					Impact				Urgency			Feasibility					
Rec. #	Recommendation	Notes	Gap	Legislative	# Lives	Magnitude	Health Equity	Average	Alternatives	Delay Consequence	Average	Infrastructure	Ease	Resources	Average	Leg. Target	Rating Total
1	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	Data	2	3	3	2.7	3	1	2.0		3	4	3.7	0	8.3
2	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	Data	3	4	3	3.3	2	2	2.0		2	4	3.3	3	11.7
3	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	Data	2	3	3	2.7	2	1	1.5		2	3	2.7	3	9.8
4	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	3	3	3	3.0	2	1	1.5		1	2	1.7	3	9.2
5	Expand surveillance testing. This will require a new funding formula for forensic toxicology, as well as better leveraging of federal funds.		Data	Data	3	2	3	2.7	2	1	1.5		2	3	2.7	0	6.8
6	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	Data	2	4	3	3.0	3	3	3.0		3	3	3.0	3	12.0
7	Partner with local Coroner/Medical Examiner, Medical Schools, and other relevant stakeholders to develop an accredited forensic pathology program.		Data	Data	3	2	3	2.7	3	1	2.0		1	3	2.3	0	7.0
8	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	Data	3	4	5	4.0	5	3	4.0		4	3	3.7	3	14.7
9	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	Data	2	3	3	2.7	3	2	2.5		2	3	2.7	0	7.8
10	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	3	3	3	3.0	2	3	2.5		3	3	3.3	0	8.8
11	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	Data	2	4	3	3.0	3	2	2.5	5	4	4	4.3	3	12.8
12	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	Treatment/Early Intervention/Recovery Support	3	3	3	3.0	3	3	3.0	4	3	4	3.7	3	12.7
13	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	Treatment/Early Intervention/Recovery Support	2	4	5	3.7	3	4	3.5	4	3	4	3.7	3	13.8
14	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	Education/Awareness Campaign	4	4	3	3.7	3	4	3.5	5	4	3	4.0	3	14.2
15	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	3	3	4	3.3	3	2	2.5	3	3	3	3.0	0	8.8

16	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	Develop Workforce	3	3	5	3.7	3	2	2.5	3	2	2	2.3	3	11.5
17	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 Workforce	3	3	3	3.0	2	3	2.5	4	2	4	3.3	3	11.8
18	Offer MAT providers training and incentives for participation in the patient-centered opioid addiction treatment (PCOAT) model. Implement procedures and policies necessary to operate the model.		Primary Prevention	Treatment/Early Intervention/Recovery Support	2	3	3	2.7	2	3	2.5	5	4	3	4.0	0	9.2
19	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	Develop Workforce	2	3	4	3.0	3	3	3.0	4	4	4	4.0	3	13.0
20	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	Develop Workforce	2	3	4	3.0	2	2	2.0	4	4	4	4.0	3	12.0
21	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	Treatment/Early Intervention/Recovery Support	4	4	3	3.7	3	4	3.5	3	3	2	2.7	3	12.8
22	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.		Primary Prevention	Develop Workforce	4	3	5	4.0	3	3	3.0	3	3	5	3.7	3	13.7
23	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	Develop Workforce	2	3	3	2.7	2	2	2.0	3	3	5	3.7	0	8.3
24	Implement family-based prevention strategies, especially for transition-age youth and young adults.		Primary Prevention	Education/Awareness Campaign	4	3	3	3.3	4	3	3.5	3	2	3	2.7	3	12.5
25	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	2	4	3	3.0	2	4	3.0	4	2	4	3.3	0	9.3
26	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	2	4	3	3.0	2	4	3.0	4	1	4	3.0	0	9.0
27	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	Education/Awareness Campaign	4	3	4	3.7	3	4	3.5	4	4	3	3.7	3	13.8
28	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	Treatment/Early Intervention/Recovery Support	5	5	3	4.3	4	4	4.0	3	3	2	2.7	0	11.0

29	Promote Screening, Breif 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	4	2	3	3.0	3	3	3.0	3	3	3	3.0	0	9.0
30	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	3	3	3	3.0	3	3	3.0	3	2	3	2.7	0	8.7
31	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	3	2	3	2.7	3	2	2.5	4	3	3	3.3	0	8.5
32	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	Education/Awareness Campaign	5	2	3	3.3	3	4	3.5	4	2	3	3.0	3	12.8
33	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	Education/Awareness Campaign	2	3	5	3.3	5	4	4.5	3	4	3	3.3	3	14.2
34	Implement an educational campaign to decrease stigma and enhance understanding of recovery for employers and landlords.		Secondary Prevention	Education/Awareness Campaign	2	3	5	3.3	5	4	4.5	3	4	3	3.3	3	14.2
35	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	2	1	3	2.0	5	1	3.0	2	3	3	2.7	0	7.7
36	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.		Secondary Prevention	Education/Awareness Campaign	4	2	4	3.3	3	4	3.5	3	4	3	3.3	3	13.2
37	Develop and implement a Statewide plan for prevention, screening, and treatment for Adverse Childhood Experiences (ACEs) across State agencies and provider settings.		Treatment	Prevent ACEs	4	3	3	3.3	3	3	3.0	3	3	3	3.0	3	12.3
38	Increase access to evidence-based family therapy practices through training availability and increased funding/reimbursement.		Treatment	Treatment/Early Intervention/Recovery Support	3	3	3	3.0	3	3	3.0	4	2	2	2.7	0	8.7
39	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	Treatment/Early Intervention/Recovery Support	2	3	4	3.0	2	3	2.5	4	4	4	4.0	3	12.5
40	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	Develop Workforce	3	2	3	2.7	3	2	2.5	5	4	5	4.7	0	9.8
41	Increase evidence-based suicide interventions to help decrease intentional overdoses.		Treatment	Treatment/Early Intervention/Recovery Support	1	5	3	3.0	3	5	4.0	3	3	3	3.0	3	13.0
42	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 Treamtents (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	Develop Workforce	2	3	5	3.3	3	3	3.0	4	3	3	3.3	3	12.7

43	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	3	3	3	3.0	3	2	2.5	4	2	4	3.3	0	8.8
44	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	Develop Workforce	3	3	4	3.3	2	2	2.0	5	3	4	4.0	0	9.3
45	Expand scope of practice for advanced practice registered nurses (APRNs). The State can engage with the State Board of Nursing to add SUD and OUD to the scope of practice for APRNs.		Treatment	Develop Workforce	3	3	3	3.0	3	3	3.0	3	3	3	3.0	0	9.0
46	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	Develop Workforce	2	3	3	2.7	3	3	3.0	4	4	3	3.7	0	9.3
47	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	2	2	3	2.3	3	3	3.0	4	4	2	3.3	0	8.7
48	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	1	3	3	2.3	4	4	4.0	3	3	3	3.0	0	9.3
49	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	Develop Workforce	2	4	4	3.3	3	4	3.5	4	4	3	3.7	3	13.5
50	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. evada 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	3	3	3	3.0	2	3	2.5	4	4	3	3.7	0	9.2
51	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	3	2	3	2.7	3	2	2.5	4	3	3	3.3	0	8.5
52	Promote team-based MAT with defined roles for nursing, behavioral health, and care coordination to support physicians with the clinical support staff and administrative resources necessary to treat patients with complex needs. Team-based MAT models are optimally cost-efficient, allowing prescribers to practice at the top of their license while nurses, behavioral health professionals, and care coordinators provide the care management, counseling, and coordination services vital to ensuring good outcomes that benefit Medicaid beneficiaries, as well as all patients seeking treatment for SUD. The MAT team evaluates patient needs, offers clinical support to providers, and provides counseling to patients.		Treatment	Treatment/Early Intervention/Recovery Support	2	3	3	2.7	3	3	3.0	3	3	3	3.0	0	8.7
53	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	2	4	4	3.3	3	3	3.0	4	4	3	3.7	0	10.0
54	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	Treatment/Early Intervention/Recovery Support	2	3	5	3.3	4	4	4.0	3	3	3	3.0	3	13.3
55	Ensure funding for the array of OUD services for uninsured and underinsured Nevadans		Treatment	Treatment/Early Intervention/Recovery Support	2	3	4	3.0	3	4	3.5	4	2	2	2.7	3	12.2
56	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	Treatment/Early Intervention/Recovery Support	1	3	5	3.0	3	3	3.0	3	2	3	2.7	3	11.7

57	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	Treatment/Early Intervention/Recovery Support	2	3	5	3.3	3	3	3.0	3	3	4	3.3	3	12.7
58	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	Crisis Services	3	4	3	3.3	4	4	4.0	4	4	2	3.3	0	10.7
59	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	1	4	4	3.0	3	4	3.5	2	4	2	2.7	0	9.2
60	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	Treatment/Early Intervention/Recovery Support	2	3	4	3.0	3	3	3.0	3	3	3	3.0	3	12.0
61	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	Treatment/Early Intervention/Recovery Support	1	4	3	2.7	4	4	4.0	4	2	4	3.3	0	10.0
62	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	1	2	3	2.0	2	2	2.0	5	4	3	4.0	0	8.0
63	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	3	2	3	2.7	2	3	2.5	5	5	3	4.3	0	9.5
64	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	Treatment/Early Intervention/Recovery Support	2	3	3	2.7	2	3	2.5	4	3	4	3.7	0	8.8
65	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	1	3	4	2.7	3	4	3.5	3	3	3	3.0	0	9.2
66	Increase withdrawal management services in the context of comprehensive treatment programs.		Treatment	Treatment/Early Intervention/Recovery Support	2	4	3	3.0	4	4	4.0	3	3	3	3.0	0	10.0
67	Increase short-term rehabilitation program capacity.		Treatment	Treatment/Early Intervention/Recovery Support	1	3	3	2.3	3	3	3.0	3	3	2	2.7	0	8.0
68	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	Crisis Services	1	4	3	2.7	5	4	4.5	4	4	2	3.3	0	10.5
69	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	Crisis Services	3	4	3	3.3	4	5	4.5	4	4	3	3.7	0	11.5
70	Increase longer-term rehabilitation program capacity.		Treatment	Treatment/Early Intervention/Recovery Support	1	4	3	2.7	4	4	4.0	4	3	2	3.0	0	9.7
71	Incorporate screening for standard SDOH needs as a routine intake procedure for all services.		Recovery Supports/SDOH	Treatment/Early Intervention/Recovery Support	5	3	3	3.7	4	3	3.5	3	2	3	2.7	0	9.8
72	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	Housing	1	3	5	3.0	4	4	4.0	4	3	3	3.3	3	13.3

73	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	Treatment/Early Intervention/Recovery Support	2	3	3	2.7	4	3	3.5	4	4	4	4.0	0	10.2
74	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	Reduce Harm	2	4	3	3.0	3	4	3.5	3	4	3	3.3	3	12.8
75	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	Reduce Harm	2	5	4	3.7	2	5	3.5	4	4	3	3.7	3	13.8
76	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	Reduce Harm	1	4	4	3.0	2	4	3.0	3	2	3	2.7	3	11.7
77	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	Treatment/Early Intervention/Recovery Support	2	3	4	3.0	3	3	3.0	3	3	3	3.0	3	12.0
78	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	2	2	3	2.3	4	2	3.0	3	2	3	2.7	0	8.0
79	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	2	4	3	3.0	3	3	3.0	3	3	3	3.0	0	9.0
80	Develop employment supports for those in treatment and in recovery.		Recovery Supports/SDOH	Treatment/Early Intervention/Recovery Support	3	3	3	3.0	4	2	3.0	3	2	3	2.7	0	8.7
81	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.		Recovery Supports/SDOH	Justice Programs	1	3	5	3.0	4	3	3.5	4	3	3	3.3	3	12.8
82	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	Treatment/Early Intervention/Recovery Support	4	2	3	3.0	2	1	1.5	4	4	3	3.7	0	8.2

83	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	3	2	3	2.7	3	2	2.5	2	2	2	2.0	0	7.2
84	Create a public-facing website for individuals looking for resources on substance use treatments. The website may also 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	Education/Awareness Campaign	3	3	4	3.3	2	2	2.0	3	3	4	3.3	3	11.7
85	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 doesn't 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	3	1	3	2.3	3	2	2.5	4	3	4	3.7	0	8.5
86	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 exception that all blended funding sources are combined and not tracked and reported on individually.		System Needs	Treatment/Early Intervention/Recovery Support	3	3	3	3.0	4	3	3.5	3	3	3	3.0	0	9.5
87	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	2	3	3	2.7	3	2	2.5	3	3	3	3.0	0	8.2
88	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	Treatment/Early Intervention/Recovery Support	2	3	5	3.3	3	3	3.0	3	3	4	3.3	3	12.7
89	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	Reduce Neonatal Abstinence Syndrome	1	3	4	2.7	2	2	2.0	3	4	4	3.7	3	11.3
90	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	Justice Programs	1	3	5	3.0	4	4	4.0	3	3	2	2.7	3	12.7
91	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	2	3	4	3.0	2	2	2.0	2	2	3	2.3	3	10.3
92	Create a scholarship fund dedicated to an individual directly affected by the epidemic.				1	2	3	2.0	3	2	2.5	3	3	4	3.3	0	7.5

	ACRN Recommendations and Corresponding Recommendations from the List Above	
ACRN1	Expanding access to evidence-based prevention of substance use disorders, early intervention for persons at risk of an SUD, treatment for SUDs, and support for persons in recovery from SUDs.	This is a restatement of the Legislative category
ACRN2	Sustainable investment in substance use prevention education and educator training in the geographic and sociodemographic areas identified in the needs assessment. (Prevention policy and funding)	See Education and Awareness Campaigns
ACRN3	Open more beds for crisis and withdrawal management should be readily available, despite an individual's ability to pay and/or type of insurance, for both adults and youth. (Treatment/Workforce/Infrastructure funding and policy)	See recommendations about opening adult and adolescent beds and adding withdrawal management
ACRN4	Sustainably invest in increasing utilization of secondary prevention interventions and strategies focusing on targeting underserved populations as noted in the needs assessment. (Prevention)	See secondary prevention category
ACRN5	Invest in behavioral health infrastructure towards the creation of more inpatient rehabilitation facilities and detoxification facilities linked to the needs assessment. (Treatment)	See recommendations about opening adult and adolescent beds and adding withdrawal management
ACRN6	Sustainably invest in peer support programs, along with community health workers implanted in the recovery support programs and across behavioral health and social services throughout the State, including review of reimbursement rates and supplementing wages. (Policy and funding)	See separate recommendations for peer support and for community health workers
ACRN7	Create interventions at a family level to fortify youth and transition-age youth and young adult individuals' sense of security and prevention of substance use.	Included
ACRN8	Expand of payment coverage for family treatments. (Policy)	Included
ACRN9	Sustainably and continually invest in and train administration of family-based treatment.	Included (as above)
ACRN10	Services to reduce the harm caused by substance use.	See Harm Reduction
ACRN11	Sustainably invest in harm reduction services in both urban and rural underserved areas, including but not limited to funding for syringe exchange, fentanyl test strips, and naloxone distribution.	See Harm Reduction
ACRN12	Campaigns to educate and increase awareness of the public concerning substance use and SUDs.	See Education and Awareness Campaigns
ACRN13	Assess efficacy of current related media campaigns. (Prevention and funding)	See Education and Awareness Campaigns; all recommendations should include a method
ACRN14	Ensure all media campaigns are evidenced based, culturally competent, multilingual, and on a diverse set of media platforms. (Prevention and funding)	See Education and Awareness Campaigns; all recommendations should be evidence-based, culturally competent, and multilingual; many mention a diverse set of media platforms
ACRN15	Development of the workforce of providers of services relating to substance use and SUDs.	See Workforce
ACRN16	Create a scholarship fund dedicated to an individual directly affected by the epidemic for workforce development to build infrastructure. (Workforce/Infrastructure funding)	Included
ACRN17	Capital projects relating to substance use and SUDs, including, without limitation, construction, purchasing, and remodeling.	See Capital Projects
ACRN18	Creating infrastructure to enhance workforce, facilities, beds, linkage to care referrals, and payment methodologies.	Included in many recommendations

(1) Expanding access to evidence-based prevention of substance use disorders, 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 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
(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
(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;
(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 the provisions of sections 2 to 6, inclusive, of this act.

Treatment/Early Intervention/Recovery Support
Reduce Neonatal Abstinence Syndrome

Prevent ACEs
Reduce Harm
Infection Diseases
Crisis Services
Housing
Education/Awareness Campaign

Justice Programs
Evaluate Programs
Develop Workforce
Data

Capital Projects

Crisis Hotline

Data
System Needs
Health Equity
Primary Prevention
Secondary Prevention
Treatment
Tertiary Prevention/Harm Reduction
Recovery Supports/SDOH