Reduce Neonatal Abstinence Syndrome | **Not Yet Rated** |
| Standardize clinical guidelines for non-pharmacological treatments, such as physical therapy, cognitive-behavioral therapy, and chiropractic care. A workgroup should be established with representation from the medical and pharmacy State boards, as well as Medicaid leadership and managed care organization (MCO) leadership. The workgroup could focus on education on non-pharmacological treatment and work to improve formulary coverage and reimbursements for non-pharmacological | Primary Prevention | Treatment/Early Intervention/Recovery Support | **12.7** |

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| treatments and multidisciplinary pain management treatment models. This must include physical and behavioral health services. The ACRN recommends the opioid settlement funds be allocated to establishing a workgroup with representation from the Board of Health, Board of Pharmacy, Nevada Medicaid, and the contracted Medicaid Managed Care Organizations. The workgroup will be tasked with standardizing clinical guidelines for non-pharmacological treatments, including but not limited to physical therapy, cognitive-behavioral therapy, and chiropractic care. | | | |
| Engage nontraditional community resources to expand treatment access in rural or underserved areas and target populations that experience health disparities. Encourage nontraditional community resources such as churches or community centers to serve as spokes in the medication-assisted treatment (MAT) hub-and-spoke model. The State should also consider population-specific programs and resources to target the provision of services through existing efforts like women's health programs. - The ACRN recommends the opioid settlement funds be allocated to grants for nontraditional community organizations (e.g., churches, community centers, Family Resource Centers, etc.) to expand treatment access in rural or underserved areas with emphasis on funding organizations whose work targets populations experiencing health disparities. - The Committee recommends issuing grants to encourage nontraditional community organizations to serve as spokes in the medication-assisted treatment (MAT) hub-and-spoke model. | Treatment | Treatment/Early Intervention/Recovery Support | **13.8** |

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| Increase the number of providers trained to offer trauma-informed treatment. There is a connection between exposure to childhood trauma and risky behaviors such as substance abuse. Nevada should consider offering trauma-informed training to all provider types, from primary care physicians to OB/GYNs, as well as to school personnel. Mental Health First Aid could be used in the school setting, as well as in primary care settings, to educate individuals on the effects of childhood trauma and available resources. Education on recognizing the signs of trauma and appropriate treatment will allow for earlier intervention and prevention efforts. - The ACRN recommends the opioid settlement funds be allocated to increasing the number of health care providers, at all levels, who are trained to recognize the signs of trauma and offer appropriate trauma-informed treatment as an early intervention. | Primary Prevention | Treatment/Early Intervention/Recovery Support | **12.8** |
| Provide analytics from the PDMP to providers to identify polysubstance use. The PDMP can be used to identify trends in stimulant prescriptions issued and dispensed. Replicating some of the work done with opioid reporting to address prescribing practices would assist in addressing issues of stimulant prescribing. | Primary Prevention | Treatment/Early Intervention/Recovery Support | **9.3** |
| Promote Screening, Brief Intervention, and Referral to Treatment (SBIRT) for primary care. Utilizing SBIRT screenings in primary care visits for all populations, including adolescents, pregnant women, and other populations, will allow for increased early identification of potential substance use problems and allow for a more preventative, early intervention model of treatment. Nevada may also wish to increase awareness of the availability of SBIRT training, and coordinate with the MCOs, as well as other health care providers, to increase training opportunities. | Secondary Prevention | Treatment/Early Intervention/Recovery Support | **9.0** |

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| Increase access to evidence-based family therapy practices through training availability and increased funding/reimbursement. | Treatment | Treatment/Early Intervention/Recovery Support | **8.7** |
| Increase evidence-based suicide interventions to help decrease intentional overdoses. - The ACRN recommends the opioid settlement funds be allocated to implementing more evidence-based suicide interventions statewide to help decrease intentional overdoses. | Treatment | Treatment/Early Intervention/Recovery Support | **13.0** |
| Modify or remove prior authorization requirement for select outpatient behavioral health services. Several therapy services such as individual, group, and family therapy do not require prior authorization from in-network providers through Medicaid managed care. Nevada should consider removing these requirements from their fee-for-service system, which will decrease administrative burden for both providers and the State. Nevada currently requires prior authorization for intensive outpatient programs (IOPs). While the State may not wish to remove prior authorization completely for this service, they may wish to consider modifying the prior authorization requirements. The benefit of requiring prior authorization after an initial time period supports the State in ensuring IOP level of care is appropriate for a beneficiary and encourages providers to revisit how and whether a patient should be advanced on the care continuum based on a real-time assessment. | Treatment | Treatment/Early Intervention/Recovery Support | **9.2** |
| Align utilization management policies between Medicaid managed care and fee for service, such as preferred drug lists and under- and over-utilization reports for consistency in review of the overall system. | Treatment | Treatment/Early Intervention/Recovery Support | **8.5** |

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| Continue to support expansion of substance use services such as MAT in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), which could increase the availability of services in rural areas, as well as increase the coordination of behavioral and physical health for individuals in treatment. This effort would include an analysis of data and working with providers to determine how many individuals in their service area they may be able to accommodate. Key stakeholders and champions will be a necessary component for expansion of MAT, including change management in perception of MAT as addiction medicine being difficult and unappealing. Tracking outcomes to provide success stories of MAT services may also assist in this endeavor. | Treatment | Treatment/Early Intervention/Recovery Support | **10.0** |
| Implement plan for expansion of mobile MAT treatment for rural and frontier communities. Nevada has been exploring purchasing vans to enable mobile MAT treatment for more rural areas, which will assist in providing treatment in areas where it may not be financially feasible for a provider to open a brick-and-mortar facility. Implementation of the plan for mobile services will assist in increased access in these underserved communities. - The ACRN recommends the opioid settlement funds be allocated to expanding mobile medication-assisted treatment (MAT) for rural and frontier communities by purchasing vans which will assist in providing treatment in areas where it may not be financially feasible for a provider to open a brick-and-mortar facility. | Treatment | Treatment/Early Intervention/Recovery Support | **13.3** |
| Ensure funding for the array of OUD services for uninsured and underinsured Nevadans. - The ACRN recommends the opioid settlement funds be allocated to funding an appropriate array of OUD services for uninsured and underinsured Nevadans. | Treatment | Treatment/Early Intervention/Recovery Support | **12.2** |

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| Establish a Medicaid benefit that supports the hub-and-spoke model. Use of the hub-and-spoke model will decrease travel time and the barrier of transportation for those in rural and frontier areas in accessing substance use services. Implementation of the model should also include establishing bundled payments, enhanced rates, or Medicaid health homes to sustainably fund the model and maintain existing gain, support building infrastructure for rural and frontier hubs, and specifically target providers who can be designated as hubs. - The ACRN recommends the opioid settlement funds be allocated to establish a Medicaid benefit (e.g., bundled payments, enhanced rates, or Medicaid health homes) that supports the hub-and-spoke model which decreases travel time and can remove the barrier of transportation for those in rural and frontier areas, so they can effectively access substance use services. | Treatment | Treatment/Early Intervention/Recovery Support | **11.7** |
| Increase adolescent beds certified to treat young adolescent and transition-age youth, as well as capable of treating co-occurring disorders. Ensure facilities are accessible to populations most in need. | Treatment | Treatment/Early Intervention/Recovery Support | **9.2** |
| Increase the availability of evidence-based treatment for co-occurring disorders for adults and children through promotion of training, enhanced reimbursement for use of specific evidence-based models, and State-sponsored training. Ensure training opportunities are marketed and available to providers in rural and frontier areas. - The ACRN recommends the opioid settlement funds be allocated to implementing trainings for providers about evidence-based treatment for co-occurring disorders for adults and children and enhanced reimbursement for use of specific evidence-based models; training opportunities must be marketed and made easily available to providers in rural and frontier areas. | Treatment | Treatment/Early Intervention/Recovery Support | **12.0** |

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| Nevada has submitted an 1115 Demonstration SUD Waiver that will allow for payment of SUD services in Institutions for Mental Disease. Room and board is not covered under this waiver and consideration for reimbursement will need to be given outside of Medicaid funding. | Treatment | Treatment/Early Intervention/Recovery Support | **8.0** |
| Support care coordination. The State of Nevada may consider financial incentives for care coordination across health care professional types, including behavioral health counselors and other non-physicians. These could be in the form of billing codes and supporting reimbursement for care coordination for particular OUD populations using established evidence-based practices. | Treatment | Treatment/Early Intervention/Recovery Support | **9.5** |
| Engage OB/GYNs in an ECHO project to encourage and improve OUD screening, referral, and treatment for pregnant women. | Treatment | Treatment/Early Intervention/Recovery Support | **9.2** |
| Increase withdrawal management services in the context of comprehensive treatment programs. | Treatment | Treatment/Early Intervention/Recovery Support | **10.0** |
| Increase short-term rehabilitation program capacity. | Treatment | Treatment/Early Intervention/Recovery Support | **8.0** |
| Increase longer-term rehabilitation program capacity. | Treatment | Treatment/Early Intervention/Recovery Support | **9.7** |
| Incorporate screening for standard SDOH needs as a routine intake procedure for all services. | Recovery Supports/SDOH | Treatment/Early Intervention/Recovery Support | **9.8** |
| Expand use of referral mechanisms. Receive periodic updates from University of Nevada, Reno (UNR), State owner of OpenBeds. Update the referral process to include use of the eligibility checklist to enable referring providers to confirm Medicaid eligibility and initiate enrollment. Develop a user-friendly standardized form that providers can complete and send with referrals to improve coordination of care. Planning and implementation of this recommendation should ensure process is as streamlined as possible and results in | Treatment | Treatment/Early Intervention/Recovery Support | **10.2** |

| | | | |
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| decreased burden to providers. Provider stakeholder may assist in ensuring further improvements. | | | |
| Address transportation needs as a SDOH. Nevada's new, Medicaid-funded non-emergency secure behavioral health transport service is equipped and staffed by an accredited individual to transport individuals in mental health crisis, including those on a legal hold. Resources may be needed to help providers with start-up costs as well as to fund transportation for people not covered by Medicaid. Additional transportation solutions need to be considered for the non-Medicaid population, especially in rural areas. - The ACRN recommends the opioid settlement funds be allocated to researching, designing, and implementing transportation solutions for both the Medicaid-enrolled and non-Medicaid populations with a particular emphasis on solutions for rural/frontier communities. | Recovery Supports/SDOH | Treatment/Early Intervention/Recovery Support | **12.0** |
| Identify opportunities for faith-based organizations to provide recovery supports in local communities. Local communities should develop coalitions to work together to ensure recovery supports are available, including the development of local recovery centers. | Recovery Supports/SDOH | Treatment/Early Intervention/Recovery Support | **8.0** |
| Implement a workforce of community health workers throughout recovery supports, behavioral health, and social service agencies. This will potentially require planning, a new Medicaid service definition and associated budget expansion, and funds for the uninsured and underinsured to access these services. | System Needs | Treatment/Early Intervention/Recovery Support | **7.2** |
| Use braided or blended funding, which merges multiple sources of funding for treatment that may not be fully covered by one individual funding source. Braided funding combines State, federal, and private funding streams for a united goal, ensuring individual funding sources are separately tracked and reported. Blended funding is the same principle, with the | System Needs | Treatment/Early Intervention/Recovery Support | **9.5** |

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| exception that all blended funding sources are combined and not tracked and reported on individually. | | | |
| Implement a reimbursement model that reduces the administrative burden of administering grant funds for organizations not accustomed to handling grant payments. One way to do this would be to run the reimbursement payments through the edits built into the Medicaid Managed Information System (MMIS); when the reimbursement is not a Medicaid expense it would filter down to the Division of Public and Behavioral Health (DPBH) code and be paid from State or federal grant money. | System Needs | Treatment/Early Intervention/Recovery Support | **8.2** |
| Continue efforts to work with Tribal communities to meet their needs for prevention, harm reduction, and treatment. Continue to build relationships with the Tribal populations by collaborating with their representatives and pursuing outreach to Tribal communities through channels such as survey and focus groups. - The ACRN recommends the opioid settlement funds be allocated to designing and launching collaborative outreach programs with Tribal communities to meet their needs for prevention, harm reduction, and treatment. | Health Equity | Treatment/Early Intervention/Recovery Support | **12.7** |
| Work in concert with the Nevada public and private school districts for the development of mandatory prevention education and educator training for K-12 grades to provide age-appropriate training [specific to the Substance Abuse and Mental Health Services Administration (SAMHSA) strategic prevention framework; good behavior model, evidence-based curriculum]. | Primary Prevention | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Implement Multi-tiered Systems of Support (Tier 1 and 2) and Social-Emotional Learning in all K-12 Schools | Primary Prevention | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |

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| Implement Multi-tiered Systems of Support (Tier 3) in all K-12 schools | Secondary Prevention | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Develop and implement parent education opportunities, resources and supports for SUD prevention | Primary Prevention | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Implement Universal Screening for ACEs and SBIRT in pediatric care settings [reimburse in Medicaid under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)] | Secondary Prevention | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Train providers on EBPs for family-focused SUD treatment interventions | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Provide specialty care for adolescents in the child welfare and juvenile justice systems | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Provide support for commercially sexually exploited children receiving centers and on-going treatment | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Increase parent/baby/child treatment options including recovery housing and residential treatment that allow the family to remain together | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Implement CARA Plans of Care with resource navigation and peer support | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Expand access to childcare options for families seeking treatment/recovery supports | Recovery Supports/SDOH | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Create street outreach teams to provide street medicine programs, harm reduction, psychiatry, and care management | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Establish and/or expand home visiting programs for families at-risk for or impacted by OUD | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Provide grief counseling and support for those impacted by the loss of a fatal overdose by family or friend | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |
| Directly fund people either at tribes or through the Nevada Indian Commission. And, to the extent that a tribe, the Inter-Tribal Council of Nevada, Nevada Urban Indians, or the Las Vegas Indian Center | Treatment | Treatment/Early Intervention/Recovery Support | **Not Yet Rated** |

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| want direct funding, for us to just direct fund them. | | | |

## Public Comment

As a requirement of SB390, the ACRN solicited comments from the public concerning the recommendations and have added all public comment here in this section of the report.

- Use current best practices and include more primary prevention
- Recovery is not mentioned enough (enhance recovery services)
- Discuss the acute situation—the opioid epidemic that is killing people at an alarming rate
- Approach that acute problem with treatment, long-term case management, and housing
- Acute care includes detoxification (detox); supportive care includes inpatient services; long-term care requires case management and housing; supportive neighborhoods include employment and community centers with activities
- More is needed to support education and stigma
- Recommendations regarding harm reduction could be activated quickly to affect change
- With youth in crisis now, secondary prevention should be supported as much as primary prevention. Secondary prevention includes screenings, drug testing, and mental health assessments
- "There are organizations and individuals throughout the state who have been working for years and years and years in this community and have proven their worth. Why aren't they just given some operating money instead of paying for themselves and/or begging individuals?"
- Money disbursed to assist those who are no longer with us and those who were there with them (victim compensation)
- Leveraging infrastructure to address individual-level risk factors for OUD including social determinants of health and co-occurring physical and behavioral health conditions and to track progress on addressing racial, ethnic and other disparities related to addiction
- Many individuals with OUD have needs including housing, transportation, employment, and food insecurity that intersect with their addiction and make engaging in treatment difficult
- Effective recovery support system which includes a robust network of community partners and the infrastructure in place to support personalized, coordinated care
- Acknowledge, measure and commit to address disparities including differences in access to treatment and fatal overdose rates across racial, ethnic and other groups
- Not just expanding treatment and wrap-around support, but also tracking to ensure that expanded services improve outcomes for the most disadvantaged and vulnerable groups
- Consider tools that increase access to health and social care and coordination of services
- Establish infrastructure that can help address the broader health and social conditions contributing to the epidemic and improve health equity across the state
- The following link was provided to state staff via email as a recommendation from the public:https://www.canva.com/design/DAFDB05Uxao/B1_buKypx5iLS6g91rYfzQ/view?utm_content=DAFDB05Uxao&utm_campaign=designshare&utm_medium=link&utm_source=publishpresent

# Appendix 1– Staff Biographies

**Ariana Saunders** is a member representing an organization that specializes in housing. She has more than ten years of experience in supporting, advocating, and implementing supportive housing projects and for the last four years worked to support the advancement of the state's behavioral health system. She provides technical assistance focused on engaging systems, aligning resources to create new supporting housing, and ensuring quality services using Corporation for Supportive Housing's national standards. She serves on the Clark County Regional Behavioral Health Policy Board, the University of Nevada, Las Vegas School of Social Work Advisory Committee, and is the vice-chair of the Nevada Behavioral Health Planning and Advisory Council.

**Brittney Collins-Jefferson** has a Master of Social Work from the University of Nevada, Las Vegas, and a Bachelor of Arts degree in Psychology. She has more than ten years' experience working with at-risk youth and families and seven years' experience working with adults and supervising program management. She is the owner and clinical supervisor of Restorative Health and Life and Mingo Health Solutions Colorado. She is a licensed clinical drug and alcohol counseling intern at Care Counseling Plus in Las Vegas. She provides counseling for mentally ill individuals and individuals who suffer from co-occurring disorder; completes psycho-social assessments, provides supervision, and writes specialized reports. She has also worked with the Clark County School District, Clark County Social Services, and several other organizations. She has personal experience showing how opioid addiction and dependence can destroy families and leave lingering wounds. She meets the statutory requirement as a member who represents a faith-based organization that specializes in recovery from substance use disorder.

**Cecilia Maria** is a member who resides in Clark County and has experience with a family member having a substance use disorder. She has been associated with Clark County's Department of Family Services as a guardian ad litem and as a foster parent specializing in the care of newborns. Many of the infants she receives are drug-exposed, usually to opioids. She had an adult family member who had substance use disorder.

**Cornelius Sheehan** is a member who possesses knowledge, skills, and experience working with persons in the criminal justice system. He is a licensed clinical social worker and supervisor. He developed the in-custody treatment programs at Washoe County Sheriff's Office Detention center and worked as the clinical program's director for those programs at American Comprehensive Counseling Services. The programs arose from recognizing the high human and economic costs to the community of recidivism due to lack of or failure to comply with treatment and subsequent relapse.

**Darcy Patterson** is the member who resides in Washoe County and has experienced having a substance use disorder or having a family member who has a substance use disorder (SUD). She is in long-term recovery from a substance use disorder and lost a family member to a heroin overdose. She is an advocate to reduce the stigma and shame associated with substance use disorder. She also advocates for families with children SUD or who have lost children to SUD.

**David Sanchez** serves as a member who has survived an opioid overdose. He has been in long-term recovery from drug and alcohol abuse for seven years. He worked as a peer recovery support specialist at Vitality Integrated Programs and as a community health worker/peer recovery specialist for Carson City Health and Human Services. He has participated in forensic assessment services triage team (FASTT) training, crisis intervention training (CIT), and is Ohio Risk Assessment System (ORAS) and Nevada Risk

Assessment System (NRAS) certified. He is a certified peer recovery support specialist. He currently works for the Crisis Prevention Program as a Resilience Ambassador

**Dr. Farzad Kamyar** serves as a physician certified in Addiction Medicine. He is board-certified in Psychiatry and Addiction Medicine by the American Board of Preventative Medicine. For the last several years, he has focused on treatment for opioid use disorder. He is the Director of Collaborative Care at the High-Risk Pregnancy Center. Its Maternal Opioid Treatment Health Education and Recover (MOTHER) program is designed to provide treatment to pregnant and postpartum patients with opioid use disorder and co-occurring mental health issues. Treatment may include medication and be combined with maternal fetal medicine service. He has helped develop and implement practice standards, provider education resources, and outreach for pregnant, postpartum/parenting, and nonpregnant women of reproductive age with substance use disorder.

**Dr. Karla Wagner** is an Associate Professor in the School of Public Health at the University of Nevada, Reno. She conducts public health research to examine the individual, social, and environmental factors associated with opioid overdose and HIV among people who use drugs and other groups at risk. In 1999 she started working with syringe access programs to identify ways to reduce risk for HIV among people who inject drugs. Since 2006, she has studied opioid overdose with a focus on programs to expand access to naloxone, reduce opioid overdose deaths, and increase access to effective, evidence-based treatment. Through her research she collaborates with clinical, social service, public health, behavioral health, and criminal justice stakeholders to identify factors that elevate risk for negative health outcomes, evaluate innovative programs to reduce HIV transmission and overdose, and inform public health policy making.

**Elyse Monroy** has knowledge, skills, and experience in the surveillance of overdose. Since 2015, she has worked on opioid and public health prevention policy and program development and implementation in Nevada. In 2018, she worked with the Division of Public and Behavioral Health Centers for Disease Control and Prevention (CDC) Crisis Grant. She currently is the program manager for Nevada's Overdose Data to Action (OD2A) program, which is the state's main source of CDC funding for overdose morbidity and mortality surveillance and data dissemination. She worked on statewide opioid policy development and implementation for former Governor Brian Sandoval. She was responsible for the development and passage of Senate Bill 459, expanding access to naloxone and implementing a Good Samaritan law. She also led in developing the state's first Controlled Substance Abuse Prevention Act (Assembly Bill 474).

**Jessica Barlow** meets the *Nevada Revised Statutes* (NRS) 433 requirement as a member who resides in a county other than Clark or Washoe County and has experience having a substance use disorder or having a family member who has a substance use disorder. She has worked with the homeless population, a homeless housing program, families in crisis, housing support, and basic needs in her community. In addition, she often works with those affected with substance use disorder to help them move ahead with their desire to stay sober and succeed. She works for the Nevada Outreach Training Organization, a nonprofit organization in Pahrump, and manages the Family Resource Center.

**Karissa Loper** serves as a member who possesses knowledge, skills, and experience in public health. She served as the bureau chief of the Bureau of Child, Family, and Community Wellness in the Nevada Division of Public and Behavioral Health. Her focus was on designing, implementing, and evaluating grant-funded projects and health programs involving immunizations, chronic disease prevention, food security and maternal, child and adolescent health. She is currently with the State's Division of Welfare and Supportive Services.

**Katherine Loudon** is the current Coordinator of school counseling and school social work for the Washoe County School District. Katherine and her talented staff support the day-to-day operations and services provided by school counselors and social workers across Washoe's 105 different school sites serving some 64,000 students and their families. The Counseling Department also oversees Career Center Facilitators, OCRs 504 and Home Hospital, SafeVoice, Handle with Care and various state and federal grants and community partnerships. Katherine Loudon has over 25 years of experience working in schools and worked for HCA's Truckee Meadows Hospital on both pediatric and adolescent units prior to her positions within Washoe County School District. She has led substance misuse prevention and intervention efforts in Washoe and will be providing insights into our Nevada schools at the ground level.

**Laura Sherwood** serves as a member who represents a program specializing in prevention of substance use by youth. She is employed as the prevention specialist for Nevada High Intensity Drug Trafficking Area (HIDTA), a program in the Office of the White House, Office of National Drug Control Policy (ONDCP). HIDTA is a diverse drug program consisting of enforcement, intelligence, prevention, and overdose reduction strategies through collaboration with law enforcement, public health, and community collaboration. As Nevada's prevention specialist, she focuses on educating youth through early intervention and supportive social connections. She works with Nevada educators, coalitions, public health stakeholders, law enforcement, and social services.

**Lilnetra Grady** holds the position required by statute that the ACRN have a member that represents a program for substance use disorder that is operated by a nonprofit organization and is certified pursuant to NRS 458.025. She is an advanced practice nurse, family nurse practitioner, and is medication-assisted treatment (MAT) certified. She has a Master of Science in Nursing, with a focus in family practice. She is the Chief Medical Officer for FirstMed Health and Wellness. She is responsible for daily administrative and clinical supervision of the MAT outpatient program and provides clinical supervision of all prescribing providers participating in the delivery of MAT services. She also ensures all site maintain their state certification.

**Pauline Salla** is the Director of Juvenile Services in Humboldt County, which provides prevention, diversion, intervention, and secure custody of youth involved in the juvenile justice system. She has over 25 years' experience in juvenile justice and substance use treatment with adolescents and has a master's degree in psychology with an emphasis in addiction. She is a licensed Alcohol and Drug Counselor (LADC) and a certified Multidimensional Family Treatment Therapist.

**Quintella Winbush** represents a nonprofit community-oriented organization that specializes in peer-led recovery from substance use disorder. She is a certified peer recovery support specialist and is in long-term recovery. She works for Foundation for Recovery and is contracted to the Dignity Health Empowered Women program for high-risk pregnant women with opioid dependency. She also works at Desert Parkway Behavioral Health Hospital.

**Ryan Gustafson** serves as a member who is the director of an agency which provides child welfare services or his or her designee. He is the Division Director for Child Welfare in Washoe County. In this position, he oversees several programs, including Assessment and Investigations, Training, Continuous Quality Improvement, UNITY and Data, Clinical Services Team, Transportation, and Visitation. He previously worked as the Deputy Administrator for Children's Mental Health in the State of Nevada's Division of Child and Family Services. He is a license Marriage and Family Therapist. He has witnessed the effect of substance use, dependence, and abuse on an individual level and on families and communities.

# Appendix 2- Bylaws

**ADVISORY COMMITTEE FOR A RESILIENT NEVADA BY-**

**LAWS**

**ARTICLE I –**
**NAME**

## Section 1. Name.

The Advisory Committee for a Resilient Nevada, herein after referred to as the Committee.

# ARTICLE II – CREATION & PURPOSE

## Section 1. Creation.

The Committee was established in compliance with the passage of Senate Bill (SB) 390 to be codified in Nevada Revised Statute (NRS) 433 by the 2021 State Legislature 81st session to obtain advice and council from persons and entities who possess knowledge and experience related to the prevention of opioid misuse, opioid related-deaths, and injury, as well as addiction and opioid use disorders within the State of Nevada. The goal is to effectively address risks, impacts, and harms of the opioid crisis in the State through the Fund for a Resilient Nevada.

## Section 2. Purpose.

The Committee will provide feedback and best practice reviews on the data-based content and use information from "opioid litigation damages report" to establish the data driven needs assessment and the development of an integrated state plan. The state plan will include an analysis of the impacts of opioid use and opioid use disorder based on quantitative and qualitative data to determine priorities for programming to be supported by the Fund for a Resilient Nevada. The state plan will prioritize overdose prevention strategies, youth substance use prevention, and focus on health equity and identifying disparities across all racial and ethnic populations, geographic regions and special populations, which includes, without limitation to: veterans, persons who are pregnant, parents of dependent children, youth, persons who are lesbian, gay, bisexual, transgender and questioning, and persons and families involved in the criminal justice system, juvenile justice system and child welfare systems.

# ARTICLE III – ROLES & RESPONSIBILITIES

## Section 1. Responsibilities.

SB 390 includes the Committee's responsibilities which shall include:

A. The Committee shall provide recommendations on the development of the statewide plan. Input to the Committee may include, without limitation, representatives of federal, state, and

local agencies, providers of services, religious organizations, persons involved in the providing or receiving substance use disorder services and member of the public.

B. The Committee must hold at least one public meeting to solicit comments from the public concerning the recommendations and make any revisions to the recommendations determined, as a result of the public comment received, before finalizing the report of recommendations to the Director.

### Section 2. Committee Support.

The Committee is authorized to collaborate with and request the assistance of providers of services or any person or entity with expertise in issues related to opioid use or the impacts of opioid use, including, without limitation, employees of federal, state, and local agencies and advocacy groups for those with Opioid Use Disorder (OUD), to assist the Committee in carrying out its duties.

### Section 3. Public Collaboration.

Legislation requires state and local agencies to collaborate with and provide information to the Committee, upon request by the Committee, to such extent it is consistent with their lawful duties.

### Section 4. Reporting to the Director.

On or before June 30 of each even-numbered year, the Committee shall submit to the Director of the Department of Health and Human Services a report of recommendations concerning the statewide needs assessment, and the statewide priority list for funding recommendations.

### Section 5. Department Responsibilities for Reporting.

On or before January 31 of each year, the Department shall transmit a report concerning all findings and recommendations made, and money expended pursuant to the Fund for a Resilient Nevada State Plan to:

A. The Governor.
B. The Director the Legislative Counsel Bureau.
C. The Committee Chair and members.
D. Each Regional Behavioral Health Policy Board.
E. The Office of the Attorney General.
F. Any other commissions or committees the Director deems appropriate.

## ARTICLE IV – MEMBERSHIP & TERMS

### Section 1. Members.

As established in SB 390, the Committee consists of seventeen members; membership shall include:

| **Attorney General** |
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| One member who possesses knowledge, skills and experience working with youth in the juvenile justice system |

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| One member who possesses knowledge, skills and experience working with youth in the criminal justice system |
| One member who possesses knowledge, skills and experience working with youth in the surveillance of overdoses |
| One member who residence in a county other than Clark or Washoe County and has experience having a substance use disorder or having a family member who has a substance use disorder |

| The Office of Minority Health and Equity |
|---|
| One member that resides in Clark County and has experience having a substance use disorder or having a family member who has a substance use disorder |
| One member who possesses knowledge, skills, and experience in public health |
| One member who is the director of an agency which provides child welfare services or his or her designee |
| One member who represents a program that specializes in prevention of substance use by youth |
| One member who represents a faith-based organization that specializes in recovery from substance use disorder |
| One member that represents a program for substance use disorders that is operated by a nonprofit organization and certified pursuant to NRS 458.025 |

| Director, Health and Human Services |
|---|
| One member that resides in Washoe County and has experience having a substance use disorder or having a family member who has a substance use disorder |
| One member that is a board-certified physician in field of addiction medicine by the American Board of Addiction Medicine |
| One member who represents a nonprofit, community-oriented organizations that specialized in peer-led recovery from substance use disorder |
| One member who has survived an opioid overdose |
| One member who represents a program to prevent overdoses or otherwise reduce the harm caused by the use of substances |
| One member who represents an organization that specializes in housing |
| One member who possesses knowledge, skills, and experience with education in pupils in kindergarten through 12$^{th}$ grade. |

## Section 2. Term.

The term of each member of the Committee is two (2) years. A member may be reappointed for an additional term of two (2) years in the same manner as the original appointment. The term begins on the date of appointment.

## Section 3. Compensation.

Should funds be allocated by the legislature, and in compliance with the State Administrative Manual, each member of the Committee who is not an officer or employee of the State or political subdivision may receive a salary of not more than $80, as fixed by the Department, for each day spent on the official business of the Committee as well as per diem allowance and travel expenses.

### Section 4. Vacancies.

Vacancies among the Committee must be filled in the same manner as the original. The initial term shall be for the remaining length of the vacated term.

### Section 5. Resignation.

A member who resigns from the Committee must provide written notification to the Chair of the Committee and to the head of the agency or organization he or she was representing.

### Section 6. Removal.

The Chair shall forward recommendations for a Committee member's removal to the Director, Attorney or Office of Minority Health and Equity based on inactivity, defined as missing three or more meetings in a calendar year, or a conflict of interest.

### Section 7. Administrative Support.

The Department of Health and Human Services, Grants Management Unit (GMU) shall provide such administrative support to the Committee as is necessary to carry out the duties of the Committee.

## ARTICLE V – MEETINGS

### Section 1. Open Meeting Law.

All proceedings and actions shall be conducted in accordance with the Nevada Open Meeting law (N.R.S. 241.010 through 241.040, inclusive).

### Section 2. Quorum.

A simple majority, nine Committee members, shall constitute a quorum for the transaction of business.

### Section 3. Regular Meetings.

The regular meetings of the Committee shall be not less than twice annually, and as called by the Chair.

### Section 4. Officers.

The officers of the Committee shall be a Committee Chair, Committee Vice Chair and Secretary. These officers shall perform the duties prescribed by these bylaws and by the parliamentary authority adopted by the Committee.

A. Committee Chair. The Committee shall elect from its member the Committee Chair at the first meeting of each calendar year. The Committee Chair:

1. Shall develop the agenda, with input from the Committee membership and the Grants Management Unit;
2. Shall conduct the Committee meetings in accordance with state laws;
3. Shall oversee public hearings and ensure public comment;

4. Shall convene special meetings, as necessary; and
5. Shall prepare reports as required.

B. Committee Vice Chair. Serves in the absence of the Chair and monitors Committee record keeping.

C. Committee Secretary.

1. Shall be responsible for standing Committee reports; and
2. Shall ensure minutes are approved timely.

D. Committee members. May nominate themselves or others for Vice Chair or Secretary. At the first meeting of each calendar year the Committee will elect these officers from its members.

E. Notification. Officer election(s) shall be posted as a business item on the agenda of a regularly scheduled meeting.

## Section 5. Committee Participation.

A. Notification. Committee members shall, to the extent practicable: Inform administrative support staff at least forty-eight (48) hours in advance of an anticipated excused absence.

B. Participation. Committee members must participate in at least 75 percent of meetings. Any absence without sufficient or overriding reason will be considered unexcused absences and may constitute grounds for the Committee recommending the members removal from the Committee to the respective Department or agency.

1. At each regularly scheduled meeting, absences, and indications of excused or unexcused will be noted. The Chair will determine if the absences are excused or unexcused at the time of the next scheduled meeting. An excused absence includes, but is not limited to, an unexpected occurrence or emergency with health, family, or employment that would prevent the member from attending the meeting. An unexcused absence includes, but is not limited to, lack of communication (no contact) with the Chair, Vice Chair, or Administrative Staff. When a member has not participated in at least 75 percent of meetings within any twelve-month period, the Chair will send a notification letter to the member that the Committee intends to take action at the next scheduled meeting. At that meeting, the member will have an opportunity to refute the action, or the Committee will proceed with the removal process.

## Section 6. Subcommittees.

The Committee shall have the ability to create no more than two (2) standing committees, to include one for technical assistance for regulation development.

A. Each standing committee must include a minimum of two voting member(s) of the Committee.

B. Each standing committee shall have one (1) Chair who is a voting member of the Committee.

C. The Committee Chair shall appoint the standing committee chairs from the Committee, except for the Communications Chair which will be the Committee Secretary.

D. Each standing committee, through the standing committee Chair, may appoint additional non- voting members to their committee, as needed based on area of expertise and/or specific projects

### Section 7. Special Meetings.

Special meetings may be called by the Chair. A request for a special meeting can also be made by other Committee members through a written request submitted to the Chair for approval or the Director can call a special meeting.

### Section 8. Voting.

Members participating in a meeting of the Committee by means of a conference call, video conference, or other such means that allow for each participant to hear and be heard by each participant at the same time, shall be deemed to be present at such meeting.

A. Voting on all matters shall be by voice vote and shall be entered in the minutes of the meeting.
B. Each Committee member shall have one vote.
C. The Committee Chair will have a vote on any measure before the Committee.
D. The Chair may not make or second motions.
E. There are no substitution voting member(s).

### Section 9. Record Keeping.

The conduct of all meetings and public access thereto, and the maintaining of all records of the Committee shall be governed by Nevada's Open Meeting law and monitored by the Committee Vice Chair.

## ARTICLE VI - FISCAL SUPPORT

### Section 1. Grants and Gifts.

As established in SB390, the Committee may accept gifts, grants, donations, and appropriations from any source for the support of the Committee in carrying out the provisions of duties. Any fiscal administration shall be overseen by the Nevada Department of Health and Human Services, Grants Management Unit.

### Section 2. Application Support.

The Department of Health and Human Services may provide a letter of support, with approval of the chair, to the lead state agency submitting a federal grant application specific to opioid use and prevention.

# ARTICLE VII - CONFLICT OF INTEREST

## Section 1. Survey.

The Department will survey the Committee members annually to collect information regarding their affiliations outside the Department. Each member is responsible for fully disclosing all current affiliations.

A. Conflicts of interest must be declared by members prior to discussion of any matter that would provide direct financial benefit for that member, or otherwise have the appearance of a conflict of interest. When funding or other decisions are made regarding an organization with which the member has an affiliation, the member shall state his intention to abstain from making specific motions or casting a vote, before participating in related discussions.

## Section 2. Declaration of Conflict.

The Chair or a majority of the Committee may also declare a conflict of interest exists for a member and ask that the member be removed from the voting process.

# ARTICLE VIII - STATEMENT OF NON-DISCRIMINATION

The Committee is an equal opportunity/ affirmative action entity. Qualified persons are considered for appointment without regard to race, sex, sexual orientation, gender identity or expression, religion, color, national origin, age, genetic information, or disability, as outlined in the state affirmative action plan.

# ARTICLE IX - REVISION OF BYLAWS

## Section 1. Bylaw Review.

These bylaws will be reviewed at least every four (4) years or sooner as deemed necessary by the Committee. Proposed amendments will be distributed to the Committee members in writing at least one week prior to a regularly scheduled or special meeting. These bylaws may be altered, amended, or repealed by a majority of the Committee members at any regularly scheduled or special meeting called by the Chair or a majority of the Committee members in compliance with Nevada's Open Meeting Law and must be in compliance with the SB 390 legislation as codified in Chapter 433 of Nevada Revised Statutes (NRS).

## Section 2. Bylaw Approval.

These bylaws were approved and adopted at a regularly scheduled meeting of the Committee on October 5, 2021.

David Sanchez
Chair, Advisory Committee for a Resilient Nevada

10/14/2021
Date