DEPARTMENT OF HEALTH AND HUMAN SERVICES

Biennial Report of the

Advisory Committee for a Resilient Nevada (ACRN)

2022

Report Date June 30, 2022

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

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

Advisory Committee for a Resilient Nevada

Working Group Members

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

Non-Member Roles

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

Administrative Support Provided by Mercer Health Partners: Dr. Courtney Cantrell…

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Introduction and Background

Context

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

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

Roles and Responsibilities

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

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

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

Appointments were made final in October 2021. Term dates are October 1, 2021, through September 30, 2023. Members are eligible to serve through 2025. The first meeting was convened on October 5, 2021. The ACRN has met 6 times in compliance with Nevada's Open Meeting Law. They have had presentations and guidance on their roles/responsibilities in relation to the legislation, processes, health equity lens and choice points, needs assessment which included gaps and the objective tool. Each meeting has included opportunity for comment from the public. ACRN bylaws are included in appendix 2.

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

Legislative Language

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

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

1. The statewide needs assessment including without limitation the establishment of priorities as it relates to information and analyses described below. Priorities must include, without limitation, priorities

related to the prevention of overdoses, addressing disparities in access to health care and the prevention of substance use among youth.

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

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

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

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

And

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

Department and the Office shall consider:

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

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

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

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

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

The statewide plan to allocate money from the Fund includes an analysis of the impacts of opioid use and opioid use disorder on this State that uses quantitative and qualitative data concerning this State and the regions, counties, and Native American tribes in this State to determine the risk factors that contribute to

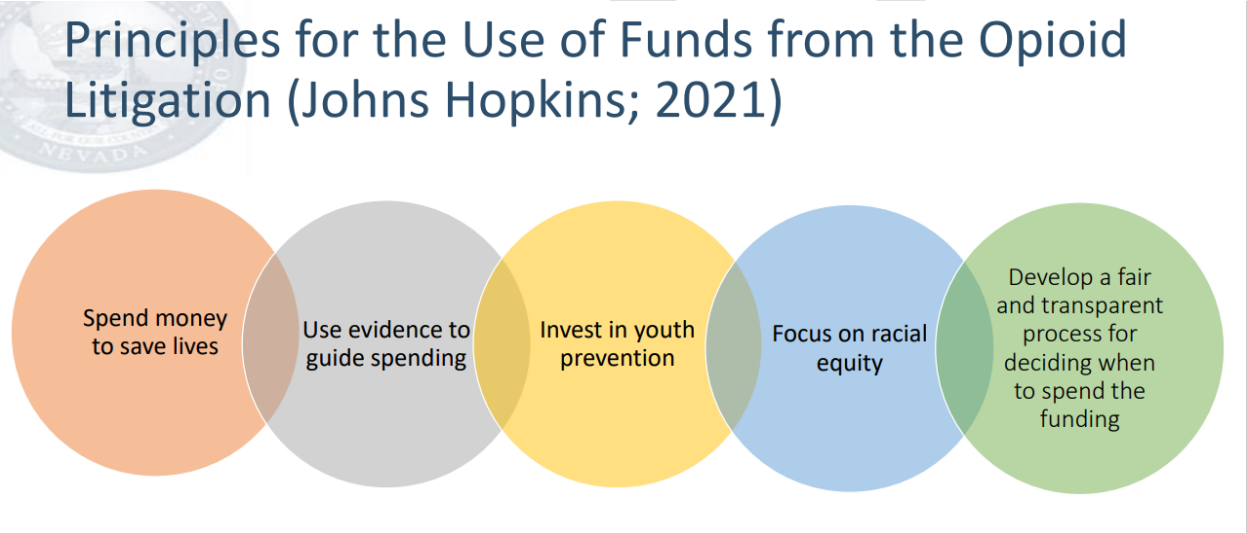
opioid use, the use of substances and the rates of opioid use disorder, other substance use disorders and co-occurring disorders among residents of this State.

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

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

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

The following principals guided prioritization:



Principal #1: Spend money to save lives

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

Principle #2: Use evidence to guide spending

1. Expanding access to evidence-based prevention of substance use disorders (SUDS), early intervention for persons at risk of a substance use disorder, treatment for substance use disorders and support for persons in recovery from substance use disorders.
2. Programs to reduce the incidence and severity of neonatal abstinence syndrome.

3. Prevention of adverse childhood experiences and early intervention for children who have undergone adverse childhood experiences and the families of such children.
4. Services to reduce the harm caused by substance use.
5. Prevention and treatment of infectious diseases in persons with substance use disorders.
6. Services for children and other persons in a behavioral health crisis and the families of such persons.
7. Housing for persons who have or are in recovery from substance use disorders.
8. Campaigns to educate and increase awareness of the public concerning substance use and substance use disorders.
9. Programs for persons involved in the criminal justice or juvenile justice system and the families of such persons, including, without limitation, programs that are administered by courts.
10. The evaluation of existing programs relating to substance use and substance use disorders.
11. Development of the workforce of providers of services relating to substance use and substance use disorders.
12. The collection and analysis of data relating to substance use and substance use disorders.
13. Capital projects relating to substance use and substance use disorders, including, without limitation, construction, purchasing and remodeling; and
14. Implementing the hotline for persons who are considering suicide or otherwise in a behavioral health crisis and providing services to persons who access that hotline in accordance with SB390

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

Principle #3: Invest in youth prevention

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

Principle #4: Focus on racial equity

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

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

The role of the Committee includes advising the DHHS on the needs assessment, prioritization, and state plan for the allocation of funding. All Committee meetings are public meetings and offer opportunities for public input which includes the needs assessment, prioritization and state plan development and will also include input and feedback from the community. Reports concerning all findings, recommendations, and funding under this bill must be created by the Department and the Advisory committee and delivered to the Legislature, Governor, Attorney General, and other agencies as well as the public.

Needs Assessment

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

Gaps

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

Overdoses (Infers Gaps)

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

Data

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

Prevention

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

Treatment

- Generally -- treatment in rural areas
- Treatment availability was the most significant and immediate need according to the June 2019 system-wide assessment using the CAST
- National data suggests significant disparities for ethnic/minority youth
- Expansion of peer support throughout treatment
- While overdoses for Blacks in 2020 were 14% and for Hispanics were 19%, white were 64% and 2.5% were Asian, in comparison Medicaid data shows that of those Medicaid members receiving OUD services, 84% were white, 9% black, 1% AI/AN, and 15% Hispanic; in 2018, a report noted that within Medicaid, the racial breakdown was 33% were Latino, 21% African American, and 36% Caucasian (GUINN Center.org "Nevada's Medicaid Population"); this is not an ideal comparison because it is from different sources, but it points to equity issues; national study found Alcoholics Anonymous (AA) and Latino youth report less information care and treatment episode data set (TEDS) data found that minority adults are less likely to seek treatment

- Lack of community-based accessible resources post-release from the justice system
- Treatment access for pregnant women (providers willing to prescribe, stigma)
- Drug courts and treatment and housing services are not available statewide
- National studies identified a gap for youth in the juvenile justice system
- Co-Occurring
- Providers certified for treating co-occurring disorders, especially for youth
- Mental health treatment (ranked almost last in the nation for access for youth

Outpatient:

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

Discharge/Recovery Support

- Funding/insurance for lack long-term care for recovery (UNLV)
- Limited duration of treatment

- Better discharge planning and communication between levels of care, incorporating social determinants of Health (SDOH) elements
- Better coordination
- Need programs for the justice system post-release, including Medicaid access
- CAST: Religious or spiritual advisors/faith-based orgs, 12-step groups in more rural areas
- Statewide: educational support, parenting education, health insurance
- Education on maintaining recovery
- Recovery centers (UNLV)

Harm Reduction

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

Workforce

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

Social Determinants of Health

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

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

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

Scoring Matrix/Objective Tool

Mercer used a Likert rating scale to assign a value to each of the recommendations included within this report. The priority rating reflects Mercer's evaluation of the potential impact of the recommendation, as

well as urgency and feasibility. Recommendation topics that were prioritized in legislation for purposes of this needs assessment are identified through a Target rating.

Scoring Definitions

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

Impact

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

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

1	2	3	4	5
Low		Moderate		High

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

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

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

1	2	3	4	5
Low		Moderate		High

Low = Minimal impact to health/safety/daily life

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

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

1	2	3	4	5
Low		Moderate		High

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

High = Recommendation is focused on alleviating disparities/promoting equity

Urgency

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

1. *Availability of alternatives*

1	2	3	4	5
Low		Moderate		High

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

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

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

1	2	3	4	5
Low		Moderate		High

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

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

Feasibility

Feasibility was assigned based on:

1. *Current infrastructure*

1	2	3	4	5
Low		Moderate		High

Low = Infrastructure does not currently exist

High = Existing infrastructure can support recommendation implementation

2. *Ease of implementation (effort)*

1	2	3	4	5
Low		Moderate		High

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

High = Minimal effort required for implementation, easy to implement

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

1	2	3	4	5
Low		Moderate		High

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

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

Target

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

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

Legislative Target Area	Score
Yes	3
No	0

Recommendations are scored for both system- and individual-level priorities, and in some cases a single recommendation can be categorized as both system- and 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.

Ranked and Prioritized Recommendations

Based on the rankings for the recommendations provided by the needs assessment and individual members of the ACRN, they voted and approved to include the following in this report to the director, listed in priority:

(ENTER VOTED ON AND APPROVED LIST)

Public Comment

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

- Use current best practices and include more primary prevention
- Recovery is not mentioned enough (enhance recovery services)
- Discuss the acute situation—the opioid epidemic that is killing people at an alarming rate
- Approach that acute problem with treatment, long-term case management, and housing

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

- Acute care includes detoxification (detox); supportive care includes inpatient services; long-term care requires case management and housing; supportive neighborhoods include employment and community centers with activities
- More is needed to support education and stigma
- Recommendations regarding harm reduction could be activated quickly to affect change
- With youth in crisis now, secondary prevention should be supported as much as primary prevention. Secondary prevention includes screenings, drug testing, and mental health assessments
- "There are organizations and individuals throughout the state who have been working for years and years and years in this community and have proven their worth. Why aren't they just given some operating money instead of paying for themselves and/or begging individuals?"
- Money disbursed to assist those who are no longer with us and those who were there with them (Victim Compensation)
- Leveraging infrastructure to address individual-level risk factors for OUD including social determinants of health and co-occurring physical and behavioral health conditions and to track progress on addressing racial, ethnic, and other disparities related to addiction
- Many individuals with OUD have needs including housing, transportation, employment, and food insecurity that intersect with their addiction and make engaging in treatment difficult
- Effective recovery support system which includes a robust network of community partners and the infrastructure in place to support personalized, coordinated care
- Acknowledge, measure, and commit to address disparities including differences in access to treatment and fatal overdose rates across racial, ethnic, and other groups
- Not just expanding treatment and wrap-around support, but also tracking to ensure that expanded services improve outcomes for the most disadvantaged and vulnerable groups
- Consider tools that increase access to health and social care and coordination of services
- Establish infrastructure that can help address the broader health and social conditions contributing to the epidemic and improve health equity across the state
- Alternative pain management

Appendix 1– Staff Biographies

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

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

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

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

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

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

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

resources, and outreach for pregnant, postpartum/parenting, and nonpregnant women of reproductive age with substance use disorder.

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

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

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

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

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

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

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

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

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

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

Appendix 2- Bylaws

ADVISORY COMMITTEE FOR A RESILIENT NEVADA BY-

LAWS

ARTICLE I –
NAME

Section 1. Name.

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

ARTICLE II – CREATION & PURPOSE

Section 1. Creation.

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

Section 2. Purpose.

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

ARTICLE III – ROLES & RESPONSIBILITIES

Section 1. Responsibilities.

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

A. The Committee shall provide recommendations on the development of the statewide plan. Input to the Committee may include, without limitation, representatives of federal, state, and local agencies, providers of services, religious organizations, persons involved in the providing or receiving substance use disorder services and member of the public.

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

Section 2. Committee Support.

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

Section 3. Public Collaboration.

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

Section 4. Reporting to the Director.

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

Section 5. Department Responsibilities for Reporting.

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

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

ARTICLE IV – MEMBERSHIP & TERMS

Section 1. Members.

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

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

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

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

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

Section 2. Term.

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

Section 3. Compensation.

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

Section 4. Vacancies.

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

Section 5. Resignation.

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

Section 6. Removal.

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

Section 7. Administrative Support.

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

ARTICLE V – MEETINGS

Section 1. Open Meeting Law.

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

Section 2. Quorum.

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

Section 3. Regular Meetings.

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

Section 4. Officers.

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

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

    1. Shall develop the agenda, with input from the Committee membership and the Grants Management Unit;
    2. Shall conduct the Committee meetings in accordance with state laws;
    3. Shall oversee public hearings and ensure public comment;
    4. Shall convene special meetings, as necessary; and
    5. Shall prepare reports as required.

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

C. Committee Secretary.

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

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

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

Section 5. Committee Participation.

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

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

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

Section 6. Subcommittees.

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

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

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

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

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

Section 7. Special Meetings.

Special meetings may be called by the Chair. A request for a special meeting can also be made by other

Committee members through a written request submitted to the Chair for approval or the Director can call a special meeting.

Section 8. Voting.

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

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

Section 9. Record Keeping.

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

ARTICLE VI - FISCAL SUPPORT

Section 1. Grants and Gifts.

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

Section 2. Application support.

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

ARTICLE VII - CONFLICT OF INTEREST

Section 1. Survey.

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

A. Conflicts of interest must be declared by members prior to discussion of any matter that would provide direct financial benefit for that member, or otherwise have the appearance of a conflict of interest. When funding or other decisions are made regarding an organization with which

the member has an affiliation, the member shall state his intention to abstain from making specific motions or casting a vote, before participating in related discussions.

Section 2. Declaration of Conflict.

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

ARTICLE VIII - STATEMENT OF NON-DISCRIMINATION

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

ARTICLE IX - REVISION OF BYLAWS

Section 1. Bylaw Review.

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

Section 2. Bylaw Approval.

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

David Sanchez
Chair, Advisory Committee for a Resilient Nevada

10/14/2021
Date

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