Biennial Report of the

Advisory Committee for a Resilient Nevada (ACRN)

2024

Department of Health and Human Services

Report Date June 30, 2024

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	***Nevada Revised Statutes* (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 1	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* 1	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.
VACANT	One member who represents a program to prevent overdoses or otherwise reduce the harm caused by the use of substances.
Toston, Malieka	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.
Ross, Jamie	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
Dawn Yohey	Department of Health and Human Services/ Clinical Program Planner
Joan Waldock	Department of Health and Human Services/ Program Officer
Vanessa Diaz	Department of Health and Human Services/Quality Assurance
Beth Slamowitz, PharmD	Department of Health and Human Services/Senior Policy Advisor on Pharmacy

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Introduction and Background:

The Advisory Committee for a Resilient Nevada (ACRN) plays a crucial role in the state's efforts to combat the opioid crisis and address substance misuse and substance use disorders. Established in compliance with Senate Bill (SB) 390 by the 2021 State Legislature (81st session), ACRN aims to provide expert advice and counsel on preventing opioid misuse, opioid-related deaths and injuries, and addressing addiction and opioid use disorders in Nevada.

Since the last report, the ACRN has convened eight times, reflecting its commitment to continuous oversight and action in the fight against the opioid crisis. This report marks the second two-year term of the committee, highlighting the ongoing dedication and sustained efforts of ACRN to address these critical issues.

Context:

The Advisory Committee for a Resilient Nevada (ACRN) has made substantial progress in addressing the opioid crisis in Nevada through its well-informed recommendations and strategic initiatives. The

committee's efforts are grounded in a thorough understanding of the community's needs and the evolving nature of substance misuse and its impacts. Since its inception, ACRN's recommendations have led to significant positive changes, underscoring the importance of a data-driven and community-focused approach.

One of the key achievements has been the successful expansion of mobile recovery units. These units have dramatically increased access to treatment in rural and underserved areas, providing essential services to individuals who might otherwise lack access to care. They offer a comprehensive range of services including medication-assisted treatment (MAT), counseling, and ongoing support and follow-up. This holistic approach ensures continuity of care and better outcomes for those battling opioid use disorder.

The implementation of mobile recovery units was facilitated by a Notice of Funding Opportunity (NOFO) issued by the Fund for a Resilient Nevada (FRN), which aligned with the recommendations made by ACRN. This funding has allowed for the deployment of mobile units specifically targeting pregnant and postpartum women through the EMPOWERED Program, and has been instrumental in extending care to Nevada's rural communities.

Another notable impact has been the enhanced funding for residential treatment facilities. This initiative has improved the quality of care and increased the number of individuals receiving necessary treatment. By focusing on comprehensive care and support, these facilities have helped many individuals in their recovery journeys, contributing to a decrease in relapse rates and improved community health.

ACRN has also prioritized the distribution and availability of naloxone, a life-saving medication that can reverse opioid overdoses. Programs like Trac-B Exchange have played a crucial role in this effort, providing essential resources such as overdose reversal medications and fentanyl test strips. These harm reduction strategies have led to a significant reduction in overdose deaths, saving countless lives across the state.

In addition to these efforts, the committee's recommendations have supported other vital initiatives such as the establishment of transitional housing and the implementation of harm reduction strategies. These efforts have collectively contributed to a more resilient and responsive healthcare infrastructure, capable of addressing the complex needs of individuals affected by the opioid crisis.

The ongoing process of reviewing and meeting the community's needs ensures that ACRN continues to provide relevant and impactful recommendations. This includes adjusting bylaws and continuously engaging with stakeholders to refine strategies and enhance the effectiveness of

interventions. Through these efforts, ACRN remains committed to fostering a healthier, more resilient Nevada.

Roles and Responsibilities:

The primary responsibility of the Advisory Committee for a Resilient Nevada (ACRN) is to effectively address the risks, impacts, and harms of the opioid crisis in Nevada. The committee employs data-driven needs assessments to develop an integrated state plan, guiding the allocation of the Fund for a Resilient Nevada (FRN) towards evidence-based programming. ACRN prioritizes overdose prevention strategies, youth substance use prevention, and health equity, focusing on vulnerable populations including veterans, pregnant individuals, parents, youth, LGBTQ communities, and those involved in the criminal justice system.

Since its inception, the ACRN has evolved significantly, reflecting the dynamic nature of the opioid crisis and the ongoing need for adaptive strategies. The committee's composition, dictated by statute, includes appointments by the Office of the Attorney General and Department of Health and Human Services (DHHS), with contributions from the Office of Minority Health and Equity. This diverse group brings together expertise in juvenile justice, criminal justice, overdose surveillance, public health, child welfare, treatment, faith-based communities, addiction medicine, peer recovery, prevention, harm reduction, housing, and primary education. Representatives from Washoe County, Clark County, and rural Nevada, many with personal or familial experience with substance use disorders, enrich the committee with their varied perspectives.

Appointments were finalized in October 2021, with initial term dates from October 1, 2021, through September 30, 2023. Members are eligible to serve through 2025. Since the last report in June 2022, the ACRN has convened eight times, ensuring robust compliance with Nevada’s Open Meeting Law. These meetings have incorporated extensive presentations and discussions on roles and responsibilities, legislative processes, health equity, and needs assessments, focusing on identifying service gaps and utilizing objective tools to prioritize actions. Each meeting has welcomed public comment, fostering community engagement and transparency.

In the past two years, ACRN has made significant strides, including the development and implementation of targeted interventions based on comprehensive data analysis. The committee has expanded its focus on health equity, ensuring that all strategies consider disparities across racial and ethnic populations, geographic regions, and special populations such as veterans and LGBTQ individuals.

Looking ahead, ACRN plans to review and adjust its bylaws this year to better reflect the evolving needs and priorities of the committee and the communities it serves. This review will ensure that the operational guidelines remain aligned with the latest best practices and legislative requirements.

The ACRN continues to advise DHHS in developing and conducting needs assessments, establishing priorities, and crafting the state plan. The committee's work is pivotal in guiding the allocation of resources and shaping the strategies to combat the opioid crisis in Nevada effectively.

Appendix 1 includes detailed biographies of the ACRN staff, while Appendix 2 provides the committee's bylaws, reflecting the structure and operational guidelines that underpin ACRN's efforts.

Legislative Language:

The legislative foundation for the Advisory Committee for a Resilient Nevada (ACRN) is established in *Nevada Revised Statutes* (NRS) 433.712 through 433.744. This legislation outlines the creation, responsibilities, and reporting requirements of the ACRN, ensuring a structured approach to addressing the opioid crisis within the state.

Establishment and Purpose

The ACRN was created under Senate Bill (SB) 390, passed during the 2021 State Legislature (81st session), to provide expert advice and counsel on preventing opioid misuse, opioid-related deaths and injuries, and addressing addiction and opioid use disorders in Nevada. The primary goal of the committee is to guide the allocation of the Fund for a Resilient Nevada (FRN) towards evidence-based programs that effectively mitigate the risks and impacts of the opioid crisis.

Reporting Requirements

Per legislative mandate, the ACRN is required to submit a report to the Director of the Department of Health and Human Services (DHHS) by June 30 of each even-numbered year. This report must include:

1. **Statewide Needs Assessment**: An evidence-based assessment that utilizes data from damages reports created by experts involved in opioid litigation. This assessment should analyze the impacts of opioid use and opioid use disorder across Nevada, using both quantitative and qualitative data. It must identify risk factors contributing to opioid use, substance use rates, and co-occurring disorders, with a focus on health equity and disparities among different populations and geographic regions, including special populations such as veterans, pregnant individuals, and those involved in the criminal justice system.
2. **Statewide Plan**: Recommendations for the statewide plan to allocate FRN resources. These recommendations should prioritize overdose prevention, address disparities in healthcare

access, and prevent substance use among youth. The plan must integrate existing resources from state, regional, local, and tribal agencies, as well as nonprofit organizations.

Collaboration and Public Involvement

The legislation requires collaboration between state and local agencies and the ACRN to provide necessary information and support for the committee's activities. Additionally, the ACRN must hold public meetings to solicit comments on its recommendations, ensuring community engagement and transparency. These meetings allow the committee to refine its recommendations based on public input before finalizing its report to the Director.

Departmental Responsibilities

On or before January 31 of each year, DHHS is required to transmit a report detailing all findings, recommendations, and expenditures related to the FRN to:

- The Governor
- The Director of the Legislative Counsel Bureau
- The ACRN Chair and members
- Each Regional Behavioral Health Policy Board
- The Office of the Attorney General
- Any other relevant commissions or committees

Meeting Highlights

During the April 9, 2024, ACRN meeting, several funded providers presented updates on their initiatives, emphasizing the positive impacts of the recommendations and the funding they received:

1. Trac-B Exchange:
    - Highlighted the success of distributing naloxone and fentanyl test strips, which have been critical in reducing overdose deaths in rural and urban areas.
2. Living Free Health and Fitness:
    - Reported increased capacity and improved outcomes in their residential treatment programs, supported by enhanced funding for comprehensive care and support services.
3. The EMPOWERED Program:
    - Focused on providing specialized care for pregnant and postpartum women, showcasing the significant impact of mobile recovery units and community health worker programs in extending care to underserved populations.

Additionally, an overview of a potential wastewater analysis project was discussed, aiming to enhance real-time data collection and response capabilities for substance use trends across Nevada.

The meeting also reviewed the statewide opioid goals, including strategies to increase the availability of evidence-based treatment, improve behavioral health treatment for special populations, and address social determinants of health. The discussions reinforced the importance of continuous evaluation and adaptation of strategies to meet the evolving needs of the community.

ACRN Revisions

In response to evolving needs and feedback, the ACRN plans to review and adjust its bylaws to enhance its effectiveness in addressing the opioid crisis. This ongoing review process ensures that the committee's governance and operational procedures remain relevant and effective.

The ACRN has determined outside facilitation is needed in order to fulfill statutory requirements.

This legislative framework ensures that the ACRN is able to advise the department regarding funding allocations, but ultimately funding allocations are at the discretion of the director of the department of health and human services and in alignment with the opioid needs assessment and statewide plan.

Providers that have been funded:

- Boys and Girls Clubs of Southern Nevada
- Carson City Community Counseling Center Regional Wellness Center
- DHCFP (Medicaid All Payers Claims)
- DHCFP (Medicaid Waiver)
- Department of Health and Human Services – Office Of Analytics (Biostatistician)
- Dignity Health
- DPBH – EMS (ODMAP)
- DPBH Public Preparedness (Poison Control)
- Living Free Health and Fitness
- Lyon County Human Services
- NPHF (DIDs)
- NPHF (Juvenile/Teel Contract)
- NV Division of Emergency Management
- NV Indian Commission
- NyE Communities Coalition
- Quest Counseling and Consulting, Inc
- Roseman University The EMPOWERED Program
- Trac B (Impact) Exchange LLC
- UNR (CASAT) Mobile Units Maintenance
- UNR (CASAT) OTTAC
- UNR (MTSS)
- Washoe County Department of Alternative Sentencing STAR Program

Goal 1: Ensure Local Programs Have the Capacity to Implement Recommendations Effectively and Sustainably

Activity	Status
Establish a Nevada opioid training and technical assistance hub to support local communities to build capacity, identify and implement best practices, and coordinate training and technical assistance opportunities from state and national subject matter experts (SME)	Funded
Create a website to serve as a central repository for training and technical assistance materials	Funded
Establish positions for regional opioid training and technical assistance to facilitate information sharing on opioid-related activities between local, regional, and state entities	Funded
Provide technical assistance around evidence-based practices (EBPs) and evidence-informed services and projects	Funded
Convene statewide pharmacist round table event	Funded
Train on EBPs and evidence-informed services and projects during implementation	Funded
Provide ongoing training as needed	Funded
Offer technical assistance while monitoring the implementation	Funded
Evaluation and mapping of currently funded opioid and substance use disorder projects	Internal
Entity needs assessment/gaps – Plan for implementation using findings from implementation science	Internal
Offer technical assistance for developing baseline, outcome measures, and reporting	Internal
Technical assistance for target population identification	Internal
Establish initial reporting requirements and process for funded programs	Internal

Goal 2: Prevent the Misuse of Opioids

Activity	Status
Identify substances involved in overdoses quickly (e.g., distribute hand-held drug testing equipment)	Funded

Educate the public on the identification of treatment needs and treatment access and resources	Funded
Promote available resources	Funded
Educate providers and pharmacists on alternative pain management and on educating patients on patient pain management expectations and safe opioid use	Funded
Decrease stigma/offer anti-stigma training for providers, including pharmacists	Funded
Educate parents and the public on ACEs prevention and intervention Implement family-based prevention strategies and expand activities under the Family First Prevention Act	Funded
Offer ACEs screening and referral to treatment in schools and medical settings	Funded
Increase access to aftercare, summer, and intramural programs Boys & Girls Club of So NV (Statewide Program including six organizations and thirty-four locations)	Funded
Increase prevention in schools	Funded
Require prevention education and educator training	Funded
Provide access to prevention activities for the transitional aged youth (TAY) to ensure all youth/adolescent populations are targeted	Funded
Prevent, screen for, and treat those with Adverse Childhood Experiences (ACEs)	Funded
Implement ages zero to three programming to support families impacted by substance use	Funded
Provide school survey results on drug trends/issues to school leaders	Internal
Determine necessary action to reduce the risk of overdose in Nevada's communities.	Internal

Goal 3: Reduce Harm Related to Opioid Use

Activity	Status
Expand the availability of harm reduction products in vending machines	Funded
Include people in recovery and those with lived experience with opioid use in planning efforts, to include peer programming	Funded
Expand accessibility of needle exchanges across the state	Funded
Use exchange sites for additional harm reduction efforts	Funded

Goal 4: Provide Behavioral Health Treatment

Activity	Status
Improve upon evidence-based SUD and OUD treatment and recovery support training and resources for providers, including for subpopulations (e.g., children and families, tribal members) who need tailored treatment – Increase evidence-based suicide interventions and trauma-informed care	Funded
Use EBPs to support mothers, babies, and families impacted by opioid use	Funded
Expand treatment options for transition-age youth – Provide specialty care for adolescents in the child welfare and juvenile justice systems	Funded
Continue to work with tribal communities to meet their needs for prevention, harm reduction, and treatment	Funded
Increase longer-term and short-term rehabilitation program capacity	Funded
Establish Community Health Worker/Peer Navigator program for pregnant and parenting persons with OUD	Funded
Increase parent/baby/child treatment options including recovery housing and residential treatment that allow the family to remain together	Funded
Implement a plan for expansion of mobile MOUD treatment for rural and frontier communities	Funded
Initiate buprenorphine in the emergency department and during inpatient stays	Funded

Expand access to MOUD treatment for youth in primary care and behavioral health settings	Funded
Create a provider forum for treatment and other resource-sharing	Funded
Offer parenting programs and home visits for at-risk pregnant women	Funded
Continue to monitor and expand ASTHO programs for Neonatal Abstinence Syndrome (NAS) with special attention to preventing health disparities	Funded
Provide tenancy supports for individuals to maintain housing through the recovery process	Funded
Develop sober and affordable housing resources through partnerships	Funded
Ensure all providers prioritize best practices for patients, family/caregivers, and neonates/infants	Internal
Require all SUD treatment programs to measure standard patient outcomes and implement best practices	Internal
Engage nontraditional community resources to expand treatment access in rural or underserved areas and target populations that experience health disparities	Internal
Support referral to evidence-based practices	Internal
Continue to expand MOUD in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)	Internal
Provide continuity of care between levels of care	Internal
Evaluate provider enrollment process to ensure it is not a deterrent for providers	Internal
Ensure funding for the array of OUD services for uninsured, underinsured, and tribal populations	Internal

Enforce parity across physical and mental health	Internal
Implement a reimbursement model that reduces the administrative burden on providers of administering grant funds	Internal
Monitor the capacity of SUD and OUD treatment providers	Internal

Goal 5: Implement Recovery Communities across Nevada
Social Determinants of Health (SDOH)

Activity	Status
Develop employment supports for those in treatment and in recovery	Funded
Address transportation needs as a SDOH	Funded
Incorporate screening for standard SDOH needs as a routine intake procedure for all services	Internal
Establish policies and funding to support evidence-based recovery housing	Internal

Goal 6: Provide Opioid Prevention and Treatment Consistently across the Criminal Justice and Public Safety Systems

Activity	Status
Provide MAT in all adult correctional and juvenile justice facilities	Funded
Connect people leaving jails and prisons to post-release treatment, housing, and other supports as well as educate about overdose risk	Funded
Expand drug court treatment availability and include treatment for multiple substances	Internal
Monitor outcomes related to SUD treatment for the criminal justice-involved population	Internal
Educate parole and probation officers on the need for treatment, recovery, housing, and employment	Internal

Goal 7: Provide High Quality and Robust Data and Accessible, Timely Reporting

Activity	Status
Collect data from the poison control hotline	Funded
Implement the All-Payer Claims Database	Funded
Create an Automated Program Interface (API) connection to Emergency Medical Services (EMS)/Image Trend	Funded
Standardize reporting and query code/logic across reporting agencies	Internal
Establish minimum data set for suspected and actual overdose for use in all agencies, including demographic characteristics	Internal
Ensure data elements include demographic characteristics to identify and address health disparities	Internal

ACRN Recommendations Based on the Goals of the Statewide Plan

The Advisory Committee for a Resilient Nevada (ACRN) has continued to advance its mission to address the opioid crisis through strategic recommendations that align with the goals of the statewide plan. These recommendations are informed by ongoing assessments of community needs, stakeholder feedback, and the latest data on substance misuse and its impacts in Nevada. The goals of the statewide plan guide the committee's efforts and ensure a comprehensive approach to combating the opioid crisis. Originally this was done in a strategic plan format, but in order to encompass more recommendations, this committee would like to prioritize recommendations within higher level goals.

In continued conversations with the ACRN, the ACRN has decided to continue prioritizing goals 1-7 of the statewide plan including the decision to roll over all previous recommendations.

Recommendation	Gap
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	Data
Develop a/an overdose fatality review committee(s).	Data
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.	Data

Establish a minimum data set for suspected opioid use and overdose death data collection to standardize data across the State and better prevent overdoses. The NV-OD2A program has identified a minimum data set from law enforcement and other first responder agencies. The minimum data set relates to indicators that law enforcement agencies can collect and report on, although at the time the report was written none were using the full minimum data points.	Data
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 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.	Data
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
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
Develop and maintain consistent query code and query logic for reporting on standard metrics across agencies to facilitate consistent reporting and monitoring of priority indicators related to the opioid epidemic. Develop and maintain a consistent timeline for when metrics should be run and reported. Develop a standard process for quality control and consistencies, as well as reporting caveats.	Data
Increase availability and access to real-time substance use disorder (SUD) and opioid use disorder (OUD) reports. The Sate 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
Partner with local Coroner/Medical Examiner, Medical Schools, and other relevant stakeholders to develop an accredited forensic pathology program.	Data
Expand surveillance testing. This will require a new funding formula for forensic toxicology, as well as better leveraging of federal funds.	Data
Develop data tools to collect and report racial, ethnic, housing status, sexual orientation, and gender identity across datasets.	Data
Expand reporting to the prescription drug monitoring program to include methadone to increase patient safety and reduce prescribing risk.	Data
Support the application programming interface (API) connection to EMS/Image Trend for data collection and reporting through the overdose mapping and application program (ODMAP).	Data
Support Poison Control hotline and data collection/reporting to track and trend; establish a communications system and dashboard.	Data
Increase reporting of Treatment Episode Data Set (TEDS) for all certified providers.	Data
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

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.	Health Equity
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.	Health Equity
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.	Health Equity
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
Fund the 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. Training should consider the unique landscape of rural, frontier, and tribal communities. Training 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.	Primary Prevention
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.	Primary Prevention
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.	Primary Prevention
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
Evaluate key partnerships. Nevada can work with CASAT and targeted organizations to identify physician-champions with addiction treatment experience to serve as consultants or mentors to peers.	Primary Prevention
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.	Primary Prevention
Implement family-based prevention strategies, especially for transition-age youth and young adults.	Primary Prevention

Work in concert with the Nevada public and private school districts for the development of mandatory age-appropriate prevention education and educator training for K–12th grades (specific to the SAMHSA strategic prevention framework, good behavior model, evidence-based curriculum), to include use of naloxone and how to talk with healthcare providers when age-appropriate.	Primary Prevention
Conduct anonymous school survey targeted to principals and staff to identify specific drug trends/issues in their schools. Results could inform additional training/resources for their students and parents.	Primary Prevention
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.	Primary Prevention
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 treatments and multidisciplinary pain management treatment models. This must include physical and behavioral health services.	Primary Prevention
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
Offer MAT providers training and incentives for participation in the patient-centered opioid addiction treatment (PCOAT) model. Incentivize treatment recruitment and retention for individuals with OUD through the PCOAT Model in Medicaid. Implement procedures and policies necessary to operate the model.	Primary Prevention
Increase access to Afterschool, Summer Recreation, and Intermural Programs in grades K–12.	Primary Prevention
Provide Prevention Specialists for schools to support implementation of evidence-based practices in grades K–12.	Primary Prevention
Develop and implement parent education opportunities, resources. and supports for SUD prevention.	Primary Prevention
Provide parent education on ACEs prevention and intervention.	Primary Prevention
Invest in Families First Prevention Act activities to reduce risk for child welfare involvement.	Primary Prevention
Implement Universal Screening for ACEs and SBIRT in pediatric care settings. Reimburse in Medicaid under early periodic screening, diagnosis, and referral to treatment provision (EPSDT).	Primary Prevention

Promote youth substance misuse interventions.	Primary Prevention
Implement public messaging campaign on the prevention and impact of ACEs.	Primary Prevention
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
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, as supported in AB 236. 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.	Recovery Supports/SDOH
Establish policies and funding to support evidence-based recovery housing using National Alliance for Recovery Residences criteria.	Recovery Supports/SDOH
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.	Recovery Supports/SDOH
Incorporate screening for standard SDOH needs as a routine intake procedure for all services.	Recovery Supports/SDOH
Develop employment supports for those in treatment and in recovery.	Recovery Supports/SDOH
Provide housing and recovery supports for homeless youth with OUD.	Recovery Supports/SDOH
Expand access to child care options for families seeking treatment/recovery supports.	Recovery Supports/SDOH
Expand 2-1-1 to identify and match individuals to resources for SDOH. As part of expanding resources, current partnerships should be reviewed to see if there is an opportunity for expansion or additional collaboration.	Recovery Supports/SDOH
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
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.	Secondary Prevention

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
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.	Secondary Prevention
Increase education to decrease stigma and enhance understanding of recovery for employers and landlords through the Recovery Friendly Workplace Initiative.	Secondary Prevention
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.	Secondary Prevention
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. Collaborative care agreements should fully utilize pharmacists as part of the care team.	Secondary Prevention
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 assisting in identifying individuals at risk, allowing for potential earlier intervention and decreased risk for lethality.	Secondary Prevention
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
Implement a school screening tool to identify adverse childhood experiences and provide early intervention for children and their families. Provide appropriate referrals for treatment/counseling services.	Secondary Prevention
Create an office/positions that can increase education, adoption, support for SBIRT in all health care settings (i.e., inpatient, outpatient, etc.) similar to Zero Suicide Initiative.	Secondary Prevention
Establish home visiting programs for families at risk for or impacted by OUD.	Secondary Prevention
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	Secondary Prevention

SBIRT Training, and coordinate with the MCOs, as well as other health care providers, to increase training opportunities.	
Implement Multi-tiered Systems of Support (Tier 1 and 2) and Social-Emotional Learning in all K–12 Schools.	Secondary Prevention
Implement Multi-tiered Systems of Support (Tier 3) in all K–12 schools.	Secondary Prevention
Implement Trauma Informed Schools.	Secondary Prevention
Provide support for commercially sexually exploited children through receiving centers and on-going treatment.	Secondary Prevention
Incentivize and implement SBIRT in OB/GYN settings.	Secondary Prevention
Promote neonatal abstinence syndrome prevention programs through home visits and parenting programs for pregnant and parenting persons with OUD.	Secondary Prevention
Implement Safe Baby Courts for families impacted by substance use.	Secondary Prevention
Establish a disease investigation model for non-fatal overdoses to identify and mitigate risk.	Secondary Prevention
Create a scholarship fund dedicated to an individual directly affected by the epidemic.	System Needs
Expand current 211 website to include successful recovery stories and outcome data that has been deidentified to assist in reducing the stigma both amongst providers and the general public toward people with SUD. The website could also link to available MAT providers, including OB-GYNs, as well as resources for SDOH and other factors in recovery. A section for families to inform them about supporting a family member in treatment and recovery would be helpful. Nevada may feature a family and consumer social marketing campaign on the website to include risks associate with use that is tailored to different populations experiencing health disparities.	System Needs
Fully implement the Zero Suicide framework Statewide, including leading system-wide culture change, training the workforce, identification, client engagement, treatment, transition to lower levels of care, and quality monitoring and improvement.	System Needs
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	System Needs

the exception that all blended funding sources are combined and not tracked and reported on individually.	
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
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
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
Train Statewide law enforcement personnel on the protections in the 911 Good Samaritan Law and the revised statute on paraphernalia possession so they are enforced as intended. Currently the fear of law enforcement intervention may put people at risk for drug overdose, HIV infections, and other health harms.	Tertiary Prevention/ Harm Reduction
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.	Tertiary Prevention/ Harm Reduction
Align priorities of 911 Good Samaritan Law protections with the enforcement of drug induced homicide (DIH) laws by de-prioritizing enforcement of the DIH law.	Tertiary Prevention/ Harm Reduction
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.	Tertiary Prevention/ Harm Reduction
Prioritize naloxone and fentanyl test strip distribution to people who use drugs and to clinics that provide MAT services.	Tertiary Prevention/ Harm Reduction
Expand access to harm reduction products through the purchase and distribution of vending machines Statewide.	Tertiary Prevention/ Harm Reduction

Prioritize naloxone distribution to people at highest risk for overdose death. This will 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 connect with people at highest risk (e.g., people who are housed, living alone, or living in settings where drug use is hidden).	Tertiary Prevention/ Harm Reduction
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.	Tertiary Prevention/ Harm Reduction
Support an increase in needle exchanges across the State. Many non-profit organizations provide needle exchange services, but more sites are needed in locations where those using them feels 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.	Tertiary Prevention/ Harm Reduction
Establish supervised drug consumption sites.	Tertiary Prevention/ Harm Reduction
Establish an advisory board that informs implementation of harm reduction services that includes people in recovery, people with lived experience of substance use, and people currently using drugs. The board can provide oversight and inform the equitable and ethical integration of harm reduction into routine public health services.	Tertiary Prevention/ Harm Reduction
Implement Child Welfare best practices for supporting families impacted by substance use.	Tertiary Prevention/ Harm Reduction
Implement Mobile Crisis Teams with harm reduction training and naloxone leave-behind.	Tertiary Prevention/ Harm Reduction
Develop no-barrier access to overdose prevention/harm reduction services, including naloxone and fentanyl testing.	Tertiary Prevention/ Harm Reduction
Purchase and distribute hand-held drug testing equipment (mass spectrometers) to allow for rapid testing of substances.	Tertiary Prevention/ Harm Reduction
Establish a "bad batch" communications program to alert communities to prevent mass casualty events.	Tertiary Prevention/ Harm Reduction

Ensure adequate funding of the State 988 crisis line such that mobile crisis can be connected by GPS and dispatched by the crisis line.	Treatment
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.	Treatment
Support crisis stabilization units across the State that can serve Nevada residents and offer critical diversion from EDs and jails for those with OUD.	Treatment
Incentivize providers for OBOT through bonuses. Targeted incentives may be used in rural areas to assist in increasing the workforce base. Other incentives may include bonuses to providers who meet pre-defined threshold(s) for providing SUD and OUD treatment and recovery services for those who participate in Project ECHO.	Treatment
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.	Treatment
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 Treatments (OBOTs) 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.	Treatment
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.	Treatment
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.	Treatment
Ensure the accuracy of the Nevada health professional shortage area designation process. Per the Health Resources and Services Administration (HRSA), states should routinely collect supplemental information (e.g., provider specialty, patient care hours). Improving the HRSA designations process will impact eligibility for organizations such as the Indian Health Service Loan Repayment Program, Centers for Medicare & Medicaid Services (CMS) HRSA Bonus Payment Program, and Nursing Corp.	Treatment

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
Expand use of Project ECHO® and participate in Opioid ECHO to increase provider capacity. Nevada should seek to expand the current program, using data from Project ECHO regarding current MAT and pain management clinics to evaluate reach and effectiveness. Participant feedback can be used to address any areas of opportunity and current known barriers to becoming an OUD treatment services provider. Opioid ECHO, a main supporting hub at the ECHO Institute, provides expert specialist teams to state spoke sites. The model offers tools and resources to meet the need for prevention, screening, and treatment of OUD.	Treatment
Increase provider rates for treatment in rural areas to incentivize providers to serve in rural communities. Work with licensure boards to ensure licensure and supervision rules do not pose barriers to practice and supervision in rural areas.	Treatment
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
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
Require all SUD treatment programs to measure standard patient outcomes and implement best practices. Monitor for adherence to best practices, standards of care, and outcomes.	Treatment
Develop and implement a Statewide plan for prevention, screening, and treatment for Adverse Childhood Experiences (ACEs) across State agencies and provider settings. Train providers and organizations on EBP's for mitigating harm from exposure to ACE's/resiliency training	Treatment
Directly fund people either at tribes or through the Nevada Indian Commission. To the extent that a tribe, the Inter-Tribal Council of Nevada, Nevada Urban Indians, or the Las Vegas Indian Center want direct funding, provide them with direct funding.	Treatment
Expand access to long-acting buprenorphine medications.	Treatment
Enforce parity across physical and mental health. For example, a pregnant patient who presents for delivery should receive all of the necessary substance use treatment and physical health care for the patient and newborn which would include labor and delivery, pediatrician, NICU, etc., as well in evaluation. Enforce the same for infectious disease specialists.	Treatment
Provide grief counseling and support for those impacted by the fatal overdose by a family or friend.	Treatment
Require the use of evidenced-based practices to address and treat polysubstance use in all treatment protocols and expand Statewide access to interventions for those who use multiple substances (including through drug courts).	Treatment

Create non-commercially sponsored meeting forum for treatment and other resource providers to share practices, concerns, scholarship, and other topical information.	Treatment
Increase education, adoption, and support for buprenorphine as a first-line treatment for reproductive/birthing/pregnant, etc., patients with OUD.	Treatment
Ensure all delivery hospitals and health care systems taking care of reproductive age, pregnant, and postpartum patients utilize currently available programming for pregnant patients that prioritizes best practices for patient, family/caregivers, and neonate/infant (i.e., SBIRT, outpatient care, inpatient care, delivery, reproductive planning, care coordination, Comprehensive Addiction and Recovery Act of 2016 [CARA] plan of care, treatment, NAS, etc.).	Treatment
Engage non-traditional community resources to expand treatment access in rural or underserved areas and targeting populations that experience health disparities. Encourage non-traditional 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.	Treatment
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.	Treatment
Increase evidence-based suicide interventions to help decrease intentional overdoses.	Treatment
Expand the Integrated Opioid Treatment and Recovery Centers (IOTRC) hub classification beyond Certified Community Behavioral Health Clinic (CCBHC), FQHC, and OTP. This will allow a broader category for hub designation to better accommodate underserved communities. Additionally, encourage the inclusion of non-traditional community resources to serve as spokes and consider population-specific programs and resources to target the provision of services through existing efforts like women's health programs.	Treatment
Partner with a TeleMAT service provider. TeleMAT programs have been increasingly utilized during the public health emergency and have been shown to be as effective as in-person programs and have yielded increased retention rates among patients. Some payers, including Anthem, have partnered with TeleMAT service providers to expand access to MAT in rural populations. A TeleMAT program in conjunction with the extension of COVID-19 flexibilities could greatly expand access to and participation in MAT Statewide.	Treatment
Ensure funding for the array of OUD services for uninsured and underinsured Nevadans.	Treatment
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.	Treatment
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.	Treatment

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 decreased burden to providers. Provider stakeholdering may assist in ensuring further improvements.	Treatment
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
Incentivize providers to initiate buprenorphine in the emergency department (ED), as well as during inpatient hospital stays. All EDs and hospitals should have providers that will provide buprenorphine induction as well as involve case managers to assist with setting up outpatient resources for continued care and management.	Treatment
Increase withdrawal management services in the context of comprehensive treatment programs.	Treatment
Increase longer-term rehabilitation program capacity.	Treatment
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
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
Engage OB/GYNs in an ECHO project to encourage and improve OUD screening, referral, and treatment for pregnant women.	Treatment
Provide continuity of care (CoC) between levels of care. Nevada's CCBHCs currently provide care coordination across various providers to ensure whole person treatment is available for both physical and behavioral health. These programs may need to be expanded to meet the needs of the State's OUD population for those not served by CCBHCs.	Treatment

Increase access to evidence-based family therapy practices through training availability and increased funding/reimbursement.	Treatment
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
Expand adolescent treatment options across all American Society of Addition Medicine levels of care for OUD with co-occurring disorder integration.	Treatment
Train providers on evidence-based practices for family-focused SUD treatment interventions.	Treatment
Provide specialty care for adolescents in the child welfare and juvenile justice systems.	Treatment
Expand treatment options for transitional age youth.	Treatment
Establish Community Health Worker/Peer Navigator program for pregnant and parenting persons with OUD.	Treatment
Promote Eat, Sleep, Console for mother/baby dyads for treating withdrawal.	Treatment
Increase parent/baby/child treatment options, including recovery housing and residential treatment, that allow the family to remain together.	Treatment
Implement ages zero to three years programming to support families impacted by substance use.	Treatment
Implement CARA Plans of Care with resource navigation and peer support.	Treatment
Expand access to medication-based OUD treatment options for youth with OUD in primary and behavioral health settings.	Treatment
Create street outreach teams to provide street medicine programs, harm reduction, psychiatry, and care management.	Treatment
Fully implement Nevada's Hub and Spoke System for MAT regardless of payer.	Treatment
Support the implementation of low threshold prescribing for buprenorphine treatment.	Treatment
Establish IOTRCs in Department of Healthcare Financing and Policy/Nevada Medicaid policy with funding.	Treatment
Establish addiction medicine fellowships.	Treatment
Nevada has submitted an 1115 Demonstration SUD Waiver that will allow for payment of SUD services in Institutions for Mental Disease. Utilize FRN funding for states share for 1115 SUD Waiver, room and board, and uncompensated care.	Treatment

Increase short-term rehabilitation program capacity.	Treatment

Summary of ACRN Meetings and Committee Input

Throughout the year, ACRN has held multiple meetings to refine these recommendations, incorporating valuable insights from various stakeholders. Highlights from these meetings include:

1. **February 13, 2024, Meeting:** Emphasis on expanding withdrawal management services and integrated mental health and substance use treatment. Committee members discussed the need for more comprehensive services and better coordination between different care providers.
2. **March 12, 2024, Meeting:** Presentation on the CARA Plans of Care and the importance of sustainable funding for Integrated Opioid Treatment and Recovery Centers (IOTRCs). Members highlighted the success of programs like the EMPOWERED initiative in supporting pregnant and postpartum women.
3. **April 9, 2024, Meeting:** Review of street outreach programs and the benefits of low-threshold prescribing for buprenorphine treatment. Committee members emphasized the importance of reaching individuals who are not accessing traditional healthcare services.
4. **May 14, 2024, Meeting:** Discussion on the expansion of harm reduction services, including naloxone distribution and syringe exchange programs. Members stressed the need for these services in rural areas to prevent overdoses and the spread of infectious diseases.

By focusing on these priorities and leveraging the insights and expertise of its members, ACRN continues to make significant strides in mitigating the opioid crisis and improving the health and well-being of Nevada's communities.

Public Comment

As a requirement of NRS433, the ACRN solicited comments from the public, but none were received.

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 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.

Section 2. Purpose.

The Committee will provide feedback and best practice reviews on the data-based content and use information from the "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: 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, juvenile justice, 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 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
One member who possesses knowledge, skills and experience working with youth in the juvenile justice system
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 12th 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 recordkeeping.

C. Committee Secretary.

1. Shall be responsible for standing Committee reports; and 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 member's 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 nonvoting 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. Recordkeeping.

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.

10/14/2021

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