Mercer

Government Human Services Consulting

# Nevada Resiliency Fund:

# Opioid Needs Assessment

**State of Nevada**

April 9, 2022

# Contents

## Section 1
# Introduction

From 2011–2015 opioid overdoses and prescribing rates were on the rise across the United States. In 2015, Nevada had the second highest prescribing rates of hydrocodone and oxycodone nationally. By late 2015, the Obama Administration declared the Opioid Epidemic a national emergency and began funding efforts to combat the crisis in early 2016. With the newly available federal funding, Nevada began working to address the crisis by holding a Statewide Opioid Conference and developing legislation to curb prescribing. In 2017, Nevada implemented the Drug Enforcement Administration High Intensity Drug Trafficking Areas (HIDTA) program to determine the critical drug-trafficking areas within the State. In 2018, rates of methamphetamines and fentanyl use drastically increased and by 2019, Nevada saw opioid overdose deaths with stimulants as a contributing factor drastically increase.

Despite tremendous improvement, Nevada ranked twenty-eighth in opioid overdose deaths and twentieth in opioid prescribing in 2019. In 2020, while also navigating the Coronavirus Disease 2019 (COVID-19) pandemic, the United States saw an overall increase of opioid-related overdose deaths nationwide by 30%. Nevada was not spared from the sharp increase. From 2019–2020, opioid-related overdose deaths increased by 76% in Nevada. There was also a significant increase in fentanyl use by 227% and opioid-related emergency department (ED) encounters also increased by 26%. Nevada also experienced a sharp increase in polysubstance overdoses and illicit pill consumption. Opioid use within subpopulations within Nevada also increased such as the self-reported use of heroin and other opioids among pregnant women, which has quadrupled since 2012, while neonatal opioid exposure has doubled.

In March of 2021, Nevada passed Senate Bill 390 (SB 390) which established the Fund for a Resilient Nevada within the Nevada Department of Health and Human Services (DHHS).[1] Per the legislation, a Statewide Needs Assessment is required to be conducted to lay the foundation for development of a plan to combat the opioid epidemic in the State and set priorities for distributions from the resiliency fund. Per SB 390, the Needs Assessment must use qualitative and quantitative data, and evidenced-based practices. In addition, SB 390 required the creation of the Advisory Council for a Resilience Nevada (ACRN) to ensure those with direct knowledge with opioid use disorders (OUDs), including those with lived experience were included in the decision-making process. Assembly Bill (AB) 374 established the Substance Use Disorder Working Group (SURG) under the Attorney General's Office to reflect the diversity of Nevada and expertise in various aspects of substance misuse and substance use disorders (SUDs).[2] The SURG is responsible for making recommendations on substance misuse and SUDs. The SURG coordinates with ACRN, which is responsible for providing guidance on the statewide needs assessment and Statewide Plan establishing the priority areas for the allocation of Resilient Nevada Fund.

Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, was contracted by the State of Nevada (State) DHHS to objectively review and

[1] SB390 Overview. Available at: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8095/Overview

[2] AB374 PDF. Available at: https://www.leg.state.nv.us/Session/81st2021/Bills/AB/AB374.pdf

assess provided documents and materials for the purpose of assembling a concise Needs Assessment summary with accompanying presentation for the State's Advisory Committee as well as respond to questions. The State's Advisory Committee will prioritize recommendations resulting from the Needs Assessment to submit to the DHHS, inclusive of feedback from the public as well as additional stakeholder groups.

Following the recommendations from SURG and ACRN, Mercer will collaborate with State staff to develop the initial Statewide Plan to address program areas and target populations focused on the State level needs identified in the Needs Assessment. This may involve recommendations on programs to implement or revise new services to offer, and other activities to address the identified needs. The Statewide Plan will define the priority in which spending of available funds will be considered. The State will be supporting a high-level budget and evaluation of the expected cost of implementing any of the activities considered in the development of the Statewide Plan.

# Section 2
# Methodology

The purpose of this Needs Assessment is to inform the Statewide Plan that will address opioid misuse and OUDs in the State. Per SB 390, the Needs Assessment must use qualitative and quantitative data as well as evidenced-based practices to determine the gaps and recommendations. Nevada is also responsible for ensuring a full and accurate reporting of all opioid litigation and settlement dollars for all programs across the State, including reporting from county and local entities.

DHHS provided key seminal reports to Mercer with information pertaining to the opioid-related issues, needs, and conditions in Nevada. These documents provided key information on the following:

- Persons and families impacted by the use of opioids and other substances
- Providers of treatment for OUDs and other SUDs
- SUD prevention coalitions
- Communities of persons in recovery from OUD and other SUDs
- Providers of services to reduce the harm caused by OUDs and other SUDs
- Persons involved in the child welfare system
- Providers of social services
- Faith-based organizations
- Providers of health care and entities that provide health care services
- Members of diverse communities disproportionately impacted by opioid use and OUDs

Over 30 reports were provided and reviewed by Mercer. A full list of reports can be found in Appendix A. Mercer reviewed all reports to pull key information and data for analysis and synthesis to prepare this report. Mercer presented early concepts and draft outlines of the Needs Assessment to both the ACRN and SURG subcommittees for feedback. Mercer also met with various stakeholders for further discussion of available reports and data.

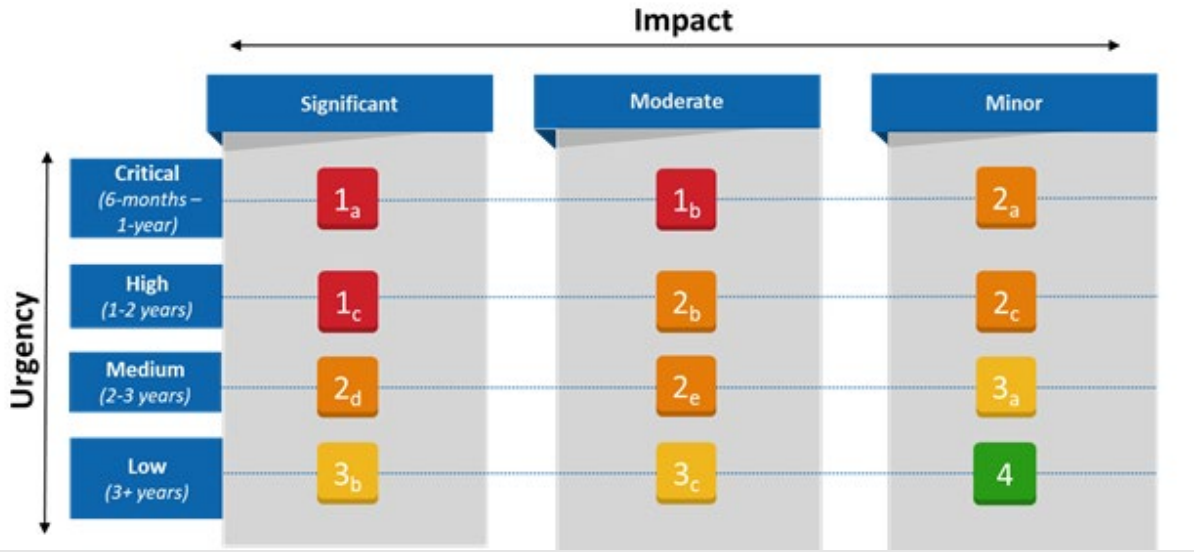
## Scoring Methodology

Mercer used a scoring matrix to assign a score based on priority level to each of the recommendations included within this report. The priority rating reflects Mercer's evaluation of the potential impact of the recommendation as well as urgency or feasibility of the recommendation for addressing each recommendation in the report. Rationale for the scoring of each recommendation is provided in the Recommendations Section of this report. Two scoring matrices were developed for this report, one to score individual-level recommendations and one to score system-level recommendations.

## Individual-Level Priority Scoring Matrix

The Individual-Level Priority Scoring Matrix (see Figure 2.1) was developed to score those recommendations that are aimed at improving gaps impacting individual-level factors. Individual-level factors for the purposes of this report are defined as factors related specifically to individuals (e.g., co-occurring behavioral and physical health issues and childhood trauma).

**Figure 2.1: Individual-Level Priority Scoring Matrix**



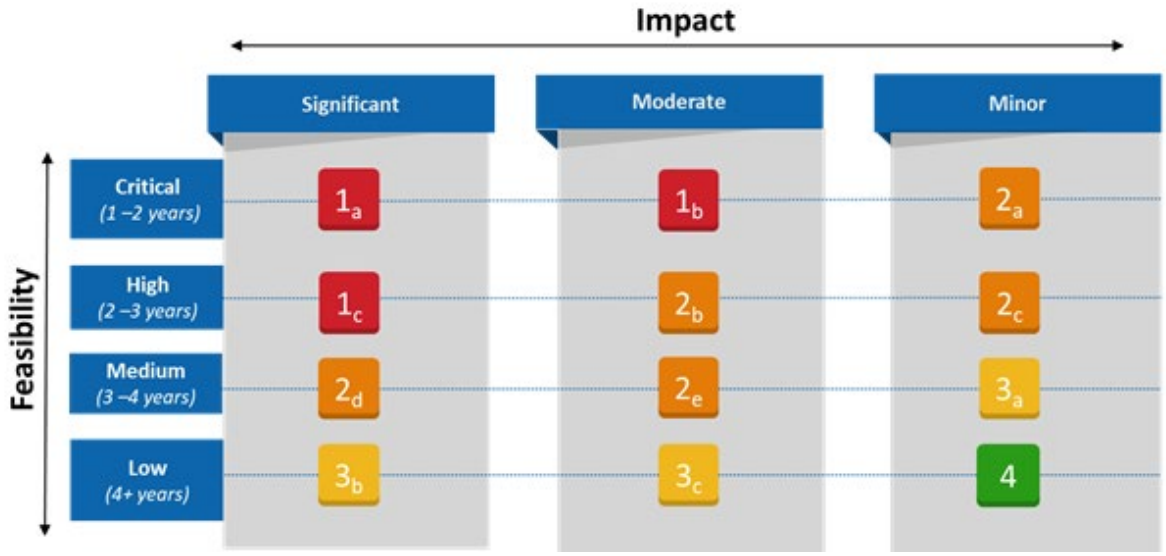

For the purposes of this priority scoring matrix:

- **Impact** was assigned based on the significance of the recommendation and/or the number of lives that would benefit or be impacted by the implementation of the recommendation.
- **Urgency** was assigned based on the urgency with which the recommendation should be implemented.

## System-Level Priority Scoring Matrix

The System-Level Priority Scoring Matrix (see Figure 2.2) was developed to score those recommendations that are aimed at improving gaps impacting system-level factors. System-level factors for the purposes of this report are defined as factors related specifically to the overall system (e.g., available prevention and harm reduction resources and provider and community education).

**Figure 2.2: System-Level Priority Scoring Matrix**




For the purposes of this priority scoring matrix:

- **Impact** was assigned based on the significance of the recommendation and/or the number of lives that would benefit or be impacted by the implementation of the recommendation.
- **Feasibility** was assigned based on how level of effort, time for implementation, and the generally estimated overall cost of the recommendation (i.e., one-time cost versus ongoing cost).

Recommendations in Section 7 are scored for both system- and individual-level priorities, and in some cases a single recommendation can be categorized as both system- and individual-level. When both categories applied to a recommendation, the scoring and justification were applied separately for the system and individual aspects of the recommendation. When prioritizing recommendations with both a system- and individual-level scores, it is reasonable that the recommendation could be prioritized twice depending on whether the resulting program is targeted to individuals or to the system.

# Structure of the Report

In accordance with SB 390, the Needs Assessment report is evidence-based, uses existing data and information from existing reports, includes analysis of the impact of opioid use and OUD, risk factors that contribute to opioid use, use of substances, and rates of OUD, other SUDs and co-occurring disorders using quantitative and qualitative data concerning the State's regions, counties, and Native American tribes. The report includes a focus on health equity and identifying disparities across all racial and ethnic populations, geographic regions, and special populations. Looking at disparate populations, Nevada is also applying tools to ensure that equity in services is being reviewed through a Health Equity Lens with support from the Office of Minority Health and Equity.

To meet these requirements, this report is divided into the following sections:

- Section 3: Opioid Impact

- Section 4: Polysubstance, Co-Occurring Conditions, Suicide Impact
- Section 5: Risk Factors
- Section 6: Best Practices
- Section 7: Recommendations

Sections 3, 4, and 5 of the report follow a similar structure of presenting the information that is currently available and the corresponding gaps that exist. Each gap that is presented in Sections 3, 4, and 5 has a corresponding recommendation in Section 7.

Section 6 provides the recommendations for tackling the opioid epidemic coming out of Johns Hopkins University. Mercer used these best practices as the foundation of this report to ensure an evidence-based approach informs the corresponding Statewide Plan.

Section 7 provides a recommended intervention to address each of the gaps identified within the report.

The opioid epidemic is complex with many intertwined contributing factors. Therefore, many topics may appear in multiple sections, but the information presented will be through the lens of the overarching section topic.

# Section 3
# Opioid Impact

The State has experienced serious impacts of the opioid epidemic over the last 10 years. In 2019, Nevada ranked twenty-eighth in opioid overdose deaths and twentieth in opioid prescribing. To assess the impact of the opioid epidemic on Nevada, key areas were reviewed including fatal and non-fatal overdoses, SUD, and OUD, the drugs contributing to the epidemic and the availability of those drugs, as well as health equity and the impact of opioids on special populations.

## Fatal and Non-Fatal Overdoses

In 2019, the Centers for Disease Control and Prevention (CDC) launched a multiyear Overdose Data to Action (OD2A) program through a cooperative agreement that aims to support jurisdictions in "collecting high quality, comprehensive, and timely data on nonfatal and fatal overdoses."[3] Nevada is one of the 66 recipients using the OD2A funding to capture State and County-level data. The Nevada-OD2A (NV-OD2A) program is focused on mortality data and on opioid prescribing data via Nevada's Prescription Drug Monitoring Program (NV PDMP). NV-OD2A supports Nevada's State Unintentional Drug Overdose Report System (SUDORS), National Syndromic Surveillance Program (NSSP), and the NV PDMP.

SUDORS captures fatal overdose data via death certificates as well as coroner/medical examiner reports, which include post-mortem, toxicology, death scene investigations, route of drug administration, and other risk factors that may be attributed to a fatal overdose. All coroner/medical examiner offices currently report the following:

- Overdose deaths are defined as a death occurring in Nevada where the decedent's place of residence is within the State of Nevada and assigned an ICD-10 code of X40–X44 (unintentional drug poisoning) or Y10–Y14 (drug poisoning of undetermined intent)
- Deaths that were determined to be a drug overdose death by the coroner or medical examiner.

NSSP data captures real-time non-fatal overdose data via hospital electronic health records. Overdoses are counted when the chief complaint and/or discharge diagnosis is associated with an overdose related ICD-10 code. The NSSP data captures visits from 90%–95% of all Nevada EDs. This data also only includes those individuals who can get to an ED.

The NV PDMP captures data regarding all controlled substance prescriptions dispensed to Nevada residents. The PDMP also captures data via electronic health records of participating clinicians. The PDMP only calculates the number of prescriptions filled to Nevada residents. It does not capture whether the prescription medication was taken as prescribed or by the person to whom it was prescribed.

[3] CDC, *Drug Overdose about OD2A*. Available at: https://www.cdc.gov/drugoverdose/od2a/about.html

## Fatal Overdoses – Statewide and Regional-Levels

From 2019–2020, the State experienced a 55% increase in drug-related overdose deaths with overdose deaths attributable to opioids increasing by 76%. In 2020, 788 drug-related overdose deaths occurred. Of those deaths, 65.2% were attributable to opioids.[4] In the Northern Region[5] of the State, opioids were listed as the cause of death for 61% of overdose deaths and 67% of overdose deaths in the Southern Region[6] as seen in Table 3.1.

**Table 3.1: State and Regional-Level Drug-Related Overdose Death Rates**

| | 2019 | 2020 | Percent Change |
|---|---|---|---|
| **State-Level** | | | |
| **Drug-Related Overdose Deaths** | 510 | 788 | ↑ by 55%* |
| **Overdose Deaths Attributable to Opioids** | 292 | 514 | ↑ by 76%* |
| **Region-Level: Northern** | | | |
| **Drug-Related Overdose Deaths** | 172 | 219 | ↑ by 27% |
| **Overdose Deaths Attributable to Opioids** | 104 | 133 | ↑ by 28% |
| **Region-Level: Southern** | | | |
| **Drug-Related Overdose Deaths** | 338 | 569 | ↑ by 68%* |
| **Overdose Deaths Attributable to Opioids** | 188 | 381 | ↑ by 103%* |

*Indicates statistically significant difference between 2019 and 2020. Source: SUDORS Statewide 2019–2020 report and 2020 regional reports. Overdose deaths were limited to Nevada resident deaths that occurred in Nevada with the underlying cause of death reported as X40–X44 or Y10–Y14. Data completeness is dependent on information documented at time of death.

## Fatal Overdoses – County-Level

Rates of drug-related and opioid-related overdoses increased in nine of the 12 counties with reportable rates from 2019–2020, as seen in Table 3.2 below. Douglas, Elko, and Nye counties experienced increases by at least 10 in 2020. While the change in rate from 2019–2020 cannot be calculated for Lander, Lincoln, and Pershing counties due to the 2019 rate being 0 or too low to report, one can infer the rates have significantly increased.

**Table 3.2: Drug-Related and Opioid-Related Overdose Deaths**

| County | Drug-Related Overdose Deaths | | | Opioid-Related Overdose Deaths | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | Change | 2019 | 2020 | Change |
| **Carson City** | 26.6 | 19.5 | ↓ 7.1 | 16.0 | 8.8 | ↓ 7.2 |
| **Churchill** | 23.3 | 19.3 | ↓ 4.0 | 19.4 | 15.5 | ↓ 3.9 |
| **Clark** | 19.2 | 24.5 | ↑ 5.3 | 11.0 | 16.6 | ↑ 5.6 |

[4] Nevada Department of Health and Human Services, *Nevada State Unintentional Drug Overdose Reporting System: Report of Deaths 2019 to 2020 – Statewide* 2020. Available at: https://nvopioidresponse.org/wp-content/uploads/2019/05/sudors_report_2019_2020.pdf

[5] Includes the following counties: Washoe County Regional Medical Examiner Office): Washoe, Carson City, Storey, Douglas, Lyon, Churchill, Mineral, Esmeralda, Lincoln, Humboldt, Pershing, Lander, Eureka, Elko

[6] Includes the following counties: Clark, Nye, White Pine

| County | Drug-Related Overdose Deaths | | | Opioid-Related Overdose Deaths | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | Change | 2019 | 2020 | Change |
| Douglas | 14.2 | 20.1 | ↑ 5.9 | 5.1 | 18.1 | ↑ 13.0 |
| Elko | 5.5 | 12.7 | ↑ 7.2 | 1.8 | 12.7 | ↑ 10.9 |
| Esmeralda | - | - | - | - | - | - |
| Eureka | - | - | - | - | - | - |
| Humboldt | 29.3 | 17.6 | ↓ 11.7 | 11.7 | 17.6 | ↑ 5.9 |
| Lander | - | 33.4 | ↑* | - | 33.4 | ↑* |
| Lincoln | - | 19.3 | ↑* | - | 19.3 | ↑* |
| Lyon | 33.4 | 20.7 | ↓ 12.7 | 21.1 | 12.1 | ↓ 9.0 |
| Mineral | 21.7 | - | ↓* | 21.7 | - | ↓* |
| Nye | 22.7 | 26.6 | ↑ 3.9 | 10.3 | 20.5 | ↑ 10.2 |
| Pershing | - | 14.4 | ↑* | - | 14.4 | ↑* |
| Storey | - | - | - | - | - | - |
| Washoe | 27.9 | 31.9 | ↑ 4.0 | 16.8 | 22.1 | ↑ 5.3 |
| White Pine | 28.3 | 28.4 | ↑ 0.1 | 18.8 | 9.5 | ↓ 9.3 |

Source: Suspected Nevada Drug Overdose Surveillance Monthly Report January 2022, Statewide Report. Data include accidental poisonings, intentional self-poisonings, and assault by drug poisonings, and drug poisoning of undetermined intent for drug-related overdose deaths and where any of the following opioid-related substances contributed to the cause of death: opium, heroin, natural and semi-synthetic opioids, methadone, synthetic opioids, and other/unspecified opioids.
Note: "-" indicates data where the count may be 0 or was suppressed due to low counts. "*" indicates a change in the rate could not be calculated.

## Fatal Overdose Demographics

### Age, Sex, Race/Ethnicity, Education

From 2019–2020, the Statewide percentage of drug-related overdoses in men grew from 63.9% to 68.3%. Increases in the percentage of drug-related overdoses in the 18–24 years and 25–34 years age bands also occurred in 2020. Most drug-related overdoses in Nevada occurred in White men, 45–64 years of age, with a high school diploma.

**Table 3.3: Statewide Drug-Related Overdose Death Demographics**

| Demographics | 2019 | 2020 | Percent Change |
|---|---|---|---|
| **Sex** | | | |
| Male | 63.9% | 68.3% | ↑ by 4.4% |
| Female | 36.1% | 31.7% | ↓ by 4.4% |
| **Race/Ethnicity** | | | |
| Asian | 3.6% | 2.5% | ↓ by 1.1% |
| Black | 14.6% | 14.0% | ↓ by 0.6% |
| Hispanic | 13.4% | 18.9% | ↑ by 5.5%* |
| White | 69.4% | 64.3% | ↓ by 5.1% |

| Demographics | 2019 | 2020 | Percent Change |
|---|---|---|---|
| **Other** | 1.0% | 1.2% | ↑ by 0.2% |
| **Age** | | | |
| **<18 years** | 0.4% | 1.6% | ↑ by 1.2% |
| **18–24 years** | 7.1% | 11.8% | ↑ by 4.7%* |
| **25–34 years** | 19.4% | 18.3% | ↓ by 1.1%* |
| **45–54 years** | 23.5% | 20.1% | ↓ by 3.4% |
| **55–64 years** | 24.7% | 20.6% | ↓ by 4.1% |
| **65+ years** | 8.6% | 8.8% | ↑ by 0.2% |
| **Education** | | | |
| **Less than High School** | 14.2% | 16.2% | ↑ by 2.0% |
| **High School/GED** | 58.3% | 53.7% | ↓ by 4.6% |
| **Some College** | 12.0% | 13.9% | ↑ by 1.9% |
| **Associates** | 6.7% | 8.5% | ↑ by 1.8% |
| **Bachelors** | 6.9% | 6.5% | ↓ by 0.4% |
| **Masters/Doctorate** | 1.9% | 1.2% | ↓ by 0.7% |

*Indicates statistically significance difference between 2019 and 2020. Source: SUDORS statewide 2019–2020 report and 2020 regional reports. Overdose deaths were limited to Nevada resident deaths that occurred in Nevada with the underlying cause of death reported as X40–X44 or Y10–Y14. Data completeness is dependent on information documented at time of death.

It is also important to note that while the rate of growth of the Hispanic population is projected to be more than twice that of the overall population,[7] overdose deaths for this population have seen a statistically significant increase beyond that of people of Asian and Black races/ethnicities. The percentage of drug-related overdose deaths in people of Hispanic origin has increased by 120% from 2019 to 2020. Of the drug-related overdose deaths of those of Hispanic origin, 25% reported a prior mental health problem, 12% reported a prior overdose, 7% reported a non-alcohol related substance use issue, and 5% had recently been released from jail or prison.

### Urban, Rural, and Frontier

The University of Nevada, Reno, School of Medicine published the tenth edition of the Nevada Rural and Frontier Health Data Book in February 2021. This health data book categorizes Nevada counties as urban, rural, or frontier using the Nevada State Office of Rural Health's guidance.[8]

Of the 17 counties within Nevada three counties are classified as urban (Carson City, Clark County, and Washoe County) another three are classified as rural (Douglas, Lyon, and Storey Counties), and the other 11 counties are classified as frontier. This means over half of

[7] Griswold, T., Packham, J., Warner, J., & Etchegoyhen, L. (2021). Nevada rural and frontier health data book – tenth edition. University of Nevada, Reno.
[8] Ibid.

the counties (64.7%) within Nevada are considered frontier.[9] While 90.9% of Nevada's population resides in urban areas or 13.1% of the State's land, the remaining 9.1% of the population live in rural or frontier counties which span across 86.9% of the State's land, approximately 95,431 square miles.[10]

With almost 9.1% of the population in frontier counties, the State faces many challenges when it comes to ensuring access to resources and treatment in these areas due to unique populations with specific needs. Rural and frontier counties tend to have older populations than urban counties, which generally results in a greater risk of death and disability within those counties. These counties also have a higher percentage of native-born Nevada residents at approximately 27.7% compared 26.3% in urban counties. [11] While 75.5% of the population rural and frontier counties is White, 17.3% of the population in these counties is Hispanic. Approximately 13.8% of the Nevada veterans' population live in rural and frontier counties.[12] Approximately 26.5% of the current prison population are incarcerated in rural or frontier counties. Income also tends to be lower in rural and frontier counties.[13] In 2019, the average per capita income for rural and frontier counties was lower than that of urban counties by more than $6,000 dollars per year ($47,990 versus $54,879).[14]

The frontier counties of Mineral, Lincoln, Eureka, and Esmeralda and the rural county of Storey, have small populations (less than 5,000 persons). While the rate of opioid-related overdose deaths could not be reported for Storey, Eureka, and Esmeralda, Lincoln's opioid-related overdose death rate was 19.3 per 100,000 in 2020, one of the highest rates in Nevada. Of the remaining frontier counties, Douglas, Humboldt, Pershing, and Lander all experienced increases in the rate of opioid-related drug overdoses in 2020.[15]

The three urban counties are home to over 90% of the population. Clark County is the largest urban county by far with a population of a little over 2.2 million persons. While Clark County experienced a decrease in the rate of opioid-related overdose deaths, Carson City, and Washoe all experienced increases.

## Drugs Contributing to Fatal Overdoses

In 2020, opioids contributed to 65.2% of drug-related overdose deaths. Of the opioid-related overdose deaths, 32.4% were due to illicitly manufactured fentanyl, 28.2% were due to prescription opioids, 15.7% were due to heroin, and approximately 5% were due to methadone.[16] Opioid overdose deaths due to fentanyl have increased by 227% since 2019.

There has also been an increase in polysubstance use. In 2020, 24.5% of opioid-related overdose deaths involved opioids and stimulants, 18.9% involved opioids and benzodiazepines, and 9% involved opioids and alcohol. The percentages of opioids combined with stimulants and benzodiazepines increased from 2019 to 2020, while the rate of deaths involving opioids and alcohol decreased.

[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Suspected Nevada Drug Overdose Surveillance Monthly Report January 2022, Statewide Report.
[16] Nevada State Unintentional Drug Overdose Reporting System, Report of Deaths 2019 to 2020 – Statewide

The routes of administration also should be noted. The most common route of administration used in drug-related overdose deaths is ingestion. The percentage of deaths involving ingestion rose from 43.1% in 2019 to 44.4% in 2020. The second most common route is smoking which accounted for 21.0% of deaths in 2020. Injection and smoking saw the most change with injection decreasing from 21.4% in 2019 to 16.0% in 2020 and snorting increasing from 6.4% in 2019 to 11.9% in 2020.

In a self-reported survey, 14.8% of high school students reported ever using a prescription such as OxyContin, Percocet, Vicodin, Codeine, Adderall, Ritalin, or Xanax, without a prescription and 2.6% reported using heroin in 2017.[17]

## Nonfatal Overdoses/ED Visits – State-Level

From 2019 to 2020, the number of drug-related ED visits statewide increased overall by about 3% (8,117 visits versus 8,352 visits). However, opioid-related ED visits due to opioids increased by 26% (2,185 versus 2,755). While the rate of drug-related ED visits decreased from 21.3 per 100,000 in 2019 to 20.0 per 100,000 in 2020, the rate of opioid related ED visits increased from 5.8 per 100,000 to per 100,000.[18]

Medicaid beneficiaries make up a relatively large percentage of the opioid-related inpatient stays in Nevada (39% in 2017). Opioid-related ED visits for Nevada Medicaid beneficiaries rose to 3,463 from only 400 in 2010. Opioid-related inpatient visits also increased from 681 in 2010 to 3,416 in 2017.[19]

In 2018, 73% of opioid-related ED visits and 73% of opioid-related hospitalizations were among White, Non-Hispanic race/ethnicity. White, Non-Hispanic Nevadans aged 25–34 made up the largest percentage of hospitalizations at 28%.[20] In 2018, ED visits and hospitalizations for all opioids except for heroin were highest for those aged 15–24 years in Humboldt County.[21]

In 2021, both the statewide drug-related ED visits and opioid-related ED visits are on the rise. The rate of drug-related ED visits increased to 22.1 per 100,000 and opioid-related ED visits increased to 7.8 per 100,000.

# SUD and OUD

The number of Medicaid members with SUD claims has steadily increased from 44,275 in 2017 to 79,940 members in 2020. Of the 79,940 members, 27% (approximately 21,583 members) had claims related to OUD. The highest number of members that were diagnosed with OUD and had claims related to OUD were members between 25–34 years. Approximately 84% of members receiving SUD and OUD services were White, 9% were Black, 1% were American Indian/Alaskan Native, and 15% identified as Hispanic.

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[17] Nevada Department of Health and Human Services, *Nevada's Crisis Care Response System: 2020 Statewide Assets and Gaps Analysis,* 2020.

[18] Nevada Department of Health and Human Services, *Suspected Nevada Drug Overdose Surveillance Monthly Report: October 2021: Statewide Report.* Available at: https://nvopioidresponse.org/wp-content/uploads/2019/05/opioid-surveillance-january-2022-statewide.pdf

[19] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[20] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[21] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

Statewide from 2015 to 2020, the number of individuals diagnosed with an OUD increased from 7,050 to 16,433 or 133% across all races/ethnicity. Of those individuals diagnosed with an OUD who received outpatient treatment increased from 37% to 47%. American Indian and Alaskan Native account for 1.1% to 1.3% of OUD diagnoses, 0.3% to 0.5% of those in outpatient treatment (including medication-assisted treatment [MAT]), and 0.1% to 00.2% of those on MAT.

One national literature review found a disparity gap in access to treatment for racial/ethnic minority populations.[22] African American adolescents noted receiving less specialty and informal care, and Latino youth reported less informal care. The Treatment Episode Data Set (TEDS)[23] maintained by NV-OD2A found that minority adults are also less likely to seek treatment when compared to White Adults, 46% of White Adults seek treatment compared to 21% of Hispanic Adults and 16% of Black Adults.[24] Some of the underlying causes for racial/ethnic disparities have been potentially identified at both the federal level in health care policies and regulations as well as at the individual level of the provider organization, the individual's environment, and the community system.[25] The State has planned to conduct research with first responder groups to determine the training needed to develop awareness regarding health disparities within the community and to create a training package for first responders including content related to cultural awareness and health disparities among the populations they serve. This research and training will help to further inform and address the health disparities and improve health equity in prevention, intervention, and treatment efforts for individuals in need.[26]

Nevada has 27 federally recognized tribes, with 32 reservations or colonies — 97% of Nevada's Tribal Nations are rural. American Indian/Alaska Natives (AI/AN) make up 1.2% of Nevada's population. AI/AN experience a variety of risk factors for SUDs, including higher unemployment, lower four-year high school graduation rates, and lower annual household income. According to United States Census Bureau aggregate data (2015–2019), the median income among those living on tribal lands is lower and unemployment rates and poverty rates are higher compared to Nevada overall.

Washoe County Mental Health court reported that 86% of mental health court participants had a co-occurring SUD, which is consistent with the estimate that 75% of Nevada's mentally ill offenders have co-occurring mental health and SUDs.[27]

## Availability of Opioids and Contributing Drugs

Due to its unique location, Nevada is a prime target for drug trafficking with its proximity to Arizona and California. The large expanse of interstate through frontier and rural areas provides a direct route for drug traffickers to move and sell drugs. In addition, Las Vegas

[22] Alegria, M., Carson, N., Goncalves, M., and Keefe, K., "Disparities in Treatment for Substance Use Disorders and Co-Occurring Disorders for Ethnic/Racial Minority Youth," *Journal of the American Academy of Child & Adolescent Psychiatry,* Volume 50 Issue 1 (2011), pp.22-31.

[23] TEDS is admissions-based data set and does not include all admissions. The data set also includes records for admissions not a count of unique individuals, TEDS also reports the primary, secondary, and tertiary substances reported and therefore may not capture all substances used at the time of admission.

[24] Nevada Overdose to Action and Nevada School of Community Health Sciences, Nevada's Overdose Landscape, 2021.

[25] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[26] Nevada Department of Health Care Finance and Policy, *Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity,* 2021.

[27] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

presents a unique challenge with its high occurrence of gaming, money laundering, and drug trafficking. Initially, the pandemic slowed the pace of drug trafficking into the United States; however, the threat of illicit drugs — including the rates of overdoses — persisted as traffickers adapted and drug compositions like fentanyl became more potent. Additionally, during the lockdown, drug dealers were able to turn to the dark web to sell and purchase drugs and other illicit commodities.

While use of opioids and overdoses increased during the pandemic, prescribing rates decreased. In 2020, the CDC reported the national opioid dispensing rate was 43.3 per 100 persons, an increase from 46.7 per 100 persons in 2019.[28] Nevada maintained a higher opioid dispensing rate than the national average in 2019 and 2020 with rates of 49.4 per 100 persons and 47.4 per 100 persons, respectively. [29] Three out of the five of Nevada's neighboring states also had opioid dispensing rates higher than the national average in 2020. Idaho, Oregon, and Utah had opioid dispensing rates of 49.9, 45.6, and 48.4 per 100 persons, respectively. [30] Arizona's rate was just under the national rate at 40.5 per 100 persons in 2020 and California's rate, the lowest of the neighboring states was 28.5 per 100 persons. [31]

Counties within Nevada also had high opioid dispensing rates in 2020. Carson City had the highest rate of opioid dispensing at 95.9 per 100 persons, over two times the national rate. Carson City's rate was almost high enough for each person in the county to have an opioid prescription. As shown in Table 3.4 below, five of the 17 counties in Nevada had rates higher than the national average.[32]

**Table 3.4: Opioid Dispensing Rate by County[33]**

| County | Rate per 100 Persons |
|---|---|
| **Carson City** | 95.9 |
| **Washoe** | 53.5 |
| **Lincoln** | 48.4 |
| **Clark** | 47.4 |
| **Mineral** | 46.6 |
| **Douglas** | 43.2 |
| **Nye** | 38.5 |
| **Churchill** | 38.1 |
| **Storey** | 29.9 |
| **White Pine** | 28.6 |

[28] CDC Drug Overdose *U.S. State Opioid Dispensing Rates, 2020.* Available at: https://www.cdc.gov/drugoverdose/rxrate-maps/state2020.html

[29] Ibid.

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Source: CDC, IQVIA Xponent 2006–2020 Note: Xponent is based on a number of pharmacies that account for nearly 92 percent of retail prescriptions in the United States. Includes new and refill prescriptions. Opioid prescriptions, including buprenorphine, codeine, fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, oxymorphone, propoxyphene, tapentadol, and tramadol.

| County | Rate per 100 Persons |
|---|---|
| **Elko** | 25.2 |
| **Pershing** | 14.9 |
| **Lyon** | 10.2 |
| **Humboldt** | 9.7 |
| **Eureka** | 8.2 |
| **Lander** | 1.7 |

Nevada's DHHS Office of Analytics maintains a PDMP dashboard.[34] This dashboard uses data from NV PDMP to provide the rates of opioid prescription by top diagnosis, rate of opioid prescriptions by month, opioid prescription by Morphine Milligram Equivalent, days' supply, and day supplies greater than 15 days. The dashboard is updated monthly and is based solely on the number of prescriptions filled by Nevada residents, it does not capture whether the prescriptions were taken or taken as prescribed. Data also are not mutually exclusive, meaning a person can be included multiple times for multiple prescriptions. The dashboard also does not take into appropriateness of prescribing or eliminating subpopulations that may appropriately have high prescription counts or Morphine Milligram Equivalents due to the severity of their condition such as hospice patients.

While data are available for the rates of prescribing of opioids within Nevada, limited data are available for other drugs that are being co-prescribed along with opioids. As mentioned early, many opioid overdoses also involve other drugs such as benzodiazepines; therefore, expanding the types of drugs tracked by the PDMP would provide better insight. Demographic data for prescribing is also limited.

## Special Populations

Special populations are defined within the legislation as veterans, homeless population, pregnant women, youth, lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual (LGBTQ+), juvenile justice, and children in welfare system. Drug-related and opioid-related fatal and nonfatal overdose data are limited for these populations. There are currently no available rates for LGBTQ+. There are currently 11,938 individuals Nevada correctional facilities. However, data are limited with regard to juveniles involved with the justice system. While approximately 6.2% of the population is veterans, limited data about the population are available. The SOUDORS data does report the rate of drug-related overdose deaths for military individuals. In 2020, 6.6% of the statewide drug-related overdose deaths were military members. There is also limited data available for homeless individuals. SUDORS data reports 8.9% of drug-related overdoses occur in homeless individuals.

The data for pregnant women and substance use and opioid use is also limited. Based on self-reported data collected by the DHHS' Office of Analytics, an average of 42 babies are

[34] Nevada Department of Health and Human Services Office of Analytics, *Nevada Prescription Drug Monitoring Program Nevada 2017-2022.* Available at: https://app.powerbigov.us/view?r=eyJrIjoiYjgyYzkyMzctNDg0OS00ZGY1LWJiMWYtM2E0NDlkZjI0MmEyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

born each year in Nevada with prenatal substance use specific to opioids. The rate of babies born to a mother using opioids (excluding heroin) as well as the rate born to mothers using heroin increased from 2018 to 2019. Between 2012 and 2016, self-reported use of heroin among pregnant women was highest in Nye, Esmeralda, and Lincoln counties, and Elko, Eureka, and White Pine were highest for self-reported opioids.[35] Neonatal abstinence syndrome rates in Nevada were highest in Southern Nevada with an incidence rate of 8.2 per 1,000 hospital births.[36]

There is some data available for children in the welfare system. In 2020, 1,892 infants were reported to the Nevada Department of Child and Family Services with substance exposure. This number has tripled since 2012.[37] A total of 11,976 Child Protective Services reports included drug or alcohol use-related characteristics. Of the 2,687 children in the foster care system in 2020, 14.2% were removed due to parental drug and/or alcohol use and of those removed 17.6% of the removed children were under the age of one year.

## Racial/Ethnic Health Equity

Racial/ethnic disparities are a well-known contributing factor that negatively impacts individuals with SUD. In Nevada, 9% of individuals under the age of 65 years have disabilities, over 12% live in poverty, over 30% speak a language other than English at home, and 11% are uninsured. Minorities represent 48% of Nevada's population with a high number of unauthorized immigrants.[38] Currently, there is a gap in race/ethnicity data for individuals receiving substance use services and overall health outcomes. Given that populations with these characteristics are known to experience more barriers to accessing treatment, it can be inferred that many Nevadans are likely to experience health disparities.

While nationally the average number of SUD providers per 1,000 is 32 providers, Nevada currently averages 11 providers per 1,000. The lack of providers presents challenges when individuals are attempting to access services and support. With more providers also concentrated in urban areas, access limitations experienced by rural residents are even more pronounced.

One national literature review found that Black adolescents receive less informal and specialty care and Hispanic adolescents receive less informal care. This is suspected to be due to the issues at the federal level in health care policies and regulations as well as at the individual level of the provider organization, community, or environment.[39]

Nevada also has 27 federally recognized tribes, each with separate reservations or colonies, and 97% of which are rural.[40] AI/AN make up 1.2% of Nevada's population and experience a variety of risk factors for SUDs, including higher unemployment, lower four-year high school graduation rates, and lower annual household income. According to United States Census

[35] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[36] Batra, K, Cruz, P, et al. "Incidence of Neonatal abstinence syndrome epidemic and associated predictors in Nevada: A statewide audit," *Int J Environ Res Public Health*, Volume 18 Issue 1 (2020).

[37] Data received from the Nevada Department of Health and Human Services, January 27, 2022.

[38] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[39] Alegria, Ml., Carson, M., et al., "Disparities in Treatment for Substance Use Disorders and Co-Occurring Disorders for Ethnic/Racial Minority Youth," Journal of the American Academy of Child & Adolescent Psychiatry, Volume 50, Issue 1, 2011

[40] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

Bureau aggregate data (2015–2019), the median income among those living on tribal lands is lower and unemployment rates and poverty rates are higher compared to Nevada overall.

Of the 14 tribal Indian Health Service clinics and health centers, only four of the tribal clinics have a provider who is DATA 2000 waivered, leaving residents of many of these areas needing to drive long distances to receive SUD treatment.

One of the efforts made by Nevada to address the opioid epidemic in the Tribal Nations was to offer two requests for applications (RFAs) offered through the State Opioid Response (SOR) grant to increase available substance use services. There were no responses from tribal organizations to the RFAs, but the SOR team continues to have ongoing conversations with interested tribal clinics about increasing the accessibility of MAT services, various training opportunities and support for implementation. The SOR team participates in the Nevada Tribal Council on request and maintains relationships with organizations that are currently distributing naloxone to their communities.[41] The lack of response to the SOR RFAs indicates an opportunity to further engage with the Tribal Nations to determine what sort of funding or technical assistance might be the most well received by the population.

# Identified Gaps

## Data Collection and Reporting Standardization

To understand the gaps in data it is important to understand each of the various sources collecting and reporting data within the State of Nevada. Currently, the State has multiple sources providing data and reporting rates of fatal and non-fatal opioid overdoses, SUD, OUD, and the corresponding demographic data. Each data set follows its own data collection protocols, criteria, and standards, which leads to different rates being reported for impact topic areas depending on the source being used. Each source also has its own limitations as detailed below in Table 3.5.

**Table 3.5: Current Data Sources and Limitations**

| Source | Description | Limitations |
|---|---|---|
| **Syndromic Surveillance** | Utilizes hospital emergency room (ER) data from the NSSP to report on the suspected overdose morbidity in the State.[42] | • NSSP data is only available from 80% of the State's hospitals.<br>• The data system only captures non-fatal overdoses that made it to the ER.<br>• Chief complaint ICD-10 codes that are reported as an overdose from a substance are "suspected" due to the lack of a urine drug screen or blood test to confirm substances. |
| **Vital Records Data** | Utilizes death certificate information from the Nevada Electronic Death | • Average two-three months delay after the death investigation to |

[41] *Nevada Center for the Application of Substance Abuse Technologies, Nevada State Opioid Response, and Nevada Department of Health and Human Services, Nevada State Opioid Response Grant II, Year 1: September 20, 2020-September 29, 2021 Annual Performance Progress Report, 2021.*

[42] Forensic Toxicology & Nevada's Overdose Surveillance System. 2020.

| Source | Description | Limitations |
|---|---|---|
| | Registry System to report on overdose mortality in the State. This source relies on ICD-10 codes. | receive cause and manner of death data.<br>• Use of ICD-10 codes that group multiple opioids together, making it difficult to separate specific opioids that may have been attributed to deaths.<br>• Complete toxicology and information about the circumstances preceding death are unavailable. |
| **Nevada SUDORS** | Utilizes death certificates and coroner/medical examiner reports (including post-mortem toxicology testing results) to capture detailed information on toxicology, death scene investigations, route of drug administration, and other risk factors that may be associated with a fatal overdose.[43] | • Reporting delays due to time required to abstract data from death records.<br>• Incomplete data due to reliance on information documented at the time of death. |
| **ImageTrend** | Statewide surveillance system utilized by the state Emergency Medical Services (EMS) program. ImageTrend is used to collect and analyze data for EMS and Fire and Rescue programs, which may include data regarding critical care transportation, hospital-based medical registries, overdose due to substance use, and integrated health care and community paramedicine. This system provides real-time location information that can be monitored by communities as well as supporting data collection for Overdose Data Mapping Application Program (ODMAPS).[44] | • Disconnect between EMS transport records and hospital care.<br>• Used ad hoc and not for regular reporting. |
| **ODMAPS** | Nevada has been working toward implementation of HIDTA's ODMAPS to gain a better understanding of overdose morbidity and mortality rates. The program design requires participation by law enforcement and first responder agencies or an automated interface with ImageTrend to transfer the data. | • Slow uptake by law enforcement.<br>• Lack of an automated interface with ImageTrend. |

[43] University of Nevada, Reno, School of Public Health, Forensic Toxicology & Nevada's Overdose Surveillance System; Needs Assessment & Recommendations. 2020.

[44] ibid.

Based on the data source limitations and the lack of standardization, the data available is often inconsistent and does not allow for the most accurate picture of the current state of the opioid epidemic in Nevada. The lack of standardization and reporting hinders the accessibility of key information such as demographic information, which is needed to assess the challenges being faced by certain populations.

While data are available for the rates of prescribing of opioids within Nevada, limited data are available for other drugs that are being co-prescribed along with opioids. There is also a lack of demographic data made available for those receiving opioid prescriptions. While PDMP also tracks high volume prescribers, data are not made available to understand areas of high volume prescribing or the changes in prescribing habits following notice from the PDMP.

Different organizations within Nevada are also collecting and calculating different process and outcome metrics to assess the impact of the opioid epidemic and drive change. However, often metrics may be named similarly and appear to capture the same information but the data being used and the way the metric is calculated is different. The limitations and caveats also may vary which does not allow for true comparison and aggregation of results.

## Availability and Robustness

1. Currently, there is limited data available when it comes to race/ethnicity and special populations. Overall, there is a universal lack of detailed data that provides key characteristics that help support the identification of the potential contributing factors of overdoses, SUD and OUD, which in turn limits the development of the most effective interventions.
2. Key Areas with Data Gaps
    A. Black, Native American, and Alaskan Native opioid-related overdose deaths and substance use populations
    B. Special Populations:
        i. Homeless
        ii. Veteran
        iii. Pregnant Women
        iv. LGBTQ+
    C. Prescribing Data
        i. Demographic data
        ii. Co-prescribing

There are plans for the State to develop an all-payer claims database that will contain information relating to health claims from medical, dental, and pharmacy benefits provided in Nevada. An advisory committee will make recommendations on the analysis and reporting of the data, as well as data security and how it will be released. All public and private insurers will provide data for the database, with some exceptions. Data to directly identify the patient

will be removed from the claim, and each claim will receive a unique identifier. Requests for data will be submitted to the DHHS.[45] This effort may help to reduce the gaps currently being seen regarding data.

## Health Equity

There are gaps in the data needed to properly address issues with health equity. Nevada also has a high population of minorities including 27 federally recognized tribes. While Nevada has a high number of individuals that are living in poverty, not native to the United States or are unauthorized immigrants, data to capture the true population and their health status are not available. Efforts need to be made to increase access to care and the recommendation to improve data capture will support these efforts.

[45] SB40 Overview, 2021 81st Session. Available at: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7216/Overview

Section 4

# Polysubstance, Co-Occurring Behavioral and Physical Health Conditions, and Suicide Impact

## Polysubstance Use

Polysubstance use in Nevada has been on the rise from 2019–2020, there were increases in overdose deaths involving one or more substances by 16%, opioid and one or more substances by 4%, and stimulants and one or more other substances by 17%.[46] While there was a 99% increase in opioid and stimulant overdose deaths in rural regions from 2019–2020, Clark County experienced a 155% increase in overdose deaths involving opioids and benzodiazepines. Among the counties, Washoe County had the highest rate of overdose deaths attributable to both the combination of opioids and stimulants and the combination of opioids and benzodiazepines.[47]

The Nevada HIDTA found several polysubstance issues when reviewing both drug trafficking and use in the State of Nevada. Many of the substances coming into the State originate in Mexico and are brought across the border through various methods from personal vehicles to commercial vehicles. Mexican drug trafficking organizations continue to be the predominant source of supply for the major drug types in Nevada. It is anticipated that the Mexican drug trafficking organizations in Nevada will continue to utilize violence to expand and maintain their operations and control within an area.

Geography presents one of the challenges both in polysubstance availability in Nevada and distribution in surrounding areas. As Nevada has a largely desert landscape with many mountain ranges, highways have minimal traffic and allow for transportation of narcotics on interstates that connect to California, Utah, Arizona, and other areas on less traveled transportation routes. The geography of the State presents challenges to prevent access to substances by law enforcement in addition to the challenges of addressing addiction and overdose. In addition, as drug traffickers become more technologically well informed, the use of the dark web for drug trafficking will become more common and increase access to illegal substances. Other methods of drug trafficking that continue to become increasingly common include Snapchat and Instagram, especially fentanyl laced pills.

One of the primary substances identified included methamphetamines, leading to constant supply and demand and an increase in methamphetamine overdose deaths. In part due to the low cost of making the drug, purity levels are greater than 97%; therefore, the supply is extremely potent while pricing is extremely low. Meanwhile, methamphetamine arrests declined in 2020 by 11%, although the overall rate of methamphetamine arrests accounted for 61% of all drug related arrests in Las Vegas. The age range accounting for most of the

[46] Nevada State Unintentional Drug Overdose Reporting System Polysubstance Report, 2019-2020 – Statewide. Available at: https://nvopioidresponse.org/wp-content/uploads/2019/05/sudors-polysubstance-report-2019-2020.pdf

[47] Ibid.

methamphetamine-related arrests were 25–34 year old adults followed closely by 35–44 year old adults. Data received from both the Clark County Office of the Coroner/Medical Examiner and the Washoe County Regional Medical Examiner's Office indicated that methamphetamine is still the most prevalent illicit drug encountered in overdose deaths followed by fentanyl in 2020.

Opiates, especially fentanyl and heroin, were also identified as high threat substances, in part due to increased availability, seizures, arrests, and overdoses. Fentanyl has increased in risk, with 196% increase in fentanyl overdose deaths between 2019 and 2020. The 2020 Nevada HIDTA report indicates fentanyl has surpassed heroin as Nevada's second biggest threat following methamphetamines. The HIDTA notes various combinations of fentanyl available. The most common combination reported was fentanyl-laced pills combined with oxycodone as well as fentanyl-laced pills combined with Xanax. According to the DEA 2020 National Drug Threat Assessment, illicit fentanyl presents a major concern in the ongoing opioid crisis in the United States. The National Drug Helpline placed Nevada on "red alert" status for increased risk of death from overdose.

While not as high of a risk as methamphetamines and opioids, cocaine was also identified as a substance of concern by HIDTA. Between 2019 and 2020, cocaine seizures increased 94% in Southern Nevada and 175% in Northern Nevada. Cocaine-related overdose deaths increased 39% in Clark County and 56% in Washoe County in 2020.

Both the Clark County Office of the Coroner/Medical Examiner and the Washoe County Regional Medical Examiner's Office also indicated that in 2020 heroin, cocaine and methylenedioxy-methampehtamine had an increase in overdose deaths. According to the CDC, although deaths involving prescription opioids declined between 2017 (276) and 2018 (235), heroin-involved deaths and those involving synthetic opioids other than methadone (mainly fentanyl and fentanyl analytics) remained stable with 108 heroin deaths and 85 synthetic opioid deaths in 2018.[48]

Nevada has recognized the need to address polysubstance use as part of its response to the opioid crisis. The Las Vegas-based eighth Judicial MAT Re-Entry Court has expanded the population that they can serve with SOR II funds allowing them to enroll individuals with a stimulant use disorder into the program; the first client was admitted in March 2021.[49] The need for additional treatment options for polysubstance use persists. Although initial steps have been taken, an additional review of existing treatment options for best practices for those using multiple substances will assist in improved treatment options and outcomes. Gold standard options for treatment of opioids such as MAT do not address the additional needs of individuals with methamphetamine or other addictions, which will also need to be addressed simultaneously during treatment.

[48] Nevada HIDTA Investigative Support Center, *2021 Threat Assessment,* 2021.

[49] Nevada Center for the Application of Substance Abuse Technologies, *Nevada State Opioid Response, and Nevada Department of Health and Human Services, Nevada State Opioid Response Grant II, Year 1: September 20, 2020-September 29, 2021 Annual Performance Progress Report,* 2021.

# Co-Occurring Behavioral Health and Physical Health Conditions

## Behavioral Health

It is common for individuals who have a SUD to also have a co-occurring behavioral health disorder. Although robust data is not available to analyze the co-occurrence of specific mental health diagnoses with substance use, the national data on co-morbidity combined with Nevada-specific information on the prevalence of common mental health diagnoses can offer a glimpse into the magnitude of the issue. In 2019, Nevada EDs handled 114,443 visits related to behavioral health disorders.[50] The behavioral health disorders most often documented included anxiety, depression, bipolar disorder, and schizophrenia. The behavioral health disorders that contributed to the most inpatient hospital stays included anxiety, depression, suicidal ideation, bipolar disorder, and post-traumatic stress disorder.[51] A national cross-sectional study found that approximately 19% of adults with a behavioral health disorder also used opioids and 16% of individuals who have a behavioral health disorder receive over half of all opioids prescribed in the United States in 2017.[52] In 2020, approximately 34.5% of individuals who died due to a drug-related overdose in Nevada had a co-occurring mental health problem.[53] Currently data are limited when it comes to co-occurring mental health disorders among those who use opioids. While data are available indicating whether a co-occurring mental health condition was present, information on the types of behavioral health conditions and the demographics of those individuals are not available, mostly due to how overdose death data is reported.

## Physical Health

SUD is also often accompanied by physical health conditions. Chronic pain conditions, tobacco use, and infectious disease are strong contributors to SUDs, especially OUD. Approximately 10% of people with chronic pain disorders misuse prescription opioids.[54] The Nevada DHHS Office of Analytics Prescription Drug Monitoring Program Dashboard provides the Top 10 ICD-10 diagnoses in which an opioid was prescribed for less than 30 days, greater than 90 days, and 30–90 days. As detailed in the figure below, top diagnoses associated with opioid prescriptions include musculoskeletal issues, nervous system issues, dental issues, and OUD.

[50] Nevada Department of Health and Human Services Office of Analytics, *Bureau of Behavioral Health Wellness and Prevention 2020 Epidemiologic Profile*, 2021. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Bureau%20of%20Behavioral%20Health%20Wellness%20and%20Prevention,%20Epidemiologic%20Profile%20for%20Nevada,%202020.pdf

[51] Ibid.

[52] Davis, M.A., Lin, L.A., Liu, H. & Sites, B.D. (2017). Prescription opioid use among adults with mental health disorders in the United States. Journal of the American Board of Family Medicine. 30 (4) 407-417.

[53] Department of Health and Human Services, *Nevada State Unintentional Drug Overdose Reporting System: Report of Deaths 2019 to 2020 – Statewide*. Available at: https://nvopioidresponse.org/wp-content/uploads/2019/05/sudors_report_2019_2020.pdf

[54] National Institute on Drug Abuse, *Common Comorbidities with Substance Use Disorders Research Report*, accessed February 2022. Available at: https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-2-co-occurring-substance-use-disorder-physical-comorbidities

**Figure 4.1: Top 10 Diagnoses for Opioid Prescriptions with Supplies less than 30 Days, Greater than 90 Days, and 30–90 Days[55]**

| Less than 30 Days | Greater than 90 Days | 30–90 Days |
|---|---|---|
| • Diseases of the Nervous System, Pain not elsewhere classified<br>• Dorsalgia<br>• Other joint disorder, not elsewhere classified<br>• Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders<br>• Dental caries<br>• Spondylosis<br>• Diseases of pulp and periapical tissues<br>• Pain, unspecified<br>• Abdominal and pelvic pain<br>• Opioid related disorders | • Dorsalgia<br>• Other joint disorder, not elsewhere classified<br>• Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders<br>• Diseases of the nervous system, pain, not elsewhere classified<br>• Migraine<br>• Neuralgia<br>• Other and unspecified osteoarthritis<br>• Spondylosis<br>• Other spondylopathies<br>• Polyosteoarthritis | • Dorsalgia<br>• Thoracic thoracolumbar, and lumbosacral intervertebral disc disorders<br>• Spondylosis<br>• Diseass of the Nervous System, pain, not elsewhere classified<br>• Other joint disorder, not elsewhere classified<br>• Intraoperative and post procedural complications and disorders of musculoskeletal system, not elsewhere classified<br>• Cervical disc disorder with radiculopathy, unspecified cervical region<br>• Other spondylopathies<br>• Neuralgia<br>• Osteoarthritis of knee |

For people suffering from OUD who inject the drug there is a high rate of transmission and contraction of viruses such as hepatitis C, hepatitis B, and HIV. These viruses are often found in the OUD population.[56]

In the July 2019 edition of the CDC's Morbidity and Mortality Report, the CDC studied the bacterial and fungal infections of persons who inject drugs in Western New York, an area with a high rate of opioid overdoses.[57] This study also noted the occurrence of endocarditis, osteomyelitis, pneumonia, bacteria, empyema, and septic arthritis infections among people who use opioid intravenously. Approximately 24% of the people who use opioids with these types of infections were hospitalized for at least 30 days. Bacterial and fungal infections such as infective endocarditis, osteomyelitis, central nervous system abscesses, and skin and soft tissue infections are also associated with SUDs.[58] The CDC also found that bacterial infections were commonly found among opioid users who inject drugs.[59] Approximately 74% of the opioid users included in the study had infections in the skin and soft tissue. The data this study had a few limitations such as that the number of bacterial and fungal infections was likely underestimated due to lack of outpatient visit information and those who did not seek care, and medical records do not always specify the route of drug administration. The study does provide insight into the type of infections that could be seen and interventions that could help to avoid these types of infections and the cost of care that is associated with these diseases. The CDC notes that while the study is limited to a small population, that does not

[55] Source: Nevada DHHS Prescription Drug Monitoring Program Dashboard, data for 2021.

[56] Centers for Disease Control and Prevention, *Persons who Inject Drugs: Infections Diseases, Opioids, and Injection Drug Use,* https://www.cdc.gov/pwid/opioid-use.html#:~:text=A%20deadly%20consequence%20of%20the,cause%20heart%20infections%20(endocarditis%20).

[57] Hartnett, K., Jackson, K., et al., "Morbidity and Mortality Weekly Report: Bacterial and Fungal Infections in Persons Who Inject Drugs – Western New York", 2017. Available at: https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6826a2-H.pdf

[58] MCCarthy, N., Baggs, J., See, I., Reddy, S.,C., Jernigan, J.A., Gokhale, R.,H. & Fiore, A.A. (2017). Bacterial Infections Associated With Substance Use Disorders, Large Cohort of United States Hospitals, 2012–2017. Clinical Infectious Diseases. 71(7) e37-e44. Available at: https://academic.oup.com/cid/article/71/7/e37/5697426

[59] Hartnett, K., Jackson, K., et al., "Morbidity and Mortality Weekly Report: Bacterial and Fungal Infections in Persons Who Inject Drugs – Western New York", 2017. Available at: https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6826a2-H.pdf

lessen the point that these skin and tissue infections could be prevented by proper hand hygiene and cleaning the site prior to injection. Education regarding hand hygiene and safe equipment could have a positive impact on these rates.

## Suicide

As of 2019, Nevada ranked seventh in the nation for the highest number of suicides with a rate of 19.8 per 100,000 persons.[60] A little over 600 people die by suicide each year in Nevada, with approximately 12% occurring in youth.[61] In 2019, suicide was the leading cause of death for 10–17 year olds and the second leading cause of death for 18–24 year olds. From 2017–2020, youth suicide rates were highest in males (75.3%), occurring mostly in White and Hispanic populations (46.8% and 28.6%, respectively). Of the 23 non-transport accidents that occurred between 2017 and 2020, all but one were the result of a drug overdose.[62] SUDORS data has found that in 2020, 9.9% of those who died due to a drug-related overdose had a history of suicidal thoughts, plans, or attempts and 6.1% had a history of attempting suicide.[63] Suicide also ranks as the ninth primary cause of death among veterans in the United States. Approximately 2% of veteran deaths in Nevada were due to suicide between 2017 and 2020.[64] From 2016–2020, approximately 88% of veteran's who died by suicides were White, 5% were Black, and 3% were Hispanic. Veteran suicides are occurring at the highest rate among individuals 20–34 years of age.[65] SUDORS data captured that 6.6% of drug-related overdose deaths occurred in active duty military members or veterans, though the delineation between active and veteran is not able to be distinguished due to how the data is captured. There is limited data available when it comes to suicides that involve drug or more specifically opioid overdoses. Information about death from suicide can often be challenging to collect as hospital records may include multiple methods.

In 2019, the National Institute on Drug Abuse and the National Institute of Mental Health collaborated to highlight the relationship between suicide deaths and the opioid crisis. Both the National Institute on Drug Abuse and National Institute of Mental Health call for collaborative care models to treat people for both OUD and co-occurring mental illness. Nevada's consistently high rankings for suicide deaths underscores the need to attend to both.

Nevada has been making efforts toward suicide prevention. Two positions within the Nevada Office of Suicide Prevention were established to coordinate with hospitals throughout the State to initiate the adoption and implementation of Zero Suicide and begin to introduce Crisis Now to communities. The coordinators provide ongoing technical assistance to nine of the 12 hospital systems from the first learning series that occurred from April 2020 to August 2020. Community of Practice (COP) meetings were occurring monthly to provide formalized

[60] Department of Health and Human Services: Office of Analytics, *Youth Suicide: Behaviors and Circumstances,* Nevada 2020. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Youth%20Suicide%20Behaviors%20and%20Circumstances%20Nevada%202020.pdf

[61] Ibid.

[62] Ibid.

[63] Nevada Department of Health and Human Services, *Nevada State Unintentional Drug Overdose Reporting: Report of Deaths 2019 to 2020 – Statewide.* Available at: https://nvopioidresponse.org/wp-content/uploads/2019/05/sudors_report_2019_2020.pdf

[64] Department of Health and Human Services, Office of Analytics, *Special Surveillance Report Veteran Suicide*, November 2021. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Veteran%20Suicide%20Report%20November%202021.pdf

[65] Ibid.

technical assistance for participating hospital systems in addition to personalized intensive technical assistance.

Coordinators completed the last COP meeting on August 3, 2021. COP meetings resumed quarterly in late 2021. These quarterly meetings provide implementation updates from the teams and their organizations. Four of the teams are working to implement their policies and procedures.[66]

Additional training and education under the Zero Suicide Initiative for the school system, parents, law enforcement, and other community partners will assist in efforts toward reducing suicide rates and assisting with early detection of intent for harm reduction.

# Identified Gaps

## Polysubstance Use

In the area of polysubstance use, Nevada would benefit from a review of treatment programming to include the application of evidence-based practices to polysubstance use in treatment protocols. Although some efforts have been made such as the expansion of individuals able to be served by the Las Vegas-based eighth Judicial MAT Re-Entry Court to include those with a stimulant disorder, interventions for people who use multiple substances should be available statewide. Continued focus on solely addressing opioid disorders will not be as effective if treatment protocols for co-occurring use of stimulants and other substances is not a part of an integrated treatment plan.

## Co-Occurring Behavioral Health and Physical Health Conditions

Currently, data are not available to accurately capture co-occurring behavioral health and physical health conditions within Nevada's OUD population. Hospital and death data may be able to provide more insight if improvements are made in reporting standards and data availability. The DHHS Office of Analytics PDMP dashboard provides a glimpse into the physical health conditions with the most opioid prescriptions. However, it does not provide insight into the individuals receiving the prescriptions. The rankings of Nevada with respect to access to mental health care for adults (42nd in the country) and youth (51st in the country) suggest that mental health treatment is a significant gap, not only for people with co-occurring disorders, but also for those at higher risk of an OUD due to a mental illness. Being able to access key information regarding the recipient will allow for the development of targeted interventions.

## Suicide

Nevada has made strides in addressing suicide risk factors, including substance use as a risk factor for heightened suicidality. While data are collected for suicides that occur due to drug overdoses, a deeper dive could be performed to understand, which drugs are being used and how populations, especially minority and special populations, are being affected. Continued intervention efforts such as Zero Suicide and Crisis Now will be helpful for individuals at risk. In addition, continued training on suicide risk factors and signs, and interventions applicable to suicide and substance use in the school system, for parents, law

[66] Nevada Center for the Application of Substance Abuse Technologies, *Nevada State Opioid Response, and Nevada Department of Health and Human Services, Nevada State Opioid Response Grant II, Year 1: September 20, 2020-September 29, 2021 Annual Performance Progress Report*, 2021.

enforcement, and other community partners will assist in reducing stigma and assisting in identifying individuals at risk. Such education may promote earlier intervention and decreased risk for lethality. In addition, like the gap in treatment for the use of multiple substances, collaborative care for those at risk for suicide who are using substances would be a gold standard treatment model. Such a model would address whole person care and assist providers trained in a collaborative care model to address the integrated needs of the individual, leading to improved whole person outcomes.

# Section 5
# Risk Factors

Multiple risk factors contribute to opioid use, both on a system level and an individual level. While an individual may have numerous resources available within their community (system) they may still have individual circumstances or health conditions that place them at an increased risk for OUD. On the other hand, individuals in a system with gaps in care and insufficient resources are at increased risk regardless of their own circumstances or health conditions. Some risk factors also exist when prevention and harm reduction measures are present but not widespread enough to be effective, making lack of access to these interventions a risk factor. Individual factors may include early trauma, social determinants of health (SDOH) such as transportation and housing, and involvement with the criminal justice system.

## System-Level Risk Factors – Risk Mitigation and Systemic Supports

In June of 2019, Nevada completed a system-wide assessment using Substance Abuse and Mental Health Services Administration's (SAMHSA's) Calculating an Adequate System Tool (CAST). The results of the tool indicate areas of least resources and therefore greatest overall risk for substance misuse-related hospitalizations, broken out by county and by Regional Behavioral Health Policy Boards. Of Nevada's five regions, only Nevada's mostly rural Northern Region fell below the national median for risk for hospitalizations, meaning the rest of the regions of the State are equal to or greater than the national median for substance use-related hospitalization risk.

### Prevention Programming

Nevada offers American Society of Addiction Medicine (ASAM) level 0.5 with no prior authorization, although there is a limit to one screening per ninety days. Nevada notes in its 1115 SUD Demonstration Waiver application that the 0.5 ASAM level of care is both early intervention and prevention. This level of care assists providers in identifying individuals to be screened for referral to treatment. According to the 2020 Medicaid data, there is not likely sufficient screening for SUDs, especially under the State's Medicaid managed care system and in rural areas. Billing encounters indicate that for Screening, Brief Intervention, and Referral to Treatment (SBIRT), which encompasses substance use and alcohol screening, most screening is being done under fee-for-service (FFS) in Clark County (690 claims). Only 91 claims were reported for SBIRT under managed care organizations (MCOs), almost all in Clark County. Rural areas only had 28 total SBIRT claims for the year.[67] There is no evidence that adequate screening in primary care and other settings is being accomplished.

Another area of prevention programming in Nevada is the Prescription Drug Abuse Prevention Act, which was signed into law in June of 2017, and went into effect on January 1, 2018. The legislation requires doctors and hospitals to report drug overdoses to the State, which allows licensing boards access to PDMP data to review inappropriate

[67] Data obtained from the Nevada Department of Health and Human Services on January 11, 2022.

prescribing and dispensing of controlled substances and requires providers to conduct a risk assessment before prescribing a controlled substance. In addition, for prescriptions over 30 days, an agreement must be created with the patient and patient utilization must be reviewed every 90 days. The system prohibits patients from receiving more than 365 consecutive days of medication.

The 2019 system-wide assessment using SAMHSA's CAST also included a review of prevention capacity across the categories of school-based prevention programs, community-based prevention programs, housing vouchers for homeless residents, needle exchanges, and prescription drug disposal events and locations. A lack of capacity was noted for all of Nevada's regions in the categories of community-based prevention programs, housing vouchers for homeless residents, and needle exchanges. One of five regions was rated to have sufficient capacity in school-based prevention programs (Southern Rural Region) while three regions, Northern, Rural, and Southern Rural, were rated to have sufficient capacity in prescription drug disposal events and locations. At the Statewide level, all prevention categories were rated to have insufficient capacity relative to need.

The 2019 CAST identified prevention services as the second highest collective need for Nevada, based on a comparison of regional priorities. Noted prevention needs included school-based prevention programs in the Washoe Region, prescription drug disposal locations and events in the Southern Rural region, and housing vouchers and affordable housing programs in the Northern and Southern regions of Clark County and Washoe.

The CAST also noted the location of a regional Prevention Technology Transfer Center in Nevada, which provides training and technical assistance services to the substance misuse prevention field. The Prevention Technology Transfer Center supports the substance misuse prevention workforce with evidence-based and promising substance misuse prevention interventions.

Public perception supporting the use of State resources to promote prevention appears to be limited according to a 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey. The survey found that only 35.2% of respondents agreed or strongly agreed that taxpayer money spent to prevent the misuse of drugs is money well spent.

Nevada's Office of Public Health Informatics and Epidemiology (OPHIE) collects and analyzes disease information, making recommendations concerning prevention and education in collaboration with multiple agencies in the State. The OPHIE has access to multiple databases of information and provides the National Outcome Measures data for the State's reports to SAMHSA. Collected information includes social determinant of health factors such as housing that play a role in both prevention efforts and treatment outcomes.[68]

Nevada noted in their 1115 SUD Demonstration waiver application that continued efforts to increase prevention programming would be a part of the demonstration. Progress has been made in prevention on the provider side. However, additional interventions for patients would also be of use, both for the public and in the school system to target youth. Many nationally recognized curricula and best practices exist, including information from SAMHSA and the

[68] Section 1115 Demonstration Waiver. *Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project.* State of Nevada Department of Health and Human Services. September 2021. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MeetingArchive/PublicHearings/2021/SPA_PH_10_26_21_NV_1115_Waiver.pdf

CDC. These could be used to expand prevention efforts in health class curricula or other targeted areas within the school setting.

## Access to Treatment – In-Person and Telehealth

A July 2019 report estimated that 400,000 Nevadans who need substance use treatment in a year do not receive it. Access to treatment encompasses access to everything from crisis intervention to outpatient through longer-term residential services. Treatment availability was found to be the most significant and immediate need for residents with OUDs. Nevada's June 2019 system-wide assessment using SAMHSA's CAST included a review of treatment capacity. In the category of outpatient treatment, the CAST identified a uniform lack of capacity relative to need in the areas of psychiatrists and psychologists specializing in SUD psychotherapy, Opioid Treatment programs (OTP), and Office-Based Opioid treatment (OBOT) offering only buprenorphine. Outpatient detoxification and licensed drug and alcohol counselors were each identified as having adequate capacity in three out of five regions and having adequate Statewide capacity overall relative to need.

Nevada has 15 OTPs, but only in Clark and Washoe counties, leaving 14 counties without an OTP.[69] OBOT is only available in 10 counties. In a State survey, most OTPs reported that they have additional capacity for treatment, indicating that either the people who need treatment are not able to access it (due to transportation, lack of knowledge of the system or stigma) or the treatment programs are not located in the areas where residents need them.

Qualitative data from the study conducted by the Nevada Minority Health and Equity Coalition also indicates difficulty accessing MAT services, especially in rural areas and on reservations.[70]

People with lived experience also noted that insurance often does not cover opioid treatment, long-term care for addiction is nonexistent among all communities within the State, duration of treatment is limited, and people must wait in their current environment while trying to detox before they can access rehabilitation.

In 2020, the Nevada State Medicaid Services Manual was updated to include a separate chapter for MAT services, making information on providing the service more accessible to interested providers and signaling the increasing dedication of Nevada to opioid treatment services.

While access to treatment is important, it is even more important to have access to quality treatment that is well coordinated. These services continue to be challenging in rural and frontier areas.[71] Nevada's analysis of OBOT providers found that a few of the OBOT providers were prescribing up to their DATA 2000 waiver capacity. The most significant barriers to serving more people were reimbursement, lack of time, and lack of referrals. Only about one fourth of the OBOTs that responded to the State's survey reported offering counseling, which is a best practice for MAT.

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[69] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[70] Nevada Minority Health and Equity Coalition, School of Public Health, University of Nevada Las Vegas, *Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada,* 2022.

[71] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

Nevada is currently expanding Certified Community Behavioral Health Center (CCBHC) capacity, with six CCBHCs under the Medicaid State Plan, three under a Centers for Medicare & Medicaid Services (CMS) demonstration, and six supported by a SAMHSA grant. CCBHCs offer critical services that can fill gaps in the service system, including opioid treatment, integration of physical and behavioral health care and 24/7 crisis services. The CCBHCs are expected to improve the quality of treatment provided in the community through attention to data-based outcomes and monitoring, as well as additional training requirements in best practice treatment models. However, currently the CCBHCs do not cover every geographical area, and many of the providers are relatively new to this model, so over time, impact on individuals with OUD is likely to increase as they gain more experience and more clients.

Higher levels of care such as withdrawal management and residential services can also be particularly skewed toward urban areas and difficult to expand due to infrastructure costs. The CAST inpatient categories of short-term rehabilitation (less than 30 days) and long-term rehabilitation (more than 30 days) were identified to have a lack of capacity relative to need in all regions of the State.[72] In June 2021, the State reported having 929 licensed residential and withdrawal management inpatient/residential beds classified as Institutions of Mental Disease (IMD), 95% of which are in Las Vegas, Reno, or Carson City. Nevada identified that 86% of withdrawal management and residential treatment beds are not eligible for Medicaid reimbursement for most adults under 65 due to their classification as IMDs under federal regulations. In the absence of the availability of these services for many Medicaid beneficiaries, beneficiaries have likely defaulted to either more expensive and potentially less effective care through multiple ED visits and regular inpatient hospital stays or under-treatment and less recovery with more crisis utilization.

In 2021, Nevada's plan to address significant gaps in the substance use services system through the 1115 waiver for SUD services was submitted for approval to CMS. The pending waiver includes the addition of residential and withdrawal management services for SUD (ASAM levels 3.1: Clinically Managed Low-Intensity Residential Program, 3.2: Clinically Managed Residential Withdrawal Management, 3.5: Clinically Managed Medium Intensity Residential Program, and 3.7: Medically-Monitored Inpatient Programs), opening up the 929 IMD beds for Medicaid payment for an average stay of 30 days for beneficiaries between the ages of 22–64, a previously excluded benefit, and providing case management for beneficiaries in IMD facilities who do not have a co-occurring mental health diagnosis (co-occurring diagnoses are already eligible for case management). Pending approval, the waiver's effective date could be January 1, 2023.[73] While this only refers to the Medicaid population, expanded funding for these services is likely to result in more providers offering the services and better sustainability and growth options for those already established.

## Special Populations and Health Equity

While Nevada-specific statewide data is not available, literature reviews and national data suggest significant disparities for racial/ethnic minority youth. Black youth with SUD-reported fewer specialty services, both Black and Latino youth reported receiving fewer informal

[72] Nevada Department of Health and Human Services, Division of Public and Behavioral Health, *Nevada Substance Abuse Prevention and Treatment Agency Capacity Assessment Report: Nevada,* 2019.

[73] Section 1115 Demonstration Waiver. *Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project.* State of Nevada Department of Health and Human Services. September 2021. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MeetingArchive/PublicHearings/2021/SPA_PH_10_26_21_NV_1115_Waiver.pdf

treatment supports due to several possible factors involving providers, environmental context, and community resources.[74] Another national study found that about half of youth who had been in detention did not receive needed treatment for substance use.[75]

Pregnant women in Nevada are also much less likely to receive needed opioid treatment. One study found that only 15% of women with an OUD who are covered under Medicaid received treatment. The underlying causes of a lack of treatment are complex and difficult to measure. Most often, the barriers to treatment for pregnant women include a lack of providers willing to provide MAT to pregnant women due to perceived and actual risks, stigma, and fear of losing custody of the child or other children in the household.

Although mental health and SUDs co-occur at a high rate, not all providers of SUD services are willing or trained to simultaneously treat both mental illness and SUDs, leaving people with co-occurring disorders at a disadvantage when seeking treatment. Fortunately, Nevada Substance Abuse Prevention and Treatment Agency (SAPTA) offers certifications to providers who meet certain criteria for treating co-occurring disorders, with 108 such certified facilities for adults and only 39 for adolescents.[76] This type of certification can help individuals to identify treatment providers who will better meet their needs.

Access to mental health care also impacts opioid treatment access and recovery, making the capacity of the mental health treatment system important to the State's opioid response. Unfortunately, Nevada has been ranked forty-second compared to all other states for low access to care and high prevalence of mental illness in adults. For youth, Nevada is ranked fifty-first in the country for mental health prevalence and treatment access.[77]

Rural and frontier areas are greatly impacted by the lack of local treatment programs. Both residential treatment programs and outpatient MAT are concentrated in urban areas of Nevada. A lack of transportation, especially for the long distances people must travel for specialized treatment, only exacerbates the disparity.

Access can be difficult to measure, especially when recent data reflects utilization during the COVID-19 pandemic restrictions. Treatment in Nevada's SAPTA facilities specializing in SUDs fell by 31% between 2019 and 2020,[78] likely due to COVID-19 restrictions and concerns in the community about the transmissibility of the virus. Not only has the pandemic exacerbated mental health and substance use issues, but also it has likely contributed to a pent-up demand now that vaccines are available and treatment providers have increased their availability in the last few months. More accurate comparisons of treatment need versus capacity are likely to become clearer in the coming months.

## Crisis Services

In addition to regular inpatient and outpatient services, a robust continuum of crisis services is essential for responding to opioid-related crises and ensuring recipients are effectively connected to treatment after the crisis. According to 2020 Medicaid data, there was a slight

[74] Alegria, Ml., Carson, M., et al., "Disparities in Treatment for Substance Use Disorders and Co-Occurring Disorders for Ethnic/Racial Minority Youth," *Journal of the American Academy of Child & Adolescent Psychiatry,* Volume 50, Issue 1, 2011.

[75] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[76] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[77] The State of Mental Health in America | Mental Health America, available at: https://mhanational.org/issues/state-mental-health-america

[78] Nevada Department of Health and Human Services, Office of Analytics, Nevada Overdose to Action, Hospital-based Overdose Data, 2021.

downward trend both in FFS and managed care Medicaid for ED utilization for SUDs, likely impacted by the COVID-19 pandemic.[79] Most recently, the first quarter of 2021 shows a rate of 352.1 per 1,000 FFS beneficiaries and 408.4 under managed care. In Medicaid, 2,408 people received a crisis service outside of the ED or inpatient setting in 2020. Nevada's crisis system could be enhanced in order to decrease some of the ED utilization for substance use and increase crisis response capacity.

As recommended by SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit,[80] Nevada has done a great deal of work to inventory their current crisis system. Planning is underway for the State's new 9-8-8 framework, a more comprehensive model for mobile crisis that includes a multi-disciplinary team of clinicians and peers and 24/7 in-person response among other best practices, and crisis stabilization units. Nevada already has a robust regional crisis call system through Crisis Support Services of Nevada, but the system cannot independently dispatch mobile crisis-type teams. There are crisis lines specific to regions and targeted to children and adolescents that do have the ability to dispatch specialized child mobile crisis teams as their limited capacity allows in Reno and Las Vegas. Furthermore, the mobile crisis element of CCBHCs is dispatched by their local CCBHC crisis line rather than through one of the other crisis lines, unless they happen to be contacted by 9-1-1 for co-response with law enforcement. Nevada is progressing in their system by planning for a more robust 9-8-8 service that is comprehensive, a single point of behavioral health crisis contact, and can potentially dispatch mobile crisis teams across the State.

Nevada's CCBHCs are filling needed gaps in mobile crisis in more populated regions, and many carry naloxone and other harm reduction tools and educational materials. The State's efforts to increase the availability of mobile crisis services to the whole community, with additional resources, should help decrease ED utilization and help those in an SUD-related crisis to connect to treatment and recovery resources.

Nevada has some innovative mobile crisis-type teams, including child mobile crisis teams that can respond in person in Reno and Las Vegas, but their capacity is limited and backed up by telephonic crisis line resources. Rural areas of Nevada have access to telephonic and televideo crisis care for adults and children, but the scope is more like that of a crisis call center. Law enforcement co-responder models with embedded behavioral health clinicians exist in Douglas and Lyon counties, Sparks City, Carson City, and Reno, but in most cases the behavioral health clinician is dressed in a uniform, which is not a preferred model of response, and due to limited team hours, the response is not usually immediate.

Las Vegas has a unique EMS mobile crisis model that is available only in a specific downtown area and is nearly available 24 hours per day and due to the advanced paramedics' scope of practice transportation can be offered directly to behavioral health facilities rather than going through an ED for medical clearance, but it is again limited in capacity. Nevada's CCBHCs are in various stages of refinement of their mobile crisis teams, and are not yet serving their communities to the capacity needed. Therefore, Nevada lacks a consistent and coordinated, in-person, 24/7 mobile crisis response system. Such a response system is essential for saving lives in overdose situations as well as ensuring that people receive appropriate follow-up care.

[79] Data received from the Nevada Department of Health and Human Services, January 10, 2022.

[80] Substance Abuse and Mental Health Agency, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, 2020.

However, significant gaps do exist across the State with respect to crisis services, as indicated in the Nevada Crisis Care Response System: Assets and Gaps report.[81] While the report focuses mostly on mental health services, not only are mental health issues frequently co-occurring with substance use, but also opioid use creates crises that can be addressed by the behavioral health crisis system. Along with the work being accomplished to implement 9-8-8 by the summer of 2022, expansion of mobile crisis teams that are trained in harm reduction and can carry naloxone are also essential to addressing the opioid crisis.

Crisis stabilization units that can address substance use concerns round out the missing pieces in the crisis continuum. Unfortunately, these only exist in urban areas, and they offer one bed per 100,000 residents rather than the recommended three beds per 100,000 residents. Expansion of these units is also essential to divert from EDs.

## Proper Discharge Planning and Transition

The 2020 Medicaid data[82] shows a need for improvement in both seven-day and 30-day Healthcare Effectiveness Data and Information Set measures of follow-up after an ED visit for alcohol and other drug use or dependence. While the average national Medicaid managed care rates were 13.8 for seven-day follow-up and 20.2 for 30-day follow-up in 2020, Nevada's MCOs ranged 10 to 16.9 for seven-day follow-up and 14.7 to 22.2 for 30-day follow-up, with a trend downward since the second quarter of 2020. For Medicaid FFS, which is mostly the rural counties, rates were flat at a range of 8.5 to 11.3 for seven-day follow-up and 13.2 to 17.4 for 30-day follow-up, with the highest rates in the third quarter of 2020. Additionally, re-admissions among beneficiaries with a SUD totaled 1,933 among FFS Medicaid and 2,732 for Medicaid members in managed care. This data supports the need for better discharge planning and transition for the SUD population.

### Harm Reduction Efforts

Fifty-one individuals from Nevada participated in a Community Based Participatory Research (CBPR) project by Nevada Minority Health and Equity Coalition, as part of the requirements for this needs assessment in SB 390.[83] CBPR is a unique framework for gathering information from those in the community with lived experience, ensuring that community members are empowered to not only respond with the requested information, but to also work as partners in both the research and resulting efforts toward improving health and impacting change in their communities. Urban respondents made up 75% of the participants while 23.5% were from rural areas. In the area of harm reduction, participants reported that they found harm reduction resources useful. However, barriers in urban areas included limited hours of operation and lack of education for the use of Naloxone. In rural areas, participants reported a significant lack of education on harm reduction resources and methods, harm reduction resources lacking privacy from the general public and from law enforcement, and lack of education on the addictive potential of opioids and alternative therapies for chronic pain and chronic illness.

Nevada has made progress in the area of integrated opioid treatment and recovery centers, which build services around individuals allowing for a more integrated care model that

[81] Nevada Department of Health and Human Services, Nevada's Crisis Care Response System: 2020 Statewide Assets and Gaps Analysis, 2020.

[82] Data obtained from the Department of Health and Human Services on January 11, 2022.

[83] Nevada Minority Health and Equity Coalition, School of Public Health, University of Nevada Las Vegas, *Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada,* 2022.

addresses SDOH and other comprehensive treatment needs. [84] Other innovative practices include peer support services and syringe vending machines. In 2013, syringe service programs (SSPs) were enacted, two of which serve Nevada's Urban Centers through mobile and storefront exchange, Trac B and Change Point. Southern Nevada Health District (SNHD) supports Trac B on efforts including vending expansion and technical assistance for other jurisdictions to implement public health vending, collaboration on outreach, rural expansion of harm reduction initiatives, linkage to care and peer support services, and alliance work, but does not fund the purchase of syringes. The syringe vending machines have allowed conversations with individuals around harm reduction and treatment. However, results of the 2019 statewide assessment using SAMHSA's CAST indicate that needle exchange capacity is low relative to need in all regions of the State. Qualitative data from a 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey underscores this finding with approximately one in four (25.1%) respondents reporting seeing discarded needles in their community. In the same survey, half of the respondents (50.0%) agreed or strongly agreed that a needle exchange program would increase the number of discarded needles on the street that some drug users can reuse, and 32.2% of respondents agreed or strongly agreed that needle exchange programs would increase overall injection use in the community.

Peer support promotes a workforce that can build relationships with individuals to encourage harm reduction efforts and understanding of issues such as stigma, allowing for self-determination in the harm reduction, treatment, and recovery process. Peer support services can also assist with outreach to minority populations and promote an increase in cultural competency through their lived experiences. Expansion of these services would allow for greater outreach to individuals living with SUDs, although implementation especially in rural and frontier areas can be challenging due to lack of available providers and programming.[85]

## Prescribing

Safe and appropriate prescribing is essential when it comes to harm reduction efforts. In 2018, it was found that person-level prescribing rates were highest in the older population. Nationally, approximately 26.8% of persons 65 years and older had filled at least one prescription for an opioid.[86] To avoid inappropriate prescribing, education, and monitoring are key.

SOR funding is also being used to enhance the skill of prescribers through in-person and on-line trainings, webinars and Project Extension for Community Healthcare Outcomes (ECHO) sessions. Project ECHO, currently offered by the University of Nevada, Reno, School of Medicine, provides a biweekly ECHO clinic on alternative pain management treatments. Topics of the trainings include:

- Mental Health Implications of Pain
- Motivational Interviewing for Patients with Chronic Pain

[84] Nevada Institute of Children's Research and Policy. (2019). Comprehensive community substance abuse prevention plan. University of Nevada

[85] Nevada Public Health Foundation, Nevada Department of Health and Human Services, and PACT Coalition, *Final Report of Nevada's Summit Proceedings,* 2019.

[86] University of Nevada Las Vegas, Nevada Institute of Children's Research and Policy, *Comprehensive community substance abuse prevention plan.* 2019.

- ED Discharge Scenarios
- Cognitive-Behavioral Therapy and Pain Management
- Strategies for Pain Patients
- How to Integrate Behavioral Health in the Primary Care Setting
- CDC Guidelines for Opiate Prescribing
- Informed Consent and Treatment Agreements

Increasing participation in these programs will help to ensure prescribers are safely and appropriately prescribing opioids while improving continuity of care.

The 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey of 669 respondents included questions around prescribing, 12.1% of the respondents reported being prescribed an opioid drug in the past year. Of those respondents, 85.3% were in Nevada at the time the drug was prescribed and 72.6% reported that their doctor and/or pharmacist provided them with information regarding the risks of becoming addicted to opioids.

### Recovery Support

Nevada's June 2019 Statewide assessment using SAMHSA's CAST reviewed the capacity of recovery supports in the categories of religious or spiritual advisors, 12-step groups, transportation for those receiving treatment, employment for those receiving treatment, educational support for those who have completed treatment, parenting education for individuals with a SUD, assistance obtaining housing and assistance obtaining health insurance.[87] The CAST identified variable capacity in recovery supports across all regions of the State. A lack of capacity was identified for religious or spiritual advisors in all regions of the State, and the categories of employment supports for those receiving treatment, assistance obtaining housing and assistance obtaining health insurance were also noted to lack capacity relative to need in four out of five regions of the State. Twelve-step groups, transportation for those receiving treatment and parenting education for individuals with a SUD were identified as having adequate capacity at the State level with a few regions noting gaps in those categories.

A small qualitative study of current and former opioid users indicated that these individuals found the various treatment and support programs to be fragmented and inadequate for the complexities of SUD. The study also noted that peer supports are extremely useful, not only in gaining trust for those in treatment, but also in offering recovery employment or volunteer opportunities.[88] They additionally noted that upon discharge from treatment, they were not educated on resources that would help maintain recovery. These individuals expressed a desire to be more integrated into the community, and identified a need for more employment support, volunteer opportunities, recovery centers, and faith-based organizations to round out a recovery-oriented system of care.

[87] Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Nevada Substance Abuse Prevention and Treatment Agency. *Capacity Assessment Report: Nevada,* 2019.

[88] Nevada Public Health Training Center, *Overdose Data to Action (OD2A): Formative research to investigate barriers and facilitators to accessing services among current and former opioid users in Nevada: Report of Key Findings and Recommendations,* 2021.

## Public Education

A small qualitative study of people who had or were currently using opioids revealed that many were unaware of their treatment options and the resources available for payment such as Medicaid, as well as how to access treatment and funding resources.[89] They expressed a lack of knowledge about the various facets of MAT, from what it is to how to access it. There are multiple training curricula available from federal agencies for use both in the general public and for school systems and providers. One resource is the SAMHSA, which provides tools such as the Opioid Overdose Prevention Toolkit[90] that can assist with education and outreach. Other potential options for education include public education campaigns that may consist of billboards, community events, or patient education materials in primary care offices or other settings.

Similar results were found by the Nevada Minority Health and Equity Coalition report from forums and interviews with 51 people with lived experience.[91] Not only did people in more rural areas report less knowledge of the risks of prescription opioids and recovery resources, but the family members of people who were in treatment experienced a great deal of anxiety due to a lack of understand of MAT and other recovery and treatment options. Overall, participants underscored the need for more public education and community understanding of the nature of addiction and the treatment process in order to combat stigma. Encouragement and a sense of community was felt to be necessary for the general public to better respond to addiction and decrease stigma.

## Provider Education

Nevada has an ongoing need for collaboration between pharmacists and physicians to reduce misuse of opioids and other prescription medications. One area of need is Collaborative Practice Agreements for all members of the individual's care team use to share information. Communication between practitioners can also assist in consolidating the different information that may be shared by the patient with each practitioner to ensure that medications are being prescribed and taken appropriately. This increases patient adherence and improves outcomes. Education for physicians on the corporate policies of pharmacies would also be a useful component of collaboration, as pharmacies may have policies on detailed ICD-10 codes or safety concerns about liability for overdose. Provider collaboration can also help to identify individuals who see multiple doctors in order to obtain prescriptions to sell. While time constraints may inhibit communication between practitioners, telephonic communication and consistent use of the PDMP can assist in the communication and improvement of prescribing protocols.

Prescribing patterns in pain management is another area of concern. The Nevada legislature passed AB 474 in 2018 to address the over-prescribing of opioids. There has been a 39% reduction in prescriptions for opioids since AB 474 has been implemented and a 56% reduction in co-administration. The legislation requires mandatory checking of the PDMP. A continued challenge is the expectation of patients to receive interventions that completely eradicate pain and the establishment of pain as a fifth vital sign, the only one of which is subjective. Continued education is needed for patients to recognize that the avoidance of all

[89] Nevada Public Health Training Center, *Overdose Data to Action (OD2A): Formative research to investigate barriers and facilitators to accessing services among current and former opioid users in Nevada: Report of Key Findings and Recommendations,* 2021.

[90] SAMHSA Opioid Overdose Prevention Toolkit, available at: https://www.samhsa.gov/resource/ebp/opioid-overdose-prevention-toolkit

[91] Nevada Minority Health and Equity Coalition, School of Public Health, University of Nevada Las Vegas, Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada, 2022.

pain may not be a reasonable expectation, and for prescribers to utilize or refer to options other than opioids for pain management, such as chiropractic intervention, acupuncture, nerve blocking, and mindfulness and meditation.[92]

Finally, stigma can be a significant problem in health care settings, especially among providers who do not specialize in substance use care.[93] The Nevada Minority Health and Equity Coalition reported that many respondents with lived experience reported avoiding seeking necessary health care, because of the negative, even belittling, treatment they received from health care providers.

### Education in Schools

In 2017, a group of medical students created the Healthier Nevada Youth Educational Modules, a curriculum to promote prevention in the Washoe County School District. A survey of students reported that 30%–35% of students in grades nine to12 had lived with someone who was a problem drinker, alcoholic, or had misused street or prescription drugs. Education in these areas is lacking in many schools. The Healthier Nevada Youth Education Modules were designed to educate youth on the impact of addiction, the opioid epidemic, and the use of naloxone.

In Washoe County School District, health class students in grades 9 to 12 were surveyed before and after a substance use and addiction presentation using a Likert scale scoring system.[94] The survey was designed to assess the students' understanding of SUDs, awareness of the opioid epidemic and naloxone use, as well as their attitudes about discussing these sensitive topics with health care providers before and after educational interventions. A total of 682 students were included in the training and given pre- and post-survey, which indicated overall improvement in the students' understanding of the substance use and addiction topics reviewed, 33% of students rated their understanding of the opioid epidemic as poor or very poor prior to the training. This number decreased to only 3% in the post-education surveys, 63% of students rated their understanding and awareness of naloxone (Narcan) as poor or very poor prior to the training versus 6% in the post-education survey. When asked if they would feel comfortable discussing sensitive information regarding substance use with their doctor, 19% of students initially reported that they strongly agreed. Including curricula such as this s as a routine part of health education programs would be a useful way to reach middle and high school students with drug education and prevention.

### Public Education Campaigns

According to information provided in a 2019 report by the Nevada Public Health Training Center, that summarizes Nevada's current efforts according to the Johns Hopkins Bloomberg School of Public Health recommendations, the Nevada SOR program supported a campaign to reduce stigma by increasing awareness about addiction being a disease. Nevada OD2A also partnered with Nevada Broadcasters Association to launch an anti-stigma campaign. *Prevention for States* funding through the CDC has supported an Rx awareness campaign called *Wake up Nevada*. Additional efforts include the SNHD OD2A project collaboration with

[92] University of Nevada Las Vegas, Nevada Institute of Children's Research and Policy, *Comprehensive Community Substance Abuse Prevention Plan*. 2019

[93] Nevada Minority Health and Equity Coalition, School of Public Health, University of Nevada Las Vegas, *Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada,* 2022.

[94] Substance Use and Addiction Education For Northern Nevada Youth Megan Rescigno; Alexa Allen; Dylan Meyer Pediatrics (2021) 147 222–223.

the Prevention, Advocacy, Choices, Teamwork coalition called *Back to Life*, which is a targeted campaign to reduce naloxone stigma with law enforcement.

Despite efforts, many people still report that stigma and the emotional toll it takes on their lives is a major barrier to recovery.[95] Stigma in the community also makes it more difficult to reintegrate into society because obtaining housing and employment is difficult when employers and property owners do not fully understand treatment and recovery. Stigma and shame contribute to anxiety over seeking help, especially among Veterans and tribal members.

The 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey identified two areas of action in the category of public education. The report recommended both educational prevention initiatives in the community for youth and providers, as well as community awareness initiatives on how to prevent drug use/misuse and reduce stigma.

### Workforce shortages

Workforce shortages present a key risk factor for individuals seeking treatment. Continued expansion of mobile treatment into the rural/frontier communities will allow more MAT options for individuals unable to travel for services. The State is continuing to investigate the purchase of mobile RVs to increase the presence of MAT opportunities in high need communities. In addition, the State is working on a hub and spoke model of delivering treatment where individuals will only have to come to the central hub on a minimal basis while receiving MAT, and other resources at the spokes of the hub more frequently. The spokes will be located in more areas, making it more likely that they will be closer to the individual's home in order to make adherence to treatment more manageable where issues such as childcare or transportation may present a challenge.[96]

Peer and Recovery Support Specialists (PRSS) have increasingly been shown to be an effective component of a substance use treatment continuum. SOR II funding was utilized to expand peer support services, resulting in 608 new clients receiving peer support assistance. Nevada is using SOR funding to place PRSS in the hospitals to assist with opioid emergencies. The first hospital to implement this was in Reno in June 2021, with brief mid-day shifts on weekends. By then end of the first month of services, day shifts were added. During the last week of August 2021, the team expanded operations in the hospital to 24/7. The team received 177 referrals or hand offs from the hospitals, completed 133 assessments, referred 109 people to treatment, transported 73 people to treatment, and successfully followed up with 49 people. The hospital has shown openness and acceptance of the team, with physicians, nurses, and a hospital Alert Team requesting the PRSS opinion in developing treatment plans and discharge plans. A second hospital, in Las Vegas, began using this model on November 1, 2021. Additionally, a peer warm line in Southern Nevada helps connect individuals to care, support, and information. In addition, three agencies were funded to provide.[97]

[95] Nevada Minority Health and Equity Coalition, School of Public Health, University of Nevada Las Vegas, Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada, 2022.

[96] Nevada Department of Health Care Finance and Policy, *Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity*, 2021.

[97] Nevada Center for the Application of Substance Abuse Technologies, Nevada State Opioid Response, and Nevada Department of Health and Human Services, Nevada State Opioid Response Grant II, Year 1: September 20, 2020-September 29, 2021 Annual Performance Progress Report, 2021.

Two agencies have developed and are staffing Mobile Recovery Outreach Teams to engage within emergency rooms and community agencies in Northern and Southern Nevada through SOR funding.[98] Continued development of mobile providers as well as the use of telehealth will assist in bringing providers to rural and frontier areas where a brick-and-mortar business model may simply not be feasible for a provider to establish themselves to deliver services.

### Addressing Disparities, Inequities, and Access

Statewide information on health disparities specific to substance use treatment, and especially to opioids, is limited or non-existent in Nevada. The SNHD publishes an easily accessible dashboard with some substance use data for the local community, and some Nevada 2-1-1 reports may offer clues to health disparities, but a more coordinated effort is needed on a statewide basis using data that can inform prevention, treatment, and recovery efforts.[99]

## Individual-Level Risk Factors – Social Situation and Comorbidities

The 2019 Nevada State Health Needs Assessment noted that the populations with the highest risk for SUD include those with behavioral health issues, seniors, children, low-income families, minority populations, homeless populations, veterans, individuals with intellectual and developmental disabilities, individuals with chronic disease, young adults and transition aged youth, and victims of domestic abuse/sex trafficking.[100] These co-occurring conditions impact individuals on both a systems and individual level, and interventions need to be planned both globally and locally.

### SDOH

The 2019 Nevada State Health Needs Assessment also flagged SDOH as a factor in SUD outcomes across all counties. SDOH barriers included lack of transportation, quality education, and vocational opportunities, while housing and lack of internet access were also highlighted.[101] A small qualitative study of 35 Nevadans with current or past opioid use reporting a lack of housing, transportation, food insecurity, and financial difficulties accessing services as barriers to recovery confirmed the importance of SDOH. People who have been involved in the justice system can also experience significant barriers to accessing post-release resources such as housing, which can contribute to the cycle of drug use and justice involvement.[102]

The Nevada Minority Health Equity Coalition's qualitative study reiterated the importance of transportation, work, and stable housing in recovery.[103] Respondents with lived experience were unanimous in their agreement that housing "is one of - if not the most - important indicator of success through recovery." Participants reported difficulty obtaining stable housing due to unfavorable background checks and long waits for housing that does not

[98] Nevada Center for the Application of Substance Abuse Technologies, Nevada State Opioid Response, and Nevada Department of Health and Human Services, *Nevada State Opioid Response Grant II, Year 1: September 20, 2020-September 29, 2021 Annual Performance Progress Report, 2021.*

[99] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[100] Ibid.

[101] Ibid.

[102] Nevada Public Health Training Center, Overdose Data to Action (OD2A): Formative research to investigate barriers and facilitators to accessing services among current and former opioid users in Nevada: Report of key findings and recommendations, 2021.

[103] Nevada Minority Health and Equity Coalition, School of Public Health, University of Nevada Las Vegas, *Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada,* 2022.

require background checks. They also noted that recovery takes a significant investment of time and requires consistency, as does holding down a job, and many times treatment and work requirements conflict with each other, putting income for housing at risk. Lack of transportation to treatment centers and an inability to pay for public transportation are further barriers. Additionally, participants cited the lack of a telephone and/or internet as major barriers to public education and communication with both case workers and family members, both of which could have increased their access to treatment and additional recovery supports.

One intervention Nevada has undertaken to address SDOH as a barrier has been to enable non-emergency secure behavioral health transport in the Medicaid State Plan to transport a person in a mental health crisis or other behavioral health condition to be taken to a treatment site. This effort should assist in increasing available transportation access to individuals who require a treatment intervention, but do not need an ambulance for transport.[104] Nevada does have Non-Emergency Medical Transportation benefit for the Medicaid population. However, transportation resources for individuals not covered under Medicaid are less available. In addition, tenancy supports have been explored as a potential method to assist individuals in recovery to remain in stable housing.

### Behavioral and Mental Health Comorbidities

Co-occurring mental health and OUDs are common in both adults and children. It is unclear whether the comorbidity of the conditions results from common risk factors for both, from mental illness increasing the likelihood of developing OUD, such as through self-medication of symptoms, or from substance use contributing to mental illness through physiological changes. Roughly half of the people who have a mental illness can expect to develop a SUD in the future, and about half of those with SUDs can expect to develop a mental illness.[105]

Although less often studied, comorbidity appears to be high between opioids and both anxiety and stress-related disorders and major depression. Numerous studies have found a higher chance of comorbidity with mental health diagnoses among people with OUDs than those without. One study reported that more than half of the annual opioid prescriptions across the country are given to individuals with depression or anxiety.[106] Additionally, people who are suffering from mental health disorders are more likely to use opioids in the long-term. SAMHSA reports that over a third of people who seek treatment for opioid use have a co-occurring mental health diagnosis.[107]

As many as 43% of people with an OUD who are in treatment for the OUD also have symptoms of another mental health disorder such as anxiety or depression.[108] Comorbidities can affect treatment and prognosis as well as risk for disorders. People who have bipolar disorder in particular experience more difficulty with recovery, and groups with anxiety, depression and bipolar disorder all experience more significant physical and psychological

[104] Nevada Department of Health Care Finance and Policy, Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity, 2021.

[105] National Institute on Drug Abuse, *Common Comorbidities with Substance Use Disorders Research Report,* 2020.

[106] Ibid.

[107] Substance Abuse and Mental Health Services Administration (SAMHSA), *Treatment Improvement Protocol (TIP) 42: Substance Use Disorder Treatment for People with Co-Occurring Disorders,* 2020.

[108] Goldner EM, Lusted A, Roerecke M, Rehm J, & Fischer B. (2014). Prevalence of Axis-1 psychiatric (with focus on depression and anxiety) disorder and symptomatology among non-medical prescription opioid users in substance use treatment: systematic review and meta-analyses. Addict Behav. 39(3):520-531. doi:10.1016/j.addbeh.2013.11.022.

symptoms than do people without a comorbid mental health diagnosis.[109] Conversely, having a mental disorder (e.g., personality disorder, mental illness, or another SUD) greatly increases the risk of non-medical opioid use. People who have both an OUD and a comorbid mental health condition are at higher risk of self-harm, especially when they have previously experienced trauma.[110] The Nevada Minority Health and Equity Coalition qualitative study also noted that respondents with lived experience reported the need for more mental health treatment during and after MAT in order to improve recovery outcomes.[111]

Such findings underscore the need to assess both conditions as well as use evidence-based approaches to both. Additionally, a *no wrong door* approach is essential for individuals seeking treatment for SUD and mental health conditions.

SAPTA performed a needs assessment and found that there is a critical need for treatment for youth with co-occurring disorders,[112] especially inpatient facilities of which there is one in the State that treats youth, making this a difficult service to access for both youth and their families. Treatment in SAPTA-funded facilities also decreased by 31% from 2019–2020.

### Physical Health Comorbidities

The CDC has found that individuals with chronic conditions who experience chronic pain (e.g., cancer, stroke, asthma, and obesity) have a higher likelihood of receiving one or more opioid prescriptions and therefore are at a higher risk of developing an OUD.[113] In fact, patients with two or more chronic conditions accounted for over 90% of opioid-related hospitalizations from 2011–2015.[114] The National Institute of Drug Abuse found that chronic pain conditions, cancer, and heart disease are common physical health disorders in those with SUDs.[115] More than 30% of individuals in the United States have some form of an acute or chronic pain disorder.[116] Approximately 10% of individuals with a chronic pain condition misuse prescription opioids, which indicates a strong need for careful pre-treatment screening, care plans that include non-pharmacological methods of pain management as well as education for providers on safe prescribing and for patients on safe use. Chronic pain conditions can also be exacerbated by behavioral health conditions. For example, individuals with chronic pain conditions are at an increased risk of depression and anxiety.[117] As mentioned in the previous section, having a behavioral health condition increases a person's risk for developing a substance used disorder. Per Nevada's DHHS Office of Analytics

[109] Zhu, Y., Mooney, L.J., Yoo, C., Evans, E.A., Kelleghan, A., Saxon, A.J., Curtis, M.E., & Hser, Y. (2021). Psychiatric comorbidity and treatment outcomes in patients with opioid use disorder: Results from a multisite trial of buprenorphine-naloxone and methadone. Drug Alcohol Dependence.

[110] Substance Abuse and Mental Health Services Administration (SAMHSA), *Treatment Improvement Protocol (TIP) 42: Substance Use Disorder Treatment for People with Co-Occurring Disorders,* 2020.

[111] Nevada Minority Health and Equity Coalition, School of Public Health, University of Nevada Las Vegas, *Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada,* 2022.

[112] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[113] Rajbhandari-Thapa J, Zhang D, Padilla HM, Chung SR. Opioid-Related Hospitalization and Its Association with Chronic Diseases: Findings from the National Inpatient Sample, 2011–2015. Prev Chronic Dis 2019;16:190169. DOI: http://dx.doi.org/10.5888/pcd16.190169external icon

[114] U.S. Department of Labor, *Risk Factors for Opioid Misuse, Addiction, and Overdose*. Available at: https://www.dol.gov/agencies/owcp/opioids/riskfactors

[115] National Institute on Drug Abuse, *Common Comorbidities with Substance Use Disorders Research Report,* 2020.

[116] Longo, D. *Opioid Abuse in Chronic Pain – Misconceptions and Mitigation Strategies,* New England Journal of Medicine, Issue 374 (2016), available at: https://www.nejm.org/doi/pdf/10.1056/NEJMra1507771?articleTools=true

[117] National Institute on Drug Abuse, *Common Comorbidities with Substance Use Disorders Research Report,* 2020.

PDMP dashboard, chronic pain disorders (e.g., dorsalgia, nerve pain, joint/muscle pain) are the top diagnoses for opioid prescriptions.[118]

As discussed in Section 4, use of intravenous opioids increases an individual's risk of developing blood borne diseases such as hepatitis C, hepatitis B, and HIV. It also increases the risk of developing skin and soft tissue bacterial and fungal infections. Hepatitis is a viral inflammatory disorder that often involves pain. Individuals with untreated hepatitis C may experience joint pain while those with hepatitis B may experience joint and abdominal pain due to the inflammation of joints and the liver. Individuals who contract HIV may also experience joint and muscle pain due to inflammation. Therefore, not only are people who use opioids intravenously at risk for contracting these diseases, but chronic pain associated with the diseases increases the likelihood of opioid misuse.

### Criminal Justice Involvement

A small qualitative study of people who are currently using or have used opioids indicated that some individuals experience a lack of community-based, accessible resources post-release, which they feel contributes to the cycle of drug use and justice involvement.

Efforts have been made to address the SUD needs of individuals involved in the criminal justice system. Insufficient supports upon re-entry presents a leading cause of relapse and overdose in this population. Engagement during incarceration is a crucial factor as individuals incarcerated are in a forced state of abstinence; therefore, more likely to relapse upon release. A warm handoff to a treatment provider such as a peer support specialist allows for improved access to community supports, as does the education of and the relationship with parole and probation officers about the needs of an individual struggling with substance use upon release.

Drug courts are another opportunity for improving SUD treatment and recovery in the criminal justice population. MAT is utilized across all courts with opioid programming and is now considered the standard of care.[119] Youth offender and re-entry programs have been incorporated into drug courts, addressing the needs of youth as well as adults. A strong relationship between probation/parole and the courts ensures access to treatment, case management and supports necessary to maintain recovery. Drug courts have also become increasingly invested in trauma informed care and SDOH such as housing to allow judges a full picture of the needs of the individual and assist in a focus on recovery rather than punishment. For the Washoe County Second Judicial Court, 92% of graduates of the State recidivism program remained arrest-free. A gap in services currently exists for this population as drug courts and services ranging from treatment to housing are not universally available, leading to a cycle of relapse and oftentimes re-incarceration.[120] Although Nevada has begun investing in these resources, there needs to be expansion to have them available Statewide.

The small qualitative study of individuals involved with opioids concluded that there is a significant need for transitional and clinical services for the justice population, especially

[118] Nevada Department of Health and Human Services Office of Analytics, *Nevada Prescription Drug Monitoring Program Nevada 2017-2022,* available at: https://app.powerbigov.us/view?r=eyJrIjoiYjgyYzkyMzctNDg0OS00ZGY1LWJiMWYtM2E0NDlkZjI0MmEyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

[119] Nevada Public Health Foundation, Nevada Department of Health and Human Services, and PACT Coalition, *Final Report of Nevada's Summit Proceedings,* 2019.

[120] Ibid.

post-release.[121] They cited long waiting lists, poor coordination in programs, an overall lack of programs, difficulties reinstating Medicaid and other challenges people leaving justice settings have in transitioning to care and housing in the community.[122]

A 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey that included 669 respondents included questions regarding public perceptions of drug misuse and justice involvement, 79.6% of the respondents agreed or strongly agreed that youth who use drugs are likely to commit crime, and 54.9% of respondents agreed or strongly agreed that non-violent criminal drug offenders should have access to various drug rehabilitation programs in Nevada. Half of the respondents (50.5%) agreed or strongly agreed that Southern Nevada should have a program that allows individuals to go to drug treatment therapy, rather than jail, if they have committed a non-violent minor crime and only 48.7% agreed or strongly agreed that treatment should be available to all individuals who misuse drugs.[123]

## Childhood Trauma/Adverse Childhood Experiences[124]

### Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is a national surveillance system that was established in 1991 by the CDC to monitor the prevalence of health risk behaviors among youth.[125] YRBS data are routinely collected on high school students and only a few states, including Nevada, collect data in middle schools. The Nevada Middle School YRBS is a biennial, anonymous, and voluntary survey of students in grades six through eight in regular public, charter, and alternative schools. This special report compares the 2019 Nevada YRBS prevalence estimates of behavioral health outcomes for students with various levels of exposure to adverse childhood experiences (ACEs).

The YRBS also reviewed high-risk behavior among middle school students and linked high-risk behaviors to ACEs scores. Of the students surveyed in 2019, 34.7% had three or more adverse childhood experiences and had made a plan to commit suicide in the 12 months prior to the survey, and 25.5% of those students responded that they had made a suicide attempt in the 12 months prior to the survey.

In terms of substance use, 62.3% of youth had three or more adverse childhood experiences and had used alcohol in their lifetime.

Of all of the students surveyed:

- 34.7% had used marijuana
- 4.7% had used cocaine
- 2.5% had used heroin

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[121] Alegria, MI., Carson, M., et al., "Disparities in Treatment for Substance Use Disorders and Co-Occurring Disorders for Ethnic/Racial Minority Youth," Journal of the American Academy of Child & Adolescent Psychiatry, Volume 50, Issue 1, 2011.

[122] Nevada Department of Health Care and Financing Policy, *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report,* 2020.

[123] Nevada Institute for Children's Research and Policy and the Cannon Survey Center, 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey Report, 2020.

[124] Additional results from ACEs and YRBS are included in Appendix B.

[125] Centers for Disease Control and Prevention, *2019 Youth Risk Behavior Survey Results and Data*, 2019.

- 3.2% had used methamphetamines
- 25.9% had used a prescription pain medication without a prescription or differently than prescribed

The high-risk behaviors of these students suggest that exposure to trauma is one risk factor for high-risk behaviors, such as suicide and drug use, in a younger adolescent population.

Nevada also administered the YRBS to high school students in 2019. For the 2019 High School YRBS, a random sample of youth from 99 schools completed the survey. ACEs scores were calculated for the 4,939 youth who answered at least one ACEs question.

When reviewing the high-risk behaviors for high school students, 33.7% with three or more high-risk behaviors had made a plan for how they would commit suicide in the 12 months prior to the survey.

Of all of the students surveyed:

- 19.7% had made an actual suicide attempt
- 77.9% had experimented with alcohol
- 56.3% had experimented with marijuana
- 9.9% had used cocaine
- 4.5% had used heroin
- 4.7% had used methamphetamines
- 33.6% had used a prescription pain medication without a prescription or differently than prescribed by the physician

The comparison between the middle school and high school populations indicates that risk factors increase as the adolescent grows older, leading to a higher probability of engaging in risky behaviors with age.

### Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) was established and sponsored by the CDC as a national system of health-related telephone surveys.[126] The main purpose of the BRFSS is to monitor and assess the prevalence of chronic disease, health-related risk behaviors, and use of preventive services among adults. The Nevada BRFSS is an annual anonymous voluntary telephone survey of adults (aged 18 years or older). This special report provides the combined 2018 and 2020 Nevada BRFSS prevalence estimates of behavioral health outcomes for adults with diverse levels of exposure to ACEs.

The BRFSS looked at more ACEs questions than the YRBS, having 11 questions over eight domains. The survey found that 29.9% of those interviewed had three or more adverse childhood experiences, for 1,393 individuals. High-risk behaviors of adults were also reviewed, 10.1% of individuals with three or more ACE scores also identified as heavy drinkers, 24.9% had used marijuana in the 30 days prior to the survey, and 21.1% had taken

[126] Centers for Disease Control and Prevention, *2020 BRFSS Data*, 2020.

a prescription drug without a doctor's prescription. Although the survey did not look at some of the same risk factors as the middle school and high school YBRS such as use of heroin or methamphetamines, the results indicate that adverse childhood experiences are also a risk factor for adults leading to increased probability of high-risk behaviors.

Enhanced supports utilizing evidence-based practices such as home visiting, and strategies to address trauma and ACEs are necessary for children and/or families that are impacted by opioid use or stimulant use. A growing body of literature suggests that child maltreatment and traumatic stressors have long-term consequences for adult health behavior and health outcomes. Growing evidence has shown that providing a family-focused approach will have beneficial effects on family members to support the recovery process and build resiliency and protective factors within the family structure. Family-focused programs include substance use prevention and treatment, in-home skills-based parenting programs that include skills training, education, counseling, Kinship Navigator Programs, residential parent-child substance use treatment programs, and developmentally appropriate transition supports with older youth and adolescents.[127]

### Regional Disparities and Challenges

Nevada Law (NRS 433.428, 433.429) created five behavioral health regions and a regional behavioral health policy board for each region. Each region employs a Regional Behavioral Health Coordinator (RBHC) to work with each health policy board. Funded partially through SOR II, each RBHC assists with the promotion and connection of SOR activities, programs and service provider organizations to stakeholders and partners throughout their respective communities. Each RBHC identifies and coordinates with other entities in the behavioral health region and throughout the State to review and identify issues relating to behavioral health. The RBHCs also develop an annual report, which includes the specific behavioral health needs of their respective region. SOR II project staff host monthly coordination meetings with the RBHCs.[128] Nevada's landscape is vast, and the various regions each face their own set of unique challenges. Urban areas may require different targets and support when compared to rural areas, therefore it is essential to assess each county to develop the most effective interventions.

### Workforce Shortages

The National Drug Helpline cited factors contributing to the risk of overdose fatalities such as reduced access to treatment programs, including EDs, lost health care capacities due to staff falling sick, increased social and economic stress and increased risk of suicide, particularly in individuals addicted to opioids. The COVID-19 pandemic has amplified the opioid crisis in many states, including Nevada. Rural health development continues to be limited by staffing shortfalls and limited resources while states are trying to expand MAT services. Nevada continues to lack behavioral health and medical providers, especially in the rural and frontier areas.[129] Eleven of Nevada's 16 counties are designated Health Professional Shortage Areas.

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[127] Nevada Center for the Application of Substance Abuse Technologies, *Nevada State Opioid Response, and Nevada Department of Health and Human Services, Nevada State Opioid Response Grant II, Year 1: September 20, 2020-September 29, 2021 Annual Performance Progress Report,* 2021.

[128] Ibid.

[129] Ibid.

Nevada introduced legislation to require insurers and other third-party payers, such as Medicaid, to provide telehealth parity for behavioral health services. AB 181, filed September of 2020, amends NRS 687B.404 to adhere to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which ensures that any insurer or other organization providing health coverage through Medicaid provides benefits for mental health or SUDs at equitable coverage at that of medical and surgical. SB 5, effective October 1, 2021, has instituted the requirement that telehealth data is collected and analyzed to improve equity. This incentivizes more providers to continue or expand their telehealth services, benefiting the rural and frontier communities.

### Stigma

Stigma continues to be a barrier for individuals seeking out treatment as well as communities adopting harm reduction measures. A social media campaign rolled out in the fall of 2020 to address community wide stigma and treatment awareness will need to be assessed for effectiveness in addressing stigma as a barrier. A new campaign targeting stigma will be released in late 2021 and early 2022 which should be built upon the previous campaign to improve effectiveness. It will include collecting provider testimonials and success stories from the field.[130]

# Identified Gaps

## Lack of Unified Statewide Prevention Programming

The CAST identified housing vouchers and housing assistance for at-risk populations, needle exchanges, transportation funding, employment support, educational support for people in recovery, and parent education and support as critical prevention and recovery needs throughout Nevada.[131] The availability of these resources is not evenly distributed statewide, leading to a gap in care. In addition, there is a lack of prevention programming for adults and youth. Efforts have been made to work with physicians on prevention through education on prescribing patterns. Additional efforts are needed with other populations to make prevention a statewide priority.

## Harm Reduction

Both the CBPR-based qualitative study of 51 individuals and a smaller qualitative study found that some current and former opioid users reported a need for more harm reduction resources throughout the State, especially in areas that promote anonymity and safety such as a safe place to use.[132] They also reported a need for consistent outreach into encampment communities.[133] Harm reduction efforts do exist in Nevada through syringe exchange programs and other initiatives, but they are not consistently available Statewide, during hours people are more likely to use, and in rural areas stigma is a particular concern

[130] Nevada Department of Health Care Finance and Policy, *Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity,* 2021.

[131] Nevada Department of Health and Human Services, Division of Public and Behavioral Health, *Nevada Substance Abuse Prevention and Treatment Agency Capacity Assessment Report: Nevada,* 2019.

[132] Nevada Minority Health and Equity Coalition, School of Public Health, University of Nevada Las Vegas, *Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada,* 2022.

[133] Nevada Public Health Training Center, *Overdose Data to Action (OD2A): Formative research to investigate barriers and facilitators to accessing services among current and former opioid users in Nevada: Report of key findings and recommendations,* 2021.

given smaller communities. Increasing the availability of these programs allows for more dialogue with active users about treatment options and assists in efforts to outreach and lead individuals into the initial stages of change, considering harm reduction and potential treatment interventions. Safe syringe exchange programs also offer the opportunity to educate users on the importance of hand hygiene, cleaning the injection site and keeping the injection site clean following administration. Increasing education regarding the importance of proper hand hygiene and cleanliness will reduce the rates of skin infections, soft tissue infections, and overall disease transmission.

## Access to Treatment

Access to treatment, especially among populations such as pregnant women, homeless people, minority populations, young adults and transition-aged youth continues to be a challenge in Nevada. OTP and OBOT treatments are not widely available in rural and frontier areas, in part because these areas do not have enough individuals to sustain brick-and-mortar programs. Mobile treatment or expanding the hub and spoke model would assist in addressing this gap in access to services.

Lack of identification and referral may be another reason people are not accessing treatment. SBIRT is necessary for ensuring that people are screened for SUDs, and that they either receive a brief intervention on use to prevent the progression to addiction or they receive referral to treatment. Although it is difficult to assess how much screening and referral is occurring in Nevada, Medicaid claims for SBIRT are very low, especially in managed care, indicating a likely underutilization of screening and referral. More screening for SUD would result in more individuals being referred to treatment.

Non-behavioral health providers, such a dentists and primary care providers, could benefit from more education on screening and referral. Lack of knowledge of benefits and treatment options has also been cited as a reason for not pursuing treatment, which indicates a need for a broader campaign of education on SUDs, treatment options, and benefits, such as through a targeted Statewide public education campaign.

Pregnant women have their own unique barriers to accessing treatment such as stigma, a lack of providers willing to treat pregnant women, and pregnant women fearing that seeking treatment will lead to them losing custody of their child due to their substance use.

The CAST additionally identified the category of treatment as the highest shared priority for all regions of the State with emphasis noted regarding the availability of crisis stabilization and outpatient detoxification services, outpatient treatment for individuals with co-occurring disorders, short- and long-term residential treatment, psychiatrists and psychologists as well as OBOTs.

Gaps in current physical health data create a barrier to understanding the physical health conditions opioid users are facing in Nevada. While national disease rates are available, establishing a standardized methodology for monitoring disease rates within the State will allow more targeted interventions to be developed.

Gaps in housing and transportation present a key issue for the homeless population, as a lack of the basic necessities can prevent self-care, both in caring for their own physical health and in mental health and substance use treatment engagement.

While the State is addressing gaps in substance use services related to the need for community-based residential treatment and withdrawal management, implementation is not likely to begin until 2023. Resources may be needed to help with the infrastructure providers will need to create or expand into the new services anticipated to be approved under the 1115 SUD waiver.

There is a gap in treatment programming for young adults and transition age youth, with only one facility for treatment in the State. Adolescent beds certified to treat co-occurring disorders are lacking.

## Crisis Services

Nevada lacks a statewide, comprehensive and consistent, 24/7/365 mobile crisis response system that uses best practices. Although a few teams do exist that could fill this gap (e.g., urban mobile crisis teams for children, EMS co-responder models, and mobile crisis services under CCBHCs), their capacity to respond quickly and robustly to everyone in their local community is limited. Some current in-person crisis teams appear to be underutilized at this time, with low per-month requests for mobile services compared to the size of the population where they are located. If more people took advantage of this resource, the community needs would quickly outstrip the teams' capacities. In areas such as Southern Nevada, where there is no in-person mobile crisis response, resources are needed to set up models that can adequately serve the sparsely populated, but expansive geographic region. As the providers and the State increases education to the community about this resource, providers of mobile crisis may need assistance increasing their own capacity to respond. Additional staff, which are difficult to find due to workforce shortages, training, and adjustment to a "firehouse model" where staff are available 24/7/365 are challenges with which providers are likely to need technical assistance. Reimbursement for current crisis codes is not likely to support this always-available, in-person model.

SB 390 affirmed the State's commitment to expanding their mobile crisis system and included the requirement that peers be an essential part of mobile crisis teams.[134] Therefore, more peers will be necessary to help staff these teams than the State currently has available.

Nevada is currently working on developing and expanding crisis stabilization units, the "somewhere to go" element of the Crisis Now model of comprehensive crisis services. Ensuring that these units can serve individuals with OUDs is essential for rounding out the mobile crisis response system. Urban areas have the infrastructure to expand to the recommended three beds per 100,000 residents likely needed to serve local residents.[135] The Rural, Clark, Southern, and Washoe Behavioral Health Regions lack dedicated acute stabilizations units within a reasonable distance from most residents. Instead, residents are transported long distances to facilities by limited public safety resources (ambulances and flight) at great cost. Nevada calculated that 123 crisis beds are needed to adequately serve the State. Due to the rural and frontier nature of Nevada, they would need to be somewhat geographically distributed.

[134] SB390. Available at: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8095/Text

[135] Nevada Department of Health and Human Services, *Nevada's Crisis Care Response System: 2020 Statewide Assets and Gaps Analysis,* 2020.

## Criminal Justice Programming

Criminal justice programming presents another area of need. Access to MAT and other treatment interventions within the jails and prisons is very limited, and individuals transitioning from incarceration to the community have limited access to treatment or care management in the community. Although progress has been made through drug treatment courts and similar interventions, these opportunities need to become more widespread and available in all criminal detention centers. In addition, working with parole and probation officers to educate them on the need for treatment and recovery would 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 them in the community.

## Proper Discharge Planning and Transition

The CAST identified education on existing resources, and how to access them, treatment access, and sufficient housing as essential to promoting sustained recovery and as part of proper discharge and transition across settings.[136]

Follow-up after crisis is essential for helping individuals to connect to treatment and move toward recovery. This includes follow-up after ED visits and hospital discharges in order to prevent readmissions, as recommended in implementation of the Zero Suicide Model.

## Expansion of Pilot Programs

Many promising pilots have been implemented in Nevada, from syringe exchange vending machines to drug treatment courts, education in the schools, and mobile response providers. Unfortunately, due to the rural and frontier geography of much of the State, some of these pilots have difficulty expanding from more urban areas. Interventions that meet the distinct needs of a more rural population, such as an increase in mobile treatment providers and implementation of the hub and spoke model and telehealth as a delivery modality to increase access in these areas may assist with this issue. Due to the unique geography of the State, many pilots and programming will not be a one size fits all model and will need to be adjusted to reach the maximum number of individuals possible.

## Workforce Shortages

Statewide data on equity and disparity of health care outcomes, especially for SUD, is non-existent. However, given Nevada's population breakdown, including having a large unauthorized immigrant population, minority population representation of about 48%, and the 30% poverty level of AI/AN, health disparities are a significant gap that. If addressed, more detailed data on SUD in these populations could clearly point to effective strategies to better address unmet prevention, treatment and recovery needs. Nevada's Office of Minority Health and Equity was recently awarded funds by DHHS to continue to build health equity, which will need to be based on strong and informative health equity data.

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[136] Nevada Department of Health and Human Services, Division of Public and Behavioral Health, *Nevada Substance Abuse Prevention and Treatment Agency Capacity Assessment Report: Nevada,* 2019.

## Section 6
# Best Practices

In 2017, the John's Hopkins Bloomberg School of Public Health published the report *The Opioid Epidemic, From Evidence to Impact*.[137] This report provides **specific, proven recommendations** as well as resources to combat the opioid epidemic in the most effective way. The report includes 10 key recommendation areas that should serve as the foundation for an entity working to battle the opioid epidemic to ensure intervention design and implementation remain evidence informed.

The 10 key recommendation areas are:

1. Optimizing the PDMP
2. Standardizing Clinical Guidelines
3. Engaging Pharmacy Benefit Managers (PBMs) and Pharmacies
4. Implementing Innovative Engineering Strategies
5. Engaging Patients and General Public
6. Improving Surveillance
7. Treating OUDs
8. Improving Naloxone Access and Use
9. Expanding Harm Reduction
10. Combating Stigma

Throughout the development of this needs assessment report, Mercer has used these recommendation areas as a framework for identifying gaps as well as drive the development of the recommendations in Section 7. Using the identified best practices and key recommendation areas, Mercer was able to produce evidence-informed recommendations as required within the supporting legislation.

## Current Progress

The State has also been working to develop interventions that align with key areas of the John's Hopkins Best Practices. In 2019, the Nevada Public Training Center in partnership with Nevada OD2A, released a summary that included the current efforts being made in Nevada that coincide with the John's Hopkins Bloomberg School of Public Health Recommendations. The information from the report is summary in nature and more detailed information as well as corresponding recommendations are reflected in other sections of this report.

[137]Alexander GC, Frattaroli S, Gielen AC, eds. *The Opioid Epidemic: From Evidence to Impact*. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland: 2017. Available at: https://www.jhsph.edu/events/2017/americas-opioid-epidemic/report/2017-JohnsHopkins-Opioid-digital.pdf

**Table 6.1: 2019 Nevada Public Health Training Center, John's Hopkins Bloomberg School of Public Health Recommendations, Current Efforts in Nevada – Summary**

| Recommendation | Current Efforts |
|---|---|
| **Optimizing the PDMP** | |
| • Mandate prescriber PDMP registration and use. | • Prescription monitoring programs have been in use in Nevada since 1995.<br>• SB 459 (2015) was passed to require prescribers to review a patient utilization report from the PDMP for new patients or new prescriptions that are for more than seven days.<br>• AB 474 revised Nevada statues to require prescribers to register for the PDMP when they receive or renew their controlled substance prescribing license. |
| • Proactively use PDMP data for education and enforcement. | • PDMPs can generate reports (e.g., doctor shopper reports, top RX count prescriber, top pill count prescriber, and top prescriber by drug) to monitor prescribing and report abnormal findings.<br>— Letters are generated quarterly and sent licensing boards. Disciplinary action for inappropriate prescribing includes participating in continuing education. |
| • Authorize third-party payers to access PDMP data with a plan for appropriate use and proper protections. | • While the Nevada Board of Pharmacy shares data with the state Medicaid program, the Board is not able to share PDMP data with health plans or the PBMs. |
| • Empower law enforcement and licensing boards for health professions to investigate high-risk prescribers and dispensers. | • AB 239 (2019) allowed licensing boards to discipline health providers that violate AB 474. |
| • Work with industry and state lawmakers to require improved integration of PDMPs into Electronic Health Records systems. | • Nevada's NV-OD2A program partnered with the Board of Pharmacy to provide optional integration of the PDMP and electronic health records to hospitals. |
| • Engage state health leadership to establish or enhance PDMP access across state lines. | • The State PDMP has interstate partnerships to share data with 34 states as well as 80% of the State's boarding PDMPs. However due to California's data controls, the Nevada PDMP is not able to obtain data from the neighboring state. |
| **Standardizing Clinical Guidelines** | |
| • Work with state medical boards and other stakeholders to enact policies reflecting the | • AB 474/AB 239 (2017) were passed to ensure patients have the opportunity to discuss treatment options with their providers. Also mandates prescribers follow |

| Recommendation | Current Efforts |
|---|---|
| CDC's Guideline for Prescribing Opioids for Chronic Pain. | steps to reduce the risk associated with certain medications and provide alternative options.[138] |
| • Mandate electronic prescribing of opioids. | • AB 310 (2019) mandates electronic prescribing for all controlled substances prescriptions by January 1, 2021.[139] |
| • Standardize metrics for opioid prescriptions. | • AB 474 requires the tracking of prescriptions of more than 30 days through a provider-patient agreement updated yearly to include the goals of treatment, consent to testing for monitoring drug use, requirement to take controlled substances as prescribed, prohibition of sharing medications, requirements for notification of the provider with certain information, authorization for the provider to conduct random counts of the controlled substance, reasons the provider may change treatment. |
| • Improve formulary coverage and reimbursement for non-pharmacologic treatments as well as multidisciplinary and comprehensive pain management models. | • Requires one of Nevada's MCOs to cover psychotherapy, exercises/movement and manual services for non-pharmacological pain management. |
| **Engaging PBMs and Pharmacies** | |
| • Inform and support evaluation research of PBM and pharmacy interventions to address the opioid epidemic. | • While PBMs are currently required to submit transparency reports related to drug rebates for drugs determined to be essential to treating asthma and diabetes, no such requirements exist for opioids. |
| • Continue the development and enhancement of evidence-based criteria to identify individuals at elevated risk for OUDs or overdose and offer additional assistance and care to these patients. | • In 2018, Opioid Stewardship and Safety: A Nevada Provider's Guide was distributed to providers to provide information regarding risk factors of opioid overdose, informed consent, prescription medication agreements, starting and tapering opioid therapy, and existing tools for assessing risk of opioid abuse. The guide also included a Reference Guide for Reproductive Health Complicated by Substance Use and a Reference Guide for Labor and Delivery Complicated by Substance Use. |

[138] AB 474/AB 239 (2017). Available at: https://www.nvopioidresponse.org/wp-content/uploads/2019/04/opioid-compendium-of-resources.pdf

[139] AB310 (2019). Available at: https://nvdoctors.org/wp-content/uploads/AB310-Legislative-Report-.pdf

| Recommendation | Current Efforts |
|---|---|
| • Improve management and oversight of individuals who are prescribed opioids for chronic non-cancer pain. | • In Nevada, health care providers are not licensed by specialty or sub-specialty; therefore, all controlled substance prescriptions are subject to Prescribe 365 regulations and monitored through the PDMP regardless of specialty. |
| • Support restricted recipient (lock-in) programs among select high-risk patient populations. | • Lock in programs are operated under the Nevada MCOs to help avoid potentially harmful overutilization of prescription drugs and help to promote continuity of care. |
| • Improve monitoring of pharmacies, prescribers, and beneficiaries. | • PDMP identifies prescribers with concerning prescribing and sends letters each quarter to the prescribers licensing boards and pharmacies alerting the concerns. |
| **Implementing Innovative Engineering Strategies** | |
| Recommendations in this section are for the FDA and the Pharmaceutical Industry; therefore, not applicable to this report. | |
| **Engaging Patients and the General Public** | |
| • Convene a stakeholder meeting with broad representation to create guidance that will help communities undertake comprehensive approaches that address the supply of, and demand for prescription opioids in their locales; implement and evaluate demonstration projects that model these approaches. | • Multiple stakeholders are meeting at the state and local levels including the Southern Nevada Opioid Accountability Coalition, Washoe County Sheriff's Substance Abuse Taskforce, NV-OD2A, Regional Behavioral Health Policy Boards, SAPTA Advisory Boards, Nevada Opioid Treatment Association, Multidisciplinary Prevention Advisory Council, and the Substance Use Response Group. |
| • Convene an inter-agency task force to assure that current and future national public education campaigns about prescription opioids are informed by the available evidence, and that best practices are shared. | • The CDC Prevention for States funds supported the Rx Awareness campaign *Wake Up Nevada* and the SNHD NV-OD2A project works in collaboration with the Prevention, Advocacy, Choices, and Teamwork (PACT) Coalition on *Back to Life.* |
| • Provide clear and consistent guidance on safe storage of prescription opioids. | • The Office of Suicide Prevention has supported safe storage efforts, but currently there has not been a concerted effort to push out safe storage methods as a harm reduction effort to reduce overdoses. |

| Recommendation | Current Efforts |
|---|---|
| • Provide clear and consistent guidance on safe disposal of prescription opioids and expand take-back programs. | • Grants have supported take-back programs in Nevada while coalitions continue DEA take-backs twice a year with separate funding. Coalitions also provide training on safe disposal of medications to parents, school officials, health nurses, senior citizens, funeral homes, and hospice programs through partnerships with the Rx Abuse Leadership Initiative retail chain pharmacies. SOR funds are also used to purchase prescription medication drop boxes for tribal organizations. |
| **Improving Surveillance** | |
| Note: Detailed information regarding opportunities to improve data collection and reporting standardization, availability, and robustness are included at Section 3 of this report regarding Opioid Impact. Information excerpted below from the Nevada Public Health Training Center, John's Hopkins Bloomberg School of Public Health Recommendations, Current Efforts in Nevada – Summary. NV-OD2A does not include the same level of detail. | |
| • Invest in surveillance of opioid misuse and use disorders, including information about supply sources. | • Currently the NV-OD2A program and the Office of the Attorney Generals are working to increase the frequency of overdose data shared with stakeholders. However, at this time there are no public health efforts seeking to collect source data. The NV-OD2A program is working to obtain the seizure data from HIDTA and increase system capacity for surveillance sample testing. |
| • Develop and invest in real-time surveillance of fatal and non-fatal opioid overdose events. | • The NV-OD2A is working to create a centralized analysis and reporting hub for overdose data. Currently NV-OD2A is using ODMAP ImageTrend, Monthly Vital Records, Center for Health Information Analysis at UNLV, and Syndromic Surveillance. Additionally, the program is working with the State Coroner/Medical Examiners to develop reporting for suspected overdoses.<br>• SNHD is also participating and purchased software to house a repository of data for EMS and hospitals. |
| • Use federal funding for interventions to address opioid-use disorders to incentivize inclusion of outcome data in those funded programs | • Outcome data must be reported to Substance Abuse and Mental Health Services Administration by organizations supported by SOR and SOR II funds. Outcome data includes abstinence, criminal justice involvement, employment/education, health/behavioral/social consequences, social connectedness, and stability in housing. |
| • Support the linkage of public health, health care, and criminal justice data related to the opioid epidemic. | • Formal data sharing is limited with public health programs and primarily limited to the Office of Analytics. NV-OD2A is working to review data sharing between public safety and public health entities regarding how local jails collect/save/share data related to SUD. |

| Recommendation | Current Efforts |
|---|---|
| **Treating OUDs** | |
| Some recommendations were at the federal level; therefore, not included in this report. | |
| • Require all state-licensed addiction treatment programs that admit patients with OUDs to permit access to buprenorphine or methadone. | • In 2017, the Division Criteria for the Certification of Programs through SAPTA per NAC 458 states that Certified treatment programs, private, public or funded **cannot deny** treatment services to clients that are on stable medication maintenance for the treatment of an OUD including FDA approved medications. |
| • Require all Federally Qualified Health Centers (FQHCs) to offer buprenorphine. | • SOR grants currently fund the Nevada Primary Care Association to expand MAT within FQHCs that are interested. All Certified Community Behavioral Health Clinic are required to provide FDA-approved MAT. |
| • Develop and disseminate a public education campaign about the role of treatment in addressing opioid addiction. | • There have been information and educational campaigns developed and deployed in Nevada over the last 10 years. |
| • Educate prescribers and pharmacists how to prevent, identify, and treat opioid addiction. | SOR/State Targeted Response (STR) has held provider education/academic detailing as well as health care provider training. Project Echo offered clinics on MAT biweekly. The University of Nevada School of Medicine Continuing Medical Education designed and recorded online trainings. SBIRT began an STR initiative that provides key resources to assist organizations to promote, prepare, adopt, and implement SBIRT in 2018. |
| • Establish access to opioid agonist treatment with buprenorphine and methadone maintenance in jails and prisons. | • Few jails currently participate in a naloxone program. Only two prisons provide access to MAT through outside agencies. Only one county jail provides induction and maintenance in MAT. |
| • Incentivize initiation of buprenorphine in the ED and during hospital stays. | • Currently, SOR funded staff are working to discuss induction programs about implementation with the director of Nevada's induction program. |
| **Improving Naloxone Access And Use** | |
| Some recommendations were at the federal level: therefore, not included in this report. | |
| • Work with insurers and other third-party payers to ensure coverage of naloxone products. | • Naloxone is currently available without a prescription and community-based organizations are able to distribute naloxone for free. Nevada Medication FFS and MCOs cover a majority of FDA-Approved medications. |

| Recommendation | Current Efforts |
|---|---|
| • Work with community-based overdose education and naloxone distribution programs to identify stable funding sources to ensure program sustainability. | • Currently, all naloxone is purchased through federal grants. Sustainable Community-based organization distribution has been established. |
| • Engage with the scientific community to assess the research needs related to naloxone distribution evaluations and identify high priority future directions for naloxone-related research. | • Some naloxone distribution programs have been evaluated by researchers at the University of Nevada, School of Community Health Sciences. |
| • Engage with the health care professional community to advance consensus guidelines on the co-prescription of naloxone. | • In 2018, the Naloxone for Opioid Safety: *A Providers Guide to Prescribing Naloxone* was developed and includes discussion on naloxone prescribing were integrated into trainings on AB 474 in 2017 and 2018. |
| • Assess the effects of state laws expanding naloxone access to the general public. | • Data for naloxone distribution has been collected through SOR/STR funded programs to understand the Good Samaritan law and whom naloxone is being distributed to. |
| **Expanding Harm Reduction Strategies** | |
| • Establish and evaluate supervised consumption spaces. | • A bill was brought forward during the 2021 legislative session regarding safe injection, but did not move out of the first house committee. |
| • Work with state and local stakeholders to establish and support needle and SSPs. | • In 2013, SSPs were enacted, which two serve Nevada's Urban Centers through mobile and storefront exchange, Trac B and Change Point. SNHD supports Trac B on efforts including vending expansion and technical assistance for other jurisdictions to implement public health vending, collaboration on outreach, rural expansion of harm reduction initiatives, linkage to care and peer support services, and alliance work but does not fund the purchase of syringes. |
| • Evaluate and disseminate the use of test kits for fentanyl-laced opioids. | • Trac B supports fentanyl test strip distribution and identified policy issues that are being addressed, so Nevada can expand future fentanyl test strip work. |
| **Combating Stigma** | |
| • Update employer human resources and benefits language to avoid stigmatizing | • In 2018, a recovery friendly workplace initiative began to promote individual wellness by creating work environments that support mental and physical |

| Recommendation | Current Efforts |
|---|---|
| language and include evidence about the effectiveness of treatment for OUDs. | wellbeing of employees, prevent substance misuse and support recovery from addition. |
| • Avoid stigmatizing language and include information about the effectiveness of treatment and the structural barriers that exist to treatment when communicating with the public about OUDs. | • SOR program supported a campaign to reduce stigma by increasing awareness about addiction being a disease. NV-OD2A also partnered with Nevada Broadcasters Association to launch an anti-stigma campaign. |
| • Educate health care providers about the benefits associated with destigmatizing language. | • Three guides for health care providers discussing de-stigmatization language as well as SNHD providing Harm Reduction 101 and Drug Related Stigma training to public health workforce and other related organizations |

## Stakeholder Priorities for Johns Hopkins Recommendations

In July 2021, Nevada OD2A hosted a meeting discussing the priorities for action. Information was gathered from over 50 stakeholders representing regions, community coalitions, juvenile services, hospitals, law enforcement, service providers, medical examiners, analytics, human services, public health, Office of the Attorney General, tribes, coroner's office, pharmacies, and others to determine the highest priority areas needing to be addressed within the State based on 9 of the 10 Johns Hopkins Best Practices recommendation areas.[140]

Survey results from the 50 participating stakeholders were as follows:

- Priority Sections
  - When asked what the *primary* priority section of the best practice recommendations Johns Hopkins Opioid Report for the State to focus efforts the top three results included: Treating OUDs (20%), Expanding Harm Reduction (20%), and Engaging Patients and General Public (16%).
  - When asked what the *secondary* priority section of the Johns Hopkins Opioid Report for the State to focus efforts the top three results included: Treating OUDs (27%), Expanding Harm Reduction (22%), and Combating Stigma (13%).
- Priority Strategies
  - When asked what the *primary* priority strategy the State should pursue the top four results included: Expansion of Harm Reduction Strategies – Specifically Syringe, Naloxone, and Fentanyl Test Strip Distribution (32%), Increasing Treatment Capacity, Expansion of Recovery Programs, Address Social Determinants of Health, and Expanded Primary Prevention and Youth Education (13%).
  - When asked what the *secondary* priority strategy the State should pursue the top four results included: Expansion of Harm Reduction Strategies – Specifically Syringe, Naloxone, and Fentanyl Test Strip Distribution (24%), Increasing Treatment Capacity, Address Social Determinants of Health, and Expanded Primary Prevention (15%).

When results are combined, the top priorities based on the Johns Hopkins Best Practices include Treating OUDs, Expanding Harm Reduction, Engaging Patients and General Public, and Combating Stigma. The top strategies based on the Johns Hopkins Best Practices include Expansion of Harm Reduction Strategies – Specifically Syringe, Naloxone, and Fentanyl Test Strip Distribution, Increasing Treatment Capacity, Expansion of Recovery Programs, Address Social Determinants of Health, and Expanded Primary Prevention and Youth Education.

The next section of this report includes recommendations that fall within these identified priority sections as well as include the priority strategies identified by the stakeholders and as well as in alignment with Johns Hopkins Best Practices.

[140] List of survey options was limited to state effort areas. The Best Practice area of "Implementing Innovative Engineering Strategies" was not included as a survey choice due to it focusing on efforts at the federal level.

# Appendix A
# Seminal Documents

Below is a list of the seminal documents that were provided to Mercer for use to develop this report.

- 2018 & 2020 Nevada Behavioral Risk Factor Surveillance System (BRFSS) Adverse Childhood Experiences (ACEs) Special Report
- 2019 Nevada High School Youth Risk Behavior Survey (YRBS) Adverse Childhood Experiences (ACEs) Special Report
- 2019 Nevada Middle School Youth Risk Behavior Survey (YRBS) Adverse Childhood Experiences (ACEs) Special Report
- 2020 Clark County Community Perceptions of Drug Use & Harm Reduction Survey Report
- Adverse Childhood Experiences Special Report
- Assembly Bill No. 239 – 2019 80th Session (Nev. 2019)
- Assembly Bill 474 – 2017 79th Session (Nev. 2017)
- Coordination Task Force 2022 Operational & Planning Framework
- Comprehensive Community Substance Abuse Prevention Plan 2020–2021
- Department of Health and Human Services Office of Analytics Neonatal Data Report
- Forensic Toxicology and Nevada's Overdose Surveillance System Needs Assessment
- Formative Research to Investigate Barriers & Facilitators to Accessing Services Among Current & Former Opioid Users in Nevada Report
- Nevada High Intensity Drug Trafficking Area 2021 Threat Assessment
- Nevada Perinatal Health Initiative & SUPPORT Act
- Nevada Public Health Crisis Response
- Nevada State Opioid Response Grant II 2019 Annual Report
- Nevada's Crisis Care Response System 2020 Statewide Assets and Gaps Analysis
- Nevada Substance Abuse Prevention & Treatment Agency Capacity Assessment Report
- Nevada Substance Use Disorder Data Book October 2019 – March 2021
- Nevada Substance Use Disorder & Opioid Use Disorder Treatment and Recovery Services Provider Capacity Expansion Strategic Plan
- Nevada Vulnerability Assessment January 2020

- Nevada's Sustainability Plan to Support Expansion of SUD & OUD Treatment & Recovery Provider Capacity
- NV-OD2A Reports:
  - 2020 Hispanic/Latinx Overdose
  - Nevada's Overdose Landscape Presentations July 7, 2021
  - Nevada State Unintentional Drug Overdose Reporting System Polysubstance Trend Report 2018–2019 – Statewide
  - Nevada State Unintentional Drug Overdose Reporting System Report of 2020 Deaths – Northern Nevada
  - Nevada State Unintentional Drug Overdose Reporting System Report of 2020 Deaths – Southern Nevada
  - Nevada State Unintentional Drug Overdose Reporting System Report of Deaths 2019 to 2020 Statewide
  - Nevada State Unintentional Drug Overdose Reporting System Northern and Southern Regional Report
  - Suspected Nevada Drug Overdose Surveillance Monthly Report – October 2021: Statewide Report
  - Suspected Nevada Drug Overdose Surveillance Quarterly Report – Quarter 2 (April 2021 to June 2021)
  - NV-OD2A Nevada Department of Health and Human Services Year 2 Annual Progress Report
- Opioid Response Summit Final Report August 2019
- ODMAP Report by Nevada Counties
- Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report
- Women of Childbearing Age Overdose Data Presentation
- Senate Bill 5 – 2021 81st Session (Nev. 2021)
- Senate Bill 40 – 2021 81st Session (Nev. 2021)
- Statewide Epidemiology Organization (SEOW) Workgroup DRAFT MEETING MINUTES
- Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report

# Appendix B
# Additional Data

## Adverse ACEs Data

### 2019 Nevada Middle School YRBS ACEs Special Report

A random sample of 5,341 youth from 113 schools completed the survey.

| | Response | Total | Percent |
|---|---|---|---|
| **Ever physically forced to have sex** | Yes | 254 | 4.6% |
| | No | 4,965 | 95.4% |
| **Ever been hit, beaten, kicked, or physically hurt in any way by an adult** | Yes | 738 | 13.1% |
| | No | 4,517 | 86.9% |
| **Sometimes, mostly, or always have been sworn at, insulted by, or put down by an adult** | Yes | 1,749 | 34.3% |
| | No | 3,438 | 65.7% |
| **Ever seen adults in their home slap, hit, kick, punch, or beat each other up** | Yes | 886 | 16.2% |
| | No | 4,356 | 83.8% |
| **Ever lived with someone who was depressed, mentally ill, or suicidal** | Yes | 1,269 | 22.2% |
| | No | 3,915 | 77.8% |
| **Ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs** | Yes | 1,298 | 23.2% |
| | No | 3,984 | 76.8% |
| **ACE Score** | 0 | 2,345 | 44.4% |
| | 1 | 1,258 | 24.8% |
| | 2 | 813 | 15.9% |
| | 3+ | 889 | 15.0% |
| **Total** | | **5,341** | **100%** |

## 2019 Nevada Middle School YRBS ACEs Special Report

| | Response | Total | Percent |
|---|---|---|---|
| **Ever physically forced to have sex** | Yes | 363 | 6.2% |
| | No | 4488 | 93.8% |
| **Ever been hit, beaten, kicked, or physically hurt in any way by an adult** | Yes | 941 | 18.7% |
| | No | 3930 | 81.3% |
| **Sometimes, mostly, or always have been sworn at, insulted by, or put down by an adult** | Yes | 1677 | 34.5% |
| | No | 3243 | 65.5% |
| **Ever seen adults in their home slap, hit, kick, punch, or beat each other up** | Yes | 892 | 18.2% |
| | No | 3988 | 81.8% |
| **Ever lived with someone who was depressed, mentally ill, or suicidal** | Yes | 1502 | 30.5% |
| | No | 3200 | 69.5% |
| **Ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs** | Yes | 1636 | 33.3% |
| | No | 3058 | 66.7% |
| **ACE Score** | 0 | 1765 | 35.9% |
| | 1 | 1233 | 26.1% |
| | 2 | 858 | 17.2% |
| | 3+ | 1083 | 20.8% |
| **Total** | | **4,939** | **100%** |

## 2018 and 2020 Nevada BRFSS ACEs Special Report

| ACE Category | Question | Response | Total | Percent |
|---|---|---|---|---|
| **Physical Abuse** | Did a parent or adult in your home beat, kick, or physically hurt you in ever hit, any way? | Yes | 1,084 | 23.8% |
| | | No | 3,375 | 76.2% |
| **Emotional Abuse** | Did a parent or adult in your home ever sweat at you, insult you, or put you down? | Yes | 1,447 | 31.2% |
| | | No | 2,990 | 68.8% |
| **Sexual Abuse** | | Yes | | |
| | | No | | |
| **Household Mental Illness** | Did you live with anyone who was depressed, mentally ill, or suicidal? | Yes | 860 | 17.9% |
| | | No | 3593 | 82.1% |
| **Household Substance Use** | | Yes | | |
| | | No | | |
| **Household Domestic Violence** | Did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up? | Yes | 901 | 21.4% |
| | | No | 3,520 | 78.6% |
| **Incarcerated Household Member** | Did you live with anyone who served time or was sentenced to service time in a prison, jail, or other correctional facility? | Yes | 415 | 10.3% |
| | | No | 4,080 | 89.7% |
| **Parental Separation or Divorce** | Were your parents separated or divorced? | Yes | 1,505 | 34.8% |
| | | No | 2,976 | 65.2% |
| **ACE Score** | | 0 | 1,496 | 34.0% |
| | | 1–2 | 1,629 | 36.1% |
| | | 3+ | 1,393 | 29.9% |

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